

Staff Findings
and Recommendations: Part II

Adolescent Health
in Connecticut:
RBA Project 2011

February 22, 2012

Legislative Program Review
& Investigations Committee

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

The Legislative Program Review and Investigations Committee is a bipartisan statutory committee of the Connecticut General Assembly. It was established in 1972 to evaluate the efficiency, effectiveness, and statutory compliance of selected state agencies and programs, recommending remedies where needed. In 1975, the General Assembly expanded the committee's function to include investigations, and during the 1977 session added responsibility for "sunset" (automatic program termination) performance reviews. The committee was given authority to raise and report bills in 1985.

The program review committee is composed of 12 members. The president pro tempore of the Senate, the Senate minority leader, the speaker of the house, and the House minority leader each appoint three members.

2011-2012 Committee Members

Senate

John W. Fonfara
Co-Chair

Steve Cassano
Eric D. Coleman
Anthony Guglielmo
John A. Kissel
Joe Markley

House

T. R. Rowe
Co-Chair

Brian Becker
Marilyn Giuliano
Mary M. Mushinsky
Selim G. Noujaim
Diana S. Urban

Committee Staff

Carrie E. Vibert, Director
Catherine M. Conlin, Chief Analyst
Jill E. Jensen, Chief Analyst
Brian R. Beisel, Principal Analyst
Michelle Castillo, Principal Analyst
Maryellen Duffy, Principal Analyst
Miriam P. Kluger, Principal Analyst
Scott M. Simoneau, Principal Analyst
Janelle Stevens, Associate Legislative Analyst
Eric Michael Gray, Legislative Analyst II
Bonnine T. Labbadia, Executive Secretary

Project Staff

Jill Jensen
Brian Beisel

Adolescent Health in Connecticut: Part II

In March 2011, the Legislative Program Review and Investigations Committee authorized its staff to conduct an assessment of state-supported health care for adolescents, using the principles of results-based accountability (RBA). The study focused on evaluating how physical, behavioral, and oral health care services provided with state resources, including Medicaid and the state's Children's Health Insurance Program (CHIP), are meeting the needs of Connecticut youth ages 10 to 19.

To keep the scope manageable, and still allow for examination of a comprehensive cross-section of adolescent health services and issues, the in-depth performance evaluation portion of the study concentrated on two major program areas: state-funded school-based health centers (SBHCs); and primary and preventive reproductive health services. The study also included a review of the extent of parental involvement in health care for adolescents in Connecticut and a comparison with practices followed in other states and cited in national research. The scope did not include development of any staff proposals concerning state policy on parental involvement regarding the medical treatment of adolescents who are minors. (The RBA framework developed by committee staff to guide the study research process is provided in Appendix A.)

This report, Part II Staff Findings and Recommendations, is the last of a series of RBA products developed by the staff throughout the study. It provides information and analysis in the form of two program performance report cards: one for school-based health centers and one for selected state-funded teen reproductive health services. Each program report card contains PRI staff proposals for low- and no-cost ways to improve efficiency and achieve better outcomes for the adolescents who use state supported health care services. Part II also contains program review committee staff recommendations for addressing several overarching adolescent health issues identified in the Part I staff findings report presented in December 2011.

Overall, the committee staff found adolescent health, because it is a large and complex area, involves many agencies, systems and programs. While Connecticut compares well on most key indicators, the state system is fragmented. A concerted effort to address barriers to better health outcomes for all adolescents is lacking. Staff identified several ways to strengthen the overall system through more effective coordination and planning, leadership, and improved data and data analysis. Greater statewide attention to making care accessible to and used by adolescents also is recommended.

Information about SBHCs and teen reproductive health services developed by PRI staff indicates they have been successful in making essential primary and preventive care accessible to adolescents, particularly those who are uninsured or underinsured, and low-income. However, committee staff identified several ways to improve these two critical system components for the most at risk teens in the state.

A more streamlined reporting and management information system at the Department of Public Health is recommended to permit fuller evaluation, based on targeted measures, of school-based health center performance, in improving health outcomes for the students served. The department also needs to refocus its SBHC grant allocation process on actual center results, and more clearly use (and summarize) SBHC performance for program administration purposes. Staff recommendations regarding teen reproductive health services are aimed at better coordination and integration of state efforts to prevent unintended pregnancies and sexually transmitted diseases and promote positive development across the adolescent population.

It became clear to committee staff as a result of this study 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 programs currently funded are: 1) helping to reduce disparities; and 2) cost-effective approaches for achieving good health outcomes for all adolescents. Taken together, the committee staff recommendations presented in this report can be a solid foundation for achieving better health results for all Connecticut youth and ensuring more effective investment of state adolescent health care resources.

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 also was 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, and Norwich, 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).

Following the forum and hearing, PRI staff had additional 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. The public health department also assisted committee staff with organizing the school-based health center data.

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.¹

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.

¹ 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, use other age categories. The age of a minor 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.² Also, much of the national survey data is based on parent-reported information gathered through telephone surveys. Finally, in Connecticut and probably other states, agency resources for data collection or analysis are very limited.

Report Organization

This report contains three sections. The first section contains several overarching recommendations committee staff believe will help the state make better progress toward desired health results for the entire Connecticut adolescent population. The recommendations follow up on the findings presented in the December report concerning: coordination and leadership for adolescent health; primary and preventive care access and utilization; and adequate data. A summary of the state-by-state parental involvement information developed by PRI staff also is provided in Section I, including how Connecticut compares to its surrounding states.

RBA report cards for the two adolescent health programs examined in detail as part of this study – state-funded school-based health centers and selected teen reproductive health services – are presented in Sections II and III. Over the past few years, PRI staff has developed a report card format to present performance information developed through its RBA program evaluation process. Under the results-based accountability approach, three main types of data are collected and analyzed to assess program-level performance. RBA measures of program accountability include:

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

² 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.

An RBA program evaluation uses information compiled to answer the main performance questions 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.

[Blank Page]

I. Overarching Issues

Achieving Better Adolescent Health Results

Overall health outcomes for Connecticut adolescents compare well with the national data for nearly all key indicators. According to the committee staff findings on population level results presented in the December 2011 (Part I) report for this study:

- Teen fatality and birth rates in Connecticut are among the lowest in the country.
- The portion of the state adolescent population that is overweight or obese is below the U.S. average.
- 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.
- A majority of those under age 18 in this state, and a higher portion than nationally, have had some preventive dental care, although comparative state-level data about teen oral health are limited at this time.

At the same time, teen fatality and birth rates in Connecticut vary substantially by race and ethnicity, as do rates of adolescent depression. Disparities in high school student obesity rates by gender and race/ethnicity also are large. There has been good progress in reducing cigarette smoking among teens and young adults in this state, but improvement in rates of binge drinking and illicit drug use among adolescents seems stalled.³

While findings in the December staff report showed Connecticut is one the top-ranked states for child and adolescent health system performance, there also 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. Making primary and preventive care, especially behavioral and reproductive health services, available to and used by low-income and minority youth also must be a priority.

Many elements regarded as critical for achieving good health outcomes for teens are in place in this state. However, PRI staff also found system weaknesses centered round: coordination and leadership; access and utilization; and adequate data for planning and accountability. Deficiencies in these overarching areas have been issues identified by previous studies and they continue to be obstacles to better health results for all adolescents in the state. Program review committee staff proposals for addressing them are presented below.

³ See Appendix B for a copy of the PRI staff Connecticut Adolescent Health Population Accountability Report Card from December 2011.

Coordination and Leadership

To meet the complex health needs of adolescents, services must be comprehensive, combining health promotion, disease prevention, and youth development. As discussed in the December staff findings report, 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.

A high quality state strategic adolescent health plan, and 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 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 recent years, with federal funding from the Centers of Disease Control and Prevention (CDC), Connecticut and a number of other states have been carrying out Coordinated School Health (CSH) programs. The 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 program, 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 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 organization and activities of Healthy Connections to better coordinate planning and implementation of state strategies to improve health outcomes for all Connecticut youth.

To provide a vehicle and framework for a concerted, fully, statewide effort to improve health outcomes for all adolescents, PRI staff 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 system.**
- **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.**

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.

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, as described in the December staff report, still lack or lose HUSKY program or other Medicaid coverage.⁴

Targeted outreach funding ended, however, 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, 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.

At present, DSS is 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.

Unfortunately, ensuring adolescents have health coverage does not guarantee they will seek or receive 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 December staff report, 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

⁴ A report on insurance coverage for children based on analysis by Connecticut Voices for Children of recently released U.S. Census data was issued in December 2011. In that report, CVC estimates 24,000 children under 18 in Connecticut were uninsured in 2010. While this study found the state has been successful in enrolling children and families in HUSKY programs, especially during the recent economic downturn, it also showed retention of coverage remains problematic.

primary and preventive health care that can improve health outcomes for low-income adolescents.⁵ 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 staff recommends:

- **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 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.

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

⁵ 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.

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.

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 were 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.”

The department’s contractor, Connecticut Voices for Children (CVC), 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. Program review committee staff believe this is a sound investment of resources for quality data analysis of services that for adolescents (10 -19) in the HUSKY programs cost around \$20 million per month.

DSS expects the quality and quantity of HUSKY and other health program data will increase with implementation of the new Administrative Services Organization earlier this year and, eventually, a new eligibility management system. 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 UCHC 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, PRI staff 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 UConn 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 Section II; 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.**

PARENTAL INVOLVEMENT SUMMARY

While not an overarching issue identified as an area for proposed staff recommendations, a much-debated question in particular areas of adolescent health care is the level of parental or guardian involvement in the health care services an adolescent may receive. The September 27, 2011 staff update report provided 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 compared to other states. The description achieved one of the purposes of the study scope adopted by the committee in March 2011, which was to identify the extent of parental involvement in adolescent health care programs, comparing Connecticut laws and practices with those of other states and cited in national research. As noted in the staff update, a key goal of policies in adolescent health care is to balance the rights, interests, and responsibilities of minors, parents, and health care professionals, while protecting public health, in the array of circumstances adolescents may find themselves.

Presented here are summaries showing how Connecticut compares to its neighboring states, as well as to all states in each of these areas: 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.⁶ For all areas, the Connecticut age of majority is 18, unless otherwise stated.⁷

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.)⁸

⁶ The primary source of information is the Guttmacher Institute, unless noted otherwise.

⁷ 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.

⁸ 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.

■ State Contraceptive Laws Relevant to Minors ■

Connecticut

- Parental consent or notice not required for contraceptive services
- Signs of sexual intercourse (e.g., use of birth control) by minor 12 and younger mandates clinical provider send a child/abuse neglect report to DCF or law enforcement

Surrounding States

- *Massachusetts*: Explicitly allows all minors to consent to contraceptive services (state funds a statewide program that gives minors access to confidential contraceptive care)
- *Rhode Island*: Has no explicit policy
- *New York*: Explicitly allows all minors to consent to contraceptive services (state funds a statewide program that gives minors access to confidential contraceptive care)

All States

- 21 states (plus D.C.) explicitly allow minors to consent to contraceptive services
- Another 25 states explicitly permit minors to consent to contraceptive services in one or more circumstances
- 4 states have no explicit law

■ State Emergency Contraceptive Laws Relevant to Minors ■

Connecticut

- Prescription required if under 17 (available over the counter if 17 or older)
- Licensed health care facilities required to provide to a sexual assault victim upon her request (a hospital may contract with independent medical professional in order to provide EC services)

Surrounding States

- *Massachusetts*: Emergency rooms required to provide information about EC and dispense upon request
- *Rhode Island*: No explicit policy
- *New York*: Emergency rooms required to provide information about EC and dispense upon request

All States

- 12 states require hospital to dispense to sexual assault victims

■ State Pregnancy Testing & Care Laws Relevant to Minors ■

Connecticut

- Parent consent or notice not required for routine prenatal, delivery, postpartum care
- Whether parent consent needed for invasive procedures (e.g., epidural, amniocentesis, c-section) unsettled

Surrounding States

- *Massachusetts*: Minor may consent to prenatal care but parent must be notified if minor's health or life is at risk
- *Rhode Island*: No explicit policy
- *New York*: Minor may consent to prenatal care

All States

- 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

■ State Abortion Laws Relevant to Minors ■

(See Table Below for Patient's State of Residence Statistics 2006-2010)

Connecticut

- Minor < 16 years old
- No parental consent/notice/judicial bypass requirement for minors to obtain abortion
- Mandatory counseling: 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

Surrounding States

- *Massachusetts*: Minor < 18; One parent consent or judicial bypass resulting in order for minor
- *Rhode Island*: Minor < 18; One parent consent or judicial bypass resulting in order for minor
- *New York*: Minor < 18; No parental consent/notification/judicial bypass requirement

All States

- 37 states require parental involvement with judicial bypass; of these: 22 states require at least one parent to consent, with judicial bypass; 11 states require prior parent notification to at least one parent, with judicial bypass; 4 states require both notification and consent from a parent, with judicial bypass (*Guttmacher update February 2012*)
- 6 states have parental consent/notice laws currently enjoined
- 7 states (plus D.C.) do not require parental consent or notification (This includes Connecticut and Maine, which explicitly allow minors to consent, as does D.C.)

■State STD Testing & Treatment Laws Relevant to Minors■

Connecticut

- No parent consent or notice required
- 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

Surrounding States

- *Massachusetts*: Minor may consent; parent must be notified if the minor's health or life at risk.
- *Rhode Island*: Minor may consent
- *New York*: Minor may consent

All States

- All 50 states and D.C. 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

■State HIV/AIDS Testing & Treatment Laws Relevant to Minors■

Connecticut

- No parent consent or notice required, but 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
- At the time of communicating test results, provider must work toward goal of involving minor's 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

Surrounding States

- *Massachusetts*: Minors may consent⁹
- *Rhode Island*: Minors may consent
- *New York*: Minors may consent to testing; does not include right to consent to treatment

All States

- 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 parents minor is seeking or receiving STI services
- No state but one *requires* parental notice in the case of a positive HIV test

⁹ Consent to Medical Treatment By Minors in Massachusetts A Guide for Practitioners. Juvenile Rights Advocacy Project, Boston College School of Law (2006)
http://www.bc.edu/content/dam/files/schools/law_sites/jrap/pdf/jrap_medical_consent.pdf (accessed on line 2/20/12)

■ State Alcohol and Drug Treatment Laws Relevant to Minors ■

Connecticut

- No parent consent or notice required
- 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 all costs

Surrounding States

- *Massachusetts*: Minors 12 and older found drug dependent by at least two physicians may consent to substance abuse treatment except for methadone maintenance therapy¹⁰
- *Rhode Island*: Minor may consent¹¹
- *New York*: Minor may consent only if requiring parental consent would have a detrimental effect on treatment, or consent is denied and the physician finds treatment necessary and in the best interest of the child.¹²

All States

- Nearly 40 states permit a minor to consent¹³
- Approximately 25% of these states require minor to be a certain age¹⁴
- If treatment/rehab facility federally funded, follow requirements of federal Public Health Services Act

■ State Mental Health Laws Relevant to Minors ■

Connecticut

- Inpatient Hospitalization
 - Minor <16
 - No parent consent or notice required but 14 and 15 year olds can be admitted on own and parent (or nearest relative) must be notified after 5 days following admission
 - Uninformed parents not liable for costs (minor responsible)
- Outpatient Services
 - Minor < 18
 - Parental consent not required if professional counselor determines notification or consent would be seriously detrimental to minor; and whether to notify parent and secure consent must be evaluated initially and reevaluated after every sixth session
 - Uninformed parents not liable for costs (minor responsible)

Surrounding States (Inpatient and/or Outpatient)

- *Massachusetts*: Minors 16 and 17 may consent to admissions at a mental health treatment facility without notifying parent; a provider may choose to provide mental health treatment without notifying the minor's parent per MA mature minor rule¹⁵
- *Rhode Island*: No explicit policy for outpatient¹⁶

¹⁰ Ibid

¹¹ National Center for Children in Poverty, Adolescent Mental Health Variables http://nccp.org/profiles/RI_profile_56.html#8 accessed 2/20/12

¹² Ibid

¹³ 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)

¹⁴ Ibid

¹⁵ Juvenile Rights Advocacy Project

¹⁶ National Center for Children in Poverty

- *New York*: Minor many consent for outpatient services only if requiring parental consent would have a detrimental effect on treatment, or consent is denied and the physician finds treatment necessary and in the best interest of the child¹⁷

All States (Inpatient and Outpatient)

- Approximately half the states permit a minor to receive mental health services without parental consent, but a majority of this include an age threshold¹⁸

Patient's state of residence statistics. Section III on Teen Reproductive Health Services provides Connecticut health statistics related to some of the areas addressed here, including abortion rates. Additional data about pregnancy terminations and the patient's state of residence are set out in Table I-1. The sources of these data are the 2006 - 2010 annual *DPH Statistical Summary of Legal Induced Abortions Occurring in Connecticut*, 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.

¹⁷ Ibid

¹⁸ Houston Journal

Table I-1: 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)					
	2006*	2007*	2008*	2009*	2010*
Total	14,112	14,534	14,442	13,732	13,438
State of Residence					
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
Total Non-CT Residents	418	443	437	462	408
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
<p>*There are records with missing age data as follows for each year: 2006, 314; 2007, 373; 2008, 615; 2009, 321; and 2010, 260.</p> <p>**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.</p> <p>Source of Data: DPH Statistical Summaries of Legal Induced Abortions Occurring in Connecticut (for 2006-2010)</p>					

II. SCHOOL-BASED HEALTH CENTERS

RBA Program Report Card

Contribute to the 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.”

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.*

Primary Partners: *State agencies (DPH, DSS, SDE, DCF); primary care providers, mental health care providers, and dental care providers; local schools/districts; local health departments; community providers; non-profit health and social service agencies; ad hoc committee on school-based health centers; associations; parents and students.*

- School-based health centers (SBHC) 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.
- 71 state-funded school-based health centers are established in elementary, middle, and high schools throughout Connecticut (see Appendix SBHC-1 for locations); 57 centers primarily serve adolescents. The state also provides funds to expand existing health services in 10 schools in 3 communities. Those sites do not offer the full range of outpatient physical and mental health care provided in school-based health centers with comprehensive care, but offer targeted services (e.g., only mental health counseling and not physical health). Further, an estimated 37 entities are licensed either as outpatient clinics or hospital satellites to provide school-based care but are not state-funded.
- 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 public and private insurance reimbursements.

RBA Program Performance Summary

School-Based Health Centers

Key measures of school-based health center performance in Connecticut developed by PRI staff are highlighted below in an RBA report card format. The summary is followed by more detailed performance information, along with program review committee staff findings and recommendations, related to each of the three main RBA program performance questions: **How Much Did We Do? How Well Did We Do It? Is Anyone Better Off?** Symbols used in the report card are:

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

I. How *Much Did We Do?*

Availability

- In FY11, 71 state-funded SBHCs in Connecticut served students in elementary schools, middle schools, and high schools; 57 are identified as *primarily* serving adolescents.
- 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 ages 10 to 19. Ten additional schools in three towns receive state funding to 'expand' existing school health services to students, but are not considered comprehensive school-based health centers offering physical and mental health services, and dental services in some instances.

Enrollment and Use

- 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. Between FYs 2006-09, on average, 33,000 adolescents were enrolled in SBHCs over the four-year period.
- 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 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 (children most in need of primary and preventive health care)	+	<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.
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 adolescent 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. <p>PRI staff survey results on how SBHCs view their capacity levels is mixed: 34% over capacity; 43% at capacity; 11% near capacity; and roughly 13% under capacity.</p>
Meet overall 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 has increased to 57 since the 1980s, when centers were first funded in Connecticut. 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.
Individual center performance	↔	<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.

		<ul style="list-style-type: none"> • 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.
Efficient and effective state-level program management	↔	<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. • 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	+?	<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

		<p>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.</p> <ul style="list-style-type: none"> 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.

Background

The school-based health center model is a strategy for increasing access to free primary health care for school-aged children.¹⁹ 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

¹⁹The 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)

improvement of school-based health centers.²⁰ The principles also help form a national standard 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 operates 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.

²⁰ National Assembly on School-Based Health Care - see:
<http://www.nasbhc.org/site/c.ckLOKbOVlK6E/b.7697107/apps/s/content.asp?ct=10860609>

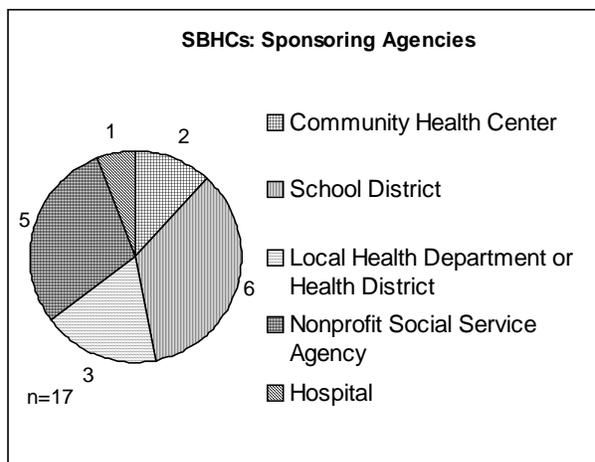
The types of primary and preventive health care offered at comprehensive school-based health centers include:

- 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-

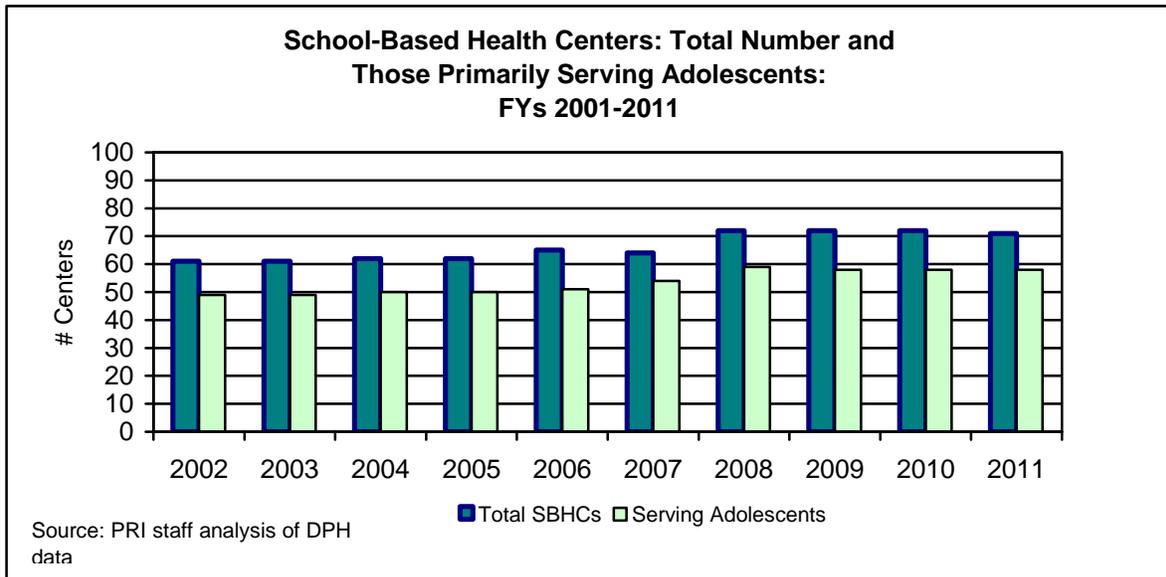


profit agencies or school districts, while community health centers and local health departments account for almost 30 percent. Sponsoring agencies may subcontract with other entities (e.g., community health centers, hospitals, nonprofit agencies) to actually operate one or more of the school-based health centers under their control, which several do.

I. How *Much* Did We Do?

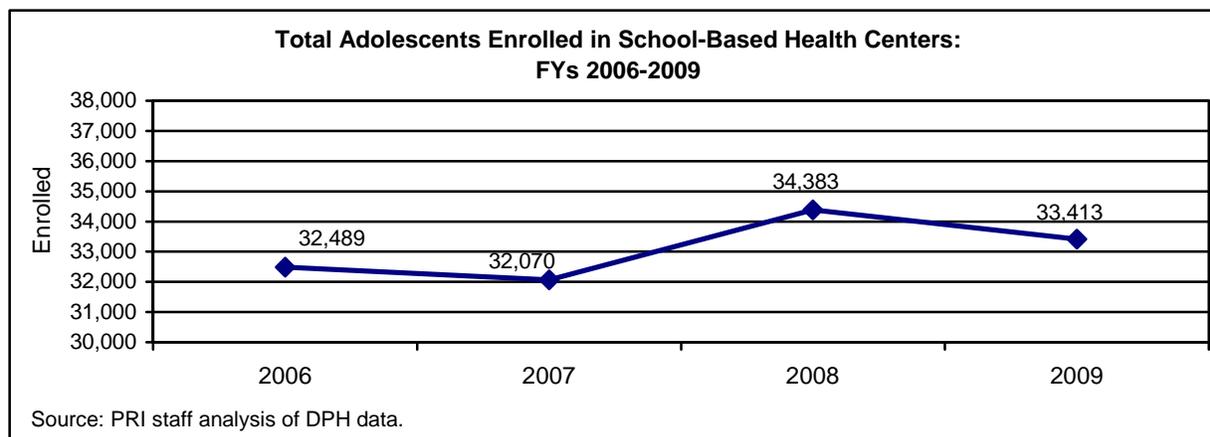
- State-funded SBHCs offered access to free primary and preventive physical and mental health services, and dental services at some sites, through 71 state-funded schools in FY 11.
- FY 11 grant allocations for SBHCs totaled \$10.3 million; grants of \$8.3 million were provided to 57 centers identified as primarily serving adolescents. An additional 10 schools received state funding to provide 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 committee staff.²¹
- 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.
- 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 Enrollment

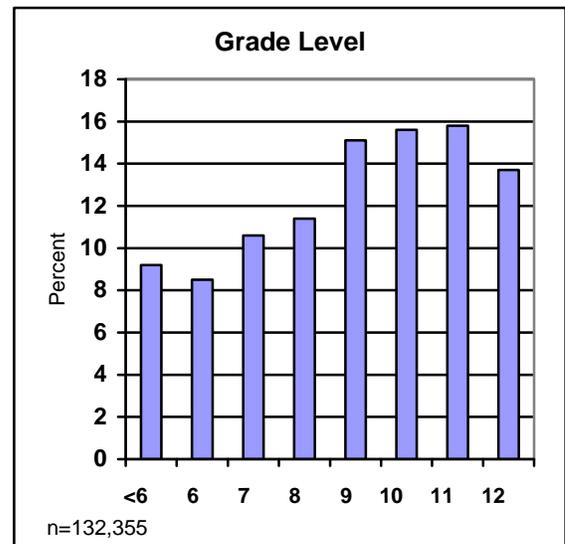
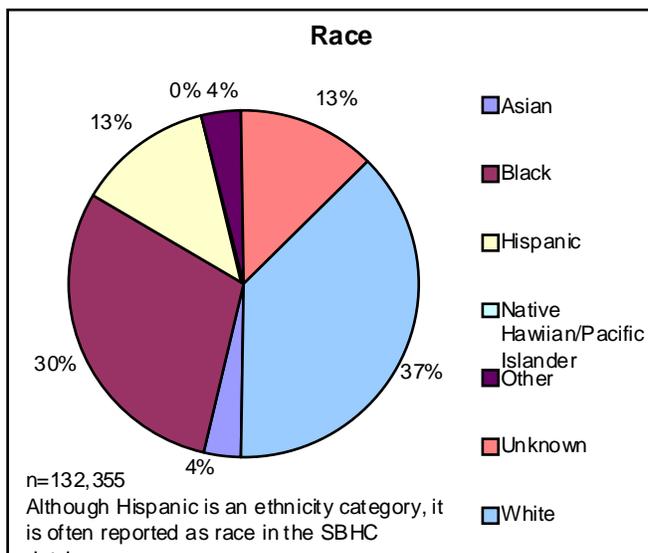
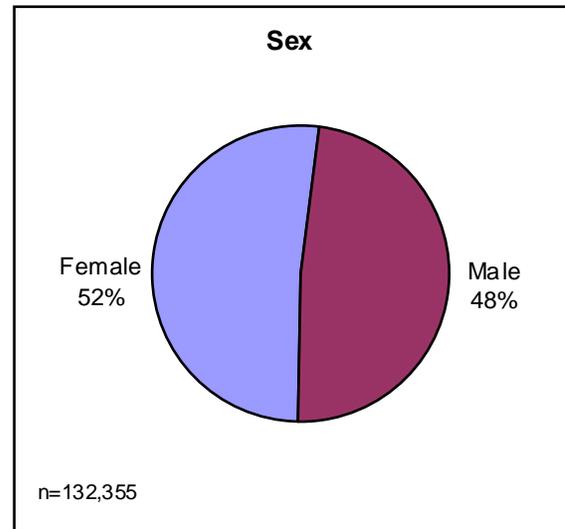
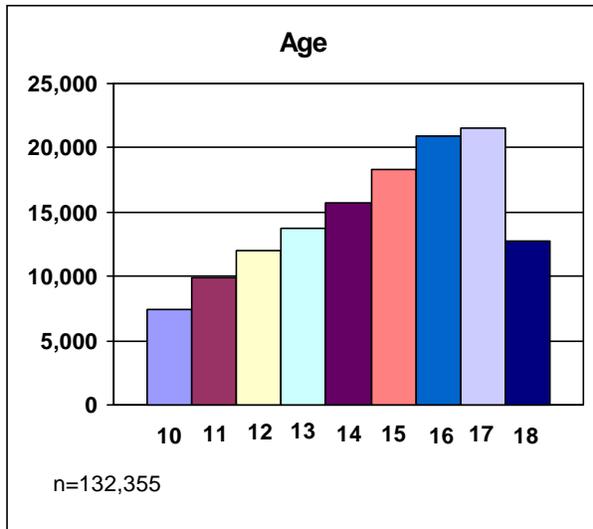


- The total number of adolescents enrolled in school-based health centers ranged from 32,070 to 34,383 during the four-year period of FYs 2006-09. Adolescents generally accounted for just over three-fourths of SBHC enrollment for all students.
- An annual average of just under 33,100 adolescents enrolled 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 section.)

²¹ 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 would not be counted.

- 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%). PRI staff does not know the exact reasons for the fluctuations in enrollment, although there was a relatively substantial increase in state funding in FY08.

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

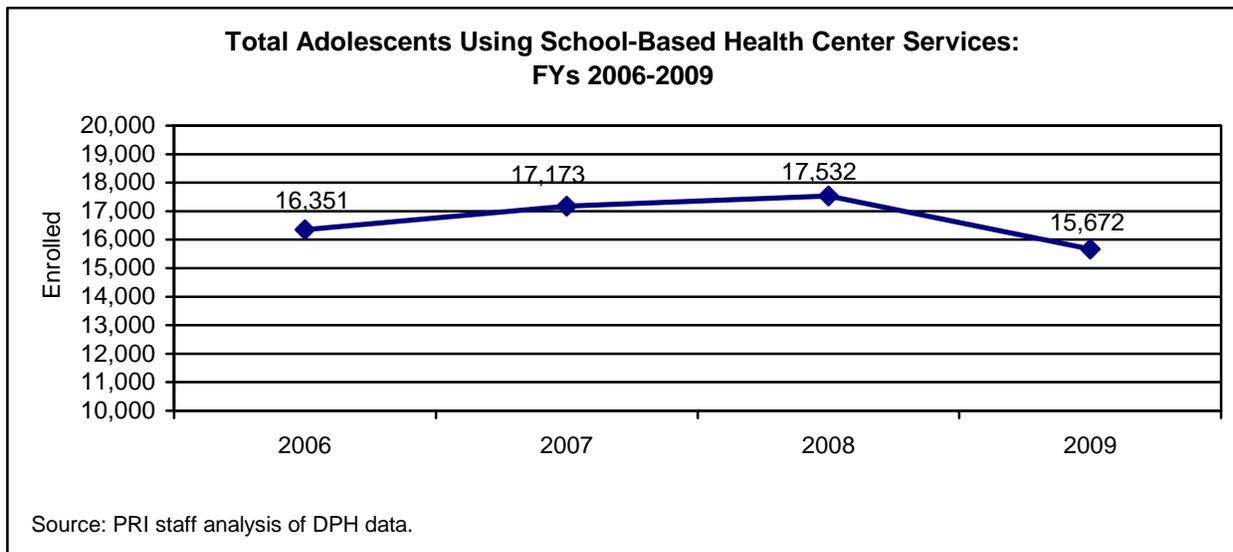


- 58% of enrollees were 14-17 years old, with 17-year olds making up the largest percentage (16%). One interesting factor in the age distribution of enrolled adolescents is the drop-off for 18-year olds. This could be a result of the way age was calculated within the DPH data. The cut-off date to determine 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, would not be included

in the overall number for that specific fiscal year which would account for roughly half of the year.

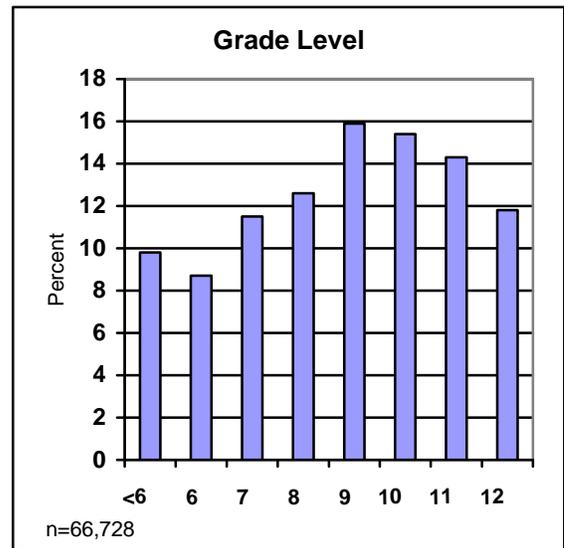
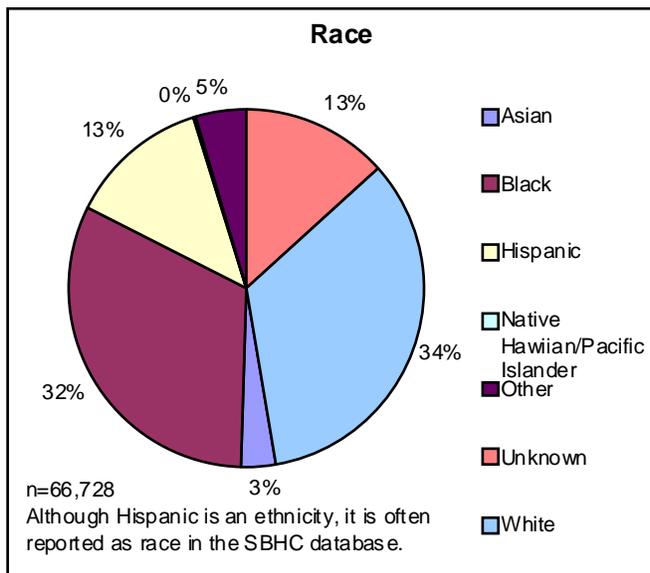
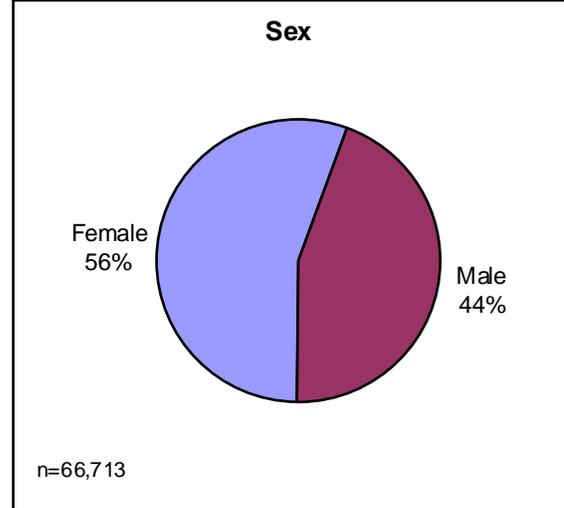
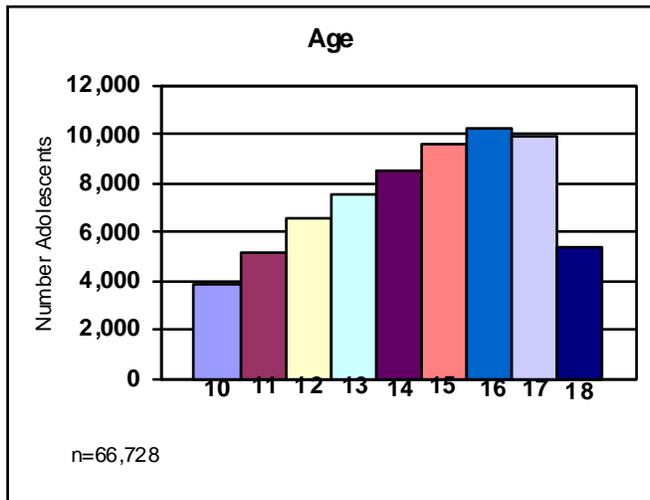
- Females accounted for 52% of adolescent enrollees, and males 48%.
- White (36%); Black (30%); Hispanic (13%); Asian (13%); other (4%); unknown (4%).
- The vast majority of adolescents (60%) enrolled in SBHCs were in grades 9-12; 30% were in grades 6-8. Just over 9% were in grades below 6th grade, which 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 decrease corresponds with a roughly three percent drop in the total number of adolescents enrolled in FY09 from the previous year. As mentioned, the decline 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.

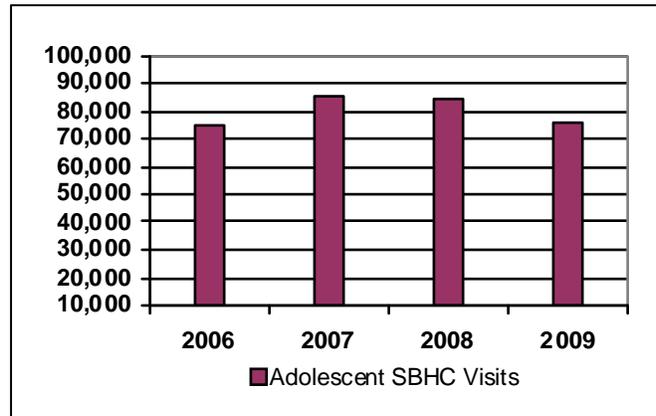
Measure 5: Demographics of Adolescent SBHC Users (FYs 2006-09)



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

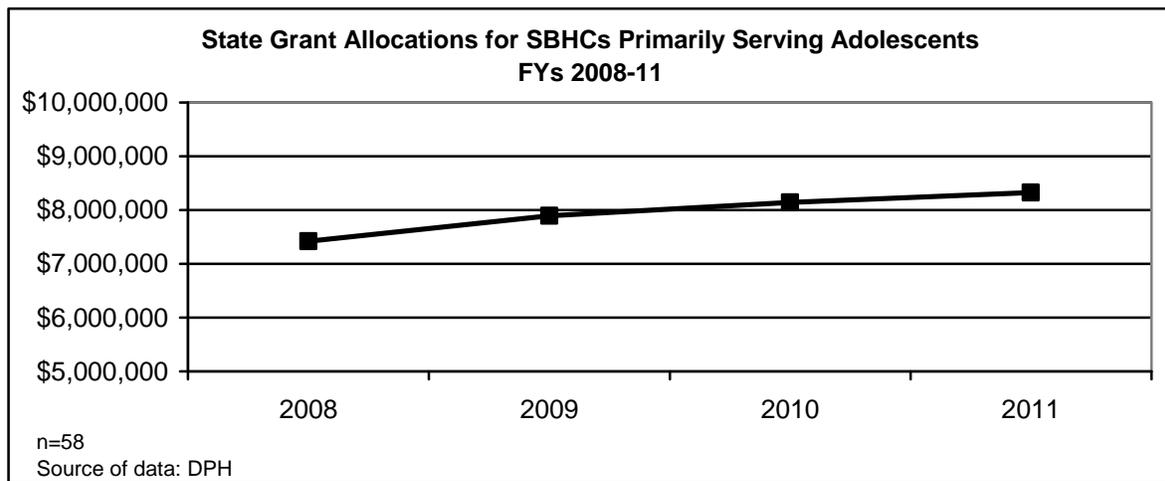
Measure 6: Total Service User Visits

- 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 Funding



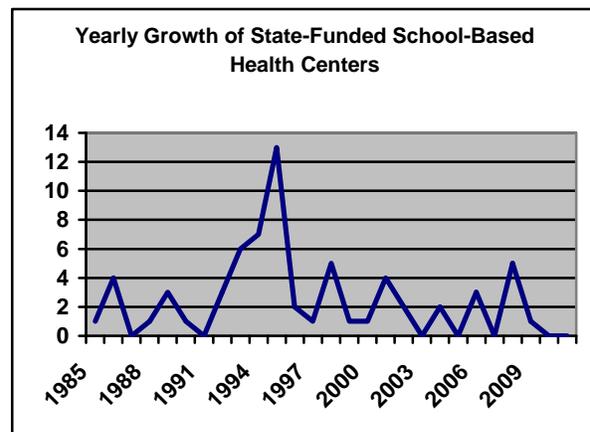
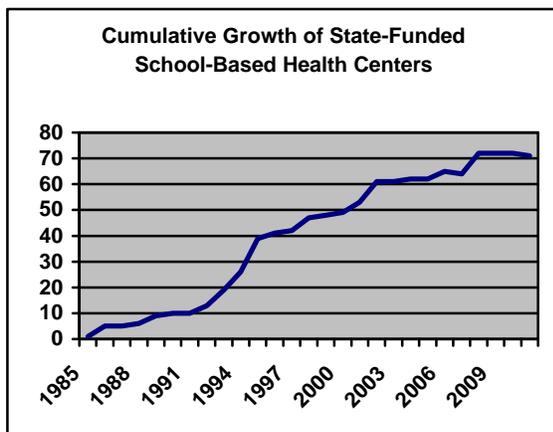
- State grant funding for SBHCs is distributed through contracts between DPH and each school-based health center’s sponsoring agency. PRI staff was able to isolate state grant allocations for the SBHCs primarily serving adolescents for FYs 2008-11. Annual funding amounts averaged just under \$8 million, or approximately \$137,000 per center.²²

²² 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.

Story Behind the Data

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.



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 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.)²³ 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 section.

Analysis of individual center performance outcomes also is challenging because of school configuration and the age range of adolescent used in this study. As such, PRI staff 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 staff 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 to committee staff 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, committee staff did not include these centers in its analysis, nor did staff include the other estimated 37 school-based health centers licensed by DPH as outpatient clinics or hospital satellites but not receiving state funding.²⁴

A map showing all current state-funded SBHC locations throughout the state is provided in Appendix SBHC-1.

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

²³ 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.

²⁴ PRI staff identified nonstate-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.

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.

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.²⁵ 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).²⁶ Following the expiration of the Ad Hoc Committee, a subsequent ad hoc stakeholder group has been meeting.²⁷ 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.

As referenced in the September 2011 PRI staff update report, the Children’s Health Insurance Program within the federal Social Security Act, defines a school-based health center (see Appendix SBHC-2 for the definition).²⁸ The National Assembly on School-Based Health Care has also developed its own position on a national definition of school-based health center.²⁹

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 section).

Actions to Turn the Curve

Committee staff 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, staff recommends: **the federal definition of school-based health center contained within the Social Security Act 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.**

²⁵ P.A. 06-195

²⁶ “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.

²⁷ C.G.S. Sec. 19a-6i

²⁸ 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

²⁹ See: http://ww2.nasbhc.org/RoadMap/PUBLIC/Advocacy_SBHCdefinition.pdf

PRI staff further recommends the Committee on School-Based Health Clinics established under C.G.S. Sec. 19a-6i 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.

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 staff 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.

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 SBHC-3 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; see Appendix SBHC-3 for details. (Additional analysis of how well individual centers meet the overall need of adolescents is provided later in this section.)
- 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

Adolescent SBHC 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
% Adolescents Enrolled Out of Students	51.9%	50.9%	52.3%	52.0%
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.				

- 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 eligible adolescents annually enrolled in their school's SBHC.
- On average, 52% (33,100) of adolescents eligible were enrolled in state-funded school-based health centers.

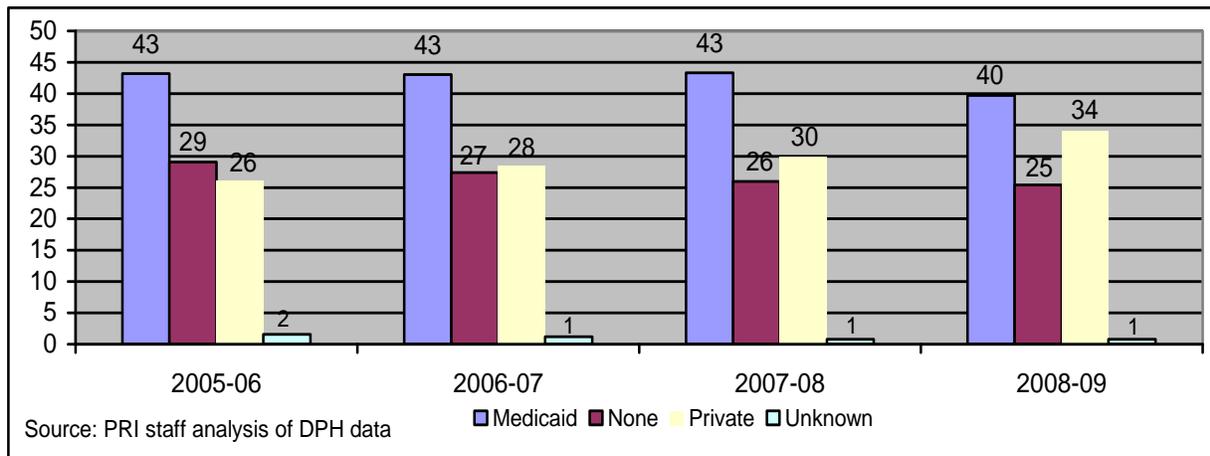
- The percent of eligible adolescents enrolled in SBHCs remained relatively consistent over the four-year period, ranging from a low of 51% in FY07 to a high of 52% in FY 09. At the same time, the overall enrollment rate for adolescents increased over the time span by 2.8%.

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.

Story Behind the Data

As noted in the committee staff findings report Part I (December 2011), 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 section, 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 SBHC-3, PRI staff selected several key socioeconomic indicators for analysis that traditionally signify 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 needs with state resources. Decisions on where to locate a 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, committee staff 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 section, additional funding for SBHCs in 2008 was dispersed using an RFP process. In addition, legislation 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.³⁰ 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, committee staff 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 SBHC-4 for full analysis)

In summary:

- Committee staff analyzed various measures of individual school-based health center performance for FY 09. The total student population of the schools identified by committee staff as primarily serving adolescents (including mixed elementary/middle schools) was

³⁰ sHB 7366, 2007.

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 staff. Staff 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.

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 committee staff's analysis of individual center, 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. Committee staff 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.

PROGRAM MANAGEMENT

PRI staff examined various factors within the department's operations for managing the school-based health center program. Specifically, committee staff 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.

Committee staff 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 much 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."

Committee staff 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. PRI staff 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, which include 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 the 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 staff 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. Committee staff 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 staff 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.

Committee staff met 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, but did not fully review either process to determine its efficiency or effectiveness.) During its discussions with the department, committee staff was told 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 staff 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 Ad Hoc committee is required. The 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.

One area PRI staff believes better coordination between the licensing unit and the contract monitoring unit should occur is obtaining information about licensed SBHCs not receiving state funding. During its review, committee staff 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 license title. Information about the services they provide, the number of students served, and the results achieved to better students’ overall health, is not known. Committee staff 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 staff recommends:

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 students’ overall health.

Committee staff 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 staff 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, committee staff 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 staff 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.

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, committee staff 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.

Story Behind the Data

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 findings include:

- 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.³¹
- Within a safety-net system, school-based health centers augment health care access and quality for underserved adolescents compared with traditional care.³²
- 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.³³

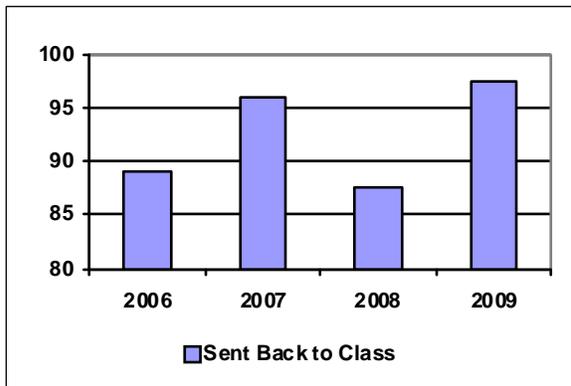
³¹ McNall MA, Lichty L, Mavis B, Bates, L. *The Michigan Evaluation of School-Based Health*. Community Evaluation and Research Collaborative, Michigan State University, December 2010.

³² 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.

³³ 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.

- 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.³⁴
- 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.³⁵

Performance 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% 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.

Story Behind the Data

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.³⁶ 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

³⁴ 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.

³⁵ U.S. General Accounting Office, Health Care Reform: School-Based Health Centers Can Promote Access to Care. May 1994.

³⁶ Centers for Disease Control and Prevention. Health-Risk Behaviors and Academic Achievement. *National Youth Risk Behavior Survey 2009*.

reasons compared to nonusers. Discipline incidents, however, were not found to be associated with SBHC use.³⁷

- 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.³⁸
- 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. 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.³⁹
- 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.⁴⁰

Performance 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.

Story Behind the Data

As noted earlier in the report, committee staff attempted to analyze SBHC user data with Medicaid data for adolescents in part to determine cost outcomes for care provided through the two systems. This analysis could not be conducted for various reasons; thus committee staff examined national information 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

³⁷ 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.

³⁸ 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.

³⁹ Strolin-Goltzman J. The relationship between school-based health centers and the learning environment. *Journal on School Health*. 2010; 80: 153-159.

⁴⁰ 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.

over three years; the estimated savings to Medicaid was approximately \$35 per student per year for students who used school-based health centers.⁴¹

- 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.⁴²
- Accessible, prevention-oriented health care provided in a SBHC can decrease the utilization of episodic health care in an emergency department.⁴³
- 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.⁴⁴
- 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.⁴⁵

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. Committee staff 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.

⁴¹ 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.*

⁴² 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.*

⁴³ Key JD. *Journal of Adolescent Health. April 2002;30(4):273-278.*

⁴⁴ 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.*

⁴⁵ 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.*

[Blank Page]

III. TEEN REPRODUCTIVE HEALTH SERVICES

RBA Program Report Card

Contribute to the 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.”

Main Contribution: *primary and preventive reproductive health services help adolescents, particularly those most at risk for unintended pregnancy and sexually transmitted diseases, stay healthy and safe, and make the transition to a successful adulthood.*

Primary Partners: *state agencies (DPH, DSS, DCF, SDE); pediatricians, primary care/family physicians, reproductive health specialists; adolescents and their parents/guardian; schools; community and school-based health centers, family planning clinics, and other nonprofit health and social service providers*

BACKGROUND

- Reproductive health care for teens, like adults, includes **a range of clinical and educational services** such as: annual examinations (pelvic, breast, genito-urinary); screening and treatment for sexually transmitted diseases and HIV; pregnancy testing, options counseling, and if necessary, referral for prenatal care, adoption, or abortion services; contraception services and supplies; education and counseling related to sexual health; and referrals for infertility and other medical or social problems as indicated.
- There also are **a variety of funding sources for adolescent reproductive health care** including: private and public (Medicaid and CHIP) insurance plans; state and federal grants for family planning, STD control, and teen pregnancy prevention programs; local health department funding; and private foundations and donations. In addition, local school districts receive funding and technical assistance from the state education department for comprehensive health education programs, which include topics related to sexual health. (See Appendix TRH-1 for a brief description of the main state-supported reproductive health services for adolescents.)
- Connecticut teens may **receive primary and preventive reproductive health services in many different settings**, ranging from health practitioner offices and hospitals, to community and school-based health centers, outpatient, family planning, or STD clinics, and programs operated by local health departments and private nonprofit agencies.
- As part of the committee's adolescent health study, **PRI staff assessed in-depth the performance of two state-supported primary and preventive reproductive health care efforts with target populations that include high-risk youth:** family planning center grant programs administered by the Departments of Public Health and Social Services; and the DSS Teen Pregnancy Prevention Initiative (TPPI). An RBA program report card summarizing the key results of these efforts and a discussion of PRI staff findings and proposals to improve performance follows. At present:
 - DPH and DSS both contract with Planned Parenthood of Southern New England (PPSNE) to make **family planning services** provided at 18 licensed PPSNE health centers accessible to uninsured, underinsured, and low-income adults and adolescents of reproductive age in areas of high need (e.g., high concentrations of Medicaid clients, high rates of poverty, teen pregnancy, infant mortality/morbidity, STDs) throughout the state.
 - DSS also funds evidence-based **teen pregnancy prevention programs** operated by 9 different organizations in 13 municipalities with consistently higher-than-average teen birth rates.

RBA PROGRAM PERFORMANCE SUMMARY

State-Funded Family Planning Services and Teen Pregnancy Prevention Initiative (TPPI)

Key measures of the performance of family planning and pregnancy prevention services for teens funded by DPH and DSS are highlighted below in an RBA report card format. This summary is followed by more detailed performance information, along with program review committee staff findings and recommendations, related to each of the three main RBA program performance questions: **How much did we do? How well did we do it? Is anyone better off?** Symbols used in this report card are:

+ Positive trend

- Negative trend

↔ Little/no change or mixed

? Cannot be determined

I. How Much Did We Do?

KEY MEASURES	CURRENT DATA
1. Clients Served	<ul style="list-style-type: none"> Funding from DPH and DSS subsidizes services at 18 family planning health centers for more than 45,000 teens and adults of reproductive age in need of publicly supported care per year at present. An estimated 20 percent of family planning clients served with DPH/DSS funding are adolescents (under age 20). Through the Teen Pregnancy Prevention Initiative, DSS currently funds 12 programs with total capacity for 690 high risk adolescents. During 2009-10, the five programs that were fully operational had a total of 248 active participants.
2. Resources Allocated	<ul style="list-style-type: none"> In FY11, DPH provided \$1,073,599 and DSS provided \$915,059 for contracted family planning services for uninsured and low-income clients of all ages. State funding for TPPI programs and related consultant services (technical assistance, training, and evaluation) totaled about \$1.9 million in FY11.

II. How Well Did We Do It?

KEY MEASURES	PROGRESS	CURRENT DATA
3. Services Accessible	+	<ul style="list-style-type: none"> Family planning centers funded by DPH and DSS are located where the need for publicly supported reproductive health care is greatest (communities with high teen pregnancy, STD, poverty rates/large numbers of Medicaid clients, uninsured/underinsured persons). 79% of family planning clients funded by DPH and DSS received services regardless of ability to pay during FY10. TPPI programs, given funding limitations, are targeted to children most at risk for early pregnancy in communities with high need.
4. Programs and Services Science-Based (Research-and/or evidence- based models)	+	<ul style="list-style-type: none"> Family planning clinical and education services provided by the contractor funded by DPH and DSS are medical best practices, evidence-based practices, or research-based promising practices. All TPPI programs currently funded by DSS are implementing one of two approved evidence-based teen pregnancy prevention models.
5. Compliance with Standards/Contract Requirements	+	<ul style="list-style-type: none"> The family planning services provider funded by both DPH and DSS: <ul style="list-style-type: none"> consistently complies with all contract requirements; has exceeded all but one contract performance measure every year from FY06 through FY10; is state licensed and nationally accredited. According to DSS staff, all currently funded TPPI programs are satisfying all contract requirements and maintaining adequate fidelity with their evidence-based models.

6. Clients Satisfied	+	<ul style="list-style-type: none"> Over 95 percent of a representative sample of clients of family planning centers funded by DPH and DSS consistently report being very satisfied or satisfied with the services received. According to DSS staff, feedback from client and parent satisfaction surveys conducted for TPPI programs is positive.
7. Programs/Services Cost-Effective	+	<ul style="list-style-type: none"> National research shows investing in quality family planning services (like those funded by DPH and DSS) achieves positive outcomes for clients and saves public dollars. <ul style="list-style-type: none"> A 2008 study calculated that every public dollar invested in family planning services saved the public sector \$4.02 in Medicaid costs. A 2009 independent evaluation of one long-standing TPPI program concluded the program's costs modestly exceed benefits during client participation but are outweighed in the long term by economic benefits realized in young adulthood.
III. Is Anyone Better Off? (Assessments based primarily on population level data for all Connecticut adolescents, not program-specific client outcomes.)		
KEY MEASURES	PROGRESS	CURRENT DATA
8. Sexual Activity: among all groups, risky behaviors avoided/initiation delayed; if sexually active, contraception used	+	<ul style="list-style-type: none"> Similar to national trends, birth, pregnancy, and abortion rates among adolescents in Connecticut have been dropping over time. National research links declining rates with significant increases in teen contraceptive use and shifts to more effective and dual methods. The percentage of Connecticut high students who ever had sexual intercourse decreased from 43.5% to 40.5% between 1997 and 2009. About one-third of all high school students were currently sexually active in 2009; by grade 12 more than one-half of white, black, and Hispanic students were (55%, 53%, 58%, respectively). In 2009, among currently sexually active Connecticut high school students, 59% used condoms, 27% used hormonal birth control and 8% used both during or before their last sexual intercourse.
9. STDs: prevented/rates reduced among all groups	+/?	<ul style="list-style-type: none"> Data at the national and state levels on trends in STD rates overall or among adolescents are limited. However, it is estimated that young people ages 15-24, who represent only 25% of the sexually experienced population, acquire half of all new STD cases each year. Connecticut data for 2000 to 2010 show reported cases of Chlamydia and gonorrhea among teens ages 15-19 has dropped to 31% and 23% (from 38% and 29%), respectively,
10. Unintended Pregnancies: prevented/rates reduced among all groups	↔	<ul style="list-style-type: none"> In Connecticut, the percentage of births to mothers under age 20, most of which are unintended, remained at about 7 percent from 2005 to 2009. Over this period, rates for black and Hispanic teen mothers decreased slightly but in 2009 were still four to five times higher than the rate for white mothers (12%, 15%, and 3%, respectively). The teen birth percentage exceeded the state average in 31 towns during 2004 – 2008; rates were consistently more than twice as high in four cities (Hartford, New Britain, Waterbury, Windham).

I. How Much Did We Do?

PRI committee staff found state funding for family planning services supports essential reproductive health care for thousands of uninsured and low income clients, many of whom are adolescents, each year. In addition, several hundred Connecticut teens at high risk for early pregnancy and parenting are served by state-funded TPPI programs. The amount of resources allocated to both programs is relatively small: about \$2 million per year in state appropriations and federal grant funds from DPH and DSS for contracted family planning; and just under \$2 million in state appropriated funding at present for the DSS Teen Pregnancy Prevention Initiative. How much each program does is described briefly below and followed by discussions of two main program output measures: clients served; and program funding (state resources invested).

Family planning services. The state public health and social services departments contract with the same organization, Planned Parenthood of Southern New England (PPSNE), to make family planning services available to uninsured, underinsured, and low income adults and adolescents of reproductive age (generally considered ages 15 to 44). Services are available on a sliding fee scale to men and women but the overwhelming majority of clients (90%) are female.

Under both agency contracts, family planning services include: general reproductive health care (e.g., physical exams, screenings for cancer, testing, treatment, and education for STDs and HIV); contraception counseling and supplies; and pregnancy tests and counseling, but not obstetric or prenatal care (or abortion services). Under the DPH contract, PPSNE, provides free pregnancy testing, counseling, and referrals for prenatal care to women and teens, as appropriate. Community education programs for young people and parents also are provided with state health department funding.

DPH and DSS funding combined supports family planning services at 18 Planned Parenthood centers located in Bridgeport, Danbury, Danielson/Killingly, Enfield, Hartford, Manchester, Meriden, New Britain, New Haven, New London, Norwich, Old Saybrook, Shelton, Stamford, Torrington, Waterbury, West Hartford, and Windham/Willimantic. Six centers receive funding from both agencies.⁴⁶

DPH funds, which are mostly state monies but include a small amount of federal Maternal and Child Health Block Grant dollars, go toward operating costs of 13 PPSNE centers located in high need areas (i.e., communities with high rates of poverty, teen pregnancy, infant mortality/morbidity, STDs). A portion of the state's federal Title XX (Social Service Block Grant) is used by DSS to subsidize family planning services for uninsured, low income persons at 12 PPSNE centers in areas with high concentrations of such clients.

⁴⁶ The state agency funding also supports services at six of the contractor's "delegate agency" sites (e.g., community health centers, local women's health centers) in Hartford, New Haven, and Waterbury.

Together, the funding from DPH and DSS makes family planning services available to an annual total of around 45,000 men and women in need of publicly supported reproductive health care. At present, about 20 percent of the clients supported with DPH funds are teens ages 14 through 19. Data on the ages of family planning center clients served with DSS funding are not readily available but it could be assumed the portion under age 20 would be the same.

Teen Pregnancy Prevention Initiative (TPPI). Under the state-funded Teen Pregnancy Prevention Initiative, DSS currently contracts with seven community-based organizations and two local health departments to carry out two types of evidence-based pregnancy prevention programs for adolescents. The approved models are: Carrera, a comprehensive program of life skills development, academic support, and sex education developed by the Children's Aid Society, and Teen Outreach Program (TOP), a service learning approach that combines a classroom component covering health and life skills topics (e.g., human growth and development, sexuality, healthy relationships, decision-making skills) with volunteer work in the community.⁴⁷

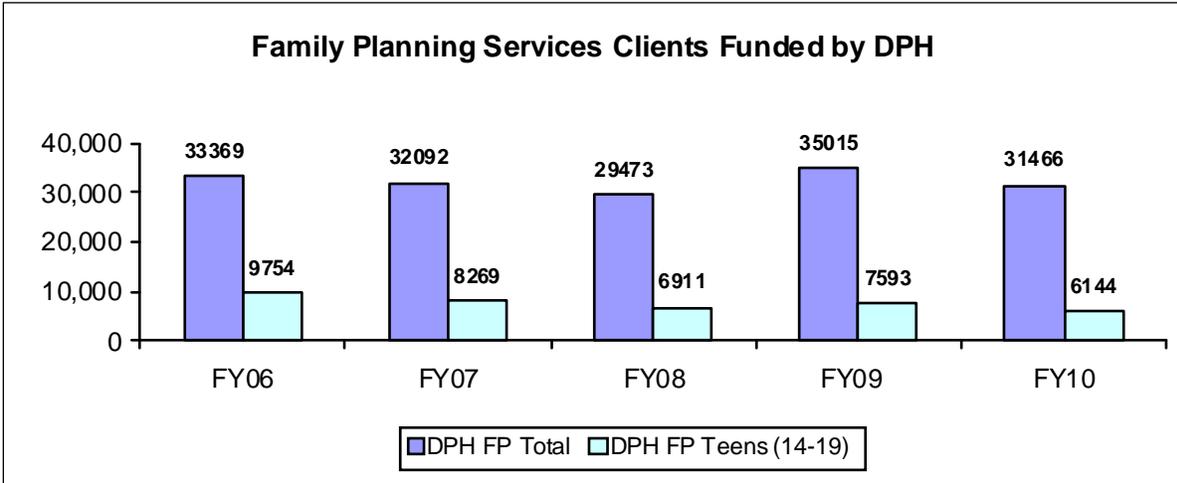
In Connecticut, the Carrera programs serve participants and their families year-round, usually beginning in sixth grade and continuing through high school graduation. TOP programs are primarily in middle schools and last one to two years, with results monitored for a period of time after completion. Four Carrera and nine TOP programs currently are being implemented or are operating with TPPI funding in 13 communities with consistently higher-than-state-average teen pregnancy rates (Bridgeport, East Hartford, Killingly, Hartford, Meriden, New Britain, New Haven, New London, Norwich, Torrington, Waterbury, West Haven, and Willimantic).

Together, the 13 TPPI sites have the capacity to serve up to 690 teens (each receives funding to serve either 50 or 60 clients during the program year). However, only five of the currently funded programs have been fully operational since the beginning of the present three-year contract period (2009-10 to 2011-12). During 2009-10, a total of 248 adolescents were actively participating in those programs. The other programs are in a start up phase or have just opened. Most, therefore, were well below full enrollment at the time of this analysis.

Measure 1: Clients Served: TPPI and Family Planning

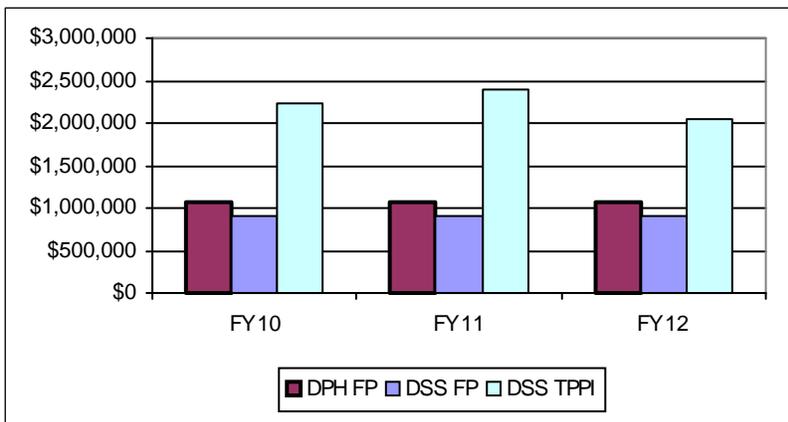
- TPPI program capacity, with the recent addition of six new sites, has about doubled over the current contract period. As noted above, although funded to serve nearly 700 teens, the number of active participants has been lower (around 350 at the end of FY11) since so many programs were just starting up.
- The number of clients whose family planning services were supported with DPH funding over the last five years (shown in the figure below) averaged around 32,000; annual totals varied from a high of 35,015 to a low of 29,473.

⁴⁷ Both models are among the programs extensive research has found to be most effective in reducing births among the teens who participate. Research also shows programs like Carrera and TOP that address a range of social and behavioral issues in addition to pregnancy prevention can have a number of positive impacts, such as: reducing substance use/abuse and violent or criminal behavior; and increasing use of primary health care and high school graduation rates.



- Each year, roughly 20 to 30 percent of all DPH-funded clients served were teens ages 14 through 19 from FY06 to FY10.
- The number of teen clients served with DPH funding dropped from a high of 9,754 in FY06 to a low of 6,144, in FY10, a 37% decrease. The portion of clients who are teens also decreased steadily over this five-year period.
- Over the past three years, Department of Social Services funding has subsidized family planning services for about another 15,800 low-income persons of all ages, including teens, each year. (Ages of clients served are not tracked by the department.)

Measure 2: Funding for Family Planning and TPPI



- Annual funding from DPH and DSS for family planning services has stayed at the same levels from FY10 through FY12: just over \$1 million, and just under \$1 million, respectively.
- Over the last three fiscal years, around \$2 million a year has been budgeted for DSS TPPI programs.
- The appropriated funding level for TPPI was reduced by nearly \$340,000 (14%) between FY11 and FY12.

Story Behind the Data

Despite the recent years of level funding from DPH and DSS for family planning services, the state's contractor continues to exceed contract goals for clients served and also avoid waiting lists. PPSNE reports it is able to stretch current resources to meet demand as needed. Generally, appointments for reproductive health exams can be booked within a week to 10 days and urgent care appointments are booked within two days. Same day and walk-in appointments also can be accommodated. According to the contractor, this is accomplished in part by conducting regular assessments of service patterns and annual assessments of client demographics and long-range population trends.

Also, the state agency funding is a relatively small portion of PPSNE revenues. All government grants, including federal Title X family planning funds it receives directly, are about 20 percent of the organization's total budget. Third party (e.g., Medicaid, private insurance) and private payments account for 65 percent of all revenues; and contributions and investment and other income make up the rest.

The family planning services contractor attributes the fairly steady drop in teen clients served with DPH funding since FY06 to several factors. First, national studies suggest when economic times are hard, women of any age without adequate health insurance delay seeking primary and preventive care, including reproductive health services. Second, other studies show teens in general are delaying the onset of sexual activity and have fewer partners. Adolescents also increasingly are using Long Acting Reversible Contraception (LARCs) like IUDS and hormonal implants and may feel less need for annual exams. Last, the contractor suspects that in recent years, more teens are getting reproductive care at school-based health centers so do not require family planning center services.

As noted in Section II, various types of reproductive health services are available at many DPH-funded school-based health centers. At present, some SBHCs in five school districts can prescribe and dispense contraception supplies (e.g., birth control pills, condoms) in accordance with local policy.⁴⁸ According to a study by the Konopka Institute for Best Practices in Adolescent Health, when well-staffed and well-run, school-based health clinics share most of the characteristics of the ideal teen reproductive health program, including: having a convenient location and staff trained to work with adolescents; reaching both females and males; providing free, comprehensive health services; being confidential; and being able to integrate medical services with counseling and education.⁴⁹

At this time, the relatively modest funding level for TPPI represents the only state money dedicated to comprehensive primary prevention of unintended adolescent pregnancy. Under the agency's most recent contract, DSS is providing, on average, about \$1,400 for each TOP client, and \$4,900 for every Carerra client per year. Significant investment would be required for expansion of either type of prevention program, but particularly for the comprehensive Carerra model.

⁴⁸ The five districts are: Bridgeport, East Hartford, Hartford, New Haven, and Windham.

⁴⁹ Konopka Institute, Academic Health Center, University of Minnesota, "Growing Absolutely Fantastic Youth: A Review of the Research on "Best Practices," July 2000.

There appears to be considerable unmet need for publicly supported primary and preventive reproductive health care, like that provided through state-funded family planning services and the Teen Pregnancy Prevention Initiative. According to a recent analysis by the Guttmacher Institute, about half of the need of Connecticut women for publicly subsidized family planning services is being met with all existing resources in the state.⁵⁰

Based on 2008 data, Guttmacher estimates about 158,000 women in Connecticut, which includes all sexually active female teens (57,890) and low-income women ages 20-44, are in need of publicly subsidized family planning services. That year, 50.4 percent were served; unmet need, therefore, totaled nearly 79,000 women (all ages).

Actions to Turn the Curve

Given the state's current budget problems, it is unlikely new funds will be available in the near term for expanded family planning or targeted pregnancy prevention services for Connecticut adolescents. To date, both DPH and DSS have managed to maintain fairly stable funding for their existing teen reproductive health programs. They also have targeted available funding to client populations and areas of the state with the greatest need.

Since around 2005, DSS has prioritized TPPI funding for communities with the highest rates and numbers of most at risk teen populations. In recent years, all contracts have been awarded on a competitive basis and state funding is only provided for proven, evidence-based models for teen pregnancy prevention. *In the opinion of PRI committee staff, the department has established a solid methodology for TPPI funding that should continue to be applied, particularly if additional resources that allow program expansion become available.*

II. How Well Did We Do It?

The program review committee staff found the family planning services and teen pregnancy prevention programs funded by DPH and DSS are performing well based on quality and process data examined for this study. The family planning services contractor funded by both departments follows accepted best practices, national accreditation standards, and relevant state licensing requirements. The state-funded TPPI providers are implementing evidence-based program models with acceptable fidelity. State contract requirements and outcome measures were met or exceeded consistently and program managers in each agency expressed satisfaction with the family planning services and all TPPI program contractors. Client satisfaction survey results also were very positive. National research and a study of one Connecticut TPPI program indicate that science-based, well-run family planning and pregnancy prevention services for adolescents are cost effective investments of public resources. Information related to five measures of how well the selected teen reproductive health programs are carried out – accessible, science-based, compliant, client satisfaction, and cost-effective – is presented below.

⁵⁰ Guttmacher Institute, *Contraceptive Needs and Services: National and State Data*, 2008 Update, May 2010.

Measure 1: Accessible Services

- Family planning services funded by DPH and DSS are widely accessible to adolescents and low-income persons of all ages in terms of location and cost.
- Currently, family planning services funded by the two agencies are available at contracted health center facilities in 18 communities; all facilities are:
 - in or near areas of greatest need (i.e., high rates of poverty, teen pregnancy, STDs, infant mortality/morbidity and large numbers of uninsured, underinsured, and low-income persons of reproductive age);
 - close to public transportation; and
 - open at least 4 weekdays and some evening and Saturday hours.
- Each year from FY06 through FY10, at least three-quarters of the state-funded family planning clients were provided served regardless of their ability to pay.
- Given the limited state resources for TPPI programs, DSS prioritizes funding for towns with the highest rates and largest numbers of teen births in the state; at present, neighborhood-based programs are operating in 13 high-need communities throughout the state.
- TPPI programs are designed for, and appear to attract and retain, youth most at risk for early pregnancy, according to the program's latest independent evaluator progress report (2009-10).

Measure 2. Science-Based Services

- Family planning clinical services provided by the DPH and DSS contractor are based on scientific research and medical best practice. All of the contractor's education programs are research- or evidence-based activities that rely on medically accurate information.
- Under its Teen Pregnancy Prevention Initiative, DSS only funds two types of evidence-based models, both of which have long-term evidence of effectiveness in reducing adolescent pregnancy.

Measure 3. In Compliance (with Contract Requirements and Other Standards)

- The state-funded family planning services contractor, as shown in the following table, has met and exceeded all but one contract requirement every year from FY 06 though FY10.⁵¹

⁵¹ The contractor attributes the recent drop in the percentage of clients receiving STD screening (for Chlamydia) to two factors: more women who are married or in monogamous long-term relationships are declining an annual Chlamydia test; and new federal and state health agency recommendations encourage screening primarily for women ages 15-25, and testing of those 26 and over only if there is a symptom or reason.

Family Planning Services Contract Performance Measures FY06- FY10						
Outcome Measures (DPH and DSS Contracts)	Goals*	FY06	FY07	FY08	FY09	FY10
Served regardless of ability to pay	60%	82%	84%	79%	75%	79%
Receive Pap test	90%	93%	97%	98%	98%	96%
Receive breast exam	90%	95%	99%	99%	99%	99%
Receive STD screening	85%	87%	85%	89%	79%	80%
Receive AIDS education	80%	91%	90%	91%	87%	86%
Additional DPH requirements						
People served (all ages)**	21,200	33,369	32,092	29,473	35,015	31,466
Teens served (ages 14-19)	5,800	9,754	8,269	6,911	7,593	6,144
Teen educational presentations (no. teens participating)	1,000	1,919	1,763	2,089	2,000	1,231
Distribute free condoms (number)	200,000	-	-	400,000	400,000	400,000
*Goals from current DPH and DSS contracts (2009-10 to 2011-12 contract term)						
** DPH contract requires minimum 35,000 client visits per year; PPSNE data indicate 1.65 visits provided per patient each year, which equates to a client served goal of 21,200						
Source of data: DPH Annual Family Planning Program Reports from Planned Parenthood of Southern New England						

- The DPH and DSS family planning services contractor is nationally accredited, through a rigorous on-site and document review process carried out by Planned Parenthood Federation of America. The most recent full, four-year accreditation was received in 2010-11.
- All of the family planning health centers operated by the state-funded contractor must be and are licensed (as outpatient clinics) by the state health department. According to state health department staff there have been no licensing issues with the family planning services contractor.
- DSS staff report that all TPPI program providers are in compliance with contract requirements and are implementing their evidence-based models with acceptable fidelity.

Measure 4. Clients Satisfied

- On a regular basis, at least 95 percent of a representative sample of family planning clients (of the health centers operated by the DPH and DSS family planning services contractor) report being very satisfied or satisfied with the services received.
- According to DSS staff, feedback from client and parent satisfaction surveys conducted for TPPI programs is positive.
- Program managers for family planning services and TPPI at both state agencies reported high satisfaction with the performance of all contracted providers to PRI staff.

Measure 5. Cost-effective

- National studies consistently show family planning services for adults and adolescents are cost-effective. One recent (2008) study by experts affiliated with the Guttmacher Institute found that nationally, public expenditures for family planning care not only have important health benefits but every \$1 invested saves the public \$4.02.⁵²
- A May 2010 Guttmacher Institute report shows that in Connecticut in 2008, the annual family planning services cost per client was \$251, while the cost per Medicaid-funded birth was \$14,307 (includes prenatal care, delivery, postpartum care, and medical care for the infant for one year). It was estimated the annual net cost savings to the state from Medicaid births averted by providing publicly funded contraceptive care (to women of all ages not just teens) was \$71 million.⁵³
- An independent economic evaluation of one of Connecticut's long-established TPPI programs, the Carerra-based Pathways/Senderos Center program in New Britain, conducted in 2009 found that in total, operating costs exceeded savings (from teen births prevented) by a modest amount during program participation; however, by young adulthood, the combined shorter and long-term economic benefits (from high school graduation) outweighed program costs.⁵⁴

Story Behind the Data

The strong performance of family planning services and TPPI programs seems due to the quality of the contractors and good contract management practice by DPH and DSS. Both agencies require and review regular reports on performance and conduct visits of all program sites at least once a year. However, PRI staff found even though they use the same contractor and have many of the same contract outcome measures there is little communication between DSS and DPH about their family planning services. Results of each agency's contract management activities are not compiled in one place to permit comparison of findings, augment accountability, or possibly reduce duplication of effort.

The DPH and DSS family planning contractor has its own quality assurance and improvement process and high performance standards. This is due, in part, to its participation in the national accreditation process and performance requirements imposed by other funders. The contractor also places a high value on customer service; client satisfaction surveys are done regularly and scientifically. All complaints are documented and the information, including how they were addressed, is maintained in a file separate from patient records. In its latest national accreditation review, PPSNE was found to have: exceptional customer service across the organization; best practices in its public affairs, education and training, and development departments; and a model strategic plan.

⁵² Frost, et. al, *The Impact of Publicly Funded Family Planning Clinic Services on Unintended Pregnancies and Government Cost Savings*, Journal of Health Care for the Poor and Underserved 19 (2008), pp. 778-796.

⁵³ Guttmacher Institute, *Contraceptive Needs and Services: National and State Data*, 2008 Update, May 2010

⁵⁴ Rosenthal, et. al., *Economic Evaluation of a Comprehensive Teenage Pregnancy Prevention Program: Pilot Program*, American Journal of Preventive Medicine, 37 (6S1): S280-S287, 2009.

A strong contract management process is in place at DSS for the Teen Pregnancy Prevention Initiative, partially because evidence-based models are used. To ensure effectiveness, fidelity with all key aspects of the models must be maintained through active program oversight. The department uses two consultants (one for each type of program) to help with training and technical assistance for program operators on implementing the evidence-based teen pregnancy prevention models. In addition, a nationally recognized teen pregnancy prevention consultant has been engaged to evaluate overall impact of the TPPI programs throughout the current contract term. DSS also has a contract with the Family Planning Program of the University of Connecticut Health Center Department of Obstetrics and Gynecology to provide technical assistance and support in overseeing TPPI programs.

At present, total annual costs for all outside services are about \$165,000, or less than 10 percent of the TPPI budget. Given the large state investment in these programs over time (at least \$3,000 to \$30,000 per client, depending on the model and duration of participation), the complexity of the service models, and the numbers of contractors and sites, it seems worthwhile to supplement DSS internal resources (one staff person managing TPPI in addition to other duties) with help from expert consultants.

As with family planning services contract management materials, PRI staff found the many performance reports and data on the TPPI programs are not brought together in one source (except for a periodic progress report prepared by the evaluation consultant). This makes it difficult to look at trends over time, compare performance across different sites or programs, and use the available data to inform management and policy decisions about continuing or expanding programs.

The substantial body of national research on the cost effectiveness of family planning and pregnancy prevention services for adolescents provide strong evidence that well-run programs, like those operating in Connecticut, are good public investments. In most cases, the studies focus on short-term program benefits in terms of averted teen births; a few also identify cost savings related to STD prevention and treatment.

However, teen reproductive health services that delay sexual initiation and reduce other risky sexual activity, or increase the use of contraception (to prevent unintended pregnancy, STDs, and HIV), have other economic benefits, both for the adolescents served and their communities. These are related to impacts difficult to monetize, but recognized as significant, such as higher future earnings (and associated tax revenues) from better academic performance and high school completion. Preventing too-early parenthood also reduces long term social costs associated with teen births including: the participation of teen mothers in public assistance programs; and the participation in child welfare, criminal justice, and public health systems among children born to teen parents.

The 2009 economic evaluation of the New Britain TPPI program cited above was one of first studies to quantify costs and benefits of a comprehensive teen pregnancy prevention program and estimate longer term program benefits. The study, which was conducted by a research team that included Yale University School of Medicine and University of Connecticut

School of Medicine faculty, found total costs (program operating costs) exceeded total benefits (savings from averted births) by about \$1,600 per client, while teenage participants were enrolled.⁵⁵ However, when economic benefits accrued through young adulthood were estimated, social benefits outweighed social costs by age 20 and reached almost \$10,500 per adolescent per year by age 30. The results of this evaluation clearly demonstrate the value of considering the long-range cost effectiveness of programs when planning and funding teen pregnancy prevention strategies.

The New Britain study research team also pointed out their benefit estimates are conservative for several reasons. The calculations only account for economic gains from high school graduation, not any higher educational attainment. Also, future savings to society from averting costs of negative consequences from too early parenthood, such as special education needed by children born to teenage mothers, are not included.

Actions to Turn the Curve

DPH and DSS have taken many steps to ensure good performance from the family planning services and teen pregnancy prevention programs they fund. There is close oversight and active management of all contractors. In the case of TPPI, social services staff activities are supplemented with expert technical assistance and independent evaluation of program results. In general, information that policymakers and the public need to assess program efficiency and effectiveness is developed, although not always readily available.

To further strengthen accountability for the results of state-funded family planning and pregnancy prevention services provided to Connecticut adolescents, **the PRI staff recommends:**

- **DPH and DSS together develop and maintain an RBA program performance report card for the family planning services they fund. The report card should include performance measures specific to adolescents served as well as for the entire client population.**
- **DPH and DSS also should consider ways to combine their field work and reporting requirements conducted for family planning services to increase the efficiency and effectiveness of their contract management and program oversight activities.**
- **DSS should develop and maintain an RBA report card for each individual TPPI program and for the overall initiative.**
- **Program performance report cards for family planning services and TPPI should include client satisfaction results and be posted on both agency websites**

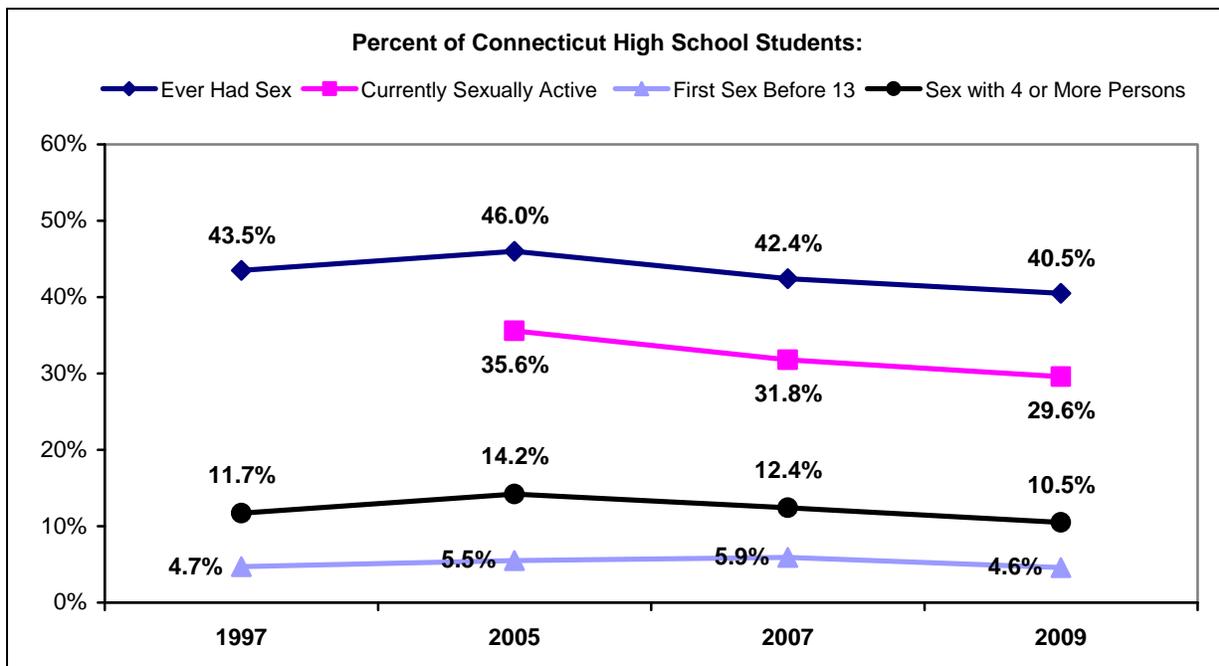
⁵⁵ Data available at the time of the evaluation showed only two pregnancies were reported in the 11.5 years the program had been operating. In addition, the program had a 100% graduation rate, with more than half of participants going on to four-year higher education, compared with an expected matriculation rate of 31%.

In addition, the program review committee staff recommends the social services department continue to fund the independent evaluation process for TPPI to ensure reliable data on overall results are gathered and reported. This information should be used as the basis for decisions on whether to continue programs and, should additional resources become available for teen pregnancy prevention, expand them.

III. Is Anyone Better Off?

Overall, primary and preventive reproductive health services for teens have two main purposes: keep adolescents free from disease and unintended pregnancy; and promote behaviors that maintain their sexual health and safety. Program review committee staff found state-funded family planning services and TPPI programs help make teens better off by giving them access to science-based reproductive health care and information. Direct client outcomes for either program are not fully known, but based on national research, PRI staff believe both are contributing to improving population-level results in Connecticut. While overall trends are positive, however, racial and ethnic disparities persist and the number of unplanned births to mothers under age 20 each year is still too high. Data for six client outcome measures related to teen reproductive health services – reported sexual activity and contraceptive use, STD and HIV cases, teen pregnancy and abortion rates, and teen birth rates by race/ethnicity and by town – are presented and briefly discussed below.

Measure 1: Connecticut High School Students: Reported Sexual Activity



- All measures of high school student sexual activity shown in the above table were lower in 2009 than in 1997. Based on the decline in the percent of high school student who ever had

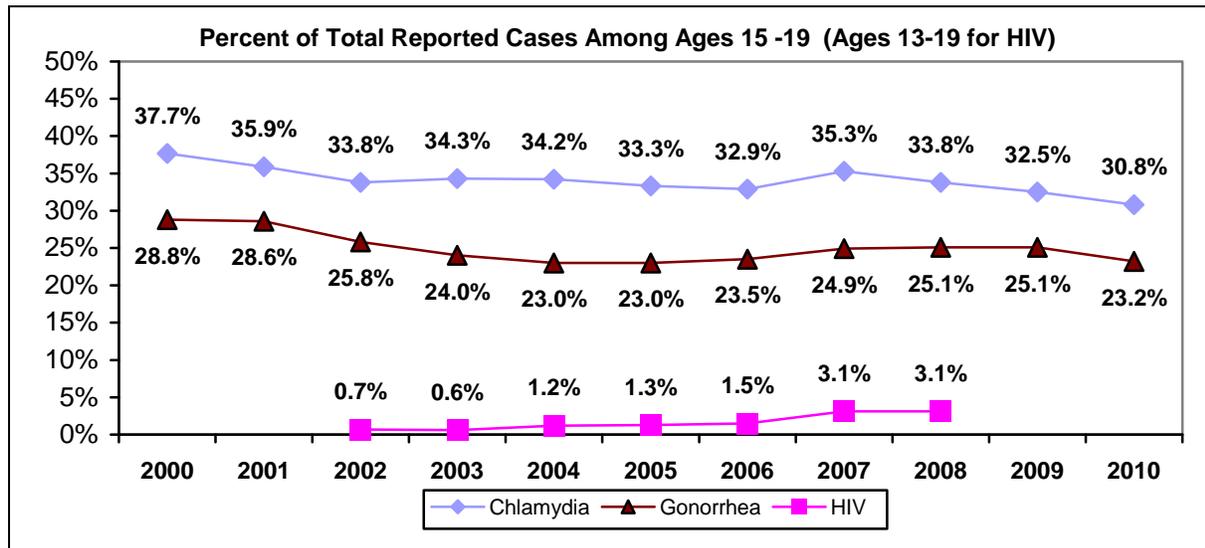
sexual intercourse (from 43.5% to 40.5%), it appears teens are waiting longer before they initiate sexual activity.

- Most reductions were small and one change (first sex before 13) was not statistically significant; however, the percent of currently sexually active students dropped 6 percent between 2005 and 2009
- Additional information from the 2009 Connecticut School Health Survey shows the percentage of high school students who ever had sex or are currently sexually active increases with age.
 - By grade 12, more than one-half of white (54.9%), black (52.8%) and Hispanic (58%) students were are currently sexually active.
 - The percentage of high school students who ever had sex was 22.3% in grade 9 but increased to 67.4% in grade 12.
- Data gathered through the school health survey only reflect the public high school population; information on behaviors of adolescents who have left school and/or in residential facilities (e.g., hospitals, treatment programs, detention or correctional centers), is not captured.

Measure 2. Connecticut High School Students: Reported Contraceptive Use

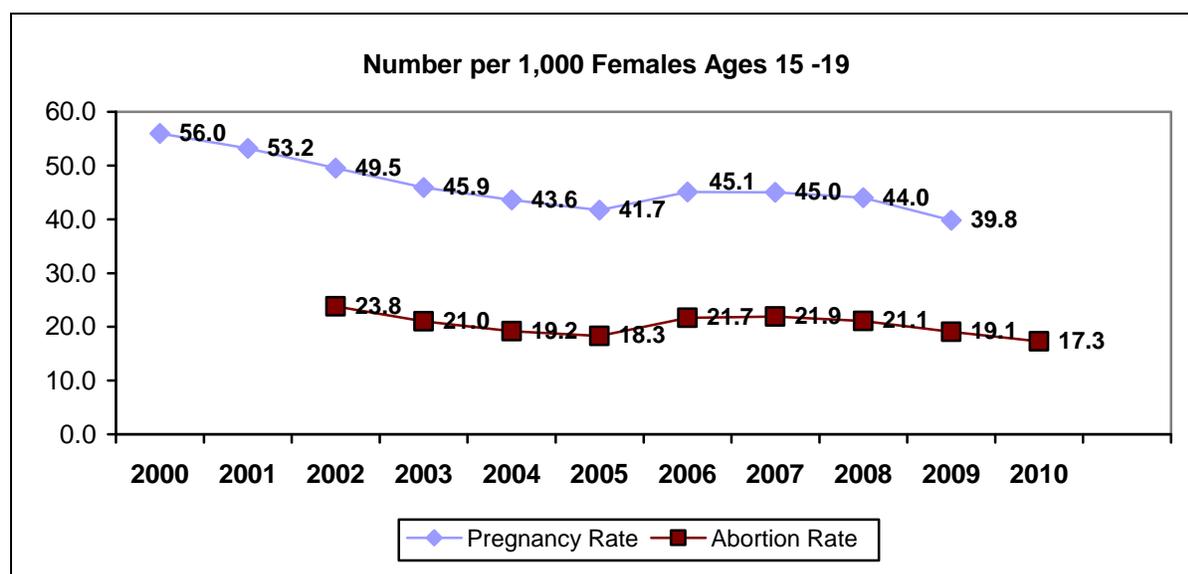
- In 2009, among high school students who have ever had sexual intercourse, about 90% reported during their last intercourse they or their partner used some form of birth control.
- Among students who were currently sexually active in 2009: most (59%) used a condom during their last sexual intercourse; 27% used hormonal birth control, birth control pills, or Depo Provera (injectible); and 8% used both a condom and hormonal birth control.

Measure 3: Connecticut Teen STD and HIV Cases



- The percent of reported STD cases among adolescents ages 15-19 in Connecticut for two diseases, Chlamydia and gonorrhea, decreased about six to seven percent over the last decade.⁵⁶
- HIV infection cases among all teens (ages 13-19), as a percent of reported new cases for all ages, increased from 2002 to 2008. At the same time, the total numbers of cases reported have steadily dropped from 835 (2002) to 352 (2009). Given the very small numbers involved, any trends must be interpreted with caution.

Measure 4: Connecticut Teen Pregnancy and Abortion Rates

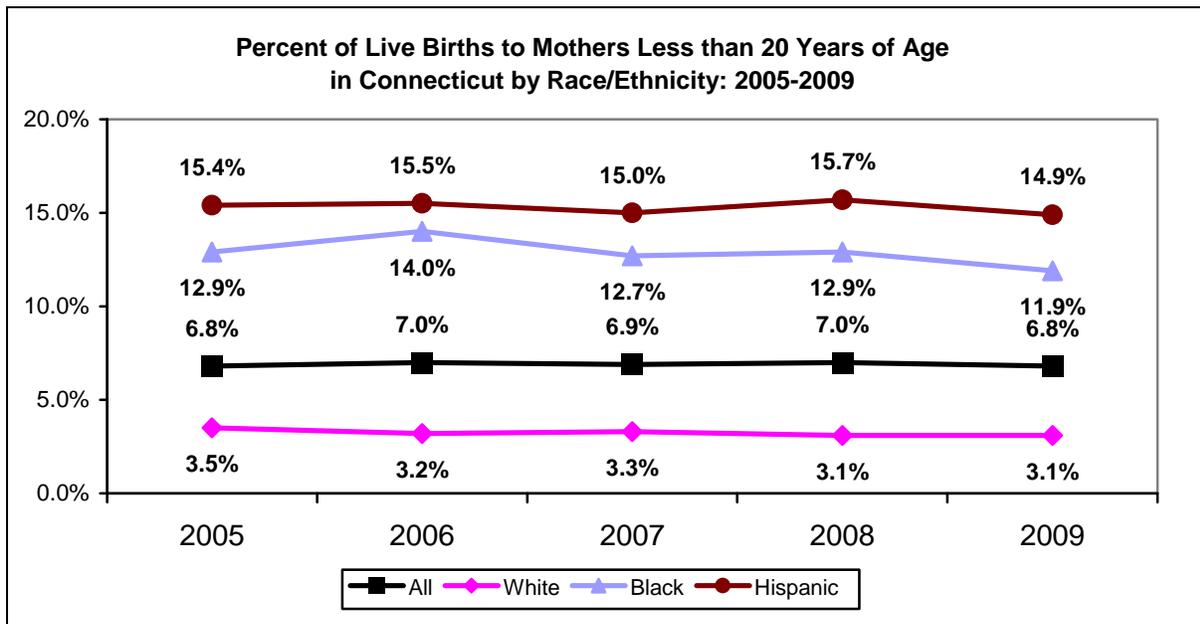


- Among Connecticut teens ages 15 through 19:
 - the pregnancy rate and the abortion rate each dropped by about 20 percent between 2002 and 2009;
 - between 2002 and 2010, the abortion rate dropped 27 percent.
- The most recent available data from DPH show in 2008 there were 2,815 live births to teen mothers (females under age 20) in Connecticut.
 - 69 percent were to 18 and 19 year olds.
 - About 30 percent were to girls ages 15 to 17.
 - Mothers younger than 15 accounted for less than 1 percent (26) of total live births to mothers under age 20.
 - 16 percent of the total number for mothers under age 20 were repeat births.
- The percentages of teen births by age group for the U.S. in 2008 were the same as in Connecticut; the national repeat birth rate for teens, however, was higher (19%).

⁵⁶ Trend data for syphilis are not useful as total numbers and number of cases among Connecticut teens are very small. In some years no cases for ages 15-19 have been reported to DPH.

- According to the latest DPH statistical summary of legal induced abortions occurring in Connecticut, a total of 13,438 were reported to the department in 2010 (in accordance with Section 19-13-D54 of the state public health code). The department's 2010 report shows:
 - 92 percent of all patients were age 18 or older (age information missing for 260 records, 1.9% of total)
 - The total number of teen patients – those under age 20 – was 2,160 (16%)
 - The total number of patients under age 16 was 180 (1%); most were either age 15 (123) or 14 (23) while 11 were age 13 and another 11 were age 12 or under
 - 97 percent of all patients were Connecticut residents (no missing state residence information)
 - 96 percent of all abortions were performed in non hospital licensed facilities; the remainder were performed in hospitals (in or outpatient) or a physician's office (no missing facility information)
 - Nearly 90 percent of the abortions were performed at an estimated gestation of 12 or less weeks (11,946, 88.9%); under 1 percent (41) were performed at 21 or more weeks (gestation information missing for 220 records, 1.6% of total)
 - For about 70 percent, the method used was surgical (e.g., suction cutterage) while almost 30 percent were medical (non-surgical) (method information missing for 3 records)

Measures 5. Connecticut Teen Births by Race/Ethnicity



- Over the last five years for which data are available (2005 – 2009), the state teen birth rate, when defined as the percent of all births to mothers less than 20 years of age, has stayed essentially the same -- around 7 percent.
- During the same period, birth rates for black and Hispanic teens declined (by one-half to one percent) but still were well above the state average, at nearly 12 and 15 percent, respectively.

- Furthermore, compared with the birth rate for white mothers less than 20 years old (about 3 percent), the rate for black teens was four times higher while the rate for Hispanic teens was five times higher.

Measure 6. Connecticut Teen Births By Town

- The percent of births to mothers under age 20 exceeded the statewide average (6.8 – 7.0 percent) in 31 Connecticut towns for at least one year between 2004 and 2008, as shown in the table below.
- In 10 communities, including four major cities (Hartford, Waterbury, Bridgeport, New Haven), the five-year average teen birth rate was at least 10 percent and ranged up to more than 18 percent. In Hartford, New Britain, Waterbury, and Windham, the percent of births to mothers less than 20 years old of age was at least two times the state average every year from 2004 to 2009.

Story Behind the Data

Overall trends in the main indicators of reproductive health for the adolescent population in Connecticut are positive. Reported rates of sexual activity among high school students in the state are lower than in 1997. High school students who are sexually experienced report high use of contraception. Teen pregnancy, abortion, and STD rates in Connecticut, like nationally, have dropped to historic lows over the last decade.

Client outcome data directly attributable to Connecticut teen reproductive health services are limited. In general, it is expensive and complicated to collect and analyze client outcome data about family planning, pregnancy prevention, and other reproductive care. Follow-up surveys and interviews are needed to gather necessary longitudinal information from clients. Scientific assessment of program effectiveness, the basis for evidence-based practice, requires costly experimental or quasi-experimental designs. Funding dedicated to program evaluation, as in the case of the DSS Teen Pregnancy Prevention Initiative, is rare.

However, it can be assumed programs that implement practices with proven effectiveness are likely to achieve good outcomes for their clients. Most recently, a 2010 report prepared by Mathematica Policy Research for the U.S. Department of Health and Human Services (HHS) identified program models with the strongest evidence of effectiveness in reducing teen pregnancy, sexually transmitted infections, and associated sexual risk behaviors⁵⁷. The DPH and DSS family planning services and TPPI programs incorporate effective evidence-based practices cited in the Mathematica report.

⁵⁷ In addition, Mathematica received federal funding to maintain and update the review, which HHS uses to prepare a list of evidence-based programs meeting its criteria for effectiveness, on an annual basis. Only programs on the HHS list are eligible for agency funding of state teen pregnancy prevention and personal responsibility education efforts.

Connecticut Communities Exceeding the Statewide Average for Births to Teen Mothers (under age 20), 2004-2008.							
Town	Pop.	2004	2005	2006	2007	2008	mean
Hartford	121,578	20.10%	17.90%	18.10%	15.84%	19.25%	18.24%
New Britain	71,538	16.00%	14.60%	17.70%	15.70%	14.68%	15.74%
Waterbury	107,271	14.50%	14.90%	15.00%	14.04%	14.51%	14.59%
Windham	22,857	15.40%	13.90%	14.10%	14.75%	14.72%	14.57%
New Haven	123,626	13.60%	13.10%	13.10%	14.35%	13.11%	13.45%
Bridgeport	139,529	13.20%	13.20%	14.30%	12.85%	13.61%	13.43%
New London	25,671	14.00%	13.80%	13.80%	10.76%	12.24%	12.92%
Meriden	58,244	13.70%	10.70%	12.60%	10.14%	9.40%	11.31%
East Hartford	49,575	10.00%	10.00%	11.70%	9.92%	10.56%	10.44%
Norwich	36,117	12.50%	8.60%	9.80%	8.99%	10.57%	10.09%
Killingly	16,472	13.60%	8.80%	7.90%	8.81%	10.75%	9.97%
Griswold	10,807	12.20%	10.50%	5.70%	7.00%	8.00%	8.68%
Putnam	9,002	9.90%	7.60%	5.90%	6.90%	11.50%	8.36%
Ansonia	18,554	10.20%	8.00%	5.60%	8.30%	9.30%	8.28%
West Haven	63,589	8.20%	7.20%	7.80%	9.22%	8.10%	8.10%
Torrington	35,202	7.70%	9.00%	9.80%	6.90%	6.54%	7.99%
Montville	18,546	7.40%	9.10%	8.50%	5.60%	7.50%	7.62%
Groton	10,010	7.00%	10.80%	6.00%	8.70%	5.60%	8.00%
Vernon	28,063	8.20%	8.60%	5.80%	7.60%	7.30%	7.50%
Brooklyn	7,977	x	7.50%	9.20%	7.60%	5.70%	7.50%
Bristol	60,062	7.40%	7.90%	7.60%	6.80%	7.00%	7.34%
Plainfield	15,442	5.60%	6.00%	7.10%	6.50%	11.50%	7.34%
Winchester	10,664	6.40%	7.70%	4.20%	8.20%	10.10%	7.32%
Thompson	8,878	9.20%	5.80%	6.80%	x	x	7.27%
East Windsor	11,041	x	7.50%	x	7.30%	6.80%	7.20%
Derby	12,391	6.60%	9.20%	5.10%	7.70%	6.60%	7.04%
Stafford	11,869	8.30%	8.30%	x	7.40%	4.10%	7.03%
CONNECTICUT		6.90%	6.80%	7.00%	6.90%	6.97%	6.91%
Bloomfield	20,696	4.40%	5.40%	8.10%	6.10%	10.30%	6.86%
Enfield	45,259	6.10%	7.70%	5.80%	7.10%	4.30%	6.20%
Plymouth	12,014	4.40%	5.00%	6.60%	5.60%	9.20%	6.16%
East Haven	28,825	4.20%	3.60%	4.40%	8.30%	4.60%	5.02%

Source: Family Planning Program, Department of OB/GYN at the University of Connecticut Health Center, based on data provided courtesy of Connecticut DPH; population estimates derived from city-data.com.

Note: X denotes a number too small to calculate Connecticut DPH

Color Key: Green denotes towns with populations less than 20,000; purple denotes a mean that does not exceed the statewide average for a given time period; turquoise denotes communities with currently funded TPPI programs through DSS; red denotes numbers averaged over fewer than 5 years.

Based on the national research, PRI committee staff believes family planning and pregnancy prevention services, such as those funded by DPH and DSS, are making adolescent clients better off in terms of: reducing unplanned pregnancies and STDs; and increasing safe and responsible sexual behaviors. Throughout the state, adolescents can receive high quality, science-based reproductive health care, counseling, and education in a confidential manner, at many convenient locations, regardless of ability to pay. Besides the state-funded family planning health centers, affordable primary and preventive teen reproductive health services, including contraception, STD testing and treatment, and counseling and education, are available at community health centers across the state and at some school-based health centers.

Testing and treatment for sexually transmitted infections for clients of all ages also are available through nine local STD control clinics funded by the state public health department. In addition, a number of municipalities and community-based organizations fund or operate programs that include general reproductive health services for adolescents or specifically address teen pregnancy, STDs, and HIV. The city of Hartford, for example, is using \$900,000 in federal funding to coordinate a five-year, teen pregnancy prevention project that provides evidence-based services to low-income black and Hispanic youth aged 13 – 19. This initiative is building on current services to reduce teen pregnancy being offered to Hartford youth through the citywide collaborative called “Breaking the Cycle.”

At the present time, there is no central inventory of all efforts, state and local, public and private, in Connecticut to: prevent teen pregnancies and STDs; reduce high risk sexual behaviors among adolescents; and help youth adopt the attitudes and behaviors that support their long-term health and well-being. There also is no current statewide mechanism to coordinate adolescent reproductive health care programs and services, help pool resources, or integrate data on needs and results. It appears the last broad, interagency coalition on teen pregnancy prevention was active more than 15 years ago.

Despite substantial improvement since the early 1990s, birth rates among U.S. females under age 20 still are the highest among many developed countries.⁵⁸ The numbers of unintended adolescent births also remain significant; in Connecticut, there were, on average, over 2,700 births to mothers less than age 20 each year between 2005 and 2009. As discussed earlier, the majority of adolescent pregnancies and births in the state occur among black and Hispanic teens.

The causes of teen pregnancy, and the reasons for racial and ethnic disparities in adolescent birth rates, are complicated and overlapping. One thing that seems clear is the drop in teen births nationally and in Connecticut is not due to increases in abortions. Both the rate and number of abortions among women under age 20, like births, have been declining. Based on analysis of the latest CDC National Survey of Family Growth data, Guttmacher Institute researchers found lower teen births are linked almost exclusively to improvements in teen

⁵⁸ In 2009, the teen birth rate for the U.S. was 39 per 1,000 females ages 15-19; Connecticut’s rate was 21.0. Except for the United Kingdom (27), rates in other, comparable countries were well below either level: Australia, 17; Canada, 14; France and Germany, 10; Sweden, 6; and Japan and Netherlands, 5.

contraceptive use; adolescent use of contraction has increased and has shifted to more effective methods.⁵⁹

However, national research also shows just making contraception available does not prevent unintended pregnancy or too-early and unsafe sexual activity. Comprehensive prevention approaches that combine high quality health and sexual health education, contraception, and positive youth development activities, like Connecticut's TPPI programs, have the most success with high-risk groups. They can be especially effective when adapted to be developmentally and culturally appropriate for different ages and racial and ethnic groups. The high cost of operating and administering such programs, however, is a major barrier to widespread implementation.

As pointed out in work by the National Campaign to Prevent Teen and Unintended Pregnancy, the complex problems of adolescent pregnancy and childbearing cannot be addressed by a single agency or strategy.⁶⁰ Multiple organizations, a wide range of activities, and secure funding are needed to make progress in reducing teen pregnancy and improving adolescent reproductive health.

Many states and communities, therefore, have organized coalitions, task forces, or other groups to address teen pregnancy. Factors that contribute to the success of such groups, according to the National Campaign, include: diverse partners from all sectors and public-private partnerships; a clear mission, vision, and focus (goals); efforts to raise public awareness (e.g., annual advocacy days, town hall meetings); training and technical assistance such as continuing education and annual conferences; involve boys and stress the importance, and responsibilities, of fatherhood; involve parents and provide them with practical support; and involve youth, through advisory boards, focus groups, and leadership teams.

Providing adolescents with comprehensive sexual health education is another, and relatively low cost, way to make teens better off. National studies show approaches to sexual health education that include, at a minimum, science-based information about abstinence and contraception can have many positive outcomes including: delayed onset of sexual activity; reduced number of partners; and when youth are sexually active, safer sex practices and better use of contraception. Further, there is no evidence that providing young people with information about sex and contraception leads to early sexual activity or experimentation.⁶¹

A 2006 study identified the characteristics of effective HIV and teen pregnancy prevention education programs at middle and high school levels that improve the likelihood of changing student behavior.⁶² These characteristics include: based on solid theory; consistent with community values and resources; focused on clear goals and specific related behaviors; culturally relevant and developmentally appropriate; and supported by administration, teachers, and youth. The most effective programs are those implemented in 12 or more sessions in

⁵⁹ Guttmacher Institute, *News in Context: New Government Data Finds Sharp Decline in Teen Births*, Dec. 1, 2011.

⁶⁰ The National Campaign to Prevent Teen and Unplanned Pregnancy, *Get Organized: Starting a Coalition or Campaign to Prevent Teen Pregnancy*, May 2010

⁶¹ Kirby, *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*, National Campaign to Prevent Teen and Unplanned Pregnancy, 2007.

⁶² Kirby, et.al, *Sex and HIV Education Programs for Youth: Their Impact and Important Characteristics*, ETR Associates, 2006.

sequential sessions over multiple years, which allows for reinforcement of key knowledge, attitudes, and skills as students age and mature.

In January 2012, the Connecticut State Department of Education issued a resource guide for local school districts called “*Guidelines for the Sexual Health Education Component of Comprehensive Health Education*.” The guidelines, which are based on national standards for health and sexual health education, were prepared by agency staff as part of the state’s federally funded Coordinated School Health (CHS) activities.

Implementation of the SDE guidelines is voluntary. (Connecticut is one of 29 states that does not mandate sex education in schools.) They are intended to provide a framework for developing sexual health education policies, programs, curriculum, and instruction that are aligned with the state comprehensive health curriculum. The goal is to ensure young people have the knowledge and skills, especially refusal and negotiating skills and how to communicate with parents, to promote their health and well-being.

The SDE guidelines incorporate all of the characteristics of effective sexual health education highlighted above. The guidelines stress providing developmentally appropriate and medically accurate information on a broad set of topics related to sexuality (human development, relationships, abstinence, decision-making, contraception, and disease-prevention). There also is a strong emphasis on abstinence and encouraging parental and community involvement. The guidelines additionally include provisions for regular evaluation to foster quality improvement and accountability within a school’s sexual health education program component.

In Connecticut, sexual health education currently is provided by public schools in a variety of ways. The department does not conduct any type of regular review of local district health education programs, so the content and quality of sexual health curricula provided to students at present is unknown.⁶³

However, some basic information about sexual health education provided by Connecticut schools is gathered through the biennial National School Health Profile Survey conducted by the Centers for Disease Control and Prevention (CDC). The last national survey results showed among Connecticut high schools in 2010, in a required course: 80% taught key pregnancy, HIV, and other STD prevention topics; 74% percent taught key topics about condom use; and 92% taught how to access valid and reliable health information, products, or services related to HIV, other STDs, and pregnancy.

⁶³ Under C.G.S. Section 10-16b, public schools must offer programs of instruction, taught by legally qualified teachers, for a number of subject matter areas including health and safety (which by statute includes but is not limited to human growth and development, nutrition, first aid, disease prevention, community and consumer health, physical, mental and emotional health, including youth suicide prevention, substance abuse prevention, safety, which may include the dangers of gang membership, and accident prevention). Annually, each local and regional board of education must attest to the state board that required programs of instruction are offered and are planned, ongoing, and systematic. The department does not audit compliance regarding health or any other program of instruction at the present time.

The national survey also shows 22% of Connecticut public high schools provided parents and families with information to increase their knowledge of HIV, STD, or teen pregnancy prevention in 2010. Further, in about one-third (34%) of state high schools, a lead health education teacher had received professional development related to HIV prevention during the prior two years; around one-quarter (28%) had a lead health teacher who had received professional development on pregnancy prevention.

Connecticut, like 32 other states and the District of Columbia, has required schools to provide HIV/AIDS education to students since 1989. Under C.G.S. Section 10-19, local and regional districts must offer planned, ongoing and systematic instruction, taught by legally qualified teachers, on acquired immune deficiency syndrome. Upon the written request of a parent or guardian, pupils can be exempted from such instruction.

The state education department, as required by law, makes materials available to assist districts in developing HIV/AIDS education. Most recently, materials were provided within the new comprehensive sexual health education guidelines. At this time, compliance with the HIV education requirement is not monitored by the department and no data on how often the opt-out provision is used by parents are compiled.

The department's new sexual health education guidelines also meet a statutory requirement in effect since 1980 that the State Board of Education develop curriculum guides to aid local and regional boards develop family life education programs. Under C.G.S. Section 10-16c, the guides must include information related to family planning, human sexuality, parenting, nutrition, and the emotional, physical, psychological, hygienic, economic, and social aspects of family life but not any information pertaining to abortion as an alternative to family planning. The new SDE guidelines are the first update of the family planning curriculum since the early 1980s.

Districts are not required to develop or institute family life education programs and state law specifies if such a program is instituted, it can only be a supplement to existing health education curriculum requirements. Also, no student can be required to participate in a family life program offered in a public school. By law, written notification from a parent or guardian to the local or regional board is sufficient to exempt a student from all or part of the program.

Actions to Turn the Curve

Over the past few years, with federal grant funding for Coordinated School Health and teen pregnancy, HIV, and STD prevention, Connecticut has undertaken several important initiatives to improve adolescent reproductive health. Most involve multiple state agencies working in partnership. The departments of public health and education, for example, established an interagency workgroup for coordinated school health that among other tasks, is creating a network of advocates in schools and community-based agencies for teen pregnancy, HIV, and STD prevention.

In addition to developing new guidelines for sexual health education, the state education department, with CHS funding, developed a cadre of trainers to provide research-based and

medically accurate professional development in HIV and STD prevention education to local schools and community groups. Statewide training on sexually transmitted diseases prevention education programs also has been conducted.

With federal Personal Responsibility Education Program (PREP) funding, the Department of Public Health, in partnership with the departments of education, children and families, and mental health and addiction services, is implementing a teen pregnancy prevention program targeted at one of the highest risk groups, youth in foster care. Evidence-based intensive pregnancy prevention education programs are being delivered to residents of DCF groups homes and other residential facilities. Agency staff and foster parents also are receiving sexual health training. An independent evaluator will be monitoring and reporting on process and client outcomes throughout the program's five-year contract period.

The state education department is the lead agency for Connecticut's latest federally funded initiative to address teen pregnancy, Supports for Pregnant and Parenting Teens (SPPT). A secondary prevention program, SPPT will target pregnant and parenting black and Hispanic high school youth in five school districts with high teen birth and school dropout rates. SDE, in partnership with the departments of public health and social services, will use an evidence-based approach to provide six core services aimed at improving health, education, and social outcomes of these students and their children.

These many interagency efforts appear promising as ways to: 1) provide more adolescents with the knowledge and skills needed to promote their sexual health and well-being; and 2) foster better coordinated, more comprehensive, and likely more efficient reproductive health services, especially for high-risk teen groups. PRI committee staff identified some additional low- and no-cost actions that could further improve reproductive health outcomes for Connecticut adolescents.

To ensure quality and consistency of sexual health education, **PRI committee staff recommends:**

- **The state department of education should establish a system for tracking the sexual health education programs local and regional districts are providing. At a minimum, data should be collected on the content included and whether it is science-based, the students served, qualifications of the teachers providing instruction, and whether SDE guidelines for sexual health education are used.** It is possible the department could use the National School Profile Survey process to collect this type of information. Adding questions to this CDC instrument, however, would involve a cost to the state that could be significant. The national survey and less expensive options, such as adding questions to the department's own annual school health services survey, should be explored by SDE.
- **The department also should collect and examine district-level data on key outcomes related to sexual health education, such as birth rates, STD and HIV rates, sexual activity measures, graduation/drop out rates, and other academic performance measures to help schools determine how well their programs are meeting the needs of their adolescent students. Consideration should be given to developing a standard**

survey to gather feedback from students about how effective they think the instruction provided is in improving their sexual health knowledge and skills.

- **SDE also should consider establishing a program of incentive funding for districts in the state with the highest teen pregnancy rates and greatest achievement gaps to implement sexual health education programs based on the new department guidelines on pilot basis.** Piloting the sexual health education guidelines in highest need districts can serve two purposes: provide a way for the department to test the effectiveness of guidelines and develop “lessons learned” information about implementation; and provide schools with the most challenging adolescent populations an evidence-based tool for reducing teen pregnancy and increasing graduation rates.

The program review committee staff found a concerted effort to make progress in reducing unintended pregnancy, STDs, and risky sexual activity across all Connecticut adolescents is lacking. As discussed above, other states have established various coalitions and multi-agency campaigns that have been successful in addressing teen pregnancy prevention. In Connecticut, the Youth Suicide Prevention Initiative (CYSPI), a broadly collaborative, multi-agency effort led by the Department of Mental Health and Addiction Services, has been effective in developing, implementing, evaluating, and sustaining evidence-based youth suicide prevention and early intervention strategies and programs.⁶⁴

To make teen pregnancy prevention a priority, and focus state resources and effort on achieving better results for adolescents, **program review committee staff recommends:**

- **The adolescent health coordination workgroup recommended in Section I should organize a statewide initiative to address teen pregnancy and related reproductive health issues.**
- **The initiative should build on the current coordinated school health partnerships as well as the collaborations formed to carry out the new Personal Responsibility Education Program for youth in foster care and Supports for Pregnant and Parenting Teen program. Partners representing the Judicial Branch, and state correction department, and community groups and service providers that work with justice-involved youth, as well as school dropouts, and other special need populations also should be included in the initiative.** Existing CHS, PREP, and SPPT efforts include many of the stakeholder groups that should be involved in preventing adolescent pregnancy and risky sexual behaviors: staff from the state departments of education, public health, children and families, social services, and mental health and addiction services; representatives of public schools and local public health agencies; foster parent and youth advocacy groups;

⁶⁴ Connecticut received multi-year federal funding beginning in 2006 to enhance youth suicide prevention efforts throughout the state. DMHAS, in partnership with the departments of children and families, public health, education, and the Judicial Branch, the state university system, and the University of Connecticut Health Center, plans and carries out Connecticut Youth Suicide Prevention Initiative. Detailed information about CYSPI including annual reports and independent evaluations is available at the Department of Mental Health and Addiction Services website (<http://www.ct.gov/dmhas/cwp/view.asp?a=2912&q=335130>).

and community groups focused on issues that impact adolescent health and well-being, such as homelessness, hunger, and sexual orientation (lesbian, gay, bisexual, and transgender youth). Adding partners from criminal justice and other nonacademic organizations helps ensure strategies also address the needs of adolescents not attending school.

- **As its first tasks, the statewide teen pregnancy prevention initiative should:**
 - **create and keep current an inventory of state and local teen pregnancy prevention activities;**
 - **identify key outcomes measures for these activities;**
 - **determine how to collect and share necessary outcome data, including ways to link agency information systems;**
 - **coordinate grant strategies and find ways to pool resources; and**
 - **develop, as top priorities, strategies for addressing racial and ethnic disparities, fatherhood, and repeat teen births.**

Last, as part of the data development and research agenda for adolescent health, program review committee staff recommends:

- **The state Medicaid and CHIP data on reproductive health services, should be analyzed to better understand disparities in access, utilization, and outcomes among adolescents and possible ways to address them. At a minimum, the analysis should determine who receives primary and preventive reproductive care, what types and amounts of services are received, the sources of care (types of providers) and whether there are differences by race, ethnicity, or other relevant characteristics.**
- **A study should be conducted of the impact of SBHCs that offer condoms and other contraceptive services and supplies that includes examination of trends in positive pregnancy and STD tests among the populations they serve. The department of public health should explore possible resources for this project including seeking assistance from state institutions of higher education.**

APPENDICES

CONNECTICUT ADOLESCENT HEALTH

TARGET POPULATION: YOUTH AGES 10 – 19 YEARS

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
---	--	--	--

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>
--	---	---	--	---

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)
--	---	--

PROGRAM LEVEL ACCOUNTABILITY

MAIN STATE AGENCY ROLES AND PROGRAMS (PRI STUDY FOCUS PROGRAMS 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) - CHCs (DPH) - CSH (DPH/SDE) - 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) 	<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 PROGRAMS):

<p style="text-align: center;"><u>School-Based Health Centers</u></p> <ul style="list-style-type: none"> ● Access to primary and preventive care (e.g., high enrollment rates, particularly for uninsured/underinsured students) ● Health status (e.g., receive recommended screenings; chronic conditions managed) ● School attendance (e.g., high return- to-class rates; fewer absences/tardy) ● Cost-effectiveness (e.g., reduced use of emergency departments) 	<p style="text-align: center;"><u>Primary and Preventive Teen Reproductive Health Services</u></p> <ul style="list-style-type: none"> ● Sexual activity (e.g., delay initiation/practice abstinence; if active, use contraception) ● Unintended pregnancy (e.g., low birth rates) ● Sexually Transmitted Diseases - STDs (e.g., low infection rates))
--	---

APPENDIX A

Acronyms Used in Adolescent Health Care RBA Framework	
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	Centers for Disease Control and Prevention
○ HRSA	Health Resources and Services Administration
○ SAMHSA	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 Centers
• CSH	Coordinated School Health
• CYSHCN	Children and Youth with Special Health Care Needs
• DHP	Dental Health Partnership
• LIA	Low Income Adult (Medicaid program)
• MCH	Maternal and Child Health
• NFN	Nurturing Family Network
• NPAO	Nutrition, Physical Activity and Obesity
• PREP	Personal Responsibility Education Program
• SBHC	School-Based Health Centers
• SNAP	Supplemental Nutrition Assistance Program (formerly Food Stamps)
• SPPTP	Support for Pregnant and Parenting Teens Project
• STD	Sexually Transmitted Disease Control program
• SVIP	Sexual Violence Intervention and Prevention program
• WIC	Women, Infant, and Children program

APPENDIX B

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 INDICATORS

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

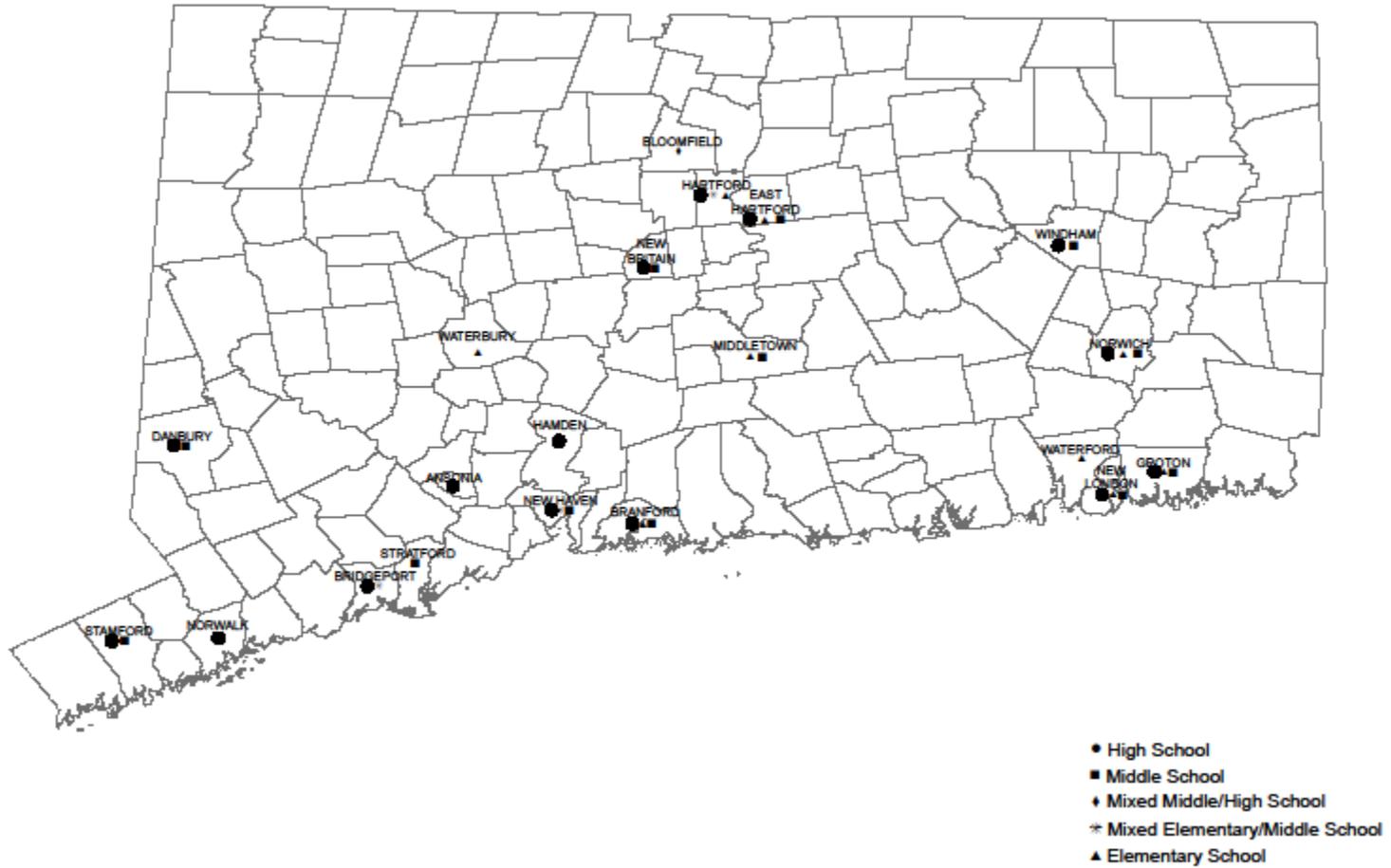
Key Indicators*	Progress	Most Current Data for Connecticut
Mortality: Adolescent deaths, accidental and intentional, are minimized.		
<p>All Causes</p> <p>1. Teen fatality rate declining</p>	-	<ul style="list-style-type: none"> Between 2003 and 2007, the most current available data, the state’s death 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>Physical</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>Behavioral</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>Oral</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.

APPENDIX B

HOW ARE WE DOING? PROGRESS ON KEY INDICATORS			
Positive trend	Negative trend	Little/no change or mixed	Cannot be determined
Key Indicators*	Progress	Most Current Data for Connecticut	
Health Risk Factors: Adolescent behaviors associated with poor health outcomes, particularly those with long-term negative consequences, are avoided.			
<p>Alcohol Use</p> <p>5. Binge drinking rate for youth declining</p>		<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%). 	
<p>Drug Use</p> <p>6. Rate of illicit drug use (other than marijuana) for youth declining</p>		<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%). 	
<p>Tobacco Use</p> <p>7. Cigarette smoking rate for youth declining</p>		<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. 	
<p>Sexual Activity</p> <p>8. Teen birth rate declining</p>		<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.			
<p>Insurance</p> <p>9. Percentage youth without health insurance decreasing</p>		<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 indicator are available in Staff Findings Part I, December 2011, Appendix B.			

APPENDIX SBHC-1

State-Funded School-Based Health Centers



N=71
As of February 2012
Source: PRI Staff

APPENDIX SBHC-2

Federal Definition of SBHC:

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 or operated by an Indian tribe or a tribal organization.

APPENDIX SBHC-3

INDICATORS OF POTENTIAL NEED FOR SCHOOL-BASED HEALTH CENTER LOCATIONS							
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

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 HUSKYmedian 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 SBHC-4. Individual School-Based Health Center Analysis: Key Measures

Center	School Population	SBHC Enrolled	Rate Enrolled	Clients	Utilization	Budget	Total Visits	Cost/visit	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. Learning Ctr.	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
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 Public 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
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 Ac.	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
	58,007	31,712	54.7%	14,878	47%	\$7,892,527	72,346	\$109	Staffing Info for FY11		
Source: PRI staff analysis									Y=Yes; N=No; m=Missing; n/a=Not Applicable		

APPENDIX TRH-1

STATE-SUPPORTED REPRODUCTIVE HEALTH SERVICES AVAILABLE TO ADOLESCENTS

PROGRAM	SERVICE AREA/ DELIVERY SYSTEM	MAIN PURPOSE/BRIEF DESCRIPTION	NO. CLIENTS SERVED/ CAPACITY (ANNUAL)	ANNUAL FUNDING/ EXPENDITURES
<i>DEPARTMENT OF PUBLIC HEALTH*</i>				
<i>Family Planning (Federal Maternal and Child Health Block Grant --- MCHBG)</i>	Statewide services under contract with Planned Parenthood of So. New England at 12 Family Planning Clinics	<ul style="list-style-type: none"> • Provide preventive and primary reproductive health care through health services, information, and education (e.g. regarding pregnancy, contraception, sexually transmitted diseases, child-bearing and fatherhood) to the uninsured or underserved individuals in the state • Includes case management, parenting, first-time motherhood, healthy choices for women/children services • Pregnant and parenting teens are linked with appropriate health, educational, employment, and social services; case management services also provided for pregnant teens, including secondary teen pregnancy prevention and parenting programs to promote positive birth outcomes 	SFY 10 served 31,466 participants (all ages)	\$1,052,419 state \$ 21,140 federal
<i>Pregnancy Risk Assessment Tracking System (PRATS)</i>	Statewide	<ul style="list-style-type: none"> • Population-based survey of postpartum women of all ages (including adolescents) used to monitor perinatal risk factors and health indicators 	All postpartum women in Connecticut	\$100,000 federal
<i>Personal Responsibility Education Program (PREP)</i>	DCF child welfare system	<ul style="list-style-type: none"> • Implement evidence-based teen pregnancy, HIV and STD prevention programs in DCF 	(program in start up)	\$599,877 federal (FFY11)
<i>Sexually Transmitted Diseases (STDs) Control Program</i>	Statewide at 9 local clinics	<ul style="list-style-type: none"> • Various activities designed to reduce the occurrence of STDS (e.g., gonorrhea, Chlamydia, syphilis) through disease surveillance, case and outbreak investigation, screening, preventive therapy, outreach, diagnosis, case management, and education • Includes programs for comprehensive STD prevention, infertility prevention, syphilis elimination, HIV partner counseling/risk education, partner notification services • Provide financial and technical support to local STD clinics • STD cases reported in Connecticut in 2009: <i>Gonorrhea</i> - Total: 2,554 (662 ages 10-19) <i>Chlamydia</i> - Total: 12,136 (4,035 ages 10-19) <i>Syphilis</i> - Total: 65 (5 ages 15-19) 	<p>All persons affected with STDs with focus on 15 - 24 year olds (highest STD burden)</p> <p>9 clinics statewide serve 6,000 patients (all ages) annually</p>	Clinic Funding: \$200,000 state (help support) \$740,000 federal (for staffing)
<i>Sexual Violence Intervention and Prevention</i>	Statewide	<ul style="list-style-type: none"> • Provide access to free and confidential crisis intervention, advocacy and support services by certified counselors to victims of sexual violence and their families; prevent sexual violence by promoting positive relationships, community, societal attitudes and behaviors 	<p>During 2010-11: Crisis intervention: 3,845 male and female victims (all ages) Primary prevention education: 28,496 students (elem. – college) Training: 1,638 professionals</p>	\$591,684 federal \$398,396 state

APPENDIX TRH-1

STATE-SUPPORTED REPRODUCTIVE HEALTH SERVICES AVAILABLE TO ADOLESCENTS

PROGRAM	SERVICE AREA/ DELIVERY SYSTEM	MAIN PURPOSE/BRIEF DESCRIPTION	NO. CLIENTS SERVED/ CAPACITY (ANNUAL)	ANNUAL FUNDING/ EXPENDITURES
DEPARTMENT OF SOCIAL SERVICES**				
Family Planning (Federal Social Services Block Grant – SSBG)	Statewide services under contract with Planned Parenthood of So. New England	<ul style="list-style-type: none"> Provide comprehensive reproductive health care services to low-income residents 	Serves 15,802 (all ages) as of 4/2011	\$915,059 federal (SSBG Funds FFY11)
Teen Pregnancy Prevention Initiative (TPPI)	Statewide - 9 contractors (community-based nonprofit agencies) with 12 sites	<ul style="list-style-type: none"> Teen pregnancy prevention programming for at-risk youth Services provided through two evidence-based models (“Teen Outreach” and “Carrera”) 	SFY11: 50-60 per site; 690 total capacity	\$1,793,400 state (SFY11)
STATE DEPARTMENT OF EDUCATION				
Young Parents Program	Local and regional school districts and community providers statewide	<ul style="list-style-type: none"> Grants provided to assist local and regional school districts in designing, developing and implementing an educational program for students who are parents Must offer high school education for young parents, child care services for their children, parenting education and information about child development, and linkage to other community resources Offers teen parents access to education programs 	Over 160 pregnant and parenting teens and their children, SFY10	\$229,330 state (SFY10)
Support for Pregnant and Parenting Teens Project (SPPT)	Five Connecticut school districts with high teen birth and school dropout rates (Hartford, New Haven, Bridgeport, New Britain, & Waterbury)	<ul style="list-style-type: none"> School-based grant project that targets pregnant and parenting Hispanic and African American youth in grades 9 through 12 with goal of improving health, education, and social outcomes through coordination among SDE, DPH, and DSS Social marketing campaign to disseminate information about existing resources for pregnant and parenting teens and their children 	(program in start up)	\$1,999,991 federal (FFY11)

* Reproductive health care for adolescents also is provided through Community Health Centers and some School Based Health Centers funded by DPH. The department also funds HIV prevention activities focused on prevention, surveillance, and management of risk factors related to HIV/AIDS, including programs for prevention education, prenatal and other counseling and testing, case management, critical health care and supports, syringe exchange, and mental health services for HIV affected children.

** Reproductive health care services also are provided to adolescents covered under HUSKY and Medicaid Low Income Adult programs administered by DSS; the department was unable to provide data on the amount or type of services provided to youth ages 10-19 within the study timeframe.

Note: Youth in the care of the Department of Children and Families (DCF) are eligible for HUSKY and could receive reproductive health care services through that program. In addition, DCF contracts for some pregnancy and STD prevention services for girls in its juvenile justice residential treatment facilities and funds five residential programs for pregnant and parenting girls.