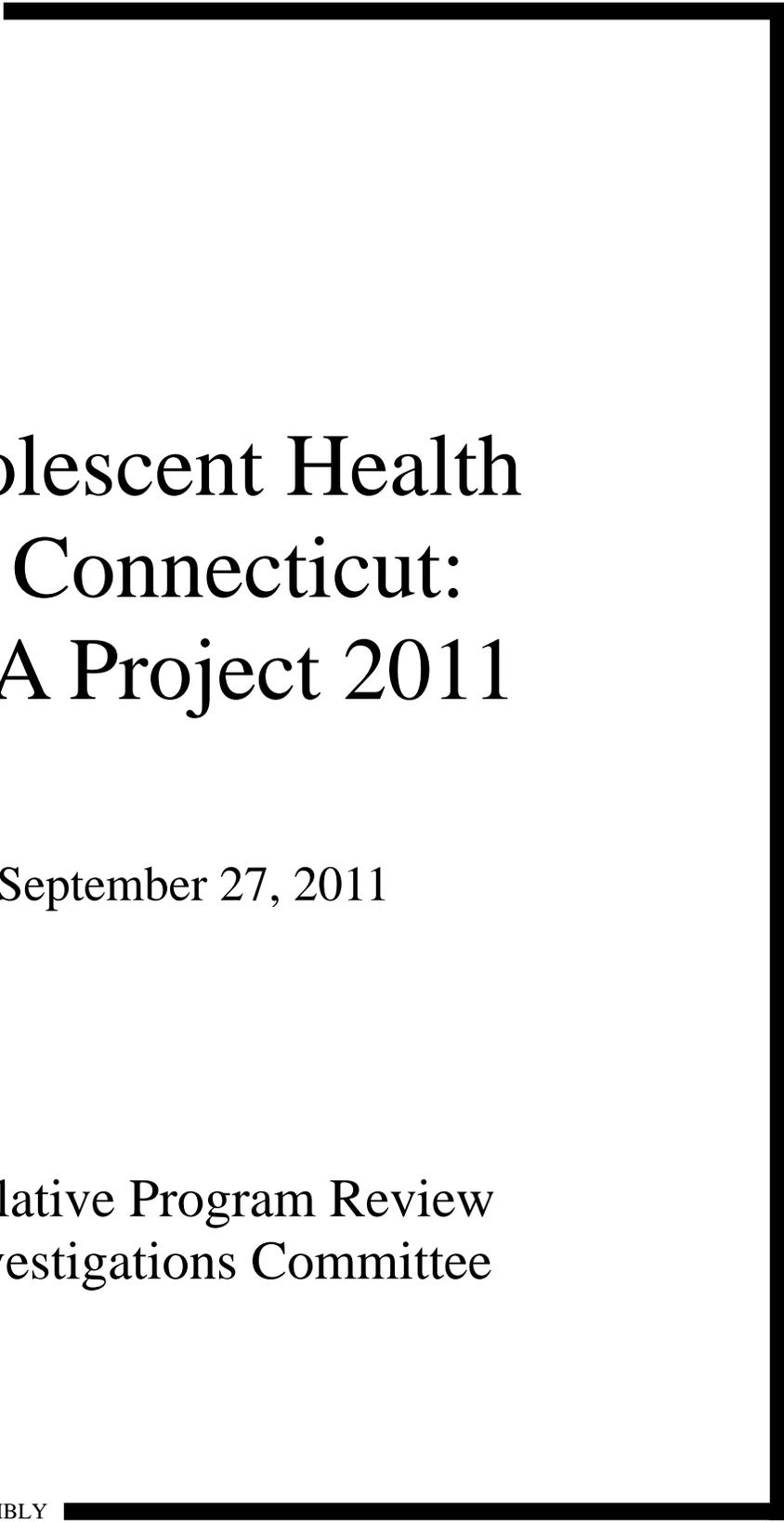


Staff Update



Adolescent Health
in Connecticut:
RBA Project 2011

September 27, 2011

Legislative Program Review
& Investigations Committee

Introduction

ADOLESCENT HEALTH IN CONNECTICUT RBA PILOT PROJECT 2011

In March 2011, the Legislative Program Review and Investigations Committee (PRI) authorized its third study using the principles of results-based accountability: an assessment of state-supported health services for Connecticut adolescents, including services funded through the state Medicaid program. For the purposes of the study, adolescents are defined as youth ages 10 to 19 and services refers to physical, behavioral, and oral health care provided to this population.

Results-Based Accountability (RBA) is a data-driven evaluation tool created by a national consultant for improving government performance and community well-being. The legislature's Appropriations Committee has been applying RBA techniques to its state budgeting process since 2005. The program review committee, in response to Public Act 09-166, employed RBA on a pilot basis for two recent studies. Based on this experience, PRI found the results-based accountability method to be a promising practice for legislative oversight work and decided to continue using it for another study during 2011. Additional background on RBA is provided in Appendix A.

Study Scope

The committee study is focused on evaluating state-funded services for meeting the health care needs of Connecticut's teens. The extent of parental involvement in adolescent health programs also will be identified and compared with practices cited in national literature and followed in other states. Program performance will be assessed by answering three main RBA questions: How much did we do? How well did we do it? Is anyone better off? Based on information developed through this process, potential ways to improve system efficiency and effectiveness and achieve better health outcomes for the state's youth will be identified.

At the committee's May 25, 2011, meeting, as noted in the minutes, PRI staff clarified that while this study includes a review of parental involvement policies and practices regarding adolescent health care, staff will not be proposing recommendations about what the state law should be concerning parental notification or consent for the medical treatment of minors. Committee members also endorsed the staff proposal to focus the program performance evaluation portion of the study on two areas: 1) school-based health centers (SBHCs); and 2) state-supported teen reproductive health services. Concentrating on these programs will keep the study scope manageable and still permit examination of a comprehensive cross-section of the services provided to adolescents and many important health care issues involving Connecticut youth.

Update Report

This update report highlights information developed to date by the program review staff in applying RBA principles to assess adolescent health in Connecticut. It contains the following three sections:

- I. RBA Framework and Key Indicators for Adolescent Health (Working Draft)
- II. RBA Program Performance Report Card: School-Based Health Centers (Preliminary)
- III. Overview: Parental Involvement and Minors' Rights in Connecticut

Several appendices provide supplemental information concerning the state adolescent health system and the study's focus programs. The main agencies and programs comprising the state infrastructure for adolescent health care are shown in chart form in Appendix C. Additional background and descriptive information about school-based health centers is presented in Appendix D. A table summarizing the major state-funded reproductive health services currently provided to Connecticut teens is provided in Appendix E.

Completed and Planned Tasks

Since the study was authorized in March, program review staff efforts have centered on:

- identifying and describing the status of adolescent health in Connecticut and recognized best practices for adolescent healthcare;
- understanding relevant state laws and policies and major agency roles and responsibilities; and
- determining what program performance and client outcome data are available, and what information should and can be developed.

Much of the information presented in the update document, therefore, is partial or preliminary at this time. Additional information and committee staff findings and proposed recommendations will be presented in an upcoming report in December.

A primary information source for committee staff is interviews conducted with personnel from the main state agencies involved with adolescent health (i.e., education, public health, children and families, and social services) and other key stakeholders. To date, PRI staff has met with:

- agency leadership and key program managers at the state education, public health, children and families, and social services departments;
- several provider organizations (i.e., 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 also have visited school-based health center sites in East Hartford, Windham, Branford, and Norwich and observed a board meeting of the state SBHC association. A recent interagency work group meeting for the state's Coordinated School Health program also was 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

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. Main themes discussed at the forum and hearing are summarized in Appendix B. (Materials from the forum and testimony from public hearing also are available at the committee staff office website: http://www.cga.ct.gov/pri/2011_ahct.asp)

Since the forum and hearing, PRI staff has had additional meetings with public health department staff about contracting and licensing procedures for school-based health centers. Arrangements also have been made to obtain the department's electronic data for the school-based health centers it funds. Committee staff has started "building" a comprehensive SBHC database that will include these data and other descriptive and outcome information gathered through a review of contract documents, a survey of all centers in state, and additional site visits.

Efforts by committee staff to obtain and analyze Medicaid program data from the Department of Social Services for youth ages 10 to 19 are underway as well. Assistance in linking the SBHC and Medicaid data to learn more about adolescent health outcomes may be available from the Connecticut Health Information Network (CHIN). 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.¹ 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.

Additional next steps planned by the committee staff in the coming weeks include:

- Compiling and analyzing teen reproductive health program data, which will involve state agency and provider interviews and may require some site visits.
- Finalizing the RBA framework and key indicators for the study.
- Summarizing best practices information for adolescent health care and comparing it with current practices in Connecticut.
- Following up on coordination issues (e.g., overlap, duplication, or gaps in service delivery or in policy roles).

¹ See the CHIN website: <http://publichealth.uconn.edu/CHIN.php>

I. RBA Framework and Key Indicators

ADOLESCENT HEALTH IN CONNECTICUT

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

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

As part of the committee's RBA approach, it is program review staff practice to compile and assess key indicator data to the extent possible within study resources and timeframes. Current versions of the accountability framework and key indicator information under development for this study are presented in this section.

Accountability Framework for Adolescent Health Study

The current working draft of the results-based accountability framework prepared by program review staff for this study is presented in Figure 1. It is based on:

- a literature review of model adolescent health care policies and practices;
- discussions with state agency staff responsible for planning and administering adolescent health services; and
- input provided by experts attending the committee's June 21, 2011, information forum.

Each of the main elements of the framework is described briefly below. PRI staff, with assistance from various stakeholders, will continue to refine the framework, as well as related key indicator and performance measure data, in the coming months.

| CONNECTICUT ADOLESCENT HEALTH CARE | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| POPULATION LEVEL ACCOUNTABILITY | | | | | | |
| QUALITY OF LIFE RESULTS STATEMENT: | | | | | | |
| <i>“Connecticut adolescents have the health care services, supports, knowledge, and skills that promote optimal physical and mental well-being and success in life.”</i> | | | | | | |
| 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. Teen Births 8. Tobacco Use | 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) - 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) - 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): | | | | | | |
| <u>School-Based Health Centers</u> | | | | <u>Primary and Preventive Teen Reproductive Health Services</u> | | |
| <ul style="list-style-type: none"> ● Access to primary and preventive care (e.g., enrollment rates, particularly for uninsured/underinsured students) ● Improved health status (e.g., receive screenings, chronic conditions managed) ● Better school attendance (e.g., fewer absences/tardy, higher return to class rate) ● Cost-effectiveness (e.g., reduced use of emergency departments) | | | | <ul style="list-style-type: none"> ● Sexual activity (e.g., delayed initiation, abstinence, contraceptive use, if active) ● Unintended pregnancy (e.g., lower rates) ● Sexually Transmitted Disease (e.g., lower infection rates, early treatment) | | |

Figure 1. Results-Based Accountability Framework : PRI Working Draft (September 2011)

| Acronyms Used in Adolescent Health Care RBA Framework (Figure 1) | |
|------------------------------------------------------------------|------------------------------------------------------------------|
| State Agencies | |
| • CSSD/JUD | Court Support Services Division, Judicial Branch |
| • DCF | Dept. of Children and Families |
| • DOC | Dept. of Correction |
| • DDS | Dept. of Developmental Services |
| • DOL | Dept. of Labor |
| • DMHAS | Dept. of Mental Health and Addiction Services |
| • DMV | Dept. of Motor Vehicles |
| • DPH | Dept. of Public Health |
| • DSS | Dept. of Social Services |
| • DOT | Dept. of Transportation |
| • OCA | Office of the Child Advocate |
| • OPM | Office of Policy and Management |
| • SDE | State Dept. of Education |
| Federal Agencies | |
| • ED | U.S. Dept. of Education |
| • HHS | U.S. Dept. of Health and Human Services |
| ○ CDC | 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 Center |
| • CSH | Coordinated School Health |
| • CYSHCN | Children and Youth with Special Health Care Needs |
| • DHP | Dental Health Partnership |
| • LIA | Low Income Adult |
| • MCH | Maternal and Child Health |
| • NFN | Nurturing Family Network |
| • NPAO | Nutrition, Physical Activity and Obesity |
| • 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 |
| • SVIP | Sexual Violence Intervention and Prevention program |
| • WIC | Women, Infant, and Children program |

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

The statement’s target population, Connecticut adolescents, is defined for the purposes of this study as young people ages 10 to 19. Definitions of adolescence vary and there is some debate about what age bracket to use. However, the 10-19 range is used by state health department for planning purposes and is endorsed by the adolescent health committee of the National Research Council.²

Key Indicators of Progress. Under the RBA approach, indicators that capture critical, measurable aspects of population-level outcomes are developed to track progress toward the desired results. Ideally, three to five key indicators (sometimes called “headline” indicators), are used to monitor and report on areas of primary importance. Depending on the complexity of the results statement, additional primary indicators may be needed but no more than 10 are recommended. Any number of secondary indicators also may be selected to capture additional aspects of how the state is doing in achieving a results statement.

Recommended criteria for selecting indicators include: easy to understand; objective and reliable; representative and balanced; and data are collected regularly, reliably, and rigorously. High quality data, however, frequently are lacking for meaningful indicators of progress toward the quality of life results governments want to achieve.

As shown in Figure 1, PRI staff has identified four broad primary indicator areas related to adolescent health:

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

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

Six health-risk behaviors have been found to have a major influence on adolescent mortality and morbidity. They include: behaviors that contribute to unintentional injury and violence; tobacco use; alcohol and other drug use; sexual behaviors that contribute to unintended

² See: National Research Council. (2009). *Adolescent Health Services: Missing Opportunities*. Committee on Adolescent Health Care Services and Models of Care for Treatment, Prevention, and Healthy Development. Washington, D.C.: The National Academies Press.

pregnancy and sexually transmitted diseases (including human immunodeficiency virus/acquired immune deficiency syndrome or HIV/AIDS); unhealthy dietary behaviors; and physical inactivity.³

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

At this time, program review committee staff has developed nine potential key indicators of state progress on adolescent health results:

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

Available trend data for each of these indicators are presented in charts later in this section.

As part of next staff report for this study, an RBA report card on the state's population-level adolescent health results will be prepared with finalized indicators. In addition to highlighting trends in performance and the reasons behind them, the report card will outline any staff proposals for low or no cost ways to achieve better adolescent health results.

Strategies. The RBA framework (Figure 1) outlines five major strategies employed by the state to achieve desired adolescent health results. They are: increasing access to, and use of, appropriate health care services; promoting healthy behaviors among adolescents; better coordinating services and supports; and enhancing accountability through improved use of data. Responsibility for implementing some or all of these strategies is shared, to varying degrees, by the many public and private partners shown in the middle of the framework.

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

Main state agency roles and programs. The major components of the adolescent health system shown in Figure 1 include: physical, behavioral (mental health and substance

³ According to the Centers for Disease Control, as cited in *2009 Connecticut School Health Survey Youth Behavior Component*, Connecticut Department of Health (in collaboration with Connecticut State Department of Education), April 2011.

abuse), oral, and reproductive health care services; health education; prevention; and nutrition and fitness. Another important dimension, positive youth development, encompasses health, safety, and social support programs intended to build the attributes young people need to be successful. Some common positive youth development efforts in Connecticut are anti-bullying initiatives, dropout prevention, mentoring, and transition-to-adulthood services.

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

The major programs carried out by state agencies within each component of adolescent health are listed in the lower part of the framework. Some programs appear more than once because they provide a wide range of health care for adolescents. A chart showing the state adolescent health care infrastructure contained in Appendix X provides some recent budget and client data for most of these programs. PRI staff will continue to revise and add basic program information to the chart as it becomes available over the course of this study.

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

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

SDE. The state education department oversees school health (school nurses), behavioral health (guidance, counseling, social work), health education, physical education, and nutrition programs carried out in public elementary, middle, and high schools across the state. At present, SDE funds two programs specifically for pregnant and parenting teens. In partnership with DPH, it also administers “Healthy Connections,” the state’s coordinated school health system that is designed to align health and education efforts to improve physical, mental, and developmental outcomes for students of all ages.

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

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

DSS. The Department of Social Services administers Medicaid and a number of other public health coverage programs that serve Connecticut youth ages 10 to 19. Eligible children up to age 18 are provided health care services through HUSKY A, the state's Medicaid program for low-income families and pregnant women. Children under 18 in families with incomes too high for Medicaid can be provided health care through HUSKY B, Connecticut's Children's Health Insurance Program.

Certain low-income adults, including 19 year old adolescents, can receive health services through the department's recently created Medicaid Low Income Adult (LIA) program. Adolescents over age 18 also can participate in the Charter Oak Program, the DSS managed health care program started in 2008 for uninsured adults not otherwise eligible for federally supported health coverage. According to DSS, one of every five children and one of every three pregnancies in Connecticut is covered by a department health care plan.

The department also funds two programs targeted to reproductive health care. DSS provides grant monies for family planning services for low-income state residents of all ages and for several teen pregnancy prevention programs.

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

Focus program core performance measures. The large number, wide range, and complexity of adolescent health programs in Connecticut prevents PRI staff from being able to assess all or even most of them within the study timeframe. Therefore, the performance evaluation portion of the study is focused on two program areas that appear central to protecting and promoting adolescent health: school-based health centers (SBHCs) and teen reproductive health services.

An overview of school-based health centers is presented in the next section and more background information is provided in Appendix D. Brief descriptions of state-supported reproductive health services for teens are contained a table presented in Appendix E.

As noted earlier, under the RBA approach program performance is measured with information that addresses inputs (how much was done), outputs (how well was it done) and

outcomes (is anyone better off?). Three to five core measures are developed to monitor the most critical program results for the clients served. In contrast to population results, primary accountability for program outcomes rests with the managers and agency leadership.

Potential core measures of program performance for SBHCs and teen reproductive health services are highlighted at the bottom of the RBA framework. Data developed by program review committee staff for core measures, along with additional program performance and descriptive information, will be presented in a report card format in the forthcoming staff findings and recommendations report. An initial version of the program performance report card for school-based health centers is provided in the next section.

Key Indicators of Progress for Adolescent Health

Initial information developed by PRI staff to track statewide progress in achieving desired health results for Connecticut's adolescent population is presented below. Best available data for each of the nine key indicators of adolescent health discussed earlier, are shown in separate charts, along with brief descriptions of general trends. Possible secondary indicators under consideration also are noted.

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

In most cases, indicator data are not readily available for the age range of adolescence adopted for the PRI study (ages 10 to 19); some are collected just for high school students. Such inconsistencies can make comparative analysis difficult.

For some indicators, like overweight and obesity rates, regular data collection began relatively recently, so only short-term trends are known. Also, a considerable amount of national child and adolescent health information either is not available or not easily accessible at an individual state level. The better indicators related to oral health, for example, are not reported by state.

Next steps. As part of the next phase of the study, program review staff will be refining these indicator data, and possibly revising or replacing some if better alternatives are identified. Once the key indicators are finalized, the overall health status of Connecticut youth can be evaluated and compared with national benchmarks and indicators from other states. Current conditions also can be compared with those found by the last assessment of adolescent health in Connecticut, which are contained in the state's 2005 adolescent health strategic plan.

At the time the plan was prepared, Connecticut adolescents were doing well on many health factors compared to national averages and many trends were positive. For example, the plan noted lower accident rates, declining homicide rates, less tobacco use, and dropping teen pregnancy rates. Areas of concern included: increasing rates of overweight and obesity,

decreasing physical activity, and dramatically rising STD rates. Also, significant disparities in health status by age and gender, and for racial and ethnic groups, were identified. The preliminary information presented in the following charts indicates some of these trends, particularly racial and ethnic disparities, persist.

INDICATOR AREA: MORTALITY

1. Teen Fatalities

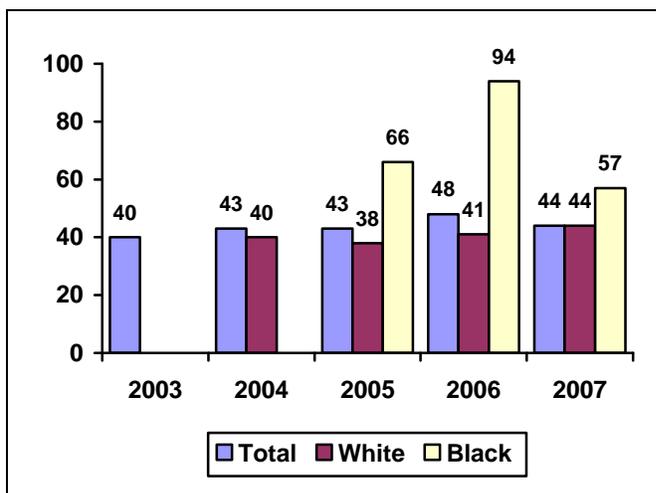
Teen death rate per 100,000 age 15-19 all causes

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

Teen fatality rates are widely used indicators of adolescent well-being. Nationally, accidental and intentional injuries cause nearly 80% of deaths among adolescents aged 15-19. Motor vehicle crashes and other unintentional injuries, homicide, and suicide are the leading causes of death for youth and young adults aged 10-24 in the U.S. and Connecticut. Fatality rates overall and by cause vary by race/ethnicity and gender.

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

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



- Between 2003 and 2007, overall teen fatality rate rose from 40 to 44 per 100,000 youth ages 15 -19.
- Fatality rates for black youth are substantially higher – more than double in 2006 – than for white teens.
- Among all states in 2007, Connecticut ranked 7th lowest on teen deaths; the state with lowest rate was Vermont (35) and highest was Alaska (100).

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

2. Obesity (Physical Health)

Percent youth ages 10-17 overweight or obese by gender

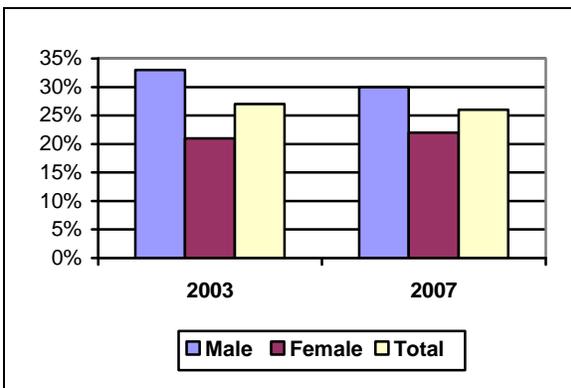
Data source: Child Trends analysis of National Survey of Children's Health data
as provided by KIDS COUNT 2011

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

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

Possible Secondary Indicators: Physical inactivity, diet quality, by gender, race/ethnicity

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



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

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

3. Depression (Behavioral Health)

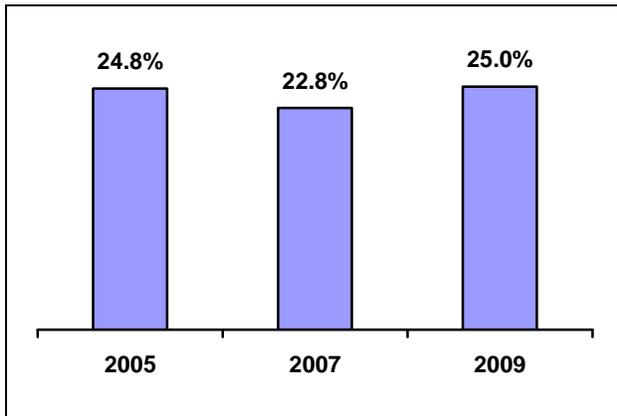
Percent high school students felt sad or hopeless for two weeks in a row

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

Adolescent depression can cause severe problems at home, school/work, and socially as well as adversely impact other health conditions such as asthma and obesity and general physical well-being. Youths experiencing major depressive episodes are more likely than other teens to attempt suicide and initiate alcohol and other substance use. Teen depression suicidal behavior rates vary by gender and also differ by race/ethnicity.

Possible Secondary Indicators: Received treatment for depression, seriously considered suicide, attempted suicide by gender and race/ethnicity

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



- In 2009, one in four high school students in Connecticut felt sad or hopeless, virtually same rate as in 2005.
- The rate is significantly higher for girls than boys (32.9% vs. 17.2% in 2009) and also higher among Hispanic high school students than their white counterparts (33.3% vs. 22.1% in 2009)
- In 2009, 14.1% of high school students seriously considered attempting suicide in the past 12 months and 7.4% actually attempted suicide at least once

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

4. Untreated Cavities (Oral)

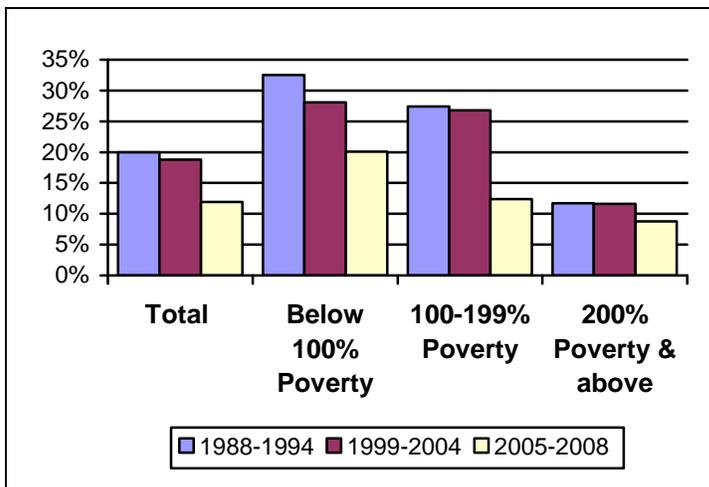
Percent youth ages 12-17 with untreated dental caries (cavities)

Data source: America's Children: Key National Indicators of Well-Being, 2011 (Federal Interagency Forum on Child and Family Statistics); not available by state at this time -- U.S. data presented below

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

Possible Secondary Indicators: Dental visit within the past year by race/ethnicity, poverty status

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



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

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

5. Binge Drinking

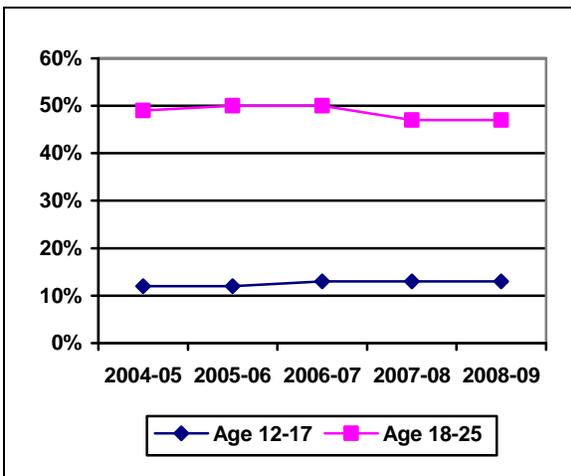
Percent binge alcohol use by age group

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

Alcohol use is associated with many negative outcomes for adolescents including injuries and death from motor vehicle accidents, fighting, and reckless behavior, as well as problems in school, the workplace, home, and community. Heavy drinking (binge alcohol use) increases the likelihood of these negative outcomes and can have serious long-term health consequences. Binge drinking for the purpose of the national survey is defined as having five or more drinks on the same occasion on at least one day in the prior 30 days.

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

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



- Binge alcohol use rates have changed very little among Connecticut youth (age 12-17) and young adults (age 18-25) between 2004 and 2009.
- In recent years, 13% of those age 12-17 and around half (47-50%) of 18-25 year olds binge drink.
- According to the Connecticut School Health Survey, among the state's high school students in 2009:
 - 26% of girls and 22.5% of boys had five or more drinks in a row (binge drinking)
 - The overall binge drinking rate for high school students in Connecticut and the U.S. in 2009 is the same – 24.2%
 - 43.5% had at least one drink on at least one day during the month before they were surveyed

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

6. Drug Use

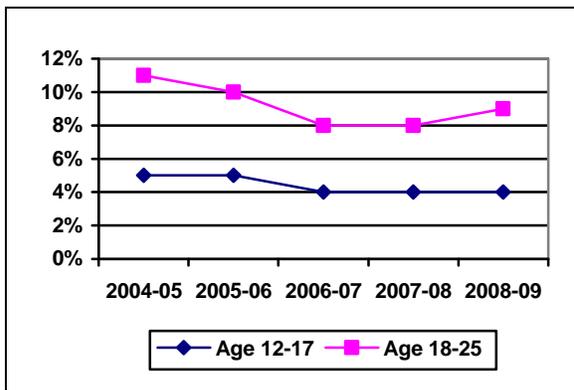
Percent illicit drug use other than marijuana in the past month by age group

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

Use of illegal drugs (e.g., hallucinogens, cocaine, heroin, and other narcotics, amphetamines, barbiturates or tranquilizers not under doctor's orders) can have immediate and long-term health and social consequences for adolescents. Health problems vary with the types and amounts of drugs used but range from heart attack and stroke, to impaired pulmonary functioning, cognitive damage, and memory loss, to premature death. Like alcohol use, the use of illicit drugs has the potential for increasing teens' risky behaviors.

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

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



- Use of illicit drugs other than marijuana declined from 5% to 4% among Connecticut adolescents aged 12-17 between 2004 and 2009.
- Illicit drug use rate for young adults, which includes 18- and 19-year olds, about double the youth rate and rose slightly from 2007 to 2009.
- According to the Connecticut School Health Survey, among the state's high school students in 2009:
 - Rates for ever using cocaine, ecstasy, methamphetamines or heroin all were similar to those among U.S. high school students.

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

7. Tobacco Use

Percent any cigarette use in the past month by age group

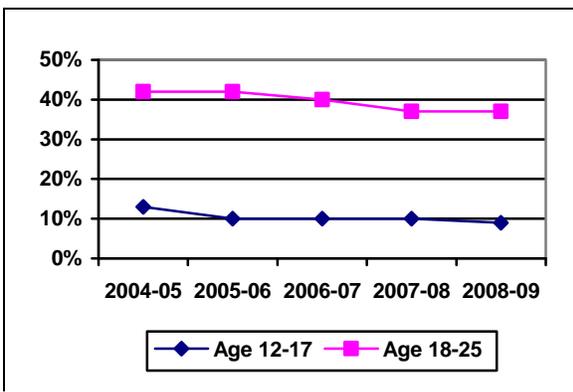
Data Source: State Estimates from National Survey on Drug Use and Health
as provided by KIDS COUNT 2011

Cigarette smoking has serious long-term consequences including the risk of premature death and smoking-related diseases. Smoking causes many types of cancer, heart disease, stroke, chronic obstructive pulmonary disease (COPD) like emphysema, asthma, hip fractures, and cataracts.

After a rapid increase in teen smoking in the early 1990s, rates of cigarette use among adolescents have steadily dropped, although certain subgroups are still more likely than others to smoke. Nationally, 19.5% of high school students smoked cigarettes on one or more days in the past 30 days in 2009. In the U.S. and in Connecticut, male high school students are more likely than females to smoke; black high school students are significantly less likely than white or Hispanic students to be frequent cigarette smokers.

Possible Secondary Indicators: Current and frequent cigarette smoking by high school students (distinctions are made in Connecticut and national surveys of youth health-risk behaviors between current use -- smoked cigarettes at least once in past month -- and frequent use -- smoked cigarettes on 20 or more of the past 30 days) by gender, race/ethnicity

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



- Cigarette use among Connecticut youth ages 12–17 dropped from 13% to 9% between 2004 and 2009.
 - Cigarette smoking rate for young adults, which includes 18- and 19-year olds, significantly higher (37% in 2008-09) but also has declined over time.
- According to the Connecticut School Health Survey, among the state’s high school students in 2009:
 - Almost 18% smoked cigarettes at least once in the past month
 - 19% of boys and 16.5% of girls were current smokers.
 - 20.3% of white students, 15.5% of Hispanic students, and 9.6% of black students were current cigarette smokers.

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

8. Sexual Activity

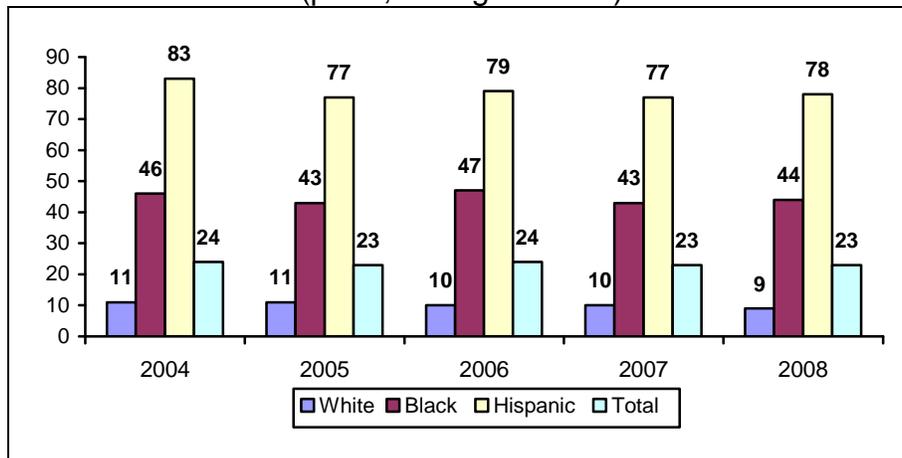
Teen birth rate per 1,000 females ages 15-19

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

Adolescent sexual activity can pose significant emotional and physical health risks. Youth who engage in risky sexual behaviors can become pregnant and contract infections and diseases, including some with lifetime consequence. Teen pregnancy is associated with a number of long-term negative consequences, for both the child and the mother. Babies born to adolescent mothers compared with older mothers are at higher risk for low birth weight and infant mortality. Teenage mothers are more likely to experience pregnancy complications and are at high risk of dropping out of school and of living in poverty.

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

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



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

INDICATOR AREA: PROTECTIVE FACTORS

9. Health Insurance Coverage

Percent Under Age 18 Without Health Insurance

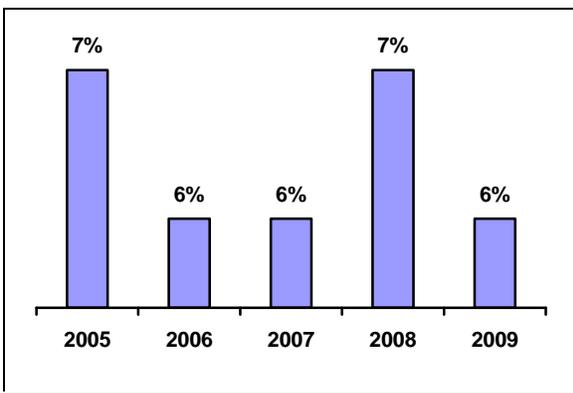
Data Source: Census Bureau, Current Population Survey (March Supplement)as provided by KIDS COUNT 2011

A regular and accessible source of quality health care is critical to ensuring the well-being of children and youth. Adolescents with insurance coverage, private or public (e.g., Medicaid), are more likely to obtain the preventive and primary care they need to promote and maintain good physical, behavioral, and oral health. The census defines without health insurance as not covered by private or public plans at any point during the year.

Nationally and in Connecticut, rates of uninsured children declined following creation in 1997 of State Children’s Health Insurance Programs (SCHIPs, e.g., HUSKY B). By 2008, just under 10% of all U.S. children (under 18) had no health insurance, although insurance status and adequacy of coverage varies by race, ethnicity and family income. Also, national data from 2007 show older children (aged 12-17) are more likely than young (aged 6-11) and very young (aged 0-5) children to lack adequate health insurance coverage (26.3%, 25.1%, 19.2%, respectively).

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

Percent Connecticut Children (ages 6-17) Without Health Insurance



- From 2005 and 2009, rate of uninsured children in Connecticut fluctuated between 6% and 7% for those aged 6-17 and for the total population under age 18.
- In 2009, national rate of children ages 6-17 without health insurance was 10%; rates ranged from a low of 4% (Massachusetts, Vermont, New Hampshire, Hawaii) to a high of 18% (Nevada, Texas).

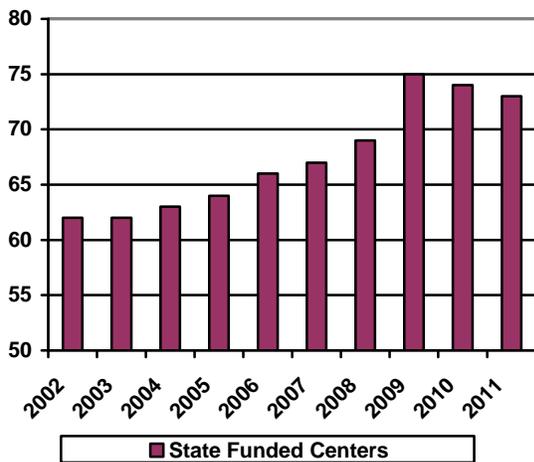
II. School-Based Health Centers

| Background Connecticut School-Based Health Centers (SBHCs) (Additional background information provided in Appendix D) | |
|-------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Purpose | <ul style="list-style-type: none"> Increase access to primary and preventative health care for school-aged students |
| Target Population | <ul style="list-style-type: none"> All students, with an emphasis on students who are uninsured or underinsured |
| Model | <ul style="list-style-type: none"> Provide a comprehensive range of services, including medical care, to specifically meet the health needs of students Free-standing medical clinics located on or within school grounds Staffed by multidisciplinary health care team, including nurse practitioners, clinical social workers, physicians, and other health professionals Health center staff works cooperatively with school nurses, counselors, classroom teachers, coaches, and principals to help ensure coordination of care A sponsoring agency (e.g., community agency, hospital, school district) is the entity responsible for administration of health center, including receiving state grant funding Parents sign written consent forms prior to enrolling their children in the health center |
| Services | <ul style="list-style-type: none"> Services vary among school-based health centers, but all at least offer primary health care; dental services provided at some |
| Funding | <ul style="list-style-type: none"> Funding comes from a variety of sources, including state grants, private foundations, federal grants, and sponsoring agencies Formal contracts are entered into between the sponsoring agency and state public health department when state grants are awarded; not all licensed SBHCs receive state funding State also provides limited funds to communities to enhance existing school health services; services vary by site and include: counseling, health education, and prevention services, but do not include the full range of outpatient physical and mental health services offered in a traditional SBHC |
| Regulation | <ul style="list-style-type: none"> All 115 school-based health centers in Connecticut are licensed by the state Department of Public Health (DPH) either as outpatient clinics (91%) or hospital satellites (9%); DPH conducts routine licensing inspections of school-based health centers <p>SBHCs receiving state funding are subject to contract compliance visits by DPH</p> |

I. How Much Did We Do?

The preliminary analysis presented below mainly relies on Department of Public Health data and not information collected directly from SBHCs by committee staff. Some data elements pertaining to school-based health centers are not current, due to a lag in DPH collecting and compiling data from centers. The information below presents data for all SBHCs, including those in elementary schools. As such, it includes information for students outside the age range used in this study. The data below also do not include sites receiving state funding to ‘enhance’ services provided by a school nurse, since such services do not rise to the same level of physical and mental health services provided at traditional school-based health centers. Additional data collection and analysis regarding school-based health centers will be presented in the staff’s subsequent findings and recommendations report.

Measure 1: Number of State-Funded SBHCs

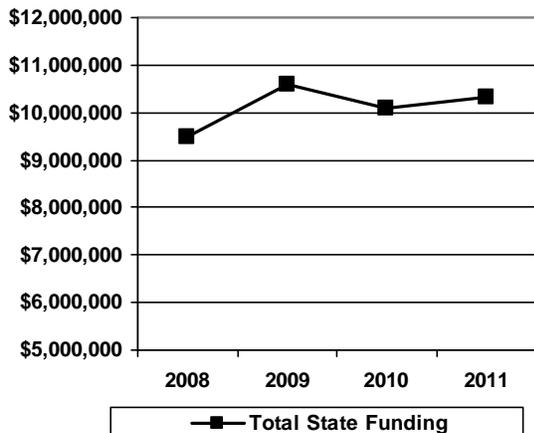


Trend: The total number of centers steadily increased between FY02 and FY09, then declined somewhat the following two fiscal years.

- The number of state-funded school-based health centers increased just over 17 percent between FY02 and FY11, from 62 centers to 73.
- Over time, centers have been created, merged with other centers, or closed.
- The vast majority of centers throughout the state are located in municipalities with low socio-economic classifications (as measured by the state’s education department – see Appendix D)

Story Behind the Data: As of August 2011, 115 school-based health centers were licensed in Connecticut by the Department of Public Health. Of those, 73 (63%) received some level of state funding. In addition, the licensing unit within DPH does not formally track data for the total number of licensed SBHCs prior to the current year; thus, historical data for total licensed SBHCs is not available.

Measure 2: State Grant Funding Levels for SBHCs

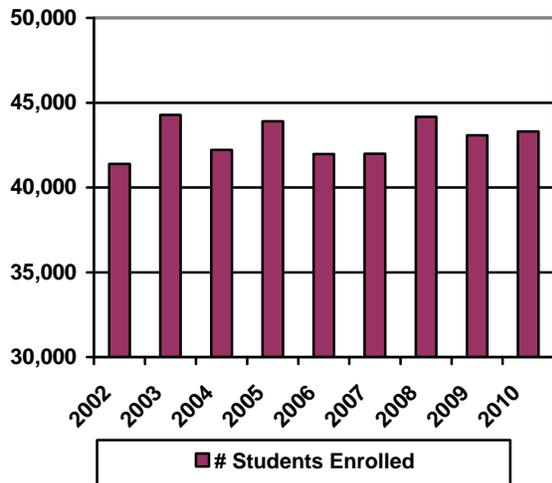


Trend: The level of state funding for school-based health centers for the last four years has fluctuated, ranging between \$9.5 million and \$10.6 million.

- State funding is a key source of revenue for school-based health center operations.
- State grants help offset costs incurred due to providing health care services to uninsured or underinsured students.
- Total state funding recently has averaged \$10.1 million a year.

Story Behind the Data: State grants are one source of revenue for school-based health centers. Funding to create, operate, and maintain health centers is also generated from other sources, including other levels of government, third-party insurance billings, and private contributors, such as foundations. PRI staff will be conducting additional analysis to try to determine all sources/amounts of revenue for SBHCs.

Measure 3: Total Students Enrolled in State-Funded SBHCs

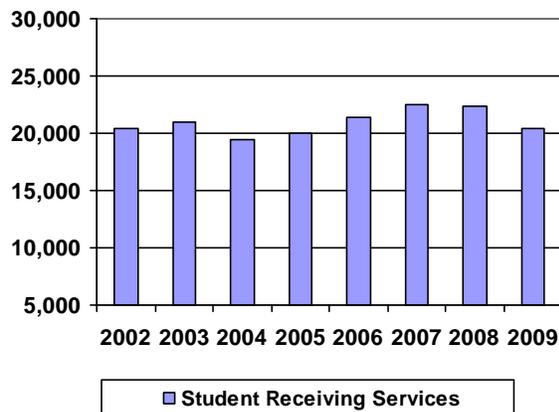


Trend: The number of students enrolled in state-funded school-based health centers has remained relatively steady, at 40,000-45,000 over the past nine years.

- Despite an overall increase in the total number of school-based health centers since FY02, the number of students enrolled has not similarly increased.
- An annual average of just under 43,000 students have been enrolled in SBHCs over the nine-year period analyzed.

Story Behind the Data: At this stage of the study, PRI staff is still examining factors that drive student enrollment in school-based health centers.

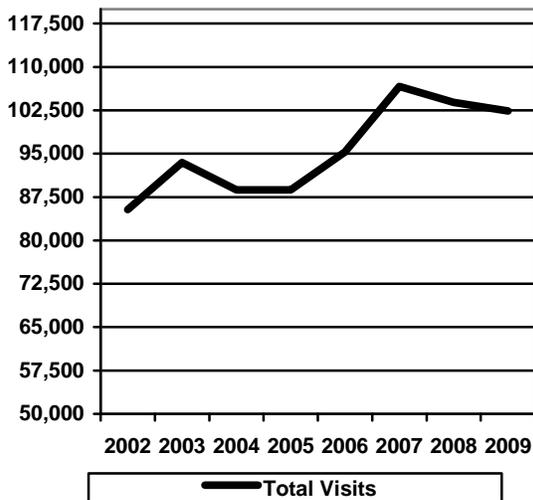
Measure 4: Students Receiving Services From State-Funded SBHCs



Trend: The number of students using SBHC services from FY02 through FY09 remained relatively steady, ranging between 19,500 and 22,500 (unduplicated count).

- An average of just under 21,000 students used the services of the school-based health center in their school between FYs02-09. This represents roughly half of the total number of students enrolled in a given year.
- There was a gradual decline in users from FY07 through FY09, after three years of steady growth beginning in FY05.

Measure 5: Number of Visits to State-Funded SBHCs

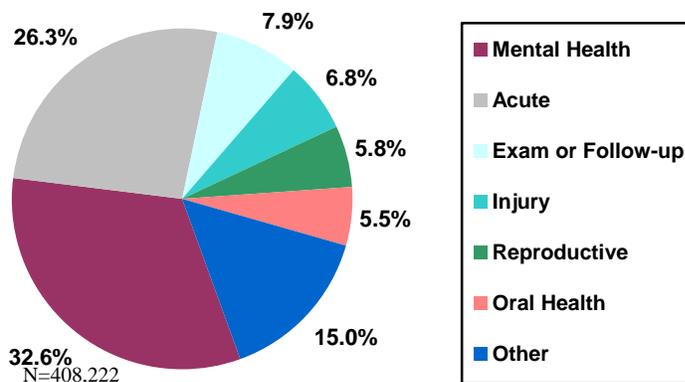


Trend: The number of visits made to SBHCs between FYs 2002-09 rose 20%.

- Despite SBHC enrollment remaining relatively steady, the number of visits made to centers actually increased during the period analyzed. In 2002, the average number of visits per student was 4.2. In 2009, it was 5.0, representing a 19% increase.
- The total number of visits by students peaked in FY07 at 106,651, and steadily decreased the next two fiscal years to 102,414 visits in FY09.

Story Behind the Data: Additional examination needs to be made as to the possible reasons for the fluctuations in the number of visits made over the period analyzed, particularly the relatively sharp increase between FYs 05-2007, and then the decline between FYs 07-09.

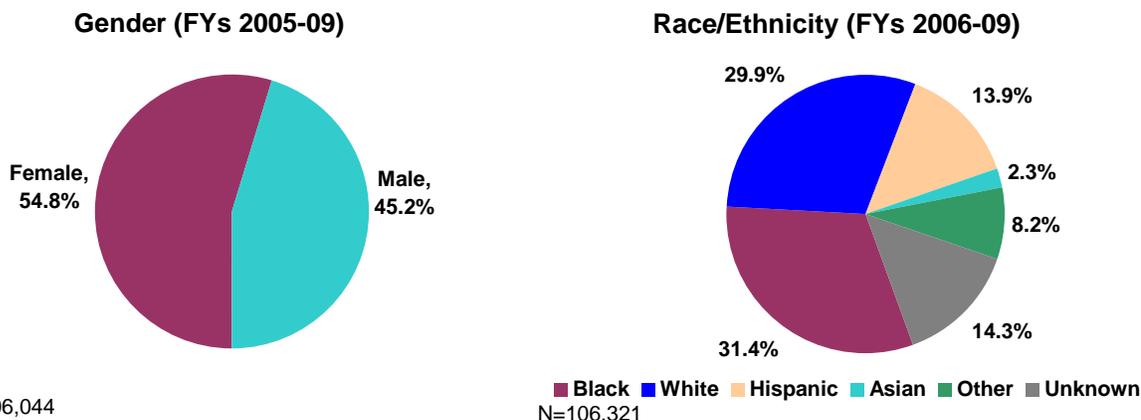
Measure 6: Reasons for Visits to SBHC (FYs06-09)



- During FYs 2006-09, the most common reason students visited school-based health centers was for mental health services, accounting for one-third (32.6%) of all visits.
- Over a quarter (26.3%) of the visits to SBHCs were for acute conditions.
- Just under 8% of visits were for exams and follow-ups; almost 6% were for oral health; and 15% were for all other reasons (e.g., immunizations, screenings, and sexually transmitted diseases).

Story Behind the Data: Although school-based health centers offer a variety of health care services to students, the general perception is that they primarily treat acute conditions among students. For each of the years analyzed in the chart above, mental health services accounted for the most visits in each of those years, followed by diagnosis and treatment of acute conditions.

Measure 7: SBHC User Demographics

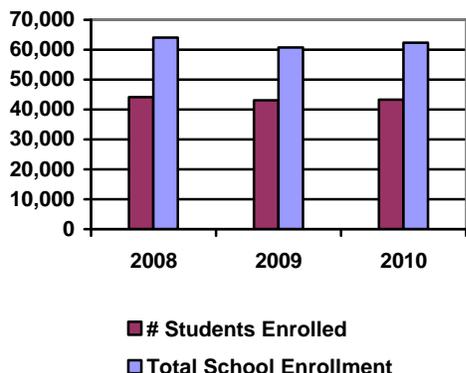


- In total, over 106,000 students received SBHC services during FYs05-09.
- Of those receiving services, 55% were female and 45% were male.
- The race/ethnicity of students using school-based health center services was 31% black, 30% white, 14% Hispanic, and 2% Asian. The remaining 23% of students had a race/ethnicity that was considered other or unknown.

Story Behind the Data: The information presented above is for those students who actually used the services of their school-based health centers, and not for those enrolled in their SBHC. Committee staff will continue examining school-based health center user demographics in more depth.

II. How Well Did We Do It?

Measure 1: Utilization (enrolled vs. school population)

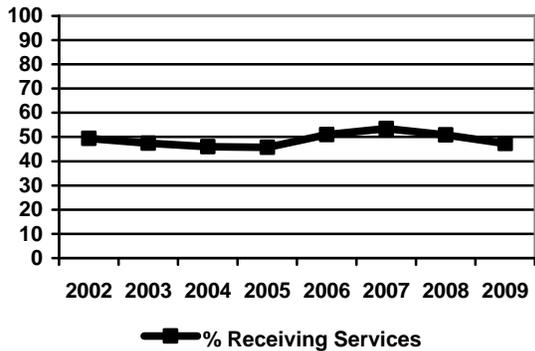


Trend: Utilization of school-based health centers remained relatively steady between FYs 08-10.

- A large percentage of the students eligible to enroll in school-based health centers actually do. On average over the three-year period analyzed, 7 out of 10 eligible students enrolled in their school's health center.

Story Behind the Baseline: Additional research is required to obtain school enrollment figures for the years not included in the graph. If available, the figures can be analyzed to more fully determine the number of students enrolled in SBHCs as a percentage of total school enrollment, which provides more complete context to the SBHC enrollment data. Additional analysis also is required to capture only those students enrolled in SBHCs who fall within this study's age range for adolescent (ages 10-19).

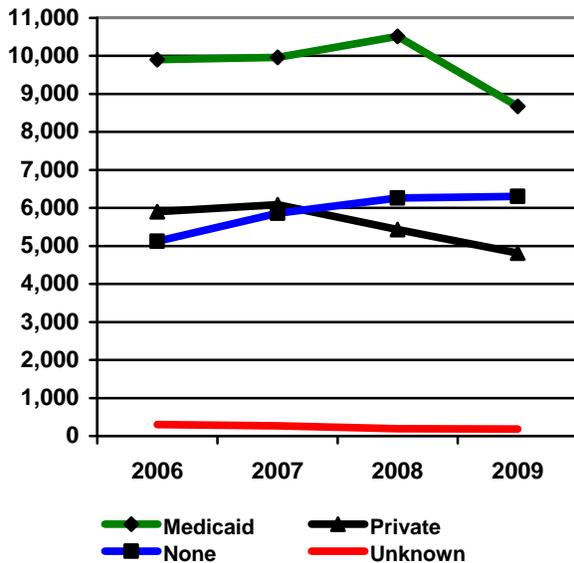
Measure 2: Utilization (enrolled vs. actually receiving services)



Trend: The trend of students enrolled in a SBHC and using the center’s services during FYs 02-09 remained relatively steady, ranging between 46% and 51%.

- For the seven-year period examined, an average of just under half (49%) of the students enrolled in school-based health centers used the SBHC services.

Measure 3: Types of Insurance Used for SBHC Services



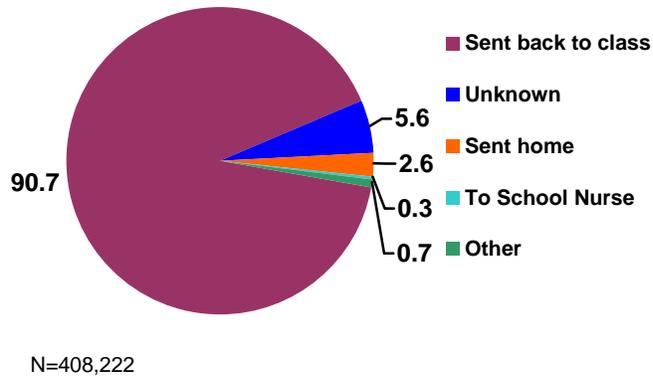
Trend: Coverage provided by Medicaid and private insurance has dropped since FY07, while the number of students with no insurance has risen.

- More students receiving SHBC services were covered by Medicaid than private insurance for the four-year period examined. This is expected, given the purpose and locations of school-based health centers. At the same time, the number of students identified having no insurance steadily increased over the period.
- Over four years, 46% of enrolled students were covered by Medicaid; 27% by private insurance; 26% had no insurance; and insurance for 1% was unknown.

Story Behind the Data: In general, insurance coverage should not be considered a barrier to receiving health care services from state-funded school-based health centers. The purpose of state grants to centers is to help offset costs associated with providing health care services to uninsured or underinsured students. Several issues related to insurance and SBHCs still need further examination by committee staff, including: 1) why was there a sudden drop in students covered by Medicaid starting in FY08; 2) why is the number of students receiving SBHC services identified by the center as not having any type of health insurance rising (note: the classification ‘insurance-none’ means a family knows it has no insurance, while ‘unknown’ usually means a family did not provide the insurance information at time of enrollment); 3) how much does state funding actually cover in helping SBHCs overcome service costs to uninsured and underinsured students; and 4) what efforts are being made to ensure the insurance status for all students enrolled in the centers is entered into the state’s central SBHC database and not classified as ‘unknown’?

III. Is Anyone Better Off?

Measure 1: Result of Visit to SBHC (FYs06-09)



Trend: Of the different outcomes of visits to SBHCs for the years examined, 9 out of 10 visits resulted in students returning to the classroom after the visit.

- Other results of visits to SBHCs included student: sent home (3%); sent to school nurse (<1%). 'Other' outcomes, such as students sent to emergency room or primary care physician occurred <1%. 6% of the visits had 'unknown' results, meaning information was not available.

Story Behind the Data: School-based health centers are designed to allow students to access quality health care at school where students spend a good portion of their day. One indicator/proxy of the relative impact SBHCs have on students is how quickly students return to the classroom following health care service. Literature indicates a key to students' academic performance is their overall health. Attending medical appointments not on school grounds may mean missing classroom time and instruction. In addition, the ability to offer quality, accessible health care on-site during school hours increases students' chances of returning to the classroom sooner than if services are sought off school grounds, which may lead to better academic achievement.

PRI staff is continuing to gather and analyze data related to the measures outlined above as well as developing additional performance measures for school-based health centers. Findings and recommendations proposed by committee staff will be presented in the next report.

III. Parental Involvement and Minors' Rights

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

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

Age of Majority and Minor Consent

In every state, persons below a certain age (generally 18) cannot receive health care without the permission of their parents or guardians for most medical procedures because they are legally minors. In Connecticut and most states, the age of majority is 18, and persons at that age are legally adults.⁴ The rationale for requiring parental consent for minors is founded on two principles: 1) minors are not yet competent in making their own decisions and need to be protected from the consequences of uninformed, immature decisions; and 2) the authority for parents to make medical decisions for their minor children is based on a legal presumption that parents will act in the best interests of their children and on the constitutional right of privacy in family matters.

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

⁴ Nationally, 46 states specify 18 as the age of majority. Alabama and Nebraska, have set the age at 19, while Pennsylvania and Mississippi use 21 as the age of majority (see: Age of Majority by State, Department of Defense Financial Management Regulation, Volume 7B, Appendix H, February 2010.)

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

The requirements pertaining to minor consent in Connecticut for general medical treatment and other health care areas are discussed below. Also discussed are Connecticut’s specific carve-outs in which minors control their own health care decisions for drug and alcohol treatment and rehabilitation, mental health counseling, reproductive health, and HIV/AIDS services. A summary of the state’s requirements is provided in Table 1

Emancipation of Minors

Connecticut’s *emancipation* statute⁵ provides a process that legally releases a resident minor who is at least 16 years old from all parental involvement requirements providing them legal status as an adult, including consenting to their own medical, dental, or psychiatric care. For emancipated minors, the laws about minor consent discussed here are not applicable.

Under Connecticut’s emancipation law, any minor who is at least 16 years old and resides in the state - or the minor’s parents or legal guardian - can petition the juvenile or probate court to determine whether the child should be emancipated. Legal notice must be given to the minor and the minor’s parents or guardian requiring them to attend a hearing, after which the judge will rule on the emancipation petition. A judge is required to make the decision about emancipation, and once the decision is made, it cannot be reversed.

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

| Year | # Minors Emancipated Granted: Juvenile Court | # Minors Emancipated Granted: Probate Court |
|-------------|-----------------------------------------------------|----------------------------------------------------|
| 2006 | 19 | 31 |
| 2007 | 22 | * |
| 2008 | 18 | 42 |
| 2009 | 18 | 27 |
| 2010 | 8 | 28 |

*Figure not available due Probate Court central office database conversion.
 Data Sources: Superior Court for Juvenile Matters; Office of the Probate Court Administrator

⁵ C.G.S. 46b-150

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

| | Definition of Minor (Age) | Parental Notice and/or Consent Required | Other Requirements | Legal Basis for Age of Consent and/or Patient Confidentiality | Requirements in Other States* |
|-------------------------------------------------------------------------------------|----------------------------------|------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Medical/Surgical Treatment (Procedure Requiring Informed Consent) | Under 18 | Yes (unless emergency or emancipated minor) | <ul style="list-style-type: none"> • Legal guardian (including DCF) can consent • Kinship caretaker with appropriate court order providing legal status of the minor to the caretaker can consent • American Medical Assoc. Code of Ethics conflicts; says competent minors should be able to consent to medical treatment | Common law (no direct state statute) | Age of Majority: <ul style="list-style-type: none"> • 18 (46 states, plus District of Columbia and Virgin Islands) • 19 (2 states) • 21 (2 states, plus Puerto Rico) |
| <i>PROTECTED CONFIDENTIAL CARE / STATUTORY AND CONSTITUTIONAL EXCEPTIONS</i> | | | | | |
| Substance Abuse | | | | | |
| Alcohol & Drug Treatment | Under 18 | No | <ul style="list-style-type: none"> • No access to drug treatment records without minor's consent, unless serious threat to life/well-being that can be diminished by disclosure to parents • Minor liable for treatment costs | State Statute: 17a-688(d) | <ul style="list-style-type: none"> • If treatment/rehab facility federally funded, follow requirements of federal Public Health Services Act |

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|--------------------------------|----------------------------------|------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Reproductive Health | | | | | |
| <i>Contraceptive Services</i> | Under 18 | No | <ul style="list-style-type: none"> Signs of sexual intercourse or activity (e.g., use of birth control) by minor under age 13 mandates clinical provider send child abuse/neglect report to DCF or law enforcement | Constitutional(1) (privacy grounds) | <ul style="list-style-type: none"> 21 states (plus D.C.) explicitly allow all minors to consent to contraceptive services 25 states explicitly permit minors to consent to contraceptive services in one or more circumstances 4 states have no explicit policy |
| <i>Emergency Contraception</i> | Under 17 | No | <ul style="list-style-type: none"> Prescription required if under 17 (available over the counter if 17 or older) Licensed health care facilities required to provide emergency contraception to victims of sexual assault upon victim's request | FDA order 4/2009 (per federal court order) | <ul style="list-style-type: none"> 12 states required hospitals to dispense EC to sexual assault victims (including CT) |

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|------------------------------------------------------------------------------|----------------------------------|------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <i>Pregnancy Testing & Care (routine prenatal, delivery, postpartum)</i> | Under 18 | No | <ul style="list-style-type: none"> Whether parental consent needed for invasive procedures (e.g., epidural, amniocentesis, c-section) unsettled | Constitutional (privacy grounds) | <ul style="list-style-type: none"> 36 states (and DC) explicitly allow some minors to consent to prenatal care; 13 of those states allow, but do not require, physicians to inform parents their minor daughter is seeking or receiving prenatal care when they deem it in the best interests of the minor |

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| | Definition of Minor (Age) | Parental Notice and/or Consent Required | Other Requirements | Legal Basis for Age of Consent and/or Patient Confidentiality | Requirements in Other States* |
|------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <i>Pregnancy Termination (Abortion)</i> | Under 16 | No (if 16 or older, considered adult, so no parental notice or consent required) | <ul style="list-style-type: none"> • Counseling required if under age 16. Physician or counselor must: 1) explain choices to minor and that the information given is not intended to coerce, persuade, or induce a decision; 2) state alternatives; and 3) discuss possibility of involving parents in the decision-making process.** | State Statute: 19a-600 | <ul style="list-style-type: none"> • CT, Maine, and DC allow minors to consent • 36 states require parental involvement (consent and/or notification) <ul style="list-style-type: none"> • 22 states require one or both parents to <i>consent</i> to the procedure • 10 states require parental <i>notification</i> • 4 require both notification and consent; • 6 states with laws currently enjoined • 8 with no parental involvement policy |

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|-------------------------------------------|----------------------------------|------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <i>STD Testing & Treatment</i> | Under 18 | No | <ul style="list-style-type: none"> • DCF must be notified if child 12 or under (exam, care, treatment remain confidential but investigation of abuse/neglect may proceed) • Minor responsible for all costs | State Statute: 19a-216 | <ul style="list-style-type: none"> • All other states and DC explicitly allow minors to consent; 11 states require minor to be a certain age of consent |

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

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| <i>Outpatient Care</i> | Under 18 | No <u>if</u> professional counselor** determines notification or consent would be seriously detrimental to minor; <i>and</i> whether to notify parent and secure consent must be evaluated initially and reevaluated after every sixth session | <ul style="list-style-type: none"> • Uninformed parents not liable for costs (minor responsible) | State Statute: 19(a)-14c(b-d) | <ul style="list-style-type: none"> • PRI staff research pending |

* Primary information source: Guttmacher Institute

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

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

Medical or Surgical Treatment (General)

Under Connecticut law, anyone at age 18 has reached the age of majority and is a legal adult, and anyone under the age of 18 is considered a minor, except if the law provides for a different age.⁶ No specific state statute governs the age of consent for medical and surgical treatment, but under common law, the minimum age for people to make their own health care choices without parental consent in the state is 18, reflecting the general statutory age of majority. As such, minors in Connecticut cannot give informed consent in the area of health care, unless permitted through law. Informed consent acknowledges the patient voluntarily agrees to a procedure, has the capacity to consent, and has been made aware of alternative procedures and the possible consequences resulting from those procedures.⁷ Informed consent must be obtained before any procedure, unless attaining consent is not reasonable, such as in emergencies.

Clearly consent, and in particular, informed consent, whoever is deemed appropriate to provide it, is a key requirement for medical treatment. The Public Health Code in Connecticut requires each hospital in the state ensure its bylaws, rules, or regulations pertaining to the hospital's medical staff include the requirement that, except in emergency situations, the responsible physician must obtain proper informed consent as a prerequisite to any procedure or treatment for which it is appropriate and provide signed evidence of consent by the patient or a written statement signed by the physician on the patient's hospital record.⁸ The extent of information to be supplied by the physician to the patient must include the specific procedure or treatment (or both), the reasonably foreseeable risks, and reasonable alternatives for care or treatment.

Mature minor doctrine. The *mature minor doctrine* is a legal principle based on common law that provides a minor who is not legally separated from his or her parents may possess the maturity to choose or reject medical treatment without the knowledge or agreement of the minor's parents, and should be permitted to do so. States may codify the doctrine in statute, or simply follow the doctrine based on common law. Connecticut does not follow the mature minor doctrine nor has there been a legal case in this area.⁹

Under the mature minor doctrine, the court must consider various factors in determining whether a minor is sufficiently mature, including the minor's age, evidence of maturity, education, and judgment to consent knowingly to medical treatment.¹⁰ The minor must be able to understand and appreciate the nature and consequences of a medical procedure. A judicial procedure determines whether an adolescent is deemed mature.

⁶ C.G.S. Sec. 1-1d.

⁷ Adolescent Health Care: Legal Rights of Teens, Fourth Edition, Center for Children's Advocacy: Medical-Legal Partnership Project, 2010, p.6.

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

⁹ Per 8/29/11 meeting with Center for Children's Advocacy, University of Connecticut School of Law.

¹⁰ Keeping Children's Secrets: Confidentiality in the Physician-Patient Relationship, Amy L. McGuire and Courtenay R. Bruce, *Houston Journal of Health Law and Policy*, 327, 2008.

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

Drug or Alcohol Treatment

Connecticut law provides that minors (under age 18) may give their own consent to receive treatment or rehabilitation for drug or alcohol dependency, without parental involvement.¹¹ The fact that a minor sought treatment or rehabilitation for drug or alcohol dependence cannot be reported to the minor's parents or guardian without the consent of the minor. Care for drug or alcohol dependence must come from a facility licensed to treat drug or alcohol dependence or a facility operated by the Department of Mental Health and Addiction Services.

Minors are afforded full confidentiality of their records when seeking or receiving alcohol or drug treatment/rehabilitation, including no third-party billing. By law, however, minors are financially liable for any costs and expenses associated with any drug or alcohol treatment or rehabilitation they request.

If a minor receives a drug test as part of a routine examination, Connecticut law is silent as to whether a physician must report the test results to the minor's parent or guardian.¹² As such, physicians are bound by their ethical duty to ensure patient confidentiality, regardless of the patient's age. American Medical Association guidelines, however, say such confidentiality may be broken if the minor is in serious harm and/or such breach enables a parent to make an informed decision about their minor's treatment.¹³

When a minor seeks drug or alcohol treatment from a licensed substance abuse counselor, state law parallels the federal Public Health Services Act (PHSA) regarding patient confidentiality. Facts relevant to reducing a threat to the life or physical well being of the minor or any other individual may be disclosed to the parent or guardian if the program director determines: a) because of extreme youth or mental or physical condition to make a rational decision on whether to consent to disclose information to his or her parent or guardian; and b) the minor's situation poses a substantial threat to the life or physical well being of the minor or any other individual, which may be reduced by communicating relevant facts to the minor's parent or guardian.¹⁴

¹¹ C.G.S. Sec. 17a-688(d).

¹² Adolescent Health Care: Legal Rights of Teens, Fourth Edition, Center for Children's Advocacy: Medical-Legal Partnership Project, 2010, p.10.

¹³ *Id.*

¹⁴ 42 C.F.R. 2.14(d)

Reproductive Health

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

Although Connecticut law provides no statutory right for minors to obtain birth control without parental consent (beyond the rights conferred to emancipated minors), U.S. Supreme Court rulings in cases such as *Carey v. Population Services Int'l*¹⁵ have established that minors' access to confidential contraceptive services is protected under constitutional privacy rights. State law also is silent as to whether parents or guardians must be notified prior to their minor child obtaining birth control.

Mandatory reporters in Connecticut (including health care practitioners), notwithstanding minors' constitutional rights, must report sexual activity of minors under age 13 if there is knowledge or suspicion of a minor engaging in sexual activity or intercourse, including the use of birth control.¹⁶ Moreover, health care providers, including clinics, may request minors inform their parents/guardians about the contraception use, but no law exists requiring such notification.

Nationally, states' policies regarding contraceptive services and their availability to minors vary:¹⁷

- 21 states and the District of Columbia explicitly allow all minors to consent to contraceptive services;¹⁸
- 25 states explicitly permit certain minors to consent to contraceptive services in *one or more* circumstances;¹⁹
 - 3 states allow minors to consent to contraceptive services if a physician determines that the minor would face a health hazard if she is not provided with contraceptive services
 - 21 states allow a married minor to consent to contraceptive services (Connecticut confers right/responsibilities of adulthood to married minors once emancipated)
 - 6 states allow a minor who is a parent to consent
 - 6 states allow a minor who is or has ever been pregnant to consent to services

¹⁵ *Carey v. Population Services International*, 431 U.S. 678.

¹⁶ *Id.*, p.15.

¹⁷ Guttmacher Institute: State Policies in Brief, *Minors Access to Contraceptive Services*, September 2011.

¹⁸ Alaska, Arizona, Arkansas, California, Colorado, Georgia, Idaho, Iowa, Kentucky, Maryland, Massachusetts, Minnesota, Montana, New Mexico, New York, North Carolina, Oregon, Tennessee, Virginia, Washington, Wyoming

¹⁹ Alabama, Connecticut, Florida, Illinois, Indiana, Louisiana, Maine, Michigan, Mississippi, Missouri, Nebraska, Nevada, New Jersey, Oklahoma, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Vermont, West Virginia
September 27, 2011

- 11 states allow a minor to consent if the minor meets other requirements, including being a high school graduate, reaching a minimum age, demonstrating maturity or receiving a referral from a specified professional, such as a physician or member of the clergy; and
- 4 states have no explicit law on minors' authority to consent to contraceptive services.²⁰

Emergency contraception. Parental consent and/or notification are not required for minors to obtain emergency contraception.²¹ The federal Food and Drug Administration (FDA), pursuant to a 2009 court order, has stated anyone age 17 or older may acquire emergency contraception without a prescription.²² The FDA has also said emergency contraception without parental notification or consent is available from a pharmacy with a prescription to anyone under 17 years old.

Connecticut law further provides that licensed health care facilities must give emergency contraception to any female victim of an alleged sexual assault upon the victim's request.²³ Such facilities are not required to provide emergency contraception to a victim of sexual assault who has been determined to be pregnant through the administration of a pregnancy test approved by the FDA. Twelve states, plus D.C., require emergency rooms to dispense emergency contraception at the request of the minor.²⁴ Connecticut has such a requirement, but a hospital may contract with an independent medical professional to provide the emergency contraception services.²⁵

Pregnancy testing and related care. Minors do not need parental consent to obtain a pregnancy test or routine gynecological care for pregnancy. Connecticut law is silent on this topic, but minors are able to consent to such care based on their constitutional right to privacy. At the same time, Connecticut law specifically states a married minor or a minor parent can consent to medical, dental, health, and hospital services for his or her child and is liable for the costs of that care.²⁶

One area of law in Connecticut that remains unsettled is if a minor needs permission from a parent or guardian to obtain invasive procedures associated with pregnancy, including amniocentesis and epidurals.²⁷ On one hand, such procedures are viewed as confidential in that

²⁰ North Dakota, Ohio, Rhode Island, Wisconsin. (Note: Connecticut is defined by Guttmacher as a state explicitly allowing emancipated married minors to consent to medical services, of which Guttmacher considers contraceptive services. For purposes of this study, Connecticut is a state with no explicit policy regarding minors and contraceptive services beyond the emancipation provision.)

²¹ Emergency contraception is used as a back-up birth control method to prevent pregnancy after unprotected sexual intercourse, sexual assault, or a contraceptive failure. The FDA has approved one type of emergency contraception (*Plan B One Step*) made available without a prescription to anyone 17 or older.

²² See: <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/2009/ucm149568.htm>, accessed 9/10/11

²³ C.G.S. Sec. 19a-112e(6)(b)(3).

²⁴ California, Connecticut, Massachusetts, Minnesota, New Jersey, New Mexico, New York, Oregon, South Carolina, Utah, Washington, Wisconsin

²⁵ C.G.S. Sec. 19a-112e

²⁶ C.G.S. Sec. 19a-285

²⁷ *Adolescent Health Care: Legal Rights of Teens*, Fourth Edition, Center for Children's Advocacy: Medical-Legal Partnership Project, 2010, p.16.

they are part of reproductive health care and affect reproductive rights, thus falling under the right to privacy for pregnancy matters. At the same time, these examples may be construed as medical procedures, which would require parental consent under the theory that the minor does not have the legal capacity to provide such consent.

Abortion. Connecticut's statute regarding abortion defines a minor to be under 16, thereby lowering the age of majority to 16.²⁸ Connecticut does not require parental consent or notification for a minor to have an abortion, based on U. S. Supreme court rulings protecting minors' privacy rights.²⁹ As such, a pregnant adolescent may consent to, or refuse, an abortion, as long as she understands the procedure, its associated risks, and alternatives in the provider's opinion.

State law requires minors to receive pregnancy information and counseling prior to an abortion procedure, in a manner and language the minor will understand.³⁰ As prescribed by law, the following licensed professionals are considered appropriate counselors: psychiatrist; psychologist; clinical social worker; marital and family therapist; ordained minister of the clergy; physician assistant; nurse-midwife; certified guidance counselor; registered professional nurse; and licensed practical nurse; although not included in the statutory definition of "counselor," physicians can provide information and counseling.

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

- information given to the minor is provided objectively and is not intended to coerce, persuade or induce the minor to choose to have an abortion or to carry the pregnancy to term;
- the decision to have an abortion may be withdrawn at any time before the abortion is performed or may reconsider a decision not to have an abortion at any time within the time period during which an abortion may legally be performed;
- alternative choices are available for managing the pregnancy, including: 1) carrying the pregnancy to term and keeping the child; 2) carrying the pregnancy to term and placing the child for adoption, placing the child with a relative, or obtaining voluntary foster care for the child; and 3) having an abortion, and explaining that public and private agencies are available to assist the minor with whichever alternative she chooses and that a list of these agencies and the services available from each will be provided if the minor requests;

²⁸ C.G.S. Sec. 19a-600(2)

²⁹ *Planned Parenthood v. Casey* (1992), *Akron v. Akron Ctr. for Reproductive Health* (1983), and *Bellotti v. Baird* (1979) are examples of cases in which the U.S. Supreme Court ruled that parental consent requirements for abortion are unconstitutional unless the requirements provide an expeditious and confidential judicial bypass procedure.

³⁰ C.G.S. Sec. 19a-601(a)

- public and private agencies are available to provide birth control information and that a list of these agencies and the services available from each will be provided if the minor requests;
- involving the minor's parents, guardian or other adult family members in the minor's decision-making concerning the pregnancy is a possibility and whether the minor believes that involvement would be in her best interests; and
- adequate opportunity for the minor to ask any questions concerning the pregnancy, abortion, child care, and adoption, and provide information the minor seeks or, if the person cannot give the information, to indicate where the minor can receive the information.

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

The statutory counseling provision does not apply when, in the best medical judgment of the minor's physician, a medical emergency exists that so complicates the pregnancy or the health, safety, or well-being of the minor as to require an immediate abortion. Such medical emergency must be documented in the minor's record.

Nationally, states have various requirements as to parental involvement regarding abortion and minors.³¹ Overall:

- 36 states require some type of parental involvement in a minor's decision to have an abortion
 - 22 states require one or both parents to *consent* to the procedure³²
 - 10 states require parental *notification* only; 1 of which requires both parents³³
 - 4 states require both parental *consent* and *notification*³⁴
- 6 states have laws that are enjoined, meaning policy not in effect³⁵
- 6 states have no laws regarding parental notification or consent³⁶

³¹ Guttmacher Institute: http://www.guttmacher.org/statecenter/spibs/spib_PIMA.pdf, accessed 9/2011

³² Alabama, Arizona, Arkansas, Idaho, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Michigan, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Washington, and Wisconsin

³³ Arkansas, Colorado, Delaware, Florida, Georgia, Iowa, Maryland, Minnesota, South Dakota, West Virginia

³⁴ Oklahoma, Texas, Utah, Wyoming

³⁵ California, Illinois, Montana, Nevada, New Jersey, New Mexico

³⁶ Hawaii, New Hampshire, New York, Oregon, Vermont, Washington

- 2 states (Connecticut, Maine) and the District of Columbia have laws giving minors authority to obtain abortions without parental notification or consent – Maine requires written consent from the minor and one parent, guardian, or adult family member.³⁷
- 35 states that require parental involvement have an alternative process for minors seeking an abortion
 - 35 states include a judicial bypass procedure, which allows a minor to obtain approval from a court³⁸
 - 6 states requiring parental involvement permit minor to obtain an abortion if a grandparent or other adult relative is involved in the decision
- Most states that require parental involvement make exceptions under certain circumstances
 - 32 states permit a minor to obtain an abortion in a medical emergency
 - 16 states permit a minor to obtain an abortion in cases of abuse, assault, incest or neglect

In *Bellotti v. Baird*, the U.S. Supreme Court said that if states require parental consent as a condition for minors seeking abortions they must also “provide an alternative procedure whereby authorization for the abortion can be obtained.³⁹ The ruling declared that a pregnant minor is entitled to such a proceeding to show either: 1) she is mature enough and well enough informed to make her abortion decision, in consultation with her physician, independently of her parents’ wishes; or 2) even if she is not able to make this decision independently, the desired abortion would be in her best interests.

Each state currently with parental consent and/or notification requirements before a minor can undergo an abortion has a judicial bypass option, as a requirement of the U.S. Supreme Court ruling.⁴⁰ Judicial bypass allows a minor to go to court for a judicial hearing when her parents refuse to consent to an abortion. This option allows minors to request a judge waive parental consent requirements, when the court finds the minor is mature or that it would be in the best interest of the minor not to involve her parents in the abortion decision.

Sexually Transmitted Disease (STD) Testing and Treatment

Connecticut law provides that minors may be examined and provided treatment by any municipal health department, state institution or facility, licensed physician, or public or private hospital or clinic for sexually transmitted diseases.⁴¹ Consent of the minor’s parent or guardian is not required as a prerequisite to the consultation, examination, and treatment of the minor.

³⁷ M.R.S. Title 22, Chapter 263-B, Sec. 1597-A(2)

³⁸ New Mexico’s abortion law is enjoined; state is shown in Guttmacher information as not having an alternative procedure.

³⁹ *Bellotti v. Baird*, 443 U.S. 622 (1979), pp. 642-644

⁴⁰ State Policies in Brief, *Parental Involvement in Minors’ Abortions*, Guttmacher Institute, September 1, 2011.

⁴¹ C.G.S. Sec. 19a-216

Minors are personally liable for all costs and expenses relating to such consultation, examination, and treatment.

Information regarding the consultation, examination and treatment of a minor for a sexually transmitted disease is confidential and must not be revealed by the facility or physician conducting the services, including through sending a bill, to any person other than the minor. One exception to this is compliance with the statutory requirement of making a report to DPH based on the list of reportable diseases and laboratory findings developed by the department. Another exception is through the facility or physician must report the name, age and address of such minor to DCF if the minor is under 13. In addition, any provider who believes a minor either cannot take care of him/herself or is endangering their own health, has an ethical duty to inform a responsible adult of the situation.

Nationally, every state and the District of Columbia allow all minors to consent to sexually transmitted infections (STI).⁴² Eighteen states allow, but do not require, a physician to inform a minor's parents that the minor is seeking or receiving STI services, when the physician determines such disclosure is in the best interest of the minor. Moreover, several states have established specific minimum ages for a minor to consent to STI services.

HIV/AIDS. A minor can be tested for Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) without parental consent.⁴³ Health care providers may give counseling, as needed, at the time the lab results are presented to the tested person. Such counseling includes coping with the emotional consequences of learning the result and information about available medical treatment and services. HIV testing is voluntary, and minors also may choose, without parental involvement, not to be tested.

Physicians examining and/or treating a minor may do so without parental consent if the physician determines: 1) notification of the minor's parents or guardian will result in denial of treatment; or 2) the minor will not seek, pursue, or continue treatment if the parents or guardian are notified, and the minor requests that his or her parents not be notified.⁴⁴ All lab results must be sent directly to the person ordering the HIV/AIDS test. Insurance billing is confidential and must not be divulged without the minor's consent to any person other than the minor, until the physician consults with the minor regarding the sending of a bill. A minor is personally liable for all costs and expenses for any HIV/AIDS services received.

Inpatient Mental Health Care

For purposes of admitting a minor to a hospital for diagnosis or treatment of a mental disorder, minor is defined under Connecticut law as someone less than 16 years old.⁴⁵ Under Connecticut law, anyone 16 or older can commit to inpatient hospitalization for treatment of a mental disorder. Further, a minor who is 14 or 15 years old may be admitted for inpatient mental

⁴² State Policies in Brief, *An Overview of Minors' Consent Laws*, Guttmacher Institute, September 1, 2011.

⁴³ C.G.S. Sec. 19a-582(a)

⁴⁴ C.G.S. Sec. 19a/592(a)

⁴⁵ C.G.S. Sec. 17a-75

health services without consent of his or her parents if such child consents in writing.⁴⁶ If this occurs, parents must be notified within five days of such admission. If the parents cannot be located, then the child's nearest relative must be notified. Hospitals can admit minors upon the written request of the child's parent.

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

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

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

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

Outpatient Mental Health Care

Outpatient mental health treatment means the treatment of mental disorders, emotional problems or maladjustments with the objective of: a) removing, modifying or retarding existing symptoms; b) improving disturbed patterns of behavior; and c) promoting positive personality growth and development. Treatment for mental health outpatient care does not include prescribing or otherwise dispensing any medication.⁴⁷

A licensed psychiatrist, independent social worker, or a marital and family therapist may provide outpatient mental health treatment to a minor without the consent or notification of a parent or guardian at the request of the minor, if: 1) requiring the consent or notification of a parent or guardian would cause the minor to reject such treatment; 2) the provision of such treatment is clinically indicated; 3) the failure to provide such treatment would be seriously detrimental to the minor's well-being; 4) the minor has knowingly and voluntarily sought such treatment; and 5) in the opinion of the provider of treatment, the minor is mature enough to participate in treatment productively.⁴⁸

⁴⁶ C.G.S. Sec. 17a-79

⁴⁷ C.G.S. Sec. 19a-14c

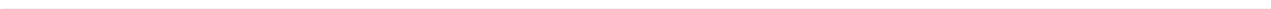
⁴⁸ *Id.*

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

The treatment providers must document in the minor's clinical record the reasons for the determination to treat the minor without parental or guardian consent or notification. This includes a written statement signed by the minor, stating he or she has: a) voluntarily sought such treatment; b) discussed with the provider the possibility of involving his parent or guardian in the decision to pursue such treatment; c) determined it is not in his best interest to involve his parent or guardian in such decision; and d) been given adequate opportunity to ask the provider questions about the course of his treatment.⁴⁹

⁴⁹ *Id.*

APPENDICES



APPENDIX A

RESULT-BASED ACCOUNTABILITY BACKGROUND

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

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

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

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

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

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

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

APPENDIX A

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

More details about RBA concepts and the PRI results-based accountability process can be found in the committee's two completed pilot project reports. (See: *RBA Pilot Project Study of Selected Human Services Programs (P.A. 09-166)*, Final Report to the Appropriations Committee January 15, 2010, and *RBA Pilot Project 2010: Department of Transportation Project Delivery*).⁵⁰

⁵⁰ Final RBA project reports and all related documents are available at the PRI committee staff office website: http://www.cga.ct.gov/pri/2009_RBA.asp (2009); http://www.cga.ct.gov/pri/2010_RBA.asp (2010)

APPENDIX B

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

Information Forum Group Discussion Summary

Legislators Attending: PRI – Reps. Rowe, Becker, Urban, Guiliano; Sens. Kissel, Markley, Coleman; also Rep. Gomes, Sen. Gerrantana

Invited Panelists (9 adolescent health experts from state agencies and the community):

Dr. Ryan, Dr. Schichor (adolescent medicine specialists); Dr. Lee (CT Voices for Children); Ms. Poiero (CT Association School Based Health Centers); Atty. Sicklick (CT Center for Children’s Advocacy); Dr. Wolman (DCF); Dr. Zavoski (DSS); Dr. Resha (SDE); and Ms. Biaggi (DPH)

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

APPENDIX B

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

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

Public Hearing Testimony Summary

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

In summary:

- **Sen. McLachlan and eight members of the public**, including two family practice physicians who also work with pregnancy resource centers and several persons speaking for themselves or as members of Connecticut Right to Life and Silent No More: *support of mandatory parental notification for a minor's abortion*
- **Rep. Ritter**: *requested that the study examine three particularly grave issues: mental health and substance abuse, STDs and complications from a lack of education and treatment, and complications of obesity for teens and young adults*
- **Rep. Lyddy**: *the committee should look carefully at adolescent substance abuse and treatment*
- **Child Advocate Jeanne Milstein**: *cabinet for adolescent health could address problems of fragmentation; youth in foster care need special attention as at greater risk for unintended pregnancy, STDs*
- **Association of School Nurses CT (ASNC)**: *school health services need to be adequately funded and staffed; care coordination effective practice but not funded*

APPENDIX B

- **City of Hartford Public Health Office:** *need to recognize and address the many social determinants of health (e.g., poverty); better coordination, e.g., pediatricians and school-based health centers, would improve services*
- **CT Association of School-Based Health Centers (CASBHC):** *SBHCs provide barrier-free access to care at low cost, help reduce inappropriate emergency room use, and keep kids healthy and in school*
- **CT National Alliance on Mental Illness (NAMI):** *access to community-based mental health prevention and treatment lacking; SBHCs play critical role in delivering mental health services; better data collection and monitoring of teens transitioning to adult mental health system needed*
- **CT Sexual Assault Crisis Services (CONNSAC):** *teens' rights regarding sexual assault evidence need to be clarified*
- **CT Speech Language Hearing Association (CSHA):** *increasing prevalence of hearing loss among teens; insurance coverage for hearing aids for 13-18 years should be mandatory as for younger children*
- **Get in Touch Foundation:** *provided information on their (free) breast self-exam program for schools*
- **Hartford Gay and Lesbian Health Coalition (HGLHC):** *lesbian, gay, bisexual, transgender, and queer youth at greater risk for poor health outcomes; special needs require more attention*
- **Six individuals,** including two nurse practitioners, one from a school-based and one from a community health center, four representatives from NARAL Pro-Choice CT, Planned Parenthood Southern New England (PPSNE) and HGLHC *supported Connecticut's current law and policy regarding adolescent health care confidentiality*
- **Eight individuals,** including seven representatives from CASBHC, CONNSACS, NARAL, PPSNE, and HGLHC, *supported comprehensive health education, including sex education, for young people*

APPENDIX C. PRI September 27, 2011 Update

STATE ADOLESCENT HEALTH CARE INFRASTRUCTURE: PRI STAFF WORKING DRAFT (Rev. 9-21-11)

| STATE AGENCY | MAJOR COMPONENTS | | | | | | |
|--------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | Physical Health Care | Behavioral Health Care | Oral Health Care | Reproductive Health Care | Health Education | Prevention | Nutrition & Fitness |
| DPH | <ul style="list-style-type: none"> • School-Based Health Centers -- SBHCs [School year 2008-09, 41,749 students (K-12) enrolled; \$10.3 million state funds SFY11] • Community Health Centers -- CHCs [2009 served almost 290,000 patients all ages statewide; \$5.1 million fed. funding] • Coordinated School Health – CSH (Healthy Connections, in partnership with SDE) [total served all ages 74,073; \$100,000 federal funding annually] • Children and Youth with Special Health Care Needs – CYSHCN [Served 3,140 ages 10-18; \$2.1 million] • Primary Care Office – PCO [all ages; federal funding \$199,830] • Asthma [e.g. Easy Breathing – 1,529 children treated; Annual state funding \$500,000] • InfoLine (contracted referral/screening services) • Family/maternal and child health care programs, e.g., Pregnancy Risk Assessment Tracking (PRATS) [all postpartum women; federal funding \$100,000] • Sexual Violence Intervention and Prevention – SVIP [\$990,000 all ages] • Sexually Transmitted Disease (STD) Control programs [9 clinics serve 6,000 all ages annually; \$990,000] | <ul style="list-style-type: none"> • SBHCs • CHCs • CSH • CYSHCN • PCO • InfoLine • PRATS • SVIP • Injury Prevention Program – Child Sexual Abuse [745 children served; Annual state funding \$255,287] | <ul style="list-style-type: none"> • SBHCs • CHCs • CSH • PCO • InfoLine • PRATS • Oral Health Office | <ul style="list-style-type: none"> • SBHCs • CHCs • CSH • InfoLine • PRATS • SVIP • STD • Family Planning [FY09: \$1.04 million; served 39,473 clients through 12 clinics operated by statewide contractor (Planned Parenthood)] | <ul style="list-style-type: none"> • SBHCs • CHCs • CSH • InfoLine • PRATS • Asthma • NPAO • SVIP • STD • Hartford Healthy Start – HHS [412 enrolled low income pregnant and postpartum women in Hartford; federal funding \$750,000] | <ul style="list-style-type: none"> • SBHCs • CHCs • CSH • CYSHCN • InfoLine • PRATS • SVIP • STD • NPAO • HHS • CT School Health Survey • HIV Prevention • Immunizations [2011 target pop. ages 10-18 = 422,262; \$40.0 million for vaccines] • Tobacco Use [20,345 students served; FY10 \$500,000 –none FY11] • Comprehensive Cancer Prev. and Control Program (women age 19+) | <ul style="list-style-type: none"> • SBHCs • CHCs • CSH • InfoLine • HHS • Nutrition, Physical Activity and Obesity program – NPAO • Communities Putting Prevention to Work [12 schools; fed. stimulus funds \$120,000] • WIC (Women, Infants, & Children) nutrition program |
| DSS | <ul style="list-style-type: none"> • HUSKY (A & B)*see below • Medicaid LIA (covers 19 yr. olds) ** | <ul style="list-style-type: none"> • HUSKY (A & B Behavioral Health Partnership – BHP) • Medicaid LIA | <ul style="list-style-type: none"> • HUSKY (A & B Dental Health Partnership -- DHP) • Medicaid LIA | <ul style="list-style-type: none"> • HUSKY/Medicaid • Teen Pregnancy Prevention Initiative - TPPI [FY11: \$1.8 million state; 690 capacity total] • Family Planning (through SSBG) [FY11: \$0.9 million; 15,802 served] | | <ul style="list-style-type: none"> • TPPI • Family Planning • Healthy Start • Nurturing Family Network | <ul style="list-style-type: none"> • SNAP (nutritional counseling) |

APPENDIX C. PRI September 27, 2011 Update

STATE ADOLESCENT HEALTH CARE INFRASTRUCTURE: PRI STAFF WORKING DRAFT (Rev. 9-21-11)

| STATE AGENCY | MAJOR COMPONENTS | | | | | | |
|--------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | Physical Health Care | Behavioral Health Care | Oral Health Care | Reproductive Health Care | Health Education | Prevention | Nutrition & Fitness |
| DCF | <ul style="list-style-type: none"> DCF-involved covered by HUSKY/Medicaid [approx. 11,800 in A & B as of May 2011; if remain voluntarily after age 18, stay on HUSKY to 21; over age 18 who do not may qualify for Medicaid LIA] DCF provides some direct care in facilities its operates (i.e., Riverview, CT Juvenile Training School, CCP) | <ul style="list-style-type: none"> DCF-involved covered by HUSKY (BHP)/ Medicaid For all under 18, DCF operates/funds mental health and substance abuse services: <ul style="list-style-type: none"> Riverview Hospital CT Children's Place Residential/ group homes EMPS Intensive In-home Extended Day Outpatient/ community-based Care Coordination Family advocacy and support (Age 18 and over served by DMHAS) | <ul style="list-style-type: none"> DCF-involved covered by HUSKY (DHP)/Medicaid | <ul style="list-style-type: none"> DCF-involved covered by HUSKY/Medicaid DCF funds: <ul style="list-style-type: none"> Reproductive care in JJ Girls Res. Programs [5 providers statewide] Pregnant & Parenting Girls Programs [5 providers statewide] | <ul style="list-style-type: none"> School Health Ed (through DCF U.S.D. #2) | <ul style="list-style-type: none"> Youth Suicide Advisory Committee | |
| SDE | <ul style="list-style-type: none"> School Health Care (School RN) [included in general state and local education funding] Health Services to Pupils in Nonpublic Schools [FY10: \$4.8 million] Coordinated School Health –CSH (Healthy Connections, in partnership with DPH) | <ul style="list-style-type: none"> School Behavioral Health (Guidance, Counseling, Social Work) [included in general state and local education funding] CSH | <ul style="list-style-type: none"> CSH | <ul style="list-style-type: none"> CSH Young Parents [2009-10 SY: \$229,330; 191 teens served] Support for Pregnant and Parenting Teens Project (SPPTP) [FFY11: \$1,999,99; 5 large urban school districts] | <ul style="list-style-type: none"> School Health Ed. [included in general state and local education funding] CSH | <ul style="list-style-type: none"> Youth Service Bureaus [FY10: \$3.6 million; 40,213 youth served] CHS | <ul style="list-style-type: none"> School Nutrition [school breakfast/lunch funding] School Physical Education [included in general state and local education funding] CSH |

OTHER STATE AGENCIES that provide health care services to segments of the adolescent population:

Judicial Branch/Court Support Services Division (CSSD) - Juvenile detention population (under 16 currently; under 17 as of July 2012); **Dept. of Correction (DOC)** - Ages 14-19 incarcerated in adult correction system; **Dept. of Mental Health and Addiction Services** – State behavioral health services for young adults including 19 year olds

* **HUSKY A** = Medicaid for children, parents and certain adult caregivers, and pregnant women: \$998 million (est.) total expended FY11 (60% federal reimbursement; returns to 50% July 1, 2011) with 256, 808 (age 0-19) enrolled as of 2/2011 (about 117,000 ages 10-19 as of 4/2011). Under the Medicaid program EPSDT (Early and Periodic Screening, Diagnosis, and Treatment), there are specific federal requirements for timely well-care, early detection and treatment, health education, and other primary and preventive care for children and young adults under age 21.

HUSKY B = SCHIP (State Children's Health Insurance Program) for uninsured/not Medicaid eligible up to age 19; \$36.6 million (est.) expended FY11 (65% federal reimbursement) with 15,000 enrolled (Feb 2011).

** **Medicaid LIA** = Low Income Adult, formerly SAGA, serves those eligible over age 18.

APPENDIX D

School-Based Health Centers in Connecticut

In May 2011, the program review committee endorsed the staff's proposal to revise the adolescent health care study scope to focus the program performance evaluation portion of the study on two areas: school-based health centers (SBHCs), which will permit examination of the full array of primary and preventive care (physical, behavioral, and dental) provided to adolescents; and state-supported teen reproductive health services. This appendix provides background information regarding school-based health centers. Information provided below augments the SBHC report card information presented earlier in the report. In addition, PRI staff will be collecting and analyzing additional information, as noted below.

Background

In Connecticut, school-based health centers are not defined within current state law. Under the federal Social Security Act, however, a school-based health center is a health clinic: 1) located in or near a school facility; 2) organized through school, community, and health provider relationships; 3) administered by a sponsoring agency; 4) providing primary health services to children through health professionals; and 5) satisfying all applicable state requirements.⁵¹

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

Viewed as the precursor to school-based health centers, in 1967, the director of Maternal and Child Health for the Cambridge, Massachusetts health department assigned a nurse practitioner to work in an elementary school and deliver primary medical care to the children enrolled in the school. Four additional health clinics were opened in Cambridge schools in the years that followed.⁵²

In the early 1970s, school-based health centers staffed with nurse practitioners and part-time physicians were established in Texas and Minnesota.⁵³ In 1977, the Robert Wood Johnson Foundation (RWJF) funded its first large initiative – the *School Health Services Program* – to increase health care access to school-aged children.⁵⁴ The seven-year program brought nurse practitioners into multiple elementary schools in four states (Colorado, New York, North Dakota, and Utah).

⁵¹ Social Security Act, Title XXI, State Children's Health Insurance Program (42 U.S.C. 1397jj(c)(9), Sec. 2110(c)(9)(A)).

⁵² The Robert Wood Johnson Foundation Anthology, *School-Based Health Clinics*, Paul Brodeur, 2000.

⁵³ *Id.*

⁵⁴ Robert Wood Johnson Foundation National Program Report – Making the Grade: State and Local Partnerships to Establish School-Based Health Centers

APPENDIX D

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

Between 1993 and 2001, the Robert Wood Johnson Foundation established another national program: *Making the Grade: State and Local Partnerships to Establish School-Based Health Centers*.⁵⁵ The \$25.2 million program was based on two components: 1) planning grants for 12 states; and 2) implementation grants for several states.⁵⁶ Connecticut was one of three states meeting their planning objectives in one year and receiving a \$2.3 million implementation grant the following year to help create four school-based health centers.

The key goals of the *Making the Grade* program were to help states and their local partners increase the availability of comprehensive school-based health services for children with unmet health care needs, and support state-local collaborations designed to expand comprehensive school-based health services for children and adolescents.⁵⁷

Nationally, 1,909 health clinics and programs connected with schools nationwide were identified during the 2007-08 school year.⁵⁸ In Connecticut, the state's first SBHC opened at New Haven's Wilbur Cross High School in the early 1980s through the proceeds of a Robert Wood Johnson Foundation grant.⁵⁹ In 1985, the first state Department of Public Health (DPH) funded SBHC opened at Bassick High School in Bridgeport. Since then, the number of SBHCs around the state has increased to the current total of 73, located in 20 communities, as shown in Table D-1.

Administrative Models (Sponsoring Agency)

In Connecticut, the decision to establish and operate a SBHC is determined by local capacity and need. The process for funding and siting centers is being analyzed by PRI staff, with any resulting findings presented in the next report. For state funding and licensing purposes, each SBHC must have a sponsoring agency (i.e., operator) responsible for obtaining the proper license and entering into funding contracts. Moreover, the host-school district where the center is located must have a formal agreement/contract with a qualified medical provider to provide services

⁵⁵ The Robert Wood Johnson Foundation Anthology, *School-Based Health Clinics*, Paul Brodeur, 2000.

⁵⁶ The 12 states participating in the *Making the Grade* program's initial planning phase were Colorado, Connecticut, Delaware, Hawaii, Louisiana, Maryland, New York, North Carolina, Oregon, Rhode Island, Tennessee, and Vermont; the nine states receiving implementation grants were: Colorado, Connecticut, Louisiana, Maryland, New York, North Carolina, Oregon, Rhode Island, and Vermont.

⁵⁷ Robert Wood Johnson Foundation National Program Report – *Making the Grade: State and Local Partnerships to Establish School-Based Health Centers*, p.4.

⁵⁸ *School-Based Health Centers: National Census, School Year 2007-08*, National Assembly on School-Based Health Care.

⁵⁹ *School-based Health Centers*, Office of Legislative Research, 2001-R-0313, John Kasprak, Senior Attorney.

APPENDIX D

| Table D-1. State Funded School-based Health Centers by Location and School Type (2011) | | | | |
|-----------------------------------------------------------------------------------------------|-------------------------------------------|----------------------|--------------------|----------------------|
| | Elementary School (inc. Pre-K) | Middle School | High School | Mixed School* |
| Ansonia | | | 1 | |
| Bloomfield | | | | 1 |
| Branford | 1 | 1 | 1 | |
| Bridgeport | 7 | | 3 | |
| Danbury | | 2 | 1 | |
| East Hartford | 1 | 1 | 1 | |
| Groton | 2 | 2 | 1 | |
| Hamden | | | 1 | |
| Hartford | 2 | 1 | 2 | |
| Middletown | 1 | 3 | | |
| New Britain | | 1 | 1 | |
| New Haven | 4 | 5 | 2 | |
| New London | 6 | 1 | 1 | |
| Norwalk | | | 3 | |
| Norwich | 1 | 2 | 1 | |
| Stamford | | 2 | 2 | |
| Stratford | | 1 | | |
| Waterbury | 1 | | | |
| Waterford | 1 | | | |
| Windham | | 1 | 1 | |
| 20 Towns | 27 | 23 | 22 | 1 |

*Combined elementary/middle school or middle/high school.
Source of data: DPH

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

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

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

APPENDIX D

Services Provided

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

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

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

Enrollment

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

APPENDIX D

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

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

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

Staffing

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

School nurses. School nurses provide daily management of most traditional school health services. Services provided by school nurses include documenting immunization status, conducting screening examinations for vision, hearing and other indicators that may affect students' academic performance, helping enroll students in public health insurance programs (i.e., HUSKY A/B), providing case management to students involved with several public agencies, caring for disabled students and students with chronic health conditions, and providing first aid and emergency care. In combination with SBHC staff, the two should work toward offering a comprehensive approach to ensuring optimal health of students.

Staff of the various school-based health centers visited to date by PRI committee staff has noted that school nurses are vital to the overall health and safety of students, and services provided by nurses and SBHCs do not overlap. Committee staff will continue examining the overall relationship between SBHC staff and school nurses and other school professionals, including the level of coordination and cooperation.

APPENDIX D

Funding

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

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

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

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

Passage of the federal Patient Protection and Affordable Care Act in March 2010 created opportunities for communities to develop new school-based health centers; when funded, the ability to expand capacity and services at existing health centers.⁶⁰ The federal act authorized \$200 million for the new School-Based Health Center Capital Program from 2010 through 2013 to address capital needs in school-based health centers. In July 2011, the federal Department of Health and Human Services (HHS) began awarding its first of a series of competitive grants: \$95 million to 278 school-based health center programs across the country to help centers expand and provide more health care services at schools (Table D-2 shows seven Connecticut centers received just under \$2 million). In awarding grants, HHS must give preference to school-based health centers that serve a large population of children eligible for medical assistance under Medicaid.

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

Criteria for awarding state funds to local school-based health center initiatives in Connecticut most likely include socioeconomic needs of the community, lack of access to health services by the adolescent student population, community support, working relationship between

⁶⁰ Public Law 111-148, Section 4101(a, b)

APPENDIX D

the health and education agencies, and likelihood of SBHC sponsors fulfilling service goals and objectives. This is borne out in Figure D-1, which shows the location of school-based health centers in relation to the state education department's District Reference Group (DRG) classifications (DRG A=most affluent, DRG I=least affluent).⁶¹

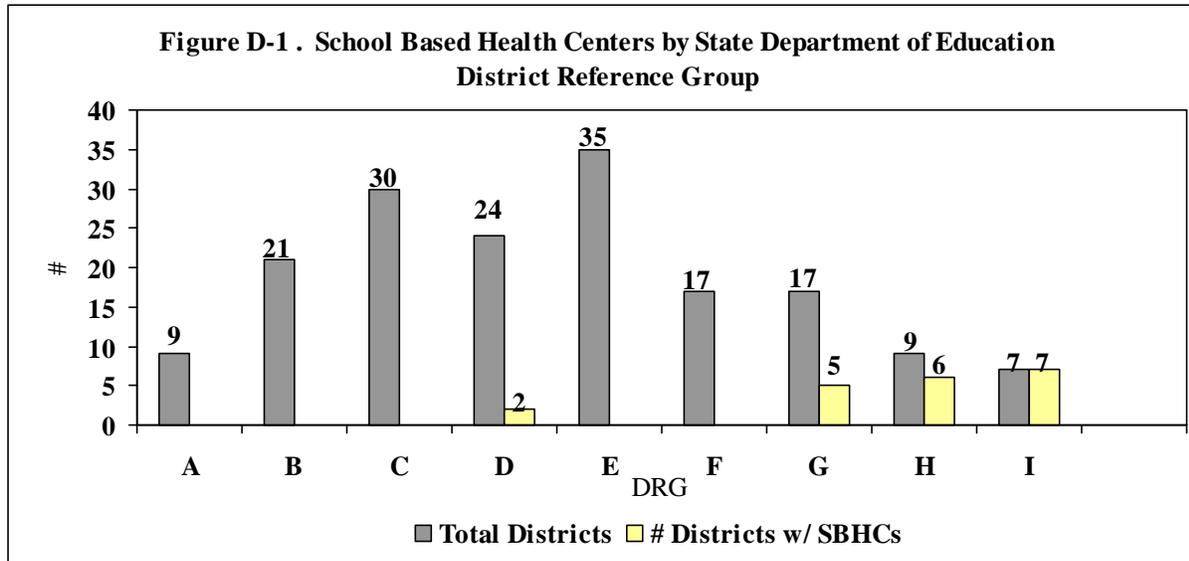
Committee staff will continue to try and determine how *state* funding levels for school-based health centers in Connecticut are determined. According to DPH, the legislature has, in the past, determined specific allocation levels for particular SBHCs in a given state budget, which precludes the department from having to make funding decisions. When the legislature has not determined funding amounts for centers, the department makes such decisions.

Other. Other sources of funding for SBHCs include foundations, private donations, local funds, community agency contributions, and in-kind contributions from host schools/districts. Committee staff will be examining the overall funding structure of school-based health centers in more depth.

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

⁶¹ District Reference Group (DRG) is a classification system in which districts having public school students with similar socioeconomic status and need are grouped together. DRGs are based on the following seven variables: income, education, occupation, family structure, poverty, home language, and district enrollment. They include nine groups, from group A (very affluent, low-need suburban districts) to group I (high-need, low socioeconomic urban districts). Charter schools, Connecticut Technical High Schools, and Regional Educational Service Centers are not given DRGs. See: <http://www.sde.ct.gov/sde/lib/sde/PDF/DEPS/StudentNutritionEd/SWP/5PhysicalEducation.pdf>

APPENDIX D



State Oversight

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

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

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

Examples of grant contract requirements include: cultural competence (services encompassing a set of behaviors, skills, attitudes, and policies promoting awareness, acceptance, and respect for diverse cultures); enrollment thresholds to meet; identifying objectives; developing an annual quality improvement work plan; and submitting standardized performance reports. DPH also conducts on-site contract monitoring, which is a process PRI committee staff will analyze during the next phase of this study.

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

APPENDIX D

database; the others submit their data electronically to DPH, which then converts the information over to its centralized system.

Licensing. Because federal Medicaid regulations do not define school-based health centers as participating entities within the program, if a state is to develop special Medicaid-related funding strategies for the centers, the state Medicaid program needs to define the centers as reimbursable ambulatory care provider-type facilities (i.e., a particular health care delivery system unit that can be shown to meet specific standards).⁶² Examples of ambulatory care providers include out-patient clinics, hospital-sponsored clinics, federally qualified health centers, and rural health centers.

SBHCs in Connecticut are licensed through DPH either as free standing outpatient clinics or hospital satellite clinics (hospital satellites have a hospital as their sponsoring agency and fall under the hospital's state license). At present, 115 school-based health centers are licensed in the state, and 73 of those are state funded. Of the total 115 SBHCs, 104 (90 percent) are licensed as outpatient clinics, with the remaining 11 are licensed as hospital satellite clinics. (DPH does not have the capability to maintain licensing data for years previous to the current year, thus licensing trends for SBHCs could not be developed.) Licensing and contract compliance are separate functions within DPH.

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

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

Ad Hoc Committee

In 2006, the legislature required DPH to establish an ad hoc committee to assist the department in examining and evaluating statutory and regulatory changes to improve health care through access to school-based health centers, particularly for students who are uninsured and underinsured.⁶³ The committee was designed as a partnership of key state agencies involved in child health care and SBHC coordinators.

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

⁶²The Center for Health and Health Care in Schools, *Issues in Financing School-Based Health Centers: A Guide for State Officials*, September 1995.

⁶³ See: PA 06-195 (Sec. 51).

APPENDIX D

was further asked to assess school-based health centers in terms of: 1) expansion of existing services in order to achieve the school-based health center model; 2) supportive processes necessary for such expansion, including the development and use of unified data systems, 3) identifying geographical areas of need; 4) financing necessary to sustain an expanded system; and 5) availability of services under the current system and under an expanded system.

The ad hoc committee met six times, and released its report in December 2006. Program review committee staff will be assessing the state's progress in implementing the ad hoc committee's recommendations in the next phase of the study.

APPENDIX E. PRI September 27, 2011 Update
STATE ADOLESCENT HEALTH CARE: PROGRAMS FOR REPRODUCTIVE HEALTH OF YOUTH AGES 10-19
 PRI Staff Working Draft (Rev. 9-21-11)

| PROGRAM | SERVICE AREA/ DELIVERY SYSTEM | MAIN PURPOSE/BRIEF DESCRIPTION | NO. CLIENTS SERVED/ CAPACITY (ANNUAL) | ANNUAL FUNDING/ EXPENDITURES |
|--------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| DEPARTMENT OF PUBLIC HEALTH* | | | | |
| Family Planning (Federal Maternal and Child Health Block Grant --- MCHBG) | 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 09 served 39,473 participants (all ages) | \$1,052,419 state \$ 21,140 federal |
| Pregnancy Risk Assessment Tracking System (PRATS) | 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 |
| Sexually Transmitted Diseases (STDs) Control Program | 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) | All persons affected with STDs with focus on 15 - 24 year olds (highest STD burden) 9 clinics statewide serve 6,000 patients (all ages) annually | Clinic Funding: \$200,000 state (help support) \$740,000 federal (for staffing) |
| Sexual Violence Intervention and Prevention | 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 | 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 | \$591,684 federal \$398,396 state |

* 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

APPENDIX E. PRI September 27, 2011 Update

| PROGRAM | SERVICE AREA/ DELIVERY SYSTEM | MAIN PURPOSE/BRIEF DESCRIPTION | NO. CLIENTS SERVED/ CAPACITY (ANNUAL) | ANNUAL FUNDING/ EXPENDITURES |
|------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------|
| management, critical health care and supports, syringe exchange, and mental health services for HIV affected children. | | | | |
| 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 |
| DEPARTMENT OF CHILDREN AND FAMILIES | | | | |
| Reproductive Health Services for Girls in Juv. Justice Res. Treatment | Statewide/5 contractors (private nonprofit agencies) | <ul style="list-style-type: none"> Pregnancy and STD prevention programming and education for residents Upon request of resident, some provide contraception/some only referral for contraception | | |
| Pregnant & Parenting Girls Programs | Statewide/5 contractors (private nonprofit agencies) | <ul style="list-style-type: none"> Residential care and supportive services for adolescent mothers and their infants Can include prenatal/postpartum care, pregnancy and STD education and prevention, counseling, parenting education | | |
| 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 (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 | | \$1,999,991 (FFY11) |

** Certain reproductive health care services also could be provided to adolescents covered under HUSKY and Medicaid Low Income Adult programs administered by DSS.