Story Behind the Baseline How To[1]

The story behind the baseline explains the data in the graph or table, how we got to where we are on a measure, and what the forecast shows. It identifies the causes and forces at work that account for the current performance. It also discusses where there are weaknesses in the data or research and references the Data Development Agenda for making improvements in them. The report card is an abbreviated document and space is limited. Please enter here only the information most critical to understanding the baseline. Do not describe what the chart shows unless clarification is essential. Use the appropriate symbol to indicate where the trend line is going.

Helpful Question for Building a Story[2]

What are some of the causes and forces at work in your community for this indicator?
Ask the question "why" three times to get at root causes
What are the key contributing factors?
Write these on your report.
Who are the partners with a role to play in helping you "turn the curve"?

[1] http://www.ct.gov/dcf/lib/dcf/rba/pdf/explanation_of_rba_report_card_elements_rev__2__2_15_14_.pdf
[2] Karen Finn, Senior Consultant RLG

Monday, December 01, 2014

Stories Behind the Curve

Referrals to Juvenile Court for Delinquency (CSSD)

Story Behind the Curve
DRAFT Sept. 2014 (for working group review)

This chart shows delinquency referrals to juvenile court in an uneven, but relatively stable trend over the past five years, but well below the highs in 2006. Of particular note, the upper age of juvenile court jurisdiction was raised to 16 on 1/1/2010 and to 17 on 7/1/2012. Despite the inclusion of two large age cohorts, delinquency referrals have not risen substantially and, in fact, were lower in 2013 than they were in 2010.

Partners
DRAFT Sept. 2014 (for working group review)

Department of Children and Families, the Governor's Office, General Assembly, Office of Policy and Management, State Department of Education, DMHAS, Office of Workforce Competitiveness, Public Defenders, Prosecutors, parents, parent and juvenile justice advocates, treatment providers, Youth Service Bureaus, Department of Correction, and universities.

What Works
DRAFT Sept. 2014 (for working group review)

- Diversion programs
- Risk/Needs/Responsivity principles
- Targeted Interventions, including Cognitive Behavioral Therapies and Family/Home-based services
- Coordinated Aftercare
- Educational and Vocations supports

Strategy
DRAFT Sept. 2014 (for working group review)

• Creation of Child Youth and Family Support Centers which will receive all Family with Service Needs clients referred to the Court. This will divert all FWSN cases away from the Court and into community-based services.

• Continued partnership with DCF to create early intervention strategies for juveniles 12 yrs. and under identified with greater risk for further delinquency or Out-of-Home Placement. The focus is on the identification of the child's and families' challenges/strengths to employ interventions designed to prevent recidivism and the child's further penetration into the Juvenile Justice system.
• Implementation of an MOU with the Department of Children and Families to address trauma experienced by children and youth referred to the Court for delinquent and FWSN behaviors by referral to community based treatment centers.
• Enhancements and re-validation of assessments used to determine the risk and needs of children and youth referred to the Court. The new assessments will include trauma and substance abuse screening.
• Enhanced quality assurance procedures to ensure the quality of client contacts as well as case planning for children and their families.
Establishment of a Crossover Youth (COY) program in partnership with DCF to better identify and serve children and youth dually involved with DCF and the Court.

DISAGS – No Story

Child Abuse and Neglect per 1,000 (DCF)

Story Behind the Curve
In Connecticut, abuse is defined as an injury to a child which didn't happen by accident - regardless of intent, and is caused, or allowed to be caused, by the person responsible for the child's care. It includes: any injury which conflicts with the history given; maltreatment such as, but not limited to, malnutrition, sexual molestation, deprivation of necessities, emotional maltreatment or cruel punishment. Neglect is the failure, whether planned or not, of the person responsible for the child's care to provide and maintain enough food, clothing, medical care, supervision, and/or education. A child may be found neglected who: has been abandoned; is being denied proper care and attention physically, educationally, emotionally, or morally; is being allowed to live under conditions, in situations, or with associations, that are harmful to his or her well-being; or who is being abused. The U.S. Department of Health and Human Services, Administration for Children and Families (ACF) emphasizes that there is no single known cause of child maltreatment, nor is there any single description that includes all families in which children are victims of abuse and neglect. Child maltreatment occurs across socio-economic, religious, cultural, racial, and ethnic groups. However, ACF maintains that research has recognized a number of risk factors or elements commonly associated with maltreatment. Risk factors associated with child maltreatment can be grouped into four general types: parent or caregiver factors; family factors; child factors; and environmental factors. It is recognized, more and more, that child maltreatment results from the interaction of multiple factors across these four general types. When we look at abuse and neglect data for Connecticut, it is important to disaggregate, or break out the data by age, by race and ethnicity, and by abuse versus neglect. When we do that we see the following: Less than 10% of substantiated reports that are reported are for abuse only; the overwhelming numbers of reports are for neglect. This tells us that families who are reported as neglecting their children are probably in need of assistance. This includes assistance dealing with poverty, unemployment, a general lack of resources, high quality child care, housing, mental health issues, and substance abuse. In short, we are talking

about multi-stressed families who require multi-system responses, and who need help getting their needs met. The data also inform communities, non-profits groups and state agencies what kinds of strategies and the types of programs that need to be expanded and/or developed in order to do better. Reported rates of both abuse and neglect are higher for African American and Latino children than for Caucasian children. In Connecticut, many African American and Latino families live in urban areas with fewer resources, while a higher proportion of Caucasian families live in better-resourced communities. Responses which address the neglect issues identified above are likely to also address the rates of disproportionality across race and ethnicity due to the similar needs. Rates of reported abuse, while still low, are higher for older children; while rates of neglect are much higher for younger children than for older children. While common sense might indicate that some of the neglect issues are more significant for younger children, especially those related to proper care, and a caregiver's ability to deliver that care, more analyses need to be performed to understand the types of neglect that are reported. This is a data development issue for the Safety sub-committee.

Partners
In this section we will identify the partners who have a potential role to play in doing better for our children.

What Works
In this section we will describe what we can do that is no-cost, or low-cost, in addition to things that cost money.

Strategy
In this section we will describe what we, as individuals, communities, agencies, and as a larger group, propose to actually do to turn the curve on the results for Connecticut's children.

Unexpected Deaths: All Causes, Ages 0 – 18 (OCA)

Story Behind the Curve
The Child Fatality Review Panel reviews deaths of children from birth through age 17 that are unexpected or unexplained, and primarily focuses its investigations on the fatalities of children involved in state systems. These data summarize findings of the past decade. The CFRP has observed positive trends, such as an overall decrease in the number of suicide deaths, but other negative trends persist, which are discussed in the full report.

DISAGS – Same Story
Unexpected Deaths – Accident, Unexpected Deaths – Homicide, Unexpected Deaths – Natural, Unexpected Deaths – Suicide, Unexpected Deaths - Undetermined/Pending Further Study/Out of State

Rate of Childhood ER Visits for Injuries of All Causes per 100,000 (DPH)

Story Behind the Curve
The rate of all injury-related emergency department visits declined slightly between 2010 and 2012 among children in Connecticut less than twenty years of age. The biggest decline over

time was in the 15 to 19 year old age group (from 14,500 to 13,100 per 100,000). However, the rates increased slightly for 0 to 5 year olds (from about 13,700 to 13,900 per 100,000) and 5 to 9 year olds (from about 9,800 to 10,200 per 100,000). Males had higher rates over all the years examined compared to females and rates increased dramatically for non-Hispanics between 2011 and 2012, while the Hispanic rates closely followed the overall downward trend.

DISAGS- No Story

High School Students Who Do Not Feel Safe

No Story

NO DISAGS

Traumatic Brain Injury ER Visits per 100,000 (DPH)

Story Behind the Curve
Between 2005 and 2012, the rates of traumatic brain injury (TBI)-related emergency department (ED) visits per 100,000 Connecticut population increased overall and among all age groups for individuals less than twenty years of age. The highest rates of TBI-related ED visits were among the 0 to 5 year olds (from about 1,300 per 100,000 in 2005 to about 2,300 per 100,000 in 2012). The next highest rates were among 15 to 19 year olds with a rate of 1,400 per 100,000 in 2012 and 10 to 14 year olds were a close third with about 1,300 per 100,000 in 2012. Overall, males had higher rates of TBI-related ED visits compared to females, 1,775 per 100,000 and 1,157 per 100,000 in 2012. Finally, Hispanic children closely followed the overall trend in direction of the curve over time, whereas non-Hispanics increased sharply between 2011 and 2012. The greatest increase occurred among non-Hispanic other (non-white and non-black) between 2011 and 2012, from 1,493 per 100,000 to 2,190 per 100,000.

DISAGS – No Story

Low Birth Weight Babies (DPH)

Story Behind the Curve
The underlying causes of low birth weight are not well-understood, but there are several factors that increase the likelihood of delivering a low birth weight. These include certain infections, prior low birth weight or preterm delivery, high blood pressure, tobacco, alcohol, or other substance abuse during pregnancy, unplanned pregnancy, late prenatal care, and stress. Low birth weight is higher among women of low and high maternal age, black race, and low income or socioeconomic status. The rates of low birth weight are higher among multiple births (e.g., twins, triplets, etc.). The use of Assisted Reproductive Technology is associated with higher rates of multiples and, consequently, higher rates of preterm birth and low birth weight. From 2000 to

2011, there was no significant improvement in the proportion of low birth weight in CT or the US.
Improving health prior to pregnancy, getting early and adequate prenatal care, and seeking medical care at any signs or symptoms of preterm labor can help prevent very low birth weight. Efforts to increase health equity and address social determinants of health are essential to achieving improved birth outcomes and eliminating disparities.
Although some LBW babies are small for gestational age, most are born preterm, before 37 weeks gestation. Babies born LBW or preterm, on average, spend more time in the hospital after birth, with higher associated hospitalization costs. They are also at increased risk of long term cognitive and physical developmental delays that may impact school readiness. Risk factors for LBW in Connecticut include: minority race or ethnicity; older maternal age; low educational level; single marriage status; first time pregnancy; medical risk factors such as chronic or pregnancy-induced hypertension; and tobacco use during pregnancy (http://www.ct.gov/dph/lib/dph/family_health/bwm_website_050409.pdf).

DISAGS – No Story

Childhood Obesity (DPH)

Story Behind the Curve
In 2012, one in every six CT children was obese (16.8%) and nearly 1 in 7 was overweight (13.7%). Likelihood of obesity decreased significantly with age: 38.6% of children 4 years old or younger were obese, compared to 19.7% of children aged 5-11 and 8.7% of children aged 12-17. Similarly, children aged 12-17 were significantly less likely to be overweight (11.8%) compared to children aged 5-11 (17%). Boys were more likely to be obese (20.2%) than girls (13.4%), but the results were not statistically significant. Children living in households with an income of at least $75,000 were significantly less likely to be obese (12.7%) than those with household incomes of $35,000-$74,999 (19.7%) or less than $35,000 (28.7%). Similarly, children in the highest earning households were significantly less likely to be overweight (10.7%) compared to children in middle-income households (18%). Children whose adult proxy had more than a high school education was significantly less likely to be obese (13.9%) than children whose proxy had a high school diploma or less (26.6%).

DISAGS – No Story

Percent of Children with Health Insurance

No Story

DISAGS – No Story

Percent of Age-appropriate Immunizations for Children Two Years Old

No Story

NO DISAGS

Monday, December 01, 2014

Rate of Asthma Related visits to the Emergency Department, per 10,000 (DPH)

Story Behind the Curve
The rate of asthma emergency department (ED) visits among children 0-19 years of age has been increasing over the years, a 26% increase was observed from 2005 (80.7 per 10,000) to 2012 (102.0 per 10,000). Such increase was observed across all different age, gender and racial/ethnic groups. Asthma ED visits rates decreased with age: 170.0 per 10,000 for children 0-4 years old, 121.5 for children aged 5-9, 71.5 for children aged 10-14, and 61.8 for children aged 15-19. Boys had a higher asthma ED visit rate (116.0) than girls (87.3). Non-Hispanic black children had the highest asthma ED visit rate (215.7), followed by Hispanic children (174.6), other non-Hispanic children (164.6), and non-Hispanic white children (46.1).
DISAGS – No Story

Percent of Children with Asthma (DPH)

Story Behind the Curve
In 2012, 12.1% of Connecticut children had asthma, a higher rate than Connecticut adults (9.9%). Children aged 12-17 were significantly more likely to be asthmatic (14.7%), relative to children aged 5-11 (12.7%). Unlike adults, there were no significant differences in the rates of asthma between males and females. Children in the poorest households were significantly more likely to be asthmatic (16.2%), relative to children in the highest income households (9.2%).

NO DISAGS

Percent of Students Seriously Considered Suicide in past 12 months

No Story

NO DISAGS – No Story

Stable:

Students Chronically Absent (SDE)

Story Behind the Curve
Chronic absenteeism is defined as missing ten percent or greater of the total number of days enrolled in the school year for any reason. It includes both excused and unexcused absences. Commonly reported aggregate attendance measures such as average daily attendance or attendance rates may not adequately highlight the extent of individual absenteeism. In CT, levels of Chronic Absenteeism have been measured at 15.3% in 2008-9, 15.7% in 2009-10 and 14.8% in 2010-11. These numbers translate to approximately eighty-thousand students each year who are missing school at least 10% of their total days enrolled. When the 2010-11 data was disaggregated into subgroups such as race, ethnicity, free/reduced lunch status, special education

status, and English language learner status, the percentages suggest that certain populations are struggling more with chronic absences. Students need to attend school daily to succeed. If chronic early absence is not addressed at the elementary level, then it may worsen in the higher grades[i]. A report by John Hopkins University[ii] outlines various research findings that highlight the association of chronic absenteeism to student academic achievement and high school graduation. Factors that contribute to chronic absence may be situated in the family, school and/or the community. Some examples of such factors include inadequate healthcare, high family mobility, low maternal education, food insecurity, ineffective parent engagement, and high levels of community violence. Solutions to high levels of chronic absenteeism will require the collaborative efforts of schools, communities, and families.

[i] Chang & Romero, Present, Engaged & Accounted For: The Critical Importance of Addressing Chronic Absence in the Early Grades, National Center for Children in Poverty: September 2008.

[ii] Balfanz, R., & Byrnes, V. (2012). Chronic Absenteeism: Summarizing What We Know From Nationally Available Data. Baltimore: Johns Hopkins University Center for Social Organization of Schools.

Prepared by the Connecticut State Department of Education, September 2012 for the Children's Results Based Accountability (RBA) Working Group on Stability.

DISAGS – No Story

Percent of children living in families where no parent that has full time, year-round employment

Story Behind the Curve
DRAFT

Source: The American Community Survey (ACS) [1]

NO DISAGS

Percent of renters who spend more than 30% of their income on housing

Story Behind the Curve
DRAFT

Source: The American Community Survey (ACS)[1]

NO DISAGS

[1] randomly samples 3.5 million addresses every year to participate in the survey. Participation is mandatory—in fact, if an address is selected, the household is legally obligated to answer all the questions. The American Community Survey covers a number of topics, including income, SNAP participation, housing, and education. This response data helps allocate federal funding to services. Data is collected electronically and by mail.

Monday, December 01, 2014

Percent of families who report not having enough money in the past 12 months to buy food for self or family

Story Behind the Curve
DRAFT

Source: The Food Resource and Action Center[2]

NO DISAGS

Rate of children in out-of-home placements (Rate per 1,000)

No Story

NO DISAGS

Percent of single parent households

Story Behind the Curve
DRAFT

Source: The American Community Survey (ACS)[3]
NO DISAGS

Percent of children eligible for free/reduced lunch

No Story

NO DISAGS

Rate of SNAP participation by recipients (per 1,000)

No Story

NO DISAGS

---

[2] analyzed survey data from the Gallup Healthways Well-being Index. The Gallup Healthways survey asks households the following question to measure food hardship: "Have there been times in the past twelve months when you did not have enough money to buy food that you or your family needed?" FRAC interpreted this data by defining a person who answered "yes" to the question as a person with food hardship.

[3] randomly samples 3.5 million addresses every year to participate in the survey. Participation is mandatory—in fact, if an address is selected, the household is legally obligated to answer all the questions. The American Community Survey covers a number of topics, including income, SNAP participation, housing, and education. This response data helps allocate federal funding to services. Data is collected electronically and by mail.

Monday, December 01, 2014

Percent of Homeowners who spend more than 30% of income on housing

Story Behind the Curve
DRAFT

Source: The American Community Survey (ACS)[4]
NO DISAGS

Percentage of High School students who ate at least one meal with their family on three or more of the last seven days

No Story

NO DISAGS

Percentage of High School students who agree or strongly agree that their family loves them and gives them help and support when they need it

No Story

NO DISAGS

Future Success:

Cohort High School Graduation Rate

No Story

DISAGS – No Story

Percent of 3rd Graders at or above goal in Reading (CMT)(SDE)

Story Behind the Curve
Research indicates that if students do not become proficient readers by age eight, there is a greater likelihood that they will be struggling readers throughout the rest of their school careers and into adulthood (Lyon, 1996).

[4] randomly samples 3.5 million addresses every year to participate in the survey. Participation is mandatory—in fact, if an address is selected, the household is legally obligated to answer all the questions. The American Community Survey covers a number of topics, including income, SNAP participation, housing, and education. This response data helps allocate federal funding to services. Data is collected electronically and by mail.

Monday, December 01, 2014

The Connecticut Mastery Test (CMT) is administered annually to all Connecticut students in Grade 3 through Grade 8. Five performance levels are reported for each tested content area. The performance levels are Advanced, Goal, Proficient, Basic, and Below Basic. The Goal range includes the Advanced and Goal levels. Scoring in the Goal range is more challenging than Proficient level and is the state target for student performance.

In 2011, statewide, 58.3% of Grade 3 students reached Goal. This increase in the percentage of students scoring At/Above Goal is 3.7 points higher than the percent of students scoring At/Above Goal in 2009 continuing a trend of incremental improvement. Results of the CMT are also disaggregated by subgroups: gender, eligibility for free or reduced-price meals, special education status, English language learners, and Ethnicity/Race[i]. Overall trends in performance for most subgroups is positive, however there is still a persistent achievement gap in Connecticut that continues to be a major focus of district and state educational efforts.

A report by the Annie E. Casey Foundation[ii] lists several factors that may undermine grade-level reading proficiency. These include:

lack of cognitive, social, emotional and physical readiness to succeed in school;

chronic absenteeism, possibly due to community and/or family stressors;

schools that don't teach to the highest standards;

childhood hunger, housing insecurity, and family mobility; and

limited participation in summer learning opportunities.

All children should master the tasks and skills that lead to healthy development and school success, regardless of the type of school they attend or their ethnicity, geographic location, economic status, language spoken, parent educational level, or special healthcare needs. To that end, the state must rethink how resources are allocated to districts, how to best provide technical assistance regarding the implementation of the Common Core State Standards, and how to support the fulfillment of the mandates in Public Act 12-116 (Education Reform) so that Connecticut's persistent achievement gap can be eliminated.

---

[i] Beginning in 2011, the reporting of Ethnicity/Race has changed. Therefore, disaggregated data for Ethnicity/Race from 2006 through 2010 cannot be compared to that from 2011.
[ii] Annie E. Casey Foundation (2010). Early Warning! Why Reading by the End of Third Grade Matters. Baltimore, MD.

DISAGS- No Story

Children under 18 Living in Households under 100% of the Federal Poverty Line

Story Behind the Curve
DRAFT

Source: The American Community Survey (ACS)[5]
DISAGS – No Story

Kindergartners Needing Substantial Instructional Support

No Story

DISAGS – No Story

Percent of Kindergartners previously enrolled in pre-school

No Story

NO DISAGS

Percent of population age 25-34 with at least an Associate's Degree

Story Behind the Curve
DRAFT

Source: The American Community Survey (ACS)[5]

DISAGS – No Story

Percent of 16-19 year olds employed or in school

Story Behind the Curve
DRAFT

Source: The American Community Survey (ACS)[5]

NO DISAGS

Percent of 8th Graders at or above goal in Reading (CMT)

No Story

DISAGS – No Story

Percent of 8th graders at or above goal in Math (CMT)

---

[5] randomly samples 3.5 million addresses every year to participate in the survey. Participation is mandatory—in fact, if an address is selected, the household is legally obligated to answer all the questions. The American Community Survey covers a number of topics, including income, SNAP participation, housing, and education. This response data helps allocate federal funding to services. Data is collected electronically and by mail.

Monday, December 01, 2014

No Story

DISAGS – No Story

Percent of 3rd Graders at or above goal in Math (CMT)

No Story

DISAGS – No Story

Percent of Live Births in Connecticut to Mothers Less than 20 Years of Age

No Story

DISAGS – No Story