EXCERPT FROM PRI STAFF UPDATE 9-27-2011: ADOLESCENT HEALTH IN CONNECTICUT
RBA PROJECT 2011

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.

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

CONNECTICUT ADOLESCENT HEALTH CARE

POPULATION LEVEL ACCOUNTABILITY

QUALITY OF LIFE RESULTS STATEMENT:

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

KEY INDICATORS
of Progress Toward Population Level Results

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

MAJOR STATE STRATEGIES
for Achieving Results Statement

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

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**			
- ***SBHCs (DPH)***	- *HUSKY- BHP/ Medicaid LIA (DSS)*	- *HUSKY DHP/ Medicaid LIA (DSS)*	- ***SVIP (DPH)***	- *School Health Ed. (SDE)*	- *Youth Suicide Advisory Comm. (DCF)*	- *School Nutrition (SDE)*
- *CHCs (DPH)*	- *State mental health & substance abuse services and facilities for all under 18 (DCF) & 18-19 (DMHAS)*	- *Oral Health Office (DPH)*	- ***STD Control (DPH)***	- ***SBHCs (DPH)***	- *Healthy Start (DSS)*	- *School Physical Ed. (SDE)*
- *CSH (DPH/SDE)*	- ***SBHCs (DPH)***	- ***SBHCs (DPH)***	- ***Fam. Planning (DPH and DSS)***	- *CHCs (DPH)*	- *NFN (DSS)*	- *SNAP (DSS)*
- *CYSCHN (DPH)*	- *CHCs (DPH)*	- *CHCs (DPH)*	- ***TPPI (DSS)***	- *CSH (DPH/SDE)*	- *Youth Service Bureaus (SDE)*	- *WIC (DPH)*
- *Asthma (DPH)*	- *CSH (DPH/SDE)*	- *CSH (DPH/SDE)*	- ***SPPTP (SDE)***	- *HHS (DPH)*	- *HIV Prev. (DPS)*	- *NPAO (DPH)*
- *Family/MCH(DPH)*	- *CYSCHN (DPH)*	- *CYSCHN (DPH)*	- ***Preg. & Parenting Girls (DCF)***		- *Tobacco(DPH)*	- ***SBHCs (DPH)***
- *HUSKY/Medicaid LIA (DSS)*	- *School Behavioral Health (SDE)*		- ***SBHCs (DPH)***		- *Immunizations (DPH)*	- *CHCs (DPH)*
- *School Health- public & nonpublic (SDE)*			- *CHCs (DPH)*		- ***SBHCs (DPH)***	- *CSH (DPH/SDE)*
			- *CSH (DPH/SDE)*		- *CHCs (DPH)*	
			- *HUSKY/ Medicaid LIA (DSS)*		- *CSH (DPH/SDE)*	

CORE PROGRAM PERFORMANCE MEASURES (FOR FOCUS PROGRAMS):

School-Based Health Centers

- *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)*

Primary and Preventive Teen Reproductive Health Services

- *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
o CDC	Centers for Disease Control and Prevention
o HRSA	Health Resources and Services Administration
o 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

INDICATOR AREA: MORTALITY

1. Teen Fatalities

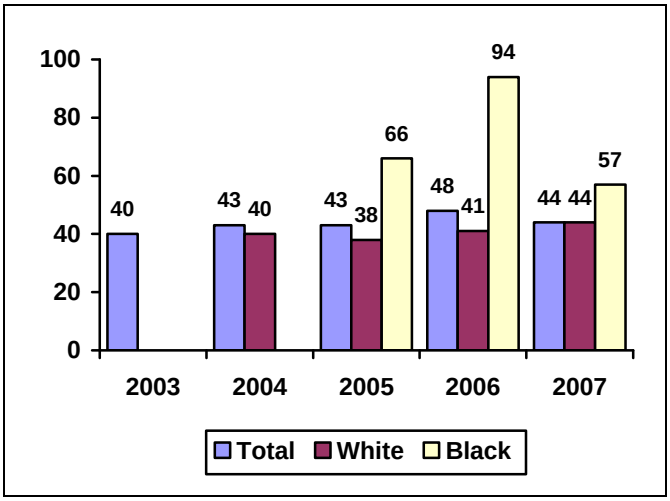
Teen death rate per 100,000 age 15-19 all causes

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)

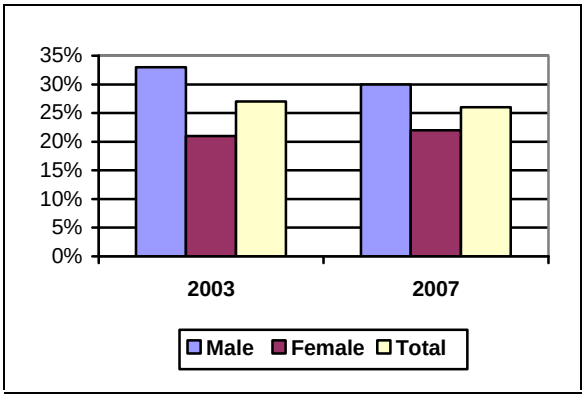
Percent youth ages 10-17 overweight or obese by gender
Data source: Child Trends analysis of National Survey of Children's Health data as provided by KIDS COUNT 2011

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

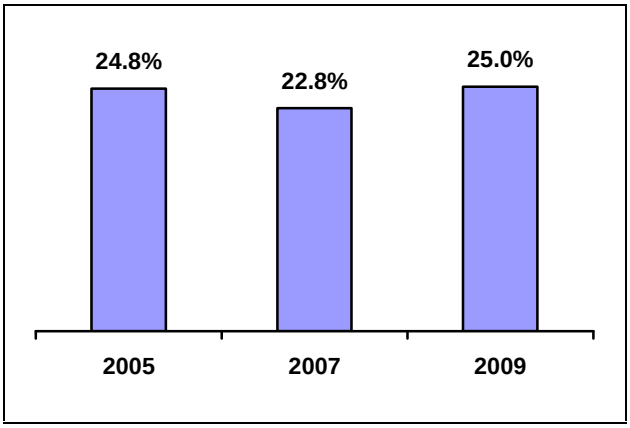
3. Depression (Behavioral Health)

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

4. Untreated Cavities (Oral)

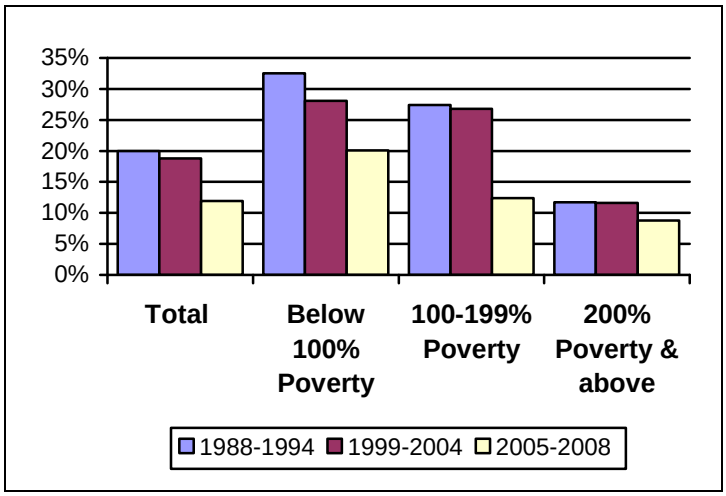
Percent youth ages 12-17 with untreated dental caries (cavities)

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

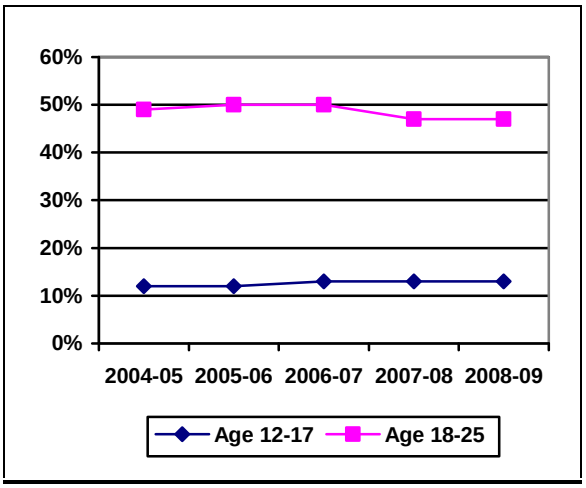
5. Binge Drinking

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

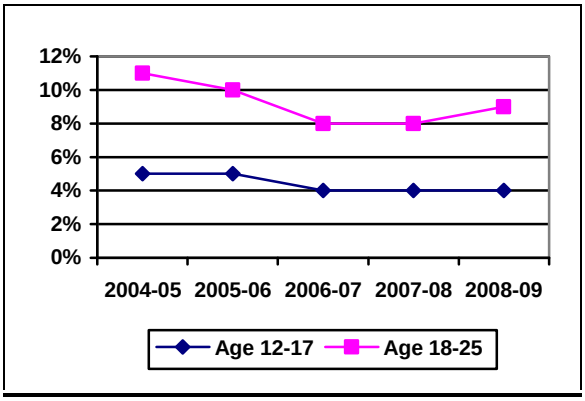
6. Drug Use

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 tranquillizers 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.

7. Tobacco Use

Percent any cigarette use in the past month by age group

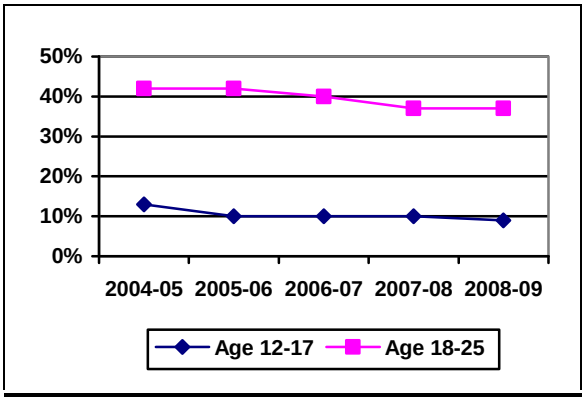
Data Source: State Estimates from National Survey on Drug Use and Health as provided by KIDS COUNT 2011

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 (CODP) 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

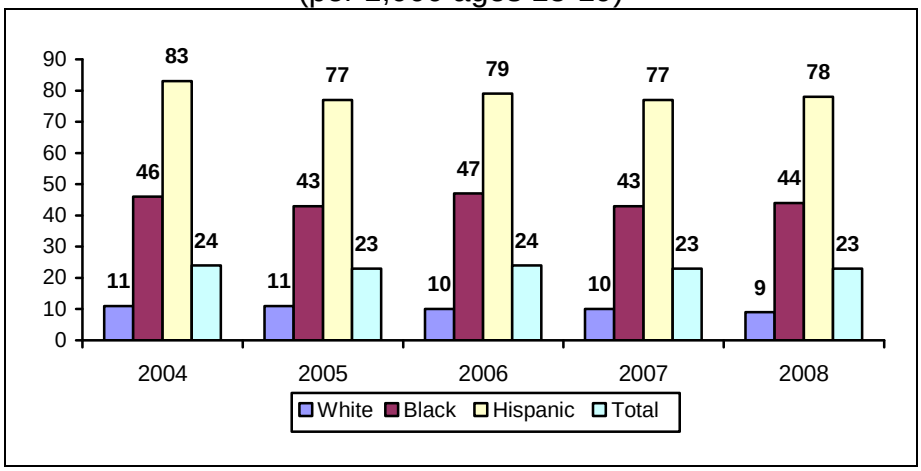
Teen birth rate per 1,000 females ages 15-19

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).

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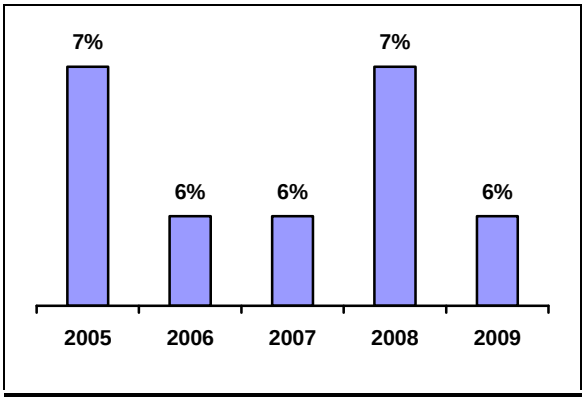
Possible Secondary Indicators: HUSKY enrollment by age, race/ethnicity, Usual source of care/Have primary care physician, Adolescent vaccination rates, by gender, race/ethnicity, family income

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).