

## CHAPTER VII

### Children and Adolescents

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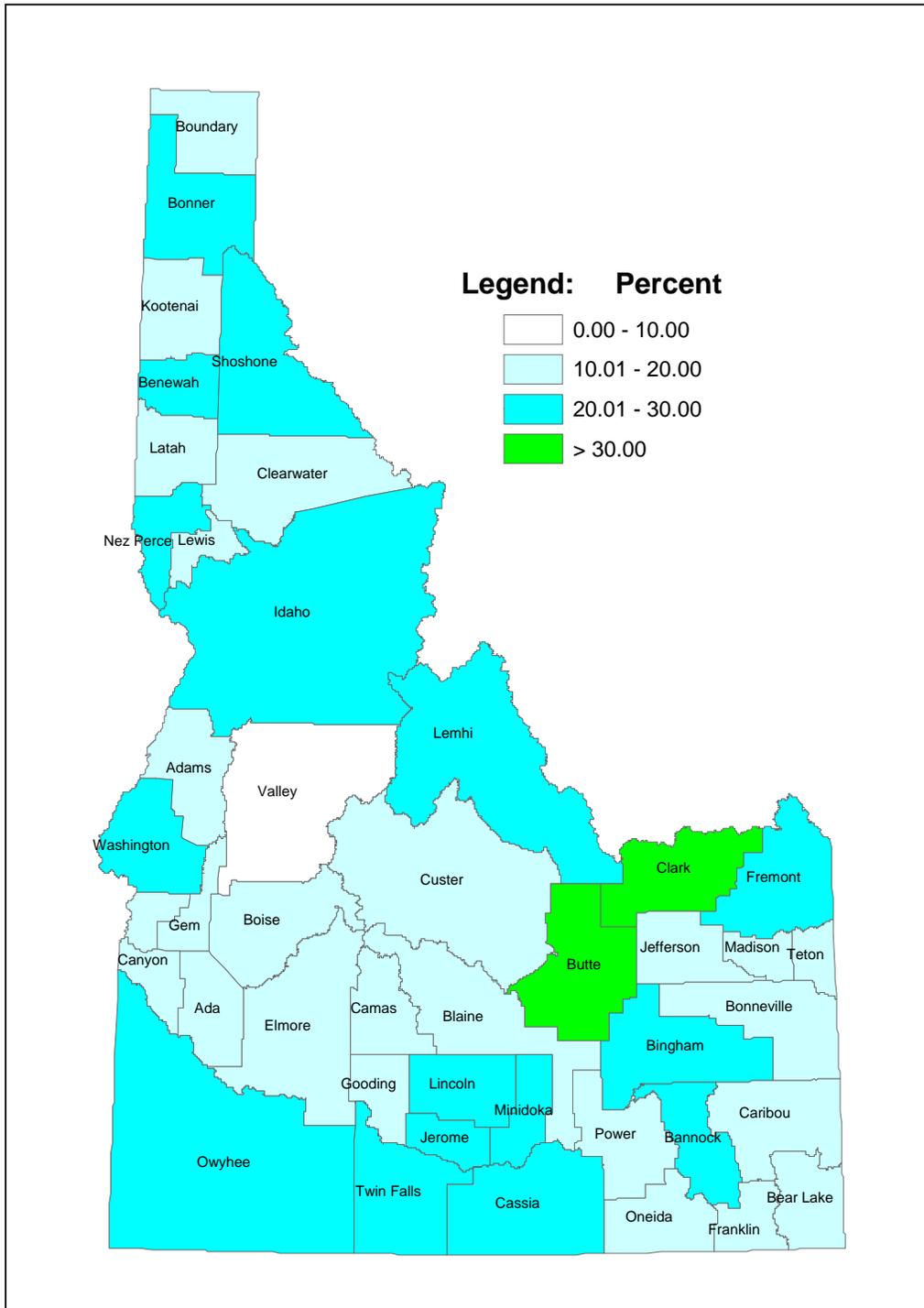
In 2004, there were 372,411 children under the age of 18 in Idaho (U.S. Census Bureau, 2004). This population represents a unique collection of health and social service needs that are constantly changing as children grow and develop with age. Children especially can be vulnerable to poor health outcomes, as they are usually solely dependent on their parents and guardians for all their health needs and thus often more sensitive to changes in family dynamics. Moreover, children have different disease patterns than adults, requiring distinctive disease prevention and management strategies. Children are more likely to have short recurrent illnesses, such as ear infections, than adults. When children do experience the same diseases as adults, they are often manifested in different ways. Important lifestyle practices such as nutrition and physical activity often begin at an early age. This time period presents an excellent opportunity to encourage healthier behavior patterns before deleterious habits become established. Upon reaching puberty, adolescents become more sensitive to peer influences and are more likely to engage in harmful risk behaviors such as using drugs and alcohol or having unprotected sex. These and other unique attributes of children and adolescents must be considered when designing programs and systems of care to promote their health and wellness (Leatherman and McCarthy, 2004).

The following section describes the current health status of children and adolescents over one year of age and the ability of State systems to address this population's needs.

#### A. Characteristics of Children and Adolescents

The number of children in Idaho under the age of 18 declined nearly 11 percent between 1990 and 2000. Still, children continue to account for a large proportion of the population. During 2000, 7.5 percent of Idahoans were under the age of 5 and another 24 percent were between the ages of 5 and 19 years. The child population has become more ethnically diverse. The proportion of Hispanic children under age 18 years has increased, from 10.5 percent in 1998 to 12 percent in 2001 (Children's Bureau, 2004a). Hispanic children are particularly likely to face severe economic pressure, as twice as many Hispanic children lived in poverty during 2000-2002 (National Center for Children in Poverty, 2005). Still, poverty is a major concern among all of Idaho's children: 19 percent of all children under the age of 18 lived in poverty during 1999, and this figure has changed little since the early 1990s (Idaho Kids Count, 2003). However, younger children in Idaho are even more at risk of living in poverty than are older children. Nearly 40 percent of Idaho's counties have more than 20 percent of children under age 5 who live in poverty (Figure VII-1), a proportion four times as high as the number of counties with greater than 20 percent of children age 5 and over that live in poverty (Figure VII-2). Poverty is one of

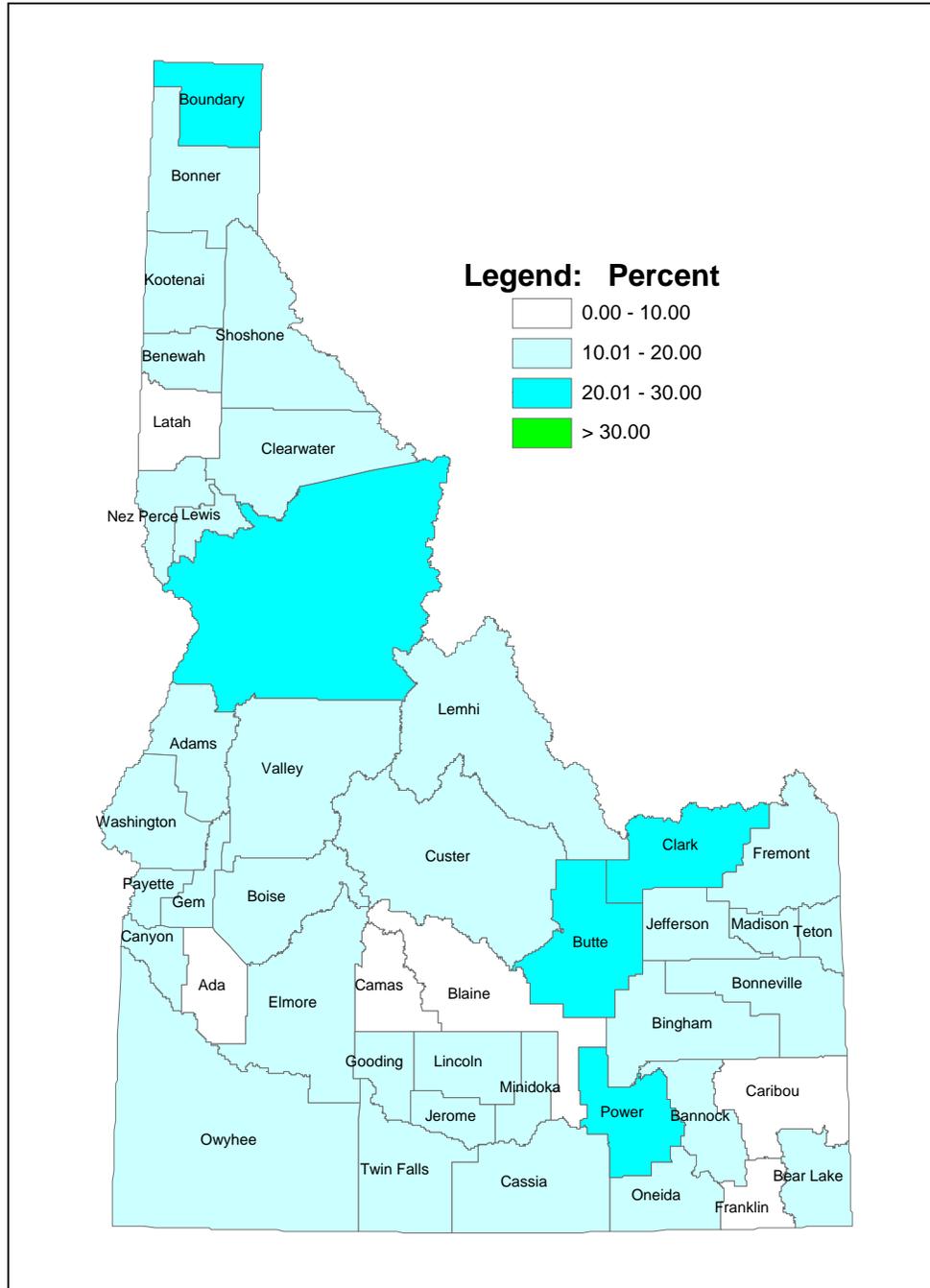
the most powerful predictors of children’s health outcomes, as it affects access to a range of basic necessities of life, including health care and a healthy living environment.



**FigureVII-1: Map Displaying Distribution of Children Under the Age of 5 that Lived Below the Poverty Line in Idaho During 2000**

Source: U.S. Census Bureau, 2001

## Percent of Children 5 to 17 in Poverty in 2002



**Figure VII-2: Map Displaying Distribution of Children Ages 5 to 17 that Lived Below the Poverty Line in Idaho During 2000**

Source: U.S. Census Bureau, 2001

## B. Child and Adolescent Outcomes Examined

Five outcomes have been selected to evaluate the health and well-being of the child and adolescent population in Idaho. Attaining these outcomes will both help these children continue to develop appropriately and promote good health practices as they transition into adulthood.

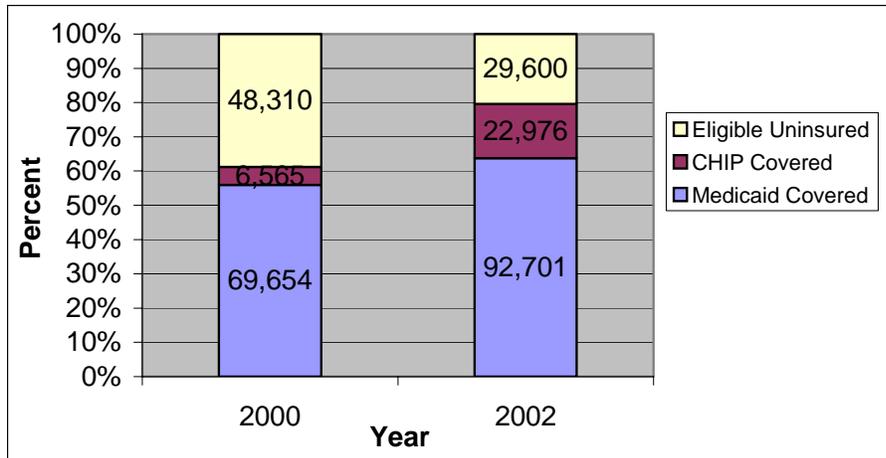
<b>Table VII-1 Idaho Child and Adolescent Outcomes</b>
Children receive ongoing and preventive health care consistent with the Bright Futures Health Supervision Guidelines.
Children are cared for in environments that protect health, promote their well-being, and ensure their safety.
Families have access to and use services that strengthen parenting skills appropriately.
Adolescent children use ongoing health services appropriate to their stage of growth and development.
Adolescent children obtain the health and lifestyle information and education that support lifelong positive health behaviors.

### 1. *Children receive ongoing and preventive health care consistent with the Bright Futures Health Supervision Guidelines.*

Health insurance coverage is one of the main means of obtaining adequate access to ongoing and preventive health care because it significantly reduces out-of-pocket costs of care to individuals. Unfortunately, a significant proportion of children are either underinsured or uninsured. Even those with comprehensive health insurance coverage still may not have access to all the basic health services that promote good health, such as immunizations and oral health care, as well as more specialized care to prevent adverse health outcomes, such as mental health treatment.

#### a. Insurance

Idaho has already met the Healthy People 2010 goal to increase the proportion of nonelderly persons with health insurance to 83 percent among children. During 2002-2003, 86 percent of children under age 18 had some form of health insurance. Yet 14 percent of these children were uninsured during this time. The number of children eligible for public health insurance programs, which include Medicaid and CHIP, that have actually enrolled has substantially increased in recent years. During 2000, nearly 50,000 children were uninsured but eligible for public coverage. By 2002, this number had shrunk to 30,000 as a greater number of children were enrolled in Medicaid and CHIP (Figure VII-3). Yet this number still represents a relatively high proportion, 60 percent, of all uninsured children that were eligible but not enrolled in public insurance.



**Figure VII-3: Children's Public Health Insurance Coverage in Idaho, 2000-2002**

Source: Idaho Kids Count, 2003

Children ages 0-5 with family incomes up to 133 percent of FPL and children ages 6-18 with family incomes up to 100 percent of FPL are eligible for Medicaid. Children that from families that are over-income for Medicaid may be eligible for CHIP coverage. CHIP-A, which is a Medicaid expansion, covers children from families with incomes above the Medicaid limits and up to 150 percent of FPL. Both programs cover the same set of comprehensive benefits, including basic preventive services and a range of treatment services (Idaho Department of Health and Welfare, 2004a). The proportion of children under age 18 eligible for Medicaid or CHIP-A was 29 percent in 2002 (Idaho Medicaid Office, 2004). The proportion of children in this age group actually enrolled in Medicaid or CHIP-A increased from 23 percent during 2001-2002 to 26 percent by 2002-2003. Both of these figures were comparable to the national average proportion of children under age 18 eligible and enrolled in Medicaid and SCHIP programs (Kaiser Family Foundation, 2005a).

When CHIP-A was introduced in Idaho, there was an initial push to recruit eligible children into the program. IDHW worked with CMHCs to increase enrollment by hiring their outreach workers. During the key-informant interviews, CMHC interests indicated that the State set unrealistically high enrollment targets, such as a completed application every 15 minutes. Workers were unable to meet this expectation and instead tried to explain that they needed more time to establish trust with residents that have long held unfavorable views of public insurance.

In 1999, Idaho set a goal of increasing enrollment in Medicaid & CHIP by 8,000 children annually. This three-year goal of adding 24,000 children to the base count of 54,000 was accomplished in 18 months. From that time, the State has continued to achieve the 8,000 per annum increase. In response to the huge caseload growth, the Idaho legislature limited (for a one-year period) the amount of CHIP-A recruitment for fear of expanding caseloads beyond capacity. The State subsequently decreased usage of mass media as a primary CHIP-A recruitment tool.

Despite these recruitment concerns, the CHIP Program was recently expanded to extend coverage to a greater proportion of the near poor. As of July 2004, children from families whose incomes exceed 150 percent of FPL but are less than 185 percent of FPL may also qualify for the

new CHIP-B/Access Card Program. This flexible program allows eligible families to choose a State-managed health plan, CHIP-B, at the cost of \$15 per month or the Children's Access Card Program to join an employer-sponsored or individual health plan. The State will pay up to \$100 per child with a cap of \$300 per month per family to cover the cost of premiums. CHIP-A eligible children can also choose the Access Card program in lieu of direct benefits. The CHIP-B plan covers the same basic services as CHIP-A, but does not cover all specialized services such as dental and durable medical equipment and supplies. The comprehensiveness of benefits included in plans selected with the Children's Access Card will depend upon the policy selected by the family (IDHW, 2004a). Individual and small group policies sold in Idaho are regulated to contain a comprehensive set of benefits. The CHIP-B/Access Card Program is limited by State funding (this is a designated funding source, not general appropriations) and was estimated that 5,600 children could be covered in the first year of operation.

The majority of children in Idaho, 55 percent, are enrolled in employer-sponsored plans, a proportion similar to the United States. This proportion has decreased in recent years: 7.6 percent fewer children in Idaho have been enrolled in such plans between 2000 and 2003, compared to the slightly smaller decline of 4.8 percent of children nationwide enrolled in employer-sponsored coverage during the same time. Idaho ranks 49<sup>th</sup> for its relatively low proportion of private-sector employers that offer health insurance coverage, only 44 percent of firms in Idaho compared to the national average of 57 percent (Kaiser Family Foundation, 2004b). In addition, 5 percent of children 18 and under were enrolled in individual insurance plans during 2002-2003.

#### What Did Parents Say?

Many parents expressed concern that public insurance programs do not adequately cover children from near-poor families, as many earn more than the maximum income limits to qualify yet often do not earn enough money to pay the full cost of health care out of pocket. Many indicated that they would prefer to sign their children up for a public insurance plan because their employer coverage often has high deductibles or only covers the employee and not their dependents. In the Hispanic focus groups, some parents were also not able to obtain public insurance for their children because they earned too much, while others were denied coverage because their children were not yet legal citizens. Some Hispanic parents mentioned that they had an easier time getting public coverage for their children, regardless of citizenship status.

On the other hand, some parents also said that they did not want to sign up for public programs like Medicaid because of the social stigma and the perception that such programs are equivalents of handouts. Some of the providers and program directors that were interviewed also felt that a number of families that qualify for public insurance do not apply because of the stigma associated with such government programs. Therefore, the Access Card has the potential to be a more appealing option to these families by giving them greater access to less stigmatized private insurance plans.

### **b. Utilization of Primary Care Services**

#### *i) Access to a Medical Home*

In recent years, increasing attention has been focused on ensuring that all children have access to a medical home and a regular source of primary care (Starfield and Shi, 2004). Children who lack a medical home are more likely to delay seeking care and thus receive fewer preventive services, which in turn increases the likelihood that children will be hospitalized for illnesses and

complications that could have been avoided if they had access to ambulatory care. Individuals in Idaho are more likely to lack a medical home than the rest of the nation. While about 12 percent of individuals nationwide lack regular access to a primary care provider, 20 percent of individuals in Idaho went without such access in 2003. Moreover, Idaho is a standout in Region X, as less than 10 percent of the population in Alaska, Washington, and Oregon lack access to a medical home (National Association of Community Health Centers, 2004).

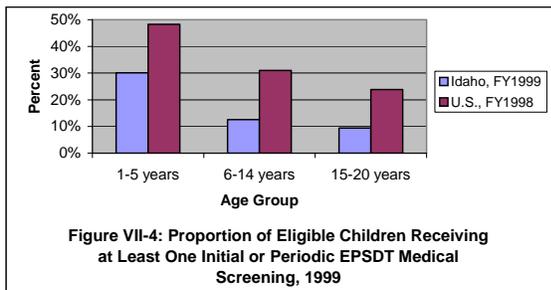
The growth of CMHCs over the last 40 years has helped to reduce significantly the proportion of children that live without a medical home. CMHCs now serve one out of five low-income children across the Nation (National Association of Community Health Centers, 2004). The proportion of pediatric patients under age 18 served at CMHCs has declined since the mid-1990s, from 45 percent in 1994 (Idaho Department of Health and Welfare, 1999) to 32 percent in 2003 (Bureau of Primary Health Care, 2004). Still, Idaho's CMHCs served nearly 20 percent of the children under age 18 living below the FPL based on 2000 Current Population Survey totals (U.S. Census Bureau, 2001), and nearly a third of these children were uninsured (Bureau of Primary Health Care, 2004). RHCs also serve a large proportion of children that lack medical homes by using physician assistants and nurse practitioners to provide Medicaid reimbursable primary care to low-income populations. There are now over 3,000 RHCs across the country (National Association of Rural Health Clinics, 2005). Unfortunately, we were unable to locate any data that tell how many children access Idaho's RHCs.

## *ii) EPSDT Compliance*

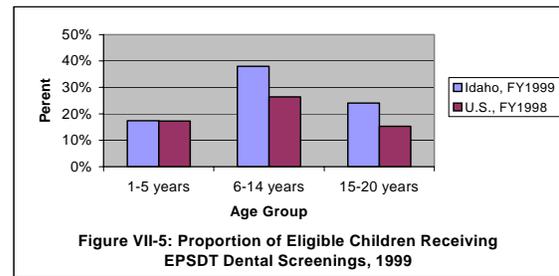
EPSDT screenings play a critical role in ensuring that at-risk children receive preventive and treatment services as they grow and develop. All children under age 21 that are enrolled in Medicaid and CHIP in Idaho are entitled to receive EPSDT screenings. Screenings are conducted at regular intervals of time, as established by the "periodicity schedule." In order to ensure that children actually receive these screenings, Congress has tried to promote outreach by requiring States to inform all enrollees of the availability of EPSDT screenings and offer support services, such as transportation and appointment scheduling assistance. Despite these measures, the EPSDT Program has experienced relatively low participation since the mid-1990s, especially among dental, hearing, and vision screenings, which have much lower utilization rates than the comprehensive medical screenings (Perkins, 1999).

The proportion of eligible children in Idaho receiving one or more medical screenings has steadily increased since the early 1990s (Centers for Medicare & Medicaid Services, 2005). However, the proportion of Idaho's eligible children receiving at least one EPSDT medical screening continued to be much lower than the national average across all age groups by the end of the decade. Medical screenings among all eligible children have been more prevalent among younger than older children. Nearly a third of children ages 1-5 have had at least one medical screening in Idaho compared to just 10 percent of children ages 15-20 years during 1999 (Figure VII-4). The most recent data for nonmedical screenings we were able to locate are from 1999. In both Idaho and the United States, the proportion of eligible children receiving additional nonmedical screenings was much lower than the proportion receiving medical screenings during this time. Among the nonmedical screenings, Idaho's children were most likely to receive dental screenings, especially when compared to the national average (Figure VII-5). Fewer than 20 percent of children across all age groups in both Idaho and the United States received vision

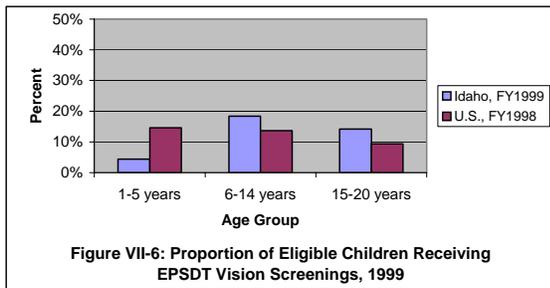
screenings (Figure VII-6). Children were least likely to receive hearing screenings, with Idaho lagging much further behind the nation; fewer than 5 percent of Idaho’s children received hearing screenings across all age groups (Figure VII-7).



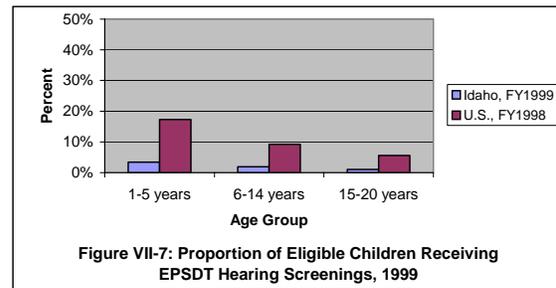
Source: Centers for Medicare & Medicaid, 2005



Source: Centers for Medicare & Medicaid, 2005

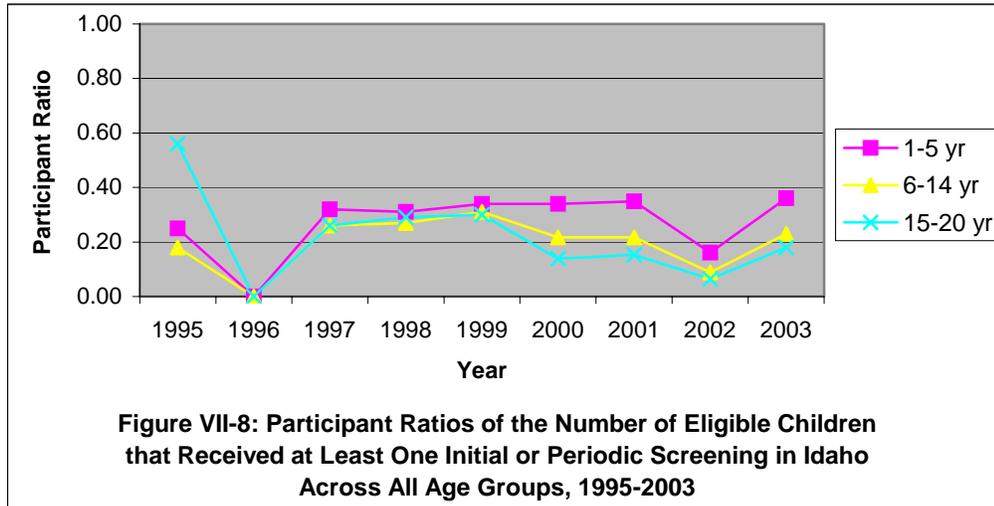


Source: Centers for Medicare & Medicaid, 2005



Source: Centers for Medicare & Medicaid, 2005

Another important trend is the large difference in EPSDT participation across age groups. Ratios compare the proportion of children eligible for screenings to the proportion that actually receive at least one initial or periodic medical screening. Younger eligible children in Idaho have been much more likely to receive screenings than older children (Figure VII-8). During 2003, twice as many eligible 1- to 5-year-olds received screenings than did eligible 15- to 20-year-olds. This trend has persisted since the mid-1990s.

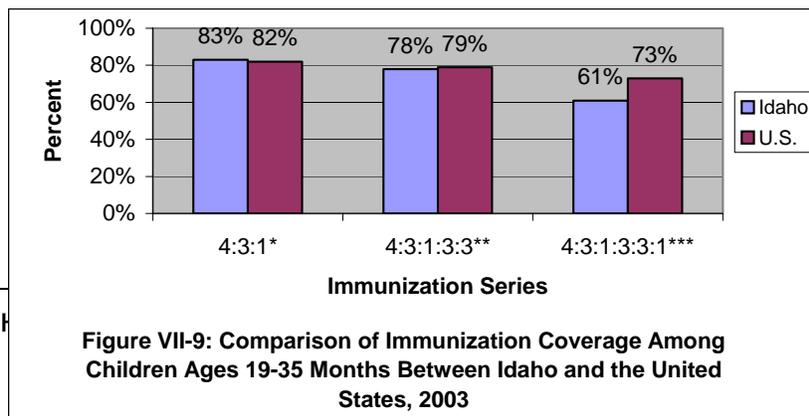


Source: Centers for Medicare & Medicaid, 2005

### iii) Immunization Rates

The introduction of vaccines in the 1940s has helped the nation reach record low incidences of once-common and often-fatal diseases like polio and measles. Moreover, administering vaccines in early childhood has helped protect the most vulnerable segment of the population, as younger children experience a higher risk of complications and death from vaccine-preventable diseases (National Immunization Program, 2005).

Idaho's young children ages 19-35 months have basic immunization coverage comparable to children across the United States, with similar proportions of young children receiving 4:3:1 and 4:3:1:3:3 vaccination series in 2003 (Figure VII-9). However, the CDC has recommended since 1996 that children also receive the varicella vaccine, which is only included in the 4:3:1:3:3:1 schedule, during routine visits by the time children reach 18 months of age (Centers for Disease Control and Prevention, 1996). Significantly fewer children in Idaho received the 4:3:1:3:3:1 series than children across the United States in 2003. All children in Idaho and across the United



States have much farther to go to meet the Healthy People 2010 goal of increasing the proportion of children 19-35 months of age that are completely up to date on immunizations to 90 percent.

Source: National Immunization Program, 2003

\*Four or more doses of any diphtheria, tetanus toxoids, and pertussis vaccines (DTP), three or more doses of poliovirus vaccine, and one or more doses of any measles or measles-containing vaccine (MCV)

\*\* Four or more doses of any DTP, three or more doses of poliovirus vaccine, one or more doses of MCV, three or more doses of *Haemophilus influenzae* type B conjugate vaccine (Hib), and three or more doses of Hepatitis B vaccine (HepB)

\*\*\* Four or more doses of any DTP, three or more doses of poliovirus vaccine, one or more doses of MCV, three or more doses of Hib, three or more doses of HepB, and one or more doses of varicella

There are also many important regional differences in vaccination coverage within Idaho. Table VII-2 presents the vaccination coverage of young children served in district health departments between 2002 and 2004. The proportion of children that are completely up to date on immunizations in District 7 was similar to the national average, while District 6 actually exceeded this average. Vaccination coverage in Districts 2 and 5, however, was particularly poor, as only about half of the children seen at district health clinics were up to date on the 4:3:1:3:3:1 vaccination series (Table VII-2).

<b>Table VII-2</b>			
<b>Proportions of Children Ages 19-35 Months that Have Received Vaccination Series Served at Idaho's District Health Departments, 2002-2004</b>			
<b>Region</b>	<b>4:3:1*</b>	<b>4:3:1:3:3**</b>	<b>4:3:1:3:3:1***</b>
District 1	82.3%	80.7%	59.0%
District 2	88.3%	87.3%	50.5%
District 3	81.0%	78.3%	63.5%
District 4	81.0%	78.7%	68.5%
District 5	75.5%	74.3%	52.5%
District 6	93.7%	93.3%	85.5%
District 7	90.0%	89.3%	75.0%

Source: Idaho Immunization Program, 2004

\*Four or more doses of any DTP, three or more doses of poliovirus vaccine, and one or more doses of any MCV

\*\* Four or more doses of any DTP, three or more doses of poliovirus vaccine, one or more doses of MCV, three or more doses of Hib, and three or more doses of HepB

\*\*\* Four or more doses of any DTP, three or more doses of poliovirus vaccine, one or more doses of MCV, three or more doses of Hib, three or more doses of HepB, and one or more doses of varicella

The recent introduction of immunization registries has also helped increase the proportion of children that are up to date by tracking the immunization status as they age and making accommodations to encourage those not up to date to come in for followup visits (Every Child by Age Two, 2005). Idaho has established the Idaho Immunization Reminder Information System (IRIS) to help centralize children's immunization records. The proportion of children enrolled in IRIS has substantially increased each year since its inception in 1999. Similarly, the proportion of providers who have submitted records to the database has increased 62 percent since 2001 to a total of 176 providers in 2003. By July, 2003, 94 percent of children age 2 and

under were enrolled in IRIS. However, a much smaller proportion of older children are enrolled. During 2002, 77,025 children under age 6 had at least one immunization record in the registry, or about 64 percent of the total population under 6 (Idaho Immunization Program, 2004). This is much lower than the Healthy People 2010 goal to increase the proportion of children under age 6 who are enrolled in immunization registries to 95 percent.

The CDC immunization schedule also includes recommendations for children up to 18 years old to guide administration of catch-up immunizations during preadolescent assessment to ensure that older children missing vaccines become up-to-date. These later assessments are especially important for older adolescents who may have been born after newer vaccines were introduced and may not have received them before age 2 (Fackler, 2004). High risk groups should also be given additional age-appropriate vaccines, such as the influenza vaccine for children 6 months of age and older with certain risk factors including asthma and sickle cell disease. No statewide data could be located that evaluate the proportion of children over 24 months old that are up to date, suggesting there is a need to begin collecting and monitoring this data. IRIS will likely be an important tool to accomplish this goal as more children are enrolled and the database is streamlined.

Another important method of monitoring childhood immunization status is school entry requirements. Beginning in 1998, the CDC broadened its recommendations to incorporate the creation of school entry requirements that also include the varicella vaccine. Varicella infection can be very serious when it occurs during adolescence and early adulthood, thus making it very important to track varicella vaccination status as children age (Fackler, 2004). Idaho currently requires students entering grades K-12 to be up to date on the 4:3:1:3:3 schedule but is one of only 15 States that do not require entering secondary school students to have the varicella vaccine, which is only included in the 4:3:1:3:3:1 schedule (American Academy of Pediatrics, 2004). In addition, the IDHW, Office of Epidemiology has yet to add varicella to its current list of reportable diseases (Idaho Department of Health and Welfare, 2004e). For these reasons, no data exist that describe the State-level prevalence of varicella among children. Healthy People 2010 has set a goal to achieve a 99 percent improvement in vaccination coverage to reduce cases of varicella (U.S. Department of Health and Human Services, 2000). The vaccination coverage of varicella in children 18-35 months is about 12 percent lower in Idaho than the national average, 73 percent compared to 85 percent (National Immunization Survey, 2003). These factors make tracking varicella among Idaho's children and actively working to achieve the HP2010 goal of increasing varicella coverage among children to 90 percent very difficult.

## **c. Disease and Illness**

### ***i) Chronic Lower Respiratory Diseases***

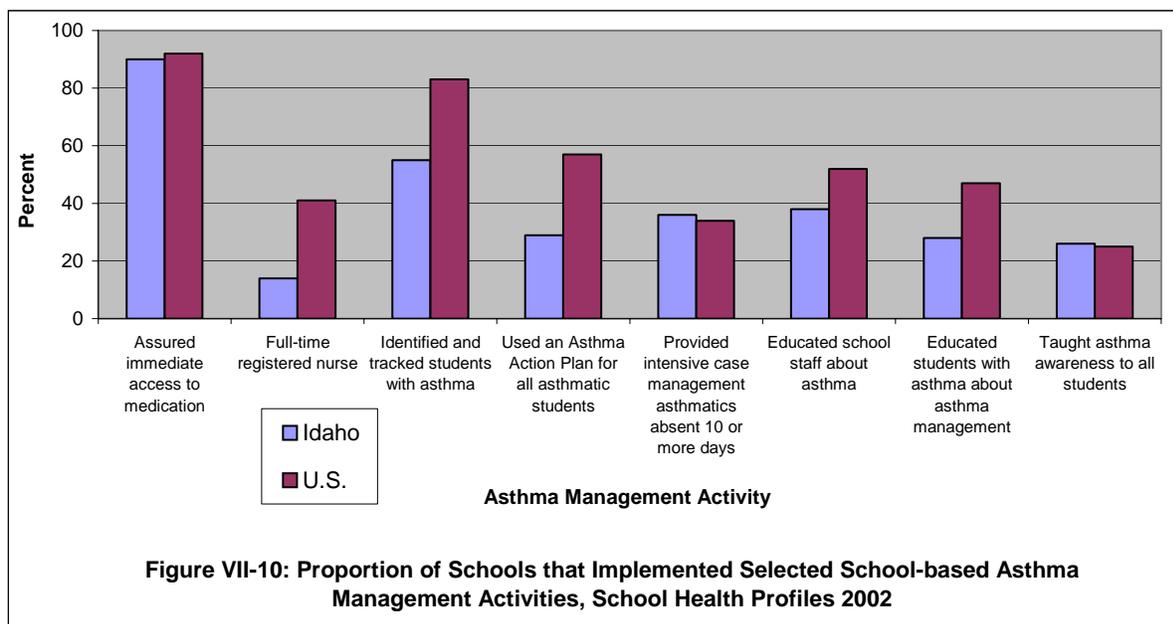
Chronic lower respiratory diseases (CLRD) include asthma, chronic bronchitis, emphysema, and other diseases characterized by permanent airflow obstruction (Idaho Department of Health and Welfare, 2001). Asthma is the most common CLRD and is one of the most common chronic childhood illnesses, affecting nearly 6 million children nationwide in 2002. The illness is characterized by ultrasensitivity of the lungs to a range of stimuli, including vigorous exercise, allergens like pet dander and cockroach dust, and cigarette smoke. Asthma is one of the leading

causes of both school absenteeism and emergency room visits (American Lung Association, 2004).

*ii) Asthma*

Currently, Idaho does not have a statewide survey tool to measure the prevalence of asthma among children, which serves as a rough estimate of prevalence. However, the 2000 Idaho BRFSS asked adults about the presence of children with asthma in their households. About 15 percent of adults reported that there was at least 1 child under age 18 with diagnosed asthma (Idaho Department of Health and Welfare, 2002). Fortunately, most children have mild-to-moderate asthma symptoms than can be successfully managed with appropriate surveillance and intervention (American Lung Association, 2004).

Schools also play an important role in addressing childhood asthma. The CDC has recommended a number of strategies to help schools create coordinated school health programs to provide services and education to students with asthma and prepare staff to handle their illnesses. Although Idaho’s middle and high schools have ensured that the majority of asthmatic students have immediate access to their medication while at school, many have not enacted a number of recommended asthma management activities (Figure VII-10). Notably, only about half of secondary schools track students with asthma, compared to over 80 percent of the Nation’s schools. Similarly, only a minority of Idaho’s schools have asthma action plans on file either with the school nurse or school office. These plans provide critical information about each asthmatic student’s prescribed treatment regime and provide instructions on how to handle asthma medical emergencies. Both Idaho and the nation have much work to do to ensure that schools follow up with asthmatic students that miss an excessive amount of school. And, as mentioned earlier, Idaho schools are much less likely than schools across the country to have an RN on staff that is available full time.



Source: Hayes et al., 2004

Lastly, asthma awareness and education efforts are relatively low both in Idaho and across the United States, although a smaller proportion of staff in Idaho's schools received asthma education.

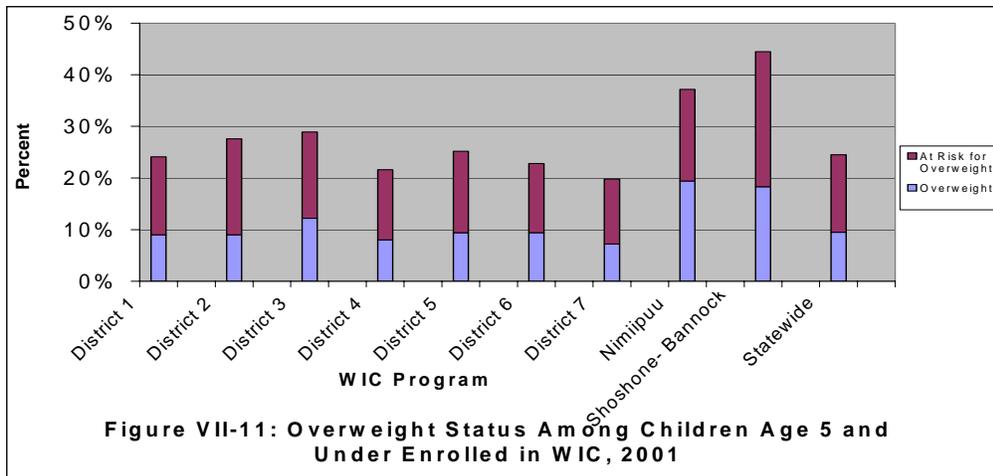
In 2002, Idaho Asthma Prevention and Control Project collaborate with Idaho's seven health district offices to conduct a statewide asthma needs assessment to enhance asthma management strategies. The assessment provided a set of recommendations based on participants' input at numerous community forums. This input will be used to establish a comprehensive statewide asthma management plan. Many recommendations specifically focused on developing protocols in school and child care settings. These included reducing exposure to indoor air triggers like environmental smoke in childcare facilities and ensuring that school staff maintain asthma action plans for all asthmatic students. The assessment also mentioned the school nurse shortage as a major impairment to adequate asthma management (Idaho Department of Health and Welfare, 2002).

### *iii) Weight Control and Obesity*

Obesity has increasingly become an important public health concern, particularly its rising prevalence among children and adolescents. The prevalence of obesity in children over the age of 5 has more than doubled since the late 1970s. Prevalence is measured by calculating one's BMI, measured as weight in kilograms per squared height in meters. An individual is defined as overweight if his or her BMI is between 25 and 29.9 and obese at 30 or greater. Currently, 30 percent of children ages 6-19 in the United States are overweight and about 15 percent are obese. The increasing trend toward weight gain has been attributed to a range of lifestyle and genetic factors, but the most likely include children consuming diets high in fat and calories but low in nutrients as well as a significant reduction in the amount of regular physical activity children have each day (American Obesity Association, 2004). Schools play an important role in the childhood obesity epidemic, both because they may increase its prevalence by serving students food of poor nutritional quality and reducing access to physical education and because schools are in a good position to reduce prevalence by implementing health promotion activities.

Healthy People 2010 has established a goal to decrease the proportion of children ages 6-19 who are overweight or obese to 5 percent (U.S. Department of Health and Human Services, 2000). There is no statewide survey that measures BMI among all young children below age 13 in Idaho. However, the Idaho WIC program does collect BMI data on WIC participants and can provide a rough approximation of the overweight status of children under 5 years old. These data are particularly important because the WIC Program can help reduce the risk of overweight with its nutrition education and vouchers for foods. It is important to note that the Idaho WIC Program does not use the term "obese" but instead defines overweight as a BMI at or above the 95<sup>th</sup> percentile on age-appropriate CDC/NCHS growth charts. The statewide prevalence of overweight among WIC children ages 0-5 has increased in recent years, from 6.9 percent in 1996

(Idaho Department of Health and Welfare, 1999) to 9.5 percent in 2001 (Idaho WIC Program, 2003). The most recent data available exclude very young children and indicate that 11.8 percent of children ages 2-5 were overweight in 2003 (Idaho WIC Program, 2005). National studies indicate that Native American children are often more likely to be overweight than the general population. Data from Idaho's WIC program indicates a similar trend among Native American children ages 0-5 in the Nimipuu and Shoshone-Bannock communities during 2001; a significantly higher proportion of Native American children were overweight or at risk of becoming overweight (Figure VII-11).

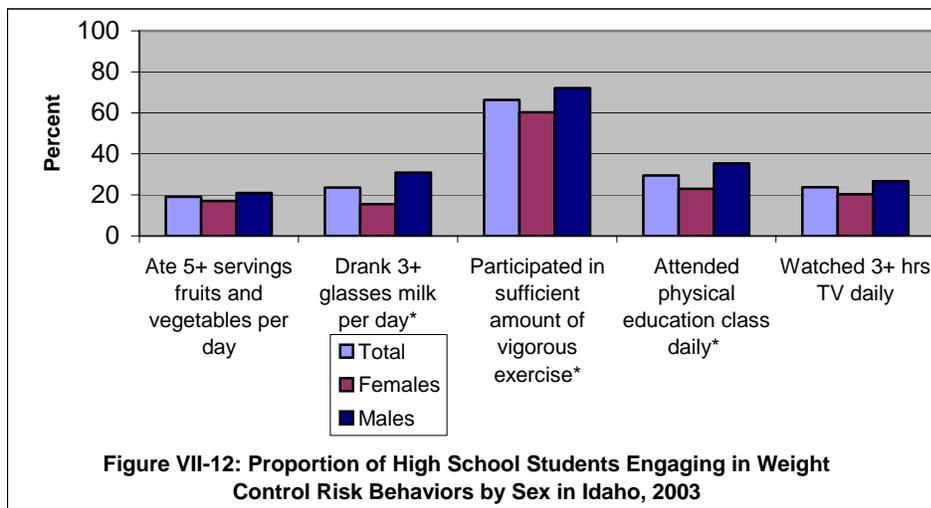


Note: At risk for overweight is defined as having a BMI at or above the 85<sup>th</sup> percentile on age-appropriate CDC/NCHS growth charts, while overweight is defined as having a BMI at or above the 95<sup>th</sup> percentile.  
 Source: Idaho WIC Program, 2003

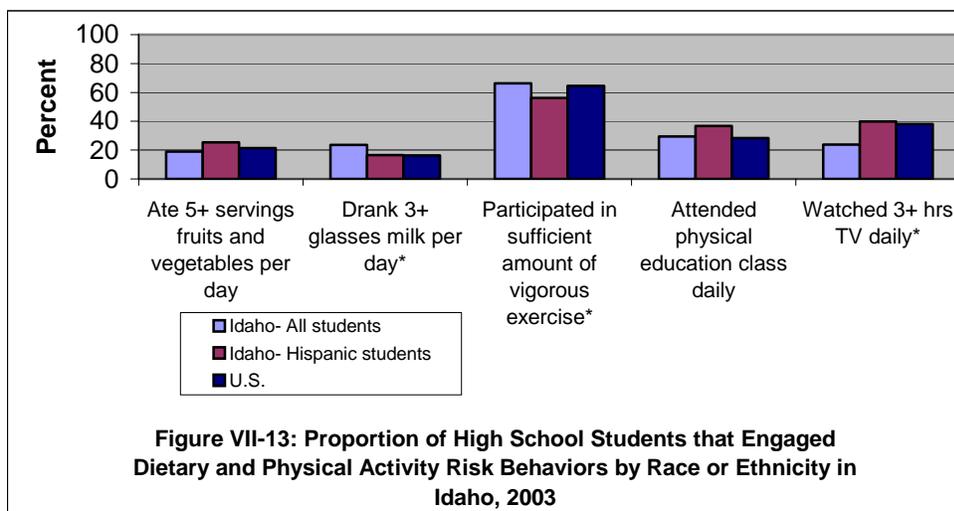
The Youth Risk Behavior Survey (YRBS) is the only statewide survey that measures overweight status, as well as the prevalence of behaviors that increase the risk of becoming overweight, among older children of high school age.

A sizeable proportion of Idaho's high school students engaged in dietary and physical activity risk behaviors during 2003. Less than a quarter of students met the CDC's recommendation that adolescents consume at least five servings of fruits and vegetables per day (National Center for Chronic Disease Prevention and Health Promotion, 2005a) (Figure VII-12). The CDC has not established similar specific recommendations for milk consumption but instead recommends that adolescents ages 14-18 consume at least 1,300 mg/day of calcium per day (National Center for Chronic Disease Prevention and Health Promotion, 2005b). Less than half of students tried to meet this recommendation by consuming three or more glasses of milk per day. Moreover, female students were significantly less likely than males to consume this level of milk, while Hispanic students were significantly less likely than all students to consume this level (Figure VII-13). A much smaller proportion of Idaho's students also met the Healthy People 2010 recommendations for physical activity; fewer than 85 percent participated in vigorous activity for at least 20 minutes 3 times a week and fewer than 50 percent attended daily physical education classes. Again, females were significantly less likely than males to meet these recommendations. Hispanic students were significantly less likely to participate in vigorous exercise than students overall. Idaho's students did meet the Healthy People 2010 recommendation that fewer than 25 percent of students watch 3 or more hours of television a day and were much less likely to

engage in this risk behavior than all students across the United State. However, Hispanic students did not meet this recommendation and were significantly more likely than all students in Idaho to watch excessive amounts of television.



\*Indicates a significant difference between female and male students  
 Source: National Center for Chronic Disease Prevention and Health Promotion, 2004

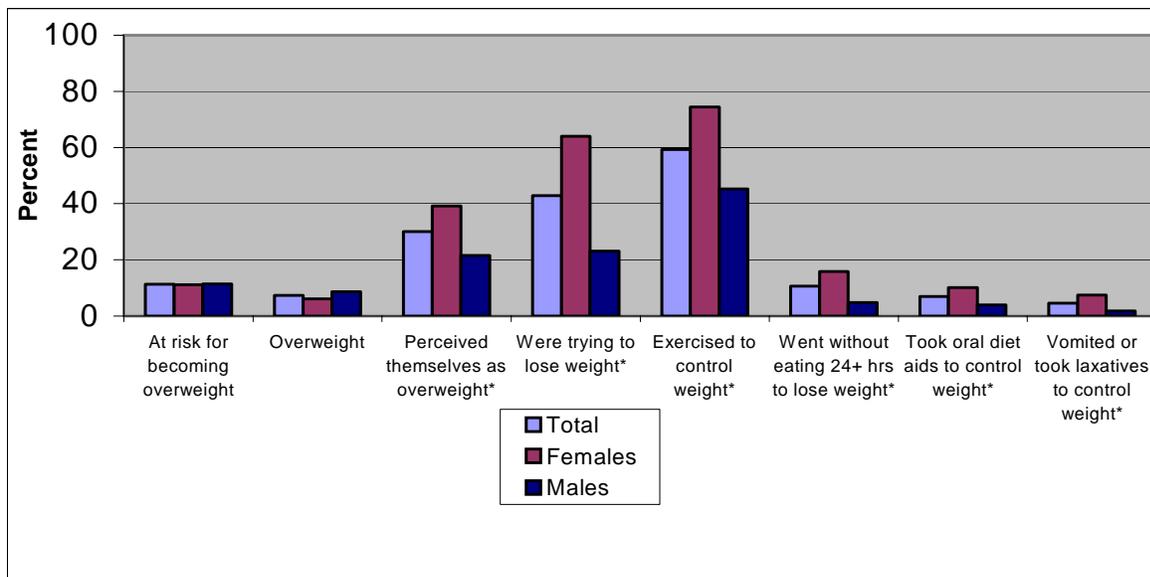


\*Indicates a significant difference between Hispanic students and students of all races/ethnicities in Idaho  
 Source: National Center for Chronic Disease Prevention and Health Promotion, 2004

A total of 7.4 percent of Idaho’s high school students were overweight in 2003, which is higher than the Healthy People 2010 goal to reduce this proportion to 5 percent (Figure VII-14). It is important to note that BMI was calculated using self-reported height and weight. Studies have found that adolescents may significantly underestimate their weight by as much as 20 percent (Brenner et al., 2004). Such underestimation may in turn underestimate BMI calculations among this population. There were no significant differences on either the proportion of students that

were overweight or at risk of becoming overweight between sexes. However, females were significantly more likely than males to perceive themselves as being overweight. Females were also significantly more likely than males to employ a variety of weight control measures. Behaviors such as excessive exercise, bingeing and purging, and starving oneself are potential warning signs of a distorted body image and a preoccupation with food that may be associated with eating disorders such as anorexia nervosa and bulimia. Females are typically more likely to develop such disorders; as many as 10 percent of American females are believed to suffer from an eating disorder (American Academy of Child & Adolescent Psychiatry, 2004). Eating disorders pose a significant threat to adolescent health, as they can lead to severe dehydration, hormonal imbalance, mineral depletion, and, in rare cases, death.

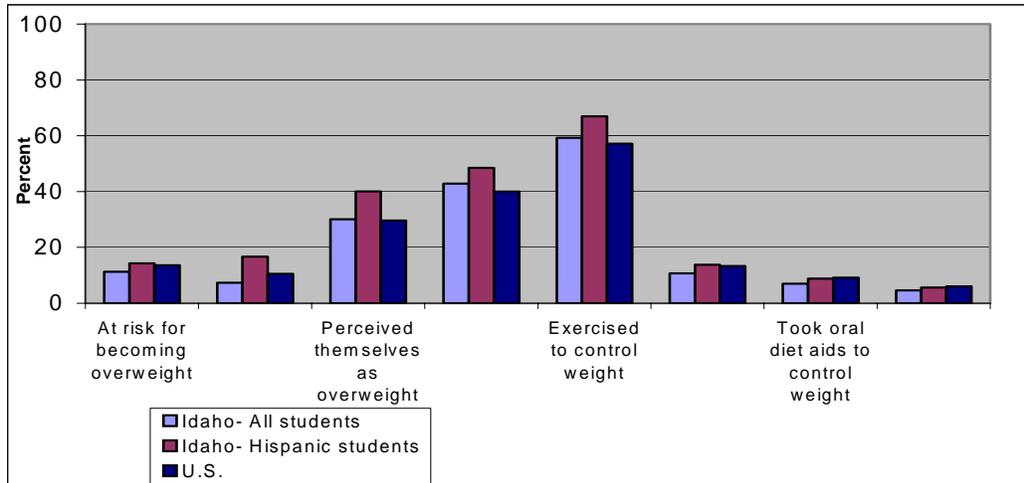
In addition, more than twice as many Hispanic students were determined to be overweight compared to all students combined: 16.7 percent compared to 7.4 percent, respectively (Figure VII-15). These data are representative of a growing national trend. From 1986 to 1998, obesity among Hispanic children increased by more than 120 percent, compared to just 50 percent among white children (Georgetown University Center on an Aging Society, 2002). Despite this disproportionately high prevalence of overweight, Hispanic students were no more likely than all students to perceive themselves as being overweight or to engage in any of the surveyed weight control measures. In national studies, students that perceive themselves to be overweight or at risk of being overweight have been significantly more likely to undertake weight control practices than students that perceive themselves as either normal weight or underweight (Brenner et al., 2004).



**Figure VII-14: Proportion of High School Students that Engaged in Weight Control Risk Behaviors by Sex in Idaho, 2003**

\*Indicates a significant difference between female and male students

Source: National Center for Chronic Disease Prevention and Health Promotion, 2004



**Figure VII-15: Proportion of High School Students that Engaged in Weight Control Risk Behaviors by Race or Ethnicity in Idaho, 2003**

\*Indicates a significant difference between Hispanic students and students of all races/ethnicities in Idaho  
 Source: National Center for Chronic Disease Prevention and Health Promotion, 2004

*iv) Diabetes and Hypertension*

The growing prevalence of overweight and obesity among children has been associated with the development of a number of other chronic diseases in childhood including hypertension and diabetes (Dietz, 1998). Although there is currently no nationwide assessment tool available to monitor trends in childhood diabetes, there has been a substantial increase in clinical reports of new childhood diabetes diagnoses. Moreover, the American Academy of Pediatric has documented a significant increase in the proportion of new cases that are Type II diabetes. Type II diabetes has been traditionally referred to as adult-onset diabetes, as it typically does not develop until adults reach middle age. In 1990, fewer than 4 percent of new diagnoses of diabetes in children were Type II. By 2000, this proportion had increased to 30-50 percent newly diagnosed cases among children (Rocchini, 2002). Native Americans are at particularly high risk of diabetes: they are over 2.5 times more likely to develop diabetes as non-Hispanic Whites of similar age.

Similar to the United States, Idaho has yet to evaluate statewide trends in diabetes prevalence among children. The only available statewide diabetes data for children under age 18 are mortality rates due to diabetes, which are a poor measure for children since the disease usually does not become fatal until much later in life. The Idaho Diabetes Prevention and Control Project (IDPCP), although very effective at improving prevention and disease management efforts among adults aged 18 years and older since its 1994 inception, has not significantly focused on children and adolescents. In fact, none of the recent IDPCP or IDHW publications specifically targets children in surveillance and intervention plans. This deficiency is potentially disconcerting in light of initial signs that the prevalence of childhood Type II diabetes is increasing in Idaho. The School Nurse Organization of Idaho (SNOI) indicated in an interview that their nurses have seen a growing number of children diagnosed with diabetes. SNOI has since requested funding to provide at least 0.4 equivalents of a person to provide a “floating RN” to help with diabetes management in schools.

An increasing number of children and adolescents are also at risk for developing hypertension. Between 1988-1994 and 1999-2000, systolic blood pressure increased 1.4 mm Hg and diastolic blood pressure increased 3.3 mm Hg among the nation's 8- to 17-year-olds (NHLBI Communications Office, 2004). These significantly high increases have led to the creation of new clinical practice guidelines that now include a prehypertension category. Prehypertension includes children with a systolic or diastolic pressure at and above the 90<sup>th</sup> percentile and up to the 95<sup>th</sup> percentile. Although cardiovascular diseases continue to be the leading cause of death among adults, there have been few efforts to begin primary prevention efforts during childhood and adolescence. As one of the most common preventable diseases, early intervention strategies could greatly reduce blood pressure measurements of children at risk of developing hypertension later in life.

#### **d. Oral Health**

Diseases of the mouth now account for the most common chronic childhood illnesses; tooth decay is five times more frequent than even pediatric asthma (Idaho Oral Health Program, 2001). Poor oral health contributes to sleep discomfort, difficulty eating, the ability to focus while in school (American Dental Association, 2004), and school absenteeism (Idaho Oral Health Summit, 2001). Fortunately, oral health presents one of the greatest opportunities to improve childhood health outcomes significantly with the advent of highly effective disease prevention strategies, such as public water fluoridation and subsidized dental sealant programs (Oral Health America, 2004).

Idaho has one of the most comprehensive State oral health data surveillance tools in the country for young children, the annual Idaho State Smile Survey (Oral Health Care America, 2004). The survey tracks the prevalence of oral health disease among elementary school children as well as the types of treatment they need and receive. The oral health diseases and treatments emphasized by Healthy People 2010 that also correspond to the most recent Idaho State Smile Survey in 2001 are presented in Table VII-3. Out of the four major oral health measures included in the survey, Idaho has met only one Healthy People 2010 oral health objective for young children; over half of third-graders did receive dental sealants in 2001. Idaho failed to meet all other Healthy People 2010 objectives across all grade levels. A large majority, 66 percent, of Idaho's students experienced dental caries by the 3<sup>rd</sup> grade. Moreover, over a quarter of third-graders' tooth decay went untreated, and only about a quarter received routine preventive services. Time trend data are available for only two measures.

**Table VII-3: Comparison of Oral Health Measures from the 2001 Idaho State Smile Survey to Healthy People 2010 Objectives**

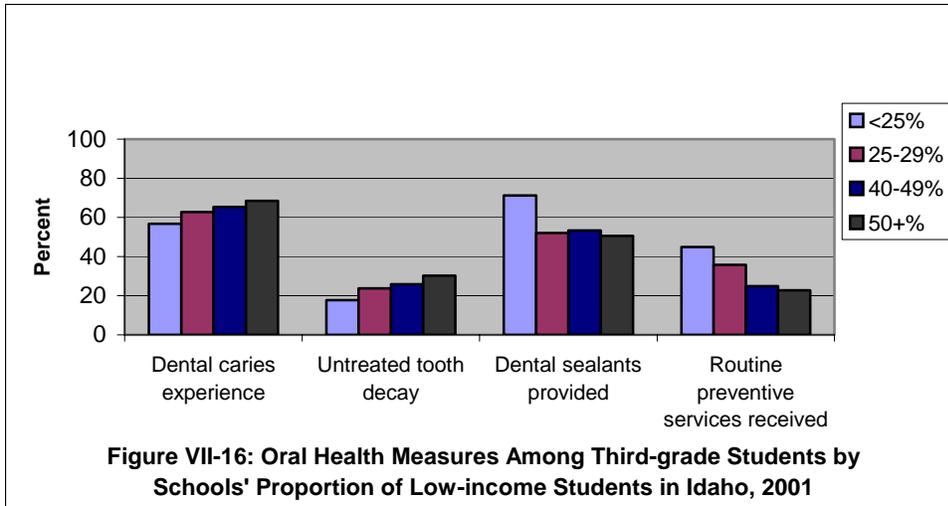
Oral Health Measure	Grade	Proportion of Idaho Students	Healthy People 2010 Target Proportion of Students
Dental caries experience	K *	46.4%	11%
	2**	62.1%	42%
	3**	65.9%	
Untreated tooth decay	K	28.1%	9%
	2	27.9%	21%
	3	27.3%	
Dental sealants received	2	38.0%	50%
	3	53.6%	
Routine preventive services received	K	42.3%	57%
	2	22.7%	
	3	27.2%	

\*All measures among kindergarteners refer to primary teeth only.

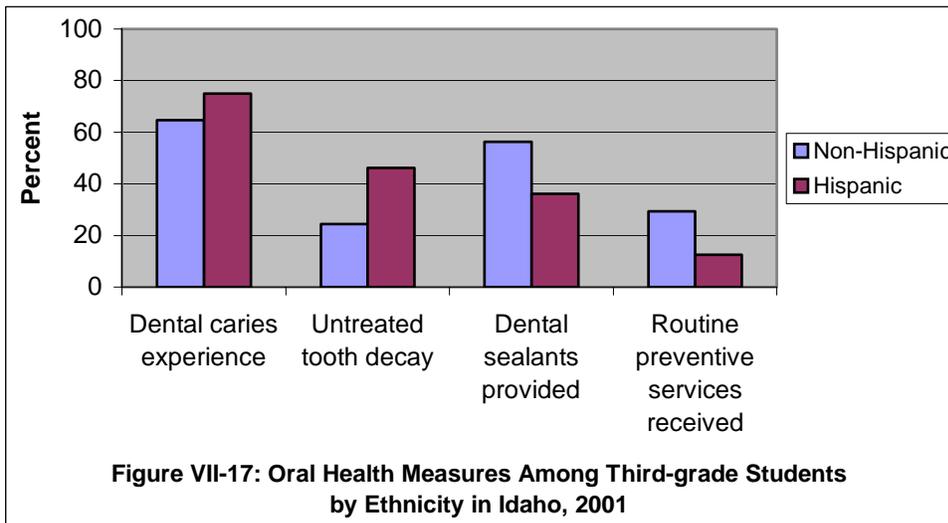
\*\*All measures among second- and third-graders refer to both primary and permanent teeth.

Sources: Idaho data is from the Idaho Oral Health Program (2003) and HP2010 objectives are from the U.S. Department of Health and Human Services (2000)

There were also some important disparities in young children’s access to oral services. Schools with the greatest proportion of low-income third-graders, as determined by participation in the National School Lunch Program, had a much greater proportion of students that experienced dental caries and suffered from untreated tooth decay (Figure VII-16). Low-income third-graders also had a smaller proportion of students that received either dental sealants or routine preventive services. These same trends were observed among Hispanic third-graders compared to non-Hispanics (Figure VII-17). Hispanic third-graders had a much greater need for oral health services, but were much less likely to receive them. Similar disparities based on school income and race or ethnicity were observed among second-grade students as well (Idaho Oral Health Program, 2003). Although the Smile Survey did identify Native American 3<sup>rd</sup>-graders, only 22 Native American students were sampled. This small sample size does not permit analysis of this racial group. National data indicates that as many as 80 percent of Native American children ages 2-5 suffer from tooth decay, a proportion nearly twice as high as the general population in that age range (Friends Committee on National Legislation, 2004).



Source: 2001 Idaho State Smile Survey (Idaho Oral Health Program, 2003)



Source: 2001 Idaho State Smile Survey (Idaho Oral Health Program, 2003)

No statewide survey comparable to the Idaho State Smile Survey exists for older children, particularly adolescents. It is therefore not possible to measure Idaho's progress in meeting Healthy People 2010 objectives for adolescents. These objectives include: 1) reduce the proportion of 15-year-olds with dental caries to 51 percent, 2) reduce the proportion of 15-year-olds with untreated tooth decay to 15 percent, 3) increase the proportion of 14-year-olds with dental sealants to 50 percent, and 4) increase the proportion of all adolescents who receive any preventive dental service during the year to 57 percent (U.S. Department of Health and Human Services, 200).

Healthy People 2010 also recommends increasing the proportion of persons over age 2 that use the oral health care systems each year to 56 percent. Access to oral health care services is partially determined by dental insurance status, which significantly reduces out-of-pocket costs.

Idaho, however, does not routinely collect data regarding the proportion of children with dental insurance. If recent trends among adults are any indication, it is likely that many children may indeed lack dental insurance. Nearly 45 percent of adults over age 18 had no dental insurance, and 34 percent had no dental visits in the past year during 2003 (Idaho Department of Health and Welfare, 2003b).

A number of children, especially those from low-income families, obtain preventive oral health services from IDHW's Oral Health Program. The Program targets children ages 0-12 by offering several types of services administered through district health departments. The School Fluoride Mouthrinse Program serves the greatest number of children: 33,276 in 2004 (National Center for Chronic Disease Prevention and Health Promotion, 2005c). IDHW conducted a cost savings analysis and determined that the Mouthrinse Program prevented nearly 17,000 cavities in FY2003 (Idaho Oral Health Program, 2004). They also found that this service would save the State nearly \$700,000, assuming all restorative treatments were from Medicaid providers, or nearly \$1.4 million, assuming such treatments were from private providers. The Early Childhood Caries Prevention Project targets high-risk individuals enrolled in WIC, Head Start, and Summer Migrant school programs. In 2004, this program served 10,735 mothers, children, and others by offering oral screening, health education, and fluoride varnish application. The School Dental Sealant Project served 343 2<sup>nd</sup>- and 3<sup>rd</sup>-graders in 2004. Lastly, the Oral Health Program provided 15,421 students, parents, and community members with oral health education and health promotion activities (ID Oral Health Program, 2005).

Another important aspect of oral health programs is ensuring access to dental care providers. Parents that responded to the Family Health Survey indicated that finding a dentist for their children was among the most difficult services to access. Nearly half (48.7 percent) of parents of children ages 1-12 indicated they needed help finding a dentist. Of these 242 parents, 6.2 percent looked but could not find this help, and another 5.2 percent were able to find help but did not consider it useful.

In 2001, the Idaho Oral Health Summit was held to address oral health issues among children and adults. This Summit and the subsequent planning sessions led to the creation of a State oral health plan for 2002-2005. The plan established six main goals to secure increased funding for oral health and to improve access to services. The goal to strengthen the dental public health infrastructure will likely have a major impact on children's oral health outcomes. Specifically, the plan seeks to:

- Provide a full-time dental hygienist in each health district
- Integrate oral health into primary care
- Establish fully funded dental public health plans in each health district
- Increase salaries of public health dental hygienists to a level comparable to those in the private sector
- Establish a State Dental Director to oversee dental public health and Medicaid oral health (Idaho Oral Health Program, 2002).

## e. Mental Health

It is estimated that nearly 20 percent of all children in the United States have a diagnosable mental, emotional, or behavioral disorder. In addition, about 10 percent of all children in the Nation have a serious emotional disturbance (SED) that severely disrupts daily functioning in various settings. Although many disorders are in part due to genetics and chemical imbalances, they may also result from traumatic experiences, such as being the victim of child abuse, the daily stress of chronic poverty, and the loss of important relationships. The most common childhood mental health disorders relate to anxiety, conduct, depression, and learning. Children diagnosed with a mental health problem should receive mental health services immediately to prevent adverse outcomes such as poor school performance, truancy, and suicide (Substance Abuse and Mental Health Services Administration, 2003).

Many of the CMHCs in Idaho have been impacted by the 1980 Jeff D. Federal Class Action Lawsuit against the State of Idaho. The Lawsuit charged that many of Idaho's services for children with SED were limited to less effective institutionalized services, such as State mental hospitals, as opposed to more community-based services. The Lawsuit lingered in the judicial system for a number of years, but increasing pressure from the court to address the complaint prompted IDHW to conduct a needs assessment of children ages 0-21 in 1998. The needs assessment defined SED as a diagnosable mental illness that significantly impairs functioning and is expected to last an extended period of time. About 4 percent of the 0- to 21-year-olds, or nearly 19,000, in Idaho were found to meet these criteria for SED. The assessment also projected that 40 percent of children with SED, or about 7,500, have more serious disorders that will require publicly funded services at some point during the next year (Lourie and Davis, 1999).

Key findings from the 1998 Children with SED Assessment:

- Medicaid serves the majority of children with SED—nearly 2,300 in 1998—but covers the least intensive services; less than \$250 per child was spent on children's mental health services.
- IDHW's Child and Family Services operates the Children's Mental Health Program (CMHP), which provides ongoing and emergency mental health services, such as care coordination through private agencies or Psychosocial Rehabilitative Services (PSR), for children and adolescents with a qualified SED:
  - IDHW served 1,200 children with SED in 1998 at the cost of \$8.1 million.
  - IDWH services in 1998 tended to be of a low level and relatively short duration.
  - The program did not take on as many new children with SED as expected.
- Idaho Department of Education's Special Education Program spent \$420,000 to serve about 600 children with SED during the 1996-1997 school year, representing just 2.4 percent of the total Special Education enrollment; the true number of children with SED may have been underreported by school officials because of the difficulty in finding services and resources for children identified with serious needs.

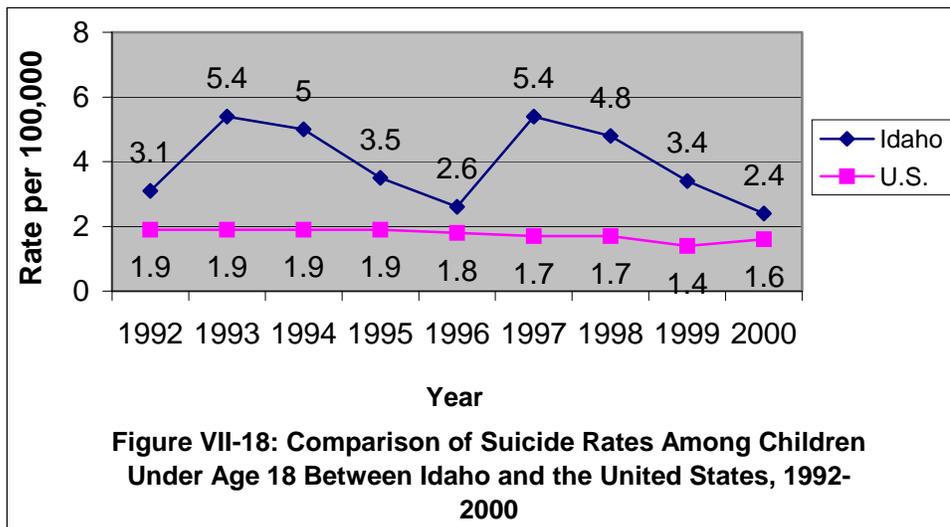
- The Idaho Department of Juvenile Corrections (IDJC) spent nearly as much money on children’s mental health services as Medicaid—about \$10,000,000—but served only 200 children with SED; IDJC offers the most costly types of treatment, such as therapeutic group homes and hospital services (Lourie and Davis, 1999).

Services should provide families of children with SED adequate choices among treatment options, with the capacity to adjust services to meet their changing needs. In addition, case management and family support services are essential to helping families navigate and learn about all available mental health services that might be of benefit (Lourie and Davis, 1999). The authors also noted that intensive treatments, such as inpatient hospital services, are often ineffective for many children with SED, especially those in the juvenile justice population. The assessment recommended that Idaho work to minimize such ineffective institutional care and instead promote more promising community-based services.

Following completion of the assessment, the State has developed an intra-agency infrastructure to coordinate services, the Idaho Council on Children’s Mental Health (ICCMH), and has begun to implement other recommendations from the assessment. Some recent accomplishments include the following:

- The proportion of children with SED that received publicly funded mental health insurance increased from 75 percent in 2002 to 85 percent in 2003 (Idaho Department of Health and Welfare, 2003b)
- The number of total children served by the CMHP nearly doubled during 1998 to 2003, from 2,349 (Lourie and Davies, 1999) to 4,317 (Idaho Council on Children’s Mental Health, 2004).
- Regional and local councils have been established to deliver coordinated, community-based services, which served 110 children in 2003 (Idaho Department of Health and Welfare, 2003b).
- The Idaho Department of Education increased the number of children with SED enrolled in the special education program to nearly 1,200 in the 2003-2004 school year, representing about 6 percent of the special education population (Idaho Department of Education, 2004a). Idaho is now much closer to matching the national trend of 8.5 percent of all special-education students served diagnosed with SED (Lourie and Davis, 1999).
- The Idaho Federation of Families for Children’s Mental Health, a parent-run advocacy organization, has been established to help children and families with mental, emotional, and behavioral disorders to access community-based services and to establish a system of care. Children do not need to meet any eligibility requirements and can receive free services, such as parent and sibling support groups, referrals to community-based services, and parent education on a range of topics (Idaho Children’s Mental Health Program, 2001).

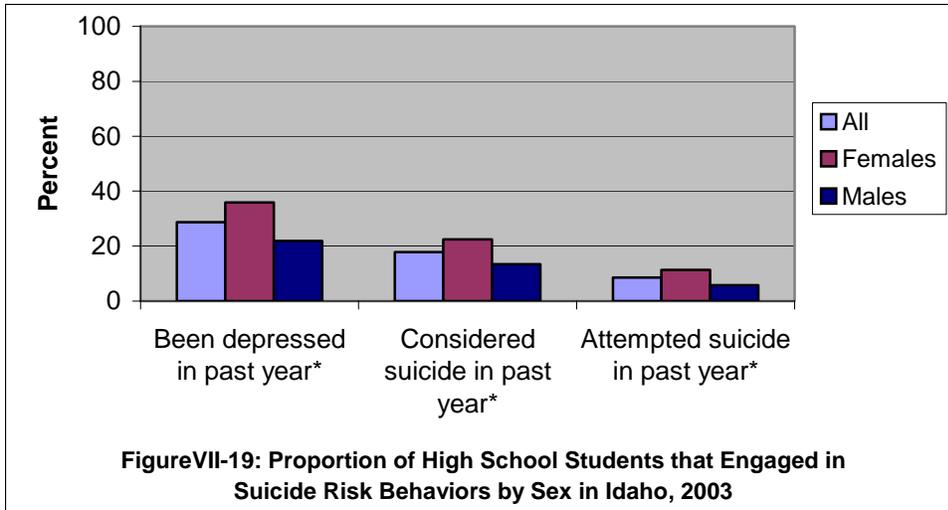
Despite the recent expansions in service capacity, many children with SED remain underserved. The number of counties with a mental health professional shortage has grown since 2001; all children in Idaho now reside in such counties (Idaho Department of Health and Welfare, 2004c). In addition, childhood suicide remains a significant area of unmet need. Historical trends indicate that the Intermountain West Region of the United States has consistently had a higher suicide rate than either the Eastern or Midwestern Regions for over a decade. Idaho's child suicide rate has been as high as three times the national rate in recent years (Figure VII-18). Much of this increased risk has been attributed to both the declining economic well-being of rural areas, leading to social instability within families, and the lack of an adequate child mental health care system (Idaho Department of Health and Welfare, 2004b).



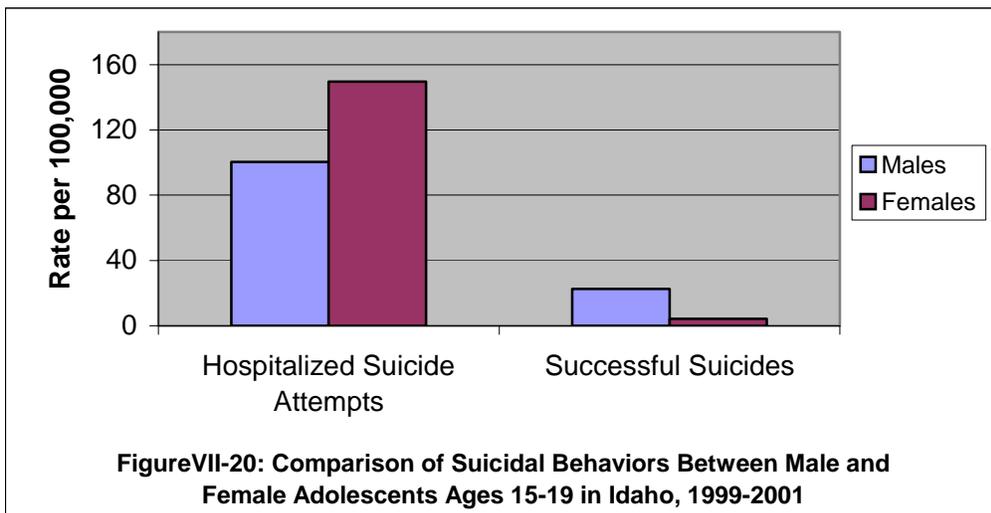
Source: Idaho Child Mortality Review Team, 2003

One of the most commonly measured precursors of suicidal thoughts is the experience of depression, defined by a 2-week or longer change in emotion, motivation, physical well-being, and thoughts (Olbrich, 2002). During 2003, nearly a third of high school students indicated that they experienced depression in the past year, with females at a significantly higher risk than males (Figure VII-19). A much smaller proportion of students, however, actually had thoughts of suicide.

The percentage of high school students reporting suicidal thoughts, 18 percent, and unsuccessful suicide attempts, 2.7 percent, were similar to national averages in 2003 and did not significantly change from 2001 (National Center for Chronic Disease Prevention and Health Promotion, 2004). Both Idaho and the nation must work to reach the Healthy People 2010 target to reduce suicide attempts to just 1 percent among 15- to 19-year-olds. It is also important to note the behavioral differences in suicide risk behaviors between male and female adolescents. A significantly higher proportion of females than males indicated they had had suicidal thoughts and attempted suicide in the past year in 2003. Following national trends, female adolescents in Idaho were much more likely to attempt suicide while male adolescents were much more likely to complete suicide during 1999-2001 (Figure VII-20).



\*Significant difference between female and male students  
 Source: National Center for Chronic Disease Prevention and Health Promotion, 2004



Sources: Data on hospitalized suicide attempts is from the Suicide Prevention Resource Center (2004) and data on completed suicides is from Idaho Department of Health and Welfare (2004b)

Adolescents in Idaho and the United States have been equally likely to attempt suicide, but those in Idaho have been far more likely to commit suicide successfully. Idaho’s adolescent suicide rate of 17.7 per 100,000 among 15- to 19-year-olds during 1999-2001 far exceeded the national rate of 8.0 per 100,000 (Suicide Prevention Resource Center, 2004). Across the Nation, suicide is the 3<sup>rd</sup> leading cause of death among 15- to 19-year-olds, but suicide was the 2<sup>nd</sup> leading cause of death for this age group in Idaho during 2002 (Idaho Department of Health and Welfare, 2004g). The suicide rate among Native American youth is even more astounding. Young Native American males 15-17 years old had the highest suicide rate of any population subgroup in Idaho, with 116 suicides per 100,000 during 1992-2001.

In November 2004, multiple State agencies, including IDHW and the Department of Education, developed a State plan to address the high suicide rate in Idaho, especially among adolescents

and Native Americans. The plan recommended creating a local community-based infrastructure to oversee the implementation of suicide prevention efforts as well as promote dissemination and use of best practices guidelines to professionals working with at-risk youth. To monitor better the progress in reducing the suicide rate, the plan also recommended developing a method of standardized data collection and performance measurement (Idaho Department of Health and Welfare, 2004b).

**2. *Children are cared for in environments that protect their health, promote their well-being, and ensure their safety.***

**a. Early Child Development**

The foundations of development and proper maturity are initially developed in the first few years of life. Therefore, it is critical to meet all the development needs of children to prevent poor health outcomes such as learning and developmental delays and poor social functioning. Children exhibiting such characteristics are more likely to end up in foster care and the juvenile justice system and have difficulty performing well in school. Quality child care and school readiness programs help promote children's social, cognitive, and emotional development (Idaho Kids Count, 2003).

**i) *Child Care***

Nearly half of all working families are unable to rely solely on family members and friends for child care and must arrange such care through private providers. Child care expenses can pose a significant economic burden on many families, ranging between \$4,000 and \$10,000 a year per child (Friedman, 2005). Parents that responded to the Family Survey indicated that child care concerns were indeed a major concern in Idaho. Nearly half (45.5 percent) of parents of children ages 1-12 indicated they needed help finding child care services. Of these 227 parents, 7.6 percent looked but could not find this help, and another 6.4 percent found help but did not consider it helpful.

The primary Federal child care program for low-income families, including TANF recipients, is administered through the Child Care and Development Fund (CCDF). This program provides subsidies for the care of typical children under age 13 and CSHCN incapable of self-care up to age 19 (Child Care Bureau, 2004b). In Idaho, CCDF subsidies are administered by the Idaho Child Care Program (ICCP). In 1999, ICCP served 7,560 children, representing 11 percent of all Idaho children eligible for this service (Child Welfare League, 2003). The number of children served has since increased to 9,413 in FY2004 (Idaho Child Care Program, 2004).

**Table VII-4.  
Comparison of the Number of Families Receiving CCDF Subsidies Between  
Idaho and Other Regions, 2000-2003**

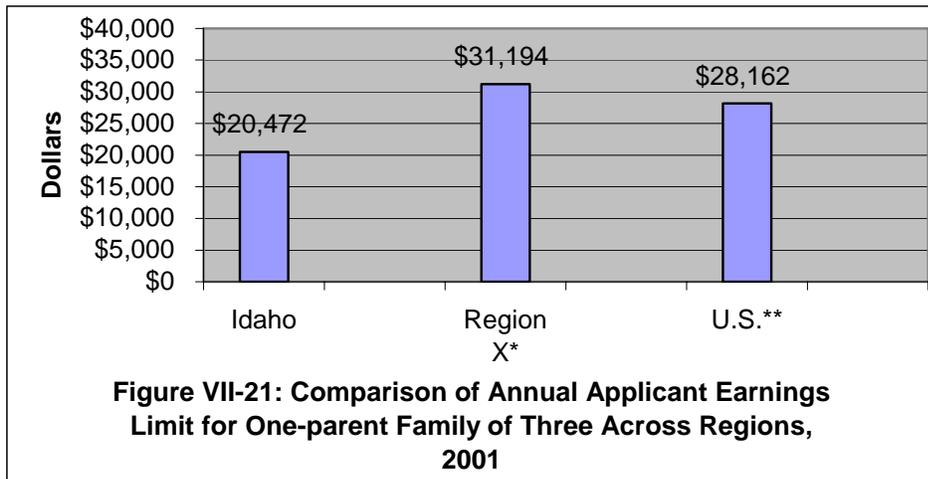
Region	2000	2001	2003
Idaho	4,800	5,600	4,400
Region X*	12,750	13,425	12,600
U.S.**	20,772	20,957	20,053

\*Represents averages of values for all Region X States

\*\*Represents averages of values for all 50 U.S. States

Source: National Center for Children in Poverty, 2005

Compared to other regions, ICCP’s impact on filling the child care affordability gap has been relatively limited. Idaho has served a much smaller number of families in the past few years than other regions. During 2003, Region X served an average of three times as many families with CCDF subsidies, while the Nation as a whole served an average of five times as many families (Table VII-4). This is likely due in part to the much lower applicant annual earning limits in Idaho than other regions: only about \$20,000 for a 1-parent family of 3 (Figure VII-21). ICCP subsidies are therefore reserved for only the most destitute of families. However, many near-poor families whose income exceeds this amount may be struggling to afford child care costs and could also benefit from access to subsidies.

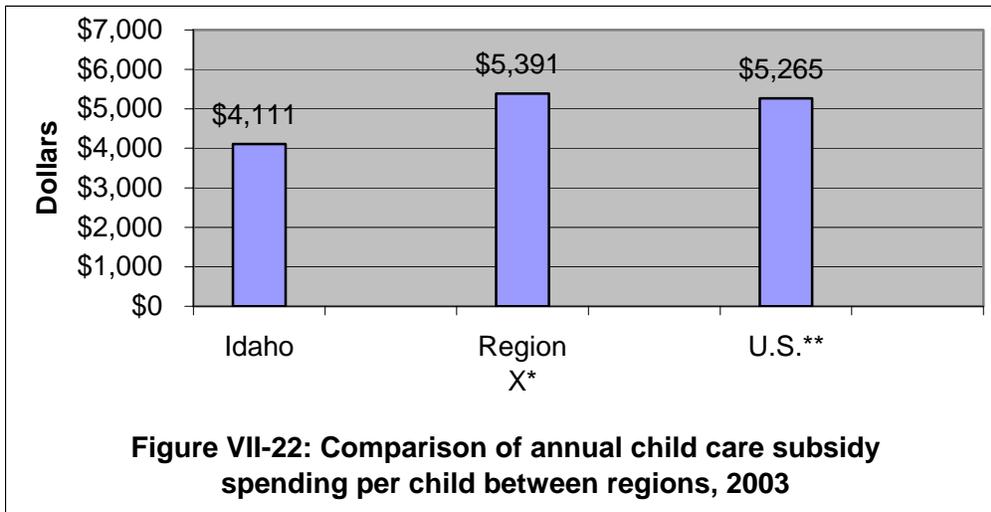


\*Represents averages of values for all Region X States

\*\*Represents averages of values for all 50 U.S. States

Source: National Center for Children in Poverty, 2005

Another important distinction of ICCP is that it is among the top 10 States with the lowest spending per child in the nation (National Center for Children in Poverty, 2004). ICCP’s spending per child during 2001, \$3,313, was 22 percent lower than the Region X average and 44 percent lower than the national average (Figure VII-22). This lower spending level has likely limited the ICCP’s ability to offer the full range of services common to many other States’ child care programs. For example, nearly half of all States provide health screenings, meals, and family case workers or home visits to their subsidized early child care programs, while the ICCP offers none of these services to its young children (Mason, 2003). However, Idaho child care providers are required to ensure that all children in their care have up-to-date immunizations.



\*Represents averages of values for all Region X States

\*\*Represents averages of values for all 50 U.S. States

Source: National Center for Children in Poverty, 2004

Child care quality is of particular concern to parents who must entrust their children's safety to staff for a large part of the day. Factors such as inadequate training, relatively low wages, and a very high turnover rate among child care staff often contribute to low-quality care. State regulation and regular monitoring of child care staff and facilities can significantly improve the quality of care provided as well as improve children's health and development outcomes (Friedman, 2005). The ICCP has a relatively limited level of regulation. In 2001, 45 percent of ICCP children were served in legal, but unregulated child care settings, compared to just 27 percent of children nationwide. However, this proportion is actually on par with Region X settings; 41 percent of children in Region are in unregulated settings (Child Care Bureau, 2004b). Except for several cities with stricter regulations, child care providers in Idaho may care for up to six children without any kind of documentation. In addition, providers can also care for 7-12 children with just certification. These providers may apply for a license, but that decision is strictly voluntary. Only providers with 13 or more children are required to apply for a State license to operate, an important distinction given that only licensed settings are subject to regular inspection from the State. Other settings are not inspected until someone files a formal complaint to trigger an investigation (Mason, 2003).

The extent of staff requirements for child care providers are criminal background checks (Idaho Department of Health and Welfare, 2005d). Providers are not required to have preservice child care experience or a minimum level of education. Also, only licensed providers are required to obtain regular training, and even this requirement is limited to a total of 4 hours per year and does not include a child development component. To help remedy this deficiency, the IDHW collaborated with other child care stakeholders, including the Idaho Association for the Education of Young Children and the University of Idaho Center on Disabilities and Human Development, in 2000 to develop a quality training program (IdahoSTARS, 2004). The Idaho State Training and Registry System (IdahoSTARS) is a voluntary professional development system for all types of child care workers, including those in the school system and Head Start, that work with children ages 0-8. Some of the main goals project are collecting and maintaining data on providers, increasing access to and affordability of care, and establishing provider

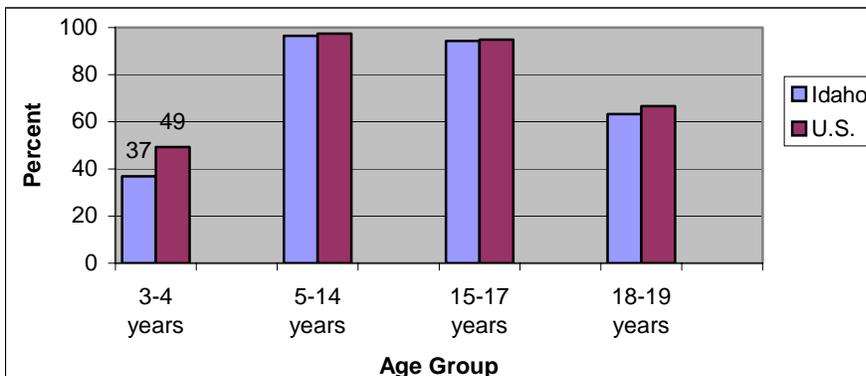
training standards and providing training opportunities. More broadly, Governor Kempthorne has also established several task forces, including the Idaho Child Care Program Advisory Panel, to address the possibility of stricter child care regulations and integrating child care services into an overall infrastructure for early childhood services. IDHW has also made injury and disease prevention a top priority in child care settings (Mason, 2003).

**What did Parents Say?**

Many parents in the focus groups indicated that child care was a very important issue for them, particularly finding quality providers with sufficient training. They expressed that it would be helpful if there were some means of acquiring information about the background and quality rating of each facility, such as a quality report card. Some who receive ICCP subsidies mentioned that some child care providers will take children enrolled in ICCP because the subsidies are too low and it takes too long for the providers to receive the payment. Hispanic parents were very concerned about the eligibility requirements for ICCP, indicating that active migrant workers are much more likely to qualify for subsidies than are low-income workers in other industries.

**ii) Early Education**

In terms of school enrollment, the majority of Idaho’s students are enrolled in school similarly to the United States, but only 37 percent of 3- and 4-year-olds are enrolled compared to 49 percent nationally (Figure VII-23). This may in part be due to the lack of a State-funded preschool program in Idaho. Across the Nation, such programs served over 730,000 students in 2002-2003, or about 10 percent of the nation’s 3- and 4-year-olds. Idaho is 1 of just 12 States that lack State-funded preschool programs. However, the State superintendent is considering pursuing a proposal for a comprehensive preschool program to the Idaho legislature within the next few years (Barnett et al., 2004). Another important public early education program is Early Head Start, which helps promote primary school readiness among low-income children.



**Figure VII-23: Comparison of School Enrollment Between Idaho and the United States, 2000**

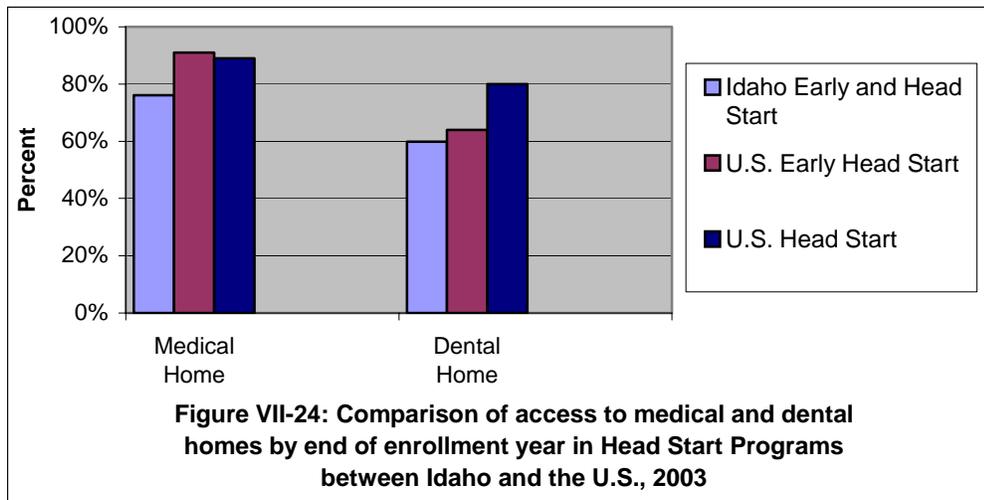
Source: U.S. Census Bureau, 2001

## Head Start Programs

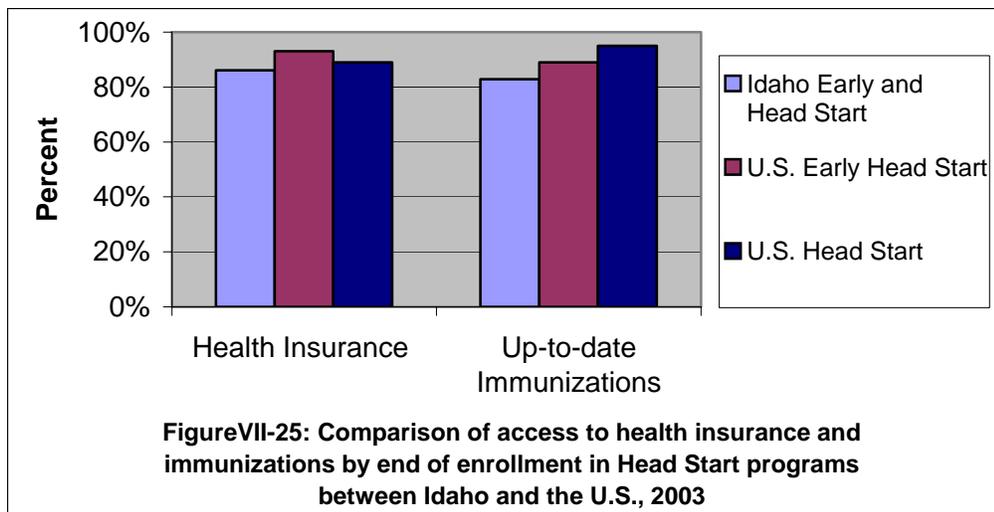
Since 1965, the Head Start program has also provided many low-income children ages 3-5 with child care, critical early education, and support services. The Early Head Start program, created in 1995, expanded these services to infants and toddlers from birth to age 2 and pregnant women. During the 2002-2003 program year, a slightly greater proportion of children were enrolled in Idaho's Early Head Start, 11 percent (Idaho Head Start Association, 2004), than the national average, 8 percent (Center for Law and Social Policy, 2004). Idaho's Head Start Programs have traditionally been funded solely by Federal and local funds and have not received State dollars. However in 1999, the Idaho Legislature designated an additional \$1.5 million to fund 188 additional Head Start enrollment slots for those receiving public assistance such as TAFI and Food Stamps (Barnett et al., 2004).

During the 2002-2003 program year, there were 13 Head Start programs throughout Idaho, including 1 program operated through the Idaho Migrant Council and 3 through tribal agencies. Total enrollment in all of Idaho's Head Start programs included 3,500 children and pregnant women. Despite the additional public assistance enrollment slots, this enrollment level served just 44 percent of Idaho's eligible 3- to 4-year-olds, the age group with the greatest enrollment (Idaho Head Start Association, 2003), compared to 54 percent of eligible 3- to 4-year-olds enrolled in Head Start programs across the Nation, based on FY2001 estimates (Gish, 2003). Lastly, five counties—Butte, Clark, Custer, Fremont, and Jefferson—do not currently offer any Head Start enrollment slots for eligible children. The 3- to 4-year-olds from these counties represented 6 percent of the unserved eligible population during 2002-2003 (Idaho Head Start Association, 2003).

Head Start programs provide a critical public health function by monitoring the health status of enrollees and helping them access needed medical and dental care (Center for Law and Social Policy, 2004). Unfortunately, fewer of Idaho's enrollees had such continuous sources of medical and dental care and received the required screenings than enrollees across the nation (Figure\_). Enrollees across the nation were slightly more likely to have health insurance than enrollees in Idaho by end of the enrollment year (Figure VII-25). Moreover, Idaho enrollees were also much less likely than the United States to be up to date on all age-appropriate immunizations. Despite these shortcomings, Idaho's programs did increase access to a range of primary health care related services between the beginning of enrollment and the end of the year. Over a quarter of enrollees, 28 percent, were initially uninsured, but this proportion later declined to just 12 percent. Similarly, 16 percent more children gained access to a medical home and 17 percent gained access to dental home (Idaho Head Start Association, 2003).



Sources: Idaho data is from the Idaho Head Start Association (2004) and U.S. data is from the Center for Law and Social Policy (2004)



Sources: Idaho data is from the Idaho Head Start Association (2004) and U.S. data is from the Center for Law and Social Policy (2004)

A comparable proportion of children were diagnosed with disabilities and received special services for their disabilities in both Idaho and the United States. No data could be located to compare mental health services between Idaho and the United States, but it is important to note that nearly 40 percent of enrollees in Idaho referred to mental health services did not actually receive these services (Table VII-5). The Head Start Program Performance Standards require that programs screen all children for developmental, sensory, and behavioral concerns (Center for Law and Social Policy, 2004), but Idaho’s programs screened only about three-quarters of enrollees.

<b>Table VII-5. Selected Mental Health Service Characteristics of Children Enrolled in Idaho's Head Start Programs, 2003</b>	
<b>Mental Health Services Received</b>	<b>Proportion of Children that Received Services</b>
Mental health professional consulted with program staff about child's behavior and/or mental health	29.0%
Referral for mental health services outside the Head Start program	4.9%
Of those referred, proportion that received services during operating period	61.8%
Received screening for developmental, sensory and behavioral concerns	76.3%
Of those screened, proportion needing followup assessment	14.0%

Source: Idaho Head Start Association (2004)

#### **b. School-based Health Services**

Outside of hospitals and community clinics, many children also receive primary health care services from K-12 schools. Many schools perform basic screenings such as vision and hearing, monitor immunization records, assist students with chronic conditions in their treatment regimes, refer students to more intensive treatment services, and provide first-response emergency medical care. Proper coordination of services and regulations can help improve the quality and scope of school-based health services.

The Idaho Department of Education does not systematically collect data about the range of health services offered, health staff characteristics, or the number or type of students served (personal contact with Idaho Department of Education). However, the School Health Policies and Programs Study (SHPPS) provides some information on Idaho's school-based health services. SHPPS is a national survey that assesses trends in school health policies and programs across States. The 2000 SHPPS indicated that Idaho's K-12 schools do not have a State health services coordinator, compared to 88 percent of all States (Hayes et al., 2002), nor does it require schools or districts to designate a health services coordinator (National Association of School Boards of Education, 2005). The survey also indicated that Idaho does not require schools or districts to screen students for hearing, height and weight, oral health, vision, tuberculosis, or scoliosis (Hayes et al., 2002).

Many schools provide a range of health services, such as comprehensive physicals and lab tests, using school-based health centers. There are currently about 1,500 school-based health centers across the country, located in 43 states—all but Idaho, Hawaii, Montana, Nebraska, North Dakota, South Dakota and Wyoming (National Assembly on School-based Health Care, 2003).

School nurses provide some of the school-based health services offered to Idaho's students. It is estimated that about 10 percent of Idaho's schools currently have school nurses that administer

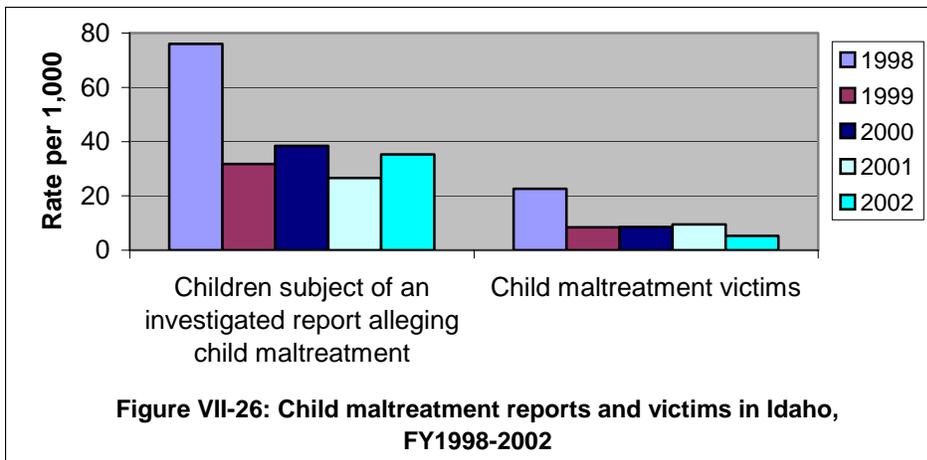
health services (Key Informant Interview with SNOI, 12/16/04). The nationally recommended nurse-to-student ratio is 1:750, which 53 percent of schools nationwide have (Hayes et al., 2002, 2000). However, it is estimated that the nurse-to-student ratio in Idaho is 1:950 (key-informant interview with SNOI, 12/16/04). School nurses are bound by strict regulations regarding administering of medicine under Idaho's Nurse Practice Act (key-informant interview with SNOI, 12/16/04) and are required to be licensed and certified (Hayes et al., 2002). Most school nurses in Idaho have just an LN, which is adequate for most health concerns. In the schools lacking a school nurse, any school staff can administer medication and emergency medicine, but they are not bound by the regulations in the Nurse Practice Act or required to have formal medical training. For more serious health concerns, schools and districts can contract with district health departments to fund a part-time RN. However, RNs are often available only to help care for CSHCN.

### **c. Child Maltreatment**

One of the most disturbing and all-too-common health risks that children face is maltreatment. There were over 980,000 maltreatment victims in 1997 across the United States and its territories. Nearly three-quarters of maltreatment perpetrators are parents, and another 10 percent are other relatives. Children that are victims of maltreatment are haunted by this experience throughout their lifetime. Victims commonly exhibit behavioral problems in school, develop substance abuse habits, engage in criminal activity, and may even grow up to abuse or neglect their own children (Idaho Kids Count, 2003). MCH systems play a critical role in identifying cases of abuse and neglect; about 60 percent of the substantiated or indicated reports of maltreatment were from legal, medical, education, and social service professionals (U.S. Department of Health and Human Services, 2000).

#### ***i) Maltreatment Prevalence***

Idaho has recently experienced a twofold decline in both the rate of child maltreatment reports filed and rates of confirmed maltreatment victims between 1998 and subsequent years during 1999-2002 (Figure VII-26). However, Idaho Kids Count (2003) attributes the higher rates of child abuse in the mid-1990s to methodological issues in counting and reporting incidents. Using the national standard method, they found that Idaho has consistently had a much lower-than-average rate of child maltreatment. In 2002, the child maltreatment rate in Idaho was 5.3 victims per 1,000, which is much lower than the Healthy People 2010 goal of 10.3 victims per 1,000 children under age 18.



Source: Idaho Kids Count, 2003

During 2002, Idaho children were much less likely to be victims of maltreatment than children across the United States. Despite this overall-lower occurrence of documented maltreatment, there have been important demographic changes over time that raise concern. A greater proportion of Idaho's maltreatment victims are increasingly younger in age; children under 5 years old comprised just 26 percent of the child victims in 1998 compared to nearly 40 percent in 2001 (Children's Bureau, 2004a). The maltreatment rate during 2002 was highest among children ages 0-3 (7.8 per 1,000) and steadily lower among older age groups. The proportion of child victims in each racial or ethnic category changed little between 1998-2001, with one notable exception: the proportion of Native American victims steadily increased from 1.5 percent in 1998 to 3.7 percent in 2001 (Children's Bureau, 2004a). During 2002, Native American children had the highest rate of victimization, 16.0 per 1,000, followed by African-Americans, 7.7 per 1,000 (Table VII-6).

<b>Table VII-6. General Demographics of Child Maltreatment Victims in Idaho and the United States, FY2002</b>		
<b>Demographics</b>	<b>Idaho Rate per 1,000</b>	<b>U.S. Rate per 1,000</b>
Total	5.3	17.3
<b>Sex:</b>		
Male	4.9	11.6
Female	5.6	13.6
<b>Age:</b>		
0-3 years	7.8	16.0
4-7 years	5.4	13.7
8-11 years	5.2	11.9
12-15 years	4.3	10.6
16-17 years	2.4	6.0

<b>Table VII-6. General Demographics of Child Maltreatment Victims in Idaho and the United States, FY2002</b>		
<b>Demographics</b>	<b>Idaho Rate per 1,000</b>	<b>U.S. Rate per 1,000</b>
<b>Race/ethnicity:</b>		
African American	7.7	20.2
American Indian/Alaska Native	16.0	21.7
White	4.7	10.7
Multiple Race	1.6	12.4
Hispanic, any race	6.3	9.5
<b>Types of maltreatment:</b>		
Physical Abuse	1.0	2.3
Neglect	3.5	7.2
Medical Neglect	0.1	0.2
Sexual Abuse	0.4	1.2
Psychological Maltreatment	0.04	0.8
Other/unknown	0.4	2.3

Source: Children's Bureau, 2004a

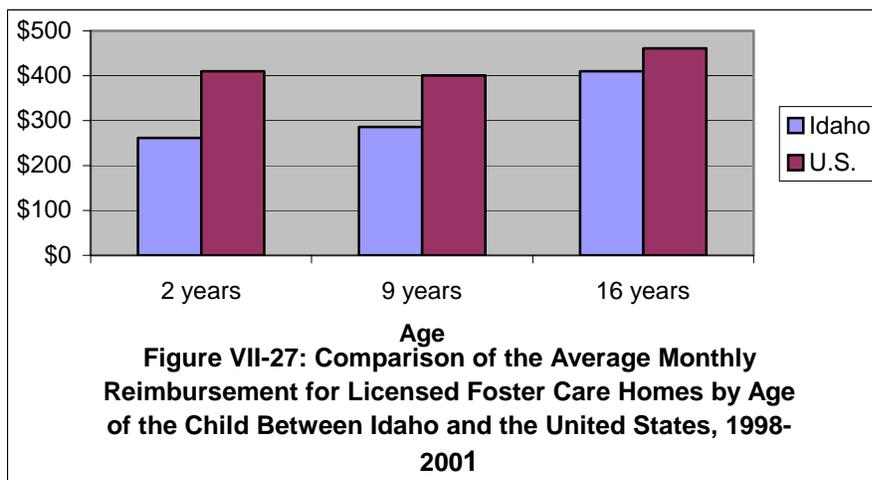
The most common type of abuse during 1998-2001 was neglect (nearly 45 percent), followed by physical abuse (nearly 20 percent). The proportion of victims experiencing sexual abuse steadily declined from 16 percent in 1998 to just 8 percent in 2001 (Children's Bureau, 2004a). During 2002, Idaho resembled the rest of the country, as children were much more likely to be victims of neglect than any other type of abuse. In addition, the child maltreatment fatality rate in Idaho, 0.54 deaths per 100,000, was lower than the national average rate of 1.98 deaths per 100,000. None of Idaho's child maltreatment fatalities occurred in foster care or families that had received prevention services or were reunited within the past 5 years (Children's Bureau, 2004a).

## *ii) Reviews of Child Protection Services*

Ideally, child protection systems should support three main goals: prevent abuse from happening, protect abused children from further maltreatment, and provide treatment for both maltreatment victims and abusers (Idaho Kids Count, 2003). To assess how well State child protection systems are meeting these goals, the ACF Children's Bureau annually conducts an Outcomes Report to evaluate performance on 13 measures that evaluate 7 national child welfare outcomes. The most recent report evaluates 2001 data. Overall, Idaho performed better than the national standard on a number of permanency measures in the Outcome Report. For example, fewer maltreatment victims in Idaho, 0.36 percent, experienced maltreatment while in foster care than the national standard of 0.57 percent or less (Children's Bureau, 2004a). Similarly, a much greater proportion, 89 percent, of foster children were reunified within 12 months than the national standard of 76.2 percent or more. However, Idaho's child protection services may need to improve performance in other key areas, such as ensuring that foster children do not re-enter the system. The national standard states that  $\leq 8.6$  percent of foster children should re-enter foster care within 12 months of discharge. Idaho previously met this goal during 1998-1999 but has

since exceeded this standard. In 2001, 12 percent of Idaho’s foster children re-entered care within a year (Children’s Bureau, 2004a).

Foster care provides temporary homes for child victims of maltreatment, and it serves a vital role in protecting these children from further harm. Nationally, there has been a substantial increase in the number of children entering State foster care systems, but there has been a decline in the number of licensed family foster homes to take in these children (Idaho Kids Count, 2003). In Idaho, all prospective families must become licensed, which involves passing a home health, fire, and safety inspection; meeting minimum income requirements; and attending various training sessions. The State provides dental and medical coverage to foster children and provides parents with a monthly reimbursement, based on children’s ages and needs, to cover child care related costs (Idaho Department of Health and Welfare, 2005a). Idaho lags behind the nation with its relatively low monthly reimbursement, especially among younger children (Figure VII-27). This low reimbursement may deter some households from becoming a foster care home.



Source: Idaho Kids Count, 2003

In addition, the Children’s Bureau also regularly conducts Child and Family Service Reviews (CFSR) using case reviews and interviews with stakeholders to assess States’ conformity with six of the seven national outcomes (Children’s Bureau, 2003). Idaho’s most recent CFSR was conducted in FY2003 and includes Ada, Bannock, and Nez Perce counties to represent several regions. The results of this review found considerable regional variation; Ada County performed less well across a number of maltreatment outcomes than the other two counties. For example, only about half of cases in Ada County achieved substantial conformity on the measure regarding providing services to ensure children’s safety and risk while in the home, compared to over 80 percent of cases in both Bannock and Nez Perce Counties (Children’s Bureau, 2003).

On some CFSR measures, all reviewed counties performed poorly. Only 48 percent of all cases reviewed achieved substantial conformity in ensuring permanency and stability in children’s living situations, which is much lower than the 90 percent required. Child protection systems ultimately seek to keep families intact and reunite children in out-of-home care with their families. However, this goal is not always feasible or in the best interests of all abused children. In these cases, it may be preferable to place such children in the long-term care of adoptive

parents. Through discussions with key Idaho officials, reviewers were able to identify important barriers to ensuring timely permanent placements. In some cases, the goal of reunification was maintained for too long when it was clear that adoption would be a much more feasible option. In others, the local agency did not take necessary steps to avoid delays in terminating parental rights and completing paperwork to accelerate adoptions (Children's Bureau, 2003).

IDHW has also conducted its own evaluation of child protection services across the State. During September through October 2004, the Regional Directors conducted focus groups with policymakers, parents, providers, and legal representatives to evaluate local child protection systems and identify gaps in services. Most of the complaints and service gaps related to mental health care services. In particular, focus group participants indicated that there was insufficient support for parents battling substance abuse. Mental health services are usually provided only to active drug users, not to those in recovery. When treatment was provided, many complained that it was of poor quality or too short in duration. Lastly, many parents lose their Medicaid eligibility when they have a child placed in protective custody. They therefore have to pay for treatment costs out of pockets, a large economic burden for most (Idaho Department of Health and Welfare, 2004h).

#### **d. Environmental Lead Exposure**

One of the greatest public health threats to children, especially very young children, is lead poisoning. Young children are most sensitive to lead exposure because of the underdevelopment of their organ systems. Children with elevated blood lead levels, or levels at or above 10 µg/dL, are at greater risk of experiencing neurotoxicity, which may impede intellectual functioning, behavioral development, and coordination. The removal of environmental sources of lead from paint, gasoline, food cans, and contaminated waste sites beginning in the 1970s has dramatically reduced the proportion of children with elevated blood lead levels (American Academy of Pediatrics, 1998). The CDC has also issued guidelines regarding local and statewide blood lead screening as a secondary prevention measure to reduce the impact and spread of lead exposure in communities. In 1991, the CDC's guidelines called for universal screening of all young children ages 9-12 months. Following concerns about the cost effectiveness of screening large numbers of children at relatively low risk of lead exposure, the CDC revised these guidelines in 1997 to limit screening to population groups most at risk for lead exposure (National Center for Environmental Health, 1997).

The IDHW has identified residents of the Coeur d'Alene River Basin as among the highest-risk groups in Idaho. The initial site in the area is the Bunker Hill Superfund Site, a 21-square-mile area commonly referred to as "the Box." The Box has been evaluated by health officials since 1974, and thousands of blood samples have been screened for lead levels. During the 1970s, as many as 75 percent of children ages 0-5 had elevated blood lead levels in the Box, and the mean blood lead level was as high as 70 µg/dL. Since then, the IDHW has collaborated with the Panhandle Health District and the Agency for Toxic Substances and Disease Registry (ATSDR) to implement public health education interventions and site cleanups. These measures have significantly reduced the elevated blood lead levels in children. In 2002, only 2 percent of the 259 children ages 0-6 screened had elevated blood lead levels, while the mean blood lead level was just 2.8 µg/dL (Agency for Toxic Substances and Disease Registry, 2003).

Children that live “outside of the Box” in the surrounding areas in the Coeur d’Alene River Basin have also been at higher risk of lead exposure. There were no regular child blood lead screenings of these areas from 1975-1995. The few child screenings that were conducted in the 1970s indicated that blood lead levels often exceeded 40 µg/dL (Agency for Toxic Substances and Disease Registry, 2003). In the summer of 1996, IDHW and the Panhandle Health District conducted the Coeur d’Alene River Basin Exposure Assessment, in which they screened 98 children under age 9 (Idaho Department of Health and Welfare, 1997). The Assessment found that 13.7 percent of all children screened had elevated blood levels (Agency for Toxic Substances and Disease Registry, 2003). IDHW have extended its interventions to areas outside the box, including annual blood lead screening for children. During 2002, just 4 percent of the 103 children ages 6 months to 9 years screened in these areas had elevated blood lead levels, and the mean blood lead level was 3.2 µg/dL (Agency for Toxic Substances and Disease Registry, 2003).

ATSDR has provided most of the funding for blood lead screenings in the Coeur d’Alene River Basin in an effort to reduce the proportion of children with elevated blood levels in the area to less than 5 percent. Results indicate that screened sites have met this goal for the past few years. Seemingly due to these stabilized blood lead levels, ATSDR has recently decided to cease funding this annual screening program (key-informant interview with IDHW Bureau of Community and Environmental Health, March 16, 2005). The number of residents that have been screened has substantially dropped since funding was cut. IDHW has not replaced this funding using their own resources but have instead focused on continuing public health education programs and cleanup efforts in the Coeur d’Alene River Basin. At the current pace of these efforts, blood lead screening levels in resident children should remain at their current low levels. The CDC’s 1997 guidelines also indicated that States should develop and implement a statewide blood lead screening plan.

#### **e. Child Mortality**

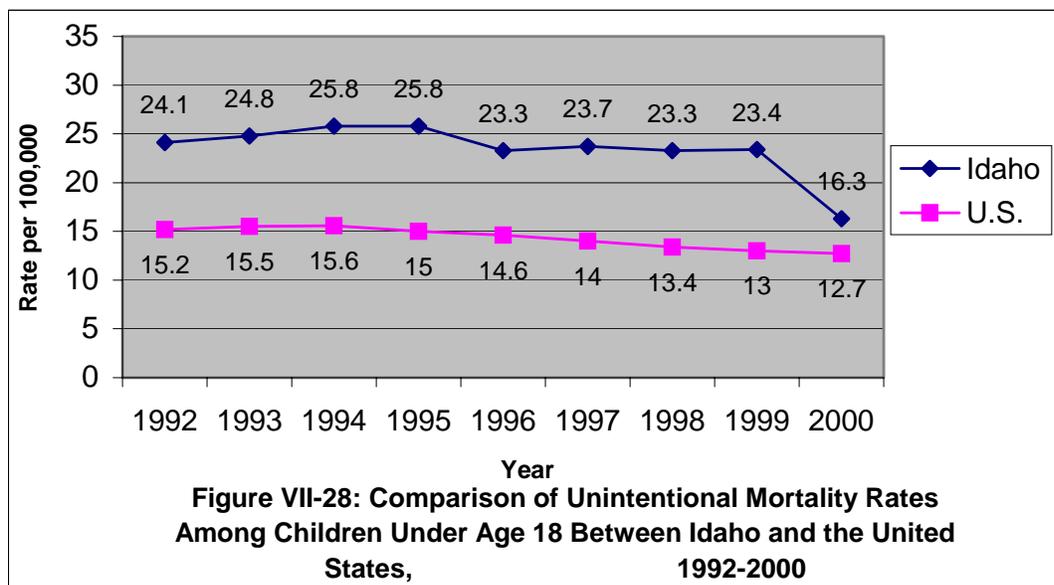
Child mortality gained greater attention in Idaho as an important public health issue with the creation of Idaho’s Child Mortality Review Team in 1998. Their annual reports have provided invaluable information about the magnitude, type, and preventability of child deaths. The Team found that during 2000, the mortality rate across all age groups in children under age 18 was much lower than the national average (Idaho Child Mortality Review Team, 2003). Child mortality rates continued to compare favorably with national trends in 2002 among children and adolescents (Table VII-7). However, the child mortality rate exceeded the national rate for older adolescents ages 15-19. Idaho has also yet to meet any Healthy People 2010 child and adolescent mortality goals.

**Table VII-7.  
Comparison of All-cause Mortality Rates per 100,000 Children Age 19 and Under in Idaho and the United States to Healthy People 2010 Child and Adolescent Mortality Goals**

Age Group	Idaho, 2002	U.S., 2002	HP2010 Goal
1-4 years	28.0	31.2	18.6
5-14 years	17.5	17.4	N/A
5-9 years	15.1	N/A	12.3
10-14 years	19.8	N/A	16.8
15-19	73.9	67.8	39.8

Sources: Idaho data is from the Idaho Department of Health and Welfare (2004g), U.S. data is from Kochanek et al. (2004), and HP2010 objectives are from U.S. Department of Health and Human Services (2000)

The leading cause of death for children of all ages in the United States is unintentional injury (U.S. Department of Health and Human Services, 2000). Since the early 1990s, children in Idaho have been at least 20 percent more likely to die of unintentional injuries than all American children (Figure VII-28). Motor vehicle crashes (MVC) are among the most frequent types of unintentional injury death. Nearly 20 percent of MVC deaths occur among 10- to 14-year-olds, and nearly 38 percent of MVC deaths occur among 15- to 19-year-olds nationwide (Centers for Disease Control and Prevention, 2004). In Idaho, children under 18 experienced 10.6 deaths per 100,000 to MVC in 2000, while the national rate was only 7.2 deaths per 100,000 (Idaho Child Mortality Review Team, 2003). In 2002, Idaho's childhood fatalities due to MVC accounted for 48 percent of deaths among 10- to 14-year-olds and 58 percent among 15- to 19-year-olds (Idaho Department of Health and Welfare, 2004g).



Source: Idaho Child Mortality Review Team, 2003

Intentional injuries comprised the next most common cause of death among children and adolescents. As previously mentioned, suicide was the second leading cause of death among children 10-19 years old, but rarely occurred in younger ages. Homicides were the third leading cause of death for children 1-4 years old and 15-19 years old.

**3. *Families have access to and use services that strengthen their parenting skills appropriately.***

**a. Parents as Teachers (PAT)**

PAT is a national voluntary program offered to pregnant women and mothers with young children up to age 3 that provides parenting education and support free of charge. Idaho currently has 34 PAT programs around the State that reached over 1,500 families and 2,200 children, with nearly 700 families on the waiting list during 2003. One of the main services includes home visits with child development specialists and developmental screenings. When screenings identify a potential developmental delay or physical problem, specialists refer parents for further assessment or treatment. Over 90 percent of parents typically follow through on referrals take their children for additional testing. PAT has also collaborated with the Infant-Toddler Program in some communities to help increase the number of developmental screenings completed. PAT also offered about 450 monthly parent support groups in 2003 and has helped families access numerous social services such as child care and mental health services (PAT, 2004).

**b. Head Start**

The Early Head Start and Head Start programs offer parenting education as part of its collection of family support services. During 2002-2003, 56 percent of families received parenting education, over 1,800 families (Idaho Head Start Association, 2004). Specifically, children receive weekly or monthly home visits to help parents reinforce the skills that children learned in classrooms as well as assistance in developing personal goals, accessing community resources and ensuring that children transition smoothly into the public school system (Idaho Head Start Association, 2003).

**c. Health care Facilities**

All seven CMHCs offer some form of parenting education on site, and nearly half refer parents outside to additional facilities offering parenting education (UDS, 2004). In addition, a number of parenting classes are offered by Idaho's hospitals, most for a small fee (Idaho CareLine, 2005).

**d. Other Community-based Organizations**

A number of community-based organizations offer parenting classes and other parenting support services. The Idaho CareLine will refer callers to many of these services in their communities. Classes may be geared just toward the parents or allow both parents and children to participate. Although some parenting services are offered free of charge, most charge at least a small fee. An

example of one of these organizations is Parents Encouraging Parents (PEP), which offers online parenting classes as well as discussions on topics such as stepparenting and joint custody (Idaho CareLine, 2005).

#### What Did Parents Say:

Some parents indicated that they had received formal parenting education while enrolled in WIC. The local WIC offices would hold classes on the days that mothers would come in to pick up their food vouchers. Others indicated they or their friends received parenting education through Family Service Alliance, which targets at-risk parents such as domestic violence victims. A couple knew of PAT as well, and one participant had received home visits from the organization. However, many women stated there were not enough parent classes and parent support groups in Idaho. They were especially interested in attending classes geared towards first-time parents and parents of CSHCN.

#### 4. *Adolescent children use ongoing health services appropriate to their stage of growth and development.*

As children grow into adolescence, they experience a range of new physical and emotional changes with the onset of puberty. During this time, youth become more sensitive to peer pressure while they also try to assert their own independence. Throughout this often confusing period, teens may be more likely to engage in a number of risk behaviors, including initiating sexual activity, experimenting with drugs and alcohol, and putting themselves at risk for injury. MCH systems can help youth make a smoother transition into adolescence by tailoring services to their unique risks and making them easily accessible.

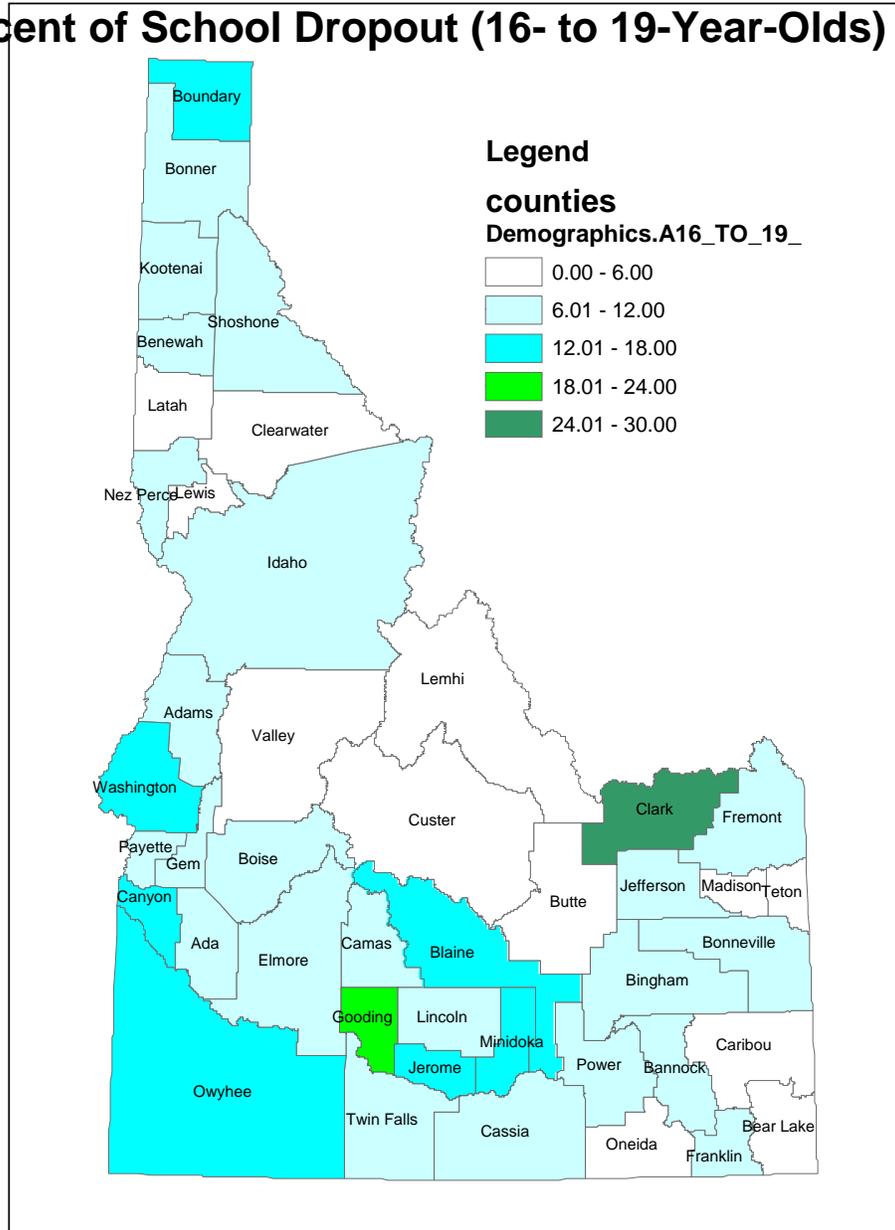
##### a. **High School Graduation**

Secondary schools play a vital role in helping youth mature and learn the basic skills necessary to progress successfully through puberty and can help promote success later in life as adults. For this reason, high school graduation has become an important health outcome for adolescents. Students that drop out of high school have a much higher likelihood of engaging in a number of risk behaviors, including substance use, delinquency, unintended pregnancy, and intentional injuries. Furthermore, adults with less than a high school diploma often have limited employment opportunities and are more likely to live in poverty (U.S. Department of Health and Human Services, 2000). Healthy People 2010 has established a goal to increase high school completion among young adults ages 18-24 to 90 percent. Idaho has not yet achieved this goal, as only 77.3 percent of young adults in this age range completed high school in 2000 (U.S. Census Bureau, 2001). However, this rate is higher than the national average, 74.7 percent.

Idaho ranks 12<sup>th</sup> in the nation for its relatively high rate of students graduating from high school, with only 5 percent dropping out during 1999-2000 (Idaho Kids Count, 2003). This represents a decline from the 7 percent dropout rate during 1995-1996 (Idaho Kids Count, 2003). There are some important regional differences within the State; Clark County had the highest dropout rate of over 24 percent (Figure VII-29). In addition, Boundary County and several Southeastern and South Central counties had particularly high dropout rates. Also, a much lower proportion of Idaho's adolescents go on to pursue higher education. In 1999, only about half of high school graduates attended a college or university, a much lower proportion than the national average of

64 percent (Idaho Kids Count, 2003). Research has long shown that individuals with only a high school diploma earn significantly lower salaries than those with postsecondary education degrees; those with a bachelor’s degree earn 54 percent more annually. High school graduates also often have less stable jobs than those with higher degrees with a nearly three times higher unemployment rate.

### Percent of School Dropout (16- to 19-Year-Olds)



**Figure VII\_29: Map Displaying Distribution of High School Dropout Rates by County Among Idaho’s Adolescents Ages 16-19 Years, 1999-2000**

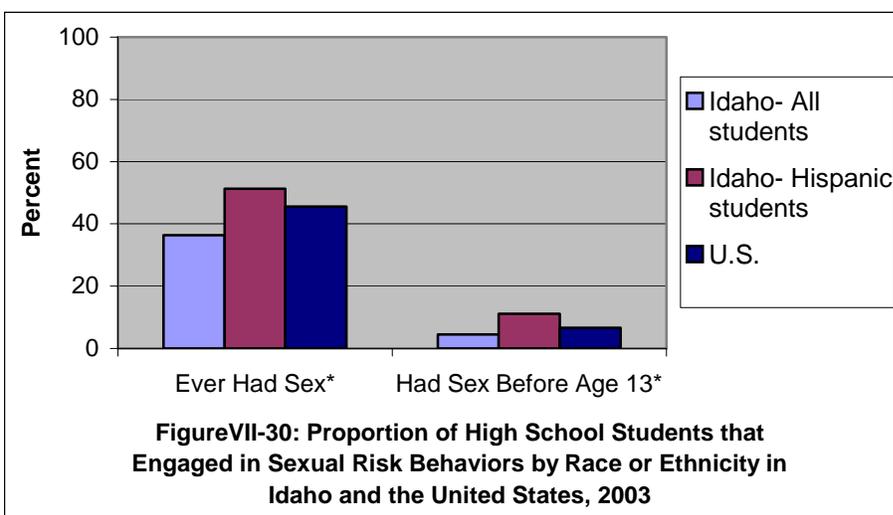
Source: Idaho Kids Count, 2003

## b. Sexual Risk Behaviors

### i) Sex Initiation and Protection

Across the Nation, the number of adolescents having sexual intercourse and becoming pregnant has been on the decline since the 1980s. In Idaho, 10 percent fewer adolescents reported ever having had intercourse than the national average (Figure\_). Also, slightly fewer Idaho adolescents have had intercourse before the age of 13 than those across the United States. There were no significant differences in either of these sexual risk behaviors between males and females (National Center for Chronic Disease Prevention and Health Promotion, 2004). These figures have likely contributed to the relatively low teen pregnancy rate in Idaho. During 2001-2003, the teen pregnancy rate in Idaho was 39.4 per 1,000 among 15- to 19-year-old females, compared to 43.0 per 1,000 in the United States. The pregnancy rate among youth under age 15 was also significantly lower in Idaho (Idaho Department of Health and Welfare, 2004g).

However, compared to White youth, Hispanic youth in Idaho were significantly more likely to report ever having sexual intercourse and were more likely to have had intercourse before age 13 (Figure VII-30). Similarly, the teen pregnancy rate among Hispanic 15- to 19-year-olds was 98.6 births per 1,000 females, versus just 38.9 births per 1,000 females among White teens during 2001-2003. Hispanic teen focus group participants felt teen pregnancy was very common among Hispanics, especially between ages 12 and 16. One participant indicated that he had nine Hispanic peers that were currently pregnant. They also perceived that most Hispanic teens did not use condoms, because of either impaired judgment due to alcohol and drug use or the limited availability and high expense of condoms in schools and the community. Sexual initiation seemed to occur at a very early age, just after puberty around 12 to 14 years of age.



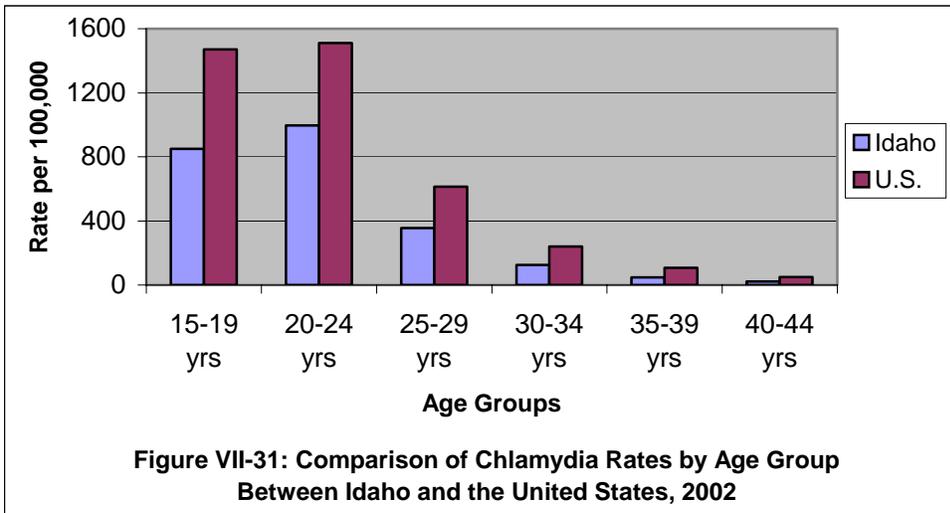
\*Indicates a significant difference between Hispanic students and students of all races and ethnicities in Idaho  
Source: National Center for Chronic Disease Prevention and Health Promotion, 2004

It is also important to monitor the proportion of sexually active youth that use protection to prevent pregnancy and sexually transmitted infections (STIs). Healthy People 2010 specifically seeks to increase the proportion of sexually active, unmarried adolescents ages 15-17 that use

contraception and barrier protection. PRATS is the only statewide survey to assess whether individuals use protection during sex, but PRATS is administered only to females ages 18 and older. No comparable statewide surveys in Idaho currently exist that specifically target male and female adolescents. In fact, Idaho is one of the few States that have consistently excluded questions regarding contraception and barrier protection in its version of the YRBS each year since the initiation of the national survey in 1991. This is a critical omission on the Idaho YRBS, given that nationally one in four sexually active teens will acquire a new STI every day (National Conference of State Legislatures, 2004).

In the absence of data specifically indicating contraceptive and barrier protection use, some data on STI rates among adolescents are available and can shed light on risky sexual behaviors in Idaho. Overall, the rate of new HIV infections has steadily declined in Idaho since the early 1990s, from 4.3 per 100,000 in 1990 to 3.4 per 100,000 in 1999. The incidence rate of HIV among males declined the most, while the rate among females has remained relatively low (Idaho Department of Health and Welfare, 2001). The majority of HIV cases in Idaho have occurred in adults over the age of 19. Just 4 percent of HIV cases occurred in children under 20 years old in 1998 (IDHW Bureau of Health Policy and Vital Statistics, 1999). In 2001, Idaho had one of the lowest HIV infection rates in the country across all age groups (Division of STD Prevention, 2004).

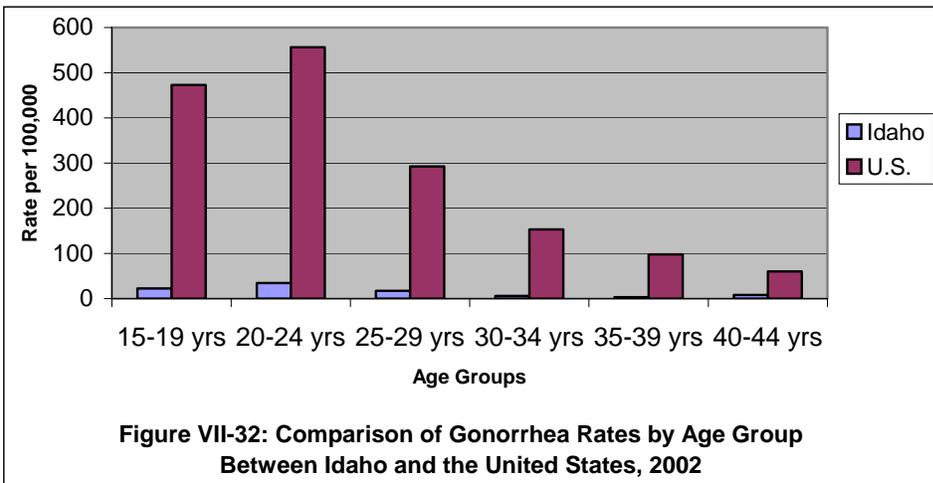
Despite the low HIV infection rate, the prevalence of all STIs has increased among adolescents aged 15-19 years, from 7.1 per 1,000 in 1999 to 8.7 per 1,000 in 2002 (Idaho Department of Health and Welfare, 2004g). The most common STI since the early 1990s has been chlamydia. By 2002, 94% of all reportable cases of STI were chlamydia (Idaho Department of Health and Welfare, 2004g). Females have been more at risk than men for contracting this STI, comprising about three quarters of cases (Idaho Department of Health and Welfare, 2001). In addition, Hispanics are also at a disproportionately high risk for chlamydia, they accounted for 13% of cases in 2004 (Idaho Department of Health and Welfare, 2004e). The largest differences in rates occur across age groups. Nearly 80% of the cases throughout the 1990s occurred among 15-24 year olds (Idaho Department of Health and Welfare, 2001). This trend continued in 2002, as the large majority of cases occurred among adolescents and young adults (Figure VII-31). However, rates of chlamydia in Idaho were lower across all age groups when compared to the national average. Untreated chlamydia can lead to pelvic inflammatory disease, a very serious condition that can cause ectopic pregnancies, infertility and chronic pain (Boonstra, 2004).



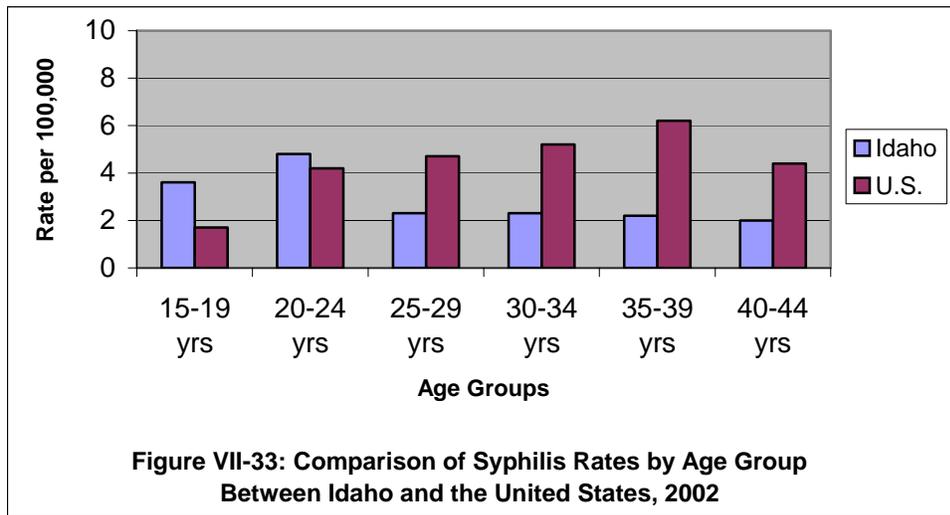
Sources: Idaho data is from IDHW STD/AIDS Program (2003), and U.S. data is from CDC Division of STD Prevention (2004).

The second most common STI in Idaho has been genital herpes, comprising 17% of all reportable STIs in 1999. Like chlamydia, genital herpes has been much more common in females, who comprised over 80% of cases in 1999. Unfortunately, genital herpes was no longer a reportable disease in Idaho after 1999. The total number of cases reported had been on the decline since 1992 (Idaho Department of Health and Welfare, 2000f). Genital herpes is currently incurable, but drug treatment has helped those infected with the virus manage the disease (Boonstra, 2004). Discomfort and inconvenience are usually the worst problems resulting from untreated genital herpes. However, those with compromised immune systems are likely to have more severe outbreaks. Also, untreated herpes often increases the risk of getting and spreading HIV.

Gonorrhea rates have fluctuated since the early 1990s, but have remained relatively low at 7.3 cases per 100,000 persons in 2002 (Idaho Department of Health and Welfare, 2004g). However, infection is over twice as high among adolescents ages 15-19 years at nearly 23 cases per 100,000 (Figure VII-32). As with chlamydia, Idaho's gonorrhea rates are much lower than the national rates across all age groups. The prevalence of syphilis has also been relatively stable over the past decade and represents the least common STI reported, averaging just 19 total cases per year from 1992 to 2002 (Substance Abuse Social Indicators, 2004). In 2002, the rate of syphilis was 1.7 cases per 100,000. However, when examining infection rates by age, youth ages 15-24 were nearly twice as likely as older age groups to contract syphilis (Figure VII-33). Rates of infection for this age group is even higher than the national average. This is particularly concerning given that the national trend indicates that older adults ages 30-39 are most at risk, not youth.



Sources: Idaho data is from IDHW STD/AIDS Program (2003), and U.S. data is from CDC Division of STD Prevention (2004).



Sources: Idaho data is from IDHW STD/AIDS Program (2003), and U.S. data is from CDC Division of STD Prevention (2004).

The prevalence of Hepatitis B has remained relatively stable in the past decade and has remained relatively low, with 8.6 cases per 100,000 persons in 1999. Adolescents and young adults are at a lower risk of infection as the majority of cases occur among 25-44 year olds (Idaho Department of Health and Welfare, 2001). Gonorrhea and syphilis can be cured by antibiotics, while Hepatitis B is incurable but can be managed with medication. However, a successful treatment outcome with each of these STIs depends on early detection (Boonstra, 2004).

Other STIs common among youth include human papillomavirus (HPV) and trichomoniasis. Unfortunately, neither of these STIs are currently reportable in Idaho and thus there is no available statewide data to describe their prevalence. HPV is the most common STI among youth in the country, accounting for over 50% or 4.6 million new cases of STIs in 2000 (Boonstra, 2004). Trichomoniasis accounted for over 20% of new STIs in the nation's youth in 2000. Both can be cured with antibiotics (Boonstra, 2004).

## *ii) Reproductive Health Services*

There are a number of reproductive health services available for adolescents in Idaho. IDHW provides gynecological services, such as Pap smears and pelvic examinations, family planning counseling, and contraceptives such as condoms, injectibles and Emergency Contraception through the Idaho Reproductive Health Program at 41 different reproductive health clinics around the state (Idaho Reproductive Health Program, 2005). Planned Parenthood of Idaho also offers these services in their Boise and Twin Falls Offices. Adolescents enrolled in either Medicaid or CHIP have coverage for basic gynecological services and family planning services and supplies (National Conference of State Legislatures, 2004). Each of these clinics accept all public and most private insurance plans and provide sliding fee scales for those paying out-of-pocket.

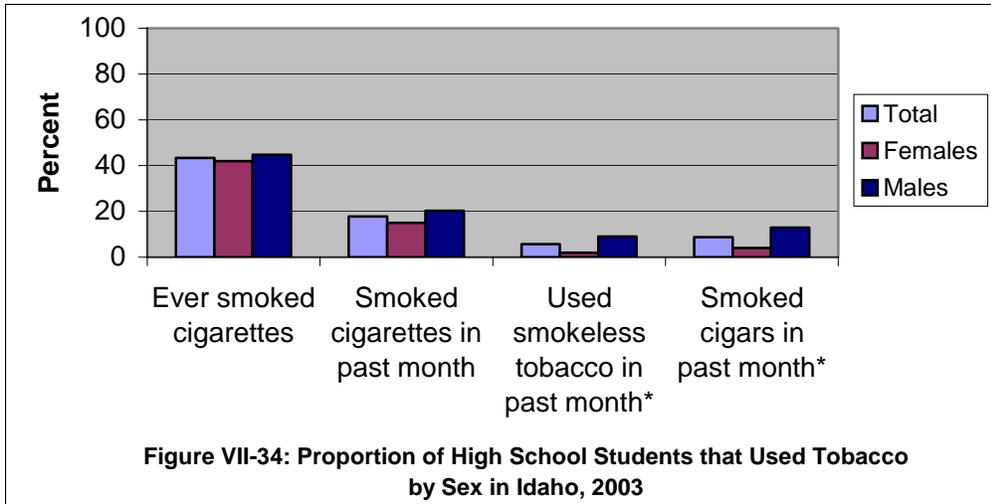
The Department of Education also supports several special programs around the state to allow pregnant girls and those with young children up to the age of 21 the opportunity to obtain a high school diploma. The Marian Pritchett High School is one such school established 1921 in Boise. Marian Pritchett accepts students from all school districts. Teen Parent Alternative serves the Nampa School District and offers instruction at Nampa High School. The Teen Parent Center in Pocatello serves students in Southeast Idaho. Each of these programs provide students with special instruction on infant care, assist in helping students access a range of social services such as Medicaid and WIC, and may help students get to medical appointments (Idaho CareLine, 2005).

The Idaho STD/AIDS Program receives Federal funding to provide testing, treatment and prevention services for Idaho's reportable STIs. These services are administered via contracts with district health departments and community-based organizations. Idaho's reportable STIs include chlamydia, HIV, AIDS, gonorrhea, syphilis, and Hepatitis B and C (Idaho Department of Health and Welfare, 2004d). Other common STIs, such as genital herpes, bacterial vaginosis, and HPV are not currently reportable diseases and thus are not funded by the IDHW's program. However, district health departments often use additional funds to cover a more comprehensive list of STIs. Planned Parenthood of Idaho also tests for a full range of STIs.

## *iii) Substance Use*

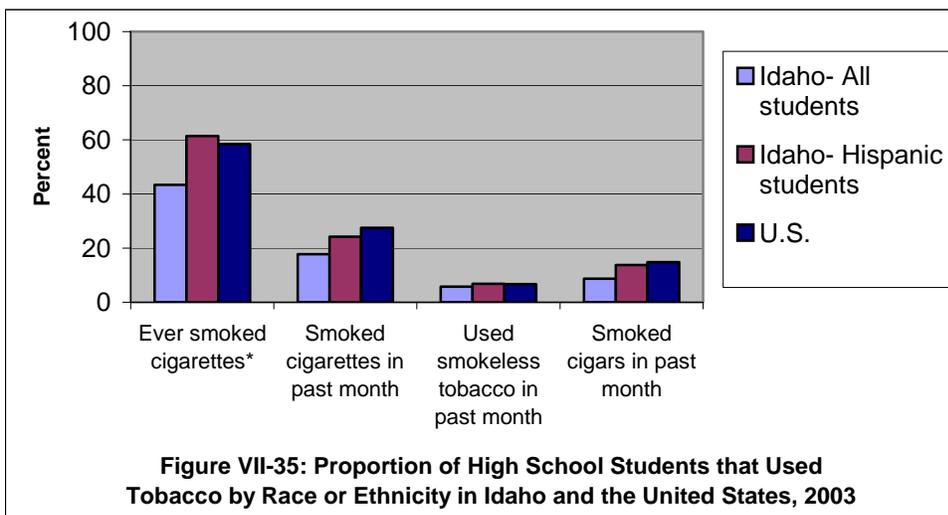
### *Substance use prevalence:*

Nationally, smoking among adolescents increased during 1990, peaking near 1995, but has since declined (Burns and Johnson, 2001). Idaho's adolescents have followed this trend, as the proportion of students who have ever smoked and the proportion who have smoked in the past 30 days have both significantly declined between 2001 and 2003. Moreover, 20 percent fewer Idaho students have smoked in their lifetime and 15 percent fewer Idaho students have smoked in the past month compared to the national averages (National Center for Chronic Disease Prevention and Health Promotion, 2004). Idaho has already met Healthy People 2010 goals for both of these smoking indicators. There were, however, some sex differences in tobacco use behaviors. While females were as likely as males to have smoked ever or to smoke cigarettes currently, females were significantly less likely than males to use smokeless tobacco and cigars (Figure VII-34).



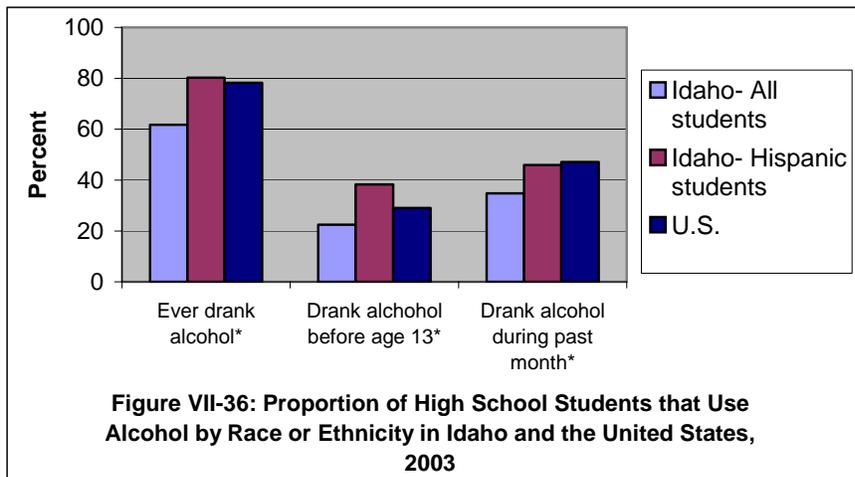
\*Indicates a significant difference between male and female students  
 Source: National Center for Chronic Disease Prevention and Health Promotion, 2004

Despite the overall decline in smoking among youth, sizeable racial and ethnic disparities have developed in smoking prevalence among America’s youth since the mid-1970s. White adolescents have been much more likely to smoke cigarettes than either Hispanic or Black adolescents (Burns and Johnson, 2001). In stark contrast, Idaho’s adolescents have experienced the reverse trend. Hispanics in Idaho were significantly more likely than all students to have ever smoked cigarettes in their lifetime and were equally likely to be current tobacco users (Figure VII-35).



\*Indicates a significant difference between Hispanic students and students of all races and ethnicities in Idaho  
 Source: National Center for Chronic Disease Prevention and Health Promotion, 2004

Adolescent alcohol use has declined steadily in the United States since the late 1990s (Idaho Department of Education, 2003a). Rates of adolescent alcohol use have been significantly lower in Idaho than in the Nation as a whole. During 2003, Idaho’s high school students were less likely to have ever drunk alcohol or to be current drinkers (Figure VII-36). In contrast, binge drinking, or consuming five or more drinks of alcohol on one occasion, has changed little among all adolescent ages since 1996 (Idaho Department of Education, 2003a) and is similar to the national average (National Center for Chronic Disease Prevention and Health Promotion, 2004). In 2003, nearly a quarter of Idaho high school students engaged in binge drinking (National Center for Chronic Disease Prevention and Health Promotion, 2004). Frequent binge drinking in adolescents is associated with poor school performance, a higher risk of experiencing an injury, and damaging property (Lyll, 1995). Interestingly, there was a significant regional difference in the prevalence of binge drinking, with 46 percent of Region I high school seniors engaging in binge drinking compared to just 25 percent in Region V (Idaho Department of Education, 2003a). There were no significant sex differences for any of these alcohol use risk behaviors (National Center for Chronic Disease Prevention and Health Promotion, 2004).



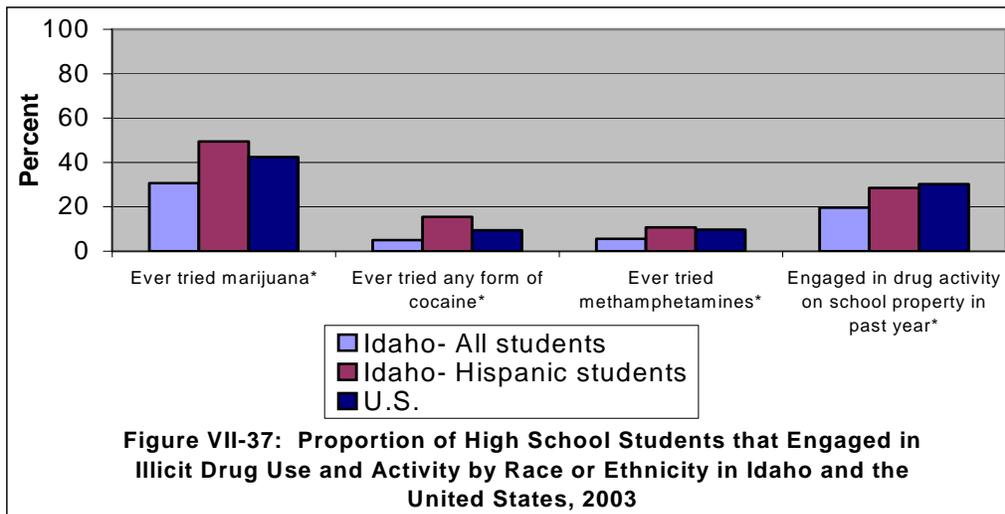
\*Indicates a significant difference between Hispanic students and students of all races and ethnicities in Idaho  
 Source: National Center for Chronic Disease Prevention and Health Promotion, 2004

Unlike the national trend, Hispanic students in Idaho were just as likely to engage in binge drinking as White students, 24 percent among all students (National Center for Chronic Disease Prevention and Health Promotion, 2004). Hispanic students were also significantly more likely to have drunk alcohol at some point during their lifetime, initiated drinking before age 13, and drank alcohol in the past 30 days (Figure VII-37). These figures mirror what Hispanic youth participants reported in our focus group. They perceived drinking alcohol to be particularly prevalent among Hispanic youth and indicated that drinking among their peers seemed to begin in the younger middle school grades.

Nationally, illicit drug use has declined since the mid-1990s (Centers for Disease Control and Prevention, 2004). In Idaho, drug use rates are at or below the national average across all types of drugs included in the YRBS. In particular, the proportion of Idaho students ever trying marijuana, one of the most frequently used drugs, was about 10 percent lower than the national average, and fewer Idaho students initiated marijuana use before age 13 and were current users in

2003 (National Center for Chronic Disease Prevention and Health Promotion, 2004). Students of all grade levels also perceived marijuana, cocaine, and methamphetamines as less easy to access than the national average did. For example, 58 percent of the nation’s high school seniors reported methamphetamines as “fairly/very easy to get” compared to just 31 percent of Idaho’s seniors (Idaho Department of Education, 2003a). In addition, Idaho students were less likely to engage in drug activity on school property than the national average, 20 percent compared to 29 percent (National Center for Chronic Disease Prevention and Health Promotion, 2004). There were no significant sex differences for any of these substance use risk behaviors (National Center for Chronic Disease Prevention and Health Promotion, 2004).

Similar to trends in alcohol use, there was also a significant regional variation in illicit drug use. Again, Region I had the highest proportion of adolescent drug users: 43 percent among high school seniors compared to only 21 percent in Region VI (Idaho Department of Education, 2003a). There were also significant disparities across racial and ethnic groups. Hispanic students were more likely to have used marijuana, cocaine, and methamphetamines ever or have engaged in drug activity on school property than White students in Idaho (Figure VII-37). Hispanic teens in our focus group perceived that over half of their peers use illicit drugs and often start using in middle schools. They indicated that marijuana, cocaine, “crystal meth,” and LSD are among the most popular drugs.



\*Indicates a significant difference between Hispanic students and students of all races/ethnicities in Idaho  
 Source: National Center for Chronic Disease Prevention and Health Promotion, 2004

***Treatment and Prevention Programs:***

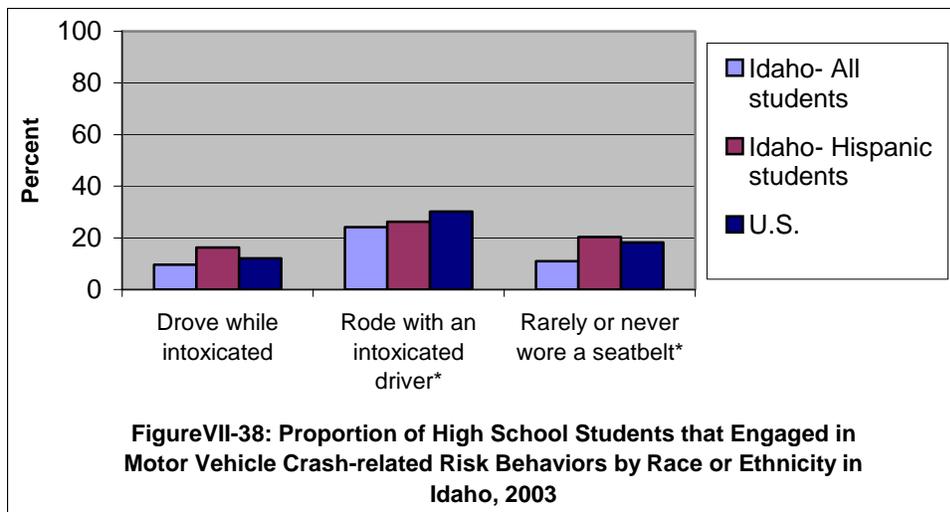
Among the students reporting substance use, relatively few adolescents appear to seek treatment for alcohol abuse. Marijuana was the most frequent primary drug of abuse, accounting for 41 percent of visits during 2001-2002. Nearly a third of clients sought treatment for alcohol abuse, representing the second most common primary drug of abuse. Less than 2 percent of the adolescents ages 15-19 years old reporting current alcohol use and/or engaging in binge drinking utilized public substance abuse treatment services for alcohol during 2001-2002. Methamphetamines were the third most frequent, accounting for 28 percent of visits. Excluding

alcohol, all other substances comprised only about 1 percent of public substance abuse treatment client visits. An important trend to note is that the number of methamphetamine visits has significantly increased in recent years. During 1999-2000, methamphetamine visits accounted for just 9 percent of total visits, but by 2001-2002, methamphetamine accounted for nearly 30 percent of visits, which were as common as alcohol visits. Intravenous drug users made up only 3 percent of visits (Substance Abuse Social Indicators, 2004). Overall, 75 percent of adolescent clients were enrolled in nonintensive outpatient programs. Over 80 percent of adolescent clients were between the ages of 15 and 17 (Substance Abuse Social Indicators, 2004).

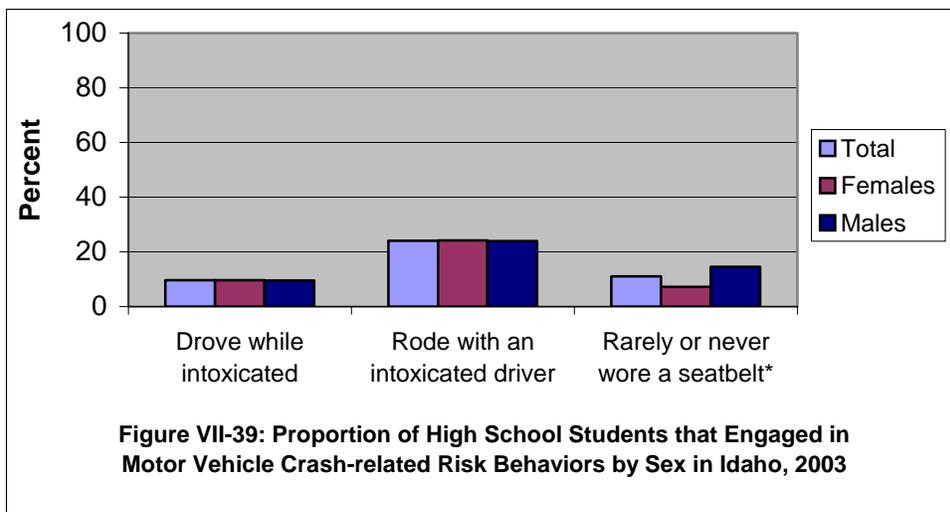
*iv) Injuries*

*Prevalence of injuries and risk behaviors:*

Two of the biggest risk factors for MVC-related mortality are drinking and driving and not wearing seatbelts. Idaho’s juvenile arrests for driving under the influence of alcohol (DUI) has recently exceeded the national average, with 1.7 arrests per 10,000 youths age 10-17 compared to just 0.6 arrests for the Nation during 2000 (Idaho Kids Count, 2003). Healthy People 2010 seeks to reduce the proportion of adolescents riding with an intoxicated driver to 30 percent. White students in Idaho have already met this goal, but 36 percent of Hispanic students currently ride in a vehicle driven by someone who had been drinking alcohol (Figure VII-38). There were no significant sex differences for this MVC-related risk behavior (National Center for Chronic Disease Prevention and Health Promotion, 2004). Healthy People 2010 also seeks to increase the proportion of youth that use seatbelts to 92 percent. White students are much closer to reaching this goal than are Hispanic students: 90 percent of White students use seatbelts compared to just 80 percent of Hispanic students (Figure VII-38). Male students were significantly more likely to wear seatbelts never or rarely than were female students (Figure VII-39).



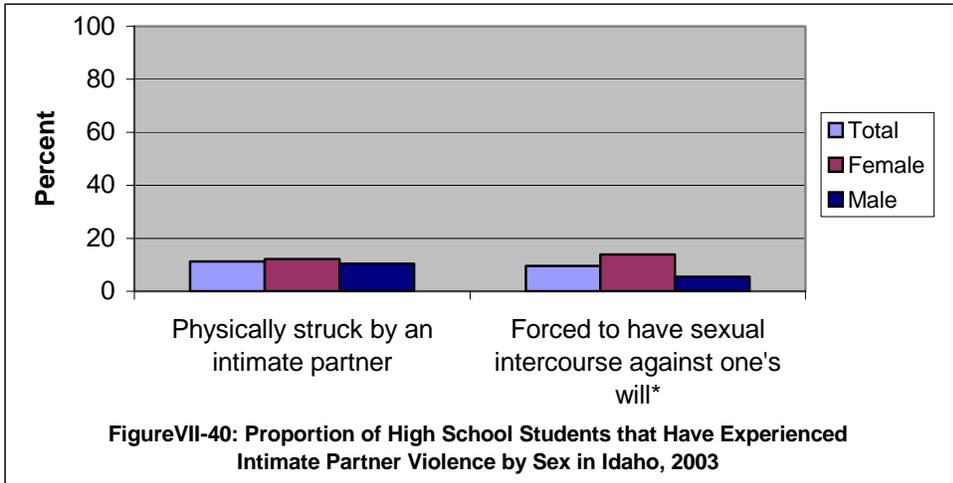
\*Indicates a significant difference between Hispanic students and students of all races and ethnicities in Idaho  
 Source: National Center for Chronic Disease Prevention and Health Promotion, 2004



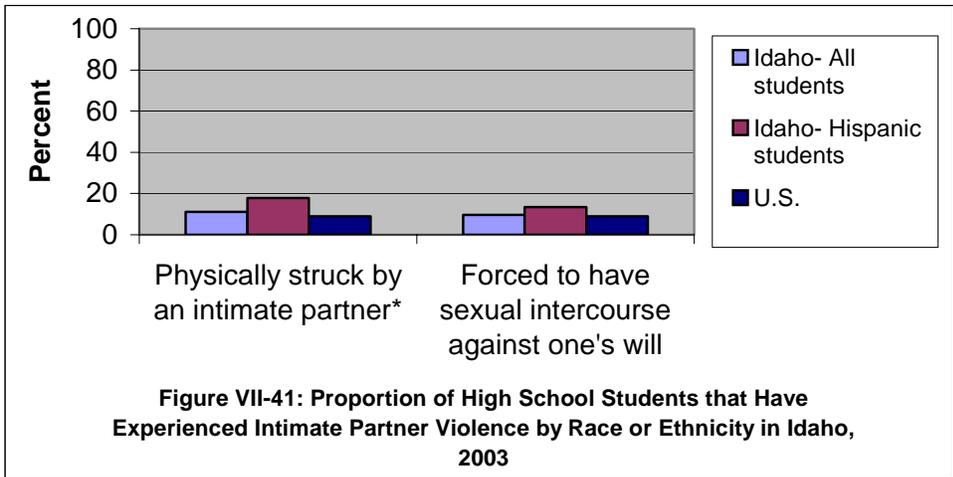
\*Indicates a significant difference between female and male students

Source: National Center for Chronic Disease Prevention and Health Promotion, 2004

Intimate partner violence (IPV) is a major problem among youth in America. All types of relationships, including those between same-sex partners, and both sexes can experience IPV. However, females in heterosexual relationships are thought to be the most common victims. It is estimated that between 20 and 30 percent of teen girls over age 13 have been physically, emotionally, or sexually abused by an intimate partner (Joyce, 2003). Pregnant adolescents are at particularly high risk for experiencing IPV, even higher than that of pregnant adults, and violence often continues into the postpartum period (Scheiman and Zeoli, 2003). However, a smaller proportion of adolescents indicate they have experienced IPV when surveyed. There were comparable numbers of students in Idaho and across the United States reporting they had been struck physically by an intimate partner, about 11 percent (National Center for Chronic Disease Prevention and Health Promotion, 2004). Interestingly, male students were just as likely to experience physical abuse by an intimate partner as were females students (Figure VII-40), which is similar to the national trend (National Center for Chronic Disease Prevention and Health Promotion, 2004). However, Idaho's female students were significantly more likely than male students to have been forced to have sexual intercourse against their will (Figure VII-40), similar to the national trend (National Center for Chronic Disease Prevention and Health Promotion, 2004). Hispanic students were equally likely to have been forced to have sexual intercourse against their will as students of all races and ethnicities but were significantly more likely to report being struck by an intimate partner (Figure VII-41).



\*Indicates a significant difference between female and male students  
 Source: National Center for Chronic Disease Prevention and Health Promotion, 2004

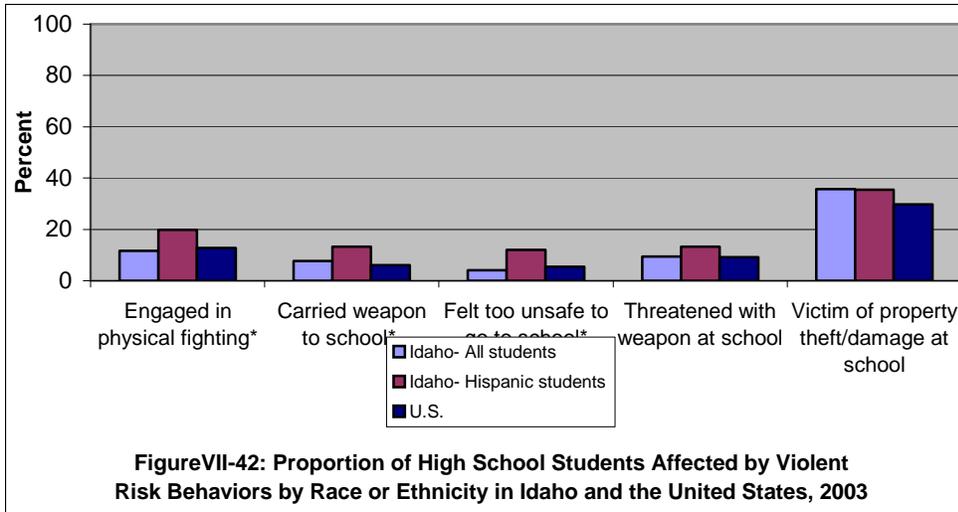


\*Indicates a significant difference between Hispanic students and students of all races and ethnicities in Idaho  
 Source: National Center for Chronic Disease Prevention and Health Promotion, 2004

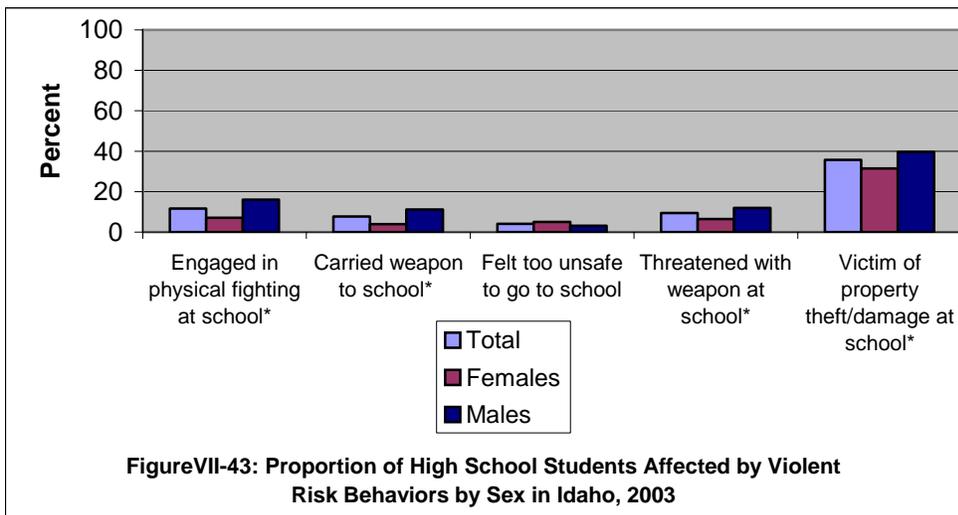
An even smaller proportion of adolescents reported incidents of IPV to official authorities. The majority of IPV victims reported in Idaho's police reports during 2003 were adult females ages 25-34, with juvenile female victims representing just 6 percent. Among the 20 percent of victims that were male, the majority were also adults between the ages of 25 and 44 years (Statistical Analysis Center, 2003). In addition, less than 1 percent of violent juvenile arrests were for forcible rape in 1997 (Idaho Department of Health and Welfare, 1999). It is important to note that these figures may represent a significant amount of underreporting, given that nationally only half of intimate partner violence incidents are reported to the police and even fewer such incidents, 40 percent, are estimated to be reported in Idaho (Statistical Analysis Center, 2003). Moreover, adolescent victims are even less likely than adult victims to report IPV incidents (Joyce, 2003).

Violence against nonintimate partners is also common among adolescents; nearly 900,000 youth ages 10-24 suffered injuries from violent acts nationwide in 2002. Homicide has become the second leading cause of death for Americans in this age group. The national homicide rate for adolescents ages 15-19 was 10.4 deaths per 100,000 in 1999 (Centers for Disease Control and Prevention et al., 2004). Idaho's adolescent homicide rate for this age group was much lower at 4.6 deaths per 100,000 in 2002 (Idaho Department of Health and Welfare, 2004g). The child firearm mortality rate in Idaho was higher than the national rate since the early 1990s, but began to decline in 1998. Idaho matched the national firearm mortality rate among children age 18 and under in 2000 at 2.2 deaths per 100,000 in 2000 (Idaho Child Mortality Review Team, 2003). Despite this lower risk of mortality from violence, Idaho's adolescents indicated they were just as likely to engage in a range of violent risk behaviors, such as physical fighting and carrying a weapon to school (Figure VII-42).

There were also important disparities among students that commit and are victims of violent behavior as well as their perception of violence. Hispanic students were significantly more likely to engage in violent risk behaviors than were White students, including carrying a weapon to school, skipping school because of feeling unsafe, and engaging in physical fighting on school grounds (Figure VII-42). The 2002 Idaho School Climate Survey asked all students about gang activity. Younger students were more than twice as likely to perceive gangs as causing trouble in their schools, with 26 percent of 6<sup>th</sup>-graders. Actual gang membership was highest in grades 8 and 10 and lowest in grades 6 and 12. Just 4 percent of 6<sup>th</sup>-graders reported gang membership, compared with 8 percent of 10<sup>th</sup>-graders. The Survey report did not stratify these responses by ethnicity, so it is unknown whether Hispanics are in fact more likely than other groups to join a gang. However, the Survey did indicate that between 28 and 41 percent of students, depending on grade level, felt that students of different races and ethnicities did not get along. Interestingly, younger students were more likely to report such racial and ethnic tension than did older students (Idaho Department of Education, 2003a). This may suggest that students learn to deal with each other's differences as they spend more time interacting with each other. Lastly, male students were significantly more likely than female students to have engaged in a number of violent risk behaviors, including physical fighting at school, carrying a weapon to school, being threatened with a weapon at school, and being the victim of property theft or damage (Figure VII-43).



\*Indicates a significant difference between Hispanic students and students of all races and ethnicities in Idaho  
 Source: National Center for Chronic Disease Prevention and Health Promotion, 2004



\*Indicates a significant difference between female and male students  
 Source: National Center for Chronic Disease Prevention and Health Promotion, 2004

Adolescents in Idaho that commit crimes may also be more likely to enter the criminal justice system. The juvenile arrest rate among 10- to 17-year-olds in Idaho has consistently exceeded the national average since the early 1990s. In 2000, Idaho's juvenile arrest rate was 11.1 per 1,000, while the national average was only 7.3 per 1,000 (Idaho Kids Count, 2003). Evaluation of the juvenile arrest statistics indicated that violent crimes only comprised a small minority, 9 percent in 1997 (Idaho Department of Health and Welfare, 1999). Among violent arrests, the majority were simple assaults (72 percent). Weapons arrests comprised just 12 percent of the violent arrests, and the numbers have declined 25 percent between 1995 and 1997.

### ***What Did Adolescents Say?***

*During the focus groups, Hispanic teens felt there was a high level of gang involvement among Hispanic youth, including males and females. Most indicated that coming from a recent immigrant experience, Hispanic youth often joined gangs to combat feelings of alienation and to find a place where they felt they belonged. Moreover, participants believed their peers joined gangs as early as 8 years old. Much of the gang experience is shaped by violence, such as drive-by shootings, and is driven by rivalry and sometimes racial tension with other gangs. Participants also felt that drugs and alcohol often exacerbated this kind of violent behavior.*

#### **v) *Prevention Services and Help***

The IDHW has focused on two main injury prevention areas, unintentional injuries and sexual violence prevention. Idaho's Unintentional Injury Prevention Program currently focuses on reducing injuries caused by falls among older adults over age 65 (Idaho Department of Health and Welfare, 2005b). There is no similar focus on reducing the most common causes of unintentional injuries among children and adolescents. IDHW also operates the Sexual Violence Prevention Program to reduce the statewide incidence of sexual violence by seeking to change knowledge, attitudes, and behaviors. One of the activities includes a statewide health promotion campaign that includes rape prevention commercials, which are aired on radio stations. Some of these aids are male-focused to complement the "Engaging Men" component to help prevent abuse before it starts or to encourage male abusers to seek treatment. IDHW has also funded a number of programs created by Idaho's universities, such as activities for Sexual Assault Awareness Month. Lastly, IDHW supports a number of youth-specific, peer-led activities in schools to promote safe relationships (Idaho Department of Health and Welfare, 2005c).

The Idaho Council on Domestic Violence and Crime Victim Assistance oversees shelters, safe houses, hotlines and other support services to assist IPV victims. IPV victim data stratified by age could not be located for this report, so it is unknown how many adolescents use these services. However, this number has likely increased in recent years. The number of crisis calls received by the Council has more than tripled between 1986-1987 and 2000-2001. The number of clients served at shelters has also increased, 2210 individuals were served in 2000-2001 (Idaho Council on Domestic Violence & Crime Victim Assistance, 2003).

There are a number of community-based programs to prevent violence in youth. The Idaho Youth Ranch is one of the largest organizations offering separate programs, including group homes, family services, adoption services to all children and families in Idaho. The Idaho State University Institute of Rural Health also operates Red Flags Idaho, which helps parents identify emotional and behavioral problems in their children before serious problems arise (Idaho CareLine, 2005).

#### **5. *Adolescent children obtain the health and lifestyle information and education that support lifelong positive health behaviors.***

In addition to health services, adolescents also benefit from timely and comprehensive health education to help them avoid health risks and make more positive decisions. One of the most important providers of health education is schools. Health promotion campaigns also offer

valuable information to youth. Together, these education services can help Idaho's youth lead more health-promoting lives.

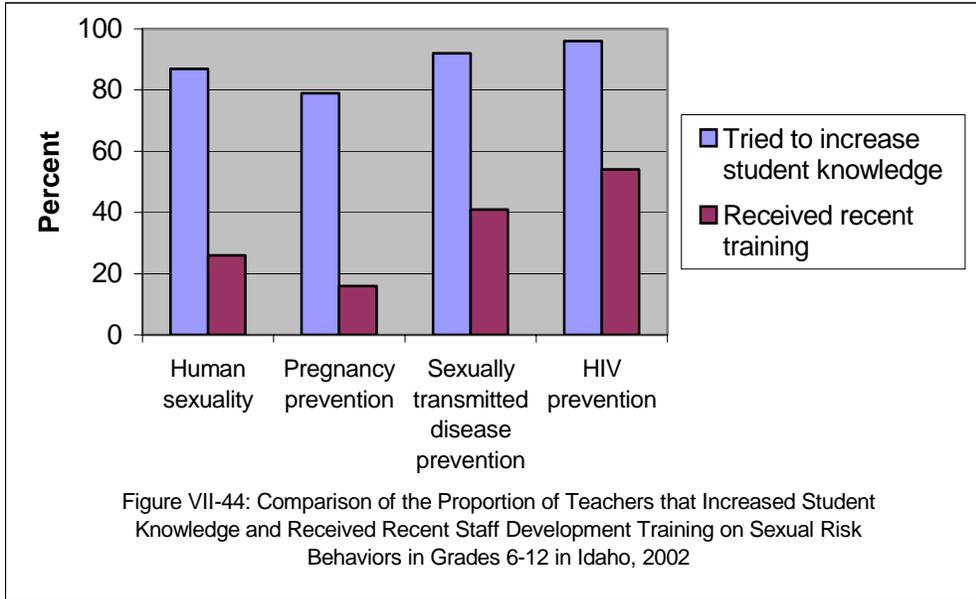
Idaho's schools have a health education coordinator at the State level. About half of schools, 49 percent, required students to have at least one health education course in 2002 (Idaho Department of Education, 2003b). Schools are required to teach the following standards to students in grades 7-12:

- Acquire the essential skills to lead a healthy life.
- Demonstrate the ability to practice health-enhancing behaviors and reduce health risks.
- Demonstrate the ability to use communication to enhance health.
- Organize, analyze, and apply health information practices and services appropriate for individual needs.
- Understand and demonstrate the key components to positive mental and emotional health (Idaho State Board of Education, 2003).

SHEPS is administered to school principals and lead health education teachers in middle and high schools to monitor the current status of school health education. Results from Idaho's 2002 SHEPS are presented in the following sections.

#### **a. Sex Education**

Among schools with a required health education course, over 75 percent of teachers taught students about human sexuality and pregnancy, STI, and HIV prevention in 2002 . However, a much smaller proportion of teachers reported receiving staff development training during the past 2 years concerning each of these topics. Specifically, 41 percent received recent training regarding human sexuality, 26 percent regarding STI prevention, and 16 percent regarding pregnancy prevention. Over half of these lead education teachers expressed that they would like to receive more training on each of these topics (Idaho Department of Education, 2003b). The majority of lead health education teachers have received recent HIV prevention training, 54 percent (Figure VII-44).



Note: Recent staff development must have been offered in the past 2 years.  
 Source: Idaho Department of Education, 2003b

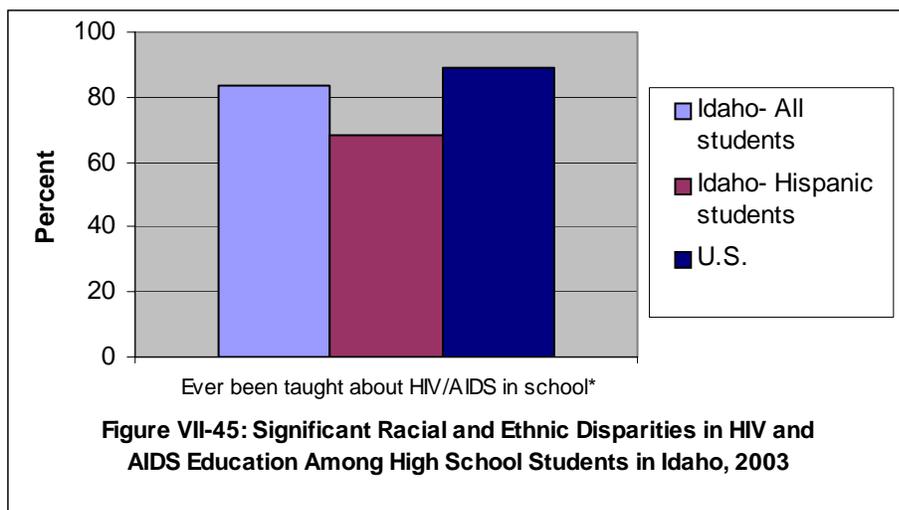
Interviews with school health officials indicated that students in middle and high schools are taught about abstinence as a viable method to prevent pregnancies but are not taught about contraceptives such as birth control pills, patches, and injections. In line with school policy, the Idaho Governor’s Council on Adolescent Pregnancy Prevention (IGCAPP) has also chosen to focus solely on reducing teen pregnancy in Idaho by “increasing the number of teens choosing abstinence” (Association of Maternal and Child Health Care Programs, 2004). Since 1994, IGCAPP has established 27 community coalitions across the State and launched a media campaign that has reached over 90 percent of residents between the ages of 10 and 54. The proportion of teens reporting that these ads influence their behavior has increased from 28 percent in 1996 to 61 percent in 2000. Similarly, the proportion of parents reporting that these ads prompted discussion with their teens about sex increased in the same period of time to from 38 percent to 50 percent (Association of Maternal and Child Health Care Programs, 2004).

Abstinence-only education in schools and the statewide IGCAPP abstinence campaign has likely contributed to helping Idaho move closer to reaching the main Healthy People 2010 goal for sexual intercourse: to increasing the proportion of adolescents aged 15-17 years who have never engaged in sexual intercourse to 75 percent (Centers for Disease Control and Prevention, 2004). During 2003, about 64 percent of Idaho’s high school students reported never having had sexual intercourse (National Center for Chronic Disease Prevention and Health Promotion, 2004). It is important to note that Healthy People 2010 has created additional goals to increase formal instruction about birth control methods and barrier methods of preventing STIs in schools before students reach the age of 18 (Centers for Disease Control and Prevention, 2004).

The IGCAPP campaign does not address either of these topics. Health officials also indicated that only high school students are taught that condoms can be used to prevent infection. Middle school students are taught about the existence of STIs and how these infections are spread but

not about methods of protection. Therefore, younger adolescents may lack critical knowledge to protect themselves from STIs if they choose to become sexually active.

The majority of high school students in Idaho have received some HIV and AIDS education in schools, but this figure is still slightly lower than the national average (Figure VII-45). Hispanic students were particularly at risk for being undereducated about sexual risk behaviors, with 16 percent fewer Hispanic students reporting they had received HIV and AIDS education. When lead health education teachers were asked about what types of HIV prevention topics were covered, 95 percent indicated they taught that abstinence is the most effective way to avoid HIV infection, but only 60 percent discussed the efficacy of condoms in preventing HIV. Moreover, just 20 percent of teachers described to their students how to use a condom correctly (Idaho Department of Education, 2003b).



\*Indicates a significant difference between Hispanic students and students of all races and ethnicities in Idaho  
 Source: National Center for Chronic Disease Prevention and Health Promotion, 2004

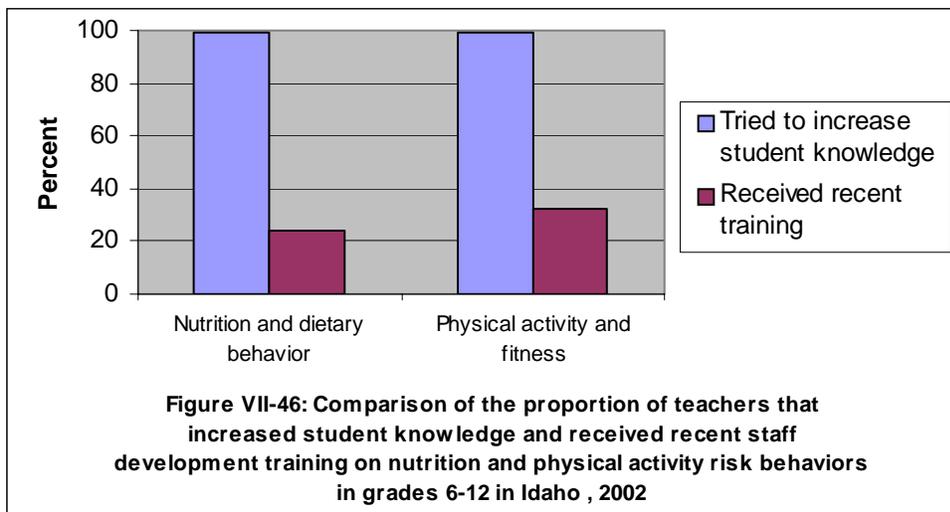
As previously mentioned, there is a lack of data regarding the use of birth control and barrier protection against STI infection among Idaho’s youth. In addition, there are also virtually no data regarding the frequency of noncoital sexual behavior and the use of STI protection when engaging in such behaviors. Noncoital sexual behaviors may include mutual masturbation, oral sex, or anal intercourse. Without this data, it is unknown how many of Idaho’s youth engage in these practices and may be at risk for STI infection.

**b. Nutrition and Physical Education**

Schools have become a much more important part of children’s daily diets, as over 50% of school-age children across the country participate in the USDA’s school meal programs. During the 2003-2004 school year, 31% of all K-12 students in Idaho received free lunch and another 11% received reduced lunch (Idaho Department of Education, 2004). However, school children

now also have greater access to alternative food selections, which are collectively called “competitive foods” by the USDA, than ever before. Competitive foods have been shown to be high in fat, sugar, and calories, but low in essential nutrients (Food & Nutrition Service, 2001). Access to vending machines ranges from 27% in elementary schools to 96% in high schools and access to fast food providers ranges from 16% to 26%, respectively (Anderson et al., 2003). As a result, these Federal school meal programs are no longer the primary provider of food to America’s students. During 2002, 89% of Idaho’s middle and high schools had vending machines where students can purchase snack foods and beverages (Idaho Department of Education, 2003b).

Action for Healthy Kids State (AFHK) is a nationwide initiative that seeks to improve nutrition and physical education in schools. In 2004, Idaho’s AFHK State Team developed “Idaho Recommendations for Promoting a Healthy School Nutrition Environment” to help ensure that all food served in Idaho’s schools meet USDA’s dietary guidelines. These recommendations, endorsed by the State Superintendent of Public Instruction, includes guidelines for both vending machines and a la carte sales as well as a list of 150 recommended nutritious snack foods (Idaho Department of Education, 2004b). School compliance with these recommendations is currently voluntary. In addition, health education teachers cover dietary and fitness topics in required health education course. The large majority of health education teachers have tried to increase student knowledge on both nutrition and physical activity in 2002. However, a much smaller proportion, less than 40%, of teachers have received recent staff development training (Figure VII-46).



Note: Recent staff development must have been offered in the past 2 years.  
 Source: Idaho Department of Education, 2004b

Many schools in Idaho receive Nutrition Education and Training Grants, which serve students, parents, teachers, and food service personnel. Participants receiving training learn about the nutritional value of foods and the relation between food and health. Food service personnel are also encouraged to use an innovative approach to increase nutrition awareness in the cafeteria. In 2002-2003, the Idaho Department of Education trained 1,509 participants (Idaho Department of Education, 2004). Despite these efforts, Idaho’s schools continue to lack a food service coordinator at the State level, compared to 97 percent of States across the Nation that currently

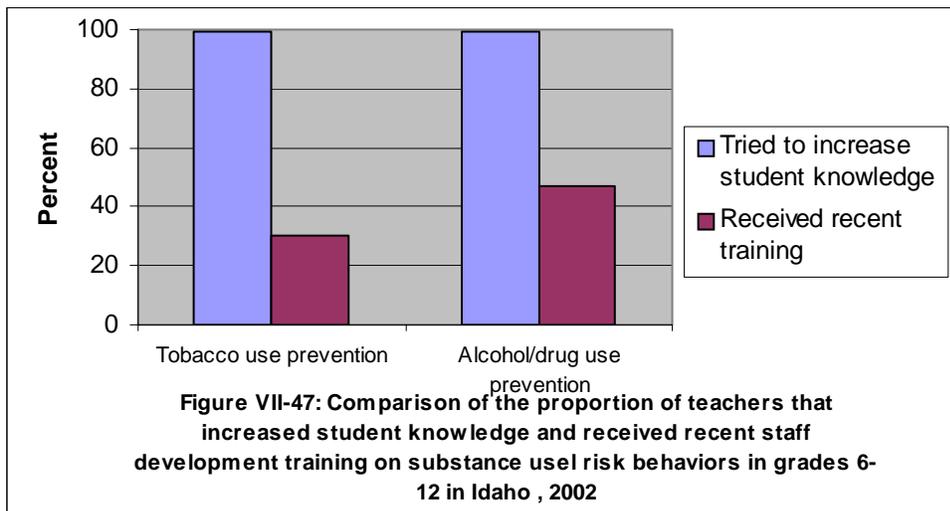
have such coordinators (Hayes et al., 2004). State funding for nutrition education has also recently been in jeopardy in Idaho, as more emphasis has been placed on strengthening basic education, like math and science (Action for Healthy Kids, 2002).

Idaho also does not have a state physical education coordinator, compared to 69% of states across the nation (National Center for Chronic Disease Prevention and Health Promotion, 2001). In addition, there are no state standards for physical education content. Students in grades 1-8 are required to participate in physical education, but there are no minimum time requirements. Also, students in grades 9-12 are offered physical education, but are not required to participate (American Council for Fitness and Nutrition, 2005). There has also been a de-emphasis on physical education in schools by the Idaho Department of Education because of a desire to redirect resources to basic education. There is currently no state funding for physical education, while funding at the school level has recently been decreased (Action for Healthy Kids, 2002).

**c. Substance Use Education**

*i) Tobacco*

The vast majority, 98 percent, of Idaho’s middle and high schools have adopted a policy to prohibit cigarette smoking by students on school grounds. Among schools that require a health education course, 99 percent tried to increase student knowledge on tobacco use prevention (Figure VII-47). However, just 30 percent of health education teachers received tobacco use prevention training in the past 2 years, although 61 percent indicated that they would have liked to receive such training (Idaho Department of Education, 2004b).



Note: Recent staff development must have been offered in the past 2 years.  
 Source: Idaho Department of Education, 2004b

The majority of youth in Idaho appear to recognize the enormous health risks of smoking. During 2003, Idaho’s youth were equally knowledgeable about the health risks of smoking across all grade levels to the national average. By grade 12, nearly three-quarters of Idaho’s students perceived smoking a pack of cigarettes daily as a “great risk” (Idaho Department of

Education, 2003a). Another important measure of tobacco use knowledge is the proportion of students that currently use tobacco that attempt to quit. Healthy People 2010 has established a goal to increase tobacco use cessation attempts by adolescent smokers in grades 9-12 to 84 percent. Unfortunately, Idaho has yet to meet this goal, as only 53 percent of Idaho's youth smokers had tried to quit in the last year during 2003 (National Center for Chronic Disease Prevention and Health Promotion, 2004).

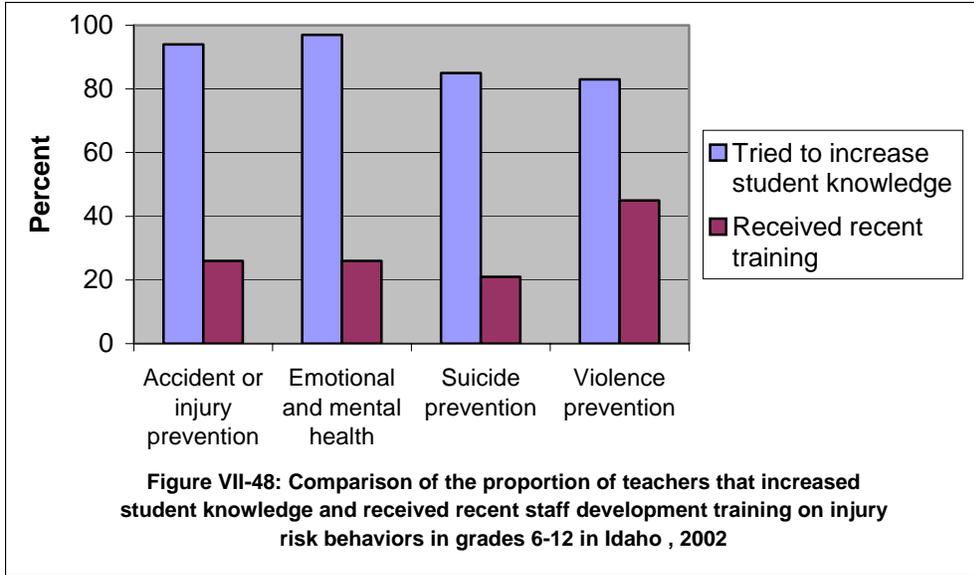
#### *ii) Alcohol and Illicit Drug Use*

All of Idaho middle and high schools in Idaho prohibit alcohol and illicit drug use on school grounds (National Center for Chronic Disease Prevention and Health Promotion, 2001). Among schools that require a health education course, 99% of teachers tried to increase students' knowledge on alcohol or other drug use prevention. Nearly half, 47%, of health education teachers received alcohol and drug use prevention training in the past two years (Idaho Department of Education, 2003b).

One of the riskiest substance use behaviors is binge drinking, particularly because youth may not be aware of its health risks. In a national study, 91 percent of women and 78 percent of the men who were frequent binge drinkers considered themselves to be moderate or light drinkers (Lyall, 1995). The lack information about the seriousness of binge drinking may be even greater among Idaho's youth. Fewer middle and high school students in Idaho perceived themselves at "greater risk" of harm by binge drinking than did most American students. This was especially true among younger students, only 38% of Idaho 8<sup>th</sup> graders found binge drinking to be a risky health behavior, compared to 57% nationwide. This disparity in health knowledge is particularly alarming given the increasing numbers of younger students who report drinking at an earlier age than do older students (Idaho Department of Education, 2003a).

#### *d. Injury Prevention Education*

All of Idaho's middle and high schools have a range of policies to prevent violence from taking place among students on school grounds, including prohibiting school fighting, weapons possession, gang activities, and harassment of other students (Idaho Department of Education, 2003b). In addition, 53 percent of schools have uniformed police, undercover security, or security guards to prevent and respond to student violence (Idaho Department of Education, 2003b). Among schools requiring health education courses, teachers have tried to increase student knowledge on both unintentional and intentional risk behaviors (Figure Vii-48). However, there was a particularly large disparity in the proportion of health education teachers reporting they had received training on these health topics in the past two years. For example, only a quarter of teachers indicated they received recent accident or injury prevention training, although 48 percent indicated they would have liked to receive it (Idaho Department of Education, 2003b). Similarly, 45 percent of teachers received recent violence prevention training, but 80 percent of teachers would have liked to receive it.



Note: Recent staff development must have been offered in the past 2 years.  
 Source: Idaho Department of Education, 2003b

**Summary**

Although children and adolescents in Idaho were equally likely to be insured as the rest of the national population, they had less access to a number of basic and specialized health services. Idaho’s children are less likely to have a regular primary care provider, receive EPSDT screenings if enrolled in Medicaid, or be up to date on all vaccinations recommended by the CDC. There is also a need for State officials to respond to rising national health issues such as the childhood obesity epidemic, the continuing high rates of unintentional injuries among children, and the rising rates of STIs among adolescents. Moreover, Idaho has relatively low levels of committed funding to a range of child and adolescent services, particularly subsidized child care and mental health services, compared to the Nation as a whole, which has only increased already high unmet needs.

Fortunately, Idaho has undertaken a number of recent initiatives to address some of these issues and has increasingly used the Healthy People 2010 objectives to guide policy and health promotion issues. Among the strongest of these initiatives has been the creation of statewide taskforces that promote a high level of collaboration and communication between State agencies, healthcare providers, community groups, and other stakeholders to address complex problems. Taskforces have recently been started to target asthma, mental health, oral health, and child care. Still, there is much more that can be done to strengthen the MCH system to address better the needs of children and adolescents in Idaho.

## Idaho Child Outcomes

### **Children receive ongoing and preventive health care consistent with the Bright Futures Health Supervision Guidelines.**

#### **Summary**

- Children in Idaho are more likely to lack a medical home than the national average.
- A significant proportion of children are eligible for public programs but are not currently enrolled.
- Idaho has created a number of statewide initiatives that promoted a great deal of interagency collaboration to address many children's issues in Idaho.
- A number of emerging children's health issues have yet to receive sufficient government attention, including childhood obesity, diabetes, and hypertension.
- There is a lack of data available to measure the extent of some health risks and childhood conditions.

#### **Analysis**

- The recent CHIP expansions can increase enrollment in public insurance, but only with adequate outreach and advertisement. Health insurance is one of the primary means of access to medical homes.
- More support and coordination of services is needed to increase children's access to primary care. Much of this can be achieved by enhancing the existing health infrastructure, such as increasing outreach to enroll more eligible children in Medicaid and CHIP or increasing the number of children that receive their regular EPSDT screenings.
- Programs like Head Start and EPSDT help identify health problems early on, often when treatment is likely to be the most effective.
- State agencies must address emerging health issues with primary prevention strategies before they become major problems in the child population.
- Some of the difficulty in responding to children's health issues stems from the lack of adequate data to describe their unique health risks. Existing data is often not stratified by age or excludes certain children altogether.

### **Children are cared for in environments that protect health, promote their well-being, and ensure their safety.**

#### **Summary**

- There is not enough investment at the State level to support early childhood development and education.
- Existing early childhood programs do not provide children and families with same benefit levels compared to the rest of the nation.
- Older children also need more educational opportunities once they finish high school.
- Support for school-based health services has significantly declined in recent time.
- There was substantial regional variation in the adequacy of child maltreatment services.
- Idaho has sustained higher-than-average child mortality rates due to unintentional injuries and suicide over the past decade

## Idaho Child Outcomes

### Analysis

- Early childhood programs are not reaching all children in need of these services. The strict eligibility requirements restrict a number of near-poor families that cannot afford to pay for child care and preschool on their own. The lack of a State-funded preschool program could significantly improve access to critical early learning skills for Idaho's young children.
- Child care homes and facilities also are in need of increased standards to increase the quality of care received, while child care staff could benefit from more widely available training opportunities.
- There is a need for more higher education opportunities for older adolescents to help break the cycle of poverty that many individuals find themselves in and to help provide a better future for their families.
- The State's child maltreatment services need to be unified into a strong system that provides adequate and timely responses to maltreatment reports in all areas of the State. Moreover, child protection agencies must work to ensure that victims ultimately end up in stable homes, even if this home is not with their parents.
- Although there has recently been a statewide taskforce to address adolescent suicide, no similar taskforce has been established to address unintentional injuries among children. Much of the increased risk of injury among children is due to MVC. MVC injuries may be prevented by stricter seatbelt enforcement, drinking and driving awareness campaigns, and similar actions.

### **Families have access to and use services that strengthen parenting skills appropriately.**

#### Summary

- Although there are a number of parenting programs available in Idaho, there is a great deal of regional variation in the number and type of programs offered.
- Even when parenting programs are available, many parents indicated that they were unaware of them or how to search for such programs.
- Some programs also charged a fee, which may be a deterrent for many low-income families in need of these services.

#### Analysis

- Parenting programs appear to be organized at the local and community levels but really are organized at the State level. Collaborating at the State level could help ensure that a range of parenting services are offered in all regions and that they are offered at a sliding-scale fee for low-income participants.
- Parenting services need much more advertisement to alert families about their availability and to alert them how helpful they can be.

## **Adolescent children use ongoing health services appropriate to their stage of growth and development.**

### **Summary**

- Overall, adolescents in Idaho were less likely to engage in a number of risk behaviors than the national average.
- Idaho's Hispanic adolescents, however, were much more likely than White adolescents to engage in most risk behaviors included in surveys.
- Non-HIV STI rates have increased in recent years among Idaho's adolescents.
- There was lack of data regarding the proportion of youth that have been tested for STIs.
- There was a general lack of data describing the proportion of children in need that receive services.

### **Analysis**

- Idaho should consider establishing school-based health centers to deliver health services to students. These centers increase access to medical homes among school-age children, can provide more effective care coordination and comprehensive services to children with chronic conditions, and help complement health education curriculums.
- The large number of ethnic and racial disparities in health risk behaviors highlights the need to develop a comprehensive strategy to address these disparities at the State level. In particular, a dedicated commitment to cultural competency is likely needed to effectively communicate health messages to at-risk population groups. In addition, many of these risk behaviors may go beyond health education and require interventions targeted at minority families.
- Without data describing rates of STI testing, it will not be possible to determine if the recent increase in rates is the result of an actual increase in new infections or an increase in the proportion of youth that got tested. In addition, to comprehensively evaluate adolescents' risk of STI infection, it will be necessary to begin collecting data regarding all types of sexual risk behaviors, especially the use of barrier protection.
- STI prevention efforts in Idaho appear to be very general and do not adequately focus on sexual behavior risks among adolescents. In particular, youth appear to be most at risk for STIs other than HIV, which has received the majority of attention.
- Existing program data is not as useful as it could be. The data needs to relate service utilization to the need for those services.

## **Adolescent children obtain the health and lifestyle information and education that support lifelong positive health behaviors.**

### **Summary**

- Only half of Idaho's middle and high schools currently requires students to receive at least one health education course.
- Nutrition and physical education have recently faced budget cuts in favor of a greater focus on basic education.
- Although most required health education courses do cover a broad range of topics, the majority of health education teachers have not received recent training on many of these health topics.
- There is a lack of data describing contraception and barrier protection use among sexually active youth.
- There are currently no statewide initiatives to address the high rate of unintentional injuries and associated risk behaviors in Idaho's youth

### **Analysis**

- Health education is an important component of adolescents' educational experience. Students who engage in risk behaviors are more likely to perform poorly in school and to miss school. Therefore, it is critical that school education teachers receive adequate support at the State level and be widely accessible to all students.
- Health education teachers need regular training to ensure that they provide students with the most accurate and up-to-date health information possible. Similarly, regular training also often provides teachers with the updates and more effective ways of communicating health education messages.
- It is important to collect data measuring the full range of health risk behaviors, including all sexual risk behaviors, to evaluate whether youth are internalizing health education messages.