

State of Connecticut
Department of Public Health

Preventive Health and Health
Services Block Grant
Allocation Plan
FFY 2006

July 2005

PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT FFY 2006 ALLOCATION PLAN

TABLE OF CONTENTS	PAGE
I. Overview of the Preventive Health and Health Services Block Grant	
A. Purpose	1
B. Major Uses of Funds	1
C. Federal Allotment Process	2
D. Estimated Federal Funding	2
E. Estimated Expenditures and Proposed Allocations	3
F. Proposed Allocation Changes from Last Year	3
G. Contingency Plan	3
H. State Allocation Planning Process	4
I. Grant Provisions	5
II. Budget and Program Objectives Tables	
Table A Summary of Appropriations and Expenditures	6
Table B Program Expenditures	7
Tables C-L Individual Program Expenditures	7-12
Table M Summary of Program Objectives and Activities	13-18
III. Summary of Major Program Categories	
A. Cancer Prevention	19
B. Cardiovascular Disease Prevention	26
C. Childhood Lead Poisoning Prevention	35
D. Emergency Medical Services (EMS)	40
E. Local Health Departments	48
Table O - Summary of Local Health Department Contractual Funding	50
F. Rape Crisis	51
G. Surveillance and Evaluation	56
H. Unintentional Injury Prevention	59
I. Intimate Partner Violence Prevention	66
J. Youth Violence/Suicide Prevention	70
IV. Summary of Program Expenditures by Sub-Category	
Table P - Summary of Program Expenditures by Sub-Category	79

I. Overview of the Preventive Health and Health Services Block Grant

A. Purpose

The Preventive Health and Health Services Block Grant (PHHSBG) is administered by the United States Department of Health and Human Services through its administrative agency, the Centers for Disease Control and Prevention (CDC). The Connecticut Department of Public Health (DPH) is designated as the principal state agency for the allocation and administration of the PHHSBG within the State of Connecticut.

The PHHSBG, under the Omnibus Reconciliation Act of 1981, Public Law 97-35, as amended by the Preventive Health Amendment of 1993, Public Law 102-531, provides funds for the provision of a variety of public health services designed to reduce preventable morbidity and mortality, and to improve the health status of targeted populations. Priority health problems and related resource capacity of states vary. For that reason, Congress, in 1981, redirected the funding previously awarded through six separate categorical public health grants to the newly created PHHSBG. The PHHSBG affords each state much more latitude in determining how best to allocate their federal funding than the categorical grants it replaced.

B. Major Uses of Funds

The Preventive Health Amendment of 1993 revised substantial portions of the initial legislation, specifically the manner in which services must be classified and evaluated. The basic portion of the PHHSBG **may** be used for the following:

1. Activities consistent with making progress toward achieving the objectives in the national public health plan for the health status of the population for the Year 2010, also known as Healthy People 2010. All PHHSBG-funded activities and budgets must be categorized under selected Year 2010 chapters and related risk reduction objectives.
2. Rodent control and fluoridation programs. Connecticut does not use funds for either of these services.
3. The planning, establishing and expanding of emergency medical services systems. Amounts for such systems may not be used for the costs of the operation of the systems or for the purchase of equipment for the systems, other than for the payment of not more than 50 percent of the costs of purchasing communications equipment for the systems.
4. Providing services for victims of sex offenses.
5. Planning, administration and educational activities related to items 1 through 3.
6. Monitoring and evaluation of items 1 through 5.

Besides the basic award, each state's total PHHSBG award includes one mandated sex offense allocation: the Sex Offense Set-Aside, which may only be used for providing services to rape victims and for rape prevention.

The PHHSBG funds cannot be used for any of the following:

1. provide inpatient services;
2. make cash advances to intended recipients of health services;
3. purchase land, buildings or major medical equipment;
4. provide financial assistance to any entity other than a public or non-profit private entity; or
5. satisfy any requirements for the expenditure of non-federal funds as a condition for the receipt of federal funds.

Additionally, 31 U.S.C. Section 1352, which went into effect in 1989, prohibits recipients of federal funds from lobbying Congress or any federal agency in connection with the award of a particular contract, grant, cooperative agreement or loan. The 1997 Health and Human Services Appropriations Act, which became effective October 1996, expressly prohibits the use of appropriated funds for indirect or "grass roots" lobbying efforts that are designed to support or defeat legislation pending before the state legislature.

No more than 5 percent of the award may be spent on the administration of the grant. The administrative costs for the 2006 PHHSBG budget represents only 4.3 percent of the estimated FFY 2006 award.

States are required to maintain state expenditures for PHHSBG-funded services at a level not less than the average of the two-year period preceding the grant award. The state's funding for individual programs can change as long as the aggregate level of state funding for all programs is maintained. Connecticut's estimated 2006 Maintenance of Effort (MOE) is \$3,280,000. The MOE total includes state-funded personnel costs, contractual funding and other expense funds directed at the attainment of the Health Status Objectives funded by the PHHSBG.

Because of the DPH's desire to fund priority health areas identified in the agency's *Looking Toward 2010 -- An Assessment of Health Status and Health Services*, the 2006 PHHSBG basic award will support the following prevention programs: Cardiovascular Disease, Cancer, Intentional Injuries (Youth Violence/Suicide and Intimate Partner Violence), Emergency Medical Services, Surveillance/Monitoring, and Childhood Lead Poisoning. The 2006 PHHSBG basic award will also provide for contractual funding to Local Health Departments that target the following priority health areas: cardiovascular disease (including obesity), cancer (including Lung Cancer in Women, Skin Cancer and Cancer Planning), the non-intentional injuries of motor vehicle accidents and falls, and surveillance/monitoring. The mandated Sex Offense Set-Aside portion of the block grant will fund rape crisis services and education.

C. Federal Allotment Process

Each state's share of the total federal basic PHHSBG appropriation is based upon the amount of funding it received in 1981 for the six categorical grants that the PHHSBG replaced: Health Education/Risk Reduction, Hypertension, Emergency Medical Services, Fluoridation, Rodent Control and Comprehensive Public Health. For Connecticut, the FFY 2005 basic appropriation was \$1,687,093. (The CDC reduced the FFY 2005 basic appropriation by \$210,312 from the previous year.) The mandated Sex Offense Set-Aside portion of the PHHSBG is based on the State's population. Connecticut receives \$83,396 (or 1.2%) of the total federal funding reserved for the Sex Offense Set-Aside award.

D. Estimated Federal Funding

Connecticut's 2005 PHHSBG award was reduced by \$210,312, providing total funding of \$1,770,489. The 2006 estimate is predicated on the assumption of level funding for each of the two separate PHHSBG appropriations:

Basic Award	\$1,687,093
Sex Offense Set-Aside	<u>\$ 83,396</u>
Total 2004 Estimated Award	\$1,770,489

E. Estimated Expenditures and Proposed Allocations

The estimated expenditures of \$2,009,492 in FFY 2005 utilize \$239,003 of the balance forward from prior years to supplement the \$1,770,489 award. A total of \$112,266 of the balance forward will supplement the \$1,770,489 estimated federal allocation for the proposed FFY 2006 budget of \$1,882,755. This would leave an estimated \$849,091 in a balance forward to fund cost increases in future years. The balance forward during the previous years is the result of unfilled budgeted positions and unexecuted contracts with local departments of public health.

As in FFY 2002-2005, there is State funding in FFY 2006 for some of the programs supported by the Preventive Health and Health Services Block Grant. These estimates are: Local Health Departments - \$71,585; Intimate Partner Violence - \$11,041; and Youth Violence Prevention - \$46,706.

F. Proposed Allocation Changes From Last Year

The reduced expenditures in the FFY 2006 budget reflect the net of annual increases in salary resulting from contractual pay scales and related fringe charges, budget cuts of three positions (1-EMS, 1-Local Health, 1-Surveillance) and the elimination of "Grants to Councils" in the EMS program budget. The health priorities and program categories for SFY 06 (July 1, 2005 through June 30, 2006) remain the same as SFY 2005. The number of budgeted positions in FY 2005 (11.5 FTEs) is reduced to 8.5 FTEs in the FY 2006 budget. There was one change in SFY 2005 to the Cancer Program category, which involved the removal of Colorectal Cancer as a program option. This change was made because Colorectal Cancer was not selected by any of the local health departments in the last two years.

Anticipating future decreases in federal funding, the PHHS Block Grant Advisory Committee (described in more detail in Section H on the next page) recommended focusing the PHHSBG on four health priority areas: cardiovascular disease prevention, obesity, comprehensive cancer planning, and lung cancer in women. The three new program areas of obesity, cancer planning and lung cancer in women have been added to the options of cardiovascular disease, cancer prevention, unintentional injuries (motor vehicle crash injuries and injuries from falls) and surveillance/monitoring that are already available to the Local Health Departments under the formula-based allocation. In addition, Local Health Departments will no longer have the option of making Food Surveillance contracts, effective July 1, 2006.

G. Contingency Plan

The Department of Public Health, with input from the PHHSBG Advisory Committee, is prepared to revise the FFY 2006 proposed budget, as needed, to accommodate any changes in the \$1,770,489 estimated award presented in this Allocation Plan. The PHHS Block Grant funding was removed from the President's budget effective 10/1/05, but has been restored by the House of Representatives at a level that would represent a 24% reduction to Connecticut's program. Should a 24% reduction occur, the Department would utilize 50% of the available carry over (\$424,545) to maintain programs at level funding and target the Intimate Partner Violence Program for the remaining \$27,315. Funding for this program is used to partially support a train-the-trainer contract that does not provide direct services to clients. This plan would allow a carry over into FFY 2007 of \$424,546. Savings due to vacant, budgeted positions, contractor refunds and other unexpended amounts will also be added to the carry forward reserve and used to offset any additional decrease in funding levels.

H. State Allocation Planning Process

The Preventive Health Amendment of 1993 requires each state to develop a plan for achieving the Year 2010 Health Objectives addressed by the PHHSBG, in consultation with a PHHSBG Advisory Committee. The committee must include representatives of the general public and local health services. The duties of the committee are:

1. To make recommendations regarding the development and implementation of an annual plan, including recommendations on:
 - (a) the activities to be carried out by the grant;
 - (b) the allocation of funds;
 - (c) the coordination of activities funded by the grant with other appropriate organizations;
 - (d) the conduct of assessments of the public's health; and,
 - (e) the collection and reporting of data, including categories of information deemed most useful to monitor and evaluate the progress of funded programs toward the attainment of the national Healthy People 2010 Objectives.
2. To jointly hold a public hearing with the state health officer, or his designee, on the state plan.

The Commissioner's designee, Dr. Mary Lou Fleissner, recruited new members for and chaired meetings of this year's Preventive Health and Health Services Block Grant Advisory Committee. The FY 05-06 Committee was comprised of 9 representatives from local health departments, community-based organizations, educational institutions and the general public.

The Committee met on May 16th and June 1st, 2005 to plan and make recommendations for the FFY 2006 Allocation Plan. A public hearing on the allocation plan was held on June 27th.

The Committee made recommendations for funding for FFY2006 based on two scenarios, current funding level and elimination of funding. Advisory group members were provided an overview of all the programs and how both internal and external funding was utilized. Six program areas were considered in the program rankings, while funding for local health departments was considered separately.

Level funding – The Committee recommended that the highest priority for funding be the two laboratory technicians for the childhood lead prevention program. Cardiovascular Disease prevention and Surveillance (BRFSS program) were ranked as the next highest priorities, followed by youth violence prevention and intimate partner prevention. It was felt that the position in Cancer Control should continue. The recommendation was made to eliminate the external funding for EMS and to fund only one internal position in EMS. The funds saved as a result of this recommendation would be used to fund obesity programs, prevention of lung cancer in women and CVD programs through an RFP process. It was recommended that level funding be continued for local health initiatives. However, funding for food surveillance under this initiative would be discontinued as a local health option beginning July 1, 2006.

Elimination of Funding – If funding were eliminated, there would only be carryover available for FFY2006. The Committee recommended that the childhood lead prevention program be given first priority for use of these funds. Any additional funds would then be used to maintain the CVD coordinator position and the surveillance position. It was felt that these two positions would take precedence over local health options, since the sizeable cut back in funds available after funding the lead program would render the formula funding for local health unrealistic.

These changes depending on the level of funding will be effective with staff beginning on October 1, 2005 and with contracts beginning **July 1, 2006**.

I. Grant Provisions

In addition to the federally mandated provisions described previously, states must also comply with the reporting requirements outlined below:

1. Submit an annual application to the CDC that specifies the following:
 - (a) the amount of PHHSBG, state and other federal funding directed towards the attainment of each of the state's PHHSBG funded Year 2010 Health Objective (HO);
 - (b) a description of each of the HO programs, strategies, risk reduction and annual activity objectives and projected outcomes for each;
 - (c) identification of any populations, within the targeted population, having a disparate need for such activities;
 - (d) a description of the strategy for expending payments to improve the health status of each target and disparate population; and,
 - (e) the amount to be expended for each target and disparate population.
2. If a state adds or deletes a Health Status Objective (HSO), or makes other substantial revisions to its Allocation Plan *after* the Application has been submitted to the CDC, it must conduct a public hearing on the revised plan and submit a revised Application. Each state must also submit an annual report on the attainment of each health status and risk reduction objectives and related activities funded during the preceding year. The Governor and the chief health officer, or his designee, must sign a certification and assurance statement for inclusion in the Application to CDC, which certifies adherence to the mandated provisions outlined in this Allocation Plan.

TABLE A
SUMMARY OF APPROPRIATIONS AND EXPENDITURES

PROGRAM CATEGORY	FFY '04 Expenditures	FFY '05 Estimated Expenditures	FFY '06 Proposed Expenditures
Administrative Support	83,378	83,703	89,628
Cancer Program		53,565	101,781
Cardiovascular Disease	388,178	397,000	402,901
Childhood Lead Poisoning/Lab	133,835	146,928	149,836
Emergency Medical Services	383,753	368,010	171,368
Local Health Departments	589,121	498,919	498,769
Rape Crisis Service	83,396	83,396	83,396
Surveillance and Data	127,953	98,864	96,812
Intimate Partner Violence	76,920	76,920	76,920
Youth Violence Prevention	202,451	202,187	211,344
TOTAL	2,068,985	2,009,492	1,882,755
SOURCE OF FUNDS			
Block Grant	1,980,801	1,770,489	1,770,489
Balance Forward From Previous Year ¹	1,288,544	1,200,360	961,357
TOTAL FUNDS AVAILABLE	3,269,345	2,970,849	2,731,846

¹ The FFY 2004 estimated expenditures of \$2,068,985 utilized \$88,184 of the balance forward from prior years to supplement the \$1,980,801 award. A total of \$292,087 of the balance forward will supplement the \$1,770,489 estimated federal allocation for the proposed FFY 2005 budget of \$2,012,576. The proposed budget for FFY 2006 of \$1,879,685 is projected to use \$109,196 in carryover. This would leave an estimated \$849,077 in a balance forward to fund cost increases in future years.

TABLE B – ALL PROGRAMS
PROGRAM EXPENDITURES

PROGRAM CATEGORY	FFY '04 Expenditures	FFY '05 Estimated Expenditures	FFY '06 Proposed Expenditures
Number of Positions (FTE) budgeted/filled	12.0/9.5	11.5/9.0	8.5/8.5
Personal Services	559,155	528,785	534,868
Fringe Benefits	256,205	277,082	291,419
Other Expenses	5,150	5,150	5,000
Equipment			
Contracts	6,000	6,000	0
Grants to:			
Local Government	945,099	945,099	804,092
Other State Agencies	76,920	76,920	76,920
Private agencies	220,456	170,456	170,456
TOTAL EXPENDITURES	2,068,985	2,009,492	1,882,755
SOURCE OF FUNDS			
Block Grant	1,980,801	1,770,489	1,770,489
Balance Forward From Previous Year	1,288,544	1,200,360	961,357
TOTAL FUNDS AVAILABLE	3,269,345	2,970,849	2,731,846

TABLE C – ADMINISTRATIVE SUPPORT
PROGRAM EXPENDITURES

PROGRAM CATEGORY	FFY '04 Expenditures	FFY '05 Estimated Expenditures	FFY '06 Proposed Expenditures
Number of Positions (FTE) budgeted/filled	1. 0/1.0	1.0/1.0	1.0/1.0
Personal Services	56,836	56,873	57,909
Fringe Benefits	26,042	26,330	31,219
Other Expenses	500	500	500
Equipment			
Contracts			
Grants to:			
Local Government			
Other State Agencies			
Private agencies			
TOTAL EXPENDITURES	83,378	83,703	89,628

**TABLE D – CANCER PREVENTION
 PROGRAM EXPENDITURES**

PROGRAM CATEGORY	FFY '04 Expenditures	FFY '05 Estimated Expenditures	FFY '06 Proposed Expenditures
Number of Positions (FTE) budgeted/filled	1.0/0 ²	1.0/.5	1.0/1.0
Personal Services	0	34,987	66,130
Fringe Benefits	0	18,578	35,651
Other Expenses			
Equipment			
Contracts			
Grants to:			
Local Government			
Other State Agencies			
Private agencies			
TOTAL EXPENDITURES	0	53,565	101,781

² Position to be supported by the Cancer Prevention Program was vacant through FFY 2004 due to State Budget restrictions

**TABLE E – CARDIOVASCULAR DISEASE PREVENTION
 PROGRAM EXPENDITURES**

PROGRAM CATEGORY	FFY '04 Expenditures	FFY '05 Estimated Expenditures	FFY '06 Proposed Expenditures
Number of Positions (FTE) budgeted/filled	1.0/1.0	1.0/1.0	1.0/1.0
Personal Services	66,344	68,589	70,428
Fringe Benefits	30,399	36,976	41,038
Other Expenses	1,000	1,000	1,000
Equipment			
Contracts			
Grants to:			
Local Government	237,135	237,135	203,470
Other State Agencies			
Private agencies	53,300	53,300	86,965
TOTAL EXPENDITURES	388,178	397,000	402,901

**TABLE F – CHILDHOOD LEAD POISONING PREVENTION/LABORATORY
 PROGRAM EXPENDITURES**

PROGRAM CATEGORY	FFY '04 Expenditures	FFY '05 Estimated Expenditures	FFY '06 Proposed Expenditures
Number of Positions (FTE) budgeted/filled	2.0/2.0	2.0/2.0	2.0/2.0
Personal Services	91,095	94,081	96,703
Fringe Benefits	41,740	51,847	52,133
Other Expenses	1,000	1,000	1,000
Equipment			
Contracts			
Grants to:			
Local Government			
Other State Agencies			
Private agencies			
TOTAL EXPENDITURES	133,835	146,928	149,836

**TABLE G – EMERGENCY MEDICAL SERVICES
 PROGRAM EXPENDITURES**

PROGRAM CATEGORY	FFY '04 Expenditures	FFY '05 Estimated Expenditures	FFY '06 Proposed Expenditures
Number of Positions (FTE) budgeted/filled	3.0/2.7	2.7/2.7	1.7/1.7
Personal Services	131,495	145,169	110,693
Fringe Benefits	60,251	80,834	59,675
Other Expenses	1,000	1,000	1,000
Equipment			
Contracts			
Grants to:			
Local Government ³	141,007	141,007	0
Other State Agencies			
Private agencies ³	50,000	0	0
TOTAL EXPENDITURES	383,753	368,010	171,368

³ The \$50,000 (FFYs 2004) budgeted under 'Grants to Private Agencies' were for the EMS Trauma Registry. Funding for the Registry and the Regional EMS Councils is eliminated in FFY 06, as recommended by the Preventive Block Grant Advisory Council in response to anticipated reductions in the Preventive Block Grant in FFY 2006.

TABLE H – LOCAL HEALTH DEPARTMENTS

PROGRAM EXPENDITURES

PROGRAM CATEGORY	FFY '04 Expenditures	FFY '05 Estimated Expenditures	FFY '06 Proposed Expenditures
Number of Positions (FTE) budgeted/filled	1.0/1.0	1.0/0	0/0
Personal Services	61,858	0	0
Fringe Benefits	28,344	0	0
Other Expenses	150	150	0
Equipment			
Contracts			
Grants to:			
Local Government	498,769	498,769	498,769
Other State Agencies			
Private agencies			
TOTAL EXPENDITURES⁴	589,121	498,919	498,769

⁴ State funding in the amount of \$71,585 was added to the local health department's allocation to maintain level funding.

TABLE I – RAPE CRISIS SERVICES

PROGRAM EXPENDITURES

PROGRAM CATEGORY	FFY '04 Expenditures	FFY '05 Estimated Expenditures	FFY '06 Proposed Expenditures
Number of Positions (FTE) budgeted/filled			
Personal Services			
Fringe Benefits			
Other Expenses			
Equipment			
Contracts			
Grants to:			
Local Government			
Other State Agencies			
Private agencies	83,396	83,396	83,396
TOTAL EXPENDITURES	83,396	83,396	83,396

**TABLE J – SURVEILLANCE AND EVALUATION
 PROGRAM EXPENDITURES**

PROGRAM CATEGORY	FFY '04 Expenditures	FFY '05 Estimated Expenditures	FFY '06 Proposed Expenditures
Number of Positions (FTE) budgeted/filled	2.0/.8	1.8/.8	.8/.8
Personal Services	83,290	61,236	62,577
Fringe Benefits	38,163	31,128	33,735
Other Expenses	500	500	500
Equipment			
Contracts	6,000	6,000	0 ⁵
Grants to:			
Local Government			
Other State Agencies			
Private agencies			
TOTAL EXPENDITURES	127,953	98,864	96,812

⁵ Contract funding was eliminated for the Behavioral Risk Factor Surveillance consultant as recommended by the Preventive Block Grant Advisory Committee.

**TABLE K – INTIMATE PARTNER VIOLENCE
 PROGRAM EXPENDITURES**

PROGRAM CATEGORY	FFY '04 Expenditures	FFY '05 Estimated Expenditures	FFY '06 Proposed Expenditures
Number of Positions (FTE) budgeted/filled			
Personal Services			
Fringe Benefits			
Other Expenses			
Equipment			
Contracts			
Grants to:			
Local Government			
Other State Agencies			
Private agencies	76,920	76,920	76,920
TOTAL EXPENDITURES ⁶	76,920	76,920	76,920

⁶ State funding in the amount of \$11,041 was added to this program to maintain level funding.

TABLE L – YOUTH VIOLENCE/SUICIDE PREVENTION

PROGRAM EXPENDITURES

PROGRAM CATEGORY	FFY '04 Expenditures	FFY '05 Estimated Expenditures	FFY '06 Proposed Expenditures
Number of Positions (FTE) budgeted/filled	1.0/1.0	1.0/1.0	1.0/1.0
Personal Services	68,237	67,850	70,428
Fringe Benefits	31,266	31,389	37,968
Other Expenses	1,000	1,000	1,000
Equipment			
Contracts			
Grants to:			
Local Government	68,188	68,188	68,188
Other State Agencies			
Private agencies	33,760	33,760	33,760
TOTAL EXPENDITURES	202,451	202,187	211,344

TABLE M - SUMMARY OF PROGRAM OBJECTIVES AND ACTIVITIES

Program Category	Objective	Activity	Number Served FFY 2004
Cancer Prevention			
Skin Cancer	Reduce the number of deaths caused by skin cancer to no more than 2.2 per 100,000.	Provide funds to local health departments (LHDs) and other community agencies to develop and implement educational programs and materials, which will reduce an individual's risk of skin cancer.	1,200
		Conduct community-based skin cancer educational programs to increase awareness and inform and educate populations of the harmful effects of the sun's ultraviolet rays and influence sun safety practices.	120
		Recruit community organizations and/or agencies for participation in a skin cancer prevention program. New Target Goal – 6 agencies total	0
Lung Cancer in Women	Reduce the lung cancer death rate for women from 41.5 per 100,000 to 30.5 per 100,000.	Provide funds to local health departments and other community agencies to develop and implement educational programs and materials, which will reduce a woman's risk of lung cancer.	Not applicable. Program starts 7/1/05
		Conduct community-based educational programs, including evidence-based smoking cessation program information, to increase awareness of the harmful effects of smoking and other risk factors in relation to lung cancer.	Not applicable. Program starts 7/1/05
Cancer Planning	Reduce the overall cancer death rate to 159.9 deaths per 100,000 population.	Provide funds to local health departments and other community agencies to develop community-based cancer prevention and control plan that parallels the Connecticut Comprehensive Cancer Control Plan, 2005-2008.	Not applicable. Program starts 7/1/05
Colorectal Cancer	Reduce the number of deaths caused by colorectal cancer to no more than 19.1 per 100,000.	This activity was not selected by LHDs during FY 2003 or FY 2004. For this reason, it is no longer offered as an option as of FFY 2005.	Option not selected by any Local Health Department/District

TABLE M - SUMMARY OF PROGRAM OBJECTIVES AND ACTIVITIES (continued)

Program Category	Objective	Activity	Number Served FFY 2004
Cardiovascular Disease (CVD) Prevention Elevate Cholesterol Levels	Cholesterol screening/referral, education and counseling aimed at assisting client action to reduce elevate cholesterol.	Two (2) LHD conducted three (3) High Blood Cholesterol Education programs.	46
Diabetes	Multi-session self-care education programs to reduce risk for CVD and other diabetes-related complications including peripheral vascular disease, neuropathy, end-stage renal disease and blindness. Enables client to practice self-care behaviors to reduce diabetes and complications.	Five (5) LHDs held seven (7) Diabetes Education Programs.	126
Obesity	Develop and implement policy and environmental initiatives designed to increase physical activity and improved nutritional practices at the community level.	Policy/environmental changes increasing physical activity, and improved nutritional practices at the community level.	Not applicable. Program starts 7/1/05
Physical Inactivity	Multi-session physical activity programs to assist individuals to establish a moderate level of physical activity into their lifestyles.	Eight (8) LHDs conducted a total of forty-one (41) physical activity programs.	489

TABLE M - SUMMARY OF PROGRAM OBJECTIVES AND ACTIVITIES (continued)

Program Category	Objective	Activity	Number Served FFY 2004
CVD (continued) Nutrition/Excess Dietary Fat	Multi-session education programs that provide needed information and practical skills to establish healthy eating patterns including the reduction of excess dietary fat in the diet.	Six (6) LHDs conducted twelve (12) nutrition education programs.	165
High Blood Pressure	High blood pressure screening, referral, education and counseling programs to initiate action to control high blood pressure.	One (1) LHD conducted one (1) High Blood Pressure educational program in 2003.	10
Childhood Lead Poisoning Prevention	Reduce the number of children less than six years of age with blood lead levels $\geq 10\mu\text{g/dL}$ to less than 2.2%, and those with levels $\geq 20\mu\text{g/dL}$ to less than 0.4%.	Conduct primary prevention activities and identify children at risk through a comprehensive program of blood lead screening that is recommended for all children. Offer intervention and risk reduction education to care givers, parents and guardians, and medical professionals. Provide surveillance, case management, environmental management, and follow-up of elevated blood-lead level cases.	In calendar year 2003, 67,480 children under 6 years of age were screened for lead poisoning. * *Most current data available.

TABLE M - SUMMARY OF PROGRAM OBJECTIVES AND ACTIVITIES (continued)

Program Category	Objective	Activity	Number Served FFY 2004
Emergency Medical Services (EMS)	Reduce the number of preventable deaths and disabilities by minimizing the time between the occurrence of a sudden, serious illness or injury and the provision of definitive care at the scene, during transport and at the destination hospital.	<p>Increase the proportion of CT residents who have access to rapidly responding and appropriate pre-hospital emergency medical services by partnering with community EMS and public safety professionals to:</p> <p>Increase the number of residents trained in "Bystander EMS," which includes basic first aid, CPR and AED (Automatic External Defibrillator) use.</p> <p>Increase the number of towns that have a designated First Responder that is equipped with, and trained in, AED use.</p> <p>Increase the number of AED's (Automatic External Defibrillators) registered with OEMS.</p> <p>Monitor the number of Primary Service Answering Points (PSAP) in CT that comply with the provisions of PA 00-151 that requires all 9-1-1 PSAP's to have an Emergency Medical Dispatch (EMD) program by 7/1/04.</p>	<p>209 residents trained in CPR/AED through OEMS programs in CY 2004.</p> <p>143 or 85% of the 169 towns have a designated 1st Responder with AED authorization as of 5/05.</p> <p>2330 AED's currently registered (16% increase over SFY '04).</p> <p>100% PSAP's self reported compliance with EMD but OSET will be conducting site visits in SFY '06 to verify compliance.</p>

TABLE M- SUMMARY OF PROGRAM OBJECTIVES AND ACTIVITIES (continued)

Program Category	Objective	Activity	Number Served FFY 2004
Local Health Departments	Address priority PHHSBG-funded health needs of communities.	Provide funding and program assistance to local health departments for approved health promotion services of their choice.	Please see the specific program options available to the local health departments: Cancer Prevention, Cancer Planning, Lung Cancer in Women, Skin Cancer, CVD Prevention (including High Blood Pressure, Smoking Cessation, Excess Dietary Fats/Nutrition Education, Cholesterol, Physical Activity and Obesity), Unintentional Injury Prevention, Surveillance and Evaluation, Intimate Partner Violence and Youth Violence/Suicide Prevention
Rape Crisis Services	Reduce the annual rate of rape or attempted rape to 0.7 rapes or attempted rapes per 1,000 persons. CT's current attainment: 0.4 per 1,000 persons (2002 latest available data)	Contract with the statewide sexual assault coalition and ten member centers for the provision of direct services for victims of rape and other sexual assaults, including crisis intervention, individual/group counseling; medical, police and court accompaniment; free and confidential hotlines; and transportation as necessary.	3,218 new primary victims: 367 male and 2,851 female.
Surveillance and Evaluation	Increase the proportion of leading health indicators, health status indicators, and priority data needs for which data, especially for selected populations, are available at the Tribal, State, and local levels.	Funds are used to collect data about behavioral risk factors that are related to leading causes of death and disability. Local Health Departments (LHDs) use these funds to track health behaviors. This year each of the LHD surveillance programs focused on ways to address obesity.	3 LHDs conducted surveillance activities.

TABLE M - SUMMARY OF PROGRAM OBJECTIVES AND ACTIVITIES (continued)

Program Category	Objective	Activity	Number Served FFY 2004
Unintentional Injury Prevention Motor Vehicle Crashes	Maintain number of deaths caused by motor vehicle crashes to no more than 7.5 per 100,000.	Provide funding and technical assistance to local health departments (LHDs) who choose to use their PHHS funds for community-based motor vehicle injury prevention programs. Activities focus on child passenger safety, safety belt use, pedestrian safety and development of community coalitions to effect environmental/policy changes.	2 LHDs conducted MV programs: <ul style="list-style-type: none"> • CPS programs served 48 children/69 adults • 2,000+ served by community awareness
Fall-related Injuries: Fall Prevention for Older Adults Fall Prevention for Children in the home setting	Maintain number of deaths caused by falls and fall-related injuries to no more than 3.8 per 100,000.	Provide funding and technical assistance to LHDs who chose to use their local health allocation for community-based unintentional injury prevention activities that include fall prevention programs for older adults and home safety for young children. Activities for older adults include home safety visits (HSV), educational presentations, medication safety reviews and fall prevention exercise classes. Activities for children include home safety visits.	3 LHDs conducted fall prevention programs: <ul style="list-style-type: none"> • 183 persons served by HSV. • 144 served by ed programs • 93 served by exercise programs • 28 children served by HSV.
Intimate Partner Violence Prevention	Reduce the rate of physical assault by current or former intimate partners by 10%.	Improve the health system's response to intimate partner violence by providing health professionals with skills and awareness to identify, plan for the safety of and refer victims of intimate partner violence.	Due to delays in contracting, no trainings took place in FFY 2003.
Youth Violence/Suicide Prevention	Reduce physical assaults and suicides to no more than 8.0 per 1,000 and 8.0 per 100,000, respectively.	Provide funding and assistance to local health and community service providers to develop, implement and evaluate youth violence and suicide prevention activities.	15,385

III. Summary of Major Program Categories

A. CANCER PREVENTION Skin Cancer

NATIONAL YEAR 2010 HEALTH OBJECTIVES

3.9 Increase the proportion of persons who use at least one of the following protective measures that may reduce the risk of skin cancer:

- avoid the sun between 10 a.m. and 4 p.m., wear sun-protective clothing, when exposed to sunlight,
- use sunscreen with a sun-protective factor (SPF) of 15 or higher, and
- avoid artificial sources of ultraviolet light.

PROGRAM GOAL

By September 30, 2006, the rate of deaths caused by skin cancer should be no more than 2.2/100,000. Baseline: 3.2/100,000 in 2001 for malignant melanoma²

STATEMENT OF ISSUES/PROBLEM

The most serious form of skin cancer is melanoma, which was responsible for 1% of all Connecticut cancer deaths in 1997. The following mortality and incidence data for Connecticut residents is for melanoma only. Basal and squamous cell skin cancer data is excluded.

Melanoma Mortality Data for Connecticut³

-2.5/100,000 people (2001)

Melanoma Incidence Data for Connecticut⁴

-For males 425/100,000 incidence cases for all ages (2001)

-For Females 333/100,000 incidence cases for all ages (2001)

Everyone is susceptible to skin cancer. Some factors for skin cancer are light skin color, a family history of skin cancer, personal history of skin cancer, chronic exposure to ultraviolet radiation, history of sunburns early in life and certain types and a large number of moles and/or have freckles, which is an indicator of sun sensitivity and sun damage.

DESCRIPTION OF THE PROGRAM STRATEGY

The cancer control program staff will provide technical assistance to, and oversight of, the local health departments that receive funding and choose this option to target risk reduction for skin cancer in their communities.

Community-based skin cancer educational programs are conducted to increase awareness and inform and educate populations of the harmful effects of the sun's ultraviolet rays and influence sun safety practices.

² Connecticut Department of Public Health Mortality Files (2001 data).

³ Cancer Incidence in Connecticut (2001 data).

⁴ Connecticut Tumor Registry (2001 data).

TARGET POPULATION

All Connecticut residents are at average risk and should limit their exposure and/or avoid exposure to ultraviolet rays.

Number:	3,272,563
Age Range:	All
Sex:	Males and Females
Race/Ethnicity:	All
Geographic Location	Statewide

FEDERAL FISCAL YEAR 2006 PROGRAM OBJECTIVES

1. By September 30, 2006, increase to at least 75% the proportion of people of all ages who limit sun exposure, use sunscreens and protective clothing when exposed to sunlight, and avoid artificial sources of ultraviolet light (e.g., sun lamps, tanning booths). This will be accomplished through educational initiatives conducted by PHHSBG-funded local health departments who select this program option. Baseline: Not Applicable.
2. By September 30, 2006, provide technical assistance to local health departments/community organizations implementing skin cancer educational initiatives. Baseline: To be established.

FEDERAL FISCAL YEAR 2004 PROGRAM ACCOMPLISHMENTS

1. The Cancer Control staff provided technical assistance to, and oversight of, three local health departments that received funding and chose to target risk reduction (prevention) for skin cancer in their communities.
2. Conducted community-based skin cancer educational programs to increase awareness and inform and educate populations of the harmful effects of the sun's ultraviolet rays and influence sun safety practices. Approximately 120 people attended the programs.
3. Completed development of skin cancer program for local health departments that utilize PHHSBG funding.
4. Followed-up, and collaborated with, local media to disseminate state tagged, nationally produced, cancer media public service announcements.

PROGRESS OF 2005 PROGRAM

1. Developed statewide skin cancer initiatives and community-based educational programs.
2. Continued to provide assistance to local health departments for cancer program development.
3. Continued to collaborate with other state agencies to disseminate cancer education materials and articles for publication.

OUTCOME OBJECTIVES

Objectives	Indicators	Progress
<p>Increase proportion of persons limiting their exposure to the sun and other artificial sources of ultraviolet light to at least 75%.</p>	<p>Participation in educational initiatives.</p>	<p>One of the three (3) the health departments are targeting primarily pre-school aged children. Program strategies will include: working with the administration and staff of two targeted pre-schools to help them develop and revise either sun safety policies or environmental change, providing staff development, a sun safety curriculum, parent educational materials and guidelines for the development of sun safety policies.</p> <p>Another health department program will be offered to college and high school students with the goal of creating personal behavioral change by integrating sun safe practices into their lifestyle.</p>
<p>Provide technical assistance with skin cancer educational initiatives.</p>	<p>Number of technical assistance sessions facilitated with the health departments.</p>	<p>Technical assistance is being provided as requested by the local health departments.</p>

**A. CANCER PREVENTION
Lung Cancer in Women**

NATIONAL YEAR 2010 HEALTH OBJECTIVES

a. Reduce the lung cancer death rate for women from 41.5 per 100,000 to 30.5 per 100,000.

PROGRAM GOAL

By September 30, 2009, increase the awareness of lung cancer as the leading cause of cancer death among women and encourage risk reduction through smoking cessation.

STATEMENT OF ISSUES/PROBLEM

The leading cause of cancer death in women in Connecticut is lung cancer. While lung cancer death rates have been declining for men, they have been increasing for women. Research studies have estimated that 75-80% of lung cancer deaths among women are related to cigarette smoking. According to the 2003 Behavioral Risk Factor Surveillance Survey (BRFSS), 17.7% of the Connecticut women age 18 and over reported being current smokers.

DESCRIPTION OF THE PROGRAM STRATEGY

Staff from the cancer control program, and tobacco use prevention and control programs will provide technical assistance to, and oversight of, the local health departments that receive funding and choose this option to target risk reduction for lung cancer in their communities.

Community-based lung cancer educational programs, including evidence-based cessation program information, will increase the awareness of the harmful effects of smoking and other risk factors in relation to lung cancer, and will reduce a woman's risk of lung cancer.

TARGET POPULATION

Number:	1,780,630
Age Range:	All
Sex:	Females
Race/Ethnicity:	All
Geographic Location	Statewide

FEDERAL FISCAL YEAR 2006 PROGRAM OBJECTIVES

By September 30, 2006, at least 75% of women participating in funded lung cancer educational programs can identify at least two risks for developing lung cancer.

By September 30, 2006, at least 20% of women participating in funded lung cancer educational programs who currently smoke report an intention to quit smoking in the next six months.

By September 30, 2006, Connecticut Quit line calls from women in communities choosing to participate in this program will increase at a greater rate than communities not participating in this program.

FEDERAL FISCAL YEAR 2004 PROGRAM ACCOMPLISHMENTS

Not applicable. Program start date: July 1, 2005

PROGRESS OF 2005 PROGRAM

Not applicable. Program start date: July 1, 2005

OUTCOME OBJECTIVES

Objectives	Indicators	Progress
At least 75% of women participating in funded lung cancer educational programs can identify at least two risks for developing lung cancer.	DPH-funded program data	Not applicable. Program start date: 7/1/05
At least 20% of women participating in funded lung cancer educational programs who currently smoke report an intention to quit smoking in the next six months.	DPH-funded program data	Not applicable. Program start date: 7/1/05
At 20% of women participating in funded lung cancer educational programs who currently smoke engage in and successfully complete a recommended smoking cessation program.	DPH-funded program data	Not applicable. Program start date: 7/1/05

**A. CANCER PREVENTION
Cancer Planning**

NATIONAL YEAR 2010 HEALTH OBJECTIVES

3.1 Reduce the lung cancer death rate to 159.9 deaths per 100,000 population.

PROGRAM GOAL

By September 30, 2009, reduce the overall cancer death rate to 159.9 per 100,000. Baseline: 190.6/100,000 in 2002 for overall cancer deaths

STATEMENT OF ISSUES/PROBLEM

Each year about 18,000 new cases of cancer are diagnosed and 7,000 Connecticut residents die of cancer. The prominence of cancer in the health of Connecticut residents is not likely to change; indeed, as our population ages, numbers of new cancer cases and deaths likely will increase, as will the number of cancer survivors; some cancers have become largely curable, whereas other are now manageable chronic diseases, because of early diagnosis and more effective treatments. Comprehensive planning at the local, regional, and state level is critical to effectively and efficiently maximize resources and efforts toward reducing the burden of cancer in Connecticut.

DESCRIPTION OF THE PROGRAM STRATEGY

The cancer control program staff will provide technical assistance to, and oversight of, the local health departments that receive funding and select this option to develop a community-based cancer prevention and control plan that parallels the Connecticut Comprehensive Cancer Control Plan, 2005-2008. Grantees will convene community partners and engage in a process to enhance infrastructure, mobilize support, use data and research, build partnerships, assess and address cancer burden, and conduct evaluation.

TARGET POPULATION

Number:	3,459,004
Age Range:	All
Sex:	Male and Female
Race/Ethnicity:	All
Geographic Location	Statewide

FEDERAL FISCAL YEAR 2006 PROGRAM OBJECTIVES

By September 30, 2006, two local health departments and other community agencies will develop a community-based cancer prevention and control plan that parallels the Connecticut Comprehensive Cancer Control Plan, 2005-2008.

FEDERAL FISCAL YEAR 2004 PROGRAM ACCOMPLISHMENTS

Not applicable. Program start date: July 1, 2005

PROGRESS OF 2005 PROGRAM

Not applicable. Program start date: July 1, 2005

OUTCOME OBJECTIVES

Objectives	Indicators	Progress
Two local health departments and other community agencies will develop a community-based cancer prevention and control plan that parallels the Connecticut Comprehensive Cancer Control Plan, 2005-2008.	DPH-funded program data	Not applicable. Program start date: 7/1/05

B. CARDIOVASCULAR DISEASE PREVENTION

NATIONAL YEAR 2010 HEALTH OBJECTIVE

12-1: Reduce coronary heart disease deaths to no more than 166 per 100,000 people.

(Age-adjusted baseline: 208 per 100,000 in 1998).

12-7: Reduce stroke deaths to no more than 48 per 100,000 people.

(Age-adjusted baseline: 60 per 100,000 in 1998).

19-2: Reduce the proportion of adults who are obese.

(Age-adjusted baseline: 23 percent in 1988-94; NHARES, US).

PROGRAM GOAL

1. By September 30, 2009, reduce coronary heart disease deaths to no more than 150 per 100,000. Baseline: Connecticut 2002 data: 153.3/100,000 coronary heart disease deaths.
2. By September 30, 2009, reduce stroke deaths to no more than 40 per 100,000. Baseline: Connecticut 2002 data: 45.2/100,000 cerebrovascular disease deaths.
3. By September 30, 2009, reduce prevalence of obesity among adults aged eighteen and older to no more than 15%. Baseline: 19.7% of Connecticut residents are obese (2004 BRFSS).

STATEMENT OF ISSUES/PROBLEM

Cardiovascular disease (CVD) is not a single disease but consists of a number of disease processes affecting the heart and blood vessels. Coronary heart disease, cerebrovascular disease (stroke), arteriosclerosis, congestive heart failure, congenital heart disease and hypertension are all forms of cardiovascular disease. This disease is the number one killer in the US and is responsible for slightly over 40% of all deaths in Connecticut each year. Many CVD deaths are considered premature and potentially preventable, or at least postponed, by modifying lifestyle. Over half of all heart disease and over two-thirds of all stroke deaths in the state can be attributed to the CVD risk factors of smoking, physical inactivity, diabetes, hypertension, high cholesterol and overweight. An estimate of the percentage of Connecticut residents affected by these risk factors is presented below.

**Population Distribution of Major Modifiable CVD Risk Factors
 Among Connecticut Adults**

Risk Factor	% of adults affected
1) High blood pressure (ever)	24.2
2) High cholesterol (ever)	30.8
3) Cigarette smoking	18.6
4) Diabetes	5.9
5) Overweight and obesity	54.8
6) Lack of regular exercise	69.4

(Source 2003, BRFSS/Morbidity and Mortality Weekly Review)

DESCRIPTION OF THE PROGRAM STRATEGY

The CVD Program staff provide technical assistance to, and oversight of, the 40 plus local health department and other community agency contractors that receive funding. Strategies utilized by the contractors to address the CVD risk factors are summarized below.

CVD Risk Factors	Contractor Funded Strategies and Objectives
Elevated Cholesterol Levels	Provide cholesterol screening/referral, education and counseling aimed at assisting client to take action to reduce elevated cholesterol.
Diabetes	Conduct multi-session self-care education programs on reducing risk for cardiovascular disease and other diabetes-related complications including: peripheral vascular disease, neuropathy, end-stage renal disease, and blindness by enabling clients to practice self-care behaviors to reduce diabetes related complications.
Physical Inactivity	Multi-session physical activity programs or facilitating policy and environmental changes to assist individuals in establishing at least a moderate level of physical activity into their lifestyles.
Nutrition/Excess Dietary Fat	Multi-session education programs that provide needed information and practical skills necessary to establish healthy eating patterns including the reduction of excess dietary fat in their diet.
High Blood Pressure	High blood pressure screening, referral, education and counseling programs necessary to initiate action to control high blood pressure.
Smoking	Individual counseling and group multi-session cessation or prevention programs to motivate and assist smokers in ceasing or reducing tobacco intake and to educate the community about making protective environmental changes to decrease exposure, especially by infants and children to environmental tobacco smoke.
Obesity	Develop and pilot population-based initiatives to address the epidemic of obesity in Connecticut.
Pilot Program	The pilot program is designed to mobilize and organize community resources to support effective and sustainable initiatives to eliminate health disparities. The program uses community-based partnerships to identify initiatives to promote policy and/or institutionalization of programs to reduce CVD risk factors for at-risk populations. A competitive Request for Proposal (RFP) was developed and awarded in 1999 to address all of the CVD risk factors. The RFP includes three phases consisting of assessment and planning, implementation, and evaluation. A second round of RFPs were initiated July 1, 2002. This second round of programs will end in FY2005.

TARGET POPULATION

Number:	3,405,584
Age Range:	All
Sex:	Male and Female
Race/Ethnicity:	All Races
Geographic Location:	State Of Connecticut

FEDERAL FISCAL YEAR 2006 PROGRAM OBJECTIVES

High Blood Pressure

1. By September 30, 2006, increase to 97% the proportion of adults 18 and older that have had their blood pressure taken in the past two years. Baseline: 95.2% of Connecticut adults 18 and older have had their blood pressure checked within the last two years according to the 1999 Behavioral Risk Factor Surveillance System (BRFSS).
2. By September 30, 2006, increase to at least 75% the proportion of adults 18 and older identified with elevated blood pressure ($\geq 140/90$), and participating in funded screening and education programs who can identify hypertension and at least three hypertension management practices. Baseline: To be determined from 2005 data.
3. By September 30, 2006, maintain at 100% the proportion of adults 18 and older identified with elevated blood pressure ($\geq 140/90$), and participating in funded screening and education programs who report seeking medical intervention and, when appropriate, taking action to control their blood pressure. Baseline: 100% of those with elevated blood pressures in DPH-funded programs took action to control their blood pressure (2004 data).
4. By September 30, 2006, contractors will provide multi-session blood pressure programs. Instructors with clinical, dietary and behavior modification training and experience must teach these programs. Baseline: One local health department conducted one educational program for individuals identified with high blood pressure (2004 data).

Cholesterol

1. By September 30, 2006, increase to at least 90% the proportion of adults 18 and older participating in funded screening programs and identified with elevated cholesterol levels (≥ 200 mg/dl) who can identify high blood cholesterol levels and at least three high cholesterol management practices. Baseline: 87% of those participating in DPH-funded programs were able to identify high blood cholesterol levels and at least three high blood cholesterol management practices (2004 data).
2. By September 30, 2006, increase to at least 90% the proportion of adults 18 and older participating in funded screening programs and identified with elevated cholesterol levels (≥ 200 mg/dl) who report taking action to reduce their cholesterol levels. Baseline: 88% of those identified with elevated cholesterol levels in DPH-funded programs reported taking action to reduce their cholesterol levels (2004 data).

3. By September 30, 2006, provide technical assistance, program and fiscal monitoring and supervision to agencies that elect to conduct cholesterol screening programs to identify individuals with elevated blood cholesterol (≥ 200 mg/dl), inform them of their level and provide counseling and follow up for appropriate action. Baseline: Three cholesterol programs were conducted (2004 data).

Excess Dietary Fats/Nutrition

1. By September 30, 2006, decrease by 10% the proportion of adults 18 and older who report consuming five or more high fat foods per day. Baseline: 61% of participants in funded nutrition programs reported their intent to take action to reduce dietary fat intake (2004 data).
2. By September 30, 2006, increase to at least 80% the proportion of adults 18 and older participating in funded nutrition education programs who report taking action to reduce dietary fat intake to no more than 30% of total calories. Baseline: To be determined from 2005 data.
3. By September 30, 2006, increase to at least 40% the proportion of adults 18 and older participating in funded nutrition education programs that report consuming at least 5 servings of fruits and vegetables per day. Baseline: To be determined from 2005 data.
4. By September 30, 2006, provide technical assistance, program and fiscal monitoring and supervision to at least three funded agencies that elect to conduct nutrition education programs. Baseline: Seven local health departments provided nutrition education programs in 2004.

Physical Inactivity

1. By September 30, 2006, increase to at least 90% the proportion of individuals who can correctly identify recommended levels of physical activity to promote heart health, at program end. Baseline: 54% of participants in funded programs correctly identified recommended levels of physical activity to promote heart health (2004 data).
2. By September 30, 2006, increase to at least 90% the proportion of individuals who report their intent to continue exercising three or more days per week, 30 minutes per day, at program end. Baseline: 59% of participants in funded programs reported their intent to continue to exercise three or more times per week for 30 minutes per day (2004 data).
3. By September 30, 2006, provide technical assistance, supervision and monitoring to at least five agencies that have elected to conduct state standardized light to moderate physical activity programs targeting individuals 18 and older. Baseline: Eight local health departments provided educational programs to reduce physical inactivity (2004 data).

Obesity

1. By September 30, 2006, implement policy and environmental changes in one pilot community to increase the availability and selection of fruits and vegetables. Baseline: To be determined from 2005 data.
2. By September 30, 2006, implement policy and environmental changes in one pilot community to increase access to, or the availability of, areas in which people can engage in physical activity. Baseline: To be determined from 2005 data.

Diabetes

1. By September 30, 2006, increase to at least 85% the proportion of adults 18 and older diagnosed with diabetes and participating in funded programs that can identify at least three self-care practices that reduce diabetes-related complications. Baseline: 75% of the participants in DPH-funded diabetes self-care programs reported the ability to identify at least three self-care practices that reduce diabetes-related complications (2004 data).
2. By September 30, 2006, increase by 75% the number of adults 18 and older diagnosed with diabetes that report practicing at least three self-care behaviors that reduce diabetes-related complications. Baseline: 71% of the participants in funded diabetes self-care programs reported that they were practicing at least three self-care behaviors that reduce diabetes-related complications. (2004 data)
3. By September 30, 2006, provide technical assistance, program and fiscal monitoring and supervision for agencies electing to conduct diabetes self-care and support programs. Baseline: Five local health departments provided seven educational programs on diabetes (2004 data).

Smoking Cessation

1. By September 30, 2006, reduce cigarette smoking to a prevalence of no more than 15% among adults 18 and older. Baseline: 18.6% of Connecticut adults 18 or older reported being current smokers (2003 BRFSS).
2. By September 30, 2006, increase to at least 90% the proportion of people participating in funded programs who make environmental changes to protect the health of nonsmokers. Baseline: 88% of participants in DPH-funded smoking cessation programs reported making environmental changes to protect the health of nonsmokers (2004 data).
3. By September 30, 2006, provide supervision and assistance to health departments that elect to conduct community based smoking prevention, education and/or cessation programs for adults 18 and older to quit smoking, decrease tobacco intake, and or make environmental changes to protect the health of nonsmokers. Baseline: Four local health departments provided smoking cessation programs (2004 data).

FEDERAL FISCAL YEAR 2004 PROGRAM ACCOMPLISHMENTS

High Blood Pressure

The number of participants in funded programs who reported taking action to control their blood pressure increased from 64% in 2003 to 100% in 2004.

Cholesterol

The number of participants in funded programs that were able to identify high blood cholesterol levels and at least three high blood cholesterol management practices increased from 60% in 2003 to 87% in 2004.

Diabetes

The number of participants in funded programs reporting the ability to identify at least three self-care practices that reduce diabetes-related complications increased from 71% in 2003 to 75% in 2004.

Excess Dietary Fat

The number of local health departments conducting nutrition education programs increased from six in 2003 to seven in 2004.

Physical Activity

54% of participants in funded programs correctly identified recommended levels of physical activity to promote heart health in 2004.

Smoking Cessation and Prevention

The number of participants in funded programs reporting making environmental changes to protect the health of nonsmokers increased from 74% in 2003 to 88% in 2004.

PROGRESS OF 2005 PROGRAM

Twenty local health departments have contracted to conduct seventy programs for 2005 for physical activity, diabetes education, high blood pressure, high blood cholesterol, nutrition and smoking cessation.

This is the final year of the second pilot for policy and environmental change programs. This pilot has focused on physical activity and nutrition. Accomplishments to date include: indoor and outdoor walking routes with historic and environmental information; institutionalized walking programs in school activities; social marketing campaigns to promote physical activity; healthier menu choices in schools; established a senior voucher program assumed by the state Department of Agriculture for a farmers' market; and increased bus transportation to farmers' market.

OUTCOME OBJECTIVES

Objectives	Indicators	Progress
Increase to 75% the proportion of high blood pressure (HBP) program participants who can identify hypertension and at least 3 HBP management strategies.	DPH-funded programs data.	To be determined in 2005 data.
Increase to 75% the proportion of HBP educational program participants who report seeking medical intervention and taking action to control their blood pressure.	DPH-funded programs data.	100% of participants (10) report taking action to control their high blood pressure.
Provide technical assistance, program and fiscal monitoring and supervision to agencies that elect to provide multi-session blood pressure programs.	Number of contractors, number of programs held and number of people served.	One contractor, one program, 14 individuals served.

Objectives	Indicators	Progress
Increase to 75% the proportion of high blood cholesterol (HBC) program participants who can identify HBC levels and at least 3 HBC management practices.	DPH-funded programs data.	87% can identify at least three HBC management practices.
Increase to at least 65% the proportion of adults participating in funded HBC screening programs and identified with elevated cholesterol levels that report taking action to reduce their cholesterol levels.	DPH-funded programs and BRFSS data.	88% report taking action to reduce their cholesterol levels.
Provide technical assistance, program & fiscal monitoring and supervision to agencies that elect to provide multi-session HBC programs.	Number of contractors, number of programs held and number of people served.	Two contractors, three programs, 46 individuals served.
Increase to at least 75% the proportion of nutrition program participants who can identify at least 3 dietary practices to promote heart health.	DPH-funded programs data.	59% can identify at least three dietary practices to promote heart health.
Increase to at least 80% the proportion of nutrition education program participants who report taking action to reduce dietary fat intake to no more than 30% of total calories.	DPH-funded programs data.	61% report taking action to reduce dietary fat intake to no more than 30% of total calories.
Provide technical assistance, program and fiscal monitoring and supervision to agencies that elect to conduct nutrition education programs.	Number of contractors, number of programs held and number of people served.	Seven contractors, twenty programs, 388 individuals served.
Increase to at least 75 % the proportion of program participants who can identify the physical activity levels recommended to promote heart health.	DPH-funded programs data.	54% can identify the physical activity levels recommended to promote heart health.
Increase to at least 80% the proportion of individuals who report their intent to continue exercising three or more days per week, 30 minutes per day.	DPH-funded programs data.	59% report their intent to continue exercising three or more days per week, 30 minutes per day.

Objectives	Indicators	Progress
Provide technical assistance, program and fiscal monitoring and supervision to agencies electing to conduct state standardized light-to-moderate physical activity programs	Number of contractors, number of programs held and number of people served.	Eight contractors, 41 programs, 489 individuals served.
Increase to at least 85% the proportion of adults diagnosed with diabetes and participating in DPH-funded programs that can identify at least three self-care practices that reduce diabetes-related complications.	DPH-funded programs data.	87% can identify at least three self-care practices that reduce diabetes-related complications.
Increase to at least 75% the number of adults diagnosed with diabetes who report practicing at least three self-care behaviors that reduce diabetes-related complications.	DPH-funded programs data.	75% report practicing at least three self-care behaviors that reduce diabetes-related complications.
Provide technical assistance, program and fiscal monitoring and supervision for agencies electing to conduct diabetes self-care and support programs.	Number of contractors, number of programs held and number of people served.	Five contractors, seven programs, 126 individuals served.
Increase to at least 90% the proportion of adults participating in DPH-funded programs who make environmental changes to protect the health of nonsmokers.	DPH-funded programs data.	88% report making environmental changes to protect the health of nonsmokers.
Provide supervision and assistance to health departments electing to conduct community based smoking prevention, education and cessation programs for adults to quit smoking, decrease tobacco intake, and or make environmental changes to protect the health of nonsmokers.	Number of contractors, number of programs held and number of people served.	Four contractors, five programs, 73 individuals served.
Provide technical assistance to health departments to implement policy and environmental changes in one pilot community to increase the availability and selection of fruits and vegetables.	Policies developed and implemented, environmental changes implemented	Not applicable. Program starts on 7/1/05.

Objectives	Indicators	Progress
Provide technical assistance to health departments to implement policy and environmental changes in one pilot community to increase access to, or the availability of, areas in which people can engage in physical activity.	Policies developed and implemented, environmental changes implemented	Not applicable. Program starts on 7/1/05.

III. Summary of Major Program Categories

C. CHILDHOOD LEAD POISONING PREVENTION

NATIONAL YEAR 2010 HEALTH OBJECTIVE

8-11 Eliminate elevated blood lead levels in children. Reduce the prevalence of blood lead levels exceeding 10µg/dL among children aged six months through five years to < 1 percent. Baseline: 2.5 percent of children aged 1 to 6 years had blood lead levels exceeding 10µg/dL during 2002.

PROGRAM GOAL

By December 31, 2005, the number of children less than six years of age with blood lead levels $\geq 10\mu\text{g/dL}$ will be less than 2.2%, and those with levels $\geq 20\mu\text{g/dL}$ will be less than 0.4%.

STATEMENT OF ISSUES/PROBLEM

Data from the most recent National Health and Nutrition Examination Survey (NHANES 1999-2002) indicates a continuing decline in lead exposure among children.

Nationally, approximately 310,000 children under 6 years of age have elevated blood lead levels (EBLLs, or blood lead levels of 10 µg/dL or greater). This is approximately 1.6% of children in this age range. This is a decline from 890,000, or approximately 4.4% of children under 6 years of age, for the most recent previous period (1991 – 1994) when NHANES data is available. During 1999-2002, some 3.1% of non-Hispanic blacks aged 1 to 5 years had EBLLs, compared to 2.0% of Mexican American children and 1.3% of White, non-Hispanic children in this age range. While the decline in percentage of minority children with EBLLs far exceeded the decline for White, non-Hispanic children since 1991-1994, children of color remain at higher risk for lead exposure. The geometric mean blood lead level (BLL) for non-Hispanic black children 1 to 5 years of age (2.8 µg/dL) remains higher than that for Mexican-American (1.9 µg/dL) and non-Hispanic white children (1.8 µg/dL), further indicating that differences in risk for lead exposure still persists. Among children under 6 years of age from low-income families, the geometric mean BLL also declined significantly, from 3.7 µg/dL in the 1991-1994 survey to 2.5 µg/dL in 1999-2002. There was also a decline in the geometric mean blood lead level of 2.7µg/dL from NHANES III, Phase 2 (1991 – 1994), to 2.0 µg/dL in NHANES 1999. Two major sources of lead exposure remain a significant health threat for children: (1) deteriorated lead-based paint in older housing, and (2) urban soil and dust that has been contaminated by previous use of leaded gasoline and the deterioration of exterior lead-based paint on dwellings. Housing built prior to 1978 and in particular, those houses built prior to 1950 pose the greatest risk of exposure for children since housing of this age is most likely to contain lead-based paint. Paint manufactured prior to 1950 contained a higher percentage of lead than paint produced through 1978 (when lead-based paint was banned for residential use).

Childhood lead poisoning is one of the most common environmental pediatric public health problems in Connecticut. Based upon Connecticut data reported for calendar year 2003, 1,481 children under 6 years of age had blood lead levels $\geq 10\mu\text{g/dL}$. Children with blood lead levels $\geq 20\mu\text{g/dL}$ numbered 242. Age of housing stock continues to be a major risk factor. The high proportion of rental housing in the major urban areas coupled with the fact that Connecticut has an extremely high proportion of housing stock built before 1950 ranks Connecticut among the top

15 states with the highest amount of at-risk housing. (According to the 1990 US Census, 35% of Connecticut's housing stock was built before 1950).

DESCRIPTION OF THE PROGRAM STRATEGY

During the past year, the DPH has continued to address the childhood lead poisoning problem. The Childhood Lead Poisoning Prevention Program (CLPPP) continues to focus on primary prevention, screening of all children 12 and 24 months of age, case management and follow-up of all elevated blood lead cases, and targeted intervention and education. The program continually strives to increase screening and follow-up rates by providing education to providers, parents, and local health department personnel. Law requires all commercial laboratories in the state to report all blood lead levels to the Department of Public Health.

To decrease the effects of lead poisoning in children, children at risk need to be identified at an early age and screening and primary prevention interventions need to be initiated in a timely manner. The Department of Public Health has finalized statewide screening recommendations that call for screening of children to occur at 12 months of age and again at 24 months of age. In addition to screening, health care providers are asked to utilize an initial risk assessment, anticipatory guidance, and parental health education. Screening at twelve and twenty-four months of age is consistent with federal requirements for children receiving Medicaid assistance. It is important to note that significant portions of the Connecticut children who have elevated blood lead results are Medicaid recipients. With this fact in mind, the Connecticut DPH is currently working with the Department of Social Services to match Medicaid data with blood lead screening data so that Medicaid children who have not been screened can be identified and screened. Furthermore, legislation has been proposed in Connecticut that calls for mandatory universal screening of all one and two-year-old children.

TARGET POPULATION

# of Children in Population:	270,187 (2000 Census)
Age Range:	0 through 5 years
Sex:	Male and Female
Race/Ethnicity:	White – Non Hispanic, African American – Non Hispanic, Hispanic
Geographic Location:	Statewide

Within the overall target population of children under six, the primary focus is all children at one and two years of age. These children are particularly susceptible to the adverse effects of lead poisoning due to their developing neurological systems. They need to be screened and, if they demonstrate an elevated blood lead level, followed-up by their medical provider with appropriate intervention. All children 3–6 years of age, who have not been previously tested, must also be screened. Program emphasis continues to be placed on assuring that children in these age groups are tested in accordance with state recommendations and federal guidelines and that all results are reported to the DPH.

Among the high-risk population, there were 38,746 screening tests reported for 1 and 2-year-old children in Connecticut during calendar year 2003 and 869 had elevated blood lead levels (≥ 10 $\mu\text{g/dL}$).

FEDERAL FISCAL YEAR 2005 PROGRAM OBJECTIVES

1. By June 30, 2006, complete the identified goals and objectives outlined in the statewide Childhood Lead Poisoning Elimination Plan that pertain to legislation and regulatory changes that need to be addressed in the State.
2. By March 15, 2006, complete audits of all funded local health departments as they pertain to screening, case management, and environmental compliance.
3. By June 30, 2006 provide education and resources to health care providers and community organizations to support increased screening efforts, awareness, and case management activities. This is an ongoing effort.
4. By June 30, 2006, maintain the capacity to electronically process at least ninety percent of blood lead lab results on an ongoing basis throughout the grant cycle. Identify laboratories that may be recruited to submit data electronically through assessment of number of hard copy blood lead lab results submitted by private and commercial laboratories. Contact identified laboratory directors to discuss technical barriers to electronic submission and develop strategies to overcome identified barriers where possible.
5. By June 30, 2006, continue to reach parents by developing outreach and education opportunities with elementary and preschools, Family Resource Centers, School Readiness programs, Head Start, Parent Teacher Organizations, and high schools with teen parents. This is an ongoing effort.
6. By June 30, 2006, complete a second targeted intervention program using a community outreach/case management approach and target the under served, high-risk population of the Willow and Walnut Street neighborhoods of Waterbury.
7. By June 30, 2006, continue outreach to Medicaid Managed Care Organizations (MCOs) using Medicaid matching data. Provide education to HUSKY parents regarding lead screening and treatment. Provide in service training for HUSKY health care providers regarding lead screening and case management. This is an ongoing effort.
8. By September 30, 2006, the Childhood Lead Poisoning Prevention Program (CLPPP) will continue to review risk factor data to identify areas of increased risk for children with elevated blood-lead levels.
9. By September 30, 2006, the CLPPP will continue to maintain capacity for the collection, management, and analysis of surveillance data on children tested for lead poisoning.
10. By January 31, 2006, the CLPPP will improve surveillance data through the collection of more comprehensive risk information, and complete reporting of all test results by utilizing the expanded capacity of the new Lead Surveillance System (LSS).

FEDERAL FISCAL YEAR 2004 PROGRAM ACCOMPLISHMENTS

1. Overall screening rates for Connecticut children are above the national average. Connecticut's action levels for childhood lead levels (10µg/dL and 20 µg/dL) are also consistent with current national standards. It is also important to note that in 2003, among children under six years of age, data indicated that there was 1,481 children identified with a blood lead level $\geq 10\mu\text{g/dL}$. In the same period, 242 children were identified with a blood lead level of $\geq 20\mu\text{g/dL}$.

2. The Systematic Tracking of Elevated Lead Levels and Reporting system (STELLAR) continues to be utilized by grantees and several other local jurisdictions as a case management tool. Users define case management and follow-up protocols for their individual programs and the STELLAR program calculates due dates for follow-up tests, medical referrals, inspections, abatements and other services.
3. The CLPPP continues to take a regionalized approach to site assistance and audits by program staff. The Case Management staff has teamed with the environmental sanitarian staff to work on a regionalized basis providing routine oversight and scheduled audits of both funded and non-funded local health departments. The Childhood Lead Poisoning Prevention Program and the Lead Environmental Management Unit have been merged into a single, consolidated unit.
4. The CLPPP convened a Lead Elimination Task Force in 2004 to develop and write a statewide elimination plan. In August 2004, that plan was submitted to the CDC. The Task Force is currently working to implement the recommendations set forth in that plan to eliminate childhood lead poisoning in Connecticut by 2010.

PROGRESS OF 2004 PROGRAM

The CLPPP continues to be active in a number of state-sponsored and municipal public and professional lead education initiatives. Program staff continues to emphasize screening of all one and two year old children. Emphasis on age appropriate screening has also been directed to Managed Care Organizations to assure that all children in their practices have been screened appropriately. Support to local health departments in the areas of public education programs, targeted education programs and coalition building continues to be a program priority. Outreach and education in lead safe work practices was continued through the annual KEEP IT CLEAN CAMPAIGN (KIC). The KIC is focused on educating customers at retail paint and hardware stores to avoid the creation of lead hazards through unsafe painting and renovation practices. Distribution of standardized educational materials and quarterly newsletters continue. The CLPPP also conducts a semi-annual educational conference that is attended by representatives from local health departments, regional treatment centers, managed care plans, and individual medical providers.

Quality improvement of data within the Lead Surveillance System (LSS) and improvement of incoming data with regard to format, completeness and accuracy of demographic information are two other continuing program focus areas. The CLPPP continues with the final phase of a three-phase project to enhance and re-engineer the current LSS. This project is being conducted on a collaborative basis with the States of Massachusetts and Rhode Island. The new system "went live" in October 2004.

Approximately 70% of the blood lead reports ultimately entered into the LSS come from the DPH Division of Laboratory Services (DLS). The remainder of lead test results are provided from several hospital based or commercial laboratories. The CLPPP now receives all reports from the DLS directly to the program electronically and the majority of the hospital based and commercial laboratories are sending blood lead results directly to the program in various electronic formats. Reduction and ultimate elimination of paper laboratory reports is considered a program priority.

The CLPPP continues to address the issue of statewide screening. In 1998, the Connecticut Lead Poisoning Screening Committee (CLPSC) recommended that universal screening of all children

should continue until more complete screening data was available. The highest prevalence of elevated blood lead levels continues to be in the one and two-year old population. Effective October 1, 1998, universal reporting of blood lead testing results was made mandatory. The screening committee re-convened during 2001 and finalized a statewide screening recommendation calling for universal screening of one and two year old children. The screening recommendations to providers also include recommendations for anticipatory guidance, risk assessment and health education of parents. These guidelines were revisited and reviewed in January 2004. The CLPSC agreed to maintain the guidelines intact and to strive toward passing legislation for mandated universal screening of all one and two year-olds (up to age six for those not screened) in Connecticut.

OUTCOME OBJECTIVES

Objectives	Indicators	Progress
Childhood Lead Poisoning Prevention	Reduce the number of children less than six years of age with blood lead levels $\geq 10\mu\text{g}/\text{dl}$ to less than 2.2% and those with levels $\geq 20\mu\text{g}/\text{dl}$ to less than 0.4%.	Conducted primary prevention activities and identify children at risk through a comprehensive program of blood lead screening that is recommended for all children. Offered intervention and risk reduction education to care givers, parents and guardians, and medical professionals. Provided surveillance, case management, environmental management, and follow-up of elevated blood lead level cases.

D. EMERGENCY MEDICAL SERVICES (EMS)

NATIONAL YEAR 2010 HEALTH OBJECTIVE

11.1 Increase the proportion of persons who have access to rapidly responding pre-hospital emergency medical services.

Note: There is no national, quantifiable Health Status Objective for 2010 for Emergency Medical Services; no national baseline response time or target number for “rapidly responding.” Nationally recommended response times include: arrival of 1st responder and/or CPR within 4 minutes from the time of dispatch; arrival of basic life support ambulance within 6-8 minutes; and advanced life support within 12 minutes.

PROGRAM GOAL

To reduce the number of preventable deaths and disabilities in CT by minimizing the time between the occurrence of a sudden, serious illness or injury and the provision of definitive care at the scene, during transport and at the destination hospital.

STATEMENT OF ISSUES/PROBLEM

The Emergency Medical Services (EMS) system, in its complexity, must be capable of providing medical care to a single individual suffering from a wide range of life threatening illnesses and/or traumatic injuries and also have the capacity to rapidly expand to accommodate hundreds affected by a mass casualty disaster. The EMS is a critical component of the overall health care delivery system. The availability of pre-hospital emergency medical services is often the only difference between life and death for emergency victims of traumatic events, cardiac arrests, strokes, and motor vehicle crashes. Out-of-hospital cardiac arrest (OHCA) is a leading cause of death in the US. An estimated 15% - 20% of all deaths in the U.S are due to OHCA. If victims of OHCA can receive immediate and appropriate treatment, including cardiopulmonary resuscitation (CPR) and Automatic External Defibrillator (AED) within 4 minutes of the cardiac arrest, evidence suggests they have a 30% - 70% chance of survival. The chance of success deteriorates with each minute.

The lack of a quantifiable, national Health Status Objective for EMS highlights the difficulty of obtaining the uniform “field” data essential to measure the degree to which EMS interventions reduce the number of preventable deaths and disabilities. According to statistics reported to DPH’s Office of Emergency Medical Services (OEMS) by EMS providers on the Service Provider Activity Reporting form, the EMS providers responded to a total of 359,740 9-1-1 calls from CT residents during CY 2004. Approximately 21% (76,160) of the calls involved trauma patients, 1% (2,120) cardiac arrest patients and 57% (205,358) were classified as general emergency patients. The statewide average of EMS providers’ average response time from the receipt of the 9-1-1 call, to the service responder’s arrival at the scene, was 8.6 minutes. The statewide average arrival time for First Responders was 5.3 minutes. Paramedics provided advanced life support services at the scene and/or during transport to the hospital, for 60% of the total service responses. Approximately 20% (101) of the 502 pre-hospital defibrillations performed on cardiac arrest patients were reported as successful as measured by the return of spontaneous cardiac activity. The statistics presented in this report include those reported by providers to OEMS through May 2005. As more 2004 data is received from additional providers, the 2004 figures noted above will continue to be updated by OEMS.

DESCRIPTION OF THE PROGRAM STRATEGY

The essential components of a rapidly responding EMS system in CT include:

- 1 public recognition of life threatening injuries and illness and knowledge of how and whom to call for emergency assistance;
- 2 public education and training concerning initial, lifesaving “bystander EMS” procedures to follow until the arrival of EMS providers, such as CPR, controlling hemorrhage, Heimlich maneuver or AED use;
- 3 access to enhanced 9-1-1 with pre-arrival instructions to the caller enabling the caller to provide assistance to the patient until EMS personnel arrive;
- 4 availability of well trained response personnel certified by OEMS;
- 5 timely and adequate response by EMS personnel and rapid transport as needed to an emergency medical facility by one of the 381 ambulance provider services certified /licensed by OEMS; and
- 6 medical direction and oversight for the EMS personnel.

The State EMS Plan adopted by the Department of Public Health (DPH) in 1997, and currently being updated, defines the goals and objectives of a model EMS system in Connecticut. The DPH contracts with five Regional EMS Councils to assist with the implementation of the EMS plan at the local level. The Councils facilitate the area-wide planning, coordination, and evaluation of emergency medical services for their respective regions. The Councils also coordinate the administration of post training exams for Medical Response Technician and Emergency Medical Technician refresher courses conducted in their region. DPH contractual funding for the EMS Regional Councils will be reduced by 22% effective 7/1/06 due to the proposed elimination of Block Grant funding for the Council contracts. OEMS and the Regional Councils will examine the effect the reduced funding will have on the Regional Councils’ current contribution to the EMS system and collaborate on strategies to minimize the effect during the coming year.

Effective January 1, 2005, DPH initiated the implementation of a statewide Trauma Registry, a population-based electronic data collection and information reporting system, at 21 Connecticut hospitals. Once fully implemented, the Trauma Registry will capture data on the care provided a trauma patient from pre-hospital to rehabilitative services. Also, on February 1, 2005, 20 EMS provider agencies in Connecticut began beta testing a separate, new, electronic data and reporting system, the EMS Data Collection System, that captures pre-hospital emergency response information. The EMS Data Collection System’s electronic reporting will replace the current paper based Quarterly Provider Activity reporting to OEMS that is required of all EMS provider agencies. The electronic system expands upon the type of essential emergency response information currently captured in the paper-based system, that includes the number, timing and types of emergency responses. Through the analysis of the response data and the data captured in the Trauma Registry, trends in EMS care delivery will be identified, such as geographic areas with high concentrations of trauma patients, variance in outcomes and relationships to response time and treatment, etc. The Trauma Registry data will be used to modify existing EMS training and clinical guidelines to further reduce the rate of injury morbidity and mortality in Connecticut.

The PHHS Block Grant is used to support the two 1.70 FTE positions for OEMS, including a data analyst position.

TARGET POPULATION

Number:	3.2 million
Age Range:	All
Sex:	Male and Female
Race/Ethnicity:	All
Geographic Location:	State of Connecticut

FEDERAL FISCAL YEAR 2006 PROGRAM OBJECTIVES

1. By September 30, 2006, increase the percentage of sudden out-of-hospital cardiac arrest patients successfully defibrillated by emergency service pre-hospital providers to 25%, as indicated on the EMS Provider Activity Reports sent quarterly to OEMS, by increasing the number of towns served by First Responders trained and authorized for Automatic External Defibrillators (AED) use. Baseline: 143 towns currently have a designated first responder that is equipped with, and trained in, AED use. 101 or 20% of the 502 defibrillations provided to cardiac patients transported during CY 2004 were successful according to the self-reported data captured in the EMS Provider Activity Reports sent to OEMS through May 2005.
2. By January 1, 2006, OEMS will conduct a needs assessment to identify the placement and use of automatic external defibrillators within the emergency medical services system and report the findings of the needs assessment to the Connecticut General Assembly's Public Health Committee, as mandated by legislation enacted in June 2004 entitled, Special Act 04-9, "*An Act Concerning the Use of Automatic External Defibrillators.*" Baseline: OEMS submitted a report on January 1, 2004 to the Legislature that outlined recommendations for maximizing community access to Automatic External Defibrillators (AED's), including strategies for developing public access to defibrillation and cardiopulmonary resuscitation (CPR) training programs. Currently 2,330 AED's maintained by entities within CT are registered with OEMS and 209 Connecticut residents received CPR/AED training through OEMS funded programs in CY 2004. OEMS does not maintain statistics on the number trained in CPR or AED use by agencies such as the American Red Cross or American Heart Association.
3. By January 1, 2006, all Connecticut hospitals will be collecting and submitting standardized trauma data to OEMS via the recently implemented, electronic State Standardized Trauma Data Collection System designed for OEMS, by Digital Innovations, the selected software vendor. Baseline: The initial version of the Trauma Registry Data Collection System was distributed to hospitals in April 2003, tested and revised as needed, prior to 21 of the larger hospitals implementing the standardized Trauma Registry data system in January 2005.
4. By September 30, 2006, OEMS will analyze the trauma data submitted by Trauma Registry participating hospitals and produce a report of the standardized trauma data captured during CY 2005 in a format designed by the Trauma Data Committee and OEMS.
5. By September 30, 2006, OEMS and the Trauma Data Committee will develop metrics to use to evaluate trauma outcome, by hospital, for those submitting data to the Trauma Registry, including the actual number of trauma deaths compared to the expected number, controlling for Injury Severity Score, Risk of Mortality, severity, age, gender, and length of stay.

6. By March 31, 2006, OEMS and the State Trauma Committee will evaluate the attainment of objectives in the 1995 Statewide Trauma System Plan and produce an updated Trauma System Plan. Baseline: The 1995 Plan has not been systematically evaluated nor updated by the Trauma Committee and OEMS since originally written in 1995. OEMS and the State Trauma Committee began the evaluation and Plan revision process in November 2004 based upon a comparison of the Plan to “Benchmark” trauma plans/systems from around the country, (i.e., Maryland, San Diego, etc.).
7. By April 15, 2006, OEMS will submit a draft Emergency Medical Services (EMS) Plan to the EMS Advisory Board for review and approval. In addition to updating the model components of the EMS Plan originally formulated in 1997, the updated Plan will identify specific staff and/or Advisory Board Sub-Committee responsibilities and the necessary action steps for the attainment of objectives within each goal area of the Plan.
8. By December 1, 2005, OEMS and Digital Innovations (DI), the software vendor that developed CT’s EMS Data Collection System, will implement Phase 2 of the beta testing of the EMS Data Collection System at 30 hospitals, which will enable hospitals to receive the EMS response data captured and reported by the pre-hospital service provider. OEMS will provide computers and/or printers to any hospital unable to accept electronic data submissions from the service providers so the “run form” data can be entered, and printed out, for inclusion in the patient’s hospital record.
9. By April 1, 2006, OEMS and Digital Innovations will implement Phase 3 of the beta testing of the EMS Data Collection System at 30 hospitals, which will link the EMS Data Collection System with the hospital’s patient record and billing information system (s).
10. By September 30, 2006, the efforts of OEMS will contribute to the enhanced reliability of wireless telecommunication providers’ automatic location identification capability in Connecticut for wireless 9-1-1 calls, which will improve EMS response time and treatment outcome for the 50% of 9-1-1 calls that currently originate from wireless phones.
11. By September 30, 2006, survey all the pre-hospital EMS provider agencies to ascertain how many have the essential pediatric equipment, and supplies, as outlined in the American Association of Pediatrics/American College of Emergency Physicians Joint Guidelines for Basic Life Support (BLS) and Advanced Life Support (ALS) providers. Baseline: This will be the initial pediatric equipment survey.
12. By January 30, 2006, pediatric representation will be incorporated in EMS Committees/boards established to advise DPH, specifically the EMS Advisory Board, CT Medical Advisory Committee, the Training Committee and the Trauma Committee. Baseline: The Trauma Committee of the EMS Advisory Board is the only EMS Board/committee of DPH that currently is in the process of appointing a pediatric representative.
13. By September 30, 2006, OEMS, with input from relevant EMS Advisory Board Sub Committees, will distribute state pediatric EMS protocols to each Sponsor Hospital. Baseline: Regional and local pediatric protocols are currently being collected and reviewed.

FEDERAL FISCAL YEAR 2004 PROGRAM ACCOMPLISHMENTS

A summary of the OEMS' SFY 04 accomplishments is outlined in the Service Statistics and Accomplishments table on the following page. Additional accomplishments are listed below.

Each of the 5 Regional Councils evaluated the attainment of the State and Regional Plan objectives in their respective geographic areas covering the period 1999 through 2004 and submitted the evaluation report along with updated Five Year Regional EMS Plans, to OEMS in July 2004. The regional evaluation reports facilitated OEMS' and the Advisory Board's Planning Committee's initiation of the revision to the state EMS Plan.

OEMS submitted a report on January 1, 2004 to the Public Health Committee of the Connecticut Legislature that outlined recommendations for maximizing community access to Automatic External Defibrillators (AED's), including strategies for developing public access to defibrillation and cardiopulmonary resuscitation (CPR) training programs.

FEDERAL FISCAL YEAR 2005 PROGRAM PROGRESS

Effective January 1, 2005, twenty one (21) of Connecticut's hospitals, including the 13 state Trauma Center hospitals, began using the recently finalized version of the statewide Trauma Registry software or, revised their existing software to ensure all specified trauma data is captured and reported in a format consistent with that of the statewide Trauma Registry system.

OEMS compiled the hard copy quarterly EMS Provider Activity Reports submitted by EMS service providers during calendar year 2004. Highlights of the regional results, which include no reporting or incomplete reporting from some providers, are presented below by region of the state.

Reporting Period 1/1/04– 12/31/04 (CY 2004)

EMS Region	Service Responses	Average Response Time (Minutes)	Average Response Time - 1st Responder	Patients By Type			Defibs Performed	Successful Defibs
				Trauma	Emergency	Cardiac Arrest		
1-SW EMS Council	62,645	7.2	4.3	15,103	36,751	423	101	30%
2-S. Central EMS Council	114,782	8.7	5.4	19,488	54,122	353	65	14%
3-Eastern EMS Council	41,604	8.8	4.9	9357	27,580	292	100	16%
4-N. Central EMS Council	92,903	7.3	4.9	21,767	57,388	619	109	24%
5-Northwest EMS Council	47,806	9.6	5.8	10,445	29,517	433	126	16%
Totals	359, 740	8.6	5.3	76,160	205,358	2,120	501	20%

Digital Innovations (DI), the software vendor selected to develop CT's Trauma Registry and the separate EMS Data Collection System, released the electronic version of the EMS Data Collection System and OEMS and DI began beta testing the software with 20 EMS service providers in February 2005. Prior to initiating the beta testing, the providers received training and computers from OEMS to facilitate the provider's adoption of the new electronic reporting system.

Connecticut is now compliant with the FCC requirements for both Phase 1 and Phase 2, of 9-1-1 wireless capabilities. This means that for people that use cell phones, PCS, Nextel, etc., the 9-1-1 Primary Service Answering Points (PSAP) can identify both the caller's telephone number as well as the caller's geographical location. Testing continues to determine the accuracy of this new capability that will improve EMS response time and treatment outcome for the 50% of 9-1-1 calls that currently originate from wireless phones.

OEMS, as a member of CT's Emergency Management and Homeland Security Coordinating Council, is contributing to the state's efforts to coordinate and regionalize emergency resources and communications, particularly for "all hazards" emergency management planning, which encompasses manmade or natural disasters.

In December 2004, OEMS convened EMS provider representatives to begin the process of evaluating the attainment of the 1997 State EMS Plan objectives and updating the EMS State Plan. As of May 2005, the following goal areas of the 1997 EMS Plan have been evaluated; Trauma, Data and Evaluation, Human Resources Education and Training, Mass Casualty, EMS for Children, Communications and Medical Direction.

OEMS' Training and Education Coordinator initiated a major review of current EMS provider curriculum as well as the candidate testing process. The review encompasses all levels of EMS providers, inclusive of EMS-Instructors and how (and if) they are meeting the student needs.

OEMS is coordinating the development and implementation of statewide mutual aid response to WMD/All-Hazards response by EMS.

OEMS is collaborating with DEMHS to establish a nerve antidote program for the protection of Connecticut's first responders. The training program has been finalized, and the implementation plan is being completed, but remains in draft form at this time.

The Statewide Training and Education Committee (DEMHS) has been established to identify and train all levels of First Responders/First Receivers as it relates to the core competencies that all disciplines will need regarding all-hazard response. This will then drive forward training requirements, e.g., NIMS / ICS that will be included in the educational programs for all disciplines, to include EMS. CT DPH Office of Public Health Preparedness is heavily involved in this process.

EMS Statistics and Accomplishments
State Fiscal Years 2004 and 2005 (YTD thru 4/30/05 unless noted otherwise).

EMS Personnel Licensed, Certified and/or Recertified	SFY 2004	SFY 2005 YTD	Current # Certified/Licensed
Medical Response Technicians (MRT)	1,875	2,360	7,540
Emergency Medical Technicians (EMT)	3,786	3,395	10,254
Emergency Medical Technicians (Intermediate)	447	350	963
Paramedics	1,604	1,586	1,704
Emergency Medical Services Instructors	211	136	393
Total Certified EMS Personnel	7,923	7,827	20,854

EMS Provider Certifications and Inspections	SFY 2004	SFY 2005 YTD	Total Currently Licensed/Certified
Ambulance/EMS Vehicles Inspected	387	449	862
EMS Providers (ambulance co., etc.) Certified and Licensed	381	381	381
New Complaint Investigations Opened of EMS Providers (ambulance companies or EMS personnel)	29	48	Not Applicable (N/A)
New Automatic External Defibrillators (AED's) Registered	264	323	2,328
EMS Average Response Time: 1 st Responder (state average)	4 min.	5.3 min.	N/A
Transporting Provider (state aver.)	8 min	8.6 min.	N/A

EMS Courses Approved	SFY 2004	SFY 2005 (thru 4/30/05)
MRT Courses	273	286
EMT/Paramedic Courses	4718	487
EMT Basic Exam Results		
% Failed Written Exam- 1 st Take	(37%)	(42%)
Failed Practical Exam-1 st Take	(27%)	(28%)

OUTCOME OBJECTIVES

Objectives	Indicators	Progress
Increase % of sudden out-of-hospital cardiac arrest patients successfully defibrillated by EMS pre-hospital providers to 25%.	Percentage reported on EMS Provider Activity Reports for CY 2005.	CY 2004 statewide average on EMS Provider Activity Reports was 20%.
All five Regional Councils will receive local EMS plans from towns in their regions as mandated in CT General Statutes.	Copies of the local EMS System Plans available for review.	81% of Connecticut towns have submitted a local plan.
Revise State EMS Plan to incorporate local, state and federal recommendations.	State EMS Plan draft contains recommendations from the NHTSA assessment and EMS Agenda for the Future.	The 5 Regional Councils evaluated the attainment of State and 1999 Regional Plan objectives in their respective regions on 7/04, and are contributing to the current OEMS/Planning Committee's update of the 1997 state EMS Plan.
OEMS to receive complete, electronic trauma data from CT's hospitals, using the 2005 Trauma Registry software by 9/30/05.	Electronic receipt by OEMS of complete standardized data.	21 of CT's larger hospitals initiated use of the Trauma Registry software on 1/1/05 and electronic submission of the data to OEMS projected to begin on target in 9/05.
Revise/enhance the EMS Data Collection System software prior to widespread distribution, based upon beta testing results.	Revised, EMS Data Collection System software that incorporates changes requested by beta testing providers.	20 EMS providers began beta testing the EMS Data System in 2/05; software enhancements continually being made to address beta testers' requests.

E. LOCAL HEALTH DEPARTMENTS

NATIONAL YEAR 2010 HEALTH OBJECTIVE

7.10 Increase the proportion of Tribal and local health service areas or jurisdictions that have established a community health promotion program that addresses multiple Healthy People 2010 focus areas.

PROGRAM GOAL

To offer preventive health services funds from the Preventive Health and Health Services Block Grant to full-time local health departments and districts, as they are deemed eligible.

STATEMENT OF ISSUES/PROBLEM

The need for the type of preventive health services funded by the PHHSBG varies by town and district, as does the ability of local communities to provide services. In an attempt to ensure communities have the flexibility to determine how best to use PHHSBG funds to address their priority needs, a portion of the PHHSBG is reserved each year for local health department grants. Each of the departments is allowed to choose each year which of the priority Health Status Objectives to address with their funds.

DESCRIPTION OF THE PROGRAM STRATEGY

The 2006 PHHSBG funding will be offered to all local health departments and districts that are staffed by a full-time public health director. The "full-time director" criterion is imposed to guarantee the local health department has the minimum resources to meet PHHSBG service requirements. For FFY 2006, \$498,769 or 25% of the total PHHSBG basic award is allocated for contractual funding to local health departments

Each local health department's share of the total allocation was calculated using a weighted, per capita formula that divides 70% of the total grants available among non-poor residents in each of the towns served by local health departments with full-time directors. The remaining 30% is for distribution to residents classified as poor according to the 2000 population estimates.

The state health status outcomes objectives, risk reduction objectives and annual activity objectives selected by the PHHSBG-funded programs serve as the menu of acceptable program activities that local health departments can elect to address. Departments are required to provide the data specified by the DPH under each Healthy People 2010 Chapter/Program to measure progress towards the attainment of the Year 2010 Objectives. Many local health departments take advantage of the PHHSBG's flexibility by addressing different program objectives each year in response to changing health priorities at the local level.

TARGET POPULATION

Number: 3,405,565
Age Range: All
Sex: Male and Female
Race/Ethnicity: All
Geographic Location: Towns and districts staffed with a full-time public health director

FEDERAL FISCAL YEAR 2006 PROGRAM OBJECTIVES

The 2006 Objectives for the Local Health Departments are presented under the individual program components of this Plan.

FEDERAL FISCAL YEAR 2004 PROGRAM ACCOMPLISHMENTS

The 2004 accomplishments of the Local Health Departments are presented under the individual program components of this Plan.

PROGRESS OF 2005 PROGRAMS

The progress of 2005 programs of the Local Health Departments is presented under the specific program components of this Plan.

Several PHHSBG-funded programs, including Unintentional Injuries, receive no direct PHHSBG contractual line item funding. The ability of these programs to implement their objectives through local health departments and districts is dependent upon the number of local health departments and districts that choose to use their PHHSBG allocation to address the respective program areas each year. The PHHSBG assists local health departments and districts in ways other than through the direct allocation of funds. Local health departments and districts are the primary beneficiaries of the program technical assistance, training, surveillance, policy, planning and regulatory guidance and laboratory support provided by the PHHSBG-funded staff.

OUTCOME OBJECTIVES

Objectives	Indicators	Progress
Local Health Departments	Address priority PHHSBG funded health needs of communities.	Provide funding and program assistance for local health departments for approved health promotion services of their choice.

TABLE O
SUMMARY OF LOCAL HEALTH DEPARTMENTS PHHSBG CONTRACTUAL FUNDING

Program Area ¹	PHHSBG Year 2003		PHHSBG Year 2004		PHHSBG Year 2005	
	No. of LHDs Addressing Area	SFY 2004 Contract Amount	No. of LHDs Addressing Area	SFY 2005 Contract Amount	No. of LHDs Addressing Area	SFY 2006 Contract Amount
Youth Violence	2	\$41,806	3	\$45,662	4	\$48,932
Unintentional Injuries	4	\$32,443	6	\$ 46,030	5	\$35,714
Cardiovascular Disease includes one or more of the following:						
High Blood Pressure	2	\$13,788	1	\$2,365	2	\$7,876
Diabetes	7	\$51,604	5	\$33,327	3	\$13,889
Smoking Cessation	5	\$26,607	3	\$19,387	2	\$10,801
Excess Dietary Fats/NUTED	7	\$49,548	5	\$30,894	9	\$75,021
Cholesterol	1	\$2,175	4	\$27,177	3	\$11,219
Physical Activity	9	\$51,970	7	\$34,089	8	\$47,428
Obesity	N/A	N/A	N/A	N/A	2	\$25,325
Total CVD		(\$195,692)	25	(\$147,239)	29	(\$191,559)
Risk Factor Surveillance (Food)	4	\$45,588	1	\$11,998	2	\$22,969
BRFSS	4	\$45,020	6	\$67,942	7	\$93,344
Lead Poisoning Surveillance	6	\$83,418	4	\$59,748	4	\$46,824
Occupational Health	0	0	0	0	1	\$2,027
Total Surveillance	14	(\$174,026)	11	(\$151,686)	14	(\$142,195)
Skin Cancer	3	\$30,621	3	\$40,206	2	\$26,042
Lung Cancer in Women	N/A	N/A	N/A	N/A	0	0
Cancer Planning	N/A	N/A	N/A	N/A	0	0
Total Cancer	N/A	N/A	N/A	N/A	2	(\$26,042)
Intimate Partners Violence	0	0	0	0	0	0
Declined Allocation/Not Yet Selected	6	\$24,181	1	\$2,152	8	(\$54,327)
Total LHDs²	60	\$498,769	46	\$498,769	48	\$498,769

¹ Totals represent only PHHS block grant funding. Certain programs receive supplement state funds, which are not reported here.

² Totals may exceed number of eligible LHDs as departments split their contract funding among multiple program areas.

F. RAPE CRISIS

NATIONAL YEAR 2010 HEALTH OBJECTIVES

15-35 Reduce the annual rate of rape or attempted rape, target 0.7 rapes or attempted rapes per 1,000 persons.

PROGRAM GOAL

By September 30, 2006, reduce by 2% the occurrence of rape in Connecticut, as measured by Connecticut's Uniform Crime Reports of Sexual Assaults.

Baseline:

740 reported rapes in 1997	(decrease of 2.0%)
727 reported rapes in 1998	(decrease of 1.8%)
654 reported rapes in 1999	(decrease of 10.0%)
668 reported rapes in 2000	(increase of 2.1%)
640 reported rapes in 2001	(decrease of 4.2%)
734 reported rapes in 2002	(increase of 14.7%)
Data unavailable for 2003	

STATEMENT OF ISSUES/PROBLEM

Sexual assault is a pervasive public health problem in the United States, affecting women and men, adults and children. The National Sexual Violence Resource Center reports that an estimated 1 in 4 women and 1 in 6 men will experience a sexual assault in their lifetime. These estimates are consistent with Connecticut's Sexual Assault Experiences and Attitudes Study (MACRO, 2000). In that study, 19% of all Connecticut adults surveyed reported that they had experienced sexual assault in their lifetime, and 14% reported being victims of childhood sexual abuse. Twenty-six percent of female residents reported being sexual assault survivors. Multiple studies have documented the many negative effects of such victimization, including post-traumatic stress disorder, fears, phobias, interpersonal difficulties, sexual dysfunction, depression, insomnia, and increased risk for substance abuse and suicide.

Current data on the prevalence of sexual assault are incomplete. Estimates of the incidence of sexual assaults must be compiled from a variety of sources. Sexual assaults often go unreported to police and victims may not access treatment for many years, if at all. According to Connecticut's Sexual Assault Experiences and Attitudes study (MACRO, 2000), only 16% of rapes were reported to the police. This rate of reporting is consistent with statistics reported nationally by the Federal Bureau of Investigation. Even though the rates at which people report rapes are low, there has been a recent decrease in the numbers of reported rapes nationally and an increase in the number of reported rapes in Connecticut. According to preliminary data from the Federal Bureau of Investigation's Uniform Crime Report (2004), the overall violent crime rate decreased 1.7% and forcible rape decreased 0.3%. According to the State Police Crimes and Data Analysis Unit, Connecticut 2002 crime statistics show that 734 rapes were reported to the police in calendar year 2002, for a rate of 41.79 rapes/100,000 females. This is an increase in the rate of reported rapes of 14.7% from 2001. Connecticut state police crimes data for 2003 are unavailable.

Between July 1, 2003 and June 30, 2004, a total of 2,851 female rape victims were served by the Connecticut Sexual Assault Crisis Services, Inc. (CONNSACS) member agencies. Of these, 1,538 were female rape victims age 12 and over who were assaulted on or after July 1, 2003. Statistics maintained by CONNSACS show that approximately 32% of assault victims

are under the age of 18 (1,030 in SFY 04). A 1994 survey of violence-related injuries treated in hospital emergency rooms (Report NCJ-156921, BJS, 1997) indicated that 5% of all such injuries were due to rape/other sexual assault. For children seen in emergency rooms for such injuries, that percentage climbs to 29% for children under the age of twelve. The median age for children treated for sexual abuse was four. In Connecticut during SFY 2004, there were 745 new cases of sexual abuse of children substantiated by the Department of Children and Families as compared to 573 in SFY 2003.

DESCRIPTION OF THE PROGRAM STRATEGY

The DPH will contract for the provision of the following types of direct services for victims of rape and other sexual assaults:

- Crisis intervention, individual and group counseling;
- Medical, police and court accompaniment;
- Free and confidential 24 hour hotlines-including local rape crisis centers and statewide toll free English and Spanish hotlines; and
- Transportation as necessary.

Services will be provided to at least 4,000 female and male victims of sexual assault, including both recent and prior assaults, of all ages. The DPH will continue to implement improved surveillance activities to enhance the capacity to measure the incidence and prevalence of sexual assault in Connecticut.

TARGET POPULATION

Prior (assaulted before July 1, 2005) and Recent (assaulted on or after July 1, 2005) Female and Male Victims of Sexual Assault.

Number:	4,000
Age Range:	All
Sex:	Males and Females
Race/Ethnicity:	All
Geographic Location:	Statewide

DISPARATE POPULATION

Recent (assaulted on or after July 1, 2005) Female Victims of Sexual Assault.

Number:	1,000
Age Range:	12+
Sex:	Females
Race/Ethnicity:	All
Geographic Location:	Statewide

The target population includes all women that have been assaulted, including the disparate population. The disparate population refers only to the most recent assaults.

FEDERAL FISCAL YEAR 2006 PROGRAM OBJECTIVES

1. By June 30, 2006, increase by 2% the percent of victims who receive medical care within 72 hours of their assault, as measured by CONNSACS client data.

<u>Baseline:</u> SFY 97	708 (20.5% of assault victims)
SFY 98	641 (22.0% of assault victims)
SFY 99	546 (25.0% of assault victims)
SFY 00	477 (27.4% of assault victims)
SFY 01	454 (37.9% of assault victims)
SFY 02	465 (34.2% of assault victims)
SFY 03	433 (39.8% of assault victims)
SFY 04	484 (27.9% of assault victims)

2. By June 30, 2006, 100% of victims will be informed of availability of acute care services. By that time, the percent of victims receiving support services within 72 hours of assault from Rape Crisis Centers (RCCs) at hospital emergency rooms and medical clinics will increase 2%. The program will continue to document the number of victims raped after 7/1/05 that reported receiving medical care within 72 hours, after 72 hours of assault and the number of victims who refused medical assistance.
3. By June 30, 2006, reduce emotional/psychological trauma of victims through counseling intervention and other support services. Through the RCCs, provide crisis intervention services (individual and group supportive counseling) to at least 4,000 sexual assault victims (both males and females) to decrease trauma and increase awareness of community support services. Counseling will be provided to at least 500 female and male victims of rape age 12 and over (raped since July 1, 2005); to at least 250 former female and male rape victims age 12 and over (raped prior to July 1, 2005); and to 1,000 new and former female and male victims of sexual assault (other than rape).
4. By June 30, 2006, the DPH will continue to measure the incidence rate of sexual assault, including rape, to females and males over age 12 in Connecticut. The rape crisis contractor will compile rape incidence data as reported by victims to RCCs, since July 1, 2005. DPH will require the contractor to report enhanced sexual assault data for the OPM outcome measures on a quarterly basis providing detailed information related to victimization. The DPH Staff will continue to integrate the enhanced sexual assault data from the Contractor, State Police, Department of Children and Families and other sexual assault databases to improve the surveillance of sexual assault in Connecticut.
5. By June 30, 2006, the contractor and DPH will enhance data collection and analysis activities to include a narrative report consistent with DPH and Federal Prevention Block Grant funding reporting requirements. DPH and the contractor will continue to evaluate outcome measures and recommend possible changes and the contractor will submit a narrative report to explain if outcome measures are not met.

FEDERAL FISCAL YEAR 2004 PROGRAM ACCOMPLISHMENTS

1. In State Fiscal Year 2004, 484 victims of sexual assault obtained medical assistance within 72 hours of their assault.
2. Counseling was provided to 3,218 primary victims of sexual assault.

3. Rape Crisis training was provided to 616 law enforcement personnel, and 2,975 school, health and human service professionals.

PROGRESS OF 2005 PROGRAM

1. CONNSACS is continuing efforts to implement a comprehensive, efficient, and flexible coalition-wide data collection and reporting system. Changes are underway to help streamline data collection and reporting processes, to increase the amount of statistical information available regarding services and clients served through CONNSACS' 10 member Sexual Assault Crisis Centers, and to improve the accuracy/consistency of the data.
2. CONNSACS collaborates with other victim advocacy organizations, including the Connecticut Coalition Against Domestic Violence, Mothers Against Drunk Drivers and Survivors of Homicide, to enhance access for victims to community based support services.
3. CONNSACS' 10 member centers employ Community Educators to provide rape prevention and education programs to school-aged children, youth, and the general public. Community Educators also provide training to law enforcement officers and health, education, and social services professionals.

OUTCOME OBJECTIVES

Objectives	Indicators	Progress
Increase by 2% the percentage of victims who receive medical care within 72 hours of assault.	Connecticut Sexual Assault Crisis Services, Inc. (CONNSACS) client data.	In 2004, 27.9% (484) of assault victims received medical care within 72 hours of assault.
100% of victims will be informed of availability of acute care services.	CONNSACS client data.	In 2004, 100% of victims were informed of the availability of acute care services.
Reduce emotional/ psychological trauma of victims through counseling intervention and other support services, providing crisis intervention services to at least 4,000 sexual assault victims.	CONNSACS client data.	Counseling was provided to 1,538 female victims of rape, age 12 and over (raped since 7/1/03); to 198 former female rape victims, age 12 and over (raped prior to 7/1/03); and to 1,482 new and former victims of sexual assault (other than rape). An appointment for individual counseling was provided to 5,590 sexual assault victims.
Continue to measure the incidence rate of sexual assault, including rape, to females and males over age 12 in Connecticut	Data reported on a quarterly and annual basis from the contractor include the number of female and male rape victims age =>12 years assaulted on or after July 1 of the reporting year.	One thousand ten (1,538) females were assaulted on or after July 1, 2003.

Objectives	Indicators	Progress
Enhance data collection and analyze activities to include a narrative report of all DPH data and evaluation requirements and the PHHSBG requirements.	Data is collected on a quarterly and annual basis from the Dept. of Children and Families, the Uniform Crime Reports (UCR) from the State Police and individual demographic and sexual assault data for victims reported by CONNSACS.	Ongoing. This information is used by DPH to respond to PHHSBG requirements.

G. SURVEILLANCE AND EVALUATION

NATIONAL YEAR 2010 HEALTH OBJECTIVE

23-5: Data and Information Systems. Increase the proportion of leading health indicators, health status indicators, and priority data needs for which data, especially for select populations are available at the Tribal, State, and Local levels.

PROGRAM GOAL

Increase the health information available at the state and sub-state level, with a special focus on Health Districts and Local Health Departments. Also, integrate chronic disease (cardiovascular, diabetes, cancer) program surveillance efforts with other surveillance system efforts (mortality, hospitalization, and the Behavioral Risk Factor Surveillance System (BRFSS) within the Department.

STATEMENT OF ISSUES/PROBLEM

State based surveillance data are needed for program planning, evaluation, and to monitor progress toward the national and state health objectives. Data at the municipal/local level are needed for planning, targeting and evaluating programs and services at the local level. Program data, including process and outcome measures, are needed to assess the effectiveness of ongoing programs.

DESCRIPTION OF PROGRAM STRATEGY

State based data on risk factors, preventive health services, health insurance and other behaviors, are collected through participation in the BRFSS, which is coordinated by and partially funded through the Centers for Disease Control and Prevention (CDC). Telephone interviews of randomly selected adults are currently conducted monthly, with a total of at least 3,500 per year. CDC provides final data, which are analyzed by DPH and results are distributed through reports, fact sheets, presentations, and other appropriate channels. Connecticut adds its own questions each year to address issues of State importance.

In order to facilitate the acquisition of local level data, starting in FY2001, Local Health Departments (LHDs) and Districts were offered the option of using their PHHSBG allocation for conducting risk factor surveillance. LHDs may collect data from a representative population of their town or district or selected target populations.

DPH staff will produce surveillance report briefs (2004-2005) that will describe chronic disease prevalence and chronic disease mortality trends in Connecticut by race, ethnicity, gender, and age. Reports will be available on the DPH website.

TARGET POPULATION

Number	3,272,563
Age range	All
Sex	Male and Female
Race/ethnicity	All
Geographic Area	Statewide

FEDERAL FISCAL YEAR 2006 PROGRAM OBJECTIVES

1. By June 30, 2006, conduct telephone interviews of adults through participation in the Behavioral Risk Factor Surveillance system (BRFSS) to collect statewide and county level data.
2. By June 30, 2006, provide technical assistance to the local health departments that select risk factor surveillance as an option.
3. By June 30, 2006, produce four surveillance report briefs (2005-2006) that will describe chronic disease prevalence and chronic disease mortality trends in Connecticut by race, ethnicity, gender, and age.

FEDERAL FISCAL YEAR 2004 PROGRAM ACCOMPLISHMENTS

1. During 2003, 5,317 BRFSS interviews were conducted on randomly selected Connecticut adults.
2. For 2004, the BRFSS sample size was 6,030. State-added questions included diabetes, childhood asthma, hypertension awareness, heart attack and stroke, arthritis, oral health, health care access for children, and awareness of environmental risks.
3. Analyses of BRFSS data were conducted for several DPH programs including cardiovascular disease, tobacco, asthma, environmental epidemiology, diabetes, nutrition, cancer, and maternal and child health.
4. During 2004 data from the Connecticut BRFSS were the basis of an article entitled "Predictors of Help Seeking Among Connecticut Adults After September 11, 2001" that was published in the September 2004 issue of the American Journal of Public Health.⁵
5. A review of vital records (infant births and deaths among women of child bearing age) from 2002 was completed as a component of maternal mortality surveillance. The matched records were submitted to CDC for surveillance and to the Public Health Initiatives unit (formerly the Family Health Division) within DPH for follow-up activities.

PROGRESS OF 2005 PROGRAM

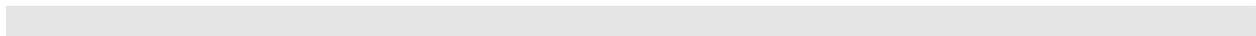
1. In 2005, the BRFSS sample size is 6,000 and the sample is stratified to sample more minority populations. State-added questions include childhood asthma, health care access, dental sealants, exercise, and fish consumption.
2. A review of vital records (infant births and deaths among women of child bearing age) from 2003 was completed as a component of maternal mortality surveillance. The matched records were submitted to CDC for surveillance and to the Public Health Initiatives unit within DPH for follow-up activities.
3. Analyses of BRFSS data are being conducted for several DPH programs including cardiovascular disease, tobacco, asthma, environmental epidemiology, diabetes, nutrition, cancer, and maternal and child health.

¹ Adams ML, Ford JD, and Dailey WF. Predictors of Help Seeking Among Connecticut Adults After September 11, 2001. Am J Public Health. 2004; 94:1956-1602.

4. A report on tobacco use using 2003 BRFSS data is being completed.
5. Three health departments are using PHHSBG funds to conduct risk factor surveillance in FY 2005. Two of the health departments (in Stamford and Milford) are collecting information related to physical activity and weight control. Stamford is using school health information to assess Body Mass Index among students; and Milford is continuing a program to measure steps taken during the day by elementary and middle school students. New Britain is administering a health assessment among students enrolled in the school-based health center.

OUTCOME OBJECTIVES

Outcomes	Indicators	Progress
Surveillance data are used to drive programs.	Names of reports/activity. BRFSS sample size.	Maternal Mortality Surveillance, 2004 Program specific analyses completed N=6,030 in 2004
Surveillance data are available at the sub-state level.	Number of local health departments conducting Risk Factor Surveys (other than food).	In FFY 2005, 3 local health departments chose this option.



H. UNINTENTIONAL INJURY PREVENTION

Motor Vehicle Crash-Related Injuries

NATIONAL YEAR 2010 HEALTH OBJECTIVES

15.13 Reduce deaths from unintentional injuries to no more than 17.5/100,000

Baseline: 35.9 per 100,000 population in 1999)

15.15 Reduce deaths from motor vehicle crashes to no more than 9.2/100,000.

Baseline: 15.0 per 100,000 in 1999)

PROGRAM GOAL

By September 30, 2009, reduce the rate for deaths caused by motor vehicle to no more than 7.5 per 100,000. Baseline: Connecticut 2002 data: 9.8/100,000.

DESCRIPTION OF THE HEALTH PROBLEM

Unintentional injuries are the leading cause of death for persons between the ages of 1 and 40 years in Connecticut and the 5th leading cause overall (2000-2002 data). They are responsible for 28% of all deaths among children 1-14 years of age and 48% of all deaths for 15-24 years of age. Motor vehicle crash-related injuries are the leading cause of unintentional injury death accounting for 31% of all unintentional injury deaths in the state. Motor vehicle crashes are the second leading cause of injury-related hospitalizations overall. Injuries to occupants and pedestrians were the two leading types of both motor vehicle-related deaths and hospitalizations^{1,2}

Motor Vehicle Crash-Related Mortality and Hospitalization Data for Connecticut^{1,2}

- 339 Motor Vehicle Crash-Related Deaths (2002)
- 9.8/100,000 Residents (AAMR 2002)
- 3,086 Motor Vehicle Crash-Related Hospital Discharges (1999)
- 46,147 Motor Vehicle Crash-Related Emergency Department Visits (1999)
- 8,455 YPLL before age 65 (This represents 7.5% of the total years of potential life lost from all causes.)

Major risk factors contributing to the likelihood and/or seriousness of a motor vehicle crash-related injury include alcohol/drug use, non-use or misuse of occupant restraints, non-use of motorcycle and bicycle helmets, vehicle speed, vehicle characteristics and crashworthiness, and roadway features. Programs funded through the block grant focus on increasing correct use of occupant restraints, increasing knowledge of pedestrian risks and safety skills, and developing community coalitions to implement environmental and policy changes.

DESCRIPTION OF PROGRAM STRATEGY

Local health departments (LHDs) may use their PHHSBG allocation funding to address motor vehicle crash-related injuries to occupants and pedestrians. Specific interventions LHDs use include:

- Child passenger safety education targeting parents and caregivers. Programs are encouraged to incorporate education into settings that already provide services to parents and caregivers.

1. CDC NCIPC WISQARS 2002 data (Mortality rates age adjusted to 2000 US population)
2. CT Hospital Association, hospital discharge data 1999

- Child safety seat clinics that check for misuse and train parents/caregivers to correctly install and use safety seats. Findings from clinics conducted throughout the state by SAFE KIDS coalitions SAFE KIDS coalitions, police, hospitals and local health departments indicate a 96% misuse rate among the 3,793 car seats checked.
- Community awareness campaigns to increase correct use of safety belts, child safety seats and improve pedestrian safety.
- Programs for health and community service providers designed to encourage them to incorporate occupant protection and pedestrian safety issues in to their work on a regular basis.
- Development of coalitions to identify community traffic safety problems, and develop plans to address these problems.
- Implementation of environmental or policy changes to reduce the risk of motor vehicle occupant and pedestrian injuries.

Strategies that the Injury Prevention Program uses statewide to address motor vehicle injuries include: provision of technical assistance to health/community agencies, analysis of injury-related data for problem identification and policy and program development and evaluation, education/training programs, and ongoing dissemination of current information/resources. The Program works closely with the CT SAFE KIDS Coalition, the CT Department of Transportation and traffic safety advocates throughout the state.

TARGET POPULATION

Motor vehicle crash-related injuries affect all segments of Connecticut's population. They are the second leading cause of injury-related hospitalization overall in Connecticut and among the top three causes of injury-related hospitalization for every age group.

Motor vehicle crash-related injuries are the leading cause of death for persons between the age of 1 and 24 years in Connecticut responsible for 25% of all deaths in this age group.³

Number:	1,113,273 (2000 US Census)
Age Range:	1-24 years
Sex:	Males and Females
Race/Ethnicity:	All
Geographic Location	Statewide

FEDERAL FISCAL YEAR 2006 PROGRAM OBJECTIVES

1. By September 30, 2009, reduce the rate for deaths caused by motor vehicle crashes at no more than 7.5/100,000. Baseline: 9.8/100,000 in 2002³
2. By September 30, 2006, at least 75% of the participants in motor vehicle safety programs conducted by PHHSBG-funded local health departments will report using occupant restraint systems, will be able to demonstrate correct use of child safety seats (CSS), and be aware of pedestrian safety measures. Baseline: SFY 04 (July 03 – June 04 contract year) 92% of participants report using child safety seats, 100% of participants demonstrate correct use, and 100% of participants aware of pedestrian safety measures.

3. CDC NCIPC WISQARS 2002 data (mortality rates age adjusted to 2000 US population)

3. By September 30 2006, PHHSBG-funded local health departments will develop or maintain a community coalition and implement environmental or policy changes to reduce motor vehicle injuries. Baseline: SFY 04 (July 03 – June 04 contract year) 1 local health department has maintained an ongoing safe communities coalition and made recommendations for environmental and policy changes.
4. By September 30, 2006, provide technical assistance and monitor at least 1 local health PHHSBG motor vehicle injury prevention programs and provide assistance to non-funded health/community organizations and individuals with motor vehicle injury prevention activities. Baseline: SFY 04 (July 03 – June 04 contract year) 2 local health departments utilized PHHSBG funds for motor vehicle injury prevention, assistance provided to 40 agencies and individuals).

ACTIVITIES

1. Develop contracts and provide programmatic and fiscal monitoring to local health departments addressing motor vehicle injury prevention.
2. Provide technical assistance to non-funded PHHSBG health and community agencies on motor vehicle injury prevention.
3. Analyze injury-related mortality and hospitalization data for use for policy/program planning and evaluation.
4. Provide ongoing dissemination of information and resources on motor vehicle injury prevention to local health and community agencies.
5. Maintain an ongoing collaboration with and provide technical assistance to DPH programs including other programs within the Public Health Initiatives unit, Emergency Medical Services, and Day Care Licensing.
6. Maintain collaboration with state and regional partnerships and coalitions including CT Department of Transportation, CT SAFE KIDS, Emergency Medical Services for Children Committee and Northeast Injury Prevention Network.
7. Provide support for DPH priority legislation related to motor vehicle injury prevention.

Note: Mortality rates for 1999 and later are age adjusted to the 2000 US population. Previously, mortality rates had been age adjusted to the 1940 US population. This may account for some of the differences between 1998 and later rates. Also, 1998 injury mortality data was coded under the ICD 9 external causes of injury classification system; 1999 and later data is coded under ICD 10.

H. UNINTENTIONAL INJURY PREVENTION (Continued)
Fall-Related Injuries Among Older Adults
Fall-Related Injuries Among Children

NATIONAL YEAR 2010 HEALTH OBJECTIVES

15.27 Reduce deaths from falls to no more than 3.0/100,000.

Baseline: 5.1 deaths per 100,000 population in 1999)

PROGRAM GOAL

1. By September 30, 2009, reduce the rate of deaths from falls to no more than 3.8/100,000.
Baseline: 4.3/100,000 in 2002.

DESCRIPTION OF THE HEALTH PROBLEM

Falls are the leading cause of injury death in Connecticut for persons ages 65 years and older. Persons 65 years and over have a death rate from falls that is six times that of the population as a whole. Falls are the leading cause of injury related hospitalization for all ages responsible for 53% of all hospitalizations due to injuries.⁴

Fall Mortality and Hospitalization Data for Connecticut⁴

- 176 Fall-related deaths (2002)
- 4.3 /100,000 residents (AAMR 2002)
- 11,046 Fall-related Hospital Discharges (1999)
- 87,457 Fall-related Emergency Department Visits (1999)

Different risk factors are associated with falls among different age groups. Falls among older adults are usually related to a combination of factors including home and environmental hazards, interaction and misuse of medications, osteoporosis, physical inactivity, certain diseases, alcohol abuse, and vision problems. Falls among children under the age of 5 usually occur in the home and are associated with furniture, stairs and windows. Falls among children ages 5 to 14 are usually associated with recreational activities.

DESCRIPTION OF PROGRAM STRATEGY

Local health departments (LHDs) may use their PHHSBG allocation funding to address fall injury prevention for older adults. Specific interventions LHDs use include:

- Home safety assessments. Agencies use a home safety checklist to identify hazards and work with older adults, their families and caregivers to identify and correct injury hazards, provide safety supplies and education.
- Fall prevention seminars for older adults, their families and caregivers that focus on environmental hazards, medication safety, exercise, osteoporosis, and the importance of using preventive health services.
- Medication safety reviews including review by a pharmacist of all prescription/OTC medications for interactions/misuse, which may place an older adult at, increased of injuries.

⁴ CDC NCIPC WISQARS 2002 (Mortality rates age adjusted to 2000 US population); CT Hospital Association, Hospital Discharge Data, 1999.

- Fall prevention exercise classes designed to increase muscle strength and improve flexibility, gait, and balance.
- CDC NCPIC WISQARS 2002 (Mortality rates age adjusted to 2000 US population); CT Hospital Association, Hospital Discharge Data, 1999
- Home safety assessments for children. Agencies use a home safety checklist to identify hazards and work with families with young children to identify and correct injury hazards, provide safety supplies and education.

Strategies that the Injury Prevention Program uses statewide to fall-related injuries include, provision of technical assistance to health/community agencies; analysis of injury-related data for problem identification and program development, education/training programs, and ongoing dissemination of information/resources.

TARGET POPULATION

Fall-related injuries are the leading cause of injury-related hospitalization overall and the leading cause of injury-related hospitalizations for persons from birth to 14 years and 40+ years. Persons age 65 years and older account for 14% of Connecticut's population and 88% of deaths from falls.⁵

Number:	470,183 (US Census)
Age Range:	65+ years
Number:	223,344
Age Range:	0-5 Years
Sex:	Males and Females
Race/Ethnicity	All
Geographic Location:	Statewide

FEDERAL FISCAL YEAR 2006 PROGRAM OBJECTIVES

1. By September 30, 2009, reduce the rate of deaths from falls to no more than 3.8/100,000. Baseline: 4.3/100,000 in 2002. (CDC NCPIC WISQARS 2002 (Mortality rates age adjusted to 2000 US population); CT Hospital Association, Hospital Discharge Data, 1999.
2. By September 30, 2006, at least 50% of the hazards identified during home safety assessments conducted by PHHSBG-funded local health departments will be corrected. Baseline: SFY04 (July03 – June 04 contract period) 71% of the hazards identified during home safety visits were corrected.
3. By September 30, 2006, at least 75% of the participants in fall prevention and medication safety programs will gain awareness of risk factors for falls and report taking action to reduce those risks. Baseline: SFY04 (July03 – June 04 contract period) 87% of the participants were able to identify risk factors and reported taking action. 76% of participants in fall prevention exercise classes reported continuing to exercise.
4. By September 30, 2006, at least 50% of the hazards identified during home safety assessments for families with young children conducted by PHHSBG-funded local health departments will be corrected. Baseline: SFY04 (July03 – June 04 contract period) 87% of the hazards identified during home safety visits were corrected.

5. By September 30, 2006, provide technical assistance and monitor at least 3 local health departments PHHSBG-funded fall prevention programs and assist non-funded health/community organizations with fall prevention activities. Baseline: SFY 04 3 local health departments utilized PHHSBG funds for older adult fall prevention, 1 local health department utilized PHHSBG fund for child fall prevention in the home setting, assistance provided to 10 agencies on fall prevention.

ACTIVITIES

1. Develop contracts and provide programmatic and fiscal monitoring for local health departments addressing fall injury prevention with PHHSBG funds.
2. Provide technical assistance to non-funded PHHSBG health and community agencies on fall injury prevention.
3. Analyze injury-related mortality and hospitalization data for use in program planning and evaluation.
4. Maintain collaborations with agencies and organizations serving older adults.
5. Maintain collaborations with agencies and organizations serving families with young children.
6. Provide ongoing dissemination of information and resources on fall prevention issues to local health and community agencies.

Note: Mortality rates for 1999 and later are age adjusted to the 2000 US population. Previously, mortality rates had been age adjusted to the 1940 US population. This may account for some of the differences between 1998 and later rates. Also, 1998 injury mortality data was coded under the ICD 9 external causes of injury classification system; 1999 and later data is coded under ICD 10.

FEDERAL FISCAL YEAR 2004 PROGRAM ACCOMPLISHMENTS

1. The DPH Injury Prevention Program (IPP) provided technical assistance and program monitoring to 4 local health departments conducting unintentional injury prevention programs with their PHHSBG allocation.
2. At least 50 groups were provided with technical assistance and resource materials including local health departments, hospitals, community health centers day care centers, VNAs, schools, EMS providers, police, businesses, other state agencies and programs within DPH.
3. The Program has provided support for legislative initiatives to enhance CT's child passenger safety and graduated driver's license laws.
4. The IPP has disseminated injury information/resources to local health and community service providers and through the DPH Family Health Section and Day Care Licensure Program networks. Booster seat educational materials were distributed to all day care providers and pediatricians in the state. Articles on injury prevention are provided to the "All Children Considered" newsletter, which reaches approximately 20,000 childcare providers.

- The IPP collaborated other state agencies and organizations on unintentional injury issues and participated in injury related coalitions including CT Safe Kids Advisory Committee, Emergency Medical Services for Children, Northeast Injury Prevention Network. The Program also assisted with the biannual distribution of community safety grants from the CT "Keep Kids Safe" License Plate fund, which is managed by CT SAFE KIDS.

PROGRESS OF 2005 PROGRAM

The Program has developed contracts and is providing technical assistance and monitoring 6 local health departments conducting unintentional injury prevention programs with their PHHSBG funding during SFY 05.

OUTCOME OBJECTIVES

Objectives	Indicators	Progress
At least 75% of participants in motor vehicle injury prevention programs conducted by PHHSBG-funded local health departments report using occupant protection systems, demonstrate correct use of child safety seats, and aware of pedestrian safety measures.	PHHSBG-funded programs	In SFY 2004, 2 local health departments utilized PHHSBG funds for motor vehicle injury prevention programs. 92% program participants reported using car seats, 100% demonstrate correct use, 100% aware pedestrian safety. One community coalition maintained.
Provide technical assistance and monitor local health department PHHSBG funded motor vehicle injury prevention programs and provide assistance to non-funded health/ community organizations.	PHHSBG-funded programs	In FY 04 provided to 2 local health departments. Technical assistance was provided to at least 40 organizations.
At least 50% of hazards identified during home safety assessments for older adults or families with young children, conducted by PHHSBG funded local health departments.	PHHSBG-funded programs	In FY 04, programs serving Older Adults: 71% of the hazards were corrected. Programs serving children: 87% hazards corrected.
At least 75% of participants in fall prevention and medication safety programs gain awareness of risk factors for falls and report taking action to reduce those risks.	PHHSBG-funded programs	In FY 04, 87 of participants were able to identify risk factors and reported tacking action to reduce risks. 76% of participants in fall prevention exercise classes reported continuing to exercise.
Provide technical assistance and monitor local health department PHHSBG funded fall prevention programs and provide assistance to non-funded health/ community organizations.	PHHSBG-funded programs	In FY 04, 3 local health departments utilized PHHSBG funds for fall prevention programs. Assistance was provided to 10 agencies on fall prevention.

I. INTIMATE PARTNER VIOLENCE PREVENTION

NATIONAL YEAR 2010 HEALTH OBJECTIVE

15-34: Reduce the rate of physical assault by current or former intimate partners. The HO's have been, in some cases, consolidated to reflect a broader program scope versus having to select every health objective in the 2010 document. For that reason, 15.34 is only listed here as the appropriate national health objective for this program.

PROGRAM GOALS

1. By June 30, 2006, reduce the number of female homicides in Connecticut related to family violence by 10%, as reported by the Uniform Crime Reporting Program.

Baseline: 11 female homicides in 1995
 13 female homicides in 1996
 14 female homicides in 1997
 13 female homicides in 1998
 18 female homicides in 1999
 15 female homicides in 2000
 18 female homicides in 2001*

*Note: this is the latest year for which statistics are available.

2. By June 30, 2006, reduce the rate of physical assault by current or former intimate partners by 10%, as measured by Connecticut's Uniform Crime Reports of Family Violence Assault on Females.

Baseline: 12,229 reports of domestic physical abuse of women in 1995 (8.9/1,000)
 11,601 reports of domestic physical abuse of women in 1996 (8.5/1,000)
 12,229 reports of domestic physical abuse of women in 1997 (8.9/1,000)
 11,352 reports of domestic physical abuse of women in 1998 (8.3/1,000)
 12,906 reports of intimate partner violence against women in 1999 (9.7/1,000)
 12,987 reports of intimate partner violence against women in 2000. (9.2/1,000)
 13,887 reports of intimate partner violence against women in 2001 (7.9/1000)*

***NOTE:** The denominator used to calculate the rate for 2001 was obtained from the 2000 U.S. Census. If one were to recalculate the rate for 2000 based upon the 2000 census the rate would be 7.4. indicating that the state continues to see an increase in reports of intimate partner violence against women. This also means that the rates for prior years are not comparable to the rate calculated for 2001.

STATEMENT OF ISSUES/ PROBLEM

Populations directly affected by intimate partner violence are women and children, but the cost to society in terms of indirect effects is staggering. Intimate partner violence is the leading cause of injury among women, and is linked to numerous other health care problems including depression, drug abuse, and suicide. (The National Center for Education in Maternal and Child Health, Children's Safety Network. Building Safe Communities, State and Local Strategies for Preventing Injury and Violence, 1994). In Connecticut, 12,906 females were reported as victims of family violence during 1999. Eighteen females were killed by a family member or a boyfriend. (Crime in Connecticut 1999 Annual Report) The 1999 Connecticut Behavioral Risk Factor Surveillance Survey results indicated that 1.9% of female respondents reported being subjected

to physical violence in the past year. This question has not been included in the survey being conducted but reports will be available to identify the number of sexual assaults by gender. Almost 20% of respondents indicated that the person was a current or former intimate partner. The 2004 Connecticut Coalition Against Domestic Violence Fact Sheet reported that 1,142 Connecticut women were provided emergency shelter during the July 2003-June 2004 fiscal year. Risk factors for intimate partner violence are difficult to define. Intimate partner violence has been defined as an issue of power and control on the part of the perpetrator against the victim. At the present time there is no documented socioeconomic, racial, ethnic or educational correlation with the incidence of intimate partner violence. Intimate partner violence continues to be underreported, contributing to the difficulty in determining the true incidence of the problem.

DESCRIPTION OF THE PROGRAM STRATEGY

Interventions that are part of the Department's intimate partner violence (IPV) initiative reach providers and future providers of women who seek care. The goal is to increase the number of women who receive early, appropriate medical treatment and referrals to supportive services by providing professional education to health, social service, mental health, public health students and professionals and consultation to providers to facilitate appropriate identification, treatment, referral and safety planning for victims and potential victims of intimate partner violence. Appropriate assessment and referral can decrease the risk of further injuries and death by identifying the intentional nature of the injury and providing resources for the victim to identify strategies to increase her safety. Specifically, based upon the continued lack of or minimal preparation in basic programs that prepare practitioners to accurately screen and refer clients of domestic violence coupled with the increasing rate there continues to be a need to provide basic education on this topic. A "Train the Trainer" model is being developed so that the efforts of the program are continued in the event that funding ceases.

TARGET POPULATION

Number:	1,756,246
Age Range:	All
Sex:	Females
Race/Ethnicity:	All
Geographic Location:	Statewide

FEDERAL FISCAL YEAR 2005 PROGRAM OBJECTIVES

1. By September 30, 2006, increase the number of physician, nurses, social workers and criminal justice professionals who have received training in the identification and referral of people who are victims of spouse abuse.

Baseline: 600 participants received training from contractor in 1995
1,010 participants received training from contractor in 1996
1,022 participants received training from contractor in 1997
876 participants received training from contractor in 1998
270 participants received training from contractor in 1999
465 participants received training from contractor in 2000
541 participants received training from contractor in 2001
No RFP was issued during the period 2002-04

2. By September 30, 2006, the IPV prevention contractor will document the impact of professional education and consultation program activities. The Contractor will provide detailed programmatic process and outcome evaluation data to the department.
3. By September 30, 2006, the IPV contractor will provide training in the issues surrounding domestic violence and the identification of and appropriate referral of victims of intimate partner violence. Contractor will provide training to a minimum of 1,000 physicians, nurses, social workers, criminal justice professionals and other health care and social service providers and students.
4. By September 30, 2006, 90% of health and social service providers who receive training in IPV issues will demonstrate competence and increased knowledge of domestic violence identification, intervention and appropriate referral. Contractor will evaluate professional education programs and submit data and analysis of process and outcome measures.
5. By September 30, 2006, the IPV Program will, in collaboration with epidemiologists and other staff within the Department of Public Health and outside agencies, identify and access other existing data sources to help identify the number of victims of intimate partner violence, target populations, risk factors and highlight gaps in data collection that are barriers to the Department's ability to develop, implement and evaluate intimate partner violence prevention strategies. DPH IPV prevention staff will consult with other Department of Public Health programs and staff and collaborate with other state agencies and community-based organizations.

FEDERAL FISCAL YEAR 2004 PROGRAM ACCOMPLISHMENTS

1. DPH completed a Memorandum of Agreement with the State Department of Social Services for collaborative funding of the Intimate Partner Violence Program.
2. DPH completed the competitive Request for Proposal process, awarded and developed a contract with the St. Francis Hospital and Medical Center Injury Prevention Program.
3. DPH staff participates in the Green Book Committee, an interagency, interdisciplinary collaboration that focuses on domestic violence and child maltreatment issues.
4. DPH participates in most Federal Region I Women's Health Work Group meetings and regional activities.
5. DPH completed a CDC Violence Against Women Planning Grant that focused on conducting an assessment process, creating or enhancing an Advisory Board and developing a state plan.

PROGRESS OF 2005 PROGRAM

1. DPH worked with St. Francis Hospital and Medical Center on a contract that was executed May 2005. To date, the contractor has:
 - a. Conducted 10 training sessions for a total of 172 participants whose follow up survey indicated that that 93-100% participants indicated desired changes in three areas on in how they addressed domestic violence in their practice.
 - b. Conducted 2 project Advisory Committee meetings.
 - c. Finalized, printed and distributed client resource cards, which provide specific information regarding services for the region in which the client resides.

- d. Developed resource packets for distribution to professions.
- e. Presented the IPV Program at the 2005 National Injury Prevention and Control Conference held on May 2005.
- f. Developed 9 surveys to be used to assess participant outcomes and hospitals pre and post activities relative to policy changes.
- g. Developed and distributed electronic versions of the IPV Program newsletter to Maternal and Child Health providers.

2. DPH, in conjunction with the Department of Corrections, developed a resource card to be used by women discharged from the state's only prison for women. This wallet size card provides names of programs and toll free phone numbers, including domestic violence resources.

OUTCOME OBJECTIVES

Objectives	Indicators	Progress
Increase the number of health and social services providers, students and others, who will be able to identify, intervene with and appropriately refer victims of intimate partner violence.	Contractor report of number of program participants receiving training.	Due to the lack of a contract, no trainings were conducted during 2004. The contractor continued to develop program materials such as resource cards, pre and post trainee and hospital surveys, and resource cards for clients and resource packets for professionals. Materials developed are utilized in the current contract.
Ninety percent of health and social service providers, students and others who receive training in intimate partner violence issues will demonstrate competence and increased knowledge of domestic violence identification, intervention and appropriate referral.	Contractor evaluation of training and report of data and analysis of outcome measure.	See above.

J. YOUTH VIOLENCE AND SUICIDE PREVENTION

Youth Violence Prevention

NATIONAL YEAR 2010 HEALTH OBJECTIVES

15.32 Reduce homicides to no more than 3.0 per 100,000 population.

15.37 Reduce physical assaults among persons aged 12 years and older to no more than 13.6 per 1,000 persons.

15.38 Reduce physical fighting to no more than 32%.

PROGRAM GOAL

By September 30, 2006, reduce physical assaults among persons 12 years of age and older to no more than 9.0 per 1,000 residents.

Baseline: 10.8/1,000 youth 12+ years of age (1996)
10.2/1,000 youth 12+ years of age (1997)
9.6/1,000 youth 12+ years of age (1998)
9.7/1,000 youth 12+ years of age (1999)
8.1/1,000 youth 12+ years of age (2000)
(Source: Uniform Crime Reports)

STATEMENT OF ISSUES/PROBLEM

Violence among the nation's youth has garnered increasing attention and is considered to be a public health issue. During the previous decade, concerns were raised about gang and drug violence, primarily among urban youth. The recent school shootings in various communities around the nation have widened the focus from an urban issue to a national concern. Violence among the nation's young people has been associated with drug use, physical and sexual abuse, lack of attachment to pro-social adults and inadequate or inappropriate treatment of mental health and behavioral problems.

In Connecticut in 2001, 106 residents died from homicide. Of those 82 were males and 24 were females. Fifty-one homicide victims were White and 52 were Black. Slightly less than two-thirds of homicide victims were younger than 25 years of age (*Crime in CT 2001*). Slightly more than 3% of persons responded "Yes" to a question about physical violence on the 1999 CT Behavioral Risk Factor Surveillance Survey. Of those more than 19% said that a stranger was involved and almost 10% said the violence involved more than one person. More than 63% said that the physical violence involved someone they knew (an acquaintance or friend, family member or other relative, spouse/boyfriend/girlfriend, former spouse/boyfriend/girlfriend). Eighty percent said that they received no medical treatment as a result of the violence. Almost 64% said they told a friend or family member about the physical violence, almost 26% told the police and almost 25% told someone else. Only 12% told a health care provider and even fewer, 9% told another service provider or a hotline. (*1999 Connecticut Behavioral Risk Factor Surveillance System data*)

Arguments and fights, precipitated by anger, have been identified as precursors to many homicides. Although some mortality and behavioral parameters related to violence among Connecticut youth have decreased, violence remains a significant public health concern in the state and continues to have high rates of death and injury, especially among those who are male, young, Black and Hispanic.

Finally, violence among youth must be understood and addressed within the context of family dynamics and larger societal issues. The youth violence prevention program in Connecticut focuses on increasing awareness of the scope of the problem, improving strategies that promote resilience, addressing related risk factors, and modeling appropriate conflict resolution. The program promotes, enhances and facilitates systems changes that could lead to improved responses to youth and families in need.

DESCRIPTION OF THE PROGRAM STRATEGY

Youth violence prevention programs contracted by the DPH focus upon increasing knowledge and changing behaviors that are manageable within the limited scope and influence of the programs. Program goals include recognizing and dealing appropriately with anger, conflicts, peer-to-peer relationships, increasing knowledge regarding the impact of, and risk factors, for violent behavior, decreasing arguments and fighting and providing knowledge of appropriate resources for help.

TARGET POPULATION

Number:	1,113,273*
Age Range:	0-24
Sex:	Male and Female
Race/Ethnicity:	All
Geographic Location:	Statewide

*CT Population - Ages 0-24; 2000 State of Connecticut Census Report.

FEDERAL FISCAL YEAR 2006 PROGRAM OBJECTIVES

1. By September 30, 2006, reduce by 20% the incidence of physical fighting among adolescents aged 14-17.

Baseline: 38.0% of high school youth reported being in a physical fight (1995)
33.8% of high school youth reported being in a physical fight (1997)
32.0% of high school youth reported being in a physical fight (1999)

Source: Youth Risk Behavior Survey (YRBS)

2. By September 30, 2006, complete the Request For Proposal Process and award contracts for a 2-year cycle of adult/elder focused suicide prevention programs.
3. By September 30, 2006, participants in youth violence prevention programs will demonstrate awareness of nonviolent alternatives to fighting. Contracted youth violence prevention programs will provide data, analysis and documentation of informal and formal measures assessing participant knowledge of non-violent alternatives to fighting.
4. By September 30, 2006, youth violence prevention programs will inform, educate, develop and facilitate the implementation of strategies that will increase pro-social skills and decrease violence among youth and adult participants. Program will have completed violence prevention contractual activities and provided process and outcome information documenting program activities.

5. By September 30, 2006, the Program will maintain and provide technical assistance to local health allocation funded contractors.
6. By September 30, 2006, conduct site visits; facilitate meetings, telephone consultations, and complete departmental reports and processes.
7. By September 30, 2006, consumers and others who call requesting information will continue to receive, within the limits of program resources, youth violence prevention and awareness information appropriate to the request and target audience.
8. By September 30, 2006, the Injury Program will continue to participate in collaborations and coalitions such as the Northeast Injury Prevention Network which conducts regional meetings, conference calls, training, conference and awareness activities for the Network, other collaborative professionals and/or consumers. The Program will also continue to facilitate and participate in coalitions, collaborations and workgroups that promote human and material resources for violence prevention and related issues. The Program will continue to facilitate the Interagency Suicide Prevention Network and participate in the Safe Schools and Communities Coalition, the CT for Community Youth Development, Child Maltreatment Domestic Violence Collaborative, Children's Trust Fund and other intentional injury related activities.
9. By September 30, 2006, facilitate strategic plans, policies and procedures to improve health status related to intentional injury. The Program will participate in local, statewide and regional task forces and ad hoc committees that are addressing policy and strategic planning related to intentional injury.
10. By September 30, 2006, youth violence prevention contracted programs will conduct evaluation activities. Contractors will submit results of program evaluations, which will be used by DPH to assess program effectiveness, guide intervention strategies and resource allocations.

J. YOUTH VIOLENCE AND SUICIDE PREVENTION (Continued)
Youth Suicide Prevention

NATIONAL YEAR 2010 HEALTH OBJECTIVES

18.1 Reduce suicides to no more than 5.0 per 100,000 people.

18.2 Reduce the rate of suicide attempts to no more than 1% over 12 months.

PROGRAM GOAL

By September 30, 2006, reduce suicides to no more than 8.0 per 100,000.

Baseline: 8.4 per 100,000 (1996) general population
6.1 per 100,000 for youths 15-19 (1996)
21.0 per 100,000 for men 20-34 (1996)
7.6 per 100,000 (1997) general population
8.3 per 100,000 (1998) general population
8.3 per 100,000 (1999) general population
4.5 per 100,000 for youths 15-19 (1997)
9.2 per 100,000 for persons ages 15-19 years (1998)
5.7 per 100,000 for persons ages 15-19 years (1999)
16.6 per 100,000 for men 20-34 (1997)
16.6 per 100,000 for men 20-34(1999)
10.5 per 100,000 for persons ages 20-34 years (1998)
9.5 per 100,000 for persons ages 20-34 years (1999)

STATEMENT OF ISSUES/PROBLEM

In Connecticut, deaths from suicide outnumber homicide deaths. In 2001, 283 Connecticut residents took their own lives, 231 of them male. While the numbers represent a decrease from the 280 state residents who completed suicide in 1997, it camouflages an increase in rates for certain age groups. For example, the suicide rate increased from 9.2/100,000 in 1998 to 9.4/100,000 in 2001 for persons who are age 15 to 19. The rate for those aged 20-34 years decreased to 9.8/100,000 in 2001 from 10.5 in 1998 (*CDC Mortality*). White males 65+ also have high rates of suicide. In 2001, firearms were the method of 41% of suicide deaths followed by hanging for 25% of suicide deaths.

The self-inflicted injury hospitalization rate in 1996 was highest among persons ages 15-19. Poisoning accounted for 83% of those hospitalizations, followed by cutting piercing injuries at 10%. The cost of completed suicides and self-inflicted injuries was approximately \$8.5 million in medical costs and \$217 million in lost wages. Seventy-two percent of those costs were for people ages 20-24. (Northeast Injury Prevention Network Databook, 2000) In 1997, persons ages 15-19 had the highest rate of hospitalizations - a rate of 105 hospitalizations per 100,000. (Northeast Regional Injury Prevention Network Poison Data Book, 2004) In 1998 mental health disorders were the 5th leading cause of hospitalization for all Connecticut residents and the leading cause for residents 15-44 years of age (*Unpublished 1998 Hospital Discharge data*). Almost 9,575 males (rate 595.3/100,000) and 11,325 females (rate 652.3/100,000) were discharged from Connecticut hospitals with a mental health diagnosis in 1998 (*Unpublished 1998 Hospital Discharge data*). Drugs were the identified method for 79% of hospitalizations for self-inflicted injury in 1996. The results of the 1999 Connecticut Youth Risk Behavior Survey indicate that 17% of the state's high school students had seriously considered suicide in the

past year and 7% had attempted suicide in the past year. The National Institute of Mental Health reports, "The strongest risk factors for attempted suicide in adults are depression, alcohol abuse, cocaine use, and separation or divorce. The strongest risk factors for attempted suicide in youth are depression, alcohol or other drug use disorder, and aggressive or disruptive behaviors" (<http://www.nimh.nih.gov/research/suifact.htm>). In 2003, 16.2 percent of students responding to the Youth Risk Behavior Survey reported that they had seriously considered attempting suicide during the past 12 months.

DESCRIPTION OF THE PROGRAM STRATEGY

The suicide prevention program in Connecticut focuses on collaborative activities that include developing a comprehensive state suicide prevention plan. Suicide prevention programs, funded by DPH, focus on increasing information and awareness of suicide, suicide risk and protective factors and places to go for help.

TARGET POPULATION

Number:	3,182,221*
Age Range:	5 years and older
Sex:	Male and Female
Race/Ethnicity:	All
Geographic Location:	Statewide

*CT Population 5+ - 2000 State of Connecticut Census Report

FEDERAL FISCAL YEAR 2006 PROGRAM OBJECTIVES

1. By September 30, 2006, reduce the incidence of suicide attempts by adolescents to 6.75%.

Baseline: 9.0% attempted in 1995
9.1% attempted in 1997
7.0% attempted in 1999
24.0% seriously considered attempting in 1995
21.6% seriously considered attempting in 1997
17.0% seriously considered attempting in 1999

Source: Youth Risk Behavior Survey (YRBS)

2. By September 30, 2006, participants in suicide prevention awareness and training programs will demonstrate awareness of suicide information, risk factors, protective factors and referral sources. The Contractor will provide data, analysis and documentation of measures assessing participant knowledge.
3. By September 30, 2006, suicide prevention program participants will have received information about suicide, risk factors, protective factors, references and referral sources and provide outcome information documenting training activities.
4. By September 30, 2006, the Program will maintain and provide technical assistance to the Request for Proposal funded contractors. The Program will conduct site visit(s), provide consultation, information and facilitate the continuation funding process.

5. By September 30, 2006, the Program will provide, within the limits of program resources, suicide prevention and awareness information appropriate to the request and target audiences to consumers and others who call requesting information.
6. By September 30, 2006, collaborations and coalitions such as the Youth Suicide Advisory Board, the Interagency Suicide Prevention Network and the Northeast Injury Prevention Network will continue to facilitate education and awareness activities among participants, target audiences and consumers. The Program will facilitate and participate in Network and Advisory board meetings and activities.
7. By September 30, 2006, the Program will continue to facilitate the Interagency Suicide Prevention Network and participate in the Youth Suicide Advisory Board, the Northeast Injury Prevention Network, coalitions which provide and facilitate suicide prevention awareness, training and planning activities.
8. By September 30, 2006, through the Interagency Suicide Prevention Network and the Youth Suicide Advisory Board, facilitate the dissemination of the CT Comprehensive Suicide Prevention Plan and work on implementation of one Recommendation from the Youth, Adult and Elder sections of the Plan.
9. By September 30, 2006, facilitate strategic plans, policies and procedures to improve health status related to intentional injury. The Program will participate in local statewide and regional task forces and ad hoc committees that are addressing policy and strategic planning related to intentional injury.
10. By September 30, 2006, suicide prevention contracted programs will conduct evaluation activities. Contractor(s) will submit results, which will be used by DPH to assess program effectiveness, guide intervention strategies and resource allocations.
11. By September 30, 2006, the Program will continue to try to facilitate increased collaboration within the Department and across agencies, individuals and disciplines.

FEDERAL FISCAL YEAR 2004 PROGRAM ACCOMPLISHMENTS

1. Overall, violence prevention programs reported an increase in knowledge of nonviolent alternatives to fighting, an increase in use of nonviolent conflict resolution strategies and a decrease in fighting behaviors. Contractors also reported increased and continued collaboration with parents, caregivers, school and community-based services and personnel. Participants were referred to job assistance, community services, mental health services, school-based resource centers, peer counseling, tutoring, academic support, State Department of Children and Families, State Department of Social Services, and Family Services agencies. Significant staffing and organizational changes decreased the productivity of the Norwalk and Capitol Region Educational Center (CREC) programs, leading to the elimination of the Norwalk program after year three and a reduction in CREC program participants in the fifth (final) program year. The Injury Prevention Program has decided to use the next competitive bidding process to focus on providing funding for Contractors to implement recommendations from the Comprehensive Suicide Prevention Plan.

2. Suicide prevention contractor provides summary data of pre-post results from each training session with relevant quarterly reports.
3. Violence prevention contractors provided 1,464 program activity sessions for 13,285 program participants.
4. Suicide prevention contractor reported that 83 adults participated in 5 training sessions during the contract year. An average of 91 percent of participants surveyed indicated increased knowledge of suicide facts, risk factors, protective factors and referral sources.
5. Provided resources and technical assistance to violence prevention contractors.
6. Training contractor conducted four, 10 session violence prevention programs for inmates at York Correctional Institution in Niantic, CT. Some inmates completing the first, second and third sessions were trained to facilitate the training with the contractors. In addition to outcomes previously described, participants demonstrated a 48% decrease in # who said they would fight, a 56% decrease in # who would argue, an 82% increase in # who would get angry and do nothing, a 74% increase in the # who would ignore the situation and a 367% increase in the number who would talk it out. Youth violence prevention contractors also reported reductions in violence related behaviors and school suspensions among students involved in their program.
7. Meetings and site visits conducted with Bridgeport local health, Ralphola Taylor, Capitol Region Education Council, Survivn' N Da Hood. Danbury and United Way of CT/Infoline not completed because of agency staffing and scheduling challenges. Completed Departmental and other reports.
8. Provided informational packets and resource lists to consumers.
9. Program participates in intentional injury and related collaborations that are interagency and interdisciplinary. Work groups share information, discuss and initiate policy changes, develop informational materials, plan awareness activities and conferences. Program staff participates in the regional Northeast Injury Prevention Network, the Safe Schools and Communities Advisory Committee, the Youth Suicide Advisory Board, CT for Community Youth Development and collaborations addressing domestic violence and child maltreatment issues. Program continues to facilitate the Interagency Suicide Prevention Network, which has completed the Comprehensive Suicide Prevention Plan, which is currently going through the DPH approval process. Awareness activities completed through collaborative efforts include updating the Youth Suicide Awareness Packet and completion of pamphlets providing suicide prevention information and referral sources for selected audiences. Program contributed to the *Preventing Girls Aggression and Violence* Report as a part of the Girls and Violence Task Force convened by The Governor's Prevention Partnership. Program also worked on a subcommittee that produced an updated State Department of Education's Suicide Prevention Protocol/Policy document. The Program worked with others to plan and implement the Suicide Prevention Conference and Girl's and Violence Conference at which each document was introduced. The Program is working with the National Suicide Prevention Resource Center and the Youth Suicide Advisory Board to plan suicide prevention conferences in 2005. The Program expects to complete the violence against women plan funded under a Cooperative Agreement with the Centers for Disease Control and Prevention (CDC) and worked with the regional Northeast Regional Injury Prevention Network initiative to complete the Bi-Regional Poison Data Book.

10. The suicide prevention training contractor completed six of ten sessions. The Contractor cited staff and administrative changes as well as scheduling difficulties with colleges and universities as reasons why they were unable to complete ten sessions.

PROGRESS OF 2005 PROGRAM

1. Middle and high-school aged youth have participated in youth violence prevention activities.
2. Contractors report that youth participants are able to identify nonviolent alternatives to fighting.
3. DPH conducted site visits with youth violence prevention contractors.
4. Suicide prevention contractor reports that adults have participated in training sessions in different state regions.
5. The DPH participated in developing and reviewing the State Department of Education document, Guidelines for Suicide Prevention: Policies and Procedures-Second Edition.
6. The DPH participated in developing suicide prevention pamphlets and awareness materials as part of the Youth Suicide Advisory Board.
7. The DPH continues to facilitate the Interagency Suicide Prevention Network, which has completed the CT Comprehensive Suicide Prevention Plan. The plan is being printed by the State of CT Judicial Branch, Court Support Services Division and is posted on the DPH website. The DPH participated in the planning of a May 2005 DCF sponsored youth suicide prevention conference and a Bi-Regional (invitational) Suicide Prevention Planning Conference sponsored by the Suicide Prevention Resource Center.
8. The Program continues to participate in interagency, interdisciplinary collaborations such as the Northeast Injury Prevention Network, Youth Suicide Advisory Board, Safe Schools and Communities Advisory Committee, Child Maltreatment/Domestic Violence Collaborative and other initiatives that are addressing violence prevention, suicide prevention, youth development strategies and other intentional injury related issues.
9. The Program is working with the Safe Schools and Communities Advisory Board to provide community forums addressing girls and violence issues.
10. The Program is, by request of DPH administration, working the departments Virtual Children's Health Bureau/Violence Prevention subcommittee and participating in a local collaboration convened to address youth violence prevention in Hartford.

OUTCOME OBJECTIVES

Objectives	Indicators	Progress ¹
Reduce by 20% the incidence of physical fighting among adolescents ages 14-17.	Youth Risk Behavior Survey, 1999.	In 1999, 32% of high school youth reported being in a physical fight.
Decrease in youth violence.	Contractor report of number and percent of program participants who can identify nonviolent alternatives to fighting.	In 2004, contractors provided youth violence prevention programming to more than 14,000 participants and report that 80-94% of participants who completed surveys state awareness of nonviolent alternatives to fighting.
Reduce the incidence of suicide attempts by adolescents to 6.75%.	Youth Risk Behavior Survey, 1999.	In 1999, 7% of high school students attempted suicide and 17% seriously considered an attempt.
Decrease in suicide rate.	Contractor report of number and percent of participants who can identify suicide facts, risk factors, protective factors and referral sources.	In 2004, the contractor provided training to 83 college and university students, providers and other adults and reports that 91.3% of participants completing surveys are able to identify suicide facts, risk factors, protective factors and referral sources.

¹ Most recent data available.

**TABLE P
 SUMMARY OF PROGRAM EXPENDITURES ¹ BY SUB-CATEGORY**

Preventive Health & Health Services Block Grant (PHHSBG)	FFY 2005 Estimated Expenditures (including carry over funds)	FFY 2006 PROPOSED Expenditures (including carry over funds)
Cardiovascular Disease	290,435	290,435
Emergency Medical Services	141,007	0 ²
Local Health Departments	498,769	498,769
Rape Crisis	83,396	83,396
Intimate Partner Violence	76,920	76,920
Youth Violence/Suicidal Prevention	101,948	101,948
Surveillance and Evaluation	6,000	0 ²
TOTAL	1,198,475	1,051,468

¹ All other programs do not have contractual figures. This table represents program expenditures for contractual services only. Salaries and fringe are not represented here. This chart represents grant and contract funds only.

² The Preventive Block Grant Advisory Committee recommended elimination of contract funding in these program categories.