



**Maternal and Child Health Services
Title V Block Grant**

**State Narrative for
Connecticut**

**Application for 2010
Annual Report for 2008**



Document Generation Date: Tuesday, July 14, 2009

Table of Contents

I. General Requirements	4
A. Letter of Transmittal.....	4
B. Face Sheet	4
C. Assurances and Certifications.....	4
D. Table of Contents	4
E. Public Input.....	4
II. Needs Assessment.....	6
C. Needs Assessment Summary	6
III. State Overview	9
A. Overview.....	9
B. Agency Capacity.....	24
C. Organizational Structure.....	35
D. Other MCH Capacity	39
E. State Agency Coordination.....	42
F. Health Systems Capacity Indicators	50
Health Systems Capacity Indicator 01:	50
Health Systems Capacity Indicator 02:	51
Health Systems Capacity Indicator 03:	52
Health Systems Capacity Indicator 04:	52
Health Systems Capacity Indicator 07A:.....	53
Health Systems Capacity Indicator 07B:.....	54
Health Systems Capacity Indicator 08:	54
Health Systems Capacity Indicator 05A:.....	55
Health Systems Capacity Indicator 05B:.....	55
Health Systems Capacity Indicator 05C:.....	56
Health Systems Capacity Indicator 05D:.....	56
Health Systems Capacity Indicator 06A:.....	57
Health Systems Capacity Indicator 06B:.....	57
Health Systems Capacity Indicator 06C:.....	58
Health Systems Capacity Indicator 09A:.....	58
Health Systems Capacity Indicator 09B:.....	59
IV. Priorities, Performance and Program Activities	60
A. Background and Overview	60
B. State Priorities	61
C. National Performance Measures.....	67
Performance Measure 01:.....	67
Performance Measure 02:.....	70
Performance Measure 03:.....	73
Performance Measure 04:.....	77
Performance Measure 05:.....	80
Performance Measure 06:.....	83
Performance Measure 07:.....	87
Performance Measure 08:.....	90
Performance Measure 09:.....	93
Performance Measure 10:.....	96
Performance Measure 11:.....	99
Performance Measure 12:.....	102
Performance Measure 13:.....	105
Performance Measure 14:.....	107
Performance Measure 15:.....	110
Performance Measure 16:.....	112
Performance Measure 17:.....	114
Performance Measure 18:.....	116

D. State Performance Measures.....	119
State Performance Measure 1:	119
State Performance Measure 2:	121
State Performance Measure 3:	123
State Performance Measure 4:	125
State Performance Measure 5:	128
State Performance Measure 6:	130
State Performance Measure 7:	133
State Performance Measure 8:	136
E. Health Status Indicators	137
Health Status Indicators 01A:.....	138
Health Status Indicators 01B:.....	139
Health Status Indicators 02A:.....	139
Health Status Indicators 02B:.....	140
Health Status Indicators 03A:.....	140
Health Status Indicators 03B:.....	141
Health Status Indicators 03C:.....	142
Health Status Indicators 04A:.....	142
Health Status Indicators 04B:.....	143
Health Status Indicators 04C:.....	144
Health Status Indicators 05A:.....	145
Health Status Indicators 05B:.....	145
Health Status Indicators 06A:.....	146
Health Status Indicators 06B:.....	147
Health Status Indicators 07A:.....	147
Health Status Indicators 07B:.....	148
Health Status Indicators 08A:.....	149
Health Status Indicators 08B:.....	150
Health Status Indicators 09A:.....	151
Health Status Indicators 09B:.....	152
Health Status Indicators 10:	153
Health Status Indicators 11:	154
Health Status Indicators 12:	154
F. Other Program Activities.....	155
G. Technical Assistance	157
V. Budget Narrative	160
A. Expenditures.....	160
B. Budget	160
VI. Reporting Forms-General Information	162
VII. Performance and Outcome Measure Detail Sheets	162
VIII. Glossary	162
IX. Technical Note	162
X. Appendices and State Supporting documents.....	162
A. Needs Assessment.....	162
B. All Reporting Forms.....	162
C. Organizational Charts and All Other State Supporting Documents	162
D. Annual Report Data.....	162

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The assurances and certifications are on file at the Connecticut Department of Public Health and are available from:

Director, Office of Affirmative Action
Connecticut Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

In an effort to gain meaningful public input into the MCHBG application, the DPH no longer conducts public hearings, but has capitalized on other venues for grassroots level input that has been more meaningful and will contribute to the upcoming five-year needs assessment. The venues utilized include; family readers, community-based focus groups and DPH website posting (least useful). We are in the process of posting online consumer (English and Spanish) and community-based surveys, which along with state agency surveys and statewide telephone surveys, will be used for the five year needs assessment.

This year, Title V staff worked with Doug Edwards, Executive Director, Real Dads Forever, to conduct a focus group of fathers. A total of 8 men participated and reported that the following were barriers to receiving the health care that they or their families needed: childcare, time off from work, cannot find a provider that they like or trust, unaffordable insurance co-pays and finances (lack of money). The health care services that they needed but were unable to get for themselves or their family include: oral health, mental health, smoking cessation and "father and kid type of programs." All men reported that either they or someone in the household smokes cigarettes and all reported using a car seat or seatbelt for their children when they are driving them in a car. None of the participants had ever heard of the MCHBG or the phrase medical home.

DPH contracted with the Connecticut Economic Resource Center (CERC) to conduct five community based focus groups. The groups were held in collaboration with: (1) Bloomfield Family Resource Center; (2) New Haven Family Alliance and a Hartford Men's group; (3) Community Health Services, Inc., Hartford (4) New Haven Healthy Start (pregnant/postpartum

women); and (5) Born Again Evangelistic Outreach Ministry Church in Groton CT. A 38 question survey was distributed to each of the focus group participants. A total of 66 people participated in the focus groups and indicated that of those services that they would like but are unable to get include: WIC services , affordable insurance, accessing dental services, state insurance process takes too long, housing, prescription medications, eye care, life skills, pregnancy prevention (for teens), job training and education and alcohol and drug rehabilitation. When asked how the state could improve the methods of delivering health care services to them and their family their responses included: more outreach (door-to-door), more surveys, better ads (TV), colorful posters, use local newspapers, pamphlets at provider offices, easy-to-read materials (no fine print, short in length), direct mailings, more education for men (re: health exams), home visiting, and make paperwork easier.

A provider focus group was conducted by CERC with the members of the MCH Advisory Committee. A total of 15 providers from various state, local, and community agencies were in attendance. Providers indicated that: (1) the health care delivery system (for the MCH population) is too complicated and ineffective. They believe that there are too many agencies offering the same services and a lack of coordination; (2) There is a lack of direct communication between state agencies; (3) There is insufficient funding to implement that MCH programs properly (not been brought to scale); and (4) programs that we need already exist. We need to streamline the process and create a results based accountability process so the work gets done.

The DPH Family Advocate recruited three families to read the MCHBG application, and two meetings were held with the family readers. During the first of these meetings, an overview of topics was presented including MCH programs, the MCHBG process and general information about their role/input. Families were then given the application to read and were reconvened a week later. During the second meeting, information was gathered and questions were answered. Suggestions or recommendations from the families include: (1) sponsoring family-centered conferences, which should be designed to inform and empower families and show examples of family/professional partnerships and how they can work together; (2) having a wider distribution for the CYSHCN Directions Manual. A reader thought that the manual can help empower families since it contains information on important topics such as medical home and transition; (3) highlighting the importance of transition and that more needs to be done to engage adult providers to be able and willing to work with populations including adolescents and young adults with special health care needs; (4) increasing the number of medical homes. One family thought the number of medical homes was low and there needs to be an increased number of pediatric providers who participate in the medical home approach; and (5) continuing to track body mass indexes (BMIs) for young children.

All focus group and family readers received a stipend for their time and expertise related to reviewing the MCHBG application and participating in the focus groups.

Although the MCHBG application was posted on the DPH's website and the public was encouraged to submit written comments, none were received.

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

/2010/ 1. Strengthen Data Collection and Reporting

FHS completed the phases of the migration of EHDI and BDR databases to the MAVEN application. Genetics/Laboratory Tracking will migrate the genetic screening component of the Newborn Screening System (NSS) to MAVEN.

FHS and Health Information Systems and Reporting (HISR) continue to implement CHIERS with information that includes births, initial newborn hearing screening results, childhood lead screening results and resident population. Data can be queried according to age, race, ethnicity, sex and town of residence. CT will move CHIERS from Missouri DHSS to a CT-based web-hosting site.

FHS linked Birth-Medicaid data for 2000-2006. The 2007 linkage is being finalized, and FHS will provide data summaries to MCHBG and constituents.

SSDI data were provided to partners supporting a wide variety of MCH programs and activities. Internally, information was used to enhance reporting to the MCHBG; produce a strategic plan for the FHS to address low birth weight; addressing health disparities in low birthweight for CT; and improve birthweight outcomes associated with WIC participation. DPH presented at a statewide health disparities meeting and to the Birth to Nine Service Integration Committee of the Governor's Early Childhood Cabinet, which identified LBW as one of its three core priorities.

Externally, information was provided to: Hartford Health Department (HHD) to support their Preconception Health Plan for the City of Hartford; a workgroup of HHD and DPH staff that focused on improving birth outcomes in Hartford; MCH Workgroup under the Legislature's Medicaid Managed Care Council, Quality Assurance Subcommittee; and the Governor's Early Childhood Education's Infant and Toddler Workgroup.

2. Establish Collaborative Relations at the State/Local Level

The Memorandum of Agreement (MOA) between DPH and the Department of Corrections (DOC) was developed to conduct a gender responsive curriculum for staff and inmates at York Correctional Institute (CT's only female jail/prison).

MOA with UCONN's School of Nursing was developed to encourage urban high school youths to pursue careers in the health care field.

MOAs were executed with State Board of Education (SDE) to support school districts and communities to improve the wellness of children and youth, and to successfully transition YSHCN to all aspects of adult life, including health care, work and independence.

MOA was executed with DDS Birth to Three program which permits that sharing of EHDI client information to assure enrollment into the Birth to Three program.

MOA with AHEC provided the healthy child and adolescent development education and training program curriculum entitled "Building Bright Futures".

An MOA will be developed with the Hartford Health and Human Services Department for

the newly acquired federal Healthy Start grant.

3. Reduce Intentional Injuries

FHS provides ad hoc support to the Injury Prevention Program. Title V funds continue to be provided to support IPP activities at CT Children's Medical Center.

4. Improve Adolescent Health Status

Seven SBHC contractors increased capacity with added staffing and hours of operation to provide prevention and intervention.

SBHCs provide individual, family and group counseling to enrolled students and their families. Health education and risk reduction activities related to violence prevention are available to all students

HRSA funding supported the establishment of Building Bright Futures in CT, an education and training program for non-mental health professionals working in state funded programs that serve children and adolescents and their families for the purposes of understanding typical middle childhood and adolescent development, distinguishing between risk and protective factors and identifying appropriate responses to challenging behavior.

5. Promote Nutrition and Exercise to Reduce Obesity

The CT Childhood Obesity Council (CCOC) held a statewide forum in 11/08: "Preventing Childhood Obesity: A Healthy Imperative for Connecticut's Next Generation". The CCOC includes state agencies and representatives of the legislative branch, with a mission of preventing childhood obesity.

Through support from DPH and the CT Cancer Partnership, the Community Health Center, Inc.'s Food & Fitness Program is testing curricula designed to support healthier eating and physical activity in elementary schools. The program will recommend ways schools can implement wellness curriculum and healthy living.

The Supplemental Nutrition Assistance Program focused on preschool nutrition education to increase fruit and vegetable consumption among children and their families in SNAP eligible households and daily physical activity. The program uses a train-the-trainer model for teachers to implement the Captain 5 A Day curriculum.

6. Increase Access to Pre-conception Education and Parenting

The First Time Motherhood/New Parents Initiative Grant will disseminate novel social marketing approaches to increase awareness of existing preconception/interconception, prenatal care, and parenting programs in Hartford, New Haven & Bridgeport to promote healthy birth outcomes.

The Centering Pregnancy model of group prenatal care was implemented in 2 New Haven sites for women most at risk for delivering LBW infants. It's goals are to achieve outcomes that include empowerment, increased care satisfaction, reduced preterm births, and increased breastfeeding.

The Case Management for Pregnant Women program provides comprehensive case management to address perinatal health disparities among African-Americans, Hispanics, teens, and adolescent fathers. Pregnant teens are referred to the program and are provided with information about the importance of prenatal care and parenting.

7. Promote access to family support services including respite care and medical home system of care for CYSHCN

The CT Lifespan Respite Coalition (CLRC) implements protocols and distributes respite

extended service funds for CT families. Respite care is provided in or out of the home to give relief to the family/caregiver from the daily responsibilities of caring for CYSHCN. CLRC hosted a workshop on the "Get Creative About Respite" manual to participants at the ARCH National Respite Conference in Alabama. The 2-part manual consists of a Parent's Guide and Child/Adolescent Guide.

8. Reduce health disparities especially related to Access to care, Race/ethnicity, and geographic location.

DPH is planning the 3rd CT PRATS including several enhancements to the survey methodology. DPH staff will continue to implement strategies from the Strategic Plan to Address Low Birth Weight. The DPH/PHI Branch convened the Health Disparities workgroup to review programs that address health disparities.

9. Collaborate with the other federal Region I states to develop indicators that measure the collective assets of their early childhood health systems, "specifically focusing on their collective assets regarding child care health consultants (CCHC)."

DPH did not actively pursue work on this SPM, as most of the Region 1 states did not have the capacity to provide information to address this issue. CSN is raising the possibility of a common SPM with Region 1 states around rural health.//2010//

III. State Overview

A. Overview

A. Overview

Connecticut is a relatively small state of about 5,000 square miles and 3.5 million persons. Nearly one million of Connecticut residents are between the ages of birth to 19, amounting to 27% of the state's population (1). It is clear that the population in Connecticut has become more diverse during the past decade. The Hispanic, Asian, and AA/Black population increased an estimated 50, 68, and 13 percent respectively since the 1990 census, while the white population decreased 4%. The white non-Hispanic population comprised 83.8 percent of the Connecticut population in 1990, but that percentage dropped to 77.5 in 2000 and has remained level since then (2). See Table 1 in the document attached to this section.

/2008/ The estimated population in CT as of July 1, 2005 increased slightly by 6,693 to 3,510,207.//2008//

/2009/ The estimated population in CT as of July 1, 2006 decreased slightly by 5,398 to 3,504,809. Data shows a shift in the racial and ethnic breakdown of CT's population where Hispanic, Asian and African American populations now represent 10.9, 3.6, and 10.7 percent respectively while the White population decreased by 2.3% to 83.3%.//2009//

/2010/ The estimated population in CT as of July 1, 2007 decreased very slightly by 2,500 to 3,502,309.//2010//

I. Maternal and Child Health Indicators

A. Maternal and Child Demographics

With Census 2000 information released, a more detailed picture of Connecticut and the United States became available. As the Census Bureau releases Supplemental Population Estimates, comparisons can be made on residents of Connecticut and the United States. See Tables 2 and 3 in the document attached to this section. Residents of the major cities (Bridgeport, Hartford and New Haven) tend to be younger, unmarried, poorer, less educated, more likely to be unemployed, on public assistance, and be Hispanic or African American/Black than the state as a whole. These comparisons are in stark contrast to the demographics of some wealthy suburbs such as Darien and New Canaan.

Many indicators of maternal and child health within Connecticut compare favorably with the United States as a whole, however, there are high risk groups which experience a greater share of the burden of adverse health risks and outcomes. In Connecticut in 2002, an African American/Black baby was two and a half times more likely to die within its first year of life than a white baby, twice as likely to have late or no prenatal care, and almost twice as likely to be born with low birthweight. See Table 4 in the document attached to this section. These disparities are documented in more detail in the Needs Assessment that was completed as part of the 2006 MCHBG Application. Reducing the disparities in maternal and child health indicators remains one of the major challenges facing the public health community.

B. Infant Mortality

The overall infant mortality rate has declined in the United States and Connecticut during the past two decades (3). However, African American/Black babies consistently have had higher infant mortality rates than White and Hispanic populations in Connecticut and in the U.S. From 1981 to 2003, Connecticut's infant death rate fell from 12.0 to 5.3 deaths per 1,000 live births. However, the infant mortality rates for African Americans/Blacks in 2003 was 11.5 and substantially exceeded the rates for whites in all years from 1981 to 2003. See Figure 1 in the document attached to this section.

This gap reflects the consistently higher prevalence among the non-white population for risk factors, such as birth rates among teenage women, lack of adequate prenatal care, and low

birthweight. Targeting prevention programs to groups showing a high rate of low and very low birthweight infants (such as women in the urban centers or the state's African American/Black population) may produce the greatest effect on reducing the overall risk factors among the nonwhite infant population in the state.

Programming within the Department of Public Health (DPH) to reduce infant mortality is aimed at the period before conception, along with the prenatal and postnatal periods. Pre-conception interventions aimed at school-aged audiences and women of childbearing age include primary care services, targeted health education programs, and outreach and case-finding to link individuals and families to primary and preventive services. Prenatal efforts are focused on getting mothers into regular care early in the pregnancy and keeping both regular and specialty care appointments as directed by their health care provider. Postnatal efforts include medical testing for genetic disorders and maintaining good health for healthy infants and their mothers. /2008/ Infant mortality rates (IMR) continue to be higher in the African American and Hispanic population. For 2005, the provisional IMR for African Americans was 10.7 per 1,000 live births compared to 3.4 per 1,000 live births for Whites. DPH is partnering with the Hartford Health Department on their CDC/CityMatCH technical assistance grant to address systems of care as it relates to preconception and interconceptional care. A Region One MCH workshop is being planned to better understand the Life Course approach and its application to the state MCH Title V programs and policies. Application of this approach could over time impact the IMRs. DPH is collaborating with the New Haven Federal MCHB Healthy Start Program to roll out an Infant Mortality campaign targeting the African American community in June.//2008// /2009/ IMR is higher in the African American (AA) and Hispanic population in 2006. (AAs was 14.6, 7.2 Hispanics and 4.5 for Whites.//2009// ***/2010/ IMR is higher in the African American (AA) and Hispanic populations in 2007 (AAs was 12.0, 6.1 Hispanics and 5.4 for Whites). This represents a slight decrease for AAs and Hispanics and increase for Whites over the past year.//2010//***

C. Births to Teens

Teen birth rates declined dramatically during the past decade as the birth rate for teens age 15-19 dropped from 59.0 to 43.0 per 1,000 teens nationally between 1993 and 2003. In Connecticut, the rate dropped from 38.8 to 25.8 infants born per 1,000 female teens (4). An African American/Black or Hispanic baby born in CT in 2003 was approximately 4 to 5 times more likely to have a teenager as a mother than a white baby. See Figure 1 in attachment to this section. According to the National Center for Health Statistics preliminary birth data for 2003, Connecticut ranked fifth in the nation for its teen pregnancy rate for 15-19 year olds, with a rate of 25.8 births per 1,000 females ages 15-19 in comparison to the national rate of 43.0 (4). The percent of births to teens varies by race and ethnicity. The overall percent of births to teens has dropped in the last decade, especially among African Americans/Blacks. However, there remains a greater percentage of pregnancies among teens in the African American/Black and Hispanic populations when compared to white teens. See Figure 2 in the document attached to this section.

Teen pregnancy is considered a public health problem for several reasons related to the health of both the mother and newborn. Early sexual activity can result in a higher risk for sexually transmitted diseases, which could harm the fetus and impair the future fertility and health of the mother. Preventive interventions to address teen pregnancy through Connecticut's Title V programs include programs to delay the onset of sexual activity, promote abstinence as the social norm, reduce the number of adolescents who have sex at young ages, and increase the number of sexually active adolescents who use contraceptives effectively. State-sponsored specialized programs such as the Right from the Start Program serve pregnant and parenting teens. This program provides intensive case management services with emphasis on promoting positive pregnancy outcomes, positive parenting and breastfeeding.

/2008/The provisional teen birth rate for 2005 was 23.3 per 1,000 teens age 15-19 years old, with the largest proportion being births to Hispanic teens (77.1) followed by African American teens (41.6). DPH is making programmatic changes to more accurately reflect the data regarding births to teens. Collaborations with JSI have been instrumental in identifying science-based teen

pregnancy prevention programs. DPH has partnered with the Konopka Institute to conduct a workshop, "You've Been Framed," to help Title V programs build good will and support for delivering positive messages to youth.//2008//

/2009/ The 2006 provisional teen birth rate was 23.4 per 1,000 teens age 15-19 yrs old, with the largest to Hispanic teens (78.1) then AA teens (46.6). The very slight increase from 2005 to 2006 is much less than that nationally.//2009//

/2010/ The 2007 teen birth rate was 23.1 per 1,000 teens age 15-19 yrs old, with the largest to Hispanic teens (76.9) then AA teens (37.5). The most significant decrease was in the AA population and is consistent with the continued decreasing trend in the teen birth rate.//2010//

D. Prenatal Care

Non-adequate prenatal care is a composite measure, reflecting both the time of the first prenatal visit and the number of visits. The "non-adequate" grouping includes both "inadequate" and "intermediate" care as defined in the Kessner Index of prenatal care (5). Adequacy of prenatal care has improved during the past decade. Although the gap is closing in differences in race, adequate prenatal care is less often achieved by African American/Black and Hispanic women. See Figure 3 in the document attached to this section. In 2002, 2.0 percent of CT women received late or no prenatal care in comparison to 3.6 percent nationally. Connecticut ranked one of the lowest rates of late or no prenatal care, along with the other New England states (6).

The Department has tried to improve access to prenatal care through several strategies, such as supporting sites for primary care and free pregnancy testing at family planning clinics. At these sites, patients are appropriately referred for early prenatal care, in keeping with established protocols.

/2008/ In 2005, the provisional percent of non-adequate prenatal care in CT was 19.8%. Non-Hispanic African American women were 1.8 times more likely to receive non-adequate prenatal care than non-Hispanic White women (28.9% among non-Hispanic African American women versus 16% among non-Hispanic White women). Hispanic women were 1.7 time more likely to receive non-adequate prenatal care (27.3%).//2008//

/2009/ The 2006 % non-adequate prenatal care was 19.9%. Non-Hispanic AA & Hispanic women were 1.7 times more likely to receive non-adequate prenatal care than non-Hispanic White women.//2009//

/2010/ The 2007 % non-adequate prenatal care was 20.9%. Non-Hispanic AA & Hispanic women were 1.8 and 1.6 times more likely to receive non-adequate prenatal care than non-Hispanic White women.//2010//

E. Low Birthweight

Low birthweight (under 2,500 grams) is a major cause of infant mortality and long-term health problems. The impact of low birthweight on infant mortality occurs primarily during the first 28 days of life (the neonatal period), when low birthweight infants are about 40 times more likely than normal weight infants to die. For very low birthweight infants (less than 1,500 grams or 3 lbs. 3 oz), the risk of death is 200 times higher than among normal-weight newborns. See Figure 4 in the document attached to this section. In 2003, 7.5 percent of births had low birthweight in Connecticut in comparison to 7.9 percent nationally (4). While there have been improvements in the infant mortality rates, low birthweight has remained relatively stable for the past two decades. Low birthweight is more common among infants of African American/Black and Hispanic mothers. Likewise, twins and multiple births have a higher frequency of low and very low birthweights compared with singleton newborns.

/2008/ In 2005, the provisional low birth weight percent in CT was 8.0%. Low birth weight remains highest among the African American mothers at 13.7% while Hispanic mothers have a percent close to the CT percent (8.3%).//2008//

/2009/ The 2006 LBW % in CT was 8.2%. LBW remains highest among the AAs at 12.7% while Hispanics have a % slightly higher than CT(8.9%).//2009//

/2010/ The 2007 LBW % in CT was 8.1%. LBW remains highest among the AAs at 12.4%

while Hispanics have a % slightly higher than CT (8.3%); this represents a slight decrease since 2006./2010//

F. Other MCH Indicators

The positive maternal and infant health effects of breastfeeding have been well documented. The estimated rate of breastfeeding in Connecticut has improved from 68.7% to 69.3%, just shy of the state's goal (69.5%). Generally, the rate of women in Connecticut breastfeeding while in the hospital is 73.2% and at 6 months the rate is 28.3% (7). Thus, the rate of initiation of breastfeeding among all women has improved (as indicated by hospital rates) but declines rapidly by six months. The role of the Title V program has been to promote breastfeeding as a social norm in the state. Other infrastructure building activities included conducting a statewide needs assessment of the breastfeeding practices of Black and African American women to determine how best to promote and support breastfeeding in this population, which breastfeeds at a lower rate than other groups.

Although pregnant women in CT were less likely to smoke than their counterparts nationwide (see the CT Needs Assessment), smoking during pregnancy remains a public health issue. The role of the Title V program is multi-fold and includes functioning as a partner with the DPH's Tobacco Control Program to address smoking cessation during pregnancy, as well as with federal and regional level initiatives (i.e. -- National Partnership to Help Pregnant Smokers Quit), which can be implemented at the state level. Other infrastructure building activities including the facilitation of meetings with the state DSS and Managed Care Organizations (MCOs) to discuss reimbursement mechanisms for smoking cessation products and support services.
/2008/ The DPH has been successful in leveraging additional federal and state funds to sustain its perinatal depression activities originally funded by MCHB in 2005. The DPH continues to address the need for perinatal depression screening and has instituted a pilot, provider consultative line (staffed by mental health clinicians) for providers who screen clients for perinatal depression. Funding from the Region One Office on Women's Health (OWH) has complemented other funding streams to continue advertisements on transit buses.//2008//
/2009/ A fact sheet on perinatal depression is mailed to new CT parents.//2009//

II. Other Indicators

A. Socioeconomic Indicators in Connecticut

In Connecticut, there is a disparity between the wealthiest and poorest citizens. While Connecticut is one of the wealthiest states in the country, several cities have high rates of poverty. With a median household income of \$55,004, Connecticut was ranked fifth in the nation (8) in 2003. Within Connecticut, however, the median family income and other characteristics recorded in the 2000 Census vary within the State and its large cities, and New York suburbs. While many children within Connecticut lived in affluent homes, nearly 86,000 lived below the poverty level (9). In Hartford, over 40% of the children were estimated to be living in poverty (10), a figure surpassed only by one other city in the nation with a population over 100,000. Despite its relative wealth, and with recent decreases in state revenues, efficiency is paramount to reversing child health disparities within the state. The economic disparity experienced by the cities is mirrored in differing maternal and child health statistics. See Table 5 in the document attached to this section.

The economic recession that began mid year 2000 appears to have ended, recovering from a downturn in the economy since the terrorist attacks of September 11, 2001. Between September 2003 and March 2005, Connecticut recovered 28,000 of the 61,000 jobs lost since 2000 (11). The state's economy is supported predominantly by services, manufacturing, and retail trade industries. Unemployment in Connecticut has risen to 5.3 percent in comparison to 5.1 percent nationally (12).
/2008/CT's labor force is expected to grow by 8,000 workers from 2006 to 2007, with

unemployment falling to 4.4 percent compared to 4.5 percent nationally.//2008//
/2009/CT's labor force is expected to grow. CT's residents had the highest per capita personal income of \$50,787(2006) that was 37% higher than the national average of \$36,629. In contrast to this affluent scenario, CT is among the states with the worst racial disparities in the nation for assets. The state budget is currently operating with a \$150 million deficit.//2009//
/2010/ CT's labor force has been negatively impacted by the current recession. CT continues to lead the nation with its per capita income. However, the decline in employment measured in February 2008 was the largest decline since 1992 (Total employed decreased by 18,244 persons, or 1%, according to the monthly Current Population Survey that provides labor force estimates measuring the work status of people who live in Connecticut.)/2010//

B. Health Care Delivery Environment in Connecticut

Connecticut does not function on a county-based system for the delivery of public health services to its residents. Direct health care services are delivered to residents through a wide range of providers including, but not limited to, school based health centers, community health centers, outpatient clinics, physicians offices for primary care services; free-standing and hospital-based outpatient surgical centers for diagnostic or minor surgical procedures; acute care hospitals for emergency care, routine outpatient or inpatient services; long term care facilities for chronic care or rehabilitative service; and increasingly non-institutional settings, such as the home, for services ranging from intravenous infusion of medications to physical therapy. The licensure or certification of health care facilities and health care professionals guides promotion of high quality health care and services. Utilization of services is dependent upon a variety of demographic, economic, social and environmental factors, all of which are considered when planning the delivery of Title V programs, services and activities.

Perinatal Care in CT is provided through a network of Healthy Start Providers. The Healthy Start Program is a collaboration between the State Departments of Social Services (DSS) and Public Health. The goal of the state Healthy Start Program is to promote positive birth outcomes and maternal and infant health among at-risk, low income families in CT. The DSS contracts with 5 agencies statewide, which in turn contract with other community based providers to provide case management services to pregnant women and their children up to age three. To complement the Healthy Start program, CT also has a Nurturing Families Network, which operates in all twenty-nine birthing hospitals in the state. It provides parent education and support for first time parents. Unlike the Healthy Start program, families are enrolled in the Nurturing Families Network when they are expecting or have just given birth to their first child.

Connecticut is part of the national trend in the delivery of health care services in which managed care has expanded and has become the dominant financing mechanism. The Connecticut care delivery system is challenged by managed care and the lack of sufficient services for the uninsured. These methods of financing affect not only the availability and delivery of services, but also the quality of patient outcomes. Hospital mergers have occurred in Connecticut and lengths of stays in hospitals have decreased, as has the rate of hospitalizations (13).

/2008/ To date, seven "Minute Clinics" have been established at local CVS pharmacies. These clinics are staffed with licensed Nurse Practitioners and Physician Assistants and serve clients ages 18 months of age and older.//2008//

/2009/The number of Minute or Convenient Care Clinics has risen to 16.//2009//

/2010/ The number of Minute clinics has declined to 11.//2010//

/2008/Legislation is currently pending that would expand the eligibility for the state Healthy Start Program from <185% of the FPL to <250% of the FPL. This expansion would increase access to case management services for pregnant women.//2008//

/2009/ Healthy Start eligibility is now 250% of the FPL.//2009//

C. Safety Net Providers

Safety Net Providers comprise the system of care that addresses the needs of those individuals who experience barriers when accessing the traditional health care system. Some of these barriers include financial, transportation, cultural, linguistic, etc. One of the primary groups targeted by safety net providers are the uninsured. In Connecticut, the safety net provider system is comprised of Community Health Centers, School Based Health Centers, Visiting Nurse Associations, Local Health Department and Family Planning Clinics. Maintaining and supporting the safety net providers is a priority for the State. With increasing financial challenges, CT's focus is to avoid the erosion of this health care delivery system. During the 2005 legislative session, the Torrington Community Health Center, an FQHC look-alike, was allocated state funding and the remaining CHCs were given a small cost of living adjustment.

/2008/ During the 2007 legislative session, United Community and Family Services, Inc. in Norwich was given \$200,000 to provide community health center services in addition to the oral health services already funded.

The CHCs and SBHCs received COLAs on state funding. State bonding dollars have been made available to CHCs and SBHCs to continue to build their capacity as a safety net provider. SBHCs have recently received \$1.0 million in bonding funds for expansion of this safety net provider system.

During the past year there has been a merger between New Britain General Hospital and Bradley Memorial Hospital. Both are now under the auspices of The Hospital of Central Connecticut. Both campuses are still providing services to CT residents.//2008//

/2009/CHCs & SBHCs will receive additional state funding in both 2008 and 2009.//2009//

/2010/ Federal stimulus funding has been provided to the CHCs in CT and all but one are now FQHCs.//2010//

D. Health Insurance

HUSKY (Healthcare for UninSured Kids and Youth) is Connecticut's health insurance plan for children and families. In 1997 when the federal government created the State Children's Health Insurance Program, Connecticut renamed part of its Medicaid program that serves children and low-income families "HUSKY A" and established the "HUSKY B" program for uninsured children with family income that exceeds the HUSKY A limits. Both HUSKY A and B are managed care programs, administered through the Department of Social Services and private health plans. HUSKY A covers pregnant women and children in families with income under 185% of the federal poverty level. HUSKY A provides preventive pediatric care for all medically necessary services. It also covers parents and relative caregivers in families with income under 100% of federal poverty. There are 310,878 persons, including 218,420 children under 19 in HUSKY A as of May 2005. The basic HUSKY package includes preventive care, outpatient physician visits, prescription medicines, inpatient hospital and physician services, outpatient surgical facility services, mental health and substance abuse services, short-term rehabilitation and physical therapy, skilled nursing facility care, home health care and hospice care, diagnostic x-ray and laboratory tests, emergency care, durable medical equipment, eye care and hearing exams, and dental care (14).

/2008/As of July 1, 2006 the FPL for HUSKY A coverage for parents and caretaker relatives was increased from 100% to 150%. There are 298,145 persons, including 207,323 children less than 19 years of age in HUKSY as of May 2007.//2008//

/2009/ The FPL for HUSKY A coverage is now 185% FPL. HUSKY has 296,484 persons, with 206,024 children.//2009//

/2010/ The FPL for HUSKY A coverage is now 300% FPL. HUSKY has 322,173 persons, with 218,689 children.//2010//

HUSKY B provides health care for children without employer-sponsored coverage for a sliding

fee. There are 15,640 children under 19 in HUSKY B as of May 2005 (15). As part of HUSKY B, HUSKY Plus provides supplemental benefits for Children and Youth with Special Health Care Needs enrolled in HUSKY B. Services include Multidisciplinary teams (Pediatricians, Advanced Practice Nurses, Benefits Specialists, Family Resource Coordinators and Advocates) who work with families to identify their child's care needs and the resources to meet those needs.

Community-based mental health and substance abuse services to children and youth with intensive behavioral health needs are also offered under HUSKY Plus.

/2008/ HUSKY B enrollment increased slightly to 17,181 as of May 2007.//2008//

/2009/ As of May 2008, HUSKY B enrollment was 16,276.//2009//

/2010/ As of May 2009, HUSKY B enrollment was 15,217.//2010//

In a January 2005 review of 2003 HUSKY data, the Connecticut Voices for Children found that just over half of the children covered by HUSKY received well-child care in 2003, with the utilization rates being the lowest among older adolescents (aged 16-19 years) (16). Utilization was lower for dental care, with only 47% of enrolled children having any dental care in 2003. While there have been improvements in dental care utilization rates during the past few years, fewer than half of enrolled children who are eligible for preventive dental care services through HUSKY A actually received these services (17).

There have been changes that limit eligibility or enrollment. On July 1, 2005 families now only receive Transitional Family Assistance (TFA) for one year rather than two years. As of July 1, 2005 new and increased premiums will be imposed on children in HUSKY B. Also there is elimination of self-declaration of income mandating that applications received after July 1, 2005 show documentation of income. Fortunately there are changes that improve eligibility and enrollment, presumptive eligibility for HUSKY A children is being restored and now pregnant women experience expedited eligibility when enrolling in HUSKY A. Another improvement is that DSS is implementing increased income guidelines for parents and caretaker relatives with incomes between 100% and 150% of the federal poverty level effective July 1, 2005.

/2008// Effective July 1, 2006, families are again allowed to self-declare unless the declared income is questionable for the applicants are self employed.//2008//

Connecticut Voices for Children released a report on Births to Mothers in HUSKY A (18). In 2002, there were 41,191 births to Connecticut residents, including 9,775 births (24%) to mothers enrolled in HUSKY A when their babies were born. Compared to other mothers who gave birth that year, mothers who were enrolled in HUSKY A were younger (average age 25, compared with 31 for other mothers) and far more likely to be teens (21% vs. 3% of other mothers). They were more likely to be Black non-Hispanic (25% v.7%) or Hispanic (32% vs. 12% of other births).

/2008// Compared to all other babies in CT, rates for low birth weight, preterm and teen births were higher for babies born to mothers covered by HUSKY A and fee for service Medicaid.//2008//

Health insurance is an important component of access to health care. People without health insurance are less likely to receive the basic health care services that the insured receive. In some cities and towns, HUSKY A covered a far greater proportion of pregnancies. In these communities, the importance of HUSKY A for improving maternal health and birth outcomes cannot be overstated. The collaborative efforts of HUSKY, prenatal care providers, community-based organizations, and other Title V funded programs are essential for ensuring that women become pregnant when they chose to, begin pregnancy in good health, begin prenatal care early, and obtain risk-appropriate high quality prenatal care and social support services throughout pregnancy (18).

As the Title V agency in Connecticut, DPH has contributed policy guidance and technical assistance to the HUSKY program by:

- Enhancing enrollment in HUSKY by participating in the Covering Connecticut's Kids coalition, a network of organizations involved in HUSKY outreach (including DSS, Benova, and

Infoline).

- Partnering in the work to expand Katie Beckett waiver and other related DSS waiver applications that will support access to comprehensive care for children and youth.
- Working with the State Medicaid Managed Care Council to promote outreach for prenatal access in first trimester and Medicaid reimbursement of care coordination services to improve access to pediatric primary health care access under Early Periodic Screening and diagnostic and Treatment Services.
- Working with State Commission on Children, HUSKY and other Connecticut key stakeholders in promoting home visitation for mothers with newborns, particularly at risk mothers using Healthy Start and Nurturing Families Programs.
- Working with Local Health Departments and Immigrant health to improve health status of the Connecticut residence.
- Providing care coordination and respite care as well as family support services to children with special health care needs in HUSKY as a way of filling the gaps in care.
- Developing linkages between HUSKY and state public health programs such as WIC, childhood immunizations, Medical Home Learning Collaborative of primary care physicians, School Based Health Centers (SBHC), Community Health Centers, Family support council, and other essential community providers and Title V funded programs, (including an MOU with DSS regarding these linkages).
- Facilitating the process by which School Based Health Centers (SBHC) are named as the only essential community providers in the DSS waiver application, resulting in all SBHCs having contracts with all managed care plans for Husky A and B.
- Supporting Community Health Centers/Connecticut Primary Care Association and SBHCs in their efforts to receive statewide outreach grants for Husky B.
- Utilizing existing services to create access points for referral or applications to enhance outreach and enrollment.
- Identifying and developing needed enabling services through work with other providers and local health departments; and
- Implementing quality improvement activities and evaluation.

A growing concern is the national and state trend among the Hispanic population being disproportionately underinsured. Although Hispanics are 10 percent of Connecticut's total population, they constitute 40 percent of its uninsured. Hispanics are five and a half times more likely to be uninsured as persons from all other ethnic or racial groups. This result reflects a national phenomenon. Hispanics are significantly less likely than non-Hispanics to have health coverage, to have a regular health care provider, and to receive regular preventative care and screenings (19).

/2008 The legislature is currently reviewing a number of proposals for universal health care for CT adults and children. There are an estimated 347,000- 407,000 uninsured adults in the state. \$1.1 million dollars in state funds were allocated to expand outreach efforts for children into the HUSKYProgram.//2008//

/2009/ The Charter Oak Plan was implemented. This is a voluntary health insurance program for adults.//2009//

/2010/ As of May 2009, 9,671 CT residents are currently enrolled in the Charter Oak Plan. Another 4,927 are eligible but not enrolled.//2010//

E. Racial and Ethnic Disparities

Reducing the disparities in maternal and child health indicators remains one of the major challenges facing the public health community. When reviewing Connecticut's maternal and child health indicators, racial and ethnic disparities are quite evident. According to the "Policy Challenges and Opportunities in Closing the Racial/Ethnic Divide in Health Care" (20), a multi-level strategy must be employed to address the potential causes of racial/ethnic disparities. In CT some of the strategies have included: 1. Improving the number and capacity of providers in underserved communities by continuing to function as a liaison in the recruitment and retention of primary care health professionals. This particular activity is carried out by the Primary Care Office

within the DPH and by working collaboratively with the CT Primary Care Association. 2. Increasing the knowledge base on causes and intervention to reduce disparities by collecting and analyzing data on health care practices and use across racial and ethnic groups. In a study of Latina adolescent women in CT who were pregnant, they all reported that their pregnancy was "accidental" and that if they thought they would have become pregnant they would have "delayed sexual activity" (21). The DPH is also in the process of finalizing a study on the breastfeeding practices of African American/Black women. CT's PRAMs-like study or the Pregnancy Risk Assessment Tracking Survey (PRATS) data is currently being weighted and should provide additional racial and ethnic specific MCH data. 3. The re-establishment of the DPH's Office of Multicultural Health in raising public and provider awareness of racial/ethnic disparities in health care. The Office is responsible for improving the health of all state residents by eliminating differences in disease, disability, and death rates among ethnic, racial and cultural populations. The office may provide grants for culturally appropriate health education demonstration projects and apply for, accept, and spend public and private funds for these projects. It also may recommend policies, procedures, activities and resource allocations to improve health among the state's racial, ethnic, and cultural populations.

The Connecticut Health Foundation (CHF) (<http://www.cthealth.org>) is the state's largest independent, non-profit grant-making foundation dedicated to improving the health of the people of Connecticut through systemic change and program innovation. After meeting with state agencies, community leaders, and health care professionals, the Foundation selected 3 program areas to focus its resources: Improving Access to Children's Mental Health Services; Reducing Racial and Ethnic Health Disparities; and Expanding Access to and Utilization of Oral Health Services.

The Foundation's Policy Panel on Racial and Ethnic Health Disparities released its final report in March, 2005 which includes state policy recommendations that begin to address health disparities. Those recommendations specific to the Department of Public Health (DPH) include:

- The Connecticut Department of Public Health should collect and integrate racial and ethnic health data into all of its statewide planning efforts and publish a biennial report on key findings from data collected on the health status of racial and ethnic populations.
- The Connecticut Office of Health Care Access and the Connecticut Department of Public Health should require health care organizations, including providers and payers, to collect data on each patient's primary language in health records and information systems, and post signage in the languages of the patients they serve.
- The Connecticut Department of Public Health should establish a certification program for all medical interpreters to ensure cultural competence and quality service.
- The Health Systems Regulations Bureau of the Connecticut Department of Public Health should establish a system for monitoring and enforcing the law regarding linguistic access in acute care hospitals (Public Act No. 00-119) and publish a report on its findings for public and legislative review.
- The Connecticut Department of Public Health should (a) collect and track data on the race and ethnicity of all licensed medical professionals and issue an annual report on the diversity of the health care workforce in the state and (b) require all health care professionals to participate in cultural and linguistic competence continuing education programs through licensure requirements.
- The State of Connecticut should allocate no less than \$2.12 million of Connecticut's State Tobacco Settlement funds to specifically support evidence-based, culturally and linguistically competent health promotion programs that respond to the health needs of underserved racial and ethnic populations.
- The Connecticut Department of Public Health should match all available federal dollars allocated to the national loan forgiveness program each year; target these funds to attract a greater number of historically underrepresented students to the health professions; and promote the loan forgiveness program broadly and effectively.

/2008/ Recent reports indicate that CT Latinos are sicker and likely to die younger than members

of any other ethnic group in the state. Although Latinos represent 9% of CT's population, they account for 40% of the state's uninsured, 25% of AIDS cases and 30% of Chlamydia cases. Language barriers remain a serious problem in getting care. 44% of the adults reported that they usually or sometimes have a hard time understanding the doctor because of language issues. Among the Black/African American population, age-adjusted death and premature mortality rates of Black/African Americans Connecticut residents are significantly higher than those of the White, non-Hispanic Connecticut residents for all six leading causes of death - heart disease, cancer, unintentional injury, cerebrovascular disease, HIV, and diabetes (1999-2001 data). African Americans have 1.2 times the age-adjusted death rate of heart disease and cancer, 1.3 times the age-adjusted death rate of cerebrovascular disease (stroke), 1.4 times the age-adjusted death rate of unintentional injury, 2.6 times the age-adjusted death rate of diabetes, and 15.7 times the age-adjusted death rate of HIV compared with White, non-Hispanic Connecticut residents (Hynes, Amadeo, and Mueller 2005).

The FHS, in collaboration with the Federal New Haven Healthy Start Program will be launching a campaign to raise awareness about infant mortality in the African American community. The campaign consists of radio and television ads, as well as posters.

The Public Health Initiatives Branch has convened an internal Health Disparities workgroup; FHS staff participate on this workgroup. The purpose of this workgroup is to assess programs in the Branch that address health disparities and strategies to provide ongoing support.

The Office of Multicultural Health is active and its goals are to: (1) Promote access to health care for all racial and ethnic minority populations (2) eliminate language barriers (3) Promote cultural competence among the healthcare and public health workforce (4) Improve data collection, analysis and reporting on health disparities and (5) Develop the healthcare and public health workforce to better represent racial and ethnic minority groups. CT recently hosted the Region One Minority Health Conference that was attended by more than 600 participants.

The PCO staff, in collaboration with an internal workgroup, developed brochures in English and Spanish to promote awareness among high school students and health care professionals regarding alternative care practice settings and opportunities such as the National Health Service Corps and the State Loan Repayment Program.

FHS staff participated in the Region One Office on Women's Health to discuss health issues identified by the Tribal Nations in the region one states. DPH will continue to foster collaborations with the Tribal Nations and will include data from this group in the next five-year MCH needs assessment. In CT, diabetes and alcoholism were identified as an outstanding health issue with Native Americans.//2008//
/2009/Staff developed an inventory of programs that address MCH health disparities.//2009//
/2010/ Staff implemented many of the recommendations from the State Plan to address Racial/Ethnic disparities in LBW. CT recently received funding to implement a federal Healthy Start program in Hartford. DPH continued to collaborate with the New Haven Federal HS Program and Hartford on the Infant Mortality campaign.//2010//

F. Rural Health

The Connecticut definition of rural, adopted June 2004 by the ORH Advisory Board, uses the 2000 U.S. Census data and OMB designations. All towns in a designated Micropolitan Statistical Area with a population less than 15,000 and those towns in Metropolitan Statistical Areas with a population of less than 7,000 are designated rural for the State of Connecticut. Of the 169 towns in CT, there are 29 with populations of less than 7,000 (22). Specific concerns identified for rural Connecticut include: emergency medical services, transportation, recruitment and retention of adequate workforce, a decreasing social services safety-net, mental health, oral health, and others. The Primary Care Office (PCO), located in the Family Health Section has taken on a formal role in meeting with the staff of the Office of Rural Health, and PCO staff has recently been

appointed to the ORH Advisory Board. The Title V program will continue to support the PCO and its collaborative efforts with the ORH and provide technical assistance to the ORH as they better assess and document the needs of the rural health community.

/2008/The CT Office of Rural Health (CT-ORH) contracted with a local firm to identify existing available data sources, analyze and report the key health care issues impacting rural CT. The overall goal was to gain a better understanding of the health status of rural residents and develop a supporting rural health database. The survey results indicated concerns regarding transportation service in rural communities, adequate services for substance abuse, domestic violence, oral health care and mental health services. The report can be found on www.ruralhealth.org/report./2008//

/2009/ FHS participates on the ORH Advisory Board./2009//

/2010/FHS Injury Prevention and MCH staff are collaborating with the Office of Rural Health (ORH) on the Region 1 initiative to address injuries in rural areas./2010//

G. Other Vulnerable Populations

The Department has been interested in the health needs of vulnerable women and children, many of whom face barriers to care which are not addressed by the state's managed care system. These populations include the uninsured, single mothers transitioning from welfare to work, homeless mothers and children, incarcerated women, adolescents who are concerned with confidentiality (parent involvement in their health care), immigrant and undocumented populations, infants who experience delays in newborn Medicaid eligibility determinations, and providers who are not prepared to deal with the multiple social and economic problems facing many of their patients. This is especially true in areas where hospital based clinics have closed and patients are referred to private practitioners.

Incarcerated Women's Health: The role of the Title V program has been to work collaboratively with other state agencies and community based organizations to address the issues of this vulnerable population. The DPH functioned as a conduit for bringing together key state agencies to address transitioning soon-to-be-released women, from York Correctional Institute (YCI), Connecticut's only female prison, back to the community healthy. As a result of this process, the DSS designated Medicaid eligibility workers to process Medicaid applications for inmates just prior to their release date. This is a model which can be replicated in the male correctional institutions throughout the state.

/2008/FHS Staff are working with DOC staff to develop an MOA to implement a gender responsive curriculum for both DOC staff and inmates at YCI. The Judicial Branch/Court Support Services Division (CSSD) has been awarded a Demonstration grant from the National Institute of Corrections called the Women Offender Case Management Model. FHS has been asked to participate on the newly formed Advisory Team./2008//

/2009/The MOA with YCI was executed and trainings on intimate partner violence were conducted for inmates and staff at YCI. Staff participated on the CSSD Advisory Team. //2009//

//2010// Staff and inmates participated in this training and plans are underway to assess the feasibility of conducting similar trainings at halfway houses and transitional housing./2010//

Homelessness: The DPH contracted with an independent public health consulting firm to assess and evaluate the health care access infrastructure for the Homeless population in order to enhance their access to health services. A statewide Homeless Health Advisory group, including governmental, public/non-for-profit, private, faith based, and advocacy organizations, was formed to guide this evaluation study. This study involved needs assessment of shelters, and their health care systems/infrastructure for the homeless population, and key informant interviews. The study is completed and the role of Title V is to identify and conduct intervention strategies to promote and enhance the health status of the homeless population.

/2009/DPH supported the survey of CT homeless people./2009//

/2010/ Survey results reported an estimated 3,444 households experienced homelessness on the night of January 30,2008. Of those, 2,257 single adults and 474 families with minor

children, and 519 adult members of those families resided in emergency shelter or transitional housing programs and 590 single adults and 8 families resided on the streets, in parks, cars, transportation terminals, or other locations not intended for human habitation. 873 homeless children were counted along with their families. Long periods of homelessness were commonly reported among all groups, though families reported shorter periods than single adults.//2010//

Male Involvement: The FHS recognized that the health of fathers and men impacts the health of women, children and families. The role of Title V has been to become an active participant on the New Haven Family Alliance-Male Involvement Network and the DSS' Fatherhood Initiative Council to conduct population based activities by developing and disseminating consumer and provider educational materials regarding the importance of men's health and the impact on maternal and child health.

/2008/ DPH has become an active member of the Adolescent Paternity Workgroup convened by the Consultation Center in New Haven. This workgroup is comprised of members from DCF, DSS, DOC, and community based organizations. The Department of Social Services (DSS) has received a Promoting responsible Fatherhood Grant, funded by the Administration for Children and Families (ACF) and DPH will participate on the grants Monitoring and Advisory Committee.

The DPH is collaborating with the Hartford Community Court and the Department of Social Services (DSS) and will be providing a four part parenting class for adolescent fathers who pass through the judicial system. The four components include: (1) infant/toddler growth and development (2) infant nutrition (3) child safety and (4) responsible fatherhood.//2008//

/2009/Staff promote the inclusion of men in MCH programs.//2009//

/2010/ Staff participate on DSS' Fatherhood Initiative Council and on the MCH Advisory Committee//2010//

III. Health Priorities

A. MCH Priorities

In 2004, the Department invited a selected group of experts in the maternal and child health field in the State, including healthcare professionals, community advocates, and representatives from state agencies, to map out a perinatal health plan with priority goals for the State to address. This Statewide group adopted the following as a standard definition of perinatal health to guide efforts in the maternal and child health "comprehensive and integrative continuum of health care from the preconception period through the prenatal and postnatal periods. Care should be sensitive to ethnic and cultural diversity with an emphasis on the family and father involvement".

The Perinatal Advisory Group identified nine goals to address perinatal health: 1. Reduce perinatal health disparities, particularly preterm/low birth weight births and infant and fetal mortality between and among racial and ethnic groups; 2. Improve access to a continuum of health care services for underserved and/or un-served women of child bearing age; 3. Enhance and encourage male involvement in the continuum of women's health care from preconception, prenatal through postnatal periods; 4. Reduce pregnancies and poor birth outcomes among adolescents; 5. Reduce unintended pregnancies for all women; 6. Reduce recognized birth-related risk factors for children with special health care needs; 7. Improve the state's system capacity to collect high quality maternal child health data and disseminate in a timely manner; 8. Improve access to mental health, substance abuse treatment and dental health services which can improve the overall health for pregnant and postpartum women; and 9. Improve inter-provider communication strategies regarding perinatal health care delivery. The Perinatal Advisory group will be reconvened to prioritize and provide guidance to the Title V program regarding the implementation of the nine identified goals and objectives. This statewide perinatal strategy will provide the needed structure to better address the MCH federal and new state performance measures.

/2008/To avoid duplication of efforts and to recognize time constraints of MCH providers, the work

of the State Perinatal Advisory Group will be merged with the recently reconvened MCH Infoline Advisory Group. The Infoline Advisory Group had been inactive for about 10 years and recently held its second meeting.//2008//

/2009/A number of the goals listed above have been met.//2009//

/2010/ The MCH Advisory Committee meets quarterly and is convened by DPH, March of Dimes (MOD) and United Way 2-1-1.//2010//

B. CYSHCN Priorities

The Children with Special Health Care Needs program includes the priority areas specific to this population in its program design. In order to enhance CYSHCN services, the Family Health Section (FHS) within DPH has redesigned the program by requiring the Center to operate a program that is family-centered with family participation and satisfaction; performs early and continuous screenings; improves access to affordable insurance; coordinates benefits and services to improve access to care; participates in spreading and improving access to medical home and respite service; participates in developing a community-based service system of care, and promotes transition services for youth with special health care needs.

The Department has been leading the State in the implementation of the State Early Childhood and Comprehensive System's grant (SECCS). This initiative is called Early Childhood Partners (ECP) and the process brought together eight State agencies and statewide institutions, with extensive input from numerous community interests since October 2003 to create an outcome-driven Strategic Plan to support all Connecticut families to ensure that their children arrive at school healthy and ready to succeed. The strategic plan will be used as a framework for the operations of the newly established Children's Cabinet by Connecticut legislators and the Governor. The Plan aims at creating an integrated service system that incorporates comprehensive health services, early care and education, and family support and parent education to ensure the sound health and full development of all children. The system would provide for easy entry, clear navigation, and appropriate supports for all families and includes six priority goals for the State, which include: 1. Every child, adolescent and pregnant woman in Connecticut will have access to comprehensive, preventive, continuous healthcare through a family-centered Medical Home; 2. All children will have access to affordable, quality early care and education programs and an effective transition to Kindergarten; 3. All parents will have access to the support and resources they need to raise healthy children; 4. Build the capacity for planning, resource allocation and monitoring of the early childhood services system through a collaborative local or regional early childhood structure for all Connecticut towns; 5. Create a state level infrastructure to guide, support, and monitor implementation of the Early Childhood Partners plan; and 6. Promote public education and public will through a broad communication and engagement strategy.

/2008/ The ECP staff has collaborated with the Children's Trust Fund to build provider capacity as it relates to identifying and referring children with developmental delays. ECP funds were leveraged to conduct 2 Ages and Stages Questionnaire (ASQ) trainings for health care providers. It is anticipated that additional trainings will be offered in the 2008 FFY.//2008//

/2010/ A Project Launch grant was submitted to complement the state's ECP Grant activities.//2010//

C. Data and MCH Impact

Consistent with the HP 2010 objectives, Connecticut gives priority to MCH surveillance through such activities as Pregnancy Related Mortality Surveillance, Child Health Profile (CHP) Database, DocSite for data management of Children and Youth with Special Health Care Needs (CYSHCN), Fetal and Infant Mortality Review, and Vital Records data collection and analysis, to name a few. The CHP is a database located in the FHS within DPH to hold information of newborns on lab screening tests, hearing tests, and birth defects reported by birth facilities through the electronic reporting system. The CHP is linked to Electronic Vital Records (EVR). The DocSite is a web-based system used by medical homes and regional medical home support centers to collect and

report CYSHCN information to DPH. Emphasis is being placed on the necessity to develop better linkages among our many sources of data. All Title V activities and programs are designed to promote and protect the health of Connecticut's mothers, children and adolescents, and children with special health care needs.

Improvements to the CHP database continue. Planned enhancements include the completion of linkage of death records into the CHP database. The matching routine will link corresponding birth newborn hearing screening results; and the commencement of the linkage of the CHP database with a fourth database.

Work towards the creation of a data warehouse of high-quality linked child health data, which has been titled HIP-Kids (Health Informatics Profile for CT Kids), will continue in the upcoming year. DPH continues to pursue funding for full implementation of HIP-Kids from both external and internal efforts. Once funded, implementation will progress using the three-year technical strategic plan. Please see SPM 1 for more information.//2007//

/2008/The above paragraph on the CHP database is revised to read: Improvements to the CHP database continue which advance the creation of a data warehouse as part of the HIP-Kids project. Planned enhancements include the completion of linkage of death records into the CHP database and its migration to DPH's Public Health Information Network that meets national infrastructure and security standards. The matching routine will link corresponding birth newborn hearing screening results; and the commencement of the linkage of the CHP database with a fourth database.

A presentation of the PRATS data analysis was held and attended by DPH staff and representatives from community based organizations. In order to continue to have access to PRAMS-like data, the PRATS survey will be repeated in 2009. Staff will be submitting a HRSA MCH Research Grant to continue to build our capacity to analyze and translate MCH data. The first Birth Defects Registry Report for 2001-2004 has been released and is posted on the DPH website.//2008//

/2009/ FHS is planning for a PRATS in 2009.//2009//

/2010/FHS is anticipating the start of the PRATS in August 2009.//2010//

There is growing emphasis on the development of data systems and linkages. Staff are coordinating the Memorandum of Understanding (MOU) between DPH and DSS regarding data exchanges. The purpose of this MOU is to improve public health service delivery and public health outcomes for low-income populations through the sharing of available Medicaid, HUSKY Plan Part B, HUSKY Plus and Title V data. The initial MOU included three addenda addressing the linkage of birth and Medicaid data, childhood lead screening and Medicaid data, and on Children Receiving Title V Services and Medicaid data. Linked data will be analyzed and used to guide MCH programs.

/2008/ The first addendum of the Data Sharing MOU related to the linkage of birth and Medicaid data was amended to include a linkage to clients under the fee-for-service component of Medicaid. This information was previously unavailable.//2008//

/2009/ MCH Epidemiologist Carol Stone completed an analysis of the 2000 birth cohort linked with Medicaid and WIC information. She presented her findings at the MCH summit "Impact of Racial & Ethnic Health Disparities on Birth Outcomes in Connecticut" on 9/11/07.//2009//

/2010/ staff completed and posted on the DPH website a fact sheet on LBW; this is one of 3 fact sheets to be developed.//2010//

The need to strengthen data linkages was identified in the five-year needs assessment. The Title V program will be taking a lead role in securing a contract with the CT Hospital Association to obtain hospital discharge data. The acquisition of this data set will enhance case ascertainment for the maternal mortality surveillance program, enhance the Crash Outcome Data Evaluation System (CODES) database and provide additional data for the Asthma and other MCH programs both at the state and local levels.

/2008/A data management module for the in-patient hospitalization and ED data was created and will be placed on DPH's Public Health Information Network to facilitate the creation of data extracts for various DPH programs who have requested access to this rich secondary data source.//2008//

/2009/Staff provided EPHI staff with in-patient hospitalization & ED data for its placement on PHIN. DPH is working to obtain in-patient hospitalization & ED data without cost.//2009//

/2010/Under the authority of the DPH Commissioner, all 31 acute care hospitals are now required to submit annual in-patient hospitalization & Emergency Department (ED) data to the agency starting with the CY 2006 & 2007 data.//2010//

In fall 2004, DPH executive staff expressed goals for improved and enhanced communications between and across programs that reduces barriers to effectiveness and efficiency across programs. To address these goals, the Virtual Child Health Bureau (VCHB) was formed. The VCHB is in the process of developing a Plan to coordinate its activities. With a special emphasis on child health, the VCHB has as its mission collaborations across branches within DPH to ensure optimum health of all children in the state. Within the VCHB, an interdepartmental group of database users and managers was formed called the VCHB Data Committee. The Data Committee now seeks to find meaningful ways to share child health information broadly across the Department. Using needs identified by staff across DPH, the Data Committee drafted a set of recommendations in spring, 2005, which may help guide its progress toward this goal. These recommendations need to be discussed, adopted and implemented. Some of these recommendations complement the state MCH priorities identified for the next five years.

/2008/The VCHB continues to meet on a quarterly basis and FHS staff are active members of the VCHB Cabinet and its data subcommittee.//2008//

IV. Conclusion

It is the role of Connecticut's Title V program, through funding of direct/enabling, population-based, and infrastructure building services, to address prioritized needs and gaps in services for the target populations. Community based programs are funded to provide direct and enabling services, such as case management and outreach. Population-based services include disease prevention, education, and the empowering of MCH populations about health and health related issues. Infrastructure building services include needs assessment, policy development, quality assurance, information systems development and management, and training that support individual, agency, and community health efforts.

The Title V Director utilizes various mechanisms to determine the importance, magnitude, value and priority of competing factors, which impact the MCH health services delivery in the State, which includes: 1. conducting ongoing statewide assessments (MCH five-year needs assessment, breastfeeding practices of African American women, bereavement services for families experiencing a fetal or infant death, Pregnancy Risk Assessment Tracking System [PRATS], Adolescent Health, Healthcare for the Homeless, CYSHCN Needs Assessment, etc.); 2. reviewing and analyzing Title V programs quarterly reports submitted by all contractors, which includes both quantitative and qualitative information. This information is reviewed and provides valuable input into MCH programming, as well as serving as a vehicle for identifying and documenting emerging MCH issues; 3. conducting quarterly technical assistance meetings with the MCH contractors (i.e., FIMR, RFTS, etc.). This provides an additional opportunity for contractors to share information with Title V program staff and their colleagues regarding MCH issues that they are facing as community-based providers of services. Other external factors, which cannot be overlooked and impact the importance of MCH service delivery, and MCH programming have been previously discussed (economy, insurance status, legislation, etc.). The combination of the ongoing assessments, quarterly reporting data, technical assistance meetings and site visits, as well as other sources, assists the Title V Director in addressing the MCH needs and determining priorities for the State.

/2008/Addressing health disparities within the MCH population continues to be an ongoing priority

for the DPH. Overall CT's birth outcomes compare favorably, however, subgroups do not fair as well. MCH outcome data by race and ethnicity paints a picture of a much different CT. The FHS has taken a more data driven approach to its MCH program design and implementation, which will impact programs available to those identified most in need. The MCH Director will continue to monitor CT's progress towards a Universal Health Care Plan.//2008//

/2009/Focus was placed on using MCH data to drive new programs & initiatives. An RFP was released for the MCHBG funded case management programs for pregnant women & eligibility for was based on the distribution of selected maternal risk and birth outcomes.

Obesity prevention activities will continue to be a focus in the coming years. 25.9 % of CT high school students are either overweight or obese. Title V funding has been allocated for obesity prevention activities & will continue as funding permits.

The new Charter Oak Program implementation will be monitored. This voluntary program includes office co-pay, deductibles & other fees that may be cost-prohibitive for vulnerable populations.//2009//

/2010/ DPH continues to analyze and translate its MCH data for programmatic use. With the upcoming 3rd round of PRATs, we will be able to better complement and gain a better understanding of the perinatal status of women in CT. In the fall, we will be conducting a 2-day workshop to assess the perinatal system of care in CT, which will complement the MCH Needs Assessment, identify gaps and overlaps in existing services and identify whether or not programs are serving the population most in need (based on data). During this volatile economic climate, resources will need to be maximized and better coordinated to ensure that the needs of the MCH population are being met. With the recent acquisition of the Federal Healthy Start grant, which will focus on the MCH population in the City of Hartford, we are hopeful to see some positive changes in health outcomes for this population.//2010//

B. Agency Capacity

Authority for the Maternal, Infant, and Child and Adolescent Health Programs is derived from the CT General Statutes and Title V Federal Grant Program Requirements. The following describes the statutes that support DPH authority for MCH programs.

Sec. 4-8(1949) Qualifications, Powers and Duties of Department Head. This statute authorizes the transfer of Title V funds to the Department of Social Services (DSS).

Sec 14-100a PA 05-58(2005) Child Restraint systems. The former infant/child seat belt law was amended to address rear-facing child seats, use of booster seats, and increase the minimum age to 6 years old or 60 pounds. The injury prevention program is impacted by this statute.

Sec. 10-206.PA 04-221(1940-2004) Health assessments. Each local or regional board of education shall require each pupil enrolled in the public schools to have health assessments conducted by a legally qualified practitioner of medicine, an advanced practice registered nurse registered nurse, a physician assistant, or by the school medical advisor. The assessment includes: a physical examination; chronic disease assessment (i.e., asthma, lead levels), an updating of immunizations; and vision, hearing, speech and gross dental screenings. The assessment also includes tests for tuberculosis, sickle cell anemia or Cooley's anemia.

Sec 19a-2a PA 93-381(1993) Powers and duties. The Commissioner of DPH shall employ the most efficient and practical means for the prevention and suppression of disease and shall administer all laws under the jurisdiction of DPH and the Public Health Code. He shall have responsibility for the overall operation and administration of DPH. All Title V Programs are impacted by this statute.

Sec. 19a-4j PA 98-250(1998) Office of Multicultural Health. The responsibility of the office is to improve the health of residents by eliminating difference in disease, disability and death rates among ethnic, racial and cultural populations. All Title V Programs are impacted by this statute. Although the Office was eliminated through layoffs in 2003, activities continued and the Office was re-established in 2005.

Sec. 19a-4i PA 93-269(1993) Office of Injury Prevention. This office coordinates and expands prevention and control activities related to intentional and unintentional injuries, including surveillance, data analysis, integration of injury focus within DPH, collaboration, support and develop community based programs and develop sources of funding. This statute impacts many Title V Programs since injury is the leading cause of death for the 1 to 19 year old age population.

Sec. 19a-7 PA 75-562(1975) Public Health Planning. DPH shall be the lead agency for public health planning and shall assist communities in the development of collaborative health planning activities. All Title V Programs are impacted by this statute.

Sec. 19a-7a PA 90-134(1990) State goal to assure the availability of appropriate health care to all state residents. The goal of the state is to assure the availability of appropriate health care to all residents, regardless of their ability to pay. All Title V programs are impacted by this statute.

Sec. 19a-7c PA 90-134(1990) Subsidized non-group health insurance product for pregnant women. DPH with DSS may contract to provide a subsidized non-group health insurance for pregnant women who are not eligible for Medicaid and have incomes under 200% of the federal poverty level. Healthy Start, Comadrona, Family Planning, Community Health Centers (CHCs) are the programs most affected by this statute.

//2010/Comadrona ended. Case Management for Pregnant Women is added.//2010//

Sec. 19a-7f PA 91-327(1991) Childhood immunization schedule. An immunization program shall be established by DPH, cost of vaccine will not be a barrier to age-appropriate vaccination. CHCs and School Based Health Centers (SBHCs) are the programs most affected by this statute.

Sec. 19a-7h PA 94-90(1994) Childhood immunization registry. The registry shall include information to accurately identify a child and to assess current immunization status. CHCs and SBHCs are the programs most affected by this statute.

Sec. 19a-7i PA 97-1(1997) Extension of coverage under the Maternal and Child Health Block Grant. DPH shall extend coverage under Title V of the SSA to cover underinsured children with family incomes between 200% -300% of the federal poverty level. If allowed by federal regulations, such expansion may be included for reimbursement under Title XXI of the SSA. CYSHCN programs are most affected by this statute.

Sec. 19a-17b, PA76-413(1976) Peer Review: Definitions, immunity; discovery permissible from proceedings. There shall be no monetary liability against any person who provides testimony, information, records, etc. The proceedings of a medical review committee are not be subject to discovery or introduction into evidence in any civil action for or against a health care provider arising from matters subject to evaluation and review by such committee. FIMR and Pregnancy Related Mortality Surveillance are the programs most affected by this statute.

Sec. 19a-25 PA 61-358(1961) Confidentiality of records procured by DPH or directors of health of towns, cities or boroughs. Describes the restricted use and confidentiality of all information, records of interviews, written reports, statements, notes, memoranda or other data procured by DPH or its representatives for the purpose of reducing the morbidity or mortality from any cause shall be used solely for the purposed of medical or scientific research and for disease prevention and control. All programs are influenced by this statute. FIMR and Pregnancy Related Mortality Surveillance are the programs most affected.

Sec. 19a-32(1949) Department authorized to receive gifts. DPH is authorized to receive, hold and use real estate and to receive, hold, invest and disburse money, securities, supplies or equipment offered it for the protection and preservation of the public health and welfare by the federal government or by any person, corporation or association, provided such assets shall be used only for the purposes designated. All Title V Programs are impacted by this statute.

Sec. 19a-35 PA 35-240(1935) Federal funds for health services to children. DPH is designated as the state agency to receive and administer federal funds which may become available for health services to children. Title V Programs serving children are most affected by this statute.

Sec.19a-48(1949) Care for Children with Cerebral Palsy. DPH shall furnish services for children who have cerebral palsy including locating the children, providing medical, surgical, corrective and allied services and care, and providing facilities for hospitalization and aftercare. CYSHCN programs are most affected by this statute.

Sec.19a-49(1961) Services for Persons with Cystic Fibrosis. DPH shall establish and administer a program of services for children and adults suffering from cystic fibrosis. CYSHCN programs are most affected by this statute.

Sec. 19a-38. PA 156(1965). Fluoridation of public water supplies. Wherever the fluoride content of public water supplies serving 20,000 or more persons supplies less than 8/10ths of a milligram per liter of fluoride, whoever has jurisdiction over the supply shall add a measured amount of fluoride so as to maintain the fluoride content. The Oral Health program is affected by this statute. /2008/The Oral Health Program has been renamed the Office of Oral Public Health.//2008//

Sec. 19a-50 PA 39-142 PA 37-430(1937, 1939) Children crippled or with cardiac defects. DPH is designated to administer a program of services for children who are crippled or suffering from cardiac defect and to administer federal funds which may become available for such services. CYSHCN programs are most affected by this statute.

Sec.19a-51 PA 63-572(1963) Pediatric Cardiac Patient Care Fund. There shall be a Pediatric Cardiac Patient Care Fund to be administered by DPH and to be used exclusively for medical, surgical, preoperative and postoperative care and hospitalization of children, residents, who are or may be patients of cardiac centers in this state. CYSHCN programs are most affected by this statute.

Sec. 19a-52(1981) Purchase of equipment for handicapped children. DPH may, purchase wheelchairs and placement equipment directly. CYSHCN programs are most affected by this statute.

Sec. 19a-53 PA 33-318(1933) Reports of physical defects of children. Each health care provider who has professional knowledge that any child under 5 years of age has any physical defect shall mail to DPH a report stating the name and address of the child, the nature of the physical defect and such other information. The CYSHCN Registry is supported by this statute.

Sec. 19a-54 PA 33-266(1933) Registration of physically handicapped children. Each institution supported in whole or in part by the state shall report to DPH, the name and address of each child under 21 years of age who is physically handicapped for whom application is made for admission, whether such child is admitted or rejected. The CYSHCN Registry is supported by this statute.

Sec. 19a-55 PA 65-108(1965, 2002) Newborn infant health screening. Each institution caring for infants shall cause to have administered to every infant in its care an HIV-related test, and a series of tests for disorders as listed in the attachment to this section. This bill has been amended to expand testing, as listed in the supporting document attached.

Sec. 19a-56a PA 89-340(1989) Birth defects surveillance program. The program shall monitor the frequency, distribution and type of birth defects occurring in CT on an annual basis. DPH shall establish a system for the collection of information concerning birth defects and other adverse reproductive outcomes. The CYSHCN Registry is supported by this statute.

Sec. 19a-56b PA 89-340(1989) Confidentiality of birth defects information. All information collected and analyzed pursuant to section 19a-56a shall be confidential insofar as the identity of the individual patient is concerned and shall be used solely for the purposes of the program. The CYSHCN Registry is supported by this statute.

Sec 19a-59 PA 81-205(1981) Program to Screen Newborn Infants for Hearing Impairment at Birth. Each institution that provides childbirth service will include a universal newborn hearing screening program as part of its standard of care and establish a mechanism for compliance review. DPH will establish a plan to implement and operate a program of early identification of infant hearing impairment. Newborn Hearing Screening Program is supported by this statute. /2007/This program is now called the Early Hearing Detection and Intervention Program.//2007//

Sec. 19a-59a PA 82-355(1982) Low Protein modified food products and amino acid modified preparations for inherited metabolic disease. DPH may purchase prescribed special infant formula, amino acid modified preparations and low protein modified food products directly. CYSHCN programs are supported by this statute.

Sec. 19a-59b PA 83-17(1983) Maternal and Child Health Protection Program (MCHPP). DPH shall establish a maternal and child health protection program to provide outpatient maternal health services and labor and delivery services to needy pregnant women and child health services to children less than 6 years of age. Comadrona, Right from the Start, and Healthy Start are supported by this statute.

/2010/Comadrona and Right from the Start ended. Healthy Start and Case Management for Pregnant Women are supported by this statute.//2010//

Sec. 19a-59c PA 88-172(1988) Administration of federal Special Supplemental Food Program for Women, Infants and Children in the state. DPH is authorized to administer the WIC program in the state, in accordance with federal law and regulations. WIC is supported by this statute.

Sec. 19a-60 PA 45-462(1945) Dental services for children. DPH may furnish dental services for children free of charge where the cost of necessary service would be a financial hardship to their parents. CHCs and SBHCs are affected by this statute.

Sec. 19a-90 PA 41-255(1941) Blood tests of pregnant women for syphilis. Each physician giving prenatal care to a pregnant woman in this state shall take a blood sample within 30 days from the date of the first examination and during the final trimester, and shall submit such sample for a standard serological test for syphilis. Family Planning, CHCs and SBHCs are affected by this statute.

Sec. 19a-110 PA 71-22(1971) Report of lead poisoning. Defines reporting requirements to DPH regarding blood lead levels equal to or greater than 10 micrograms per deciliter of blood or any other abnormal body burden of lead. CHCs and SBHCs are affected by this statute.

Sec.19a-62a(2000) Pilot program for early identification and treatment of pediatric asthma. DPH, with DSS, shall establish pilot program for the early identification and treatment of pediatric asthma. The DPH Asthma Program is impacted by this statute.

/2008/Sec. 47-48 of Public Act 06-188 (2006) Medical home pilot program. The Commissioner of Public Health, in consultation with Medicaid managed care organizations, may establish a medical home pilot program in one region of the state in order to enhance health outcomes for children, including children with special health care needs, and evaluate such pilot program to

ascertain specific improved health outcomes and cost efficiencies achieved not later than one year following the establishment of such program. The Children and Youth with Special Health Care Needs program is impacted by this Act.

Sec. 51 of Public Act 06-195 The Commissioner of Public Health shall establish an ad hoc committee for the purpose of assisting the commissioner in examining and evaluating statutory and regulatory changes to improve health care through access to school based health centers, particularly by persons who are underinsured, uninsured or receiving services under the state Medicaid program.//2008//

CYSHCN Program Capacity in CT

The CYSHCN program provides care coordination, advocacy and family support to CYSHCN regardless of enrollment financial status. A review of the CYSHCN program resulted in a new infrastructure and capacity building strategy to meet the Healthy People 2010 goals of parent partnership, comprehensive care within a medical home, adequacy of insurance, screening for special needs, community-based service system and transition to all aspects of adult life. The CYSHCN/Regional Medical Home Support Centers (RMHSCs) are responsible for providing services to children receiving Supplemental Security Income benefits who meet program eligibility criteria. The 5 centers are The Stamford Health System serving Southwest CT, Yale School of Medicine, serving South Central CT, St Mary's Hospital serving Northwest CT, LEARN serving Eastern CT and Charter Oak Health Center serving North central CT. /2008/Contracts for LEARN and Charter Oak Health Center were terminated in 10/06 due to non-compliance with contract terms. The program is transitioning from a center-based approach to a more community based practice center approach to medical home. Based on the feedback from a Medical Home retreat DPH has issued an RFP for Care Coordination services.//2008//

The RMHSCs will enhance the capacity for medical homes in the region to screen children and assist the medical homes through community-based health care systems. There are an estimated total of 120,000 CYSHCN in CT. The second purpose of the RMHSCs is to improve availability of programmatic and health care service data on CYSHCN for evaluation and development of quality programs. Data and practice management for this new approach will be supported through Doc Site, a quality assurance web-based program. Multi-state agency Memoranda of Understanding (MOUs) will be utilized to support care coordination and data sharing on CYSHCN. /2008/DocSite is no longer being used for collecting information on clients receiving services through the medical home program. DPH Epidemiology staff developed a Microsoft Access database to assure that information on the clients receiving services continued. DPH staff who assumed the coordination of client services from the two de-funded regional medical centers were trained on the use of the Access database. The DPH epidemiology staff also shared the database with the other regional medical home centers, provided training and continued technical support for these centers.//2008//
/2009/CT has an estimated 133,000 CYSHCN.//2009//

Care Coordination, the core of both the RMHSCs and the medical homes will be technically supported to assure that there is an inter-agency collaboration in meeting the needs of the CYSHCNs. RMHSCs will also support families with community-based resources, family networking and building parent partnerships in medical homes. Funds for durable medical equipment, prescriptive medications, special nutritional formulas and respite care needs for the uninsured and underinsured families are available on a limited basis./2008/ Three RFPs have been issued to better operationalize the medical home project in CT; one for care coordination, one for administering the respite/extended services funds and one to provide provider and consumer outreach and education regarding medical homes.//2008//

/2010/The community based care coordination RFP was reissued and Stamford Health System will serve Southwest CT, Coordinating Council for Children in Crisis will serve South Central CT, St Mary's Hospital will serve Northwest CT, United Community and Family Services will serve Eastern CT, and CT Children's Medical Center will serve North

central CT. The provider and consumer outreach and education RFP was reissued with a focus on Family/Professional Partnerships.//2010//

Regional Family Networks (RFN) will be groups of parents and/or caregivers of CYSHCN whose primary responsibilities within this system include family support services and quality assurance for the service delivery system. RFN will serve as an additional support to the care coordinators within the RMHSCs on family-centered training and capacity building. /2008/ RFN will continue with the new contracts, family support will be funded through one contract and not through five to ensure a more cohesive group that will provide uniform supports and services. The proposed sub-contractor for this part of the contract will be the Family Support Network. Activities will include the following; DPH will continue to enhance the family-centered Medical Home concept in Connecticut by the selection of a contractor to provide statewide outreach and culturally competent education to pediatric primary care providers and families on the concept of medical home for children and youth with special health care needs, and, link these children to medical homes when available and family support services.//2008//

/2010/ Regional Family Networks (RFN) will continue through a new statewide contract through Child Health and Development Institute with an additional focus on the education of CYSHN and their families/caregivers in the area of Family/Professional Partnerships and continued additional support to families and care coordinators.//2010//

A CT Medical Home Learning Collaborative resulted from participation in the National Institute of Child Health Quality's (NICHQ) Medical Home Learning Collaborative with the purpose of improving care for CYSHCN by implementing the AAP's Medical Home concept. The collaborative meets quarterly and is open to all providers interested in building their capacity as a medical home, especially in meeting the needs of CYSHCN. A Medical Town News is published quarterly by DPH and posted on DPH's website. /2008/ The statewide systems strategic planning work on medical homes for CYSHCN, initiated by the CT MHLC, is now being implemented and evaluated regionally by the RMHSC. The collaborative continues to meet quarterly.//2008//

/2010/The CT MHLC now includes community partners, state and private agencies and has undertaken a revision of the CT Medical Home Training Academy Curriculum to include a module on transition to adult services.//2010//

The United Way's INFOLINE (211) Child Development Infoline (CDI) is the primary intake source for CYSHCN. CDI caseworkers assess the caller's situation, and make referrals to CT Birth to 3 System, Help Me Grow, Preschool Special Education, and/or CYSHCN/RMHSC. The 211 component of Infoline, funded as CT's Maternal and Child Health Information and Referral Service, will work closely with the RMHSCs on their resource information updates./2007/DPH initiated a Medical Home Advisory Council, which is comprised of representatives from state agencies, community-based organizations and parents of CYSHCN. Their mission is to provide guidance to DPH in its efforts to improve the community-based system of care for CYSHCN.//2007//

Title V Partnership Programs for Pregnant Women, Mothers and Infants

Breastfeeding Initiative: Initially funded through the SSDI Initiative and in-kind support, staff are working to develop internal mechanisms and evaluate the DPH's capacity to collect population based breastfeeding data. As a result of these efforts, in January 2004 the Electronic Newborn Screening Database started to collect data from all birthing hospitals on the mother's intent to breastfeed. /2007/DPH has identified a state Breastfeeding Coordinator who is co-funded by the MCHBG and USDA/WIC funding.//2007//

Comadrona: DPH contracts with the Hispanic Health Council of Hartford to provide culturally appropriate intensive case management services to pregnant Latina and African-American women and their children who reside in the greater Hartford area.

/2009/ RFP was issued.//2009//

/2010// Community Health Centers received state funds to improve transportation and

infrastructure. Comadrona ended. See Case Management for Pregnant Women. Case Management for Pregnant Women is a new program in 3 cities developed through an RFP process with funds from Comadrona and Right from the Start to provide comprehensive, integrated case management services during the perinatal and interconceptual periods to pregnant and post partum teenagers and women and their partners in an effort to improve birth outcomes. An RFP was issued to address racial and ethnic health disparities as they relate to low birth weight infants and develop the Centering Pregnancy model of group prenatal care in organizations that provide outpatient prenatal care services to low income women, who are most at risk for delivering low birth weight infants. Fair Haven CHC and St. Raphael's Hospital in New Haven were selected for the Centering Pregnancy project.//2010//

Family Planning: Through its contract with Planned Parenthood of CT, Inc., comprehensive reproductive health services are available in 15 locations across the state. Family Planning promotes decreasing the birth rate to teens, age 15-17, preventing unintended pregnancy, and increasing access to primary reproductive health care.
/2008/There are currently 12 DPH-funded Planned Parenthood program locations and 4 Delegate Agency locations.//2008//
/2010/There are currently 12 DPH-funded Planned Parenthood of CT Centers and four subcontractor locations (agencies separate from PPC).//2010//

Fetal and Infant Mortality Review (FIMR): Six high-risk communities are funded to examine confidential, de-identified cases of infant deaths, with a goal of understanding how local social, economic, public health, educational, environmental and safety issues relate to infant deaths in order to improve community resources and service delivery. To complement and expand the FIMR process, Perinatal Periods of Risk will be introduced next year.
/2010/The state funded five FIMR programs were no longer funded as of May 2009. This was a direct result of the state budget deficit.//2010//

/2007/DPH will develop a statewide surveillance system to identify health related FIM issues to gain understanding of how and why communities take action to prevent fetal and infant deaths, and identify additional geographic areas of need.//2007//
/2008/An MOA between DPH and UCONN was executed to develop a statewide surveillance system to identify the health related issues regarding fetal and infant mortality to understand what motivates and mobilizes communities to take action to prevent fetal and infant deaths. The statewide effort will identify areas of greatest need and involve community collaboration, case ascertainment utilizing vital statistics and other data sources and record review.//2008//
/2010/Due to State budget cuts, the FIMR program was defunded.//2010//

Healthy Choices for Women and Children (HCWC): HCWC provides intensive case management services to low income, pregnant and postpartum women who abuse substances or are at risk for abusing, or whose partner abuses substances, and their children from birth to age 3, who reside in the city of Waterbury or surrounding communities. Referrals and linkages to community-based health and health related services are provided.

Healthy Start: This statewide collaboration between DSS and DPH aims to reduce infant mortality, morbidity and low birthweight, and to improve healthcare coverage and access for children and eligible pregnant women. Last year, DPH signed a collaborative agreement with the federal New Haven Healthy Start Program. Several priorities emerged as common concerns: Male Involvement; MCOs; Care Coordination; Consortium Development; FIMR/PPOR; and Data Collection. /2008/ DPH continues to collaborate with the Federal New Haven Healthy Start and has renewed its letter of agreement.//2008//
/2010/An evaluation of the Healthy Start program identified areas in need of improvement with the current data collection methods. //2010//

Maternal and Child Health Information and Referral Service (MCH I&R): DPH contracts with the United Way of CT to administer the toll-free MCH hotline that provides information on health and related services. Services are accessible to non-English speaking callers and to speech/hearing impaired callers. More information on INFOLINE is noted above.

/2008/United Way of CT has reconvened its MCH Advisory Committee. This committee has been inactive for about 10 years; the DPH Perinatal Advisory Committee will be integrated with the MCH Advisory Committee.//2008//

Oral Health: The Office of Dental Public Health has a comprehensive public health strategy for the prevention of oral diseases and disorders in CT's children and their families. The Office works with the American College of Obstetrics and Gynecology and the March of Dimes to address oral health during the prenatal period, and has partnered with DSS to implement a Dental Loan Repayment Program for dentists and hygienists to work in underserved areas of the state. Work is currently underway to develop a new state oral health plan. /2008/The Office of Dental Public Health has been renamed the Office of Oral Public Health.//2008//

Pregnancy Related Mortality Surveillance (PRMS): An OB-GYN consultant conducts maternal mortality reviews and based on findings, provides education to medical providers to prevent future maternal deaths

/2009/Completed 10-yr. report.//2009//

Right from the Start (RFTS): Located in four communities, the RFTS program provides intensive case management services to pregnant and/or parenting teens. Services provided by community-based contractors must include: intensive case management; outreach and case-finding activities; promotion of breastfeeding; integration of the USPHS/Smoke Free Families Smoking Cessation Intervention model; and public awareness activities. Services must be comprehensive, culturally appropriate, community-based and family centered. /2008/An RFP will be issued in 2006-7 to provide case management services to pregnant women and teens to promote healthy birth outcomes in up to 3 communities in the state. This program will address interconceptional care counseling, male involvement, health disparities, breastfeeding, smoking cessation, and develop community capacity and collaboration with key stakeholders.//2008//

/2010/Right from the Start Program ended. See Case Management for Pregnant Women.//2010//

Sudden Infant Death Syndrome (SIDS): In previous years, DPH provided bereavement services to families statewide who experienced a sudden infant death, based on referrals from the Office of the Chief Medical Examiner. Services included home visits, referrals to community-based services, and follow-up. A statewide assessment of cultural appropriateness of bereavement services is currently being conducted. Upon completion, MCHBG funding will be allocated to expand access to and awareness of bereavement services for fetal and infant mortality, including SIDS events.

/2008/ An Infant Mortality Campaign to increase awareness around infant mortality in the African American population and to promote early prenatal care will kickoff in June 2007.//2008//

/2010/A new Infant Mortality Campaign was funded to continue to promote awareness around Infant Mortality through media advertisement and bus ads. First-time Motherhood/New Parent Initiative HRSA grant will build on an existing Infant Mortality Social Marketing Campaign in Hartford and New Haven to increase awareness of and linkages to existing preconception/interconception, prenatal care and parenting resources as well as to increase the likelihood of a healthy pregnancy.//2010//

SSDI: CT is focusing on 3 main activities: assess and enhance programmatic data collection systems in order to improve DPH's ability to report on the many required outcome measures; expand the linkage of the Birth and Supplemental Nutrition Program for Women, Infants and Children (WIC) to include a linkage with the state Medicaid eligibility files; and develop and evaluate a database for community-based providers who participate in the CYSHCN Medical Home Learning Collaborative. /2008/The 2007-2011 SSDI Project goals have been modified to

(1) Further enhance the FHS programmatic data collection systems to improve and increase the availability of quality data for the MCHBG and MCH programs, and (2) Develop data dissemination systems of analytic reports and presentations to help inform public health programs at the state and local level.//2008//

/2010/SSDI activities have moved forward to enhance data collection activities with the migration of the NSS to the MAVEN application.//2010//

The Injury Prevention Program (IPP): In collaboration with its many partners, the program provides resource materials, and technical assistance on injury prevention issues for Title V funded programs and other community service providers. The Program also facilitates the Interagency Suicide Prevention Network.

/2008/FHS continues to provide ad hoc support to the IPP for the developing Injury Surveillance System and its related grant requirements. This includes obtaining in-patient hospitalization and Emergency Department data from the CT Hospital Association.//2008//

/2010/FHS is coordinating with IPP staff and the Office of the Child Advocates (OCA's) Child Fatality Review staff on the Keeping Kids Alive initiative. DPH collaborated with DCF and OCA on safe sleep for infants.//2010//

Title V Partnership Programs for Children and Adolescents, Age 1 through 22 years.

Comadrona: As described above.

Healthy Start: As described above.

School Based Health Centers (SBHC): DPH funds 63 SBHCs in 19 communities, serving students in grades pre-K-12. Licensed as outpatient facilities or hospital satellites. They offer services addressing the medical, mental and oral health needs of youth, including crisis intervention, health education, social services, outreach, and substance abuse prevention.

/2008/DPH now funds 68 SBHCs in 20 communities with three additional communities providing expanded school health services.//2008//

/2009/DPH now funds 73 SBHCs in 20 communities.//2009//

Expanded School Health Services (ESHS): DPH funds 2 ESHS projects. One site focuses on preventing and improving mental health status and service referral for children and youth in a regional school system and one site provides access of physical and behavioral health services to preschool aged children and families who are at risk for learning in one community.

/2008/DPH now funds an additional ESHS program that provides mental health and dental services to students in eight elementary schools in a high need community. This brings the total number of funded ESHS programs to three. //2008//

Family Planning: A special effort is made to target services to teens and provide STD screening and treatment, HIV/AIDS screening, and contraception services. Other services include free pregnancy tests and counseling for adolescents at or below 150% federal poverty level, outreach efforts at health fairs, teen life conferences, and statewide events to provide reproductive health and STD prevention literature, as well as conducting community educational programs to teens at risk.

Healthy Choices for Women and Children (HCWC): As described above.

Maternal and Child Health Information and Referral Service (MCH I&R): As described above.

Oral Health: DPH funds 6 School Based Programs to improve dental access and services underserved children as well as conduct ongoing surveillance for planning purposes of dental health status of youth through the CT BRFSS.

2007/DPH now funds 4 School Based programs.//2007//

Right from the Start: As described above.

The Early Childhood Partners (ECP): The ECP Comprehensive Systems Plan aims to create an integrated service system that incorporates comprehensive health services, early care and education, family support and parent education to ensure the sound health and full development of children. The CT Early Childhood Cabinet was established by the State Legislature in 2005 and created CT's early childhood framework: Ready by 5 & Fine by 9. The Cabinet includes the Commissioners of the departments with primary responsibility over early childhood services.

The Injury Prevention Program (IPP): The CT Young Worker Safety Team, a collaboration of DPH and State Departments of Labor and Education, federal and local agencies, promotes safety of adolescents in the workplace through awareness, education and training activities. The Program, in collaboration with partners to facilitates the Interagency Suicide Prevention Network and participates in the Youth Suicide Advisory Board. /2007/As described above, IPP was transitioned to the HEMS section.//2007//

Title V Partnership Programs for Children with Special Health Care Needs

Children & Youth With Special Health Care Needs (CYSHCN): Children who are screened for special health care needs and are either uninsured or underinsured may be eligible for durable medical equipment, prescriptive pharmacy and special nutritional formulas. The CYSHCN program also offers a limited respite program based on available funds, and transition services to adult care. /2008/An RFP was developed and issued for administering the Respite and Extended Services Funds. The CT Lifespan Respite Coalition was selected as the contractor for this service.//2008//

Adult and Maternal Phenylketonuria Program (PKU): The 2 Regional Genetic Treatment Centers (UConn Health Center and Yale) maintain current records on all adolescent and adult females in CT with PKU, and serve as genetics consultants for primary care providers throughout the state. Genetic and nutritional counseling and high-risk pregnancy care is provided to adolescent and adult females in CT with PKU.

Genetics: The 2 Regional Genetic Treatment Centers provide access to genetic services for all residents. These services include confirmation testing for newborns identified with abnormal metabolic screening results, prenatal testing, genetic counseling, and ongoing treatment, support for adults with PKU, and high risk pregnancy care for the maternal PKU clients. See the attachment to this section for the list of CT Newborn Screening Panel Disorders.

Oral Health: The Office of Dental Public Health addresses the oral health needs of CYSHCN through health promotion activities, particularly early childhood caries prevention. Oral health promotion and disease prevention is an integral part of the goals, objectives and educational activities of the CYSHCN program.

/2010/Renamed the Office of Oral Health.//2010//

Pregnancy Exposure Information Services (PEIS): PEIS provides information and referral services via a statewide toll-free telephone number to pregnant women and health care providers concerning the potential teratogenic effects of drugs, maternal illness, and occupational exposure. /2008/ A total of 988 calls were received by the PEIS hotline, with 967 risk assessments performed and treatment plans developed which included counseling services.//2008//

/2010/ A total of 909 call were received by the PEIS hotline in CY2008.//2010//

School Based Health Centers: SBHCs provide primary and preventive physical and behavioral health care to CYSHCN who are mainstreamed in school settings. In such cases, they coordinate the care they provide with a child's primary and specialist caregivers, and provide support while the child is in school. /2007/SBHCs help CYSHCN students transition from a school setting to the

community upon graduation by linking them to needed services.//2007//

Sickle Cell Program: The 2 State funded Regional Sickle Cell Programs, located at Yale University and CCMC, provide comprehensive care programs that include confirmation testing, counseling, education and treatment for newborns identified with hemoglobinopathies through the NBS program. The Sickle Cell Disease Association of America located in New Haven and Hartford serves youth with transition to adult health providers and provides educational programs to increase community awareness. The Southern Regional Sickle Cell Association enhances testing, counseling, case management in the Southwest region of CT.

/2008/A three-day sickle cell certification training was conducted and 30 people participated (14 were certified as hemoglobinopathy counselors, 5 attained the level of professional educator, 8 became peer educators and 3 did not complete the course). DPH provided stipends to families/consumers who attended and completed the training.//2008//

Universal Newborn Screening: The statewide Universal Newborn Screening (UNBS) program is a population-based program to test, track and treat all newborns. All newborns are screened for the disorders as listed in the document attached to this section, "CT Newborn Screening Panel." Infants with abnormal screening results are referred for comprehensive testing, counseling, education, and treatment services. The program provides increased public health awareness of genetic disorders, public health education, and referrals.

Universal Newborn Hearing Screening (UNHS): All 30 birthing facilities in the state implemented a UNHS program. Standardized equipment is used to screen all newborns prior to discharge. Hospital staff notify the primary care providers of all infants who are in need of follow-up audiologic testing. Tracking and follow-up of children are conducted at the state level. A web-based reporting system tracks screening results from the birth hospitals. A database is used to track infants referred to audiologists for further evaluation. Those with hearing loss are enrolled in the CT Birth to 3 Program. /2007//The Early Hearing Detection and Intervention (EHDI) program works with 16 diagnostic audiology centers that provide follow-up testing from the hearing screens conducted at birth.//2007//

/2010// The EHDI program works with 9 diagnostic audiology centers that provide follow-up testing from the hearing screens conducted at birth. //2010//

Cultural Competency

The Office of Multicultural Health was re-established in April 2005. Cultural Competence language is standard for Title V funded contracts as of July 1, 2003. The FHS staff remain committed to addressing cultural competency during site visits to contractors. Staff have developed an assessment tool to assure that our contractors are providing culturally appropriate services containing key items to be discussed during a site visit. A check box on DPH's Site Visit Monitoring Tool reminds staff to discuss and address cultural competency during site visits.

DPH is presently working with a consultant to assess and evaluate breastfeeding initiation and duration rates of African American/ Black women in CT. Consultant will make recommendations to DPH on ways to improve these rates. DPH collaborated with the CT Breastfeeding Coalition (CBC) to develop and produce a document in English and Spanish describing CT's breastfeeding laws. This document is mailed to all new mothers in CT.

/2008/Recommendations from the CT Breastfeeding Assessment included training of health care professionals.//2008//

DPH continues to address the health care needs of CT's homeless population by implementing activities outlined in the Healthcare for the Homeless Strategic Plan. DPH has provided funding to 10 CHCs to enhance and strengthen the infrastructures and linkages with homeless shelters while enabling the center's ability to effectively address the healthcare needs of CT's homeless population. The CT Youth Health Service Corp., a program co-funded by DPH and prepares high school youth for careers in the health care field, includes a module in its curriculum regarding

working with the homeless population and a module on cultural competency. //2008/DPH is contracting with the Latino Community Services Inc, to support the LCS' faith based initiative. LCS has developed a relationship with 33 faith-based organizations in CT and has developed a Learning Academy, which include modules on cultural and linguistic competence, coalition building on addressing health disparities. //2008//

//2010/ The DPH continues to include cultural competence language in its contracts with community based organizations. Contractors are provided with a cultural competence self assessment tool, which is reviewed during site visits. Staff are also ensuring that programs are collecting racial and ethnic data as recommended by the federal reporting requirements. Several programs have modified their data collection systems to allow for this revision. The PHI Branch convened the Health Disparities workgroup to specifically assess programmatic data as it relates to race and ethnicity and to identify programs that could better address this issue. Staff worked with the City of Hartford to obtain a federally funded Healthy Start grant, which will directly address racial and ethnic disparities in perinatal health. FHS staff are including questions in the PRATS survey to help determine and quantify 'perceived discrimination' in the perinatal health care delivery system. The analysis of this data will provide insight into the level of provider education regarding cultural competency that may be needed. Ongoing collaboration with the Office of Multicultural Health is expected, however, due to the lack of staff in this Office, the PHI Branch Chief will work closely with the Planning Branch Chief to identify specific activities for collaboration. Finally, with MCHBG carryover funds, the DPH collaborated with the University of Connecticut's Translating Research Into Policy and Practice (TRIPP) Center, to expand the Sister Talk Hartford program to the Greater Hartford community. This is truly a culturally appropriate response to weight loss and weight management in African American women. This healthy lifestyle model, although targeting women, impacts the entire family and in some instances the community.//2010//

C. Organizational Structure

Governor M. Jodi Rell has been serving as CT's Governor since July 2004. Dr. J. Robert Galvin, DPH Commissioner since December 2003, serves as the leading health official in CT and advisor to the Governor on health-related matters. Dr. Galvin brings experience in the fields of medicine and public health, as well a strong commitment to serving the people of Connecticut. DPH is the center of a comprehensive network of public health services, and is a partner to local health departments for which it provides advocacy, certification and training, technical assistance, consultation and specialty services. DPH is a source of health information used to monitor the health status of CT's residents, set health priorities and evaluate the effectiveness of health initiatives. The agency is a regulator of the health community, focusing on health outcomes while maintaining a balance between health status and administrative burden. DPH works to prevent disease and promote wellness through community-based education and programs. As a result of agency-wide focus groups and strategic planning workshops conducted in late 2004, DPH was reorganized and is now comprised of eight Branches. The Oral Health Program, previously located in the Family Health Section, is now the Office of Oral Public Health and is under the auspices of the Deputy Commissioner. The majority of the Title V activities are located in the Public Health Initiatives (PHI) Branch and a detailed description follows: Within the Public Health Initiatives Branch, led by Richard Edmonds, MA, Lisa Davis, RN, BSN, MBA serves as the Section Chief of the Family Health Section (FHS) and as the Title V Director. The majority of CT's Title V program activities reside organizationally within the FHS of the PHI Branch, however, other MCH related programs such as oral health, nutrition, childhood lead poisoning prevention, diabetes, tobacco, obesity prevention and asthma are located organizationally in other Sections within the Public Health Initiatives Branch. Other Branches within DPH work cooperatively with Title V funded programs and provide support to programs that promote maternal and child health in the state of CT. For example, in the Laboratory Branch staff analyzes blood specimens from newborns for genetic screening. In the Planning Branch, Health Information Systems and Reporting Section, under the direction of Julianne Konopka, vital record

data bases containing information on births, deaths, hospitalizations and risk factors related to maternal and child health are maintained. Epidemiologists within this branch use vital record information to help direct and evaluate Title V program activity.

/2007/ The Childhood Lead Poisoning Prevention program is no longer in the PHI Branch.

The program is now centralized in the Regulatory Services Branch.//2007//

/2008/ Childhood lead poisoning prevention activities are centralized in the Lead Poisoning Prevention and Control Program of the Regulatory Services Branch.//2008//

/2008/ Janet Brancifort, Public Health Services Manager has joined the PHI Branch and has been assigned to the FHS. The Primary Care and Prevention Unit and School and Adolescent Health Unit Supervisors report to Ms. Brancifort.//2008//

/2008/ Laboratory Branch staff analyze (1) blood specimens from newborns for genetic screening, (2) blood specimens from children for lead and (3) environmental samples related to lead.//2008//

/2009/ The Office of Multicultural Health has been relocated to the Planning Branch. The comprehensive Cancer program is now part of the HEMS Section. Charlene Gross, Administrative Assistant has joined the FHS as the AA for Lisa Davis. Ms. Gross was previously in the Office of Multicultural Health.//2009//

/2010/ The Immunizations Program has been relocated from the Infectious Disease Section and integrated with the Family Health Section. This relocation of Immunizations added 26 additional staff to the FHS, and includes the CT Immunizations Registry Tracking System (CIRTS) and the Vaccines For Children Program. A Retirement Incentive Package (RIP) has been offered and future reorganization is anticipated. As a result of the RIP, 66 employees retired from the State Department of Public Health. Richard Edmonds, Chief of the Public Health Initiatives Branch (PHI) retired effective July 1st and Lisa Davis, Title V Director, is providing managerial oversight for the Branch. Charlene Gross is the Administrative Assistant to Ms. Davis. Ms. Davis is currently participating on the Executive Leadership Team, spearheaded by the Commissioner. Rosa Biaggi (previously Section Chief for the AIDS and Chronic Disease Section) has assumed the role as FHS Chief. Liliana McIntyre is providing administrative support for Ms. Biaggi. Barbara Pickett, Supervisor of the School and Adolescent Health Program retired July 1.//2010//

The Family Health Section has identified their mission as "improving the health of CT's resident across the lifespan through culturally appropriate surveillance, public education, family-centered interventions and community-based capacity building." FHS's core purpose is "to optimize the health of families" with a vision that "all individuals and families achieve optimal health through appropriate and comprehensive health services." FHS will develop crucial business alliance and work with both internal and external stakeholders as partners to optimize the health of families. The Family Health Section is comprised of three units: Women, Men, Aging & Community Health (WMACH); Child, Adolescent & School Health; and Epidemiology and Injury Prevention. Programs within each unit are defined in the Other (MCH) Capacity section of this report. This structure enables the FHS to focus on and improve the health status of individual members of a family as a cohesive unit. The WMACH unit primarily focuses on the adult members of a family and their public health primary care access point, however, safety net providers such as the CHCs, provide services to clients throughout the entire lifespan. The Child, Adolescent & School Health unit focuses on the pediatric and adolescent members of a family and their public health primary care access point. The Epidemiology and Injury Prevention unit is structured to focus on supporting the programs with necessary data analyses and program evaluation to track and measure results and ultimately assure that identified objectives are attained and provide quality care/services to Title V clients.

/2007/ The FHS is now comprised of five units. The Child, Adolescent and School Health Unit has been divided into three units: the School and Adolescent Health Unit, the Newborn Screening Unit and the CYSHCN Unit. With the transition of the Injury Prevention Program to another section, the Epidemiology and Injury Prevention unit is now known as the Epidemiology Unit. The ECP project is managed by staff who report directly to the Title V Director.//2007//

/2008/ The Women, Men, Aging and Community Health Unit has been renamed the Primary Care

and Prevention Unit. This name change more accurately reflects the scope of services provided by this Unit. Other Units in the FHS include: Epidemiology Unit, School and Adolescent Health, Children and Youth with Special Health Care Needs and Newborn Screening. The ECP program is seeking a Health Program Assistant 1 who will function as the ECP Program Coordinator.//2008//

/2009/Christine Buckley has been hired as the HPA-1 for the ECP Program.//2009//

/2010/ The FHS is comprised of the following Units/Programs: School and Adolescent Health, MCH Epidemiology, Primary Care and Prevention, CYSHCN, and Immunizations. Norida Grant, has been hired for the Integrated Services Grant, Hope Mitchell for Primary Care and Prevention Program and Mike Fuller for the CYSHCN program (consumer representative). There are currently two MCHBG funded vacant positions. Paperwork has been submitted in anticipation of filling both vacancies. Currently all new positions are on hold.//2010//

The Office of Dental Public Health is organizationally located outside of the PHI Branch and reports directly to the Deputy Commissioner. Dr. Ardell Wilson, DDS, MPH has been designated as the State Oral Health Director and is responsible for the Office of Dental Public Health. Although organizationally in a different area within DPH, a strong collaborative relationship exists with the MCH programs.

/2007/ New to the Office of Dental Public Health is Linda Ferraro, RDH. FHS Epidemiology Unit continues to support this Office's programs. //2007//

/2008/ The Office of Dental Public Health has been renamed the Office of Oral Public Health.//2008//

/2009/The renamed Office of Oral Health has recruited a part-time clerical support staff and a full-time Health Program Associate.//2009//

/2010/ The Office of Oral Health now has 3.0 FTEs. Dr. Ardell Wilson, Oral Health Director, will be retiring as of July 1, 2009 and the Office of Oral Health is now housed in the Local Health Administration Branch, which is managed by Pamela Kilby-Fox.//2010//

Sharon Tarala, RN, JD is the Supervising Nurse Consultant of the WMACH unit. Staff within this unit work on the following programs: CT Youth Health Service Corp, Comadrona, CHCs, Family Planning, FIMR Program, Healthy Choices for Women and Children, Infant Mortality Bereavement Services, Intimate Partner Violence, MCH Referral and Information Services, Pregnancy Related Mortality Surveillance, Primary Care Office, Right from the Start, and Sexual Assault Prevention and Intervention.

/2008/ The Women, Men, Aging and Community Health Unit has been renamed the Primary Care and Prevention Unit.//2008//

/2009/ The CT Youth Health Services Corp, Bereavement Services, Comadrona and the Right from the Start Program are no longer provided by the DPH. An RFP was issued to integrate the Comadrona and Right from the Start Program activities into a new case management program for women who are ineligible for the State Healthy Start and Nurturing Families Programs. This program was developed to help ensure that pregnant women were not falling through the cracks and not receiving duplicate services. Three community-based programs for the new case management services are located in Waterbury, Hartford and New Haven.//2009//

/2010/ Due to the state deficit, the FIMR and maternal mortality surveillance programs are no longer funded through DPH. Two centering pregnancy programs were implemented this year with MCHBG funding. It is anticipated that these programs will be continued with carryover funding. The Rape Prevention Education Coordinator will be partially funded with MCHBG funds effective next year and will work to integrate RPE into the MCH programs.//2010//

Dorothy Pacyna, MS, RN is the Supervising Nurse Consultant of the Child, Adolescent & School Health Unit. The programs served by these staff are: Abstinence Only Education, Expanded School Health Services, SBHCs, Children and Youth with Special Health Care Needs, Genetics Services, Maternal PKU, Pregnancy Exposure Information Service, Sickle Cell Services, Sickle Cell Transition Program, Universal Newborn Hearing Screening, Universal Newborn Screening,

Early Childhood Partners Program and Family Advocacy.

/2007/ The CYSHCN program is supervised by Dorothy Pacyna, RN. This unit has been responsible for the implementation of the five Regional Medical Home Support Centers. The FHS Family Advocate who works closely with staff to provide support for all areas of the Medical Home System reports to Ms. Pacyna.//2007//

/2007/ The Newborn Screening Unit, led by Health Program Supervisor Vine Samuels, MPH consists of the Newborn Genetic Screening program (Maternal PKU, Sickle Cell Services and the Pregnancy Exposure Information Services), the Early Hearing, Detection and Intervention program (EHDI) and the newly established Sickle Cell Disease Transition program.//2007//

/2007/ The School and Adolescent Health Unit, led by Health Program Supervisor Barbara Pickett, includes the Abstinence Only Education program, Expanded School Health Services, School Based Health Centers, and the MCH Referral and Information Services.//2007//

/2008/ Dorothy Pacyna retired from State service and has been replaced by Mark Keenan, RN, Supervising Nurse Consultant, CYSHCN Program, which now includes Medical Homes and the EHDI Program.//2008//

/2008/ The EHDI program is now part of the Children and Youth with Special Health Care Needs Program. Plans are underway to re-located the metabolic screening program to the State Laboratory.//2008//

/2008/ The Abstinence Only Education Program is no longer funded in CT.//2008//

/2009/ The CYSHCN Program was awarded a HRSA State Implementation Grant for Integrated Community Systems for CSHCN. A new staff position will be established to conduct the activities of the grant.//2009//

/2009/ The School and Adolescent Unit was awarded a State Agency Partnership for Promoting Child and Adolescent Mental Health grant from HRSA.//2009//

/2010/ The CYSHCN program was awarded a CDC data integration grant that will enhance and integrate tracking and surveillance for the Early Hearing Detection and Intervention program with other DPH tracking programs. A Coordinated School Health Grant was awarded to the State Department of Education and an MOA will be developed to establish a position at the DPH to assist with the grant activities.//2010//

Marcia Cavacas, MS, Epidemiologist 4, is the supervisor for the Epidemiology and Injury Prevention Unit. Programs in this unit include the Child Health Access Project, Crash Outcome Data Evaluation System (CODES), Statewide Systems Development Initiative (SSDI), the Children with Special Health Care Needs Registry, and the Injury Prevention Program.

/2007/ With the transition of the Injury Prevention Program to another section, this is now known as the Epidemiology Unit. The Epidemiology Unit seeks to identify, collect, and analyze population-based MCH data and create new systems that complement existing data and that will enhance capacity for programmatic planning, evaluation and surveillance.//2007//

/2008/ The Crash Outcome Data Set (CODES) project was moved to the HEMS Section where the Injury Prevention Program resides. The Epidemiology Unit in the FHS continues to provide ad hoc support to both the CODES Project and IPP's Injury Surveillance System. The Epidemiology Unit in the FHS is also responsible for the Birth Defects Registry.//2008//

/2009/ The Epidemiology Unit has filled the Epidemiologist 2 position that supported the Birth Defects Registry.//2009//

/2010/ Marcie Cavacas, Supervising Epidemiologist, is working with the Immunizations Field Epidemiology staff and is primarily responsible for the development of the web-based immunizations registry.//2010//

Coordination of the development of the Title V Block Grant is supervised by Julianne Konopka, Section Chief of the Health Information Systems and Reporting (HISR) Section in the Planning Branch. It is a collaborative effort between the FHS and the HISR Section on all aspects of the Block Grant Application and Annual Report development. Also under the supervision of Julianne Konopka is the State Office of Vital Records. Epidemiologists within this Section use vital records

information to help direct and evaluate Title V program activity and also provide epidemiological support to the FHS and Title V programs.

/2007/The coordination of the development of the MCHBG application will be transitioned to staff in the FHS.//2007//

/2008/ FHS staff has taken over the responsibility for coordinating the MCHBG application process.//2008//

/2010/ Marcie Cavacas, Supervising Epidemiologist, is the lead staff person for the five-year MCH Needs Assessment, which is underway. Kevin Sullivan is the lead staff person for coordination of the MCHBG annual application.//2010//

Resumes are included as Supporting Documents and are on file at DPH for Lisa Davis, Marcia Cavacas, Dorothy Pacyna, and Sharon Tarala. DPH Organizational charts are attached to this section and included in the Supporting Documents Section.

/2007/ Resumes for Barbara Pickett and Vine Samuels are also included.//2007//

/2008/ Resumes are included for Mark Keenan and Janet Brancifort//2008//

/2010/ Resumes for Vincent Sacco and Rosa Biaggi are included.//2010//

An attachment is included in this section.

D. Other MCH Capacity

The CT Department of Public Health is comprised of eight Branches, a new organizational structure as a result of agency-wide focus groups and strategic planning workshops in late 2004 and implemented February 2005. Within the Public Health Initiatives (PHI) Branch, led by Richard Edmonds, MA, Lisa Davis, RN, BSN, MBA serves as the Director of the Family Health Section (FHS) and as the Title V Director. Robin Lewis provides secretarial support to Ms. Davis. The majority of CT's Title V program activities reside organizationally within the FHS in the PHI Branch.

/2007/ Ms. Davis was promoted to Section Chief, Family Health Section effective December 2005.//2007//

/2008/Jackie Douglas now provides secretarial support to Ms. Davis. In addition to functioning as the Title V Director, and Chief for the FHS, Ms. Davis was recently selected to participate in the Robert Wood Johnson Executive Nurse Fellows Program. Participation in this program will help strengthen Ms. Davis' leadership skills. In addition, Ms. Davis is participating in the AMCHP Title V Directors mentor program and is being mentored by Sally Fogerty of the MA DPH.//2008//

/2010/ Ms. Davis has now been designated as the Management Team Leader for the PHI Branch. Ms. Davis continues to function as State Title V MCH Director and has worked at the DPH for over 14 years. This new role will allow Ms. Davis to better integrate other PHI programs with MCH. These include tobacco, asthma, perinatal hepatitis, AIDS and other chronic diseases. It is anticipated that the Title V Director position will be reassigned by the end of the year. Rosa Biaggi was previously the Section Chief for the AIDS and Chronic Disease Section and is now the Section Chief for the Family Health Section.//2010//

Sharon Tarala, RN, JD was recently promoted to Supervising Nurse Consultant and is now responsible for the Women, Men, Aging and Community Health Unit. Staff within this unit include Nurse Consultants Donna Fox, RN, MA, and Anthony Mascia, MSN, RN. Additional staff include Health Program Associates Marilyn Binns, Felicia Epps and Veronica Korn. These staff work on the following programs: Comadrona, Community Health Centers, Family Planning, Fetal and Infant Mortality Review, Healthy Choices for Women and Children, Intimate Partner Violence, MCH Referral and Information Services, Pregnancy Related Mortality Surveillance, Right from the Start, Sexual Assault Prevention and Intervention.

/2007/Anthony Mascia, Donna Fox, Marilyn Binns, and Veronica Korn no longer work in this unit. Additional staff include Shiu-Yu Kettering, Health Program Associate and Lauren Backman, Epidemiologist 3. Staff in this unit now work on the Healthy Start program and the MCH Referral and Information Services program is now within the and School and Adolescent Health

Unit.//2007//

/2008/ this Unit has been renamed to the Primary Care and Prevention Unit. Ms. Tarala is the State Women's Health Coordinator. The Primary Care Office grant and activities are housed in this Unit.//2008//

/2010/ Shiu-Yu Kettering and Lauren Backman no longer work in this unit. Staff within this unit include: Donna Maselli, Nurse Consultant; Regina Owusu, Nurse Consultant; and Hope Mitchell, Health Program Assistant. Ms. Tarala is the Supervising Nurse Consultant for this Unit, and there is one vacant MCHBG funded positions in this unit. Plans are underway to fill this vacancy once we are permitted to proceed with hiring.//2010//

Within the Child, Adolescent and School Health Unit, The CYSHCN program is supervised by Dorothy Pacyna, RN and includes Epidemiologist Chun-Fu Liu, and Health Program Associates Robin Tousey-Ayers and Ann Gionet. Ms. Gionet also serves as a Family Advocate, and works closely with staff to provide support for all areas of the Medical Home System with focus on the respite component, the Regional Family Support Network (RFSN). She also provides consultation to staff regarding family issues, participates in the development and review of appropriate program policies to ensure that a family-centered, culturally competent perspective is maintained. The Newborn Screening program in this unit, led by Vine Samuels, includes Nurse Consultants Fay Larson, RN, MSHA, Donna Maselli, RN, BS, MPH and Dottie Trebisacci, RN as well as Health Program Associate Shiu-Yu Kettering and Health Program Assistant Amy Okrongly. The School and Adolescent Health Program in this unit, led by Barbara Pickett, includes Nurse Consultants Donna Heins, RN, CHES, MPH and Regina Owusu, RN, BSN, MPH; Health Program Associate Linda Durante Burns and Nutrition Consultant Charles Slaughter. Rose Marie Mitchell provides secretarial support to the unit. The programs served by this entire unit are: Abstinence Only Education, Expanded School Health Services, School Based Health Centers, Children and Youth with Special Health Care Needs, Genetic Services, Maternal PKU, Pregnancy Exposure Information Services, Sickle Cell Services, Sickle Cell Transition, Universal Newborn Screening (metabolic and hearing). Kevin Sullivan, Health Program Associate, is responsible for coordinating the CT Early Childhood Comprehensive Systems (Early Childhood Partners, ECP) program.

/2010/ The Metabolic Newborn Screening Program is housed at the state laboratory. The Child, Adolescent and School Health Unit was renamed the School and Adolescent Health Unit. This Unit is discussed in more detail below. There is one vacant MCHBG funded position in the School and Adolescent Health Unit.//2010//

/2007/ The new CYSHCN Unit, led by Dorothy Pacyna, Supervising Nurse Consultant, includes Health Program Associates Ann Gionet, who is part time, and Robin Tousey- Ayers. There is one Health Program Associate position vacant. This unit has been responsible for the implementation of the 5 Regional Medical Home Support Centers. Ms Gionet, the FHS Family Advocate, provides coordination activities related to the Family Support Network protocols and advocacy for families. Ms Tousey-Ayers coordinates activities for the Medical Home Network protocol as well as coordinating with the A.J. Papanikou Center, which was responsible for facilitating this year's regional inter-agency workgroups on youth transition. The Health Program Associate position formerly held by Ms. Burns would coordinate the utilization of the Extended Service and Respite Funds and DocSite training activities.//2007//

/2008/ The CYSHCN Unit is now under the supervision of Mark Keenan, Supervising Nurse Consultant (Ms. Pacyna retired from state service). In addition to Ms. Tousey-Ayers and Ms. Gionet, the Consumer Information Representative position will be filled by mid-summer. The Newborn Hearing Screening Program is now housed in the CYSHCN Unit.//2008//

/2010/This Unit is still led by Mark Keenan, Supervising Nurse Consultant. Newborn Hearing Screening staff includes Amy Mirizzi, Health Program Associate and Kathryn Britos-Swain, Nurse consultant who also manages the sickle cell activities. Robin Tousey Ayers, HPA provides contractual oversight. Nordia Grant CT Careers Trainee/Health Program Assistant 1 has been added to the CYSHCN unit to coordinate the State Implementation Grant for Integrated Community Systems for CYSHCN, with the designation Youth Transition Coordinator. Mike Fuller has been hired as the Consumer

Information Representative, which complements the DPH funded (part-time) Family Advocate position held by Ann Gionet. Ms. Gionet has worked at the DPH for 15+ years. There are 7 staff in this Unit and no vacant positions.//2010//

/2007/ The Newborn Screening Unit, led by Health Program Supervisor Vine Samuels, BA, MPH, includes Nurse Consultants Fay Larson, RN, MSHA, Donna Maselli, RN, BS, MPH and Dottie Trebisacci, RN as well as Health Program Associate Marilyn Binns and Health Program Assistant 1 Amy Mirizzi. This program consists of Newborn Genetic Screening (Maternal PKU, Sickle Cell Services and the Pregnancy Exposure Information Services), the Early Hearing, Detection and Intervention program (EHDI) and the newly established Sickle Cell Disease Transition program. Gloria Powell, RN, Nurse Consultant will begin in the NBS program in July.//2007//

/2008/ The Metabolic Newborn Screening Program remains under the supervision of Vine Samuels. The Newborn Hearing Screening program has been relocated to the CYSHCN Unit. It is anticipated that by mid-summer the metabolic screening program staff will be relocated to the state laboratory.//2008//

//2010/ The HPA position was reclassified as an HPA1 and Sally Fraley occupies this position. The Early Hearing Detection and Intervention Program and the Sickle Cell Disease program are now part of the CYSHCN Unit (formerly part of the Newborn Screening program). The NBS Genetics Tracking Program remains at the State Public Health Laboratory, in the Biological Sciences Branch. There are 3 Nurse Consultants and a Supervisor who support the NBS program. Plans are underway for construction of a new state laboratory.//2010//

/2007/ The School and Adolescent Health Unit, led by Health Program Supervisor Barbara Pickett, includes Nurse Consultants Donna Heins, RN, CHES, MPH and Regina Owusu, RN, BSN, MPH; Social Worker Meryl Tom, LCSW and Cheryl Poulter, Health Program Assistant Trainee. The programs served by this entire unit are: Abstinence Only Education, Expanded School Health Services, School Based Health Centers, and the MCH Referral and Information Services.//2007//

/2008/ Donna Heins, Nurse Consultant in the SAHU also functions as the State Adolescent Health Coordinator.//2008//

//2010/ Donna Heins is no longer with DPH and a State Adolescent Health Coordinator has not been designated. The Unit Supervisor, Barbara Pickett retired effective July 1st. The SAHU Unit currently has 2 FTE (Meryl Tom, Social Worker and Faraz Wasti, Health Program Assistant). There is one MCHBG funded vacancy in this Unit. Janet Brancifort is providing supervisory oversight for this unit until the supervisor position is refilled or reassigned. The previous supervisor held a state funded position.//2010//

Marcia Cavacas has been promoted to Epidemiologist 4 and serves as the supervisor of the Epidemiology and Injury Prevention Unit. Clerical support is provided by Jacqueline Douglas. Epidemiologists Carol Stone, PhD., and Jennifer Morin, MPH support programs across FHS. Social Worker Meryl Tom and Health Program Associates Marian Storch and Margie Hudson also serve programs in the unit including Child Health Access Project, Statewide Systems Development Initiative (SSDI), Children with Special Health Care Needs Registry, CODES and injury prevention activities. This unit is currently recruiting for two Title V-funded Epidemiologist 2 positions.

/2007/ With the transition of the Injury Prevention Program to another section, this is now known as the Epidemiology Unit. New to this unit in the past year are Chunfu Liu, MS, MPH, Johanna Davis, and Ann Kloter, MPH, who now support programs across FHS. Meryl Tom, Marian Storch and Margie Hudson have relocated along with their programs to other units. The Unit seeks to identify, collect and analyze population-based MCH data, and to create new systems that complement existing data that will enhance FHS's capacity for programmatic planning, evaluation and surveillance. //2007//

/2008/ The CODES project has been relocated to the Health Education Management and

Surveillance (HEMS) Section where the injury prevention program is located//2008//
/2010/ Marcie Cavacas works with the Immunization Program Field Epidemiologists and on the migration of the Immunizations Registry to a web-based application. Karin Davis has been hired as an Epidemiologist 2 to support the Birth Defects Registry and Centering Pregnancy Program. There are a total of 5 MCH Epidemiologists in this Unit and 6 field Epidemiologists in the immunizations program. Plans are underway to promote an Epidemiologist to provide supervisory oversight (in addition to Ms. Cavacas who will focus more on the immunizations component). We also anticipate hiring another fulltime Epidemiologist (for the Primary Office grant) who will be housed with the MCH Epidemiologist staff./2010//

Dr. Ardell Wilson, DDS, MPH has been designated as the State Oral Health Director and is responsible for the Office of Dental Public Health. Recruitment continues for staffing to support the activities conducted by this Office.

/2007/ Linda Ferraro, RDA has now joined the Office of Dental Public Health as a Health Program Associate.//2007//

/2008/ Staff are collaborating with the Office of Dental Public Health, which has been renamed the Office of Oral Public Health, to submit a HRSA grant application for Perinatal oral health.//2008//

/2010/ Dr. Ardell Wilson retired and the Office of Oral Public Health is now housed in the Local Health Administration Branch. //2010//

Within the Planning Branch, the Health Information Systems and Reporting Section, support through the preparation of the MCHBG application is provided. Also, Epidemiologists Diane Aye, MPH, PhD, Marijane Mitchell, MS, Celeste Jorge, BA, and Associate Research Analyst Federico Amadeo, MPA, provide epidemiologic support to FHS programs and through their work on other programs such as the Connecticut School Health Survey, Health Professional Shortage Areas, and Vital Statistics.

/2008/ FHS has assumed the role of preparing the MCHBG application.//2008//

/2010/ MCHBG funding also partially supports staff in other areas of the DPH who are instrumental in the analysis of MCH data and work closely with MCH program staff. This includes staff in the DPH's Planning Branch, Contracts Unit, Finance Office, and Laboratory./2010//

Within the Administrative Branch, support to Title V programs is given by the Contracts Management Division and Fiscal Services. At the State Public Health Laboratory, Lab Assistant Leslie Mills offers support to the Newborn Screening program. Resumes are on file at DPH for Lisa Davis, Dorothy Pacyna, Marcia Cavacas, and Sharon Tarala and can be found in the Supporting Documents section.

/2007/ Resumes for Barbara Pickett and Vine Samuels are also included.//2007//

/2008/ Resumes for Mark Keenan and Janet Brancifort are included.//2008//

/2010/ Resumes for Rosa Biaggi and Vinny Sacco are included./2010//

E. State Agency Coordination

CT's Title V Program has established working relationships with the organizations found in the document attached to this section. Because of the diverse programs funded by the Block Grant, DPH works with other state agencies and within its own programs to insure coordination of services. Please see the attachment to this section for a listing of all organizations. The narrative below describes the most important of those collaborations.

Abstinence-Only Education program staff work closely with School Based Health Centers (SBHCs), the CT Association of Schools, and other State and local agencies and organizations affected by the project, including CYSHCN Program, STD Program, AIDS Program, SDE, DSS, DCF, and OPM. Staff coordinate with representatives of Network CT, a SPRANS community-

based abstinence education grantee, to share information and resources, including but not limited to peer mentors and counselors, parent/guardian outreach activities, and public awareness activities, such as radio spots, program brochures and posters.

/2008/The Abstinence program is working closely with UConn to evaluate its Abstinence Education Program.//2008//

/2009/The Abstinence-Only Education program evaluation was completed last year and DPH doesn't conduct any related activities.//2009//

The CYSHCN program collaborates with the Social Security Administration/Disability Determination Unit at DSS to identify and refer potential enrollees to the Program. CYSHCN program staff also network with the Bureau of Rehabilitation Services at DSS regarding the provision of occupational services to youth transitioning to adulthood.

Staff from DPH and the CYSHCN Regional Centers participate on: DCF Advisory Committee for Medically Fragile Children in Foster Care, DMR's Birth to 3 Public Awareness and Medical Advisory Committee and Interagency Coordinating Council (ICC), and the legislatively mandated Family Support Council.

/2008/DPH staff participate in the AJ Papanikou Center's Consumer Advisory Council.//2008//

/2009/DPH staff participate on the DSS ABCD Screening Academy, Pay for Performance, and Primary Care workgroups.//2009//

Memoranda of Understanding are being drafted by DPH with multiple state agencies (DSS, DMR, DCF, SDE). Through these agreements, the parties intend to recognize their shared goals and to establish methods of coordination and cooperation to ensure that CYSHCN and their families/caregivers who are served by the Regional Medical Home Support Centers (RMHSC) receive timely and comprehensive health care services.

/2008/The MOU were put on hold due to the new direction of the medical home project.//2008//

/2009/DPH has included DSS, DDS (formerly DMR) and DCF on the Medical Home Advisory Council.//2009//

/2010/DPH was awarded the State Implementation Grant for Integrated Community Systems for CYSHCN. DPH will collaborate with DSS, SDE, DCF, CT KASA, PATH/CT Voices for Children, CT Epilepsy Foundation, and FAVOR on this initiative. //2010//

DPH joined in partnership with United Way of CT/2-1-1 Infoline, DMR (Birth to 3), and the Children's Trust Fund (Help Me Grow) supporting the CDI to serve as the centralized point of entry for all CYSHCN in a system of care. CDI will develop and implement a referral and coordination of services model to assess and refer appropriate CYSHCN to Birth to 3, Ages and Stages, Help Me Grow and a local RMHSC.

/2007/DPH contracted with CREC/Soundbridge to implement the Listen & Learn program which provides follow-up of infants identified through the EHDI program who were not eligible for Birth-to-3 services.//2007//

DPH, through its partnership with the CHDI, contracted with AHEC to develop and implement a Medical Home Academy (MHA) for pediatric physicians, nurses, other allied health professionals, and families. The CT MHA was introduced as one full-day Medical Home Implementation Conference on March 8, 2005.

DPH and the CT Lifespan Respite Coalition, Inc. (CLRC) have partnered to create a two-section "Get Creative About Respite" manual. To determine the importance of respite services and provide information to families in the state, DPH conducted a needs assessment and found the top 5 gaps included planned respite, emergency respite, after school programs, summer day camp, and summer overnight camp. DPH contracted with CT Lifespan Respite Coalition, Inc. to provide 8 statewide information sessions on the Get Creative About Respite manual.

/2008/ "Directions: Resources for Your Child's Care" an information organizer for families, was made available.//2008//

/2010/ "Directions: Resources for Your Child's Care" was made available in Spanish and

Portuguese./2010//

DPH is working with the Champions for Progress Center housed at the Early Intervention Research Institute at Utah State University for assistance in the production of leadership to accelerate the process of systems building at the state and community levels. The Champions for Progress Center assists with the development of private/public partnerships using a Participatory Action Research Approach (PARA), coordinates State/territory plans and activities with partners around the 6 core measures for CYSHCN.

The Newborn Screening program staff work with the 30 CT birthing facilities, State Laboratory, Audiology Diagnostic Centers, the Regional Treatment Centers and individual medical homes to assure the testing, tracking, and treatment components of the Universal Newborn Screening Hearing and Laboratory Programs.

A Newborn Screening program staff is an active member of the CT Newborn Hearing Screening Task Force. The Task Force members include representatives from the DSS, DMR, birth hospital nurse managers, UConn Division of Family Studies, neonatologists and audiologists. The group meets monthly to plan and coordinate activities across state and other agencies, that promotes optimal outcomes for infants identified with hearing loss.

/2007/The EHDI program contracted with the UConn Division of Human Genetics to develop a web based training for pediatric healthcare providers on genetic testing in newborns and partnered with the UConn Communication Disorders Center and the American Speech and Hearing Association to offer continuing education units to audiologists who attend annual training./2007//

/2008/ The web-based training was launched in April./2008//

/2009/To date, 207 providers have accessed the web-based training./2009//

/2010/ 209 providers have accessed the web-based training./2010//

Quarterly meetings are held with a Genetic Advisory Committee (GAC), comprised of the Sickle Cell, Genetics and Metabolic specialty treatment centers and Newborn Screening Program staff from the FHS and DPH State Laboratory, as well as a consumer representative from the Citizens for Quality Sickle Cell Care, Inc.

A DPH CT Genetics Stakeholder Advisory Committee was formed to advise the Commissioner on the development of a Genomics Statewide Plan. This committee is comprised of representatives with expertise in genetics, law and bioethics; individuals from industry, insurance and academia; medical providers and genetic counselors; and consumer advocates.

/2007/The committee is now known as the CT Expert Genomics Advisory Panel. FHS staff participate on these panels. One serves as co-chair on the Services Workgroup, and another participates on the Sciences Workgroup./2007//

/2007/In January 2006, a Statewide Sickle Cell Planning group was developed to address transition services for youth and adults with Sickle Cell. The planning group is comprised of advocacy groups, sickle cell associations, hospitals, treatment centers, university students and DPH staff. DPH was approved for MCHB TA for a consultant to develop the comprehensive statewide sickle cell plan./2007//

/2008/ MCHB TA was utilized to develop a statewide sickle cell plan./2008//

/2009/Staff participate in the Sickle Cell Consortium and the statewide plan is on the DPH website and has been widely disseminated to 9 other states and the National Sickle Cell Disease Association./2009//

/2010/ Staff participate on the statewide consortium and held a forum to address sickle cell care in Emergency Departments./2010//

Health professionals of the DPH Newborn Screening Program and the Regional Treatment Centers participate on various state, regional, and national committees and resource groups such as: the CT PKU Planning Group, NE Mothers Resource Group, New England Consortium of

Metabolic Programs, NERGG, Inc., National Newborn Screening Genetic Resource Center, and the National Newborn Screening Advisory Committee. Participation on these committees provides the opportunity to network experts and consumers, participate in educational conferences, and keep abreast of advances in genetics and newborn screening as they impact public health. Program staff participate in the UConn MPH Program and provide NBS educational sessions to students as part of the Genetics course curriculum.

Site Coordinators of SBHCs meet bi-monthly with FHS staff to address grantee issues, training and technical assistance, information and resource sharing and input on overall project direction. CT SBHCs have formed a non-profit independent organization, the CT Association of SBHCs, Inc., to advocate for this service delivery model.

Sixty-three SBHCs in 18 communities are partially funded by DPH serving students in elementary, middle and high schools. SBHCs are licensed as outpatient facilities and staffed by both Advanced Nurse Practitioners and Licensed Social Workers. They offer an array of services addressing the medical, mental and oral health needs of youth, including crisis intervention, health education, social services, outreach, and substance abuse prevention services. Students enrolled in the SBHCs are provided with early periodic screening, diagnosis and treatment (EPSDT). The practitioners coordinate the care they provide with a child's primary and specialist caregivers, while integrating the needs of the child with other school personnel.

/2008/ A SBHC Ad Hoc Committee was formed with the goal of improving health care through access to SBHCs, particularly by under- or uninsured people or Medicaid recipients.//2008//
/2009/Ad Hoc Committee continues to meet and presents annual report to legislature.//2009//
/2010/There are now 73 SBHCs in 20 communities.//2010//

Child, Adolescent and School Health Unit staff are engaged in the interagency steering team of the Coordinated School Health Program. This team is comprised of members from DPH, SDE, and DCF. A Nurse Consultant with DPH's SBHC program is an active member of the State Adolescent Health Coordinator's Network, which is a national association of all state and territorial adolescent health coordinators, and a member of the National Assembly on School Based Health Care. Staff also participate in the Regional Stakeholders Group, with representation from DPH and SDE. The group works to enhance collaboration on issues of HIV, STDs, and Abstinence.

/2010/DPH collaborates with the DSS, DMHAS, SDE and Juvenile Justice through the HRSA "State Agency Partnerships for Promoting Child & Adolescent Mental Health Grant" it receives. To date, 2 train-the-trainer sessions have been conducted.//2010//

Within the Women, Men, Aging and Community Health Unit of the FHS, MCH program staff represent DPH on the New Haven Family Alliance, Male Involvement Network, The Community Foundation for Greater New Haven Perinatal Partnership Committee, and DSS's Fatherhood Initiative Council.

/2008/ FHS staff will participate on the Advisory Committee for DSS' Responsible Fatherhood Grant.//2008//

/2010/ staff are active members of the DSS' Fatherhood Initiative Council.//2010//

In an effort to build and strengthen community collaborations and to provide technical assistance to our community partners, DPH, in collaboration with the United Way of CT/Infoline 211, developed "A Resource Manual Designed to Help CT Communities Develop and Sustain Coalitions." It will complement the MCH Training, "Developing and Sustaining Coalitions" that was conducted in 2004 by The Consultation Center in New Haven.

/2010/ In collaboration with the Hartford Health and Human Services Department and several other agencies, DPH submitted and received a Federal Healthy Start Program "Eliminating Disparities in Perinatal Health" grant to serve all eligible women and their families in Hartford, with a special emphasis on families within the city's Black/African American communities.//2010//

Community Health Centers (CHCs) provide comprehensive primary and preventive health care and other essential public health services at 39 sites, and many additional sites for health care for the homeless. All centers are located in HPSA and/or Medically Underserved Areas and operate in accordance with Federally Qualified Health Center Guidelines. Approximately 176,894 people were served with 782,000 visits documented in 2004. Patients served within the CHCs are provided with a wide variety of comprehensive services, including EPSDT. The CHCs also work with Family Planning, WIC, SBHCs, Infoline and many community based organizations that provide other health care and social services.

/2008/In 2005, over 200,000 people sought services, generating nearly 900,000 visits to CHCs.//2008//

/2009/In 2006, CHCs continued to serve over 200,000 clients. Comprehensive information is on DPH website.//2009//

/2010/In 2007, 13 CHCs served 233,105 clients with 1,097,066 encounters. Torrington moved its site and a new satellite by CHC, Inc was added in Danbury, which borders New York.//2010//

The statewide family planning program is implemented through a contract with Planned Parenthood of CT in 15 sites (10 Planned Parenthood centers and 5 designated agencies). The services provided include comprehensive preventive and primary reproductive health care for adolescents and adult males and females. During FY 2004, 41,838 clients received services. The program goals and activities include education in a variety of forums for youth, parents, teachers, social workers and clergy. Forums are held in schools, churches, community based social service offices and recreational programs. The prevention focus includes the prevention of pregnancy (including abstinence education), STIs, Hepatitis and HIV/AIDS.

/2008/ Planned Parenthood of CT has 16 sites and during FY 06, 33,669 clients received services.//2008//

/2009/Planned Parenthood of CT has 16 sites and during FY 07, 32,092 clients received services.//2009//

/2010/29,473 clients received services at the 16 sites.//2010//

All DPH-funded community health centers in CT are members of the CT Primary Care Association (CPCA). DPH and CPCA work together on a number of important initiatives to promote, inform policy, and develop community based systems of care for the state's most vulnerable populations and to support CHCs. Among these are the CT River Valley Farmworker Health Program (in conjunction with the Massachusetts League of CHCs), National Health Service Corps recruitment and retention activities, immunization program initiatives, breast and cervical cancer screening, domestic violence prevention and homelessness.

/2008/ DPH contracted with two CHCs to pilot a perinatal depression screening tool.//2008//

/2009/DPH contracted with Yale University to provide perinatal depression (PD) screenings to community partners and establish a PD consultative line. CPCA changed its name to Community Health Center Association of CT. DPH collaborated with them to provide materials to share with CHCs. In order to promote interest in careers in health care, Be A Health Care Hero brochures were mailed to guidance counselors at several hundred middle and high schools statewide.//2009//

In collaboration with CPCA, a Healthcare for the Homeless Advisory Board was established and a conference was held to strengthen links between healthcare providers and shelters. A needs assessment of homeless persons in CT and a strategic plan to improve the health status of CT's homeless men, women and children was conducted. The Advisory Board is in the process of implementing activities identified in the strategic plan. Mini-grants were provided to 10 CHCs to better address and link homeless persons in their communities with primary health care services.

DPH partnered with AHEC to co-fund and implement the CT Youth Health Service Corp (CYHSC) with a purpose of promoting teen pregnancy prevention by engaging youth in activities that promote healthy behaviors and lifestyles and support workforce development by facilitating the transition of youth from school to employment in the health care field, particularly with

underserved populations. A curriculum was developed that provided students with information on confidentiality/HIPPA, Homelessness 101, Ethical and Legal Issues and Applied Health Services. /2008/Although this program continues to operate, DPH no longer funds the CYHSC through the PCO grant.//2008//

The DPH participates on the CT Breastfeeding Coalition (CBC), which includes representatives from the state and local WIC program, La Leche League, AAP, Hospitals, CHCs, HMOs, Universities, independent Lactation Consultants, Medela Corporation and consumers. The Coalition meets on a monthly basis and has 4 active committees: Policy and Advocacy, Data, Provider Education, and Public Awareness. The goals of CBC are to increase public awareness and support for breastfeeding statewide and promote breastfeeding as the social norm. In May 2005, in collaboration with the DPH, the CBC sponsored a symposium attended by over 100 health care providers, which focused on the integration of breastfeeding support in office practices. The FHS continues to work closely with the WIC program to promote and support breastfeeding in the state.

/2008/The goals of the CBC have been revised to a mission to improve CT's health by working collaboratively to protect, promote and support breastfeeding.//2008//

/2010/CBC includes representatives from breast pump manufacturers. The CBC provided information and input on breastfeeding in the legislative arena, and held annual conferences from 2004-2008, reaching more an 600 health care professionals with timely, evidence-based breastfeeding information. In 2008, the CBC was among the first 10 state coalitions to receive HRSA funding to pilot The Business Case for Breastfeeding worksite initiative.//2010//

As part of the Women's Health Initiative, DPH staff actively participates in the Office of Women's Health Region 1 Workgroup to increase the focus on women's health, foster collaboration, and encourage the development of women's health activities in the state and in the New England region. The DPH convened a collaborative workgroup, "Going Home Healthy," at York Correctional Institute, the State's only female correctional facility, with the purpose of transitioning women back into the community healthy. The workgroup is comprised of representatives from various state and community-based agencies and has developed a community-specific resource guide and gender-specific discharge cards for soon to-be released inmates. In addition, DPH funded contractors have been invited to participate in the on-site "community days" so that inmates have a better understanding of where and how to access health and social services in their particular community of discharge.

/2008/DPH will execute an MOA with the DOC & UConn to facilitate activities & training regarding Intimate Partner Violence for inmates and staff at the YCI. DPH has formed a partnership with the Hartford Community Court and the DSS to work with adolescent fathers.//2008//

/2009/DPH executed an MOA with DOC and a contract with CT Women's Consortium to provide gender based training regarding Intimate Partner Violence for inmates and staff at YCI.//2009//
/2010/ Training was provided to 530 DOC staff and 66 inmates.//2010//

During National Women's Health week, DPH collaborated with the CT Sexual Assault Crisis Services (Connsacs) and other DPH initiatives to raise awareness about sexual assault prevention, nutrition, cardiovascular disease and HIV/AIDS. Community based forums that addressed these topics were conducted in New Haven, Bridgeport, Hartford and at a shopping mall.

/2008/During National Women's Health Week, DPH provided health screenings (blood pressure, BMI, etc.) to state employees.//2008//

/2009/DPH collaborated with CT VNA Partners, American Lung Association and American Cancer Society during National Women's Health Week in May.//2009//

Facilitated by Central AHEC, DPH convened the statewide perinatal advisory committee. The purpose of this committee was to develop a comprehensive, statewide plan to address perinatal health services in CT. Representation on the committee included: the State Agencies DPH, DSS, DCF, DMHAS, and also the New Haven Health Department, New Haven Healthy Start, The CT

Hospital Association, CT Women's Consortium, CT Chapter of the March of Dimes, Real Dads Forever, Planned Parenthood of CT, CPCA, Permanent Status on the Commission of Women, AAP, UConn Department of Neonatal and Perinatal Medicine, UConn Department of Obstetrics and Gynecology, and the CT State Medical Society. The Advisory Committee identified 9 goals and objectives to address the perinatal health needs in CT.

/2007/The Perinatal Depression Workgroup is comprised of representatives from the DPH, DMHAS, DSS, Local Health Departments, CT Chapters of the AAP, ACOG, Nurse Midwives, and March of Dimes, United Way of CT/ Infoline, Yale University, UConn, CT Women's Consortium, PCSW, CPCA, CHCs, Office of Rural Health, and consumers. A statewide summit was convened in May 2006 and the perinatal depression campaign (print and media) will be launched in the summer. //2007//

/2008/The Perinatal Advisory Committee will be integrated with the recently reconvened Infoline MCH Advisory Committee. The Perinatal Depression Workgroup remains active.//2008//

/2009/The MCH Advisory Committee met quarterly to discuss topics of interest and make recommendations for implementation of the Perinatal State Health Plan.//2009//

/2010/ The MCH Advisory Committee meets quarterly.//2010//

CT's Healthy Mothers/Healthy Babies Coalition is jointly chaired by a staff member within the FHS and the CT Chapter of the March of Dimes. The mission of the Coalition is to promote the health and well being of women and children in CT through leadership, collaboration, and resource sharing.

Within the Surveillance, Evaluation, and Quality Assurance Unit (SEQA) of FHS, staff has worked to establish the CT Birth Defects Registry and work closely with birthing units within the hospitals of the state. A web-based reporting system for the CYSHCN is used by medical homes and Regional Medical Home Support Centers (RMHSC), and is linked to the registry at DPH. Infoline is working with DPH and has become the single entry-point of CYSHCN for referrals to the Birth to 3 Program and the RMHSC for needed services.

SEQA staff represent DPH on the steering committee for Early Childhood Data CONNections, a public-private partnership of DSS and CHDI to bring together stakeholders to address the needs for better information on key early childhood indicators. The goal is to further build the capacity of state government to collect, analyze and report key information on the needs and services for young children (birth to age 8) and to develop and facilitate a research agenda for advancing early childhood public policy through partnerships.

The MOU between DPH and DSS regarding data exchange exists to improve public health service delivery outcomes for low-income populations through the sharing of available Medicaid, HUSKY Part B and Plus, and Title V data. The initial MOU addresses the linkage of birth and Medicaid data, childhood lead screening and Medicaid data, and data on Children Receiving Title V Services and Medicaid data.

/2008/The first addendum of the Data Sharing MOU related to the linkage of birth & Medicaid data was amended to include a linkage to clients under the fee-for-service component of Medicaid.//2008//

/2010/The DPH-DSS MOU was amended to include the Department of Children and Families (DCF) to include data from DCF of children for whom DCF is the legal guardian and whether these children have been screened for elevated blood lead levels.//2010//

SEQA staff act as the state identified data contact for the Office of Women's Health Region 1 database project. Staff has facilitated the collection of the health status information needed for this database and coordinated the subsequent in-state training for use of this database.

/2008/FH Epidemiology staff continue to coordinate the provision of data to the OWH Region 1 database.//2008//

DPH has worked with the Office of the Governor through the Governor's Collaboration for Young

Children to establish The Healthy Child Care CT initiative. Its goal is to achieve optimal health and development for all children in childcare by guiding and supporting service integration between the childcare community and health care providers. DPH participates on the 5-member Leadership Team that guides the Healthy Child Care CT, along with the executive director of the Children's Health Council. The team has established a regional Core Committee representing organizations that play a key role in the planning and delivery of childcare and health care for children and their families. Healthy Child Care CT also works closely with the national Healthy Child Care America campaign, which is coordinated by the AAP with support from the DHHS Child Care and MCH Bureaus. As part of the Healthy Child Care CT initiative, DPH collaborated with staff from DSS, Yale University School of Nursing, UConn Stamford, and Southern CT State University to conduct a 6-day training program for Day Care Health Consultants, Education Consultants and Directors of Day Care Facilities. This program addressed many aspects relating to the health and safety of children in day care facilities.

The CT Coalition to Stop Underage Drinking, designed to curb under age drinking, involves all state agencies and advocacy groups across the state. The coalition is headed by the Governor's Partnership Project, Drugs Don't Work! and is funded by the RWJ Foundation.

CT does not function on a county-based system for the delivery of public health services to its residents. However, the Commissioner of DPH, through the Local Health Administration Branch, assists and advises local health districts in the state as they play a critical role in planning, providing, and advocating for public health services on the local level. The services provided include prenatal and family planning clinics, child health clinics, nutrition services, immunizations, communicable disease surveillance and control, HIV counseling and testing and other services. DPH's Local Health Branch administers state funding for local health departments and districts.

The Early Childhood Partners Initiative established a steering team and developed a memorandum of agreement with the Commission on Children to co-sponsor a roundtable on shared outcomes. The ECP process brought together 8 State agencies and statewide institutions, and the community to create a performance-based, outcome-driven Strategic Plan to support all CT families so their children arrive at school healthy and ready to learn.

/2007/The ECP Steering Committee was expanded and convened. The DPH's Deputy Commissioner has been appointed to the new Governor's Early Childhood Education Cabinet. The purpose of the Cabinet is to develop a strategic plan to assure that children enter kindergarten fully ready for school success //2007//

/2008/Plans are underway to better integrate the goals of the ECP plan into that of the ECE Cabinet.//2008//

/2009/DPH applied for the SAMHSA Project LAUNCH grant and is also partnering with DSS & DCF to better integrate social-emotional health into the EC system.//2009//

/2010/CT reapplied for the Project Launch grant and continues to work with the CTF to promote the use of Ages & Stages Questionnaire. DPH staff participate on the Governor's Early Childhood Education Cabinet's data workgroup.//2010//

To address intentional and unintentional injuries, DPH staff collaborate with the CT DOT, SDE, DCF, DSS, OCA, CSSD, and other public, private, and community-based organizations. State and local SAFE KIDS Coalitions (membership includes health care, EMS, Police, Fire and community service providers) address motor vehicle injuries. DPH facilitates the CT Young Worker Safety Team, a collaboration that includes the CT and US Departments of Labor and the CT SDE. The group promotes awareness and training to decrease adolescent work related injuries. DPH facilitates the Interagency Suicide Prevention Network, an interagency, interdisciplinary collaboration that has completed a statewide, comprehensive suicide plan. DPH also works with collaborators to address violence prevention, domestic violence and child maltreatment. DPH staff participates in the Northeast Injury Prevention Network, which includes State Health Injury Prevention Programs from Regions I and II, University Injury Research Centers and representatives from Federal Regional Offices. The Network collaborates on injury prevention initiatives of relevance to both the region and the individual states.

/2008/ An MOA between DPH and UCONN was executed to develop a statewide surveillance system to identify the health related issues regarding fetal and infant.//2008//

/2009/The legislature sustained funding for the FIMR Programs to continue. The new MOA between DPH and UCONN allowed new efforts to begin to look at fetal and infant mortality surveillance statewide.//2009//

/2010/Fetal Infant and Maternal Mortality Surveillance ended due to budget cuts. The Immunization Program joined the Family Health Section, and provides recommended childhood and adolescent vaccines to health care providers statewide. Funding to supports 14 contracts with local health departments for delivering immunization services to under-immunized children in high-risk areas of the state. The immunization registry maintains immunization records on children up to six years of age. There are 487,000 children in the registry and over 7.5M immunizations in the registry database.//2010//

F. Health Systems Capacity Indicators

Introduction

CT has seen some positive outcomes among the HSCIs evidenced by increases in both the Medicaid and SCHIP enrollees age < 1 receiving one initial periodic screen. This was accompanied by the increasing trend in the percent of Medicaid eligible children who have received a service paid by the Medicaid program. These positive outcomes may be from efforts in the State to promote insurance coverage for children and access to the available services.

A concern was noted about the timing and frequency of prenatal care being at sub-standard levels. Recommendations from the Strategic Plan to Address Low Birth Weight in CT like implementation of the Centering Pregnancy model; advertising the use of 2-1-1 Infoline to assure referrals for prenatal care; and developing a curriculum that addresses the need for father/partner support during and after pregnancy, will hopefully bring positive results to improve the timing and frequency of prenatal care.

CT's SSDI is submitting its continuing application for year four of the five-year project period to address HSCI 9A. FHS linked Birth-Medicaid data for 2000-2006. The 2007 linkage is being finalized, and FHS will provide data summaries to MCHBG and constituents.

SSDI data were provided to numerous partners. Internally, information was used to enhance reporting to the MCHBG; produce a strategic plan to address low birth weight; address health disparities in low birth weight for CT; and improve birth weight outcomes associated with WIC participation.

Externally, information was provided to: Hartford Health Department (HHD) to support their Preconception Health Plan; a workgroup of HHD and DPH staff that focused on improving birth outcomes in Hartford; and the MCH Workgroup under the Legislature's Medicaid Managed Care Council, Quality Assurance Subcommittee.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	31.5	32.0	39.5	37.3	
Numerator	658	676	802	788	
Denominator	208772	211036	202831	210985	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	

Notes - 2008

CY 2008 hospitalization data not available.

Notes - 2007

Source: CY 2007 in-patient hospitalization data provided by J.Morin, FHS, PHI Branch. Numerator is 2007 hospital discharge data and denominator is 2007 population estimates, provided by F. Amadeo - Table 1 of the Registration Report.

Notes - 2006

Source: CY 2006 in-patient hospitalization data provided by J.Morin, FHS, PHI Branch.

Narrative:

/2010/ The rate of children less than five years of age hospitalized for asthma has slightly decreased in CY 2007 by 2.2%. This decrease does not bring this percent down to that seen in 2004 and 2005. The DPH Asthma Program will continue its focus on the identification, treatment and control of asthma among this population.//2010//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	85.3	87.9	86.2	86.6	94.2
Numerator	13475	14386	14429	15133	16833
Denominator	15795	16369	16739	17475	17866
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008

Source: CT Dept of Social Services, FFY2008.

Notes - 2007

Source: CT Dept of Social Services, 2007 CMS 416.

Notes - 2006

Source: CT Dept of Social Services, 2006 CMS 416.

Narrative:

/2010/ In CY 2007, 94.2% of Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen. This figure shows an increasing trend in the percent of Medicaid enrollees receiving this screen with exception of the single data point in CY 2005. We will monitor this trend to assure that it continues in the positive direction.//2010//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	79.4	81.0	73.7	82.0	
Numerator	377	482	365	445	
Denominator	475	595	495	543	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008

Source: CT Dept of Social Services, CY 2008 data not available.

Notes - 2007

Source: CT Dept of Social Services, SFY2007 HUSKY participation report.

Notes - 2006

Source: CT Dept of Social Services, SFY2006 HUSKY participation report.

Narrative:

//2010/ In CY 2007, 82.0% of SCHIP enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen. Similar to that for the Medicaid enrollees, this figure shows an increasing trend in the percent of SCHIP enrollees receiving this screen with exception of the single data point in CY 2006. We will monitor this trend to assure that it continues in the positive direction. According to DSS, FFY07 is the most recent completed annual report. CY 2008 data was not available due to the change in Managed Care Organizations (MCOs) during 2008 (2 MCOs leaving the program in 2008, and a third in early 2009) along with changes in the reporting timelines and periods covered in those reports.//2010//

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	80.7	80.2	80.2	79.1	
Numerator	32962	32773	32809	32152	
Denominator	40841	40885	40898	40659	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years					

is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008

Source: CY2008 Vital Statistic data not available.

Notes - 2007

Source: CT Dept of Public Health, Final 2007, Vital Statistics.

Notes - 2006

Source: CT Dept of Public Health, Final 2006, Vital Statistics.

Narrative:

/2010/ In CY2007, 79.1% of women (15 through 44 years) with a live birth during the reporting year whose observed to expected prenatal visits were greater than or equal to 80% of the Kotelchuck Index. This continues the decreasing trend for this measure. NPM #18 also showed a decrease in CY2007 in the percent of infants born to pregnant women receiving prenatal care in the first trimester. These measures continue to raise concerns about the timing and frequency of prenatal care being at sub-standard levels. Recommendations from the Strategic Plan to Address Low Birth Weight in CT like implementation of the Centering Pregnancy model; advertising the use of 2-1-1 Infoline to assure referrals for prenatal care; and develop a curriculum that addresses the need for family or father support during pregnancy, will hopefully bring positive results to improve the timing and frequency of prenatal care. MCHB TA funds have been approved to assess CT's perinatal system of care. A two-day workshop is being developed and will be held in the fall./2010//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	46.9	47.9	48.8	52.2	54.9
Numerator	121521	129346	137566	145359	156715
Denominator	258978	269941	281910	278677	285538
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008

Source: CT Department of Social Services, 2008 CMS 416

Notes - 2007

Source: CT Department of Social Services, 2007 CMS 416

Notes - 2006

Source: CT Dept of Social Services, 2006 CMS 416.

Narrative:

/2010/ The percent of potentially Medicaid-eligible children who received a service paid by the Medicaid program continues to steadily increase. The percent of potentially Medicaid-eligible children receiving a service has increased from 46.9% in CY 2004 to 54.9% in CY 2008. This continued increase is a positive sign since DSS has had changes in the number of MCOs participating in the program./2010//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	46.5	43.7	48.1	53.0	52.3
Numerator	25099	24689	26848	29007	29283
Denominator	53922	56549	55848	54775	55971
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008

Source: CT Dept of Social Services, FFY2008.

Notes - 2007

Source: CT Dept of Social Services, 2007 CMS 416.

Notes - 2006

Source: CT Dept of Social Services, 2006 CMS 416.

Narrative:

/2010/ The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year is somewhat erratic in its pattern. Unfortunately, the most recent data for CY 2007 has shown a decrease to 52.3%./2010//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	3.6	3.6	4.3	8.8	
Numerator	76	47	259	546	
Denominator	2120	1296	6008	6230	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008

Source: CY2008 data not available.

Notes - 2007

Source: A total of 5931 CYSHCN recieved services from the program. An estimated 9.2% of these receive SSI of 546 for the numerator. The denominator is the actual number of CT residents <16 receiving SSI 6230. This data source is different than that used in 2006, but the CYSHCN Program feels that the 2007 figures are a more accurate method of calculating the percent of SSI beneficiaries receiving rehabilitative services.

Notes - 2006

Source: In CY 2006, the CYSHCN Program estimated that approximately 85% (2397) of children served by the CYSHCN Program are under 16 years of age. The denominator is the number of children in CT under 16 years receiving SSI reported on the Healthy and Ready to Work website (www.hrtw.org).

Narrative:

/2010/ The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program has seen a dramatic increase from 4.3 % in CY 2006 to 8.8% in CY 2007. This dramatic change is probably due to the change in the data source used in 2006, but the CYSHCN Program feels that the 2007 figures are a more accurate method of calculating the percent of SSI beneficiaries receiving rehabilitative services.//2010//

Health Systems Capacity Indicator 05A: Percent of low birth weight (< 2,500 grams)

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2006	matching data files	9.5	7.5	8.2

Notes - 2010

Source: DPH Vital Statistics final 2006 matched births to Medicaid eligibilty information. CY2007 data are not available.

Narrative:

/2010/ The most recent linked birth-Medicaid data file available is for CY 2006 birth cohort. For all four indicators in this measure, the Medicaid population shows poorer outcomes than the non-Medicaid population. The magnitude of the measures were similar from the 2005 birth cohort to the 2006 birth cohort except in the rate of infant deaths per 1,000 live births. A fairly substantial drop in the infant mortality rate in the Medicaid population was reported from 9.4 in the 2005 birth cohort to 6.8 in the 2006 birth cohort. DPH continues to collaborate with the Department of Social Services, which administers the State's Medicaid program. DPH provides MCHBG funding for the state Healthy Start program which provides case management services to pregnant Medicaid-eligible women and their children up to age three.//2010//

Health Systems Capacity Indicator 05B: Infant deaths per 1,000 live births

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2006	matching data files	6.8	4.7	5.4

Notes - 2010

Source: DPH Vital Statistics final 2006 matched births to Medicaid eligibility information. CY2007 data are not available.

Narrative:

/2010/ See narrative under HSCI #05A //2010//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2006	matching data files	73.8	91.8	85.8

Notes - 2010

Source: DPH Vital Statistics final 2006 matched births to Medicaid eligibility information. CY2007 data are not available.

Narrative:

/2010/ See narrative under HSCI #05A //2010//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate	2006	matching data files	71.9	84.4	80.2

prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])					
--	--	--	--	--	--

Notes - 2010

Source: DPH Vital Statistics final 2006 matched births to Medicaid eligibility information. CY2007 data are not available.

Narrative:

/2010/ See narrative under HSCI #05A //2010//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Infants (0 to 1)	2008	185
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Infants (0 to 1)	2008	300

Notes - 2010

Source: Dept of Social Services

Notes - 2010

Source: CT Department of Social Services, Medical Care Administration, Managed Care Unit.

Narrative:

/2010/ There have not been any changes to the eligibility requirements for Medicaid and SCHIP programs for any of the three population groups.//2010//

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Medicaid Children (Age range 1 to 22) (Age range to) (Age range to)	2008	185
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2008	300

Notes - 2010

Source Dept of Social Services

Notes - 2010

Source: CT Department of Social Services, Medical Care Administration, Managed Care Unit.

Narrative:

/2010/ See narrative under HSCI #06A //2010//

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Pregnant Women	2008	250
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Pregnant Women	2008	250

Notes - 2010

According to DSS, Medicaid eligibility level changed for pregnant women as of 1/1/2008.

Notes - 2010

Source: CT Department of Social Services, Medical Care Administration, Managed Care Unit.
Medicaid eligibility level changed for pregnant women as of 1/1/2008.

Narrative:

/2010/ See narrative under HSCI #06A //2010//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	2	Yes

Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	2	Yes

Notes - 2010

Narrative:

/2010/ This measure continues to remain unchanged from last year. Staff continue to pursue regular access to WIC eligibility files that will allow linkage to the birth records. CT's third PRATS survey is scheduled to begin in August 2009./2010//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2010

Narrative:

/2010/ The most recent CT School Health Survey (YRBS) was conducted in 2007. This survey is currently being conducted (2009) with preliminary results to be available in the Spring 2010./2010//

IV. Priorities, Performance and Program Activities

A. Background and Overview

The priority needs presented in the next section were identified through a comprehensive needs assessment during August 2004 through May 2005, to identify state MCH priorities, to arrange programmatic and policy activity around these priorities, and to develop state performance measures to monitor the success of their efforts. The MCH needs assessment was designed to be population-based, community-focused, and framed within a family context.

The MCH Director established an MCH Needs Assessment Planning Committee to assist in the oversight and direction of the needs assessment. The Planning Committee included staff from the various MCH programs, staff from the Health Information Systems and Reporting Section, and staff from the Health Education, Management and Surveillance Section.

In order to include key stakeholders in a meaningful and integral part of the needs assessment, DPH staff identified and convened an initial collaborative meeting with many invited state agencies and community and professional organizations. The MCH Director presented an overview of the MCH Block Grant and the required five-year needs assessment at the initial collaborative meeting. This collaborative group, which met several times over a six-month period, also provided oversight of the community centered needs assessment.

The Planning Committee also determined that the needs assessment process would include two components: 1) DPH Internal Needs Assessment, and 2) Community Centered Needs Assessment. The DPH Internal Needs Assessment process gathered data and reports housed at DPH, interpreted the data for programmatic implications, and recommended 7-10 state priority needs. The Community Centered Needs Assessment process identified community level data and reports, and all methods of collecting community data. This provided a forum for community input into the determination of the state priority needs.

Each Internal Needs Assessment workgroup was instructed to recommend 5 priority needs for a total of 15 priority needs to be considered by the DPH Planning Committee. It was part of the Planning Committee's charge to reduce the recommended 15 priority needs to 7-10 state priority needs. The Planning Committee, after much discussion and consideration, drafted a set of state priority needs, which were subsequently considered along with those identified by the Community Centered Needs Assessment.

In the Community Centered Needs Assessment, both qualitative and quantitative methods were used to inform the comprehensive needs assessment process. A health profile was developed for target populations including women, pregnant women, children, adolescents and children with special health care needs (CYSHCN). Additional feedback on the health needs of women and children was obtained from providers and consumers. Engaging the various stakeholder groups facilitated the inclusion of their insights and experience of their practical experiences and served as a valuable reality check. A concerted effort was made to engage providers, advocates and consumers in both identifying priority needs and successful solutions to identified problems.

The Planning Committee met in late May 2005, to review the identified priority needs from the Internal and Community Centered Needs assessment components to assure that the three population groups were appropriately included and establish measurable State Performance Measures. The MCH program selected seven priority needs from the list of potential areas for improving maternal and child health. Criteria used to select top priorities include the likelihood that the intervention will result in improved maternal and child health outcomes, the feasibility of success, and alignment with federal MCH priorities. The DPH Planning Committee added an eighth priority need regarding health disparities as it was deemed a repeated imperative need across the MCH population. The DPH Planning Committee also added a ninth priority need as part of the collaborative work of the federal Region I states to "measure the collective assets of

their childhood health systems."

/2007/ This measure was further developed by Region 1 Title V directors to measure the percentage of licensed child care centers serving children age birth to five who have onsite health consultation.//2007//

/2008/ During the 2006-07 grant year, FHS staff had in-depth conversations with Day Care Licensing staff to discuss the actual available data from the CT Day Care Health Consultant database. In light of the fact that the database was not able to report whether a center had been visited at least once a month by a licensed health care consultant, we updated the language to reflect information that can be obtained from the database with the resulting new SPM language: "The percent of licensed child day care centers serving preschool age children that have reported having contracts with the required four consultants (health, dental, educational and social service) to conduct the required site visits, and to ensure that the health, dental and social service consultants' licenses are current."//2008//

/2010/ FHS staff did not actively pursue work on the SPM related to health consultants, as most of the Region 1 states did not have the capacity to provide information to address this issue. This was briefly discussed during the monthly Region 1 conference calls and at the February 2009 AMCHP meeting where states were more inclined to pursue a measure around rural health. Future efforts will then be focused on continued collaboration as the MCH partner with Injury Prevention staff and the CT Office of Rural Health staff in the Children's Safety Network (CSN) initiative to address the prevention of injuries in rural areas. CSN is raising the possibility with Region 1 states to implement this issue as a common State Performance Measure.//2010//

The nine identified State Priority Needs are similar in many ways to those identified 5 years ago. The similarities include the need to address data capacity issues, reduce injuries to children and adolescents, improve child adolescent health status with an added focus on overweight/obesity, enhance CYSHCN services especially family support services, increase access to health care for women and children, and reduce the health disparities that continue to exist specifically in the areas of teen pregnancy, low birth weight, prenatal care, breastfeeding, and infant mortality. One change was the removal of the priority need related to asthma diagnosis and management, as DPH has enhanced its capacity to more effectively address this issue through the now well-established DPH Asthma Program. Another change was the inclusion of the need to address asset-based measurement efforts among the federal Region I states.

/2009/ There are no changes to the priority needs at this time. In the fall, we will begin to map out the process for conducting the next five-year MCH Needs Assessment that is due with the 2011 Application. We will review the former process utilized and identify any additional funding that will be required to complete the process. There will be a stronger emphasis placed on community/parent/consumer input.//2009//

/2010/ As described above, FHS is shifting one priority related to health consultants to move toward the proposed measure addressing injury prevention in rural areas. FHS did begin the process for conducting the next five-year MCH Needs Assessment in the fall of 2008. The process does include what we found to be successful in the use of 3 populations focused internal workgroups and expanded its activities to conduct several focus groups and surveys to gather more community/parent/consumer input.//2010//

B. State Priorities

Through the Needs Assessment process completed for the 2006 Application, DPH identified nine areas of priority needs. These nine areas and how they relate to the National and State Performance Measures, and the capacity and resource capability of the Title V program are described below.

1. Strengthen Data Collection and Reporting

Effective decision-making requires timely and useful data on maternal and child health. One strategy that DPH implemented was the creation of the Virtual Children's Health Bureau (VCHB) in the fall 2004, whose charge was to remove barriers to the effective and efficient sharing of data across sections of the agency to fully maximize the use of child health information. The resulting commitment from DPH staff and executive leadership was the creation of a data warehouse of high-quality linked child health data, which has been titled HIP-Kids (Health Informatics Profile for CT Kids).

The information from HIP-Kids will be an important data source to enhance the DPH's ability to report on performance measures, as well as other required outcome measures. It also will support the goal outlined in the Health Systems Capacity Indicator #9A "the ability of states to assure that the MCH Program and Title V agency have access to policy and program information and data."

This priority need is somewhat related to HP2010 23-11: (Developmental) Increase the proportion of State and local public health agencies that meet national performance standards for essential public health services.

The SPM #1, to create HIP-Kids, will support interdivisional public health research activities and initiatives. A broadly accessible data system will enhance the capacity to conduct public health assurance and assessment activities within Connecticut, and will also inform public health policy. Some enhanced essential activities that are anticipated include reducing health disparities among childhood disease prevention activities through better outreach to "hard to reach" populations; increasing ability to evaluate population-based health activities within DPH; improving data quality through better data validation and coordinated data improvement efforts; and enhancing comprehensive data accessibility to support grant activities and health programming.

/2008/ The creation of HIP-Kids fit well with EPHT's goal to develop and modify systems that meet the Public Health Information Network (PHIN), National EPHT Network, & the Environmental Protection Agency's (EPA) Environmental Exchange Network requirements. The data warehouse will collect data from a variety of existing sources, with enhancements to the collection processes for some of that data, & make it available to the DPH to support their query, extraction, & reporting needs.//2008//

/2010/ FHS staff continued their collaboration with EPHT staff and the Public Health Information Network (PHIN) Workgroup to further progress towards integrating child health databases into HIP-Kids. Family Health Section Early Hearing Detection & Intervention (EHDI) and Birth Defects Registry (BDR) staff worked with EPHT and Consilience Software, Inc. staff, to complete the migration of the EHDI and Birth Defects databases to the MAVEN application. The Genetics/Laboratory Tracking staff decided to also migrate the genetic screening component of the NSS to MAVEN. This will now result in the successful migration of the entire Newborn Screening System to MAVEN. Genetics/Laboratory Tracking staff are now working with Consilience Software, Inc. staff to complete the implementation phases of the migration of this component of the NSS to the MAVEN application with a projected completion date of December 2009.//2010//

2. Establish Collaborative Relations at the State/Local Level

The MCH Program acknowledges that improving the health and well-being of women and children requires a collaborative response from state agencies and community providers. For this reason, the MCH Program proposes to enhance and establish formal processes to collaborate with state and local stakeholders committed to improving the health of women and children. Specific issues best addressed through collaborations with state and local partners include increasing access to needed services such as mental health, oral health, specialty care and health services in rural communities, and expanding access to health insurance for low income

populations.

While there are no specific National Performance Measures (NPMs) that directly relate to this priority need, the NPMs seek to improve the health of women and children, and many NPMs can only be achieved by collaborating with other state agencies. Similarly, there are no HP2010 objectives that specifically discuss fostering and implementing collaborations with state and local stakeholders, however there are numerous HP2010 objectives relating to the overarching goal to improve the health of women and children (refer to Form 16).

/2008/ FHS Staff are working with the DOC to implement a gender responsive curriculum for both DOC staff and inmates at YCI. An MOA between DPH and UCONN was executed to develop a statewide fetal and infant mortality surveillance system.//2008//

/2010/ There were five new MOAs implemented.//2010//

3. Reduce Intentional Injuries

The increase in violence and intentional injuries poses a serious public health threat to the adolescent population. Participation in fights is one marker of violent behavior that often results in serious injuries. Efforts to decrease violent behavior will help reduce intentional injuries to adolescents.

The single NPM most closely related to this priority need is #16, the rate of suicide deaths among youths. The selection of this priority need and the related SPM to reduce the number of injuries to adolescents in grades 9-12 due to violence and intentional injury, was purposely identified as part of an early intervention and prevention concept with the intent to address the tendencies to violent and injurious behaviors at an earlier stage. There are three HP2010 objectives that were cited related to this priority need from the Injury and Violence Prevention Chapter of the HP2010 document (see Form 16).

There are several Title V programs (e.g., CHCs and SBHCs) that already address this priority need through education and prevention programs, as well as specific programs like anti-bullying campaigns.

/2008/ FHS provides support to the IPP for the developing Injury Surveillance System & its related grant requirements, including obtaining in-patient hospitalization & ED data from the CT Hospital Association.//2008//

/2010/ One MCH Epidemiologist is collaborating with the DPH Injury Prevention Program and the CT Office of Rural Health staff in an initiative to prevent injuries in rural areas as part of the Children's Safety Network's "Keeping Kids Alive".//2010//

4. Improve Adolescent Health Status

Adolescents of diverse racial, ethnic backgrounds and those of low socio-economic status who live in very rural sections of the state are at especially high risk for mental health, substance abuse and unintentional injuries. They need easy access to age-appropriate services and are often under-served due to the gap between pediatric and adult medical care services. SBHCs are reaching a number of adolescents but are only available at some schools and not in others. In addition, there is a sub-population of adolescents who are not reached because they are not in school due to dropping out, being incarcerated or are migrant workers.

While there is no specific NPM to address the increase in access to age-appropriate services for adolescents 10-20 years, HP2010 1-4b addresses this priority need with the goal to increase the proportion of persons who have a specific source of ongoing care (Children and youth aged 17 years and under). The HP2010 objective states that, "Young children and elderly adults, aged 65 years and older, are most likely to have a usual source of care, and adults aged 18 to 64 years are least likely. Young adults aged 18 to 24 years are the least likely of any age group to have a usual source of care."

The availability of age-appropriate services for adolescents through the SBHCs has been a positive model in which there has been moderate increased capacity to serve adolescents. The new SPM #4 related to this priority need will seek to further increase this capacity. /2008/ A legislatively mandated SBHC Ad Hoc Committee was formed with the goals of improving health care through access to school-based health centers (SBHCs).//2008//
/2010/The SBHC Ad Hoc Committee meets on a quarterly basis and will be submitting a report to the legislature this summer.//2010//

5. Promote Nutrition and Exercise to Reduce Obesity

Obesity and its consequences is now the top emerging public health issue in the state. Its importance as a priority health issue stems from it being a preventable condition that is increasing across all major public health population groups, and that it is linked to health problems such as heart disease and Type II diabetes. Obesity is an ideal health issue for community wide action that addresses all aspects of its prevalence among the MCH population.

While there is no NPM that addresses obesity/overweight directly, the new Health System Capacity Indicator #9C seeks to measure whether States have the ability to determine the percent of children who are obese or overweight. CT should be able to obtain percentages from the 2007 and 2009 CT School Health Survey (with a YRBS component) to determine this percentage. As a complimentary approach, the SPM developed for this priority need was focused on the reduction of overweight/obesity in the child and adolescent population with the increase in the number of public schools using educational programs to reduce obesity through physical exercise and nutrition education. /2007/ As part of the new 2007 Guidance, there is now an NPM (# 14) which addresses obesity and overweight in young children.//2007//

There are several HP2010 objectives that were cited related to this priority need (see Form 16).

The capacity for the State to address this priority need will be possible through a formal collaboration with the Department of Education (see new SPM #2) to promote culturally appropriate physical activity and nutrition in schools. This would be especially possible through the Coordinated School Health Model. /2007/ DPH is pursuing the use of the School Health Program Report Card that will be administered by SDE which is based on CDC's School Health Policies and Programs Survey (SHPPS). The SDE is planning to implement the survey to obtain the data for the Report Card in April 2006 from all public schools, and annually thereafter.//2007// /2008/ DPH was successful in obtaining the survey data from the SDE's School Health Program Report Card & will use these data to report on this SPM.//2008//

6. Increase Access to Pre-conception Education and Parenting

Overall Connecticut's families and children fare well compared to their national counterparts with respect to key national indicators of maternal and child health. Birth rates in Connecticut are lower than national rates; there are proportionally fewer pre-term births; and there are smaller percentages of low birth weight babies. Connecticut children overall are also more likely to receive primary care services, including dental care and other routine and preventive services.

However, there are great disparities in many of the key health indicators between certain segments of the state's population, particularly between teens and adult populations and White (non-Hispanic) majority and minority populations. The causes of some of these disparities are linked to poverty, racism, and other societal problems but many of the disparities are also clearly linked to lack of proper pre-conception education, parent education, and other parenting supports. Young and inexperienced parents, as well as parents with limited knowledge of healthy behaviors and habits, need to have better access to formal, quality pre-conception and parenting education programs.

This priority need directly relates to NPM 18, with a focus on the women under age 20 years,

since it was identified that the teen population was a disparate group needing particular attention, as well as race and ethnic disparities. There were three HP2010 objectives identified from the Maternal, Infant and Child Health chapter (see Form 16).

CT could address this priority need by: identifying and promoting the development of quality pre-conception and parent education programs, particularly in the schools and in areas where there are high rates of teen births; developing and disseminating culturally appropriate educational materials and curricula geared to teens and young adults; tracking the number of teens and young adults who receive quality pre-conception and parent education in schools and in other community settings; and promoting provider training and education programs geared to encouraging brief pre-conception counseling and parenting education and referral to community-based educational programs.

/2008/ DPH is partnering with the HHD on their CDC/CityMatCH TA grant to address preconception care. An RFP will be issued for case management services for pregnant women (and teens) in July 2007. This new program is expected to include parenting classes./2008//
/2010/ The Case Management for Pregnant Women Program is a new program to provide comprehensive, integrated case management services during the perinatal and interconception periods to pregnant and post partum teenagers and women and their partners in an effort to improve birth outcomes. The program includes parenting classes and has developed a draft curriculum for pregnant women and their partners about prenatal care and early attachment./2010//

7. Promote access to family support services including respite care and medical home system of care for Children and Youth with Special Health Care Needs

According to data collected by the SLAITS survey there could be as many as 118,000 children with special health care needs living in CT. A number of agencies in the State assist CYSHCN and their families by providing and facilitating family support services including respite care. The two major agencies are DPH and the Department of Mental Retardation (DMR). Great strides have been made to identify and serve families with CYSHCN in the state, particularly families with young children but there are still many families who struggle and efforts need to be made to: 1) improve access to family support and respite care, 2) increase the overall service capacity and the resources available for home and respite care, and 3) support families who have trouble identifying respite providers.

This priority need has three NPMs that relate to the need to increase access to family support services including respite care and the medical home system of care for CYSHCN (NPM #2, #3 and #5). This SPM was developed with the particular focus on assuring that families have access to respite services and the new medical home system of care. There were 3 HP2010 objectives identified related to this priority need (see Form 16) including that have a focus on medical home and service systems for CSHCN.

To address this priority need, the State will use the newly initiated community-based system of care for children and youth with special health care needs. This initiative complements the American Academy of Pediatrics belief that all children should have a medical home where care is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally competent.

Five RMHSCs will be contracted as of July of 2005. Through linkages, the outcome is for the RMHSC to increase the number of children screened and identified with special health care needs in the region by coordinating family support services and respite care, educating health and social service providers on the resources available to families of CYSHCN, collaborating with community-based organizations, colleges and universities in the state, particularly those with training programs for students who want to provide services to CYSHCN; and promoting the development of respite care practicum programs that link students to families who need respite care services.

/2008/ The medical home program is transitioning from a center based approach to a community based approach.//2008//

8. Reduce health disparities especially related to Access to care, Race/ethnicity, and Geographic location. (Specific issues: teen pregnancy, low birthweight, prenatal care, breastfeeding, and infant mortality)

Compared to national statistics, CT residents report good health status overall, however, large health disparities exist between the White population and that of the African American/Black and Hispanic populations within CT. This issue was identified in the last needs assessment conducted four years ago, and remains one that DPH needs to focus efforts. Specifically, lack of access to health care for low income and uninsured populations differs across these populations. Even women with health insurance lack access to mental health, oral health and specialty care services including follow-up procedures and testing due, in part, to high out-of-pocket expenses.

Lack of access to basic needs negatively impacts overall health status of target populations. There are documented delays in seeking care by hidden populations including undocumented, immigrants and refugees. In general, these populations are not seeking routine and preventive care due to both perceived and actual barriers, which contributes to poor health outcomes and a greater burden on the health care delivery system. Significant health disparities are documented with African American/Black and Hispanic populations experiencing dramatically poorer health status. While the overall percent of births to teens has dropped in the last decade, especially among African Americans/Blacks, there remain a greater percentage of pregnancies among these teens when compared to white teens.

While there was no specific SPM developed for this priority need, the goal to reduce health disparities has been incorporated explicitly in two of the SPMs, e.g. the reduction of intentional injuries and infants whose mother received prenatal care in the first trimester. All of CT's MCH programs collect standardized racial and ethnic information of populations they serve with the overarching goal to monitor whether or not these programs are meeting the needs of all sub-populations.

/2008/ The PHI Branch convened an internal Health Disparities workgroup.//2008//

/2010/ The PHI Branch continues to convene an internal Health Disparities workgroup that has completed the "Strategic Plan within the Family Health Section Addressing Low Birth Weight Outcomes and Low Birth Weight Disparities in Connecticut" available at: http://www.ct.gov/dph/lib/dph/family_health/revised_strategic_plan_for_lbwt_021909_final.pdf //2010//

9. Collaborate with the other federal Region I states to develop indicators that measure the collective assets of their early childhood health systems, "specifically focusing on their collective assets regarding child care health consultants (CCHC)."

SPM to be determined. /2007/The language of this performance measure has been formalized by participating Region I states as "Percent of licensed child care centers serving children age birth to five who have on-site health consultation, as defined by the standards in Caring for Our Children: 'Center-based facilities that serve any child under 2 years of age shall be visited at least once a month by a health professional with general knowledge and skills in child health and safety. Center-based facilities that are not open 5 days a week or serve only children 2 years and older shall be visited at least quarterly on a schedule that meets the needs of the composite group of children.'"//2007//

/2008/ This SPM was updated to reflect information that can be obtained from the database. Please refer to the SPMs section//2008//

/2009/ There were no changes to the State Priorities. //2009//

/2010/ FHS is shifting this priority related to health consultants to move toward the proposed measure addressing injury prevention in rural areas. While there were no overt changes to the State Priorities, there have been changes in how we measure progress with

a few of the State Priorities in response to changes in the availability of data. These changes are addressed in more detail within the State Performance Measures narrative.//2010//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	43	56	60	55	77
Denominator	43	56	60	55	77
Data Source					CT DPH Newborn Screening Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	100	100	100	100	100

Notes - 2008

Source: CY2008 CTDPH Newborn Screening Program supplied the percentage of confirmed cases that also received appropriate follow-up. (For more info on CT's newborn screening procedures/data see also the detailed note with Form # 6)

Notes - 2007

Source: CY2007 CT DPH Newborn Screening program supplied the percentage of confirmed cases who also received appropriate follow-up. (For more info on CT's newborn screening procedures/data see also the detailed note with Form 6).

Notes - 2006

Source: CY2006 CTDPH Newborn Screening Program, Family Health Section. Most recent data June 2008.

a. Last Year's Accomplishments

CT met this objective by assuring that 100% of infants screened as positive with condition(s) received follow-up to definitive diagnosis and clinical management. Of the 41,244 (occurrent births) in CT for 2008, 99% received newborn screening (NBS) prior to discharge or within first week of life. All 878 suspect positive results were reported to Regional Treatment Centers and/or primary care physicians for further testing and follow-up. Of these, 77 were confirmed as disease cases and 921 trait cases were identified.

Of 652 cases of unsatisfactory NBS specimens, all but 1 was resolved with receipt of a 2nd specimen. There were 10 CT State Waivers submitted to the lab for refusal of screening due to conflicts with religious tenets. Five families, or 50% who refused screening, later had screens collected at their primary care physicians' office. The tracking staff followed 245 infants with transfusions. Those babies who were transfused prior to the NBS blood test were tracked until a 90-day post-transfusion specimen was collected and tested for Hemoglobinopathies and Galactosemia

NBS Program Laboratory and Tracking staff meets quarterly to discuss data systems challenges, quality assurance, statistical reporting and emerging genetic issues. NBS staff meets quarterly with the Genetics Advisory Committee to discuss current and emerging issues related to NBS; Laboratory protocols, confirmed disorders, potential expansion, consumer concerns and proposed NBS legislative bills.

NBS staff served on regional workgroups including the Department of Public Health Genomics Office (DPH-GO), New England Genetics Collaborative (NEGC), New England Consortium of Metabolic Disorders, New England Regional Genetics Group (NERGG) Board of Directors and the New England Public Health Genetic Education Collaborative (NEPHGEC) funded by HRSA for some of their education projects. The project included the development of Family Health History Tool, piloting and implementation; Region 1 NBS brochure and translation into 15 languages; and their inclusion in a Pilot Project of the NBS Education Tool Kit for 5 Hospitals in each of the New England states. The NERGG and NEPHGEC Co-Chairs were invited and participated in National Conferences to share and serve as a model for other states; discuss how the Public Health Collaborative group evolved; identify program needs; discuss how the group selected projects; and presented the development and implementation plans through project completion.

State Regional Treatment Center Genetic Specialists provided NBS educational programs through grand rounds conferences throughout CT. The University of Connecticut Health Center (UCHC) continues to provide a Pregnancy Exposure Information Services (PEIS) toll-free telephone line to provide information to pregnant women about the effect(s) to the fetus if exposed to toxic or possibly toxic substances during pregnancy. Treatment Centers provide an interim emergency supply of metabolic formulas for newborns identified with metabolic disorders. Treatment Centers receiving MCH funds provide development of treatment plans, genetic counseling, nutritional management and educational support to individuals or families whose gross annual income falls below the poverty level, as defined by the federal government. These services are without charge.

To increase the performance of NBS data systems, the staff has been engineering new data programs with the Laboratory Administration, Family Health Services and the State Department of Information Technology (DOIT), that will become more efficient for our data collection efforts.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participate in the quarterly Genetics Advisory Committee(GAC) meetings				X
2. Work with other groups to provide education on Genetics and NBS		X		
3. Screen all infants for selected metabolic or genetic disorders			X	
4. Refer newborns with abnormal screening results for appropriate services			X	
5. Update educational programs to reflect the expansion of the				X

NBS testing panel				
6. Participate in various State, Regional, and National conferences				X
7. Support families identified with genetic and metabolic disorders		X		
8.				
9.				
10.				

b. Current Activities

DPH ensures early identification of infants at increased risk for selected metabolic or genetic disorders. Nurse Consultants provide TA to the birthing facilities to address the changes in the 2008 Laboratory NBS Guidelines for Birthing Facility and the Clinical and Laboratory Standards Institute, and address the importance of data entry, maternal clinical conditions affecting NBS results, resources and facility needs and concerns. The Genetics Advisory Committee will transition to a governing body to advise and direct the NBS staff in it's testing, tracking and treatment practices to assure definitive diagnosis and clinical management for infants with confirmed disorders.

NBS staff participate on Region I activities including the NEGC; NERGG Board of Directors; NEPHGEC Newborn Screening Education Tool Kit Pilot Project to 5 Hospitals in each state in Region I that include NBS Brochures in 15 languages; Updating the NERGG, Inc. website, CT resources and links; and updating of the New England Genetic Resource Directory that was translated into Spanish. This year's activity included application guideline, development for the Innovative Grants.

c. Plan for the Coming Year

CT will assure that infants are screened for genetic disorders, adding other selected metabolic or genetic disorders to the screening panel when appropriate. All newborns with abnormal screening results will continue to be referred to State Regional Treatment Centers for comprehensive testing, genetic counseling & education, and treatment services so that medical treatment can be promptly initiated.

Quality improvement reviews (findings from TA sessions) will be conducted to assure that all newborns are screened in a timely and accurate manner to enable prompt identification of disorders and referrals to State Regional Treatment Centers for confirmation testing, treatment, education, counseling and follow-up services.

NBS staff will work collaboratively with the Genetics Advisory Committee (GAC), the specialty treatment centers, and others in the development and implementation of educational materials and programs, especially for the birthing facilities. DPH will enhance its website with additional information and explore other opportunities for web-based educational programs. NBS staff will continue to participate and collaborate on the implementation of the CT Genomic Action Plan.

Staff will participate in the HRSA grant awarded to the NEGC. CT DPH will collaborate with the NEGC and will seek other funding opportunities to address the program's genetic, and NBS short-term follow up for infant and children's treatment needs and family care concerns. Staff will also participate on the New England Consortium of Metabolic Disorders Group, the NERGG and various other New England projects and programs.

The Laboratory Newborn Screening Program may be migrating the Newborn Screening Data System into new Public Health Information Network (PHIN) MAVEN software. Should this migration move forward, the benefits to NBS include: updated operating system and databases; reduction of costs (hardware, software & IT support) to maintain the data system; and the reduction of data information silos within the DPH by taking advantage of shared platform

capabilities. The PHIN platform promises to be a more stabilized environment that offers the latest technologies for support and data recoverability.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	59.8	59.8	59.8	59.8	59.8
Annual Indicator	59.8	59.8	59.8	57.8	57.8
Numerator					
Denominator					
Data Source					National Survey of CSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	59.8	59.8	59.8	59.8	59.8

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2007

The data reported in 2006 are from the most recent national SLAITS Survey. CT has no updates to the national SLAITS Survey data, as reported previously, for national performance measures #2-6.

Notes - 2006

The data reported in 2006 are from the most recent national SLAITS Survey. CT has no updates to the national SLAITS Survey data, as reported previously, for national performance measures #2-6.

a. Last Year's Accomplishments

This measure was not met since there was a 2% decrease from the 2001 SLAITS survey (57.8% in the 2005-06 SLAITS vs. 59.8% in 2001 SLAITS). CT, however, does remain slightly higher than the national figure of 57.4%.

Connecticut's System of Care for CYSHCN, "The Connecticut Medical Home Initiative for Children and Youth with Special Health Care Needs" (CMHI), was fully implemented and provided a community based, coordinated system of care for children and families. Contractors provided services to 5,931 CYSHCN in the following categories: administration of extended services and respite funds, medical home care coordination, provider and family education, outreach and family support.

Child Health and Development Institute (CHDI) and their subcontractors the Family Support Network provided the provider and family education, outreach and family support components of CMHI; together with the University of Connecticut, worked with pediatric primary care settings and families to survey knowledge regarding medical home and/or assistance with establishing or linking with medical homes. Highlights from "Medical Home Surveys: Primary Care Practices and Parents", July 2008, University of Connecticut, showed that primary care practice respondents were more likely to use informal mechanisms of partnering with families, rather than focus groups or family advisory groups and that care coordination was most often done as needed, without a formal mechanism. The parent survey indicated that approximately half of the respondents stated their child's doctor has no staff person to assist with referrals or to help find services.

The Family Support Network (FSN) expanded the level of support, information, referral and networking available to families throughout CT. The FSN hosted a forum on November 13, 2008 in Waterbury, "Supporting Children with Special Health Care Needs and Families in a Medical Home". The importance of family/professional partnership was emphasized and more than 150 people attended the forum from across the state.

Families participated and were compensated for their work on the Medical Home Advisory Council. Eight family representatives served as voting members of the Medical Home Advisory Council and established three workgroups including a Family Experience workgroup. DPH provided stipends to assist families to participate on either Council and/or work group activities, and teleconferencing was available. The Family Experience Workgroup requested and received feedback from families on all National Performance Measures, which highlighted success and barriers to care for Connecticut CYSHCN, including the need for additional family-centered and community based care coordination services.

Families were active members of the legislated Family Support Council, CT Lifespan Respite Coalition and Family Voices. DPH compensated families to review CT's Title V MCH Block Grant and invited families to submit written comments on the MCHBG application. The Family Support Council list serve provided information about local and statewide services and was utilized to provide creative solutions for needed services and support. A family member was nominated and awarded a family scholarship to the Association of Maternal and Child Health Programs (AMCHP) National Convention in Washington D.C. The DPH Family Advocate was sponsored by DPH to attend the national conference as well.

DPH partnered with key stakeholders to respond to a Health Resources Services Administration (HRSA) grant for a second level of funding for the CT Family-to-Family Health Information Network. The project builds upon the accomplishments of the existing Network and assists families and providers in navigating public and private health care financing service delivery systems and in developing appropriate strategies and policies to improve these systems.

DPH monitored, enhanced and revised the statewide respite system available through CMHI. DPH distributed the Get Creative About Respite manual through community activities, and disseminated more than 1,200 copies of Directions: Resources for Your Child's Care, an information organizer that includes sections on medical home and connecting parents and families (in English, Spanish and Portuguese) -- available in hardcopy and electronically through the DPH website.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Encourage families to participate in family forums, CMHI meetings, Medical Home Advisory Council, Block Grant review,				X

Family Support Council and meetings as appropriate				
2. Support families to participate through training and mentoring and compensate for time and knowledge				X
3. Provide trainings for families on statewide and local supports, link families to existing trainings and other resources				X
4. Have families provide training for all stakeholders and encourage sharing lessons learned				X
5. Assure families from diverse backgrounds are involved				X
6. Distribute family surveys		X		
7. Assure establishment and growth of family/professional partnerships				X
8. Provide families with tools such as "Get Creative About Respite" and "Directions"		X		
9.				
10.				

b. Current Activities

The DPH supports and enhances a family-centered medical home concept through the Child Health and Development Institute (CHDI) and their subcontractors, and the Family Support Network (FSN) provide statewide outreach and culturally competent education to pediatric primary care providers and families on the concept of medical home for CYSHCN.

Family support services include providing assistance and culturally appropriate education to families of CYSHCN that will enable them to acquire skills necessary to access medical and related support services and become empowered, competent supporters for their children.

FSN enhances the level of support, information, referral and networking available to families. The FSN hosted a forum on May 7, 2009 in Cromwell, "Supporting Children with Special Health Care Needs and Families in a Medical Home". The importance of family/professional partnership was emphasized and more than 150 people attended the forum from across the state.

DPH promotes partnering of families in decision making for CSHCN. Activities include but are not limited to: compensation for families reviewing the Title V Maternal and Child Health Block Grant application, invitation for families to comment at MCHBG public hearings or focus groups, distribution of the "Get Creative About Respite" and "Directions: Resources for Your Child's Care" manuals.

The DPH Family Advocate is available to the public and all MCH programs within DPH.

c. Plan for the Coming Year

A request for proposal has been made to identify a contractor to continue the provider and family outreach and education component of the CT Medical Home Initiative for CYSHCN for three years with a new focus on Family/Professional Partnership. Family/Professional partners will provide training to families in linking to resources, and will work in partnership with primary care providers.

DPH will work with key stakeholders including the following family and consumer agencies: CT-KASA (Kids As Self Advocates), Parent to Parent of CT, Parents Available to Help (PATH), and Family Advocacy for Children's Mental Health, Inc. (FAVOR) on a collaborative project organized through the HRSA State Implementation Grant for Integrated Community Systems for CYSHCN focusing on transition, with a primary outcome to improve access to a statewide comprehensive, community based, family-centered system of care of CYSHCN and their families. The project, entering its second year, will promote family-centered care by strengthening the partnership

between families and primary care providers in medical homes.

Families will be active members of the Medical Home Advisory Council (MHAC) and the MHAC work groups, Family Experience, Quality Indicators, Finance, and Sustainability, the legislated Family Support Council, CT Lifespan Respite Coalition and Family Voices. Families will be compensated for their time through stipends for all MHAC meetings and workgroups.

DPH will participate as an active member of the CT Family-to-Family Health Information Network to assist families and providers in navigating the public and private health care financing service delivery systems and to develop appropriate strategies and policies to improve these systems.

DPH will promote the partnering of families in decision making for CSHCN. Activities will include compensation for families to review CT's Title V Maternal and Child Health Block Grant (MCHBG) application, invitation for families to comment at the MCHBG public hearings or focus groups, distribution of the "Get Creative About Respite" and "Directions: Resources for Your Child's Care" manuals, provision and support of an Access database to manage and report information on CYSHCN, and partnership in the Family-to-Family (F2F) Health Information Network management team.

The database will also manage and report data on CYSHCN. The system will allow DPH to collect information from families to support CYSHCN program surveillance, planning and evaluation.

DPH will identify grant funding to assist in the building of a strong family/professional partnership in CT. A family support group for families with children who are hearing impaired will be organized through the Early Hearing Detection and Intervention program.

The DPH Family Advocate will be available to all MCH Programs within DPH, the CMHI, and family support groups throughout the state.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	56.9	56.9	56.9	56.9	48.5
Annual Indicator	56.9	56.9	56.9	48.5	48.5
Numerator					
Denominator					
Data Source					National Survey of CSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	48.5	48.5	48.5	48.5	48.5

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Annual performance objectives for 2009-2013 were updated using this more recent data.

Notes - 2007

The data reported in 2006 are from the most recent national SLAITS Survey. CT has no updates to the national SLAITS Survey data, as reported previously, for national performance measures #2-6.

Notes - 2006

The data reported in 2006 are from the most recent national SLAITS Survey. CT has no updates to the national SLAITS Survey data, as reported previously, for national performance measures #2-6.

a. Last Year's Accomplishments

This objective was successfully met using a comparison of the CT 56.9 % versus the national 47.1 % reported in the 2005-2006 SLAITS

Connecticut's system of care for CYSHCN, "The Connecticut Medical Home Initiative for Children and Youth with Special Health Care Needs" (CMHI), was fully implemented and provided a community-based, culturally competent, coordinated system of care for children and families. Contractors provided services to 5,931 CYSHCN in administration of extended services and respite funds, medical home care coordination, provider and family education, outreach and family support.

DPH provided technical assistance for medical home care coordination. CMHI contracts with the Hispanic Health Council, St. Mary's Hospital, Stamford Health System, Coordinating Council for Children in Crisis, Inc., and United Community and Family Services, Inc. Care coordinators were co-located and imbedded in a variety of pediatric practice settings (hospital based primary care clinics, community health centers, private family and pediatric practices) and worked in partnership with clinicians and families in accessing services and resources. Care coordination activities included: assessment, care planning, home visits, family advocacy, linkage to specialists, linkage to community based resources, coordination of health financing resources, and coordination with school based services. These services were provided statewide through 26 medical homes.

DPH supported an Access database to manage and report data on CYSHCN. The system allowed DPH to collect information from families and medical home based care coordinators to support CYSHCN program surveillance, planning and evaluation.

The DPH Medical Home Advisory Council (MHAC), comprised of more than 30 representatives from state agencies, community-based organizations and parents of CYSHCN, served to provide guidance to DPH in its efforts to improve the system of care for CYSHCN by ensuring their connection to a medical home. DPH staff facilitated and attended all MHAC meetings.

The MHAC established four workgroups to address specific areas of concern. The Family Experience Workgroup focused on educating and informing families on topics such as the MCH Block Grant National Performance Measures and strategies for advocacy. The Quality Indicators workgroup developed process as well as outcome based measures to improve the quality of care coordination in medical homes. The Finance Workgroup explored strategies to increase and maximize funds and resources for CYSHCN on a state systemic level. The Sustainability Workgroup worked to strengthen, expand and sustain a statewide medical home model for

CYSHCN through development of care coordination standards of practice, policy development and education. DPH participated in all MHAC workgroup meetings and co-chaired the Family Experience, Quality Indicators and Finance Workgroups.

DPH was awarded the HRSA State Implementation Grant for Integrated Community Systems for CYSHCN. The project allowed numerous state and private sector agencies to become connected to the medical home infrastructure existing through CMHI. These included: Connecticut Youth Leadership Project, Inc./Kids As Self Advocates (CT-KASA), Parents Available to Help, Inc. (PATH)/ Family Voices of CT, Family Advocacy for Children's Mental Health (FAVOR, Inc.), Epilepsy Foundation of Connecticut, State Department of Education/Bureau of Special Education (SDE/BSE), and Department of Social Services Bureau of Rehabilitation Services (DSS/BRS). Several lead agency members as well as a number of families served by each of these agencies received a detailed training on medical home and care coordination. Working relationships between CMHI medical home care coordinators and agency lead staff were established.

DPH staff presented "The Medical Home Model in Connecticut: An Approach to Service Provision and Parent-Professional Partnerships and Bringing Care Coordination and Family Support to Families Within the Medical Home Model" at the annual Together We Will Conference. The presentation provided an overview of medical home and the implementation of medical home as the model of service provision in Connecticut. More than 400 early childhood educators and service providers attended the conference.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement, monitor and evaluate CT Medical Home Initiative				X
2. Assist the CT Medical Home Initiative with expanding the medical home provider network				X
3. Work with CT Medical Home Initiative and the Family Support Network to facilitate family-professional partnerships				X
4. Participate on Medical Home Advisory Council and workgroups				X
5. Provide families with tools such as "Get Creative About Respite" and "Directions"		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DPH ensures successful implementation of the CT Medical Home Initiative for CYSHCN through technical assistance, training, and support of an Access database used to manage and report data. Biweekly CMHI conference calls are held to address technical assistance needs, and to ensure collaboration and communication between CMHI contractors.

Care coordination services have been expanded to include co-located or imbedded care coordination services to 32 medical homes. A projected 7,000 CYSHCN will receive care coordination services through CMHI this year.

Contractors have been identified through a request for proposal to continue the current community based care coordination model of services for a further three years. A kick off

meeting for the continuation was held on June 10, 2009. New expectations that included an emphasis on care planning and the provision of technical assistance in building care coordination capacity on the part of medical home practice staff were reviewed.

In response to a legislative mandate and in consultation with the Medicaid managed care organizations administering the HUSKY A Plans, DPH is implementing a medical home pilot program in three sites located in Hartford, Stamford and Waterbury. The goals of the pilot are to increase EPSDT services and build care coordination capacity in order to enhance health outcomes for children, including children and youth with special health care needs.

c. Plan for the Coming Year

The Medical Home Advisory Council (MHAC) will further improve the system of care for CYSHCN, including progress made through workgroups. The Sustainability Workgroup will finalize a "care coordination standards of practice" document to be shared with a Learning Collaborative organized through the Implementation Grant for Integrated Community Systems for CYSHCN. This document, together with a revised Medical Home Training Academy curriculum, will be used to train care coordinators and recruit medical home providers. DPH will attend all MHAC and workgroup meetings.

CMHI will provide community-based, culturally competent, medical home care coordination services. Medical home care coordination contractors will include: Connecticut Children's Medical Center (for the North Central area of the state), Stamford Health System (Southwest), Coordinating Council for Children in Crisis (South Central), United Community and Family Services, Norwich (Eastern), and St. Mary's Hospital (Northwest). The number of CMHI medical homes is expected to expand to 37, and a projected 7,500 CYSHCN will receive care coordination services next year.

DPH will provide technical assistance to CMHI contractors through site visits, biweekly conference calls, and bi-annual meetings of the entire CMHI. Quarterly regionally based meetings will be held with CMHI contractors, Family Support Network staff, Child Development Infoline case coordinators, and Child Health and Development Institute staff to share information and case scenarios to ensure access to community based resources, and to improve referrals and access to the CMHI.

DPH will support the Access database to manage and report data on CYSHCN. The system will allow information from families and medical home based care coordinators to support CYSHCN program surveillance, planning and evaluation.

DPH will collaborate with the Department of Social Services in implementing two Primary Care Case Management (PCCM) pilot programs and will promote access to PCCM as an alternative to the Medicaid Managed Care plans as the pilot is implemented statewide. In PCCM, patients choose a PCP who agrees to provide them with primary care services and case management. This includes identifying a person who is responsible for patient care management and conducting an initial risk assessment and developing a care plan approved by the patient. DPH staff will participate on the Medicaid Managed Care Council's PCCM subcommittee. CMHI will work collaboratively with PCCM to avoid duplication of services, share resources, promote the medical home model, and maximize care coordination capacity in pediatric practice settings.

The legislatively mandated medical home pilot program will be completed. A report will be prepared for the General Assembly reflecting the outcome of implementing a medical home model on increasing EPSDT services and building care coordination capacity in three sites.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	61.3	61.3	61.3	61.3	61.7
Annual Indicator	61.3	61.3	61.3	61.7	61.7
Numerator					
Denominator					
Data Source					National Survey of CSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	61.7	61.7	61.7	61.7	61.7

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Annual performance objectives for 2009-2013 were updated using this more recent data.

Notes - 2007

The data reported in 2006 are from the most recent national SLAITS Survey. CT has no updates to the national SLAITS Survey data, as reported previously, for national performance measures #2-6.

Notes - 2006

The data reported in 2006 are from the most recent national SLAITS Survey. CT has no updates to the national SLAITS Survey data, as reported previously, for national performance measures #2-6.

a. Last Year's Accomplishments

This objective was successfully met as evidenced by the reported 2005-06 61.7% vs. the 2005 SLAITS 61.3%.

Connecticut's System of Care for CYSHCN, "The Connecticut Medical Home Initiative for Children and Youth with Special Health Care Needs," was fully implemented and provided a community based, culturally competent, comprehensive, accessible, coordinated system of care for children and families. Contractors provided services in the following categories: administration of extended services and respite funds, medical home care coordination, provider and family education and outreach. All three included facilitating access to adequate public and/or private insurance to pay for services families needed.

The medical home care coordination and the extended services and respite fund administration contractors provided benefits coordination for families of CYSHCN to assist in accessing public/private sources to pay for services needed including the facilitation of eligibility

determination and application for Healthcare for Uninsured Kids and Youth (HUSKY). Under HUSKY, children and youth up to age 19 receive a comprehensive health care benefits package, including preventive care, physician visits, prescriptions, vision care, dental care, physicals, mental health/substance abuse services, durable medical equipment, emergency and hospital care. The Connecticut Lifespan Respite Coalition, the contractor for the management of Extended Services and Respite funds, provided assistance to families in accessing existing insurance benefits and assisting in the process of filing appeals when claims are denied. More than \$35,000 in denied claims were recovered on appeal on behalf of families, and an additional \$35,000 in claims were accessed through secondary insurances (often carried by non-custodial parents).

DPH staff represented Connecticut's Public Health Commissioner at the Connecticut Medicaid Managed Care Council. The Medicaid Managed Care Council was established as a collaborative body consisting of legislators, Medicaid consumers, advocates, health care providers, insurers and state agencies to advise the Department of Social Services (DSS) on the development and implementation of Connecticut's Medicaid (HUSKY Part A) and SCHIP (HUSKY Part B) Managed Care program and for ongoing legislative and public input in the monitoring of the program. The Council has a legislative mandate to assess and make recommendations to the DSS concerning access to and implementation of the HUSKY program.

The number of participants in the Katie Beckett Waiver remained at 200. The Katie Beckett Waiver enables severely disabled children to receive an institutional level of care at home and bases eligibility for Medicaid on income and assets without counting the income and assets of legally liable relatives (parents).

A daylong forum was held on March 27, 2008 in New Haven for medical home care coordinators and families associated with the Medical Home Initiative for CYSHCN. The Department of Social Services Bureau of Rehabilitation Services (DSS/BRS) and the Department of Developmental Services (DDS) presented information concerning eligibility requirements for supports and services available, including eligibility for Medicaid and waiver programs. Eligibility and application for the Katie Beckett Waiver was emphasized and information pertaining to undocumented citizens was presented -- including eligibility information specific to children of legal citizenship status whose parents are undocumented.

A forum on the topic of financial estate and trust planning was held for families of CYSHCN on May 8, 2008 in Glastonbury. The forum included information concerning ongoing access to private insurance.

A Family-to- Family Health Information forum was held on October 2, 2008 in Meriden. Information and resources available through Title V, public insurance resources, and private insurance information for CYSHCN was presented.

A Family Support Network (FSN) forum was held on November 13, 2008 in Waterbury with a focus on Supporting Children with Special Health Care Needs and families in a Medical Home. Presentations included the role of the medical home care coordinator extending to the coordination of health financing resources, including insurance. Resource materials concerning HUSKY eligibility and application, and the Katie Beckett waiver were distributed to all attendees.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assess family's insurance status		X		
2. Provide education on benefits/services provided by insurance/other programs				X
3. RMHSC and Medical Homes identify CYSHCN and provide		X		

care coordination including access to private/public insurance				
4. Coordinate with HUSKY Infoline		X		
5. Work with Medicaid Managed Care Council and DSS to ensure CYSHCN population is identified, provided all needed services, and providers are reimbursed for identification and care coordination services				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Care coordination contractors provide coordination of health care financing resources, and facilitate access to public insurance. Referrals are made to HUSKY infoline and assistance is given in making application to include filling out application forms.

DSS staff attend DPH Medical Home Advisory Council (MHAC) and MHAC Family Experience workgroup meetings and respond to questions concerning eligibility determination, access, application process, barriers experienced and related issues. They participate in CT Medical Home Initiative for CYSHCN contractors' conference calls to address insurance issues and questions.

DSS is implementing a Primary Care Case Management (PCCM) pilot in two locations. DPH collaborates to facilitate access to PCCM as an alternative to the Medicaid Managed Care plans. DPH staff participate on the Medicaid Managed Care Council's PCCM subcommittee.

A FSN forum was held on May 7, 2008 in Cromwell with a focus on Supporting Children with Special Health Care Needs and families in a Medical Home. Presentations included the role of the medical home care coordinator extending to the coordination of health financing resources. Resource materials concerning HUSKY eligibility and application, and the Katie Beckett waiver were distributed to attendees.

c. Plan for the Coming Year

The DPH Title V Children and Youth with Special Health Care Needs Program will integrate and improve access to a quality, comprehensive, coordinated, community-based system of care for children and youth with special health care needs within a medical home. Requests for proposal have been made and contractors identified to continue the current community based medical home care coordination model of services for five years.

To address the public and private insurance needs of Children and Youth with Special Health Care Needs, the DPH Title V CYSHCN Program is planning to integrate and improve of strategies for CYSHCN and their families in accessing public/private sources and to continue assisting families with eligibility determination and application for HUSKY A and B. A training session as part of a contract grantees kick off meeting for the CT Medical Home Initiative for CYSHCN is planned for June 10, 2009. Training will be provided by HUSKY Infoline and DSS staff and will include information on eligibility, access and referrals. Additional information concerning PCCM will be included.

The Connecticut Lifespan Respite Coalition, the contract grantee for the management of Extended Services and respite funds, will provide assistance to families in accessing existing insurance benefits and in the process of filing appeals.

The DPH will facilitate access to Primary Care Case Management (PCCM) as an alternative to the Medicaid Managed Care plans currently offered under HUSKY and encourage increased participation in the PCCM model, based on results of the pilot. DPH will collaborate with DSS and provide technical assistance as PCCM is implemented statewide. DPH staff will continue to participate on the Medicaid Managed Care Council and it's PCCM subcommittee.

Additional educational forums, focusing on continuous updates on insurance options and accessing public/private sources to pay for services, will be held for families and professionals who work with CYSHCN. A request for proposal has been made to identify a contractor to continue the Provider/Family outreach and education component of the CT Medical Home Initiative for CYSHCN with a new focus on Family/Professional Partnership. The contractor identified will develop and provide training to families including curricula on accessing public and private insurance.

Connecticut DPH and DSS representatives will attend the Medical Home Advisory Council and the Family Experience workgroup meetings and respond to issues concerning eligibility determination, access, application process and related issues. DSS staff will participate in CT Medical Home Initiative for CYSHCN contractors' conference calls to address specific insurance issues and questions.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	76.8	76.8	76.8	76.8	89.4
Annual Indicator	76.8	76.8	76.8	89.4	89.4
Numerator					
Denominator					
Data Source					National Survey of CSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	89.4	89.4	89.4	89.4	89.4

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Annual performance objectives for 2009-2013 were updated using this more recent data.

Notes - 2007

The data reported in 2006 are from the most recent national SLAITS Survey. CT has no updates to the national SLAITS Survey data, as reported previously, for national performance measures #2-6.

Notes - 2006

The data reported in 2006 are from the most recent national SLAITS Survey. CT has no updates to the national SLAITS Survey data, as reported previously, for national performance measures #2-6.

a. Last Year's Accomplishments

This objective was successfully met using a comparison of the CT 89.4% vs. the national 89.1% reported in the 2005-2006 SLAITS. Connecticut's System of Care for CYSHCN, "The Connecticut Medical Home Initiative for Children and Youth with Special Health Care Needs" (CMHI), was fully implemented and provided a community based, coordinated system of care for children and families. Contractors provided services to 5,931 CYSHCN in the following categories: administration of extended services and respite funds, medical home care coordination, provider and family education, outreach and family support.

Five medical home network contractors provided care coordination services statewide as follows: Stamford Health System serving Southwest CT; St. Mary's Hospital (Northwest CT); United Community & Family Services (Eastern CT); Coordinating Council for Children in Crisis (South Central CT); and Hispanic Health Council (North Central CT). Each network contractor affiliated with and provided imbedded care coordination for numerous clinical sites. Care coordination was co-located in 26 pediatric practices, making care coordination services easier to access for families.

DPH actively advanced the family-centered medical home concept and care coordination for CYSHCN in Connecticut. Together, these ensured that community-based service systems were organized so CYSHCN and their families can use them easily. Central to this system was the development of coordinated care plan templates for use by medical homes with their CYSHCN. Care coordination contractors provided training and technical assistance in the use of these care plans.

The Child Health and Development Institute and the University of Connecticut Center for Excellence in Developmental Disabilities developed, distributed and collected family surveys to acquire information on the care that CYSHCN received from their pediatrician or primary care provider including provision of information about community-based service systems. Survey results were utilized to design trainings to promote learning methods of linking with community-based supports.

CHDI and its subcontractors provided statewide outreach and culturally effective education for pediatric primary care providers and families on the concept of medical home. CHDI and the Family Support Network provided statewide outreach and culturally effective education to 10 pediatric primary care providers and 756 families on the concept of medical home for CYSHCN including information regarding accessing community service systems. Family support services provided assistance and culturally effective education for families of CYSHCN. This enabled families to acquire the skills necessary to organize their access to needed medical and related support services.

DPH collaborated with United Way of CT 2-1-1/Child Development Infoline (CDI) to coordinate referrals to the community-based system. CDI - CMHI/CYSHCN contractor meetings took place to monitor, evaluate and improve referral to the care coordination system of care for CYSHCN. CDI served as a statewide entry point to CMHI.

CT Lifespan Respite Coalition (CLRC) is the DPH contractor managing approval of applications for distribution of Department approved extended service funds and respite funds. Respite and

extended services were accessible directly through CLRC, referral from the medical home care coordinators, or through referral from CDI. CLRC served as an additional statewide entry point to CMHI.

DPH maintained public/private partnerships with organizations serving CYSHCN and their families. DPH staff participated on legislated councils, including the CT Family Support Council, Medicaid Managed Care Council, Birth to Three Interagency Coordinating Council, State Department of Education Bureau of Special Education (SDE/BSE) Transition Task Force, and National Governor's Award Task Force on Transition of Youth with Disabilities to Work. CMHI access information was distributed among these partners as well as to partners involved in the State Implementation Grant for Integrated Community Services for CYSHCN. These additional partners included SDE/BSE, Department of Social Services/Bureau of Rehabilitative Services, CT Kids As Self-Advocates, Epilepsy Foundation, Parents Available to Help, and FAVOR (family behavioral health advocacy organization).

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement, monitor and evaluate CT Medical Home Initiative for Children and Youth with Special Health Care Needs				X
2. Implement, monitor and evaluate referral and coordination of services system with United Way of Connecticut 2-1-1 Infoline/Child Development Infoline				X
3. Develop and release requests for proposals to expand the medical home concept throughout Connecticut				X
4. Work with contractors to survey families regarding access to community-based service systems				X
5. Develop trainings to enhance families ability to access community-based service systems				X
6. Enhance public/private partnerships with agencies and organizations serving CYSHCN and their families				X
7. Implement recommendations from Medical Home Advisory Council strategic planning process				X
8.				
9.				
10.				

b. Current Activities

DPH ensures successful implementation of the CT Medical Home Initiative for CYSHCN through technical assistance, training and support of an Access database used to manage and report data. Care coordination services have been expanded to include co-located or imbedded care coordination services to 32 medical homes. CDI and CLRC serve as statewide access points. A projected 7,000 CYSHCN will receive care coordination services through CMHI this year.

A request for proposals has been made, and contractors identified to continue the current community based care coordination model of services for a further five years.

Through this community-based system of care, DPH and its contractors: reach more CYSHCN and their families to assist them with coordination of the multiple systems of care they need to access; provide training and support to pediatric primary care providers (PCPs) to improve quality of care by addressing family needs that optimize the health of CYSHCN; assist PCPs with care coordination for CYSHCN who have high severity needs; assist with coordination between PCPs and specialists; and promote the establishment of medical homes with pediatric PCPs that care

for CYSHCN.

CMHI care coordination contractors survey families regarding their access to community-based service systems. Survey results are utilized to monitor and evaluate the community-based system of care to determine if CYSHCN are receiving coordinated, comprehensive care in their local communities.

c. Plan for the Coming Year

DPH will monitor and expand services available through CMHI. The goals of this community-based system of care are: 1) reach more CYSHCN and their families and assist them with coordination of the multiple systems of care they need to access; 2) provide training and support to pediatric primary care providers (PCPs) to improve quality of care by addressing family needs that will optimize the health of CYSHCN; 3) assist pediatric PCPs with care coordination for CYSHCN who have high severity needs; 4) assist with coordination between pediatric PCPs and specialists; and 5) promote the establishment of "medical homes" with pediatric PCPs that care for CYSHCN.

The system will focus on increased availability of medical homes for CYSHCN and their families/caregivers; improved care coordination; technical assistance to medical homes; forums for parent/care-giver interaction through parent/care-giver networks; improved parental/care-giver support, partnership and respite services; and increased stakeholder oversight and involvement through the Connecticut Medical Home Advisory Council.

CMHI will provide community based, culturally competent, medical home care coordination services. Medical home care coordination contractors will include: Connecticut Children's Medical Center, (for the North Central area of the state), Stamford Health System (Southwest), Coordinating Council for Children in Crisis (South Central), United Community and Family Services, Norwich (Eastern) and St. Mary's Hospital (Northwest). The number of CMHI medical homes is expected to expand to 37, and a projected 7,500 CYSHCN will receive care coordination services next year. Child Development Infoline and CLRC will serve as statewide points of access for CMHI. A contractor identified through a request for proposal will provide Family/Professional Partnership training and support to providers and families including assistance in accessing CMHI and community based resources. Quarterly regionally based meetings will be convened with participants from DPH, the Family Support Network, CDI, CLRC, CMHI locally based care coordinators, and others, to facilitate access to the system and services available to CYSHCN and their families.

Additional partners will be engaged through the State Implementation Grant for Integrated Community Systems for CYSHCN, including the Department of Children and Families. Information pertaining to access to services will be shared with new partners.

DPH will expand dissemination of Directions: Resources for Your Child's Care. This family information organizer is available in hard copy and electronically. It includes sections on accessing the system of services, medical home, health plan information, emergency preparedness, transition, and connecting parents and families. DPH, in partnership with a community-based organization, implemented translation of Directions into Spanish and Portuguese and identified community networks to assist with dissemination.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	5.8	5.8	5.8	5.8	43.3
Annual Indicator	5.8	5.8	5.8	43.3	43.3
Numerator					
Denominator					
Data Source					National Survey of CSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	43.3	43.3	43.3	43.3	43.3

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Adjustments to the annual performance objectives were made for 2009-2013 because of the wording changes to this measure. Adjustments used CT's 2007 figure which is higher than the national % for this measure.

Notes - 2007

The data reported in 2006 are from the most recent national SLAITS Survey. CT has no updates to the national SLAITS Survey data, as reported previously, for national performance measures #2-6.

Notes - 2006

The data reported in 2006 are from the most recent national SLAITS Survey. CT has no updates to the national SLAITS Survey data, as reported previously, for national performance measures #2-6.

a. Last Year's Accomplishments

This measure was successfully met (CT 43.3% vs. national 41.2%).

DPH CYSHCN program staff emphasized the importance of healthcare transition in the lives of young adults as a member of the State Department of Education Bureau of Special Education Transition Task Force. The task force supports the SDE in promoting positive postsecondary outcomes in education, training, employment and independent living for students with disabilities. DPH's membership has raised awareness of task force members to the importance of YSHCN being healthy and ready to work. The task force initiated development of a website to assist young adults with disabilities in locating transition resources available through Connecticut state agencies and community-based organizations.

The CT DPH Title V CYSHCN Program was awarded the HRSA State Implementation Grant for Integrated Community Systems for CYSHCN. Goals of this three year project are: 1) build system

capacity to successfully transition adolescents and young adults with complex health needs and/or disabilities to all aspects of adulthood; 2) nurture linkages between healthcare specialists, educational services, vocational services, out-of-home care, family support, public and private payers to ensure community services are organized and easy to use; and 3) promote family-centered care by strengthening partnerships between CYSHCN and families/caregivers with primary health care providers in medical homes.

Grant activities included the development of formal agreements with state agencies and community-based organizations to promote system capacity building and interagency collaboration. These partners include: CT Dept of Social Services/Bureau of Rehabilitation Services (DSS/BRS), State Dept of Education/Bureau of Special Education (SDE/BSE), Epilepsy Foundation of CT, CT Youth Leadership Project/CT-KASA (Kida As Self Advocates), Family Advocacy for Children's Mental Health and Parent to Parent/Family Voices of CT.

CT DSS/BRS and SDE/BSE initiated plans for statewide training programs for agency staff on the importance of health in achieving successful transition of YSHCN to all aspects of adulthood. On April 7 and April 8, 2009, The State Education Resource Center (SERC), in collaboration with Connecticut's State Departments of Public Health, Social Services, and Education, and the Bureaus of Rehabilitation Services and Special Education Services provided a workshop for youth and their families, educators, school nurses, guidance counselors, and state and local agency representatives to help youth and their families achieve successful transition into the adult world. More than 50 care coordinators and transition coordinators from these agencies attended the two-day workshop. Keynote speakers included Patti Hackett, M.Ed and Ceci Shapland, RN, MSN of the Healthy and Ready to Work National Resource Center (HRTW).

CT DPH Medical Home Advisory Council (MHAC) initiated efforts to extend membership to YSHCN. CT-KASA is now an integral member of MHAC in addition to their role in the State Implementation Grant for Integrated Community Systems for CYSHCN.

DPH care coordination contractors routinely identified and linked CYSHCN and their families/caregivers to multiple services including healthcare, educational, vocational, respite, recreational, durable medical equipment, and social services. DPH contractors also provided transition planning and coordination services to YSHCN and their families/caregivers. DPH staff and care coordinators associated with the Connecticut Medical Home Initiative for CYSHCN partnered with state agency regional offices to distribute transition resources to YSHCN and their families/caregivers. These resources included: Building A Bridge From School to Adult Life for Young Adults with Disabilities in Connecticut, and Transition Planning for Adolescents with Special Health Care Needs and Disabilities.

A YSHCN user-friendly link was added to the DPH website. The website offers information which links the user with national, state and local groups committed to successful YSHCN transition.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identify youth with special health care needs			X	
2. Identify and strengthen relationships with schools, community-based organizations and State Agencies				X
3. Provide children and families individualized transition packets		X		
4. Identify and provide training for adult health care providers interested in serving YSHCN transitioning to adult health care				X
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities

On May 21, 2009, DPH hosted "Keeping the Balance: Children and Youth with Special Healthcare Needs, Families and Professionals Functioning Effectively as a Team". The theme of this day and evening conference was transition and included presentations from Dr. Dale Atkins, Ceci Shapland, Dr. Jaideep Talwalker, and CT KASA youth. The day and evening sessions were well attended, the more than 150 attendees included participants from healthcare, education, mental health, vocational services, the Department of Corrections, juvenile justice, the Department of Children and Families, the Department of Developmental Services, community-based organizations, caregivers, families, and YSHCN.

DPH staff and HRSA State Implementation Grant for Integrated Community Systems for CYSHCN project partners are actively identifying primary care physicians and specialists to provide healthcare services for YSHCN in support of YSHCN transition to adult medical care. Providers are offered participation in the CT Medical Home Learning Collaborative and receive medical home EPIC (Educating Practices in the Community) training.

DPH staff participate on the newly formed Coordinated School Health Interagency Workgroup in addition to the SDE/Bureau of State Education Transition Task Force.

Community based, medical home care coordinators associated with the Connecticut Medical Home Initiative for CYSHCN (CMHI) provide comprehensive services including transition planning by age 14.

c. Plan for the Coming Year

The CT Title V Youth Transition Coordinator (a full time position recently established) will coordinate and implement activities consistent with the goals of the State Implementation Grant for Integrated Community Systems for CYSHCN.

The CT Medical Home Training Academy Curriculum (CMHTAC) will be revised to include a module emphasizing successful transition of YSHCN to all aspects of adult life, including healthcare, work, and independence. The new transition module will be available for primary care providers and others interested in serving CYSHCN and their families/caregivers in the process of transitioning to adult healthcare and will include a transition resource manual. The curriculum will be available to providers for individual or group professional presentations and will be used to engage providers in the CT Medical Home Learning Collaborative.

DPH staff and CMHI care coordinators will expand efforts to identify, recruit and educate pediatric/adolescent/family practice primary care providers interested in providing successful healthcare transition services for YSHCN and their families/caregivers. These providers will be encouraged to consider becoming medical homes for CYSHCN and their families and will receive EPIC and medical home training. DPH staff, CMHI care coordinators, and HRSA State Implementation Grant for Integrated Community Systems for CYSHCN project partners will expand efforts to identify and recruit adult medicine providers to serve YSHCN and to facilitate transition to adult healthcare services.

DPH will further cultivate relationships with other state and community based agencies. These collaborations will be used to further develop a strategy across state and other agencies to address youth transition, including the transitioning of CYSHCN from pediatric to adult health care and related services.

DPH will partner with the Department of Developmental Services and the Developmental Disabilities Council through a Memorandum of Agreement in support of a statewide developmental disabilities youth leadership event planned for September 2009. The event will provide training to engage youth with developmental disabilities to become active in self-advocacy. Data collected from event participants will be incorporated into the MCHB five-year needs assessment.

A formal agreement will be developed through the HRSA State Implementation Grant for Integrated Community Systems for CYSHCN to engage the Department of Children and Families as a project partner.

Youth directed input from CT-KASA will be incorporated into website improvements to ensure that the DPH youth link is a relevant resource for YSHCN and their families. CT-KASA will be formally involved in MHAC meetings.

DPH and the CT Comprehensive Sickle Cell Consortium will repeat the media awareness campaign "Face of Sickle Cell" incorporating feedback from a survey and evaluation of the original campaign. Plans include production of a radio PSA in Spanish.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	91.4	92.8	88.2	88.6	89
Annual Indicator	92.4	87.8	81.8	86.7	78.7
Numerator	79216	74327	67594	71449	67885
Denominator	85732	84655	82633	82372	86258
Data Source					CDC Website
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	89.4	89.8	89.8	90.2	90.2

Notes - 2008

Source: See website: www.cdc.gov/vaccines/stats-surv/nis/tables/0708/tab03_antigen_state.xls
 CDC NIS data Q3/2007-Q2/2008 survey for 4:3:1:3:3:1 ((4 or more doses of diphtheria and tetanus toxoids and acellular pertussis vaccine, 3 or more doses of poliovirus vaccine, 1 or more doses of MMR vaccine, 3 or more doses of Haemophilus influenzae type b vaccine, 3 or more doses of hepatitis B vaccine, and one or more doses of varicella vaccine). The birth cohort for the Q3/2007 – Q2/2008 NIS data includes children born July 2004 – January 2007. Children in the 2007 NIS were born during July 2004 – January 2007, so there is considerable overlap in the months of birth of children included in the 2007 and Q3/2007 – Q2/2008 NIS data. CT's ranking

for the first time dropped significantly from prior years to 13th overall nationally among the states. Denominator represents 2008 CT Population Projections, projected population estimates for ages 0-18 years projected from 2000 census figures. The numerator is not an actual #, but a synthetic estimate based on the percentage derived from the National Immunization Survey Sampling data of children with DOB 7/04-1/07.

*Possible explanation as to why CT's coverage rate dropped may be attributed to the NIS survey sample size for CT. This NIS data for families surveyed in CT was based only on 185 children (prior yrs the sample size was at 350+). With a relatively small sample size the wide confidence intervals is a sign of relatively less precision. It's more important to look at CT's NIS data over time to get an accurate read on changes in childhood coverage rates. Also, NIS vaccination coverage estimate is based on the provider-verified responses from children who live in households with telephones (over 25% population does not have land phones). Our registry data provides a more accurate picture regarding childhood immunization coverage rates for CT children. Immunization coverage rate for children born in 2005 was 83% for 4:3:1:3:3:1 series, which represents 35,111 children or 84% of the 41,575 births recorded in CT.

Notes - 2007

Source: See website: www.cdc.gov/vaccines/stats-surv/nis/tables/07/tab03_antigen_state.xls
CDC NIS data Q1/2007-Q4/2007 survey for 4: 3: 1: 3: 3:1 (4 DTaP, 3 Polio, 1MMR, 3 Hib, 3 Hep B and 1 varicella). CT ranks among the top 4 states for immunization success rate. Denominator represents 2008 CT Population Projections, projected population estimates for ages 0-18 years projected from 2000 census figures. The numerator is not an actual #, but a synthetic estimate based on the percentage derived from the National Immunization Survey Sampling data of children with DOB 1/04-7/06. Starting with the 2005 NIS, the series 4:3:1:3:3:1 became the standard measure for national Healthy People 2010 reporting.

Notes - 2006

Source: The NIS survey measurement changed in 2005 to capture varicella (chicken pox vaccine coverage). In 2005, for Immunization Performance measure, we still reported data from the NIS survey for the 4:3:1:3:3 coverage rate (4 DTaP, 3 Polio, 1MMR, 3 Hib and 3 Hep B). In 2006, the benchmark for childhood immunization coverage that the National immunization Survey (NIS) measured added varicella vaccine to the list of vaccines. The 2006 benchmark became 4:3:1:3:3:1 with inclusion of varicella to the series. The addition of varicella resulted in a drop off in coverage rates. However based on this new standard, CT nationally still ranked 3rd in the country last year among all fifty states.

There is no indication that family fears regarding vaccines and autism has had any impact on these coverage rates.

a. Last Year's Accomplishments

CT did not meet the annual objective in 2008. In 2008, CT's ranking for the first time dropped significantly from prior years to 13th* overall nationally among the states. Possible explanation as to why CT's coverage rate dropped may be attributed to the NIS survey sample size for CT. This NIS data for families surveyed in CT was based only on 185 children (prior yrs the sample size was at 350+). With a relatively small sample size the wide confidence intervals is a sign of relatively less precision. It's more important to look at CT's NIS data over time to get an accurate read on changes in childhood coverage rates. Also, NIS vaccination coverage estimate is based on the provider-verified responses from children who live in households with telephones (over 25% population does not have land phones). However, based on this years NIS data, we met the Healthy People 2010 goal for universally recommended vaccines among young children aged 19-35 months with 90% coverage for 4 DTaP, 3+Polio, 1+MMR, 3+Hib, 3+Hep B, 1+Var and 3+PCV. A number of Title V funded and non Title V programs promote age appropriate immunizations.

The Immunization Program was also unable to successfully launch a web-based registry application to replace our current DOS based system in 2008. The vendor was unable to deliver a functional system to be deployed to CT's hosting environment. As of June 2008, termination

process with existing vendor was initiated for failure to deliver functional application after several bug fixes. We did not meet our goal of deploying a new system and bringing 25% of pediatric providers on-line and 95% actively using the new web-based registry (CIRTS -- CT Immunization Registry and Tracking System) to input immunizations real-time for all of their patients under age six by the beginning of 2009.

Right From The Start, Comadrona, Healthy Start and Healthy Choices for Women and Children provided case management to pregnant women and their children, monitored, encouraged and educated parents regarding the importance of keeping well child care visits. The programs assessed immunization status and linked children with primary care providers to maintain up-to-date immunizations. All Community Health Centers follow national guidelines for administration of childhood immunizations. Chart reviews are used to assure that infants and children are in compliance.

The CYSHCN program assessed children for required immunizations and referred them to appropriate resources. Care coordination is used to support families in accessing services.

The WIC Program encouraged parents and caregivers to obtain well childcare and referred participants to eligible programs. The CT WIC certification form includes a check-off box for the health care provider to indicate if the child is up-to-date on immunizations, which then enables the WIC nutritionist to reinforce the importance of obtaining missed immunizations.

The Immunization Program provided funding to support the Connecticut Immunization Registry and Tracking system (CIRTS) and 14 contractors to conduct immunization activities, procure and distribute publicly funded childhood vaccines. Contractor activities consisted of: performing clinic immunization assessments to monitor immunization coverage rates for preschool children; coordinating and providing outreach and referrals for children identified by CIRTS who are behind in their immunizations; conducting immunization education campaigns that are culturally appropriate for pregnant women, new parents, and new immigrants; and provide training and support to medical providers who utilize the CIRTS.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor infants and children for compliance with immunization schedules	X			
2. Outreach and identify infants and children for up to date immunizations		X		
3. Provide support, information and linkage to necessary services		X		
4. Procure and provide publicly purchased vaccines		X		
5. Provide funding and technical support to health care providers to improve childhood immunization levels				X
6. Provide WIC check box to identify up to date immunization status			X	
7.				
8.				
9.				
10.				

b. Current Activities

The Immunization Program plans provides funding to support the Connecticut Immunization Registry and tracking system (CIRTS) and 14 contractors to conduct

immunization activities, procure and distribute publicly funded childhood vaccines. Contractor activities consist of: performing clinic immunization assessments to monitor immunization coverage rates for preschool children; coordinating and providing outreach and referrals for children identified by CIRTS who are behind in their immunizations; conducting immunization education campaigns that are culturally appropriate for pregnant women, new parents, and new immigrants; and provide training and support to medical providers who utilize the CIRTS.

All Title V programs (CYSHCN, case management programs for pregnant women) assess the immunization status of the infants/children and refers them as necessary to their medical home/primary care provider for any needed immunizations. Those without a designated primary care provider are referred to community health centers.

c. Plan for the Coming Year

The immunization program will 1) assess and monitor immunization rates including HEDIS (Health plan Employer Data and Information Set) immunization rates for children enrolled Medicaid Managed Care; 2) continue efforts in 2009-10 to build a web-based registry application by exploring possibility of using Maven Immunization Registry product developed by Consilience; 3) convene local advisory/planning groups in all 14 Immunization Action Plan funded sites to improve immunization services for children in high risk areas; 4) partner with community organizations, coalitions, businesses and public and private professional and civic organizations to promote childhood immunizations and vaccine safety; and 5) strive to achieve the Healthy People 2010 goal of enrolling > 95% of children under age six in our immunization registry.

The case management programs for pregnant women (and their children), will ensure that the children are current with their immunizations and refer to the medical home/primary care provider as necessary to ensure compliance.

Efforts will also begin to migrate the CT Immunization Registry Tracking System (CIRTS) to the Maven application. This migration will provide CIRTS the availability to updated state-of-the-art software and hardware that has already been completed for the Newborn Screening Program. It will facilitate the use of common reference tables used by these programs and enhance the quality of data as cross-reference of information will be possible between programs.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	14	12.9	12.8	12.3	12.2
Annual Indicator	12.8	12.3	12.3	12.0	
Numerator	917	909	914	885	
Denominator	71623	74155	74323	74029	
Data Source					DPH Vital Statistics
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	
	2009	2010	2011	2012	2013
Annual Performance Objective	11.9	11.9	11.8	11.8	11.7

Notes - 2008

The CY2008 Vital Statistics data are not available.

Notes - 2007

Source: The CY2007 Vital Statistics data are final. The 2005 and 2006 annual objective fields are "locked in" and will not allow us to change the objective to reflect our most recent experience. If we were able to change these fields we would have modified the objective for 2005 to read 12.8 and for 2006 to read 12.3.

Annual performance objectives for 2009-2013 were updated using this more recent data.

Notes - 2006

Source: The CY2006 Vital Statistics data are final. The 2005 and 2006 annual objective fields are "locked in" and will not allow us to change the objective to reflect our most recent experience. If we were able to change these fields we would have modified the objective for 2005 to read 12.8 and for 2006 to read 12.3.

Annual performance objectives for 2008-2012 were updated using this more recent data.

a. Last Year's Accomplishments

CT successfully met this measure with a slightly lower rate (12.0) than the annual performance objective of 12.3. The 2005 and 2006 annual objective fields are "locked in" and will not allow us to change the objective to reflect our most recent experience. If we were able to change these fields we would have modified the objective for 2005 to read 12.8 and for 2006 to read 12.3. Note the Annual Performance Objectives for 2009-2013 have been updated based on the most recent data with the hope that the trend toward decreasing the rate continues.

One major focus of last year's activities was the provision of continuing education opportunities to key stakeholders, especially on subjects related to best practices in teen pregnancy prevention, counseling, and asset-based approaches to engaging youth in health promoting behaviors. A SBHC APRN was offered a scholarship to attend a multi-day conference focused on reproductive health. In collaboration with the John Snow Institute (JSI), a workshop was held in May 2007 entitled, "Best Practices in Teen Pregnancy Prevention -- Designing, Promoting and Evaluating Programs that Work." Approximately 75 participants attended. JSI continued to provide TA to certain attendees who desired to move forward with efforts to support a community-based approach in the prevention of teen births. In efforts to reach non-traditional partners promote positive youth development, two workshops were also held in May to disseminate information on communication strategies that build public support for healthy youth development. Glynis Shea, Communications Coordinator from the Konopka Institute, presented. Over 75 individuals attended representing: health care providers, educators, faith based organizations, the Department of Labor, insurance companies, and many youth service organizations - including Park and Recreation Departments. The event offered networking opportunities for groups that traditionally do not work together on a day-to-day basis.

Collaboration continued with one of our key partners, State Department of Education (SDE). Planning focused on many major initiatives designed to prevent teen births in the state. Plans commenced to develop a workshop on science based approaches to teen pregnancy prevention. The target audience will be school health practitioners and educators. In addition, the Connecticut National Stakeholders Team met in February with AMCHP. During this TA visit, the CT Action Plan was revised. The Plan will help to drive future initiatives of the Stakeholder Team. In addition, the Department continued its partnership with SDE to promote the Coordinated School Health Model to school systems. The adolescent health coordinator continued to serve as a resource on issues related to teen pregnancy prevention both within the Agency as well as to

community providers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide risk assessments and referrals for reproductive health services			X	
2. Implement teen pregnancy prevention programs		X		
3. Collaborate with traditional and non traditional teen pregnancy prevention partners				X
4. Develop curriculum for addressing adolescent paternity for at-risk youth				X
5. Convene the interagency adolescent workgroup				X
6. Provide education opportunities to key stakeholders on best practices in teen pregnancy prevention and youth development				X
7. Establish an "Implementation Team" to address reproductive health and sexuality strategic issues identified as a priority in the State Adolescent Health Plan (activities will promote teen pregnancy, STD, and HIV prevention)				X
8.				
9.				
10.				

b. Current Activities

A 2-day conference: Making The Connections: Creating Partnerships to Develop and Implement Comprehensive Sexuality Education, was held in October. Target audience included school health educators, administrators, nurses and local community based partners. In partnership with the CT Chapter of the AAP, a teleconference is planned for September for health care practitioners and office staff on how to incorporate positive youth development into routine health care practices. Each SBHC site was given a new 3rd edition of the Bright Futures guides.

Two goals were met from the Perinatal State Health Plan: DPH provided funding to DSS for a Region I Fatherhood Conference and MCHB technical assistance funds have been secured to work with Real Dads Forever to develop a prenatal attachment curriculum for fathers, including teens.

Funds from Right From the Start and Comadrona programs were merged and an RFP was submitted for a new case management program for pregnant women that will also address teen pregnancy. The program that was selected to provide services in the New Haven area will primarily focus on teens and is housed in one of the High Schools.

DPH is on the statewide Collaborative on Adolescent Paternity made up of 7 state agencies targeting young males in DCF care. A Rites of Passage Program featured an all day conference, a wilderness experience, and a daylong discussion on fatherhood. One goal was for participants to make an informed choice on when to become sexually active.

c. Plan for the Coming Year

FHS staff will provide technical assistance and professional development to SBHC staff as they provide health education, risk assessments and referrals for reproductive health services. A new survey tool was developed to assist SBHCs in providing data for this Performance Measure. The SBHC Yearly Report now has questions specifically asking what activities address the following:

teen pregnancy prevention, oral health, intentional and unintentional injury, access to health insurance, access to services in the SBHC and violence.

FHS staff will support professional development opportunities for both traditional and non-traditional partners to increase their capacity to utilize science- based approaches in teen pregnancy prevention.

The National Stakeholder team as well as the Coordinated School Health Program teams will be utilized to plan, implement and evaluate initiatives to support strategies outlined in the CT Action Plan (promoting teen pregnancy, STD and HIV prevention efforts). An awareness campaign targeting parents/grandparents to promote youth development will be implemented. Collaboration will continue with JSI and SDE to sponsor a teleconference targeting school nurses on the topic of Skilled Birth Attendants to teen pregnancy prevention.

Title V supported programs such as Healthy Start, Healthy Choices for Woman and Children, and the new case management program for pregnant woman will provide case management to pregnant women, including teens (both female and male).

The statewide Collaborative on Adolescent Paternity will design a second Rites of Passage program for next year. FHS staff will be an active member of DCF's Adolescent Paternity Workgroup.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	30	30	30	12	38
Annual Indicator	26.0	26.0	11.4	38.0	18.0
Numerator	357	357	2984	1687	4276
Denominator	1374	1374	26171	4440	23747
Data Source					CT Dept. of Social Services SCHIP Division
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	34	36	38	40	42

Notes - 2008

Source: 2008 Annual Indicator for dental sealants was the CT Department of Social Services SCHIP Division. As in 2006 reporting the denominator represents all 8 and 9 year olds enrolled in SCHIP and the numerator represents all 8 and 9 year olds who received dental sealants.

Notes - 2007

Source: The Office of Oral Health developed an oral health status report of children in Connecticut based on the results from oral health basic screening survey (Every Smile Counts)

conducted in the 2006- 2007 school year of Head Start, kindergarten and third grade children. Only 38% of the third graders had dental sealants.

Note: The Annual Performance Objectives were updated beginning with 2008 based on the more recent data. The annual performance objectives were all set to 38% since it is unknown when the screening survey will be repeated. This objective was unable to be updated for 2007 since TVIS has this field locked.

Notes - 2006

Source: CT Voices for Children SFY06, HUSKY A population. Projections were made based on this data even though this data may not be representative of the population as a whole. Data from the state survey conducted this year should be available for next year's report.

a. Last Year's Accomplishments

This measure was not met, however, the changing data source is problematic in getting a consistent measurement. As a result of the 2007 Legislative Session, the Office of Oral Public Health is now a mandated Office within the Department of Public Health (DPH). The Office is charged with coordinating and directing state activities with respect to state and national dental public health programs; serve as the department's chief advisor on matters involving oral health; and planning, implementing and evaluating all oral health programs within the department.

The Office of Oral Health (OOH) developed an oral health status report of children in Connecticut based on the results from oral health basic screening survey (Every Smile Counts) conducted in the 2006- 2007 school year of Head Start, kindergarten and third grade children. A total of 9,364 were screened to assess their oral health status, in particular, the presence and severity of tooth decay (dental caries) and preventive dental sealants. The report states that while the prevalence of tooth decay has declined in some children, dental caries remains a significant public health problem for Connecticut's children, particularly those who are low income and minority. The highest level of dental disease and the lowest level of dental sealants were found in minority and low-income children. Only 38% of the third graders had dental sealants.

OOH was the recipient of a HRSA grant to develop a statewide infrastructure that will increase early childhood oral health interventions. The goals of the "Home by One" Program include: increased coordination and exchange of oral health information with early childhood services, developing oral health advocates, training non-dental providers on oral health interventions, expand the number of dental homes for children including those with special health care needs and promoting dental visits by age one

OOH prepared a report of the status of oral health in Connecticut in 2007. The Oral Health in Connecticut Report reflected the most current Connecticut data available regarding oral health in the state. Oral health status, risk and protective factors, workforce and access to oral health care were components of the Report.

The Office of Oral Public Health had worked in collaboration with a wide variety of stakeholders to develop a Connecticut Oral Health Improvement Plan. In June 2007, the Office co-sponsored a statewide oral health conference called "Sharing the Vision", to introduce the Connecticut State Oral Health Improvement Plan 2007-2012. This plan is the result of widespread community input and the work of diverse group of stakeholders throughout Connecticut, Connecticut Coalition for an Oral Health Plan, (CCOHP), who met for over two years to develop goals and objectives to address dental care access issues and improve the oral health of all Connecticut residents. Over 140 people from various disciplines attended the conference, including educators, medical providers, social service providers, dental advocates and dental professionals.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service
------------	--------------------------

	DHC	ES	PBS	IB
1. Develop a strategic plan for enhancing DPH data and information systems to improve the monitoring of dental sealants' prevalence.				X
2. Continue OPENWIDE training of non-dental providers.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The "Home by One" program has been established and has had several achievements during its first year of implementation. To date, 13 "dental home networks", consisting of a general dentist, pediatric dentist and pediatrician have been established within the communities that are serviced by WIC programs to ensure a dental home is established, and to increase collaboration/communication between the medical and dental providers for WIC children in the state.

Over 300 childcare providers have been trained in oral health preventive strategies, including fluoride varnish application throughout Connecticut. In addition, 100 WIC nutritionists and other health and social services providers have been trained on the importance of early childhood oral health and age one dental visits.

DPH was the recipient of a \$1.25 million five-year grant/cooperative agreement from the Centers for Disease Control and Prevention for State-based Oral Disease Prevention Programs and infrastructure development for the Office of Oral Health.

DPH received a \$25,000 grant from the National Association of Chronic Disease Directors to address the oral health issues of older adults in the state and is in the process of developing a strategic plan to implement goals and objectives identified by the Office of Oral Health's Task force on Oral Health for Older Adults to improve the oral health and overall health of CT's elderly residents.

c. Plan for the Coming Year

OOH plans on concentrating a great deal of its activities it's two major initiatives, "Home by One" and the CDC cooperative agreement. Through the Home by One program, the Office will continue to develop the statewide infrastructure that will increase early childhood oral health interventions. The training modules for the child health providers, dental professionals and WIC staff will be made available through web-based curriculums which will be developed and offered on "CT-Train", an online learning resource provided by DPH.

The CDC cooperative agreement identifies 8 core activities the office of oral health program should include. These activities include appropriate staffing for the office, collaborations with partners both inside and outside of state agencies, a state oral health plan, community water fluoridation, a statewide oral health coalition, school based dental sealant programs, surveillance and an evaluation component. While several of these activities are already underway, such as a state oral health plan, strong partnerships within DPH and others and a mandate that any community water system that serves over 20,000 people fluoridate their water supply, the Office plans on: developing a statewide dental sealant program, a statewide oral health coalition that meets the requirements of the CDC, conducting a training session for community water operators

on the benefits of water fluoridation, conduct surveillance on the oral health status of older adults in CT, as well as a survey of the oral health status and BMI of third graders and kindergarten students. All of these activities will have an evaluation component.

In addition, OOH will work with the WIC program identified through an RFP process in the state to demonstrate the effectiveness of a dental hygienist being on site at a WIC program. The hygienist will provide oral health education and information to staff and parents and oral health preventive services when practical. In addition, the hygienist will work to increase the awareness of age one dental visits, establish dental homes in the community and create referral systems to these dental homes by age one. The program will be required to monitor and report on the number of WIC parents and children receiving oral health education and information as well as the number of children who actually had a dental visit by age one.

OOH will also develop training modules to supplement the curriculum developed to train non-dental care providers on oral health issues and preventive practices to include prenatal and geriatric oral health. This curriculum called "OPEN WIDE" has been identified as a best practice by the Association of State and Territorial Dental Directors and has been modified by the MCH Oral Health Resource Library as an online curriculum.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	0.7	0.9	1.5	1.4	1.3
Annual Indicator	1.9	1.6	0.8	1.5	
Numerator	13	11	5	10	
Denominator	691876	682998	665901	668663	
Data Source					No Vital Statistics data available
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2009	2010	2011	2012	2013
Annual Performance Objective	1.2	1.1	1	0.9	0.9

Notes - 2008

CY 2008 data are not available.

Notes - 2007

Source: CT Dept. of Public Health, HISR, CY 2007 final Vital Statistics.

The annual performance objectives are locked and although we saw a dramatic decrease in the 2006 rate, the 2007 rate returns to a similar magnitude seen in 2005. There for the single year data point in CT 2006 appears to be an outlier.

Notes - 2006

Source: CT Dept. of Public Health, HISR, CY 2006 final Vital Statistics.

The annual performance objectives are locked and although we see a dramatic decrease in this rate, we are unable to adjust the annual performance objectives .

It may also not be prudent to change the annual performance objectives as this single year data point in CY 2006 may be an outlier.

a. Last Year's Accomplishments

This measure was not met in 2007. In 2006, there were 5 deaths due to motor vehicle crashes among children aged 14 years and younger, for a rate of 0.7 per 100,000 in 2006. This figure is suspected to be an outlier as there were 10 deaths due to motor vehicle crashes among children aged 14 years and younger in 2007. Unfortunately this magnitude is more in line with that from years prior to 2006 and results in a rate of 1.5 per 100,000. Connecticut addresses this National Performance Measure through Title V and non-Title V programs and collaborations that provide activities designed to reduce deaths and non-fatal injuries due to motor vehicle crashes.

The Injury Prevention Program, using MCHBG funding, developed a contract with Safe Kids Connecticut. Safe Kids conducted 15 child passenger safety workshops for families, healthcare, childcare and community service providers. These workshops covered selection of appropriate child restraint systems based on age and size of child, importance of correct use and relevant state laws. The workshops served approximately 266 adults and 310 children. Family Workshops targeted low-income families and provided booster seats to those who needed them. Workshops were spread geographically throughout the state. Communities included Waterbury, North Haven, New Haven, New Milford, Shelton, New London, Danbury, Derby, Torrington, East Hartford, and Killingly. Workshops were held at a variety of sites including a community health center, hospitals, community/neighborhood centers, Head Start/Early Head Start, an elementary schools, a domestic violence shelter, a Boys & Girls Club and an Early Education Center.

Through this contract, Safe Kids also conducted one 4-day Child Passenger Safety (CPS) Technician Training Course. This leads to national certification as a CPS technician, which is strongly recommended for anyone who is providing car seat education and installation programs.

The Injury Prevention Program participated in several initiatives lead by the CT Department of Transportation that impact motor vehicle injuries and deaths among children including the CT Safe Routes to School and state Pedestrian-Bicycle Advisory Committees and the Traffic Records Coordinating Committee.

Through the Preventive Health and Health Services Block Grant Local Health Allocation, DPH provided funding to local health departments to address community identified health needs. One local health department chose to use this funding for motor vehicle injury prevention activities last year.

The Injury Prevention Program provided technical assistance on motor vehicle injury related issues to units within DPH, individuals, and community-based programs.

The CT CODES (Crash Outcome Data Evaluation System) Project completed linkage of 3 years of police crash reports and hospital/ED data. The National Highway Traffic Safety Administration funds this project. CODES data was analyzed for seat belts/child seats and teen drivers. Results were incorporated into DPH testimony in support of stricter teen driving laws.

The Injury Prevention Program provided staff support to the Governor's Task Force on Teen Driving, which was co-chaired by the DPH Commissioner. Enhanced teen driving legislation was passed during 2008.

The Program published the "Injury in Connecticut" data book, which presents five years of injury mortality and hospitalization data and includes a section on motor vehicle injuries. This

information was posted on the DPH website.

Comadrona, HCWC and RFTS provided referrals and linkages so that infants and children served are properly secured when riding in a motor vehicle. CHCs, as EPSDT providers, provided age appropriate risk assessments to children and/or caregivers, anticipatory guidance and injury prevention information related to motor vehicle safety.

SBHC professionals routinely offered motor vehicle safety information to students in the form of one-on-one meetings as well as group sessions.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide technical assistance, resources, and funding to support to motor vehicle injury prevention activities				X
2. Provide linkages to motor vehicle injury prevention resources		X		
3. Provide screening, risk assessment and anticipatory guidance in Title V funded programs	X			
4. Provide guidance and support for policy development regarding motor vehicle related mortality in children				X
5. Participate in statewide coalitions and collaborations addressing motor vehicle injury prevention through public and professional education, policy change and system enhancements				X
6. Utilize injury-related data to guide planning for state and community based programs and policy development				X
7.				
8.				
9.				
10.				

b. Current Activities

The Injury Prevention Program (IPP) is contracting with Safe Kids CT to conduct 18 child passenger safety workshops targeting families, healthcare, childcare and community service providers. Two major topics will be booster seat education and transportation safety for "tweens."

The Injury Prevention Program is collaborating with state and local partners including Safe Kids and the CT Dept. of Transportation on motor vehicle injury prevention issues. Initiatives include CT Safe Routes to School and the state Pedestrian-Bicycle Advisory Committees and the CT Department of Motor Vehicles Teen Driver Advisory Committee.

The Injury Prevention Program completed a comprehensive state injury prevention plan, which identifies motor vehicle injury prevention as a priority. The Program is also analyzing additional years (2005-06) of injury related mortality, hospital and ED data.

The CT CODES Project has five consecutive years (2001-2005) of linked motor vehicle crash and hospital/ED data. Additional analysis of teen motor vehicle crash data is being completed.

Through the Preventive Health and Health Services Block Grant Local Health Allocation, DPH continues to provide funding to local health departments to address community identified health needs. Three local health departments are using this funding for motor vehicle injury prevention activities this year.

c. Plan for the Coming Year

The Injury Prevention Program will use CODES and Injury Surveillance system data in the development and support of programs and policies that address the risk factors for motor vehicle injuries among children and adolescents.

The Injury Prevention Program and a Maternal & Child Health representative along with the CT Office of Rural Health will collaborate on the Children's Safety Network's "Keeping Kids Alive" initiative that plans to address the prevention of injuries in rural areas. CSN is also proposing a common State Performance Measure for the Region 1 states regarding this issue. CT will participate in the planning conference calls and meetings to forward this proposal.

DPH funded case management programs for women and children will work more closely with Injury Program staff to enhance activities to reduce the death rate for children age 14 years and under caused by motor vehicle crashes. DPH will identify injury prevention resources for state Healthy Start Programs.

SBHCs will have motor vehicle safety as an integral focus of events and services. Community Health Centers, as EPSDT providers, will continue to provide children and/or their Caregivers age appropriate risk assessments, anticipatory guidance and injury prevention Information related to motor vehicle safety.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			36.8	39	48
Annual Indicator		36.8	38.8	43	42.9
Numerator					
Denominator					
Data Source					CDC National Immunization Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.				Yes	Yes
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	49	50	51	52	53

Notes - 2008

Source: This measure monitors the rate of breastfeeding at 6 months using information from the National Immunization Survey based on the year of the birth cohort. The birth cohort reported is the CY 2005. Webservice: www.cdc.gov/breastfeeding/data/report_card2.htm

Notes - 2007

Source: This measure monitors the rate of breastfeeding at 6 months using information from the National Immunization Survey based on the year of the birth cohort. The birth cohort reported is the CY 2004. CDC's National Immunization Survey results present estimated breastfeeding rates according to the year of the child's birth to facilitate the evaluation of breastfeeding interventions and progress toward the Healthy People 2010 breastfeeding objectives. Webservice: www.cdc.gov/breastfeeding/data/report_card2.htm

Notes - 2006

The prior/retired breastfeeding measure NPM 11 monitored breastfeeding rates at hospital discharge. As of June 2007, CDC's National Immunization Survey results present estimated breastfeeding rates according to the year of the child's birth to facilitate the evaluation of breastfeeding interventions and progress toward the Healthy People 2010 breastfeeding objectives.

Prior to June 2007, CDC presented this breastfeeding information by year of respondent interview as given in the current table.

CT's revised rates using the new methodology as of June 2007 are 40.8% for 2003 and 44.6% for 2004. Using this more recent data, annual performance objectives should be 45.0 for 2005, 46.0 for 2006 and 47.0 for 2007.

Annual performance objectives for 2008-2012 have been updated accordingly.

Webservice: www.cdc.gov/breastfeeding/data/report_card2.htm

a. Last Year's Accomplishments

This measure was not met. The estimated rate of breastfeeding at 6 months of age in CT was 43.0% among infants born in 2004 and 42.9% in 2005 (as reported in 2007 and 2008, respectively), according to the National Immunization Survey (NIS).

A number of activities addressing the recommendations in the 2006 Connecticut Breastfeeding Initiative report and The CDC Guide to Breastfeeding Interventions (CDC, 2005) continued. A July 2008 breastfeeding teleconference for physicians was funded by DPH and co-sponsored with the CT Chapter of the American Academy of Pediatrics (AAP). The teleconference was well received by physicians and other health professionals. A second teleconference was held in November 2008. DPH provided resources to Title V case management programs for pregnant women (HCWC, Healthy Start, Comadrona, RFTS) and informed them of continuing education opportunities. DPH also continued to provide English/Spanish breastfeeding information sheets for the packets mailed to all new mothers by the Immunization Program. In celebration of World Breastfeeding Week in August, DPH again displayed a prominent banner outside of the State Office Building.

The DPH Breastfeeding Coordinator presented on breastfeeding at the Childhood Obesity Forum co-sponsored by DPH and the CT Commission on Children in November 2008. She also presented to the CT Public Health Association's health education committee and to AmeriChoice, one of CT's Medicaid Managed Care Plans.

DPH continued to be actively involved with the CT Breastfeeding Coalition (CBC), participating in monthly meetings and serving on the Board of Directors and conference committee. The DPH Breastfeeding Coordinator also served on the committee that developed CBC's successful application to become one of the first 10 state coalitions to receive funding from HRSA to implement The Business Case for Breastfeeding worksite lactation initiative.

The WIC Program continued to partially fund the Breastfeeding: Heritage and Pride (BHP) breastfeeding peer counseling program that is jointly administered by the Hispanic Health Council and Hartford Hospital. WIC funds were identified to replicate the program at Yale-New Haven Hospital during FY 2009. The DPH Breastfeeding Coordinator chairs a statewide WIC Breastfeeding Committee that comprises WIC Breastfeeding Coordinators from each local WIC Program. The WIC Program maintains an inventory of electric breast pumps that are issued to eligible women who are returning to work or school.

The breastfeeding initiation rate among WIC infants in CT increased to 62.8% and the 6-month duration rate was 24.4%, based on data submitted to the Pediatric Nutrition Surveillance System in 2008. However, both rates continue to fall below the HP 2010 targets.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Attend and participate in the monthly CBC meetings				X
2. Identify and track breastfeeding data sources to further build infrastructure				X
3. Promote provider and consumer education and awareness through training and education				X
4. Implement recommendations of provider survey and consultant analysis of disparities in breastfeeding rates in African American women as appropriate				X
5. Promote and support the WIC Breastfeeding Peer Counseling Program		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The CBC's 10/08 conference attracted 150 attendees. CBC completed all of the requirements for The Business Case for Breastfeeding worksite initiative pilot. The DPH Breastfeeding Coordinator prepared CBC's Final Report in collaboration with the project's Co-Coordinators. CBC continues to promote this initiative. A half-day training for local WIC Programs was co-sponsored with the CBC in October 2008.

The consumer flyer to promote breastfeeding duration is distributed to all new mothers in the state. DPH co-sponsored a second breastfeeding teleconference in collaboration with the CT Chapter AAP on 11/6/08 and a third teleconference is scheduled for 6/11/09. DPH provides education, support and referrals to mothers to initiate & maintain breastfeeding. The DPH Breastfeeding Coordinator presented to the case managers working with one of DPH's contractors for the PN Case Management Program in May 2009.

The WIC Program fully funded the DPH Breastfeeding Coordinator position during FY 09. WIC continues to partially fund the Hartford-based Breastfeeding: Heritage and Pride (BHP) breastfeeding peer counseling program, and the replication of the program at Yale-New Haven Hospital is underway. The YNHH BHP Program will serve a largely African American population. All local WIC nutrition staff had the opportunity to attend two in-state breastfeeding conferences and WIC is funding the 45-hour Certified Lactation Counselor course in New Haven in August 2009.

c. Plan for the Coming Year

All DPH perinatal health programs will provide or refer clients to breastfeeding support services as integrated in their case management activities. A wide array of breastfeeding promotion and support activities will continue to be implemented by the WIC Program statewide. A consultant will assist the WIC Program in implementing the USDA Loving Support: Building Breastfeeding Competencies for Local WIC Staff training program in Connecticut in the Spring of 2010.

DPH will participate in monthly meetings of the CBC, as well as Board of Directors and committee meetings, as appropriate. World Breastfeeding Week and CT Breastfeeding Awareness Month activities will be planned and implemented. Consumer education materials will be distributed via the Immunization Program's hospital discharge packets and other appropriate vehicles. DPH will continue to participate in the implementation of The Business Case for Breastfeeding and collaborate with the CT Chapter AAP on physician education.

Additional resources will be sought to continue to implement the recommendations in the 2006 Connecticut Breastfeeding Initiative report, in an effort to address racial and ethnic disparities in breastfeeding rates and to improve access to breastfeeding information and support for all families.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	99.9	98.2	99	99.1	99.2
Annual Indicator	98.0	98.9	99.0	99.1	99.4
Numerator	41696	41696	41744	41889	40672
Denominator	42545	42142	42186	42266	40930
Data Source					CT DPH Early Hearing Detection and Intervention Pr
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	99.3	99.4	99.5	99.6	99.6

Notes - 2008

Source: CT DPH Early Hearing Detection and Intervention Program. Universal newborn hearing screening was implemented in CT on 7/1/00.

Notes - 2007

Source: CT DPH Early Hearing Detection and Intervention Program. Universal newborn hearing screening was implemented in CT on 7/1/00.

The 2007 denominator is provisional data from Vital Records as obtained in April 2009.

Notes - 2006

Source: CTDPH, CY2006 Final, E.H.D.I. Program, Family Health Section

a. Last Year's Accomplishments

This measure was met for CY 2008. CT hospitals have electronically reported newborn screening (hearing, bloodspot, and birth defects) data to the DPH since 2002. The Newborn

Screening System has been linked to the Electronic Vital Records System (EVRS) since 2006. The Newborn Screening electronic reporting system will be replaced by a secure, web-based application compliant with CDC Public Health Information Network published standards. From 8/07-11/07, DPH staff worked with an outside contractor to develop use case specifications for the Newborn Screening System.

The Early Hearing Detection & Intervention (EHDI) Program's goal is to identify infants with hearing loss as early as possible in order to minimize speech/language and other delays by linking them to early intervention services. The EHDI Program has a proactive tracking and follow-up system in place to ensure: all babies are screened at birth, those who do not pass receive timely diagnostic follow-up, and those diagnosed with a hearing loss are enrolled in early intervention. Bi-monthly reports are sent to hospitals to obtain missing screening results. In an effort to reduce lost to follow-up after an infant fails to pass the newborn hearing screening, letters are sent to the mother and primary care provider (PCP) of any child who does not pass the hearing screen and for whom DPH does not have a diagnostic audiological evaluation documented. Follow-up phone calls are made to the child's family and PCP in an effort to determine if audiological testing is scheduled and/or has been conducted. EHDI staff is in regular communication with audiology centers regarding children who were referred from newborn hearing screening. CT's lost to follow-up rate was 16/3% in 2007.

Enrollment into early intervention (EI) is confirmed for each newborn diagnosed with a hearing loss. The CT EHDI Advisory Board was instrumental in encouraging the CT Birth to Three System (IDEA, Part C) to expand their eligibility requirements to include children with mild and/or unilateral hearing loss. The proposed budget option to expand eligibility was approved by the Governor, and took effect 7/1/07. In 2007, 85% of infants diagnosed with a hearing loss and referred to EI were eligible and subsequently enrolled in Birth to Three.

In 9/07, the DPH sponsored a conference for hospital newborn screening staff titled, "Maternal and Child Health Public Health Initiatives." The agenda included education on the EHDI Program, the Birth Defects Registry, laboratory newborn screening, the Birth to Three System, lead exposure risks, child passenger safety, and perinatal depression.

The EHDI Program, in collaboration with the CT EHDI Advisory Board, developed a resource for pediatric providers titled: "What YOU Need to Know About Providing Health Care for Infants & Young Children with Hearing Loss;" a one-page form that covers a broad range of information from hearing screening and diagnostic recommendations to risk indicators and ongoing monitoring of children's hearing as well as early intervention referral information.

The EHDI program provided funding to the one home birth practice in the state to obtain OAE screening equipment, and home births are now screened within one week of birth. As of 1/08, the midwife practice began reporting the hearing screening results through the Newborn Screening reporting system, which enables DPH to accurately report the screening status of this cohort of home births.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Improve state data tracking system				X
2. Improve follow-up on missed or abnormal screens				X
3. Improve follow-up on infants lost to diagnostic follow up				X
4. Improve tracking on follow up program for infants at risk for hearing loss			X	
5. Educate primary care providers on genetic factors associated with hearing loss				X

6. Distribute culturally sensitive educational materials to parents			X	
7. Assure linkage to a medical home		X		
8. Hire support staff to assist with tracking and follow-up				X
9.				
10.				

b. Current Activities

EHDI staff conduct ongoing tracking and follow-up to assure that infants are screened at birth, receive audiological follow up by 3 months of age, when indicated, and enroll in EI by 6 months of age, when diagnosed with hearing loss. Technical assistance is provided to hospital staff and audiology centers as needed.

EHDI staff attends the monthly CT EHDI Advisory Board meetings to discuss issues relevant to infant hearing, early identification and habilitation.

Efforts to develop an improved newborn screening reporting system are underway. In 10/08, a project team was assembled to work with the contractor, Consilience Software, to design the web-based application (the Maven: Newborn Health Profile).

Fall '08, EHDI staff revised two parent brochures distributed by CT birth facilities and both are being translated into Spanish. Revised EHDI Program Guidelines for Infant Hearing Screening were distributed in November 2008 to all 31 birth facilities and one midwife practice. The revised guidelines incorporated new recommendations from the Joint Committee on Infant Hearing 2007 Position Statement, including updated risk indicators and monitoring information.

The DPH conducted a one-day educational conference, "Setting the Tone: Providing Assurance to Families," for 30 pediatric audiologists and 36 hospital newborn screening staff to increase their knowledge of hearing screening guidelines, risk indicators, late onset/progressive hearing loss, and communicating results to families.

c. Plan for the Coming Year

EHDI staff will focus on initiatives aimed at reducing the number of babies lost to follow-up after failure to pass newborn hearing screening.

The EHDI Program will collaborate with the Connecticut Medical Home Initiative for CYSHCN in an effort to locate children for whom there are no documented follow up audiological results to determine if an evaluation did take place. Care coordinators imbedded in medical homes will also provide follow up when a child who is lost to follow-up is identified as receiving primary care through the medical home following periodic searches of the CYSHCN access database.

EHDI staff will develop an analytical plan and conduct an analysis of loss to follow-up differences in order to analyze potential trends in the various stages of the screening process in an attempt to identify potential barriers in access to care, to develop plans for additional provider training and parent education, and to improve tracking and outreach strategies to reduce the numbers of infants who are lost to follow-up.

A programmatic survey will be distributed to all 31 CT birth facilities to update the EHDI Program regarding hospital newborn hearing screening programs and practices. The results of the survey will be compiled and analyzed to identify program strengths and weaknesses. The findings will drive future initiatives.

The CT EHDI Advisory Board will distribute an information gathering survey to determine how many pediatric primary care providers are using OAE screeners in their offices to conduct follow-up testing of infants.

The EHDI Program will renew its focus on educating hospital staff, pediatric healthcare providers and families on the importance of assessing and providing follow-up audiological testing to infants identified with risk factors for late onset/progressive hearing loss. EHDI staff will work with the CT AAP Chapter Champion to visit pediatric primary care offices to provide outreach on this topic.

The Memorandum of Agreement between the DPH, Family Health Section, and the Department of Developmental Services, Birth to Three Program, has been renewed and will allow for additional data exchange on children with late onset/progressive hearing loss as well as outreach to families of infants born at 28 weeks gestation or less and/or were less than 1,000 grams.

The DPH project team will work to test the Maven: Newborn Health Profile in preparation for implementation. On-site training at all 31-birth facilities and the one midwife practice will be conducted on the new application before it goes live, some time before 12/31/09.

EHDI staff have been invited to participate on the multi-agency CT Coalition for Education of Children who are Deaf and Hard-of-Hearing, including reviewing the Early Identification and Intervention section of the state blueprint the group is developing.

The EHDI Program will allocate funds to support the goal of increasing parent involvement in CT EHDI process, including parent-to-parent support.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	4.4	4.4	8.4	7.6	5.9
Annual Indicator	4.5	8.5	7.7	6	5.2
Numerator					
Denominator					
Data Source					US Bureau of Census, Current Population Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	5.1	5	5	4.9	4.9

Notes - 2008

Source: US Bureau of Census, Current Population Survey, 2007 Table Package, Table HI05. Annual performance objectives for 2009-2013 were updated based on the most recent data.

Notes - 2007

Source: US Bureau of the Census, Current Population Survey, Table HIA-5, 2006. Annual performance objectives for 2008-2012 were updated based on the most recent data indicating a steady decrease.

Notes - 2006

Source: US Bureau of the Census, Current Population Survey, Table HIA-5, 2005.

a. Last Year's Accomplishments

This measure was successfully met. Since 2005, when this measure was first met there has been a steady decreasing trend in the percent of child without health insurance. A decreasing trend has been indicated since 2005 showing a 2.5% decrease in the percent of children without health insurance. Healthy Start, Family Planning, Community Health Centers, Healthy Choices for Women and Children, Regional Medical Home Support Centers and WIC screened families for insurance coverage, and provided support, information and linkages to health care insurance coverage for children. The Case Management for Pregnant Women and Teens Program initiated in 2008 through a competitive bid process screened and provided linkages to insurance coverage to families and children in Hartford, New Haven and Waterbury.

The Perinatal State Health Plan identified as one of its goals the need to improve access to a continuum of health care services for underserved and/or uninsured women of childbearing age. The development of this goal has implications for improved birth outcomes and will assist in identification of insurance for infants as well as their mothers.

Infoline provided MCH information and referral services including access to insurance, and conducted presentations and training to community based agencies and groups regarding the HUSKY program.

A daylong forum was held on March 27, 2008 in New Haven for CYSHCN medical home care coordinators and families associated with the Medical Home Initiative for CYSHCN. Department of Social Services staff presented information concerning eligibility requirements for supports and services available, including eligibility for Medicaid and waiver programs.

A Family-to- Family Health Information forum was held on October 2, 2008 in Meriden. Information and resources available through Title V, public insurance resources, and private insurance information was presented.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide outreach, screening and referral to sources of health insurance		X		
2. Provide advocacy and liaison to assist families in obtaining health care coverage		X		
3. Provide education regarding resources to consumers and community-based providers				X
4. Support the state's information and referral services as a point of access for insurance coverage			X	
5. Provide follow-up and assistance with insurance application process		X		
6. Develop capacity with local organization as resources for outreach and enrollment				X
7. Provide education regarding resources to consumers and community-based providers				X
8.				
9.				
10.				

b. Current Activities

Healthy Start, Family Planning, Community Health Centers, Healthy Choices for Women and Children, Case Management for Pregnant Women and Teens, Medical Homes (care coordinators) and WIC screen families for insurance, and provided support, information and linkages to health care insurance coverage for children. All MCH programs will continue to collect data on the number of uninsured children that are served.

Infoline serves as the state's single-point-of-entry, toll-free (24 hours/day, 7 days/week) information and referral service for health care coverage. Infoline has a HUSKY line that is dedicated to providing information about the HUSKY program. Both Infoline and the Department of Social Services' (administrator of the HUSKY program) websites provide families with information about the HUSKY program.

The care coordinators co-located in the CYSHCN medical homes provide families with information about insurance for their children. Care Coordinators will assist families with insurance/HUSKY applications, which are often burdensome and difficult to understand for families. DSS periodically participates in CYSHCN contractor conference calls to address difficulties and answer questions regarding access to HUSKY.

c. Plan for the Coming Year

A legislative mandate is being implemented that requires the State Department of Education to identify students who lack health insurance and provide information to their parents about the HUSKY plan. This new mandate coupled with the protocols in place at each of the DPH funded SBHC sites to reduce the number of uninsured enrollees will provide opportunities for increased collaboration between the school and the SBHC sites to expand HUSKY outreach and enrollment.

Infoline will provide MCH information and referral services including access to insurance, and conduct presentations and training to community based agencies and groups regarding the HUSKY program.

Case Management for Pregnant Women and Teens Program will provide case management services to pregnant women and teens in the cities of Waterbury, Hartford and New Haven who do not qualify for other existing programs. Other programs such as Healthy Choices, State Healthy Start and the Hartford and New Haven federally funded Healthy Start programs will assist with access to health insurance for children.

SBHCs are considering a proposal to study uninsured elementary students to estimate the prevalence of the problem of lack of insurance, identify best practices to increase insurance enrollment, and develop recommendations regarding SBHC's practices to enroll more families in HUSKY.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			23.9	9.2	32.1
Annual Indicator		24.0	9.2	32.2	31.0
Numerator		7143	2709	7521	7944

Denominator		29729	29481	23356	25623
Data Source					CDC's Pediatric Nutrition Surveillance System
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	32	31.9	31.8	31.7	31.6

Notes - 2008

Source: CDC's Pediatric Nutrition Surveillance System (PedNSS) revealed that 15.7% of children enrolled in the WIC Program in 2008 were at risk of overweight (BMI \geq 85th and $<$ 95th percentile) and that 15.5% were overweight (BMI \geq 95th percentile). A total of 7,944 out of 25,623 children had a BMI at or above the 85th percentile, for a combined prevalence of 31.2%. Annual performance objectives for 2009-2012 have been left the same for now since one year's results do not reflect a trend. This will be reassessed pending next year's results.

Notes - 2007

Source: CDC's Pediatric Nutrition Surveillance System (PedNSS) revealed that 16% of children enrolled in the WIC Program in 2007 were at risk of overweight (BMI \geq 85th and $<$ 95th percentile) and that 16.2% were overweight (BMI \geq 95th percentile). A total of 7,521 out of 23,356 children had a BMI at or above the 85th percentile, for a combined prevalence of 32.2%. Annual performance objectives for 2008-2012 have been adjusted based on the most recent data.

Notes - 2006

Source: CTDPH, WIC Program, SWIS monthly report on risk factors, Jan. 2007 (Children's BMI between 85 and 95%). This data is provisional because the WIC program was just beginning to calculate BMI electronically.

a. Last Year's Accomplishments

This measure was met using a comparison of 2007 and 2008 Connecticut PedNSS data and national figures. The Connecticut PedNSS 2007 annual indicator of 32.2% of children with a BMI at or above the 85th percentile decreased to 31.2% in 2008, which is slightly below the national figure of 31.3% in the PedNSS 2008 report.

The local WIC programs in Connecticut continued to use the automated BMI calculation feature in the Statewide WIC Information System (SWIS) as a tool for assessing growth and teaching parents and care providers about their children's growth patterns.

During 2008, the Connecticut WIC Program continued the transition to statewide implementation of "Value Enhanced Nutrition Assessment" (VENA). This is a national USDA initiative to improve nutrition services in the WIC Program. Its guiding principle is to "strengthen and redirect WIC nutrition assessment from eligibility determination to individualizing nutrition education in order to maximize the impact of WIC nutrition services." Connecticut activities included continued collaboration with the VENA core committee with representation from all local agencies, revisions of policies/forms, and continuing education for local WIC staff. Local WIC nutrition staff continued

to provide individual nutrition counseling and group education to participants.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Automate WIC database to generate BMI				X
2. Training of WIC providers in using BMI				X
3. Meet with CHCs re: BMI and nutritional services				X
4. Support the No Child Left Inside campaign			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Connecticut WIC VENA implementation continues through FY 2009. However, major efforts of the VENA committee have shifted towards preparation for the new WIC Food Package Implementation. Major changes to foods provided by the WIC Program will start in fiscal year 2010 due to new WIC federal regulations. The result for children is that healthier, lower fat foods are offered. This includes low fat milk only for healthy children, less juice and cheese, and the addition of fruits, vegetables, and whole grains.

A fall summit was held to promote the Sister Talk Hartford (STH) program to the greater Hartford area (surrounding towns). Funding is being sought to offset the expenses of the program in order to attract African American women who would not be able to afford a more traditional weight loss program. The STH project is a joint initiative between the DPH, the University of Connecticut Translation Practice Into Policy (TRIPP) Center, and the Ethel Donaghue Foundation. To date, proposals have been submitted to several foundations and an award was granted from the Aetna Foundation.

c. Plan for the Coming Year

Major aspects of the VENA Implementation Plan will be finalized in FY2010. Continued focus will include quality nutrition assessment, participant focused education, and moving towards more standardized nutrition documentation throughout the State.

The new WIC Food Packages will be implemented in FY2010, and parent/participant education for children will include emphasis on benefits of lower fat milk, increased fruits, vegetables grains, and physical activity.

The Physician's Outreach Initiative, part of the New WIC Food Package Implementation Plan, was started in FY2009 and will continue in FY2010. The purpose is to update health care providers on the WIC Program and the rationale/benefits of the new WIC food packages, inform them of WIC Program requirements, coordinate referrals and networking, and to collaborate with them on providing consistent messages with the ultimate purpose of best serving our mutual clients.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			3	0.2	0.2
Annual Indicator		3.1	0.2	0.2	
Numerator			84	79	
Denominator			41461	40969	
Data Source					No Vital Statistics data available
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2009	2010	2011	2012	2013
Annual Performance Objective	0.1	0.1	0.1	0.1	0.1

Notes - 2008

CY 2008 data are not available.

Notes - 2007

Source: CY2007 final data, CTDPH, Vital Statistics. Similar to 2005 and 2006 calculations, percent is based on the removal of data where prenatal care and tobacco use in the third trimester was unknown. It has been noted that this figure is very low, however, this information is self-reported by the mother on the birth certificate.

Note: The 2005 column was based on the removal of data where prenatal care and tobacco use in the third trimester was unknown. The calculations reported a numerator of 89 and a denominator of 41,086 resulting in an annual indicator of 0.2%. This column is locked and so these updates are not possible to this form.

Notes - 2006

Source: CY2006 final data, CTDPH, Vital Statistics. Similar to 2005 calculation, percent is based on the removal of data where prenatal care and tobacco use in the third trimester was unknown. It has been noted that this figure is very low, however, this information is self-reported by the mother on the birth certificate.

Note: The 2005 column in last year's application was based on the removal of data where prenatal care and tobacco use in the third trimester was unknown. The calculations reported a numerator of 89 and a denominator of 41,086 resulting in an annual indicator of 0.2%. This column is locked and so these updates are not possible to this form.

a. Last Year's Accomplishments

This measure remained the same as the previous year CY2006 and since we adjusted the Annual Performance Measure Objective last application year, the measure was essentially met. It is too early to assume that this trend will remain.

The Connecticut Quitline counseled and referred any Connecticut resident about tobacco use cessation. A small adult cessation media campaign was held during the spring of 2009, and

along with the increase in the federal tax per pack of cigarettes, the number of calls to the Quitline has been increasing.

Quitline materials were distributed through a variety of venues, including health care providers, community health centers, state and local libraries, and other community programs. An emergency room and pharmacy pilots are both occurring that distribute Quitline information and referrals. Providers can fax a referral sheet directly to the Quitline, which then contacts the patient directly.

The Tobacco Control Program awarded six grants for tobacco use cessation programs to community health centers targeting pregnant women and women of childbearing age. These programs began in November 2008 and will run until June 2010. In addition, training was provided to community partners in the new Clinical Guidelines that were released in the fall of 2008.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide cessation counseling and referral through the CTQuitline	X			
2. Educate health care professionals and providers in cessation intervention and treatment				X
3. Educate public about the effects of tobacco use and secondhand smoke			X	
4. Screen and refer women to smoking cessation programs		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

While it was intended that the Quitline be funded until 2010, funds no longer support the Quitline.

Seven additional community tobacco use cessation programs are being awarded funds to provide services to the general population, and specialized services are also being established in Connecticut.

Staff continue to work on the implementation of smoking cessation programs at the CHCs. There is an independent evaluation that will be conducted and the analysis will be disseminated.

c. Plan for the Coming Year

The Title V supported programs Healthy Start and Healthy Choices for Women will screen and counsel women for smoking. New case management programs for pregnant women include the promotion of tobacco use cessation, including screening during the first and third trimesters, counseling, and referrals to tobacco use cessation programs.

A new proposed TA request includes an initiative to collect information to characterize the demographics of women who smoke in successive pregnancies, associating this with adverse

birth outcomes, with the ultimate goal of informing public health intervention strategies.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	5.6	2.5	2.5	3.8	6.4
Annual Indicator	2.9	4.0	6.4	5.2	
Numerator	7	10	16	13	
Denominator	241182	247415	250071	250994	
Data Source					No Vital Statistics data available
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2009	2010	2011	2012	2013
Annual Performance Objective	6.3	6.2	6.1	6	6

Notes - 2008

CY2008 data is not available.

Notes - 2007

Source: CT Dept of Public Health, Vital Statistics final CY2007 data

Note: The Annual Performance Objectives for 2008 and 20013 have been updated based on the most recent data.

Notes - 2006

Source: CT Dept of Public Health, Vital Statistics final CY2006 data

Note: The Annual Performance Objective for 2006 and 2007 can not be changed based on the most recent data because the fields are locked. The Annual Performance Objective for 2008 forward were changed to reflect the more recent data.

a. Last Year's Accomplishments

Based on the previously set Annual Performance Objective for CY2007, this measure was not met. However we adjusted the APO's last year based on the recent data. Considering this, the decrease from CY2006 to CY 2007 is a wanted trend although it is too early to assume this trend will be maintained.

CHCs provided mental health services through assessment, direct care and/or referrals. They continue to assure these mental health services through direct provision via onsite clinicians such as social workers, psychiatrists and psychologists and through referrals to community agencies such as local hospitals, child guidance centers and mental health centers. The Community Health

Centers (CHC) are working closely with the Child Guidance Centers across CT, and some of the Child Guidance Centers are operated by CHCs.

SBHCs provided anticipatory guidance and mental health risk assessments at all locations. Other mental health services include crisis intervention, individual, family, and group counseling and referral and follow-up for specialty care. All SBHCs offer services directed at high-risk populations, such as youth with suicidal thoughts/attempts.

Through the use of a specially designed mid-year report, SBHC sites reported on the following mental health related issues: successes in service delivery, trends, gaps/barriers, and potential solutions.

Thirty-five individual SBHC mental health clinicians received Master Therapist training funded by DPH. Clinicians may opt to attend workshops covering diverse mental health issues. A total of 52 workshops were funded this year. A total of 26 therapists attended the workshop on bipolar disorder in adolescents.

Healthy Choices for Women and Children provided comprehensive assessment of clients, including the need for mental health services. Referrals are initiated as necessary. This program continues to identify and refer clients who are at risk for suicide to appropriate resources.

A new Case Management Program for Pregnant Women and Teens was implemented through a competitive bid process. This program included screening for perinatal depression and covered the towns of Hartford, New Haven and Waterbury. Perinatal depression screening was also implemented in the state Healthy Start programs that provide case management services for pregnant women (and teens) at or below 185% of the FPL.

There were also non-Title V funded activities. The Injury Prevention Program provided guidance related to suicide prevention information, data and resources, when requested to other DPH programs.

The Maternal and Child Health Information and Referral Services reported 5148 requests for mental health and counseling services and 2,354 requests for crisis intervention services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide suicide prevention training to students				X
2. Provide suicide prevention training to providers and other adults				X
3. Provide technical assistance and guidance for MCH programs				X
4. Provide anticipatory guidance and risk assessments in Title V funded programs, especially SBHCs		X		
5. Provide mental health services through assessment, direct care and/or referrals in SBHCs, CHCs and other MCH programs	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities

School Based Health Centers provide anticipatory guidance, risk assessments and mental health therapy at all locations. Staff work with SBHCs to enhance data collection tools related to mental health service delivery at SBHCs.

Community Health Centers provide mental health services through screening, assessment, primary care, and referrals. Most CHCs have onsite mental/behavioral health services.

The Maternal and Child Health Information and Referral Service track requests for mental health and counseling services and crisis intervention services. In the first two quarters of the current year, requests for mental health and counseling services and crisis intervention services totaled 2,371 and 2,166 respectively.

The Case Management for Pregnant Women and Teens Program includes screening for perinatal depression. This program covers the towns of Hartford, New Haven and Waterbury Perinatal depression screening will be incorporated into the new federally funded Healthy Start program for the city of Hartford.

c. Plan for the Coming Year

Women will be screened for perinatal depression through the new case management program for pregnant women and teens and through other case management programs such as Healthy Start and HCWC.

CHCs will provide mental health services through assessment, direct care, and/or referrals.

The Maternal and Child Health Information and Referral Service will provide information regarding service requests for mental health and crisis intervention services.

School Based Health Centers will provide anticipatory guidance, risk assessments and mental health services at all locations. Groups focused on: anger management, self esteem, social skills, life skills and violence prevention will continue to be offered to help students develop healthy ways of coping with life challenges.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	87.5	87.5	87.3	87.4	87.5
Annual Indicator	87.1	87.1	86.3	84.9	
Numerator	575	580	591	541	
Denominator	660	666	685	637	
Data Source					No Vital Statistics data available
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3					

years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2009	2010	2011	2012	2013
Annual Performance Objective	87.6	87.6	87.7	87.8	87.8

Notes - 2008

CY 2008 data are not available.

Notes - 2007

Source: CY2007 final data, CTDPH, Vital Statistics. Eleven of CT's acute care hospitals with self-declared NICU's were included in this survey.

Notes - 2006

Source: CY2006 final data, CTDPH, Vital Statistics. Eleven of CT's acute care hospitals with self-declared NICU's were included in this survey.

a. Last Year's Accomplishments

This objective was not met and there appears to be a steady decline in the percentage. CT has 30 birthing hospitals statewide and one birthing center located in Danbury, CT, contiguous to the New York border. There are 11 "self-defined" Level III Neonatal Intensive Care Units in CT.

The State Perinatal Health Advisory Committee, which is now part of the MCH Advisory Committee met as scheduled (quarterly). One of the recommendations in the previously developed State Perinatal plan identifies the need to reduce pregnancy and birth related risk factors by facilitating maternal transfers to tertiary perinatal/neonatal centers for high risk antepartum, intrapartum and postpartum care.

The Title V-funded programs Healthy Start, Case Management for Pregnant Women, Family Planning, and Healthy Choices for Women and Children provided outreach, screening, intensive case management, and referral for high-risk pregnant women to specialists and tertiary care centers. Through a case management approach, women identified as at-risk were referred for appropriate evaluation.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide outreach, identification and referral of high-risk pregnant teens		X		
2. Provide intensive case management and supports to promote positive pregnancy outcomes		X		
3. Provide culturally competent and linguistically appropriate care to high-risk populations	X			
4. Collaborate with tertiary care centers that provide specialized delivery and neonatal care				X
5. Collaborate with the members of the State Perinatal Health Advisory Committee to implement the plans goals and objectives				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Healthy Start, Family Planning, Healthy Choices for Women and Children, and Community Health Centers assess and refer high-risk pregnant women to facilities for high-risk deliveries and neonates. The Case Management for Pregnant Women Program promote case management for pregnant women and teens in Hartford, New Haven, and Waterbury; this program will continue to provide outreach, screening, case management and referral for high-risk pregnant women to specialists and tertiary care centers.

The MCH Advisory Committee continues to meet quarterly. The MCH Advisory Committee is the vehicle for discussing and implementing the recommendations from the State Perinatal Plan, and specifically reviewing the activities and resources needed to better address this NPM. There have been discussions with the March of Dimes regarding this data and performance measure.

This downward trend is somewhat alarming; however, it is consistent with the recommendations identified in the recently developed Strategic Plan for Addressing Low Birth Weight in CT, which identified the need to coordinate with medical providers to ensure that high-risk pregnancies deliver in tertiary care hospitals.

c. Plan for the Coming Year

Healthy Start, Family Planning, Healthy Choices for Women and Children, the new case management program for pregnant women, and Community Health Centers will provide outreach, screening, intensive case management, and referral for high-risk pregnant women to specialists and tertiary care centers.

The MCH Advisory Committee will meet and identify resources, develop and implement strategies to better address this objective. The conveners of the MCH Advisory Committee are working with the DPH on it's TA request for this year to conduct a two day workshop to review CT's Perinatal System of Care. This performance measure and data will be addressed during this event.

FHS Epidemiologist will conduct a more in-depth review of the birth data, to better assess where (which facilities) the VLBW are occurring, and look for any trends or other indicators that might better explain this gradual decrease.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	88.9	88.9	87.8	87	87.3
Annual Indicator	87.2	86.7	85.8	86.5	
Numerator	36090	35654	35303	35424	
Denominator	41392	41103	41161	40969	
Data Source					No Vital Statistics data available
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the					

last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2009	2010	2011	2012	2013
Annual Performance Objective	87.6	87.9	88.2	88.5	88.5

Notes - 2008

CY2008 data is not available

Notes - 2007

Source: CY2007 final, CT DPH Vital Statistics.

Notes - 2006

Source: CY2006 final

The objective field here is locked and not able to be changed as we would like to 87.0 i.e. a more reasonable projection based on a two-year downward trend.

a. Last Year's Accomplishments

CT did not meet this measure in 2007 with a lower rate (86.5) than the annual performance objective of 87.0. While there was a slight increase from 2006, the magnitude of the 2007 percent still is slightly less than that seen in 2005. It is too early to assume this a change in direction for the trend. The 2005 and 2006 annual objective fields are "locked in" and will not allow us to change the objective to reflect our most recent experience, which may actually be unwise. We also did not change the annual performance objectives for the future as further analyses may indicate the factors that are contributing to this decline that could lead to programmatic activity changes to address this issue.

Funds from the Right from the Start and Comadrona programs were blended and a Request for Proposal submitted to create a new program to promote case management for pregnant women and teens; this program provides outreach to identify and refer women for early entry into prenatal care. Healthy Start, Healthy Choices for Women and Children, Case Management for Pregnant Women, Family Planning, School Based Health Centers, Community Health Centers and WIC identified and referred women to prenatal care, provided advocacy and a culturally sensitive approach in promoting the benefits of early and continuous prenatal care.

Fetal and Infant Mortality Review (FIMR) continued in five communities in CT. The FIMR process uses a confidential record abstraction and maternal interviews to identify mortality related issues including late entry into prenatal care.

A public awareness campaign regarding infant mortality, particularly among African Americans and encouraging early entry into prenatal care, was conducted using radio, television, and minority newspaper advertising in the Greater Hartford and New Haven areas.

The newly developed state added performance measure # 6 will allow CT to more effectively address the racial and ethnic disparities that were identified as part of the five-year needs assessment that impacts this measure.

A Health Disparities workgroup was convened to address the issue of health disparities. As a result, a Strategic Plan was developed to address low birth weight that often results from late or inadequate prenatal care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service
-------------------	---------------------------------

	DHC	ES	PBS	IB
1. Provide outreach and case management to identify and enroll clients in early prenatal care		X		
2. Provide culturally and linguistically appropriate services to decrease barriers to prenatal care services	X			
3. Provide outreach to targeted populations (i.e. pregnant substance users)		X		
4. Provide support, information and advocacy to pregnant teens		X		
5. Continue to analyze and disseminate PRATS Survey data			X	X
6. Provide pregnancy testing, reproductive health education, counseling and linkage to healthcare providers	X			
7. Develop a statewide fetal and infant mortality surveillance program			X	X
8. Promote early enrollment into prenatal care as a linkage from programs such as WIC		X		
9. Provide/promote comprehensive services to encourage women of reproductive age to enter prenatal care early		X		
10.				

b. Current Activities

WIC, Healthy Start, Family Planning, School Based Health Centers, Healthy Choices for Women and Children, Case Management for Pregnant Women, and Community Health Centers encourage early entrance into prenatal care.

Due to State budget cuts, the FIMR program was defunded.

The infant mortality campaign that was previously developed was redesigned to incorporate messages about the importance of early and regular prenatal care as well as promotion of protective factors like exercise, diet, and healthy behaviors. This television campaign is focused on African American women in the Hartford and New Haven communities.

The First Time Motherhood/New Parents Initiative Grant was received from HRSA to develop, implement, evaluate, and disseminate novel social marketing approaches that concurrently increase awareness of existing preconception/interconception, prenatal care, and parenting services/programs in Hartford and New Haven and address the relationship between such services and healthy birth outcomes.

The Centering Pregnancy model of group prenatal care was implemented in New Haven at 2 sites. This model provides outpatient prenatal care services to women most at risk for delivering low birth weight infants and works to achieve outcomes that include empowerment and community building, increase satisfaction with care, reduction in preterm births, and increased breastfeeding.

c. Plan for the Coming Year

Title V Programs Healthy Start, Healthy Choices for Women and Children, and the new Case Management Program for Pregnant Women will provide outreach and identification of pregnant women to promote early entry into prenatal care. Programs not fully funded by the MCH Block Grant including Family Planning, School-Based Health Centers, Community Health Centers and WIC, will also promote early entry into prenatal care.

Epidemiology Unit staff will continue preparations for Round 3 of the CT PRATS survey. This work will include refining the sampling plan based upon analyses of respondents versus non-respondents from the previous 2 surveys; identifying an appropriate birth cohort and drawing the

sample; finalizing survey content; and releasing an RFP to identify a contractor to administer the survey. Data from Round 3 will be used to identify and further investigate important factors related to seeking and accessing early prenatal care.

With the launch of the Charter Oak Plan, more adults (especially the working, but uninsured population) will have access to health insurance. This may impact this measure in a positive direction.

We will work to implement the following recommendations from the LBW Strategic Plan: (1) facilitate case management services for first time pregnancies; (2) coordinate with medical providers to ensure evidence-based treatment for pregnancies at risk of preterm-birth; (3) Advertise the use of Infoline 2-1-1 to assure referrals for early and regular prenatal care; (4) document that all DPH funded initiatives address language, culture, diversity and health literacy; and, (5) continue to provide technical assistance to the Hartford Health Department in the implementation of the new federally-funded Healthy Start Program.

D. State Performance Measures

State Performance Measure 1: *Cumulative number of datasets incorporated into integrated warehouse (called HIP-KIDS).*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			3	2	3
Annual Indicator		2	2	2	2
Numerator		2	2	2	2
Denominator	7	7	7	7	7
Data Source					DPH
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	4	5	6	7	7

Notes - 2008

Source: The number of databases linked as part of HIP-Kids remained at 2. During CY2008 the focus remains on the migration of the migration of the NSS to the PHIN platform the EHD and BDR databases, now referred as the Newborn Health Profile, more successfully migrated. Delays in the successful migration of all three NSS components was due to the Genetics/ Laboratory Tracking agreeing to also migrate after approximately 8 months into the project.

Notes - 2007

The number of databases linked as part of HIP-Kids remained at 2. Database linkages were put on hold due to the shift of DPH's focus on the migration of databases to a standardized network platform that met IT state-of-the-art requirements.

Adjustments were made to the 2008-2012 annual performance objectives due to this change in plans.

Notes - 2006

Data is supplied by DPH staff working on the HIP-KIDS project. Two of the seven databases were incorporated into the data warehouse in 2005. There were no new additions in 2006.

a. Last Year's Accomplishments

This measure remained static with the number of linked databases remaining at 2. The migration process to move databases to a single platform became a major focus within DPH with the goal of prioritizing which databases should be migrated first to the Public Health Information Network (PHIN) platform. The Newborn Screening's CHP database was included in the priority list of databases to be migrated. This precipitated the need for FHS staff to identify the business needs of the Newborn Screening System. During the summer and fall of 2007, FHS worked with Scientific Technologies Inc. to complete a detailed documentation of the business needs of the entire Newborn Screening System (NSS) including the CHP in preparation for its migration to the PHIN platform. This took priority over completing the linkage of the death records.

The electronic reporting system, CHIERS, was updated to include the 2006 birth data; added new confidence interval option (from MICA system) for percentages to the CT CHIERS version; and the web page was modified to meet the CT DoIT standard.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Prepare for the migration of the CHP database to the PHIN platform by documenting the business needs of the NSS				X
2. Pursue funding for HIP-Kids project				X
3. Continue to participate on the Department-wide Data Committee				X
4. The electronic reporting system, CHIERS, was updated				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Using funds supplied by the Environmental Public Health Tracking program, and the Early Hearing Detection & Intervention (EHDI) Infrastructure grant, the EHDI and Birth Defects staff worked with a consultant firm Consilience Software, Inc. staff to complete the phases of the migration to the Public Health Information Network (PHIN) platform using Consilience's recommended IT application, MAVEN. These two components of the Newborn Screening system, now referred to as the Newborn Health Profile (NHP), were scheduled to start training hospital staff in the summer 2009. This was pushed to the end of the year after the Genetics/Laboratory Tracking staff decided to also migrate the genetic screening component of the NSS to MAVEN.

Once the NSS is migrated to the PHIN platform, advancements for the data warehouse will be restarted. FHS staff have met with Vital Records staff to assure that the electronic birth records will continue to be linked to the NHP. A few confidentiality and security issues are being discussed to comply with Federal laws that protect the sharing of birth record information. Vital Records staff have indicated their willingness to work through these issues to come to a resolution that meets the needs of both parts of DPH.

c. Plan for the Coming Year

Completion of the death record linkage to the NHP database and the birth records is being reconsidered due to the known delays with the processing of death records. Identification of an

alternative database for inclusion in the HIP-Kids data warehouse will be discussed as part of other plans to migrate the CT Immunization Registry database to the MAVEN application. This more recent development would influence the decision to select the Immunization Registry database as the next database to be selected for linkage.

FHS and HISR epidemiologists will continue collaborations to implement CHIERS. 2007 birth data will be added to CHIERS as we expect to move forward with plans to move CHIERS from Missouri DHSS to a Connecticut-based web-hosting site. This migration should allow DPH to expand CHIERS to include other databases and to make this information accessible to the public, contingent on available resources.

State Performance Measure 2: *Cumulative number of formal agreements, in the format of Memoranda of Agreements (MOA's) and collaborative agreements, that serve the needs of the three MCH populations.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			13	17	21
Annual Indicator		12	16	20	25
Numerator					
Denominator					
Data Source					Survey of FHS programs
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	28	31	34	37	40

Notes - 2008

Source: CY2008 data are from a survey of FHS programs. Adjustments were made to the 2009-2013 annual performance objective based on this most recent data.

Notes - 2007

CY2007 data are from a survey of FHS programs. Adjustments were made to the 2008-2012 annual performance measures based on this most recent data.

Notes - 2006

Data is from a survey of DPH programs including the CGMS database.

a. Last Year's Accomplishments

This measure was successfully met with a total of 25 MOU's or agreements that occurred. FHS Staff worked with the Department of Corrections (DOC) staff to develop an MOA to implement a gender responsive curriculum for both DOC staff and inmates at York Correctional Institute (CT's only female jail/prison).

DPH collaborated with the Federal MCHB Healthy Start Program to roll out an Infant Mortality campaign targeting the African American community in June 2007. It is expected that the campaign will be aired during this current year as well. The DPH has an Letter of Agreement with the New Haven Healthy Start Program.

DPH worked with Hartford Health Dept. to complete the Action Plan for addressing preconception

care in the City. Recommendations include conducting a city-wide summit to address preconception care.

DPH has an MOA with the Department of Social Services for the State Healthy Start Program. The program provides case management services to pregnant Medicaid-eligible women and their children up to age three.

An MOA with the Children's Trust Fund was executed to complete care coordination services for CYSHCN for the North Central and Eastern regions after the termination of contracts with LEARN and Charter Oak Health Center. The MOA will continue to provide support for the transition of services to new care coordinators who will be identified in the RFP process effective 7/1/07. Through the state's Early Childhood Partner's grant, an MOA was executed with the CTF to assist with the Ages and Stages Training for health care providers.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identify collaborating partners at the state and local level				X
2. Inventory existing collaborations				X
3. Identify gaps in existing collaborations and opportunities for new partnerships				X
4. Monitor the effectiveness of collaborations and interventions				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MOA between DPH and the Department of Corrections (DOC) conducts gender responsive curriculum for staff and inmates at York Correctional Institute (CT's only female prison).

MOA with UCONN's School of Nursing through the federal Primary Care Office grant includes encouraging high school students from urban high schools and Boy Scouts and Girl Scouts to pursue careers in the health care field.

MOAs were executed with CT State Board of Education to support local school districts and communities to improve the wellness of children and youth; and to promote successful transition of YSHCN to all aspects of adult life, including adult health care, work and independence.

MOA was executed with DDS Birth to Three Program to share EHDI client's information for those who are eligible for Birth to Three Program. The current MOA was expanded to include the sharing of vital records data, specifically those low birth weight infants, who are automatically eligible for the Birth to Three Program.

MOA with Area Health Education Center (AHEC) provides the healthy child and adolescent development education and training program curriculum entitled "Building Bright Futures". This is the last year of this HRSA grant and has consisted of a train-the-trainer model approach.

c. Plan for the Coming Year

The Department of Public Health (DPH) and the Department of Children & Families (DCF) are planning on entering into a Memorandum of Agreement (MOA) to collaborate in partnership to promote and enhance a DCF statewide educational and resource website for Connecticut parents, with a goal to promote and improve infant, child and family health, safety and well-being. DPH will provide funding to DCF through this contract to advertise the CTParenting.com website by Google Ads. DCF has funded these ads in the past and it has proven to be an effective means of promoting access to the website.

The MOA with DSS is expected to continue to support the state Healthy Start Program. This program will now be complemented by the receipt of the federal Healthy Start funding, which will target the city of Hartford.

DPH, DMHAS and DCF collaborated on a federal Fetal Alcohol Syndrome Surveillance grant application. If funded an MOA will be developed and exchange of data will be included.

The Letter of Agreement will be renegotiated and executed with the federally funded New Haven Healthy Start Program. It is expected to continue to address health disparities in the MCH population.

If funded, the Project Launch Grant will require a multi-state agency MOA with DPH, DSS, DCF, DMHAS and SDE.

State Performance Measure 3: *Percent of 9-12 graders who reported being in a fight within the past 12 months.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			32.7	32.6	32.6
Annual Indicator		32.7	32.7	31.4	31.4
Numerator		715	715	630	630
Denominator		2185	2185	2007	2007
Data Source					CDC's YRBS national surveys
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	32.5	32.5	32.4	32.4	32.3

Notes - 2008

Source: This survey is conducted every other year in conjunction with CDC's YRBS national surveys. The next survey is being conducted in 2009.

Notes - 2007

This is weighted 2007 CT High School Survey (formerly called YRBS) data.

Notes - 2006

This is weighted 2005 CSHS(formerly called YRBS) data. The survey is conducted every other year, so new data is not available this year, but anticipated for the following year's MCHBG reporting.

a. Last Year's Accomplishments

The School Health Survey was not conducted in 2008 so data for this measure is the same as what was reported in 2007.

Continuing education for SBHC mental health clinicians was provided to 38 SBHC mental health clinicians registered to attend one of four child and adolescent focused UConn Health Center sponsored Master Therapist Workshops including one entitled, "Angry Adolescents: Struggles and Strategies."

SBHC mental health clinicians provided individual, group and family counseling SBHC groups focused on: anger management, conflict resolution, social skills, healthy relationships and life skills to prevent/reduce school violence including fights. Several sites targeted students in detention and provided them with education and insight into their behaviors.

Seven SBHC programs statewide were awarded additional dollars through RFP to increase staffing/hours of operation resulting in an increased capacity of SBHC sites to provide prevention and intervention service to address fighting and other violent behavior.

SBHC mental health clinicians provided individual, group and family counseling to students having difficulty managing anger. Groups focused on anger management, conflict resolution, social skills, healthy relationships and life skills that served to provide students with the tools to handle their feelings in a non-violent manner.

HRSA grant funds supported the establishment of Building Bright Futures in Connecticut (BBFCT), an education and training program for non-mental health professionals in the state workforce/working in state funded programs that serve children and adolescents and their families for the purposes of: understanding typical middle childhood and adolescent development, distinguishing between risk and protective factors, promoting resilience (working with strengths and assets) and identifying appropriate responses to challenging behavior. Fifty-seven state employees participated in the Two BBFCT Train the Trainer programs conducted in 2008.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Trends related to the number of students who reported being in a physical fight in the past year will be monitored with the completion of the 2006 CT School Health Survey			X	
2. Creation of opportunities for teen employment and workforce skill development				X
3. Increase opportunities and venues where adolescents can learn and practice positive social-emotional skills				X
4. Increase the number of schools that have peer mediation/conflict resolution and social development programs				X
5. Improve availability and accessibility of education and support on violence prevention and non-violent behaviors for parents/guardians, families and caregivers of adolescents				X
6. Support efforts to reduce availability of weapons				X
7. Provide schools with resources to address violence in schools, such as support for peer mentoring programs, lesson plans addressing positive social-emotional skills and conflict resolution, and support for increased security on school grounds				X
8. Reduce demand for drugs through substance abuse prevention and treatment strategies				X
9. Support efforts at the community level				X
10.				

b. Current Activities

Continuing education for SBHC mental health clinicians was provided to 40 SBHC mental health clinicians that attended one of four child and adolescent focused UConn Health Center sponsored Master Therapist Workshops. Copies of the book, Cognitive-Behavioral Interventions for Emotional and Behavioral Disorders: School-Based Practice was provided to SBHC mental health clinicians to use as a therapeutic resource with regard to the use of a cognitive-behavioral approach with adolescents that are angry/aggressive.

Expansion funds allocated through RFP were awarded to 7 existing SBHC contractors were utilized to increase the capacity of SBHCs, through increased staffing and hours of operation to provide prevention and intervention activities geared toward addressing fighting and violent behavior.

SBHCs statewide continue to provide individual, family and group counseling to enrolled students and their families. Health education, promotion and risk reduction activities related to violence prevention continue to be available to all students. SBHC groups continue to focus on anger management, conflict resolution, social skills, healthy relationships and life skills to prevent/reduce school violence including fights

One hundred sixty non-mental health professionals in the state workforce that serve children, adolescents, and their families participated in eight Building Bright Futures in Connecticut training programs conducted statewide.

c. Plan for the Coming Year

SBHCs statewide will provide individual, family and group counseling to enrolled students and their families and conduct health education, promotion and risk reduction activities related to violence prevention that are available to the entire school population.

Continuing education opportunities will be offered within available resources so that SBHC mental health clinicians can continue to build clinical capacity to address fighting and other violent behavior among students in grades 9-12.

The HRSA funded Building Bright Futures in CT activities will include another Train-the-Trainer program that will be open to SBHC staff and other DPH contractors that serve children, adolescents and their families.

State Performance Measure 4: *Percent increase in the number of adolescents 10-20 years old who receive services in school based health centers.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			4.2	15	20
Annual Indicator		3.1	10.2	15.6	13.3
Numerator		597	1986	3039	2982
Denominator		19439	19439	19439	22421
Data Source					School-Based Health Center database
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013

Annual Performance Objective	15.5	15.5	16	16	16.5
------------------------------	------	------	----	----	------

Notes - 2008

Source: Baseline denominator is 2003-2004 number of students (19,439) receiving SBHC services.

2007-8 there were 22,421 students seen. These 2,982 additional students seen represent a 15.3% increase over the baseline. Projections for the Annual Performance Indicator are based on an additional increase in the number of students receiving SBHC services each year expressed as a percentage increase over this original base year. Adjustments were made to the 2009-2013 annual performance objectives due to the most recent data that appears to show plateau of the number of students receiving services at SBHCs.

Notes - 2007

Source: 2006-7 School-Based Health Center database, CT Dept of Public Health, Family Health Section. Baseline denominator for the start of this SPM represents the 2003-2004 number of students (19,439) receiving SBHC services. In School Year 2006-7 there were 22,478 students seen. These 3039 additional students seen represent a 15.6% increase over the base year. Projections for the Annual Performance Indicator are based on an additional increase in the number of students receiving SBHC services each year expressed as a percentage increase over this original base year.

Notes - 2006

Source: 2005-6 School-Based Health Center database, CT Dept of Public Health, Family Health Section. Baseline denominator for the start of this SPM represents the 2003-2004 number of students (19,439) receiving SBHC services. In School Year 2005-6 there were 21,425 students seen. These 1986 additional students seen represent a 10.2% increase over the base year. Projections for the Annual Performance Indicator are based on an additional increase in the number of students receiving SBHC services each year expressed as a percentage increase over this original base year.

a. Last Year's Accomplishments

This measure was not successfully met for the 2007-2008 school year as we suspect a plateau has been reached. The CT legislature allocated funding to enhance/expand SBHCs. Some of these monies were specific allocations that included funds to support four new SBHC sites, two existing sites previously funded through other sources and additional mental health/medical staff at another three existing SBHCs.

The remainder of the allocation was used to expand medical, mental health and dental services and mental health services at existing DPH funded SBHC sites located in priority school districts or medically underserved areas or serve medically underserved populations. Funds were dispersed through an RFP process to be used for variety of activities including but not limited to: expanding staffing and staff hours, providing SBHC services over the summer months. Seven existing SBHC contractors were awarded partial/full funding under the RFP.

State bond funds for school based health clinics for the purchase of equipment, renovations, improvements and expansion of facilities, including acquisition of land or buildings were also made available through RFP. Recipient requests included but were not limited to: the purchase of dental and other equipment and structural renovations

A series of regional data training sessions were provided to SBHC contractors to enhance their ability to provide quality data. Also, a support network consisting of volunteer peer mentors is currently available to provide technical assistance/support to their counterparts requiring assistance with Clinical Fusion.

Thirty-eight SBHC mental health clinicians registered to attend one of four child and adolescent focused Master Therapist Workshops sponsored by the University of Connecticut Health Center.

Regional workshops for SBHC clinical staff on psychotropic medication and mutual aid support groups were also conducted.

The legislatively mandated an Ad Hoc Committee that was established to provide assistance to the DPH Commissioner in improving health care through access to School-Based Health Centers (SBHC) met quarterly. An updated report outlining the status of goals and objectives established in the initial Committee report was completed in July 2008.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide outreach and intensive case management to identify and enroll clients in early prenatal care		X		
2. Provide culturally and linguistically appropriate services to decrease barriers to prenatal care services and providers	X			
3. Provide outreach to targeted populations (i.e. pregnant substances users)		X		
4. Provide support, information and advocacy to pregnant teens	X			
5. Provide pregnancy testing, reproductive health education, counseling and prenatal linkage to community based providers	X			
6. Promote early enrollment into prenatal care as linkage from programs such as WIC		X		
7. Provide and promote comprehensive services to encourage women of reproductive age to enter prenatal care early		X		
8.				
9.				
10.				

b. Current Activities

Forty SBHC mental health clinicians registered to attend one of four child and adolescent focused Master Therapist Workshops sponsored by the University of Connecticut Health Center. DPH sponsored a Bright Futures/Oral Health conference for SBHC nurse practitioners and coordinators and provided scholarships for several SBHC staff to attend an adolescent health conference in Boston. A regional conference focused on the legal rights of adolescents was also conducted. The book entitled, Cognitive-Behavioral Interventions for Emotional and Behavioral Disorders: School-Based Practice, was provided to all SBHC mental health clinicians.

The legislatively mandated an Ad Hoc Committee that was established to provide assistance to the DPH Commissioner in improving health care through access to School-Based Health Centers (SBHC) meets quarterly. An updated report outlining the status of goals and objectives established in the initial Committee report is in process.

CT is a Coordinated School Health Grant recipient and has created a 5-year plan and an Interagency Workgroup to assist in accomplishing plan goals. This is a collaborative effort with the State Department of Education.

c. Plan for the Coming Year

Plans for the coming year include assisting SBHC contractors in maintaining current staffing and funding levels to the extent possible given the economic projections.

SBHC outreach activities at the state and community level including: disseminating the SBHC

brochure, the DPH website, participating in health fairs, attending conferences, increasing new collaborations with other state agency staff and community based providers around matters related to adolescents and school based health centers will continue.

Efforts to ensure the quality of the data provided by the SBHC contractors will continue as will the availability of the support network. DPH staff provide ongoing technical assistance and training to SBHC contractors regarding data collection and the use of the data collection system (Clinical Fusion).

Recommendations from the State Adolescent Health Plan will be implemented and staff will convene the legislatively mandate Ad Hoc Committee for SBHCs.

SBHC staff will be represented on the CSHP Advisory Group to assure the integration of SBHC services into the coordinated school health model.

State Performance Measure 5: *Percent of schools that have used a program to reduce obesity through physical exercise and nutrition education programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			6.5	7	7.5
Annual Indicator			6.5		
Numerator			19		
Denominator			294		
Data Source					The School Nutrition and Physical Activity Practic
Is the Data Provisional or Final?					
	2009	2010	2011	2012	2013
Annual Performance Objective	8	8.5	9	9.5	10

Notes - 2008

CY2008 data not available. The School Nutrition and Physical Activity Practices (SNPAP) survey was intended to be the source of data for this measure. However, the State Dept. of Education (SDE) was unable to repeat this survey due to budget constraints and staffing resources.

Notes - 2007

CY 2007 data are not available.

Notes - 2006

State Dept of Education (SDE) completed their first School Nutrition and Physical Activity Practices (SNPAP) survey in the Spring 2006. Therefore, there is no 2005 baseline data. We have projected a conservative 0.5% increase annually among the approximately 1000 public schools in the state that will implement school policies that promote healthy lifestyles to a degree which meets the acceptable level.

a. Last Year's Accomplishments

The original data source for this measure was the School Nutrition and Physical Activity survey conducted by the Dept of Education (SDE). Due to the lack of staffing and funding resources, SDE was not able to continue with this survey. Future efforts in this area will need to identify a new data source.

In November 2008, the Connecticut Childhood Obesity Council (CCOC) successfully held a statewide all-day forum entitled "Preventing Childhood Obesity A Healthy Imperative for Connecticut's Next Generation". The CCOC consists of state government agencies and representatives of the legislative branch, with a mission of establishing priorities that prevent and reduce childhood obesity and related health risks.

Through support from DPH and the Connecticut Cancer Partnership, the Community Health Center's Food & Fitness Program is testing curricula designed to support healthier eating and physical activity in elementary schools. In June, at the conclusion of this one-year study, the Food & Fitness Program will make recommendations to the DPH regarding ways for schools throughout the state to implement wellness curriculum and healthy living. The recommendations will derive from input gathered through the ongoing participatory evaluation that is being led by the Yale University Consultation Center.

Through the Preventive Health and Health Services (PHHS) Block Grant, the Nutrition, Physical Activity and Obesity Prevention Program (NPAO) provides funding, resources, and technical assistance for self-sustaining initiatives that support population-based environmental and related policy change interventions that positively influence physical activity and nutrition behaviors to twenty health departments/districts.

The SNAP-Ed (Supplemental Nutrition Assistance Program -- Education) program, with funding from the United States Department of Agriculture, disseminates nutrition education to low-income children attending over 100 preschool centers in Connecticut. The Captain 5 A Day program delivers interactive nutrition education and physical activity messages with the goal of improving healthy behaviors early in life that can be sustained through adolescents and adulthood. Family and community involvement is also a critical component of the evidence-based Captain 5 A Day curriculum.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support allocation of \$500,000 state funds to develop fitness programs and nutrition programs for overweight children				X
2. Promote partnership with newly created Obesity Program within DPH				X
3. Promote partnership with state Department of Education				X
4. Support partnerships with school-based health centers and community health centers				X
5. Support survey through Department of Education to monitor school policies across the state				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

With funding from the Connecticut Tobacco and Health Trust Fund, NPAO funded seven communities to develop, implement and evaluate policies and environmental changes that support healthy eating and being physically active targeting children 8-18 and their families, including: (1) CitySeed Inc., who work with the New Haven Food Policy Council to review federal, state, and local policies that affect the ability of public school districts like New Haven's to serve fresh, healthy school meals. The goal is to increase student consumption of fresh cooked foods

and fresh fruits and vegetables while decreasing consumption of processed foods served in New Haven schools; (2) Ledge Light Health District, who are partnering with the Town of Groton Parks and Recreation to construct an "all inclusive" playground that will increase opportunities for low income children; (3) Central Connecticut Health District, who created a Wethersfield trail guide identifying safe trails and routes using the U.S. DOT's Walkability and Bikeability Checklist; and (4) established a community garden at Fodor Farm (city-owned property) with a total of 373 plots open to the community to grow fresh fruits and vegetables.

c. Plan for the Coming Year

The SNAP-Ed (Supplemental Nutrition Assistance Program--Education) annual funds will focus on their preschool nutrition education program that aims to increase fruit & vegetable consumption among children and their families in SNAP eligible households. It encourages healthy eating in combination with daily physical activity. The program uses the Captain 5 A Day curriculum and teachers implement the curriculum after participating in a train-the-trainer workshop. The program also includes a strong parent component with take-home notes for parents and parent workshops -- Supermarket Smarts.

Program staff will provide technical assistance and manage Preventive Health And Health Services Block Grants with Local Health Departments/Districts that promote physical activity and healthy eating.

State Performance Measure 6: *Percent of infants born to women under 20 years of age receiving prenatal care in the first trimester*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			70.5	70.5	70.7
Annual Indicator		69.8	69.8	70.9	
Numerator		1984	2002	2015	
Denominator		2842	2867	2841	
Data Source					
Is the Data Provisional or Final?				Final	
	2009	2010	2011	2012	2013
Annual Performance Objective	70.9	71.1	71.3	71.4	71.5

Notes - 2008

Source: CY2008 data are not available.

Notes - 2007

Source: CTDPH Vital Statistics CY2007 final data.

Notes - 2006

Source: CTDPH Vital Statistics CY2006 final data.

a. Last Year's Accomplishments

This measure was met for CY2007. However, data for both CY2005 and CY2006 indicate that 69.8% of women less than 20 years of age receive prenatal care in the first trimester (lower than the goal of 70.5%). Although this measure was met in CY2007, this single data point does not provide solid evidence of an upward trend. Further suspect for this single data point is reflected in the poor outcomes for NPM#18 where infants born to mothers of all ages are not meeting the

goal of receiving prenatal care in the first trimester (CT=86.5% vs. a goal of 87.0%), further investigation into the factors contributing to these poor outcomes is needed.

Healthy Choices for Women and Children provided outreach and intensive case management to pregnant women, who by virtue of a history of substance use, may encounter barriers in obtaining early prenatal care. The program educated clients on the benefits of early pregnancy care.

Funds from the Right from the Start and Comadrona programs were blended and a Request for Proposal submitted to create a new program to promote case management for pregnant women and teens; this program provides outreach to identify and refer women for early entry into prenatal care. These programs are located in the cities of Hartford, Waterbury and New Haven.

Planned Parenthood of CT provided pregnancy testing, reproductive health education, counseling and prenatal linkage to community providers to promote first trimester care. PPC also provided linkages to health related programs such as WIC and Healthy Start to support compliance with prenatal care schedules.

Using a confidential and de-identified case approach, the FIMR program (in 5 distinct communities) used record abstraction and home visits to identify issues such as a lack of availability of perinatal services and lack of client knowledge that may contribute to perinatal deaths. During 2006-2007 a more statewide approach to Fetal Infant Mortality Surveillance program was implemented through an MOA with UCONN.. Efforts began to collect fetal and infant data statewide, including data from urban areas (Bridgeport, Waterbury, etc.) that were not part of the previous FIMR activities. Due to budget cuts, the FIMS program was defunded.

A public awareness campaign regarding infant mortality, particularly among African Americans and encouraging early entry into prenatal care, was conducted using radio, television, and minority newspaper advertising in the Greater Hartford and New Haven areas.

SBHCs provided outreach to identify pregnant women and age-appropriate reproductive health education, counseling and referrals of women to other related programs such as Healthy Start and WIC. Although the clinics are not considered primary sources of prenatal care for pregnant teens, they prioritize the need to assist and support pregnant teens in accessing early prenatal care. Many sites utilize a team approach (APRN and social worker) to support pregnant students.

A reproductive health workgroup, comprised of diverse stakeholders, was convened to address the reproductive health strategy outlined in the State Adolescent Health Strategic Plan. WIC emphasized and promoted early enrollment into their program and provided screenings and referrals to prenatal care providers. The program continually focuses on 1st trimester enrollment to low-income pregnant women.

CHCs, through a comprehensive care model, provided early identification of pregnant women and continuous prenatal care. Selected centers (10 of 13) provided obstetrical services on site. Smaller centers referred clients to other local prenatal care providers.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide outreach and intensive case management to identify and enroll clients in early prenatal care		X		
2. Provide culturally and linguistically appropriate services to decrease barriers to prenatal care services and providers	X			
3. Provide outreach to targeted populations (i.e. pregnant substances users)		X		

4. Provide support, information and advocacy to pregnant teens	X			
5. Provide pregnancy testing, reproductive health education, counseling and prenatal linkage to community based providers	X			
6. 6.Promote early enrollment into prenatal care as linkage from programs such as WIC				
7. Provide and promote comprehensive services to encourage women of reproductive age to enter prenatal care early				
8.				
9.				
10.				

b. Current Activities

The infant mortality campaign, previously developed, was redesigned to incorporate messages about the importance of early and regular prenatal care and promotion of protective factors like exercise, diet and healthy behaviors.

Epidemiology staff continues preparations for Round 3 of the CT PRATS survey. This work refines the sampling plan, identifies an appropriate birth cohort and improved methodology for drawing the sample, and finalizes survey content.

Family Planning provides reproductive health care to outreach and refer pregnant women to community-based programs to promote early prenatal care.

The state funded five FIMR program were no longer funded as of 5/1/09. This was a direct result of the state budget deficit.

The First Time Motherhood/New Parents Initiative Grant was received from HRSA to develop, implement, evaluate, and disseminate novel social marketing approaches that concurrently increase awareness of existing preconception/interconception, prenatal care, and parenting services/programs in Hartford and New Haven and address relationships between such services and healthy birth outcomes.

The Centering Pregnancy model of group prenatal care was implemented in New Haven at 2 sites. This model provides outpatient prenatal care services to women most at risk for delivering low birth weight infants and works to achieve outcomes that include empowerment and community building, increase satisfaction with care, reduction in preterm births, and increased breastfeeding.

c. Plan for the Coming Year

The Case Management for Pregnant Women program will provide comprehensive case management to pregnant and/or parenting women to address perinatal health disparities with emphasis on African-American/Blacks, Hispanics, teens, and adolescent fathers. The programs will provide linkages to community based providers for prenatal care services and the New Haven program is co-located in Wilbur Cross High School. Pregnant teens are referred to the program and are provided with information about the importance of prenatal care and parenting.

Healthy Choices for Women and Children, state Healthy Start Program, WIC, CHCs, and Family Planning will to provide linkages to prenatal care.

The First Time Motherhood Grant will expand the social marketing campaign into the Bridgeport area to continue to raise awareness of preconception/interconception, prenatal care, and parenting services and linkages.

DPH will work the DSS to link Birth-Medicaid data files (2000-2005 birth cohorts linked, 2006 birth

cohort recently sent to DSS for linkage). Subsequent analyses could then be conducted that may identify demographic populations that are at risk for not seeking early prenatal care. Strategies could then be developed to address these at-risk populations.

The FHS plans to complete the triple match with the WIC data as the WIC data becomes available. FHS found through an analysis of the 2000 linked Birth-WIC-Medicaid data that WIC enrollment at least 12 weeks before delivery had a protective effect on low birth weight outcomes in CT, controlling for multiple characteristics known to be predictors of adverse birth events. Similar analyses will be completed that may provide information related to the early entry into prenatal care.

State Performance Measure 7: *Percent of CYSHCN who receive family-centered, community-based, culturally-competent, comprehensive, coordinated family/caregiver support svcs incl. respite in the Regional Medical Home System of Care*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			26.4	54.1	89.8
Annual Indicator			44.9	86.4	
Numerator				4037	5931
Denominator				4675	
Data Source					Regional Medical Home Centers
Is the Data Provisional or Final?				Final	
	2009	2010	2011	2012	2013
Annual Performance Objective	50.9	52.9	53.9	54.4	54.7

Notes - 2008

Source: Due to changes in contract requirements the CY2008, the numerator would exceed the previously established benchmark, resulting in greater than 100% achievement of this performance measure. For this reason, we changed the wording of this SPM to reflect the percent increase each year of the number of CYSHCN who receive respite and support services using a baseline from CY2007 (the first year that an existing database could provide the total number of CYSHCN served).

CY2008 is based on full year regional site numbers. Annual Performance Objectives for 2008-2013 have been altered to reflect the change in measuring success by 4%, 2%, 1%, .5% and .25% respectively.

Notes - 2007

The numerator is based on a full year of the number CYSHCN served by the regional medical home sites. The denominator is the estimated number of CYSHCN that the regional medical home sites were expected to serve.

The annual performance objectives for 2008-2012 were updated to reflect this more recent data.

Notes - 2006

The annual indicator for FY2006 reflects the first year of a new methodology to collect data on CYSHCN receiving respite. These data attempted to capture information from the then existing five Regional Medical Home Centers.

a. Last Year's Accomplishments

The measure was met with an increase in the number of CYSHCN who receive respite and support services in CY2008 compared to CY2007. The Connecticut Medical Home Initiative

(CMHI) for CYSHCN was fully implemented throughout Connecticut to assure more families of children/youth with special health care needs have access to a family-centered, community-based, culturally-competent, comprehensive, coordinated system of care. CMHI contractors provided family/caregiver support services that covered a full range of needs including medical, educational, and community supports; and linked information through the medical home. The Connecticut Lifespan Respite Coalition (CLRC), a CMHI contractor, distributed respite funds and creative solutions to respite concerns to Connecticut children and youth with special health care needs and their families.

DPH monitored, enhanced, and revised the statewide respite system available through the Connecticut Lifespan Respite Coalition. In order to address the growing list of families waiting for respite relief, respite funding was distributed per family per year (previously payment had been per child.) This program change allowed more families to be served and resulted in a reduction of the respite waiting list. A second change was made to exclude families receiving discretionary funding through other state agencies, (discretionary funds and other respite options available through other state agencies far exceeds that available through DPH program).

In order to increase families' access to respite information, CLRC provided presentations to families and providers statewide that reviewed the CMHI application, statewide and community respite opportunities, creative respite solutions; and distributed the Get Creative About Respite manual. Other CLRC activities included: an updating of the Connecticut Respite Resource list, introduction of web access, distribution to support groups and professionals; a presentation to the Grandparents Raising Grandchildren Program (funded through the Area Agency on Aging); and family mentoring on how to find creative care for their special needs child/youth during the summer.

In order to share the importance of respite and to reflect the wealth of creative solutions available, CLRC began collecting anecdotal respite stories. These short vignettes demonstrated how families used a small amount of funding to creatively find a rich respite solution. One Waterbury family shared they loved to go away for a weekend but their son screamed when in a hotel room. The family purchased some camping equipment and went away for their first weekend. Finally, they were able to get away on a regular basis to enjoy time together as a family. This compilation of stories was shared with families and providers to show creative respite solutions and the impact respite funding on the lives of families who have children and youth with special health care needs.

DPH distributed the Get Creative About Respite manual through community activities and funded additional copies of the manual. DPH staff edited, printed and disseminated Directions: Resources for Your Child's Care, an information organizer for families, available both in hard copy and electronically (through the DPH web site) and included sections on Medical Home, health plan information, transition, connecting parents and families, and more. The Directions manual was translated into Spanish and Portuguese and, like the English version, was available in hard copy as well as electronically.

DPH, CLRC and other members of the CMHI followed the National Lifespan Respite Care Act of 2006, public law 109-442 which authorized competitive grants to Aging and Disability Resource Centers in collaboration with a public or private non-profit state respite coalition or organization to make quality respite available and accessible to family caregivers regardless of age or disability. The law allows grantees to identify, coordinate and build on federal, state and local respite resources and funding streams, and would help support, expand and streamline planned and emergency respite, provider recruitment and training, and caregiver training.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service
------------	--------------------------

	DHC	ES	PBS	IB
1. Provide family-centered, community-based, culturally competent, comprehensive, and coordinated family/caregiver support services		X		
2. Capture and document care coordination activities		X		
3. Distribute "Get Creative About Respite" and "Directions" manuals, and family directed respite funds	X			
4. Provide forums for sharing of "Get Creative About Respite" manual and other community support solutions		X		
5. Work with state agencies, community providers, and families to further expand the sharing of community support solutions				X
6. Follow national Lifespan Respite legislation for possible funding opportunities				X
7.				
8.				
9.				
10.				

b. Current Activities

DPH contracts through the Connecticut Lifespan Respite Coalition (CLRC) to implement respite protocols and distribute respite and department approved extended service funds for Connecticut families. Respite care includes processing of requests for respite care provided in or out of the home for the purpose of providing relief to the family/caregiver from the daily responsibilities of care provision for a child or youth with special health care needs. These services are family-directed with provider and location of the respite services of the family's choice.

CLRC staff provided a workshop on components of and uses for the Get Creative About Respite manual to participants at the ARCH National Respite Conference in Huntsville, Alabama. Get Creative About Respite, a two-part manual developed in partnership by CLRC and DPH, consists of a Parent's Guide and a Child/Adolescent Guide. The Parent Guide outlines information including types of respite care available, how to find and select respite providers, and how to prepare for respite. The Child/Adolescent Guide assists the family in documenting important information for their respite providers such as medications, health information, and how a child/adolescent spends their day. CLRC's presentation was the most widely attended workshop of the conference with over seventy-five participants; (approximately 300 individuals attended the multi-day national conference).

c. Plan for the Coming Year

The Connecticut Lifespan Respite Coalition (CLRC), functioning as a component of the CMHI, will implement respite protocols, and distribute both respite and department approved extended service funds for Connecticut families. Respite services will be family-directed with the provider and location of respite services of the family's choice. Creative respite solutions will be supported.

CT Medical Home Initiative for CYSHCN care coordinators will support medical homes in providing family-centered, community-based, culturally competent, comprehensive, and coordinated family/caregiver support services including respite to children and youth with special health care needs. Contractors will capture data related to care coordination activities covering a full range of needs including medical, educational, and community supports.

Family support services will be identified through a Family/Professional Partnership request for proposals. Assistance and culturally appropriate education to families of CYSHCN will be provided, enabling families to acquire skills necessary to access needed medical and related support services. Families will be offered opportunities to learn how to link to needed supports,

becoming empowered, competent supporters for their children.

CLRC will provide presentations to families and providers statewide - reviewing the CMHI application, statewide and community respite opportunities, creative respite solutions, and share copies of the Get Creative About Respite manual in order to increase families' access to respite information.

CLRC and the CMHI contractors will work with state agencies, community providers, and families statewide to further distribute the Directions manuals and provide forums to share local community support solutions. CLRC staff will provide a presentation on the Directions manual to participants of the ARCH National Respite Conference scheduled for Los Angeles, California.

CLRC will continue to update and distribute the Connecticut Respite Resource list; and a respite presentation will be provided to organizations with limited access to respite funding such as the Grandparents Raising Grandchildren Program (funded through the Area Agency on Aging).

DPH, CLRC, and other members of CMHI will follow the status of the LifeSpan Respite Care Act for possible funding opportunities.

State Performance Measure 8: *Percent of licensed child care centers serving children age birth to five who have on-site health consultation, as defined by the standards in "Caring for Our Children".*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			0	0	0
Annual Indicator					
Numerator					
Denominator					
Data Source					
Is the Data Provisional or Final?					
	2009	2010	2011	2012	2013
Annual Performance Objective	0	0	0	0	0

Notes - 2008

Source: CY2008 data not available for State Performance Measure, as most of the Region 1 states did not have the capacity to provide information to address this issue.

Notes - 2007

CY2007 data are not available.

Notes - 2006

This SPM is now labeled developmental as CT is working to implement methodology to collect data to measure the percent of day care centers who have on-site health consultation by an appropriately qualified health professional.
CY 2006 data are not available.

a. Last Year's Accomplishments

This measure was not met. During the 2007-2008 grant year, FHS staff had in-depth conversations with Day Care Licensing staff to discuss the actual available data from the CT Day Care Health Consultant database. In light of the fact that the database was not able to report whether a center had been visited at least once a month by a licensed health care consultant, we

updated the language to reflect information that can be obtained from the database with the resulting new SPM language: "The percent of licensed child day care centers serving preschool age children that have reported having contracts with the required four consultants (health, dental, educational and social service) to conduct the required site visits, and to ensure that the health, dental and social service consultants' licenses are current."

FHS clerical support staff will also continue to assist the Day Care Licensing Program with the data entry of the health consultation information into the database on a periodic basis to assure the availability of information for this performance measure. Once the data is at a point where queries can be completed, FHS staff will work with IT staff to obtain the baseline data from this database.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Meet with the Radon Program to review the collected Day Care Licensing inspection forms				X
2. Enter forms into an Excel spreadsheet with the assistance of the Radon Program				X
3. Review data looking to identify Child Day Care Centers that were non-compliant on the inspection forms on maintaining a health consultation log				X
4. Establish baseline on the compliance of maintaining the health consultation log at Child Day Care Centers for future comparison				X
5. Participate on the monthly Region 1 conference calls to continue the dialogue regarding the progress of other Region 1 states in meeting this measure				X
6. Discuss progress towards meeting this measure at the CT Early Childhood Partners quarterly steering committee meeting, to seek additional input from steering committee members				X
7.				
8.				
9.				
10.				

b. Current Activities

FHS staff did not actively pursue work on this State Performance Measure, as most of the Region 1 states did not have the capacity to provide information to address this issue. This was briefly discussed during the monthly Region 1 conference calls and at the February 2009 AMCHP meeting where states were more inclined to pursue a measure around rural health.

c. Plan for the Coming Year

FHS will continue to collaborate as the MCH partner with Injury Prevention staff and the CT Office of Rural Health staff in the Children's Safety Network (CSN) initiative to address the prevention of injuries in rural areas. CSN is raising the possibility with Region 1 states to implement this issue as a common State Performance Measure.

E. Health Status Indicators

Introduction

/2010/ The slight decreases of the birthweight outcomes may be a positive sign but it is too early to assume there has been a change to increasing trends. A similar caution was noted in the Health Systems Capacity Indicators about the timing and frequency of prenatal care being at sub-standard levels. Recommendations from the Strategic Plan to Address Low Birth Weight in CT may help bring positive results to improve the timing and frequency of prenatal care.

CT seemed to be making some progress with the reduction of deaths due to unintentional injuries through CY 2006 but this only held true for the continued decrease in the death rate due to motor vehicle crashes among youth age 15-14 years for CY 2007. As reported last year, this may be the result of stricter teen driver rules. Further discussion with the IPP may shed light on efforts that could be made to address the death rate among the children aged 14 and younger.

One notable change is the decrease in the infant mortality rate in CY 2006 to CY 2007 among both the African American (14.4 to 12.0) and Hispanic (7.2 to 6.1) populations. This is in contrast to the increase in the IMR for the White population between CY 2006 and CY 2007 (4.5 to 5.4).

There was very little change in the percent of the 0-19 population at the 50% and 100% below the poverty level indicators from CY 2006 to CY 2007. However, among those at 200% of the poverty level there was a decrease from 28.8% to 19.6% for this population group.//2010//

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	7.8	8.0	8.2	8.1	
Numerator	3270	3312	3389	3357	
Denominator	41749	41416	41455	41308	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008

CY2008 Vital Statistics data are not available.

Notes - 2007

Source: CTDPH final Vital Statistics data CY2007.

Notes - 2006

Source: 2006 final Vital Stats, CT DPH (denominator adjusted for unknowns)

Narrative:

/2010/ The percent of live births weighing less than 2,500 grams slightly decreased in CY 2007 by only 0.1% from CY 2006. This percent is not even lower than that seen in CY 2005 and so it is too early to assume this is a change in direction in the previously noted

increasing trend. A strategic plan was recently developed for the FHS to address low birth weight, and several objectives have been implemented. We will continue to implement strategies as funds permit. We will also continue to monitor this measure.//2010//

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	5.9	5.9	6.1	5.9	
Numerator	2354	2334	2434	2336	
Denominator	40015	39517	39679	39473	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008

CY2008 Vital Statistics data are not available.

Notes - 2007

Source: CTDPH final Vital Statistics data CY2007.

Notes - 2006

Source: 2005 final Vital Stats, CT DPH (denominator adjusted for unknowns)

Narrative:

/2010/ Similar to HSI #01A, there was a slight decrease in the percent of live births weighing less than 2,500 grams among singleton births. The CY 2007 of 5.9% is only 0.1% less than the CY 2006 figure and the same as that in CY2004 and CY 2005. Several implemented objectives, such as the funding of case management services for pregnant women in selected local areas, will continue. We will continue to monitor this measure.//2010//

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	1.6	1.6	1.7	1.5	
Numerator	660	666	686	637	
Denominator	41749	41415	41455	41308	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008

CY2008 Vital Statistics data are not available.

Notes - 2007

Source: CTDPH final Vital Stastica data for CY2007.

Notes - 2006

Source: 2006 final Vital Stats, CT DPH (denominator adjusted for unknowns).

Narrative:

/2010/ Again, there is a slight decrease in the percent of live births weighing less than 1,500 grams in CY 2007 to 1.5%. It is too early to assume this is a change in direction in the previously noted increasing trend. We will continue to monitor this measure./2010//

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	1.2	1.2	1.3	1.1	
Numerator	474	474	499	431	
Denominator	40015	39517	39679	39473	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008

CY2008 Vital Statistics data are not available.

Notes - 2007

Source: CTDPH final Vital Statistics data CY2007.

Notes - 2006

Source: 2006 final Vital Stats, CT DPH (denominator adjusted for unknowns).

Narrative:

/2010/ Similar to HSI #02A, there was a slight decrease in the percent of live births weighing less than 1,500 grams among singleton births. The CY 2007 of 1.1% is only 0.2% less than the CY 2006 figure and 0.1% less than that in CY2004 and CY 2005. Recently implemented strategies, such as the funding of Centering Pregnancy initiation at prenatal clinics serving low income women, will continue. We will also continue to monitor this measure./2010//

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	4.5	4.0	2.7	3.7	
Numerator	33	27	18	25	
Denominator	729316	682998	655901	668663	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008

CY2008 Vital Statistics data are not available.

Notes - 2007

Source: CTDPH final Vital Statistics data for CY 2007.

Notes - 2006

Source: CT DPH Vital Stats final 2006 with denominator from 2006 DPH population estimates using NCHS estimates (see DPH web site for more details).

Narrative:

//2010/ The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger has increased in CY 2007 to 3.7 per 100,000. This rate is not as high as the magnitude seen in CY 2004 and CY 2005 but it still of concern.//2010//

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	1.6	1.5	0.8	1.5	
Numerator	12	10	5	10	
Denominator	729316	682998	665901	668663	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008

CY2008 Vital Statistics data are not available.

Notes - 2007

Source: CTDPH final Vital Statistics CY2007 are not available.

Notes - 2006

Source: CT DPH Vital Stats final CY2006 with denominator from 2006 DPH population estimates.

Narrative:

/2010/ The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes in CY 2007 has increased to a rate as reported in CY 2004 and CY 2005. It may be that the single data point in CY 2006 was an outlier but we will need to monitor this trend to see if it remains.//2010//

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	20.4	16.0	20.8	15.8	
Numerator	85	75	98	75	
Denominator	416352	467721	472149	474211	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008

CY2008 Vital Statistics data are not available.

Notes - 2007

Source: CTDPH final Vital Statistics data CY2007.

Notes - 2006

Source: CT DPH Vital Stats final CY2006 with denominator from DPH 2006 population estimates.

Narrative:

/2010/ The death rate per 100,000 for unintentional injuries among youth age 15 -- 24 years due to motor vehicle crashes in CY 2007 has decreased to a rate slightly lower than seen in CY 2005. The higher rate in CY 2006 may be an outlier but we will need to monitor this trend to see if a decreasing trend continues.//2010//

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	214.9	220.4	235.9	228.8	
Numerator	1468	1505	1571	1530	
Denominator	682998	682998	665901	668663	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last					

3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	

Notes - 2008

CY 2008 hospitalization data not available.

Notes - 2007

Source: Hospital Discharge data: CT Hospital Association

Population data: National Center for Health Statistics. Postcensal estimates of the resident population of the United States for July 1, 2000-July 1, 2007, by year, county, age, bridged race, Hispanic origin, and sex (Vintage 2007). Prepared under a collaborative arrangement with the U.S. Census Bureau; released August 7, 2008. Available from: <http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm> as of September 5, 2008.

Notes - 2006

Source: FHS and Injury Prevention Program staff provided the non-fatal injury information from 2006 in-patient hospitalization data and used population figures from the 2006 Registration Report for denominators. (Note: The in-patient hospitalization data do not include data from Sharon and Milford Hospitals).

Narrative:

/2010/ The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger has decreased in CY 2007 but not as low as the magnitude seen in CY 2004 and CY 2005. We will need to monitor this measure to determine if it continues to decrease./2010//

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	22.7	22.4	18.3	18.8	
Numerator	155	153	122	126	
Denominator	682998	682998	665901	668663	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	

Notes - 2008

CY 2008 hospitalization data not available.

Notes - 2007

Source: Hospital Discharge data: CT Hospital Association

Population data: National Center for Health Statistics. Postcensal estimates of the resident population of the United States for July 1, 2000-July 1, 2007, by year, county, age, bridged race, Hispanic origin, and sex (Vintage 2007). Prepared under a collaborative arrangement with the U.S. Census Bureau; released August 7, 2008. Available from: <http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm> as of September 5, 2008.

Notes - 2006

Source: FHS and Injury Prevention Program staff provided the non-fatal injury information from 2006 in-patient hospitalization data and used population figures from the 2006 Registration Report for denominators. (Note: The in-patient hospitalization data do not include data from Sharon and Milford Hospitals).

Narrative:

/2010/ In contrast to HSI #04A the reverse pattern was seen in this measure. The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger has increased in CY 2007 but not as high the magnitude seen in CY 2004 and CY 2005. We will need to monitor this measure.//2010//

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	149.2	136.8	123.7	148.7	
Numerator	698	640	584	705	
Denominator	467721	467721	472149	474211	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	

Notes - 2008

CY 2008 hospitalization data not available.

Notes - 2007

Source: Hospital Discharge data: CT Hospital Association

Population data: National Center for Health Statistics. Postcensal estimates of the resident population of the United States for July 1, 2000-July 1, 2007, by year, county, age, bridged race, Hispanic origin, and sex (Vintage 2007). Prepared under a collaborative arrangement with the U.S. Census Bureau; released August 7, 2008. Available from: <http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm> as of September 5, 2008.

Notes - 2006

Source: FHS and Injury Prevention Program staff provided the non-fatal injury information from 2006 in-patient hospitalization data and used population figures from the 2006 Registration Report for denominators. (Note: The in-patient hospitalization data do not include data from Sharon and Milford Hospitals).

Narrative:

/2010/ The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15-24 years has been volatile over the past 4 years.//2010//

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	26.7	29.0	25.0	31.6	32.5
Numerator	2812	3060	3025	3328	3426
Denominator	105336	105336	120767	105335	105335
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008

Source: 2008 CT DPH STD MIS, CT STD Control Program denominator = 2000 Census.

Notes - 2007

Source: 2007 CT DPH STD MIS, CT STD Control Program denominator = 2000 Census.

Notes - 2006

Source: 2006 CT DPH STD MIS, CT STD Control Program denominator = 2000 Census.

Narrative:

//2010/ The rate per 1,000 women aged 15 -- 19 years with a reported case of chlamydia has been volatile over the past 4 years.//2010//

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	7.0	8.0	8.3	8.1	8.9
Numerator	4304	4954	4886	4996	5511
Denominator	617215	617215	589349	617215	617215
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008

Source: 2008 CT DPH STD MIS, CT STD Control Program denominator = 2000 Census.

Notes - 2007

Source: 2007 CT DPH STD MIS, CT STD Control Program denominator = 2000 Census.

Notes - 2006

Source: 2006 CT DPH STD MIS, CT STD Control Program denominator = 2000 Census.

Narrative:

//2010/ Similar to HSI #05A, the rate per 1,000 women aged 20 -- 44 years with a reported case of chlamydia has been volatile over the past 4 years.//2010//

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	41785	32440	6037	128	1862	51	1267	0
Children 1 through 4	169200	133656	21737	817	7605	133	5252	0
Children 5 through 9	219527	175399	27828	939	8678	211	6472	0
Children 10 through 14	238151	192819	30286	977	7948	229	5892	0
Children 15 through 19	202528	165006	26862	851	5563	209	4037	0
Children 20 through 24	223217	181242	29252	1088	7182	305	4148	0
Children 0 through 24	1094408	880562	142002	4800	38838	1138	27068	0

Notes - 2010

Source: CT Dept of Public Health, 2007 Population Estimates, Backus & Mueller, O.H.C.Q.S.A.R.

Source: CT Dept of Public Health, 2007 Population Estimates, Backus & Mueller, O.H.C.Q.S.A.R.

Source: CT Dept of Public Health, 2007 Population Estimates, Backus & Mueller, O.H.C.Q.S.A.R.

Source: CT Dept of Public Health, 2007 Population Estimates, Backus & Mueller, O.H.C.Q.S.A.R.

Source: CT Dept of Public Health, 2007 Population Estimates, Backus & Mueller, O.H.C.Q.S.A.R.

Source: CT Dept of Public Health, 2007 Population Estimates, Backus & Mueller, O.H.C.Q.S.A.R.

Narrative:

/2010/Overall, the demographic breakdown of CT by race and ethnicity changed very little from CY2006 to CY 2007. One very clear example of this is the number of infants in CY 2006 was 41,789 and in CY 2007 was 41785. Another is the total number of number of children 0-24 for these two years was 1,098,884 and 1,094,408 (a decrease of 4.1 % in all races but with a slight increase of the Hispanic population of 1.8%).//2010//

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	33332	8453	0
Children 1 through 4	137897	31303	0
Children 5 through 9	183524	36003	0
Children 10 through 14	202611	35540	0
Children 15 through 19	173983	28545	0
Children 20 through 24	190726	32491	0
Children 0 through 24	922073	172335	0

Notes - 2010

Source: CT Dept of Public Health, 2007 Population Estimates, Backus & Mueller, O.H.C.Q.S.A.R.

Source: CT Dept of Public Health, 2007 Population Estimates, Backus & Mueller, O.H.C.Q.S.A.R.

Source: CT Dept of Public Health, 2007 Population Estimates, Backus & Mueller, O.H.C.Q.S.A.R.

Source: CT Dept of Public Health, 2007 Population Estimates, Backus & Mueller, O.H.C.Q.S.A.R.

Source: CT Dept of Public Health, 2007 Population Estimates, Backus & Mueller, O.H.C.Q.S.A.R.

Source: CT Dept of Public Health, 2007 Population Estimates, Backus & Mueller, O.H.C.Q.S.A.R.

Narrative:

/2010/Overall, the demographic breakdown of CT by race and ethnicity changed very little from CY2006 to CY 2007. One very clear example of this is the number of infants in CY 2006 was 41,789 and in CY 2007 was 41785. Another is the total number of number of children 0-24 for these two years was 1,098,884 and 1,094,408 (a decrease of 4.1 % in all races but with a slight increase of the Hispanic population of 1.8%).//2010//

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Women < 15	33	25	7	0	0	0	0	1
Women 15 through 17	885	620	228	2	2	7	0	26
Women 18 through 19	1954	1379	477	7	4	16	0	71
Women 20 through 34	29390	22765	3916	199	292	1512	0	706
Women 35 or older	9331	7702	826	21	172	365	0	245
Women of all ages	41593	32491	5454	229	470	1900	0	1049

Notes - 2010

Source: CT Dept of Public Health, 2007 Final Vital Statistics.

Source: CT Dept of Public Health, 2007 Final Vital Statistics.

Source: CT Dept of Public Health, 2007 Final Vital Statistics.

Source: CT Dept of Public Health, 2007 Final Vital Statistics.

Source: CT Dept of Public Health, 2007 Final Vital Statistics.

Narrative:

//2010/A similar pattern was seen in the number live births to women of all ages. The number of live births to women of all races decreased by only 0.5% and increased in the Hispanic population by 4%. Recognizing the increasing distribution of families with Hispanic ethnicity, implemented strategies will continue to be available Spanish, when possible. //2010//

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Women < 15	15	18	0
Women 15 through 17	418	464	3
Women 18 through 19	1110	836	8
Women 20 through 34	22683	6520	187
Women 35 or older	8211	953	167
Women of all ages	32437	8791	365

Notes - 2010

Source: CT Dept of Public Health, 2007 Final Vital Statistics.

Source: CT Dept of Public Health, 2007 Final Vital Statistics.

Source: CT Dept of Public Health, 2007 Final Vital Statistics.

Source: CT Dept of Public Health, 2007 Final Vital Statistics.

Source: CT Dept of Public Health, 2007 Final Vital Statistics.

Narrative:

//2010/A similar pattern was seen in the number live births to women of all ages. The number of live births to women of all races decreased by only 0.5% and increased in the Hispanic population by 4%. Recognizing the increasing distribution of families with Hispanic ethnicity, implemented strategies will continue to be available Spanish, when possible. //2010//

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	269	160	57	1	4	4	16	27
Children 1 through 4	38	0	0	0	0	0	0	38
Children 5 through 9	11	0	0	0	0	0	0	11
Children 10 through 14	22	0	0	0	0	0	0	22
Children 15 through 19	103	0	0	0	0	0	0	103
Children 20 through 24	161	0	0	0	0	0	0	161
Children 0 through 24	604	160	57	1	4	4	16	362

Notes - 2010

Source: CT Dept of Public Health, 2007 Provisional Vital Statistics.

Source: CT Dept of Public Health, 2007 Provisional Vital Statistics.

Source: CT Dept of Public Health, 2007 Provisional Vital Statistics.

Source: CT Dept of Public Health, 2007 Provisional Vital Statistics.

Source: CT Dept of Public Health, 2007 Provisional Vital Statistics.

Source: CT Dept of Public Health, 2007 Provisional Vital Statistics.

Narrative:

//2010/ One notable change is the decrease in the infant mortality rate in CY 2006 to CY 2007 among both the African American (14.4 to 12.0) and Hispanic (7.2 to 6.1) populations. This is in contrast to the increase in the IMR for the White population between CY 2006 and CY 2007 (4.5 to 5.4). Current efforts in the state are focused on the reduction of disparities in perinatal outcomes. We will continue to monitor this indicator to ensure that the reduction in racial/ethnic disparities is not due to increases in adverse outcomes among the White population. //2010//

Health Status Indicators 08B: Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)

HSI #08B - Demographics (Total deaths)

CATEGORY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Total deaths			
Infants 0 to 1	206	56	7
Children 1 through 4	27	10	1
Children 5 through 9	9	2	0
Children 10 through 14	15	6	1
Children 15 through 19	91	11	1
Children 20 through 24	144	17	0
Children 0 through 24	492	102	10

Notes - 2010

Source: CT Dept of Public Health, 2007 Provisional Vital Statistics.

Source: CT Dept of Public Health, 2007 Provisional Vital Statistics.

Source: CT Dept of Public Health, 2007 Provisional Vital Statistics.

Source: CT Dept of Public Health, 2007 Provisional Vital Statistics.

Source: CT Dept of Public Health, 2007 Provisional Vital Statistics.

Source: CT Dept of Public Health, 2007 Provisional Vital Statistics.

Narrative:

//2010/ One notable change is the decrease in the infant mortality rate in CY 2006 to CY 2007 among both the African American (14.4 to 12.0) and Hispanic (7.2 to 6.1) populations. This is in contrast to the increase in the IMR for the White population between CY 2006 and CY 2007 (4.5 to 5.4). Current efforts in the state are focused on the reduction of disparities in perinatal outcomes. We will continue to monitor this indicator to ensure that the reduction in racial/ethnic disparities is not due to increases in adverse outcomes among the White population. //2010//

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown	Specific Reporting Year
All children 0 through 19	871191	699320	112750	3712	31656	833	22920	0	2007
Percent in household headed by single parent	7.3	5.2	22.7	0.0	3.4	0.0	0.0	0.0	2005
Percent in TANF (Grant) families	0.0	67.2	30.6	0.5	1.1	0.3	0.3	0.0	2008
Number enrolled in Medicaid	239296	173596	57436	1323	5905	856	69	111	2008
Number enrolled in SCHIP	16695	10852	2075	37	571	27	224	2909	2008
Number living in foster home care	5450	2747	1730	6	26	3	380	558	2008
Number enrolled in food stamp program	212708	149182	58810	1124	3105	269	218	0	2008
Number enrolled in WIC	45684	30203	11255	2014	933	527	752	0	2008
Rate (per 100,000) of juvenile crime arrests	4214.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2005
Percentage of high school drop- outs (grade 9 through 12)	1.8	1.2	2.6	2.2	0.7	0.0	0.0	0.0	2006

Notes - 2010

Source: CT DPH, 2007 population estimates, Backus & Mueller, OHCQSAR

Source: (no new data from last year) US Bureau of the Census, American Community Survey 2005, Table #50201, data represent female sole head of household with own children under age 18 as a percent of all households. Data for CT in Table #51101 report that female heads of households with own children under age 18 represent 80% of all singlehead households, with males accounting for 20% of single parent households. Race-specific data are not available for the combined heads of household from this source. Married couple households represent 70.8% of all households with own children under 18, the remaining 29.2% of these households have a single head of household. There is a margin for error in all of these estimates based on survey data.

Source: CT Dept of Social Services, FFY2008. TANF Family % represents % of all CT households with children less than 18 in column 1 and racial % among all TANF Families for the race-specific columns. The 2008 figures are much higher then last year but were confirmed by DSS to be accurate. Total all races is unknown and noted with a 0.

Source: CT Dept of Social Services, 2008

Source: CT Dept of Social Services, 2008

Source: CT Dept of Social Services, FFY2008.

Source: CT DPH, WIC Program, Susan Hewes.

Source: CT Dept. of Public Safety, Crimes Analysis Unit CY 2005 juvenile arrests per 0-19 population (population from #09A). Total number of arrests were only available, breakdown by race was not available.

Source: (no new data) CT Dept of Education, www.csde.state.ct.us, 2005-2006 represents annual dropout rate for CT public high schools. Continued improvement is seen for all race/ethnic groups over time ranging from a 30% to 62% decrease compared with 1997-1998 data.

Source: Dept. of Children and Families CY2008.

Narrative:

//2010/The changes from CY 2006 and CY 2007 in the demographic breakdown of infants and children age 0-29 by race and ethnicity in miscellaneous situations are most noticeable in the number enrolled in the food stamp program and the juvenile crime rate. Both these indicators increased dramatically however we are unclear if this was due to a change in the way DSS and the Dept of Public Safety reported the new figures.//2010//

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported	Specific Reporting Year
Miscellaneous Data BY HISPANIC ETHNICITY				
All children 0 through 19	731347	139844	0	2007
Percent in household headed by single parent	6.1	20.8	0.0	2005
Percent in TANF (Grant) families	58.7	41.3	0.0	2008
Number enrolled in Medicaid	0	89815	171590	2008
Number enrolled in SCHIP	0	3909	12796	2008
Number living in foster home care	1268	4182	0	2008
Number enrolled in food stamp program	132520	80188	0	2008
Number enrolled in WIC	23468	22216	0	2008
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	0.0	2005
Percentage of high school drop-outs (grade 9 through 12)	0.0	4.4	0.0	2006

Notes - 2010

Source: CT DPH, 2007 population estimates, Backus & Mueller, OHCQSAR

Source: (no new data from last year) US Bureau of the Census, American Community Survey 2005, Table #50201, data represent female sole head of household with own children under age 18 as a percent of all households. Data for CT in Table #51101 report that female heads of households with own children under age 18 represent 80% of all singlehead households, with males accounting for 20% of single parent households. Race-specific data are not available for the combined heads of household fromt this source. Married couple households represent 70.8% of all households with own children under 18, the remaining 29.2% of these households have a single head of household. There is a margin for error in all of these estimates based on survey data.

Source: CT Dept of Social Services, FFY2008. TANF Family % represents % of all CT households with children less than 18 in column 1 and racial % among all TANF Families for the race-specific columns. The 2008 figures are much higher then last year but were confirmed by DSS to be accurate.

Source: CT Dept of Social Services, 2008

Source: CT Dept of Social Services, 2008

Source: CT Dept of Social Services, FFY2008.

Source: CT DPH, WIC Program, Susan Hewes.

Source: CT Dept. of Public Safety, Crimes Analysis Unit CY 2005 juvenile arrests by ethnicity was not available.

Source: (no new data) CT Dept of Education, www.csde.state.ct.us, 2005-2006 represents annual dropout rate for CT public high schools. Continued improvement is seen for all race/ethnic groups over time ranging from a 30% to 62% decrease compared with 1997-1998 data.

Source: Dept. of Children and Families CY2008.

Narrative:

/2010/The changes from CY 2006 and CY 2007 in the demographic breakdown of infants and children age 0-29 by race and ethnicity in miscellaneous situations are most noticeable in the number enrolled in the food stamp program and the juvenile crime rate. Both these indicators increased dramatically however we are unclear if this was due to a change in the way DSS and the Dept of Public Safety reported the new figures.//2010//

Health Status Indicators 10: Geographic living area for all children aged 0 through 19 years.

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	844496
Living in urban areas	795610
Living in rural areas	124112
Living in frontier areas	0
Total - all children 0 through 19	919722

Notes - 2010

Source: CT 2007 data from American Factfinder; <http://factfinder.census.gov>; Detailed Tables; B01001 SEX BY AGE. Options - Geographic Components (found on table results)

Source: CT 2007 data from American Factfinder; <http://factfinder.census.gov>; Detailed Tables; B01001 SEX BY AGE. Options - Geographic Components (found on table results)

Source: CT 2007 data from American Factfinder; <http://factfinder.census.gov>; Detailed Tables; B01001 SEX BY AGE. Options - Geographic Components (found on table results)

Source: CT 2007 data from American Factfinder; <http://factfinder.census.gov>; Detailed Tables; B01001 SEX BY AGE. Options - Geographic Components (found on table results)

Narrative:

//2010/There were some shifts in the geographic living area figures from CY 2006 to CY 2007. The number of children age 0-19 living in metropolitan and urban areas increased by 17.6 % and 16.1%, respectively. In contrast, the number living in rural areas decreased by 35.0%. Emphasis of programmatic activity in urban areas will continue. //2010//

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	3387524.0
Percent Below: 50% of poverty	3.6
100% of poverty	7.9
200% of poverty	19.6

Notes - 2010

Source: US Bureau of Census, Current Population Survey, 2007 Table Package, Table S1701.

Source: US Bureau of Census, Current Population Survey, 2007 Table Package, Table S1701.

Source: US Bureau of Census, Current Population Survey, 2007 Table Package, Table S1701. (note: specific column was labeled "below poverty level")

Source: US Bureau of Census, Current Population Survey, 2007 Table Package, Table S1701.

Narrative:

//2010/There was very little change in the percent of the population at various levels of the federal poverty level from CY 2006 to CY 2007.//2010//

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	871191.0
Percent Below: 50% of poverty	5.3

100% of poverty	11.1
200% of poverty	19.6

Notes - 2010

Source: CT DPH, 2007 population estimates, Backus & Mueller, OHCQSAR

Source: US Bureau of Census, Current Population Survey, 2007 Table Package, Table S1703.

Source: US Bureau of Census, Current Population Survey, 2007 Table Package, Table S1703.

Source: US Bureau of Census, Current Population Survey, 2007 Table Package, Table S1701.

Narrative:

/2010/There was very little change in the percent of the 0-19 population at the 50% and 100% below the poverty level indicators from CY 2006 to CY 2007. However, among those at 200% of the poverty level there was a decrease from 28.8% to 19.6% for this population group. This is a measure we will need to monitor to hopefully see this continued trend./2010//

F. Other Program Activities

Many other programs within DPH affect the MCH population but are not funded through MCHBG. Some of these are listed below:

The Abstinence-Only Education Initiative supports a community-based abstinence-only education program in Bridgeport CT, to promote abstinence from sexual activity among racially and ethnically diverse, nine- to 14-year-old males and females.

/2008/ Connecticut no longer receives funding for Abstinence Only programs./2008//

The Asthma Program's mission is to reduce asthma-associated morbidity and mortality and improve the quality of life for people with asthma. The asthma program and FHS staff have collaborated to assess Title V program data and activities to develop interventions for children diagnosed with asthma.

/2008/ The Asthma Program's mission is to reduce asthma-associated morbidity and mortality and improve the quality of life for people with asthma. The Program collaborated with the FHS staff to assess Title V data for children with a diagnosis of asthma and develop a baseline that can be used to evaluate effectiveness of future interventions./2008//

/2010/The Asthma Program and FHS staff have collaborated to assess Title V program data available to evaluate appropriate asthma diagnosis and medical management and patient self-management education for children diagnosed with asthma./2010//

Breast and Cervical Cancer Early Detection Program provides screening and diagnostic services through 18 primary health care facilities and over 100 subcontractors throughout the state. The program provides case management and community-based education and outreach targeting medically underserved women.

Childhood Lead Poisoning Prevention Program operates a comprehensive lead surveillance system, provides professional and community education services and operates 2 regional lead treatment centers. The DPH laboratory provides blood lead testing.

/2008/Has been renamed the Childhood Lead Poisoning Prevention and Control Program and lead poisoning prevention activities are now centralized in the Regulatory Services Branch./2008//

/2009/CLPPCP also provides regulatory oversight and consultative services, and supports two Regional Lead Treatment Centers. The major goal is to eliminate elevated blood lead levels (>10mcg/dL) in children less than 6 years of age in CT by 2010.//2009//

/2010/CLPPCP provides funding support but does not operate the two Regional Treatment Centers.//2010//

Chlamydia Infertility Prevention provides free chlamydia screening and treatment services to females and their partners who attend targeted Planned Parenthood clinics.

/2008/ Free services are available at clinics to under and uninsured females, particularly those under 25 and sexually active, and their partners.//2008//

Comprehensive STD Prevention Systems Projects provides services to reduce the transmission and incidence of STDs including surveillance to monitor the trends facilitating individual case intervention.

/2010/ Since there is no additional funding for the Comprehensive STD Prevention systems Projects, the provision of services may be more limited.//2010//

Enhanced Perinatal HIV Surveillance receives CDC funding to conduct surveillance. All perinatal HIV exposures (approximately 75 infants per year) are followed-up with medical record reviews to collect information about maternal HIV testing, prenatal care, risk factors, treatment compliance, etc.

"Five-a-Day" Head Start Project focuses on providing direct nutrition education to Food Stamp eligible families in CT with the "Captain 5-A-Day" program for children and the "Supermarket Smarts" program for parents and families. These programs are delivered through workshops by state nutrition staff and provide education on food budgeting and developmentally appropriate feeding practices, and encourage dietary behavior modification including the purchase and consumption of fruits, vegetables and other low-fat foods.

Healthy Child Care CT is comprised of over 50 organizations that play a key role in the planning and delivery of child care and health care for children and families. Leadership is provided by a collaborative effort of DPH, DSS, and the Children's Health Council through the CT Head Start State Collaboration Office. /2007/ This program will be reported with the Early Childhood Program.//2007//

/2010/ Assisted by CT-ECCS funding, the CT Nurses Association coordinates the HCC-CT health consultant training effort.//2010//

/2009/ Connecticut Immunization Program activities are designed to prevent disease, disability and death from vaccine-preventable diseases in infants, children, adolescents and adults through surveillance, case investigation and control, vaccination, monitoring of immunization levels, provision of vaccine and professional and public education. The Immunization Action Program funds 11 full time health departments, 4 health districts, and 1 regional community provider to conduct activities to raise immunization rates and the Vaccines for Children provides free vaccines to over 600 health care providers to eliminate cost as a barrier to receiving immunizations. Also, The CT Immunization Registry and Tracking System permanently records and tracks all CT children's immunizations given in childhood.//2009//

/2010/The IAP now funds 2 health districts.//2010//

Intimate Partner Violence prevention is currently addressed at hospitals statewide by providing training to health, mental health and public health professionals, paraprofessionals and students statewide regarding intimate partner violence issues, screening and appropriate referral. Efforts are underway to address intimate partner violence with the women's correctional institute (York Correctional Institute).

/2010/ Last year, CT provided IPV prevention training to YCI staff and inmates. Plans are underway to work with halfway houses on this topic.//2010//

Perinatal Hepatitis B Prevention: All hepatitis B positive pregnant women and their providers are contacted to provide education about the implications of hepatitis B infection in pregnancy, offer testing and vaccination to family members and ensure that the infant receives appropriate immunization and testing.

/2007/ Primary Care Services Resource Coordination and Development Grant activities coordinate local, state, and federal resources that contribute to primary care service delivery and workforce issues in the state to meet the needs of CT's vulnerable and high risk populations.//2007//

Ryan White Care Act provides federal support for comprehensive health and social services for people living with AIDS and HIV disease, including women, infants and children. There are many AIDS activities aimed to serve women, infants, and adolescents.

Sexual Assault Prevention and Intervention Services provides direct services to victims of rape and other sexual assaults throughout the state as well as primary prevention education. DPH contracts with the CT Sexual Assault Crisis Services, Inc., an umbrella agency, to coordinate these efforts.

/2008/ Staff will be convening a committee to develop a statewide sexual assault prevention strategic plan.//2008//

/2010/A Sexual Violence Prevention Planning Committee was convened with key community stakeholders to develop a Sexual Violence Prevention Plan. Implementation of this plan will occur over the next several years.//2010//

WIC serves approximately 55,000 participants in CT. They include low income pregnant, breastfeeding and postpartum, non-breastfeeding women, as well as infants and children up to five (5) years.

/2009/ WIC serves approximately 55,000 participants monthly in CT through 12 agencies located throughout the State. The WIC Program provides food, nutrition, breastfeeding and health education, and referral services for categorically eligible individuals found to be at nutritional and/or medical risk. Categorically eligible individuals are defined as pregnant, breastfeeding and postpartum women, and infants and children up to age five who reside in CT.//2009//

/2010/WIC serves approximately 60,000 participants monthly.//2010//

WISEWOMAN (The Well-Integrated Screening and Evaluation for Women Across the Nation Program) incorporates cardiovascular disease screening and intervention services into the healthcare delivery system at nine contracted health care provider sites.

G. Technical Assistance

During the FFY 2008, CT was fortunate to receive technical assistance in the following four areas:

Population

1. Children and Youth with Special Health Care Needs

Youth with Disabilities Statewide Forum to be held September 2009. The CT Department of Public Health (DPH) and the Council on Developmental Disabilities will address, encourage and support youth with disabilities to become active on disability issues and become leaders on these issues on individual, local, statewide and national levels. Implemented under the direction of youth, particularly youth with developmental disabilities of high school and college age, this statewide youth event will address what youth with developmental and/or other disabilities perceive as issues and how the adult with disabilities and advocacy community can provide assistance and guidance. Evaluations will be completed by event participants and will include specific questions regarding youth transition. Information compiled will be incorporated into the

MCH five-year needs assessment.

2. Pregnant women/mothers

Addressing CT's Perinatal System of Care forum will be conducted in August, 2009. The DPH received technical assistance to contract with a consultant whose expertise is perinatal health. The successful contracted consultant is Dr. Heather Lipkind from the Albert Einstein College of Medicine, who is a practicing high-risk obstetrician and public health consultant. She is evaluating the state's MCH birth outcome data, and will facilitate a meeting with state and local MCH staff. An expected outcome of the meeting will be a set of recommendations to create a quality-driven perinatal system of care in Connecticut. A set of two meetings are scheduled for late August and early September, and a summary report of the proceedings is expected by the end of September 2009.

3. Children

Strategic Plan for Health Care Consultants will be completed by August 2008. The CT DPH will work with Carole Bergeron, Executive Director of the Connecticut Nurses Association to develop a strategic plan for child care health consultants. The strategic plan will eliminate redundancies and overlap in the child care health consultant field and will help develop a better system of care for children. The plan will look at what health consultants are and what services they should be providing to child care settings, facilities, children and parents. This plan will help identify and better meet the needs of children in licensed child care facilities in Connecticut.

Child Health Care Consultants Manual. The CT Department of Public Health will work with expert consultant Kim Sandor on the development of a toolkit and one-day workshop for child care health consultants. The toolkit will provide health consultants with an assessment checklist and supporting documents and will be a standardized resource to use when visiting licensed child care facilities. Together the toolkit and the workshop will help promote early intervention services for addressing health problems as early as possible in child care facilities.

4. Fathers

Early Prenatal Attachment Curriculum -- The CT Department of Public Health is working with an expert consultant, Doug Edwards, who is the Program Director of "Real Dads Forever," a Fatherhood Strategies Development organization. Mr. Edwards is a family educator, Certified Family Development Credential (FDC) Trainer and a family mediator with a community-based Families Transition Program. Mr. Edwards is also a very active member of the state MCH Advisory Committee, which is co-convened by the Title V Director and the United Way of CT. Mr. Edwards and the CT DPH have developed a draft 12-week curriculum on how to integrate or enhance the role of men in Title V programs and in particular, supporting woman during the perinatal period. The draft curriculum includes communication with the mother, strategies to reduce stressors in the relationship, impact of nutrition and lifestyle, preparing for the birth of the child, etc. The curriculum will be piloted this summer with funding from the newly awarded federal Healthy Start grant.

/2010/ Technical Assistance requests for the next year will focus on:

1. CYSHCN

The DPH contracted community based medical homes have a varying degree of expertise in the utilization of data systems. We will focus on the ability to improve care coordination capacity by better understanding and utilizing the National Data Resource Center information. The medical homes have formed learning collaborative. The purpose of this collaborative is to address an identified challenge of coordination with sub-specialists. The TA will be used to provide consultation to the collaborative to strengthen the medical home care coordination system. The medical home learning collaborative will address an additional identified challenge of ensuring the incorporation of cultural competency when implementing medical home care coordination services. The TA will be used to provide consultation to the collaborative to strengthen the medical home care coordination

system.

2. Pregnant women

The DPH is currently working with a consultant to address the perinatal system of care in the state. TA for next year is requested to take the information obtained from the state level process and replicate at the local level. The anticipated outcome will be a high-quality perinatal system of care in urban areas that focus on the reduction of health disparities. Research by the FHS Epidemiologist, Dr. Carol Stone, confirmed an association with a reduced risk for low birth weight outcome with women who are co-enrolled in the WIC program. The requested TA will be used to collaborate with the Ethel Donaghue Translating Research Into Practice (TRIPP) Center at the University of Connecticut, to conduct focus groups to address why women are not co-enrolled. The final TA request is to characterize the demographics of women who smoke in successive pregnancies with the ultimate goal of informing public health intervention strategies. This TA will be used to form a stronger collaboration with the DPH's Tobacco Cessation program.//2010//

V. Budget Narrative

A. Expenditures

There were many overall factors that impacted the actual expenditures in comparison to the FFY2008 budget. Details specific to any significant expenditure variations on each of the Budget Forms are described below.

Form 3

For FFY2008, not all of the Federal Allocation was spent for several reasons, including staff moving to other positions, delays in filling other Title V funded vacancies, and delays in the initiation of certain contracts services.

The increase in the State Funds in FFY2008 is due to the Genetics Diseases Program receiving an additional \$10,000 (one-time only) in State Match funds.

Form 5

The amount exceeded for Population Based Services was largely due to reallocation of carryover funds to activities that had a slightly different focus compared to our original plans. This is also why the expended amount for Infrastructure Building Services was less than originally budgeted.

B. Budget

State matching funds are met through funding of School-Based Health Centers, The Genetics Diseases Program, and the CYSHCN (Medical Homes). These matching funds will total \$3,975,000 for FFY2010. For FFY2008, the maintenance of effort requirement is met from several sources: Community Health Centers, Family Planning Programs and the School-Based Health Centers located throughout the state. The State of Connecticut dollars for these programs total \$3,125,000 for FFY2008. The Maintenance of Effort amount for FFY2008 is \$7,100,000 (maintenance of effort total includes the matching).

Other state-funded programs that serve the maternal and child health population include: Community Health Centers, Lead Poisoning Prevention, Asthma, Genetic Sickle Cell Program, Healthy Choices for Women and Children, Expanded School Health Services, Rape Crisis and Prevention Services, Youth Risk Behavior Surveillance, and Family Planning. In addition to these programs, there are several state-funded DPH personnel who provide support to the maternal and child health programs.

The requirement that there be three dollars of State matching funds for each four dollars in federal funding is met for FFY2010. The federal allocation for FFY2010 is \$4,729,890, which means that the State of Connecticut must match with at least \$3,547,418. Maintenance of Effort for FFY2010 is in the amount of \$7,100,000, which is \$322,809 more than the required FFY1989 base of \$6,777,191.

Other federal grants received by the Family Health Section that serve the maternal and child population will include: Healthy Start, First Time Motherhood, Primary Care Office, Rape Prevention and Education, Universal Newborn Hearing Screening, State Systems Development Initiative (SSDI), CYSHCN Integration, and ECP, CT's CECCS program.

The allocation plan requires that 30% of the FFY allocation be budgeted for Prevention and Primary Care services, as well as 30% for Children with Special Health Care Needs. For the FFY2010 award amount, \$1,419,590 (30%) is allocated for Preventive and Primary Care for Children; and \$1,997,005 (42%) for the CSHCN program. There is an allocation of administrative

costs of \$236,285 (5%) of the projected federal allocation to all programs.

In FFY2010, the federal allocation is \$4,729,890 plus using \$450,581 of the carry forward from FFY2008 funds for a total of \$5,180,471 of federal funding. When combined with the state funds of \$7,100,000 there is a federal-state block grant partnership total of \$12,280,471.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.