Maternal and Child Health Services
Title V Block Grant

State Narrative for Connecticut

Application for 2012
Annual Report for 2010

Document Generation Date: Tuesday, September 13, 2011

Table of Contents

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. IA - Letter of Transmittal

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

An attachment is included in this section. IC - Assurances and Certifications

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

Five consumers provided input by reading and reviewing the Maternal and Child Health Services 2012 Block Grant (MCHBG) application and 2010 Annual Report. The "reviewers" attended two meetings. At the first meeting we discussed the Maternal and Child Health (MCH) Programs, the Block Grant Process, and the importance of the public review process. Readers were asked to provide feedback on national and state performance measures and to relate comments about their experience around access to healthcare. Reviewers had the opportunity to contact the Family Advocate (FA) as needed before the next meeting. During the second meeting the reviewers' input was gathered and questions were answered. Block grant materials and reader notes were collected. The final application will be shared with the readers and we will procure further input as to how DPH can integrate consumer suggestions into program activities.

Reviewers were identified from DPH programs serving children who are deaf or hard of hearing, or those with involvement with the DPH Office of Oral Health.

The first reviewer was a 47 year old married mother of two daughters (12 and 14 years old), from Wethersfield, CT. The mother is a college graduate with an Associate's Degree in Liberal Arts and a Bachelor's Degree in Communications with a writing/marketing minor. She works approximately twenty-five hours per week as a substitute teacher. Both daughters attend the Middle School in Wethersfield. Interests and volunteer work focus on school activities. The reviewer is involved in education process in her town and co-chairs a town-wide parent committee, in which her primary function is to advocate for education and communication in the schools.

The second reader was a single mother of two young men. One son was diagnosed with PPD/NOS and Sensory Integration Dysfunction when he was two years old. Her nephew, born addicted to cocaine, came to live with her at the age of two and later she adopted him.

The third reviewer was a mother of two children, the youngest having bi-lateral hearing loss, is considered deaf and has a heart condition that is monitored annually. The family recently relocated to CT for dad's job (after three months dad was laid off). The family currently has medical insurance through the HUSKY program.

The fourth reviewer was thankful for the opportunity to review the MCHBG. She found it enlightening and gave her a more complete view of DPH and all the work done to promote positive and healthier outcomes for the citizens of CT. The fourth reviewer lives in Wethersfield, CT with her husband and three children; two daughters ages 16 and 12, and a son, age 15. Her youngest daughter was born with Down Syndrome, which was diagnosed through amniocentesis. Knowing prior to her birth that she would have a developmental disability gave them the opportunity to put their grieving behind and start learning about how to raise a child with special needs. "My husband and two eldest children are extremely supportive and are all full partners in helping raise our youngest to become the independent, fully included young lady that she is today". The mother has attended countless seminars, trainings, workshops, sat on various boards and committees, run a parent support group. She has become the best advocate she could be, and helps other families achieve that goal as well. She shares her experience to bring about a positive change. When her youngest daughter was in first grade, she was diagnosed with a mild to moderate hearing loss. She was very disappointed with the lack of information available to her family at that time. There were no active parent advocacy support groups that she could find, and because her daughter wasn't "born" into the deaf/hard of hearing world, she always felt as if she was not a knowledgeable advocate for her daughter with regard to her hearing loss. "Last year, a friend encouraged me to join the EHDI Task Force, where at one of my first meetings, I learned that my daughter's hearing loss could quite possibly be attributed to a case of bacterial meningitis she developed during her first year. At no time during her hospitalization did anyone at the hospital ever provide us with information of what the lasting effects could be, so we never even considered the meningitis may have been the cause of her hearing loss". It is her hope that DPH will work to help hospitals and providers to bring more timely and pertinent information to families. She often wonders, had she had known the signs of hearing loss, could they have discovered it earlier and through earlier intervention, averted or lessened some of the special services her daughter now receives.

The fifth reviewer was a married mom of four (ages 10 through 18) and resides in Glastonbury. One son, age 16, born with special health care needs consisting of cerebral palsy, significant intellectual delays, non-verbal, and global development delays. Accessing a medical home model of care allows the family to have assistance coordinating care between primary care and five specialty care providers. The reviewer has been involved in family advocacy since 1997 and presently is the Director for the Family Support Network and sits on several statewide Councils. The reviewer states that all members of her family have been able to utilize a medical home model of care delivery and she is grateful that CT providers embrace this practice.

Comments for MCHBG reviewers included that they loved reading and reviewing the grant, and that it was a valuable learning opportunity, packed with information, and that topics were clearly written. Four reviewers mentioned the need to have a glossary for acronyms. Two reviewers started a list of acronyms for their own use while reading.

One reviewer was overwhelmed by the number of agencies that seem to overlap services to the community and to populations most at risk. This reviewer suggested more consumer representatives of the population be included in the Needs Assessment Workgroup.

Several reviewers had specific comments about oral health summarizing that CT does an

excellent job of promoting and educating parents on oral health services. Since most of the education takes place under the Home By One Program, and in many cases since teeth may erupt well before one year of age, oral health education should happen before one year of age. All families should receive education on reducing the use of sugar water or fruit juice in bottles and/or allowing babies to fall asleep with a bottle. Suggestions included that it would be good to provide information about the importance of good oral health at the time of immunizations, educate young moms about good oral health practices possibly right after birth of child and partner with pediatricians.

Three family reviewers noted the difficulty of being on HUSKY. Complications include medical providers who do not accept that insurance, difficulty obtaining referrals, and families in the program feeling that they are not treated respectfully. Families feel a negative stigma attached to being on Husky, and feel that improvement is needed in the provider's mentality. They also stated that it is very difficult to obtain information and that communication between the Department of Social Services (DSS) and families regarding services need to be improved. They would also like to receive information about upcoming forums, conferences and other training opportunities.

One reviewer was impressed with the number of school based health centers and thought the opportunity existed to work closely with programs that serve children and youth with special health care needs (CYSHCN). The reviewer identified the need to link the First Time Motherhood/New Parent Initiative to the CMHI resources since enrollees may have a child with a special health care need.

They discussed the importance to enhance linkages between family, primary care providers, and schools.
One reviewer was concerned about the confidentiality of the data, and the safeguards built into the system to protect it.

Mental/behavioral health services are identified as a state priority and workforce issues are a concern with providers needed to serve this population. Health Professional Shortage Areas (HPSA) are exacerbated by providers who do not take state insurance. Access to care for families with this type of insurance is limited.
In addition to the reviews described above, a graduate level student developed a MCHBG study guide which bookmarks sections of the grant and assists the reader in navigating through the entire document. The study guide is accompanied by a web-based survey for consumers and one for providers. The study guide and surveys will be used for collecting feedback with next year's grant application. The study guide was presented to MCH and Home Visiting leaders and stakeholders at a welcome reception for the new DPH Commissioner on April 20, 2011.

The Title V Director shared information with stakeholders through Power Point presentations and handouts including descriptions of the Needs Assessment process and the grant application. Presentations were offered at: 1) FHS Staff meeting (8/12/2010); 2) Legislative Appropriations Committee (9/22/2010); 3) Women's Health Forum (11/17/2010); 4) MCH Advisory Committee (12/7/2010); 5) Education Committee of the CT Public Health Association (4/13/2011); and 6) UConn MPH class (4/13/2011).

II. Needs Assessment

In application year 2012, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

Changes in the population strengths and needs in the State Priorities

The five-year Needs Assessment conducted for the FFY 2011 MCHBG application identified nine State Priorities similar to those identified in the 2005 Needs Assessment. These nine State Priorities remain the same for FFY 2012 application.

1) Enhance Data Systems
2) Improve Mental/Behavioral Health Services
3) Enhance Oral Health Services
4) Reduce Obesity among the three target MCH populations
5) Enhance Early Identification of Developmental Delays, Including Autism
6) Improve the Health Status of Women, related to depression
7) Improve Linkages to Services/Access to Care
8) Integrate the Life Course Theory throughout all state priorities
9) Reduce Health Disparities within the three MHC target populations

Changes in the State MCH program or system capacity in those State priorities

Five of the State Performance Measures (SPMs) have been revised:
• Improve Mental/Behavioral Health Services-Percent of students that had a risk assessment with a mental health component conducted during a comprehensive, annual physical exam at a SBHC.
• Enhance Oral Health Services-Percent of child health providers/dental providers who serve at risk populations that perform dental caries risk assessments and provide oral health education and risk based preventive strategies by age one.
• Reduce Obesity among the three target MCH populations -- Increase the redemption rate of fruit and vegetable checks issued to women and children enrolled in the Connecticut WIC program.
• Improve the Health Status of Women, including Depression -- The percent of pregnant and postpartum women who receive preconception and interconceptional health screening (including depression) and education in DPH-funded case management/Home Visiting programs.
• Reduce Health Disparities within the three MCH target populations --the extent to which the ratios of key perinatal health measures for non-Hispanic Black/African Americans relative to non-Hispanic Whites has changed.

On-going NA activities that enable the State to continue to monitor and assess on an on-going basis its priority needs and its capacity to meet those needs

A Study Guide for the Maternal and Child Health Block Grant was developed with the intent to obtain participation and feedback from community members, stakeholders, services providers, and consumers. The Family Health Section wanted to develop a template for a guided discussion with outside partners. The study guide is intended to cross reference essential information included in the different sections of the Block Grant, such as: 1) Priority Needs, 2) Risk Factors, 3) National Performance Measures, 4) State Performance Measures, 5) Program Activities, and 6) Organizational Capacity. The study guide will serve for quick reference of these components.

The study guide is accompanied by a web-based survey for consumers and one for providers.

The surveys were designed to collect feedback from community participants around the process used by the DPH to: 1) be inclusive of the community in the writing of the grant application, conducting/updating the Needs Assessment, and revising corresponding performance measures as needed, and 2) share with the community the final draft of the grant application, progress/annual reports, and needs assessments prior to submitting to HRSA. The study guide and surveys will be used for collecting feedback with next year's grant application.

A brief description of any activities undertaken to operationalize the NA, such as establishing an advisory group to monitor State progress in addressing the findings and recommendations resulting from the NA.

The CT State Title V Director meets quarterly with the Maternal and Child Health (MCH) Advisory Committee to provide regular updates to the group and solicit feedback from participants. The MCHBG Study Guide was reviewed with the Advisory Committee during a Spring meeting.

III. State Overview

A. Overview

Connecticut (CT) is a small state of about 5,000 square miles and 169 towns, and has an estimated statewide population of 3,501,252 (July 1, 2008). The average town population is about 20,000. Five towns have a population greater than 100,000: these are the towns of Bridgeport (136,405), Hartford (124,062), New Haven (123,669), Stamford (119,303), and Waterbury (107,037). In 2008, there were 41 towns that had high unemployment rates, of which18 had populations that exceeded the average. The need for social services in the state is not limited to towns of high population.

CT is characterized by high social and economic contrast and racial and ethnic diversity. It is the third smallest state in the U.S. in terms of area, but it has the 29th highest population and is the fourth most densely populated state. Approximately 88% of CT's population lives in urban areas. While CT is one of the wealthiest states in the country, several cities have high rates of poverty. With a median household income of $68,595, CT was ranked third highest in the nation in 2008.

Racial and ethnic disparities exist across town lines, and between urban and rural populations. Racial and ethnic diversity is increasing in CT. From 2000-2007, the state's Asian population increased by 38.2%, the native Hawaiian or other Pacific-Islander population increased by 29.3%, and the Hispanic/Latino population increased by 24.8%. Hispanics or Latinos have shown the most growth of any CT racial or ethnic subgroup in terms of overall numbers during this period. (The CT Health Disparities Report, 2009). In 2007, the Hispanic or Latino population comprised 11.5% of the CT population, black or African Americans 9.3% and Asian 3.4%. These differences have engendered the concept of two CT's -- one comprising people who live in the wealthiest state in the nation, and the other consisting of those who live in some of the most severe and concentrated pockets of poverty in the U.S. The overall health of CT's people varies between its wealthiest and poorest communities.

According to the U.S. Census Bureau (2006), one in ten (10.3 percent) CT children under 18 (84,000) lived in a household with income below the federal poverty level ($20,516 for a family of four). That's down from the 2004 level (12.4 percent) but represents no improvement from the 2003 level (10.1 percent), according to the U.S. Census Bureau's Current Population Survey (CPS). One in four (25.8 percent) CT children lived in a household with income below 200 percent of the federal poverty level in 2006, according to CPS data (The 2004 level was 23.9%). According to a second measure that uses a larger sample, 10.7 percent of CT children under 18 (86,000 children) in 2006 lived in a family with income below the federal poverty level. This data from the U.S. Census Bureau's American Community Survey represents no improvement from the 2004 level (10.1 percent).

Employment levels in CT have plummeted since the start of the recession in December 2007. One year since the CT economy began losing jobs, it has already shed 95 percent of the total jobs lost during all three years of the previous recession. CT lost 58,000 jobs, (3.4 percent decline in total jobs), between March 2008 and March 2009 (CT Department of Labor (DOL), April 2009. This level of job loss is similar to the national employment decline of 3.5 percent. The Initial claims for unemployment insurance jumped 75.5% from 16,268 to 28,551, the highest number since the 1991-1992 recession (The CT Economic Digest, January 2010).

I. Maternal and Child Health Indicators

1.A. Maternal and Child Demographics

In 2008, there were 40,106 births to CT residents. Of these births, 23,406 were to non-Hispanic White/Caucasian mothers, 5,017 were to non-Hispanic Black/African American mothers, and 8,662 births were to women of Hispanic/Latino ethnicity. Seventeen percent of the births to non-Hispanic White/Caucasian mothers, 57% of the births to non-Hispanic Black/African American

mothers and 54% of the births to Hispanic mothers were paid by public insurance. Thirteen percent of the births to Hispanic mothers were either self-paid or were uninsured vs. 2% for non-Hispanic White/Caucasian mothers.

Many maternal and child health indicators of health within CT compare favorably with the United States as a whole. High-risk groups experience a disproportionate burden of adverse health risk factors and outcomes. These disparities are documented in more detail in the Needs Assessment. To address racial and ethnic disparities in the state is a priority. Reducing the disparities in maternal and child health indicators remains one of the major challenges facing the public health community.

1.B. Infant Mortality

Approximately 260 babies die annually in CT, of whom about 200 die within the first month of life. Approximately 50% of these deaths are associated with low birth weight (LBW). Analysis of the 2000-2004 birth cohort, broken down into Perinatal Periods of Risk (PPOR) categories, indicates that fetal and infant deaths for babies of very LBW among non-Hispanic Black/African American mothers is nearly 4 times higher that that among non-Hispanic White/Caucasian mothers. Also significantly elevated are deaths to babies with higher birth weights.

The racial/ethnic disparity seen in feto-infant mortality rates 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 birth weight. Focusing prevention programs on groups showing a high rate of low and very LBW 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.

DPH programs intended to reduce infant mortality start before conception and continue through the prenatal and postnatal periods. Preconception interventions aimed at school-aged audiences and women of childbearing age include primary care services, health education programs, outreach and case-finding to link individuals and families to primary and preventive services. 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. Programs that include home visiting services funded by the Maternal and Child Health Block Grant (MCHBG) have been implemented to provide special care to pregnant women at high risk for adverse infant health. In 2009, DPH received federal funding to establish a Healthy Start community in Hartford, joining the New Haven Healthy Start program. These programs include outreach services to the Black/African American communities of the state.

1.C. Births to Teens

Teen birth rates in the state have decreased since calendar year 2000, but remained high in 2008 within the Hispanic/Latino community, where the teen birth rate was nearly ten times higher than that within the non-Hispanic White/Caucasian community. The teen birth rate within the non-Hispanic Black/African American community was over four times higher that that within the non-Hispanic White/Caucasian community. Among all the towns in CT, teen birth rate was highest within New Britain, where one in every 13 teen gave birth during the calendar year (birth rate 75.6 per 1,000). This rate was three times higher than the statewide average of 25.0 per 1,000 women, and nearly two times higher than the 2007 U.S. rate of 42.5 per 1,000.

Teen pregnancy is considered a public health problem for 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 CT'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. Programs such as the Case Management Program for Pregnant Women and Parenting Teens, Healthy Choices, and Healthy Start (state and federal) serve pregnant and parenting teens. These programs provide case management services with emphasis on promoting positive pregnancy outcomes and positive parenting. The DPH FHS implemented a new Case Management for Pregnant Women program in three large cities with high rates of teen births. The program targets pregnant females and teens under the age of 20 who are at greatest risk for poor birth outcomes. This is a coordinated, culturally-sensitive approach to providing individualized client services through intensive case management and home visitation. The services are provided during the perinatal and interconceptional periods, with a focus on all aspects of achieving a healthy birth outcome, as well as building social supports, providing education, promoting birth spacing, family planning, referral to ongoing medical care, and building social supports promoting client self-efficacy.
The DPH recently submitted a grant proposal for funding in teen pregnancy prevention programs. If funded, the program will bring much needed intervention into high need communities, including the town of New Britain.

1.D. Prenatal Care
Early and regular prenatal care are protective factors against maternal and infant adverse outcomes, including infant mortality, low birth weight, and maternal complications. The Department has tried to improve access to prenatal care through strategies, such as supporting sites for primary care and free pregnancy testing at family planning clinics. At these sites, patients are referred for early prenatal care, in keeping with established protocols. Outreach services in Hartford through the recently funded Hartford Healthy Start program may help encourage pregnant women into early and regular care. Changes in the state's public insurance policies increased the eligibility limit for pregnant women to 250% of the federal poverty level (FPL) and provides presumptive eligibility to receive healthcare as the application is being processed, may encourage early entry into prenatal care. Coordination of home visiting services enhanced by the Patient Protection and Affordable Care Act of 2010 may also help to address early entry into prenatal care.

1.E. Low Birth Weight (LBW)
LBW (with weights less than 2,500 grams, or 5.5 pounds) is a major risk factor of infant mortality and long-term health problems. The impact of LBW on infant mortality occurs primarily during the first 28 days of life (the neonatal period), when LBW infants are about 32 times more likely than normal weight infants to die.

LBW rates among all singleton births in CT have not changed significantly since calendar year 2000. In 2008, low birth rate among non-Hispanic White/Caucasian mothers was 4.5 per 100 live births, 10.5 per 100 among non-Hispanic Black/African American mothers, and 6.5 per 100 live births among women of Hispanic/Latino ethnicity. LBW events were most concentrated in six towns: Hartford, New Haven, Bridgeport, Waterbury, New Britain, and East Hartford. Recent media campaigns focused on the African American and Hispanic communities of Hartford, New Haven and Bridgeport with funding from the federal First Time Motherhood Initiative. Additional efforts to address LBW in the state include a strategic plan within the FHS, state legislation to monitor LBW as a consequence of the recession, and a recent emphasis on LBW within the Women's Health Subcommittee of the Medicaid Managed Care Council, suggest that efforts surrounding LBW will continue in the future.

1.F. Maternal Depression
Information about maternal depression prevalence in CT is not readily available. Results of a point-in-time survey conducted in 2003, probed a variety of social risk factors for adverse births. The survey was conducted with women two to four months postpartum. Results of the survey revealed disparities in how women experienced their most recent pregnancy. Relative to non-Hispanic White/Caucasian women, three-times more non-Hispanic Black/African American women indicated that their pregnancy was one of the worst times in their life. These results do not explore the reasons why women of minority race and ethnicity experience more difficulty, but

recent publications indicate that social support structure is an important component to healthy maternal and birth outcomes. A new survey will be initiated within the next few months, and questions contained in the survey may further explore maternal depression in the state.
DPH contracted with Yale University to conduct training session of health care providers (obstetricians, family practitioners, pediatricians, social workers, nurses, mental health care professionals) about perinatal depression including perinatal risk factors, screening, diagnostic questionnaires, barriers to patient care, medications and service referral. This was a successful collaboration demonstrated by training 465 health care professionals in SFY 2008; toolkits were distributed to over 169 locations and 659 individuals that practices can use on an ongoing basis to educate, screen, and refer women and families. All Child Development Infoline (MCH Information and Referral Service) staff were trained regarding perinatal depression screening. Some practices and hospitals have adopted use of the screening tool as part of their assessment of pregnant women at their first prenatal visit. Trainings of health care professionals are continued in SFY10.

1. G. Oral Health

Dental caries (tooth decay) is an infectious disease process affecting both children and adults. During childhood, tooth decay is the single most common chronic disease, five times more common than asthma.

A 2007 oral health assessment of preschool (2-4 years old), kindergarten (5-6 years old and third grade (8-9 years old) students in CT determined the following: 1) dental decay is a significant public health problem for CT's children; 2) many children in CT do not get the dental care they need; 3) one in every 4 preschool children have experienced dental decay; 4) more than 60 percent of children in CT do not have dental sealants, a well accepted clinical intervention to prevent tooth decay in molar teeth; 5) there are significant oral health disparities in CT with minority and low-income children having the highest level of dental disease and the lowest level of dental sealants; 6) forty-one (41%) of third grade children have experienced dental decay and of those with decay experience, 18 percent have untreated decay.

The Office of Oral Health has initiated the Home by One program to build integrated partnerships with the early childhood community at the state and local levels that focus on oral health as essential to the overall health and well-being of children in CT.

1.H. Breastfeeding

Breastfeeding provides optimal nutrition for infants and is associated with decreased risk for infant morbidity and mortality as well as maternal morbidity (US Dept of Health and Human Services, Agency for Healthcare Research and Quality; 2007). Maternity practices in hospitals and birthing centers can influence breastfeeding behaviors during a period critical to successful establishment of lactation. All of CT's birth facilities have the option of reporting on the mother's intent to breastfeed. Since some mothers have not decided to breastfeed within twenty-four hours of birth, the hospital staff often leave this question unreported or report intent as "undecided".

CT has a Baby-Friendly hospital initiative in place and currently has three hospitals designated as Baby-Friendly. Baby-Friendly Designation is a globally recognized symbol of world-class maternity care, endorsed by the United States Breastfeeding Committee, the World Health Organization, and UNICEF. The pathway to designation provides maternity facilities the opportunity to improve health outcomes for mothers and babies; improve patient satisfaction, elevate reputation and standards of care, and increase market share; enhance a professional environment of competence; demonstrate a commitment to quality improvement; and build leadership and team skills among staff. All CT hospitals report breastfeeding data to the CDC's Maternity Practices in Infant Nutrition and Care (mPinc) project. DPH and CT Breastfeeding Coalition (CBC) assist the birth facilities through the initial discovery and development phase of the process. A program consultant will help the birth facilities complete at least five of the ten steps towards designation, by offering 40 hours of consultation with an International Board Certified Lactation Consultant (IBCLC) with Baby-Friendly experience, and a two day training

course. CT has an agreement with the Connecticut Breastfeeding Coalition through ARRA funding, to support ten (10) hospitals in earning the "Baby Friendly Hospital" designation.

In FFY09, the twelve regional CT WIC sites reported breastfeeding rates that exceeded the WIC goal of > 55%, yet only two of the twelve sites met or exceeded the HP 2010 objective of 75%. CT birth facilities require further education on adhering to the standard clinical practice guidelines against routine bottle supplementation when breastfeeding. Nine percent of CT hospitals have comprehensive breastfeeding policies as recommended by the Academy of Breastfeeding Medicine. Nine percent of CT hospitals provide patients with post-discharge telephone or opportunity for a follow-up visit. DPH's Immunization Program now includes breastfeeding educational materials in the hospital discharge packet in all birth facilities. The information provides contact information for support and referral.

Most WIC nutrition staff are Certified Lactation Counselors (CLC), trained to provide individualized support for breastfeeding mothers and each site has a dedicated Breastfeeding Coordinator to provide breastfeeding support, education and referrals. CT WIC continues to provide annual training for nutritionists to become CLCs and renew their certification.

The CT WIC program has expanded the Hispanic Health Council/Hartford Hospital Breastfeeding: Heritage and Pride (BHP) breastfeeding peer counseling program to Yale-New Haven Hospital (YNHH). YNHH has a number of breastfeeding initiatives underway that demonstrate its unique suitability for successfully implementing a breastfeeding peer counseling program, including: initiation of a breastfeeding clinic, providing an alternate location for peer counselors to meet with their clients to provide follow up and support, with access to a Lactation Consultant or physician, integration of the peer counseling program into the administrative structure of the Yale Primary Care Center (PCC) as well as inpatient maternity services. The Yale PCC serves largely African American individuals and this segment of the population has lower breastfeeding duration rates that its White or Latino counterparts. The provision of this evidence-based service to the YNHH population is consistent with national and state health objectives to reduce or eliminate racial and ethnic disparities.

1.I. Obesity

Obesity is the second leading cause of preventable death in the United States after smoking (Wee, American Journal of Public Health, 2005). According to the 2008 Pediatric Nutrition Surveillance System, which assesses weight status of children from low income families participating in WIC, 31.2% of low income children age 2-5 are overweight or obese in CT. One in four (26%) CT high school students are obese (12.3%); are overweight (13.3%) (2007 YRBS). Adolescents who are overweight have an 80% chance of being obese as adults. One in five CT high school students (21.5%) eats the recommended five or more daily servings of fruits and vegetables (2007 YRBS).

1.J Immunizations

The Immunizations Program distributes vaccines to providers throughout the state, conducts surveillance for vaccine preventable diseases, conducts quality assurance reviews for vaccines for children programs, conducts educational programs for medical personnel and the public, works with providers using the immunization registry to assure that all children in their practices are fully immunized, promulgates rules and regulations related to vaccination requirements for day care, schools, colleges and universities. Beginning August 1, 2010 all incoming CT college freshman (full-time or matriculating) will be required to show proof of 2 doses of measles, mumps and rubella vaccine and 2 doses of varicella (chickenpox vaccine). Beginning September 1, 2010 all children born on or after January 1, 2009 who attend a child day care center, group day care home, or family day care home ages 12-23 months are required to have one dose of the Hepatitis A vaccine; two doses are required for those aged 24 months and older. By January 1, 2011 and each January 1 thereafter, children aged 6-59 months attending a child day care center, group day care home, or family day care home are required to receive at least one dose of influenza vaccine between September 1 and December 31 of the preceding year. The Immunization's staff

facilitates the Vaccine Purchase Advisory Committee (VPAC) that makes recommendations to the State Department of Public Health on issues related to the use of publicly purchased vaccines for childhood and adolescent vaccinations.

II. Other Indicators

II.A. Socioeconomic Indicators in CT

CT is a small state of about 5,000 square miles and 169 towns, with a July 1, 2008 estimated statewide population of 3,501,252. The average town size is about 20,000, and only five towns have a size greater than 100,000. These five towns are Bridgeport (population 136,405), Hartford (124,062), New Haven (123,669), Stamford (119,303), and Waterbury (107,037).

41 towns had high unemployment rates reported in 2008, with Hartford having the highest at 10.9%. Eighteen towns with high unemployment rates had populations that exceeded the average town size. These data indicate that the need for social services in the state is not limited to towns of high population.

II.B. Health Care Delivery Environment in Connecticut

CT's direct health care services are delivered through a range of providers including, but not limited to, school based health centers (SBHC), community health centers (CHC), 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. To date, 11 "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. The licensure or certification of health care facilities and health care professionals guides delivery of 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 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. To complement the Healthy Start program, CT also has a Nurturing Families Network, which operates in all 29 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.

II.C. Safety Net Providers

Safety Net Providers are part of the system of care that addresses the needs of individuals who experience barriers when accessing the traditional health care system. Some of these barriers include financial, transportation, cultural and linguistic differences, etc. Populations targeted by safety net providers include uninsured, underinsured, immigrants, and the homeless. The safety net providers in CT include CHC, SBHC, Visiting Nurse Associations (VNA), Local Health Departments (LHD) and Family Planning Clinics. In the past year, federal stimulus funding allowed community health centers to cover costs associated with treating additional patients, develop infrastructure, and allowed existing CHC to add sites. Three CHC obtained 330 Federally Qualified Health Center (FQHC) funding (Community Health and Wellness Center of Greater Torrington, Norwalk Community and Family Services, Inc., and the Greater Danbury CHC). State bonding dollars have been made available to CHC and SBHC to continue to build their capacity as a safety net provider.

II.D. Health Insurance

As of May 2009, 9,671 CT residents were enrolled in the Charter Oak Plan (CT's universal health coverage plan, available to all consumers on an income-based sliding scale). Another 4,927 were eligible but not enrolled.

HUSKY (Healthcare for UninSured Kids and Youth) is CT's health insurance plan for children and families. In 1997 when the federal government created the State Children's Health Insurance Program, CT 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. HUSKY A and B are managed care programs, administered through the Department of Social Services (DSS) and private health plans. HUSKY A covers pregnant women (with income under 250% of the FPL and children in families with income under 185% of the FPL. Parents and relative caregivers can also obtain comprehensive benefits. The basic HUSKY package includes preventive care, outpatient physician visits, inpatient hospital and physician services, outpatient surgical facility 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.

Mental and behavioral health services; and dental services are carved out and administered through Administrative Service Organizations (CT Behavioral Health Partnership, and CT Dental Health Partnership). Pharmaceuticals are administered directly through the Department of Administrative Services.

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

HUSKY gives families the flexibility to choose one of three participating managed health care plans: Aetna Better Health, AmeriChoice by United Healthcare, or Community Health Network of CT.

A fee for service option, HUSKY Primary Care, Connecticut's Primary Care Case Management (PCCM) program, is now available to HUSKY A members in the Hartford, New Haven, Waterbury, and Windham areas. In HUSKY Primary Care, the primary care provider has a greater role in coordinating health care on a Per Member Per Month (PMPM) reimbursement basis. The providers in HUSKY Primary Care offer the same services offered by a managed care health plan, such as health education, reminders about immunizations and well-child visits, and help in scheduling appointments.

There are 378,571 persons, including 249,156 children under 19 enrolled in HUSKY A as of June 1, 2010. HUSKY B provides health care for children without employer-sponsored coverage for a sliding fee. There are 15,476children under 19 in HUSKY B as of June 1, 2010 (CT Voices for Children; web site www.ctkidslink.org).

DPH has provides policy guidance and technical assistance to the HUSKY program through:

- DPH medical home care coordination, extended services, and respite fund administration contractors provide benefits coordination for families of Children and Youth with Special Health Care Needs (CYSHCN) to assist in accessing public/private sources to pay for services needed.
- Participation in the Covering CT's Kids coalition, a network of organizations involved in HUSKY outreach (including DSS, and MCH Information and Referral Service),
- Partnering in the work to expand Katie Beckett waiver and other related DSS waiver applications to 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 under Early Periodic Screening and diagnostic and Treatment Services,
-Working to facilitate access to PCCM as well as to the Medicaid Managed Care plans.
- Working with the State Commission on Children, HUSKY and other CT key stakeholders in promoting home visitation for mothers with newborns, particularly at risk mothers using Healthy Start and Nurturing Families Programs,
- Providing care coordination and respite care as well as family support services to children with special health care needs in HUSKY.
- Developing linkages between HUSKY and state public health programs such as WIC, childhood immunizations, Medical Home Learning Collaborative of primary care physicians, SBHC, CHC, Family Support Council, and other essential community services and Title V funded programs.
- Utilizing existing services to create access points for referral or applications to enhance outreach and enrollment; and
- Implementing quality improvement activities and evaluation.

E. Racial and Ethnic Disparities
In 2007, the Hispanic or Latino population comprised 11.5% of the CT population. Hispanics represented 35.1% of uninsured CT adults (2004-2006 CT BRFSS). Hispanics represented 17.5% of all reported Chlamydia cases (2001-2005). Hispanics represented 35.1% of all reported HIV/AIDS cases (2001-2005). In 2005, about 22% of Connecticut doctors reported that they felt unprepared to treat patients with limited English proficiency (Hispanic Health Council 2006, 31-32).

Among the Black/African American population, age-adjusted death and premature mortality rates of Black/African Americans CT residents are significantly higher than those of the White, non-Hispanic Connecticut residents for the following leading causes of death - heart disease, cancer, cerebrovascular disease, HIV, and diabetes (2000-2004 data). African Americans have 1.2 times the age-adjusted death rate for all causes, 1.2 times the age-adjusted death rate for heart disease, 1.1 times the age-adjusted death rate for cancer, 1.4 times the age-adjusted death rate for cerebrovascular disease (stroke), 2.5 times the age-adjusted death rate for diabetes, and 14.9 times the age-adjusted death rate for HIV/AIDS compared with White, non-Hispanic CT residents. (The CT Health Disparities Report, 2009)

The Title V programs have incorporated contract language that requires providers to deliver culturally competent services and demonstrate this by: developing a mission statement committing to cultural diversity, develop materials in languages reflecting the needs of the patient population, policies and procedures to address the needs of the patient population, taking into account factors such as race, ethnicity, age, gender, hearing impairment, visual impairment, physical disability, mental illness, developmental disability and sexual orientation.

The DPH Office of Multicultural Health (OMH) is responsible for providing leadership in promoting, protecting, and improving the health of all CT residents by eliminating differences in disease, disability, and death rates among ethnic, racial and culturally diverse populations. The Office promotes access to quality health education and health care services; facilitates presence of diverse populations in health planning, program development, policy formation, and outreach and awareness initiatives. OMH functions largely through collaboration with statewide partners, and recommends policies, procedures, activities, and resource allocations to improve health among the states' underserved and diverse populations, and to eliminate health disparities.

OMH leads state and local partners in addressing multicultural health issues and eliminating health disparities by focusing on the goals of: 1) Improving Language proficiency; 2) Promoting Cultural Competency; 3) Increasing Workforce Diversity; and 4) Enhancing Awareness, Access to Health Care and Health Education.

F. Rural Health

The CT definition of rural 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 CT. Of the 169 towns in CT, there are 52 with populations of less than 7,000 as of 2008. Specific concerns identified for rural CT include: emergency medical services, transportation, recruitment and retention of adequate workforce, a decreasing social services safety-net, mental health, oral health, and others. Currently there are 7 of CT's rural towns, which are designated as Medically Underserved Areas/Populations (MUA/Ps). The Title V program will continue to support the Primary Care Office (PCO) now located in the Family Health Section (FHS), to continue to assess and designate Connecticut's rural communities collaborating with the ORH. The DPH has representation on the Office of Rural Health (ORH) Advisory Board.

The CT ORH identifies data sources, analyze and report the key health care issues impacting rural CT. The overall goal is to gain a better understanding of the health status of rural residents and develop a supporting rural health database. Results from a survey 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 at www.ruralhealthct.org/report.htm.

CT DPH Injury Prevention Program and MCH staff are collaborating with the CT-ORH on the Region 1 Rural Injury Community of Practice initiative facilitated by the Children's Safety Network. An analysis of rural and non-rural injury-related mortality and hospitalizations for leading causes of injury was recently completed. The next step is to look at additional sources of data on rural injuries, identify existing prevention efforts/partnerships and develop a rural focus for these efforts as needed.

G. Other Vulnerable Populations

DPH is interested in the health needs of vulnerable women and children, many of whom face financial, language, and cultural barriers to care. 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), and immigrant and undocumented populations. Safety net providers, such as community health centers and school based health centers, as well as case management programs, help address the needs of vulnerable populations.

Incarcerated Women's Health: The DPH collaborated with DOC and a community-based agency to continue to provide intimate partner violence/trauma training to inmates onsite at York Correctional Institute (YCI), CT's only female prison. In addition, plans are underway to provide this training to recently released women at halfway houses and resettlement programs. The goal is to help this vulnerable population understand what intimate partner violence is, prevent repeated trauma, seek appropriate resources and supports, and develop healthy relationships.

Male Involvement: The FHS recognized that the health of fathers and men impacts the health of women, children and families. The Title V Program is an active participant on the DSS Fatherhood Initiative Council that develops and disseminates consumer and provider educational materials regarding the importance of men's health and the impact on maternal and child health. This workgroup is comprised of members from DCF, DSS, DOC, and community based organizations. DPH is contracting with Real Dads Forever, Inc. who will pilot, conduct and evaluate a train-the-trainer training of its recently developed health education curriculum for male partners to providers in the Hartford Healthy Start Program. The goal of the training to men is to increase involvement between fathers/family men ages 15 through 30+, single or married, and their children. The training will provide strategies directed at male partners to support women during pregnancy by providing strategies that reduce stressors in their relationships and that positively impact lifestyles in support of the child.

DPH supports and partially funds the annual New England Fatherhood Conference, which

reaches out to birth fathers, fatherhood practitioners, child welfare leaders, and community-based staff workers to participate in the conference and share information in both formal and informal venues.

DPH also was a signatory in a Memorandum of Understanding among the State Departments of Social Services, Children and Families, Mental Health and Addiction Services, Correction, Labor, and Education, and the Judicial Branch to collectively develop an annual report to be presented to the Fatherhood Advisory Council to provide information on expenditures and programmatic/statistical activities.

III. Health Priorities

A. MCH Priorities
The nine identified state priority needs are: 1) Enhance Data Systems; 2) Improve Mental/Behavioral Health Services; 3) Enhance Oral Health Services; 4) Reduce Obesity among the three target MCH populations; 5) Early Identification of Developmental Delays, Including Autism; 6) Improve Health Status of Women, particularly related to depression; 7) Improve Linkages to Services/Access to Care; 8) Integrate the Life Course Theory throughout all state priorities; and 9) Reduce Health Disparities within the three MCH target populations

B. CYSHCN Priorities
The DPH requires that the CYSHCN community based networks: 1) operate programs that are family-centered with family participation and satisfaction; 2) perform early and continuous screenings; 3) improve access to affordable insurance; 4) coordinate benefits and services to improve access to care; 5) participate in spreading and improving access to medical home and respite services; 6) participate in developing the community-based service system of care, and 7) promote transition services for youth with special health care needs. Emphasis is placed on family education and in building care coordination capacity within provider practices.

DPH is the state's lead agency for implementation of the State Early Childhood and Comprehensive System's (SECCS) grant, called Early Childhood Partners (ECP), which supports all CT families to ensure that children arrive at school healthy and ready to succeed. ECP 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 are leveraged to conduct annual Ages and Stages Questionnaire (ASQ) trainings for health care providers.

DPH is a board member of the CT Association for Infant Mental Health (CT-AIMH). CT-AIMH promotes social emotional health and development of infants, young children and their families.

C. Data and MCH Impact
Consistent with the HP 2010 objectives, CT gives priority to MCH surveillance through the creation of a comprehensive linked database containing high-quality, record-level, child health data (HIP-Kids), a database for CYSHCN, Fetal and Infant Mortality Review, and Vital Records data collection and analysis. The HIP-Kids database project is located in the FHS and holds information of newborns on lab screening tests, hearing tests, and birth defects reported by birth facilities through the electronic reporting system. The HIP-Kids project is being migrated to a web-based application called MAVEN and includes a planned electronic link to the Electronic Birth Record followed by a link to the death record system. All Title V activities and programs are designed to promote and protect the health of CT's mothers, children and adolescents, and children with special health care needs.

Additional activities include the completion of the PRATS survey in 2009 to obtain information about the experiences and health behavior of pregnant women before, during and after their most recent pregnancy. The first Birth Defects Registry Report for 2001-2004 has been released and is posted on the DPH website. The Birth Defects Registry submitted data on 6/18/10 to the Centers for Disease Control (CDC) and National Birth Defects Prevention Network for children

born in 2007 in June 2010. The 2005-2007 registry report has data for children born with 45 reportable birth defect conditions. Data for year 2008 is being analyzed and will be published in 2011. The Birth Defects Registry is working closely with the Environmental Public Health Tracking System and has submitted birth defects data through the birth cohort 2007.

The birth defects epidemiology staff received notification that the New England Genetics Collaborative (NEGC) Innovative Project Awards, 2010-2011 application for the Development & initiation of a New England Birth Defects Consortium (NEBDC) was funded for a second year in June 2010. New Hampshire is the lead in this six-state consortium. The Consortium is working to: 1) Implement routine data sharing among member states; 2) Support research into the causes of birth defects in New England; and 3) Prevent Birth Defects in New England by engaging members in a pilot project to standardize a prevention campaign among all states in the NEBDC.

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. 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 (PHIN) to facilitate the creation of data extracts for various DPH programs that have requested access to this secondary data source. In-patient hospitalization & ED data for its placement on PHIN was provided. 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.

In March 2009, an MOU was signed between DPH and the Department of Developmental Services (DDS). The purpose of this MOU is for early detection and intervention for infants with hearing impairments, or with other medical conditions that have a high probability of resulting in developmental delay. The Birth Defects Registry monthly identifies children born weighing less than 1,000 grams and/or born at 28 weeks gestation or less with the Birth to Three System.

IV. Conclusion

It is the role of CT'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 and education. Infrastructure building services include needs assessment, policy development, quality assurance, development and management of information systems, and training.

The Title V Program determines factors that impact services in the State, through: 1) conducting statewide assessments (MCH five-year needs assessment); 2) reviewing and analyzing Title V programs quarterly reports submitted by all contractors, which include quantitative and qualitative information; 3) technical assistance meetings with the MCH contractors; 4) analyzing data from various sources; and 5) continuous feedback from stakeholders through advisory groups.

The Title V Program has taken a more data driven approach to its prioritization of MCH program design and implementation, and is committed to use resources effectively to address health disparities. As a result, the need to enhance our data collection system and integrate information becomes very apparent to support continued assessment, evaluation, research, and development of public health policy for the MCH population.

/2012/ Jewell Mullen, MD, MPH, MPA became DPH Commissioner in 2011. As a former member of the National Health Service Corps and Director of the Bureau of Community Health and Prevention at another state health department, she brings to her

role the recognition that efforts to improve the health of individuals and communities must be informed by an understanding of the social context which determines their behaviors and their access to resources. The Commissioner's leadership and commitment to promote a seamless relationship between state government and local communities is supported by the increased collaboration and partnerships that have developed over the last year to address maternal and child health.

The Title V Director partnered with the New Haven Health Department, the Community Foundation for Greater New Haven Healthy Start Program, and Hartford Health Department to submit an application for a Partnership to Eliminate Disparities in Infant Mortality (PEDIM). This Action Learning Collaborative has been funded by CityMatCH, AMCHP, and NHSA (June 2011).

The Medicaid Care Management Oversight Council's Women's Health Committee in collaboration with the March of Dimes, DPH, DSS, Lily's Kids, Inc., Community Health Center, Inc. and other stakeholders held a forum to discuss Woman's Health Before, During and After Pregnancy in November 2010. The focus of the forum was to identify strategies to 1) improve prenatal care/postpartum care, 2) Reduce low birth weight/prematurity, 3) Reduce disparities in prenatal care, birth outcomes and infant mortality and 4) Integrate preconception/inter-conception care into practice. Carol Stone, PhD, MPH, MPA, MAS provided a presentation on The Epidemiology of Poor Birth and Infant Outcomes in Connecticut and Rosa Biaggi, MPH, MPA, State Title V MCH Director provided an overview of DPH initiatives that address low birth weight and prenatal care initiatives.

DPH serves as the lead in a collaborative partnership with DCF, SDE, and Department of Mental Health and Addiction Services (DMHAS) on the development and implementation of CT's Personal Responsibility Education Program (PREP) plan. The goal of this project is to provide education and training to the DCF system that supports behavior change in youth in foster care, in an effort to delay sexual activity and associated risks, reduce planned or unplanned pregnancy, and increase access to reproductive health care. The target population are youth (ages 13-19) served by DCF, who are in an out of home setting

During the past year, DPH convened a group of stakeholders to conduct the Statewide Needs Assessment for Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Programs submitted in September 2010. It can be found at: http://www.ct.gov/dph/lib/dph/needs_assessment_complete_091510.pdf . Another Advisory Committee was convened to assist in the development of the updated state home visiting plan which has been submitted to HRSA.

CT received two awards at the NIC in Washington D.C. from Dr. Regina Benjamin, Surgeon General, U.S. Public Health Service and Dr. Anne Schuchat, Assistant Surgeon General and Director of the National Center for Immunization and Respiratory Diseases, in recognition of CT's outstanding achievement in improving adolescent immunization coverage by 16% from 2008-2009 for three vaccines that have been recommended for adolescents to protect them from serious diseases such as meningitis, cervical cancer, and pertussis (Whooping Cough) The second award was in recognition of CT's extraordinary achievement of 55.6% coverage of influenza vaccination among children by December 2010. Connecticut was also among the top states in the country for overall teen vaccination with an average coverage rate of 73 percent. Connecticut's immunization coverage rate was third only to Massachusetts and Rhode Island, and well above the national average of 58 percent.

The Connecticut General Assembly (CGA) has adopted Results-Based Accountability (RBA) approach as a critical planning and policy tool for the Appropriations Committee. FHS staff received RBA training to use when reporting about the impact of state funded

programs. RBA enables policy makers, funders and program administrators to identify how well a program is doing against an historical trend line and to judge progress in terms of whether they are "turning the curve" or beating the baseline. The FHS has used the RBA process to provide a detailed report on the status of: SBHC, CHC and the Immunizations programs. The RBA process was utilized when reporting to CGA's Appropriations Committee to for use in the budgeting process. DPH held two half-day training workshops, Performance Management and Quality Improvement applications for state public health agencies for managers, directors and Branch Chiefs in spring 2011. The workshops were facilitated by the Public Health Foundation covering Quality Improvement (QI) methods and tools. As a recipient of a Component 1 grant through the National Public Health Improvement Initiative supported through the Prevention and Public Health Fund of the Affordable Care Act, DPH wants to enhance its workforce capacity to apply QI tools and methods in order to improve work efficiencies and increase effectiveness. Other employee groups will be included in educational sessions later this year.

One of Connecticut's most pressing challenges is trying to maintain and improve programs and services for the MCH population while working with reductions in state and federal funding. DPH is committed to examine all opportunities to work collaboratively with our stakeholders to leverage existing state and federal funds to maximize programs and services and explore no cost or low cost initiatives. FHS will continue to apply for additional funds as they become available and work synergistically with providers and MCH state and community leaders so that services are coordinated, efficient, and effective resulting in the MCH population having access to and receiving quality preventive and primary services throughout the life course.//2012//

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.

The statutory basis for maternal and child health services in Connecticut originates from the statute passed in 1935, SS19a-35 PA 35-240 authorizing the Department of Public Health to receive Title V funds for its existing maternal and child services. Statute SS19a-59b PA 83-17(1983) established the Maternal and Child Health Protection Program (MCHPP) to provide outpatient maternal health services and labor services to needy pregnant women and to children less than 6 years of age; and SS19a-7i PA 97-1 (1997) extended coverage under the Maternal and Child Health Block Grant.

Statutes passed to provide maternal and child care include: SS19a-7c PA 134(1990) subsidized non-group health insurance for pregnant women; SS19a-90 PA 41-255(1941) blood tests of pregnant women for syphilis; SS19a-59c PA 88-72(1988) special supplemental food program for women, infant and children (WIC); SS19a-59a PA 82-355(1982) low protein modified food products and amino acid modified preparations for inherited metabolic disease; SS19a-55 PA 65-108(1965, 2002) newborn infant screening; SS19a-59 PA 81-205(1981) newborn infant screening for hearing impairment; SS19a-49(1961) and SS19d-55b PA 09-21(2009) screening and care for infants and children for cystic fibrosis; SS19a-7f PA 91-327(1991) and SS19a-7h PA 94-90(1994) childhood immunization schedule and registry; SS19a-54 PA 33-266(1933) and SS19a-52(1981) physically handicapped children registration and equipment; SS19a-53 PA 33-318(1933) childhood physical defects; SS19a-50 PA 39-142 PA 37-430(1937, 1939) and SS19a-51 PA 63-572(1963) children crippled or with cardiac defects; SS19a-48(1949) care for children with cerebral palsy; SS19a-53 PA 33-318(1933) physical defects of children; SS19a-56a PA 89-340(1989) and SS19a-56b PA 89-340(1989) birth defects surveillance and confidentiality; SS19a-60 PA 45-462(1945) and SS19a-38 PA 156(1965) dental services for children and fluoridation of

public water; SS19a-110 PA 71-22(1971) lead poisoning; SS19a-62a(2000) pediatric asthma; and SS47-48 PA 06-188(2006) Medical Home Pilot Program

Other statutes exist to provide regulatory authority for Title V related services that include: SS10-206 PA 04-221(1940-2004) health assessments of school pupils; SS14-100a PA 05-58(2005) child restraint systems; SS19a-7a PA 90-134(1990) availability of appropriate healthcare to all CT residents; SS19a-4j PA 98-250(1998) addressing disparity of disease in racial, ethnic, and cultural groups; SS19a-4i PA 93-269(1993) injury prevention; SS19a-7 PA 75-562(1975) public health planning; SS19a-17b PA 76-413(1976) peer review; SS19a-25 PA 61-358(1961) confidentiality of records; SS4-8 (1949) transfer Title V funds to Department of Social Services; SS19a-32(1949) authority to receive, hold, invest, and disperse assets; SS19a-2a PA 93-381(1993) powers and duties of Commissioner of DPH in the prevention and suppression of disease; SS51 PA06-195 to establish a School Based Health Center ad hoc committee.

Program Capacity in CT

The mission of DPH is to protect and improve the health and safety of the people of Connecticut. Within DPH, the Family Health Section (FHS) is part of the Public Health Initiatives (PHI) Branch. The FHS is comprised of five units: 1) Primary Care and Prevention, 2) Children and Youth with Special Health Care Needs, 3) Program Development, 4) Immunizations, and 5) Registry.

The focus of programs within the FHS is to promote community based, coordinated, culturally competent, family centered services to pregnant women, mothers and infants, children and adolescents (including CYSHCN) through the life course. Staff within the units work collaboratively to coordinate resources and maximize program capacity.

Programs supported with MCH Title V funds provide direct services, enabling services, population based services and/or infrastructure building services. CT's Title V Program focuses on three main populations: 1) Pregnant Women, Mothers and Infants (PWMI), 2) Children and Adolescents (CA), and 3) Children and Youth with Special Health Care Needs (CYSHCN).

Title V Partnership Programs for Pregnant Women, Mothers and Infants

Breastfeeding Initiative: DPH is developing internal mechanisms and evaluating capacity to collect population-based breastfeeding data. The Electronic Newborn Screening Database collects data from all birthing hospitals on the mother's intent to breastfeed.

Case Management for Pregnant Women: provides comprehensive, integrated case management services during the perinatal and interconceptional periods to pregnant and post partum teenagers and women in an effort to improve birth outcomes. The program is offered in three towns/cities and includes the partners of pregnant women.

Centering Pregnancy: Two Centering Pregnancy programs in New Haven provide services to women who are most at-risk for delivering low birth weight infants, so as to achieve outcomes that include: 1) empowerment and community-building among pregnant group members, 2) increased satisfaction of pregnant women with prenatal care, 3) reduction in premature or preterm births, and 4) increased breastfeeding of infants by their mothers. The Centering Pregnancy model includes three "care components" of assessment, education, and support, which are provided within a group setting and facilitated by a credentialed health provider and a co-facilitator. ***/2012/ Programs are now financially self-sustaining.//2012//***

Community Health Centers receive state funds to provide primary and preventive health services across the lifespan.

Family Planning: promotes decreasing the birth rate to teens, age 15-17, preventing unintended pregnancy, and increasing access to primary reproductive health care. Through its contract with

Planned Parenthood of Southern New England (formerly Planned Parenthood of CT, Inc.), comprehensive reproductive health services are available in 12 locations with 4 subcontractor locations across the state.

Fetal and Infant Mortality Review (FIMR): to identify and address contributing factors to fetal and infant mortality. The state budget did not include funding for the FIMR program in state fiscal year 2010. Funding to the former FIMR contractors was restored in State fiscal year 2011. ***/2012/ Funding was rescinded for FIMR in State fiscal year (FY 2011). //2012//***

Healthy Choices for Women and Children (HCWC): provides intensive case management services to low income, pregnant and postpartum women in the City of Waterbury or surrounding communities, who abuse or are at risk for abusing substances (or whose partner abuses substances), and their children from birth to age three. Services include case management with intensive home visiting, prevention education, parenting education, domestic violence, planning, and assistance with housing and transportation.
State Healthy Start: provides case management services to eligible pregnant women for the purpose of 1) improving CT birth outcomes by reducing the rate of infant mortality, morbidity and low birth weight, 2) providing access to prenatal/postpartum care services through CT's HUSKY A healthcare program, and 3) promoting and protecting the health of both mother and baby. This program is offered through a MOA with the DSS.

Federal Healthy Start Program: designed to increase the number of low-income black African American pregnant women who enter early prenatal care to promote healthier pregnancies and reduced rates of birth complications such as infant morbidity and mortality. DPH secured federal funding to address racial and health disparities in the city of Hartford. ***/2012/The program serves pregnant and postpartum women and their children up to two years of age.//2012//***

Maternal and Child Health Information and Referral Service: administers 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. DPH contracts with the United Way of CT for the service.

First-Time Motherhood/New Parent Initiative: an Infant Mortality Social Marketing Campaign in Hartford, New Haven, and Bridgeport 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. The HRSA grant supporting this initiative ends August 2010. ***/2012/Grant ended in 2010.//2012//***

The Office of Oral Health works with the American College of Obstetrics and Gynecology and the March of Dimes to address oral health during the prenatal period.

The 2007-2011 State Systems Development Initiative (SSDI) Project goals are to: 1) 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.

CT is focusing on 3 main activities to achieve these goals: 1) implementing HIP-Kids, a comprehensive linked database containing high-quality, record-level, child health data; 2) linking birth records with WIC enrollment and visit data, and to include a linkage with the state Medicaid eligibility files; and 3) conducting a PRAMS-like survey of postpartum women in CT.

Injury Prevention: focuses on the "reduction of the factors associated with intentional, unintentional and occupational injury". The Injury Prevention Program, following National recommendations for intentional and unintentional injury prevention, conducts community-based programs to address risk and resiliency factors and implements strategies to decrease injury.

/2012/ Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program:
The DPH was designated by the Governor as the Lead Agency for the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program. An Advisory Committee was convened to work with DPH on this project. A State Needs Assessment (September 2010), State Plan (June 2011), and competitive grant application (July 2011) were submitted to HRSA. //2012//

/2012/ Personal Responsibility and Education Program (PREP): focuses on teen pregnancy prevention, particularly among young men and women transitioning out of the foster care system within the State. An Advisory Committee was convened to work with DPH on this project and a State Plan was submitted and approved by the Administration for Children and Families (ACF) (February 2011).//2012//

/2012/ The Title V Director partnered with the New Haven Health Department, the Community Foundation for Greater New Haven Healthy Start Program, and Hartford Health Department to submit an application to Eliminate Disparities in Infant Mortality Action Learning Collaborative to CityMatCH, AMCHP, and NHSA (June 2011). The application was approved. The Title V Director is also the DPH representative for the New Haven Mental health Outreach for MotherS (MOMS) Partnership, the Hartford Action Plan on Infant Health Committee, the Fatherhood Advocacy Council and the Commission on Children.//2012//

/2012/Program Development staff represent DPH on the Regional Adaptation for Payer Policy Decisions (RAPiD) initiative, funded by the Agency for Healthcare Research and Quality (AHRQ) under the American Recovery and Reinvestment Act to provide guidance on the application of medical evidence to clinical practice and payer policy decisions across New England.//2012//

/2012/The CT Coalition for Oral Health is comprised of a core team of state agencies and other stakeholders. The goals of the coalition are: to maximize agency capacity and resource allocations, and improve the oral health of CT's residents with emphasis on vulnerable populations.//2012//

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

State Healthy Start: As described above.

School Based Health Centers (SBHC): DPH funds 75 SBHC in 23 communities. Licensed as outpatient facilities or hospital satellites, they offer services addressing the medical, mental and oral health needs of youth.
/2012/DPH funds 71 SBHC that provide comprehensive services in 20 communities, 11 expanded school health services in 3 communities, and one school-linked site.//2012//

Expanded School Health Services (ESHS): DPH funds 3 ESHS projects at 10 sites. 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 children and families who are at risk for learning. An additional ESHS program provides mental health and dental services to students in eight elementary schools in a high need community. ***/2012/ESHS provide limited services such as counseling, health education, health screening, and prevention services to enhance existing school health services. Two Madison sites and one Chaplin site provide mental health services in a regional school system, and eight Meriden sites provide mental and dental health services.***

School-linked services: A school-linked site is linked to another existing SBHC for support. DPH funds one school-linked health center in New London that provides medical

and behavioral health services to preschool children.//2012//

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, teen life conferences, reproductive health and STD prevention literature, and community educational programs to teens at risk.

/2012/The Legislative Program Review and Investigations Committee is conducting a study on the state's system of primary and preventive medical, behavioral, and oral healthcare for Adolescents in partnership with state agencies and other Stakeholders. The Title V Director is the DPH representative for this initiative.//2012//

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

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

Case Management for Pregnant Women: As described above.

/2012/Federal Hartford Healthy Start: As described above.//2012//

The Early Childhood Partners (ECP) Initiative: funded through the HRSA Early Childhood Comprehensive Systems Grant, works to develop a comprehensive statewide system to support all CT families so their children attain optimum health and school readiness by age five. ECP efforts include expanding the number of pediatric practices and clinics providing medical homes for all children and especially CYSHCN; increasing the number of parents and providers trained and participating in their communities as advocates for children; meeting the developmental needs of children through access to comprehensive health, mental health and education consultation for families and early care and education providers; and meeting the developmental needs of children through the increase of perinatal depression screenings among postpartum mothers. The CT Early Childhood Cabinet serves as the State Advisory Council on early education.

The DPH Injury Prevention Program (DPH-IP): 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. DPH-IP collaborates with partners to facilitate the Interagency Suicide Prevention Network, and participates in the Youth Suicide Advisory Board.

/2012/ Maternal, Infant, and Early Childhood Home Visiting: As described above.//2012//

Title V Partnership Programs for Children with Special Health Care Needs

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 systems and transition to all aspects of adult life. There are an estimated 133,000 CYSHCN in CT.

The Connecticut Medical Home Initiative (CMHI) for Children and Youth with Special Health Care Needs: enhances capacity for medical homes in the five state regions to screen children; and assists medical homes through community-based health care systems while enhancing access to services. The five networks providing co-located and/or embedded care coordination on a regional basis are: 1) CT Children's Medical Center (north central), 2) St. Mary's Hospital (northwest), 3) Stamford Health System (southwest), 4) Coordinating Council for Children in

Crisis, Inc. (south central), and 5) United Community and Family Services, Inc. (eastern). Services include: administration of extended services and respite funds, medical home care coordination, provider and family education, outreach and family support.

Children with an identified chronic condition and are either uninsured or underinsured may be eligible for payment of durable medical equipment, prescriptive pharmacy and special nutritional formulas through CYSHCN/CMHI. The CYSHCN program offers a limited respite program based on available funds, and transition services to adult care. The CT Lifespan Respite Coalition is the statewide administrator of extended services and respite funds for CMHI, and serves as an additional statewide point of entry.

CYSHCN program surveillance, planning and evaluation: DPH epidemiology staff developed a Microsoft Access database to assure that information was collected and the database is utilized by each of the five regional care coordination networks. DPH is working with developers to migrate the CYSHCN database to a web-based platform. This will allow for integration of data with other databases at DPH, and allow for future connection to Electronic Medical Records. The system will allow information from families; medical home based care coordinators, and other stakeholders to be integrated.

The United Way's (2-1-1) (the MCH Information and Referral Service) Child Development Infoline (CDI): serves as a statewide point of entry to CMHI and for information and resource referral for CYSHCN. CDI caseworkers make referrals to the CT Birth to 3 System, Help Me Grow, Preschool Special Education, and/or CYSHCN/CMHI. The 2-1-1component of MCH Information and Referral Service works closely with the CMHI on their resource information updates.

The Child Health and Development Institute (CHDI): provides a statewide family outreach and education component of the CMHI with a focus on Family/Professional Partnership. Family/Professional partners provide training to families in linking to resources and work in partnership with primary care providers.***/2012/CHDI will provide outreach to pediatricians of children diagnosed with hearing loss to strengthen the role of the medical home in promoting the healthy development of children with hearing loss.//2012//***

Adult and Maternal Phenylketonuria Program (PKU): The 2 Regional Genetic Treatment Centers (UConn Health Center (UCHC) 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.

Oral Health: The Office of Oral 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 The Home by One Program partners with DDS and the Family Support Network to implement oral health educational activities of the CYSHCN program.

Pregnancy Exposure Information Services (PEIS): a toll-free telephone line supported by the UCHC Genetics Program. During 2009, this line provided information to 841 pregnant women who were concerned about exposure to toxic substances during pregnancy and the possible effect(s) to their baby.

School Based Health Centers: provide primary and preventive physical and behavioral health care to CYSHCN who are mainstreamed in school settings. SBHC coordinate care with a child's

primary physician and/or specialist.

The Sickle Cell Disease Community Outreach and Support Program: services include Sickle Cell Disease education, screening, trait testing and referral, and case management services including: advocacy, family support, systems navigation, and transition services. The program is contracted to the Hospital for Special Care, which collaborates with providers and hospitals to facilitate access for individuals with Sickle Cell, and subcontracts with The Sickle Cell Disease Association of America Southern CT Chapter and Citizens for Quality Sickle Cell Care.

Universal Newborn Screening (UNBS): 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 and treatment services. Counseling and education are provided to the parents of these children. The program provides increased public health awareness of genetic disorders, public health education, and referrals.

Universal Newborn Hearing Screening (UNHS): All 31 CT birthing facilities participate in a legislatively mandated UNHS program. Standardized equipment is used to screen all newborns prior to discharge. Hospitals notify the primary care providers of all infants 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 Three Program. The Early Hearing Detection and Intervention (EHDI) program works with eleven diagnostic audiology centers that provide follow-up testing from the hearing screens conducted at birth.

Federal Hartford Healthy Start -- as described above.

Cultural Competency

The Title V programs have incorporated contract language that requires providers to deliver culturally competent services and demonstrate this by: developing a mission statement committing to cultural diversity, develop materials in languages reflecting the needs of the patient population, policies and procedures to address the needs of the patient population, taking into account factors such as race, ethnicity, age, gender, hearing impairment, visual impairment, physical disability, mental illness, developmental disability and sexual orientation. The Title V Program will continue to address health disparities based on data by race and ethnicity to identify and allocate resources.

The Office of Multicultural Health (OMH) promotes access to quality health education and health care services, facilitates presence of diverse populations in health planning, program development, policy formation, and outreach and awareness initiatives. The OMH functions largely through collaboration with statewide partners. The Office recommends policies, procedures, activities and resource allocations to improve health among the state's underserved and diverse populations, and to eliminate health disparities.

The FHS received technical assistance from the National Center for Cultural Competence for Title V staff at DPH and to MCH community providers over two days in May 2010.

The DPH is a participant on the newly formed Commission on Health Equity (Public Act No. 08-171), which mission is to eliminate disparities in health status based on race, ethnicity and linguistic ability, and improve the quality of health for all of the state's residents.***/2012/The Commission's First Annual Report was shared (September 2010).//2012//***

/2012/The Hartford Healthy Start program seeks to reduce racial and ethnic disparities in low birth weight and infant mortality within Hartford, particularly within the Black/African

American community. Enhanced outreach and recruitment of pregnant and postpartum women and their children up to two years of age.//2012//

C. Organizational Structure

Governor M. Jodi Rell has been CT's Governor since July 2004. J. Robert Galvin, MD, MPH, MBA, 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 CT. 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. The mission of the DPH is to protect and improve the health and safety of the people of CT by: assuring the conditions in which people can be healthy; promoting physical and mental health, and preventing disease, injury and disability.
/2012/Dannel P. Malloy was elected Governor in 11/10 and in 2/11, Jewell Mullen, MD, MPH, MPA became DPH Commissioner.//2012//

The Office of Health Care Access merged with the DPH and became a branch within DPH in SFY 2010. As a result, DPH is now comprised of nine Branches. The majority of the Title V activities are located in the Public Health Initiatives (PHI) Branch and a detailed description follows:

The Title V Program is located within the FHS, which is part of the Public Health Initiatives (PHI) Branch. The majority of CT's Title V program activities reside within the FHS. Other MCH-related programs such as oral health, childhood lead poisoning prevention, diabetes, tobacco, obesity prevention and asthma are in other sections within the DPH. 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. The Title V Program is responsible for the administration (or the supervision of the administration) of programs carried out with funds from the MCHBG.
/2012/Reorganization shifted programs among units. The CYSHCN Unit added the MCH Information and Referral Program. The Program Development Unit added Case Management/Parenting Programs, Centering Pregnancy, State Healthy Start and Family Planning. //2012//

CT's 31 birthing facilities send blood specimens collected from all newborns to the Laboratory Branch for genetic screening. Following specimen analysis, the laboratory staff forwards all abnormal screening results to the Newborn Screening Tracking Program (NBST) for rapid short-term follow-up. NBST is partially funded by the MCHBG. ***/2012/CT's 30 birthing facilities send blood specimens collected from all newborns to the State Laboratory for genetic and metabolic screening. All abnormal screening results are forwarded to the Newborn Screening Tracking Program (NBST) for rapid short-term follow-up. NBST is partially funded by the MCHBG.//2012//***

Block Grant funds support a full time equivalent in the Health Information Systems and Reporting Section, in the Planning Branch to maintain vital record databases containing information on births, deaths, hospitalizations and risk factors related to maternal and child health. Epidemiologists use vital record information to help direct and evaluate Title V program activity.

The Primary Care and Prevention (PCP) Unit promotes health care to the Maternal and Child Health population, including women of childbearing age, pregnant and postpartum women, and their partners and children. Access to care is promoted through support of safety net providers. Contractors provide: (1) case management services for pregnant women and teens (including secondary teen pregnancy prevention and parenting programs) to promote good birth outcomes; (2) comprehensive primary care services through community health centers; (3) family planning; (4) rape prevention education and crisis intervention and the prevention of intimate partner

violence; (5) medical and mental health services to children and adolescents in School Based Health Centers (SBHC); and (6) perinatal depression training to health care providers.

Programs supported in this unit include 1) Case Management/Parenting Programs, 2) Centering Pregnancy, 3) First Time Motherhood/New Parents Initiative, 4) State Healthy Start, 5) Healthy Choices for Women and Children, 6) Perinatal Depression Training, 7) MCH Information and Referral Service, 8) Intimate Partner Violence Prevention, 9) Rape Prevention Education and Crisis Intervention, 10) Community Health Centers, 11) Family Planning, 12) School Based Health Centers/Expanded School Health, and 13) Waterbury Health Access Program. ***/2012/First Time Motherhood ended 8/10 and Healthy Choices for Women & Children will terminate all services as of 6/30/11.//2012//***

This unit provides representation to the federal Office on Women's Health -- Region I, Department of Health and Human Services.

The Registry and Program Support Unit provides data and analytical support to the FHS programs, including the provision of required information for the MCHBG and the Preventive Health and Health Services Block Grant national and state performance measures. This unit also coordinates the State Systems Development Initiative grant (the infrastructure grant related to the MCHBG). The Birth Defects Registry and the CT Immunization Registry and Tracking System (CIRTS) staff are in this unit. CIRTS collaborates with the Immunization Program activities. This unit seeks to identify and collect population-based MCH data, as well as create new data systems to complement existing data that will enhance the section's ability for program planning, evaluation and surveillance.

The Children and Youth with Special Health Care Needs (CYSHCN) Unit includes: 1) the Medical Home Initiative, 2) the Early Hearing, Detection and Intervention (EHDI) Program, 3) Sickle Cell Disease Program, and 4) State Implementation grants for Integrated Community Systems for CYSHCN. The goal of the Medical Home Program is to build the state infrastructure to: 1) reach more CYSHCN and their families and assist them with access and coordination of multiple systems of care and resources; 2) assist the Pediatric Primary Care Providers (PCPs) to identify CYSHCN with high severity needs who need care coordination; 3) link with regional family support networks; 4) provide respite planning and funding for respite family-based services; 5) provide benefits coordination for families to access durable medical equipment, prescriptive medications and specialized formulas; 6) assist PCPs to identify youth with special health care needs to receive the services necessary to make transitions to all aspects of adult life, and 7) liaison with Child Development Infoline (MCH Information and Referral Services for CYSHCN). The EHDI Program ensures early hearing detection and intervention for infants identified with a hearing loss. The goal of the EHDI program is to assure quality developmental outcomes for infants identified with hearing loss. The Sickle Cell Disease Program provides comprehensive coordination of adults with Sickle Cell Disease (SCD) and Trait by improving adult SCD healthcare services and improving transition from pediatric to adult SCD healthcare services. The program also provides advocacy for optimal use of state and federal resources.

The Immunizations Unit's main focus is to prevent disease, disability and death from vaccine-preventable diseases, through surveillance, case investigation and related control, and by monitoring immunization levels in infants and children through annual daycare and school surveys, provision of vaccines for all children and selected adults, support to local health departments for immunization coordination and outreach, and conducting professional and public education. Programs include 1) Vaccines for Children Program, 2) Immunization Action Plan, 3) Vaccines for Preventable Diseases Surveillance, and 4) Adult Immunization Program.

The Program Development Unit performs public health surveillance and research on MCH topics, prepares reports and other communications. The unit supports administration of the Title V Block Grant, manages other federally funded grants in the Section, and seeks new funding for evidence-based and theory-driven interventions that address emerging MCH needs. Initiatives

include 1) the Pregnancy Risk Assessment Tracking System (PRATS), 2) Early Childhood Comprehensive Systems, 3) federal Hartford Healthy Start, and 4) Primary Care Office. ***/2012/ The FHS applied for and received ACA funding to implement the PREP and the MIECHV Program. //2012//***

The Office of Oral Health has been transitioned to the Local Health Administration Branch. A strong collaborative relationship exists with the MCH programs and the Office of Oral Health.

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

The CT Department of Public Health is comprised of nine Branches. The Title V Program is located within the FHS, which is part of the Public Health Initiatives (PHI) Branch. Lisa A. Davis, RN, BSN, MBA, is the Chief of the Public Health Initiatives (PHI) Branch.

Rosa M. Biaggi, MPH, MPA, is the Chief of the Family Health Section (FHS) and the State MCH Title V Director. Ms. Biaggi began working in the FHS in 2009. Janet M. Brancifort, MPH, became the Public Health Services Manager for the FHS in March 2007.

Administrative support to the Section management is provided by an Administrative Assistant and a Secretary 2.

The Family Health Section employs 54 permanent staff with expertise and skills in various areas of public health and MCH related fields. Most of the professional staff within the Family Health Section have graduate degrees or have experience in nursing, social work, allied health, health education, research, evaluation, epidemiology, law, planning, administration and management. The majority of CT's Title V program activities reside organizationally within the FHS in the PHI Branch.

Sharon Tarala, RN, JD, Supervising Nurse Consultant, supervises the Primary Care & Prevention (PCP) Unit and serves as the State Women's Health Coordinator. There are seven staff in the unit: two (2) Nurse Consultants, one (1) Social Work Consultant, two (2) Health Program Assistant 1, one (1) Health Program Assistant 2, and one (1) vacant CT Career Trainee position and is in the process of being filled.
/2012/Seven staff consist of (1) Nurse Consultant, (1) Social Work Consultant, (1) Health Program Associate, and (3) Health Program Assistant 1. //2012//

Marcia Cavacas, MS, supervises the Registry and Program Support Unit. There are seven staff in the unit: two (2) are Epidemiologist 2; one (1) Epidemiologist 3, one (1) Health Program Associate, two (2) Health Services Workers, and one (1) Office Assistant.

Mark Keenan, RN, MBA, Supervising Nurse Consultant, serves as the state's Title V CYSHCN Director and leads the CYSHCN Unit. There are seven staff in the unit: one (1) is a nurse consultant, three (3) are Health Program Associates, two (2) Health Program Assistant 1 and one (1) Secretary 1. One of the Health Program Assistant positions is vacant and is in the process of being filled. One (1) Health Program Associate serves as the agency Family Advocate and is a parent of children with special health care needs. This staff member provides consultation regarding family issues ensuring that a family-centered, culturally competent perspective is maintained. ***/2012/Vacant Health Program Assistant 1 position in the CYSHCN Unit is eliminated.//2012//***

Vincent Sacco, MS, Epidemiologist 4, supervises the Immunizations Program. There are 20 staff in the unit: three (3) Epidemiologist 3, six (6) Epidemiologist 2, one (1) Health Program Assistant 1, three (3) Clerk Typists, one (1) Health Program Associate, two (2) data entry clerks, one (1) Information Technology Analyst 2, one (1) Materials Storage Handler, one (1) Secretary 2, and

one (1) Assistant Program Coordinator. ***/2012/The Assistant Program Coordinator is a CDC employee.//2012//***

Carol Stone, PhD, MPH, MAS, MA, Epidemiologist 4, supervises the Program Development Unit. There are five (5) staff in the unit: two (2) are Epidemiologist 3, One (1) Health Program Associate, one (1) Health Program Assistant 1, and one (1) Epidemiologist 1. ***/2012/ Effective 7/10, the unit consists of 2 Epidemiologist 3, 2 Nurse Consultants, 1 Health Program Assistant 1 and 1 Epidemiologist 1.//2012//***

Funding from the MCHBG also provides support for staff in the Newborn Screening Program, Health Information Systems (Vital Records), the Fiscal Office and Grants and Contracts.

Staff from other programs within the DPH collaborate and/or provide support to the Title V staff. These programs include: Obesity, Asthma, WIC, Environmental Health, STD, HIV, Vital Records, State Laboratory (Newborn Screening) and Tracking Units, Oral Health, Tobacco, Nutrition, Facility Licensing, and Injury Prevention. ***/2012/Staff collaborate with Healthcare Quality, Statistics and Analysis within DPH.//2012//***

E. State Agency Coordination

CT's Title V Program works with other state agencies and within its own programs to ensure coordination of services. The narrative below describes the most important of those collaborations.

Under the state's Medicaid program, grants are made to hospitals, clinics, departments of health and other organizations to expand and enhance health services to low income pregnant women and children, and to assist women in obtaining Medicaid coverage for themselves and their children. Healthy Start contracts are jointly administered by the DSS and the DPH.

CT Maternal-Child Health Advisory Committee offer a networking opportunity for MCH providers to share relevant information and resources available to the state's MCH populations and coordinate efforts in order to maximize resources and services available to Connecticut's women, children and families. The Committee meets on a quarterly basis.

/2012/Program Development staff provides representation on the Women's Health Subcommittee of the CT Medicaid Care Management Oversight Council whose mission is to improve the health status of pregnant and postpartum women and their infants.//2012//

The CYSHCN program collaborates with the DSS Health Insurance for Uninsured Kids and Youth Unit to promote access to public health insurance for CYSHCN, to align and improve services and programs for CYSHCN. CYSHCN staff serve on the legislatively mandated Medicaid Managed Care Council. CYSHCN program staff network with the Social Security Administration/Disability Determination Unit at DSS to facilitate the referral of enrollees to the program.

DPH CYSHCN program participates on the Birth to Three Interagency Coordinating Council, the CT Council on Developmental Disabilities, the A.J. Pappanikou Center for Excellence on Developmental Disabilities Consumer Advisory Board, and the legislatively mandated Family Support Council. CYSHCN staff facilitate and participate on the DPH Medical Home Advisory Council (MHAC), which provides guidance to DPH on efforts to improve the system of care for CYSHCN. The MHAC membership is comprised of more than 40 representatives, including family representation, providers, contractors involved in the CT Medical Home Initiative for CYSHCN, public and private agencies, and youth with special health care needs. State agencies participating in the MHAC include: DPH, State Department of Education (SDE), DSS, Department of Children and Families (DCF), DDS, Office of Policy and Management (OPM), and Office of the

Child Advocate (OCA).

A State Implementation Grant for Integrated Community Systems for CYSHCN activities focusing on transition of youth with special health care needs to adult services has resulted in MOUs with the DCF, the SDE- Bureau of Special Education, and DSS-Bureau of Rehabilitation Services.

The CYSHCN program partners with United Way of CT/2-1-1 Infoline (CT's MCH Information and Referral Service), DDS (Birth to Three), and the Children's Trust Fund (Help Me Grow) in supporting United Way's Child Development Infoline (CDI) to serve as the statewide point of entry and referral for all CYSHCN. CDI implements a referral and coordination of services model to assess and refer appropriate CYSHCN to Birth to Three, Ages and Stages, Help Me Grow and CT Medical Home Initiative for CYSHCN resources (including referral to community based medical homes). CYSHCN staff serve on the CDI steering Committee.

The CYSHCN program and the CT Lifespan Respite Coalition, Inc. (CLRC) have partnered to create and disseminate a two-section "Get Creative About Respite" manual.

The CYSHCN program staff work with partners implementing the CT Medical Home Initiative for CYSHCN that includes family and professional partnership and support staff, respite and extended services administration, and community based medical home staff.

The CYSHCN program partners with contractors associated with the CT Medical Home Initiative for CYSHCN to distribute "Directions: Resources for Your Child's Care" an information organizer for families, available in English, Spanish, and Portuguese.

The Early Hearing Detection and Intervention program staff work with the 31 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 Hearing Screening and Laboratory Programs. ***/2012/Facilities refers to 30 Birthing Facilities and one Home Birthing Agency.//2012//***

CYSHCN/EHDI program staff are active members of the CT Early Hearing Detection and Intervention (EHDI) Task Force. The Task Force members include representatives from the DSS, DDS, 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 promote optimal outcomes for infants and children through age 5 identified with hearing loss. The EHDI program has a data sharing MOU in place with DDS Birth to Three to facilitate outreach.

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. ***/2012/ Changes to the external Newborn Screening (NBS) Program Advisory Committee (formerly GAC), includes the addition of the Sickle Cell Disease Association of America and replacement of FHS with Laboratory Management and NBS Program staff representing DPH. //2012//***

The CT Expert Genomics Advisory Panel advises 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, genetic counselors; and consumer advocates.

Family Health Section staff participates in the Sickle Cell Consortium, working to implement the statewide sickle cell plan. The consortium is comprised of advocacy groups, sickle cell associations, hospitals, treatment centers, and providers. The plan has been widely disseminated to nine other states and the National Sickle Cell Disease Association. The consortium is

finalizing an emergency department protocol for the management of Sickle Cell crisis to be implemented statewide. ***/2012/The emergency department protocol has been finalized for dissemination.//2012//***

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 with experts and consumers, participate in educational conferences, and keep abreast of advances in genetics and newborn screening as they impact public health. Program staff participates in the UConn MPH Program and provide NBS educational sessions to students as part of the Genetics course curriculum.

CT SBHC have formed a non-profit independent organization, the CT Association of SBHC, Inc., to advocate for this service delivery model. The epidemiologist supporting the SBHC program convenes conference calls with a Data Steering Committee that identifies technical, data quality and other issues that need resolution. The committee members are peer mentors for other sites requiring assistance.

Seventy-five SBHC in 23 communities are partially funded by DPH serving students in elementary, middle and high schools. SBHC are licensed as outpatient facilities and staffed by both a licensed primary care provider and licensed mental health clinician. 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. The practitioners coordinate the care they provide with a child's primary providers and/or specialists, while integrating the needs of the child with other school personnel. There are 10 Expanded School Health Service programs in three communities, which vary by site and do not provide the full compliment of services provided through traditional SBHC. Services are available to all enrolled students in the school. All expanded school health services programs are currently providing mental health services. Eight offer oral health care.
/2012/Seventy-one SBHC, 11 Expanded School Health Service Programs, and one school-linked service exist in 23 communities.//2012//

A SBHC Ad Hoc Committee was formed with the goal of improving health care through access to SBHC, particularly by under- or uninsured people or Medicaid recipients.

Community Health Centers (CHC) provide comprehensive primary and preventive health care and other essential public health services at over 150 sites in CT. DPH funds 13 of the 14 community health center corporations in CT, and 12 of the 13 are members of the Community Health Center Association of CT (CHCACT). All centers are located in HPSA and/or Medically Underserved Areas and operate in accordance with Federally Qualified Health Center Guidelines. In FY09, 242,034 people were served with a wide variety of comprehensive services, including EPSDT. The CHC also work with Family Planning, WIC, SBHC, Infoline and many community-based organizations that provide other health care and social services. ***/2012/In calendar year (CY) 08, 242,034 clients were served in 13 DPH funded CHCs. In CY 09, 289,395 clients were served in the 13 CHCs.//2012//***

DPH and CHCACT 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 CHC. Among these are National Health Service Corps recruitment and retention activities and immunization program initiatives.

The statewide family planning program is implemented through a contract with Planned Parenthood of Southern New England (formerly Planned Parenthood of CT, Inc.) in 16 sites. The services provided include comprehensive preventive and primary reproductive health care for

adolescents and adults. During FY 2009, 35,015 clients received services; of those, 32,210 were women, 7,593 were teens, 17,630 were women and men of color, and 26,171 were low-income. 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, sexually transmitted infections, Hepatitis and HIV/AIDS.

The DPH participates on the CT Breastfeeding Coalition (CBC), which includes representatives from the state and local WIC program, La Leche League, AAP, Hospitals, CHC, Health Management Organizations (HMO), 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. The FHS continues to work closely with the WIC program to promote and support breastfeeding in the state. The CBC includes representatives from breast pump manufacturers, and provides information and input on breastfeeding in the legislative arena.

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.

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.

The SBHC staff participate participates in Regional Adolescent Health Coordinators monthly conference calls.

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. The DPH-DSS MOU was amended to include the Department of Children and Families.

DPH worked the Governor's Collaboration for Young Children to establish the Healthy Child Care CT (HCC-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 HCC-CT leadership team. HCC-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 HCC-CT initiative, DPH contracted with the CT Nurses Association (CNA) to conduct child care health consultant workshops for day care health consultants, education consultants and directors of day care facilities, and will coordinate with DSS and CNA to offer medication administration training. DPH will allow HCC-CT access to its learning management site, CT TRAIN, to facilitate workshop enrollment and track participant's CEUs.

The DPH-Local Health Administration Branch assists and advises local health districts in the state 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 (ECP) Initiative, funded through the Early Childhood Comprehensive Systems grant, works to develop a comprehensive statewide system to support all CT families so their children attain optimum health and school readiness by age five. Staff serve on the Fatherhood Initiative, facilitated by DSS, and as alternate to the DPH Deputy Commissioner on the State Early Childhood Advisory Council. ***/2012/With the retirement of the deputy commissioner, the ECP project director was selected to serve on the Council.//2012//***

To address intentional and unintentional injuries, the DPH Injury Prevention Program (DPH-IP) collaborates with the CT Department of Transportation (DOT), SDE, DCF, DSS, OCA, Court Support Services Division (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-IP 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-IP facilitates the Interagency Suicide Prevention Network, an interagency, interdisciplinary collaboration that has completed a statewide, comprehensive suicide plan and works with collaborators to address intentional injury issues including suicide prevention, violence prevention, domestic/dating violence prevention and child maltreatment. DPH-IP participates in the Northeast Injury Prevention Network, which includes State Health Injury Prevention Programs from Regions I and II, university-based 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. DPH-IP is also collaborating with MCH and the Connecticut Office of Rural Health on a rural injury initiative focused on motor vehicle and self-inflicted injury.

The Immunization's staff facilitates the Vaccine Purchase Advisory Committee (VPAC) that makes recommendations to the State Department of Public Health on issues related to the use of publicly purchased vaccines for childhood and adolescent vaccinations. Membership of committee includes the AAP, CHCACT, CT Association of Public Health Nurses, and CT Association of School Nurses. The committee also includes representatives of the vaccine manufacturers, medical directors, and medical insurers. The VPAC is open to the public.

/2012/ The federal Hartford Healthy Start program partners with organizations in Hartford that serve pregnant women and their children, including the Hartford Health Department, Hispanic Health Council, St. Francis Hospital, Charter Oak Health Center, and Community Health Services. //2012//

/2012/ A group of stakeholders was convened to conduct the Statewide Needs Assessment for Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Programs submitted in September 2010. It can be found at: http://www.ct.gov/dph/lib/dph/needs_assessment_complete_091510.pdf . //2012//

/2012/ DPH convened an Advisory Committee to assist in the development of the state's updated state home visiting plan which has been submitted to HRSA.//2012//

/2012/ DPH serves as the lead in a collaborative partnership with DCF, SDE, and Department of Mental Health and Addiction Services (DMHAS) on the development and implementation of CT's Personal Responsibility Education Program (PREP) plan. The goal of this project is to provide education and training to the DCF system that supports behavior change in youth in foster care, in an effort to delay sexual activity and associated risks, reduce planned or unplanned pregnancy, and increase access to reproductive health care. The target population are youth (ages 13-19) served by DCF, who are in an out

of home setting.//2012//

F. Health Systems Capacity Indicators

Introduction

This has been a challenging year to obtain current data from several data sources for the Health Status Capacity Indicators including information from the Department of Social Services (DSS), Vital Statistics and hospitalization data. However, these data sources have reported that the information will be available for September 2011 at which time FHS will update the HSCIs.

DSS has released a Request for Proposal to create an Administrative Services Organization (ASO) to replace the existing Medicaid Managed Care Organizations which supported the Medicaid population in the State. DSS is also implementing a new data system which is changing what and how they can report data. DPH plans to meet with DSS staff to discuss these changes and work to a common goal of sharing data.

We have successfully executed a Memorandum of Agreement (June 2011) with DSS to link birth data to Medicaid eligibility data on a semi-annual basis. This data linkage has occurred in the past, but the MOA expired in June 2010. DSS was proactive in facilitating the linkage of the 2008 birth cohort even in the absence of the MOA with the resulting expectation that the 2008 linked birth-Medicaid file will be provided to DPH by the end of July 2011.

The 2009 Vital Statistics data file became available for analyses to FHS staff on June 14, 2011.. Vital Statistics staff will provide the data analyses results to update the HSCIs in September 2011.

The in-patient hospitalization data will also be available for updating HSCI #01 in September 2011.

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	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	39.5	37.3	33.8	35.0	35.0
Numerator	802	788	715	737	737
Denominator	202831	210985	211637	210470	210470
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 - 2010

Source: Repeated 2009 data. CY 2010 in-patient hospitalization data is not yet available. CY 2010 data should be available by end of July 2010. This measure will be updated in September 2011.

Notes - 2009

Source: CY 2009 in-patient hospitalization data provided by J.Morin, FHS, PHI Branch. Numerator is 2009 hospital discharge data and denominator is 2009 population estimates, provided by K. Backus- Table 1 of the Registration Report.

Notes - 2008
Source: CY 2008 in-patient hospitalization data provided by J.Morin, FHS, PHI Branch. Numerator is 2008 hospital discharge data and denominator is 2008 population estimates, provided by K. Backus- Table 1 of the Registration Report.

Narrative:
The rate of children less than five years of age hospitalized for asthma fluctuated in 2005 and 2006 between 32.0 and 39.5 per 10,000 children, and since then has remained at 37.3 per 10,000 children. DPH is awaiting receipt of 2008 and 2009 hospitalization data to update this measure. A slight increase in this rate is possible.

Narrative will be updated in September 2011.

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	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	86.2	86.6	94.2	86.5	86.5
Numerator	14429	15133	16833	15542	15542
Denominator	16739	17475	17866	17961	17961
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 - 2010
Source: Repeated 2009 data. CY 2010 data not available from DSS 2010 CMS 416 report. Data should be availalbe by August 2011 and will be updated in September 2011.

Notes - 2009
Source: CT Dept of Social Services, 2009 CMS 416 report.

Notes - 2008
Source: CT Dept of Social Services, 2008 CMS 416.

Narrative:
The percent of Medicaid enrollees whose age is less than one year during the reporting year and who received at least one initial periodic screen has fluctuated since 2005, with a low of 86.2% in 2006 and a high of 94.2% in 2008. A slight increasing trend in this percentage may have occurred.

Narrative will be updated in September 2011.

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	2006	2007	2008	2009	2010
Annual Indicator	73.7	82.0	83.9	83.9	83.9
Numerator	365	445	366	366	366
Denominator	495	543	436	436	436
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 - 2010
Source: Repeated 2008 data. DSS indicates that they are not able to report this measure because the HUSKY participation report is no longer available.

Notes - 2009
Source: CT Dept. of Social Services was not able to report on this measure for 2009 due to the HUSKY participation report no longer being available. SFY2008 data used.

Notes - 2008
Source: CT Dept of Social Services, SFY2008 HUSKY participation report (This represents data from 2 MCOs that were part of the SCHIP program).

Narrative:
The percent of SCHIP enrollees whose age is less than one year and who received at least one periodic screen varied from a low of 73.7% in 2006 to a high of 83.9% in 2008 and 2009. A slight increasing trend may have occurred.

Narrative will be updated in September 2011.

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	2006	2007	2008	2009	2010
Annual Indicator	80.2	79.1	79.0	80.3	80.3
Numerator	32809	32152	31382	30542	30542
Denominator	40898	40659	39739	38012	38012
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 - 2010
Source: CT Dept of Public Health, final 2009, Vital Statistics updated Sept 2011.
CY2010 Vital Statistics data not available.

Notes - 2009

Source: Final CY2009 Vital Statistics data, updated Sept 2011.

Notes - 2008
Source: CT Dept of Public Health, Final 2008, Vital Statistics.

Narrative:
In 2009, 79.0% of women 15 through 44 years old with a live birth during the reporting year received an observed-to-expected ratio of prenatal visits that was greater than or equal to 80% of the Kotelchuck Index. No trend is apparent with the data. It is possible that implementation of recent interventions in the state, such as presumptive eligibility and expedited enrollment for HUSKY, may positively impact this measure.

Narrative will be updated in September 2011.

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	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	48.8	52.2	54.9	52.5	52.5
Numerator	137566	145359	156715	157840	157840
Denominator	281910	278677	285538	300731	300731
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 - 2010
Source: Repeated 2009 data. CY 2010 data not available from DSS 2010 CMS 416 report.

Notes - 2009
Source: CT Dept. of Social Services, 2009 CMS 416 report, representing the percentage of children under 21 who received a well child visit during the noted Fiscal year.

Notes - 2008
Source: CT Department of Social Services, 2008 CMS 416

Narrative:
The percent of potentially Medicaid-eligible children who received a service paid by the Medicaid program increased from a low of 47.9% in 2005 to a high of 54.9% in 2008. This continued increase is a positive since DSS has had changes in the number of MCOs participating in the program, and has also introduced the Charter Oak health insurance plan for all state residents.

Narrative will be updated in September 2011.

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	2006	2007	2008	2009	2010
Annual Indicator	48.1	53.0	52.3	52.1	52.1
Numerator	26848	29007	29283	30567	30567
Denominator	55848	54775	55971	58683	58683
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 - 2010
Source: Repeated 2009 data. CY 2010 data not available from DSS.

Notes - 2009
Source: CT Dept. of Social Services, FFY2009.

Notes - 2008
Source: CT Dept of Social Services, FFY2008.

Narrative:
After an initial increase in the percent of EPSDT-eligible children aged 6 through 9 years who received a dental service during the year (43.7% in 2005 to 53.0% in 2007), the percentage decreased slightly to 52.1% in 2009. Efforts to encourage pediatric oral health services will continue.

Narrative will be updated in September 2011.

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	2006	2007	2008	2009	2010
Annual Indicator	4.3	8.8	8.8	9.6	8.3
Numerator	259	546	546	624	565
Denominator	6008	6230	6230	6475	6829
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 - 2010
Source: Social Security Administration, Supplemental Security Record, December 2010.

Notes - 2009
Source: 2009 data are from the CYSHCN Access database that includes information from active Medical Homes. A total of 6782 CYSHCN received services from the program. An estimated

9.2% of these receive SSI of 624 for the numerator. The denominator is the actual number of CT residents <16 receiving SSI 6475.

Notes - 2008
Source: CY2008 data not available.
Source of 2007 data are from the CYSHCN Access database that includes information from active Medical Homes. 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.

Narrative:
Change in the data source this year to Social Security Administration website.

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

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2008	matching data files	9.2	7.2	8

Notes - 2012
Source: CT DPH Vital Statistics Final 2008 matched births to Medicaid eligibility information, updated Sept 2011.

Narrative:
The most recent linked birth-Medicaid data file available is for the CY 2007 birth cohort. The percent of low birth weight babies was 1.2 times higher among Medicaid births (9.2%) than among non-Medicaid births (7.4%). 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 and home visitation services to pregnant Medicaid-eligible women and their children up to age three. A recently developed strategic plan to address low birth weight in the state may also help address this disparity.

Narrative will be updated in September 2011.

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

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**

Infant deaths per 1,000 live births	2008	matching data files	6.7	5	5.6

Notes - 2012
Source: CT DPH Vital Statistics Final 2008 matched births to Medicaid eligibility information, updated Sept 2011.

Narrative:
The percent of infant deaths is 1.6-times higher among births to Medicaid enrollees.

Narrative will be updated in September 2011.

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

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	matching data files	78	92.7	87.1

Notes - 2012
Source: CT DPH Vital Statistics Final 2008 matched births to Medicaid eligibility information, updated Sept 2011.

Narrative:
The percent of infants born to women who received early prenatal care was 1.2-times better among non-Medicaid enrollees (92.6%) than among Medicaid enrollees (75.9%). The FHS represents DPH on the Women's Health Subcommittee of the Medicaid Managed Care Council and will continue to explore ways to encourage entry into prenatal care.

Narrative will be updated in September 2011.

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 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant	2008	matching data files	72.2	83	78.9

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

Notes - 2012
Source: CT DPH Vital Statistics Final 2008 matched births to Medicaid eligibility information, updated Sept 2011.

Narrative:
The percent of pregnant women with adequate prenatal care was 1.2-times better among non-Medicaid enrollees (82.0%) than among Medicaid enrollees (69.9%). The FHS represents DPH on the Quality Assurance Subcommittee of the state's Medicaid Managed Care Council and will continue to explore ways to increase the quality of prenatal care for women enrolled in Medicaid. Also, initiation of the Primary Care Case Management program within the HUSKY system may help address this disparity in the future.

Narrative will be updated in September 2011.

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)	2010	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)	2010	300

Notes - 2012
no change in FPL from 2009: <185%FPL

Notes - 2012
No change in percent of poverty level for SCHIP infants 0-1: >185 to 300% FPL.

Narrative:
Eligibility for HUSKY A increased in January, 2009 from 185% to 250% of the federal poverty level.

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)	2010	185

(Age range to)		
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)	2010	300

Notes - 2012
no change from 2009: <185% FPL for children 1-22

Notes - 2012
No change in percent of poverty level for SCHIP children 1 - 18 (<19yrs): >185 to 300% FPL.

Narrative:
There has been no change in eligibility for the state's SCHIP program. Eligibility remains at 300% of the federal poverty level.

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	2010	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	2010	250

Notes - 2012
No change in FPL for pregnant women from 2009: <250%FPL

Notes - 2012
SCHIP not applicable to pregnant women; but Medicaid eligibility is still <250%FPL.

Narrative:
There has been no change in eligibility in the Medicaid and SCHIP programs. Eligibility remains at 250% of the federal poverty level.

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)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death	3	Yes

certificates		
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 - 2012

Narrative:
This measure remained unchanged. FHS personnel continue to pursue regular access to WIC eligibility files that will allow linkage to birth records. Connecticut's fourth PRATS survey is currently being conducted. A fifth PRATS survey is planned as part of the new 5-year cycle for SSDI and will begin in year 2 of that project.

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 - 2012

Narrative:
The most recent Connecticut School Health Survey (YRBS) was conducted during this calendar year 2011.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Connecticut (CT) Department of Public Health (DPH), Family Health Section (FHS) utilized the framework included in the Title V Application Guidance (engaging stakeholders, assessing needs and identifying desired outcomes and mandates, examining strengths and capacity, selecting priorities, seeking resources, establishing performance objectives, developing an action plan, allocation of resources, monitoring impact on outcomes, and reporting back to stakeholders) to ensure all steps in the needs assessment were addressed to identify needs for 1) preventive and primary care services for pregnant women, mothers and infants up to age one; 2) preventive and primary care services for children; and 3) services for Children with Special Health Care Needs (CSHCN) from October 2008 -- May 2010. The MCH needs assessment was designed to be population-based, community focused, and framed within a family context.

The MCH Title V Program 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.

The Planning Committee determined that the needs assessment process would include a DPH Internal Needs Assessment, a Community Centered Needs Assessment, and a Stakeholders Committee that would assist with selecting State priority areas.

Each Internal Needs Assessment workgroup was instructed to recommend up to 5 priority needs for a total of 15 priority needs to be considered by the Stakeholders Committee. In the Community Centered Needs Assessment, both qualitative and quantitative methods were used to inform the comprehensive needs assessment process. 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 Stakeholders Committee met in May 2010, to review the identified priority needs from the Internal and Community Centered Needs assessments and to select 7-10 priority areas to improve maternal and child health. The Stakeholders Committee selected 9 priority areas.

DPH established state performance measures for each priority area.

/2012/Five of the State Performance Measures (SPMs) have been revised:
• Improve Mental/Behavioral Health Services-Percent of students that had a risk assessment with a mental health component conducted during a comprehensive, annual physical exam at a SBHC.
• Enhance Oral Health Services-Percent of child health providers/dental providers who serve at risk populations that perform dental caries risk assessments and provide oral health education and risk based preventive strategies by age one.
• Reduce Obesity among the three target MCH populations -- Increase the redemption rate of fruit and vegetable checks issued to women and children enrolled in the Connecticut WIC program.
• Improve the Health Status of Women, including Depression -- The percent of pregnant and postpartum women who receive preconception and interconceptional health screening (including depression) and education in DPH-funded case management/Home Visiting programs.
• Reduce Health Disparities within the three MHC target populations --the extent to which the ratios of key perinatal health measures for non-Hispanic Black/African Americans

relative to non-Hispanic Whites has changed.//2012//

B. State Priorities

Through the Needs Assessment process completed for the 2011 Application, DPH identified nine State priority needs.

1. Enhance Data System

The goal is to increase the number of core databases integrated into the Health Informatics Profile for CT Kids (HIP-Kids), a data warehouse containing a comprehensive child health profile created by linking disparate databases into a single comprehensive system. There is no National Performance Measure that addresses this need and the rationale for creating a State Performance Measure.

Insufficient data and research are available to adequately support MCH program development and the evaluation of existing programs, especially in terms of obtaining new funding and reporting the appropriate information for existing grants and initiatives. Databases containing child health information are housed in different areas of the agency. These data are currently not linked, and they are analyzed in isolation of one another, thus limiting essential public health functions. The Health Informatics Profile for CT Kids (HIP-Kids), a data system of linked child health information at the record level, is currently under development to address this problem. The seven (7) core datasets identified for inclusion in HIP-Kids are not yet integrated completely. The fully developed HIP-Kids data warehouse will support the agency's public health assurance, assessment and evaluation activities; interdivisional public health research activities and initiatives, and inform public health policy.

2. Improve Mental/Behavioral Health Services

Annually, about one out of every five CT children has a mental health or substance abuse problem. Fewer than half get any treatment. In 2008-2009, mental health as a primary diagnoses accounted for more than one third (37%) of all SBHC clinic visits. There is no National Performance Measure that addresses this need and the rationale for creating a proxy State Performance Measure to attempt to measure improvement in mental health services provided to adolescents. The proxy measure is intended to monitor the SBHC students that visited a SBHC clinic that received a risk assessment with a Mental Health component who come in for intake physical exams or children referred by parents, teachers, etc.

3. Enhance Oral Health Services

Dental caries is the single most common chronic childhood disease, 5 times more common than asthma and 7 times more common than hay fever. Prolonged lack of treatment can lead to tooth loss, systemic infection, and the entry of toxins and by products of inflammation into the bloodstream. Dental disease in a young child can affect their development, school readiness, and attendance. While National Performance Measure #09 addresses children receiving dental sealants, there was a strong consensus that more preventive activities needed to be monitored.

This resulted in the goal to reduce the prevalence of dental caries through increased recognition of the importance of early dental caries prevention prior to tooth eruption, dental visits beginning at age one, fluoride varnish applications (where appropriate) and the importance of optimal oral health for the mother. A new State Performance Measure was created to expand on monitoring prevention activities completed by dental care providers.

4. Reduce Obesity among the three target MCH populations

The association between the consumption of fruits and vegetables and preventing or reducing obesity prevalence has been established. There is no National Performance Measure that addresses this need and the rationale for creating a proxy State Performance Measure to attempt to measure improvement in reducing obesity among the three target MCH populations. Offering fruit and vegetables vouchers to WIC participants works as incentives for participants to purchase more fresh fruits and vegetables. With increased availability and access to fresh fruits and vegetables, it is hoped that the participants would change their dietary habits and increase their consumption of fruits and vegetables. By increasing the consumption of fruits and vegetables, participants would be in a better position to combat obesity or prevent becoming obese.

5. Enhance Early Identification of Developmental Delays, Including Autism

The five National Performance Measures addressing the needs of the CYSHCN population do not directly address this aspect of the life of a CYSHCN. The 2005/2006 National Survey of CSHCN revealed that 3.8% of Connecticut's CSHCN population, or roughly 5,057 children were diagnosed with Autism Spectrum Disorder (ASD). Early identification is a component of meeting the needs of CYSHCN, including those with ASD, and the focus will be on the 0-3 population and provider education. A State Performance Measure was created to increase awareness and recognition of the importance of early identification of developmental delays on the part of providers as evidenced by an increase in the percentage of 0 to 3 year olds receiving a developmental screening within the last twelve months; thereby facilitating subsequent evaluation and referral to services.

6. Improve the Health Status of Women, including depression

A woman's health across the lifespan includes her reproductive years, as well as pre-reproductive and post-reproductive years. Use of a culturally-sensitive and evidence-based preconception screening tool can address many risk factors (including depression) for pregnancy and birth complications before a woman becomes pregnant, and needs to be encouraged as a best-practice protocol among professional service providers who serve women. There is no National Performance Measure that addresses this need and the rationale for creating a proxy State Performance Measure to measure the number of DPH funded Case Management programs whose healthcare professionals complete preconception health screening (including depression) of women.

7. Improve Linkages to Services/Access to Care

There is no National Performance Measure that addresses this need. DPH's PCO works to identify medically underserved areas in CT that may qualify for a federal designation as Medically Underserved Area or Population or Health Professional Shortage Area as underserved areas for primary care, dental or mental health care. Identifying needy areas in the state and then obtaining a federal designation are the first steps toward getting the necessary resources to improve health care services and access in local communities. A State Performance Measure was created using the information available from the PCO to promote and provide access to health care programs and services especially among the underserved populations by increasing the number of Health Professional Shortage Area (HPSA) designations in the State.

8. Integrate the Life Course Theory throughout all state priorities

There is no National Performance Measure that addresses this need. The general concept of life course theory is to address early childhood determinants of adult health, before health conditions are realized in adulthood. Interventions are needed in childhood that decrease the risk factors of poor health in adulthood and that maximize protective factors. A paradigm shift is needed to focus public health initiatives on children, with the intention of curbing poor health in adulthood. A State Performance Measure was created to monitor the extent to which DPH has incorporated public health interventions that address early childhood determinants of adult health into

programmatic action plans.

9. Reduce Health Disparities within the three MCH target populations

There is no National Performance Measure that addresses this need. Improvements in the quality of data collected will further increase our statewide capacity to accurately monitor and devise plans to reduce health disparities. The goal is to increase the availability of racial/ethnic data in the context of the other eight State Priority needs based on Federal and State data collection standards. With adequate resources and attention, a number of documented gaps in health status can be narrowed. Improvements in the quality of data The 2009 Connecticut Health Disparities Report (Stratton, Alison, Margaret M. Hynes, and Ava N. Nepaul. 2009, Connecticut Department of Public Health.), collected will further increase our statewide capacity to accurately monitor and devise plans to reduce health disparities.

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	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	60	55	77	68	54
Denominator	60	55	77	68	54
Data Source			CT DPH Newborn Screening Program	CT DPH Newborn Screening Program	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	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	100	100	100	100	100

Notes - 2010
Source: CY2010 CT DPH Newborn Screening Program supplied the percentage of confirmed cases that also received appropriate follow-up. (For more information on CT's newborn screening procedures/data, see also the detailed note with Form # 6)

Notes - 2009

Source: CY2009 CT DPH Newborn Screening Program supplied the percentage of confirmed cases that also received appropriate follow-up. (For more information on CT's newborn screening procedures/data, see also the detailed note with Form # 6)

Notes - 2008
Source: CY2008 CT DPH Newborn Screening Program supplied the percentage of confirmed cases that also received appropriate follow-up. (For more information on CT's newborn screening procedures/data, see also the detailed note with Form # 6)

a. Last Year's Accomplishments
CT met this objective by ensuring 100% of infants screened as positive received follow-up to definitive diagnosis and treatment services. In 2010, 98% of the 38,519 occurrent births were screened prior to discharge or within the first week of life. 38,809 babies received at least one screen. There were a total of 4,213 presumptive suspect positive screens. 54 newborns had confirmed cases and 54 newborns that needed treatment received treatment. There were 38 hemoglobinopathies and 993 hemoglobin traits were identified.

Treatment centers that provide universal CF testing are responsible for collection of Cystic Fibrosis (CF) statistics and reporting to the National Newborn Screening Information System (NNSIS).
390 newborns had unsatisfactory NBS specimens; all but three (lost to follow-up) were resolved with repeat testing. 11 CT State waivers for refusal of screening were submitted to the lab due to conflicts with religious tenets. Of these, 4 newborns had specimens later obtained by their PCP.

The NBST Program set up the Missing Scan Report internal system to track specimens delivered to the DPH Lab from birthing facilities, there were 846 missed scan specimens and over 130 specimens needed tracking and follow-up in 2010.

The UCHC Genetics Program continued to offer the PEIS toll-free phone line. Referrals for follow-up were made to UCHC Genetics. In 2010, 841 pregnant women called the line concerned about exposure to toxic substances and the possible effect(s) to their baby.

DPH NBST continued to ensure early identification of infants at increased risk for over 40 selected metabolic or genetic disorders.

The GAC agreed to restructure the clinical and technical components of the NBS program. The Newborn Screening Program Advisory Committee (NSPAC), formerly GAC, adopted a mission and purpose statement. It will provide structure that will be governed by By-Laws, officers and expansion of the NSPAC membership.

Due to the increase in abnormal results in 2010, NBS program reviewed the Clinical and Laboratory Standards Institute's "Newborn Screening for Preterm, Low Birth Weight, and Sick Newborns; Approved Guidelines." The state birthing facilities' neonatologists and treatment center physicians met to develop a newborn screening schedule for Neonatal Intensive Care Unit and Sick Baby Nursery babies. Implementation is planned for spring 2011.

A Nurse Consultant is working full time on short term-follow-up and is the NBS representative to the statewide SCD Consortium.

Staff provided technical and phone assistance to Hartford Hospital, neonatologists around the state, and birthing facilities to ensure timely and accurate collection of NBS specimens and compliance standards.

Treatment Centers are in year 2 of a 3 year level funded contract until June 30, 2012. Collaboration between NBS, CYSHCN programs and NSPAC was planned on grant applications to ensure care coordinated connections to pediatric treatment centers.

NBS program and CYSHCN program submitted an application to the Maternal and Child Health Bureau, Division of Services for Children with Special Health Needs, Genetic Services Branch for the SCD Newborn Screening Program, Follow-up Network grant funds.

The Supervising Biologist and NBS Program Supervisor attended the Association of Public Health Laboratories meeting on Severe Combined Immunodeficiency (SCID) screening. The legislature has mandated that SCID be included as a disorder on the CT screening panel, with implementation date of Jan. 2012.

A Nurse Consultant participated on the DPH Genomics Office's (DPH-GO), Council of Genomics (COG), the Expert Genetic Advisory Panel (EGAP), New England Consortium of Metabolic Disorders (NECMD), the New England Regional Genetics Group (NERGG), and as a board member of the Public Health Genomics Committee and the Citizens for Quality Sickle Cell Care.

NBST program supervisor was an advisory committee member on the New England Genetics Collaborative (NEGC) to develop regional innovative grants and programs that promote the health and social wellbeing of those with inherited conditions through collaborations with public health stakeholders.

MAVEN consultant continued to meet with LIMS and Laboratory Screening to advance the development and intersection of the web-based reporting system with the LIMS through HL7 messaging. NBST staff developed the birthing facility and disease workflow (including missed scan report) specifications and corresponding reports and letters.

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. Development of treatment center services on the expanded NBS panel				X
6. Update educational programs to reflect the expansion of the NBS testing panel				X
7. Participate in various State, Regional, and National conferences				X
8. Support families identified with genetic and metabolic disorders		X		
9. Enhancing data collection technology for electronic reporting				X
10. Quality Assurance Measures to track blood specimens				X

b. Current Activities

NBST screens for early identification of infants at increased risk of selected metabolic or genetic diseases to allow prompt initiation of treatment. Newborns with suspect positive results are referred for confirmation testing, treatment, follow-up, genetic and nutritional counseling, and education.

NBST continued to: 1) monitor and collect data on unsatisfactory NBS specimens, refusal

waivers, and missing scan reports from the birthing facilities; 2) meet with the LIMS and MAVEN staff for the development and implementation of the web-based reporting system; 3) train birthing facility NBS staff to use the web-based system; 4) monitor activities on NBS education; 5) advocate for increased funding; and 6) meet with the NSPAC.

NBST Nurse Consultants provide technical assistance to selected birthing facilities on the NBS process. NBST staff meet with the NSPAC to discuss data system challenges, quality assurance, statistical reporting, and emerging genetic issues.

Case and protocol reviews foster timely and accurate screening reporting. The NBLS Testing and Tracking program monitors the implementation of CLSI guidelines and the NBS Screening Schedule proposed by Yale New Haven Hospital.

NBS Supervisor reviewed the Healthy People 2020 Initiatives to incorporate them into the program consonant with the Healthy People CT health priorities.

A Nurse Consultant participates on the DPH-GO, COG, EGAP, NECMD, and NERGG.

NBST Program Supervisor is a member of the NEGC advisory committee.

c. Plan for the Coming Year

DPH NBST will ensure that newborns at increased risk are screened for early identification of selected metabolic or genetic diseases, allowing for prompt initiation of treatment to avert complications and prevent irreversible problems or death. All newborns with suspect positive results will be referred to state Regional Treatment Centers for confirmation testing, treatment & follow-up, and genetic and nutritional counseling & education;

NBST will continue to: 1) monitor and collect data on unsatisfactory NBS specimens, refusal waivers, and missing scan reports from the birthing facilities; 2) meet with the LIMS System Coordinator and the MAVEN Consultant to proceed with the development and implementation of the web-based reporting system; 3) train birthing facility NBS staff to use the web-based system; 4) monitor activities on NBS education through grand rounds conferences at birthing hospitals and medical schools, increased NBS follow-up and care coordination capacity building; 5) advocate for increased funding for the PEIS hotline, daily patient referrals and comprehensive treatment services for patients and their families; 6) meet quarterly with the NSPAC

NBST will: 7) implement at least one of the Healthy People 2020 Initiatives in the NBST program; 8) identify, discuss and act on issues related to Lab NBS, protocols, confirmed disorders, consumer concerns, and proposed NBS legislative bills; 9) continue case and protocol reviews with appropriate staff to foster timely and accurate reporting and to decrease false positive and false negative screening results.

NBSLT staff will meet to discuss data systems challenges, quality assurance, statistical reporting, and genetic issues.

If Sickle Cell Disease Newborn Screening Program, Follow-up Network (SCDNSFN) grant funds are obtained, the NBS program will be able to enhance newborn screening capacity and communication between NBSLT staff and pediatric genetic treatment centers and build upon existing SCD service infrastructure to establish a comprehensive SCDNSFN.

NBST Nurse Consultants will provide technical assistance to selected birthing facilities to assess the NBS process from data entry at the birth of the baby through collection of the specimen and receipt of the laboratory report. The Nurse Consultants will educate birthing facilities' Neonatal Intensive Care Unit Nurse Managers and Primary Care Providers on the "Newborn Screening for

Preterm, Low Birth Weight, and Sick Newborns; Approved Guidelines."

A NBST Nurse Consultant will participate on the DPH-GO's COG and EGAP, and regional committees and advisory groups.

The NBST Program Supervisor will remain an advisory committee member on the NEGC whose goal is to develop regional innovative grants and programs that promote the health and social wellbeing of those with inherited conditions through collaborations with public health stakeholders.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**39170**					
Reporting Year:	**2010**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	38809	99.1	35	1	1	100.0
Congenital Hypothyroidism (Classical)	38809	99.1	327	8	8	100.0
Galactosemia (Classical)	38809	99.1	234	0	0	
Sickle Cell Disease	38809	99.1	38	14	14	100.0
Biotinidase Deficiency	38809	99.1	158	9	9	100.0
Congenital Adrenal Hyperplasia	38809	99.1	553	2	2	100.0
Hemoglobin Traits	38809	99.1	993	0	0	
Maple Syrup Urine Disease	38809	99.1	63	0	0	
Other Hemoglobinopathies	38809	99.1	38	11	11	100.0
Tyrosinemia Type I	38809	99.1	28	0	0	
Methylmalonic Acidemia (MMA)	38809	99.1	79	0	0	
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	38809	99.1	73	2	2	100.0
Isovaleric Acidemia	38809	99.1	73	0	0	
Propionic Acidemia	38809	99.1	79	0	0	
Carnitine Uptake Defect	38809	99.1	58	0	0	

3-Methylcrotonyl-CoA Carboxylase Deficiency	38809	99.1	72	0	0	
Ornithine Transcarbamylase Deficiency (OTC)	38809	99.1	72	0	0	
Carnitine/Acylcarnitine Translocase Def. (CACT)	38809	99.1	139	0	0	
Carnitine Palmitoyl Transferance I (CPT I)	38809	99.1	88	0	0	
Carnitine Palmitoyl Transferance II (CPT II)	38809	99.1	139	0	0	
Glutaric Acidemia II (GA II)	38809	99.1	127	0	0	
Glutaric Acidemia Type I	38809	99.1	19	2	2	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	38809	99.1	44	1	1	100.0
Homocystinuria Hypermethionemia	38809	99.1	70	0	0	
3-Hydroxy-3-Methylglutaryl-CoA Lyase Def. (HMG)	38809	99.1	72	0	0	
Multiple CoA Carboxylase Def. (MCD)	38809	99.1	72	0	0	
Nonketotic Hyperglycinemia (NKH)	38809	99.1	12	0	0	
Multiple acyl-CoA Dehydrogenase Deficiency (MADD)	38809	99.1	127	0	0	
Argininosuccinic aciduria (ASA) / Argininosuccinase Lyase (ALD)	38809	99.1	57	0	0	
Hyperammonemia-Hyperornithinemia-Homocitrullinemia Syndrome (HHH)	38809	99.1	28	0	0	
Malonic Aciduria	38809	99.1	16	0	0	
Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency/Trifunctional Protein Deficiency	38809	99.1	0	0	0	
Citrullinemia or Argininosuccinic Acid Synthetase Deficiency (ASD)	38809	99.1	57	1	1	100.0
Short-Chain ACYL-CoA Dehydrogenase	38809	99.1	31	3	3	100.0

Deficiency (SCADD)						
Argininemia – Arginase Deficiency (Arg)	38809	99.1	68	0	0	
2, 4, Dienoyl CoA Reductase Def. (DCR)	38809	99.1	1	0	0	
Beta-Ketothiolase Deficiency and 2M3HBA	38809	99.1	11	0	0	
Short Chain 3-Hydroxyacyl-CoA Dehydrogenase Def. (SCHADD)	38809	99.1	10	0	0	
Long-Chain Acyl-CoA Dehydrogenase Def. (LCADD)	38809	99.1	4	0	0	

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	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	59.8	59.8	59.8	59.8	59.8
Annual Indicator	59.8	57.8	57.8	57.8	57.8
Numerator					
Denominator					
Data Source			National Survey of CSHCN	National Survey of CSHCN	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
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	59.8	59.8	59.8	59.8	59.8

Notes - 2010
Source: 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 - 2009
Source: Indicator data come 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 - 2008

Source: Indicator data come 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.

a. Last Year's Accomplishments
This measure was not met as there was a 2% decrease from the 2001 SLAITS survey (57.8% in the 2005-06 SLAITS vs. 59.8% in 2001 SLAITS). Connecticut (CT) does remain higher than the national average of 57.4%.

CT's Title V System of Care for CYSHCN, "The CMHI provided a community-based, coordinated system of care for children and families. Services in the following categories were provided to 8,264 CYSHCN: administration of extended services and respite funds, medical home care coordination, provider and family education, outreach and family support.

The CHDI and their subcontractor the Family Support Network (FSN) continued to implement the provider and family outreach, education, and support component of the CMHI for CYSHCN. FSN and CHDI provided training to families about linking resources, and worked in partnership with primary care providers to provide education through the EPIC modules including a module on family and professional partnership and Family-Centered Care and Care Coordination for CYSHCN.

CHDI and FSN developed a survey for parents of CYSHCN. Fifty-three parents/caregivers of CYSHCN completed the online survey about their children's access to and utilization of medical home services. The first set of analyses from the survey indicate few families have care plans in place and there remains a tremendous need for child health providers to address family support issues, including the connection of families to support services.

The DPH Family Advocate attended the national EHDI conference, and gathered information and tools to: 1) enhance the EHDI System in CT; and 2) achieve family support and care coordination through enhanced linkage with CMHI.

Activities included expansion of a contract with CHDI to support EHDI activities to improve quality of care related to hearing-loss among pediatric-age patients in the primary care setting through the development of an EPIC Module and use of the Module to conduct statewide training in each of five CMHI for CYSHCN service areas.

In May 2010 DPH sponsored the Making Change Happen: Individual and Organizational Level Strategies for Child and Adolescent Health Success during Times of Change conference. Over two hundred and twenty five families and providers attended, speakers included Tesha Imperati from the FSN who shared a parent's perspective of family-centered care.

The FSN hosted a forum on June 2, 2010 focusing on the Home By One Program and the DPH Office of Oral Health. The presentation focused on building partnerships with medical and dental practitioners, social services providers, and parents and caregivers as to the importance of oral health as essential to the overall health and well-being of children, more than 150 people attended the forum from across the state.

Eight family representatives served as voting members of the Medical Home Advisory Council (MHAC) and were compensated for travel and childcare expenses. Family representatives participated in three ongoing MHAC workgroups, including a Family Experience workgroup. DPH provided stipends to assist families in participation on either Council and/or work group activities, and teleconferencing was available for all meetings.

A FSN Family Advocate was nominated and awarded a family scholarship to the AMCHP National Convention in Washington D.C. and for the first time MCH offered a year-long training and education for family scholars.

DPH partnered with key stakeholders to implement the Health Resources Services Administration (HRSA) grant for the CT Family-to-Family Health Information Network. The project 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.

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, and Family Support Council and meetings as appropriate.				X
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

Family support services, including education for families of CYSHCN, are offered statewide through the FSN to enable them to acquire skills necessary to access medical and related support services and become empowered, competent supporters for their children.

The EHDI program is strengthening family and professional partnerships through the recent establishment of the first Deaf and Hard of Hearing Outreach Coordinator as part of the CMHI, FSN. The Coordinator has created and is further developing an electronic list of statewide resources for families with children who are hearing impaired.

Information about Hands & Voices, a national organization to provide unbiased communication options, is shared with community stakeholders to create a CT Hands & Voices Chapter. CT was granted provisional Hands & Voices status in March of 2011. A start-up stakeholders meeting was held on May 24, 2011. Attendance included over forty families of infants and children who are deaf and hard of hearing as well as professionals with the purpose to work collaboratively as a start-up team that will develop into a Board of Directors comprised by a majority of parents.

The Medical Home Family Survey, available in English and Spanish, is posted online and is being distributed through the CMHI.

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

c. Plan for the Coming Year

DPH and CMHI will support and enhance a family-centered Medical Home concept through statewide outreach and culturally competent education to pediatric primary care providers and families. CHDI and the FSN will continue to implement Family/Professional Partnership education and outreach. CMHI partners and contractors, including the Child Development Infoline of 2-1-1-United Way, will connect families to support, advocacy, and resources.

Families will be members of the MHAC, its workgroups and subcommittees, and will be compensated for their time through stipends. Family participation will continue on the legislated Family Support Council, the CT Lifespan Respite Coalition, and Family Voices organizations.

Implementation of the CHDI contract expansion will further enhance family involvement in the CT DPH EHDI process and improve awareness and availability of information for families of children in CT who are deaf or hard of hearing and will further promote family-professional partnerships within the CT EHDI System.

DPH will monitor, enhance and revise the statewide respite system available through CMHI. DPH will distribute the Get Creative About Respite manual through community activities, and disseminate Directions: Resources for Your Child's Care an information organizer that includes sections on medical home and connecting parents and families to services (available in English, Spanish and Portuguese). These documents are available in hardcopy and through the DPH website.

DPH will promote the partnering of families in decision making for CYSHCN. Activities will include, but not be limited to: compensation for families to review CT's MCH Block Grant (MCHBG) application, invitation for families to comment at the MCHBG public hearings or focus groups, and provision and support of an Access database to manage and report information on CYSHCN.

DPH will work with key stakeholders and family and consumer agencies, including FSN, CHDI, and Parents Available to Help/Family Voices CT, with a primary outcome to improve access to Medical Home and related services including family support.

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 develop appropriate strategies and policies to improve these systems.

Additional outreach activities will include collaboration with the FatherWorks Program through the Village for Families and Children in the Hartford area with a primary focus of supporting fathers of CYSHCN in becoming involved in accessing and coordinating services for their children. The collaboration will support teenage fathers who are YSHCN themselves. Activities will include health literacy education.

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	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	56.9	56.9	48.5	48.5	48.5
Annual Indicator	56.9	48.5	48.5	48.5	48.5
Numerator					
Denominator					
Data Source			National	National	National

			Survey of CSHCN	Survey of CSHCN	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
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	48.5	48.5	48.5	48.5	48.5

Notes - 2010
Source: 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.

Notes - 2009
Source: Indicator data come 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.

Notes - 2008
Source: Indicator data come 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 these more recent data.

a. Last Year's Accomplishments
This objective was not met using a comparison of the CT 48.5% reported in the 2005-2006 SLAITS verses the 56.9% reported in the 2001 SLAITS. CT remains higher than the national average of 47.1%.

CT's system of care for CYSHCN, "The Connecticut Medical Home Initiative (CMHI) for CYSCHN", provided a community-based, culturally competent, coordinated system of care for children and families.

CMHI provided community-based care coordination to 8,264 CYSHCN through 39 community based medical homes including: community health centers, hospital clinics, pediatric and family practices. CMHI care coordination network contractors included: Connecticut Children's Medical Center (North Central area of the state), St. Mary's Hospital (Northwest), Stamford Health System (Southwest), Coordinating Council for Children in Crisis (South Central) and United Community and Family Services, (Eastern). CMHI provided technical assistance (TA) to an additional 16 practices implementing a medical home model. Care coordination activities included: assessment, care planning, home visits, family advocacy, linkage to specialists and community-based resources, coordination of health financing resources, coordination with school-based services, chronic disease management, family education and transition planning.

The DPH Medical Home Advisory Council (MHAC) comprised of more than 40 representatives, including youth representation from CT Kids as Self Advocates, state and private agencies, community-based organizations, and parents of CYSHCN, provided guidance to DPH in its efforts

to improve the system of care for CYSHCN by ensuring their connection to a Medical Home (MH).

Care Coordination Collaborative Partnership meetings were conducted in the Eastern and South Central areas of the state. Meetings centered on specific families and included team members involved in the child's care to address care planning and implementation within existing resources.

In March 2010, the program was represented through a poster session "Medical Home Implementation Served Best By Community-Based Ownership, Connecticut Decentralizes Management and Services" at the National Initiative for Children's Health Care Quality (NICHQ) Annual Forum. The session generated interest and inquiry from practice sites from within and outside CT.

DPH and South Central medical home staff collaborated to present an introductory MH presentation at Yale New Haven Hospital Pediatric Grand Rounds on March 23, 2010 to 30 pediatric and family medicine providers.

The CYSHCN unit hosted an undergraduate student intern who compiled a resource guide for use by CMHI care coordinators, agency staff, and case managers providing services to CYSHCN.

During October 2010, MCHB technical assistance was accessed to develop an MHAC strategic plan; activities included a planning retreat facilitated by Peggy Hayden. The MHAC's mission statement was revised, priority goals for the next 2-3 years were established, and a work plan for the next year written. 45 MHAC members attended the planning retreat.

Title V CYSHCN Director Mark Keenan presented "Local Strides Toward Medical Home" during the University of Connecticut's Primary Care Week. Over 180 students from the UCONN Schools of Medicine and Pharmacy, and Quinnipiac University's Physician Assistant Program attended the presentation in person or via videoconferencing.

Medical Home Family Satisfaction Survey results (February to June 2010) indicated 87% of 200 respondents receiving care coordination through CMHI had access to their child's physician when needed, 91% reported their physician listened to their concerns, 85% reported office staff were knowledgeable of their child's condition and history. Families reported care plans were in place 44% of the time (baseline was 23%), 96% of those reported they understood their care plans, and 78% reported participation in developing the care plan. Responses indicated care coordinators always helped to communicate with others involved in the child's care 88% of the time, and always worked to connect the family to resources 86% of the time. 66% of respondents with children over 13 years of age indicated they received assistance in addressing health care needs moving towards adult services. Access database information confirmed the findings and indicated 64% of children served by the program were linked to resources outside the medical home.

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
CMHI provides community-based, culturally competent medical home care coordination services. 9,000 children are projected to receive care coordination services through CMHI this year.

Care Coordination Collaborative Partnership meetings are conducted on an ongoing basis in three areas of the state. The North Central collaborative was cited in the Governor's policy framework as a process vital to working within existing resources and reducing duplication of services.

DPH provides CMHI networks technical assistance (TA) through participation in Collaborative Partnership Meetings, site visits, quarterly TA care coordinators' meetings, and biweekly conference calls. Conference calls include case scenarios shared to ensure access to community-based resources, to improve referrals and access to CMHI, and to address individual issues with collective experience from care coordinators throughout the system.

A summary report of a MH pilot project implemented in three practice sites is under review by the General Assembly. Findings include confirmation that: establishment of protocols facilitates care coordination, medical home care coordination improves care delivery, and sustainability is ensured through provider recognition of care coordination's value to consumers. Recent Results Based Accountability (RBA) cohort trend analysis indicates that CYSHCN receiving care coordination through CMHI experience fewer and shorter hospitalizations.

c. Plan for the Coming Year
CMHI will provide community-based, culturally competent MH care coordination services and provide technical assistance to practices engaged in medical home implementation. CMHI is projected to provide care coordination services through 41 medical homes and as many as 9,500 CYSHCN are projected to receive care coordination in the coming year.

DPH will provide TA to CMHI care coordinators through collaborative partnership meetings; site visits, biweekly conference calls, and quarterly TA care coordinators' meetings.

Care Coordination Collaborative Partnership meetings will be expanded to all five areas of the state.

Additional data from the Medical Home Family Satisfaction Survey will be collected and further analyzed for use in program planning. The surveys are available in English and Spanish, are disseminated through CMHI care coordinators and are available online at http://www.ct.gov/dph/site/default.asp (search Family Medical Home Satisfaction Survey). Additional sources of data will be developed and strategies put in place to strengthen legislatively mandated RBA efforts. Additional training will be provided and emphasis placed on the use of comprehensive care plans.

The Access database used by CMHI care coordinators will be migrated to the Maven web-based platform, allowing for web-based reporting, integration with other databases utilized by DPH (including the Birth Defects Registry, Newborn Screening, and Early Hearing Detection and Intervention databases), and ensure future linkage to electronic medical records. The system will

allow information from medical home care coordinators and others providing services to be integrated in support of CYSHCN program surveillance, planning and evaluation. Maven is projected to "go live" in late 2011. On-site training at CMHI medical homes will be conducted and technical assistance provided in support of the new data reporting system.

Final edits and review of the CT Medical Home Training Academy Curriculum revision will be completed and DPH will partner with the UCHC to post the four team-based curriculum modules online including: Background and Current Context of Medical Homes in CT, Care Coordination, Family-Professional Partnerships and Transition to Adulthood.

Additional MH presentations will be made to providers, including a project in collaboration with the DPH PCO.

The MHAC's priority goals will be implemented through further partnering with community stakeholders in support of medical home access for all children, including those with special health care needs. An intern will work with MHAC membership and DPH staff to develop a presentation and conduct outreach to educational institutions to assess the availability of training and educational opportunities within existing programs and curricula that support medical home care coordination at various levels of expertise.

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	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	61.3	61.3	61.7	61.7	61.7
Annual Indicator	61.3	61.7	61.7	61.7	61.7
Numerator					
Denominator					
Data Source			National Survey of CSHCN	National Survey of CSHCN	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
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	61.7	61.7	61.7	61.7	61.7

Notes - 2010
Source: 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.

Notes - 2009

Source: Indicator data come 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.

Notes - 2008
Source: Indicator data come 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.

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 (CMHI) for CYSHCN", provided a community based, culturally competent, comprehensive, accessible, coordinated system of care for children with special health care needs. Services were provided in the following categories: administration of extended services and respite funds, community-based medical home care coordination, provider/ family education and outreach. All included facilitating access to adequate public and/or private insurance to pay for services families needed.

The medical home care coordination networks 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 insurance benefits and assisting in the process of filing appeals when claims were denied.

DPH staff served on the legislative CT Medicaid Managed Care Oversight Council (MMCOC). The Council is 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 CT'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 MMCOC has a legislative mandate to assess and make recommendations to DSS (the state's Medicaid agency) 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 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. DSS expanded a Primary Care Case Management (PCCM) pilot to five municipalities (Waterbury, New Haven, Hartford, Windham, Putnam). DPH collaborated to facilitate access to PCCM as well as to the Medicaid Managed Care plans. DPH staff participated on the (MMCOC) PCCM subcommittee.

A FSN forum -- Supporting CYSHCN in a Dental Home - was held on June 2, 2010 in collaboration with the DPH Office of Oral Health and the state's Medicaid Dental Administrative Services Organization, the CT Dental Health Partnership (DHP). Resource materials concerning HUSKY eligibility and application, and the Katie Beckett waiver were distributed to 150 attendees. CMHI promoted and distributed DHP materials concerning eligibility and access to the Medicaid dental program to more than 2,000 consumers of medical home services through the year.

Representatives from DSS, as well as representatives from the MCOs administering HUSKY participated in Medical Home Advisory Council (MHAC) meetings as well as the MHAC planning retreat (October 2010), facilitating the incorporation of HUSKY outreach as an integrated part of Connecticut's medical home efforts. HUSKY MCO staff participated in all Care Coordination Collaborative Partnership meetings, answering eligibility and access questions, and working to meet case specific needs.

DSS staff participated on CMHI biweekly technical assistance conference calls, providing updates and assistance with eligibility regarding complex family needs.

DPH, DSS and CMHI staff collaborated with the CT Family-to-Family Health Information Network to update and distribute the HUSKY eligibility manual -- disseminated in hard copy, electronically and on flash-drives. Dissemination to consumers included channels through CT SCD Consortium and CT EHDI Task Force partners.

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 care coordination including access to private/public insurance		X		
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

CMHI care coordinators provide coordination of and facilitate access to health care financing resources, including public insurance. Referrals are made to HUSKY infoline and assistance is provided in filling out applications.

The DSS PCCM pilot is under expansion to include the municipality of Torrington. In PCCM, providers are given a per member per month payment to provide care coordination in addition to a Fee-For-Service payment structure. DPH collaborates to facilitate access to PCCM as well as to Medicaid Managed Care plans. There are approximately 530 consumers participating in PCCM. DPH staff participate on the MMCOC's PCCM subcommittee, which is working to address barriers to enrollment in the pilot.

The CT DPH Title V CYSHCN Program continues integration and improvement of strategies for CYSHCN and their families in accessing public/private insurance sources and assist families with eligibility determination and application for HUSKY.

In April 2011, the DSS released a Request for Proposals to programmatically change the existing Medicaid Managed Care HUSKY structure. The change will result in implementation of a revised system of care that will utilize an Administrative Services Organization (ASO) structure to change

local service delivery to support the emergence of medical homes, health homes, and integrated care organizations. The emerging structure is likely to be a PCCM model.

c. Plan for the Coming Year
CMHI community-based medical home care coordinators will provide coordination of and facilitate access to health care financing resources, including insurance.

The Connecticut Lifespan Respite Coalition, the contract grantee for the management of extended services and respite funds, will assist families in accessing existing insurance benefits and in the process of filing appeals.

DPH staff will serve on the MMCOC and PCCM subcommittee, providing input to the emerging Medicaid ASO restructure, planned for implementation by January 2012. The resources and experience of DPH and CMHI staff, as well as the MHAC membership will be made available to DSS and the ASO to ensure consumers, including CYSHCN, experience continuing improvement in access to both medical homes and insurance.

The DPH will facilitate access to PCCM as well as to the Medicaid Managed Care plans currently offered under HUSKY until the ASO restructure is implemented, at which time access to the new insurance structure will be facilitated.

Connecticut DPH and DSS representatives will attend MHAC and workgroup meetings and respond to issues concerning eligibility determination, access, application process and related issues. DSS staff will participate in CMHI for CYSHCN contractors' technical assistance conference calls to address insurance issues and questions.

HUSKY ASO and MCO staff will be invited to participate in all Care Coordination Collaborative Partnership meetings, and an invitation for participation in the MHAC will be extended to the identified Administrative Services Organization(s).

Child Health and Development Institute and FSN will implement the Provider/Family outreach and education component of the CT Medical Home Initiative for CYSHCN with a focus on Family/Professional Partnership. The partnership focus will include education for both providers and families of CYSHCN in working to navigate access to insurance.

DPH will partner with the A.J Pappanikou Center for Excellence in Developmental Disabilities (the state's UCEDD) to provide an educational presentation to care coordinators, providers and families regarding potential gaps in future coverage for CYSHCN as a result of restructuring due to the Affordable Care Act (ACA). The presentation will include potential differences in coverage and strategies to ensure families understand differences between employer based, public, and exchange based plans when making decisions in selecting a plan.

Additional forums, including Family Support Network and Family-to-Family forums, will be used to disseminate access and eligibility resource materials. DPH will assist Family-to-Family to disseminate the HUSKY eligibility manual electronically and on flash drives through additional partners, including the CF Foundation, Epilepsy Foundation, and other disease specific support organizations.

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	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	76.8	76.8	89.4	89.4	89.4
Annual Indicator	76.8	89.4	89.4	89.4	89.4
Numerator					
Denominator					
Data Source			National Survey of CSHCN	National Survey of CSHCN	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
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	89.4	89.4	89.4	89.4	89.4

Notes - 2010
Source: 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.

Notes - 2009
Source: Indicator data come 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 NPM05.

Notes - 2008
Source: Indicator data come 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.

a. Last Year's Accomplishments
This objective was 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 (CMHI) for CYSHCN" provided a community based, coordinated system of care for children and families. Contractors provided services to 9,000 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 community-based 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 Connecticut Children's Medical Center (North Central CT). Each network contractor affiliated with and provided embedded care coordination for numerous clinical sites. Care coordination was co-located in community based clinical practices,

making care coordination services easier to access for families.

CHDI and their subcontractor the FSN provided statewide outreach and culturally effective education to 15 pediatric primary care providers and 5,278 families on the concept of MH for CYSHCN including information regarding accessing community service systems. Family support services provided assistance and culturally effective education for families of CYSHCN.

DPH implemented the Medical Home Family Survey to collect information on accessibility, quality, and affordability of community-based service systems. Available in English, Spanish, hard copy and electronically, families served by CMHI are surveyed on an ongoing basis. Survey results are used to determine training needs for CMHI coordinators, and to monitor and evaluate CMHI to determine if CYSHCN are receiving family-centered, community-based, coordinated, comprehensive care in their local communities. .

CMHI programmatic progress was monitored through an Access database. Process measures evaluated included the percentage of care plans in place and number of consumers successfully linked with services. An analysis of the database indicated more that 64% of children served by CMHI were successfully linked to resources outside the medical home and 43% had care plans in place. Results were used to promote the use of care plans in assisting consumers to navigate the system and in accessing services. This was the first year that programmatic expectations included implementation of methodologies to address linkages and care planning, including standardized documentation of these activities. (The baseline from the previous year indicated approximately 50% received successful linkages outside medical home and 23% had care plans in place).

DPH collaborated with United Way of CT 2-1-1/Child Development Infoline (CDI) to coordinate referrals to the community-based system. CDI/CMHI 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) managed the administration of DPH 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 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 Advisory Council to the Division of Autism Spectrum Services. CMHI access information was distributed among these partners.

Outreach efforts included collaborative presentations by DPH staff and CMHI care coordinators to the Hartford/West Hartford System of Care and the Genetic Services Advisory Board, providing CMHI access information and linking counseling and case management services to medical home care coordination.

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				X

Infoline/Child Development Infoline				
3. Work with contractors to survey families regarding access to community-based service systems				X
4. Develop trainings to enhance families ability to access community-based service systems				X
5. Enhance public/private partnerships with agencies and organizations serving CYSHCN and their families				X
6. Implement recommendations from Medical Home Advisory Council strategic planning process				X
7.				
8.				
9.				
10.				

b. Current Activities

DPH ensures community-based 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. Plans are underway to move the database to a web-based system allowing for improved integration of data and services. Care coordination services include co-located or embedded services to 39 medical homes. An additional 16 medical homes receive some level of support from CMHI care coordinators. CDI and CLRC serve as statewide access points. A projected 9,000 CYSHCN will receive care coordination services through CMHI this year.

Through a 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 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.

DPH staff participate on the SCD Consortium, a cooperative with the mission of improving health care of individuals with SCD through maximizing linkages with professionals and family organizations. Efforts are being made to integrate consortium partners with CMHI.

c. Plan for the Coming Year

DPH efforts to improve access to services available through CMHI will address: increased availability of medical homes for CYSHCN; improved care coordination; forums for parent/care-giver interaction through parent/care-giver networks; improved parental/care-giver support, partnership and respite services.

Quarterly regional meetings will be convened with participants from DPH, the FSN, CDI, CLRC, CMHI locally based care coordinators, and others, to facilitate access to the system and services available to CYSHCN and their families.

Care Coordination Collaborative Partnership meetings taking place in three regions of the state will be expanded to all five. In the collaborative meetings, area care coordination providers meet to discuss services available from each organization that offers care coordination (including medical home care coordination), identify barriers that prevent maximizing the coordination of resources for the range of services that families need, develop an ongoing process for communication, strategize to improve coordination and timeliness of services/care offered to families; and address direct service and systems' level obstacles confronting families in securing appropriate services in a timely manner. Meetings often focus on developing a care plan for a family for the purpose of strengthening working relationships of collaborative participants, to meet

the needs of the family, and to provide a practicum for problem solving.

DPH will disseminate 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.

DPH will collaborate with Parents Available to Help (PATH/CT Family Voices), CT's new Family-to-Family Health Information Center grantee to develop strategies to improve access to health financing resources and services. DPH will collaborate with PATH to provide training to care coordinators and families at numerous workshops.

DPH and the MHAC will collaborate in support of the DSS' HUSKY Medicaid program as it is restructured from a managed care organization to an administrative services organization (ASO) format. The restructure proposes to include provision of Primary Care Medical Home as a component of the program. Family representatives from the MHAC Family Experience Workgroup will provide input to DSS consultants developing questions for consumer focus groups to be conducted. DPH and the MHAC will organize consumer focus groups on behalf of DSS.

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	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	5.8	5.8	43.3	43.3	43.3
Annual Indicator	5.8	43.3	43.3	43.3	43.3
Numerator					
Denominator					
Data Source			National Survey of CSHCN	National Survey of CSHCN	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
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	43.3	43.3	43.3	43.3	43.3

Notes - 2010
Source: 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.

Notes - 2009
Source: Indicator data come 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 NPM#06 and the 2005-2006 may be considered baseline data.

Notes - 2008
Source: Indicator data come 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 NPM#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 percentage for this measure.

a. Last Year's Accomplishments
This measure was successfully met (CT 43.3% vs. national 41.2%).

The CT Title V CYSHCN Program implemented activities to achieve goals and objectives of the HRSA State Implementation Grant for Integrated Community Systems for CYSHCN (D70 Grant). The primary outcome of the project is to assist youth with special health care needs (YSHCN) and their families/caregivers to overcome barriers to successful transition to all aspects of adulthood, including healthcare, work and independence.

DPH, CMHI and D70 partners met throughout the past year to further develop and revise the Connecticut Medical Home Training Academy Curriculum (CMHTAC). The CMHTAC is a CT specific version of the American Academy of Pediatrics "Every Child Deserves a Medical Home" curriculum. The CMHTAC includes four modules: Background and Current Context of Medical Homes in CT, Care Coordination, Family-Professional Partnerships and Transition to Adulthood. The review group included parents of CYSHCN, health care providers, YSHCN and representatives from community-based organizations, disability advocacy groups, CYSHCN care coordinators, SDE/BSE, DSS/BRS and DCF. In addition to providing team based training for providers in implementing a medical home model, the CMHTAC will be used to identify and recruit adult health care providers who are interested in serving and assisting YSHCN and their families with transition to adult health care.

In May 2010, the National Center on Cultural Competence (NCCC) conducted a TA visit for the Title V program and its agency partners; and provided a workshop for CMHI contractors, providers, community-based partners and families. Strategies specific to CT to incorporate cultural and linguistic competence into community-based services and medical home care coordination services, including transition services, were discussed and developed at length. The workshop included training about disparities in health and healthcare services experienced among CYSHCN, and by those with disabilities who are also part of an underserved population.

On June 8, 2010, DPH staff collaborated with SDE/BSE and DSS/BRS to facilitate a presentation at the 2010 Annual Nurse Supervisor's Conference: What Does Health Have to Do with Secondary Transition? The session assisted participants to better understand the importance of incorporating healthcare in transition planning.

In October 2010, CT hosted the Division of Career Development and Transition (DCDT) Regional Conference with the National Secondary Transition Technical Assistance Center (NSTTAC). DPH collaborated with its partners to support a health care session titled "What's Health Got to Do with Transition? Everything! The session was presented by Mallory Cyr from the Got Transition? National Center. Mark Keenan, the State's Title V CYSHCN Director, participated on a panel discussion with representatives from the Board of Education and Services for the Blind, the Bureau of Rehabilitative Services and the DMHAS. Information was provided and questions answered about agency services and programs in support of transition. DPH provided stipends as compensation for transportation and/or childcare to 55 youth and families who attended the conference.

Community-based medical home care coordinators associated with the CMHI for CYSHCN provided comprehensive services, including transition planning by age 14 for YSHCN and their families/caregivers.

DPH staff served on the SDE/BSE Transition Task Force (TTF). The TTF supports the SDE/BSE in promoting positive postsecondary outcomes in education, training, employment and independent living for students with disabilities.

DPH supported and collaborated with PATH-Parent to Parent, Family Voices of CT who conducted Transition to Adulthood workshops for parents of CYSHCN and professionals in Trumbull and Hartford. Workshop topics included Transition from Pediatric to Adult Health Care, Transition from High School, Guardianship and Special Needs Trust and were attended by YSHCN, parents of CYSHCN, health care providers, community-based providers and CMHI contractors.

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

DPH CYSHCN staff and D70 project partners are identifying and collaborating with adult providers with the capacity and expertise to provide services to young adults with complex needs. To fully engage Federally Qualified Community Health Centers (FQHC) in the provision of care for YSHCN, the Community Health Center Association of CT's (CHCACT) Director of Performance Improvement (DPI) participates on the DPH Medical Home Advisory Council. The DPI met with DPH staff, the CMHI Care Coordinators in the South Central area of the state and Cornell Hill Health Center staff and providers to discuss collaboration around transition services for YSHCN.

On May 12, 2011, DPH hosted a conference on transition and Lifecourse titled "Launching Into

Adulthood: It's Not Like it Used to Be! Keynote speakers include John Reiss, PhD and Keith Jones. Debbie Allen, ScD is presenting on the integration of Lifecourse Theory and Transition and Mallory Cyr is co-facilitating a youth/young adult panel session.

The CT Transition to Adulthood surveys are now posted on the DPH CYSHCN webpage http://www.ct.gov/dph/cwp/view.asp?a=3138&Q=387702&PM=1 and YSHCN webpage http://www.ct.gov/dph/cwp/view.asp?a=3138&q=432684&PM=1. Both a youth/young adult and parent/caregiver version are available in English and Spanish. The surveys address key transitional outcomes of YSHCN in CT.

c. Plan for the Coming Year

DPH will engage in and support initiatives to promote the sustainability of activities initiated through the D70 project, including a request for a no cost extension, and development of ongoing no-cost MOUs with the SDE, DCF, and the DSS/BRS.

Final edits will be made to all CMHTAC modules following review and input by focus groups (including youth focus groups reviewing the Transition module) and review by project consultants Patti Hackett, Umbereen Nehal M.D., and Richard Antonelli M.D. The state's UCEDD (A.J. Pappanikou Center) and the UCHC will collaborate with DPH to develop and post an on-line version of the CMHTAC. This online version will be available to providers as the state's Medicaid system converts to an ASO structure with provisions for medical home and health home over the coming year.

DPH will collaborate with CMHI CYSHCN contractors to expand and facilitate Interagency Collaboration on Care Coordination & Transition Planning Meetings to all five CMHI service regions. These meetings have been implemented in three of five CMHI service regions. The plan is to provide each region with tools and resources needed to independently plan and facilitate meetings, with participation from YSHCN, families, key state and community-based agencies and providers.

A pilot demonstrating efficacious transition for Youth with Special Health Care Needs (YSHCN) to adult health care through access to the FQHCs will be fully developed in the South Central service area of the state for future replication. The pilot will develop protocols and processes giving providers a framework to follow when transitioning YSHCN from private pediatric services to FQHC adult services.

DPH and DCF will partner to develop a transition curriculum for use by DCF social workers. The curriculum will provide information and resources about transition services for youth in the foster care system, including YSHCN.

SDE/BSE and DPH will develop an electronic listserv of CT school social workers, counselors and psychologists. The listserv will be used to disseminate transition resources, and CYSHCN Program information.

DPH will pursue transition related needs assessment and program evaluation opportunities. The Connecticut Economic Resource Center will analyze and provide a written report on survey results from the CT Medical Home Family Satisfaction Survey; transition data in the CYSHCN Access Database; Interagency Collaboration on Care Coordination & Transition Planning Meeting pre and post meeting assessments; and will analyze a YSHCN and Parent/Caregiver Transition to Adulthood survey.

DPH and CMHI will distribute educational materials including Transition and IDEA 2004.

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	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	88.2	88.6	89	89.4	83.6
Annual Indicator	82.6	83.4	83.2	83.1	85.0
Numerator	29686	29765	29207	29091	30000
Denominator	35929	35674	35111	35000	35309
Data Source			CIRTS	CIRTS	CIRTS
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
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	89.8	90	90.2	90.4	90.6

Notes - 2010
Source: Connecticut Immunization Registry and Tracking System (CIRTS), 2007 birth cohort. The CIRTS data provide a more accurate picture regarding childhood immunization coverage rates for CT children. The immunization coverage rate for children born in 2007 was 85% for the 4:3:1:2*:3:1 series, The 35,309 children represent 85% of the 41,413 births recorded in Connecticut for 2007. A total of 17,829 children or 43% of the 41,413 births are also enrolled in Medicaid and 3,924 children or 9% of the 41,413 births refused registry enrollment.

*2006-2007 Birth Cohort, Schedule 4,3,1,2,3,1: 4 DTaP, 3 IPV, 1 MMR, 2 Hib, 3 Hep B, 1 Varicella (Schedule reflects 2 Hib due to the Hib shortage and Feb. 2008 to July 2009 Hib booster dose deferment.)

Notes - 2009
Source: Connecticut Immunization Registry and Tracking System (CIRTS), 2006 birth cohort. The CIRTS data provide a more accurate picture regarding childhood immunization coverage rates for CT children. The immunization coverage rate for children born in 2006 was 83.1% for the 4:3:1:2*:3:1 series, which represents 35,000 children or 87% of the 40,260 births recorded in CT.
*2 Hib were measured instead of 3 Hib due to the February 2008-July 2009 Hib shortage and deferment of the Hib booster dose.

Notes - 2008
Source: Connecticut Immunization Registry Tracking System (CIRTS), 2005 birth cohort.
The CIRTS data provide a more accurate picture regarding childhood immunization coverage rates for CT children. Immunization coverage rate for children born in 2005 was 83.2% for 4:3:1:3:3:1 series, which represents 35,111 children or 84% of the 41,575 births recorded in CT.

a. Last Year's Accomplishments
CT did meet the annual objective in 2010. In 2009, CT's 4:3:1:3:3:1 coverage rate (based on the modified Hib schedule of 2 or 3 doses) of 71.4% was lower than the 2009 national estimate of 75.7%. The Hib vaccine shortage that occurred from December 2007 to September 2009 continues to impact overall immunization coverage rates.

The CIRTS registry data provide a more accurate picture regarding childhood immunization coverage rates for CT children. The immunization coverage rate for children born in 2007 was 85% for the 4:3:1:2*:3:1 series, which represents 35,309 children or 85% of the 41,413 births recorded in CT.*2 Hib were measured instead of 3 Hib due to the December 2007 to September 2009 Hib shortage and deferment of the Hib booster dose.

The availability of one-time ARRA (American Recovery and Reinvestment Act) funds in September 2009 enabled the Immunization Program to begin replacement of CT's outdated immunization registry with a web-based immunization registry and tracking system. In 2010, a Project Manager Consultant experienced in Project Management methodologies and web-based technologies was hired to assist in implementation of a vendor-based immunization registry and tracking system. A contract was established in October 2010 with a vendor (Consilience Software Inc.) to build a new web based immunization registry using their MAVEN registry application product. The Immunization program also established a partnership in September with the MA Immunization program, who is also using the MAVEN application as the base for their immunization registry, to share application development documents, training information, etc. Most of 2010 was spent on completing the System Development Methodology (SDM) documents required by the CT Department of Information Technology (DOIT) for DPH business requirements and general design phase for the registry application.

The Healthy Start and HCWC programs provided case management to pregnant women and their children and 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 CHC 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 child care 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 CT Immunization Registry and Tracking System (CIRTS), 12 contractors to conduct immunization activities and procuring and distributing 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 providing 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 provides funds to support: the CIRTS, 12 contractors to conduct immunization activities, and procuring and distributing publicly purchased 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. The program established a project steering committee to develop a new web based registry utilizing ARRA funding and began completing the System Development Methodology (SDM) documents required by DOIT. A Business Requirement Phase Kick off meeting was held with DOIT and SDM Business Requirements Phases 1 and 2 were completed.

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

c. Plan for the Coming Year

The immunization program will: 1) continue to assess and monitor immunization rates including HEDIS (Health Plan Employer Data and Information Set) immunization rates for children enrolled in Medicaid Managed Care; 2) procure and distribute childhood vaccines: 3) continue efforts to implement MAVEN registry application by completing development Phases 4, 5 and 6 (Construction, Testing and Implementation) by November 2011 and begin rollout to providers by January 2012; 4) convene local advisory/planning groups in all 11 Immunization Action Plan funded sites to improve immunization services for children in high risk areas; 5) partner with community organizations, coalitions, businesses and public and private professional and civic organizations to promote childhood immunizations and vaccine safety; and 6) strive to achieve the Healthy People 2020 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/PCP as necessary to ensure compliance.

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	2006	2007	2008	2009	2010

Annual Performance Objective	12.8	12.3	12.2	11.9	11.5
Annual Indicator	12.3	12.0	11.7	10.7	10.7
Numerator	914	885	846	766	766
Denominator	74323	74029	72503	71840	71840
Data Source			DPH Vital Statistics	DPH Vital Statistics	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	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	10.5	10.5	10.4	10.4	10.3

Notes - 2010
Source: CY2010 Vital Statistics data are not available.
Final CY2009 Vital Statistics data as of Sept 2011. The 2006 annual objective field is "locked in" and will not allow us to change the objective to reflect our most recent experience. If we were able to change the field the objective for 2006 would read 12.3.
Annual performance objectives for 2011-2015 were updated using these more recent data.

Notes - 2009
Source: Final CY2009 Vital Statistics data as of Sept 2011. 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 2010-2014 were updated using these more recent data.

Notes - 2008
Source: The CY2008 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 these more recent data.

a. Last Year's Accomplishments
This measure was met. SBHC staff continued to address teen pregnancy through risk assessments and provision of reproductive health services including: individual/group counseling, health education sessions, student empowerment activities, and referrals to community-based reproductive health care providers. Counseling and education were also provided to pregnant and parenting teens on numerous topics, including prevention of additional pregnancies. Seven SBHC clinical staff attended an adolescent health conference that featured presentations on contraceptive management for adolescents. SBHCs in the southwestern part of the state conducted a regional conference entitled, The Legal Rights of Adolescents.

DPH funded two adolescent confidentiality teleconferences for community-based health care professionals. A total of 660 individuals registered.

The DPH funded three Case Management for Pregnant Women programs in Waterbury, New Haven and Hartford targeting low income pregnant women under the age of 19. The program provided a comprehensive system of case management and home visitation that included risk

assessments, perinatal depression screening, screening and referral for tobacco cessation, parenting education, promotion of breastfeeding, family planning, child development education, and establishing support systems. The case management services were provided in the perinatal and interconceptional periods in an effort to improve birth outcomes, reduce fetal and infant mortality and improve maternal health and well-being.

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

SBHCs continue to address teen pregnancy through risk assessments and provision of reproductive health services including: individual/group counseling, health education sessions, student empowerment activities and referrals to community-based reproductive health care providers. The State Adolescent Health Coordinator participates in monthly regional conference calls to share information about adolescent health and updates on the new federal teen pregnancy prevention program with SBHCs and other relevant DPH programs.

The Case Management for Pregnant Women program provides counseling to women at risk for poor birth outcomes. Fatherhood initiatives at all sites teach fathers about interconceptional care and birth spacing.

DPH contracts with Planned Parenthood of Southern New England (PPSNE) to provide reproductive health education and prevention services to women and men. Planned Parenthood centers are located in 12 CT cities with high rates of teen pregnancy. Over 1,231 teens participated in educational programs offered by PPSNE.

DPH received the Personal Responsibility Education Program grant to develop initiatives to reduce teen pregnancy and risky behavior among youth in and aging out of foster care in partnership with the Department of Children and Families and Department of Education. Youth in 47 group homes will receive the "Teen Talk" program. Trainings for DCF staff, contractors and foster parents on "How to Be an Effective Sex Educator" are planned.

c. Plan for the Coming Year

SBHC staff will continue to address teen pregnancy through implementation of risk assessments and provision of reproductive health services including: individual/group counseling, health education sessions, student empowerment activities and referrals to community-based reproductive health care providers. The State Adolescent Health Coordinator will continue to participate in monthly regional conference calls and will provide information on adolescent health, including updates on the new federal teen pregnancy prevention program with SBHCs and other relevant DPH programs.

Title V supports programs such as Healthy Start and case management programs including teens (both female and male) and provides interconceptional counseling. The Hartford Healthy Start project will provide care coordination and outreach services to pregnant and postpartum women.

Planned Parenthood will continue to provide reproductive and preventive health education throughout the state.

DPH will implement the activities and initiatives aimed at reducing teen pregnancy and risk taking behavior among youth in, and, aging out of foster care. Youth in 47 group homes will participate in the Teen Talk program. DCF staff, contractors training and foster parents will be trained on "How to Be an Effective Sex Ed Educator."

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	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	30	12	38	34	23.9
Annual Indicator	11.4	38.0	18.0	26.1	29.2
Numerator	2984	1687	4276	6147	6867
Denominator	26171	4440	23747	23535	23544
Data Source			CT Dept. of Social Services SCHIP Division	CT Dept. of Social Services SCHIP Division	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
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	24.5	24.5	24.5	24.5	24.5

Notes - 2010
Source: CT Department of Social Services SCHIP Division. 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.
Annual performance objectives for 2011-2015 were updated using these more recent data.

Notes - 2009
Source: CT Department of Social Services SCHIP Division. 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.
Annual performance objectives for 2010-2014 were updated using the most recent data.

Notes - 2008
Source: CT Department of Social Services SCHIP Division. 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.

a. Last Year's Accomplishments
This measure was met. The Office of Oral Health (OOH) is focused on two major initiatives: "Home by One" and the CDC Cooperative Agreement. Through "Home by One," the OOH is developing a statewide infrastructure to increase early childhood oral health interventions. Training modules for child health providers and dental professionals will be made available through web-based curricula.

The CDC Cooperative Agreement identifies eight core activities on which the OOH should focus: 1) ensuring appropriate staffing for the office, 2) building collaborations with internal/external partners, 3) developing a state oral health plan, 4) ensuring community water fluoridation, 5) creating a statewide oral health coalition, 6) increasing the number of school-based dental sealant programs, 7) enhancing surveillance, and 8) creating an evaluation component. CT has a state oral health plan, strong partnerships, and a mandate that any community water system serving over 20,000 people fluoridate their water supply. The OOH has developed a statewide dental sealant pilot program, an oral health coalition that meets the requirements of the CDC, and conducted a training session for community water operators on the benefits of water fluoridation.

A statewide oral health conference was held in June to: inform oral heath stakeholders about OOH programs and activities, state plan implementation, re-engage CT Coalition for Oral Health members, and discuss health care reform's impacts on oral health.

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 OOH continues to work on eight core activities for the CDC Cooperative Agreement. OOH is conducting its second surveillance survey of the oral health status of children.

OOH conducted its second training session for community water operators on the benefits of water fluoridation and held a statewide oral health conference to advise oral health stakeholders about OOH programs, state plan implementation, how to build and foster collaborations and provide continuing education in June.

The CT Coalition for Oral Health expanded to include members beyond its core group. Focus areas and activities to implement the CT Oral Health State Plan 2007-2012 objectives were identified. Discussions to develop an updated plan for the next five years began.

A dental sealant demonstration pilot was set up for existing school-based/linked dental programs to use specific software to collect dental sealant data delivered in a school setting. Funding and technical assistance will be provided to participating programs.

In its fourth year "Home by One" continues to work toward its goal for children to have a dental visit and dental home by age one. Parent advocates will receive oral health and advocacy training specific to children with special health care needs. Training for health providers on age one dental visits, oral health risk-assessment and fluoride varnish applications is self-sustaining with on-line courses and network development follow-up.

c. Plan for the Coming Year

The OOH will continue to work on the eight core recipient activities for the CDC Cooperative Agreement. The CT Coalition for Oral Health will implement strategies to improve the oral health and overall health of CT residents. Collaboration with the DPH Drinking Water Section will be maintained to promote optimal water fluoridation.

The dental sealant demonstration pilot will end in Sept 2012. The eight participating school-based/linked dental programs will hopefully demonstrate a successful implementation of the SEALS software into their programs. Dental sealant data will be generated and a report on lessons learned will be helpful in future SEALS software implementation.

The reporting on the second Basic Screening Survey of kindergarten and third grade students will be completed by the spring of 2012. A separate report on the BMI of CT children will also be available in 2012. This will be the first time the CT has statewide data on the BMI of CT's elementary school children.

The Home by One program will become self-sustaining; trainings for medical and dental providers on age one dental visits, fluoride varnish application and oral health risk-assessments will be offered online.

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	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	1.5	1.4	1.3	1.2	1.2
Annual Indicator	0.8	1.3	1.0	0.8	0.8
Numerator	5	9	7	5	5

Denominator	665901	672521	667742	660975	660975
Data Source			DPH Vital Statistics	DPH Vital Statistics	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	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	1	1	1	1	1

Notes - 2010
Source: CY 2010 final data are not available. CY2009 data is final as of Sept 2011.
CT Dept. of Public Health, HISR, CY 2008 final Vital Statistics.
The annual indicator is a rolling average of 2007, 2008, and 2009 numerator (10, 6, 5) and denominator (668663, 668663, 660975) CY numbers.

Notes - 2009
Source: CT Dept. of Public Health, HISR, CY 2009 final Vital Statistics.
The annual indicator is a rolling average of 2007, 2008, and 2009 numerator (10, 6, 6) and denominator (668663, 668663, 668663) original numbers.
Annual performance objectives for 2010-2014 were updated using these most recent data.

Notes - 2008
Source: CT Dept. of Public Health, HISR, CY 2008 final Vital Statistics.
The annual indicator is a rolling average of 2006, 2007, and 2008 numerator (5, 10, 6) and denominator (665901, 668663, 668663) original numbers.

a. Last Year's Accomplishments
This measure was met in 2010. Compared to an annual performance objective of 1.2, the annual indicator was 1.1 per 100,000 children. CT addresses this NPM through Title V and non-Title V programs and collaborations to reduce deaths and non-fatal injuries due to motor vehicle crashes.

The Injury Prevention Program, using MCHBG funding, contracted with Safe Kids CT. Safe Kids conducted 18 child passenger safety workshops for families. The workshops primarily targeted low-income families with booster seat age (4-8 years) children and provided booster seats to those who needed them. The workshops covered selection of appropriate child restraint systems based on age and size of child, correct use and relevant state laws. The workshops served approximately 250 adults and 693 children. Workshops were conducted throughout the state. Communities included Waterbury, New London, Plainfield, Manchester, Brooklyn, Groton, Wallingford, Hartford, Tolland, Colchester, Harwinton, Westbrook and Norwich Partners and workshop sites included churches, hospitals, community/neighborhood centers, elementary schools, Birth to Three Programs, family resource centers, home care agencies, the Salvation Army, the DCF, car dealerships, and fire departments.

The Injury Prevention Program, the FHS, and the CT Office of Rural Health continued to partner on the Children's Safety Network's (CSN) facilitated New England Rural Injury Community of Practice. An analysis was completed, which showed higher rates of motor vehicle deaths and hospitalizations among children, adolescents and young adults in CT's rural towns.

The Injury Prevention Program participated in several initiatives that address motor vehicle

injuries and deaths among children, including the CT DOT's Safe Routes to School, the Safe Teen Driving Partnership, the Capitol Region Council of Governments (CRCOG) Pedestrian-Bicycle Committees, the Safe Kids CT Coalition, and the Emergency Services for Children Advisory Committee.

Two local health departments used Preventive Health and Health Services Block Grant (PHHSBG) funding for motor vehicle injury prevention activities.

The Injury Prevention Program (IPP) provided TA on issues related to motor injuries to units within DPH, individuals, and community-based programs.

The CT CODES (Crash Outcome Data Evaluation System) Project completed linkage of seven years of police crash reports and hospital and emergency department data. An analysis of CODES data showed that children less than 13 years experienced significantly higher risk of severe/moderate injury if they were sitting in the front seat compared to the back seat in a motor vehicle crash. The IPP and partners, including Safe Kids CT, will use this information to promote back seat travel for children.

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 IPP contracts with Safe Kids CT to conduct at least 14 child passenger safety workshops. The focus is on families with children of booster seat age. National studies indicate that this age group is least likely to be appropriately restrained while traveling in a motor vehicle.

The IPP, the FHS, and the CT Office of Rural Health continue to collaborate on the CSN-facilitated Rural Injury Community of Practice. The IPP collaborates with state and local partners, including the Safe Teen Driving Partnership, the Pedestrian/Bicycle Committee, the Safe Kids CT coalition, and the Emergency Medical Services for Children Advisory Committee on motor vehicle injury prevention issues.

The IPP is completing 2005-2008 analysis of injury-related mortality, hospital and ED data, including motor vehicle injuries.

The CT CODES Project continues to link additional years of crash, hospital and emergency department data for use in planning motor vehicle injury prevention initiatives. Through PHHSBG funding, one local health department is conducting motor vehicle injury prevention activities during the SFY 2010.

DPH-funded case management programs, CHCs and SBHCs, continue to provide guidance and resources on motor vehicle injury prevention.

c. Plan for the Coming Year

The IPP will use CODES and Injury Surveillance system data to develop and support programs and policies that address the risk factors for motor vehicle injuries among children and adolescents. The IPP will work with members of the CODES Advisory Board and other internal and external partners to ensure that the data meet the needs of users and are widely disseminated.

The IPP will provide technical assistance to FHS programs, contractors, and target populations about motor vehicle injury prevention. The IPP will continue to collaborate with the FHS, other DPH Programs such as Day Care Licensing, EMS for Children, and external partners about transportation safety issues that impact children and adolescents.

DPH-funded case management programs for women and children will work more closely with IPP staff to enhance activities and identify resources to reduce the death rate for children age 14 years and under caused by motor vehicle crashes.

SBHCs will have motor vehicle safety as an integral focus of events and services. Community Health Centers, as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) providers, will continue to provide guidance about age-appropriate risk assessments 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	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	36.8	39	48	49	45
Annual Indicator	38.8	43	42.9	41.9	49.3
Numerator					
Denominator					
Data Source			CDC National Immunization Survey	CDC National Immunization Survey	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			Yes	Yes	Yes

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
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	49.8	50.3	50.8	51.3	51.8

Notes - 2010
Source: This measure monitors the rate of breastfeeding at 6 months of age using information from the National Immunization Survey based on the year of the birth cohort. The birth cohort reported is the CY 2007. Websource: www.cdc.gov/breastfeeding/data/reportcard2.htm Annual performance objectives for 2011-2015 have been updated using this more recent data.

Notes - 2009
Source: This measure monitors the rate of breastfeeding at 6 months of age using information from the National Immunization Survey based on the year of the birth cohort. The birth cohort reported is the CY 2006. Websource: www.cdc.gov/breastfeeding/data/report_card2.htm Annual performance objectives for 2010-2014 have been updated using this more recent data.

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. Websource: www.cdc.gov/breastfeeding/data/report_card2.htm

a. Last Year's Accomplishments
This measure was met. Activities address the recommendations in the 2006 CT Breastfeeding Initiative report and the CDC Guide to Breastfeeding Interventions. DPH provided resources to Title V case management programs for pregnant women (Healthy Start, Case Management for Pregnant Women and Parenting Teens) and informed them of continuing education opportunities. DPH also continued to mail English/Spanish breastfeeding information sheets to all new mothers served by the DPH Immunization Program (IP).

DPH is actively involved with the CT Breastfeeding Coalition (CBC), participating in monthly meetings and serving on the policy committee. The Breastfeeding Coordinator was also involved in the ARRA-funded CT Breastfeeding Initiative, a project to assist 10 maternity facilities in the state achieve 5 of the 10 steps to Baby-Friendly Hospitals.

Comprehensive statewide training was provided to all WIC staff in 2010, using USDA's Loving Support: Building Breastfeeding Competencies for Local WIC Staff curriculum. A combination of 100 state and local WIC staff, including the CT-WIC Medical Advisor attended the CT-La Leche League conference in April.

The WIC Program continued to fund the Breastfeeding: Heritage and Pride (BHP) peer counseling program that is jointly administered by the Hispanic Health Council and Hartford Hospital. WIC Peer Counseling funds were allocated to continue the second year of the program at Yale-New Haven Hospital during FY 2010. The DPH Breastfeeding Coordinator chaired a statewide WIC Breastfeeding Committee comprised of coordinators from each local WIC program. A major focus of 2010 and 2011 was the update/revision of the electric breast pump policy to include guidance on collaboration with the State HUSKY insurance providers.

DPH/WIC continued its collaboration with the CT Chapter of the American Academy of Pediatrics (CT-AAP) to educate physicians on breastfeeding topics. In March 2010, the fifth breastfeeding

teleconference was conducted, and addressed breastfeeding duration to six months, data and issues/barriers to breastfeeding duration. Additional calls were planned in 2011.

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

DPH staff collaborates with CT-APP physicians.

In May 2011, CBC announced mini grants supporting lactation at the workplace.

DPH, the state's Commission on Human Rights & Opportunities (CHRO), the DOL and CBC are developing a document about public breastfeeding and lactation at the workplace. Outreach to libraries will ensure resources are up-to-date, and children's sections promote positive images of breastfeeding.

Flyers about CT's breastfeeding laws will be updated by Sept. 2011, and will be distributed to new mothers through the DPH IP packet and the CBC website.

DPH-WIC staff co-chair a WIC Breastfeeding Committee. Four-breastfeeding sheets address: exclusive breastfeeding, building and maintaining a milk supply, pumping for medical reasons, and pumping for short separations.

WIC funds the Hartford Hospital-based Breastfeeding: Heritage and Pride (BHP) breastfeeding peer counseling program, and its expansions to in East Hartford and Hartford. The Yale-New Haven Hospital (YNHH) BHP targets the African American population. A pilot WIC Peer Counseling program will be launched in three WIC sites: TVCCA, Fair Haven and Day-Kimball. Activities include revision of program protocols, update of forms and educational materials, and peer counseling.

WIC funded recertification of 31 WIC lactation counselors.

DPH assists 10 maternity facilities achieve 5 of the 10 steps to Baby-Friendly Hospitals.

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 broad array of breastfeeding promotion and support activities will continue to be implemented statewide by the WIC Program specifically scheduled reviews of WIC local agencies breastfeeding promotion and support services using the CT Breastfeeding Guidelines and quarterly local agency breastfeeding coordinators' meetings.

The WIC/DPH Interim Breastfeeding Coordinator(s) will work with the WIC Program Director to identify opportunities to expand WIC peer counseling services in the State with FY 2011 and 2012 USDA WIC Breastfeeding Peer Counseling funds. A group of eight (8) DPH and local WIC agency staff will attend the USDA-sponsored Peer Counseling training update in Boston, Massachusetts in November 2011. DPH will participate in monthly meetings of the CBC, and in 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 department's 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 further 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	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	99	99.1	99.2	99.3	99.4
Annual Indicator	99.0	99.1	99.4	99.0	99.2
Numerator	41744	41889	40672	39070	38234
Denominator	42186	42266	40930	39481	38537
Data Source			CT DPH EHDI Program	CT DPH EHDI Program	CT DPH EHDI 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	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	99.3	99.4	99.4	99.4	99.4

Notes - 2010
Source: CT DPH Early Hearing Detection and Intervention Program. Universal newborn hearing screening was implemented in CT on 7/1/00. Denominator data collected on 6/14/11 from Vital

Records.
Annual performance objectives for 2011-2015 were updated using these more recent data.

Notes - 2009
Source: CT DPH Early Hearing Detection and Intervention Program. Universal newborn hearing screening was implimented in CT on 7/1/00. Numerator data collected on 6/16/10.

Notes - 2008
Source: CT DPH Early Hearing Detection and Intervention Program. Universal newborn hearing screening was implemented in CT on 7/1/00.

a. Last Year's Accomplishments
This measure was not met, as CT's hearing screening rate for CY 2010 was 99.2%, falling short of the Performance Objective of 99.4%. Tracking and follow-up continues on babies born in late 2010, and the provisional rate may improve once final data is available.

CT hospitals have electronically reported newborn screening data to the DPH since 2002. NSS records are matched to the Electronic Vital Records System (EVRS). The total number of births reported in the NSS is consistently less than the EVRS annual occurrent birth count. The NSS will be replaced by an online reporting system (Maven) within the next year. Once a formal data sharing agreement with Vital Records is in place, the goal is to create a two-way match between Maven and EVRS, which will provide missing demographic information and facilitate tracking and surveillance activities to accurately report the screening status of all occurrent births.

The EHDI Program's goal is to identify infants with hearing loss as early as possible to minimize speech/language and other delays by linking them to early intervention (EI) services. EHDI has a proactive tracking and follow-up system in place to ensure: 1) all babies are screened at birth; 2) those who do not pass receive timely diagnostic follow-up; and 3) those diagnosed with a hearing loss are enrolled in EI. Bi-monthly reports are sent to hospitals to obtain missing screening results. To reduce the number "lost to follow-up" (LTF) after an infant fails to pass the newborn hearing screening, letters are sent and follow-up phone calls made to the mother and primary care provider of any child who fails the hearing screen and for whom DPH does not have a diagnostic audiological evaluation documented. EHDI is in regular communication with audiology centers about children who were referred from newborn hearing screening. CT's LTF rate was 21.9% in CY 2009. Of those children receiving follow-up, 77% were evaluated before 3 months of age. Seventy-seven infants with hearing loss were identified. Enrollment into EI is confirmed for each newborn diagnosed with a hearing loss, and infants with a permanent mild and/or unilateral hearing loss are automatically eligible for CT's IDEA, Part C, EI program (Birth to Three). In 2009, 70% of infants diagnosed with a hearing loss were eligible for Birth to Three services and 85% were enrolled before 6 months of age.

EHDI is focused on educational initiatives aimed at reducing the number of babies LTF after failure to pass newborn hearing screening. In April 2009, DPH conducted a one-day educational conference, "Setting the Tone: Providing Assurance to Families," for 30 pediatric audiologists and 36 hospital newborn screening staff. Topics included: communicating results to families, updated hearing screening guidelines, risk indicators for hearing loss, and reducing LTF. EHDI staff spoke at a statewide NBS Symposium for birth facilities on their role in reducing LTF in September 2009. EHDI staff presented to University of CT graduate-level audiology and speech language pathologist students in November.

The existing contract with the CHDI was amended to include: 1) development of an EPIC module on EHDI with the intent to improve quality of care related to hearing loss among pediatric-age patients in the primary care setting, and 2) work with the CT FSN to improve information availability and parent-to-parent support for families of children who are deaf or hard-of-hearing.

DPH revised two parent brochures for re-publication in English and Spanish. The "Listen Up!" and

"A Parent's Guide to Diagnostic Hearing Testing of Infants" brochures were distributed by CT birth facilities to parents of newborns.

The DPH EHDI attends monthly CT EHDI Task Force meetings to discuss issues relevant to infant hearing, early identification and habilitation.

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

DPH EHDI conducts ongoing tracking and follow-up to ensure infants are screened at birth and, when indicated, receive audiological follow up by 3-months of age and are enrolled in EI by 6-months. Phone and on-site TA is provided to hospital staff and audiology centers as needed.

Efforts to develop an improved newborn screening web-based reporting system are underway, and the DPH project team continues to work with the contractor, Consilience Software, to develop the Maven: NSS in preparation for implementation.

EHDI has allocated funds to support the goal of increasing parent involvement in the CT EHDI process. EHDI staff facilitated regular participation of parent leaders/parent of a hard of hearing/deaf child in monthly EHDI Task Force meetings and disseminated Hands & Voices materials to incite discussion regarding a CT Chapter. CHDI subcontractor, the FSN, hired a Deaf and Hard of Hearing Advocacy Outreach Coordinator who is working to establish a formalized parent-to-parent support group for families of children who are deaf or hard-of-hearing in the state.

In March 2010, EHDI staff attended the annual National EHDI Conference in Chicago, IL, for training on best practices in early hearing detection and surveillance.

c. Plan for the Coming Year

EHDI will continue its focus on educating hospital staff, pediatric healthcare providers, and families about the importance of follow-up audiological testing of infants who did not pass newborn hearing screening within 3-months of age.

In collaboration with pediatric experts and other stakeholders, CHDI developed an EHDI EPIC module, which has been presented to five primary care practices. CHDI will continue to present the EHDI EPIC module to practices in each of the state's five CYSHCN Program service areas, and provide each practice with tools and resources to ensure better outcomes in the medical

home for children who are deaf or hard-of-hearing. CHDI in collaboration with DPH, will begin working with CT Children's Medical Center physicians to provide physician to physician TA and consultative services to PCPs, including "just in time" educational materials to support access to care and links to the three statewide EI programs serving infants and toddlers who are deaf or hard of hearing and the FSN as well as other needed resources.

The Maven: NSS, under-development, is scheduled to "go live" within the next 6 to 9 months. Final testing and data migration phases will need to be completed. On-site training at all 31-birth facilities and the one midwife practice will be conducted on the new data system before it goes live, and a written training manual will be completed for use during the training and implementation phase.

EHDI is distributing two national resources developed by the National Center for Hearing Assessment & Management: "Communicate with Your Child" pamphlet for parents of a newly diagnosed young child, and a Newborn Hearing Screening Training Curriculum DVD designed to assist birth facilities with ongoing competency-based training.

In February 2011, EHDI staff attended and presented at the National EHDI Conference in Atlanta, GA, to share the latest information and collaborate with other experts in the field of early hearing loss.

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	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	8.4	7.6	5.9	5.1	5
Annual Indicator	7.7	6	5.2	5.4	7.7
Numerator					
Denominator					
Data Source			US Bureau of Census, Current Population Survey	US Bureau of Census, Current Population Survey	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
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	4.7	4.4	4.1	3.8	3.8

Notes - 2010
Source: US Bureau of Census, Current Population Survey, 2009 Table Package, Table HI05.
Annual performance objectives for 2011-2015 were updated based on the most recent data.

Notes - 2009
Source: US Bureau of Census, Current Population Survey, 2008 Table Package, Table HI05.
Annual performance objectives for 2010-2014 were updated based on the most recent data.

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.

a. Last Year's Accomplishments
This measure was not met. Healthy Start, Family Planning, CHC, HCWC, CMHI care coordinators, WIC staff and programs with a case management component screened families for insurance coverage, and provide support, information and linkages to health care insurance coverage for children.

DPH staff worked in support of The Perinatal State Health Plan goal to improve access to a continuum of health care services for underserved and/or uninsured women of childbearing age.

A legislative mandate required the SDE to identify students without health insurance, and provide information to their parents about the HUSKY plan. DPH-funded SBHC sites provide the opportunity for increased collaboration between the school and the SBHC regarding HUSKY outreach and enrollment.

Infoline provided MCH information and referral services including access to insurance, and conducted presentations and training to community based agencies and groups regarding 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.

DPH staff served on the legislative CT Medicaid Managed Care Council. The Council has a legislative mandate to assess and make recommendations to DSS (the state's Medicaid agency) concerning access to and implementation of the HUSKY program

DPH staff collaborated with the Family to Family (F2F) Health Information Network to disseminate information regarding health finance resources, including public and private insurance.

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, CHC, HCWC, Case Management for Pregnant Women and Teens, CMHI care coordinators and WIC staff screen families for insurance, and provide support, information and linkages to health care insurance coverage for children.

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 to provide information about the HUSKY program. Both Infoline and the DSS websites include information about the HUSKY program.

The DSS Primary Care Case Management (PCCM) pilot now includes Waterbury, Windham, Hartford, New Haven and Torrington. In PCCM, providers are given a per member per month payment to provide care coordination in addition to a Fee-For-Service payment. DPH collaborates to facilitate access to PCCM as well as to the Medicaid Managed Care plans under HUSKY.

Care coordinators located in CYSHCN medical homes provide families with information about insurance for their children. Care Coordinators assist families with insurance/HUSKY applications.

c. Plan for the Coming Year
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 services in the cities of Waterbury, Hartford and New Haven to women who do not qualify for other programs. Other programs such as State Healthy Start and the Hartford and New Haven federally funded Healthy Start programs will assist with access to health insurance for children.

DPH staff and CMHI contractors will collaborate with DSS staff in support of a pending state Medicaid restructuring (from the current MCO format to a ASO structure). Roll out of the restructure is scheduled for January 1, 2012. Information regarding changes will be disseminated through the CMHI networks.

DPH will collaborate with Connecticut's new F2F Information Grantee, Parents Available to Help/CT Family Voices. DPH will provide training around medical home and health financing resources for newly hired F2FHealth Information Specialists working for Parents Available to Help/CT Family Voices, who in turn will provide health and resource related trainings for families of CYSHCN.

A CT Voices for Children analysis of 2008-2009 enrollment data (conducted in May 2011) indicated four of every ten babies lost Medicaid (HUSKY) coverage when they turned one year old. DPH staff and CMHI network coordinators will collaborate with DSS to develop strategies to reduce gaps in coverage, and will disseminate revised renewal notices through the CMHI networks.

DPH staff and CMHI providers will participate in the CT Voices for Children Covering CT's Kids and Families (CCKF) initiative, a statewide coalition of organizations concerned with access to health care for children and their parents. Coalition activities will include technical assistance and support to local outreach efforts; working to maintain and expand HUSKY enrollment and simplification of enrollment process; and supporting DSS to increase the retention of eligible HUSKY families.

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	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	23.9	9.2	32.1	32	31.9
Annual Indicator	9.2	32.2	31.0	31.4	30.7
Numerator	2709	7521	7944	8928	8719
Denominator	29481	23356	25623	28432	28401
Data Source			CDC's Pediatric Nutrition Surveillance System	CDC's Pediatric Nutrition Surveillance System	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
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	30.6	30.5	30.4	30.3	30.2

Notes - 2010
Source: Centers for Disease Control & Prevention (CDC), 2010 Pediatric Nutrition Surveillance (PedNSS); Connecticut, Calendar Year 2010 data, Table 2C, run date March 25, 2011. (Note: PedNSS data in Connecticut come exclusively from WIC.)
Annual performance objectives for 2011-2015 were updated using these more recent data.

Notes - 2009
Source: Centers for Disease Control & Prevention (CDC), 2009 Pediatric Nutrition Surveillance (PedNSS); Connecticut, Calendar Year 2009 data, Table 2C, run date March 23, 2010: 15.4% of 2-to-5-year old children enrolled in the Connecticut WIC Program in Calendar Year 2009 had a BMI = 85th and < 95th percentile, and 16.0% had a BMI = 95th percentile, for a combined prevalence of overweight of 31.4% (BMI at or above the 85th percentile).

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 >= 85th and < 95th percentile) and that 15.5% were overweight (BMI >= 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 of results do not reflect a trend. This will be reassessed pending next year's results.

a. Last Year's Accomplishments
This measure was not met. The local WIC programs in CT continued to use the automated BMI calculation feature in the (SWIS) as a tool for assessing growth, and for teaching parents and care providers about their children's growth patterns. Local WIC nutrition staff continued to provide individual nutrition counseling and group education to participants.

During 2010, the CT Program entered the final 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." 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. The major focus of the VENA committee shifted from preparation to implementation for both the new WIC Food Packages and the final phase of the VENA Initiative. The new WIC Food Package revisions include low fat milk only for healthy children, less juice and cheese, and the addition of fruits, vegetables and whole grains. Local agencies were trained on several nutrition education resources promoting fruits/vegetables and low fat milk. Packets of these were sent to local WIC agencies in March 2010 to celebrate National Nutrition Month and promote fruits/vegetables and low fat milk.

The Physician's Outreach Initiative, part of the New WIC Food Package Implementation Plan, continued in FY 2010. Its purpose is to update health care providers about the WIC Program and the rationale/benefits of the new WIC food packages, inform them of WIC Program requirements, coordinate referrals and networking, and collaborate with them on providing consistent messages with the ultimate purpose of best serving our mutual client.

The CT State WIC Office collaborated with the Supplemental Nutrition Assistance Program (SNAP-Ed) Program in an initiative providing "Loving Your Family, Feeding Their Future" group education classes at local WIC agencies. The SNAP-Ed Program has adapted several low-cost recipes, which include CT WIC-approved foods promoting fruits and vegetables that can be distributed to participants who are SNAP-eligible. A follow-up presentation and workshop with the SNAP-Ed staff and local WIC agencies occurred focusing on lessons learned and USDA CORE nutrition messages in the educational materials.

A CT AAP teleconference on obesity, sponsored by the CT DPH and coordinated by the CT WIC Program, was held. The topic was the Middletown based FIT for Kids Program. This presentation was provided to local WIC staff, along with a presentation from CT Children's Medical Center staff on their outpatient-based obesity program.

Due to other high priority issues, the plans to begin to work on a new data measure tracking BMI rates among children in WIC who are 2-5 years of age and who were breastfed, compared to those who were not breastfed and the feasibility of future tracking of BMI rates among children 2-5 years of age whose mothers gained more than the recommended weight during pregnancy, based on the Institute of Medicine's (IOM) new weight gain guidelines during pregnancy have been put on hold. Plans to implement a new outcome objective for BMI for all local WIC agencies are under way.

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. Collaboration with WIC local agency VENA committee				X
4. WIC Physician's Outreach Initiative				X
5. Collaboration with SNAP –Ed program				X
6. Promote the positive changes in new WIC food packages				X
7. Develop/provide WIC educational resources promoting fruits/veg and low fat milk				X
8.				
9.				
10.				

b. Current Activities

WIC VENA implementation continues in quality nutrition assessment, participant focused education, standardized nutrition documentation and procurement of standardized educational materials. Educational guidance and materials on promoting fruits and vegetables in children via individual education or group classes for use by all local WIC agencies is under development.

The CT State WIC Office continues to collaborate with the SNAP-Ed Program in an initiative providing "Loving Your Family, Feeding Their Future" group education classes at local WIC agencies. A follow-up presentation and group education workshop are planned with the SNAP-Ed staff and local WIC agencies before the end of FY2011.

Plans are underway to incorporate the revised Dietary Guidelines into WIC nutrition education. An initial training and workshop has already been provided and will provide the foundation for future planning.

Plans are underway for training and incorporation of the new WHO growth charts within the WIC Program.

c. Plan for the Coming Year

The WIC VENA committee will continue to work on quality nutrition assessment, participant-focused education, standardized nutrition documentation, and procurement of standardized educational materials. Nutrition education guidance for each category served and for specific topics based on priority will continue to be developed.

The Physician's Outreach Initiative will continue in FY2012 and will continue to explore development of consistent messages/resources for our mutual client bases.

Continue to transition USDA's core nutrition objectives, designed to enhance optional nutrition and feeding relationships between family members, as a key part of WIC nutrition education messages.

Continue collaboration with the SNAP-Ed program, based on outcome of the 2010 trial SNAP-Ed classes at local WIC agencies and subsequent follow-up workshop feedback.

Incorporate newly developed nutrition education guidance documents created into the State WIC Plan.

Implement the new World Health Organization growth charts into daily assessment at local level, as determined by guidelines set by the State WIC Office.

Develop and implement a new nutrition outcome objective for obesity rates in children that all local WIC agencies will have to adapt into their yearly local agency plans.

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	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	3	0.2	0.2	0.1	0.1
Annual Indicator	0.2	0.2	0.2	0.1	0.1
Numerator	84	79	65	54	54
Denominator	41461	40969	39854	38362	38362
Data Source			DPH Vital Statistics	DPH Vital Statistics	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	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	0.1	0.1	0.1	0.1	0.1

Notes - 2010
Source: CY 2010 data are not available.
CY2009 final data as of Sept 2011, CT DPH, Vital Statistics. Similar to 2006 and 2007 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.

Notes - 2009
Source: CY2009 final data as of Sept 2011, CT DPH, Vital Statistics. Similar to 2005, 2006 and 2007 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 - 2008
Source: CY2008 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.

a. Last Year's Accomplishments
This measure was met. The CT Quitline registered 3,150 callers for Quitline services that included counseling and nicotine replacement therapy, as appropriate. The Quitline is offers services and nicotine replacement therapy products of patches, gum or lozenges to CT residents that sign up for the program. Medicaid participants and the uninsured are able to receive up to eight weeks of products.

Quitline materials continued to be distributed through health care providers, community health centers, state and local libraries, and other community programs. Health care providers are encouraged to use a fax referral system that is in place to refer their patients to the Quitline for services.

During the fall of 2009, another state tax increase on each pack of cigarettes went into effect, causing a rise in the number of calls to the Quitline and an anticipated drop in youth initiation.

The Tobacco Control Program continued to provide funding to six FQCHCs for tobacco use cessation programs focused on pregnant women and women of childbearing age. These programs began in November 2008 and ran through June 2010. Six additional community programs are funded for the period beginning November 1, 2009 to June 2011, which will provide services to additional participants.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide cessation counseling and referral through the CT Quitline	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
The DPH Tobacco Use Prevention and Control Program continues to work on training and implementation of tobacco use cessation programs. An independent evaluation is underway that will collect data and results to determine the effectiveness and cost efficiency of each DPH-funded program. The results will be used for planning efforts.

During the spring of 2010, DPH began a media campaign that promotes the use of the Quitline and provides referrals to the community cessation programs. This campaign also includes a

grassroots component that provides opportunities to share information about Quitline services and the hazards of exposure to second hand smoke. This campaign runs through the summer of 2011.

c. Plan for the Coming Year
The Tobacco Use Prevention and Control Program will continue to work on establishing tobacco use cessation and prevention programming, and encouraging all clinic and health care provider locations to screen and refer patients for cessation services. The availability of telephonic, online, and face-to-face programs will provide many CT residents who wish to quit using tobacco with the opportunity to have support for their quit. We anticipate that programs will be funded through December of 2012.

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	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	2.5	3.8	6.4	6.3	5.5
Annual Indicator	6.4	5.2	5.6	5.9	5.9
Numerator	16	13	14	15	15
Denominator	250071	249493	250373	253362	253362
Data Source			DPH Vital Statistics	DPH Vital Statistics	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	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	5.5	5.4	5.4	5.3	5.3

Notes - 2010
Source: CY 2010 final data is not available.
Final CY2009 data as of Sept 2011, CT Dept. of Public Health, HISR, Vital Statistics.
The annual indicator is a rolling average of 2007, 2008, and 2009 numerator (13, 14, 14) and denominator (250994, 250053, 253973) CY numbers.

Notes - 2009
Source: Final CY2009 data as of Sept 2011, CT Dept of Public Health, Vital Statistics.
The annual indicator is a rolling average of 2007, 2008, and 2009 numerator (13, 14, 14) and denominator (250994, 250053, 250053) original numbers.
Annual Performance Objectives for 2010-2014 have been updated based on the most recent data.

Notes - 2008
Source: CT Dept of Public Health, Vital Statistics final CY2008 data.
The annual indicator is a rolling average of 2006, 2007, and 2008 numerator (16, 13, 14) and

denominator (250071, 250944, 250053) orginal numbers.
Note: The Annual Performance Objectives for 2008 and 2013 have been updated based on the most recent data.

a. Last Year's Accomplishments
This measure was not met. Community Health Centers (CHC) provide mental health services through assessment, direct care and/or referrals. They continue to ensure these 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 CHCs work with the Child Guidance Centers across CT. Some of the Child Guidance Centers are operated by CHC.

School Based Health Centers (SBHC) continue to provide 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 SBHC offer services directed at high-risk populations, such as youth with suicidal thoughts/attempts.

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 provides 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.

MCHBG funds were used to support a consultative hotline about perinatal depression for healthcare professionals in the state. A set of grand rounds was also implemented through 9/30/10 to highlight the need for perinatal screening.

There were also non-Title V funded activities. The Injury Prevention Program provides guidance related to suicide prevention information, data and resources, when requested to other DPH programs.

FHS staff participated in the Women's Health Subcommittee of the Medicaid Managed Care Council, which focused on issues related to perinatal depression.

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
SBHC are providing anticipatory guidance, risk assessments and mental health therapy at all locations. Staff are working with SBHC to enhance data collection tools related to mental health service delivery at these centers.

Community Health Centers provide mental health services through screening, assessment, primary care, and referrals.

The Case Management for Pregnant Women and Teens Program includes screening for perinatal depression. This program covers Hartford, New Haven and Waterbury. Perinatal depression screening occurs in the state Healthy Start programs and Hartford Healthy Start that provide case management services for pregnant women at or below 185% of the FPL.

c. Plan for the Coming Year
Hartford Healthy Start, Case Management for Pregnant Women and Teens, and other case management programs will continue to screen for perinatal depression.

CHC and SBHC will continue to provide mental health services through assessment, direct care, and/or referrals. The FHS will continue to participate on the Women's Health subcommittee of the Medical Managed Care council, which has a special focus on perinatal depression.

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	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	87.3	87.4	87.5	87.6	86.5
Annual Indicator	86.3	84.9	86.6	85.6	85.6
Numerator	591	541	529	475	475
Denominator	685	637	611	555	555
Data Source			DPH Vital Statistics	DPH Vital Statistics	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	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	86.6	86.7	86.8	86.9	87

Notes - 2010

Source: CY 2010 data are not available.
Final CY2009 data as of Sept 2011, CT DPH, Vital Statistics.
Eleven of CT's acute care hospitals with self-declared NICU's were included in this survey.
Annual performance objectives for 2011-2015 have been updated based on the most recent data.

Notes - 2009
Source: Final CY2009 data as of Sept 2011, CT DPH, Vital Statistics. Eleven of CT's acute care hospitals with self-declared NICU's were included in this survey.
Annual performance objectives for 2011-2015 have been updated based on the most recent data.

Notes - 2008
Source: CY2008 final data, CT DPH, 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. CT has 30 birthing hospitals statewide and one birthing center located in Danbury, CT, contiguous to the New York State 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 quarterly as scheduled. One plan recommendation 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, including State Healthy Start, Centering Pregnancy, Case Management for Pregnant Women, and Family Planning provided outreach, screening, intensive case management, and referral for women at risk for having a poor birth outcome. Through a case management approach, women received screening, education, support and referrals for services in an attempt to promote a better birth outcome.

A Strategic Plan within the FHS was developed May 2008, and later updated in February 2009. The plan addresses low birth weight and its disparities. The following activities have been completed: 1) two community-based health care centers were funded to initiate the CenteringPregnancy model of group prenatal care; 2) a statewide infant mortality campaign was expanded to incorporate life course theory; 3) dissemination of a brochure about fish consumption during pregnancy was broadened; 4) recommendations of an agency-wide workgroup to address disparities in low birth weight within Hartford; 5) DPH applied and received funding to build a Healthy Start community within Hartford; 6) DPH developed an MOA to share low birth weight records with the state's Birth-to-Three program; 7) the FHS included life course theory in its MCHBG state priorities, and 8) using a TA grant with HRSA funding, the FHS conducted a statewide symposium to address disparities in the CT's perinatal system of care.

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				X

Advisory Committee to implement the plans goals and objectives				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The MCH Advisory Committee meets 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.

Recommendations identified in the recently developed Strategic Plan for Addressing Low Birth Weight in CT, include the need to coordinate with medical providers to ensure that high-risk pregnancies deliver in tertiary care hospitals.

c. Plan for the Coming Year
DPH's contract with DSS for the State Healthy Start program ends on 9/30/11. DPH and DSS will examine the existing Healthy Start Program and services and make recommendations for change to promote enrolling women in the first trimester of pregnancy. DPH is the Lead agency responsible for Maternal, Infant, and Early Childhood Home Visitation (MIECHV) Program. Healthy Start will be incorporated into the state plan as part of the statewide system for home visiting services with the maternal, infant, and early childhood population.

The MCH Advisory Committee will continue to meet and identify resources to develop and implement strategies to address this objective.

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	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	87.8	87	87.3	87.6	88.5
Annual Indicator	85.8	86.5	87.6	88.1	88.1
Numerator	35303	35424	34898	33792	33789
Denominator	41161	40969	39845	38362	38359
Data Source			DPH Vital Statistics	DPH Vital Statistics	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	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	88.9	89.4	89.9	90.4	90.8

Notes - 2010
Source: CY2010 data are not available.
Final CY2009 data as of Sept 2011, CT DPH Vital Statistics.
Annual performance objectives for 2011-2015 have been updated based on the most recent data.

Notes - 2009
Source: Final CY2009 data as of Sept 2011, CT DPH Vital Statistics.
Annual performance objectives for 2010-2014 have been updated based on the most recent data.

Notes - 2008
Source: CY2008 final, CT DPH Vital Statistics.

a. Last Year's Accomplishments
The objective was not met. In 2010, 88.1% of women received early prenatal care, not exceeding the objective of 88.5%. State Healthy Start, Hartford Healthy Start, Family Planning, HCWC, Case Management for Pregnant Women, WIC, CHC, and SBHC, encourage pregnant women to obtain early and continuous prenatal care.

The First-Time Motherhood/New Parent Initiative implemented a media campaign incorporating 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, New Haven and Bridgeport communities.

The Centering Pregnancy model of group prenatal care continued in New Haven at two sites to provide group prenatal care and education to women most at risk for delivering low birth weight infants and promote early access to prenatal care.

Recommendations from the LBW Strategic Plan were initiated, and included: 1) facilitating case management services for first time pregnancies; 2) coordinating with medical providers to ensure evidence-based treatment for pregnancies at risk of preterm-birth; 3) advertising the use of Infoline 2-1-1 to assure referrals for early and regular prenatal care; 4) documenting that all DPH-funded initiatives address language, culture, diversity and health literacy; and 5) continuing to provide TA to the Hartford Health Department in support of their federally-funded Healthy Start Program.

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. Promote early enrollment into prenatal care as a linkage from programs such as WIC		X		
6. Provide/promote comprehensive services to encourage women of reproductive age to enter prenatal care early		X		

7. Continue to analyze and disseminate PRATS Survey data			X	X
8.				
9.				
10.				

b. Current Activities
Title V-funding helps support programs such as the State Healthy Start, Family Planning, Case Management Program for Pregnant Women and Parenting Teen, and SBHC that provide outreach and identification of pregnant women to promote early entry into prenatal care. HCWC (state funded) provided outreach and case management for pregnant women at risk for substance abuse and promote early entry into prenatal care until June 30, 2011. Other programs such as Community Health Centers and WIC, promote early entry into prenatal care. Hartford Healthy Start is also performing active outreach in Hartford to women in early pregnancy.

The State Healthy Start contract begins in September 2011, and will be revised to include more outreach and direct follow-up to support early access to prenatal care. The reporting forms used by the contractors were revised to include collection of the trimester of pregnancy at mother's time of enrollment.

c. Plan for the Coming Year
Title V-funding will continue to support programs such as the State Healthy Start, Family Planning, Case Management Program for Pregnant Women and Parenting Teens, and SBHC that provide outreach and identification of pregnant women to promote early entry into prenatal care. Other programs such as Community Health Centers and WIC will continue to promote early entry into prenatal care. Hartford Healthy Start will also perform active outreach in Hartford to women in early pregnancy.

The CT Maternal, Infant and Early Childhood Home Visiting Program(s) will also support early entry into prenatal care.

D. State Performance Measures

State Performance Measure 1: *Cumulative number of core datasets integrated into Connecticut's comprehensive child health information data warehouse, HIP-Kids.*

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

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective					
Annual Indicator					2
Numerator					2
Denominator					7
Data Source					HIP-Kids
Is the Data Provisional or Final?					Final
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	3	4	5	6	7

Notes - 2010
FFY 2012 application is the first year of reporting on this new SPMs. The 2010 Annual performance objective is 2.

a. Last Year's Accomplishments
Efforts to migrate EHDI and BDR data into the MAVEN application continued. Funding was secured to include the CYSHCN database. The State Laboratory agreed to have the Newborn Screening System (NSS) Genetic/Laboratory tracking component migrated to the MAVEN application. .

The project was delayed due to a temporary hold on all MAVEN projects until late 2009 through early 2010. The "Go-Live" date for this project was re-set to April 2011. During January 2010 -- March 2010, the contractor completed the preparatory work for EHDI, BDR and CYSHCN to be ready for migration to MAVEN. Work began on the Genetics/Laboratory component in April/May 2010 and continued through September 2010. Challenges encountered when the vendor was working with the Genetic/Laboratory component included the need for a HIPAA rider requiring the vendor to agree to protect the confidentiality of personal health information and documenting the complexity of the Genetic/Laboratory business requirements.

Once completed, the EHDI, BDR, Genetic/Laboratory, and CYSHCN programs will have an integrated web-enabled, electronic messaging capable, secure surveillance system that will improve the efficiency of data collection, case monitoring and data analysis.

The Immunization Registry and Tracking System (CIRTS) was selected as the next database for integration into MAVEN. CIRTS migration efforts were supported with ARRA funds in the fall 2009. Immunization Registry staff had begun efforts to document the project needs for successful migration. These funds along with other grant funds facilitate execution of a contract with the same vendor used for the NSS in Oct 2010. The CIRTS project is scheduled to be completed by December 2011.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Complete the documentation of the business needs of the Genetic/Laboratory component of the NSS.				X
2. Move into production of the Newborn Screening System				X
3. Continue to identify funding for the HIP-Kids project				X
4. Identify future methods for data integration/linkage of the newly created child health database systems as MAVEN instances.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Death Registry is undergoing a major upgrade in 2010-2011 to the electronic reporting of death records impacting the availability of these records for linkage. Since the Childhood Lead Surveillance System was another system migrating to the MAVEN application, this system will replace the Death Records as one of the seven core databases.

Work continues on the Genetics/Laboratory component especially with the complexity of the Genetic/Laboratory business requirements. Another complex part of the project is the integration of the Genetics/Laboratory information with the Laboratory Information Management System

(LIMS) to deliver HL7 messages that will contain genetic test results. There have been delays in the implementation of the LIMS and may require a "work-around" for the Genetic/Laboratory component to continue use of the existing laboratory result reporting system (Gemini) until LIMS is functional.

c. Plan for the Coming Year
Once all components of the NSS have migrated to the MAVEN application including the import of legacy data into the system, this instance of MAVEN will be considered in production. DPH staff will roll out the application to the 30 birthing hospitals by providing regional trainings to hospital staff. DPH staff will provide technical assistance and support to hospital staff on the use of the NSS as needed.

DPH staff will investigate methods to further integrate the various MAVEN instances that have been developed containing child health information. The goal is to integrate the MAVEN instances so that each child is identified once with its attached health information from the various MAVEN instances.

State Performance Measure 2: *Percent of students that had a risk assessment with a mental health component conducted during a comprehensive, annual physical exam at a SBHC.*

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

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective					
Annual Indicator					58.5
Numerator					17158
Denominator					29307
Data Source					Survey of SBHCs in 2011
Is the Data Provisional or Final?					Final
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	60	62	64	66	68

Notes - 2010
Source: A survey was sent to all SBHCs in CT to collect initial information about usage of risk assessments with a mental health component during annual physical exams. This was used as a baseline for 2010.

a. Last Year's Accomplishments
FHS staff developed and emailed a survey to all 19 SBHC contractors in order to obtain baseline information regarding utilization of risk assessments with a mental health component. All 19 contractors responded. DPH followed up to clarify some responses. The survey showed that 63.2% of SBHC used risk assessments with a mental health component for pre-kindergarten through high school. Of those that used a risk assessment, 42% used the GAPS tool while others used a variety of other tools. Risk assessments were administered 57.9% of the time to students who came for an annual physical exam, 73.7% of the time to student walk-ins with a self-identified mental health issue, and 73.7% of the time for students who were specifically referred to the clinic.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop and administer a survey to obtain baseline data regarding utilization of a risk assessment tool with a mental health component.				X
2. Monitor use of current risk assessment tools with a mental health component during comprehensive, annual physical exams.				X
3. Collaborate with SBHC staff to identify 3-5 risk assessment tools with a mental health component to be used by all SBHCs.				X
4. Provide technical assistance to SBHCs to assure best practices.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DPH staff added questions regarding utilization of a risk assessment with a mental health component to the Year-end Report due annually. Because this is the first year that this information is collected, we anticipate that coordinators will need some technical assistance to provide uniform responses and also that their collection of data may require adjustment going forward. Some of the program coordinators are attending the annual NASBHC conference in June 2011 and have been asked to share information learned with DPH and other SBHC coordinators at a follow-up SBHC meeting. This collaboration and discussion will help us better define best practices for conducting risk assessments with a mental health component during comprehensive annual examination and for data collection. We will also work together over this year to help identify 3-5 acceptable risk assessment tools for use.

c. Plan for the Coming Year

DPH will to collaborate with SBHC staff to assure that mental health staff is available at SBHC clinics and to troubleshoot issues that may arise regarding the implementation and administration of the risk assessment tool. DPH will monitor use of specific risk assessment tools during site visits and also based on quarterly and annual reporting.

State Performance Measure 3: *Percent of child health/dental providers who serve at risk populations that perform dental caries risk assessments, and provide oral health education and risk-based preventive strategies by age one.*

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

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective					
Annual Indicator					29.2
Numerator					447
Denominator					1533
Data Source					Dept Social Services
Is the Data Provisional or Final?					Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	31	33	33	35	35

Notes - 2010
New state performance measure for FFY 2012.
Source: Department of Social Services 2010 data sets combined of child health providers enrolled in Medicaid/SCHIP/HUSKY A and HUSKY B,eligible to bill dental codes on children 23 months and younger. Dental providers enrolled in Medicaid/SCHIP/HUSKY A and HUSKY B billing preventive dental codes on children 23 months and younger. Medicaid/SCHIP billing codes for caries risk assessments,oral health education and fluoride varnish applications.

a. Last Year's Accomplishments
The Home by One Program promoted the message of first dental visit by age one throughout the state, while connecting dental homes proficient in dental caries risk assessments for risk populations, targeting children under age three enrolled in the WIC program and Early Head Start programs, with medical providers proficiently trained through the DSS ABC dental program and credentialed to bill for preventive dental codes at well-baby visits beginning with the six month well-baby visit for children enrolled in the SCHIP HUSKY. The Home by One Program partnered with 35 dental homes across the state accepting referrals of children by age one from the local WIC sites. The Dental Providers' Perspective on the Age One Dental Visit was launched on CT TRAIN as an effort to sustain the trainings. The child health providers were trained in their offices through EPIC or through a teleconference presented through a collaboration of AAP and the DPH Immunization program. To date 262 child health providers have been credentialed to bill for dental services with DSS and are encouraged to refer children to dental homes by age one. Parents are made aware of the first dental visit by age one through information shared in the New Born packets, sent through DPH immunization program to all parents of newborns delivered in CT hospitals.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to educate dental and medical professionals in providing dental caries risk assessments, oral health education and appropriate risk-based preventive strategies to children by age one.				X
2. Continue to identify funding for the Home by One Program				X
3. Expand the number of dental practices and clinics providing dental homes for children beginning at age one	X			
4. Expand the non-dental workforce competent in preventive dental strategies.	X			
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
A Medical Dental Partners conference brought medical and dental professionals together in a workshop entitled "Infant and Toddler Oral Health: Building Effective Networks between the Dental and Medical Professions." Medical and dental providers worked together in a "hands on" portion of the workshop, applying fluoride varnish to children under age three who volunteered from the WIC programs. Anticipatory guidance and oral health education was delivered to the children's parents. Of the 935 child health professionals trained in fluoride application, 262 have received full billing credentials. Fluoride varnish start-up kits, including mirrors, toothbrushes for both child and parent, educational materials for distribution to parents, puppets and anticipatory guidance resources were shared with 935 medical providers, through funds to the CT DPH from

the Samuel Harris Fund for Children's Dental Health Grants Program of the American Dental Association Foundation for 2010-2011.

Fluoride varnish Application for Pediatric Medical Providers: Home by One course on CT TRAIN launched as a video on demand webinar which meets the criteria for training requirements of the DSS ABC dental program, allowing medical providers to train and credential to bill for preventive dental codes during a well-child visit.

c. Plan for the Coming Year
The Home by One Program will have an evaluation report completed on the first four years of the Program funded through a 4-yr HRSA targeted MCH Oral Health Services Systems grant 2007-2011. Dental providers and medical providers will continue to train in proficiency of assessing the dental caries of children by age one. DPH staff will continue to educate the public on the importance of utilizing early preventive dental services in order to reduce the burden of oral disease in CT's children.

State Performance Measure 4: *Increase the redemption rate of fruit and vegetable checks issued to women and children enrolled in the Connecticut WIC program.*

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

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective					
Annual Indicator					80.5
Numerator					43494
Denominator					54045
Data Source					CT WIC database (SWIS)
Is the Data Provisional or Final?					Final
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	82	83	84	85	86

Notes - 2010
Source: CT WIC Program, Statewide WIC Information System (SWIS).
Note: The exact wording of this SPM has been updated for FFY 2012 as described in the detail sheet. Data for this measure has only been collected since October 2010 and the percentage only reflects 5 months of data available as of June 13, 2011.

a. Last Year's Accomplishments
Starting in October 2009 (Federal Fiscal Year 2010), the Special Supplemental Nutrition Program for Women, Infants & Children (WIC) implemented its new WIC Food Packages. Participant women and children aged 1 to 5 years are now issued cash-value checks which enable them to purchase fresh fruits and vegetables valued at $10 per month for women and $6 per month for each child.

Local WIC agencies were trained on and provided with several nutrition education resources promoting fruits and vegetables. Farmers Markets now redeem WIC checks at their stands for purchase of fresh produce. The Physician's Outreach Initiative, also part of the New WIC Food Package Implemen¬ta¬tion Plan, was initiated to update health care providers about the rationale and benefits of the new WIC food packages and collaborate with them on providing messages with the purpose of best serving our mutual clients.

During 2006 - 2009 the Connecticut WIC Program prepared for the transition to statewide implementation of Value Enhanced Nutrition Assessment (VENA), effective October 2010, 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."

CT's activities included collaboration with the VENA core committee with representation from all local agencies, revisions of policies and forms, and continuing education for local WIC staff. Local WIC nutrition staff continued to provide individual nutrition counseling and group education to participants.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote fruit and vegetable consumption among WIC participants				X
2. Continue the WIC Physician's Outreach Initiative				X
3. SNAP Ed to pursue funding to continue its nutrition education activities in partnership with WIC				X
4. Continue to work with the VENA committee on standardizing nutrition education materials and providing educational resources				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The VENA committee is standardizing nutrition education materials. Increasing fruit and vegetable consumption among children has been identified as one of four key topics for developing nutrition education resources and guidelines.

The Supplemental Nutrition Assistance Program -- Education (SNAP-Ed) at the CT DPH partners with the State WIC Program to improve fruit and vegeta¬ble consumption among WIC participants.

This collaboration began with the implementation of the new WIC Food Package in FFY2010, and fosters a comprehensive, statewide approach at the local agency level, where SNAP-Ed leads facilitated group discussions with participants to promote increased fruit and vegetable consumption. These discussions include a produce food demonstration with subsequent tasting opportunity. The fruit and vegeta¬ble message is expanded to a larger audience with interactive display boards in the WIC lobby areas. The SNAP-Ed program developed and disseminates fruit and vegetable recipe cards that highlight items in the WIC food package.

c. Plan for the Coming Year

Key activities planned for FY 2012 include:

•The WIC VENA committee will continue to work on quality nutrition assessment, participant-focused education, standardized nutrition documenta¬tion, and procurement of standardized educational materials. Nutrition education guidance for each participant category served, and for

specific topics based on participant priority, will continue to be developed. Promoting fruit & vegetable consumption among children will be addressed.
•The Physician's Outreach Initiative will continue in FY2012 and will explore the development of consistent messages and resources for our mutual client bases, with promotion of fruits and vegetables under consideration as one of the potential topics.
•The SNAP-Ed program has requested federal funds for FFY2012 to continue its nutrition education activities in partnership with WIC.
•Incorporate newly developed nutrition education guidance documents -- which include the promotion of fruits and vegetables among children -- into the State WIC Plan.

State Performance Measure 5: *Percent of 0-3 year olds participating in the state Medicaid Program (HUSKY - Health Insurance for Uninsured Kids and Youth) who received a developmental screening within the last twelve months.*

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

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective					
Annual Indicator					26.2
Numerator					14462
Denominator					55100
Data Source					Medicaid Claims Data
Is the Data Provisional or Final?					Final
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	29	31	33	35	37

Notes - 2010
FFY 2012 is the first year for the new state SPMS.
Source: 2010 Medicaid Claims data obtained from the CT Department of Social Services. In 2009, Developmental screening became billabe at the same time as well child visits. This lead to an increase in uptake of screenings due to this change in payment structure.

a. Last Year's Accomplishments
This is a new state performance measure.

The 2005/2006 National Survey of CSHCN revealed that 3.8% of CT's CYSHCN population, or roughly 5,057 children were diagnosed with Autism Spectrum Disorder (ASD). The rapid rise in prevalence of ASD in CT mirrors the national trend with the 1998 prevalence rate of 1.8% growing to 4.2% in 2004 and reaching 7.4% in 2008 in looking at Connecticut students with an individualized education program for an Autism Spectrum Disorder (SDE, 2009). Early identification is recognized as an important component of meeting the needs of CYSHCN, including those with ASD, and therefore the focus is on the 0-3 population and provider education.

Connecticut's Title V System of Care for CYSHCN, "The Connecticut Medical Home Initiative for Children and Youth with Special Health Care Needs" (CMHI), provides a community based, coordinated system of care for children and families. Contractors provided services to 8,264 CYSHCN between July 1, 2009 and June 30, 2010 in the following categories: administration of extended services and respite funds, medical home care coordination, provider and family education, outreach and family support. Referral sources for CMHI include DSS and the Birth to Three System. A review of programmatic data reported by CMHI care coordinators revealed the following: as of March 31, 2011 there were over 14,000 children in the CYSHCN database, (cumulative number of consumers serviced since an access database was implemented in January 2006); 13.6% of clients in the previous year had a diagnosis which indicated Autism,

Pervasive Developmental Disorder (PDD) or Aspergers's. This makes ASD one of the three most frequently diagnostic groups receiving services (other prevalent diagnoses included ADHD at 12%, and Asthma at 24% - there are over 100 different diagnoses found in the database). Further review of gender specific data indicated findings similar to national statistics with a male to female ratio of 4:1 (approximately 78% males). Racial and ethnic comparison with overall state population statistics were not consistent as Whites with ASD comprised 41% of the total (overall state population is 74% White), for Blacks the diagnosis was slightly higher than the overall state statistics at 16% (10% of the state's population is Black), and Hispanics accounted for 21% of ASD consumers in the database, (the state's population is 12% Hispanic).

Claims data reported by the DSS, CT's Medicaid agency, indicated the number of developmental screenings performed by providers participating in the HUSKY in CY 2009were:: 9,041 screens were done for 0-3 year olds, and 1,396 for 4-6 year olds. The number of developmental screenings performed for 0-3 year olds increased to 14,662 (approximately 62 % increase) in 2010. An increase was reported in the number of developmental screens for 4-6 year olds with 2,374 screened (approximately 58 % increase).

The most consistent and largest data source available for developmental screening is DSS claims data. As the denominator for this population is well defined and available, DSS claims data will be used as the matrix for this measure. Medicaid data will be used to reflect outcomes in the system. In 2009, developmental screenings became billable at the same time (on the same visit) as well child visits. This change in payment structure leads to an increase in screenings. The percentage of HUSKY enrollees 0-3 receiving a developmental screen with a formal tool rose from 9.2% in 2008 to 16.4% in 2009.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Partner with Child Health and Development Institute (CHDI) to identify strategies to support an increase in developmental screening				X
2. An overview of CHDI's Educating Practices In the Community (EPIC) Developmental Screening training module will be shared with CMHI networks.				X
3. CMHI network will coordinate developmental disabilities screening trainings for two pediatric practices in each of state regions				X
4. DPH staff will increase awareness of the Centers for Disease Control and Prevention's (CDC) "Learn the Signs. Act Early" campaign				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DPH submitted an application in May 2011 for the HRSA State Implementation Grant for Improving Services for Children and Youth with Autism Spectrum Disorders (ASD) and other Developmental Disabilities (DD) to improve access to comprehensive, coordinated health and related services for CT CYSHCN. Proposed outcomes of the project include: (1) implementation of the CT State Autism Plan, with activities that strengthen stakeholders awareness of early signs

of ASD; knowledge about and access to evidenced-based, individualized and timely screening; diagnostic assessment and interventions implemented by a competent workforce; (2) engage ASD specific family support and training organizations to provide information and education on ASD; (3) work with the AAP, pediatric primary and family care providers, and the CMHI for CYSHCN providers to expand practices proving family-centered, comprehensive coordinated health care and related services including screening, linkage to diagnosis, and transition to evidence-based interventions.

A statewide CMHI for CYSHCN Care Coordinators meeting in June 2011 focused on developing strategies to increase developmental screening. DPH staff provided a review of the National and State Performance Measures (SPM) with an emphasis on this SPM.

c. Plan for the Coming Year

Elements of the proposed ASD project will be implemented irrespective of the application's success. Strategies to support an increase in developmental screening will include partnering with Child Health and Development Institute (CHDI); an overview of CHDI's Educating Practices In the Community (EPIC) Developmental Screening training module will be shared with CMHI network care coordinators and providers. The presentation will emphasize the importance of screening in light of research showing the importance of early brain development, acknowledging that screening is recognizing by the AAP as part of pediatric care at 9, 18 and 24 (30) months of age. The presentation will include examples of developmental screening tools such as the PEDS (Parents' Evaluation of Developmental Status) and ASQ (Ages & Stages Questionnaire) as well as information about billing for developmental screening.

A presentation will also be provided by Child Development Infoline (CDI), a specialized call center of CT United Way 2-1-1, who helps families with children who are at risk for or experiencing developmental delays or behavioral health issues to find appropriate services. CDI offers care coordinators who have access to a computerized inventory of resources and provide free and confidential telephonic support. This combination of presentations links the importance of developmental screening in child health sites with a resource for identifying community supports once a delay is identified.

Each CMHI network will coordinate trainings for two pediatric practices in their area, for a total of ten additional trainings statewide.

DPH will partner in the A. J. Pappanikou Center for Excellence on Developmental Disabilities, Leadership Education in Neurodevelopmental and related Disabilities (LEND) grant - the goals of which include training child health professionals to improve care for children with developmental disabilities, with an emphasis on autism, and coordination of activities for the Region 1 Act Early Summit to enhance the identification, assessment, service coordination and provision of services for children with autism spectrum disorders and related DD.

DPH staff will increase awareness of the Centers for Disease Control and Prevention's (CDC) "Learn the Signs. Act Early" campaign by obtaining available CDC materials, enhancing it with CT specific information, and dissemination statewide through the CMHI networks.

DPH staff will work with an ASD "Action Team" consisting of a family leader, ASD "Physician Champion", a nurse or social worker, and A.J. Pappanikou staff assigned to the LEND Program to provide technical assistance to CMHI care coordinators and providers on ASD awareness, screening, diagnosis and intervention.

DPH staff will work with the ASD "Physician Champion" to implement ASD screening protocols in fifteen CMHI network medical homes.

State Performance Measure 6: *The cumulative number of DPH funded Case Management programs whose healthcare professionals complete preconception and interconceptual health screening (including depression) of women.*

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

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective					
Annual Indicator					3
Numerator					3
Denominator					8
Data Source					Quarterly and annual program reports.
Is the Data Provisional or Final?					Final
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	4	5	6	7	8

Notes - 2010
The programs that provide Case Management are undergoing a re-structuring during 2011.

a. Last Year's Accomplishments
Perinatal depression education (FFY 9 and 10) and training sessions were provided to health care providers (obstetricians, pediatricians, social workers, nurses, psychologists and psychiatrists) in CT. around The training was provided by mental health and Psychiatry experts from the Yale School of Medicine. The training sessions included the following areas: 1) risk factors for perinatal depression; 2) screening and diagnostic questionnaires; 3) barriers to care; 4) medications for treatment and 5) referral to services. Attendees were provided with toolkits developed during the first year of the project and with CD-ROMs of the content for all training sessions. It is expected that providers incorporate perinatal depression screening into their practices once trained.

DPH funded three contracts that provided Case Management Programs. All women enrolled received periodic perinatal depression screening and were referred for services if they screened positive. All women enrolled received interconceptional screening and education.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. % women who receive preconception screening and education.	X			
2. % women enrolled in Case Management programs who receive interconceptional screening and education.	X			
3. % women enrolled in Case Management programs who are screened for depression screening	X			
4.				
5.				
6.				
7.				
8.				
9.				

10.				

b. Current Activities
DPH funded three contracts that provided Case Management Programs. All women enrolled in the MCH Funded programs received periodic perinatal depression screening and are referred for services if they screen positive. All women enrolled receive interconceptional screening and education. Three of the Case Management contracts will expire on 9/30/11. If refunded, DPH will issue a Request for Proposal for the new contracts.

c. Plan for the Coming Year
DPH will incorporate language in all case management and home visiting contracts that require pregnant and postpartum women to receive preconception and interconceptional health screening for depression and interconceptional screening/education. Contractors will be required to report the number of women screened on an annual basis.

State Performance Measure 7: *Increase the number of People served by increasing the number and area covered by Health Professional Shortage Area (HPSA) Designations in CT.*

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

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator				3	6
Data Source					
Is the Data Provisional or Final?				Final	Final
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	12	15	18	21	24

Notes - 2010
Source: DPH staff was trained to use a Geographic Information System (GIS) based mapping system called Application Submission & Processing System (ASAPS) to submit HPSA applications. that can then identify thenumber of HPSA's in CT.

Notes - 2009
Source: DPH staff had started their training to use a Geographic Information System (GIS) based mapping system called Application Submission & Processing System (ASAPS) to submit HPSA applications. that can then identify thenumber of HPSA's in CT.

a. Last Year's Accomplishments
DPH staff completed work to collect data on the Primary Care Providers (PCP) in CT. An external contractor prepared and submitted shortage area designation applications previously. DPH staff was trained to use a Geographic Information System (GIS) based mapping system called Application Submission & Processing System (ASAPS) to submit HPSA applications. DPH staff began the process to create surveys in order to collect data from providers to be uploaded in ASAPS to replace outdated 2001 American Medical Association (AMA) data.

During this time frame, two Mental Health HPSA's (Danbury and Hartford) and one Dental HPSA (Enfield) were approved.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide technical assistance to organizations/communities seeking HPSA designation.				X
2. Provide relevant state data to organizations/ communities seeking HPSA designation.				X
3. Identify HPSA's for designations or re-designation.				X
4. Submit HPSA applications to HRSA.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DPH staff mailed out cover letters containing a link to complete a web-based survey (SurveyMonkey) to more than 8,000 Primary Care Providers and 2,000 Dentists throughout the state. DPH staff is in the process of sending out letters to those who did not respond. DPH staff has collaborated with the Practitioner Licensing Section to obtain information collected at the time of license renewals for physicians. The data collected from Licensing has been incorporated into the newly developed PCO Primary Care database. In late July 2011, DPH staff will provide follow-up calls with each physician that has not responded to the surveys.

During this time frame, two Primary Care HPSA's (Groton and New London) and four Mental Health HPSA's (Litchfield County, New London County, Windham County, and Danbury) were approved.

c. Plan for the Coming Year

The Primary Care and Dental Health database is expected to be finalized this upcoming year. The database will be sent to Health Resources & Services Administration (HRSA) so that the data can be uploaded into ASAPS. Once the data is uploaded into ASAPS, DPH staff will have the opportunity to focus their efforts to expanding the number of HPSA applications for Primary Care, Mental, and Dental Health Care that are sent to HRSA. A fully updated physician database will enable DPH staff to identify high need HPSA areas in the state. Submitting applications and obtaining federal designations will serve as the necessary steps toward obtaining the resources to improve health care services and access throughout Connecticut.

State Performance Measure 8: *Integrate the Life Course Theory (LCT) throughout all state priorities. Increase the number of state priorities that have incorporated LCT into their programs.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective					
Annual Indicator					
Numerator					13
Denominator					8
Data Source					2010 Semi-decennial needs assessment
Is the Data Provisional or Final?					Final

	2011	2012	2013	2014	2015
Annual Performance Objective	2	2.5	3	3.5	4

Notes - 2010
Information from Carol Stone, CT DPH Family Health Section. Detailed data source described in Form 16.

a. Last Year's Accomplishments
In the absence of an assessment for the fiscal year (FY) ending September 30, 2009, it is assumed that all state priorities were at Stage 1, or Pre-Contemplation. During the FY, activities designed to increase awareness about LCT were limited to those supported by the Knowledge-to-Practice translational grant funded to Boston University. This grant was funded to work with the Region 1 states and support a broader base of knowledge about LCT and how it could be used in the MCH field. A symposium conducted throughout the region and within CT of statewide MCH experts was followed up during FY2009 with another conference. The state-specific topic was childhood obesity and how a medical home could be used to incorporate LCT. This conference was conducted by real time audio-visual feed, and CT participants convened at the University Connecticut (UConn) School of Medicine audio-visual feed room, with funding from the DPH Obesity program. Participants in CT included Mark Keenan and Johanna Davis of the CT CYSHCN program; Sharon Tarala, Supervising Nurse Consultant within DPH, and Stephanie Rendoulic and Mario Garcia of the DPH Obesity program. In addition, Paula Liebovitz, Community Healthcare Center, Inc., and Director of a federal Living Healthy/Living Fit grant, attended the conference. During the state-specific discussion, CT participants identified five future activities that could be implemented within medical homes, including how the CYSHCN program could incorporate LCT into its medical home initiative.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Stage 1. Seek learning opportunities among DPH program staff and among other state and community leaders.				X
2. Stage 2. Pursue technical assistance to incorporate LCT action steps into program plans.				X
3. Stage 3. Assist with grant seeking and other funding opportunities that incorporate LCT into program activities.				X
4. Stage 4. Pursue technical assistance and provide MCHBG and MCH Epidemiologic support to evaluate program activities related to LCT.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The overall stage of change was 1.6, above the objective of 1.5. Four of the state priorities were at Stage 1 with no activity related to LCT. Three of the state priorities were at Stage 2 with an understanding of LCT. One state priority was at Stage 3 with inclusion of LCT into an action plan. A seminar was conducted on November 12, 2010, with funding from the Knowledge-to-Practice grant. Twenty-nine DPH staff participated from within and outside the FHS. The CYSHCN staff later repeated the seminar on May 12, 2011 with key stakeholders. On November 17, 2010 and December 7, 2010, LCT was introduced to the State Women's Health Subcommittee and the State MCH Advisory committee, respectively. On December 16, 2010, a presentation on LCT

was also provided to the Advisory Committee of the HRSA-funded Maternal Outreach for Mothers (MOMS) Partnership in New Haven. Topics on LCT have been incorporated into written materials, including the Sickle Cell Disease Transitional grant, and the Needs Assessment for Maternal, Infant and Early Childhood Home Visiting Program. With funds from federal the Hartford Healthy Start, the "Someday" campaign was re-issued in Hartford. Staff within the FHS are members of the MCH Lifecourse Research Network and participate in periodic webinars.

c. Plan for the Coming Year

During the FY ending September 30, 2012, DPH will continue efforts to move SPM toward change that incorporates LCT. With available funding, DPH will seek technical assistance to conduct an agency-wide seminar by Dr. Bernard Guyer, to discuss how the agency can incorporate LCT into its programs and policies. In addition, technical assistance, possibly with funding by a continuation of the Knowledge-to-Practice grant, efforts will continue to move SPM leads to Stage 3, with ideas for how programmatic action steps can be incorporated into existing plans. The "Someday" campaign may be re-issued, with available funding, and oral presentations to MCH leaders across the state will include messages about LCT. Epidemiology staff will continue to participate on the MCH Lifecourse Research Network.
An attachment is included in this section. IVD_SPM8_Plan for the Coming Year

State Performance Measure 9: *The extent to which the ratios of key perinatal health measures for non-Hispanic Black/African Americans relative to non-Hispanic Whites has changed.*

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

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective					
Annual Indicator					10
Numerator					
Denominator					
Data Source					VitalRecords
Is the Data Provisional or Final?					Final
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	12	14	16	18	20

Notes - 2010
Source: 2008 and 2009 Vital Statistics

a. Last Year's Accomplishments

Title V-funded programs that serve to reduce racial and ethnic disparities in perinatal outcomes included Case Management for Pregnant Women, Centering Pregnancy, Family Planning, and State Healthy Start. Other programs in CT funded by other sources to reduce racial and ethnic disparities in perinatal outcomes include: Hartford Healthy Start, First-Time Motherhood/New Parent Initiative (FTM), Community Health Centers (CHC), Healthy Choices for Women and Children, and Maternal, Infant, and Early Childhood Home Visiting. These programs and activities have been described elsewhere in the application.

The FHS implemented activities outlined in its Strategic Plan to address low birth weight and its disparities, which are described elsewhere in the application.

The FHS received technical assistance from the National Center for Cultural Competence for Title V staff at DPH and to MCH community providers over two days in May 2010. The Title V programs have incorporated contract language that requires providers to deliver culturally competent services. MCH Staff monitored compliance with the terms of the contract that address

cultural competency.

The FHS continued its collaboration with Office of Multicultural Health, described elsewhere in the application.

The DPH participated on the CT Commission on Health Equity, which mission is to eliminate health disparities and inequities based on race, ethnicity and linguistic ability, and improve the quality of health for all CT residents.

Data collection for the PRATS survey began, which will provide essential information to further quantify and investigate perinatal disparities. A special set of questions are included regarding perceived discrimination to determine its effects on health-seeking behavior and outcomes.

FHS epidemiologists collected, analyzed, and disseminated perinatal data to monitor and investigate racial and ethnic disparities in perinatal outcomes, and assist in enhancing/developing strategies to reduce these disparities.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide outreach, referral, and case management to high-risk populations.		X		
2. Provide intensive case management and supports to promote positive pregnancy outcomes.		X		
3. Provide pregnancy testing, reproductive health education, counseling and linkage to healthcare providers.	X			
4. Provide/promote comprehensive services to encourage early entry into prenatal care.		X		
5. Provide culturally competent and linguistically appropriate services.	X			
6. Provide/promote comprehensive services, support, information and advocacy to optimize preconception health among women of childbearing age.	X	X	X	
7.				
8.				
9.				
10.				

b. Current Activities

The programs that serve to reduce racial and ethnic disparities in perinatal outcomes, described above, continue except for the FTM Initiative (completed in FFY2010), FIMR (state funding was cut for 2011) and Healthy Choices for Women and Children (state funded). The newly funded Personal Responsibility and Education program began, described elsewhere in the application.

FHS applied for and was selected to be part of a national Action Learning Collaborative (ALC) to Eliminate Disparities in Infant Mortality. The DPH will co-lead the ALC with the New Haven Health Department and New Haven Healthy Start Program, and work with community partners to identify and design strategies to address racism and its impact on disparities in infant mortality in the city of New Haven.

The DPH continues its collaboration with Office of Multicultural Health and participates on the CT Commission on Health Equity, described elsewhere in the application.

Data collection for the PRATS survey will be completed by September 2011. PRATS will provide essential information to further quantify and investigate perinatal disparities.

FHS epidemiologists collect, analyze, and disseminate perinatal data to monitor and investigate racial and ethnic disparities in perinatal outcomes, and assist in enhancing/developing strategies to reduce these disparities.

c. Plan for the Coming Year
Title V-funded programs that serve to reduce racial and ethnic disparities in perinatal outcomes are described above and elsewhere in the application.

The Title V Director and FHS epidemiologist will partner with representatives from the New Haven Health Department, New Haven Healthy Start Program, and community partners in New Haven to identify and design strategies to address racism and its impact on disparities in infant mortality

The DPH will collaborate with Office of Multicultural Health and participate on the CT Commission on Health Equity, described elsewhere in the application.

PRATS survey data will be analyzed and disseminated to DPH and statewide partners to inform efforts to address racial and ethnic disparities and health inequities.

FHS epidemiologists will continue to collect, analyze, and disseminate perinatal data to monitor and investigate racial and ethnic disparities in perinatal outcomes, and assist in enhancing/developing strategies to reduce these disparities.

E. Health Status Indicators

Introduction
Similar to the Health Status Capacity Indicators, obtaining Vital Statistics and hospitalization data for this FY 2012 application was a challenge. However, FHS staff will update these indicators in September 2011 when these data become available.

The rate of Chlamydia has generally increased in the 15-19 year age group over the last few years as well as in the 20-44 year old age group in 2010.

A review of the demographic data in the 0-24 year age group shows a potential shift in this population with an increased representation in ethnic and racial minorities. This is accompanied by Black/African American mothers giving birth at a younger age than other racial populations; and Hispanic/Latino mothers giving birth more often in the teen years.

It was also found that children 0- 19 years old living in high risk households are more likely to be of ethnic and racial minority populations.

All public health interventions within the state need to be culturally and linguistically sensitive, and conscious of the belief systems and other environmental factors among the different age groups within the MCH population.

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	2006	2007	2008	2009	2010
Annual Indicator	8.2	8.1	8.0	8.0	8.0
Numerator	3389	3357	3214	3106	3106
Denominator	41455	41308	40087	38597	38597
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 - 2010
Source: CY 2010 Vital Statistics data not available. Used CY2009 final data, updated Sept 2011.

Notes - 2009
Source: Final CY 2009 Vital Statistics data updated Sept 2011.

Notes - 2008
Source: CT DPH final Vital Statistics data CY2008.

Narrative:
No updates have been made to this HSI narrative since 2010 not available. Update to be made in September 2011.

The rate of live births weighing less than 2,500 grams decreased slightly from 2006 to 2009, from a high of 8.2 per 100 live births in 2006 to 8.0 per 100 live births in 2009. The low birth weight rate in 2009 was the same as that observed in 2005, suggesting that recent interventions may have had a small positive effect on birthweight. A strategic plan was recently developed within the FHS to address low birth weight, and several objectives have been implemented, including receipt of federal funding for a federal Healthy Start community in Hartford. We will continue to implement strategies as funds permit.

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	2006	2007	2008	2009	2010
Annual Indicator	6.1	5.9	5.8	5.8	5.8
Numerator	2434	2336	2235	2121	2121
Denominator	39679	39473	38309	36775	36755
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 - 2010
Source: CY 2010 Vital Statistics data not yet available.
Used CY 2009 final Vital Statistics data updated Sept 2011.

Notes - 2009
Source: CY 2009 final Vital Statistics data, updated Sept 2011.

Notes - 2008
Source: CT DPH final Vital Statistics data CY2008.

Narrative:
No updates have been made to this HSI narrative since 2010 not available. Update to be made in September 2011.

After an initial increase in the rate of singleton low birth weight from 2005 to 2006, the rate dropped to 2005 levels in 2007 and has remained at 5.0 per 100 live births. Several home visiting programs were recently implemented, such as Care Management for Pregnant Women, and Healthy Choices for Women and Children. Funding for these programs will continue as funds permit. Additional home visiting programs made possible by the ACA of 2010 may also impact this measure.

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	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	1.7	1.5	1.5	1.4	1.4
Numerator	686	637	611	555	555
Denominator	41455	41308	40087	38597	38597
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 - 2010
Source: CY 2010 Vital Statistics data not available. Used CY2009 final Vital Statistics, updated Sept 2011.

Notes - 2009
Source: Final CY 2009 Vital Statistics data, updated Sept 2011.

Notes - 2008
Source: CT DPH final Vital Statistics data CY2008.

Narrative:
No updates have been made to this HSI narrative since 2010 not available. Update to be made in September 2011.

The very low birth weight rate fluctuated from 2005 to 2009, ranging from a low of 1.5 per 100 live births to a high of 1.7 per 100 live births. Home visiting and other prenatal services described previously may help impact this measure in the future. In addition, a focus on preconception screening and care, as described in the FHS low birth weight plan, may positively affect this measure.

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	2006	2007	2008	2009	2010
Annual Indicator	1.3	1.1	1.0	1.1	1.1
Numerator	499	431	402	394	394
Denominator	39679	39473	38309	36766	36766
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 - 2010
Source: CY 2010 Vital Statistics data not available. Used CY2009 final Vital Statistics data, updated Sept 2011.

Notes - 2009
Source: Final CY 2009 Vital Statistics data, updated Sept 2011.

Notes - 2008
Source: CT DPH final Vital Statistics data CY2008.

Narrative:
No updates have been made to this HSI narrative since 2010 not available. Update to be made in September 2011.

The singleton very low birth weight rate has fluctuated slightly since 2005, but generally has remained steady since 2007, at 1.1 per 100 live births. A recently implemented media campaign on preconception health was implemented in New Haven and Hartford through the First Time Motherhood initiative. The media campaign was focused on the African American community and may positively impact this measure in the future.

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	2006	2007	2008	2009	2010
Annual Indicator	2.7	3.7	3.3	2.9	2.9
Numerator	18	25	22	19	19
Denominator	655901	669187	663576	660975	660975
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 - 2010
Source: CY2010 Vital Statistics data are not available.
Used CT DPH final Vital Statistics data for 2009, updated Sept 2011. Denominator is from July 1, 2009 census estimates for Connecticut.

Notes - 2009
Source: Final CY 2009 Vital Statistics data, updated 2009. Denominator is based on July 1, 2009 census estimates for Connecticut.

Notes - 2008
Source: CT DPH final Vital Statistics data CY2008.

Narrative:
No updates have been made to this HSI narrative since 2010 not available. Update to be made in September 2011.

The death rate per 100,000 due to unintentional injuries among children aged 14 year and younger has fluctuated since 2005, from a low of 2.7 per 100,000 in 2006, to a high of 4.0 per 100,000 in 2005. MCH staff will work with injury prevention staff in the coming year to better understand why types of injuries are most prevalent in the state and to seek interventions that may impact this measure.

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	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	0.8	1.2	0.9	0.8	0.8
Numerator	5	8	6	5	5
Denominator	665901	672521	663576	660975	660975
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 - 2010
Source: CY2010 Vital Statistics data are not available. Used CT DPH final Vital Statistics data for 2009. Denominator is from July 1, 2009 census estimates for Connecticut.

Notes - 2009
Source: Final CY 2009 Vital Statistics data, updated Sept 2011.
Denominator is from July 1, 2009 census estimates for Connecticut.

Notes - 2008
Source: CT DPH Vital Statistics final CY2008 with denominator from 2008 DPH population estimates.

Narrative:

No updates have been made to this HSI narrative since 2010 not available. Update to be made in September 2011.

The death rate among children 14 years and younger due to motor vehicle accidents fluctuated from 2005 to 2009, from a low of 0.8 per 100,000 in 2006 to a high of 1.5 per 100,000 in 2005 and 2007. No trend is apparent.

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	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	20.8	15.8	15.6	10.5	10.5
Numerator	98	75	67	51	51
Denominator	472149	474211	428772	487560	487560
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 - 2010
Source: CY2010 Vital Statistics data are not available. Used CT DPH final Vital Statistics data for 2009, updated Sept 2011. Denominator is from July 1, 2009 census estimate for Connecticut.

Notes - 2009
Source: Final CY 2009 Vital Statistics data, updated Sept 2011. Denominator is from July 1, 2009 estimated census for Connecticut.

Notes - 2008
Source: CT DPH final Vital Statistics data CY2008.

Narrative:
No updates have been made to this HSI narrative since 2010 not available. Update to be made in September 2011.

The death rate per 100,000 for unintentional injuries among youth age 15 -- 24 years old due to motor vehicle crashes decreased since 2006 to a low of 14.1 in 2008 and 2009. New teen driving laws were implemented across the state in 2009, which may positively affect this measure.

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	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	235.9	228.8	231.6	216.0	225.5
Numerator	1571	1530	1537	1428	1498
Denominator	665901	668663	663576	660975	664405
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 - 2010
2010 Hospitalization data not available.
2010 Population estimates not available.
Used 3 year average of 2007, 2008, 2009 for both numerator and denominator (1530, 1537, 1428 and 668663, 663576, 660975, respectively).

Notes - 2009
Source: CY 2009 hospitalization data.

Hospital Discharge data: CT Hospital Association

Population Data: Backus, K, Mueller, LM (2010) State-level Bridged Race Estimates for Connecticut, 2009, Connecticut Department of Public Health, Office of Health Care Quality, Statistics, Analysis & Reporting, Hartford, CT.

Notes - 2008
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, 2008, by year, county, age, bridged race, Hispanic origin, and sex (Vintage 2008). Prepared under a collaborative arrangement with the U.S. Census Bureau; released May 14, 2009. Available from: http://www.cdc.gov/nchs/nvss/bridge_race.htm as of September 2, 2009.

Narrative:
No updates have been made to this HSI narrative since 2010 not available. Update to be made in September 2011.

The rate per 100,000 of all nonfatal injuries among children 14 year old and younger due to motor vehicle accidents fluctuated from a high of 235.9 per 100,000 in 2006 to a low of 220.4 per 100,000 in 2005. The rate was also reduced in 2007, 2008, and 2009.

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	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	18.3	18.8	17.3	13.2	16.4
Numerator	122	126	115	87	109
Denominator	665901	668663	663576	660975	664404
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 - 2010
2010 Hospital discharge data not available.
2010 Population estimates not available.
Used 3 year average for numerator and denominator (126, 115, 87 and 668663, 663576, 660975, respectively).

Notes - 2009
Source: CY 2009 hospitalization data.
Hospital Discharge data: CT Hospital Association

Population data: Backus, K, Mueller, LM (2010) State-level Bridged Race Estimates for Connecticut, 2009, Connecticut Department of Public Health, Office of Health Care Quality, Statistics, Analysis & Reporting, Hartford, CT.

Notes - 2008
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, 2008, by year, county, age, bridged race, Hispanic origin, and sex (Vintage 2008). Prepared under a collaborative arrangement with the U.S. Census Bureau; released May 14, 2009. Available from: http://www.cdc.gov/nchs/nvss/bridge_race.htm as of September 2, 2009.

Narrative:
No updates have been made to this HSI narrative since 2010 not available. Update to be made in September 2011.

The rate per 100,000 of nonfatal injuries due to motor vehicle accidents among youth aged 15 -- 24 years old fluctuated in 2005 and 2006, but has remained constant from 2007 through 2009 at 18.8 per 100,000. New teen driving laws, as well as a new law prohibiting hand-held phones, may positively affect this measure.

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	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	123.7	148.7	136.0	113.8	133.2
Numerator	584	705	583	505	598
Denominator	472149	474211	428772	443810	448931
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 - 2010
2010 Hospital discharge data not available.
2010 Population data not available.

Used 3 year average for numerator and denominator (705, 583, 505 and 474211, 428772, 443810, respectively).

Notes - 2009
Source: CY 2009 hospitalization data.
Hospital Discharge data: CT Hospital Association

Population Data: Backus, K, Mueller, LM (2010) State-level Bridged Race Estimates for Connecticut, 2009, Connecticut Department of Public Health, Office of Health Care Quality, Statistics, Analysis & Reporting, Hartford, CT.

Notes - 2008
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, 2008, by year, county, age, bridged race, Hispanic origin, and sex (Vintage 2008). Prepared under a collaborative arrangement with the U.S. Census Bureau; released May 14, 2009. Available from: http://www.cdc.gov/nchs/nvss/bridge_race.htm as of September 2, 2009.

Narrative:
No updates have been made to this HSI narrative since 2010 not available. Update to be made in September 2011.

The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth 15-24 years old increased from a low of 123.7 per 100,000 in 2006 to a high of 148.7 per 100,000 in 2007, 2008, and 2009. New teen driving laws in the state may positively affect this measure in the future.

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	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	25.0	31.6	32.5	32.5	30.3
Numerator	3025	3328	3426	3427	3190
Denominator	120767	105335	105335	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 - 2010
Source: 2010 CT DPH STD MIS, CT STD Control Program. Denominator from 2000 Census.

Notes - 2009
Source: 2009 CT DPH STD MIS, CT STD Control Program. Denominator from 2000 Census.

Notes - 2008

Source: 2008 CT DPH STD MIS, CT STD Control Program
denominator = 2000 Census.

Narrative:
The rate per 1,000 women aged 15-19 years old with a reported case of Chlamydia has generally increased from a low of 25.0 per 1,000 in 2006 to a high of 32.5 per 1,000 in 2008 and 2009. There was a slight drop in the rate in this sexually-transmitted disease in 2010. It is too early to assume the trend has been reversed.

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	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	8.3	8.1	8.9	8.9	9.5
Numerator	4886	4996	5511	5487	5857
Denominator	589349	617215	617215	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 - 2010
Source: 2010 CT DPH STD MIS, CT STD Control Program. Denominator from 2000 Census.

Notes - 2009
Source: 2009 CT DPH STD MIS, CT STD Control Program. Denominator from 2000 Census.

Notes - 2008
Source: 2008 CT DPH STD MIS, CT STD Control Program
denominator = 2000 Census.

Narrative:
Similar to HIS #05A, the rate per 1,000 women aged 20-24 years old with a reported case of Chlamydia has fluctuated since 2005, but has shown a general increase to a high of 8.9 per 1,000 in 2008 and 2009. The continued increase for 2010 is not an encouraging sign. Interventions are needed to stem the increase in this STD among this age group.

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	41216	31222	6129	244	2050	61	1510	0
Children 1	169254	130821	22299	1083	8426	189	6436	0

through 4								
Children 5 through 9	219783	174310	26678	1284	9968	246	7297	0
Children 10 through 14	230722	185434	29236	965	8511	232	6344	0
Children 15 through 19	253973	205976	33569	1150	7605	268	5405	0
Children 20 through 24	233587	188611	30889	1127	8342	286	4332	0
Children 0 through 24	1148535	916374	148800	5853	44902	1282	31324	0

Notes - 2012
Source: 2009 US Census Bureau population estimates. SC-EST2009-alldata6-AL_ID.

2010 data is not available, so 2009 data was used as provisional data for 2010.

Source: 2009 US Census Bureau population estimates. SC-EST2009-alldata6-AL_ID.

2010 data is not available, so 2009 data was used as provisional data for 2010.

Source: 2009 US Census Bureau population estimates. SC-EST2009-alldata6-AL_ID.

2010 data is not available, so 2009 data was used as provisional data for 2010.

Source: 2009 US Census Bureau population estimates. SC-EST2009-alldata6-AL_ID.

2010 data is not available, so 2009 data was used as provisional data for 2010.

Source: 2009 US Census Bureau population estimates. SC-EST2009-alldata6-AL_ID.

2010 data is not available, so 2009 data was used as provisional data for 2010.

Source: 2009 US Census Bureau population estimates. SC-EST2009-alldata6-AL_ID.

2010 data is not available, so 2009 data was used as provisional data for 2010.

Narrative:
Among all children 0-24 years old in Connecticut, 13.0% were Black/African American, 0.5% were American Indian, 3.9% were Asian, 0.1% were Native Hawaiian/Other Pacific Islander, and 2.7% were of multiple races. The majority (79.8%) of children 0-24 years old were of White/Caucasian race. The concentration percentage of Black/African American children was among infants (14.9% of all races), compared to a range of 12.1% to 13.2% among other age groups. The highest percentage of Asian children was among infants and the 1-4 year old age groups. In sharp contrast, the highest percentage of White/Caucasian children was among teens aged 15-19 years. This indicates a shift in the state's childhood population toward minority races, and emphasizes the need for culturally sensitive public health interventions.

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	31308	9408	0
Children 1 through 4	133104	36150	0
Children 5 through 9	180311	39472	0
Children 10 through 14	193781	36851	0
Children 15 through 19	215138	38835	0
Children 20 through 24	196384	37203	0
Children 0 through 24	950026	197919	0

Notes - 2012
Source: 2009 US Census Bureau population estimates. SC-EST2009-alldata6-AL_ID.

2010 data is not available, so 2009 data was used as provisional data for 2010.

Source: 2009 US Census Bureau population estimates. SC-EST2009-alldata6-AL_ID.

2010 data is not available, so 2009 data was used as provisional data for 2010.

Source: 2009 US Census Bureau population estimates. SC-EST2009-alldata6-AL_ID.

2010 data is not available, so 2009 data was used as provisional data for 2010.

Source: 2009 US Census Bureau population estimates. SC-EST2009-alldata6-AL_ID.

2010 data is not available, so 2009 data was used as provisional data for 2010.

Source: 2009 US Census Bureau population estimates. SC-EST2009-alldata6-AL_ID.

2010 data is not available, so 2009 data was used as provisional data for 2010.

Source: 2009 US Census Bureau population estimates. SC-EST2009-alldata6-AL_ID.

2010 data is not available, so 2009 data was used as provisional data for 2010.

Narrative:
Of all children aged 0-24 years in Connecticut, the percent of Hispanic/Latino children was 17.2%. Compared to this overall percentage among all ages, the percent of Hispanic/Latino infants was 22.8%. No other age category had such a high concentration of Hispanic/Latino children. This indicates that the demographics of the childhood population is shifting toward more ethnic minorities, and culturally-sensitive and linguistically-sensitive public health interventions are needed.

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	22	15	6	0	0	0	0	1
Women 15 through 17	764	544	194	1	2	1	0	22
Women 18 through 19	1834	1290	465	8	1	6	0	64
Women 20 through 34	27738	21447	3795	228	295	1347	0	626
Women 35 or older	8201	6702	820	37	169	355	0	118
Women of all ages	38559	29998	5280	274	467	1709	0	831

Notes - 2012

Narrative:
Among all births in the state, 78% were to White/Caucasian women and 13.7% were to Black/African American mothers. Black/African American mothers age 18-19 had almost 3 times the number of births comapred to White/Caucasion mothers (8.8% vs. 3.3%). Most American Indian and Native Hawaiian mothers were 20-34 years old, and most Asian mothers were at least 20 years of age. These data indicate that culturally-sensitive messages also need age-appropriate, in which messages to Black/African American mothers should be directed at younger ages.

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	10	12	0
Women 15 through 17	340	423	1
Women 18 through 19	989	842	3
Women 20 through 34	21316	6313	109
Women 35 or older	7204	962	35
Women of all ages	29859	8552	148

Notes - 2012

Narrative:
Among all births in the state, 22.3% were to women of Hispanic/Latino ethnicity. More than half (55.4%) of all births to teens 15-17 years were to Hispanic/Latinos. Fifteen percent (14.9%) of all births to Hispanic/Latinos were to women under age 20, the majority of which were to females 18-19 years (9.9%); 4.9% of births were to Hispanic/Latinos 15-17 years. In comparison, 4.5% of all births to non-Hispanic/Latino women were under age 20. These data indicate that culturally-sensitive messages to
Hispanic/Latino mothers need to include messages to teens.

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	215	127	63	0	1	3	0	21
Children 1 through 4	27	12	6	0	0	2	0	7
Children 5 through 9	27	19	5	0	0	1	0	2
Children 10 through 14	15	13	1	0	0	1	0	0
Children 15 through 19	91	72	6	0	0	3	0	10
Children 20 through 24	170	112	32	1	0	2	0	23
Children 0 through 24	545	355	113	1	1	12	0	63

Notes - 2012

Narrative:
Among deaths to children ages 0-24 years in Connecticut, 67.6% are to White/Caucasian children, while 21.5% are to Black/African American children. A smaller percentage of childhood deaths occurred to Hawaiian/Other Pacific Islanders (2.3%), American Indian/Native Alaskans (0.2%), and Asians (0.2%). The highest concentration of deaths to White/Caucasian, Black/African American, and Asian children occurred among infants. The highest concentration of deaths to Hawaiian/Other Pacific Islanders was among infants and among children aged 15-19 years. The highest concentration of deaths to American Indian/Native Alaskans was youth aged 20-24 years.

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 deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	153	58	4
Children 1 through 4	16	8	3
Children 5 through 9	17	10	0
Children 10 through 14	13	2	0
Children 15 through 19	67	21	3
Children 20 through 24	139	27	4
Children 0 through 24	405	126	14

Notes - 2012

Narrative:
Among deaths to children 0-24 years old in Connecticut, 24.2% were to Hispanic/Latino children. The highest percentage of deaths to Hispanic/Latino children were to infants (46.0%), followed by children aged 15-19 years (16.7%) and 20-24 years (21.4%).

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	914948	727763	117911	4726	36560	996	26992	0	2009
Percent in household headed by single parent	7.4	5.4	18.7	0.0	3.2	0.0	21.5	0.0	2009
Percent in TANF (Grant) families	100.0	68.1	29.4	0.6	1.4	0.2	0.2	0.0	2010
Number enrolled in Medicaid	263582	196895	56880	1387	7865	278	277	0	2010
Number enrolled in SCHIP	15460	10768	1800	25	635	23	236	1973	2009
Number living in foster home care	4738	2766	1482	6	20	2	410	52	2010
Number enrolled in food stamp program	139999	100335	36262	747	2331	163	161	0	2010
Number enrolled in WIC	41888	27544	10015	2028	926	521	854	0	2010
Rate (per 100,000) of juvenile crime arrests	3498.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2009
Percentage of high school drop-outs (grade 9 through 12)	1.8	1.2	3.1	2.0	1.3	0.0	0.0	0.0	2008

Notes - 2012
Source: Connecticut Population Estimates for April 1, 2009 from the US Census Bureau, Population Division, SC-EST2009-alldate6: Annual State Resident Population Estimates for 6 Race Groups by Age, Sex, and Hispanic Origin: April 1, 2000 to July 1, 2009
From Jon Olson, CT DPH, HQSAR unit

Source: US Census Bureau, American Community Survey
S0201. Selected Population Profile in the United States
Data Set: 2009 American Community Survey 1-Year Estimates
Notes: Per ACS protocols, numbers for American Indian or Native Alaskan and Native Hawaiian or Other Pacific Islander race groups are not reported because the total population falls below the reporting threshold of 65,000.
Other and Unknown are not reported in ACS.

Source: Connecticut Department of Social Services, September 2010 TFA data from DMF 8017I. Since the percent of TANF families out of all CT families is unknown, the Total All Races percent of TANF families is shown as 100%.

Source: CT Department of Social Services, HCFA Medicaid data from September 2010, DMF8017l)

2010 data not available from the CT Department of Social Services. Data presented (2009) are what were reported in last year's application.

Source: Connecticut Department of Social Services, September 2010 Supplemental Nutritional Assistance Program data from DMF 8017I.

Source: CT DPH Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Susan Hewes
Calendar Year 2010
Numbers are 12-month average of monthly closeout counts for infants (<1 yr old) and children ages 1 through 5 years enrolled in WIC.

Source: CT Department of Public Safety, Uniform Crime Reports
www.dpsdata.ct.gov/dps/ucr/ucr.aspx
2008 and 2009 data reported
Notes: Data for juvenile offenders not available by race or ethnicity. Number represents the total rate for all arrests for children 0 through 19 years of age at the time of the arrest.

Source: State Department of Education, Connecticut, Annual Dropout Rates, class year 2007-08. The annual rate reflects all high school students (grades 9 through 12) who dropped out during a school year, including the preceding summer. The total dropout count is divided by the total grade 9 through grade 12 enrollment for October 1 of the school year. Rate is presented as a percentage.
Note: Race/ethicity counted as either White, Black, American Indian, Asian American, or Hispanic, so percentages do not add up to 100%.

Source: Connecticut Department of Children and Families, data as of July 1, 2010.
Represents all children <20 years old in foster care regardless of reason.

Narrative:
Among children 0-19 years old, 7.4% were living in single households. More than one-fifth of multiple races, 18.7% of Black/African Americans, 5.4% of White/Caucasians, and 3.2% of Asian children aged 0-19 years lived in a single parent household. Almost thirty percent (29.4%) of children 0-19 in TANF families were Black/African American (29.4%). The statewide percentage of high school drop-outs was 1.8%. The highest dropout rate was in Black/African American population (3.1%), followed by American Indians (2.0%), Asians (1.3%), and White/Caucasians (1.2%). These data indicate the children living in high-risk households in the state are more likely to be of minority race, and emphasize the need for culturally-sensitive interventions.

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 Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	754232	160716	0	2009
Percent in household headed by single parent	6.1	19.2	0.0	2009
Percent in TANF (Grant) families	58.6	41.4	0.0	2010
Number enrolled in Medicaid	180722	82859	0	2010
Number enrolled in SCHIP	11863	3441	156	2009
Number living in foster home care	3208	1530	0	2010
Number enrolled in food stamp program	91043	48955	0	2010
Number enrolled in WIC	21020	20867	0	2010
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	0.0	2009
Percentage of high school drop-outs (grade 9 through 12)	0.0	4.0	0.0	2008

Notes - 2012
Source: Connecticut Population Estimates for April 1, 2009 from the US Census Bureau, Population Division, SC-EST2009-alldate6: Annual State Resident Population Estimates for 6 Race Groups by Age, Sex, and Hispanic Origin: April 1, 2000 to July 1, 2009
From Jon Olson, CT DPH, HQSAR unit

Source: US Census Bureau, American Community Survey
S0201. Selected Population Profile in the United States
Data Set: 2009 American Community Survey 1-Year Estimates
Notes: Other and Unknown are not reported in ACS.

Source: CT Department of Social Services, TFA data from September 2010, DMF8017l)

Source: CT Department of Social Services, HCFA Medicaid data from September 2010, DMF8017l)

2010 data not available from the CT Department of Social Services. Data presented (2009) are what were reported in last year's application.

Source: CT Department of Social Services, Supplemental Nutritional Assistance Program data from September 2010, DMF8017l)

Source: CT DPH Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Susan Hewes
Calendar Year 2010
Numbers are 12-month average of monthly closeout counts for infants (<1 yr old) and children ages 1 through 5 years enrolled in WIC.

Notes: Data for juvenile offenders not available by ethnicity so no numbers are available for this HSI.

Source: State Department of Education, Connecticut, Annual Dropout Rates, class year 2007-08. The annual rate reflects all high school students (grades 9 through 12) who dropped out during a school year, including the preceding summer. The total dropout count is divided by the total grade 9 through grade 12 enrollment for October 1 of the school year. Rate is presented as a percentage.
Note: Race/ethicity counted as either White, Black, American Indian, Asian American, or Hispanic, so percentages do not add up to 100%.

Source: Connecticut Department of Children and Families, data as of July 1, 2010. Represents all children <20 years old in foster care regardless of reason.

Narrative:
Nearly one-fifth (19.2%) of Hispanic children aged 0-19 years old were living in a single parent household, and 4.0% were high school dropouts. Among children living in TANF families, 41.4% were Hispanic/Latino. These data indicate the Hispanic/Latino children 0-19 years old are living in high-risk households in CT, and emphasize the need for culturally-sensitive interventions.

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	841115
Living in urban areas	798021
Living in rural areas	118780
Living in frontier areas	0
Total - all children 0 through 19	916801

Notes - 2012
Source: CT 2009 data from American Community Survey; (http://factfinder.census.gov); From Table B01001 SEX BY AGE. Using geo components from the options drop down and then selecting Urban, Rural, In Metropolitain Statistical Area. Table results were posted into Excel to obtain subtotals for the 0-19 yesr olds. (It appears the american Community Survey was not the data source used in the FFY 2009 MCHBG Application).

Source: CT 2009 data from American Community Survey; (http://factfinder.census.gov); From Table B01001 SEX BY AGE. Using geo components from the options drop down and then selecting Urban, Rural, In Metropolitain Statistical Area. Table results were posted into Excel to obtain subtotals for the 0-19 yesr olds. (It appears the american Community Survey was not the data source used in the FFY 2009 MCHBG Application).

Source: CT 2009 data from American Community Survey; (http://factfinder.census.gov); From Table B01001 SEX BY AGE. Using geo components from the options drop down and then selecting Urban, Rural, In Metropolitain Statistical Area. Table results were posted into Excel to obtain subtotals for the 0-19 yesr olds. (It appears the american Community Survey was not the data source used in the FFY 2009 MCHBG Application).

Source: CT 2009 data from American Community Survey; (http://factfinder.census.gov); From Table B01001 SEX BY AGE. Using geo components from the options drop down and then selecting Urban, Rural, In Metropolitain Statistical Area. Table results were posted into Excel to obtain subtotals for the 0-19 yesr olds. (It appears the american Community Survey was not the data source used in the FFY 2009 MCHBG Application).

Narrative:
Of all children in Connecticut ages 0-19 years, 91.7% lived in metropolitan areas of the state, and 87.0% lived in urban areas. Only 13.0% lived in rural areas. These data indicate that public health interventions implemented in urban areas of the state are more likely to reach the largest proportion of the childhood population.

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	3409901.0
Percent Below: 50% of poverty	4.4
100% of poverty	9.4
200% of poverty	21.1

Notes - 2012
Source: U.S. Bureau of Census 2009 American Community Survey, Table #S1701.

Source: U.S. Bureau of Census 2009 American Community Survey, Table #S1701.

Source: U.S. Bureau of Census 2009 American Community Survey, Table #S1701.

Source: U.S. Bureau of Census 2009 American Community Survey, Table #S1701.

Narrative:
Across the state of Connecticut, 4.4% of its population was living below 50% of the federal poverty level, 9.4% were living below the 100% federal poverty level, and 21.1% were living below the 200% federal poverty level.

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	799678.0
Percent Below: 50% of poverty	5.6
100% of poverty	12.1
200% of poverty	21.1

Notes - 2012
Source: U.S. Bureau of Census 2009 American Community Survey, Table #S1703.

Source: U.S. Bureau of Census 2009 American Community Survey, Table #S1703.

Source: U.S. Bureau of Census 2009 American Community Survey, Table #S1703.

Source: U.S. Bureau of Census 2009 American Community Survey, Table #S1701.

Narrative:
Across the state of Connecticut, 5.6% of its children were living below the 50% federal poverty level, 12.1% were living below the 100% federal poverty level, and 21.1% were living below the 200% federal poverty level. Compared to HSI #11, these data suggest that children in the state are more likely to live in poverty and are at risk for poor short-term outcomes than adults.

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 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 available to evaluate appropriate asthma diagnosis and medical management and patient self-management education for children diagnosed with asthma.

The Connecticut Breast and Cervical Cancer Early Detection Program provides screening, diagnostic and treatment referral services through 14 major health care facilities and over 350 clinical subcontractors throughout the state. The Program also provides case management, patient and public education and outreach targeting uninsured and underinsured Connecticut women, as well as professional education and quality assurance.

The Childhood Lead Poisoning Prevention and Control 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. CLPPCP also provides regulatory oversight and consultative services, and funding support for two Regional Lead Treatment Centers. The program's major goal is to eliminate elevated blood lead levels (>10mcg/dL) in children less than 6 years of age in CT by 2010.

Chlamydia Infertility Prevention provides free chlamydia screening and treatment services to females and their partners who attend targeted Planned Parenthood clinics. Free services are available at clinics to uninsured sexually active females 25 years of age and younger and their sexual partners.

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.

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.
DPH worked the Governor's Collaboration for Young Children to establish the Healthy Child Care CT (HCC-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 HCC-CT leadership team, which 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. HCC-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.

The 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 local health departments, health districts, and a regional community provider to conduct activities to raise immunization rates. The Vaccines for Children (VFC) provides free vaccines to over 600 health care providers. The CT Immunization Registry and Tracking System records and tracks all CT children's immunizations.

DPH contracts with the Connecticut Women's Consortium, Inc. to provide intimate partner violence prevention curricula to incarcerated women at the York Correctional Institute (YCI), to women recently released from YCI who live in halfway houses and resettlement programs, and to staff of these community based agencies.

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.

Ryan White Care Act: Provides federal support for comprehensive health and support services for people living with HIV/AIDS, including women, infants and children.

Sexual Assault Prevention and Intervention Services: DPH contracts with the CT Sexual Assault Crisis Services, Inc., to coordinate primary prevention education and direct services to victims of rape and other sexual assaults. DPH is implementing the Sexual Violence Prevention Plan (2009-2017).

The WIC Program: Serves approximately 60,000 participants through 12 agencies located throughout the State. The program provides food, nutrition, breastfeeding and health education, and referral services for individuals found to be at nutritional and/or medical risk. Eligible clients are defined as pregnant, breastfeeding and postpartum women, and infants and children up to age five.

WISEWOMAN (The Well-Integrated Screening and Evaluation for Women Across the Nation Program): Provides cardiovascular disease risk reduction screening and lifestyle modification intervention services to uninsured and underinsured women at health care provider sites.

G. Technical Assistance

During the FFY 2010, CT was fortunate to receive technical assistance in the following areas:

1. Children and Youth with Special Health Care Needs
Technical assistance was received to facilitate a planning retreat for the Medical Home Advisory Council in October 2010. Peggy Hayden, an independent consultant familiar with CT services (Ms. Hayden has previous experience facilitating planning for the state's UCEDD and the SDE) provided on site facilitation during the retreat as well as a week of planning and consultation. Over 40 family advocates, providers, and representatives of state and private agencies, community based organizations, and Managed Care Organizations attended the retreat. The Council's Mission Statement was revised and a work plan developed including priority goals for

the next year. The work plan will support the integration of services for CYSHCN and the implementation of Person Centered Medical Home for CT's Medicaid enrollees.

Technical Assistance requests for the next year will focus on:

1. CYSHCN
Contracted community based medical home partners have varying levels of knowledge regarding Health Reform, the Affordable Care Act, and the potential impact on health financing resources available to CYSHCN. This TA will utilize expertise (possibly through the Catalyst Center) to provide a workshop for the purpose of strengthening the knowledge of medical home care coordinators and other community partners.

2. Adolescent Health
Protecting and enhancing the overall health and well-being of adolescents is a priority of the Department. The Legislative Program Review and Investigations Committee voted to undertake a study of adolescent health in CT in 2011. This study will focus on evaluating services for meeting the health care needs of CT adolescents with an emphasis on improving the physical health of adolescents. Adolescent health issues affect multiple programs and units within the FHS. This TA will utilize the expertise of consultants to enhance program staff and community partners' knowledge of factors that impact adolescent's development over the life course as well as help guide strategic planning around reproductive health.

3. Pregnant Women
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 for a stronger collaboration with the DPHs Tobacco Cessation Program.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2010		FY 2011		FY 2012	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	4729890	4459931	4748137		4693379	
2. Unobligated Balance *(Line2, Form 2)*	450581	450581	166438		288206	
3. State Funds *(Line3, Form 2)*	7100000	7100000	7095000		7940000	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	0	0	0		0	
7. Subtotal	12280471	12010512	12009575		12921585	
8. Other Federal Funds *(Line10, Form 2)*	6778683	6778683	2284695		3197317	
9. Total *(Line11, Form 2)*	19059154	18789195	14294270		16118902	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2010		FY 2011		FY 2012	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	988779	850681	772130		856774	
b. Infants < 1 year old	1316142	1243050	1230464		1084061	
c. Children 1 to 22 years old	5854736	5842485	5810242		7037242	
d. Children with	3825901	3788416	3917316		3647950	

Special Healthcare Needs						
e. Others	58628	95022	45827		48354	
f. Administration	236285	190858	233596		247204	
g. SUBTOTAL	12280471	12010512	12009575		12921585	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	100000		100000		100000	
c. CISS	0		0		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	750000		750000		750000	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	595977		582991		306016	
j. Education	0		0		0	
k. Other						
ECP	105000		132000		140000	
EHDI	149988		299874		300000	
Home Visiting	0		0		855073	
PCO	119830		119830		149788	
PREP	0		0		596440	
CYSHCN Integration	299506		300000		0	
FirstTime Motherhood	500000		0		0	
Immunizations	4158382		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2010		**FY 2011**		**FY 2012**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	4503220	4645449	4487936		4514936	
II. Enabling Services	2211755	2252771	2230771		2247454	
III. Population-Based Services	821126	787727	952809		764366	
IV. Infrastructure Building Services	4744370	4324565	4338059		5394829	
V. Federal-State Title V Block Grant Partnership Total	12280471	12010512	12009575		12921585	

A. Expenditures

There were several overall factors that impacted the actual expenditures in comparison to the FFY2010 budget. Details specific to any significant (>10%) expenditure variations on each of the Budget Forms are described below.

Form 4

FFY10 expenditures were less than the budgeted amount for Pregnant Women, and greater for All Others, due to the reallocation of carryover funds to activities that had a slightly different focus compared to our original plans.

FFY10 Administration expenditures were less than the budgeted amount due to one position being split-funded with other grants.

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 $7,940,000 for FFY2012. For FFY2010, 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 FFY2010. The Maintenance of Effort amount for FFY2010 is $7,100,000 (maintenance of effort total includes the matching).

State-funded programs that serve the maternal and child health population include: Community Health Centers, Lead Poisoning Prevention, Asthma, Genetic Sickle Cell Program, 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 FFY2012. The federal allocation for FFY2012 is $4,693,379, which means that the State of Connecticut must match with at least $3,520,034. Maintenance of Effort for FFY2012 is in the amount of $21,500,362, which is $14,723,171 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; Primary Care Office; Rape Prevention and Education; Universal Newborn Hearing Screening; State Systems Development Initiative (SSDI); Personal Responsibility Education Program (PREP); Maternal, Infant, and Early Childhood Home Visiting; 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 FFY2012 award amount, $1,475,321(31.43%) is allocated for Preventive and Primary Care for Children; and $1,813,800 (38.65%) for the CSHCN program. There is an allocation of administrative costs of $247,204 (5.27%) of the projected federal allocation to all programs.

In FFY2012, the federal allocation is $4,693,379 plus using $288,206 of the carry forward from FFY2010 funds for a total of $4,981,585 of federal funding. When combined with the state funds of $7,940,000 there is a federal-state block grant partnership total of $12,921,585.

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.