

Directory of  
CONNECTICUT  
PUBLIC HEALTH PLANS



Connecticut Department of Public Health  
Planning Branch, Planning and Workforce Development Section

2009

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*Directory of*

CONNECTICUT  
PUBLIC HEALTH PLANS

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# THE CONNECTICUT HEALTH PLANNING DATABASE PROJECT

## **The Need**

In Connecticut, responsibility for health planning, health programs, and health services is divided among several agencies. Within individual agencies, planning often is categorical by disease, condition, population group, or type of service, in accordance with federal and State funding streams. As a result, inter- and intra-agency overlap of activities is common, with the same diseases, health conditions, population health issues, or services being addressed by several agencies or several programs within a single agency. Across and within agencies, administrative and organizational infrastructure largely is fragmented, resources—including staff and funding—are inadequate, different data are used for decision-making about the same subject, information is not always shared, and efforts may be duplicative and lacking coordination.

The U.S. Department of Health and Human Services and other federal agencies have launched initiatives to address these problems through coordinated public health planning through stakeholder coalitions; however, many areas are not yet involved.

## **Addressing the Need**

In 2009, the Planning Branch of the Connecticut Department of Public Health (DPH) initiated the Connecticut Health Planning Database Project. The purpose of the project is to encourage and facilitate collaboration among State agencies with similar programs and services and among related programs within the same agency. This is achieved through a clearinghouse of statewide health planning efforts that identifies mutual priorities, goals, objectives, and strategies for addressing public health issues.

In Phase 1 of the project, completed in May, 2009, twelve Connecticut State Agencies and Offices with published health-related plans were identified, and an inventory of the plans was compiled in database format.

The *Directory of Connecticut Public Health Plans* represents Phase 2 of the project. It contains key information from the database about plans issued by the Connecticut Department of Public Health; lists of priorities, goals, objectives, strategies, and/or recommendations excerpted from the plans; and cross-tabulations of plans by subject and target population.

In 2010, Phase 3, a companion directory of health-related plans issued by agencies other than DPH will be developed. Phase 4 will involve production of an inventory and directory of Connecticut surveillance reports and health assessments, the data from which can be applied consistently, across programs and agencies, to inform planning and decision-making.

## HOW TO USE THIS DIRECTORY

The *Directory of Connecticut Public Health Plans* is intended for use by State agencies and offices, by programs within each agency, and by health-related organizations in the private sector, to identify where and by whom goals, objectives, and priorities similar to their own have been targeted for action in plans developed by the Connecticut Department of Public Health. This will promote consistency among strategies and initiatives to improve overall public health and health programs for Connecticut residents. The Directory has three parts: the Keyword Index, the Target Population Index, and the Plan Abstracts.

**Keyword Index** is an alphabetical listing of topics addressed in the priorities, goals, objectives, strategies, and/or recommendations of one or more DPH plans, cross-referenced to the associated plans. The plans in which each topic can be found in the *Plan Abstracts* section of this Directory are listed below each keyword.

**Target Population Index** is an alphabetical listing of populations addressed in each plan, cross-referenced to the associated plans. The populations include groups characterized by age, sex, race, Hispanic ethnicity, socioeconomic status, program participation, health status, and other factors. The plans in which each population can be found in the *Plan Abstracts* section of this Directory are listed below each population name.

**Plan Abstracts** are arranged in alphabetical order by the subject of plan. This section consists of key information (taken from the Plan Database) and lists of priorities, goals, objectives, strategies, and recommendations excerpted from the plans. The latter are given in the language and organization as written in the plans. Each abstract contains the following information:

- Subject of plan
- Title of plan
- Publication date
- Web location (Hyperlink to the full plan, if available on the DPH web site)
- Authority for the plan (Federal, State, or other initiative behind the planning effort)
- Contact information (Name, phone number, and e-mail address)
- Listings of Priorities, Goals, Objectives, etc.

To identify where a particular health topic or population of interest has been included in a plan issued by the Department of Public Health, locate the item in the *Keyword Index* or *Target Population Index*, then view the specifics in the associated *Plan Abstracts*. Abstracts contain links to downloadable versions of the full plans, when available, on the DPH web site.



# KEYWORD INDEX



## KEYWORD INDEX

*This Index cross-references public health plans containing objectives or priorities related to the listed keywords. Refer to the Plan Abstracts section of this Directory for details about the plans and objectives. Plans that address specific population groups are listed in the Target Population Index.*

### -A-

- Abatement, asbestos and lead
  - Respiratory Protection*
  - Health Status and Health Services*
- Access to care or services
  - Adolescent Health*
  - Cancer*
  - Children, Birth to 5 Years*
  - Genomics and Genetics (1)*
  - Genomics and Genetics (2)*
  - HIV/AIDS*
  - Injury*
  - Low Birthweight*
  - Maternal and Child Health Services*
  - Newborn Hearing Screening*
  - Oral Health (1)*
  - Oral Health (2)*
  - Perinatal Health*
  - Health Status and Health Services*
  - Stroke*
  - Suicide*
  - Tobacco*
- Access to food
  - Nutrition Education*
- Acquired immune deficiency syndrome
  - HIV/AIDS*
- Addiction
  - Tobacco*
- Adolescent health
  - Adolescent Health*
  - Maternal and Child Health Services*
- Adolescent paternity
  - Maternal and Child Health Services*
- AIDS
  - HIV/AIDS*
  - Health Status and Health Services*
- Air pollution
  - Environmental Public Health Tracking*
- Air quality
  - Environmental Public Health Tracking*
- Airborne particulate hazards
  - Respiratory Protection*
- Alcohol use, abuse
  - Adolescent Health*
  - Cancer*
  - Injury*
  - Health Status and Health Services*
- Alcohol, binge drinking
  - Cancer*
- Alternative medicine
  - Sickle Cell Disease*
- Anemia
  - WIC*
- Arthritis
  - Arthritis*
- Asbestos
  - Respiratory Protection*
- Assault
  - Injury*
  - Preventive Health and Health Services*
  - Sexual Violence*
- Asthma
  - Asthma*
  - Environmental Public Health Tracking*
  - Maternal and Child Health Services*
  - Tobacco*

### -B-

- Barriers
  - Arthritis*
  - Children with Special Health Care Needs*
  - Genomics & Genetics (2)*
  - HIV/AIDS*
  - Occupational Health*
  - Perinatal Health*
- Behavioral change
  - Nutrition Education*
- Behavioral health care
  - Suicide*
- Behavioral interventions
  - HIV/AIDS*
- Behavioral Risk Factor Surveillance System
  - Genomics and Genetics (1)*
  - Suicide*
  - Tobacco*

- Binge drinking
  - Cancer*
- Birth defects
  - Environmental Public Health Tracking*
  - Genomics and Genetics (1)*
- Birth outcomes
  - Children, Birth to 5 Years*
  - Perinatal Health*
- Birth-to-Three Program
  - Children, Birth to 5 Years*
  - Newborn Hearing Screening*
- Birthweight
  - Low Birthweight*
  - Maternal and Child Health Services*
  - Perinatal Health*
  - WIC*
- Blood lead levels
  - Lead Poisoning, Childhood*
  - Environmental Public Health Tracking*
- Blood lead screening
  - Lead Poisoning, Childhood*
  - Health Status and Health Services*
- Bloodstream infections, central line associated
  - Healthcare Associated Infections*
- Body mass index
  - Obesity*
  - Maternal and Child Health Services*
  - WIC*
- Breast cancer, screening
  - Cancer*
  - Health Status and Health Services*
- Breastfeeding
  - Maternal and Child Health Services*
  - Obesity*
  - WIC*
- Burns
  - Injury*
  - Occupational Health*
- C-**
- Calorie intake
  - Nutrition Education*
- Cancer
  - Cancer*
  - Environmental Public Health Tracking*
  - Preventive Health and Health Services*
  - Tobacco*
- Cancer planning
  - Preventive Health and Health Services*
- Cancer screening
  - Cancer*
  - Health Status and Health Services*
- Cancer signs and symptoms
  - Cancer*
- Cancer survivors
  - Cancer*
- Captain 5-A-Day program
  - Nutrition Education*
- Cardiovascular disease
  - Environmental Public Health Tracking*
  - Obesity*
  - Tobacco*
  - Arthritis*
- Care coordination
  - Maternal and Child Health Services*
- Case management
  - HIV/AIDS*
  - Lead Poisoning, Childhood*
  - Perinatal Health*
  - WIC*
- Certification
  - Emergency Medical Services*
  - WIC*
- Cervical cancer screening
  - Cancer*
  - Health Status and Health Services*
- Child maltreatment
  - Injury*
- Child neglect
  - Injury*
  - Lead Poisoning, Childhood*
- Child sexual abuse
  - Injury*
  - Sexual Violence*
- Childhood cancer survivors
  - Cancer*
- Childhood immunization
  - Maternal and Child Health Services*
- Childhood lead poisoning
  - Lead Poisoning, Childhood*
  - Preventive Health and Health Services*
- Children and youth with special health care needs
  - Maternal and Child Health Services*
- Children with special health care needs
  - Children with Special Health Care Needs*
  - Children, Birth to 5 Years*
  - Genomics & Genetics (1)*

- Genomics & Genetics (2)*
- Maternal and Child Health Services*
- Perinatal Health*
- Cholesterol
  - Preventive Health and Health Services*
  - Health Status and Health Services*
- Chronic disease
  - Arthritis*
  - Environmental Public Health Tracking*
  - Genomics & Genetics (1)*
  - Obesity*
  - Stroke*
  - Suicide*
  - Tobacco*
- Chronic disease control
  - Asthma*
  - Cancer*
  - Diabetes*
  - Emergency Medical Services*
  - Injury*
  - Lead Poisoning, Childhood*
  - Preventive Health and Health Services*
  - Tobacco*
- Chronic disease management
  - Obesity*
- Chronic disease prevention
  - Obesity*
  - Tobacco*
- Civil rights
  - WIC*
- Clinical genetics
  - Genomics and Genetics (2)*
- Clinical trials
  - Cancer*
  - Stroke*
- Clinics, occupational medicine
  - Occupational Health*
- Clinics, pediatric
  - Children, Birth to 5 Years*
- Clostridium difficile* infections
  - Healthcare Associated Infections*
- Colorectal cancer screening
  - Cancer*
  - Health Status and Health Services*
- Community health centers
  - Maternal and Child Health Services*
  - Nutrition Education*
- Complementary and alternative medicine
  - Sickle Cell Disease*
- Confidentiality
  - Genomics and Genetics (1)*
  - Suicide*
- Conflict resolution
  - Maternal and Child Health Services*
- Connecticut Tumor Registry
  - Tobacco*
- Continuity of operations
  - Influenza, Pandemic*
- Contraceptives
  - Perinatal Health*
- Costs, health care
  - Children, Birth to 5 Years*
  - Injury*
  - Lead Poisoning, Childhood*
  - Tobacco*
- Counseling, obesity
  - Obesity*
- Counseling, cholesterol
  - Preventive Health and Health Services*
- Counseling, high blood pressure
  - Preventive Health and Health Services*
- Counseling, genetic
  - Genomics & Genetics (1)*
  - Sickle Cell Disease*
- Counseling, tobacco cessation
  - Tobacco*
- Criminal justice
  - Suicide*
- Cultural competency
  - Adolescent Health*
  - Cancer*
  - Children, Birth to 5 Years*
  - Genomics and Genetics (1)*
  - Genomics and Genetics (2)*
  - HIV/AIDS*
  - Maternal and Child Health Services*
  - Perinatal Health*
  - Preventive Health and Health Services*
  - Sexual Violence*
  - Sickle Cell Disease*
- D-**
- Dairy food consumption
  - Nutrition Education*
- Data collection and use
  - Adolescent Health*
  - Arthritis*
  - Asthma*
  - Children, Birth to 5 Years*

- Diabetes*
- Emergency Medical Services*
- Environmental Public Health Tracking*
- Genomics & Genetics (1)*
- Genomics & Genetics (1)*
- HIV/AIDS*
- Injury*
- Maternal and Child Health Services*
- Obesity*
- Occupational Health*
- Perinatal Health*
- Preventive Health and Health Services*
- Sexual Violence*
- Health Status and Health Services*
- Suicide*
- Tobacco*
- WIC*
- Data exchange
  - Diabetes*
- Data standards
  - Healthcare Associated Infections*
  - WIC*
- Date rape
  - Injury*
  - Sexual Violence*
- Dating violence
  - Injury*
- Day care
  - Asthma*
- Day care, child
  - Maternal and Child Health Services*
- Death(s)
  - Asthma*
  - Cancer*
  - Injury*
  - Maternal and Child Health Services*
  - Preventive Health and Health Services*
  - Tobacco*
- Deaths, infant
  - Maternal and Child Health Services*
- Deaths, preventable
  - Cancer*
  - Emergency Medical Services*
  - Influenza, Pandemic*
  - Preventive Health and Health Services*
  - Suicide*
- Dental caries
  - Oral Health (1)*
  - Oral Health (2)*
  - Perinatal Health*
- Dental health workforce
  - Oral Health (1)*
  - Oral Health (2)*
  - Perinatal Health*
- Dental sealants
  - Maternal and Child Health Services*
  - Oral Health (1)*
  - Oral Health (2)*
- Depression
  - Maternal and Child Health Services*
  - Suicide*
- Depression, perinatal
  - Maternal and Child Health Services*
- Developmental disabilities
  - Environmental Public Health Tracking*
  - Perinatal Health*
- Developmental disorders
  - Environmental Public Health Tracking*
- Diabetes
  - Diabetes*
  - Obesity*
  - Preventive Health and Health Services*
  - Health Status and Health Services*
- Dietary fat, excess
  - Preventive Health and Health Services*
- Direct-to-consumer marketing
  - Genomics and Genetics (2)*
- Disabilities
  - Arthritis*
  - Children with Special Health Care Needs*
  - Environmental Public Health Tracking*
  - Injury*
  - Perinatal Health*
  - Preventive Health and Health Services*
  - Sexual Violence*
  - Stroke*
- Disability, preventable
  - Emergency Medical Services*
  - Preventive Health and Health Services*
  - Tobacco*
- Discrimination
  - Genomics and Genetics (1)*
  - Genomics and Genetics (2)*
  - Low Birthweight*
  - Sexual Violence*
  - WIC*
- Disease (*See also specific diseases*)
- Disease, neurological
  - Environmental Public Health Tracking*

## Disease, cardiovascular

*Environmental Public Health Tracking*  
*Obesity*  
*Preventive Health and Health Services*  
*Tobacco*

## Diseases, chronic

*Arthritis*  
*Environmental Public Health Tracking*  
*Genomics & Genetics (1)*  
*Obesity*  
*Stroke*  
*Suicide*  
*Tobacco*

## Diseases, infectious

*Genomics and Genetics (1)*  
*Healthcare Associated Infections*  
*Influenza, Pandemic*

## Diseases, non-infectious

*Environmental Public Health Tracking*

## Diseases, preventable

*Influenza, Pandemic*  
*Maternal and Child Health Services*  
*Preventive Health and Health Services*

## Disparities

*Asthma*  
*Cancer*  
*Oral Health (1)*  
*Oral Health (2)*  
*Tobacco*

## Disparities, geographic

*Maternal and Child Health Services*

## Disparities, racial and ethnic

*Arthritis*  
*Low Birthweight*  
*Maternal and Child Health Services*  
*Perinatal Health*  
*Preventive Health and Health Services*

## Domestic violence

*Injury*

## Drinking water

*Environmental Public Health Tracking*  
*Emergency Response, Public Health*

## Drowning

*Injury*

## Drug users, injection

*HIV/AIDS*

## Drugs, gateway

*Tobacco*

**-E-**

## Early detection

*Cancer*

## Economics

*Asthma*

*Injury*

*Tobacco*

## Education and training

*Arthritis*

*Asthma*

*Children with Special Health Care Needs*

*Diabetes*

*Emergency Medical Services*

*Genomics & Genetics (1)*

*Healthcare Associated Infections*

*HIV/AIDS*

*Maternal and Child Health Services*

*Newborn Hearing Screening*

*Nutrition Education*

*Obesity*

*Occupational Health*

*Oral Health (1)*

*Preventive Health and Health Services*

*Sexual Violence*

*Sickle Cell Disease*

*Stroke*

*Suicide*

*Tobacco*

*WIC*

## Education, community

*Stroke*

## Education, genetics and/or genomics

*Genomics & Genetics (1)*

*Maternal and Child Health Services*

## Education, nutrition

*Maternal and Child Health Services*

*Nutrition Education*

*WIC*

## Education, provider

*Adolescent Health*

*Arthritis*

*Asthma*

*Cancer*

*Diabetes*

*Emergency Medical Services*

*Newborn Hearing Screening*

*Oral Health (2)*

- Perinatal Health*
  - Sickle Cell Disease*
  - Stroke*
  - Tobacco*
  - Education, rape prevention
    - Sexual Violence*
  - Education, suicide prevention
    - Suicide*
  - Electronic medical records
    - Diabetes*
    - Health Information Technology*
  - Electronic reporting
    - Healthcare Associated Infections*
    - Occupational Health*
  - Emergency department visits
    - Asthma*
  - Elderly, services for
    - Health Status and Health Services*
  - Emergency medical services
    - Emergency Medical Services*
    - Preventive Health and Health Services*
    - Stroke*
    - Suicide*
  - Emergency medical services, pediatric
    - Emergency Medical Services*
  - Emergency preparedness
    - Emergency Response, Public Health*
    - Influenza, Pandemic*
  - Emergency response
    - Emergency Response, Public Health*
    - Influenza, Pandemic*
    - Suicide*
  - Emergency Support Function 8
    - Emergency Response, Public Health*
  - Endocrine disruption
    - Environmental Public Health Tracking*
  - End-of-life care
    - Cancer*
    - Suicide*
  - Environmental exposures
    - Cancer*
    - Environmental Public Health Tracking*
  - Environmental health
    - Environmental Public Health Tracking*
    - Genomics and Genetics (1)*
  - Environmental public health tracking
    - Environmental Public Health Tracking*
  - Environmental risks
    - Asthma*
  - Cancer*
  - Children, Birth to 5 Years*
  - Environmental tobacco smoke
    - Asthma*
    - Cancer*
    - Tobacco*
  - Epidemic
    - Influenza, Pandemic*
  - Exercise (*see also "physical activity"*)
    - Maternal and Child Health Services*
    - Obesity*
- F-**
- Falls
    - Injury*
    - Preventive Health and Health Services*
  - Family health history
    - Asthma*
    - Genomics and Genetics (1)*
    - Genomics and Genetics (2)*
  - Family violence
    - Injury*
  - Farmers' Market Nutrition program
    - WIC*
  - Fat, excess dietary
    - Preventive Health and Health Services*
  - Fetal development
    - WIC*
  - Fetal mortality
    - Perinatal Health*
  - Fibromyalgia
    - Arthritis*
  - Fires
    - Injury*
  - Flu
    - Influenza, Pandemic*
  - Food protection
    - Health Status and Health Services*
  - Food poisoning
    - Health Status and Health Services*
  - Foster care
    - Sexual Violence*
  - Fruit and vegetable consumption
    - Cancer*
    - Nutrition Education*
    - Stroke*
- G-**
- Gender equality
    - Sexual Violence*

- Genetic counseling
    - Genomics & Genetics (1)*
    - Sickle Cell Disease*
  - Genetic disorders
    - Genomics & Genetics (2)*
    - Maternal and Child Health Services*
  - Genetic testing
    - Genomics and Genetics (1)*
    - Genomics and Genetics (2)*
    - Newborn Hearing Screening*
  - Genetics
    - Asthma*
    - Genomics and Genetics (1)*
    - Genomics and Genetics (2)*
    - Maternal and Child Health Services*
    - Newborn Hearing Screening*
  - Genetics, clinical
    - Genomics and Genetics (2)*
  - Genomics
    - Genomics and Genetics (1)*
    - Genomics and Genetics (2)*
  - Guidelines
    - Asthma*
    - Cancer*
    - Diabetes*
    - Emergency Medical Services*
    - Newborn Hearing Screening*
    - Obesity*
    - Stroke*
- H-**
- Hazardous waste sites
    - Environmental Public Health Tracking*
  - Head Start program
    - Nutrition Education*
  - Health care costs
    - Children, Birth to 5 Years*
    - Injury*
    - Lead Poisoning, Childhood*
    - Tobacco*
  - Health insurance coverage
    - Emergency Medical Services*
    - Genomics and Genetics (1)*
    - Maternal and Child Health Services*
    - Newborn Hearing Screening*
    - Obesity*
    - Oral Health (2)*
    - Health Status and Health Services*
  - Stroke*
  - Tobacco*
  - Health literacy
    - Genomics and Genetics (1)*
    - Genomics and Genetics (2)*
    - Perinatal Health*
    - Sexual Violence*
  - Hearing disorders
    - Genomics and Genetics (1)*
    - Newborn Hearing Screening*
  - Hearing screening
    - Maternal and Child Health Services*
    - Newborn Hearing Screening*
  - Heart attack, signs and symptoms
    - Preventive Health and Health Services*
  - Heart disease (*See also* Cardiovascular disease)
    - Preventive Health and Health Services*
    - Tobacco*
  - Healthcare Associated Infections (*see also* Infections)
    - Healthcare Associated Infections*
  - Hemoglobinopathies, newborn
    - Genomics and Genetics (1)*
  - High blood pressure
    - Preventive Health and Health Services*
  - Hip fractures
    - Injury*
  - HIP-kids
    - Genomics and Genetics (1)*
    - Maternal and Child Health Services*
  - HIV
    - HIV/AIDS*
    - Health Status and Health Services*
  - HIV testing
    - HIV/AIDS*
  - Homeless children
    - Children, Birth to 5 Years*
  - Homicide
    - Injury*
  - Hospice care
    - Cancer*
    - Stroke*
  - Hospital-acquired infections
    - Healthcare Associated Infections*
  - Hospitalizations
    - Asthma*
    - Injury*
  - Human immunodeficiency virus
    - HIV/AIDS*



## Hypertension

*Preventive Health and Health Services*

**-I-**

## Immunizations

*Health Status and Health Services*

## Immunizations, childhood

*Lead Poisoning, Childhood*

*Maternal and Child Health Services*

## Immunization registry

*Lead Poisoning, Childhood*

*Maternal and Child Health Services*

## Inactivity (See also Physical activity)

*Obesity*

## Incidence

*Asthma*

*Cancer*

*Genomics and Genetics (1)*

*Injury*

*Maternal and Child Health Services*

*Obesity*

*Sexual Violence*

*Stroke*

*WIC*

## Income

*Asthma*

*Children, Birth to 5 Years*

*Maternal and Child Health Services*

*WIC*

## Indoor air laws

*Tobacco*

## Infant mortality

*Maternal and Child Health Services*

*Perinatal Health*

## Infections healthcare associated (See also specific types of infections)

*Healthcare Associated Infections*

## Infectious diseases

*Environmental Public Health Tracking*

*Genomics and Genetics (1)*

*Influenza, Pandemic*

*Health Status and Health Services*

## Influenza

*Influenza, Pandemic*

*Maternal and Child Health Services*

## Infoline

*Maternal and Child Health Services*

## Infrastructure, public health

*Health Status and Health Services*

*Healthcare Associated Infections*

## Injury

*Injury*

*Maternal and Child Health Services*

*Emergency Medical Services*

*Occupational Health*

*Preventive Health and Health Services*

*Health Status and Health Services*

## Insurance coverage (See Health insurance coverage)

## Intentional injuries

*Injury*

*Maternal and Child Health Services*

*Preventive Health and Health Services*

*Health Status and Health Services*

## Intimate partner violence

*Injury*

*Preventive Health and Health Services*

**-J-**

## Joint injuries

*Arthritis*

## Juvenile justice

*Suicide*

**-L-**

## Laboratory capacity

*Genomics and Genetics (1)*

## Laboratory, Connecticut State

*Lead Poisoning, Childhood*

## Landfill sites

*Environmental Public Health Tracking*

## Law enforcement

*Suicide*

*Tobacco*

## Laws, indoor air

*Tobacco*

## Lead

*Environmental Public Health Tracking*

*Lead Poisoning, Childhood*

*Preventive Health and Health Services*

*Respiratory Protection*

## Lead abatement

*Lead Poisoning, Childhood*

*Respiratory Protection*

## Lead poisoning

*Lead Poisoning, Childhood*

*Preventive Health and Health Services*

## Local health departments

*Emergency Response, Public Health*

*Genomics and Genetics (1)*

*Lead Poisoning, Childhood*

- Occupational Health*
- Preventive Health and Health Services*
- Tobacco*
- Low birthweight
  - Low Birthweight*
  - Maternal and Child Health Services*
  - Perinatal Health*
  - WIC*
- Lung cancer
  - Cancer*
  - Preventive Health and Health Services*
- M-**
- Mammography
  - Cancer*
- Managed care (*See also* Medicaid Managed Care)
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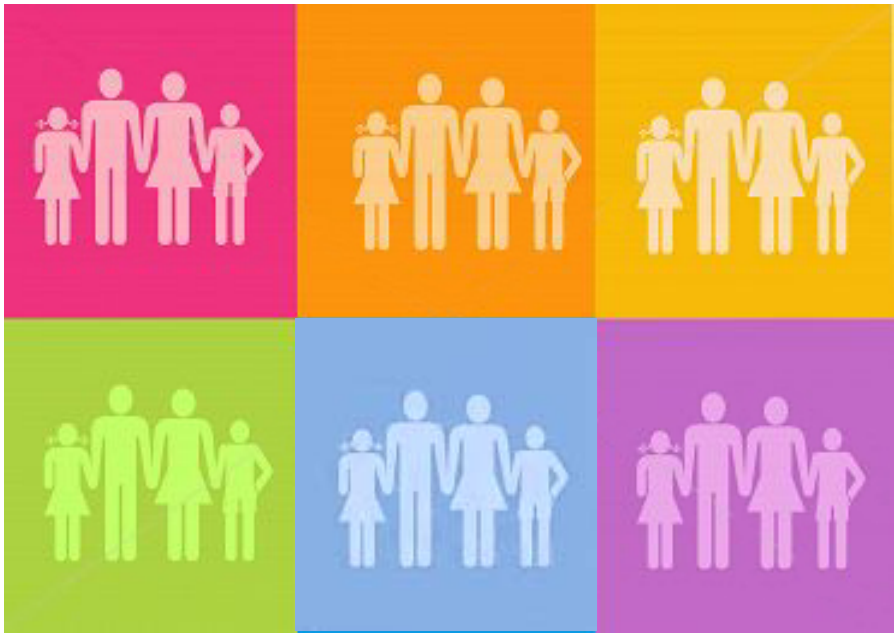
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## TARGET POPULATION INDEX

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Teachers

*Children, Birth to 5 Years*

*Nutrition Education*

*Sexual Violence*

*Tobacco*

Teens

*Adolescent Health*

*Cancer*

*Maternal and Child Health Services*

*Perinatal Health*

Toddlers

*Oral Health (2)*

Transgender youths

*Sexual Violence*

**-U-**

Underserved populations

*Cancer*

*Oral Health (1)*

*Oral Health (2)*

*Perinatal Health*

*Health Status and Health Services*

Uninsured and underinsured persons  
*Maternal and Child Health Services*  
*Perinatal Health*  
*Health Status and Health Services*

Urban residents  
*Asthma*  
*Perinatal Health*

**-V-**

Veterans  
*Cancer*

Vulnerable populations  
*Oral Health (1)*  
*Oral Health (2)*  
*Health Status and Health Services*

**-W-**

WIC enrollees  
*Lead Poisoning Prevention, Childhood*  
*Low Birthweight*  
*Maternal and Child Health Services*  
*Nutrition Education*  
*WIC*

Women  
*Arthritis*  
*Asthma*  
*Injury*  
*Maternal and Child Health Services*  
*Preventive Health and Health Services*

Women 15-44 years of age  
*Low Birthweight*

Women 18+ years of age  
*Cancer*

Women 40+ years of age  
*Cancer*

Women 45-65 years of age  
*Arthritis*

Women of childbearing age  
*Children, Birth to 5 Years*  
*Low Birthweight*  
*Maternal and Child Health Services*  
*Perinatal Health*

Women, breastfeeding  
*WIC*

Women, incarcerated  
*Suicide*

Women, low-income  
*WIC*

Women, postpartum  
*Perinatal Health*

Women, pregnant (*See Pregnant Women*)

Workers  
*Arthritis*  
*Genomics and Genetics (1)*  
*Injury*  
*Obesity*  
*Occupational Health*  
*Oral Health (2)*

**-Y-**

Youths  
*Adolescent Health*  
*Cancer*  
*Genomics and Genetics (1)*  
*HIV/AIDS*  
*Injury*  
*Preventive Health and Health Services*  
*Tobacco*

Youths 15-19 years of age  
*Maternal and Child Health Services*  
*Suicide*

Youths 15-24 years of age  
*Maternal and Child Health Services*

Youths, bisexual  
*Sexual Violence*

Youths, gay  
*Sexual Violence*

Youths, intersex  
*Sexual Violence*

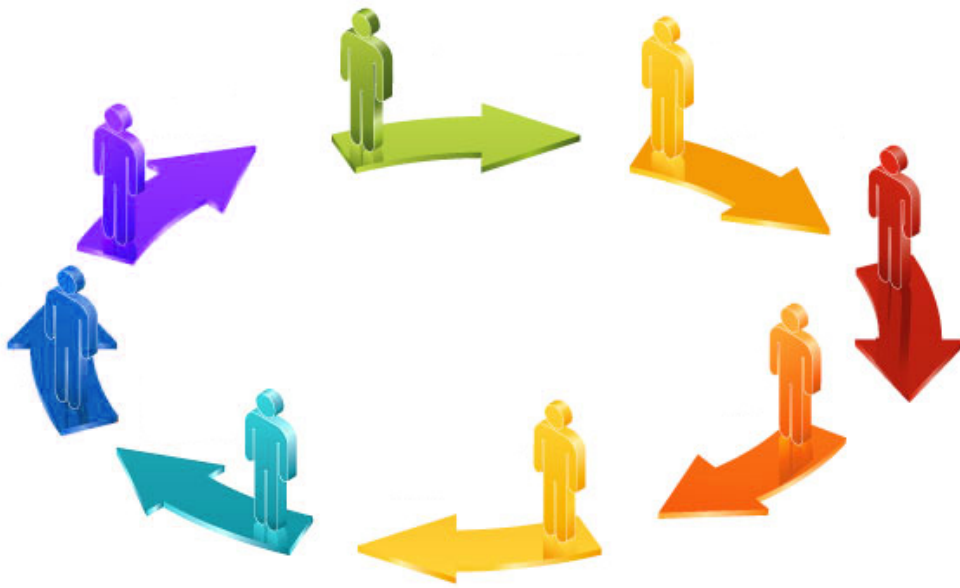
Youths, lesbian  
*Sexual Violence*

Youths, queer  
*Sexual Violence*

Youths, transgender  
*Sexual Violence*

Youths with special health care needs  
*Genomics and Genetics (1)*  
*Maternal and Child Health Services*

# PLAN ABSTRACTS



<b>Subject:</b>	<b>ADOLESCENT HEALTH</b>
<b>Title:</b>	Adolescent Health Strategic Plan
<b>Publication Date:</b>	2005
<b>Web Location</b>	<a href="http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/adolescent_health_plan_2005.pdf">http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/adolescent_health_plan_2005.pdf</a>
<b>Authority:</b> <i>(Federal, State, or Other Grant or Initiative)</i>	Not specified
<b>Contact:</b>	Meryl Tom Social Worker Consultant, Family Health Section (860) 509-8078 <a href="mailto:meryl.tom@ct.gov">meryl.tom@ct.gov</a>
<b>Target or Special Populations:</b>	Adolescents, parents
<b>Priority Issues and Goals:</b>	<p><b>Priority Issue 1</b></p> <p>Provide adolescents with the support, options, and resources they need to successfully transition to healthy, empowered, and productive adulthood.</p> <p><b>Goals</b></p> <ol style="list-style-type: none"> <li>1.1. Connecticut adolescents are empowered to assume responsibility for their health and behavior.</li> <li>1.2. Connecticut adolescents and their families and caregivers have access to timely and affordable health and mental health services that are culturally, medically, developmentally and linguistically appropriate.</li> <li>1.3. Parents and guardians, providers and adolescents have meaningful opportunities to participate in policy decisions affecting adolescent health.</li> </ol> <p><b>Priority Issue 2</b></p> <p>Enhance communication, coordination and collaboration among stakeholders in adolescent health.</p> <p><b>Goals</b></p> <ol style="list-style-type: none"> <li>2.1. Programs and agencies serving youth (including efforts that are both public and private, and that are at the federal, state and local levels) have the mechanisms and opportunities to share data and information including best practices, challenges, and lessons learned in research and service delivery.</li> <li>2.2. Adolescents receive coordinated, integrated physical health, oral health and mental health services.</li> <li>2.3. Appropriate data are collected and available on adolescents to inform decision-making about adolescent health.</li> </ol>



**Priority Issues  
and Goals:****Priority Issue 3**

Improve adolescent health and well being.

**Goals*****Mental Health***

- 3.1. Programs, services and information that create a culture of prevention and positive mental health are available to adolescents and their families and to healthcare providers and educators.
- 3.2 All adolescents who need mental health services have access to these services and utilize the services.

***Obesity and Healthy Lifestyles***

- 3.3. Adolescents achieve and maintain healthy nutrition and physical activity/fitness.

***Substance Abuse***

- 3.4. Adolescents abstain from using alcohol, marijuana, tobacco and other substances.
- 3.5. All adolescents who need substance abuse treatment have access to timely, affordable, and culturally, medically, developmentally and linguistically appropriate services.

***Reproductive Health and Sexuality***

- 3.6. Adolescents adopt behaviors that support healthy sexuality.

***Violence***

- 3.7. Adolescents live in neighborhoods and go to schools that are violence-free.

<b>Subject:</b>	<b>ARTHRITIS</b>
<b>Title:</b>	Connecticut Arthritis A.C.T.I.O.N. Plan: A Public Health Strategy
<b>Publication Date:</b>	2002
<b>Web Location:</b>	<a href="http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/arthritis_action_plan_2002.pdf">http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/arthritis_action_plan_2002.pdf</a>
<b>Authority:</b> (Federal, State, or Other Grant or Initiative)	Not specified
<b>Contact:</b>	Janet Brancifort Manager, Family Health Section (860) 509-8074 <a href="mailto:janet.brancifort@ct.gov">janet.brancifort@ct.gov</a>
<b>Target or Special Populations:</b>	Adults 18+ years of age; women 45-65 years of age; persons 65+ years of age; African Americans; Hispanic; low income persons; low socioeconomic status persons; workers
<b>Overall Goal:</b>	To reduce the burden of arthritis and to increase the quality of life of persons with arthritis who live in Connecticut.
<b>Specific Goals &amp; Objectives:</b>	<p><b>Surveillance and Epidemiology</b></p> <p><b>Goal</b></p> <p>To obtain accurate and reliable data in order to identify knowledge, gaps, barriers, strengths, and weaknesses, as well as trends related to arthritis in Connecticut.</p> <p><b>Objectives</b></p> <ol style="list-style-type: none"> <li>1. To improve statewide arthritis surveillance systems and activities.</li> <li>2. To interpret data to trend and compare state and national best practices.</li> <li>3. To use data and analysis as part of the evaluation plan in order to monitor progress and to identify areas of improvement.</li> </ol> <p><b>Prevention</b></p> <p><b>Short-term Goal</b></p> <p>To implement and document outcomes of secondary and tertiary prevention intervention initiatives.</p> <p><b>Long-term Goal</b></p> <p>To stress the integration of primary prevention measures in education and health care delivery systems.</p>

**Specific Goals & Objectives:****Objectives**

1. To promote awareness and increase recognition of arthritis as a public health issue.
2. To increase knowledge among people at risk for arthritis concerning the importance of the three prevention level initiatives.
3. To facilitate consistent and accessible provider resources for the purpose of increasing awareness of arthritis.
4. To facilitate the increased dissemination and utilization of arthritis evidence-based self-management programs.
5. To achieve appropriate arthritis-related prevention objectives from Healthy People 2010.
6. To translate scientific data into prevention programs and initiatives.

**Communication and Outreach****Goals**

1. To ensure the development, utilization and dissemination of structured health communication messages and health education materials that are appropriate for the audience.
2. To reach three broad audiences via multi-level social marketing initiatives, with respect to target populations previously cited in this document.
3. To work with partners and chronic disease linkages on these initiatives in order to increase market penetration and outreach; promote consistent messages and best practices; facilitate the best utilization of resources.

**Objectives**

1. Increase awareness of primary prevention strategies for osteoarthritis for people at risk.
2. Promote awareness about the importance of arthritis secondary prevention, specifically early diagnosis and treatment of chronic joint symptoms and other symptoms of arthritis.
3. Promote an awareness of the importance of the evidence-based Arthritis Self-Help Course (ASHC) and to market its availability.
4. Facilitate awareness concerning the impact that arthritis-related disabilities have on activities of daily living.
5. To explore outreach and access issues especially concerning arthritis-related disabilities and limitation in activities of daily living.
6. To promote an increased awareness of coping mechanisms and resources in the proportion of adults with arthritis (aged 18 years and older) who experience personal or emotional problems.
7. To promote awareness for the need to increase the proportion of adults who see a health care provider for their chronic joint symptoms.

**Specific Goals & Objectives:****Programs and Education****Goals**

1. To cultivate statewide partnerships in order to facilitate the development and delivery of credible, consistent and science-based arthritis education and program initiatives.
2. To reduce the burden of arthritis and improve the quality of life of persons with arthritis in Connecticut, via primary, secondary and tertiary intervention measures.

**Objectives**

1. To promote an increase in the mean number of days without severe pain among adults who have chronic joint symptoms.
2. To increase participation in the evidence-based self-care management program (ASHC) for persons in Connecticut who are affected with arthritis.
3. To encourage a reduction in the proportion of adults with chronic joint symptoms who experience a limitation in activity due to arthritis.
4. To promote a reduction in the proportion of all adults with chronic joint symptoms who have difficulty in performing two or more personal care activities, thereby preserving independence.
5. To encourage the reduction of the proportion of adults aged 18-years and older with arthritis, who seek help in coping if they experience personal or emotional problems.
6. To facilitate an increase in the proportion of persons with arthritis who have had effective, evidence-based arthritis education as an integral part of their condition.
7. To promote a reduction in the proportion of adults with arthritis who engage in no leisure-time activity.
8. To promote an increase in the proportion of adults with arthritis who engage in regular (preferably daily) moderate physical activity for at least 30 minutes per day.
9. To promote an increase in the proportion of adults who engage in vigorous physical activity that promotes the development and maintenance of cardio-respiratory fitness 3 or more days per week for 20 minutes or more per occasion.
10. To promote an increase in the proportion of adults who perform physical activity that enhance and maintain muscular strength and endurance.
11. To promote an increase in the proportion of adults who perform physical activity that enhance and maintain flexibility.
12. To promote an increase in the proportion of adults who are at a healthy weight.
13. To promote a reduction in the proportion of adults who are obese.
14. To facilitate an increase in the level of knowledge of allied health professionals and other physician extenders, through educational conferences and mechanisms, in order to promote the delivery of accurate messages regarding arthritis.
15. To facilitate physician and provider patient educational materials that will promote knowing the type of arthritis that a patient has and will detail appropriate treatment options based on different types of arthritis.
16. To facilitate the education and partnership of policy-makers, decision-makers and third party payers concerning priority arthritis issues.

**Specific Goals & Objectives:****Policies, Systems and Sustainability****Goals**

1. To develop and promote the integration of comprehensive prevention initiatives into policies, systems and existing infrastructures.
2. To engage support and a call to action from special interest groups, decision-makers, and policy-makers as partners in arthritis-related initiatives.
3. To establish arthritis as a major public health initiative in Connecticut by incorporating the arthritis-related Healthy People 2010 Objectives into the Public Health infrastructure; creating awareness of arthritis as a public health issue; building arthritis capacity and competency into the public health infrastructure; and building state interagency alliances to address arthritis issues.
4. To secure resources for arthritis-related initiatives, targeting those at highest risk.
5. To promote environmental changes that will facilitate program initiatives.

**Objectives**

1. Explore with employers, employment rates among adults with arthritis in the working-age population in order to improve job retention efforts.
2. Explore evidence for racial disparities with the rate of total knee replacement procedures using the Connecticut OPPE Hospital Discharge database analysis. If these disparities are confirmed by the data, then to decrease and/or eliminate them.
3. Collaborate with Department of Public Health colleagues who are the program contact persons for the Obesity and Cardiovascular Health Programs in order to promote statewide environmental changes (e.g., walking trails) that will reduce the related risks associated with obesity and physical inactivity.
4. Partner to explore funding resources, opportunities and synergistic program initiatives.
5. To distribute this ACTION Plan throughout the State, in order to facilitate communication and provide easy access to key constituents and the community at large.
6. Provide information that will educate policy makers.
7. Initiate programs, policies and systems that promote an increase in the quality of life, facilitate a decrease in pain and promote optimal independence for persons living with arthritis.
8. Improve surveillance systems and to apply information for the implementation of data driven and evidenced-based activities.
9. Promote endorsement of this plan and its initiatives by credible professional organizations (e.g., orthopedic physicians, rheumatologists, physical therapists, health educators).
10. Actively participate as a national partner with groups [CDC Arthritis Grantees, ASTHO Arthritis Council, the Arthritis Foundation, the American College of Rheumatology, etc.]

<b>Subject:</b>	<b>ASTHMA</b>
<b>Title:</b>	A Collaborative Approach for Addressing Asthma in Connecticut, 2009-2014
<b>Publication Date:</b>	2009
<b>Web Location:</b>	<a href="http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/asthma_plan_2009-2014.pdf">http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/asthma_plan_2009-2014.pdf</a>
<b>Authority:</b> (Federal, State, or Other Grant or Initiative)	Centers for Disease Control and Prevention, National Asthma Control Program, Addressing Asthma from a Public Health Perspective
<b>Contact:</b>	Eileen Boulay Nurse Consultant, Asthma Program (860) 509-7298 <a href="mailto:eileen.boulay@ct.gov">eileen.boulay@ct.gov</a>
<b>Target or Special Populations:</b>	Hispanics; non-Hispanic blacks; children, people living in poverty, adult women, adults 65+ years of age; people with low socioeconomic status; residents of urban areas.
<b>Overall Goal:</b>	To decrease the number of hospitalizations and emergency department visits for asthma
<b>Specific Goals &amp; Objectives:</b>	<p><b>Goal 1</b></p> <p>Improve Connecticut's surveillance system to identify asthma burden for disparities, high-risk populations, and trends.</p> <p><b>Objectives</b></p> <ol style="list-style-type: none"> <li>2.1 Assess the prevalence and incidence of asthma in Connecticut and identify additional data sources to improve surveillance.</li> <li>2.2 Assess the health outcomes and impact of asthma, especially to high-risk, disparate populations and improve asthma surveillance in CT at the statewide and local levels.</li> <li>2.3 Assess asthma management in Connecticut</li> <li>2.4 Explore feasibility of epidemiological review of asthma deaths case by case.</li> </ol> <p><b>Goal 2</b></p> <p>Increase awareness and knowledge in the general public and among key asthma stakeholders in the professional community of the signs, symptoms and seriousness of asthma and that asthma can be managed.</p> <p><b>Objectives</b></p> <ol style="list-style-type: none"> <li>2.1 Increase multiple outreach avenues to make asthma information widely available.</li> <li>2.2 Increase the number and types of asthma education opportunities offered to the public that promotes proper asthma management in the home, clinical, daycare, and school settings.</li> <li>2.3 Increase the number of certified asthma educators developed by professional education efforts and connect them to settings without asthma education programs.</li> <li>2.4 Increase asthma education opportunities to the professional non-clinical community.</li> </ol>

**Specific Goals & Objectives:**

- 2.5 Increase the availability of and disseminate educational materials for patients with asthma in the school, day care and community settings to enable patients and their families to better understand their asthma, its triggers and its optimal self-management.
- 2.6 Increase awareness of genetics and family health history as predictors of asthma risk.

**Goal 3**

Improve systems of asthma care.

**Objectives**

- 3.1 Decrease the inpatient hospitalizations and emergency department visits with a primary diagnosis of asthma, especially among racial and ethnic minorities.
- 3.2 Establish a baseline and then increase the number of persons treated for asthma in acute care settings who receive appropriate medications and comprehensive discharge instructions.
- 3.3 Develop a comprehensive, integrated system of asthma care across all healthcare settings.
- 3.4 Increase the number of medical students, nursing students, and health care students who are trained in asthma management consistent with national asthma guidelines.
- 3.5 Advocate for uniform reimbursement of comprehensive asthma care in Connecticut.
- 3.6 Train future health care providers in establishing and implementing a system of asthma management consistent with national asthma guidelines.

**Goal 4**

Reduce exposure to environmental conditions that cause and/or exacerbate asthma.

**Objectives**

- 4.1 Reduce the number of children who are exposed to diesel and particulate matter pollution in schools, consistent with the Connecticut Clean Diesel Plan.
- 4.2 Reduce by 5% of current DEP baseline the ozone precursor and particulate matter emissions from stationary sources including electric generators, boilers, turbines and industrial processes.
- 4.3 Maintain and increase infrastructure and programs to develop the capacity of people with asthma, especially people experiencing disparate risk of asthma burden, to identify, avoid, and reduce exposure to indoor environmental asthma triggers.
- 4.4 Increase the capacity of schools and childcare settings, including other congregate care settings such as group homes, residential facilities and detention settings, to identify, avoid and reduce exposure to environmental asthma triggers.
- 4.5 Increase the capacity of health care professionals to identify and report work-related asthma.

**Specific Goals & Objectives:**

- 4.6 Increase the capacity of employees, employers, unions, Connecticut State agencies including Connecticut DPH and Conn-OSHA safety and health officers to identify and reduce exposures to work and building-related asthma agents and respiratory irritants.
- 4.7 Increase awareness and resources to improve the indoor environment in non-industrial work places to promote asthma healthy environments.
- 4.8 Reduce the number of people with asthma and all children who are exposed to environmental tobacco smoke.

**Goal 5**

Increase the awareness and use of standardized guidelines for asthma self-management in educational and community settings.

**Objectives**

- 5.1 Increase the number of asthma-friendly policies and guidelines for appropriate asthma management in schools and the community.
- 5.2 Increase awareness of asthma-friendly policies and guidelines for asthma management available for implementation in daycare and other pre-school settings.
- 5.3 Increase dissemination of asthma guidelines to institutions of higher learning concerning best practices for the management of asthma in such settings.
- 5.4 Increase awareness and dissemination of asthma guidelines for optimal asthma care to be available for the management of children and adults in organized activities outside of school such as camp, after-school programs and town park and recreation events.

**Goal 6**

To create an environment that supports effective and comprehensive care through the engagement of consumers, providers and asthma-related agencies.

**Objective**

- 6.1 Increase the number of partners with expertise in advocacy and systems change that can identify and act on opportunities for systems or policy changes that improve asthma outcomes.



<b>Subject:</b>	<b>CANCER</b>
<b>Title:</b>	Connecticut Cancer Plan, 2009-2013
<b>Publication Date:</b>	2009
<b>Web Location:</b>	<a href="http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/cancer_plan_2009-2013.pdf">http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/cancer_plan_2009-2013.pdf</a>
<b>Authority:</b> (Federal, State, or Other Grant or Initiative)	Centers for Disease Prevention and Control, National Cancer Prevention and Control Cooperative Agreement #UA58 DP000833
<b>Contact:</b>	Lisa McCooley Co-Director, Comprehensive Cancer Program (860) 509-7825 <a href="mailto:lisa.mccooley@ct.gov">lisa.mccooley@ct.gov</a>
<b>Target or Special Populations:</b>	All Connecticut residents, children, adolescents, teens, adults 18+ years of age, adults 50+ years of age, women 18+ years of age, women 40+ years of age, cancer survivors, low socioeconomic status persons, prison inmates, veterans, medically underserved populations
<b>Overall Goal:</b>	To reduce the burden of cancer and improve the quality of life of people living with cancer in Connecticut.
<b>Specific Goals &amp; Objectives:</b>	<p><b>Prevention</b></p> <p><b>Goal:</b></p> <p>Reduce cancer risk, incidence, and mortality through the development and adoption of policies and interventions that support healthy lifestyles and risk reduction practices among children and adults.</p> <p><b>Objectives:</b></p> <ol style="list-style-type: none"> <li>1. Decrease tobacco use among adults (= 18 years) from 15.4% to 12%; among youth (grades 9-12) from 21.1% to 10%, and among low socioeconomic status adult smokers by 25%.</li> <li>2. Increase the percentage of adults (= 18 years) who consume at least five fruits and vegetables a day from 8.5% to 75%; and youth (high school and middle school) from 21.5% to 75%.</li> <li>3. Increase the percentage of people who engage in regular physical activity (ACS activity guidelines) from 52.4% for adults and 45.1% for youth to 70%.</li> <li>4. Reduce cancer-related environmental exposures at home and in the workplace.</li> <li>5. Increase the percentage of persons who use sunscreen and practice sun/ultraviolet protection behaviors that may reduce the risk of skin cancer from 50.4% for adults and from 10.3% for youth to 75%.</li> <li>6. Decrease the percentage of adults and youth consuming alcohol: from 5.9% to 4% for adults who exceed the ACS recommendations for drinks per day; and from 46% to 40% of high school students who consume alcohol; and reduce to 20% the percentage of high school students who report binge drinking. Increase the practice of safe sexual behaviors in youth and adults.</li> </ol>

**Specific Goals & Objectives:****Early Detection****Goal**

Ensure that Connecticut residents receive appropriate and timely cancer screenings to detect cancer as early as possible, using quality, accessible, affordable, comprehensive, and evidence-based methods.

**Objectives**

1. Increase the percentage from 82% to 90% of women age 40 and over who have had a mammogram in the past 2 years.
2. Increase from 90.3% to 95% the percentage of women participating in the Connecticut Breast and Cervical Cancer Early Detection Program who receive appropriate follow-up and diagnosis within 60 days from 90.6% to 95% after receiving abnormal breast cancer screening results.
3. Increase the percentage of women 18 years of age and over who have had a Pap test within the past 3 years from 86.8% to 90%.
4. Increase the percentage of women 18 years of age and over who have had a Pap test within the past 3 years from 86.8% to 90%.
5. Increase the proportion of Connecticut residents who know the early signs and symptoms of lung, ovarian, prostate, testicular, skin, and oral cancers, for which there are no recommended evidence-based screening modalities.

**Treatment****Goal**

Ensure that Connecticut residents will have access to high quality cancer care (evidence-based where possible) consistent throughout the state.

**Objectives**

1. Increase the numbers of patients and health care providers who have recent and comprehensive information about cancer treatment and standards of care.
2. Increase the number of Connecticut patients participating in clinical trials.
3. Increase the number of approved cancer programs and oncology certified/specialized health care professionals in Connecticut.

**Survivorship****Goal**

Ensure a high quality of life and care for all Connecticut residents living with cancer and for their families.

**Objectives**

1. Increase the proportion of provider referrals and cancer survivors who access and use survivor support services.
2. Increase the number of health care providers who are knowledgeable about survivorship care.

**Specific Goals & Objectives:**

3. Increase the number of providers, families, and caregivers who are knowledgeable about the needs of children surviving cancer.
4. Increase the proportion of cancer survivors who practice positive health behaviors regarding weight, diet, physical activity, tobacco and alcohol use, sun exposure, and cancer screenings, using culturally appropriate methods.

**Palliative and Hospice Care****Goal**

Ensure that high quality palliative and hospice care services are available and accessible to all Connecticut residents.

**Objectives**

1. Increase the number of health care professionals who specialize in or are certified in palliative and hospice care. Increase from 27 to 30 the number of physicians; from 163 to 250 the number of certified nurses; and from 0 to 6 the number of nursing administrators.
2. Increase the number of health care settings offering palliative and hospice care services. Increase from 14 to 20 the number of hospitals offering palliative care services; and from 32 to 40 the number of Home Care Providers with Hospice Licensure.
3. Increase number of people served by palliative and hospice care initiatives, including current pediatric, prison, and Veterans' initiatives, that address targeted and/or medically underserved population groups.
4. Increase the proportion of patients receiving effective pain management.
5. Increase the percentage of Connecticut residents who receive hospice care in a timely manner and at home. Increase from 28% to 35% the percentage of Medicare patients in Connecticut who are on hospice benefit at time of death; from 27.7% to 35% the percentage of persons receiving hospice care at home at time of death; and increase from 45 to 56 days the average length of stay on Medicare hospice benefit prior to death.

**Disparities and Access****Goal**

Maintain a consistent focus on eliminating disparities within the context of each of the continuum committees' objectives and strategies.

**Objective**

1. Share positive practices, identify and engage appropriate partners to effectively reduce disparities, and universally improve access to care in Connecticut.

**Communications, Education, and Training****Goal**

Provide an active, coordinated communications program that will raise awareness about the Connecticut Cancer Plan 2009-2013 and the Partnership for a wide variety of audiences.

**Specific Goals & Objectives:****Objectives**

1. Improve existing methods for ongoing communications with Partnership members.
2. Prepare campaign for release of Connecticut Cancer Plan 2009-2013.
3. Inform the general public, target audiences and populations groups about funded implementation activities.
4. Explore new technologies and delivery methods for communicating information about the Partnership and the Plan.
5. Support the education and training implementation activities of the Partnership's committees.

<b>Subject:</b>	<b>CHILDREN, BIRTH THROUGH 5 YEARS OF AGE</b>
<b>Title:</b>	Connecticut Early Childhood Partners Strategic Plan, 2006-2008
<b>Publication Date:</b>	2006
<b>Web Location:</b>	<a href="http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/early_child_partners_strat_plan_2006-2008.pdf">http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/early_child_partners_strat_plan_2006-2008.pdf</a>
<b>Authority:</b> <i>(Federal, State, or Other Grant or Initiative)</i>	U.S. Department of Health and Human Services, Maternal and Child Health Bureau, State Early Childhood Comprehensive Systems Initiative
<b>Contact:</b>	Kevin J. Sullivan Health Program Associate, Family Health Section (860) 509-7108 <a href="mailto:kevin.j.sullivan@ct.gov">kevin.j.sullivan@ct.gov</a>
<b>Target or Special Populations:</b>	Children <6 years of age, children with special health care needs, parents of children <6 years of age, pregnant women, women of childbearing age, low-income families, low socioeconomic status persons
<b>Long-term Outcomes &amp; Goals:</b>  <i>(Priority Goals are shown in italics)</i>	<p><b>Outcome 1: Comprehensive Health</b></p> <p>Every child from birth to age six, their parents, and all pregnant women in Connecticut will have access to comprehensive, preventive, continuous health care.</p> <p><b>Goals</b></p> <ol style="list-style-type: none"> <li>1.1 <i>Expand the number of pediatric practices and clinics providing medical homes for all children, particularly those with special health care needs.</i></li> <li>1.2 Expand the number of children with access to coordinated and continuous, primary health care.</li> <li>1.3 Implement and expand programs and services for improving birth outcomes and early parenting experiences.</li> <li>1.4 Build the capacity of the KidCare systems of care and the mental health provider network to address early childhood mental health needs.</li> <li>1.5 Expand eligibility for Birth-to-Three services to include children subject to environmental risks or otherwise at risk of developmental delays.</li> </ol> <p><b>Outcome 2: Early Care and Education</b></p> <p>All children will have access to affordable, healthy, safe, and developmentally-appropriate early care and education programs with comprehensive support services for transitions to kindergarten.</p> <p><b>Goals</b></p> <ol style="list-style-type: none"> <li>2.1 <i>Ensure access to quality early care and education for children ages 0-5 years through a variety of best practice models, targeting communities where children are achieving at lower rates.</i></li> <li>2.2 <i>Meet the developmental needs of children through access to comprehensive health, mental health, and educational consultation for families and early care and education providers.</i></li> </ol>

**Long-term Outcomes & Goals:**  
*(Priority Goals are shown in italics)*

- 2.3 Ensure that low- and moderate-income families have access to child care subsidies to offset the costs of quality early care and education.
- 2.4 Expand access to child care for children with special needs in appropriate settings.
- 2.5 Increase credentials and qualifications for early childhood teachers to enhance the development of young children across all domains.
- 2.6 Ensure effective transitions from birth to Kindergarten.
- 2.7 Improve the capacity of center and home-based early care providers to serve hard-to-reach populations, including homeless children.

**Outcome 3: Family Support and Parenting Education**

All families will have access to the information and resources they need to raise healthy children, and parents will be involved as partners in the planning of services.

**Goals**

- 3.1 *Involve parents as partners in the planning and delivery of all early childhood services.*
- 3.2 *Provide families with the skills and knowledge to nurture their children’s development.*
- 3.3 *Enhance Connecticut’s coordinated State-local information, referral, and assessment system to ensure that all families and care providers have access to information and services to effect optimal child health and development.*
- 3.4 Facilitate access to economic, social support and education services to promote self-sufficiency among low-income families and strengthen communities.

**Outcome 4: Local Collaboration**

Effective local or regional early childhood collaborative structures will ensure the provision of integrated services.

**Goals**

- 4.1 *Direct state resources to support local/regional early childhood collaboratives.*
- 4.2 *Engage existing local collaboratives in state agency planning and service design.*

**Outcome 5: State Level Infrastructure**

A state level infrastructure with community representation will guide, support, and monitor implementation of a comprehensive, integrated system of services for children and families.

**Goals**

- 5.1 *Enhance the capacity of the state and local communities to use data for planning, administration and quality enhancement.*
- 5.2 *Develop tools and resources to ensure cultural competence in the delivery of all early childhood services.*
- 5.3 Launch the Early Childhood Education Cabinet as the state level accountability structure with community representation to provide statewide leadership and direction for the comprehensive early childhood system.

**Long-term Outcomes & Goals:**  
*(Priority Goals are shown in italics)*

- 5.4 Establish an Early Childhood Research and Policy Network / Council to inform planning and policy.
- 5.5 Implement a cross-cutting financing plan that maximizes and integrates the use of the myriad federal, state, municipal, and private resources.

**Outcome 6: Communications**

A broad-based communications and engagement strategy will develop public education and public will in support of early childhood services.

**Goals**

- 6.1 *Develop broad-based support for comprehensive, integrated early childhood services for all children through expanded public awareness of the importance of the early childhood years.*
- 6.2 Assure that different cultural communication styles and strategies are used to inform and engage the evolving diverse population.

**Note:**

Early Childhood Partners comprises the following State agencies, along with other statewide organizations: Department of Public Health, Department of Social Services, Department of Children and Families, Department of Education, Department of Developmental Services (formerly Department of Mental Retardation), Department of Mental Health and Addiction Services, Children's Trust Fund, Office of the Child Advocate, and Commission on Children. Plan development was facilitated by the Connecticut Department of Public Health.

<b>Subject:</b>	<b>CHILDREN WITH SPECIAL HEALTH CARE NEEDS</b>
<b>Title:</b>	Children with Special Health Care Needs
<b>Publication Date:</b>	2003
<b>Web Location:</b>	<a href="http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/cyshcn_needs_assmt__&amp;_reccomend_2003.pdf">http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/cyshcn_needs_assmt__&amp;_reccomend_2003.pdf</a>
<b>Authority:</b> (Federal, State, or Other Grant or Initiative)	Not specified
<b>Contact:</b>	Mark Keenan Supervising Nurse Consultant, Family Health Section (860) 509-7187 <a href="mailto:mark.keenan@ct.gov">mark.keenan@ct.gov</a>
<b>Target or Special Populations:</b>	Children with special health care needs, parents.
<b>Recommendations:</b>	<ol style="list-style-type: none"> <li>1. Create local/regional networks of parents so that parents can become better trained to advocate and address their child(ren)s needs.</li> <li>2. Enhance and expand respite service providers for CSHCN.</li> <li>3. Establish education and training center(s) that will also serve the function of coordination and linkage for statewide CSHCN activities.</li> <li>4. Create a vision of longer term systems level changes.</li> </ol>

**Note:**

This publication is a needs assessment with recommendations, not a formal plan. As such, it is not organized with goals, objectives, and strategies consistent with health improvement and strategic plans.



<b>Subject:</b>	<b>DIABETES</b>
<b>Title:</b>	The Connecticut Diabetes Prevention and Control Plan, 2007-2012
<b>Publication Date:</b>	2007
<b>Web Location:</b>	<a href="http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/diabetes_prev_contr_plan_2007-2012.pdf">http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/diabetes_prev_contr_plan_2007-2012.pdf</a>
<b>Authority:</b> (Federal, State, or Other Grant or Initiative)	Centers for Disease Control and Prevention, Division of Diabetes Translation
<b>Contact:</b>	Cindy Kozak, RD, MPH, CDE Diabetes Program Coordinator (860) 509-7737 <a href="mailto:cindy.kozak@ct.gov">cindy.kozak@ct.gov</a>
<b>Target or Special Populations:</b>	Connecticut adults 18 years of age and older
<b>Objectives:</b>	<p><b>Prevention</b></p> <ol style="list-style-type: none"> <li>1. By 2012, reduce by 0.5% the prevalence of type 2 diabetes by preventing or delaying the progression of pre-diabetes to diabetes.</li> </ol> <p><b>Disease Management</b></p> <ol style="list-style-type: none"> <li>1. By 2012, increase by 50% the number of Connecticut physicians and other health care providers who use ADA and other evidence-based guidelines to diagnose and monitor pre-diabetes and diabetes as measured by the number of physicians recognized by the ADA.</li> <li>2. By 2012, improve patient care by increasing the number of health care providers using electronic medical records or disease registries by 10% to establish a statewide health data exchange, increase outreach, and improve communication among providers.</li> <li>3. By 2012, establish a system of process and outcome measurement used by all health care providers on the patient care team.</li> <li>4. By 2012, increase by 5% the percentage of adults age 18 and older who are conducting comprehensive self-management to control their disease.</li> <li>5. By 2012, increase by 10% the proportion of at risk individuals who are screened for diabetes and pre-diabetes using evidence-based guidelines.</li> <li>6. By 2012, increase by 10% the proportion of health care providers who adopt a uniform system of reporting, including the coding of diabetes diagnoses.</li> </ol>

**Objectives:****Education and Awareness**

1. By 2012, increase by 5%, the proportion of people with diabetes participating in diabetes self-management education programs in order to learn about controlling their diabetes.
2. By 2012, increase by 10% the number of providers who participate in continuing education programs focused on diabetes.
3. By 2012, improve public awareness of the impact of diabetes by increasing by 10% the number of partnerships with community organizations such as schools, libraries, the media, town halls, and other public places.

**Access and Policy**

1. By 2012, increase by 5% the proportion of people who receive comprehensive diabetes care, i.e., diabetes preventive care, treatment, supplies, equipment, medication, education and medical nutrition therapy.

**Surveillance**

1. By 2012, increase by 5% the number of hits to the diabetes surveillance Web page as a means of increasing accessibility to the diabetes prevalence, morbidity and mortality data.

<b>Subject:</b>	<b>EMERGENCY MEDICAL SERVICES</b>
<b>Title:</b>	Connecticut Emergency Medical Services Plan: A System to Save Lives
<b>Publication Date:</b>	2006 (Draft)
<b>Web Location:</b>	<a href="http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/ems_plan_2006.pdf">http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/ems_plan_2006.pdf</a>
<b>Authority:</b> (Federal, State, or Other Grant or Initiative)	<i>Connecticut General Statutes</i> , Sec. 19a-178. Office of Emergency Medical Services. State-wide coordinated delivery plan. Model local emergency medical services plans and performance agreements.
<b>Contact:</b>	Gary Wiemokly Section Chief, Office of Emergency Medical Services (860) 509-7975 <a href="mailto:gary.wiemokly@ct.gov">gary.wiemokly@ct.gov</a>
<b>Target or Special Populations:</b>	All Connecticut residents, children, older adults
<b>Mission:</b>	The Mission of the Connecticut Emergency Medical Services System is to save lives and minimize disability through the creation of regional networks of Emergency Medical Services providers. Such a system will ensure that consistent and high quality pre-hospital emergency medical care is available throughout the state 24 hours per day, 7 days per week.
<b>Goals &amp; Objectives:</b>	<p><b>Human Resources Education and Training</b></p> <p><b>Goal</b></p> <p>All EMS Training programs will conform to uniform national and statewide standards. Training programs will be available to ensure an approved proficiency level for every class of EMS personnel (citizen CPR, dispatchers, MRT, EMT, paramedics, emergency nurse, through to medical director.)</p> <p><b>Objectives</b></p> <ol style="list-style-type: none"> <li>1. Complete the integration of the new DOT EMT-B curriculum into the initial and refresher training programs.</li> <li>2. Include early defibrillation training in all MRT, EMT, EMT-I, initial and refresher courses.</li> <li>3. Streamline the administrative functions of the OEMS training section. Introduce new technologies such as voice mail service, enhanced computerization for testing, test results distribution, certification verification and database maintenance.</li> <li>4. Develop a standardized operating procedures manual for the OEMS Training Section. Include in this manual training requirements for all certification levels, practical/written testing process and a quality improvement program for EMS training programs.</li> <li>5. The OEMS Training Division, in conjunction with the Regional Coordinators, will develop a plan to provide oversight of EMS courses and evaluate course test results. They will identify problems and develop a process of checks and balances to monitor course content.</li> </ol>

**Goals & Objectives:**

6. In conformance with the trauma regulations, integrate pre-hospital field triage training into all EMS provider initial and refresher training.
7. By September 1, 2009, every emergency vehicle operator will have successfully completed an Emergency Vehicle Operations Course which meets or exceeds the National Standard Curriculum – EVOC standards and which is approved by the State Office of Emergency Medical Services.
8. Annually conduct a statewide EMS educational conference for statewide education, information dissemination and team building.
9. Develop and maintain effective and efficient procedures for the dissemination of training information, policies and procedures to the regional councils and EMS providers.
10. Develop a joint certification program, with EMS involvement, to establish CPR, MRT and EMT as part of the public school curriculum focusing on students age 10 and above.

**Communications****Goal**

Develop a technologically effective and comprehensive emergency medical communications network to facilitate rapid access to care by the patient and provide the communications pathways between the field and the emergency medical facility necessary to enhance on-line medical direction/control.

**Objectives**

1. Maintain the requirement that all EMS vehicles be equipped to communicate over the state approved EMS communications system.
2. Develop a comprehensive State EMS Communications Plan and annually update that plan. This plan will address coordination issues and provide standards and operating procedures for the statewide EMS communications system. Further, the plan will promote the implementation of an approved EMS communications concept paper as the basis for the replacement of the existing communications system.
3. Support the efforts of the State 9-1-1 Commission and the OSET in updating the capabilities of the statewide E 9-1-1 system and provide technical assistance as needed.
4. Adopt comprehensive Emergency Medical Dispatch (EMD) standards and promulgate regulations to ensure implementation, maintenance, training and quality assurance statewide.
5. Support the adequate funding of and resources for the existing EMCCs.
6. Develop the communications portion of the medical directors course. Implement a mandatory medical director's course with bi-annual medical director's training.

**EMS for Children****Goal**

Optimize the level of emergency care for children within the existing structure of the statewide EMS system.

**Goals & Objectives:****Objectives**

1. Develop a comprehensive 5-year plan that will address the needs of children within the EMS system.
2. In conjunction with the Advisory Board Funding Committee, explore and develop funding sources for continued implementation of the EMS-C plan.
3. Standardized statewide data collection of pediatric pre-hospital care as well as the pediatric trauma patient.
4. Training /Guidelines: The pre-hospital care providers will continue to have standardized pediatric education i.e. PALs and PEPP. Pre-hospital providers will have sound evidence based and consistent protocols/guidelines.
5. Pre-hospital provider agencies will have the essential pediatric equipment and supplies needed, as outlined in the American Academy of Pediatrics/ American College of Emergency Physicians Joint Guidelines for BLS and ALS providers, as well as State of Connecticut EMS Regulations. Will know the status of all BLS/ALS provider ambulance services equipment by December, 2007 to be able to make recommendations to services.
6. Coalition building to enhance the care of the pediatric patient. To bring together other groups interested in the health and well being of the pediatric population. Coordinated with in the EMS-C program. This group could include corporate sponsors to enhance current pediatric initiatives, as well as family representatives on the EMS-C Advisory Group.
7. Integrate EMS-C into EMS/Trauma regulations.

**Medical Direction****Goal**

Ensure that emergency medical care is rendered consistent with standards of quality medical practice via the involvement of the physicians in design, implementation, management and provision of emergency care.

**Objectives**

1. Define the roles, responsibilities and authority of the Office of Emergency Medical Services (OEMS) Medical Director and the Connecticut Emergency Medical Services Medical Advisory Committee (CEMSMAC). Define roles of other related providers of medical direction.
2. Revise existing EMS regulations to reflect the American College of Emergency Physicians (ACEP) definition of medical direction and make recommendations related to required qualifications.
3. Develop statewide protocols for medical directors and their provision of medical control directives. Develop a training program and a handbook for medical directors.
4. Develop criteria for the DPH evaluation of sponsor hospitals' responsibilities and interaction with EMS services during the inspection process.
5. Develop a process for pre and post evaluation of sponsor hospitals' EMS interaction and responsibilities by the EMS regional councils.

**Goals & Objectives:**

6. Establish “Levels of Care” protocols for all certification and licensure levels and associated standing orders for pre-hospital care.
7. Require the provision of sponsor hospital medical control for all OEMS certified pre-hospital personnel including Medical Response Technician (MRT) and Emergency Medical Technician (EMT) basic personnel.
8. Develop criteria for evaluating and reporting outcomes of Emergency Medical Direction (EMD).
9. Establish statewide protocols based on (EMTALA) for determining the patient destination for patients in the 911 system.
10. Develop statewide protocols for inter-facility transfers.
11. Develop ethical standards of practice and establish a DPH due process review for the removal of medical control.

**Trauma System****Goal**

Develop an organized statewide system of trauma care. Implement the necessary components of such a system in order to insure that the performance of the trauma system is cost effective, cost efficient, and provides the appropriate level of care to patients with major injuries.

**Objectives**

1. Participate in the development of the Statewide Trauma Plan Revision Process.
2. Educate pre-hospital and hospital care providers regarding the system, policies, procedures and protocols.
3. Provide financial opportunities to support pre-hospital trauma education programs from state, federal and private organizations and sources.
4. Collect and analyze statewide information related to trauma. Prepare and disseminate reports to regions and related providers that measure trauma system performance, cost, outcomes and other relevant indicators. Propose enhancements to the system based on the analysis of the data.
5. Compile the trauma data that is to be gathered by the Connecticut Trauma Centers. Enter that data into the centralized Department of Public Health’s trauma registry program. Prepare and distribute trauma reports to the Regional Emergency Medical Services (EMS) offices, which will include recommendations and guidance for improvement, and enhancement to existing EMS systems. Such recommendations will include injury preventions programs and other such programs that are specific to each region.
6. Develop a mechanism designed to collect, merge and then collate outcome data from the Department of Public Health (DPH) Trauma Data Registry and the Public Transportation Safety and Crash Data system. Such data will then be prepared in a report format that will be initially distributed to the EMS regions and utilized for planning and other related purposes

**Goals & Objectives:**

7. Develop a mechanism designed to collect, merge and then collate outcome data from the Department of Public Health (DPH) Trauma Data Registry and the Public Transportation Safety and Crash Data system. Such data will then be prepared in a report format that will be initially distributed to the EMS regions and utilized for planning and other related purposes.
8. The Department of Public Health will identify all injury preventions programs within the State and work with them in an effort to provide effective and consistent injury prevention programming based on state and regional needs.

**Data and Evaluation**

**Goal**

Design a functional system for collecting data and evaluation system components to ensure the ongoing quality and integrity of the EMS system.

**Objectives**

1. Hire a full time data system manager. Maintain ongoing operation of the data system.
2. Develop a system that is “user friendly” so as to facilitate rapid integration into the daily operations of the EMS system.
3. Pilot test the data system and get approval from the EMS Advisory Board before formal acceptance and implementation.
4. Explore sources of long term funding, with Advisory Board funding committee, for the EMS data system.
5. Evaluate data system performance and make appropriate changes where necessary.
6. Disseminate reports that address EMS system performance based on the outcomes from hospital and Emergency department discharge data linked to the run reports of the EMS data system.

**Mass Casualty Care**

**Goal**

All patients in Connecticut who are injured in an event where the patient capacity and need outweighs local resources will receive optimal emergency medical care at the scene, during transportation and at the hospital.

**Objectives**

1. There shall be a presence of the following planning components within 80% of all Connecticut towns and cities. Those components are:
  - a. Written and approved local mass casualty response plans – Development of a Template.
  - b. Written mutual aid protocols as part of the plan – Development of a formal evaluation for the above noted Template.
  - c. Utilize formal evaluation guidelines in the evaluation of all drills and MC events.

**Goals & Objectives:**

2. Train personnel who are assigned a primary or organizational role at all drills and actual MCI events. They will be trained via the Triage and Mass Casualty Scene Management course and in field evolutions. Train personnel who are assigned a secondary or support role in overview via a course in mass casualty scene management.
3. Achieve integration of all scene EMS operations to the National Incident Management System incident command structure.
4. Achieve compliance in drills and actual field operations using Connecticut mass casualty protocols and guidelines.
5. Develop and implement an evaluation tool to be used in the evaluation of all MCI drills.
6. Regulations will be drafted and introduced to mandate operational compliance with local EMS plans including MCI planning, PSA assignments, integration with first responders, etc.



<b>Subject:</b>	<b>EMERGENCY RESPONSE, PUBLIC HEALTH</b>
<b>Title:</b>	Connecticut Public Health Emergency Response Plan, Emergency Support Function 8, Public Health and Medical Services
<b>Publication Date:</b>	2005
<b>Web Location:</b>	<a href="http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/pub_hlth_emerg_resp_plan_2005.pdf">http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/pub_hlth_emerg_resp_plan_2005.pdf</a>
<b>Authority:</b> (Federal, State, or Other Grant or Initiative)	<p><i>Federal:</i> U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Public Health Emergency Response Grant.</p> <p><i>State:</i> Connecticut General Statutes, Public Act 03-236, Section 8, and such Executive Orders and Special Acts, as may be applicable. Emergency Response Plans and Annexes are required under <i>Connecticut General Statutes</i>, Section 28-7(a) of Title 28, Chapter 517.</p>
<b>Contact:</b>	<p>Mary Pettigrew                      Planning Specialist, Planning and Workforce Development Section                      (860) 509-7544  <a href="mailto:mary.pettigrew@ct.gov">mary.pettigrew@ct.gov</a></p>
<b>Target or Special Populations:</b>	All Connecticut residents
<b>Goals &amp; Objectives:</b>	<p><b>Communications Technology</b></p> <p><b>Goal</b></p> <p>To securely facilitate communication of critical health, epidemiological, and bioterrorism information on a 24/7 basis to local health departments, health care providers and organizations, and other key partners.</p> <p><b>Response Training</b></p> <p><b>Goal</b></p> <p>To assure that response personnel are adequately trained to fulfill their responsibilities without endangering their safety and the safety of others. This includes training emergency services and health care personnel to recognize a public health emergency, as well as training those who would respond to that event.</p> <p><b>Public Health Investigation</b></p> <p><b>Goal</b></p> <p>To gather information to inform public health intervention and communication.</p> <p><b>Objectives</b></p> <ol style="list-style-type: none"> <li>1. Define the problem in person, place and time (who and how many are at risk, where is/was the risk, when did the risk begin and when did it end).</li> <li>2. Identify the source and magnitude of exposure.</li> <li>3. Determine whether exposure or the consequences of it are ongoing. (Is there person-to-person transmission? Is there lingering environmental contamination of concern? Are there consequences of exposure that may result in health problems later?)</li> <li>4. Monitor the impact of intervention.</li> </ol>

**Goals & Objectives:**

**Public Health Intervention**

***Overall Goal***

To minimize morbidity and mortality resulting from a public health emergency.

***Specific Goal***

To use medical methods (prophylaxis, vaccination) and physical separation methods (isolation, quarantine, personal protection, cancellation of public events) to prevent disease in those exposed and/or to limit exposure to the public health threat.

**Environmental Management**

***Goals***

1. To respond to emergencies and situations of an unexpected or uncertain nature, which could have a detrimental effect on the State's drinking water, resulting in public health impact.
2. To reduce the risk of food borne illness by ensuring reasonable protection from contaminated food and improving the sanitary conditions of food service establishments.

**Medical Management**

***Overall Goal***

To minimize morbidity and mortality resulting from a public health emergency.

***Specific Goals***

1. To treat all ill persons as promptly and fully as possible by coordinating care across medical settings.
2. To assure adequate and appropriate distribution of staff and supplies to make optimal medical care happen.

**Clean-Up/Recovery**

***Overall Goal***

Returning the area affected by the threat to a state that is healthy for people.

**Notes:**

This is an operations plan. As such, it is not organized into goals, objectives, and strategies consistent with health improvement plans and strategic plans.

Protocols for specific types of events and responses are given in annexes to this base plan.

<b>Subject:</b>	<b>ENVIRONMENTAL PUBLIC HEALTH TRACKING</b>
<b>Title:</b>	A New Strategic Direction: A Plan to Implement Environmental Public Health Tracking in Connecticut
<b>Publication Date:</b>	2005
<b>Web Location:</b>	<a href="http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/enviro_nub_hlth_tracking_plan_2005.pdf">http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/enviro_nub_hlth_tracking_plan_2005.pdf</a>
<b>Authority:</b> (Federal, State, or Other Grant or Initiative)	Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network
<b>Contact:</b>	Gary Archambault Environmental Public Health Tracking Coordinator (860) 509-7780 <a href="mailto:gary.archambault@ct.gov">gary.archambault@ct.gov</a>
<b>Target or Special Populations:</b>	All Connecticut residents
<b>Goal and Recommendations:</b>	<p><b>Goal</b></p> <p>To develop Connecticut's portion of a National Environmental Public Health Tracking Network</p> <p><b>Recommendations</b></p> <ol style="list-style-type: none"> <li>1. Continue the commitment to environmental public health tracking by: A) Convening a new Consortium to inform and advise the CT DEP and CT DPH on Environmental Public Health Tracking and to assist in the implementation of the following recommendations; B) Pursuing additional funding to implement recommendations; and C) Assigning appropriate resources to accomplish all tasks.</li> <li>2. Develop coordinated systems to systematically track chronic diseases and other adverse health outcomes and develop coordinated systems to systematically track environmental exposures.</li> <li>3. Seek to explore: A) Emerging risks and links identified by public health and environmental science and B) concerns brought forward by the public.</li> <li>4. Develop an equivalent to the National Health and Nutrition Examination Survey (NHANES) in Connecticut, with affiliated biomonitoring, to allow tracking of both noninfectious diseases and exposure to environmental agents.</li> <li>5. Identify past, present, and future land use and development patterns use as an integral data and information base for the environmental public health tracking initiative.</li> <li>6. Initiate EPHT efforts in Connecticut through the development/enhancement of data systems and trial linkages for the following initial areas of prioritized health and environmental topics:</li> </ol>

**Goal and  
Recommendations:*****Asthma***

Improve data collection systems to collect and evaluate data regarding asthma and potentially related environmental factors.

***Lead***

Evaluate potential linkage between blood lead levels and learning disabilities as a trial link between an environmental toxin and a chronic neurological disease.

***Cardiovascular***

Explore the links between cardiovascular disease and air pollution

***Cancer***

Develop an infrastructure that will facilitate investigations of possible environmental influences on cancer rates.

***Pesticides***

Develop a pesticide use and accidental exposure database.

***Water***

Expand evaluation and monitoring of data of Connecticut's water supplies

<b>Subject:</b>	<b>GENOMICS AND GENETICS (1)</b>
<b>Title:</b>	Connecticut Genomics Action Plan
<b>Publication Date:</b>	2005
<b>Web Location:</b>	<a href="http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/genomics_action_plan_2005.pdf">http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/genomics_action_plan_2005.pdf</a>
<b>Authority:</b> <i>(Federal, State, or Other Grant or Initiative)</i>	Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, Maternal and Child Health Block Grant
<b>Contact:</b>	Beverly Burke Lead Planning Analyst, Genomics Office (860) 509-7122 <a href="mailto:beverly.burke@ct.gov">beverly.burke@ct.gov</a>
<b>Target or Special Populations:</b>	All Connecticut residents, newborns, children, children and youth with special health care needs, workers
<b>Priorities, Goals, &amp; Objectives:</b>	<p><b>Priority I - Infrastructure</b></p> <p>Establish a formal, stable, and sustainable infrastructure that promotes the integration of genomics into all relevant areas of public health across the lifespan.</p> <p><b>Goal I.1</b></p> <p>Create an Office of Genomics within DPH that has agency-wide reach and experienced Directorship.</p> <p><b>Short-Term Objectives</b></p> <p>I.1a. Continue the Department's commitment to genomics through the creation of an interim Virtual Office of Genomics.</p> <p>I.1b. Establish position, and recruit a Director of Genomics, with broad-based experience in genetics to direct DPH genomics policy and activities.</p> <p>I.1c. Seek funding sources to fully implement the Connecticut Genomics Action Plan.</p> <p><b>Long -Term Objective</b></p> <p>I.1d. By year 2010, have developed an active, fully functioning Office of Genomics, operating across units to serve as a clearinghouse and central site for genomics within DPH.</p> <p><b>Goal I.2</b></p> <p>Establish internal and external interdisciplinary genomics advisory capacity within DPH.</p> <p><b>Short-Term Objectives</b></p> <p>I.2a. Formalize the ongoing internal Gene Team for the purposes of internal genomic development, information dissemination and advocacy within DPH, and expanding the genetic competencies.</p>

**Priorities, Goals,  
& Objectives:**

- I.2b. Identify, recruit and formalize a multidisciplinary external Expert Genomics Advisory Panel with the capability of guiding DPH genomic integration and ongoing efforts. The Panel should consist of researchers, scientists, educators, health professionals, consumers and affected families, payers, community leaders, legal experts, ethicists, and representatives from advocacy groups and appropriate governmental agencies.

**Goal I.3**

Promote genomic public health interests by engaging the public and mobilizing community partnerships at the state and local levels to identify those communities that could benefit from genetic services and provide feedback about related needs and attitudes within the state, and by looking to key players at the national level for guidance and support.

**Short-Term Objectives**

- I.3a. Establish partnerships with local health departments, community groups and health service providers.
- I.3b. Outreach to other state agencies (Departments of Mental Retardation and Social Services, among others) and community providers to clarify and establish appropriate roles for each regarding genomic issues.

**Long-Term Objective**

- I.3c. Monitor community attitudes about genomics and genetic services, and facilitate consensus building for genetic policy development.

**Goal I.4**

Develop policies and practices and support legislation that ensure quality genomics programs throughout the state, and that address the ethical, legal and social implications of the expanding use of genetic testing and genetic information.

**Short-Term Objectives**

- I.4a. Facilitate regular, ongoing review and discussion of ethical, legal and social implications for genomic policy development.
- I.4b. Establish a process for coordinating state genomic policy issues pertaining to genetic testing, disclosure and use of genetic information, guided by reviews of national/state privacy, discrimination, and informed consent policies.

**Long-Term Objectives**

- I.4c. Foster policies and support legislation that improve reimbursement for comprehensive genetic services and coordinated care.
- I.4d. Ensure regular, periodic dissemination of pertinent privacy regulations and policies to public health and other healthcare professionals who are impacted by them.

**Priority II - Genomics Education**

Educate the public about genomics, and ensure a public health and healthcare workforce that is competent in genomics, including the associated ethical, legal and social implications.

**Goal II.1**

Inform the general public and policymakers about genetics and its impact on health.

**Short-Term Objective**

- II.1a. Create a DPH Genomics Speaker's Bureau to reach a variety of audiences.

**Priorities, Goals,  
& Objectives:*****Long-Term Objectives***

- II.1b. Assess community needs for genetic information/education services.
- II.1c. Develop and offer educational programs for school age youth that increase genetic awareness.
- II.1d. Develop and offer educational programs for the general public and disadvantaged groups that increases genetic awareness, including ethical and social implications.

**Goal II.2**

Develop, maintain, and assure availability of a public health and healthcare workforce that is competent in genetics.

***Short-Term Objectives***

- II.2a. Identify opportunities for including genetic information in the breadth of existing programs within DPH, having to do with chronic and infectious diseases, environmental and occupational health, family health and epidemiology.
- II.2b. Create and offer educational opportunities for workforce development among public health and healthcare workers, and build genomics literacy training into ongoing public health training.

***Long-Term Objectives***

- II.2c. Prepare students of public health and other healthcare areas for the role of genetics in professional practice.
- II.2d. Assure availability of a competent genetics workforce particularly genetic counselors and medical geneticists.
- II.2e. Partner with health departments in other states to develop educational materials that could be shared regionally.
- II.2f. Review licensing requirements of health professionals, both generalists and specialists, to consider incorporating genetic competencies.

**Goal II-3**

Develop and implement a regional strategic plan that addresses educational needs.

***Short-Term Objective***

- II.3a. Identify needed partners, and educational areas of common need.

***Long-Term Objective***

- II.3b. Develop regional response to areas of shared genetic education needs.

**Priority III - Services**

Assure equal access to, and appropriate use of genomic services across the lifespan.

**Goal III.1**

Assure high-quality, culturally competent genetic services, and help provide linkages for those needing services.

**Priorities, Goals,  
& Objectives:*****Long-Term Objectives***

III.1a. Continue to assess the need for specific genomic services (public and private), identify ways to assess testing and other genetic services provided in state, and evaluate such services on an ongoing basis to identify and eliminate gaps.

III.1b. Develop a strategic plan for ensuring high quality genetic services across the lifespan.

**Goal III.2**

Assure access to genetic services across the lifespan and across a broad range of conditions including infectious and chronic diseases.

***Short-Term Objective***

III.2a. Assure access to genetic information that is culturally competent and effective in improving health.

***Long-Term Objectives***

III.2b. Assure that all persons with genetic conditions have adequate public/private insurance to pay for needed services.

III.2c. Assure seamless transition for children with genetic conditions to appropriate adult services.

**Goal III.3**

Ensure that an adequate capacity is in place to support the DPH newborn screening program and to address future needed capacity.

***Short-Term Objectives***

III.3a. For the optimal provision of services, continue the implementation of the integration of all child health data.

III.3b. Expand newborn screening resources to support comprehensive testing, tracking, and treatment options.

***Long-Term Objective***

III.3c. Assure that all children with genetic conditions receive coordinated, ongoing, comprehensive care within a medical home.

**Goal III.4**

Expand DPH laboratory capacity to support comprehensive testing, tracking and treatment, options for genetic conditions.

**Priority IV - Information Systems Development & Integration**

Develop a system of linked health databases that enables the monitoring of health status, and that could be enhanced with genetic information.

**Goal IV.1**

Develop a child health informatics profile (HIP-Kids) of child health databases within DPH.



**Priorities, Goals,  
& Objectives:****Goal IV.2**

Expand the HIP-Kids initiative to link with databases external to DPH and to incorporate health information across the lifespan.

***Short-Term Objectives***

IV.2a. Develop a strategy to expand the HIP-Kids.

IV.2b. Identify genetics information currently available within the HIP-Kids data system.

**Goal IV.3**

Seek ways to collect new genetic information from existing data sources for inclusion into HIP-Kids.

***Short-Term Objective***

IV.3a. Incorporate genetics awareness questions into BRFSS.

***Long-Term Objectives***

IV.3b. Analyze SLAITS data specific to Connecticut to assess needs of children with genetic conditions.

IV.3c. Identify new ways to use existing infectious disease, chronic disease, and environmental health data systems to help quantify the genetic basis of disease and to identify populations at risk of developing a genetic-related condition.

**Priority V - Improved Health Outcomes**

Monitor health status to identify health problems linked to genomics.

**Goal V.1**

Use health data linked across divisions to identify genetic risk factors that can be incorporated into existing public health programs and that indicate needed development of new programs across the lifespan.

***Short-Term Objectives***

V.1a. Assess the annual occurrence of newborn metabolic disorders and hemoglobinopathies, hearing disorders, and birth defects.

V.1b. Analyze incidence, mortality, and morbidity data to support existing genetics-related programmatic activities aimed at early intervention, reduction of disease burden, and primary prevention of disease throughout the lifespan.

***Long-Term Objectives***

V.1c. Monitor ongoing demographic trends such as: the aging population and its impact on chronic disease prevalence; growing racial and ethnic diversity; and the impact of delayed childbearing.

V.1d. Encourage the use of genetic information in epidemiological analyses to associate genetics with disease and to support the development of novel genetics-related programs that reach across DPH divisions.

V.1e. Analyze incidence, mortality, and morbidity data to identify environmental factors that may interact with genes to cause disease.

**Priorities, Goals,  
& Objectives:****Goal V.2**

Develop new strategies for linking genetics with adverse health outcomes within the state.

***Long-Term Objectives***

V.2a. Assess the use of family history and other genetics programs in public health.

V.2b. Develop a program that links adverse health outcomes with genetics that can be used to advise on the design of a needed response or intervention.

V.2c. Assure the effectiveness of programs targeted at the prevention and reduction of disease burden of genetics-related diseases.

**Goal V.3**

Review and monitor the scientific merit and adverse health outcomes of genetic tests across the lifespan.

***Long-Term Objectives***

V.3a. Establish models for evaluating adult genetic tests.

V.3b. Review promising genetics tests to support related legislative considerations.

V.3c. Establish a model for ensuring informed consent for genetics tests.

**Goal V.4**

Ensure scientific accuracy of genetics materials.

***Short-Term Objectives***

V.4a Assess research findings for appropriate use in public health.

V.4b Ensure availability of updated genetics materials.

***Long-term Objective***

V.4c. Become a resource for balanced information that tempers commercial marketing.

<b>Subject:</b>	<b>GENOMICS AND GENETICS (2)</b>
<b>Title:</b>	Connecticut Genomics Action Plan: Recommendations and Status Update
<b>Publication Date:</b>	2007
<b>Web Location:</b>	<a href="http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/genomics_action_plan_2007_update.pdf">http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/genomics_action_plan_2007_update.pdf</a>
<b>Authority:</b> (Federal, State, or Other Grant or Initiative)	Not specified
<b>Contact:</b>	Beverly Burke Lead Planning Analyst, Genomics Office (860) 509-7122 <a href="mailto:beverly.burke@ct.gov">beverly.burke@ct.gov</a>
<b>Target or Special Populations:</b>	All Connecticut residents, newborns, children, children with special health care needs
<b>Recommendations:</b>	<ul style="list-style-type: none"> <li>• Continue to engage the public health and health care community in dialogue and activities that increase the awareness, knowledge and skilled delivery of genetic services and which promote genetic literacy among the citizens of Connecticut.</li> <li>• Continue to guide and inform policies on genetics and genomics, and research and respond to opportunities for advocacy of such policy.</li> <li>• Continue to bridge public health with emerging clinical genetics and health care and genetics and genomics research.</li> <li>• DPH review and consider the results of the survey efforts that may yield useful information for future planning efforts and in identifying barriers to access.</li> <li>• Continue to detect, assess and address barriers that may prevent individuals with limited genetics literacy from accessing, comprehending, and taking advantage of genetics related health information and services.</li> <li>• Define the process for sharing information about availability/access to culturally competent genetic services.</li> <li>• Expand existing partnerships with regional, community-based organizations and providers to develop and disseminate culturally competent genetic information.</li> <li>• Assure necessary services are provided for genetic testing, treatment and follow-up services. Continue to identify or create opportunities for networking with providers, affected families, advocates and other stakeholders to ensure quality of and access to needed genetic services.</li> <li>• Assess transition services from pediatric to adult primary care and specialty care services.</li> <li>• DPH continue to monitor the effects of direct-to-consumer (DTC) marketing of genetic tests.</li> </ul>

**Note:**

This is a status update to the 2005 *Genomics Action Plan*. As such, it is not organized into goals, objectives, and strategies consistent with health improvement and strategic plans.

**Subject:** **HEALTHCARE ASSOCIATED INFECTIONS**

**Title:** Connecticut Healthcare Associated Infections. Interim State Plan 2010

**Publication Date:** 2009

**Web Location:** [http://www.ct.gov/dph/lib/dph/state\\_health\\_planning/dphplans/hai\\_plan\\_2010\\_interim.pdf](http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/hai_plan_2010_interim.pdf)

**Authority:** (Federal, State, or Other Grant or Initiative) U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; American Recovery and Reinvestment Act (ARRA); Connecticut Public Act 06-142, "An Act Concerning Hospital Acquired Infections" (CGS 19a-490 n-o).

**Contact:** Richard Melchreit, MD  
Coordinator, Healthcare Associated Infections Program  
(860) 509-7833  
[richard.melchreit@ct.gov](mailto:richard.melchreit@ct.gov)

**Target or Special Populations:** All Connecticut residents

**Purpose:** The purpose of this Plan is to guide the public health surveillance and prevention interventions related to the serious and growing problem of infections associated with health care in Connecticut. It is based on the framework of the national HAI prevention plan. It will guide efforts in Connecticut to track and reduce HAIs for the next 12 to 18 months, until a comprehensive State strategic plan for HAI surveillance and prevention is developed.

**Objectives:**

**HAI Program Infrastructure**

1. Establish a statewide HAI prevention leadership through the formation of multidisciplinary group or state HAI advisory council.
2. Establish an HAI surveillance, prevention, and control program.
3. Integrate laboratory activities with HAI surveillance, prevention, and control efforts.
4. Improve coordination among government agencies or organizations that share responsibility for assuring or overseeing HAI surveillance, prevention, and control.
5. Facilitate use of standards-based formats (e.g., Clinical Document Architecture, electronic messages) by healthcare facilities for purposes of electronic reporting of HAI data.

**Surveillance, Detection, Reporting & Response**

1. Improve HAI outbreak detection and investigation.
2. Enhance laboratory capacity for state and local detection and response to new and emerging HAI issues.
3. Improve communication of HAI outbreaks and infection control breaches.
4. Identify priority prevention targets for surveillance in support of the HHS HAI Action Plan for at least two of the following:
  - a. Central line-associated bloodstream infections
  - b. *Clostridium difficile* infections
  - c. Catheter-associated urinary tract infections
  - d. Methicillin-resistant *Staphylococcus aureus* infections
  - e. Surgical site infections
  - f. Ventilator-associated pneumonia

5. Adopt national standards for data and technology to track HAIs (e.g., NHSN)
6. Develop state surveillance training competencies
7. Develop tailored reports of data analyses for state or region prepared by state personnel.
8. Validate data entered into HAI surveillance (e.g., through healthcare records review, parallel database comparison) to measure accuracy and reliability of HAI data collection.
9. Develop preparedness plans for improved response to HAIs.
10. Adopt integration and interoperability standards for HAI information systems and data sources.
11. Enhance electronic reporting and information technology for healthcare facilities to reduce reporting burden and increase timeliness, efficiency, comprehensiveness, and reliability of the data.
12. Make available risk-adjusted HAI data that enable state agencies to make comparisons between hospitals.
13. Enhance surveillance and detection of HAIs in nonhospital settings.

#### **Prevention**

1. Implement HICPAC recommendations.
2. Establish prevention working group under the state HAI advisory council to coordinate state HAI collaboratives.
3. Establish HAI collaboratives with at least 10 hospitals (i.e., this may require a multi-state or regional collaborative in low population density regions).
4. Develop state HAI prevention training competencies
5. Implement strategies for compliance to promote adherence to HICPAC recommendations.
6. Enhance prevention infrastructure by increasing joint collaboratives with at least 20 hospitals (i.e., this may require a multi-state or regional collaborative in low population density regions).
7. Establish collaborative to prevent HAIs in nonhospital settings (e.g., long term care, dialysis).

#### **Evaluation and Communications**

1. Conduct needs assessment and/or evaluation of the state HAI program to learn how to increase impact.
2. Develop and implement a communication plan about the state's HAI program and progress to meet public and private stakeholders' needs.
3. Provide consumers access to useful healthcare quality measures.
4. Identify priorities and provide input to partners to help guide patient safety initiatives and research aimed at reducing HAIs.

<b>Subject:</b>	<b>HEALTH STATUS AND HEALTH SERVICES</b>
<b>Title:</b>	Looking Toward 2000: An Assessment of Health Status and Health Services
<b>Publication Date:</b>	1999
<b>Web Location:</b>	<a href="http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/looking_toward_2000_fullplan.pdf">http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/looking_toward_2000_fullplan.pdf</a>
<b>Authority:</b> (Federal, State, or Other Grant or Initiative)	<i>Connecticut General Statutes</i> , Section 19a-7. Public Health Planning. State Health Plan. See also CGS, Sec. 19a-7a, 19a-613, 19a-634, and 19a-647.
<b>Contact:</b>	Kristin Sullivan Chief, Planning and Workforce Development Section (860) 509-8070 <a href="mailto:kristin.sullivan@ct.gov">kristin.sullivan@ct.gov</a>
<b>Target or Special Populations:</b>	All Connecticut residents
<b>Connecticut Public Health Priorities:</b>	<p><b>Health Status Priorities</b></p> <p><b>Overall</b></p> <p>Reduce known risk factors and promote early interventions for leading causes of mortality and premature mortality.</p> <p><b>Specific Priorities</b></p> <ol style="list-style-type: none"> <li>1. Prevention and cessation of tobacco use.</li> <li>2. Reduction of the factors associated with intentional, unintentional, and occupational injury.</li> <li>3. Improvement in rates of breast, cervical, and colorectal cancer screening and follow-up.</li> <li>4. Improvement in rates of hypertension detection and control.</li> <li>5. Improvement in rates of diabetes monitoring and control.</li> <li>6. Improvement in diet and rates of blood cholesterol monitoring and control.</li> <li>7. Further determination and reduction of the factors associated with adverse pregnancy outcomes.</li> <li>8. Reduction of risky sexual behavior that leads to acquisition of HIV/AIDS, STDs, and unwanted pregnancy.</li> <li>9. Reduction of physical inactivity.</li> <li>10. Reduction of alcohol abuse.</li> <li>11. Reduction of illicit substance use and practices associated with transmission of infectious diseases.</li> </ol>

**Connecticut Public Health Priorities:**

**Health Services Priorities**

**Overall**

Increase access to care for vulnerable populations, develop and disseminate better health data, and maintain quality health services for the state’s residents.

**Specific Priorities**

1. Reinforce and strengthen the public health infrastructure.
2. Focus resources on the collection, analysis, interpretation, and dissemination of health data and information for better monitoring of the health care delivery system.
3. Promote the development of adequate programs and services for persons 65 years of age and older.
4. Monitor the growth and development of managed care and its impact on the delivery and utilization of personal health care services.
5. Expand access to affordable health insurance and primary and preventive health care services to the uninsured and underinsured.

**Essential Public Health Programs:**

**1. Infectious disease control**

- 1.1. Monitoring and control of all infectious diseases.
- 1.2. Investigation of outbreaks of infectious diseases and food poisoning.
- 1.3. Immunization programs.

**2. Health provider quality assurance**

- 2.1. Setting and enforcing standards for professional provider qualifications and provider and facility quality assurance.

**3. Environmental assurance**

- 3.1. Protection of food and water through the setting and enforcing of quality standards.
- 3.2. Lead abatement in housing and testing of children for blood lead levels.

**4. Health services assurance**

- 4.1. Setting and enforcing standards for preventive health care.
- 4.2. Assuring the provision of health care services to underserved populations.
- 4.3. Family nutrition programs.

**Note:**

This comprehensive state health assessment serves as the State Health Plan in accordance with statutory requirements.

<b>Subject:</b>	<b>HEALTH INFORMATION TECHNOLOGY</b>
<b>Title:</b>	Connecticut State Health Information Technology Plan
<b>Publication Date:</b>	2009
<b>Web Location:</b>	<a href="http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/hit_plan_2009.pdf">http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/hit_plan_2009.pdf</a>
<b>Authority:</b> (Federal, State, or Other Grant or Initiative)	<i>Connecticut General Statutes, Sec. 19a-25d. State-wide health information technology plan.</i>
<b>Contact:</b>	Meg Hooper Chief, Planning Branch (860) 509-8070 <a href="mailto:meg.hooper@ct.gov">meg.hooper@ct.gov</a>
<b>Target or Special Populations:</b>	All Connecticut residents
<b>Overall Goal:</b>	To develop a statewide integrated health information exchange (HIE) network for use by healthcare providers and institutions that are funded by the State of Connecticut.
<b>Project Goals for Connecticut Health Information Network:</b>	<ol style="list-style-type: none"> <li><b>1. Continuity of Care Record</b> Provide patient summary including vital statistics, insurance information, provider information, and other summary information in support of patient transfer or referral.</li> <li><b>2. Electronic Health Record and Health Information Exchange Development</b> Develop direct patient care domain HIE and HER, providing clinical data at the point of care aggregated from multiple clinical settings.</li> <li><b>3. Electronic Medical Record Promotion and Adoption</b> Promote and adopt hospital-based or IPA-based standards-based EMR software application.</li> <li><b>4. Health Information Exchange Hub</b> Develop a centralized infrastructure and support organization that provides data exchange and data management resources.</li> <li><b>5. Medication Management and ePrescribing</b> Integrate medication history through prescription data aggregators as well as pharmacies and providers, in support of exchanging prescriptions and medication information.</li> <li><b>6. Pay-for Performance (Chronic Disease Management)</b> Collect and report on clinical indicators which are tied to provider incentives for program participation and compliance with performance measures.</li> <li><b>7. Personal Health Record</b> Provide patient summary, including vital statistics, insurance information, provider information, and other summary information in support of patient care and patient involvement in the care process.</li> <li><b>8. State Health Agencies HIE and Program Registry Platform</b> Collect and manage data in support of public health programs and public health oversight functions.</li> <li><b>9. Mentoring &amp; Evaluation HIE and Data Warehouse</b> Develop data collection, analysis, and reporting based projects, using de-identified data that support the overall quality of the Connecticut healthcare system.</li> </ol>

**Note:**

The above items comprise the elements of Appendix N of the State Health Information Technology Plan, re-worded as goal statements for the purposes of this Directory.



<b>Subject:</b>	<b>HIV/AIDS</b>
<b>Title:</b>	Connecticut Comprehensive HIV Care and Prevention Plan, 2009-2012
<b>Publication Date:</b>	2009
<b>Web Location:</b>	<a href="http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/hiv_care_prev_plan_2009_2012.pdf">http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/hiv_care_prev_plan_2009_2012.pdf</a>
<b>Authority:</b> <i>(Federal, State, or Other Grant or Initiative)</i>	Centers for Disease Control and Prevention, HIV Prevention Grant; Health Resources and Services Administration, Ryan White Part B Grant
<b>Contact:</b>	Chris Andresen Manager, AIDS and Chronic Diseases Section 860 (509-7828 <a href="mailto:chris.andresen@ct.gov">chris.andresen@ct.gov</a>
<b>Target or Special Populations:</b>	Adults, youths, HIV-positive persons, injection drug users, men who have sex with men, heterosexuals, prison inmates, people living with HIV/AIDS (PLWHA), gay men, African Americans, Hispanics
<b>Plan Goals:</b>	<ol style="list-style-type: none"> <li>1. To create an ideal system of care and prevention that creatively responds to the needs of the target population with a focus on getting people into primary care and treatment.</li> <li>2. To decrease the number of HIV infections.</li> <li>3. To create appropriate links for a comprehensive continuum of care that increases efficiency and avoids duplication of effort.</li> <li>4. To maximize resources through efficacy of planning and allocation, flexibility, and effective program fiscal management.</li> </ol>
<b>Objectives:</b>	<p><b>Collaboration</b></p> <ol style="list-style-type: none"> <li>1. Implement a fully collaborative statewide needs assessment for both in care and/or out-of-care in 2010 to allow for uniformity and strength of data, the CHPC, its members and partners (Ryan White Parts A, B, C, D, F/SPNS) and prevention. This will involve the examination of timelines to meet federal guidance for each Part, to ensure each group receives their data in a timely fashion. The survey would be developed in full cooperation with direct input from all Ryan White Parts and prevention.</li> <li>2. Collaborate with all stakeholders to develop a model for a service matrix analysis process to further understand the HIV/AIDS prevention and care landscape. This will include services, utilization, and epidemiology. The service matrix analysis should drive the Part B and Prevention RFP process, and inform the Ryan White Parts A, C, D, F in their planning processes.</li> </ol> <p><b>Service Capacity</b></p> <ol style="list-style-type: none"> <li>3. Create a procedure to collect, analyze, monitor and share with stakeholders client level data to provide the most accurate picture of HIV/AIDS in Connecticut among all Ryan White Parts and Prevention.</li> <li>4. Explore methods to address barriers to services.</li> </ol>

**Objectives:****Public Awareness and Training**

5. Provide training and continuing education for medical practitioners on risk assessment and risk reduction, secondary prevention and available HIV care and prevention services to link all individuals to appropriate HIV care and prevention services and applicable state services.
6. Provide ongoing training to medical case managers (MCMs) on the medical model and clinical practices, and available resources and services within the state.

**Outcomes:****Client Level**

1. Expedient referrals to prevention/care services.
2. Services are culturally competent.
3. Clients referred for care, remain in care.
4. Increased quality.

**Community Level**

1. Decreased number of HIV infections.
2. Decreased number of AIDS cases.
3. Decreased number of sexually transmitted diseases.
4. Increased newly identified HIV + cases.
5. Increased referrals and enrollment in CADAP.
6. Increased number of HIV tests for persons contacted after PCRS notification.
7. Increased proportion of persons completing HERR sessions.
8. Increased number of HIV+ inmates who receive outreach, education and referral to health care, prevention, and entitlements both pre- and post-release.
9. Increased accessible prevention /care services (Possible co-location of services).
10. Increased the number of clients who access prevention/care services.

**State Level**

1. Increased cost effectiveness.
2. Increased efficiency.

**Recommendations  
for Improving HIV  
Prevention for Youth:**

1. Give youth all the facts.
2. Teach adults how to engage youth.
3. Start younger.
4. Make it easier for young people to participate.
5. Involve youth in decision-making.

<b>Subject:</b>	<b>INFLUENZA, PANDEMIC</b>
<b>Title:</b>	Pandemic Influenza Response Plan
<b>Publication Date:</b>	2006
<b>Web Location:</b>	<a href="http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/pan_flu_plan_2feb06.pdf">http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/pan_flu_plan_2feb06.pdf</a>
<b>Authority:</b> (Federal, State, or Other Grant or Initiative)	Connecticut General Statutes, Public Act 03-236, Section 8, and such Executive Orders and Special Acts, as may be applicable. Emergency Response Plans and Annexes are required under <i>Connecticut General Statutes</i> , Section 28-7(a) of Title 28, Chapter 517.
<b>Contact:</b>	Matthew Cartter, MD State Epidemiologist; Chief, Infectious Diseases Section (860) 509-7995 <a href="mailto:matt.cartter@ct.gov">matt.cartter@ct.gov</a>
<b>Target or Special Populations:</b>	All Connecticut residents
<b>Overall Objective:</b>	To provide a framework for government agencies and private organizations to work together to mitigate the consequences of pandemic influenza.
<b>Purpose:</b>	To support the following four functions of the Connecticut emergency response effort: <ol style="list-style-type: none"> <li>1. Maximize the protection of lives and health care properties while minimizing preventable morbidity and mortality.</li> <li>2. Document the DPH procedures to implement when responding to an influenza pandemic that threatens the public health of Connecticut.</li> <li>3. Contribute to emergency support functions (ESF), as appropriate, particularly ESF #8 (Public Health and Medical Services) at the state level to define policies and procedures for DPH and other public health partners in preparation for, and in response to, an influenza pandemic.</li> <li>4. Enable the Connecticut Department of Public Health to continue to operate and provide essential services as effectively as possible in the event of an influenza pandemic.</li> </ol>

**Note:**

This is an operations plan. As such, it is not organized into goals, objectives and strategies consistent with health improvement plans and strategic plans.

<b>Subject:</b>	<b>INJURY</b>
<b>Title:</b>	Connecticut Injury Prevention and Control Plan, 2008-2012
<b>Publication Date:</b>	2008
<b>Web Location:</b>	<a href="http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/injury_prev_plan_2008-2012.pdf">http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/injury_prev_plan_2008-2012.pdf</a>
<b>Authority:</b> (Federal, State, or Other Grant or Initiative)	Centers for Disease Control and Prevention, Integrated Core Injury Prevention & Control grant
<b>Contact:</b>	Eileen Boulay Nurse Consultant, Asthma Control and Injury Prevention Programs (860) 509-7298 <a href="mailto:eileen.boulay@ct.gov">eileen.boulay@ct.gov</a>
<b>Target or Special Populations:</b>	All Connecticut residents, children, women, college students, adolescents, older adults, persons 65+ years of age, workers.
<b>Priority Injuries:</b>	<ul style="list-style-type: none"> <li>• Older adult falls.</li> <li>• Suicides and self-inflicted injuries.</li> <li>• Homicides and assault injuries.</li> <li>• Motor vehicle crashes.</li> </ul>
<b>Goals &amp; Objectives:</b>	<p><b>Overarching Goals</b></p> <ul style="list-style-type: none"> <li>• Increase the quality, availability and timeliness of statewide and community specific data for planning, surveillance, and evaluation.</li> <li>• Establish a sustainable infrastructure to coordinate, monitor, and evaluate state plan implementation.</li> <li>• Build community capacity to reduce and prevent injuries to high-risk groups and effectively address injury priorities.</li> <li>• Improve awareness of injury prevention among stakeholders and the general public</li> <li>• Increase the use of evidence-based interventions.</li> <li>• Build capacity to develop evaluation measures that assess the impact of the state injury plan, and other injury prevention initiatives and interventions.</li> <li>• Strengthen advocacy for public policies that impact injury prevention.</li> </ul> <p><b>Unintentional Injuries</b></p> <p><b>Goals</b></p> <ul style="list-style-type: none"> <li>• Reduce Injuries, Disabilities and Deaths Due to Unintentional Injuries.</li> <li>• Reduce Substance Abuse to Protect the Health, Safety, and Quality of Life for All.</li> </ul>

**Goals & Objectives:****Objectives*****General***

- By 2010, Reduce deaths caused by unintentional injuries to no more than 33 per 100,000 population.
- By 2010, Reduce hospitalizations for nonfatal unintentional injuries to no more than 421 per 100,000 population.

***Motor Vehicle Crashes***

- By 2010, Reduce deaths caused by motor vehicle crashes to no more than 8.5 per 100,000 population.
- By 2010, Reduce hospitalizations caused by motor vehicle crashes to no more than 65.0 per 100,000 population.
- By 2010, Reduce pedestrian deaths on public roads to no more than -TBD per CDC, Healthy People 2010
- By 2010, Reduce nonfatal pedestrian injuries to no more than -TBD per CDC, Healthy People 2010.
- By 2010, Increase use of safety belts to 86%.
- By 2010, Reduce the percentage of motor vehicle fatalities that are alcohol-related to 41.0 %.
- By 2010, Reduce the proportion of adolescents who report that they rode with a driver who had been drinking alcohol to no more than 26.5%.

***Falls***

- By 2010, Reduce deaths from falls to no more than 5.3 per 100,000 population.
- By 2010, Reduce hospitalizations due to falls to no more than 245.0 per 100,000 population.
- By 2010, Maintain the rate of hip fractures among adults age 65 and older at no more than 681 per 100,000 population.

***Fire/Burn Related***

- By 2010, Reduce fire-and burn-related deaths to no more than 0.7 per 100,000 population.
- By 2010, Reduce hospitalizations caused by fires and burns to no more than 7.3 per 100,000 population.

***Poisoning***

- By 2010, Reduce deaths caused by unintentional poisonings to no more than 7.8 per 100,000.
- By 2010, Decrease the hospitalization rate from non-fatal poisonings to no more than 19.9 per 100,000.

***Drowning***

- By 2010, Reduce deaths caused by drowning to no more than 0.6 per 100,000 population.

**Goals & Objectives:*****Suffocation***

- By 2010, Reduce deaths caused by suffocation to no more than 3.3 per 100,000 population.

***Intentional Injuries*****Goals**

- Reduce Injuries, Disabilities and Deaths Due to Violence.
- Improve Mental Health and Insure Access to Appropriate, Quality, Mental Health Services.
- Reduce Substance Abuse to Protect the Health, Safety, and Quality of Life for All.

**Objectives*****All Intentional Injury***

- By 2010, Reduce Intentional Injury Deaths to no more than 10.8 per 100,000 Total Population.
- By 2010, Reduce Intentional Injury Hospitalizations to no more than 50.5 per 100,000 Total Population.
- By 2010, Reduce firearm related deaths to no more than 4.4 per 100,000 total population.
- By 2010, Reduce firearm related injuries to no more than 5.4 per 100,000 total population.
- Improve intentional injury-related data access, quality and use.
- Enhance evaluation of intentional injury-related programs and services.
- Develop, implement, facilitate more comprehensive prevention and early interventions for children and youth.
- Develop, implement and facilitate more comprehensive prevention and early interventions focused on adults and elders.

***Homicide and Assault***

- By 2010, Reduce homicides to no more than 2.8 per 100,000 population.
- By 2010, Reduce assault injuries to no more than 15 per 100,000 population.
- By 2010, Reduce the incidence of physical fighting among high school youth to no more than 28% of high school students being in a physical fight.

***Child Maltreatment***

- By 2010, Reduce child maltreatment to no more than 21,671 (rate of 25.7 per 1,000 children) Abuse/Neglect/Uncared for substantiated allegations.

***Dating/Domestic/Intimate Partner Violence***

- By 2010, Reduce the number of family violence victims who are spouses, former spouses, live-ins, boyfriend, girlfriend to no more than 16,000 victims. (469.3 per 100,000 population).

**Goals & Objectives:*****Sexual Violence***

- By 2010, Reduce the annual rate of rape to no more than 20.1 per 100,000 persons.
- By 2010, Reduce the annual rate of rape to no more than 40.3 per 100,000 females.
- By 2010, Reduce forcible rape offenses to no more than 276 arrests/offenses (rate of 8.1 per 100,000 persons).
- By 2010, Reduce sex offenses to no more than 750 arrests/offenses (rate of 22.0 per 100,000 persons).

***Child Sexual Abuse***

- Reduce child sexual abuse to no more than 660 (rate of 0.78 per 1,000) cases of substantiated child sexual abuse allegations per year.

***Suicide, Self-inflicted Injury, Attempted Suicide***

- By 2010, Reduce the suicide rate to no more than 8.0 per 100,000 total population.
- By 2010, Reduce suicide self-inflicted injuries to no more than 32.0 per 100,000 total population.
- By 2010, Reduce suicide attempts among adolescents to no more than 8% reported suicide attempts -high school students.

**Traumatic Brain Injury****Objectives**

- By 2010, Reduce deaths due to traumatic brain injuries to no more than 11.0 per 100,000 population.
- By 2010, Reduce hospitalizations for traumatic brain injuries to no more than 65.0 hospitalizations per 100,000 population.

**Occupational Injury****Objectives**

- By 2010, Reduce deaths from work-related injuries to no more than 2.0 per 100,000 workers.
- By 2010, Reduce hospitalizations (or emergency room visits) due to work-related injuries to no more than -TBD.
- By 2010, Reduce work-related injuries resulting in medical treatment, lost time from work, or restricted work activity to no more than - TBD.

<b>Subject:</b>	<b>LEAD POISONING, CHILDHOOD</b>
<b>Title:</b>	Plan to Eliminate Childhood Lead Poisoning in Connecticut by 2010
<b>Publication Date:</b>	2004
<b>Web Location:</b>	<a href="http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/childhood_lead_plan_2010.pdf">http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/childhood_lead_plan_2010.pdf</a>
<b>Authority:</b> <i>(Federal, State, or Other Grant or Initiative)</i>	Centers for Disease Control and Prevention, Preventive Health and Health Services Block Grant
<b>Contact:</b>	Francesca Provenzano Health Program Supervisor, Childhood Lead Poisoning Prevention and Control Program & Radon Program (860) 509-7367 <a href="mailto:francesca.provenzano@ct.gov">francesca.provenzano@ct.gov</a>
<b>Target or Special Populations:</b>	Children less than 6 years of age, WIC enrollees
<b>Overall Goal:</b>	To decrease the rate of children under 6 years of age residing in Connecticut with blood lead levels of 10 µg/dL or above to less than 1%.
<b>Recommendations:</b>	<p><b>Environment and Housing</b></p> <ol style="list-style-type: none"> <li>1. Modify current regulations and statutes to lower the threshold for mandatory epidemiological investigation from 20 µg/dL to a confirmed blood lead level of 15 µg/dL. Explore mechanisms for providing increased support to local health departments most directly impacted by the increased case-load.</li> <li>2. Revise the Connecticut Public Health Code, statutes, and state regulations to strengthen the ability of the state and local health departments to enforce existing codes, statutes, and regulations.</li> <li>3. Expand the use of lead safe work practices for lead abatement, hazard reduction, and home maintenance and improvement by: (1) mandating that contractors, maintenance personnel, or property owners participate in trainings, (2) funding trainings for contractors, maintenance personnel and property owners be trained prior to doing work that may generate lead dust or fumes, (3) expanding the resources available to support the costs of undertaking these efforts, and (4) making regulatory changes to allow for lead-safe work practices. These will include interim controls to be utilized in place of full abatement in circumstances where an EBLL (elevated blood lead level) child is NOT involved.</li> <li>4. Enforce compliance with existing HUD lead safety requirements through improved inspection. Expand application of these requirements to all other Federal Rental Assistance Programs, State Assistance Programs (including Rental Assistance Program, RAP), and all other local Certificate of Occupancy Programs.</li> <li>5. Implement the use of "Limited Lead Hazard Evaluations" during other (non-lead) home inspections in CT by requiring their addition to all ongoing housing inspections by local code officials and sanitarians and by private, Department of Consumer Protection (DCP) licensed home inspectors.</li> </ol>



**Recommendations:**

6. Encourage homeowners to test their own property for lead by eliminating the reporting requirements to the State and local health department (LHD) when a certified private sector Lead Inspector inspects an owner-occupied single family home, providing there is not a child under the age of six (6) years with a known EBLL in residence. Consideration will be given to expanding this exclusion on reporting requirements for other private sector inspections of residential properties that do not involve an EBLL child.
7. Explore the development of a web-based registry of lead safe and lead-free properties to be maintained on a statewide basis by a private entity.
8. Develop guidelines on cases under which it may be permissible to allow children to remain in residence during abatement; in all other cases relocation will be required during abatement.

**Screening**

1. Legislatively mandate blood lead screening for all one and two year olds in Connecticut.
2. Expand methods to monitor compliance with this new screening mandate by: (1) collaborating with CT Department of Social Services (DSS) and their Medicaid managed care organizations (MCO) to address provider compliance, (2) requiring that family, group, and center child care facilities monitor and report missing lead screenings of one and two year olds entering their programs, (3) exploring with the Women, Infants and Children Program (WIC) the addition of lead screening as a condition of enrollment and recertification in the program as well as the training of WIC case workers to encourage lead testing with their clients (concurrent with currently required hemoglobin testing); and by (4) adding lead testing to the medical form required by DCF for new cases whenever a child under 5 years old is involved in a complaint of abuse or neglect.
3. Utilize the new CLPPP system to identify for LHD all children within their jurisdiction who have not been screened by the age of 2 to monitor and improve compliance with new screening requirements.
4. Increase capacity to provide lead testing services at the State Laboratory including: private pay reimbursements for blood lead tests and personnel and equipment to handle the anticipated increase in blood lead level screenings as well as environmental testing (dust wipes, paint chips).
5. Investigate the possibility of generating revenue by creating a nominal tax or fee that would be tied to the housing market through closing costs to support lead screening efforts.

**Case Management**

1. Establish regulations to require case management for all children in Connecticut with blood lead levels of 20 µg /dL or greater, by amending State statutes.
2. Enhance and improve case management for children with EBLLs in Connecticut by: (1) working with DSS to require more clinical case management by Medicaid Managed Care Organizations (MCOs) with EBLLs as the criteria that triggers and justifies case management. (2) building partnerships among MCOs and the Regional Lead Treatment Centers (RLTCs), and (3) piloting, evaluating, and then expanding intensive efforts to improve case management in Connecticut's five largest cities.
3. Expanding resources for case management services of EBLL children in Connecticut by restoring to previous levels, and securing additional funding for case management and other supportive services, provided by the two RLTCs. Seek opportunities for additional funding for LHDs to enhance their capacity to assist with case management.

**Recommendations:**

4. Promote the use of Lead Safe Homes for families whose homes are being abated by: (1) enforcing requirement for LHDs to relocate families with a child with an EBL, (2) building partnerships with other housing programs, and (3) expanding and supporting Lead Safe Homes by ensuring adequate resources for their survival.
5. Improve case management at the LHDs by increasing oversight and support to local programs from CLPPP, DPH Lead Environmental Management Unit (LEMU), and the RLTCs.

**Surveillance**

1. Develop surveillance data for programmatic use, increase compliance with existing reporting (lab based) of blood lead levels, and utilize Geographic Information systems (GIS) mapping to match EBL cases with abatement activities.
2. Partner with the immunization registry to identify providers who consistently fail to screen their patients for lead poisoning at 1 and 2 years of age.

**Training and Public Information**

1. Coordinate all lead poisoning public information and training efforts statewide. Establish an organization/body to serve as a central clearinghouse for training and public information activities.
2. Increase the level of awareness, concern, and compliance among target audiences through a statewide public information/ social marketing campaign.
3. Enhance ongoing statewide training efforts through better coordination, expanded availability, better recruitment, and enhanced publicity/recruitment through the organization/ program developed in Training and Public Information Recommendation 1.

**Note:**

The following objectives were revised after publication of the plan:  
 Environment & Housing, Objective1;  
 Surveillance, Objectives1 and 2.

<b>Subject:</b>	<b>LOW BIRTHWEIGHT</b>
<b>Title:</b>	Low Birth Weight Outcomes and Disparities in Connecticut: A Strategic Plan for the Family Health Section, Department of Public Health
<b>Publication Date:</b>	2009
<b>Web Location:</b>	<a href="http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/low_bwt_strategic_plan_2009.pdf">http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/low_bwt_strategic_plan_2009.pdf</a>
<b>Authority:</b> (Federal, State, or Other Grant or Initiative)	Not specified
<b>Contact:</b>	Rosa Biaggi Section Chief, Family Health Section (860) 509-7773 <a href="mailto:rosa.biaggi@ct.gov">rosa.biaggi@ct.gov</a>
<b>Target or Special Populations:</b>	Women of childbearing age, women 15-44 years of age, pregnant women, Medicaid eligibles and enrollees, WIC enrollees, newborns, racial and ethnic minority groups.
<b>Recommendations:</b>	<ol style="list-style-type: none"> <li><b>1. Address Individual-level Factors</b> <ol style="list-style-type: none"> <li>1a. Pursue ways to increase Preconception Care for all women of childbearing age (15-44 years).</li> <li>1b. Promote the use of the CenteringPregnancy® model of prenatal care.</li> <li>1c. Expand tobacco use cessation programs targeted to pregnant women.</li> </ol> </li> <li><b>2. Address Environmental-level and Community-level Factors</b> <ol style="list-style-type: none"> <li>2a. Develop and implement measures for addressing psychosocial factors in women's lives.</li> <li>2b. Maximize co-enrollment in WIC and Medicaid for all eligible women.</li> <li>2c. Assure the quality of and access to health care services before, during, and after pregnancy.</li> <li>2d. Engage and partner with medical providers.</li> <li>2e. Increase activities around male involvement.</li> </ol> </li> <li><b>3. Address System-level Factors</b> <ol style="list-style-type: none"> <li>3a. Identify funding to implement an ongoing PRAMS-like survey.</li> <li>3b. Investigate the role of racial and ethnic discrimination as it relates to both acute and chronic stress in the lives of women, and how it impacts the health care they seek and receive.</li> <li>3c. Conduct intragroup studies to better understand racial and ethnic disparities in health outcomes.</li> <li>3d. Foster greater collaboration between State agencies, with a commitment to reduce health disparities in LBW in Connecticut and work collaboratively across programs.</li> </ol> </li> </ol>

<b>Subject:</b>	<b>MATERNAL AND CHILD HEALTH SERVICES</b>
<b>Title:</b>	Maternal and Child Health Services Title V Block Grant: State Narrative for Connecticut, Application for 2010
<b>Publication Date:</b>	2009
<b>Web Location:</b>	<a href="http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/mch_block_grant_2010.pdf">http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/mch_block_grant_2010.pdf</a>
<b>Authority:</b> <i>(Federal, State, or Other Grant or Initiative)</i>	U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, Maternal and Child Health Services Title V Block Grant
<b>Contact:</b>	Marcie Cavacas Supervising Epidemiologist, Family Health Section (860) 509-7775 <a href="mailto:marcia.cavacas@ct.gov">marcia.cavacas@ct.gov</a>
<b>Target or Special Populations:</b>	Women, pregnant women, women of childbearing age, men, newborns, infants, children, adolescents, low-income women and children, children and youth with special health care needs, Medicaid-eligible persons, State Child Health Insurance Program (SCHIP)-eligible persons, uninsured and underinsured persons, uninsured children, WIC (Women, Infants, and Children) enrollees, youths 15-19 years of age, youths 15-24 years of age
<b>Purpose:</b>	The MCH Services Block Grant is designed to provide quality maternal and child health services for mothers, children and adolescents (particularly of low income families), to reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children, and to treat and care for children with special health care needs. The MCH Block Grant program is the only Federal/State program whose sole purpose is to build system capacity to enhance the health status of mothers and children.
<b>State Priorities and 2013 State Performance Objectives (SPO's):</b>	<p><b>Data (Public Health Information Network)</b></p> <p><b>Priority 1</b> Strengthen data collection and reporting SPO-1. Increase to 7 the cumulative number of datasets incorporated into integrated warehouse (called HIP-KIDS)</p> <p><b>Collaborative Agreements</b></p> <p><b>Priority 2</b> Establish collaborative relations at the state/local level SPO-2. Increase to 40 the cumulative number of formal agreements, in the format of Memoranda of Agreements (MOA's) and collaborative agreements, that serve the needs of the three MCH populations</p> <p><b>Intentional Injuries</b></p> <p><b>Priority 3</b> Reduce intentional injuries. SPO-3. Decrease to 32.3% the percent of 9-12 graders who reported being in a fight within the past 12 months.</p>

**State Priorities and 2013 State Performance Objectives (SPO's):**

**Adolescent Health**

**Priority 4**

Improve adolescent health status

SPO-4. Increase to 16.5% the percent in the number of adolescents 10-20 years old who receive services in school based health centers

**Obesity**

**Priority 5**

Promote nutrition and exercise to reduce obesity

SPO-5. Increase to 10% the percent of schools that have used a program to reduce obesity through physical exercise and nutrition education programs

**Adolescent Health**

**Priority 6**

Increase access to pre-conception education and parenting

SPO-6. Increase to 71.5% the percent of infants born to women under 20 years of age receiving prenatal care in the first trimester

**Children and Youth with Special Health Care Needs**

**Priority 7**

Promote access to family support services including respite care and medical home system of care for children and youth with special health care needs

SPO-7. Increase to 54.7% the percent of children and youth with special health care needs (CYSHCN) who receive family-centered community-based, culturally-competent, comprehensive, coordinated family/caregiver support services, including respite in the Regional Medical Home System of Care

**Disparities**

**Priority 8<sup>a</sup>**

Reduce health disparities especially related to access to care, race/ethnicity, and geographic location. (Specific issues. teen pregnancy, low birthweight, prenatal care, breastfeeding, and infant mortality)

**Priority 9<sup>b</sup>**

Collaborate with the other federal Region 1 states to develop indicators that measure the collective assets of their early childhood health systems, "specifically focusing on their collective assets regarding child care health consultants (CCHC)."

**2013 National Performance Objectives (NPO's):**

**Newborn Screening**

NPO-1. 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 (100%)

**2013 National  
Performance  
Objectives (NPO's):**

**Children with Special Health Care Needs**

NPO-2. 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 (59.8%)

NPO-3. The percent of children with special health care needs age 0 to 18 years who receive coordinated, ongoing, comprehensive care within a medical home (48.5%)

NPO-4. 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 (61.7%)

NPO-5. The 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 (89.4%)

NPO-6. 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 (43.3%)

**Childhood Immunizations**

NPO-7. 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 (90.2%)

**Teen Births**

NPO-8. The rate of births (per 1,000) for teenagers aged 15 through 17 years (11.7 per 1,000)

**Oral Health**

NPO-9. Percent of third grade children who have received protective sealants on at least one permanent molar tooth (42%)

**Unintentional Injuries - Motor Vehicle Crashes**

NPO-10. The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children (0.9 deaths/100,000)

**Nutrition - Breastfeeding**

NPO-11. The percent of mothers who breastfeed their infants at 7 months of age (53%)

**Newborn Hearing Screening**

NPO-12. Percentage of newborns who have been screened for hearing before hospital discharge (99.6%)

**Health Insurance Coverage**

NPO-13. Percent of children without health insurance (4.9%)

**Obesity**

NPO-14. Percentage of children, ages 2 to 5 years, receiving WIC services with a body mass index (BMI) at or above the 85th percentile (31.6%)

**2013 National Performance Objectives (NPO's):****Tobacco Use**

NPO-15. Percentage of women who smoke in the last three months of pregnancy (0.1%)

**Teen Suicide**

NPO-16. The rate (per 100,000) of suicide deaths among youths ages 15 through 19 (6 deaths per 100,000)

**Low Birthweight**

NPO-17. Percent of very low birthweight infants delivered at facilities for high-risk deliveries and neonates (87.8%)

**Prenatal Care**

NPO-18. Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester (88.5%)

**2009 Health Status Measures (HSM's):<sup>c</sup>****Low Birthweight**

HSM-1A. The percent of live births weighing less than 2,500 grams (< 8.1%)

HSM-2A. The percent of live births weighing less than 1,500 grams (< 1.5%)

HSM-2B. The percent of live singleton births weighing less than 1,500 grams (< 1.1%)

**Unintentional Injuries**

HSM-3A. The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger (< 3.7 deaths per 100,000)

HSM-3B. The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes (<1.5 deaths per 100,000)

HSM-3C. The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years (< 15.8 deaths per 100,000)

**Non-fatal Injuries**

HSM-4A. The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger (<228.8 per 100,000)

HSM-4B. The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger (<18.8 per 100,000)

HSM-4C. The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years (<148.7 per 100,000)

**Sexually Transmitted Diseases**

HSM-5A. The rate per 1,000 of women aged 15 through 19 years with a reported case of chlamydia (<32.5 per 1,000)

HSM-5B. The rate per 1,000 of women aged 20 through 24 years with a reported case of chlamydia (<8.9 per 1,000)

**2009 Health Systems Capacity Measures (HSCM's):<sup>d</sup>**

**Asthma**

HSCM-1. The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age (< 37.3 per 10,000)

**Screenings**

HSCM-2. The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen (> 94.2%)

HSCM-3. The percent State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen (> 82%)

**Prenatal Care**

HSCM-4. 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 (> 79.1%)

HSCM-5C. Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester (> 85.8%)

HSCM-5D: Percent of pregnant women with adequate prenatal care (observed) to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index] (> 80.2%)

**Low Birthweight**

HSCM-5A. Percent of low birthweight [<2,500 grams] (Medicaid, <9.5%; non-Medicaid, <7.5%; All, <8.2%)

**Infant Deaths**

HSCM-5B. Infant deaths per 1,000 live births (Medicaid, <6.8/1,000; non-Medicaid, <4.7/1,000; All, < 5.4/1,000)

**Eligibility in SCHIP Program**

HSCM-6A. The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs (Infants 0 to 1 year, 185%; Medicaid children, 185%; pregnant women, 250%)

HSCM-6B. The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs (Infants 0 to 1 yr, 300%; Medicaid children, 300%; Pregnant women, 250%)

**Access to Care**

HSCM-7A: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program (>54.9%)

**Oral Health**

HSCM-7B. The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year (52.3%)

**Children with Special Health Care Needs**

HSCM-8. 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. (> 8.8%)

**Notes:**

<sup>a</sup> There is no objective for Priority 8 because health disparities are incorporated across all other objectives.

<sup>b</sup> The objective for Priority 9 was eliminated from reporting because most of the Region 1 (New England) states did not have data on day care centers with child health care consultants.

<sup>c</sup> Target values for Health Status Measures were not specified for 2009 in the plan, and thus are expressed here as less than (<) or more than (>) the actual values from the most recent year.

<sup>d</sup> Target values for Health Systems Capacity Measures were not specified for 2009, and thus are expressed here as less than (<) or more than (>) the actual values from the most recent year.



<b>Subject:</b>	<b>NEWBORN HEARING SCREENING</b>
<b>Title:</b>	Planning Document: Newborn Hearing Screening Program Goals and Objectives, July 1, 2005 - June 30, 2008
<b>Publication Date:</b>	2005
<b>Web Location:</b>	Not available
<b>Authority:</b> (Federal, State, or Other Grant or Initiative)	Department of Health and Human Services, Health Resources and Services Administration, Universal Newborn Hearing Screening and Early Intervention Grant
<b>Contact:</b>	Rosa Biaggi Section Chief, Family Health Section (860) 509-7084 <a href="mailto:rosa.biaggi@ct.gov">rosa.biaggi@ct.gov</a>
<b>Target or Special Populations:</b>	Children, infants, newborns
<b>Goals &amp; Objectives:</b>	<p><b>Goal 1</b></p> <p>To establish a continuous, formalized program to track infants lost to follow-up.</p> <p><b>Objectives</b></p> <ol style="list-style-type: none"> <li>1. By December 1, 2005, a Health Program Assistant will be hired to assist in tracking infants who were discharged without a hearing screen or who were identified as at-risk for hearing loss from the initial screen and did not receive audiological follow-up.</li> <li>2. By March 1, 2006 a formalized Child Find program will be established.</li> </ol> <p><b>Goal 2</b></p> <p>To assure that all hearing-impaired infants receive ongoing monitoring and are linked to a medical home to assure quality developmental outcomes</p> <p><b>Objectives</b></p> <ol style="list-style-type: none"> <li>1. By March 1, 2006, DPH will contract with the three statewide early intervention audiology centers that specialize in working with infants and children who are deaf or hearing-impaired to provide ongoing monitoring and follow-up of infants with hearing loss who are not eligible for EI services.</li> <li>2. By July 1, 2006, 90% of families of infants with unilateral hearing loss or a bilateral hearing loss of &lt;40db will be linked to a medical home, providers will be educated on developmental milestones, and families will be educated on environmental modifications that can facilitate hearing and speech development. The audiologists will provide a comprehensive audiological assessment at no charge to the family for those infants in which it is not a covered health insurance benefit. The assessments will include an OAE screening, tympanogram, acoustic reflex testing, ABR threshold measurement with frequency specific tone bursts, air and/or bone conduction ABR, speech discrimination assessment, visual reinforcement and play conditioning for the child 2 to 2 1/2 years old. At the completion of this funding project, the audiologists will prepare a report on the benefits of ongoing monitoring, family education, and support. The information will be presented to the CT Birth-to-Three Advisory Board, and they will be asked to reconsider eligibility guidelines for infants with hearing loss.</li> </ol>

**Goals & Objectives:****Goal 3**

To have a mechanism in place to provide ongoing follow-up to infants who screen negative but are identified as at-risk for hearing loss

**Objectives**

1. By July 1, 2006, UNHS staff will have a plan and protocols developed to implement a follow-up monitoring program for the children at risk for hearing loss.
2. By July 1, 2006 the UNHS staff will collaborate with the CT Newborn Hearing Screening Task Force and will outline recommendations for follow-up monitoring of the infants and children at risk.
3. By October 1, 2006, DPH will increase awareness about risk indicators through education to hospital newborn screening staff in the 31 birth facilities. Hospital screening staff will be educated on the identification of risk indicators in newborns and the importance of educating families about the importance of ongoing monitoring of these at-risk infants.
4. The Department of Public Health will develop informational materials pertaining to audiological follow-up and monitoring for these infants and will disseminate the information to all health care providers by November 1, 2006. The Nurse Managers will be asked to assist in the development of the materials and/or to evaluate the materials before finalized to increase their involvement and awareness in the process.

**Goal 4**

Ensure that all birthing facilities with NICUs provide standardized newborn hearing screening prior to discharge

**Objectives**

1. Provide funding to 4 NICUs to purchase ABR screening equipment so that all high-risk infants will have an ABR screening conducted prior to hospital discharge.
2. By March 1, 2006, 100% of all NICUs will have ABR screening equipment available to screen high-risk infants.
3. By July 1, 2006 90% of all NICU infants will have an ABR screening before discharge.

**Goal 5**

To provide informational and educational materials for families and health care providers on hearing screening, risk indicators, diagnostic and genetic evaluations, and early intervention options

**Objectives**

1. By December 1, 2005 a pamphlet will be developed for families with information on the availability of genetic testing in hearing loss.
2. By June 30, 2006 a resource guide will be developed to educate health care providers on all aspects of the UNHS program and support services available for families of infants with hearing loss.
3. By June 30, 2006 an educational newborn hearing conference will be held for audiologists, otolaryngologists, and PCPs to inform them about all aspects of the UNHS program and to educate them on the advances in medical genetics and hearing loss.

**Note:**

These goals and objectives were extracted from the Universal Newborn Screening Application, Grant No. H61MC00088

<b>Subject:</b>	<b>NUTRITION EDUCATION</b>
<b>Title:</b>	Connecticut Supplemental Nutrition Assistance Program - Education (SNAP-Ed), 2009-2010 (Draft)
<b>Publication Date:</b>	2009
<b>Web Location:</b>	Not available
<b>Authority:</b> (Federal, State, or Other Grant or Initiative)	U.S. Department of Agriculture, Food and Nutrition Service, Supplemental Nutrition Assistance Program - Education
<b>Contact:</b>	Mario Garcia Manager, Nutrition, Physical Activity, and Obesity Program (860) 509-7138 <a href="mailto:mario.garcia@ct.gov">mario.garcia@ct.gov</a>
<b>Target or Special Populations:</b>	Adults, children, preschool children, college students, teachers, parents, adult clients of WIC, adult clients of Supplemental Nutritional Assistance Program, adult clients of Community Health Centers
<b>Program Goals &amp; Objectives:</b>	<p><b>Goals</b></p> <ol style="list-style-type: none"> <li>1. Balanced calorie intake</li> <li>2. Healthier social norms</li> <li>3. Strengthened food and family values</li> </ol> <p><b>Objectives</b></p> <p><b>Short-term Objectives</b></p> <ol style="list-style-type: none"> <li>1. Improved program quality assurance</li> <li>2. Expanded program reach</li> <li>3. Strengthened teacher training</li> <li>4. Improved curriculum implementation</li> <li>5. Increased access to nutrition &amp; physical activity resources</li> <li>6. Participant behavior change readiness</li> </ol> <p><b>Medium-term Objectives</b></p> <ol style="list-style-type: none"> <li>1. Preschoolers, parents and teachers, and adults acquired fruit and vegetable knowledge, skills, and self efficacy.</li> <li>2. Preschoolers, parents and teachers, and adults acquired dairy food knowledge, skills, and self efficacy.</li> <li>3. Preschoolers, parents and teachers, and adults acquired whole grain food knowledge, skills, and self efficacy.</li> <li>4. Preschoolers, parents and teachers, and adults acquired physical activity knowledge, skills, and self efficacy.</li> <li>5. Preschoolers, parents and teachers, and adults acquired resource management knowledge, skills, and self efficacy.</li> </ol>

**Program Goals & Objectives:**

***Long-term Objectives***

1. SNAP participants and eligibles increased their fruit and vegetable preference and consumption.
2. SNAP participants and eligibles increased their dairy food preference and consumption.
3. SNAP participants and eligibles increased their whole grain food preference and consumption.
4. SNAP participants and eligibles increased their physical activity.
5. SNAP participants and eligibles increased their access to food.

**Preschool Focused Nutrition Education:**  
(Head Start / School Readiness Programs)

**Nutrition Education Objectives**

***1. Fruit & Vegetable Consumption***

By September 30th, 2010, 50% of Head Start/School Readiness preschoolers who participate in the Captain 5-A-Day will increase their fruit & vegetable preference by 25%.

***2. Physical Activity***

By September 30th, 2010, 50% of Head Start/School Readiness preschoolers who participate in the Captain 5-A-Day will engage in at least 60 minutes of physical activity per week.

***3. Resource Management***

By September 30th, 2010, 50% of parents who attend a Supermarket Smarts workshop will be able to identify 3 tips to save money at the supermarket.

**DPH Program Objectives**

1. By September 30th, 2010, 80% of eligible preschools centers in priority clusters will participate in the Captain 5-A-Day program.
2. By September 30th, 2010, 100% of newly participating preschool centers will receive a Captain 5-A-Day train-the-trainer workshop.
3. By September 30th, 2010, 25% of currently participating preschool centers will receive a Captain 5-A-Day train-the-trainer workshop.
4. DPH staff will conduct random preschool center evaluations to determine the effectiveness of the Captain 5-A-Day program implementation.
5. By September 30th, 2010, at least 75% of participating Captain 5-A-Day preschool centers will submit monthly nutrition logs and receive nutrition education materials for their classrooms. (Pertains to School Readiness programs).

**Adult Client Focused  
Nutrition Education:****Nutrition Education Objectives****1. Fruit & Vegetable Consumption**

After completion of the Loving Your Family or MyPyramid class, 50% of participants will increase their fruit & vegetable consumption by ½ cup daily.

**2. Healthy Food**

After completion of the Loving Your Family or MyPyramid class, 50% of participants will report they consume three cups of low-fat dairy or dairy products daily.

**3. Healthy Food**

After completion of the Loving Your Family or MyPyramid class, 50% of participants will report they consume at least 3 ounces of whole grains daily.

**4. Physical Activity**

After completion of the Loving Your Family or MyPyramid class, 50% of participants will report they are physically active at least 30 minutes most days of the week.

**DPH Program Objectives**

1. By September 30th, 2010, DPH will establish a collaborative partnership with at least 50% of the targeted WIC, SNAP, and CHC offices to ensure future SNAP-Ed nutrition programming.
2. DPH will work with the targeted WIC, SNAP, and CHC offices to ensure a steady increase in Loving Your Family and MyPyramid class attendance throughout the year.
3. By September 30th, 2010, DPH will develop an internship program for college students to help teach Loving Your Family and MyPyramid classes.
4. By September 30th, 2010, the DPH SNAP-Ed program will collaborate with the DPH WIC program to ensure all WIC clients receive quarterly recipe cards.

**Notes:**

The two projects described above are managed by the Connecticut Department of Public Health as part of the Connecticut Department of Social Services' Supplemental Nutrition Assistance Education Program Plan.

Children and adult clients must meet SNAP eligibility criteria.

<b>Subject:</b>	<b>OBESITY</b>
<b>Title:</b>	Healthy Eating and Active Living
<b>Publication Date:</b>	2005
<b>Web Location:</b>	<a href="http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/obesity_hlth_promo_plan_2005.pdf">http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/obesity_hlth_promo_plan_2005.pdf</a>
<b>Authority:</b> (Federal, State, or Other Grant or Initiative)	Centers for Disease Control and Prevention, Obesity Prevention Program and Preventive Health and Health Services Block Grant
<b>Contact:</b>	Mario Garcia Manager, Nutrition, Physical Activity, and Obesity Program (860) 509-7138 <a href="mailto:mario.garcia@ct.gov">mario.garcia@ct.gov</a>
<b>Target or Special Populations:</b>	All Connecticut residents, children, adolescents, workers
<b>Overall Goal:</b>	Promotion of overall personal health and reduction of chronic diseases that are caused or aggravated by overweight and obesity and lack of physical activity
<b>Program Goals:</b> (Social-Ecological Model)	<p><b>Statewide</b></p> <ol style="list-style-type: none"> <li>1. Develop a strong statewide partnership to address the obesity issue.</li> <li>2. Increase personal and general awareness of the need for prevention and intervention to reduce obesity through ongoing communication.</li> <li>3. Develop data and surveillance capabilities. Accurate data on the incidence, prevalence, patterns, and characteristics of overweight and obesity in Connecticut will be essential to effective planning and evaluation of our interventions.</li> </ol> <p><b>Community</b></p> <ol style="list-style-type: none"> <li>1. Increase collaboration of nutrition and physical activity professionals between state and community to present consistent and effective messages within and across communities.</li> <li>2. Identify and promote best practices to help communities statewide to change their environment to support healthy choices.</li> <li>3. Support the development of comprehensive community plans that change policy in the community environment to support healthy choices in municipalities across the state.</li> </ol> <p><b>Settings</b></p> <p><b>Schools</b></p> <ol style="list-style-type: none"> <li>1. Provide healthy school nutrition environments--from cafeteria lines to concessions at sports games.</li> <li>2. Develop state and local school district policies that increase physical activity opportunities and healthy eating habits.</li> </ol>

**Program Goals:**  
(*Social-Ecological Model*)

3. Communicate the positive correlation between child health, physical activity and, academic performance .
4. Provide tools to help educators make changes in their own classroom/education environments.

**Health Care Systems**

1. Coordination: Develop common practices, standards, and referral mechanisms for addressing overweight and obesity across MCOs, Health Plans, and Public Health Systems, and disease management programs.
2. Quality Improvement: Adopt, recognize and use best practice guidelines related to a) prevention screening assessment, treatment and referral for overweight and obesity, b) nutrition services for related chronic diseases such as cardiovascular disease and diabetes, and c) promotion of physical activity .
3. Coverage: Address health plan coverage and reimbursement issues related to service provision, interventions, education and counseling programs, and referral processes.

**Industry/Institution**

1. Promote healthier nutritional practices .
2. To promote participation in physical activities.

**Worksite**

1. Promote wellness programs and policies in worksites that encourage improved nutritional practices, physical activity opportunities, and chronic disease management and prevention.
2. Promote worksite initiatives that support lactating mothers in the work place.

**Health Improvement Objectives:**  
(*From Healthy People 2010*)

**Physical Activity**

- 22-1. Reduce the proportion of adults who engage in no leisure-time physical activity
- 22-2. Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes per day.
- 22-11. Increase the proportion of children and adolescents who view television 2 or fewer hours per day
- 22-12. Increase the proportion of schools that provide access to their physical activity spaces and facilities to all persons outside of normal school hours

**Weight Management**

- 19-1. Increase the proportion of adults at healthy weight
- 19-2. Decrease the proportion adults who are obese
- 19-3. Decrease the proportion of children and adolescents who are overweight or obese.

<b>Subject:</b>	<b>OCCUPATIONAL HEALTH</b>
<b>Title:</b>	Occupational Disease in Connecticut: Data for Action
<b>Publication Date:</b>	2000
<b>Web Location:</b>	<a href="http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/occupational_disease_plan_2000.pdf">http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/occupational_disease_plan_2000.pdf</a>
<b>Authority:</b> (Federal, State, or Other Grant or Initiative)	Connecticut Occupational Health Clinics Bill, 1990 Connecticut General Statutes 31-396 to 31-402
<b>Contact:</b>	Thomas St. Louis Epidemiologist , Occupational Health Unit (860) 509-7740 <a href="mailto:thomas.st.louis@ct.gov">thomas.st.louis@ct.gov</a>
<b>Target or Special Populations:</b>	Workers
<b>Recommendations:</b>	<ol style="list-style-type: none"> <li>1. Recognize the critical role played in Connecticut by the network of occupational medicine and auxiliary clinics in identifying, reporting, and following up cases of occupational disease and injury, and their essential role in prevention and intervention efforts. Institutionalize long-term stable funding for the network of clinics and the interagency Occupational Disease Surveillance System.</li> <li>2. Expand efforts to educate primary care providers about recognition of occupational diseases and injuries to increase their participation in occupational disease surveillance and prevention efforts.</li> <li>3. Eliminate the barriers to electronic reporting of occupational disease and injury data.</li> <li>4. Continue to foster collaborative relationships among the three state agencies with responsibilities in occupational disease and injury, DPH, DOL and WCC. Include other agencies as appropriate when designing programs that may affect workers within those agencies' purviews, such as Connecticut Departments of Transportation, Education, and Public Safety, as well as local health departments.</li> <li>5. Expand cooperative activities at the federal level, particularly with the National Institute for Occupational Safety and Health (NIOSH) and the Occupational Safety and Health Administration (OSHA). In particular, Connecticut can influence the development of a national surveillance system for occupational disease, injuries, and hazards through strengthening of relationships with NIOSH and other states.</li> <li>6. Design specific strategies for reduction of occupational injuries, as well as diseases, in special populations using public health planning models. Initiatives could include such interventions as prevention of occupational burns in restaurants and specific education designed for adolescent workers.</li> <li>7. Initiate and design cooperative activities for education and intervention on an industry-wide basis, thinking broadly about partners in the private sector, such as industry trade groups, unions, and distributors of materials.</li> <li>8. Assure that resources are sufficient to implement comprehensive activities for surveillance, education, and intervention. Explore possibilities for increased and alternative funding for specific intervention strategies.</li> </ol>

**Note:**

This is a surveillance report containing recommendations. As such, it does not contain goals, objectives, and other components of health improvement and strategic plans.



<b>Subject:</b>	<b>ORAL HEALTH (1)</b>
<b>Title:</b>	Oral Health Improvement Plan for Connecticut, 2007-2012
<b>Publication Date:</b>	2007
<b>Web Location:</b>	<a href="http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/oral_health_plan_2007_2012.pdf">http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/oral_health_plan_2007_2012.pdf</a>
<b>Authority:</b> <i>(Federal, State, or Other Grant or Initiative)</i>	Not specified
<b>Contact:</b>	Linda Ferraro Program Coordinator, Oral Health Program (860) 509-8203 <a href="mailto:linda.ferraro@ct.gov">linda.ferraro@ct.gov</a>
<b>Target or Special Populations:</b>	All Connecticut residents, adults, children underserved populations, vulnerable populations
<b>Vision:</b>	Connecticut's children and adults will have good oral health as part of their overall health and well-being.
<b>Intent:</b>	To set priorities, organize efforts, and guide resource allocations for the public and private sectors to improve the oral health of Connecticut's children and adults, with special emphasis on the vulnerable populations.
<b>Goals &amp; Objectives:</b>	<p><b>Goal 1</b> Increase integration of oral health promotion into all aspects of public health.</p> <p><b>Objectives</b></p> <ol style="list-style-type: none"> <li>1. By 2011, increase by 50% the proportion of children, adults, and vulnerable populations who receive annual preventive and necessary restorative oral health care.</li> <li>2. By 2010, 50% of children should receive age appropriate dental sealants.</li> <li>3. By 2011, at least 10% of the non-dental providers will promote oral health as an integral part of general health throughout the life cycle.</li> <li>4. By 2010, incorporate oral health education into the education curricula.</li> </ol> <p><b>Goal 2</b> Ensure that there is an adequate dental health workforce to meet the needs of Connecticut residents.</p> <p><b>Objectives</b></p> <ol style="list-style-type: none"> <li>1. By 2008, double the number of dental providers that actively participate in Medicaid.</li> <li>2. By 2010, improve recruitment and retention of dental providers and support personnel in Connecticut.</li> <li>3. By 2012, increase the number of dental school faculty and dental hygiene school faculty in Connecticut schools, particularly underrepresented minorities.</li> </ol>

**Goals & Objectives:**

4. By 2010, 25% of the Connecticut school districts will provide structured health career awareness programs to promote dental careers to K-12 students to recruit a more diverse and “home-grown” dental workforce.

**Goal 3**

Build a strong and sustainable oral health infrastructure.

**Objectives**

1. By 2008, provide authority for an Oral Health Program Office in the state health agency by legislative mandate.
2. By 2008, establish a timely and accurate oral health surveillance system.
3. By 2009, implement at least three population-based strategies for the delivery of effective oral health services to underserved children and adults.
4. By 2010, ensure that all counties in Connecticut have improved capacity to enhance community level interventions that improve oral health.
5. By 2008, develop policies to promote and facilitate the provision of oral health services.
6. By 2008, increase public awareness of oral health issues.
7. Continually leverage resources to adequately fund oral public health activities.

**Goal 4**

Advance best practices for oral health.

**Objectives**

1. By 2012, promote and implement effective and efficient models that increase access to quality oral health services.
2. By 2008, assure ongoing evaluation of effective and efficient oral health interventions.
3. By 2012, implement best practices that integrate oral health with overall health.

<b>Subject:</b>	<b>ORAL HEALTH (2)</b>
<b>Title:</b>	Every Smile Counts: The Oral Health of Connecticut's Children
<b>Publication Date:</b>	2007
<b>Web Location:</b>	<a href="http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/oral_health_every_smile_counts_2007.pdf">http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/oral_health_every_smile_counts_2007.pdf</a>
<b>Authority:</b> <i>(Federal, State, or Other Grant or Initiative)</i>	Connecticut Health Foundation; Centers for Disease Control and Prevention, Maternal and Child Health Block Grant; Connecticut State Dental Foundation; Connecticut State Dental Association
<b>Contact:</b>	Linda Ferraro Program Coordinator, Oral Health Program (860) 509-8203 <a href="mailto:linda.ferraro@ct.gov">linda.ferraro@ct.gov</a>
<b>Target or Special Populations:</b>	Children, preschoolers, young children, infants, parents, pregnant women, SCHIP-eligible persons, toddlers, underserved populations, vulnerable populations, workers (dentists)
<b>Key Strategies:</b>	<p><b>Patients</b></p> <ol style="list-style-type: none"> <li>1. Expand comprehensive decay prevention to include pregnant women, infants and toddlers all through the lifespan.</li> <li>2. Provide anticipatory guidance to prevent dental disease to parents in health and social service settings.</li> <li>3. Teach parents how to use the dental health care system and advocate for oral health for themselves and their children.</li> <li>4. Increase the number of dental insurance (private and public) enrollees who use their annual exam benefits for themselves and their children.</li> </ol> <p><b>Providers</b></p> <ol style="list-style-type: none"> <li>1. Increase the number of dental providers in under-served areas.</li> <li>2. Educate non-dental health care providers about the relationship of oral health and general health and their role in oral health prevention.</li> <li>3. Increase the number of dentists participating in Medicaid/SCHIP.</li> <li>4. Increase the number of dentists that have skills in treating young children and vulnerable groups.</li> <li>5. Increase the number of dental professionals providing sealants.</li> </ol> <p><b>Systems</b></p> <ol style="list-style-type: none"> <li>1. Develop preschool dental programs and expand the number of dental programs in community- and school-based centers.</li> <li>2. Promote annual dental exams as a minimum standard of dental care, particularly for high-risk children by one year of age.</li> <li>3. Increase access to dental insurance for high-risk children and parents.</li> <li>4. Increase the provision of dental sealants in schools and safety nets.</li> <li>5. Build capacity in dental public health at the state and local levels.</li> <li>6. Develop an ongoing campaign to promote oral health as part of general health and well-being.</li> <li>7. Increase private and public sector participation in mobilizing resources and developing policy to pursue and sustain these strategies.</li> </ol>

<b>Subject:</b>	<b>PERINATAL HEALTH</b>
<b>Title:</b>	Perinatal Health Plan for Connecticut, 2005-2009
<b>Publication Date:</b>	2005
<b>Web Location:</b>	<a href="http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/perinatal_health_plan_2005-2009.pdf">http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/perinatal_health_plan_2005-2009.pdf</a>
<b>Authority:</b> (Federal, State, or Other Grant or Initiative)	Department of Health and Human Services, Maternal and Child Health Bureau, Title V Maternal and Child Health Block Grant
<b>Contact:</b>	Rosa Biaggi Section Chief, Family Health (860) 509-8074 <a href="mailto:rosa.biaggi@ct.gov">rosa.biaggi@ct.gov</a>
<b>Target or Special Populations:</b>	Adolescents, African Americans, children, children with special health care needs, Hispanics, infants, racial and ethnic minority groups, newborns, parents, people of color, postpartum women, pregnant women, teens, underserved and unserved women of childbearing age, urban residents, uninsured and underinsured children and adults
<b>Goals &amp; Objectives:</b>	<p><b>Goal 1</b></p> <p>Reduce perinatal health disparities, particularly preterm/low birth weight births and infant and fetal mortality between and among racial and ethnic groups.</p> <p><b>Objectives</b></p> <ol style="list-style-type: none"> <li>1. Assure that services are competent to language, culture, and diversity, including health literacy.</li> <li>2. Collaborate with CT Workforce Coalition to recruit people of color to enter the health care field, and to promote National Health Service Corps and DPH's state loan repayment programs.</li> <li>3. Encourage Title V program-funded staff to incorporate culturally competent, evidence-based strategies and initiatives into their programs and services.</li> <li>4. Determine culturally competent initiatives that impact the African-American and Hispanic communities, such as those developed under DPH (e.g. breast feeding assessment and Latino teen pregnancy study).</li> <li>5. Evaluate and strengthen proven outreach strategies that target the MCH population.</li> </ol> <p><b>Goal 2</b></p> <p>Improve access to a continuum of health care services for underserved and/or un-served women of child bearing age.</p> <p><b>Objectives</b></p> <ol style="list-style-type: none"> <li>1. Increase the percentage of women who receive early, timely, and sufficient prenatal care by continued funding for programs such as Comadrona, Healthy Choices for Women and Children, and Healthy Start.</li> <li>2. Strengthen innovative case management and community outreach services to women and men to improve access to perinatal health care.</li> </ol>

**Goals & Objectives:**

3. Explore/support the development of a Medicaid Family Planning Waiver (using the California model) that would subsidize a range of primary GYN services and family planning supplies for under-insured or uninsured women and men.
4. Reduce provider related barriers to ensure that adequate health care providers and facilities exist to make appropriate pregnancy-related and perinatal care available to Connecticut women and infants throughout the continuum of risk from basic to complex medical care.

**Goal 3**

Enhance and encourage male involvement in the continuum of women's health care from preconceptional, prenatal through postnatal periods.

**Objectives**

1. Raise awareness among health care and social services providers and among educators of the need and the barriers to men receiving preventive and reproductive health care.
2. Encourage male involvement in reducing unintended pregnancies.
3. Create a pilot Fatherhood Development Program with an emphasis on prenatal care.

**Goal 4**

Reduce pregnancies and poor birth outcomes among adolescents.

**Objectives**

1. Support the work of school-based health centers that are addressing students' reproductive health care needs.
2. Incorporate reproductive health care needs into well child visits through the transitional period from pediatrics to adult primary care.
3. Promote increased access to intensive case management (I.e., Carrera Model) for minority teenage women in urban communities.
4. Engage and support parents in the initiation of parent-child dialogue regarding sex and pregnancy, such as the Latino teen pregnancy study.

**Goal 5**

Reduce unintended pregnancies for all women.

**Objectives**

1. Preconceptional and interconceptional health care needs to be approached as a continuum of care (longitudinal view) to promote pregnancy planning and/or early confirmation of pregnancy, such as the New Haven Healthy Start Interconceptional Assessment Tools.
2. Increase the availability of contraceptives.

**Goal 6**

Reduce recognized birth-related risk factors for children with special health care needs.

**Objectives**

1. Decrease the number of premature births, which is a leading cause of developmental disabilities.
2. Reduce poor neonatal outcomes secondary to birth injuries and congenital anomalies.

**Goals & Objectives:****Goal 7**

Improve the state's system capacity to collect high quality maternal child health data and disseminate in a timely manner.

**Objective**

1. Increase the timeliness of the state's data review and analysis process so the professional community will have access to current perinatal information.

**Goal 8**

Improve access to mental health, substance abuse treatment and dental health services which can improve the overall health for pregnant and postpartum women.

**Objectives**

1. Increase the percentage of women who receive needed behavioral health services during the prenatal and interconceptional period, e.g. through replication of established models such as New Haven Healthy Start.
2. Improve the ability of 200 providers to identify individuals with mental health, substance abuse treatment, and dental health needs and improve access to those services.
3. Train 200 dentists and other oral health care specialists on the importance of treating pregnant women as well as the association between poor maternal oral health and preterm birth, low birth weight and early childhood caries.
4. Increase access for pregnant women to receive oral health care services and treatment.

**Goal 9**

Improve inter-provider communication strategies regarding perinatal health care delivery.

**Objectives**

1. Improve coordination of care among providers for women.
2. Improve timeliness of transfer of health information among the providers.

<b>Subject:</b>	<b>PREVENTIVE HEALTH AND HEALTH SERVICES</b>
<b>Title:</b>	Preventive Health and Health Services Block Grant Allocation Plan, FFY 2010
<b>Web Location:</b>	<a href="http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/phhs_block_grant_alloc_plan_2010.pdf">http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/phhs_block_grant_alloc_plan_2010.pdf</a>
<b>Publication Date:</b>	2009
<b>Authority:</b> (Federal, State, or Other Grant or Initiative)	Centers for Disease Control and Prevention, Preventive Health and Health Services Block Grant
<b>Contact:</b>	Julianne Konopka Manager, Health Information Systems & Reporting (860) 509-7658 <a href="mailto:julianne.konopka@ct.gov">julianne.konopka@ct.gov</a>
<b>Target or Special Populations:</b>	Adolescents, African Americans, blacks, children, children <6 years of age, older adults, prison inmates, women, youths
<b>Objectives:</b>	<p><b>Cancer Prevention</b></p> <p><b><i>Skin Cancer</i></b></p> <p>Increase the proportion of persons who use at least one of the following protective measures that may reduce the risk of skin cancer: avoid the sun between 10 a.m. and 4 p.m., wear sun-protective clothing when exposed to sunlight, use sunscreen with a SPF of 15 or higher, and avoid artificial sources of ultraviolet light.</p> <p><b><i>Lung Cancer in Women</i></b></p> <p>Reduce cigarette smoking by adult females.</p> <p><b><i>Cancer Planning</i></b></p> <p>Increase the proportion of LHDs that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs (specifically, cancer).</p> <p><b>Heart Disease and Stroke Prevention</b></p> <p><b><i>Elevated Cholesterol Levels</i></b></p> <p>Cholesterol screening/referral, education and counseling aimed at assisting client action to reduce elevated cholesterol.</p> <p><b><i>Diabetes</i></b></p> <p>Develop and implement multi-session self-care education programs to reduce risk for CVD and other diabetes-related complications including peripheral vascular disease, neuropathy, end-stage renal disease and blindness. Enables client to practice self-care behaviors to reduce diabetes and complications.</p> <p><b><i>Obesity</i></b></p> <p>Develop and implement policy and environmental initiatives designed to increase physical activity and improved nutritional practices at the community level.</p>

**Objectives:*****Physical Inactivity***

Develop and implement multi-session physical activity programs to assist individuals to establish a moderate level of physical activity into their lifestyles.

***Smoking Cessation***

Provide smoking cessation programs that provide smokers with the information and tools to successfully quit smoking.

***Nutrition/Excess Dietary Fat***

Develop and implement multi-session education programs that provide needed information and practical skills to establish healthy eating patterns including the reduction of excess dietary fat in the diet.

***High Blood Pressure***

Develop and implement high blood pressure screening, referral, education and counseling programs to initiate action to control high blood pressure.

***Childhood Lead Poisoning Prevention***

Reduce the proportion of children less than six years of age with blood lead levels >10 µg/dL to less than 1.4%, and those with levels >20 µg/dL to less than 0.25%.

***African American Initiative***

Provide culturally specific community-level heart disease and stroke prevention programs to address disparities among black residents in Connecticut. The program focus will be on: recognition of signs and symptoms of heart attack and stroke, and the need to call 911; controlling high cholesterol; controlling high blood pressure; reducing other heart disease and stroke risk factors (including but not limited to tobacco use, diabetes, physical inactivity, and poor nutrition).

***Emergency Medical Services (EMS)***

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

***Local Health Departments***

Address priority PHHSBG-funded health needs of communities.

***Surveillance and Evaluation***

Increase the proportion of leading health indicators, health status indicators, and priority data needs for which data, especially for selected populations, are available at the State and local levels.



**Objectives:****Unintentional Injury Prevention*****Motor Vehicle Crashes***

Reduce the rate of motor vehicle crashes to no more than 7.5/100,000.

***Fall-related Injuries, Fall Prevention for Older Adults, Fall Prevention for Children in the Home Setting***

Reduce the rate of deaths from falls to no more than 3.0/100,000.

**Intentional Injury Prevention*****Rape Crisis Services***

Reduce the annual rate of rape or attempted rapes to 0.7 rapes or attempted rapes per 1,000 persons. CT's current attainment: 35 per 1,000 persons (2006 - latest available data from the FBI Uniform Crime Report).

***Intimate Partner Violence Prevention***

Increase training regarding intimate partner violence to incarcerated women within York Correctional Institute by 10%.

***Youth Violence/Suicide Prevention***

Reduce assault injuries to no more than 16 per 100,000 and suicides to no more than 7.7 per 100,000.

<b>Subject:</b>	<b>RESPIRATORY PROTECTION</b>
<b>Title:</b>	Respiratory Protection Plan
<b>Publication Date:</b>	2008
<b>Web Location:</b>	<a href="http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/respiratory_protection_plan_2008.pdf">http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/respiratory_protection_plan_2008.pdf</a>
<b>Authority:</b> <i>(Federal, State, or Other Grant or Initiative)</i>	Required by OSHA (U.S. Department of Labor, Occupational Safety and Health Administration)
<b>Contact:</b>	Ronald Skomro Supervising Environmental Analyst, Asbestos Program (860) 509-7367 <a href="mailto:ron.skomro@ct.gov">ron.skomro@ct.gov</a>
<b>Target or Special Populations:</b>	Environmental sanitarians in DPH Asbestos and Lead Poisoning Prevention Programs
<b>Purpose:</b>	<ol style="list-style-type: none"> <li>1. To ensure that Connecticut Department of Public Health employees are protected from exposure to any respiratory hazards, in particular those that are related to airborne asbestos and other particulate hazards</li> <li>2. To achieve compliance with all applicable regulations governing respiratory protection</li> </ol>

**Notes:**

This Plan originally was developed for use by Lead Program staff. Currently it is maintained by the Asbestos Program and is used primarily for protection of environmental sanitarians who may be exposed to asbestos or other airborne particulates during the course of field inspections of abatement or renovation projects.

This is an operations plan; therefore it does not have goals and objectives consistent with health improvement plans and strategic plans.

<b>Subject:</b>	<b>SEXUAL VIOLENCE</b>
<b>Title:</b>	State of Connecticut Sexual Violence Prevention Plan, 2009-2017 (Draft)
<b>Publication Date:</b>	2009
<b>Web Location:</b>	<a href="http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/svpp_2009-2017_draft.pdf">http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/svpp_2009-2017_draft.pdf</a>
<b>Authority:</b> (Federal, State, or Other Grant or Initiative)	Centers for Disease Control and Prevention, Rape Prevention and Education Grant
<b>Contact:</b>	Regina Owusu Coordinator, Rape Prevention Education and Crisis Intervention (860) 509-8092 <a href="mailto:regina.owusu@ct.gov">regina.owusu@ct.gov</a>
<b>Target or Special Populations:</b>	All Connecticut residents, adolescents, children, children in foster care, children with disabilities, college students, parents, teachers, youths (lesbian, bisexual gay transgender, queer, and intersex)
<b>Vision:</b>	Connecticut communities--healthy, safe, and free of sexual violence
<b>Mission:</b>	To prevent sexual violence by promoting positive individual, relationship, community, and societal attitudes and behaviors.
<b>Goals &amp; Objectives:</b>	<p><b>Goal 1 - All Connecticut Residents</b></p> <p>To promote healthy relationships and sexual violence prevention across Connecticut.</p> <p><b>Objectives</b></p> <ol style="list-style-type: none"> <li>1.1. Children and adolescents will demonstrate a 20%-25% increase in their understanding of gender equality and pro-social knowledge, attitudes, and behaviors towards the primary prevention of first-time sexual violence perpetration.</li> <li>1.2. Each of the RPE funded centers will conduct primary prevention education for children and adolescents in one new town annually from 2010-2017.</li> <li>1.3. Parent/caregiver education and training in the primary prevention of sexual violence will be literacy level appropriate, culturally and linguistically responsive.</li> <li>1.4. Parents/caregivers in three new towns will receive sexual violence primary prevention education and training by June 30, 2010.</li> <li>1.5. Revise and modify training curricula that are used for professionals, until 75% of training curricula content contains primary prevention information for selected professional groups (e.g., teachers and social workers).</li> </ol> <p><b>Goal 2 – Connecticut Youths at Risk</b></p> <p>To reduce the incidence of first time perpetration of sexual violence among youth.</p> <p><b>Objectives</b></p> <ol style="list-style-type: none"> <li>2.1. Youth in high risk populations will experience a 20%-25% increase in their understanding of gender equity and pro-social knowledge, attitudes, and behaviors towards the primary prevention of first-time sexual violence perpetration.</li> <li>2.2. Multi-session training events for universal and selected audiences will increase until a minimum of 75% of all primary prevention training provided are multi-sessions.</li> </ol>

**Goals & Objectives:**

- 2.3. Target, without segregating, populations at higher risk to be victimized (e.g., children with disabilities, youth in foster care and independent living, LGBTQI) to participate in programs that are designed to meet their needs and offer protective strategies and safety measures.
- 2.4. Colleges and universities will disseminate gender equity, mutual respect, violence prevention strategies and safety measures through a social marketing campaign to incoming freshman by 2015.
- 2.5. Professionals working with children and adolescents in high risk communities will receive sexual violence prevention training annually and at least three new community locations will be added by 2012.

**Goal 3**

To increase capacity to prevent sexual violence.

**Objectives**

- 3.1. Increase annual primary prevention social marketing events from three to six, including one statewide SVPPC sponsored event (e.g., Walk/Run event) by 2015.
- 3.2. Develop a comprehensive training inventory and toolkit by mid-2010 that is updated bi-annually.
- 3.3. CONNSACS and RPE funded member centers will model programmatic environments that promote gender equity and the intolerance of gender discrimination.

**Goal 4**

To increase the capacity to collect, analyze, interpret, disseminate and use information about sexual violence to improve prevention efforts.

**Objectives**

- 4.1. Eighty percent of the SVPPC members in programmatic roles (including RPE funded centers) will collect and submit data and/or progress reports to the SVPPC Coordinator.
- 4.2. Monitor existing data collection repositories related to sexual violence to target high risk communities in the prevention of first time perpetration.
- 4.3. Statewide implementation of the Sexual Violence Safe Zone Program.
- 4.4. Evaluate the implementation process and effectiveness of the strategic plan.

**Goal 5**

To advance policies, legislation, and partnerships that promote healthy relationships, reduce the incidence of first-time perpetration, and increase capacity to prevent sexual violence and improve prevention efforts.

**Objective**

- 5.1. Support and encourage key legislation that promotes the primary prevention of sexual violence and reduces and/or penalizes societal norms that tolerate male superiority and sexual entitlement.

<b>Subject:</b>	<b>SICKLE CELL DISEASE</b>
<b>Title:</b>	Designing a Comprehensive System Across the Life Span: Connecticut's State Plan to Address Sickle Cell Disease and Trait
<b>Publication Date:</b>	2007
<b>Web Location:</b>	<a href="http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/sickle_cell_plan_2007.pdf">http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/sickle_cell_plan_2007.pdf</a>
<b>Authority:</b> (Federal, State, or Other Grant or Initiative)	Department of Health and Humans Services, Health Resources and Services Administration, Connecticut Sickle Cell Newborn Screening Program: Community-Based Initiative; Connecticut Department of Public Health, #2005-901: Sickle Cell Disease Initiative
<b>Contact:</b>	Rosa Biaggi Section Chief, Family Health (860) 509-8074 <a href="mailto:rosa.biaggi@ct.gov">rosa.biaggi@ct.gov</a>
<b>Target or Special Populations:</b>	African Americans, children, college students, newborns
<b>Priorities &amp; Recommendations:</b>	<p><b>Priorities</b> <i>(Based on rankings of recommendations below)</i></p> <ol style="list-style-type: none"> <li>1. Establish ED protocols for treating patients with SCD and train/support hospitals in implementing them.</li> <li>2. Provide education and training to health care providers.</li> <li>3. Establish protocols for transitioning patients with SCD from pediatric to adult care and train/support providers in implementing the transitional process.</li> </ol> <p><b>Recommendations</b> <i>(Priority level of each recommendation for providers/consumers given in parentheses. H=High; M=Medium, L-Low; 0=None)</i></p> <ol style="list-style-type: none"> <li>1. Create and maintain an infrastructure mechanism to provide communication, coordination and integration among all the infrastructure components and to track, measure and evaluate sickle cell related activities. (M / M)</li> <li>2. Conduct outreach/info and testing via schools (high schools and colleges), faith based organizations and community based organizations. (M / H)</li> <li>3. Offer follow-up services to those who test positive for the disease or trait. (M / L)</li> <li>4. Develop and carry out an ongoing, multi-level media campaign. (M / L)</li> <li>5. Design and carry out a legislative education and advocacy campaign on both the federal and state level. (L / L)</li> <li>6. Establish and maintain a 24/7 hotline and an information and referral service. (L / M)</li> </ol>

**Priorities & Recommendations:**

7. Create and maintain a web site. (0 / M)
8. Design and carry out a legislative education and advocacy campaign on both the federal and state level. (H / L)
9. Keep current hard copy directories (for consumers and providers). (0 / 0)
10. Develop and formalize partnership on the local level. (L / 0)
11. Offer genetic counseling. (0 / M)
12. Provide newborn screening to identify babies with SCD or trait. (L / L)
13. Offer follow-up information and referrals to families with SCD or trait. (M / H)
14. Offer screening and follow-up counseling through community based outreach efforts. (M / M)
15. Offer respite care to families with children with SCD. (M / L)
16. Explore using home visitation resources for patients in need of care that can be provided in the home. (0 / L)
17. Establish two (North and South) Centers of Excellence (without walls) for SCD/trait. (H / L)
18. Establish advocacy protocols for treating patients with SCD and train patient advocates for implementation at health care facilities. (L / L)
19. Establish protocols for medical homes that care for patients with SCD and train/support providers in implementing them. (0 / L)
20. Establish ED protocols for treating patients with SCD and train/support hospitals in implementing them. (H / H)
21. Provide, within a context of cultural and ethnic sensitivity, education and training to health care providers. (H / H)
22. Establish protocols for transitioning patients with SCD from pediatric to adult care and train/support provides in implementing the transitional process. (H / H)
23. Explore and support the use of Complementary and Alternate Medicine. (L / 0)
24. Develop and formalize partnerships on the international/national level. (0 / 0)

<b>Subject:</b>	<b>STROKE</b>
<b>Title:</b>	Connecticut Comprehensive Plan for Stroke Prevention and Care, 2009-2013
<b>Publication Date:</b>	2009
<b>Web Location:</b>	<a href="http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/stroke_prev_care_plan_2009-2013.pdf">http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/stroke_prev_care_plan_2009-2013.pdf</a>
<b>Authority:</b> (Federal, State, or Other Grant or Initiative)	Centers for Disease Control and Prevention, State Heart Disease and Stroke Prevention Program; and Preventive Health and Health Services Block Grant
<b>Contact:</b>	Chris Andresen Section Chief, AIDS and Chronic Diseases 9860) 509-7828 <a href="mailto:chris.andresen@ct.gov">chris.andresen@ct.gov</a>
<b>Target or Special Populations:</b>	All Connecticut residents, stroke survivors
<b>Goals &amp; Objectives:</b>	<p><b>Overall Plan Goal</b></p> <p>To create a coordinated system of stroke care and prevention in which it is possible for every Connecticut resident to access appropriate and timely care for optimal post stroke outcomes. A coordinated care system involves EMS, hospital stroke teams, specialized stroke units (where applicable), and standardized care protocols.</p> <p><b>Prevention and Community Education</b></p> <p><b>Goal</b></p> <p>To promote healthy living for all Connecticut residents, particularly high risk individuals, through a coordinated community effort and to reduce the prevalence of stroke risk factors, incidence of stroke, and stroke complications.</p> <p><b>Objectives</b></p> <ol style="list-style-type: none"> <li>1. Increase the percentage of Connecticut residents aware of the risk factors for stroke, stroke prevention strategies, signs &amp; symptoms of stroke, and the importance of calling 9-1-1 through a local, regional, and statewide network of communication and dissemination of information.</li> <li>2. Increase the percentage of stroke care providers, stroke patients, and persons at risk who have access to, and receive, appropriate education and information on stroke prevention and care.</li> <li>3. Work with Chronic Disease partners (e.g., Nutrition, Physical Activity and Obesity Prevention Program, Tobacco Use Prevention &amp; Control Program) to promote healthy behaviors (e.g., safe walking paths, physical activity, eating five or more fruits and vegetables a day, and coverage for individuals without insurance) through policy, environmental, and systems changes in communities and workplaces.</li> <li>4. Increase the number of screenings and stroke education programs statewide.</li> </ol>

**Goals & Objectives:****Emergency Medical Services: Notification and Response****Goal**

Facilitate timely access to EMS care, enhance pre-hospital recognition and treatment, and promote rapid transport to the appropriate health care facility of stroke patients.

**Objectives**

1. Create an EMS statewide stroke protocol with core elements for assessment, transportation, and communication among hospitals and EMS responders that allows for regional differences.
2. By 2013, develop a stroke assessment tool based upon best practices for EMS responders.
3. By 2013, all EMS responders receive initial and ongoing training in stroke assessment, treatment, and care.

**Hospital Care****Goal: Hyper-Acute Care (The First Six Hours)**

To ensure that Connecticut residents that have experienced a stroke have equal access to high quality, acute stroke care.

**Objectives**

1. By 2013, all stroke care providers (hospitals and EMS) have a readily accessible statewide inventory of information on the location of designated stroke centers, available stroke services, and bed capacity.
2. By 2013, increase the number of Connecticut Hospitals that meet the Primary Stroke Center designation criteria.
3. By 2013, advocate for revisions to state legislation that currently requires a power of attorney to make decisions for clinical trials and to consider next of kin as sufficient decision maker.

**Goal: Acute Care (Stay to Discharge)**

Standardized stroke care protocols are available and consistently implemented during acute care stay through discharge including post-hospitalization care referrals and rehabilitation services.

**Objectives**

4. By 2013, all hospitals use the same standard for stroke education that meets Joint Commission and DPH education requirements for all levels of professionals providing stroke care, which includes core elements of a stroke care curriculum.
5. By 2013, all hospitals have practice guidelines and protocols for treatment and care of stroke patients whose condition deteriorates, and identification and treatment of non-stroke patients who may develop stroke-like symptoms during their hospital stay.
6. By 2013, all hospitals have established protocols that include criteria to make appropriate referrals, for follow-up care and to ensure a reciprocal relationship among all stroke care providers and primary care physicians (PCPs).



**Goals & Objectives:****Rehabilitation and Post-Stroke Care****Goal**

All stroke survivors will receive an initial hospital evaluation or standardized screening by rehabilitation professional to determine their individual rehabilitation needs. All stroke survivors will receive appropriate care in a timely manner with periodic re-evaluation of rehabilitation needs and resources to achieve optimal outcomes.

**Objectives**

1. By 2013, all survivors receive individualized assessment, intervention, and referral to appropriate levels of rehabilitation care necessary to achieve optimal post-stroke outcomes. Patients, acute care and rehabilitation teams, rehabilitation facilities (e.g., skilled nursing facilities, home health agencies), primary care physicians, community agencies, community professionals, and the patient's social networks are actively involved in the development of a stroke survivor recovery plan.
2. By 2013, establish communication systems to ensure that all stroke survivors have a written plan of care for follow-up services following hospitalization.
3. By 2013, ensure that preventable complications and secondary prevention issues are addressed, including all modifiable risk factors. Increase awareness of optimal post-acute care by healthcare providers and third party payers.
4. By 2013, ensure that stroke survivors and their social networks receive appropriate post-stroke education according to established protocols, and receive written information on stroke risk factors, warning signs, and the importance of timely use of EMS services.

**Surveillance: Tracking and Monitoring****Goal (PSC Designation Program)**

To decrease premature deaths and disabilities associated with stroke through early diagnosis and treatment.

<b>Subject:</b>	<b>SUICIDE</b>
<b>Title:</b>	Connecticut Comprehensive Suicide Prevention Plan
<b>Publication Date:</b>	2005
<b>Web Location:</b>	<a href="http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/suicide_prev_plan_2005.pdf">http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/suicide_prev_plan_2005.pdf</a>
<b>Authority:</b> (Federal, State, or Other Grant or Initiative)	Department of Health and Human Services, Preventive Health and Health Services Block Grant
<b>Contact:</b>	Eileen Boulay Nurse Consultant, Asthma Program (860) 509-7298 <a href="mailto:eileen.boulay@ct.gov">eileen.boulay@ct.gov</a>
<b>Target or Special Populations:</b>	All Connecticut residents, children, adolescents, elderly, older adults
<b>Goals and Recommendations:</b>	<p><b>Goals</b></p> <ol style="list-style-type: none"> <li>1. Reduce the suicide rate.</li> <li>2. Reduce suicide attempts.</li> <li>3. Increase the number of persons seen in primary health care who receive mental health screening and assessment.</li> <li>4. Increase the proportion of children with mental health problems who receive treatment.</li> <li>5. Increase the proportion of juvenile justice facilities that screen clients for mental health problems.</li> </ol> <p><b>Recommendations</b></p> <p><b>Overarching/Lifespan</b></p> <ul style="list-style-type: none"> <li>• Promote awareness that suicide is preventable and that mental health is important to overall health.</li> <li>• Promote, develop and implement effective prevention strategies.</li> <li>• Promote improved access to behavioral health care.</li> <li>• Promote the provision of quality behavioral health care.</li> <li>• Enhance suicide and behavioral health data collection, surveillance, research and program/service evaluation.</li> </ul> <p><b>Children and Youth - Birth to 19</b></p> <ul style="list-style-type: none"> <li>• Promote awareness that suicide is preventable and that mental health is important to overall health.</li> <li>• Promote, develop and implement effective prevention strategies.</li> <li>• Promote improved access to behavioral health care.</li> </ul>

**Goals and Recommendations:*****Adults Ages 19-64***

- Promote awareness that suicide is preventable and that mental health is important to overall health.
- Promote, develop and implement effective prevention strategies.
- Promote improved access to behavioral health care.
- Promote the provision of quality behavioral health care.

***Elders 65+***

- Promote awareness that suicide is preventable and that mental health is important to overall health.
- Promote, develop and implement effective prevention strategies.
- Promote improved access to behavioral health care.
- Promote the provision of quality behavioral health care.

***Law Enforcement and Emergency Response***

- Examine police training programs and provide recommendations specific to suicide and mental illness.
- Encourage emergency service providers and other first responders to collaborate with local hospitals, training organizations and mental health providers to enhance knowledge of mental illness and suicide.
- Encourage collaboration of police and mental health agencies.
- Encourage development of specialized police units to deal with behavioral emergencies.
- Review existing and encourage availability of critical incident services to police and emergency personnel impacted by suicide.
- Review policies, practice and protocols in police lock-ups including screening and observation of persons in custody.
- Encourage more police academy and police continuing education seminars and courses that facilitate an increase in police officer's knowledge of mental illness, suicidal thinking and related issues that could be relevant to their work.

***Criminal Justice******Crosscutting/Overarching***

- Increase knowledge of appropriate national standards related to: Suicide prevention in the criminal justice system; Education of all staff; Screening of all inmates; Proper access to mental health care; Establishing and implementing concise and clear policies and procedures related to suicide prevention; Administrative review of serious suicide attempts and suicides; Critical incident support to corrections staff following serious suicide attempts or suicides; Reviewing each facility for environmental safety risks and taking corrective action where possible.

**Goals and  
Recommendations:****Children/Youth**

- Examine best practice models for treatment of youth in the Criminal Justice system, incorporate principles of developmental psychology into services for children and youth.
- Provide: Training in suicide prevention with annual refresher training for all youth corrections staff; Clear and concise policy and procedures; Proper screening and referral of all children coming into the criminal justice system including screening for risk factors including: depression, physical and sexual abuse, conduct problems, agitated and aggressive behavior; Correctional institutions and alternative settings that provide access to age appropriate care and specialists; Institutions that facilitate access to victims services; Institutions that facilitate access to post release health care through Medicaid enrollment, discharge planning.

**Adults**

- Encourage and provide ready access to health and mental health care.
- Provide/ Promote: Training of all corrections staff in suicide prevention with annual refresher training; Immediate screening of all inmates for suicide risk upon intake; Avoidance of segregation and isolation, particularly within the first 24 hours; Prompt evaluation of inmates by health and mental health staff; Development of special needs treatment plans for seriously mentally ill offenders; Development of continuity of care plans for inmates post release including enrollment in necessary treatment programs; Training of correctional health staff in maintaining confidentiality of protected health information.

**Elders**

- Consider age-similar housing to decrease likelihood of victimization.
- Assess for necessity of increased access to medical resources due to increased likelihood of elder having a medical condition.
- Improve access to medical specialists, including mental health clinicians experienced in treating an older population.
- Make accommodations for work and recreation to decrease isolation and to assure as active a lifestyle as possible.
- Train all corrections staff in suicide prevention with annual refresher training.
- Facilitate recognition by corrections staff that proper approach should include sensitivity to aging issue.
- Assist elder inmates in coping with chronic diseases, infirmities and end-of-life issues.

<b>Subject:</b>	<b>TOBACCO</b>
<b>Title:</b>	Connecticut Tobacco Use Prevention and Control Plan
<b>Publication Date:</b>	2002
<b>Web Location:</b>	<a href="http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/tobacco_plan_2002.pdf">http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/tobacco_plan_2002.pdf</a>
<b>Authority:</b> <i>(Federal, State, or Other Grant or Initiative)</i>	Connecticut Legislature, Tobacco and Health Trust Fund
<b>Contact:</b>	Barbara Walsh Supervisor, Tobacco Use Prevention and Control Program (860) 509-8251 <a href="mailto:barbara.walsh@ct.gov">barbara.walsh@ct.gov</a>
<b>Target or Special Populations:</b>	All Connecticut residents, adolescents, adults, children, disparate populations, teachers, youths
<b>Overall Purpose:</b>	To reduce disease, disability, and death related to tobacco use
<b>Plan Goals:</b>	<p><b>Initiation</b> Prevent the initiation of tobacco use among young people.</p> <p><b>Cessation</b> Promote cessation among young people and adults.</p> <p><b>Environmental Tobacco Smoke</b> Eliminate exposure to environmental tobacco smoke.</p> <p><b>Disparities</b> Identify and eliminate the disparities related to tobacco use and its effects among different population groups.</p>
<b>Plan Outcomes:</b>	<p><b>Short-Term (&lt;12 months)</b></p> <ul style="list-style-type: none"> <li>• Increased public awareness of the new comprehensive tobacco control program's visibility and of media campaign themes.</li> <li>• Increased numbers of smokers accessing new or established tobacco cessation services (e.g., a toll-free Quitline).</li> <li>• Increased earned media, especially anti-tobacco media coverage (Earned media refers to the action of creating newsworthy stories or events to generate media coverage).</li> <li>• Increased number of smokers attempting to quit.</li> </ul> <p><b>Intermediate (1-3 years)</b></p> <ul style="list-style-type: none"> <li>• Increased number of successful quit attempts.</li> <li>• Increased number of smokers counseled by health and allied health professionals to quit</li> <li>• Decreases in cigarette sales to minors.</li> <li>• Decreased tobacco use on school grounds.</li> </ul>

**Plan Outcomes:**

- Increased public awareness of the key messages used in the media campaign.
- Decreased overall consumption of tobacco products.
- Decreased average number of cigarettes smoked per day.
- Increases in the establishment of private and public non-smoking environments.
- Increased percentage of households that prohibit smoking.
- Decreased reports of violations of indoor air laws.

**Long-Term (3-10 years)**

- Decreased percentage of adults smoking every day.
- Decreased percentage of youth smoking in all grades.
- Decreased exposure to environmental tobacco smoke.
- Increased number of former smokers who quit in the past year.
- Increased age at which smoking is initiated, recognizing that no age is a good age.
- Reduced number of asthma attacks due to exposure to ETS.
- Reduced number of cigarette vending machines.
- Increased number of insurance plans covering cessation and pharmaceutical quit aids.
- Increased anti-tobacco policies in place.
- Reduced cigarette sales to minors, recognizing such sales are illegal.

**Longer-Term Outcomes (10+ years)**

- Decreased percent of adults who smoke.
- Decreased disparities in patterns of tobacco initiation and use.
- Reduced number of tobacco-related cancers.
- Reduced number of heart attacks and strokes.
- Reduced health care costs related to tobacco use.

**Intermediate Process Objectives:****Community-Based**

- Increase the number of smoking cessation programs offered in the community.
- Increase the number of businesses establishing work-friendly policies that help smokers quit.
- Increase the number of local officials who are working to restrict sales to minors.
- Increase the number of organizations and individuals involved in planning and conducting community-level education and training programs addressing tobacco related issues and illnesses that include: oral health, cardiovascular health, cancer, respiratory disease prevention, and addiction and gateway use to other drugs.
- Increase the number of establishments and households restricting smoking/tobacco use
- Increase the number of organizations that have tobacco use policies by promoting the voluntary adoption of public and private tobacco control policies.
- Increase the number of community interventions that link tobacco control interventions with chronic diseases and substance abuse prevention and addiction treatment programs.
- Decrease the number of successful attempts by underage youth to buy tobacco.

**Intermediate  
Process Objectives:****Chronic Disease**

- Increase the number of community interventions that link tobacco control interventions with cardiovascular disease prevention.
- Increase the number of strategic media marketing events that provide public awareness of environmental tobacco smoke (ETS) as a trigger for asthma.
- Increase the reporting capacity of the Tumor Registry related to tobacco use.
- Increase the number of individuals screened for oral cancers, especially among disparate populations.
- Increase the number of training workshops and materials offered to health care providers.
- Increase the number of individuals served by chronic disease prevention and treatment programs that deliver comprehensive healthy lifestyle messages.
- Increase the number of towns and regions using tobacco-related mortality and morbidity data.
- Increase the number of quit attempts by those whose chronic disease is related to, or aggravated by, tobacco.

**School-Based**

- Increase the number of school districts in the state which have teachers and staff trained in tobacco use prevention curricula.
- Increase the school district-specific or comparable data that are available to school districts that identify local tobacco use prevalence and social influences that promote youth tobacco use and other data to better describe the local youth tobacco use dynamics.
- Increase the number of school districts in the state with tobacco-free policies on school campuses and at school-sponsored events.
- Increase the number of school districts in the state that have parental and youth involvement in programs.
- Increase the number of school districts in the state with access to cessation services.
- Increase the number of school districts in the state which have at least one link to community-based and social marketing and media programs.
- Increase the number of schools that have developed and implemented alternatives to out-of-school suspension and expulsion for tobacco-free policy violations.
- Increase the number of school-based health services and school-based health centers that actively participate in anti-tobacco use and health promotion activities in school and in communities.

**Enforcement**

- Increase the number of annual random, unannounced inspections from about 1 per vendor to 4 per vendor to ensure better compliance with the law in order that levels are improved.
- Increase the number of community-based events to maintain an inspection failure rate of less than 20% of outlets accessible to youth.
- Increase the number of individuals who are authorized to conduct and who conduct compliance checks of vendors.
- Decrease the percentage of underage youth who report success buying tobacco products.
- Reduce the number of tobacco vending machines and self-service displays in stores accessible to young people.

**Intermediate  
Process Objectives:****Statewide**

- Increase the number of statewide organizations that are enlisted and supported to inform their membership about tobacco control issues and encourage participation in local efforts.
- Increase the number of individuals among these organizations who participate in local efforts.
- Increase the number of non-duplicated members of statewide organizations that are provided technical assistance.
- Increase the number of smokers who contact a statewide Quitline.
- Increase the number of persons reached by pro-health messages.
- Increase the number of health and allied health professionals who assess patients for smoking status and counsel smokers to quit.
- Increase the number of smokers counseled by health and allied health professionals to quit smoking.
- Increase the number of households that ban smoking.

**Strategic Media and Social Marketing**

- Increase the number of paid TV, radio, newspaper, billboard and other mass media ads for tobacco control and the number of persons potentially reached.
- Increase the number of earned media events for tobacco control and the number of persons potentially reached.
- Increase the number and types of venues at which anti-tobacco messages are displayed and the number of persons potentially reached.
- Increase the number of Connecticut residents who have seen an anti-tobacco message in the media.
- Increase the number of smokers who have heard cessation messages in the media.

**Cessation Program**

- Increase the number of cessation, counseling and treatment programs statewide.
- Increase the number of free cessation programs.
- Increase the number of persons who attend/enlist in these programs.
- Increase the number of smokers in these programs who try to quit smoking.
- Increase the number of smokers who quit in each program, at program end.
- Increase the number of providers who follow AHCPH/AHRQ recommendations.
- Increase the number and percentage of the state's population and disparate population groups that have access to cessation programs.
- Increase the number of persons who are offered free smoking cessation programs.
- Increase the number of youth who are offered free smoking cessation programs in schools and after school programs.



**Intermediate  
Process Objectives:****Surveillance and Evaluation**

- Increase the number of programs using standardized outcome measures.
- Increase the number of outcomes being measured.
- Increase the number of Connecticut residents sampled by the BRFSS and the Adult Household Survey.
- Increase the number of Connecticut towns and cities that are over-sampled to capture accurate information on all population groups.
- Increase the number of local health departments, regional action councils, and districts that can conduct their own local level behavioral risk factor surveys.
- Increase the number of tobacco-related questions in other surveys (e.g. DMHAS Adult Substance Abuse Treatment Surveys and the DPH's PRAMS) to enhance data collected on tobacco use in Connecticut.
- Establish schedules for implementation of the YTS, YRBS, GPIY and other school-based surveys consistent with school operations and to prevent inappropriate or excessive sampling of the student population.

**Administration and Management**

- Increase interagency collaboration of tobacco-related activities.
- Increase the number of providers using web-based reporting.
- Increase the number of tobacco use prevention programs that have access to available tobacco resources statewide.
- Increase the number of training events and workshops conducted to increase the number of providers proficient in tobacco use prevention strategies, outcomes and evaluation.

<b>Subject:</b>	<b>WIC (WOMEN, INFANTS, AND CHILDREN)</b>
<b>Title:</b>	Connecticut State Plan for Program Operation in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Federal Fiscal Year 2009
<b>Publication Date:</b>	2008
<b>Web Location:</b>	<a href="http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/wic_plan_2009.pdf">http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/wic_plan_2009.pdf</a>
<b>Authority:</b> <i>(Federal, State, or Other Grant or Initiative)</i>	U.S. Department of Agriculture, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). In accordance with USDA Food and Nutrition Service, Federal Regulations 246.4(A) - State Plan
<b>Contact:</b>	John Frassinelli State WIC Director (860) 509-8084 <a href="mailto:john.frassinelli@ct.gov">john.frassinelli@ct.gov</a>
<b>Target or Special Populations:</b>	Breastfeeding women, pregnant women, children, children <5 years of age, infants, low-income women and children
<b>Mission:</b>	The Connecticut WIC Program is committed to Improving the health of eligible pregnant women, new mothers, and children by providing nutrition education, breastfeeding support, healthy foods, and referrals to health and social programs during the critical stages of fetal and early childhood development.
<b>Goals &amp; Objectives:</b>	<p><b>Program Functional Area 1: Management and Organization</b></p> <p><b>Goal 1</b></p> <p>Ensure program integrity, cost-effectiveness, quality of services and accountability in the delivery of nutrition services in the provision of food benefits.</p> <p><b>Objectives</b></p> <ol style="list-style-type: none"> <li>1.1. Develop an action plan to engage Medicaid/Managed Care, OBGYNs &amp; Pediatricians to provide seamless and consistent services to WIC clients.</li> <li>1.2. Develop a CT WIC Annual Report by March 30, 2009.</li> <li>1.3. Ensure clean quality data collection and analysis by September 30, 2009.</li> <li>1.4. Enhance SA capacity to conduct surveys.</li> <li>1.5. Explore the hosting of an interactive WIC outside of CT DPH.</li> <li>1.6. Provide a 1-2 day leadership and management workshop for LA Coordinators/Program Nutritionists/SA staff.</li> <li>1.7. Direct the activities and processes necessary to procure a new/transfer WIC automated system.</li> </ol> <p><b>Program Functional Area 2: Nutrition Services and Breastfeeding Support and Promotion</b></p> <p><b>Goal 2</b></p> <p>Improve the nutritional and overall health of WIC families in Connecticut and to increase the proportion of WIC-enrolled infants who are breastfed exclusively for at least 6 months.</p>

**Goals & Objectives:****Objectives**

- 2.1. At least 70% of pregnant women participating in the WIC Program for a minimum of 6 months gain appropriate weight.
- 2.2. The incidence of low birth weight (LBW) among infants whose mothers were on the WIC Program for at least 6 months during pregnancy does not exceed 6%.
- 2.3. The prevalence of anemia among children enrolled in the WIC Program for at least one year does not exceed 9%.
- 2.4. Establish a baseline prevalence rate of BMI > 95th percentile for children 2-5 years of age.
- 2.5. To ensure that at least 55% of infants enrolled in the WIC Program initiate breastfeeding.
- 2.6. To ensure that at least 25% of infants enrolled in the WIC Program breastfeed for 6 months or more.
- 2.7. The Value Enhanced Nutrition Assessment (VENA) Implementation Plan tasks are completed on schedule and updated or revised bi-annually.
- 2.8. Work with Management, Fiscal Unit and Food Delivery Unit to develop a strategy to reduce non-contract formula issuance (current range 4-19%) and refine existing State and local formula policies and procedures.

**Program Functional Area 3: Food Delivery and Food Instrument Accountability****Goal 3**

To improve food delivery operations at the state and local agency level.

**Objectives**

- 3.1. To improve communications for the Farmers' Market Nutrition Program (FMNP) between the state and local agencies.
- 3.2. Increase to 80% timely local agency submission of unused check stock inventory reports.
- 3.3. To decrease the number of rejected checks by 10%.
- 3.4. To implement the new food packages by July 1, 2009.

**Program Functional Area 4: Vendor Management****Goal 4**

To improve communication and effectiveness in Vendor Management.

**Objectives**

- 4.1. To enhance the WIC website to provide important vendor related information.
- 4.2. To provide selected vendor management documents in languages most commonly used by vendors.
- 4.3. To increase from 5% to 10%, authorized vendors that receive random monitoring visits.
- 4.4. To increase from 10% to 50% the number of compliance investigations that are initiated and completed within FY 09.

**Goals & Objectives:****Program Functional Area 5: Management Information Systems****Goal 5**

To maintain and enhance the Statewide WIC Information System (SWIS) and the WIC IT infrastructure.

**Objectives**

- 5.1. Implement solutions to address changes in USDA regulations and/or state policy.
- 5.2. Improve the usability and functionality of SWIS.
- 5.3. Identify and correct any system bugs discovered by users or IT staff.
- 5.4. Continue the mainframe cost containment initiative.
- 5.5. Perform an alternative system analysis for the procurement of a new WIC system.
- 5.6. Perform periodic data extracts as required for USDA, CDC, auditors and data analysts.
- 5.7. Attend food package committee meetings to assist in food choice development, cost neutrality determination and redesign of user interface.
- 5.8. Re-engineer SWIS food package methodology and user interfaces, especially food package tailoring.
- 5.9. Restructure all fields related to food package and instruments currently residing in mainframe DB2 tables, extract files, daily and monthly reports.
- 5.10. Replace out-dated equipment as part of IT life-cycle plan.
- 5.11. Repair or replace broken IT equipment.
- 5.12. Implement new technologies as mandated by USDA and/or DOIT requirements.
- 5.13. Implement new technologies to enhance productivity or system security.

**Program Functional Area 6: Caseload Management/Outreach****Goal 6**

Effectively reach all eligible individuals as resources allow, and achieve the maximum caseload capacity to serve the greatest number of women, infants and children.

**Objectives**

- 6.1. By September 30, 2009, increase the percentage of high-risk individuals receiving benefits by directly targeting resources of high-risk populations.
- 6.2. By September 30, 2009, develop a system to improve the no-show rate.
- 6.3. By September 30, 2009, develop an outreach strategic plan to ensure consistent marketing of program eligibility and benefits.

**Goals & Objectives:****Program Functional Area 7: Coordination of Services****Goal 7**

Strengthen coordination of information and resources with other CT State Agencies to respond to the needs of the WIC clients.

**Objectives**

- 7.1. Synchronize with management to provide current information on WIC.
- 7.2. Clarify policies and procedures on mandated and targeted referrals.
- 7.3. Develop baseline and create SWIS report.

**Program Functional Area 8: Civil Rights****Goal 8**

Establish and administer policies and procedures that assure client-oriented customer friendly service environment for all applicants and participants and comply with Racial/Ethnic Federal mandate to ensure uniformity and comparability in the collection and use of data as required by OMB standards.

**Objectives**

- 8.1. By September 30, 2009 provide updated civil rights materials in different languages for use by local agency WIC staff.
- 8.2. Ensure compliance of civil rights requirements in the use of the non-discrimination statement at the local and State level and assure that services provided are in compliance with civil rights requirements.
- 8.3. Ensure all employees in the LA are trained in the area of civil rights.
- 8.4. Ensure compliance with OMB racial/ethnic data collection procedure at local agencies via reviews.
- 8.5. By December 30, 2008, updated FFY2009 State Plan policy on racial/ethnic data collection procedures.

**Program Functional Area 9: Certification & Eligibility****Goal 9**

Improve and maintain program integrity in the areas of certification and eligibility.

**Objectives**

- 9.1. By December 31, 2008 develop new certification forms.
- 9.2. By September 30, 2009 investigate and assess the issuance of non-contract standard and special formulas.
- 9.3. By September 30, 2009 assess local agencies accuracy in assigning new/revised risks (revision 8 & 9).

**Goals & Objectives:****Program Functional Area 10: Monitoring & QA****Goal 10**

Conduct on-site programmatic management and nutrition services reviews of local agencies to ensure compliance with federal and State regulations.

**Objectives**

- 10.1. Monitor six (6) service regions including satellites.
- 10.2. Evaluate applications of VENA principles in LA operations and identify training and TA needs.
- 10.3. Improve local agency monitoring reviews (nutrition services and program operations) outcomes.

**Program Functional Area 11: Fiscal Management****Goal 11**

Maximize the utilization of WIC food funds.

**Objectives**

- 11.1. By September 30, 2009, expand the usage to 97% of all food dollars.
- 11.2. By September 30, 2009, finalize a model for food costs estimation and written procedures.
- 11.3. By September 30, 2009, assist in the development of cost-neutral new food packages.