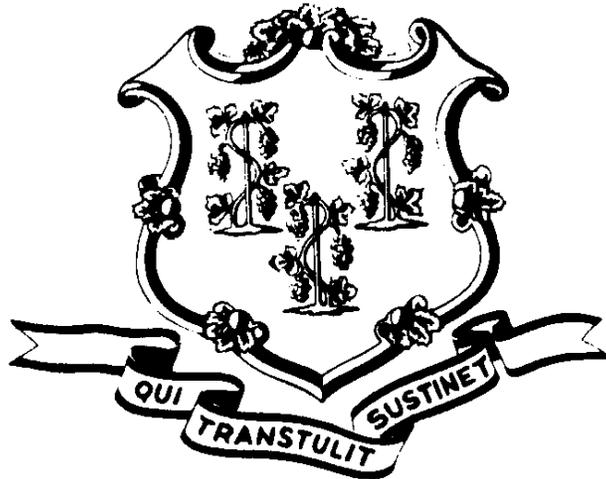


STATE OF CONNECTICUT
AGENCY PREVENTION REPORT



A REPORT TO THE
CHILD POVERTY AND PREVENTION
COUNCIL

2013

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NOVEMBER 2013

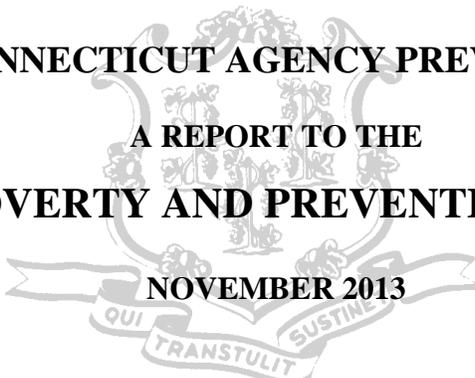


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REPORT TO THE CHILD POVERTY AND PREVENTION COUNCIL

I. LEGISLATIVE AUTHORITY

Section 4-67x of the Connecticut General Statutes sets forth the requirement that each budgeted state agency with membership on the Child Poverty and Prevention Council that provides prevention services to children must submit an agency prevention report to the Council by November 1st of each year through 2014. The agencies must report on at least two prevention services. This report represents the seventh annual State Agency Prevention

The prevention report includes the following:

- A description of the purpose of the prevention service including the number of children and families served through the service;
- A description of the agency’s long-term goals, strategies, performance-based standards outcomes and performance-based vendor accountability;
- A statement on the overall effectiveness of prevention with the agency;
- Methods used to reduce disparities in child performance outcomes by race, income and gender; and
- state and federal funding amount

II. STATE AGENCY REPORT

The prevention programs in this report are administered by State agencies that serve on the Child Poverty and Prevention Council and provide primary prevention services to children and families. The following State agencies included in this report are:

Department of Children and Families

Department of Developmental Services

Department of Education

Department of Labor

Department of Mental Health and Addiction Services

Department of Public Health

Department of Social Services

Judicial Branch

Office of Policy and Management

The Departments of Transportation, Higher Education, Economic and Community Development, Office of Health Care Access, Commission on Children, and the Commission on Human Rights and Opportunities determined that their prevention programs did not meet the definition of primary prevention, and therefore, no reports from these agencies are included in this report.

Prevention is defined as: *Policies and programs that promote healthy, safe and productive lives and reduce the likelihood of crime, violence, substance abuse, illness, academic failure and other socially destructive behaviors.*

Furthermore, the prevention programs and services highlighted in this report serve children aged 0-18 and their families. Primary prevention refers to programs designed to prevent or eliminate at-risk behavior before a problem occurs and promote the health and well-being of children.

State Agency Prevention Programs - SUMMARY

State Agency Prevention Programs

This section of the report provides a summary on state agency primary prevention services that provide intensive, comprehensive and family-centered resources and support which reduces or eliminates high-risk behavior and promotes the health and well-being of children and families.

In Fiscal Year (FY) 2013, these agencies expended over \$430 million to administer 26 comprehensive primary prevention programs and services that positively impact Connecticut’s children and families. The chart below provides a snapshot of the state agency primary prevention programs included in this report.

Department of Children and Families			
Program	FY13 Funding	Service Level	Description
Early Childhood Consultation Partnership	\$2,347,995	2,889 children and 1,195 teachers and assistant teachers	Prevent children birth to age 6 from being suspended or expelled from their early care and education setting due to challenging behaviors.
Triple P	\$5,374,863	New program-service level not available	Provides in-home parent education curriculum and support to create a safe and healthy home environment for children and the family.
Total	\$ 7,722,858		

Department of Developmental Services			
Program	FY 13 Funding	Service Level	Description
Birth to Three	\$49,546,941	9,345 children and families	Early intervention services to all infants and toddlers who have developmental delays or disabilities.
Family Support Services	\$9,524,375	917 individuals including 178 children-Respite Centers; 738 individuals including 196 children – Family Support Services	Services, resources and other forms of assistance to help families raise their children who have intellectual disabilities.
Total	\$59,071,316		

Department of Education			
Program	FY13 Funding	Service Level	Description
Early Childhood Program	\$81,315,753	11,420	Expand and enhance access to and availability of school readiness and child day-care programs.
Even Start Family Literacy	\$479,919	54 even start families	Intensive family literacy services to low-income parents and children.
Total	\$81,795,672		

Department of Labor			
Program	FY 13 Funding	Service Level	Description
Jobs First Employment Services	\$17,657,471	15,393 annual caseload	Provides employment services to families in receipt of time- limited state cash assistance.
Connecticut Youth Employment Program	\$4,500,000	3,117 youth	Provides employment services for youth aged 14 through 21.
Total	\$22,157,471		

Department of Mental Health and Addiction Services			
Program	FY 13 Funding	Service Level	Description
Best Practices Initiative	\$1,785,901	398,462 children, family members, prevention and treatment professionals	Fourteen statewide funded projects that employ a population-based public health approach to address demonstrated substance abuse prevention needs.
Local Prevention Council Programs	\$552,470	255,932 elementary and high school students, parents and family members, school faculty and staff.	The Local Alcohol, Tobacco and Other Drug Abuse Prevention Council Grant Program (LPCP) initiative supports the activities of local, municipal-based alcohol, tobacco, and other drug (ATOD) abuse prevention councils.
Partnership for Success	\$2,300,000	1,878,983 clients served by PFS coalition (a combination of direct service counts and impacts)	The Partnership for Success (PFS) Initiative uses a public health approach in over 30 municipalities and statewide across college campuses to decrease alcohol consumption in youth ages 12 to 20.

Regional Action Council	\$1,850,833	2,854,189 children, families, community members and prevention professional	Regional Substance Abuse Action Councils (RACs) are public-private agencies comprised of community leaders. Its purpose is to establish and implement an action plan to develop and coordinate needed services across the behavioral health continuum.
Statewide Service Delivery Agents	\$1,899,168	87,160 children, families, community members and prevention professional	Four entities funded by DMHAS to support prevention efforts across the state by building the capacity of individuals and communities to deliver prevention services.
Tobacco Prevention and Enforcement	\$618,984	1,437 retail inspections and 13,829 printed material	Enforcement and strategies to reduce underage tobacco use.
Total	\$9,007,356		

Department of Public Health			
Program	FY13 Funding	Service Level	Description
Asthma Program: Pediatric Easy Breathing Program	\$500,000	10,275 surveyed and 2,798 or 27% diagnosed with asthma	A professional education program that trains pediatric providers to administer a validated survey to determine whether a child has asthma.
Asthma Program: Adult Easy Breathing Program	\$150,000	1,319 patients surveyed and 342 or 26% diagnosed with asthma	Focuses on adults treated by medical resident physicians in Bridgeport Hospital.
Immunization Program	\$59,219,300	875,580 children served	Prevent disease, disability and death from vaccine preventable diseases in infants, children adolescents and adults.
Special Supplemental Nutrition Program for Women, Infant and Children	\$61,848,534	14,123 infants, 30,365 children, and 12,092 women	Provides nutrition and breastfeeding education, supplemental food, and referrals for health and social services to eligible women, infants and children.
Tobacco Use Prevention and Control	\$1,079,069	13,100 individuals	Provides local cessation and prevention programs.
Total	\$122,796,903		

Department of Social Services			
Program	FY 13 Funding	Service Level	Description
Tobacco Cessation Program	\$2,899,366	6,000 over a five year period	Provides incentives to reduce smoking rates among the estimated 25-30% of Connecticut's Medicaid recipients.
Perinatal and Infant Oral Health Quality Improvement	\$120,000,000	Over 300,000 children	Focuses on oral health improvement and community integration strategies for improving preventive oral healthcare.
Fatherhood Initiative	\$445,000	410 individuals and couples	Provides outreach, awareness and training for parents relating to parenting, healthy relationships and healthy marriages.
Total	123,344,366		

Judicial Branch Court Support Services			
Program	FY 13 Funding	Service Level	Description
Educational Support Services	\$765,264	306 cases opened and 294 cases closed	Supports families to ensure that children's educational needs are identified and free and appropriate educational services are accessible.
Family Support Centers	\$3,541,097	753	A multi-service "one-stop" service for children and families referred to juvenile court.
Total	\$ 4,306,361		

Office of Policy and Management			
Program	FY 13 Funding	Service Level	Description
Title V Delinquency Prevention Program	\$84,945	N/A	Provides grants to cities and towns for delinquency prevention and early intervention projects.
Enforcing Underage Drinking Laws	\$318,643	N/A	Supports comprehensive and coordinated enforcement initiatives to address the problem of underage drinking.
Total	\$ 403,588		

Department of Children and Families

- **Early Childhood Consultation**
- **Triple P Program**

Long-Term Agency Goals: The Department of Children & Families applies a generalized knowledge of prevention in the design and implementation of all its prevention programs and activities. The programs use existing data and national research as the foundation for designing and implementing appropriate evidence-based programs and practices. Similar to other state and federal agencies, risk and protective factors play an important role in the Department's planning process. For example, the federal Children's Bureau has outlined five protective factors that may diminish the likelihood of maltreatment: nurturing and attachment between family members; knowledge of parenting and child development; parental emotional resilience; social connections for parents; and concrete supports such as food, clothing, housing, transportation, and services. The theory is that parents and caregivers who better understand how to care for their children, have access to more and better resources and feel safe and connected to their community will thrive and be less likely to abuse or neglect their children. The programs described here have been shown through research and evaluation to be effective at addressing at least one of these important factors. Knowing that prevention resources are limited, the Department works diligently to collaborate with other state and community based agencies as well as internally to maximize existing prevention dollars. All of the programs listed are examples of collaborations and partnerships.

Goals:

- Prevention/Less Need for DCF Services
- Children to Remain Safely at Home
- Achieve More Timely Permanency
- Improved Child Well-Being
- Transitioning Youth Better Prepared for Adulthood

Strategies: Meeting the desired outcomes is best achieved through building agency and local capacity, public awareness, programs and services, and

integrating prevention principles, strategies and resources throughout the department.

Performance-Based Outcomes: The Department is working diligently to meet the Exit Outcomes for its Consent Decree. Therefore, the following outcomes are aimed at meeting these court defined measures. A complete list of Outcome Measures can be found at http://www.ct.gov/dcf/LIB/dcf/positive_outcomes/pdf/Two_Page_Summary_Outcomes_1_22.pdf

1. Prevention/Less Need for DCF Services

- Fewer investigations
- Fewer open cases
- Fewer delinquency petitions
- Fewer Families with Service Needs (FWSN) petitions
- Increase numbers of families receiving appropriate and effective services
- Fewer re-entries into child welfare system

2. Children to Remain Safely at Home

- Fewer removals from home
- Fewer re-entries into care
- Fewer delinquency commitments
- Lower recidivism
- Fewer disrupted adoptions
- Fewer FWSN commitments

3. Achieve More Timely Permanency

- Fewer youth aging out with APPLA goal
- Reduce average Length of Stay (LOS) for reunification & Meet Outcome Measure (OM) 7 re: Reunification
- Reduce average LOS for Transfer of Guardianship (T Of G) & Meet OM 9 re: T/G
- Reduce average LOS for adoption & Meet OM 8 re: Adoption

4. Improved Child Well-Being

- Fewer school changes
- Improved school achievement
- Fewer placement changes
- Meet OM 14 re: Placements

- within License Capacity
- Increase of placement with siblings
- Meet OM 6 re: Child maltreatment in Out of Home (OOH) care
- Increase percentage of children placed with relatives
- Timely medical/dental care
- Lower percentage of children in congregate care
- Reduction of children on discharge delay
- Improved performance on OM 15 re: Needs Met

5. Transitioning Youth Better Prepared for Adulthood

- Increased percentage with family/adult connection
- Increased percentage of high school graduates
- Increased percentage engaged in treatment if needed
- Increased percentage with financial literacy
- Increase percentage with sustainable housing
- Meet OM 20 re: Discharge
- Meet OM 21 re: Discharge to DMHAS/DDS

Measure of Effectiveness: The findings thus far indicate that programs targeting and strengthening families have been the most effective. Research tell us that the earlier interventions are introduced into children’s lives the greater the chance for positive results now and later. National research studies shows that very young children are especially vulnerable. The Adverse Childhood Experience Study (ACES) found that adverse childhood experiences are strongly related to the development and prevalence of risk factors for disease and health and social well-being throughout the lifespan. This emphasizes the need for prevention and early intervention programs for very young children and the need to target children in the context of their families and the communities in which they live.

Methods: At the ground level, programs such as The Breakthrough Series (a program implemented in Waterbury to look at the issue of overrepresentation of minorities in the child welfare system) and Better

Together (a program to engage families in our work to inform the Department's ongoing efforts) work to concretely address the issue of disparities in outcomes by race, income and gender. At the systems level, two new DCF initiatives, the Differential Response System and the Best Practice Model combine to support the mission of the Department to protect children, improve child and family well-being and support and preserve families. The goal is to provide a framework for how the agency as a whole will work internally and partner with families, service providers, and others to put our mission and guiding principles into action in daily practice and operations. The Department's workforce reflects the populations it serves. In addition, DCF requires all contractors to administer, manage and deliver a culturally responsive and competent program with specifics clearly articulated in every contract.

Other: Prevention is just one of the Department of Children and Families' many mandates but it is one of its most important. DCF defines prevention as the promotion of wellbeing for all children and families. This is accomplished by building local and agency capacity, public awareness and funding prevention and early intervention programs and services.

Building capacity is done primarily through training. Since 2005, thousands have been trained in a variety of workshops and conferences on early childhood specific topics, youth substance abuse, depression, suicide prevention, Strengthening Families 10 -14 (a nationally recognized evidence-based curriculum), working with parents with cognitive limitations and shaken baby prevention - to name just a few.

Knowledge is power. It is this belief that drives the Department's Public Awareness campaigns. Getting important and timely information to families, providers and DCF personnel requires constant contacts. Along with the dissemination of letters and brochures to schools, superintendents, police, youth service bureaus, and DCF Area Offices and the information regularly distributed electronically through the Prevention list serve, the new CT Parenting website <http://www.ctparenting.com/> offers parents and other individuals a user friendly internet site for information on a multitude of topics for parents and caregivers.

The Department's prevention programs and services are designed to strengthen children and families.

Early Childhood Consultation Partnership (ECCP): The goal of ECCP is to prevent children birth to age 6 from being suspended or expelled from their early care and education setting due to challenging behaviors. ECCP promotes and facilitates the early identification of children in daycare education settings with mental health needs. The focus of this service is the provision of consultation and training to staff in Early Care and Education Settings in order to promote young children's social and emotional wellness in order to prevent behaviors that could result in the child being suspended or expelled from the early care and education setting. The program also provides service to DCF foster homes, safe homes, childcare homes, and parent child residential facilities.

Number Served: Since its inception in 2003 the program has served over 21,563 children and over 7,696 teachers and assistant teachers within an estimated 941 of Connecticut's licensed early care or education centers. In 2012-2013, 2,889 children and 1,195 teachers and assistant teachers were served.

Program Cost: FY 2012-2013: \$2,347,995

Performance-Based Standards: ECCP is a data driven program demonstrating its effectiveness through the internal quality assurance and program improvement measures it employs and through external research evaluations and national studies. ECCP is further backed by a 2007 rigorous randomized control evaluation conducted by Walter S. Gilliam, PhD, of Yale Child Study Center. A randomized study compared outcomes for children who were/ were not enrolled in classrooms that received ECCP services. Results indicated significant effectiveness in reducing classroom behavior problems in children, demonstrating changes such as decreased oppositional behaviors and hyperactivity. Program measures such as 6 month follow up data show that 99 percent of children in programs that received consultations were neither suspended nor expelled from their early care or education settings, and that 92 percent of classrooms served demonstrated improvement in the overall quality of classrooms environments.

Performance-Based Outcomes:

- Increased number of early childhood education centers and staff who have access to education and support services related to social and emotional wellness.
- Increased the number of caregivers and teachers that are implementing practices supportive of social and emotional health
- Improved ability of educators to observe and document children's behavior and identify behaviors that may be clinically significant
- Improved ability of educators to deliver classroom strategies and interventions targeted to specific children
- Improved ability of educators to initiate discussions with parents regarding children's behavioral difficulties, and to work in partnership with families, in helping to address children's individual needs
- Reduced incidence of suspension and expulsion in young children due to behavioral problem
- Increase coordination between parent /guardians, providers, DCF workers
- Increased capacity of parent /guardians, providers, DCF workers and early educators in the areas of healthy social/emotional development and attachment
- Increased support for children in foster care and for DCF staff

Performance-Based Vendor Accountability: ECCP is funded through Connecticut's State Department of Children and Families and is managed by Advanced Behavioral Health (ABH®), a non-profit behavioral health care management company. ABH has been responsible for the development and administration of the ECCP program. ABH subcontracts with 10 non profit behavioral health clinics for 20 Early Childhood Mental Health Consultants to provide statewide coverage. ECCP is backed by a rigorous research evaluation and features a fully manualized service approach, customized central Information System, and an integrated and competency based workforce development and training program. ECCP is now an evidence-based effective practice and nationally recognized as an evidence-based model for other states to follow.

Triple P:

This service utilizes the evidenced-based model, Triple P (Positive Parenting Program®) of the University of Queensland, to provide an in-home parent education curriculum along with support and guidance so that parents will

become resourceful problem solvers and will be able to create a positive and safe home learning environment for children to develop emotional, behavioral, and cognitive strengths. Within the multi-tiered Triple P system, this service will use Triple P's Level 4 Standard and Level 4 Standard Teen courses. In addition to Triple P, this service will provide short term case management supports to help parents fully utilize the parenting services.

Number Served: Not available; this is a new program that began in spring 2013.

Program Cost: FY 2012 – 2013 \$5,374,863 (serves parents and primary caregivers of children and adolescents)

Performance-Based Standards: Level 4 Standard and Standard Teen Triple P is designed to decrease the key risk factors for child abuse and neglect. Risk factors include child's level of behavior problems, parent's level of hostility, parent's level of over-reacting, parent's level of laxness, and parent's level of stress, anxiety, and depression.

Performance-Based Outcomes:

- For the parents assessed at intake as having a dysfunctional level of child behavior problems, did we decrease the level of the child behavior problems?
- For the parents assessed at intake as having a dysfunctional disciplinary style, did we decrease the dysfunctional disciplinary style?
- For the parents assessed at intake as having a dysfunctional level of symptoms for anxiety, stress, or depression, did we decrease the parents' dysfunctional level of symptoms for anxiety, stress, or depression?

Performance-Based Vendor Accountability: Monthly, quarterly, and annual reports; statewide data system being developed.

Department of Developmental Services

- **Birth to Three**
- **Family Support Services**

Long-Term Agency Goals: The Department of Developmental Services (DDS) provides services and supports to 16,037 individuals who have a diagnosis of intellectual disability in Connecticut including 2,478 children under the age of 18. This number does not include approximately 9300 eligible children who are served each year in the Birth to Three System. While most of the children served by DDS live with their families, approximately 149 children live in other residential settings. The department's long term prevention goal is to 1) provide early intervention to families of very young children with delays or disabilities to ameliorate the delay or to prevent secondary disabilities; 2) support families to care for their children in the family home; and 3) to prevent out-of-home placement.

Strategies: For children enrolled in Birth to Three, family-centered early intervention services are delivered in natural environments as early as possible. Most families who have children with intellectual disability over the age of three need extra support to care for their children at home. DDS provides Family Supports to assist families caring for their children at home. Family Supports include goods, services, resources, and other forms of assistance that help families to successfully raise their children who have intellectual disability. The Department of Developmental Services plans to continue to provide Individual and Family Grants, Respite, and Family Support Workers to families. Within available resources, the department serves as many families as possible with these Family Supports.

In addition to the Family Support services offered by the department, DDS continues to implement Home and Community Based Services Waivers which offer services in the community as an alternative to institutional care for children over the age of three. The department continues to expand the range and number of services available under the waivers that assist families to care for their children within the family home. These services include personal services, individualized supports, respite, home and vehicle modifications, family training and consultative services. All children who receive Medicaid fee for services are provided with a DDS case manager. A

help line exists in each of the three DDS regions to assist families who do not have a case manager to access appropriate family support services. DDS also has worked on developing a waiver for three- and four-year-olds who have autism spectrum disorder but do not have intellectual disability. This Medicaid waiver is expected to receive approval from the Centers for Medicare and Medicaid Services (CMS) in the coming months.

Performance-Based Outcomes: For children enrolled in Birth to Three, children are identified as early as possible, children's developmental trajectories are improved, parents feel more confident and competent to foster their child's development, and fewer children need special education services by Kindergarten. Children over the age of three are able to live at home longer with their families, receiving appropriate supports and avoiding more costly residential or out-of-home care.

Measures of Effectiveness: Because individuals eligible for DDS supports and services have a diagnosis of intellectual disability or autism spectrum disorder, they are likely to require lifetime services. While intellectual disability or autism spectrum disorder in and of itself is not "preventable", strategies are pursued to lessen or delay the need for more comprehensive services throughout an individual's lifetime and to provide supports and services that build skills and independence. The provision of in-home services often delays the need for more comprehensive and thus more expensive residential or out-of-home services. In Birth to Three, family survey outcome data supports that the stated outcomes are being achieved to a great degree.

Methods: Any child that meets the DDS eligibility criteria in section 1-1g of the Connecticut General Statutes is eligible for services, irrespective of race, income level, gender or town of residence. Funding for these services is allocated to a child and their family based upon the child's level of need and available appropriations. Birth to Three is an entitlement program and all eligible children may receive services. Data about all children born during a given calendar year (birth cohort) indicate no racial, income level, or town of residence disparities. The prevalence of a wide range of developmental disabilities is greater for males than for females, however, and Birth to Three enrollment is 65% boys.

The focus of early intervention services is in teaching the family and other caregivers to facilitate the child's development during naturally occurring routines and activities.

BIRTH TO THREE: The Department of Developmental Services (DDS) is the lead agency (17a-248 C.G.S.) for the Birth to Three program, which is also operated under the provisions of Part C of the Individuals with Disabilities Education Act. This is the same federal law that governs special education for children ages 3 to 21.

The mission of the program is to strengthen the capacity of families to meet the developmental and health-related needs of their infants and toddlers who have developmental delays or disabilities. The program ensures that all families have equal access to a coordinated program of comprehensive services and supports that:

- foster collaborative partnerships
- are family centered
- occur in natural settings
- recognize current best practices in early intervention
- are built upon mutual respect and choice

Birth to Three seeks to assist families to ameliorate delays in their infants' or toddlers' development that are identified early or to prevent secondary delays or disabilities. Birth to Three works with families to ensure that their children are ready for Kindergarten at age five.

The federal law requires that two groups of children receive services 1) those with developmental delays and 2) those with diagnosed conditions expected to lead to a developmental delay without the benefit of early intervention. States are given quite a bit of latitude in defining both of those groups.

Early intervention services must be delivered in natural environments which, for children at this age, are typically the home, (although services can be delivered in any setting that the child and family typically frequent, such as at child care.) Most services are delivered by occupational, physical, and speech therapists along with early childhood special education teachers, although there are many other professionals and paraprofessionals who can be service providers as well.

Number Served: In FY 2013, 8,333 referrals were accepted for evaluation. During some portion of fiscal year 2013, 9,345 eligible children and their families received services with an average of 5,000 children enrolled on any given day. Data about children born each year between 2000 through 2009 show that the Birth to Three System has consistently served 10% to 11% of the children born in that year (birth cohort). Data on those children born in 2008 shows that one out of every eighty-five children born that year received autism services sometime before their third birthday.

Program Cost: FY 2012 -2013 \$49,546,941
State: \$36,617,837 Federal: \$6,833,033 *Other: \$6,096,071

*In addition to state and federal funding, the state netted \$1,129,424 from parent fees and \$4,966,647 from commercial insurance in FY13. (Medicaid billing resulted in \$7,050,483 federal reimbursement for the state's general fund.)

Performance-Based Standards: There is a single statewide point of access, which is easily marketed to health care providers and other referral sources. Once children are referred, they are evaluated and, if eligible, family service plans are developed within 45 days of referral. All new services are delivered no later than 45 days from the writing of the plan. Individualized Family Service Plans (IFSPs) are reviewed at least every six months and rewritten at least annually. School Districts are notified of all children receiving early intervention services shortly before the child turns three, if the children have not already been referred to the districts. Parents are encouraged to refer their children no later than age two and a half.

Performance-Based Outcomes:

- All eligible children and their families are identified and offered services
- Children receive early intervention services as early as possible
- Children’s developmental trajectories are improved
- Families feel more confident and competent to foster their children’s development
- Fewer children need special education services by Kindergarten

Performance-Based Vendor Accountability: Birth to Three has an in-depth, multi-layered process for assuring the quality of services and the performance of its contractors:

- *Data System.* All contractors are part of a real-time web-based data system that enables the state to view their performance on a daily basis. As part of that web-based data system, the contractors have a “performance dashboard” that allows them to monitor their own performance.
- *State Performance Plan/Annual Performance Report.* The department submits a five-year State Performance Plan to the U.S. Department of Education and then submits an Annual Performance Plan each year reporting on progress. Each indicator of performance in the annual plan is also reported for each contractor. Any contractor not in 100% compliance with the IDEA for any indicator receives a finding of non-compliance, which must be corrected as soon as possible but not later than 12 months from written identification. Connecticut’s Annual Performance Report for IDEA Part C has resulted in a determination of “meets requirements” for the past seven consecutive years.
- *Self-Review.* In addition, every three years, each Birth to Three contractor submits a self-review looking at their performance over a wide variety of indicators. That review is submitted electronically to DDS central office staff, who verifies the data. The contractor is required to prepare an improvement plan for any items that are either not in compliance with the law or any performance items that need improvement. Once a year, the state ranks contractors on one or more specific indicators chosen by a stakeholder group. Low-performing contractors receive an on-site monitoring visit by a team composed of state staff, a program director from a different agency, and parents. The team focuses on the indicator that was low but then delves much deeper into issues of quality. The team reviews child records, interviews staff, and interviews parents. The monitoring report is issued and any findings of non-compliance are made. Corrections of non-compliance findings or items needing improvement are added to the contractor’s existing improvement plan. Any finding of non-compliance must be corrected as soon as possible, but not later than 12 months from written identification.
- *Dispute Resolution.* The last check on contractor performance is procedural safeguards for parents. Each written complaint received is investigated and may result in one or more findings that must be corrected by the contractor. The same is true for any administrative hearings, although the last hearing held was in 2007. All of these accountability processes are detailed in the Birth to Three Quality Assurance Manual found on www.birth23.org under “How are we doing?”

FAMILY SUPPORT SERVICES: The Department of Developmental Services (DDS) provides Family Supports that assist families to care for their children who have intellectual disability in their homes. Most families who have children with intellectual disability need extra support to help them keep their children at home. Family Supports include goods, services, resources, and other forms of assistance that help families successfully raise their children who have an intellectual disability. Family Supports include Respite Services provided by DDS and DDS Family Support Workers. Family Supports help children grow up in a nurturing family home where they are more likely to live healthy, safe and productive lives. DDS Respite Centers provide 24-hour care for extended weekends in comfortable home-like environments.

Family Support Workers provide temporary in-home and community support to DDS consumers who live at home with their families. These supports are provided by DDS staff who have skills needed to work with children with intellectual disability and their families. The types of supports and services provided include in-home and community supports, respite, skill building, implementation of behavior programs, activities to promote health and wellness, transportation to medical appointments, and support with transitions to adult programs.

Number Served: The department has 11 Respite Centers which served a total of 917 individuals statewide in FY 13, including 178 children. During FY 13, DDS family support workers provided services to more than 738 individuals statewide, including 196 children

Program Cost: FY – 2012-2013 \$9,524,375

Performance-Based Standards: The goal of DDS Family Supports is to provide a range of supports for children with intellectual disability and their families to keep these children in their family home. DDS prioritizes family supports based upon the level of need of the child; for instance, a child who is a high priority on the waiting list for residential services is also a high priority for services at respite centers.

Performance-Based Outcomes: Specific outcomes in measuring the success and effectiveness of Family Supports provided by DDS include the number of children and families served and the number and percentage of children who live in family homes compared to children in out-of-home placements.

Performance-Based Vendor Accountability: Family Supports are provided by DDS staff through the department's programs and are not contracted services. Family Support programs are operated based upon DDS policies and procedures specific to those services. These procedures are described in the eligibility criteria, priority for services, and service operational guidelines. DDS regional offices maintain data on the numbers of children and adults served. DDS has a centralized process to review requests for out-of-home placement for children. The department's Children's Services committee meets monthly to review any requests to place a child under age 18 out of the family home. The committee reviews alternative supports that have been put in place, makes recommendations for additional supports that may be successful in keeping families together and makes recommendations to the Commissioner regarding the appropriateness of placements.

Connecticut State Department of Education

- **Early Childhood Program**
- **Even Start Family Literacy Program**

Early Childhood Program: To significantly increase the number of accredited and/or approved spaces for young children in order to provide greater access to high-quality programs for all children; To significantly increase the number of spaces for young children to receive full-day, full-year child care services to meet family needs and to enable parents to become employed; and to establish a shared cost for such early care and education programs among the state and its various agencies, the communities and families. All programs must receive National Association for the Education of Young Children (NAEYC) or Head Start accreditation within three years of initial funding and must maintain such accreditation for continued funding to ensure high-quality programs for all children. Communities must offer a range of options regarding the length of program day and year in order to meet the needs of families. Families are offered a sliding fee scale as a means of providing affordable high-quality early education programming. The program serves resident children in priority school districts and competitive grant municipalities who are ages 3- and 4- years of age and children age 5 years of age who are not eligible to enroll in school.

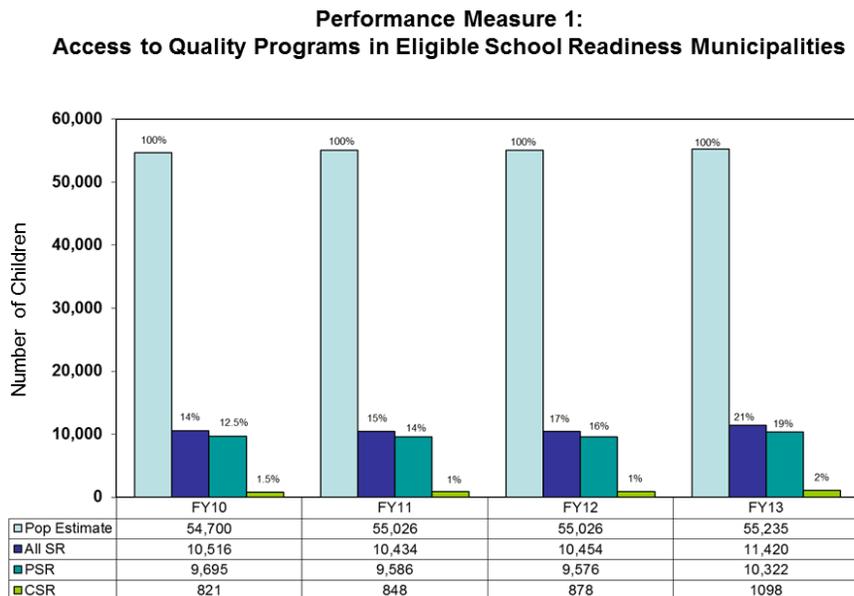
Number Served: A total of 67 towns/school districts in Connecticut served 11,420 children in priority and competitive School Readiness programs.

Program Cost FY 2013: \$81,315,753

Performance-Based Standards: Quality preschool services are available for 100 percent of eligible children in priority school districts. By 2015 every School Readiness classroom will have a teacher with an early childhood associates or bachelor’s degree or higher. By 2020 every School Readiness classroom will have teacher with an early childhood bachelor’s degree or higher. All of the School Readiness Programs are accredited or approved under the recognized systems.

Performance-Based Outcomes: Quality early childhood programs ameliorate the risk factors that lead to achievement gaps. Two components that contribute to program quality are: teachers with early childhood specific training; and systematic monitoring across multiple program components.

Performance Measure 1: Access to quality early childhood programs in eligible municipalities.



This graph shows a comparison of the School Readiness-funded space capacity over the past four fiscal years in relation to the preschool population estimates, for eligible 3-4 year olds, in the 67 School Readiness Municipalities. The School Readiness municipalities were increased by 2% in capacity to serve more preschool children. An increase in funding to serve 1,000 more children (750 to priority districts and 250 to competitive municipalities) was effective October 2012. School Readiness programs within eligible municipalities continue to enroll children in need of such program. Additional funding for capacity building would be needed in order to absorb any further space increases.

Performance Measure 2: Progress of teacher qualifications toward a Baccalaureate degree.

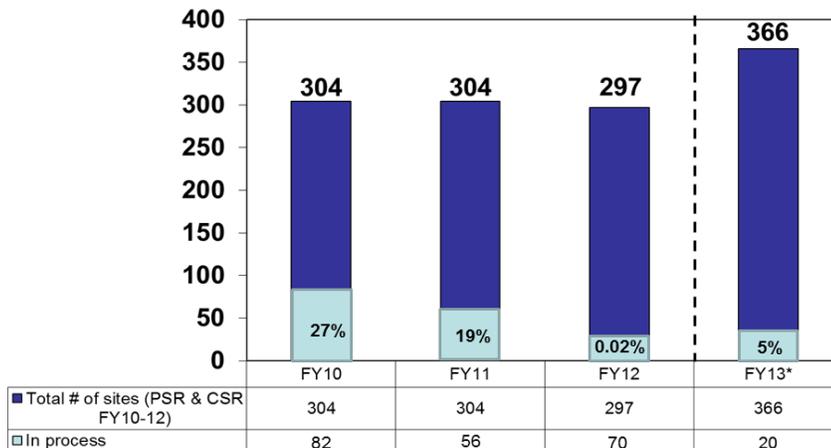
Registry Report of Teaching Staff in Publicly Funded Centers		
	Teachers	
Education and Training	Number	Percent
BA or more plus 12 ECE credits	876	47%
AS plus 12 ECE credits	451	24%
CDA plus 12 ECE credits or 30 credit credential	241	13%
CDA or 12 ECE credits	119	6%
Less than a CDA or 12 ECE credits	165	9%
TOTAL	1852	

The Registry Report process for gathering data has changed to include teaching staff in all publicly funded centers. Current legislation states that by 2015, all publicly funded classrooms must have a teacher with an early childhood associate’s or bachelor’s degree or higher. By 2020, all publicly funded classrooms must have a teacher with an early childhood bachelor’s degree or higher.

This information shows that currently, 47 percent of teachers hold a bachelor’s degree or higher and 24 percent hold an associate’s degree or higher which reflects significant progress towards meeting the legislative educator requirements.

Performance Measure 3: Progress toward quality standards

**Performance Measure 3:
Progress Toward Quality Standards**



*NOTE: FY13 data includes Child Day Care contracted sites

There was a significant effort this year for programs to become NAEYC accredited. There are 366 School Readiness sites in Connecticut. 348 of these programs are participating in the NAEYC accreditation system; 95 percent of which hold accreditation and 5 percent are in process of achieving such status. There are 10 programs that hold Head Start status not pursuing NAEYC accreditation. The NAEYC and Head Start systems align with the School Readiness quality components and are therefore adopted as the School Readiness quality monitoring system. These systems address multiple program quality components such as health, curriculum, family, assessment, physical environment, teaching, leadership, and community partnerships.

Performance-Based Vendor Accountability: School Readiness programs are based on 10 quality components and provide supports and services for collaboration with community agencies, health, nutrition, parent education and services, transition to kindergarten, professional development that includes training in emerging literacy and diversity, family literacy, child and program evaluation, a sliding fee scale and a non-discriminatory admissions process. The plan to implement these supports and services is described by each school readiness program in their application. The program's adherence to the quality components is reported through the Connecticut School Readiness Preschool Program Evaluation System (CSRRPES), as well as state monitoring visits and community liaison site visits. These reports focus on the program's implementation of the services and emphasize collaboration with outside service providers in order to support the individual needs of families in the context of their community.

Even Start: To break the cycle of poverty and illiteracy for low-income families. In FY 2013, Even Start moved from a federally funded program to a Connecticut State funded program to continue to provide intensive family literacy services involving parents and children in a cooperative effort to help parents become full partners in the education of their children and assist children in reaching their full potential as learners. Even Start helps break the cycle of poverty and illiteracy by improving the educational opportunities of families most in need in terms of poverty and illiteracy by integrating early childhood education, adult literacy or adult basic education, and parenting education into a unified family literacy program. Local programs are implemented through cooperative projects that build on high-quality existing community resources, creating a comprehensive range of services for low income children and parents.

Even Start helps children and families achieve the academic standards set forth by the state and uses instructional programs that are based on scientifically-based reading research to:

- enrich language development, extend learning and support high levels of educational success for children birth to age seven and their parents;
- provide literacy services of sufficient hours and duration to make sustainable changes in a family;
- provide integrated instructional services for families, where children and their parents learn together to develop habits of life-long learning; and
- support families committed to education and to economic independence.

NUMBER OF CLIENTS SERVED: Even Start in Connecticut operated with three programs serving the high-need areas of Middletown, New London, and Torrington. Programs served 54 families (56 Even Start adults and 63 children) through all Even Start components. The number of programs supported has dropped significantly each year from a previous service level of 10 programs in FY 2003.

PROGRAM COST: FY 2012-2013 \$479,919

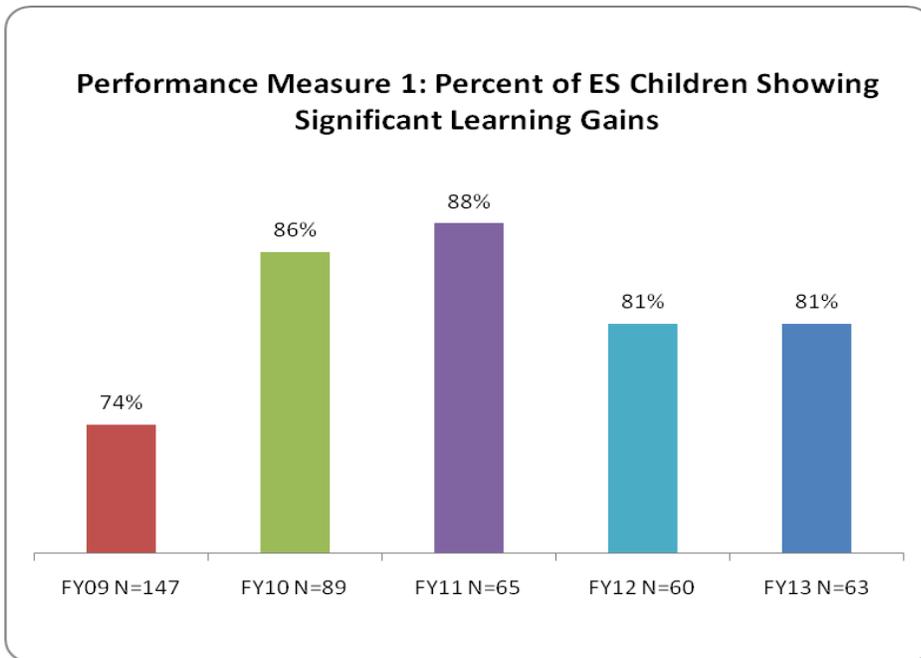
PERFORMANCE-BASED STANDARDS:

1. It is expected that 50 to 65 percent of the Even Start children birth through kinder-bound will meet the reading readiness standards for their age group.

2. It is expected that 40 percent or more of the adults will meet adult literacy goals in adult Basic Education or English as a Second Language (ESL) reading and 60 percent of the adults in a high school diploma or General Educational Development (GED) program will make progress toward attaining a high school diploma or its equivalency.
3. It is expected that 40 to 60 percent of the parents will meet standards for skill development in family literacy such as reading to child, encouraging child to read with them at home, etc.

PERFORMANCE–BASED OUTCOMES: After federal funding for this program was cut at the close of FY 2011, Even Start became fully funded by the state of Connecticut in FY 2012. Funding for this program was set at the FY 2011 level of \$479,919. Even Start families at all three programs operational during FY2013 continue to make solid gains.

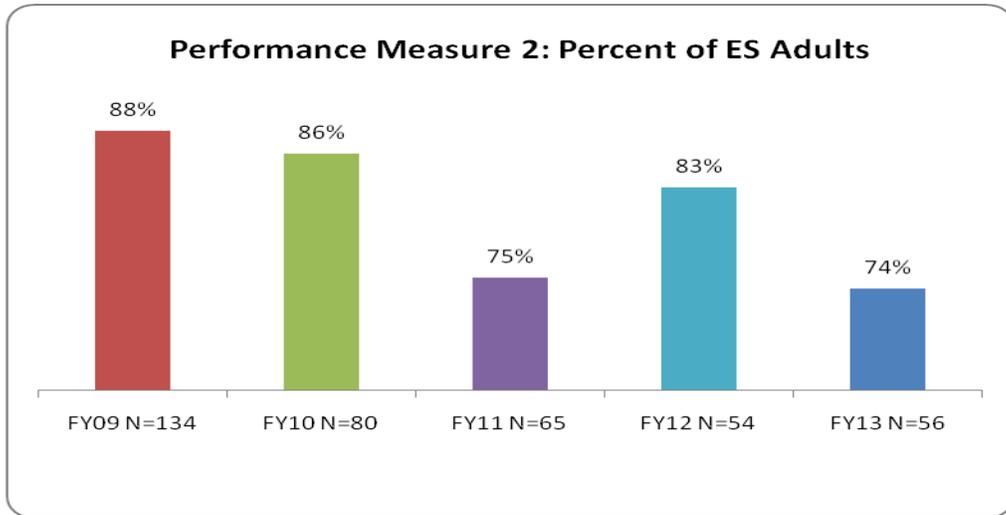
Performance Measure 1: Percent of Even Start children meeting standards in reading/reading readiness skills.



Even Start program performance data over five years show that on average, 81 percent of the children met or exceeded standards in reading readiness for their age group (birth to kinder-bound). Children participated an average of 55 hours per month in early childhood classrooms, interactive literacy activities and during home based instruction. This year, over 70% of the children were infants and toddlers and were assessed every four months using the Ages and Stages Questionnaire (ASQ). Other assessments used for older children include: Phonological Awareness Literacy Screening (PALS), the Peabody Picture Vocabulary Test (PPVT), Concepts About Print, and the Developmental Reading Assessment (DRA).

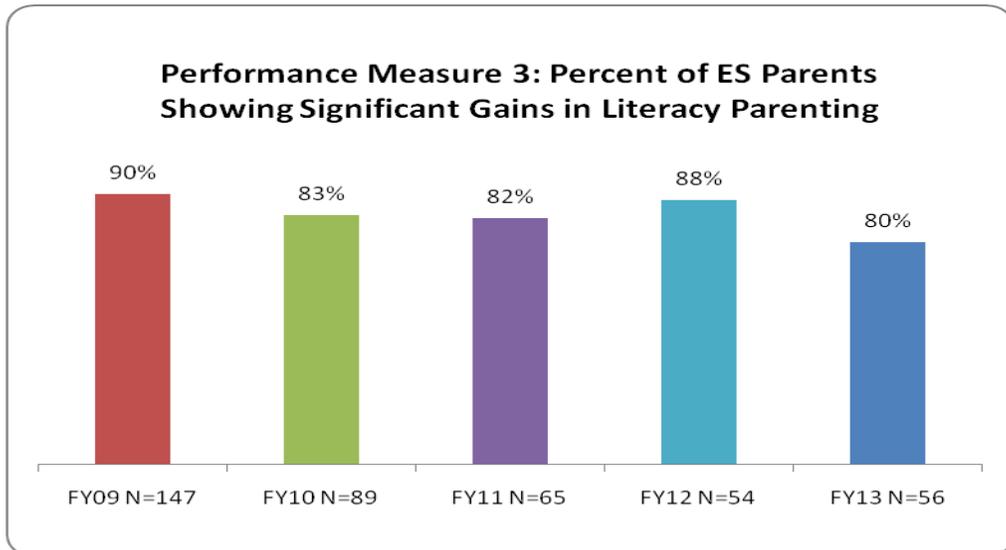
Although research data are not available for Connecticut, research from other states indicates that children who receive Even Start services outperform children who do not participate in Even Start. These studies suggest that Even Start children score significantly higher on measures of reading readiness and are twice as likely as non-Even Start children to be reading at or above grade level (Link, D.E. and Weirauch, 2005)

Performance Measure 2: Percent of Even Start parents showing significant learning gains or earning a high school diploma.



Over the past five years, adults in Even Start have consistently made significant gains. Every year, the program has exceeded its expected standard by more than 30 percent. The average percent of adults making significant progress during the year on their goals is 74 percent, exceeding the overall standard for adult literacy by 40 percent or more. These are impressive gains on measures of high school completion and English language acquisition.

Performance Measure 3: Percent of Even Start parents demonstrating gains in family literacy skills.



Results show that in the past five years, on average, 85 percent of the parents learned and applied parenting skills related to family literacy. Parents participate in parenting education classes, interactive literacy activities (with their child), and home-based instruction visits averaging 13 hours per month. Parents are encouraged to work directly with the child during interactive literacy activities and home-based instruction under the guidance of Even Start staff or collaborators. Parenting education classes are aligned with what children are learning in their early childhood

classroom. Concepts underscored in parenting education are enhanced through application during interactive literacy activities and home-based instruction.

PERFORMANCE-BASED VENDOR ACCOUNTABILITY: Even Start is required to contract for local program evaluation. All programs must report on attendance and outcomes. They receive 3-5 visits per year from the evaluator who monitors the quality of Even Start components. To ensure quality, programs must develop local objectives that are measurable and meet standards. Local evaluation visits include participant record reviews, observations of components (protocol developed for each component), ECERS and ITERS reviews of early childhood classrooms and reviews of lesson plans. Evaluators also conduct focus groups and interviews with participants and staff.

References:

Link, D.E. and Weirauch, D.M. (2005). Questioning the validity of the evidence against family literacy programming: A critical analysis of the National Even Start Evaluations. Literacy Harvest/ Family Literacy forum, 12, 33-38 New York: Literacy Assistance Center.

Department of Labor

- **Jobs First Employment Serv**
- **Connecticut Youth Employment Program**

Long-Term Agency Goals: The Department of Labor (DOL) is committed to protecting and promoting the interests of Connecticut workers. In order to accomplish this in an ever-changing environment, the DOL assists workers and employers to become competitive in the global economy using a comprehensive approach to meeting the needs of workers and employers, and the other agencies that serve them.

Within the context of DOL's long term agency goals, the DOL has two programs that target families and children: Jobs First Employment Services (JFES) and CT Youth Employment Program. The goals of the JFES program are to enable all families who receive time-limited state cash assistance to become and remain independent of welfare through employment by the end of the 21-month durational limit on cash assistance. The goal of the CT Youth Employment Program (CYEP) is to provide low-income youth aged 14 through 21 years with meaningful paid work experiences.

Strategies: To meet the goals of the JFES program, parents on cash assistance are provided with employment-related assessments, job counseling, case management, vocational education, adult basic education, subsidized employment and support services to enable them to become employed before their cash assistance ends. TFA recipients often have multiple and/or severe barriers to participating in the program and obtaining and retaining employment. The program offers intensive, home-based case management which provides in depth assessments and assistance obtaining the services necessary to overcome the barriers to employment.

To meet the goals of the CYEP program, low-income youth are provided with job-readiness training, career exploration and guidance, exposure to the world of work and paid work experience.

Measure of Effectiveness: The DOL measures the effectiveness of these programs by collecting and reporting on obtained employment information on these two groups. The JFES program issues monthly figures on the number of JFES participants who are employed by vendor and statewide. The number of participants with earnings higher than the TFA payment standard and the Federal Poverty Level are also issued monthly. JFES contracts with vendors contain performance standards and contractors' performance are measured and issued once the wage file information is available.

CYEP measures effectiveness by collecting data on the number of youth to participate in a paid work experience and compare these numbers to the vendors' goals as stated in their contracts. DOL also collects data on the number of youth to participate in job-readiness training and to receive support services. Compliance monitoring is conducted at all five regional Workforce Investment Boards (WIBs). This includes a review of financial management, consisting of financial reporting, cost allocation methodology, cash management, allowable costs, payroll controls, audit requirements, procurement and property controls. Also, WIA eligibility verification for youth is reviewed by sampling client files throughout the state.

Jobs First Employment Services: Provides employment services to families in receipt of time-limited state cash assistance. These services assist TFA recipients to prepare for, find and keep employment so that they can become independent from welfare.

Number Served: 15,393 annual caseload

Program Cost: FY 2012-2013 \$17,657,471

Performance-Based Standards:

- Number of participants to obtain employment during the State Fiscal Year
- Number of participants and percentage of JFES caseload to obtain employment with wages higher than the cash benefit that they receive during the State Fiscal Year
- Number of participants and percentage of JFES caseload to obtain employment with wages higher than the federal poverty level for their family size during the State Fiscal Year

Performance-Based Outcomes: SFY 13 complete employment data will not be available until January 2014.

SFY 12 data is: total annual caseload 15,742, 6,046 or 38% of the caseload obtained employment; 5,712 or 36% of the caseload earned wages above temporary family assistance benefits; and 1,883 or 12% of the caseload earned wages above the federal poverty level.

Performance-Based Vendor Accountability: Indicators of performance toward achieving these standards at contractor and statewide levels are determined and issued monthly. Contracts with program vendors and subcontractors include these performance base standards. Standards are measured using the DOL wage data when it is available (normally six months after the end of a program period). Until the recent recession, all vendors consistently met these standards.

Connecticut Youth Employment Program: The state funded subsidized employment program serves low income youth aged 14-21 years. The State Youth Employment Program provides employment opportunities, work-readiness skills training and supportive services. In some instances, academic remediation is also provided.

Number Served: 3,117 youth were served between the summer component and the year round component.

Program Cost: FY 2012-2013 \$4,500,000

Performance-Based Standards: As established in the contract, the number enrolled and successfully completed the program and the wages paid.

Performance-Based Outcomes: FY 2012 –2013 – 3,117 youth served and 2,852 successful completions (91% success rate).

Performance-Based Vendor Accountability: Workforce Investment Boards (WIBs) ensure all vendors are knowledgeable about wage and workplace standards applicable to youth under the age of 18. Monitoring is conducted to ensure contractual obligations are being met, including the security of the payroll system. Worksites and working conditions are examined for compliance with health and safety laws and laws governing the employment of minors.

Department of Mental Health and Addiction Services

- **Best Practices Initiative**
- **Local Prevention Council**
- **Partnership for Success**
- **Regional Action Council**
- **Statewide Service Delivery Agent**
- **Tobacco Prevention and Enforcement**

Long-Term Agency Goals: The goals of the Department of Mental Health and Addiction Services (DMHAS) include:

- Reduce the incidence of problem behavior and improve the health and well-being of Connecticut's citizens
- Achieve quantifiable decreases in substance abuse rates across the state
- Establish a quality care management system to achieve defined goals, service outcomes and the continued improvement of the integrated DMHAS health care system.
- Maintain a broad array of programs and practices that are data informed and will respond to changing needs as the prevention system grows.
- Increase workforce capacity to provide culturally competent and integrated services to persons whose needs are challenging or not well met.
- Create a resource base to support DMHAS' prevention services goals, expansions, and fiscally sound system investments

Strategies: The Departments' strategies include:

- Assess the prevention needs for youth, families and communities across the state
- Provide cost-effective, research based, developmentally appropriate prevention services that promote the health & well-being of children and families
- Develop, maintain and increase partnerships with state and local agencies to implement, evaluate and diffuse effective prevention programs and strategies that focus on youth and families
- Implement program standards to monitor the service system
- Increase funding of evidence-based programs that focus on families, early childhood and youth development
- Explore resources to implement the prevention data infrastructure, policy and program recommendations

- Provide training and technical assistance to increase the cultural ability of prevention program providers to work effectively with youth and parents from culturally, economically and geographically diverse populations

Performance-Based Outcomes:

- Streamlined and on-line data collection
- Increased number of evidence-based programs for youth, families and professionals that focus on youth suicide prevention, tobacco and alcohol use prevention, and prescription drug abuse prevention
- A more refined quality assurance process that assesses effectiveness and fidelity of implementation of prevention programs
- An integrated state plan that supports families and communities in youth and early childhood development
- Increased partnerships with state and local agencies
- Increased number of providers trained and receiving technical assistance on cultural competency
- Increased cost-effectiveness and community readiness to implement prevention programs

Population Outcomes

- Reduction in the illegal drug/alcohol use/prescription drug abuse and misuse
- Reduction in suicidal behavior among youth and young adults
- Increased employment or school retention
- Decreased criminal justice involvement
- Increased social connectedness

Program Outcomes

- Increased enforcement of alcohol, tobacco and other drug laws
- Reduction in access to alcohol, tobacco and illegal drugs by minors
- Reduction in retailer violation rates for tobacco and alcohol sales to minors

Measure of Effectiveness:

DMHAS continues to document gains in the federal health outcome measures, namely:

- A reduction in cigarette and other tobacco use rates among 12-17 year-olds, as well as recent use of illicit drugs across all ages (2011 NSDUH report)

- Although alcohol and marijuana use remains above the national average, the state has seen a reduction in alcohol use rates over the past year among ages 12-20 and 21 and over
- The number of tobacco merchants selling tobacco products to minors has decreased to 14.8% in 2013 from a high of 70% in 1996
- The percentage of funded prevention programs that are evidence-based is at 67% in 2012. The percentage of expenditures on evidence-based programs and strategies has also increased.

Methods: DMHAS provides Prevention services aimed at increasing the health and wellness of children and their families through funding and assessing its pool of over 160 non-profit providers statewide. To address disparities, DMHAS contracts with several statewide and regional technical assistance resources to ensure that all products, activities and services are culturally competent and developed and implemented with fidelity.

BEST PRACTICES INITIATIVE: Fourteen (14) statewide funded projects that employ a population-based public health approach to address demonstrated substance abuse prevention needs. Contractors conduct activities focusing on the prevention of community problem substance use utilizing the five-step Strategic Prevention Framework. Approximately 50% of their overall funding for the initiative is used to reduce underage drinking and related consequences in youth ages 12-20 with the remaining funds used to reduce other problem substance use identified through a regional needs assessment process such as prescription drug misuse and underage tobacco use.

Number Served: A total of 398,462 children, family members, prevention and treatment professionals, as well as other adults were served in SFY 13.

Program Cost: FY 2012-2013 \$1,785,901

Performance-Based Standards: DMHAS requires programs under the Best Practices Initiative to adhere to Prevention Program Operating Standards. These standards establish a minimum level of program operation intended to reflect quality and articulate a service philosophy that promotes health and builds strengths. The purpose of the standards is to provide assurances to the public that alcohol and drug abuse prevention and early intervention programs are regulated under a set of minimum standards established by DMHAS.

Performance-Based Outcomes: Contractors under this initiative are expected to:

- Assess the risk and protective factors associated with problem substance use and related consequences in targeted communities using relevant epidemiological and other data
- Build community capacity to understand and implement prevention strategies utilizing existing substance use prevention coalitions of community leaders, key stakeholders and representatives of underserved populations
- Update DMHAS-approved prevention plans for problem substance use and related consequences that describes evidence-based environmental interventions/strategies to reduce problem substance use consumption
- Implement evidence-based interventions/strategies to reduce problem substance use consumption, and
- Evaluate changes in problem substance use consumption and consequences in the target population.

Performance-Based Contractor Accountability: Program contractors for this initiative complete a strategic plan of community needs and resources, evidence-based programs and strategies to address them and evaluation information and measures. An action plan that sets the stage for the collection of process measures necessary for federal reporting is also completed. It identifies and codes the action steps for implementing goals and objectives, the staff hours required to implement activities and the numbers to be served by each activity. Contractors are required to use the federal guidance document for identifying and selecting evidence-based programs which assures program fidelity and fit. Progress reports are also required and consist of bi-monthly narrative and process data submitted electronically. The report generally allows contractors to share information with DMHAS regarding program participants and services that are delivered and helps staff to track compliance with contractual obligations as well as provides an opportunity to discuss any program changes and challenges. An annual site visit by DMHAS staff is conducted to validate program activities, assess continuing contractor capacity, determine technical assistance needs, and substantiate eligibility for continued funding.

Local Prevention Council Programs: The Local Alcohol, Tobacco and Other Drug Abuse Prevention Council Grant Program (LPCP) initiative supports the activities of local, municipal-based alcohol, tobacco, and other drug (ATOD) abuse prevention councils. The intent of this grant program is to facilitate the development of ATOD abuse prevention initiatives at the local level with the support of chief elected officials. The specific goal of this grant initiative is to increase public awareness focused on the prevention of ATOD abuse, and stimulate the development and implementation of local substance abuse prevention activities primarily focused on youth through 120 local municipal and town councils serving the 169 towns and cities in Connecticut.

Local Prevention Councils (LPCs) are advisory and coordinative in nature and reflective of each community's racial/ethnic, political, and economic diversity. Councils include representation from professionals working in the prevention field in general and ATOD abuse prevention in particular. Additionally, council membership includes a cross-section of the community which it serves including city/town agencies, organizations, communities and ethnic groups, parents, media, business, senior citizens, health care sector, etc., concerned with prevention issues. The LPCP initiative is designed to: 1) support the on-going prevention activities of established councils; 2) support specific prevention projects of local councils; and 3) support activities that increase public awareness of the problem of ATOD use and abuse.

Number Served: A total of 255,932 elementary and high school students, parents and family members, school faculty and staff, were served in SFY 13

Program Cost: FY 2012-2013: \$552,470

PARTNERSHIP FOR SUCCESS: The Partnership for Success (PFS) Initiative uses a public health approach in over 30 municipalities and statewide across college campuses to decrease alcohol consumption in youth ages 12 to 20. Programs under this initiative build on existing resources to implement environmental strategies known to be effective in reducing youth alcohol use rates, such as curtailing retail and social access, policy change, enforcement, media advocacy, and parental and merchant education. The initiative is intended to measure changes in underage drinking utilizing student survey and social indicator data. The target populations are: school aged children 12 to 17 years old, college students 18 to 20, and those adults who influence these youth including parents, family members, care-givers, schools, communities at large and the agencies, organizations and institutions within those communities.

Number Served: 1,878,983 clients served by PFS coalition (a combination of direct service counts and impacts)

Program Cost: FY –2012-2013 \$ 2,300,000

Performance-Based Standards: DMHAS requires programs under the PFS Initiative to adhere to Prevention Program Operating Standards. These standards establish a minimum level of program operation intended to reflect quality and articulate a service philosophy that promotes health and builds strengths. The purpose of the standards is to provide assurances to the public that alcohol and drug abuse prevention and early intervention programs are regulated under a set of minimum standards established by DMHAS.

Performance-Based Outcomes: Contractors under this initiative are expected to:

- Assess risk and protective factors associated with underage alcohol consumption and related consequences in the target community using relevant epidemiological and other data.
- Build community capacity to understand and implement prevention strategies utilizing existing alcohol prevention coalitions of community leaders, key stakeholders and representatives of underserved populations
- Develop a community strategic plan that describes community methods to address the underage alcohol consumption using environmental strategies
- Develop a community strategic plan that describes community methods to address the underage alcohol consumption using environmental strategies
- Implement evidence-based or innovative environmental intervention(s)/strategies to reduce underage alcohol consumption, and

- Evaluate reductions in past 30 day use of alcohol by the target population. Evaluate community changes in underage alcohol consumption risk and protective factors through changing data and new information on alcohol-related problems in the community.

Performance-Based Vendor Accountability: Program contractors for this initiative complete a five-step planning process to guide their prevention activities. The steps include: 1) assessing population needs; 2) building capacity to address the needs; 3) developing a comprehensive strategic plan that articulates a vision for organizing programs, policies and practices to address the needs; 4) implementing evidence-based programs, practices and policies identified in step 3; and 5) monitoring implementation and evaluating effectiveness. Contractors also complete an action plan which identifies and codes the action steps for implementing their plan, the staff hours required to implement activities and the numbers to be served by each activity. Progress reports are also required and consist of bi-monthly narrative and process data submitted electronically. The report generally allows contractors to share information with DMHAS regarding program participants and services that are delivered and helps staff to track compliance with contractual obligations as well as provides an opportunity to discuss any program changes. An annual site visit by DMHAS staff is conducted to validate program activities, assess continuing contractor capacity, determine technical assistance needs, and substantiate eligibility for continued funding.

Regional Action Council: Thirteen (13) sub-regional planning and action councils that have responsibility for the planning, development and coordination of behavioral health services in their respective region.

Regional Substance Abuse Action Councils (RACs) are public-private agencies comprised of community leaders. Its purpose is to establish and implement an action plan to develop and coordinate needed services across the behavioral health continuum. These services are generally described as a continuum of care which includes community awareness and education, prevention, intervention, treatment and aftercare. The members of the Regional Action Council serve as volunteers assisted by professional staff. Members include representatives of major community leadership constituencies: chief elected officials, chiefs of police, superintendents of schools, major business and professional persons, legislators, major substance abuse service providers, funders, minority communities, religious organizations and the media.

Number Served: 2,854,189 children, families, community members and prevention professional

Program Cost: FY 2012-2013 \$1,850,833

Performance- Based-Standards: DMHAS requires all contractors to adhere to Prevention Program Operating Standards. These standards establish a minimum level of program operation intended to reflect quality and articulate a service philosophy that promotes health and builds strengths. The purpose of the standards is to provide assurances to the public that alcohol and drug abuse prevention and early intervention programs are regulated under a set of minimum standards established by DMHAS.

Performance-Based Outcomes: Performance outcomes for the RACs are as follows:

- 100% of towns in sub regions are funded through Local Prevention Councils
- 25% of funding efforts are focused toward underage alcohol initiatives resulting in a reduction in use across sub regions
- 25% of funding efforts are directed towards the prevention of underage tobacco use resulting in a violation rate of less than 20% among tobacco retailers in the sub region
- The development of a Priority Needs Assessment on the substance abuse continuum of care from prevention through treatment and recovery in the sub region
- The development of SPF Sub-Regional Profiles to include alcohol, prescription drugs, heroin, cocaine, marijuana and other substances of note

Performance-Based Contractor Accountability: Program contractors for this initiative complete program information and measures during the biannual contract renewal process. An action plan that sets the stage for the collection of process measures necessary for federal reporting is also completed. It identifies and codes the action steps for implementing goals and objectives, the staff hours required to implement activities and the numbers to be

served by each activity. Progress reports are also required and consist of bi-monthly narrative and process data submitted electronically. The report generally allows contractors to share information with DMHAS regarding program participants and services that are delivered and helps staff to track compliance with contractual obligations as well as provides an opportunity to discuss any program changes. An annual site visit by DMHAS staff is conducted to validate program activities, assess continuing contractor capacity, determine technical assistance needs, and substantiate eligibility for continued funding.

STATEWIDE SERVICE DELIVERY AGENT: The Statewide Services Delivery Agents (SSDA), also known as the DMHAS Resource Links, are four entities funded by DMHAS to support prevention efforts across the state by building the capacity of individuals and communities to deliver prevention services. Their target populations include local communities, individuals, and agencies providing prevention programming; regional and statewide service agencies; societal organizations and institutions, e.g. corporate, medical, religious and recreational entities. The Statewide Service Delivery Agents utilize multiple strategies like information and public awareness, education, community development, capacity building and institutional change, and social policy to promote the health and well being of all Connecticut's residents across the life span. Within the last two years these SSDAs have provided distinct services to move Connecticut's prevention system to align with the blueprint of the Strategic Prevention Framework (SPF).

The Statewide Services Delivery Agents consists of the following entities:

1. Connecticut Clearinghouse - is a comprehensive information resource center that makes available thousands of books, tapes and printed reports, and provides electronic access to the latest information on substance abuse, mental health and a variety of other issues.
2. Multicultural Leadership Institute, Inc. - is an agency dedicated to promoting culturally and linguistically proficient services regarding the prevention of ATOD and other related problems among African origin and Latino populations.
3. Governor's Prevention Partnership - is a statewide organization comprising of public/private partnerships designed to change the attitudes and behaviors of Connecticut youths and adults toward substance through its School, Campus, Workplace and Media Partnerships.
4. Prevention Training Collaborative - is to provide prevention practitioners and others in the field of prevention the training needed to obtain and maintain certification status and provide support to individuals looking to increase their knowledge and skills in the prevention area.

Number served: A total of 87,160 children, family and community members, and prevention professionals were served in SFY 13 with an additional 8,921,517 duplicated number served through the states media markets.

Program Cost: FY 2012-2013 \$1,899,168

Performance-Based Standards:

DMHAS requires contractors to adhere to Prevention Program Operating Standards. These standards establish a minimum level of program operation intended to reflect quality and articulate a service philosophy that promotes health and builds strengths. The purpose of the standards is to provide assurances to the public that alcohol and drug abuse prevention and early intervention programs are regulated under a set of minimum standards established by DMHAS.

Performance-Based Outcomes:

- Improvement in the health and wellness of gay, lesbian, bisexual, trans-gendered and questioning clients
- Increase in the number of DMHAS providers with approved cultural competency plans
- Increase in the number of Hispanic and African American staff in substance abuse agencies across the state
- Increase in the number of school and community based mentoring programs
- Reduction in the state rate for underage drinking
- Increase in the number of resources aimed at alcohol, tobacco and other drug prevention

- Increase in the capacity of prevention contractors to implement evidence-based programs, policies and practices

Performance-Based Vendor Accountability: Program contractors for this initiative complete program information and measures during the biannual contract renewal process. An action plan that sets the stage for the collection of process measures necessary for federal reporting is also completed. It identifies and codes the action steps for implementing goals and objectives, the staff hours required to implement activities and the numbers to be served by each activity. Progress reports are also required and consist of bi-monthly narrative and process data submitted electronically. The report generally allows contractors to share information with DMHAS regarding program participants and services that are delivered and helps staff to track compliance with contractual obligations as well as provides an opportunity to discuss any program changes. An annual site visit by DMHAS staff is conducted to validate program activities, assess continuing contractor capacity, determine technical assistance needs, and substantiate eligibility for continued funding.

TOBACCO PREVENTION and ENFORCEMENT:

Target Population: Youth 0-17, tobacco retail merchants across the state

Prevention Program Description: The federal government requires that states enforce and enact laws and implement strategies that reduce underage tobacco use. DMHAS employs a variety of strategies and activities to comply with the federal mandate. These include:

1. Legislation & Law Enforcement: passing and enforcing youth tobacco access laws
2. Sampling Method & Survey Design: obtaining scientifically valid and reliable measure of tobacco retailer compliance with laws
3. Inspection Protocol & Implementation: following approved inspection protocols for conducting random, unannounced inspection of tobacco retailers
4. Merchant Education: producing and distributing educational and awareness materials for a merchant education program
5. Community Education & Media Advocacy: increasing public awareness on youth tobacco issues through youth forums and focus groups, community mini-grants and a statewide hotline for information and complaints.
6. Community Mobilization: forming coalitions to mobilize community support;

Number Served: During FY 2013, 1,437 retail inspections were completed to assess compliance with state tobacco laws and 13,829 print materials were developed and distributed to tobacco merchants to raise awareness and increase compliance with the laws.

Program Cost: FY 2012-2013: \$ 618,984

Performance-Based Standards: DMHAS must comply with the federal requirements to enforce the state tobacco laws and maintain the tobacco retailer violation rate at or below 20%. Failure to do so will result in a 40% cut to the federal Substance Abuse Prevention and Treatment Block Grant allocation.

Performance –Based Outcomes:

- Increase in age of first use for tobacco products
- Decrease in tobacco use rates among youths ages 12-17
- A rate of no more than 10% of merchants across the state who sell tobacco products to minors

Performance-Based Vendor Accountability: Tobacco merchant inspections are completed in strict adherence with federal Substance Abuse Mental Health Services Administration (SAMHSA) guidelines. Annual reports on these inspections and their results, changes in the state’s tobacco laws, coordination and collaboration activities are submitted and available for public review and comment on the DMHAS website

Department of Public Health

- **Asthma Program: Pediatric Easy Breathing**
- **Asthma Program: Adult Easy Breathing**
- **Immunization Program**
- **Special Supplemental Nutrition Program for Women, Infant and Children**
- **Tobacco Use Prevention and Control**

ASTHMA PROGRAM: PEDIATRIC EASY BREATHING PROGRAM: The Connecticut Children’s Medical Center (CCMC) Asthma Center is conducting Easy Breathing, an asthma clinical management program. The program has successfully expanded beyond the original five communities to provide statewide coverage. The Easy Breathing program is a professional education program that trains pediatric providers to administer a validated survey to determine whether a child has asthma, to conduct an assessment to determine asthma severity, to utilize treatment protocol guidelines for determining proper therapy, and to develop individual treatment plans. Easy Breathing is an asthma recognition and management program that is implemented by primary care providers that documents adherence to the National Asthma Education and Prevention Program Guidelines (NAEPP) standards for asthma care.

Number Served: 10,275 patients surveyed for asthma with 2,798 (27%) diagnosed with asthma

Program Cost: FY 2012-2013 \$500,000

Performance-Based Standards: The contractor conducts quarterly site visits with the Regional Program Coordinators to review and rectify data issues, training needs and/or implementation problems. The contractor submits quarterly narrative and surveillance data to DPH. Indicators are guideline adherence for prescribing inhaled corticosteroids for those with persistent asthma and patient education and provision of patient written treatment plans to enable patients to effectively manage their asthma symptoms before they become acute. The contractor trained 22 new providers for a total of trained 364 providers.

Performance-Based Outcomes: Improved asthma diagnosis and medical management by primary care providers for better patient control and self-management based on the National Institute of Health’s Asthma Guidelines was reported as follows: **for patients with persistent asthma, 85% of patients had a an Asthma Action Plan and 95% of patients with persistent asthma were prescribed inhaled corticosteroids. This is an excellent measure of adherence to NAEPP treatment guidelines.**

Performance-Based Vendor Accountability:

Documentation of DPH oversight conducted under this contract with the contractor and subcontractors through audits, site visits, quarterly and annual aggregate reports as follows:

- Documentation of technical and professional assistance provided
- Description of the contractor-created, locally managed data quality control program and the actual assistance provided for the management of the Easy Breathing data system, generation of reports at each district
- Documentation of monitoring each participating district for adherence to required program activities
- Documentation of review of all survey and treatment plan data from each district for consistency and appropriateness
- Documentation of the results of data analysis that include demographics of children surveyed in each community for asthma, by age, race/ethnicity, and number of newly diagnosed children by age, race/ethnicity
- Evaluation results of the effectiveness of the Easy Breathing Program in each participating community by analyzing the following process measures and outcome measures over time (quarterly).

ASTHMA PROGRAM: ADULT EASY BREATHING PROGRAM: Bridgeport Hospital continued Easy Breathing for Adults. This Program is based on pediatric Easy Breathing with the focus being on adults treated by medical resident physicians in Bridgeport Hospital's Primary Care Clinic. Easy Breathing for Adults is an asthma clinical management program. The program has successfully integrated training for medical residents to implement Easy Breathing. The Easy Breathing program is a professional education program that trains medical resident providers to administer a validated survey to determine whether a patient has asthma, to conduct an assessment to determine asthma severity, to utilize treatment protocol guidelines for determining proper therapy, and to develop individual treatment plans. Easy Breathing is an asthma recognition and management program that is implemented by primary care providers that documents adherence to the National Asthma Education and Prevention Program Guidelines (NAEPP) standards for asthma care.

Program Cost: FY 2012-2013 One contract for Adult Easy Breathing at Bridgeport Hospital was funded for the amount of \$150,000.

Number Served:

1,319 patients surveyed for asthma with 343 (26%) diagnosed with asthma.

- 52 providers were trained in Easy Breathing
- 88% of patients had an AAP
- 98% of patients with persistent asthma were prescribed inhaled corticosteroids

Performance-Based Standards: The contractor conducts weekly meetings with the Physician Champion and conducts monthly meetings with all Easy Breathing clinic staff to review and rectify data issues, training needs and/or implementation problems. The contractor submits quarterly narrative and surveillance data to DPH. Indicators are the number of providers trained in Easy Breathing. The contractor trained 52 medical resident physicians, attending physicians and RNs/LPNs in the Bridgeport Hospital Medical Clinic.

Performance-Based Outcomes: Improved asthma diagnosis and medical management by primary care providers for better patient control and self-management based on the National Institute of Health's Asthma Guidelines was reported as follows: for patients with persistent asthma, 98% were prescribed inhaled corticosteroids. This is an excellent measure of adherence to NAEPP treatment guidelines. In addition, 88% with persistent asthma received a written treatment plan per the NAEPP guidelines.

Indicators are guideline adherence for prescribing inhaled corticosteroids for those with persistent asthma and patient education and provision of patient written treatment plans to enable patients to effectively manage their asthma symptoms before they become acute.

Performance-Based Vendor Accountability:

Documentation of DPH oversight conducted under this contract with the contractor and subcontractors through audits, site visits, quarterly and annual aggregate reports as follows:

- Documentation of technical and professional assistance provided,
- Description of the contractor-created, locally managed data quality control program and the actual assistance provided for the management of the Easy Breathing data system, generation of reports at each district,
- Documentation of monitoring each participating district for adherence to required Program activities,
- Documentation of review of all survey and treatment plan data from each district for consistency and appropriateness,
- Documentation of the results of data analysis that include demographics of children surveyed in each community for asthma, by age, race/ethnicity, and number of newly diagnosed children by age, race/ethnicity,
- Evaluation results of the effectiveness of the Easy Breathing Program in each participating community by analyzing the following process measures and outcome measures over time (quarterly).

IMMUNIZATION PROGRAM: The prevention of disease, disability and death from vaccine-preventable diseases in infants, children, adolescents and adults through surveillance, case investigation and control, vaccination, monitoring of immunization levels, provision of vaccine and professional and public education.

Number Served: Children from birth through 18 years of age. Total CT population 0-18 years of age served for CY 2013 is 872,580.

Program Cost: FY 2012-2013 \$59,219,300

Performance-Based Standards: Immunization coverage is one of our principal performance-based standards. The program uses data from the National Immunization Survey (NIS) conducted annually by CDC estimates vaccination coverage among children aged 19-35 months old nationally and for each state and our statewide immunization registry called CIRTS to measure immunization coverage rates for children in CT.

Performance –Based Outcomes: According to the 2012 National Immunization Survey (NIS), Connecticut’s 2012 NIS coverage for 4 doses of DTaP, 3 doses polio, 1 dose MMR, full series of Hib vaccine (3/4 doses depending on product type), 3 doses hepatitis B, 1 dose varicella and 4 doses PCV (4:3:1:3*:3:1:4) was 77%. Based on this information, CT was ranked 4th among all 50 states with highest immunization coverage rates. The 2012 NIS survey included children born January 2009 through May 2011.

According to our Connecticut Immunization Registry and Tracking System (CIRTS) immunization registry data which looked at the records of 34,316 two-year-olds born in 2008, 4:3:1:2:3:1.4* coverage is 79%. The 34,136 children represent 85% of the 40,230 births recorded in CIRTS for 2008.

Performance-Based Vendor Accountability: Funding provided to 11 health departments representing the largest municipalities in Connecticut to increase immunization levels among children residing in their communities by conducting the following activities to improve vaccine/immunization delivery, tracking, outreach, referral, education and assessment.

Specific Program Outcomes and Measures

Outcomes	Measures
1. Children 0-24 months of age who reside in the contractor’s service area who are enrolled in CIRTS have been age-appropriately immunized against vaccine- preventable diseases	1. At least 85% of children 24 months of age who reside in the contractor’s service area, and who are enrolled in CIRTS have been age-appropriately immunized against vaccine preventable diseases
2. Children 0-24 months of age referred to the IAP Coordinator for outreach are successfully identified and referred for appropriate care, and/or their records are updated in CIRTS.	2. At least 90% of children 0-24 months of age who are referred to the IAP Coordinator for outreach are successfully identified and referred for appropriate care, and/or their records are updated in CIRTS.

SPECIAL SUPPLEMENTAL NUTRITION PROGRAMS FOR WOMEN INFANT and CHILDREN:

The Connecticut *Special Supplemental Nutrition Program for Women, Infants & Children* (CT WIC Program) serves pregnant, postpartum and breastfeeding women, infants, and children up to five years of age. The program provides services in five (5) major areas during critical times of growth and development in an effort to improve birth outcomes and child health: 1. Nutrition Education & Counseling; 2. Breastfeeding Promotion & Support; 3. Referral to appropriate health & social services; 4. Referral from Health Care Providers to ensure clients have a medical home; and, 5. Vouchers for healthy foods (WIC “Food Packages”) prescribed by WIC Nutritionists. Eligibility is determined based on income [up to 185% of the Federal Poverty Level (FPL)] and nutritional need, based on a complete assessment of

health and dietary information. Alternatively, active enrollment in Medicaid / HUSKY A qualifies applicants for adjunctive eligibility in the WIC Program.

The WIC Program's promotion and support of breastfeeding and efforts to prevent childhood anemia also contribute to childhood health and school readiness. WIC clients are seen in WIC offices or satellite clinic sites at least every three (3) months, but can be seen monthly if identified as high risk. Currently, WIC services are provided to an average of 56,589 participants each month through a service provider network of 12 local agency sponsors at 58 service sites statewide. Local agency sponsors include hospitals, community health centers, city and town health departments, and community action agencies throughout the State. The Department of Public Health (DPH) also has agreements with a total of 697 food stores (500), pharmacies (157) and farmers (40) that are authorized to accept and redeem participants' checks (food "vouchers") in exchange for WIC-approved supplemental foods.

Number served 2012-2013: Average monthly participation: 56,580 (12,092 women, 14,123 infants and 30,365 children up until their 5th birthday).

Program Cost 2012-2013 \$61,848,534.

Performance-Based Standards:

Federal and state regulations include a number of prevention-related standards that Local WIC Agencies must meet, including timeframes for enrolling program applicants; requirements regarding the early and continuous enrollment of pregnant women; policies to ensure that all pregnant women are encouraged to breastfeed unless medically contra-indicated, and provided breastfeeding information and support; requirements to provide information regarding the risks associated with drug, alcohol and tobacco use during pregnancy; and, to ensure that children are screened for anemia and lead poisoning by their health care provider.

Performance-Based Outcomes (12 WIC Regions):

- **First Trimester Enrollment in WIC:** Increase to 50% the rate of first trimester enrollment of pregnant women.
 - Statewide average [Federal Fiscal Year (FFY) 2013 to date (YTD)]: 54.2%; Range: 44.0% – 70.4%.
- **Maternal Weight Gain (MWG):** At least 70% of pregnant women who participate in the WIC Program for a minimum of 6 months gain appropriate weight:
 - Statewide average (FFY 2013 YTD): 72.6%; Range: 55.8% - 86.6%.
- **Low Birth Weight (LBW):** The incidence of low birth weight among infants whose mothers were on the WIC Program for at least 6 months during pregnancy does not exceed 6%.
 - Statewide average (FFY 2013 YTD): 6.5%; Range: 3.5% - 9.0%.
- **Breastfeeding Initiation (BFI):** At least 65% of infants whose mothers were enrolled in the WIC Program for any length of time during pregnancy breastfeed.
 - Statewide average (FFY 2013 YTD): 75.9%; Range: 66.7% - 90.3%.
- **Childhood Anemia:** The prevalence of anemia among children 2-4 years of age enrolled in the WIC Program for at least one year does not exceed 7.5%.
 - Statewide average (FFY 2013 YTD): 7.9%; Range: 4.2% - 10.9%.
- **Overweight in Children:** The prevalence of overweight (BMI \geq 85th percentile to < 95th percentile) among children 2-4 years of age enrolled in the WIC Program for at least one year does not exceed 10%.
 - Statewide average (FFY 2013 YTD): 12.7%; Range: 9.5% - 15.8%.
- **Obesity in Children:** The prevalence of obesity (BMI \geq 95th percentile) among children 2-4 years of age enrolled in the WIC Program for at least one year does not exceed 15%.
 - Statewide average (FFY 2013 YTD): 13.4%; Range: 8.1% - 18.3%.

Performance-Based Accountability:

- Local agencies that sponsor WIC Programs must submit annual program plans that identify measurable process and outcome objectives, and specify action plans and evaluation methods.
- The state WIC office analyzes and provides outcome data to the local agencies on a quarterly basis for their use in program planning, monitoring and evaluation.

- The state WIC office conducts on-site performance evaluations of each local agency at least once every two years.
-

TOBACCO USE PREVENTION AND CONTROL PROGRAM: The Tobacco Use Prevention and Control Program follows guidelines and recommendations put forward by the Department of Health and Human Services, Centers for Disease Control and Prevention (CDC) in their document “Best Practices for Comprehensive Tobacco Control Programs.”

The program works towards addressing all areas in tobacco control that includes educating the public about the risks associated with the use of tobacco products and the hazards of exposure to secondhand smoke.

Areas of focus include preventing initiation among youth and young adults, promoting quitting among all tobacco users, eliminating exposure to both second- and third-hand smoke for all state residents, and identifying and eliminating tobacco-related disparities among population groups including those of low socioeconomic status, individuals with mental illness, gay/lesbian/bisexual/transgender, and pregnant women; all of whom are disproportionately affected by tobacco use.

Number of Clients Served: Community-based tobacco use cessation programs funded during the period along with the telephone-based tobacco use cessation telephone Quitline served at least 13,100 Connecticut residents, with many of those services being targeted to individuals with low socio-economic status.

Program Cost: 2012-2013 \$1,079,069

Performance-Based Standards:

Our standards include the reduction and elimination of use of all forms of tobacco products, to prevent tobacco use initiation, and to reduce all residents’ exposure to second and third-hand smoke. Our funded programs must adhere to CDC’s best practice guidelines and must use evidenced-based curricula. All programs offered include education regarding the harmful effects of second- and third-hand smoke.

Performance-Based Outcomes

- At least 75% of program participants will reduce their tobacco use;
- At least 75% of program participants will make changes to protect the health of non-smokers.

Performance-Based Accountability:

Contractors are required to collect data at intervals during the period in which services are provided, in order to assess program effectiveness. This includes the use of pre-and post-program surveys as well. Contractors must submit periodic progress reports detailing their program activities including their self-evaluation and the results of their outcome measures.

In addition, an independent evaluator is on contract to evaluate funded programs.

Department of Social Services

- **Tobacco Cessation Prevention**
- **Perinatal and Infant Oral Health Quality Improvement**
- **Fatherhood Initiative**

Long Term Agency Goals: The Department of Social Services collects and uses internal program and service data as well as data collected from other local and national agencies, organizations and institutions to inform the development of programs, services, policies, and procedures that address factors that contribute to as well as prevent poverty. The Department's mandate is unique; its stakeholder (client) population includes all demographics. Therefore, its goals include:

- Through the implementation of ConneCT, increase efficiency, effectiveness, and access to staff and services for initial applicants for agency services as well as ongoing program participants.
- Increase awareness and educate communities and clients about the availability and access to food/good nutrition for income eligible children, families, and individuals.
- Increase efficiency in the application process for SNAP Program participants.
- Increase awareness about and access to preventive and curative health care for income eligible children, families, and individuals.
- Increase efficiencies in the program eligibility process/system for children, families, and individuals by implementing technological improvements.
- Implement function based staff development and training to increase accuracy and improve staff performance in order to better serve children, families, and individuals.

Strategies:

- Program and contract staff will have the most up to date local, regional, and national data related to

clients' needs, poverty and its concomitants as well as knowledge and awareness of objectively determined effective program/service outcomes for targeted low income/income eligible children and families that will be used to inform/plan, develop, and contract for services for clients, with external agencies/organizations. On-going training will be provided to individuals as well as cohorts to ensure that this strategy is realized.

- In addition to actually enumerating level of program participation, within the next 12 months contractees will be required to provide objective outcome measures that demonstrate effectiveness of programs/services based on documented client progress and client feedback. Documentation will also include progress outcomes based on income, ethnicity, culture, language, proficiency, etc. to support and inform the Department's efforts to address disparities in outcome and impact.
- Quarterly reviews/evaluations of client outcome data will be provided by contractees.
- Make information about the Department's programs and services for low income children and families available through many access points public libraries, doctors' offices, health care centers, neighborhood markets and stores, malls, schools, hospitals, other agencies/organizations, child care/day care, etc., in order to increase awareness and program participation.
- Engage in ongoing recruitment of health care providers/physicians in order to increase access to health care for income eligible children, individuals and families. Special efforts will also focus on identifying and addressing individual and social determinants of health disparities within health care settings among health care providers.
- Enhance contractual relationships with community action agencies to ensure awareness and supportive access for clients to programs/services provided by DSS, via various community based locations.

- Whenever possible, dispatch staff to provide information about the Department's programs/services such as speaking at community events, participating in community fairs, and convening focus groups for purposes of providing, collecting program/service related information.
- Introduce a formal mechanism to collect program participant/service recipients' feedback related to the receipt and use/usefulness of services provided.
- Train and support staff in modifying contracts based on objectively determined clients/program participants' outcome data.
- Continue to refine ConneCT in order to ensure optimal access to accounts/setting up of accounts for clients twenty-four hours per day seven days per week.

Measure of Effectiveness: The effectiveness of prevention is best measured longitudinally; the Department is in the process of formalizing a data collection and analysis approach that addresses this issue.

Methods: Current data collection processes do not lend themselves to performance measures and outcomes based on race, income level, language proficiency, and gender. The Department plans to rectify this within the next 18 months.

Methods to Reduce Disparities: As the Medicaid, TANF agency, lead agency for persons with disabilities, subsidizer of child care, and the administrator/manager of the Supplemental Nutritional Assistance Program, the Department provides programs and services that by their very nature address the health and safety needs of children, individuals, and families. There is no doubt that it succeeds in doing so; however, in the coming months and years, DSS will collect data that will guide the development and implementation of its Health Disparities Plan as well as the resulting Action Plan. Because disparities are intricately connected with ongoing poverty, the implementation of the Plan will assist in clearly demonstrating the extent to which current programs are succeeding in preventing intergenerational poverty, the concomitants of poverty, and poor health conditions. The information will also allow the Department to make adjustments in its allocation of funds, and in programs and services, based on sound data.

Other Relevant Information:

DSS' staff represent the agency on various local, regional, and state-wide task forces, commissions, committee and councils. This level of involvement supports and enhances ongoing program and service reviews. It also allows members of various service communities to secure information about DSS and to share information with DSS.

Tobacco Cessation Program: This tobacco cessation initiative is being funded by a five-year federal grant of up to \$10 million. Connecticut is one of 10 selected grantees, nationwide, of a larger Medicaid Incentives for Prevention of Chronic Disease grant that seeks to determine the impact of financial incentives on preventing chronic disease. The goal of "Rewards To Quit" is to significantly reduce smoking rates among the estimated 25-30 percent of Connecticut Medicaid recipients who currently smoke. Through the program, providers (local mental health authorities, federally-qualified health centers and primary care practices) will offer counseling and training sessions, peer coaching and other smoking-cessation techniques. Participating beneficiaries will receive financial incentives for both engaging in an intervention strategy (i.e. attending an individual or group counseling session) and outcomes (having a negative CO breathalyzer test) aimed toward quitting smoking. In doing so, the Department intends to increase the quit rate among Medicaid recipients in Connecticut. Pregnant women and parents of young children are specially targeted for program participation.

Number Served: estimated 6,000 over the life of the project

Program Cost 2012-2013 \$2,877,366 projected for 2013

Performance- Based Standards:

- Strong evaluation design and internationally recognized evaluation team;
- Comparison of incentive types (process vs. outcome) through randomization;
- Deploying and testing these innovations in the context of a medical home

Performance-Based Outcomes: Evidence and documentation of:

- Broad community involvement in design, implementation and oversight
- Participation of a broad range of communities with racial, ethnic and socio-economic diversity
- Participation of all adult Medicaid populations including low income parents; individuals who are aged, blind or disabled; and low income adults
- Strong working relations across state agencies, community groups, Hispanic Health Counsel and the Yale research team

Performance- Based Vendor Accountability: Evidence and documentation of:

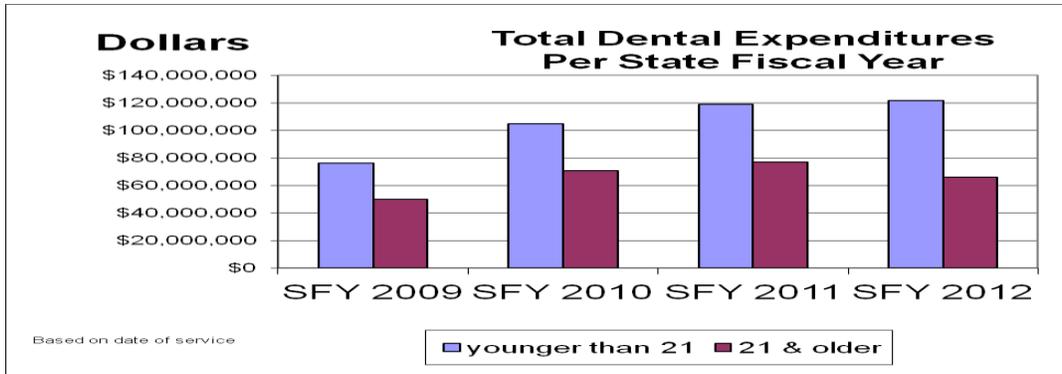
- Flexibility in recipient choice of service type and incentives
- Use of incentives for engagement and for improvements in behaviors and outcomes
- Special focus on pregnant women, new mothers, and relapse prevention
- Special focus on access for individuals with serious mental illness (SMI)
- Use of a peer community member as a health behavior coach
- Reduction in smoking among parents with small children and pregnant women

Perinatal and Infant Oral Health Quality Improvement: Connecticut is one of only four states awarded a U.S. Department of Health and Human Services, Health Resource and Services Administration (HRSA) Grant for Perinatal & Infant Oral Health Quality Improvement (PIOHQI), focused upon oral health improvement and community integration strategies for improving preventive oral healthcare.

Preventable oral disease, particularly caries, among low-income/at-risk children is a serious persistent concern in Connecticut. Early childhood decay is five times more prevalent than asthma. Thirty-one percent of Head Start children, 27% of kindergarten children and 41% of third graders have experienced dental disease according to the “Every Smile Counts Survey”; a surveillance system utilized by the Department of Public Health. These statistics demonstrate the need for Connecticut to continue to focus on early childhood oral disease prevention. Unfortunately, oral health initiatives have not yet been fully incorporated into early childhood whole – health systems on the national level.

The PIOHQI/ICO project’s is funded over five years for an amount of up to \$1,000,000. The grant will enhance the current Connecticut Dental Health Partnership’s outreach activities to the preschool and grammar school populations to continue to increase the utilization of prevention based dental services over the restorative based approach to controlling dental disease. Below is a graph that shows total program expenditures.

The Connecticut Dental Health Partnership is using a long term approach changing oral health status in the population served. The expenditures for the dental program have remained relatively stable despite an increase in the population served. For federal year 2013, there was a negative 1% growth which is an indicator that the prevention targeted approach is reducing the need for the more costly services.



Number Served: Over 300,000 children

Program Cost: FY 2012-2013 \$120,000,000

Performance Based Standards: The PIOHQ/ICO project's purpose is to provide a coordinated approach across Connecticut that addresses the comprehensive oral health needs of pregnant women and infants most at risk, supporting an environment that seeks to eliminate oral health barriers and disparities. Lack of oral care during pregnancy and in infancy, poverty and low economic status, lack of education, and racial background are some of the determinants associated with high rates of dental diseases such as early childhood caries. Through PIOHQI Connecticut will expand its current pilot project, into 15 communities in the state, develop statewide policy, procedures and clinical standards of practice that support the reduction of oral health disparities and reduce dental disease while improving and maintaining better oral healthcare delivery systems in the targeted communities.

Performance Based Outcomes: The long-term goal of the grant is to achieve sustainable improvement in the oral health status of the Maternal Child Health (MCH) population. Documentation of successful outcomes and lessons learned will be applied to the development of a national strategic framework for the purpose of replicating effective and efficient approaches to serving the oral health care needs of this targeted MCH population. This grant dovetails into the current premise of the Connecticut Dental Health Partnership's mission and strategy to get children into early preventive care reducing the need for the more costly restorative care producing better oral health outcomes.

Performance Based Vendor Accountability:

- Identification and referral of children and for dental care.
- Increase in utilization.
- Improvement in outcomes, including reduction of caries in young children.
- Objective reports that include client demographics correlated with outcomes.
- Reduction in secondary more costly dental services for children.

Fatherhood Initiative: Outreach /awareness education and training for parents related to parenting, healthy relationships, and healthy marriages. Also, support services that connect parents/program participants to programs and services that address their emotional and socio-economic needs.

Number Served: 410 participants

Program Cost: FY 2012-2013: \$445,000

Performance- Based Standards:

- Increase in effective communication skills (between partners/parents)
- Increase in knowledge about responsible parenting

- Increase in the ability to secure and retain employment
- Decrease in the potential for child abuse and neglect
- Increase in responsible parenting
- Identify and assess potential for spouse/partner/child abuse
- Targeted intervention strategies for parents with cognitive limitations

Performance-Based Outcomes:

- Results of pre and post-test of training offered for each program participant
- Decrease in child/partner/spousal abuse
- Improved communication between parents/partners
- Improved parent-child relationships
- Increase in marriage between partners (couples)

Primary Prevention Outcomes:

- Decrease in child poverty
- Prevention of child abuse and/or neglect
- Collaboration with DCF to prevent the occurrence/reoccurrence of child abuse/neglect among parents referred to DCF for services.

Performance –Based Vendor Accountability: Grant access to Yale researchers who are evaluating the program; evidence of dissemination and collection of pre-pos test of curricula; observable use of the 24/7 Curriculum developed by the National Fatherhood Initiative and approved/required by the federal government; report number of program participants; evidence of recruiting and retaining program participants; attend and participate in mastering curricula related to assessing domestic violence and working with parents with cognitive limitations; and evidence of a program plan for each participant in which all services and rationale for the service/referral is included.

Judicial Branch Court Support

- Educational Support Services
- Family Support Centers

Long Term Goals: The prevention goal of the Judicial Branch, Court Support Services Division (CSSD) is to divert children from juvenile court involvement and penetration into the criminal justice system.

Strategies:

- Divert children from the judicial process through non-judicial supervision services and referrals to appropriate community-based agencies and diversion programs.
- Identify needs and risk factors of children and families through the use of valid risk/need screening and assessment instruments, and refer children and families to programs and services that address their needs in order to prevent further juvenile court involvement or penetration into the criminal justice system.
- Collaborate with schools, community partners, provider agencies, and other state agencies to support local and state efforts designed to prevent or eliminate at-risk behaviors and to promote the health, well-being, and success of children.

Performance-Based Outcomes:

- Reduction in juvenile court intake (Families with Service Needs-FWSN, and Delinquency referrals)
- Juveniles engaged in criminogenic need-based treatment
- Reduction in 24-month re-arrest rates for juveniles on probation or supervision
- Fewer delinquency commitments

Measures of Effectiveness: CSSD has adopted a results-based accountability framework to measure the effectiveness of its strategies. Data is collected on outcome measures and reportedly quarterly to management, line staff, judges, attorneys, and contracted service providers as part of a continuous quality improvement effort. In addition, CSSD conducts, through both internal and contracted resources, evaluations of targeted strategies and/or programs. Performance measures include:

- Performance Measure 1 – Juvenile Court Intake: Intake fell 32% from 15,857 in FY 2007 to 10,787 in FY 2013, despite the

inclusion of 16 and 17 year olds in the juvenile court system, beginning January 1, 2010 and July 1, 2012, respectively.

- Performance Measure 2 – Juveniles Engaged in Criminogenic Need-based Treatment: Research suggests that completion of targeted treatment is connected to lower recidivism rates. The starting treatment rate in 2009 was 67% and rose to 96%, through September 2013. The treatment completion rate in 2009 was 20% and has risen to 76% as of October 2013.
- Performance Measure 3 – Reduction in 24-month Re-arrest Rates: The rate of re-arrest (recidivism) at 24-months after the start of a period of probation or supervision has remained consistent over the last four years and is beginning to show progress in the right direction. For example, 66 percent of the juveniles placed on probation or supervision in 2005 were re-arrested by the time their 24-month follow up period ended in 2007. The trend is beginning to decline showing a 59% re-arrest rate as of October 2013.
- Performance Measure 4 – Juveniles Committed to the Department of Children and Families: Juveniles committed to either long-term residential placement or for incarceration at the Connecticut Juvenile Training School have decreased by nearly 50 percent in the past 7 years, from 401 juveniles committed in 2004 to 206 in 2012 and a projection of 264 juveniles for 2013, due to the inclusion of 16 and 17 year olds in the juvenile system.

Methods: A core goal of the CSSD strategic plan is to engage in activities that provide a diverse, gender responsive and culturally competent environment for staff and clients that are sensitive to values and responsive to needs. CSSD established a Cultural Competency Advisory Committee which guides the implementation of this strategic goal. CSSD employees a diverse staff that is representative of the population served, including in key management positions within the agency. The Training Academy has embarked on an organization-wide cultural competency training initiative as well as hired staff to focus solely on increasing the cultural competency of

the agency. CSSD provides culturally competent, research- and evidence-based programming, interventions and supervision services through the use of race- and gender-neutral screening and risk/need assessment tools, and a network of contracted providers. CSSD requires all contractors to meet cultural competence expectations in hiring and service delivery. CSSD routinely reviews operation and program performance measures for any disparities based on gender or race/ethnicity. In addition no race/ethnicity disparity was found in case handling, adjudication rates, court outcomes and placement rates in an independent report, *A Reassessment of Disproportionate Minority Contact (DMC) in the Connecticut Juvenile Justice System* (May 2009), funded by the OPM Juvenile Justice Advisory study. Beginning in 2011, CSSD began work with the Hartford and Bridgeport communities on specific disproportionate minority contact reduction initiatives that have increased diversion from court rates and resulted in a revision to the Probate Graduated Sanctions Policy to include incentives to encourage compliance with court orders and decrease the use of detention for probation violations. In 2013, DMC reduction initiatives began in the New Haven and Waterbury communities.

Other: CSSD has implemented several strategies to support the prevention or diversion of children and youth from court referral, including a focus on increasing family engagement, decreasing school arrests, and building local partnerships. Detention clinicians are meeting with families of newly detained juveniles to engage the family in the child's care while in detention and to help prepare the family for working with the Court and treatment providers to support the child's success and limit further court involvement. Probation staff is being trained in parent engagement to assist officers in working with families to support them in managing at home behaviors and providing parents with alternatives to calling police during domestic disagreements. Juvenile Probation also engages in outreach efforts to better coordinate with schools to manage the in-school behaviors of court involved juveniles. In addition, CSSD recently revised the Probation Intake policy to allow probation supervisors to return any referral that does not warrant court intervention, which resulted in the return of over 800 referrals in the first two years. These efforts, in addition to the expansion of the School-Based Diversion Initiative highlighted below, should reduce the number of court referrals for in-school arrests, which may be better managed by local schools and service providers. CSSD, in conjunction with DCF and through its partnership with other stakeholders of

the Executive Implementation Team of the Joint Juvenile Justice Strategic Plan, has established a local interagency services team (LIST) for each juvenile court district to increase local awareness and support for the needs of children at risk for juvenile justice involvement. The LIST initiative is increasing community attention and local-state partnerships in addressing the contributing factors to juvenile delinquency.

A model intervention that holds great promise in diverting school-based arrests is the School-Based Diversion Initiative (SBDI), jointly developed and piloted by CSSD, DCF and CHDI, and funded by the MacArthur Foundation. As of FY 13, CSSD, DCF and SDE fully funded the program. SBDI seeks to bridge existing behavioral health services and supports to children and youth with mental health needs to prevent juvenile justice involvement. The creation of SBDI was based on three areas of concern in Connecticut, and nationally. First, although juvenile arrest rates have trended downward in the last 5 to 10 years, there remain high rates of *in-school* arrests, as well as expulsions and out of school suspensions, particularly among students with mental health needs. Exclusionary discipline results in more arrests, leading to academic failure and eventually to school drop-out. Youth with unmet behavioral health needs are disproportionality represented among students arrested in schools and approximately 65-70% of youth in detention have a diagnosable behavioral health condition. Second, students who are arrested or expelled are disproportionately to be students of color, particularly African-American and Hispanic males. Even when the behaviors are the same, too often school responses to behaviors are more severe for students of color. Third, to meet the needs of students at-risk of arrest or expulsion, schools report a need for better linkage to community-based mental health resources, particularly crisis response. The SBDI model was designed to address these concerns and attends to the underlying needs of school professionals, which in turn allows schools to more effectively meet the needs of at-risk students. SBDI incorporates a Graduated Response model for disciplinary intervention, which seeks to ensure that school policies and procedures are fair and equitable, do not rely excessively on juvenile justice system interventions, and effectively meet students' needs.

The primary goals and objectives of SBDI include:

Goal 1: Enhance knowledge and capacity of school professionals for early identification of mental health needs, diversion from arrest and expulsion, and referral to community-based services

Objective 1: Coordinate delivery of expert training to school professionals in key content areas

Objective 2: Facilitate staff skill development and attitude change regarding key competencies

Goal 2: Reduce number of in-school arrests and expulsions and associated racial/ethnic disparities

Objective 3: Develop individualized school policies and procedures to build capacity for reducing arrests and expulsions

Objective 4: Enhance awareness of racial/ethnic disparities in arrests and expulsions

Goal 3: Increase utilization of community-based resources as alternatives to arrest or expulsion for youth with mental health needs

Objective 5: Enhance collaboration between participating schools, local law enforcement, and service providers to improve service referrals

Objective 6: Improve early identification and referral of youth with mental health needs to effective diversionary services such as Emergency Mobile Psychiatric Services (EMPS)

Students in SBDI-participating schools are diverted from arrest whenever possible, and instead linked to appropriate community-based resources. SBDI emphasizes use of each community's local EMPS team. EMPS is a statewide mobile crisis response program that deploys teams of specially trained mental health professionals to respond immediately to requests for crisis stabilization, provide brief treatment, and ensure appropriate linkage to ongoing care. EMPS providers respond directly to homes, schools, and emergency departments and services are intended to reduce inappropriate service referrals to

correctional and inpatient settings. EMPS is available to every school in the state; however, existing data suggests that schools have historically underutilized this resource due to a lack of awareness and in some cases, a history of poor collaboration with the broader mental health provider community. SBDI seeks to strengthen relationships between schools and EMPS as a key community resource.

Outcomes: SBDI was piloted in four school districts (2 in SY 09-10, 2 in SY 10-11), expanded to three districts in SY 11-12, two school districts in SY 12-13, and one additional school district in SY 13-14. Recent data from all 17 former and current participating schools from 2012-2013 school year indicate:

- 19% decrease in school-based court referrals across SBDI schools, with one inner-city school decreasing by 92%
- 44% increase in utilization of EMPS Crisis Intervention Services by schools

An external evaluation by Yale University compared EMPS utilization rates and court referral data for communities with SBDI compared to similar communities without SBDI with the following results:

- Communities participating in SBDI during 2010-2011 school year had a significantly higher rate of referral to EMPS compared to non-SBDI comparison communities
- Youth served by EMPS had fewer subsequent court referrals the following year (11%) compared to those referred directly to court (42%) for an in-school behavior incident, regardless of prior court involvement

Educational Support Services: Approximately 50% of the children referred to the juvenile justice system have academic performance concerns and/or learning difficulties. High school graduation is closely linked to future success as related to income earning levels, court involvement and recidivism. The goal of *Education Support Services (ESS)* is to support families in ensuring that their children’s educational needs are properly identified and that children have access to a free and appropriate education as required by law. *Education Support Services* include legal case consultation, advocacy, and training by contracted special education attorneys serving families and probation officers of children referred to juvenile court due to status offending or delinquent behaviors, and who exhibit school difficulties and/or performance challenges. Services are available at all twelve (12) juvenile courts.

Number of Clients Served: 306 cases opened and 294 cases closed

Program Cost 2012-2013: \$765,264

Performance-Based Standards:

- Percentage of clients that obtained/modified/preserved special education services
- Percentage of clients that overcame proposed suspension or expulsion
- Percentage of clients that obtained education-related benefits
- Percentage of clients that obtained procedural protections

Performance –Based Outcomes:

- 68% (vs. 63% in FY 12) of clients obtained/modified/preserved special education services
- 20% (vs. 16% in FY 12) of clients overcame proposed suspension/expulsion
- 49% (vs. 49% in FY 12) of clients obtained education-related benefits
- 24% (vs. 21% in FY 12) of clients obtained procedural protections

Performance-Based Vendor Accountability: CSSD has established a continuous quality improvement team for each contracted service. Each team includes best practices staff, who develop program models based on the best practice literature and oversee program implementation; contract compliance specialists, who ensure that providers are adhering to the program model and the contract requirements; data collection support staff, who ensure that providers are inputting data into the CSSD “contractor data collection system” (CDCS) and the data meets quality standards; and program analysis staff, who analyze the data to ensure that programs are meeting benchmarks. Provider performance is reviewed by CSSD management staff on a quarterly basis, and the CQI team works with the provider to ensure quality service.

Family Support Centers: Since 2005, legislative change impacting the treatment and handling of status offenders (Families with Service Needs, FWSN) resulted in the development of distinct services for FWSN children and their families. Beginning with the prohibition on a court’s placing an adjudicated child in detention for a violation of a court order, changes in the law also called for statewide process modification for the handling of FWSN referrals. Public Act 05-250 established that “no child that is found to be in violation of any such FWSN order may be punished for such violation by commitment to any juvenile detention center”. In 2006, the legislature authorized an amendment to this legislation, Public Act 06-188, which established the Families with Service Needs Advisory Board to oversee the implementation of services in response to 05-250. The most recent legislative change came in an amendment of 46b-149 which changed the FWSN statute substantially, resulting in the development and funding of Family Support Centers.

A Family Support Center (FSC) is a multi-service “one-stop” service center for children and families referred to juvenile court due to status offenses (e.g., truancy, beyond control, runaway) and serves as a diversion to formal court processing. There were four (4) FSCs servicing the Bridgeport, Hartford, New Haven, and Waterbury juvenile courts. FSCs services were made available to the eight (8) remaining juvenile courts in FY 10-11. The purpose of the FSC is to quickly assess service and/or treatment needs for the children and families and then provide and/or access the needed services in a timely fashion. Services offered include assessment, crisis intervention, family mediation, educational advocacy, case planning and management, psycho-educational groups, and flexible funds for pro-social supports.

Number of Clients Served: 753

Program Cost: \$3,541,097

Performance-Based Standards:

- Program completion rate: completion of the FSC program means that the client satisfied 80 percent of the goals identified on the collaborative plan. The goal through December 2012 is for 85% of clients under age 16, and 78% of 16 and 17 year olds to successfully complete the program.
- Arrest rate for completers: percentage of program completers arrested within 12 months of program discharge. The goal is improved program performance by at least one percentage point each year.
- Re-referral rate for completers: percentage of program completers who have a new status offending court referral within 12 months of program discharge. The goal is improved program performance by at least one percentage point each year.

Performance –Based Outcomes:

- Program completion rate: 87% for clients under age 16, and 82% for clients ages 16 and 17. (In FY 12, the rate was 87% and 78%, respectively.)
- Arrest rate for completers: 32% for clients under age 16, and 21% for clients ages 16 and 17. (In FY 12, the rate was 32% and 29%, respectively.)
- FWSN referral rate for completers: 20% for clients under age 16, and 13% for clients ages 16 and 17. (In FY 12, the rate was 21% and 12%, respectively.)

Performance-Based Vendor Accountability: CSSD has established a continuous quality improvement team for each contracted service. Each team includes best practices staff, who develop program models based on the best practice literature and oversee program implementation; contract compliance specialists, who ensure that providers are adhering to the program model and the contract requirements; data collection support staff, who ensure that providers are inputting data into the CSSD “contractor data collection system” (CDCS) and the data meets quality standards; and program analysis staff, who analyze the data to ensure that programs are meeting benchmarks. Provider performance is reviewed by CSSD management staff on a quarterly basis, and the CQI team works with the provider to ensure quality service.

- **Title V Delinquency Prevention Program**
 - **Enforcing Underage Drinking Laws**
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TITLE V DELINQUENCY PREVENTION PROGRAM: The Title V Delinquency Prevention Program goal is to reduce delinquency and youth violence by supporting communities in providing their children, families, neighborhoods and institutions with the knowledge, skills and opportunities necessary to foster a healthy and nurturing environment. The program provides grants to cities and towns (units of local government) in Connecticut for delinquency prevention and early intervention projects based upon a risk and protective factor approach. This approach provides communities with a conceptual framework for prioritizing the risk and protective factors in their community, assessing how their current resources are being used, identifying resources which are needed, and choosing specific programs and strategies that directly address those factors. A youth advisory committee that reflects the racial, ethnic, and cultural composition of the community's youth population and includes youth at various levels of academic and social competencies must provide input into the design and implementation of program strategies.

Program Cost: FY: 2012-2013 \$84,945

Performance-Based Standards: Program communities must develop and implement a local delinquency prevention plan that:

- Assess the prevalence in the community of specific, identified risk and protective factors, including the establishment of baseline data for the factors and a list of priority factors to be addressed;
- Identify all available resources in the community;
- Assess gaps in the needed resources and how to address them;
- Establish goals and objectives along with an implementation timeline; and
- Insure the collection of data for the measurement of performance and outcome of planned program activities.

Performance-Based Outcomes: Program grantees are required to collect the following data elements:

Outputs

- Number of full time equivalent employees funded with grant funds;
- Number of planning activities conducted; and
- Number of program youth served.

Outcomes

- Number and percent of program youth exhibiting an increase in school attendance;
- Number and percent of program youth completing program requirements;
- Number and percent of program youth satisfied with the program; and
- Number and percent of program staff with increased knowledge of program area.

Performance-Based Vendor Accountability: Program grantees prepare quarterly progress reports and collect evaluation data for the measurement of performance and outcome of planned program activities.

Enforcing Underage Drinking Laws: The Office of Policy and Management and its Juvenile Justice Advisory Committee address the problem of underage drinking by focusing on limiting youth access to alcohol through efforts at two target populations—liquor establishments and parents and other adults. This project supports the implementation of compliance checks or “minors-in-stings” operations, which allow the Liquor Control Division and the police to monitor retailer compliance with liquor laws regulating the sale and or purchase of alcohol by minors. Training for youth in conducting these sting operations and funding for overtime for Liquor Control agents to participate in compliance checks are measured by collecting and comparing statistics on the percentage change in retail establishments that are found to be in compliance.

Program Cost 2012-2013: \$318,643

C.G.S. Section 4-67x (g)

(g) (1) On or before November first of each year from 2006 to 2014, inclusive, each budgeted state agency with membership on the council that provides prevention services to children shall, within available appropriations, report to the council in accordance with this subsection.

(2) Each agency report shall include at least two prevention services not to exceed the actual number of prevention services provided by the agency. For each prevention service reported by the agency, the agency report shall include (A) a statement of the number of children and families served, (B) a description of the preventive purposes of the service, (C) for reports due after November 1, 2006, a description of performance-based standards and outcomes included in relevant contracts pursuant to subsection (h) of this section, and (D) any performance-based vendor accountability protocols.

(3) Each agency report shall also include (A) long-term agency goals, strategies and outcomes to promote the health and well-being of children and families, (B) overall findings on the effectiveness of prevention within such agency, (C) a statement of whether there are methods used by such agency to reduce disparities in child performance and outcomes by race, income level and gender, and a description of such methods, if any, and (D) other information the agency head deems relevant to demonstrate the preventive value of services provided by the agency. Long-term agency goals, strategies and outcomes reported under this subdivision may include, but need not be limited to, the following:

(i) With respect to health goals, increasing (I) the number of healthy pregnant women and newborns, (II) the number of youths who adopt healthy behaviors, and (III) access to health care for children and families;

(ii) With respect to education goals, increasing the number of children who (I) are ready for school at an appropriate age, (II) learn to read by third grade, (III) succeed in school, (IV) graduate from high school, and (V) successfully obtain and maintain employment as adults;

(iii) With respect to safety goals, decreasing (I) the rate of child neglect and abuse, (II) the number of children who are unsupervised after school, (III) the incidence of child and youth suicide, and (IV) the incidence of juvenile crime; and

(iv) With respect to housing goals, increasing access to stable and adequate housing.