



# Section II. Connecticut Maternal and Child Health Needs Assessment Application

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Health Resources in Action  
*Advancing Public Health and Medical Research*

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# Connecticut Maternal and Child Health Needs Assessment Application

## II.A. OVERVIEW OF THE STATE

### Current Initiatives

The Connecticut Department of Public Health (DPH) released the Healthy Connecticut 2020 in March 2014, a statewide health assessment and plan for improving the health of all Connecticut residents in the current decade.

Joined by Lt. Governor Nancy Wyman, and Dr. Paul Jarris, Executive Director of the Association of State and Territorial Health Officials, DPH Commissioner Dr. Jewel Mullen formally presented the state health assessment and plan before over 150 members of the Connecticut Health Improvement Planning Coalition.

“Healthy Connecticut 2020 is a ‘Call to Action’ to address current and emerging health issues that most affect the health and well-being of our residents,” said Dr. Mullen. “It provides a roadmap for improving the state’s health and ensuring that all people in Connecticut have the opportunity to attain their highest potential for health.”

“Healthy citizens mean better schools, a stronger workforce, and a higher quality of life overall,” said Lt. Governor Wyman. “Our health care exchange, Access Health CT, is a national leader in providing affordable, quality health insurance to residents—a very good first step in promoting good health and well-being, but there is more we can do. Healthy Connecticut 2020 is another step to address the health of our residents, health equity, and disease prevention. I want to thank Commissioner Mullen for her leadership, and the Coalition members for their commitment to ensuring our citizens can live healthy, productive lives.”

The assessment contains good news for Connecticut, but also presents important challenges. “While Connecticut meets or exceeds many national targets for health status and risk factors, many of our residents are dying prematurely from chronic diseases and injuries,” Dr. Mullen said. “Profound disparities in health exist among certain demographic and socioeconomic groups and even adjacent towns.”

The plan, which is based up on the findings of the assessment, provides a blueprint for collective action among a wide array of partners to address some of Connecticut’s most challenging health issues, including obesity, tobacco use, high blood pressure, falls, poor birth outcomes, and prescription drug misuse. It provides a common framework for organizations to use in leveraging resources, engaging partners, and identifying their own priorities and strategies for collective action.

The coalition, a body of experts from government agencies, local health departments, educational institutions, community organizations, health care facilities, and businesses from across Connecticut, developed the assessment and plan through a planning process led by DPH.

Dr. Mullen thanked the coalition members for their contributions to this process, and stressed the importance of partnering among organizations as implementation of the plan begins. “Health is a

shared responsibility, and it takes the collaboration of many partners from all sectors to address health and improve health outcomes across Connecticut,” she said.

The Healthy Connecticut 2020 State Health Improvement Plan and Assessment are included as attachments. Healthy Connecticut 2020 addresses the following seven distinct health Focus Areas:

- Focus Area 1: Maternal, Infant, and Child Health
- Focus Area 2: Environmental Risk Factors and Health
- Focus Area 3: Chronic Disease Prevention and Control
- Focus Area 4: Infectious Disease Prevention and Control
- Focus Area 5: Injury and Violence Prevention
- Focus Area 6: Mental Health, Alcohol, and Substance Abuse
- Focus Area 7: Health Systems

### Health Status

Connecticut (CT) is a small state of about 5,000 square miles and 169 towns, and in 2012 had an estimated statewide population of 3,596,080 (*source: CT DPH, July 1, 2012*). Five towns had a population greater than 100,000 and included: Bridgeport (147,216), New Haven (130,660), Stamford (126,456), Hartford (125,017), and Waterbury (109,676). Eighteen percent of the state’s residents lived in these five towns. The remaining 164 towns had a population of about one-tenth the size of these large towns (median population size =12,229).

The State of CT is characterized by high social and economic contrasts. In 2012, the median household income of the five large towns in CT varied widely from a low of \$29,430 in Hartford, to moderate levels in New Haven (\$37,428), Waterbury (\$40,639), and Bridgeport (\$41,050), and to a high of \$76,779 in Stamford (*source: USCB, 2013*). Of the remaining 164 towns in Connecticut, more than half had a median household income that exceeded that in Stamford, and all had a household income greater than Hartford. Among the five largest towns in CT from 2000 to 2013, the population of Stamford grew the fastest, with a 7.8% increase. This growth rate was higher than the overall statewide growth rate of 5.5%. The towns of Bridgeport (5.3%) and New Haven (5.6%) grew at a rate comparable to the overall rate. The town of Waterbury, however, grew at a slower rate (2.1%), and Hartford grew at a rate of only 0.5%.

Although CT was slower than other states to enter into the great recession from 2008-2010, its recovery now lags behind the nation (*source: CT Department of Labor, 2001-2015*). In April, 2015, the unemployment rate in CT was 6.3%, a rate that has been steady for the past eight months and that represents the lowest since 2010. The national unemployment rate is now 5.5%, however, well below the CT rate, and has not been as high as the CT rate for more than a year. In 2013, 90% of the state’s civilian labor force was employed, but 31 towns, including all five of the large towns in CT, were below the statewide unemployment rate (*Source: USCB, 2013*). More than 20% of the civilian labor force in the City of Hartford was unemployed, the highest percent in the state.

The demographic landscape of CT is changing. Between 2000 and 2010, Connecticut’s population increased by about 5%. The proportion of residents who were at least 65 years of age increased by nearly 8% during the time period, increasing the statewide median age to 40 years. In 2012, about one in seven residents (14.8%) was 65 years of age or older. Connecticut is also becoming increasingly diverse by race and ethnicity. During the last decade, the White population decreased,

whereas there were increases in the numbers of other population groups, notably Asian (65% increase) and Hispanic/Latino (50% increase) residents.

Although the statewide median age is increasing, about one in four CT residents (25.2%) in 2012 was under 20 years of age. CT's largest towns had a greater proportion of young persons than the state overall, with more than half of the population younger than 35 years of age in New Haven, Hartford, and Bridgeport, compared to about 44% statewide. These statistics have policy implications for women of childbearing age and young mothers.

In CT during 2012, 70% of the population was non-Hispanic White. Among racial and ethnic minorities, the percentages were: 14.2% Hispanic/Latino, 9.4% non-Hispanic Black/African American, 4.1% non-Hispanic Asian, and 2.3% of another race or multi-racial background. In 2012, CT's largest towns had greater racial and ethnic diversity than CT overall. Fully 36.2% of New Haven's population was non-Hispanic Black/African American, and 4.6% was non-Hispanic Asian. The Hispanic population accounted for more than 40% of the population in Hartford and Bridgeport.

In 2012, 30% of houses in CT were constructed before 1950, while only 7% were constructed in 2000 or later. Homes in CT's largest towns are generally older than those across the state. In New Haven, 59% of homes were built before 1950, followed by 48% of homes in Bridgeport, and 45% of homes in Hartford. In CT, 67% of homes were owner-occupied in 2012, while 33% were renter-occupied. In CT's largest towns, a greater proportion of residents were renters, relative to CT overall. In Hartford, 76% of residents rented their home, followed by 69% in New Haven and 58.8% in Bridgeport. Rental costs were highest in New Haven (\$1,089), Bridgeport (\$1,042), and Hartford (\$838).

Although much of the state is home to higher income families, and although disparities are greatest in large urban areas, poverty is scattered across the state in both urban and rural areas. The median household income in CT was \$67,276 in 2012. Household income was lower, however, in CT's largest towns. The median household income was about half the statewide median in the towns of Bridgeport and New Haven, and about 40% of the statewide median in the City of Hartford. In addition, approximately one in ten CT residents had incomes below the federal poverty level in 2012. CT's largest towns had higher proportions of persons with incomes below the federal poverty level, compared to the state overall. In 2012, 38% of individuals in Hartford had incomes below the federal poverty level, as did 26% of residents in New Haven, and 25% in Bridgeport.

In 2012, about 10% of CT adults had less than a high school education, 28% completed high school or had a GED, 25% had some college education, and 37% had a bachelor's degree or higher. Relative to the state overall, CT's largest towns had a greater proportion of adults with the lowest levels of educational attainment.

Relative to the general population, a different pattern of demographics exists among children living in CT. In 2013, 13.6% of all children less than 18 years old in the state were living in poverty, below 100% of the federal poverty level (source: USCB, 2013). As expected, given the economics of all ages living in CT, the magnitude and highest percent of childhood poverty exists in four of the five large towns of CT. Whereas the percent of childhood poverty in 2012 was 15% in Stamford, one in every three children in Bridgeport, Waterbury, and New Haven lived in poverty, and 45%, nearly half, of all children in Hartford lived in poverty. Other towns, however, also exhibited a high percent of childhood poverty. These towns included: New London (37.2%), Suffield (37.0%),

Windham (34.9%), Ansonia (32.5%), and New Britain (30.9), and these towns are in rural and suburban areas of the state. These data indicate that, although public health interventions for the general high-risk population, including women of reproductive age, should be focused in large urban areas, interventions for families and their children need to be expanded into other areas of the state.

## 1. Maternal and Child Health Indicators

### Maternal and Child Demographics

During calendar year 2012, there were 36,512 births to CT residents (source: CT DPH, 2012). Of these births, 28,063 were to non-Hispanic White mothers, 5,014 were to non-Hispanic Black/African American mothers, and 7,945 births were to women of Hispanic/Latino ethnicity. Over 63% of all births to non-Hispanic Black/African American mothers occurred in the five large towns of CT: Bridgeport (17.9%), Hartford (16.8%), New Haven (16.0%), Waterbury (7.5%), and Stamford (5.3%). Similarly, 54% of all births to Hispanic/Latino mothers occurred in these large towns: Hartford (14.5%), Bridgeport (13.7%), New Haven (9.8%), Waterbury (8.8%), and Stamford (7.5%). Additionally, 5.5% of all births to non-Hispanic Black/African American mothers occurred in East Hartford, and over 5% of all births to Hispanic/Latino women occurred in New Britain (7.4%), Norwalk (5.7%), and Danbury (5.4%). These data show that women of reproductive age who are of minority race/ethnicity are largely residents of only a handful of large towns and surrounding suburbs. As noted above, these areas are characterized by low income, poor education and housing arrangements, and high rates of unemployment. Public health programs to maximize health and readiness for pregnancy need to be focused in these areas and need to address the socio-economic factors that limit optimal health and wellbeing.

Many maternal health indicators within CT compare favorably with the United States, but are dominated by the majority of non-Hispanic White women, masking the racial and ethnic disparities within the numbers. High-risk groups experience a disproportionate burden of adverse health risk factors and outcomes, and these disparities are documented in more detail in the Needs Assessment section of this application. Addressing racial and ethnic disparities in the state is a priority. Reducing disparities in maternal and child health indicators remains one of the major challenges facing the public health community, requiring coordinated and simultaneously executed multi-ecological strategies.

## 2. Infant Mortality

In CT during 2012, there were 192 deaths among CT babies, representing an infant death rate of 5.3 per 1,000 live births (source: CT DPH, 2012). Of these deaths, more than three of every four (150; 78%) occurred during the neonatal period, and the remaining 42 were post-neonatal. The infant mortality rates in the towns of Bridgeport, Hartford, New Haven, and Wethersfield were significantly higher than that of the national rate of 6.0 per 1,000 live births, and, in Bridgeport, represented a significant increase since the previous year.

Of all infant deaths in CT during 2012, 113 (59%) occurred among babies born to White mothers of all ethnicities, 59 (31%) occurred among babies born to Black/African American mothers of all ethnicities, and 57 (30%) occurred among babies born to Hispanic/Latino mothers. This

racial/ethnic disparity reflects the consistently higher prevalence among the non-White population for risk factors, such as teen births, lack of adequate prenatal care, and low birth weight. Focusing prevention strategies on groups showing a high rate of LBW and very LBW infants such as women in the urban centers or the state's Black/African American population, is likely to have the greatest impact on reducing one of the strongest risk factors for infant mortality.

### 3. Births to Teens

From 2000 to 2011, there was a significant annual 4.2% decrease in the rate of births per 1,000 teen women (*Source: CTDPH*). The overall rate of teen births in CT declined by nearly 50% over the past decade and was fueled by significant declines for each racial or ethnic group (ranging from decreases of 4.6% to 10.5% per year).

Despite the decreasing trend in teen births, there were 1,920 births to women 15-19 years of age in 2012, representing 5.2% of all births (*Source: CT DPH, 2012*). Of these births, 958 were to Hispanic/Latino teens (12.1% of all births to Hispanic/Latino mothers), and 370 were to non-Hispanic Black/African American teens (8.1% of all births to non-Hispanic Black/African American mothers). In sharp contrast, 509 births were to non-Hispanic White teens, representing only 2.5% of all births to non-Hispanic White women. Births to Hispanic/Latino and non-Hispanic Black/African American teens accounted for 70% of all teen births in the state.

During the five year period from 2008 through 2012, combined, the overall statewide teen birth rate was 18.89 per 1,000 women 15-19 years old (*source: CT DPH, 2012*). Relative to this rate, the teen birth rate was significantly higher in four of the five large towns of the state, including Hartford, Waterbury, Bridgeport, and New Haven, with teen birth rates of 54.1, 48.2, 48.2, and 38.1 per 1,000 teens, respectively). Additionally, the teen birth rate was exceptionally high in the surrounding towns of New Britain (48.2 per 1,000 teens), Norwich (39.6 per 1,000 teens), and Meriden (38.1 per 1,000 teens). Support services for young mothers are important, not only within the large towns, but also in surrounding towns of high need.

Support for young mothers is a public health imperative, and coupled with teen pregnancy prevention, is likely to have a large impact on the health and well-being of women across the lifespan. Preventive interventions to address teen pregnancy through CT's Title V programs include programs to delay the onset of sexual activity, promote abstinence as the social norm, reduce the number of adolescents who have sex at young ages, and increase the number of sexually active adolescents who use contraceptives effectively. Programs such as the Case Management Program for Pregnant Women and Parenting Teens, Healthy Choices, and federal Hartford Healthy Start serve pregnant and parenting teens and include inter-conception services. The Case Management for Pregnant Women program in three large cities with high rates of teen births is similar to the federal Healthy Start program in the City of Hartford. The program focuses on pregnant females and teens under the age of 20 who are at greatest risk for poor birth outcomes. This is a coordinated, culturally-sensitive approach to providing individualized client services through intensive case management and home visitation. The services focus on building social supports, providing education, promoting birth spacing and family planning, and providing referrals to ongoing medical care.

In addition to support services for young mothers, DPH is grant-funded to implement teen pregnancy prevention programs. This program is focused in geographies with a high teen birth rate. A state priority is to ensure that young people, and in particular young women, receive regular preventive well-visits, and pregnancy prevention interventions during these visits is a means to reducing the teen pregnancy rate in areas of high risk.

#### **4. Prenatal Care**

Among all births in CT during 2012, 13.1% were born to mothers who initiated pregnancy beyond the first trimester (*Source: CT DPH, 2012*). The percent of women who initiated prenatal care after the first trimester was significantly higher than the statewide percent among non-Hispanic Black/African and Hispanic/Latino mothers (20.6% and 19.4%, respectively). Four of the five large towns in CT were home to one-third of all women who received late prenatal care (New Haven, Waterbury, Hartford, and Bridgeport). The towns of Meriden, New Britain, Norwalk, Greenwich and Naugatuck also had significantly higher percentages of late prenatal care, and the percent increased significantly relative to the previous year in Waterbury, Greenwich, and Naugatuck.

Compared to a statewide percent of 23.4% of all births for which women received non-adequate prenatal care in 2012, the percent among non-Hispanic Black/African and Hispanic/Latino mothers was significantly higher (29.7% and 26.7%, respectively). Three of the five large towns in CT were home to women who received significantly higher percentages of non-adequate care: Stamford, 36.9%; Bridgeport, 33.9%; and Hartford 27.3%. Ten additional towns surrounding these large towns also had significantly higher percentages of non-adequate care, with the highest percent occurring in New Britain (39.6%).

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

#### **5. Low Birth Weight (LBW)**

During 2012 in CT, there were 2,873 LBW (less than 2,500 grams or 5.5 pounds) babies born in the state, representing 7.9% of all births. Compared to this statewide rate, the percent of LBW babies born to non-Hispanic Black/African American and Hispanic/Latino mothers was significantly higher at 12.3%, and 11.2%, respectively, and among Hispanic mothers represented a significant increase since the previous year. Of the total number of LBW babies in the state, more than 70% were born to these two minority race/ethnic groups.



Masked within the racial/ethnic disparity in LBW is an even greater disparity in VLBW (very low birth weight; less than 1,500 grams or 3.3 pounds). There were 536 VLBW babies born in CT during 2012, representing 1.5% of all births in the state. In sharp contrast, the rate of VLBW among non-Hispanic Black/African American mothers was 3.1%, and the rate among Hispanic/Latino mothers was 1.6%. Both rates among these minority groups were significantly higher than the statewide rate. Significantly higher rates of both LBW and VLBW were observed in the City of Hartford. Other towns with significantly higher rates of LBW were East Hartford (11.3%), New Britain (10.1%), and New Haven (9.9%).

## **II.B. FIVE-YEAR NEEDS ASSESSMENT SUMMARY**

### **1. Process**

The MCH Needs Assessment and Planning process is an iterative, collaborative process that has engaged organizations, agencies, and residents across the state. The process was guided by a life course perspective to examine risk and protective factors across the lifespan, social determinants of health framework to explore the upstream factors that influence population health, and a health equity lens to identify differential patterns of health across population groups.

The MCH Needs Assessment and Planning process was nested within the larger Connecticut State Health Assessment and Planning process and engaged stakeholders and Connecticut residents throughout the process. Community and stakeholder engagement at multiple levels is critical throughout all components of a health improvement planning process, from conducting the assessment to developing and implementing the improvement plan. Involving a broad range of stakeholders and developing multi-sector partnerships was essential for developing a comprehensive portrait of Connecticut's health status. An Advisory Council of 25 Connecticut leaders from statewide organizations was engaged during a 14-month period. Additionally, a workgroup of organizations focused on maternal and child health issues across the state (e.g., March of Dimes, Planned Parenthood, Early Childhood Alliance, Life Focus Nutrition Centers, Connecticut Commission on Children, Hispanic Health Council) met regularly to discuss the data and provide insight into potential priorities in the state. Additionally 29 key informant interviews were conducted with leaders around the state. The interviews included leaders from state agencies, community service organizations, statewide organizations focused on specific population groups, the state legislature, academia, education, and business. Community members participated in eight community-level forums throughout the state in September-October 2014 to be engaged in the process, hear about preliminary findings, and provide feedback and comment.

Data sources for the MCH Needs Assessment were from a variety of sources. Indicators of the social and economic context are derived from the US Census. Health indicators such as birth outcomes, mortality, infectious diseases, reasons for hospitalization and emergency department visits, and supply of primary care, mental health, and oral health providers are managed by the Connecticut Department of Public Health. Indicators of self-reported chronic disease and health behaviors such as smoking and physical activity are based upon responses to the Connecticut School Health Survey (CSHS; also known as the Youth Risk Behavior Surveillance System) for youth in grades 6 to 8 and 9 to 12. Other sources from which the health indicators were derived include, but are not limited to: Behavioral Risk Factor Surveillance System,

National Immunization Survey, Substance Abuse and Mental Health Services Administration (SAMHSA) Survey on Drug Use and Health Model-Based Estimates, US Department of Health and Human Services Administration for Children and Families, Connecticut Department of Public Safety, Bureau of Labor Statistics, National Survey of Children's Health, National Survey of Children with Special Health Care Needs, and the Connecticut Department of Environmental Protection.

A comprehensive Maternal and Child Health Needs Assessment Report can be found at [\[LINK\]](#).

## 2. Findings

### a. MCH Population Needs

#### Domain 1: Women's/Maternal Health

In 2013, 74.0% of women in Connecticut had a preventive medical visit or check-up in the past year.<sup>1</sup> This finding is similar to the data provided in National Performance Measure (NPM) #1: Percent of Women with a Past Year Preventive Visit. The Federally Available Data (FAD) for NPM #1 was used to calculate the five year average (2009-2013) from the Behavioral Risk Factor Surveillance System (BRFSS) of 68.2% and provided the baseline for the Annual Performance Objectives (APO's).

Adults with health care coverage were significantly more likely to have had a check-up (75.2%), compared to uninsured adults (41.6%). In 2010 and 2011 (combined), 44.7% of women reported that they discussed preconception health with a health care provider prior to their pregnancy.<sup>2</sup> More than half of white non-Hispanic women (52.3%) discussed preconception health with their health care provider prior to pregnancy, compared to only 28.9% of black non-Hispanic women and 34.0% of Hispanic women in 2010-2011.

Slightly more than one-third of women (34.5%) reported that they had a planned pregnancy in 2010 and 2011, combined. In 2010 and 2011, 60.6% of black non-Hispanic women reported that they had an unplanned pregnancy, followed by 46.5% of Hispanic women. Only one quarter (25.4%) of white non-Hispanic women reported that they had an unplanned pregnancy.

In 2011, there were 37,277 births in Connecticut.<sup>3</sup> There were 10.4 births per 1,000 population in Connecticut in 2011. Birth rates have declined over the past decade for each of Connecticut's largest racial and ethnic groups. From 2001 to 2011, the decline in birth rate was highest for white non-Hispanics, who experienced a 22% decline over this period. However, the major reduction in birth rate for the state between 2007 and 2010 can be attributed to the Hispanic population. Between 2000 and 2007, the Hispanic birth rate was the highest and remained steady at approximately 20 births per 1,000 Hispanic persons. Between 2007 and 2010, the Hispanic birth rate dropped by 17% compared to 11% for each of the other racial and ethnic groups.

From 2000 to 2011, there was a significant annual 4.2% decrease in the rate of births per 1,000 teen women. The overall rate of teen births in Connecticut declined by nearly 50%

over the past decade, fueled by significant declines for each racial or ethnic group (ranging from -4.6% to -10.5% per year). Even with the substantial reduction in teen birth rates, Hispanic (47.2 per 1,000) and black non-Hispanic (29.1 per 1,000) mothers had significantly higher rates in 2011 as compared with white non-Hispanic mothers (5.8 per 1,000).

Since most births are singleton deliveries, the total C-section rate follows trends for C-sections for singleton births.<sup>4</sup> C-sections rates among singleton births increased significantly between 2000 and 2006, with an 8.0% annual increase. From 2006 to 2011 the rates have leveled out at a 0.7% annual increase. In 2011, there were 33.9 C-sections per 100 births for singleton births, compared to 79.9 per 100 births for multiple births.

In 2011, 13.0% of pregnant women received late or no prenatal care.<sup>5</sup> Also in 2011, more than double the proportion of black non-Hispanic mothers (20.9%) and Hispanic mothers (19.4%) received late or no prenatal care relative to white non-Hispanic mothers (8.8%). These differences were statistically significant.

In 2011, 77.8% of women received adequate prenatal care. Compared to white non-Hispanic women (80.7%), a significantly lower proportion of black non-Hispanic (71.5%) and Hispanic (73.8%) women received adequate prenatal care.

The percent of women receiving non-adequate prenatal care increased significantly from 2000 through 2005, with an 8.9% annual increase over this period. From 2006 to 2011, the proportion of women receiving non-adequate prenatal care leveled off, with a 1.0% annual increase over this period. Both white non-Hispanic (11.1%) and black non-Hispanic (9.9%) women experienced significant and high annual percent increases in non-adequate prenatal care for the first part of the decade (2000-2004 and 2000-2005, respectively). The rate of increase in non-adequate prenatal care slowed among white non-Hispanic women after 2004, but still continued to increase for steadily from 2005 to 2011. The percent of Hispanic mothers receiving non-adequate prenatal care increased significantly from 2000 to 2005 (5.5% annual change), then leveled off from 2006 to 2011 (-1.3% annual change). From 2000 to 2011, there was a 2.9% annual increase in the proportion of Asian women who received non-adequate prenatal care.

## **Domain 2: Perinatal and Infant's Health**

In 2011, 8.0% of singleton births were preterm in Connecticut.<sup>6</sup> In 2011, the proportion of preterm births for black non-Hispanic and Hispanic women was significantly higher than that for white non-Hispanic women. The percent of singleton preterm births among black non-Hispanic women (12.1%) was 1.9 times higher than that for white non-Hispanic women (6.5%). For Hispanics (9.2%), the proportion of singleton preterm births was 1.4 times higher than that for white non-Hispanics (6.5%) in 2011. Additionally, from 2000 to 2011, there was little change in the percent of preterm births for the total population and Connecticut's largest racial and ethnic groups, suggesting that the gap in preterm births between black non-Hispanics and white non-Hispanics is not improving.

In 2011, 5.6% of singleton births were low birth weight in Connecticut. In 2011, the proportion of low birthweight births among black non-Hispanics (9.6%) and Hispanics (6.4%) was significantly higher than that for white non-Hispanics (4.1%). Additionally, from 2000 to

2011 there was no improvement in the proportion of low birthweight births for the total population or by race and ethnicity, suggesting that disparities in low birthweight births have not improved.

In 2011, there was a significantly higher proportion of very and moderately low birthweight births among black non-Hispanics relative to white non-Hispanics. There was a significantly higher percent of moderately low birthweight births among Hispanic women relative to white non-Hispanics. The NPM #3: Percent of VLBW Infants Born in a Hospital with a Level III+ Neonatal Intensive Care Unit (NICU) was selected as there was a significantly higher proportion of very low birthweight births among black non-Hispanics relative to white non-Hispanics. The supporting data for this measure would allow tracking of whether these VLBW Births are in the highest quality care facilities.

Infants born to women with Medicaid coverage tended to have poorer outcomes, particularly very low birthweight births. For example, approximately 10% of infants born to women with Medicaid coverage were low birthweight (less than 2,500 grams) or preterm (less than 37 weeks gestation).

Infant mortality rates have continued to decline over the last 20 years (1990-2011) in Connecticut. Infant mortality rates among singleton births have declined at a rate of 2.4% per year. Rates among multiple gestation deliveries have declined at a more modest 1.9% per year. In contrast, fetal mortality rates have not changed significantly in Connecticut over the last 20 years. The infant mortality rate for black non-Hispanics (11.7 per 1,000 live births) was 3.2 times that for white non-Hispanics (3.7 per 1,000) and the infant mortality rate for Hispanics (6.1 per 1,000 live births) was 1.7 times that for white non-Hispanics in 2010. These differences in the infant mortality rate by race and ethnicity were statistically significant.

In 2010-2011, combined, 88.5% of infants in Connecticut were ever breastfed.<sup>7</sup> Overall, 37.1% of infants were breastfed exclusively at three months, while only 12.3% were breastfed exclusively at 6 months. Nearly 4 in 10 white non-Hispanic infants (39.6%) were exclusively breastfed at 3 months, compared to only 31.7% of black non-Hispanics and 32.5% of Hispanics. Exclusive breastfeeding at 6 months ranged from 9.3% among black non-Hispanic infants to 14.7% among Hispanic infants. While the Needs Assessment finds the disparities among infants who were ever breastfed, the NPM #4: Percent of infants who are ever breastfed tracks the trend in the percent of infants who were ever breastfed. Data from the National Immunizations Survey (NIS) reported a consistent increase in the trend of infants who were ever breastfed.

Among infants enrolled in WIC, only 6.7% were exclusively breastfed, 21.3% were partially breastfed, and 72.0% were only formula fed. A greater proportion of white non-Hispanic (10.6%) infants enrolled in WIC were exclusively breastfed, compared to black non-Hispanic (4.6%) and Hispanic (5.4%) infants. Similar to infants who were ever breastfed, NPM #4: Percent of infants who were breastfed exclusively through 6 months, NIS data showed a recent increase in the number of infants breastfed exclusively at six months.

### **Domain 3: Child Health**

In 2011-2012, only 26.6% of children age 10 months to 5 years were screened for being at risk for developmental, behavioral, and social delays using a parent-reported standardized screening tool during their health care visit.<sup>8</sup> This data as reported by the National Survey of Children's Health (NSCH), is exactly the same as NPM #6: Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool; therefore, this NPM was selected for this domain. In 2011, 34.1% of black non-Hispanic children were screened for developmental, behavioral, and social delays during their health care visit in the past year, followed by white non-Hispanic (28.6%) and Hispanic children (22.0%).

Overall, 90.3% of children in Connecticut saw a health care provider for preventative medical care in the past year in 2011-2012. In 2011, 92.4% of white non-Hispanic children saw a health care provider for preventative care in the past year, followed by black non-Hispanic (87.5%) and Hispanic (86.7%) children.

In 2013, the prevalence of vaccine series completion among children 19 to 35 months was 78.2, and 91.4% completed at least one dose of the measles, mumps, and rubella (MMR) vaccine.<sup>9</sup>

Asthma was the leading cause of preventable hospitalization among children, followed by gastroenteritis and urinary tract infections. While two time points may not constitute an epidemiologic trend, the hospitalization rate varied from 2004 to 2008 for hospitalizations due to the three leading causes. The greatest variation in pediatric preventable hospitalizations over this period was for gastroenteritis, which changed by 38%.<sup>10</sup>

### **Domain 4: Children with Special Health Care Needs**

In Connecticut in 2009-2010, 17.3% of children were classified as having special health care needs. Among respondents, 89.5% of children with special health care needs had at least one reported health condition.<sup>11</sup> Allergies (45.3%), asthma (37.7%), and ADD or ADHD (29.0%) are the most prevalent health conditions among children with special health care needs.

In 2009-2010, 81.4% of children with special health care needs (CSHCN) were screened early and continuously for special health care needs and 70.4% of CSHCN had families who reported that they are partners in the decision-making process for their child's optimal health. In addition, 67.4% indicated that they received family-centered care and 66.8% reported that CSHCN could easily access community-based services. Approximately 6 in 10 (59.6%) reported that CSHCN had consistent and adequate private and/or public health insurance to cover needed services.

Less than half of respondents reported that CSHCN received coordinated, ongoing, comprehensive care within a medical home (46.0%) or reported that they received the services necessary to make appropriate transitions to adulthood (46.0%). The selection of NPM #11 and NPM #12 within this domain will allow tracking of children and youth with special health care needs with a medical home and those who received the services

necessary to make a transition to adult health care. Four in ten reported that CSHCN received care coordination that met all needed components of care. In 2009-2010, only 31.1% of parents of children with special health care needs completed a standardized developmental behavioral screening tool during their child's health care visit in the past year.

In 2011-2012, 54.4% of Connecticut children across health care need status had a medical home. Generally, a greater proportion of children from higher-income households had a medical home. Connecticut has a system of care for Children with Special Health Care Needs, the Connecticut Medical Home Initiative. This system provides care coordination and family support services through 47 community-based medical homes (e.g., community health centers, hospital clinics, and pediatric and family practices). There are 5 care coordination network contractors. Technical assistance is provided to 16 additional practices implementing medical homes. In 2011-2012, 49.6% of children with special health care needs had a medical home, compared to 56.3% of children who did not have a special health care need.

### **Domain 5: Adolescent Health**

In this Domain, NPM #10: Percent of adolescents with a preventive services visit in the last year was selected as an overarching measure to track the overall health and wellness of adolescents. The NSCH reported in 2011-2012 that 91.5% of adolescents had a preventive services visit in the last year.

In 2011-2012, 88.2% of youth age 12 to 17 engaged in physical activity that made them sweat or breathe hard for at least 20 minutes on at least one day per week.<sup>12</sup> Thirty-seven percent reported engaging in physical activity 4-6 days per week, followed by 29.1% being physically active for 1-3 days per week, and 22.1% participating in physical activity for at least 20 minutes daily.

In 2012, 57.6% of females 13 to 17 years of age and 20.3% of males completed at least one dose of the human papillomavirus (HPV) vaccine.<sup>13</sup> Approximately four in ten females (43.6%) completed 3 doses of the HPV vaccine, while only 8.5% of males completed 3 doses of the vaccine. In 2012, 93.5% of persons 13 to 17 years of age received at least 2 doses of the varicella vaccine, 89.3% received at least 1 dose of Tdap (tetanus, diphtheria, and acellular pertussis) vaccine, and 88.8% received at least one dose of meningococcal conjugate vaccine. In 2011-2012, 91.5% of adolescents saw a doctor, nurse, or other health care provider for preventive medical services in the past year.<sup>14</sup>

The prevalence of current alcohol use among students in grades 9-12 ranged from 45.3% in 2005 to 41.5% in 2011<sup>15</sup>. This change in current alcohol use among students was not statistically significant. Binge drinking among students also varied over this period, from 27.8% in 2005 to 22.3% in 2011. In 2011, 27.8% of students in grades 9-12 were offered, sold, or given an illegal drug on school property within the past year. In 2011 the most common drugs used by students in grades 9-12 were marijuana, over-the-counter drugs, prescription drugs, and inhalants. From 1997 to 2011 there was a significant decrease (from 44.9% to 39.6%) in the percent of students who used marijuana one or more times during their life. However, the percent of students reporting that they are current

marijuana smokers did not change during the same time frame. From 1997 to 2011, there was a significant linear decrease (from 19.1% to 9.0%) in the percent of students who sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paints or sprays to get high one or more times during their lifetime.

A greater proportion of male students have ever used marijuana, ecstasy, cocaine, methamphetamines, and heroin as compared to female youth. Fully 22% more male students used marijuana than female students. During the 12 months before the survey, a greater proportion of male students (32.3%) than female students (23.3%) were offered, sold, or given an illegal drug on school property.

The percent of high school students who reported ever been bullied on school property ranged from 25.9% of 9<sup>th</sup> grade students to 19.0% of students in 12<sup>th</sup> grade.<sup>16</sup> The percent of high school students who reported ever experiencing bullying on school property ranged from 13.0% of black non-Hispanic students to 23.6% of white non-Hispanic students and 22.4% of Hispanic students. There are two possible data sources to track adolescents who are bullied. The information provided above used the Connecticut School Health Survey. The other data source is the FAD National School Health Survey which was used for the NPM #9: Percent of adolescents, ages 12-17 years, who are bullied. **Please note that we are limited to selecting 8 of the 15 NPM's, this measure will be included as a State Performance Measure (SPM) in year 2.**

The prevalence of physical dating violence among students in grades 9-12 has decreased significantly from 2005 to 2011, from 16.0% to 8.2%.<sup>17</sup> From 2007 to 2011, a significant linear decrease (from 9.7% to 7.3%) occurred in the percent of students who were ever physically forced to have sexual intercourse when they did not want to.

In 2011, 16.7% of students in grades 9-12 reported that they experienced verbal or emotional abuse from a boyfriend or girlfriend. Fully 8.2% reported an experience of physical abuse from a boyfriend or girlfriend and 7.3% were ever forced to have sexual intercourse. In 2011, the prevalence of students in grades 9-12 who reported ever being verbally or emotionally abused by their boyfriend or girlfriend was significantly higher among female (20.7%) than among male (12.7%) students. In 2011, compared to their male counterparts (4.4%), a greater proportion of female students (10.2%) reported ever being physically forced to have sexual intercourse. Hispanic students were more likely to report ever being forced to have sexual intercourse than white non-Hispanic students.

Compared to persons who reported sexual contact with persons of the opposite sex only, a significantly higher proportion of students who had sexual contact with both males and females reported being in a physical fight, experiencing dating violence, or being forced to have sexual intercourse. A significantly larger percent of students who had sexual contact only with the same sex reported experiencing dating violence relative to persons who only had sexual contact with the opposite sex.

From 2005 to 2009, the proportion of students who reported that they attempted suicide was similar for males and females. However, in 2011, female students (8.2%) were more likely than male students (5.2%) to report having attempted suicide one or more times in the past year.<sup>18</sup> In 2011, 14.6% of students in grades 9-12 seriously considered attempting

suicide during the 12 months preceding the survey. In 2011, 17.3% of female students reported that they seriously considered suicide relative to 11.9% of male students.

Over the 2006 to 2010 period, combined, there were 8.4 deaths due to suicide per 100,000 Connecticut residents.<sup>19</sup> The suicide rate was highest for persons 45 to 54 years of age (13.6 deaths per 100,000 population), followed by those 55 to 64 years of age (11.7 deaths per 100,000 population) and 35 to 44 years of age (10.8 deaths per 100,000 population). The rate of suicide deaths among youth age 15 to 19 years ranged from 9.4 per 100,000 population in 2001 to 4.4 per 100,000 population in 2010.

### **Domain 6: Cross-Cutting or Life Course**

In this Domain, the first of 2 NPM's that was selected is NPM #13a: Percent of women who has a dental visit during pregnancy. FAD was not available for this measure and therefore, data from a point-in-time Pregnancy Risk Assessment and Monitoring System (PRAMS)-like survey was used as the data source for this measure. According to the 2010-2011 Pregnancy Risk Assessment Tracking System (PRATS), 50.9% of women reported having their teeth cleaned by a dentist or dental hygienist during pregnancy.

In 2008-2010, combined, almost one-fifth (19.9%) of children 5 to 12 years of age in Connecticut were obese.<sup>20</sup> In 2008-2010, combined, a greater proportion of children from low-income households (<\$25,000 household income) were obese (38.4%) relative to Connecticut's total population of children 5 to 12 years of age (19.9%). In 2011, 16.5% of male students and 8.4% of female students were obese. The prevalence of obesity among students in grades 9-12 in 2011 was significantly higher among male (16.5%) than among female (8.4%) students. A significantly greater proportion of male (16.5%) students were overweight as compared to female (11.7%) students in 2011.

A significantly greater proportion of Hispanic students in grades 9-12 (15.2%) were obese in 2011 relative to white non-Hispanic students (9.8%). The proportion of overweight black non-Hispanic students (19.9%) was significantly greater than that for white non-Hispanic students (12.3%) in 2011. There were no statistical differences in overweight between Hispanic and white non-Hispanic students in 2011.

The proportion of students with dental decay varied by grade level, with 19.0% of children in Head Start, 29.0% of kindergarten students, and 40.0% of third-grade students having dental decay.<sup>21</sup> Untreated decay ranged from 10.0% for children in Head Start to 13.0% for kindergarten children, and 12.0% for third-grade students.

In 2010 and 2011, combined, it appeared that a greater proportion of black non-Hispanic (50.0%) and Hispanic (50.0%) elementary school students (kindergarten and 3<sup>rd</sup> grade) experienced dental decay relative to white non-Hispanic students (33.0%). Untreated dental decay ranged from 18.0% among black non-Hispanic elementary students and 15.0% among Hispanic students to 9.0% for white non-Hispanic students. In 2010 and 2011, 43.0% of third grade children in Connecticut had received protective sealants on at least one molar.



In 2011-2012, 68.6% of children up to age 5, and 94.1% of youth 6 to 11 years of age received preventive dental care or cleanings in the past year.<sup>22</sup> In 2011, 81.2% of students in grades 9-12 saw a dentist for a check-up, exam, teeth cleaning, or other dental work during the past 12 months. In 2011, use of dental services among students in grades 9-12 varied by race and ethnicity. Fully 87.1% of white non-Hispanic students in grades 9-12 saw a dentist in the past year, compared to 64.8% of black non-Hispanic students and 71.4% of Hispanic students. The second measure selected in this domain is NPM #13b: Percent of infants and children, ages 1 to 6 years, who had a preventive dental visit in the past year. The NSCH reported in 2011-2012 that 86.3% of infants and children in this age group had a preventive dental visit in the last year.

In 2009 there was a significant increase in the percent of children with Medicaid coverage who received any dental care, preventative dental care, or dental treatment, relative to 2008.<sup>23</sup> This increase coincided with Connecticut's improved dental services reimbursement for children with Medicaid or SCHIP. The proportion of children under 3 who had Medicaid coverage and received any dental care, preventative dental care, or dental treatment in 2010 and 2011 was also significantly higher than that in 2008.

In 2011, use of any type of dental care among children under 3 with Medicaid or primary care case management ranged from 49.1% in Hartford to 55.3% in New Haven.<sup>24</sup> Use of preventive dental care appeared to be highest among children under 3 in New Haven (52.6%) compared to the towns of Bridgeport (45.6%) and Hartford (44.2%). Use of any type of dental care or preventive dental care among children under 3 with Medicaid or primary care case management appeared to be highest for Hispanic children, followed by black non-Hispanic children and white non-Hispanic children.

In 2011-2012, 76.8% of Connecticut children had health insurance coverage that was adequate to meet their needs.<sup>25</sup> Adequate health insurance coverage ranged from 82.1% among children in households with incomes below the federal poverty level (FPL), to 70.0% for children in households that have incomes 200-399% of the FPL.

## **b. Title V Program Capacity (Not Required)**

## **c. Partnerships, Collaboration, and Coordination**

### Family/consumer partnerships and leadership programs

The CT Title V Children and Youth with Special Health Care Needs Program supports family and consumers through the CT Medical Home Initiative. The Connecticut Family Support Network (CTFSN) provides regional and specialty coordinators who work one-to-one with families and link them to information to help them access supports and services and learn to advocate effectively for their own needs and the needs of their children. The CTFSN offers parent support groups, local and statewide email distribution lists, networking opportunities with other families, parent training and educational workshops, state agency referrals and eligibility information, telephone support, Individual Family Service Plans and

Individual Education Plans preparation assistance and help with advocating for local programs/services.

CTFSN's broad statewide membership serves a valuable role and potential catalyst to change. One of the most effective tools the CTFSN offers is a workshop called "Meeting Halfway: Positive Communication with Families". This training is designed for professionals who work directly with parents and caregivers, and offers effective ways to engage empower and inform them. The training is conducted by parents who have experience receiving services for their children and allows trainees the rare opportunity to ask difficult questions about challenging situations that can arise. "Meeting Halfway" aims to assist professionals in their ability to understand a parent's perspective, actively listen and build a quality parent/professional partnership.

The CTFSN has a data base of "Mentor" parents, and is launching a referral system to get more parents connected to a mentor parent. The CTFSN is developing and providing a training module for supporting "Mentor" parents with a process for and communication techniques associated with their role.

The CTFSN is experiencing a rapid pace of growth within the Parent Faculty Program. As outreach to families has increased, a new group of parent leaders has begun to emerge. The CTFSN staff identifies these emerging leaders and invites them to join the Parent Faculty Program in a unique way. The Parent Faculty Program puts parents of children with disabilities and special healthcare needs at the table (boards, committees, agency advisory councils, etc.) where people are discussing, developing and planning programs that serve children with special needs - bringing the parent voice to the table. This includes diverse parents from varied rural and urban communities, across cultures, socioeconomic levels and languages.

The CTFSN considers Parent Faculty members to be adjunct staff who also assist with training and other outreach activities. Parent Faculty members are paid stipends for their time, travel and childcare. These opportunities provide flexible, meaningful employment that capitalizes on parents' expertise earned in care giving. These provide opportunities to develop leadership among parents of children with disabilities in all communities.

The Medical Home Advisory Council (MHAC) was established to provide guidance and advice to the CT Department of Public Health in its efforts to improve the community-based system of care for children and youth with special health care needs (CYSHCN) by ensuring their connection to a medical home that is accessible, compassionate, comprehensive, coordinated, continuous, culturally effective and family-centered. The MHAC's membership includes representation from parents (families/caregivers) of CYSHCN, partners in the Connecticut Medical Home Initiative, service providers, community-based organizations, and public and private agencies.

The CT Department of Public Health Medical Home Advisory Council has a Family Experience workgroup who provides consistent support for bimonthly meetings and offer a gateway to additional family voices through the facilitation of focus groups on behalf of the consumer input section of the MCHBG. Parents representing different organizations are at the table including AFCAMP, the African Caribbean American family organization whose

mission is to educate, empower and engage parents and community providers to improve the quality of life for children with special needs and others at risk of education inequity or system involvement. AFCAMP provides training, support, and access to resources including; Understanding Special Education Training, Parent Leadership Training, Information on Disability Laws, monthly "Straight Talk" Parent Support Groups, referrals to community resources, Pupil Planning Team technical assistance and support at meetings when possible, training for families and professionals, Access CT Health Assister Site for health insurance enrollment and advocacy for reforms in child-serving systems. AFCAMP has a history of successful collaboration with schools, government agencies, private providers and community stakeholders to ensure that families get the services they need. As a parent voice for systems change, AFCAMP encourages, trains and supports parents to become leaders and active participants in service system reforms

The Guide by Your Side (GBYS) Program, supported through CT DPH Early Hearing Detection and Intervention funding, offers support to families who infant is deaf or Hard of Hearing without a bias around communication modes or methodology. GBYS training was provided over a two day time period for Parent Guides and the CGYS Program Coordinator. All stakeholders were invited including DPH staff, Birth to Three staff, Deaf and Hard of Hearing specialty programs and CT Hands & Voices Board members. The GBYS is the newest service available from CT Hands & Voices a parent-driven, non-profit organization providing families with the resources, networks, and information to improve communication access and educational outcomes for their children. CT Hands & Voices provides outreach activities, parent/professional collaboration, and advocacy to assist in empowering children who are Deaf and Hard of Hearing to reach their highest potential.

PATH (parents Available to Help) Parent to Parent/Family Voices of Connecticut (PATH/FVCT) is also supported through the CT DPH funding and represents a network of families providing informational and emotional support to others who have a child with developmental or health related needs. PATH/FVCT reaches out to help strengthen families coping with similar situations in Connecticut, and the organizations that serve them to reduce isolation, empower families as advocates for their children and reaffirm their values as parents and caregivers.

PATH/FVCT offers services to families of children with special health care needs including information and assistance about applying for state services and supports programs including Birth to Three, Section 8 housing, insurance coverage, and transition to adulthood. PATH/FVCT offer training on cultural and linguistic competence for helping both professionals and parents learn the values and principles of cultural and linguistic competence. ASD training covers considering culture in Autism Screening and promoting the early identification of ASD across culturally and linguistically diverse populations. Early Signs of Autism and the *"Top 10 things every child with Autism would like you to know"* (video).

Through their federally funded Family to Family Health Information Center, PATH/FVCT provides help navigating all aspects of healthcare. They help families to increase understanding and utilization of appropriate health resources for their children and youth with special health care needs. PATH/FVCT expands the mechanism through which families are receiving health resources and information by disseminating information and providing education and training for families and the professionals that serve them. They build the

leadership of families of CYSHCN and their capacity to improve health policies and practices in CT by providing training, advocacy and opportunities through which they can serve and not only offer their expertise as parents but also expand their knowledge and become better advocates for their children.

CT Title V staff serve on the CT Council on Developmental Disabilities, which works to improve life for CT citizens through policy and service improvement regarding such issues as housing, access to health care, transportation, emergency planning for individuals with special needs, employment, and family/self-advocacy training.

CT DPH works closely with the CT Autism Action Coalition (CAAC) a group of family organizations, families and community and state agency providers who provide one unified voice to support CT in the development and improvement of service access and quality for all individuals who are affected by Autism Spectrum Disorders. CAAC hosts Autism Awareness Day at the capitol where this April more than 150 autism awareness advocates converged on the Connecticut Capitol to raise awareness for autism programs and rally for funding.

## II.C. STATE SELECTED PRIORITIES

The table below lists the State Selected Priorities. These priorities were identified through examination of needs assessment findings, as well as discussion and rating and ranking methodology with both internal and external MCH stakeholders. The priorities were narrowed from a larger list of 36 emerging priority areas. The rating and ranking tool asked participants to consider the following selection criteria:

<b>Selection Criteria</b>			
<b>RELEVANCE</b> <i>How Important Is It?</i>	<b>APPROPRIATENESS</b> <i>Should We Do It?</i>	<b>IMPACT</b> <i>What Will We Get Out of It?</i>	<b>FEASIBILITY</b> <i>Can We do It?</i>
<ul style="list-style-type: none"> <li>- Burden (magnitude and severity ; economic cost; urgency) of the problem</li> <li>- Community concern</li> <li>- Focus on equity and accessibility</li> </ul>	<ul style="list-style-type: none"> <li>- Ethical and moral issues</li> <li>- Human rights issues</li> <li>- Legal aspects</li> <li>- Political and social acceptability</li> <li>- Public attitudes and values</li> </ul>	<ul style="list-style-type: none"> <li>- Effectiveness</li> <li>- Coverage</li> <li>- Builds on or enhances current work</li> <li>- Can move the needle and demonstrate measureable outcomes</li> <li>- Proven strategies to address multiple wins</li> </ul>	<ul style="list-style-type: none"> <li>- Community capacity</li> <li>- Technical capacity</li> <li>- Economic capacity</li> <li>- Political capacity/will</li> <li>- Socio-cultural aspects</li> <li>- Ethical aspects</li> <li>- Can identify easy short-term wins</li> </ul>

Following the process of rating and ranking, an exercise that included both internal and external stakeholders, priority areas that receive the highest overall rating; 17 priorities, were compared against additional crosswalk prioritization measures by internal CPH MCH staff. This internal prioritization crosswalk looked at the following areas:

- Data – Do we have data to support and measure ongoing efforts for this area?
- Existing Programs – were there programs already existing in the State that were presently addressing this issue?
- Capacity – does the Department have the capacity and support to do work in this area?
- SHIP Priority – has the priority area already been identified through our State Health Improvement Plan?
- Plan to Improve Birth Outcomes Coalition – A statewide initiative to examine birth outcomes; we took into consideration those priorities that were identified through this broad cross-sector group

When examining the 36 emerging priority areas against these selection criteria and crosswalk measures, we were able to rate and rank the priorities to establish the 7-10 highest priority needs for the State, that were also the best positioned for successful implementation.

Domain	State Selected Priorities
<b>Women’s and Maternal Health</b>	1. Well woman care/health of women of reproductive age
<b>Perinatal and Infant’s Health</b>	2. Preterm births and low birth weight births 3. Breastfeeding
<b>Child Health</b>	4. Developmental screening, well-child visits and immunizations
<b>Children with Special Health Care Needs</b>	5. Transition to Adult Health Care 6. Medical home
<b>Adolescent Health</b>	7. Bullying 8. Adolescent Wellness
<b>Cross-Cutting or Life Course Issues</b>	9. Oral health

## II.D. LINKAGE OF STATE SELECTED PRIORITIES WITH NATIONAL PERFORMANCE AND OUTCOME MEASURES

Based on the identified state priorities, 9 national performance measures have been selected to address over the five-year Title V program period.

Domain	State Selected Priorities	National Performance Measure	Rationale for Selection
<b>Women's and Maternal Health</b>	1. Well woman care/health of women of reproductive age	Well-woman visit (Percent of women with a past year preventive medical visit)	N/A
<b>Perinatal and Infant's Health</b>	2. Preterm births and low birth weight births	Perinatal regionalization (percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU))	N/A
	3. Breastfeeding	Breastfeeding (A. Percent of infants who are ever breastfed and B. Percent of infants breastfed exclusively through 6 months)	N/A
<b>Child Health</b>	4. Developmental screening, well-child visits and immunizations	Developmental screening (Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool)	N/A
<b>Children with Special Health Care Needs</b>	5. Transition to Adult Health Care	Transition (Percent of adolescents with and without special health care needs who receive services necessary to make transitions to adult health care)	N/A
	6. Medical home	Medical home (Percent of children with and without special health care needs having a medical home)	N/A
<b>Adolescent Health</b>	7. Bullying	Bullying (Percent of adolescents, 12 through 17, who are bullied or who bully others)	N/A
	8. Adolescent Wellness	Adolescent well-visit (Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year)	N/A
<b>Cross-Cutting or Life Course Issues</b>	9. Oral health	Oral health (A. Percent of women who had a dental visit during pregnancy and B. Percent of children, ages 1 through 17, who had a preventive dental visit in the past year)	N/A

## II.E. LINKAGE OF STATE SELECTED PRIORITIES WITH STATE PERFORMANCE AND OUTCOME MEASURES

To be reported in Year 2.

## **II.F. FIVE-YEAR STATE ACTION PLAN**

### **1. State Action Plan and Strategies by MCH Population Domain**

#### **Women/Maternal Health**

The CT Title V Women's Health programs recognize the importance of supporting women's health through screening, early identification, prevention and education across the lifespan. The Department also recognizes that health disparities currently exist in our state. Title V funding is utilized to serve the most vulnerable of women.

The Family Planning Program is administered by Planned Parenthood of Southern New England (PPSNE) and is funded with State and Title V funds. The program provides services in those areas of Connecticut with high a concentration of low-income women of "reproductive age," and with high rates of teen pregnancy. The sliding-fee scale services provided included pregnancy testing, counseling visits, and referrals for prenatal care, contraceptive service visits, breast and cervical cancer screenings, STD and HIV screenings, and other medical services visits as appropriate. Free services to those who qualify, and offer a sliding fee scale. The reproductive health care services provided are in accordance with nationally recognized standards of care and include: include clinic services, breast and cervical cancer screenings, STD testing, including HIV, outreach activities, health education programs, pregnancy testing (including free testing when appropriate), distribution of free condoms, referral and follow-up services as needed.

The CT Breast and Cervical Cancer program is funded through the Centers for Disease Control & Prevention. The program provides comprehensive screening to Connecticut women that are medically underserved, uninsured, and low income, all factors that are barriers to healthcare access. The primary objective of the program is to increase the number of women who are screened for breast or cervical cancer and referred for diagnostic testing and treatment.

#### **Annual report:**

The Family Planning Program provided reproductive health services to 49,595 women and men. This includes: 6,809 teens; 49,595 clients at or below 250% of the federal poverty level; 23,760 women of color and/or Latinas. Approximately 75 % of those served lacked private health insurance. The program also provided professional training sessions and workshops to over 800 youth-serving professionals as well as education and outreach in at-risk communities.

The Connecticut Breast and Cervical Cancer Early Detection Program enrolled and provided screening services to 5,142 women. Screening services were delivered by eleven contracted providers.

The Genomics Office worked to promote information and increase awareness surrounding the importance of Family Health History collection and utilization by promoting the US Surgeon General's "My Family Health Portrait" tool, as well as patient and provider information sheets on hereditary cancer syndromes such as Hereditary Breast and Ovarian Cancer (HBOC) and Lynch Syndrome.



The Family Planning Program served 7,000 additional people from the previous year. The 12 Family Planning Centers implemented an electronic medical record system at all sites. A tablet-based patient satisfaction survey was created. Tablets are stationed at each sign out counter for patients to complete at the end of every visit. The results are used for quality improvement purposes.

### **Teen birth rates continue to decrease in CT.**

Outreach, marketing and increased awareness have increased requests from youth-serving professionals to conduct reproductive health trainings to trainings and workshops to youth-serving professionals and social services agency staff. Over 800 workshops and trainings were completed last year. Due to improved outreach and education efforts, more women are requesting/receiving long acting contraceptives. 73% of female patients served received a reproductive health exam and were current with PAP screening, as per national AGOG (2009), ACS and USPSTF guidelines. 80% of patients ages 15-24 years received a screening for Chlamydia trachomatis and Gonorrhea. 94% of female patients with a preventive reproductive health exam receive a clinical breast exam. At least 65% of patients receiving a preventive reproductive health exam or sexually transmitted disease screen received an HIV test and referral for care as needed.

### **Challenges that have impeded progress:**

Although the overall Connecticut teen birth rate has been on a steady decline since 1994, statistically significant disparities in teen birth rates have persisted in our state throughout the decade. This is evident particularly among non-Hispanic Black/African American and Hispanic teens between 15-19 years old, as compared to non-Hispanic White/Caucasian teens (Figure 1;  $p < 0.001$ ). In 2008, one in every 13 Hispanic women between 15 and 19 years of age gave birth to a baby (78 per 1,000), a figure over nine times higher than that among non-Hispanic White/Caucasian women (8.5 per 1,000). The teen birth rate among non-Hispanic Black/African American women was over four times higher (41.8 per 1,000).

The City of New Britain has the highest repeat teen pregnancy rate in the state, yet the Family Planning Center is only operational on a part-time basis. Finding and funding a new location has been a challenge, but is expected to be completed by 2017.

The biggest challenge of the Breast and Cervical Cancer program is that undocumented women who screen positive, cannot obtain treatment due to their inability to obtain health insurance due to their residential status.

Breast cancer is the most commonly diagnosed cancer, and second leading cause of cancer death, among Connecticut women. Connecticut has the second highest female breast cancer incidence rate in the nation for women of all ages and the highest rate in women younger than 50 years of age. Together, BRCA1 and BRCA2 mutations account for about 20-25% of hereditary breast cancers and about 5-10% of all breast cancers. In addition, mutations in these genes account for approximately 15% of ovarian cancers. Primary care providers are expected to play an increasing role in the identification and referral of patients at high risk for hereditary cancers. About one in 22 women in primary care may require genetic services for hereditary breast and ovarian cancer, but very few receive these services.

### **Revisions to the program:**

There is an increased focus on dialogue with uninsured women on how to access health insurance.

Plan for the coming year (in response to both the successes and challenges):

Planned Parenthood of Southern New England (PPSNE) staff will seek options to expand and relocate the New Britain, CT PPSNE center to a full-time site.

DPH expects to increase knowledge about breast cancer genomic best practices among primary care providers; increase awareness of hereditary cancers and appropriate genetic services among the public and targeted subpopulations; increase awareness about the importance of family health history among the general public; and increase the proportion of the population enrolled in health plans aligned with evidence-based breast cancer genomic clinical guidelines.

#### **Critical partnerships with other MCHB-supported programs:**

The Family Planning program provided reproductive health education and trainings to the Title V and other State agency staff. Families enrolled in the Maternal, Infant and Early Childhood Program are referred to PPSNE for family planning and counseling on birth spacing. The Personal Responsibility Education Program is conducting a rigorous evaluation of the Teen Talk program, developed by Planned Parenthood of Southern New England. The PREP program contracts with PPSNE to provide Human Sexuality trainings, Evidenced-based Teen Pregnancy, HIV, STD prevention program Facilitator Trainings and Sex Ed for Parent Trainings.

Through new and expanded education, surveillance, and policy strategies, the Title V Genomics Office (DPH-GO) will advance cancer genomic best practices to ultimately reduce the burden of breast and ovarian cancer in Connecticut by targeting women at high risk for inherited forms of the disease, as well as their healthcare providers.

The Breast and Cervical Cancer program plans to further engage participants and providers on obtaining insurance coverage. Breast and cervical cancer screening services will be conducted through an integrated screening program and the program will partner with other chronic disease programs, sister agencies, and non-profit organizations.

#### **Perinatal / Infant Health**

The DPH and the CT Title V Program work with many partners to improve perinatal health outcomes for pregnant women and infants in Connecticut. The perinatal period is defined as “pertaining to the period immediately before (through the period) after birth... Depending on the definition, it starts at the 20<sup>th</sup> to 28<sup>th</sup> week of gestation and ends 1 to 4 weeks after birth.” (<http://www.medicinenet.com> )

During the prenatal period, strategies for well-woman care and decreasing adverse perinatal outcomes include adequate prenatal care, and early entry into prenatal care- preferably in the first trimester, assuring that pregnant and parenting women who qualify receive WIC services and preparation for childbirth, and encouraging the pregnant woman to adopt breastfeeding. Community Health Centers in Connecticut are nonprofit health care practices located in medically underserved areas that provide high quality , primary health care which includes well-woman, prenatal, perinatal care, and well child care and immunizations. The Connecticut Special Supplemental Nutrition Program for Women, Infants and Children (WIC), provides

healthcare referrals, nutrition education, breastfeeding promotion and support and supplemental foods to : Pregnant women through pregnancy and up to 6 weeks after birth or after pregnancy ends, Breastfeeding women up to the infants first birthday, Non-breastfeeding postpartum women up to 6 months after the birth of an infant or after pregnancy ends, Infants up to the first birthday and children up to their 5<sup>th</sup> birthday. Breast feeding services are also provided through hospitals, community-based agencies and maternal and child health programs throughout CT.

An infant is defined as a child in the first year of life and a neonate or newborn infant as a child less than 28 days of age. Reducing preterm and low birth weight births is a state selected priority of the CT Title V Program. One strategy is to support perinatal regionalization by increasing the percent of very low birthweight infants who are born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU). The DPH works closely with the March of Dimes, hospitals, and other partners in support of the 39+ weeks initiative to decrease C-section rates before 39 weeks of gestation. In addition to traditional labor and delivery services at hospitals, CT has seven “Baby Friendly” birthing hospitals located in different areas of the state. Care provided at Neonatal Intensive Care Units seeks to reduce complications and provide optimal care for sick and premature babies. Connecticut has NICUs at several hospitals in Connecticut including Yale-New Haven Children’s Hospital, CT Children’s Medical Center at UCONN Dempsey Hospital in Farmington, St. Francis Hospital and Medical Center in Hartford, Danbury Hospital, Bridgeport Hospital, Stamford Hospital and Greenwich Hospital. CT Title V supports the Newborn Screening Program at the DPH which consists of testing, tracking and treatment. “Connecticut state law mandates that all newborns delivered in Connecticut be screened for selected genetic and metabolic disorders. The aim of the program is to screen all babies born in CT prior to hospital discharge or within the first 4 days of life and the goal is early identification of infants at increased risk for selected metabolic or genetic diseases.”

(<http://www.ct.gov/dph/>)

Additional state priorities include developmental screening, well-child visits and immunizations. Providers and maternal and child health (MCH) programs encourage and facilitate the family’s adherence to the immunization schedules, well-child visits and developmental screening, especially for the infant. The Center for Disease Control and Prevention’s Act Early Learn the Signs program is disseminated widely by consumers and MCH programs in CT, linking user-friendly information about developmental milestones to families with children from birth through age 5. Providers and MCH Programs also integrate the Ages and Stages Screening into their work with families, and CT has a comprehensive Birth to Three Program that assists families in need by strengthening their “capacity to meet developmental and health-related needs of their infants and toddlers who have delays or disabilities”. (<http://www.birthing23.org>) The mission of the CT Immunization Program at the DPH is to “prevent disease, disability and death from vaccine-preventable diseases in infants, children, adolescents and adults through surveillance, case investigation and control, monitoring of immunization levels, provision of vaccine, and professional and public education.” (<http://www.ct.gov/dph/>) Environmental Health programs at the DPH provide information and resources about indoor air pollution, asthma, radon, tobacco, lead and drinking water. Infants are especially at risk for adverse outcomes because their body systems are still developing, toxins have more impact in relation to their body size and as the infant begins to crawl and put things in her mouth she can be exposed to more chemicals and organisms. (<http://www.ct.gov/dph/>)

The DPH participates in CT initiatives or collaboratives that impact perinatal and infant health including the Child Fatality Review Panel (CFRP), Safe Sleep, and Keeping Infants Drug-Free (K.ID). Unsafe sleep conditions are a significant contributor to infant deaths in CT. The DPH is a representative on the CFRP and works collaboratively with the CFRP and other partners to disseminate information, influence policy, regulations, recommendations and practice to reduce infant deaths due to unsafe sleep conditions. Substance use including alcohol and drugs during pregnancy, can be a significant risk factor for adverse birth outcomes, and contribute to substance exposed infants. The Departments of Children and Families, and Mental Health and Addiction Services are the lead agencies for the In-Depth Technical Assistance, Substance Exposed Infants (SEI) / Fetal Alcohol Spectrum Disorders (FASD) Project which will develop an integrated approach to address SEI and FASD. The DPH is part of the Core Team. The Project includes numerous diverse partners from agencies and organizations throughout CT as well as consumers. The Project will develop a coordinated plan to prevent, identify and intervene to mitigate substance exposure among infants.

### **Child Health**

The CT Title V program and our partners recognize the importance of access to a comprehensive health and mental health care system for all children, with a focus on underserved children and health equity. CT Title V works to advance improvements in collaboration with providers, policymakers, consumers and state agencies with an emphasis placed on early screening and intervention.

This past year, CT completed activities identified in the HRSA State Implementation Grant for Improving Services for Children and Youth with Autism Spectrum Disorders and other Developmental Disabilities (SIG/ASD) to improve access to comprehensive, coordinated health and related services. The grant was a collaborative project between DPH – the state’s Title V agency and A.J. Papanikou Center – the state’s University Center for Excellence on Developmental Disabilities (UCEDD). Proposed outcomes of the project included: (1) implementation of the CT State Autism Plan, with activities that strengthen stakeholders awareness of early signs of ASD; knowledge about and access to evidenced-based, individualized and timely screening; diagnostic assessment and interventions implemented by a competent workforce; (2) engage ASD specific family support and training organizations to provide information and education on ASD; (3) work with the AAP, pediatric primary and family care providers, and the CT Medical Home Initiative for CYSHCN (CMHI) providers to expand practices proving family-centered, comprehensive coordinated health care and related services including screening, linkage to diagnosis, and transition to evidence-based interventions.

Title V and SIG/ASD partners disseminated [CT Guidelines for a Clinical Diagnosis of Autism Spectrum Disorders](#), complete with the DSM-5 definitions, to practices in each of the five CMHI network regions. The clinical guidelines were created as part of the CT State ASD Plan. To date, 7,400 hard copies of the Guidelines have been distributed.

Title V staff worked with Dr. Thyde Dumont-Mathieu from the University of Connecticut on the Early Detection Study (EDS), a screening study for detecting Autism in pediatric practices at age 18-24 months using the Modified Checklist for Autism in Toddlers –Revised (M-CHAT- R). The study was completed and published showing the effectiveness of utilizing the M-CHAT-R.

Ann Gionet, DPH Family Advocate, was selected as the Center for Disease Control and Prevention (CDC's) "Learn the Signs. Act Early" Ambassador for Connecticut. The program aims to improve early identification of children with autism and other developmental disabilities and to raise awareness of the importance of screening and early identification through the distribution of materials for parents and professionals working with young children

The CMHI Access database was enhanced to include fields specifically related to developmental screening. Fields include whether the child received a developmental screening, screening results, confirmation of screening results and referrals made. This mandatory data entry gathered information from parents on developmental screening of CYSHCN under the age of four who are currently served by CMHI contractors.

CT and Maine SIG/ASD staff co-hosted a peer-to-peer meeting in Mystic, Connecticut focused on the creation and implementation of a data action plan. Nine states attended the two day event that highlighted the following; strategies for successful use of data to build and evaluate systems, effective methods for collecting useful data for evaluating Combating Autism Act Initiative (CAAI) activities in the state, promote strategic partnerships and collaboration around CAAI evaluation, and drive policy development for children and youth with ASD. Ninety-two percent of the participants strongly agreed or agreed that the information gained was relevant to their professional needs, eighty-three percent said they would be able to apply one or more of the concept's they learned to their work, and eighty percent said it increased their knowledge.

Title V partnered with Child Health and Development Institute (CHDI) and CT Children's Medical Center (CCMC) to conduct ASD training including two new Educating Practices In the Community (EPIC) training modules that build upon the American Academy of Pediatrics (AAP) recommendation of formal screening at 9, 18 and 24 (30) months of age. Seventy-one ASD EPIC presentations have been provided to date.

SIG/ASD partners presented an AAP webinar/teleconference presented as part of the CT Chapter Series, [Beyond Screening: Identifying Autism Spectrum Disorders in Primary Care Practices.](#) The webinar provided a review of the most recent changes to autism screening, diagnosis and treatment including children over the age of three. The program provided guidance on post-diagnosis treatment including quality referrals and effective roles for primary care providers as they provide ongoing support. Seventy providers took part in the webinar/teleconference. The information remains available to providers and may be accessed at <http://ct-aap.org/2014>.

DPH staff will work with the ASD "Physician Champion" to implement ASD screening protocols in CMHI sites statewide and will focus on the importance of detecting and treating developmental delays as early as possible and linking families to appropriate resources. Sarah Schlegel, MD and Jennifer Twachtman-Bassett, M.S. CCC-SLP, will offer one day training sessions on the ASAP (Autism Spectrum Assessment Program) throughout the state. A [Directory of Resources](#) will continue to be updated and distributed to educate CMHI staff about services available through SIG/ASD partners.

SIG/ASD staff will work with grant partners to distribute CT customized (LTSAE) materials through trainings such as: the [SIT for Autism](#) training, which increases knowledge of the characteristics of autism and teaches participants up to five strategies that can be used while

sitting for an individual with autism; and the Parent Advocacy Training, which trains parents, advocates and guardians on advocating for children with ASD. An abbreviated advocacy training series entitled, Parent Advocacy Boot Camp, which is a shortened four session program, will also be available.

A comprehensive service resource guide is being placed on line as part of the CT legislature's study of individuals with ASD. The guide is a user-friendly clearinghouse to facilitate access to services, catalog resources currently available (federal, state, private), catalog qualified professionals/facilities based on Qualified Credentialing Application; and catalog existing training opportunities for parents and professionals. SIG/ASD staff will serve as the liaison for the comprehensive resource guide initiative and the training initiative. SIG/ASD staff and grant partners will work to have CDI identified as the host site for the resource guide.

The CQI plan will continue to be implemented through interviews with primary care providers to identify screening training needs. Trainings will be matched to providers' needs and will address barriers such as; insufficient office time, better screening policies and practices, prolonged wait time for evaluation, language and reading level barriers, and time.

SIG staff is a member of the Federal Workgroup for Autism/developmental Screening and Referral, Diagnosis and Services (SARDS) Expert Workgroup. The Workgroup was assembled to review the policy, program, clinical and data barriers to improving developmental and autism screening in states. CT SIG staff presented an update on the CT model at the SARDS meeting in Washington DC and highlighted efforts to bridge to CT Medical Home Initiative, the replications and expansion to successful models including the physician champion, academic detailing and distribution of Learn the Signs. Act Early materials.

The Northeast Regional Developmental Screening, Referral and Response Conference, held on May 21 and May 22, 2015 in Hartford, CT, was organized by the [Learn the Signs. Act Early](#). Ambassadors in each participating state, with funding from the Association of Maternal & Child Health Programs (AMCHP), Connecticut Department of Public Health and Rhode Island Department of Health, along with support from our national partners: Health Resources and Services Administration, Association of University Centers on Disabilities and Centers for Disease Control and Prevention.

Each state invited up to fourteen stakeholders committed to early identification, developmental screening, and referral and response activities. Breakout sessions are woven in to the agenda to allow time for state teams to gather and identify two to four strategies and outcomes to enhance their state autism plan. The conference provided a unique opportunity to exchange national and state information on early identification, developmental screening, referral and response strategies and time for state teams to enhance state autism plans. On the link below find conference materials

<http://www.amchp.org/programsandtopics/CYSHCN/projects/spharc/peer-to-peer-exchange/Pages/Northeast-Regional-Conference.aspx/>

The CT State Act Early team identified two action items the first was about data collection and the work necessary to have an individual child profile. The group outlined a multiple step process to identify where data is being integrated within the Office of Early Childhood and then look to places where data can be integrated outside of the agency. The group also identified a process to bring an Act Early team together, greater than the conference attendees, to

coordinate activities related to developmental screening and should include members from health, education, early childhood education and families.

Title V (SIG staff member) was requested to attend the State Interagency Coordinating Council on behalf of the Commissioner. The same staff member was requested to join the Connecticut's Early Childhood Comprehensive Systems (ECCS) planning grant focuses on increasing developmental screening and needed services for young children statewide. The United Way of CT and the CT Office of Early Childhood are bringing stakeholders together to; have more children screened in early care and education settings across the state; increasing early screenings (for children birth to three years old) in child care, health care, and family settings; and get necessary services to the children and families who need them.

The Connecticut Early Hearing Detection and Intervention (EHDI) program aims to optimize language, social, and literacy development specifically for children who are deaf or hard of hearing through various initiatives and activities focused on hearing screening best practices, maintaining and enhancing data systems to understand and inform efforts, and maintaining and building collaborative partnerships. The Connecticut EHDI program (1) oversees hospital newborn hearing screening programs to ensure all infants are screened for hearing loss at birth and that home births are screened; (2) conducts parent and provider outreach and education to facilitate timely audiological follow up for infants who do not pass newborn hearing screening; and (3) ensures infants diagnosed with a hearing loss are referred and enrolled in early intervention (Connecticut Birth to Three) before by 6 months of age, when appropriate. The challenge of babies being lost to follow-up/lost to documentation after failure to pass newborn hearing screening remains a major focus at both the national and state level. Additional education to both parents and providers regarding the importance of seeking follow-up testing by 3 months of age and reporting it to the Department of Public Health continues to be a focus of the Connecticut EHDI program. The program works alongside a multidisciplinary team of stakeholders to implement small change strategies for the successful implementation of quality improvement methodology to improve screening and follow-up rates. Furthermore the EHDI program works with Connecticut's American Academy of Pediatrics EHDI Chapter Champion to: (1) provide one-on-one educational opportunities for pediatric primary care providers regarding the provision of care for children who are deaf or hard-of-hearing and (2) present to pediatric practices to promote communication between the medical home and hearing screening and diagnostic providers. The program subcontracts with Connecticut Hands and Voices, a family support group that includes the Guide By Your Side parent mentor program for parents of children who are deaf or hard-of-hearing. Additional program partners include: members of the Connecticut EHDI Task Force, which works to ensure a coordinated state EHDI system; the Connecticut Birth to Three System in order to ensure infants who are deaf or hard-of-hearing have access to early intervention services; and the University of Connecticut Speech and Hearing Clinic, which recently conducted a mini-grant funded Early Childhood Outreach Training targeting Early Head Start providers with otoacoustic emissions hearing screening equipment. Connecticut continues to improve upon the established EHDI program to reduce the number of infants lost to follow-up after failure to pass newborn hearing screening in an effort to support quality developmental outcomes for infants with hearing loss.

SBHCs are comprehensive primary care facilities located in or on the grounds of schools. They are licensed by DPH as outpatient or hospital satellite clinics. SBHCs assure that students, particularly those that are uninsured and underinsured have access to comprehensive health and preventative services needed to be healthy, in school, and ready to learn. SBHCs help

schools do their job of educating by improving the health and well-being of students and addressing the health issues that interfere with learning. Services are provided free of charge. Parent/guardian permission is required for enrollment. SBHC identify uninsured students/families that might be eligible for state insurance coverage and provide assistance with the enrollment process.

Through a state budget line and MCH Block Grant funds, DPH supports 96 school health service sites in 28 communities statewide. Included in this number is the newly opened SBHC at Newtown Middle School. SBHCs serve students ,Pre K-12, and are located in elementary, middle and high schools as well as in combination schools where two schools are located in one facility (elementary and middle school or middle and high school). Most SBHCs are located within communities identified as experiencing health disparities or in state Department of Education identified Alliance Districts. Eligible students are those that attend the schools in which the SBHC is located. SBHC staff work collaboratively with superintendents, principals, school nurses, student support staff (social workers, psychologist and guidance counselors), teachers, school personnel, and families to identify students at risk, address the service needs of the student and family, and ensure a coordinated approach. SBHC staff also establish and maintain relationships with community based providers/organizations to ensure service coordination and continuity of care.

A number of DPH funded SBHC are participating in activities related to the Comprehensive Asthma Control through Evidence-based Strategies and Public Health-Health Care Collaboration grant which focuses on in providing comprehensive asthma control to students who are disproportionately affected by asthma. Asthma surveillance data reveals that 22,200 students have asthma in CT; and that they miss approximately 60,000 school days per year. The burden of asthma is greatest in children, females, Hispanics, non-Hispanic Blacks and residents of Bridgeport, Hartford, New Haven, Waterbury and Stamford (Burden of Asthma in Connecticut 2012 Surveillance Report). Numerous SBHCs have chosen Asthma as a Results Based Accountability outcome measure for the coming school year.

### **Adolescent Health**

The CT Title V program recognizes the value of providing adolescents with appropriate, comprehensive, timely health care and related services as well as the challenges to both adolescents in respect to access and providers in respect to appropriate prevention and screening. We also recognize the importance of efficacious transition to all aspects of adult life, including health care and related services. In addressing the needs of adolescents, the CT Title V program strategies emphasize supporting Adolescent Wellness (including comprehensive well child visits) and process improvement for the transition to adult life – inclusive of the identification of primary care providers for Youth with Special Health Care Needs. Previous emphasis was placed on the transition of CYSHCN to adult services – with successes and lessons learned now expanded to services for all youth.

DPH supports 96 school health service sites in 28 communities statewide through a state budget line item as well as MCHB funds. Included are 85 School Based Health Centers (SBHC) and 11 Expanded School Health (ESH) sites. Included in this number is the newly opened SBHC at Newtown Middle School. SBHCs serve students, Pre K-12, and are located in elementary, middle and high schools as well as in combination schools where two schools are located in one facility (elementary and middle school or middle and high school). Eligible students are those



that attend the schools in which the SBHC is located. All DPH funded SBHCs provide primary care, mental/ behavioral health services and health education/promotion activities designed to meet the physical and psycho-social needs of children and youth within the context of family, culture and environment. In some instances, dental care is also offered. ESH sites offer some level of behavioral/mental health services and/or risk reduction education. Care is delivered in accordance with nationally recognized medical/mental health and cultural and linguistically appropriate standards. The school based health service sites serve as the principal vehicle for promotion and improvement of adolescent health services with more than 20,000 students receiving one or more service visit per year. Services include, but are not limited to: anticipatory guidance, health assessments, including comprehensive physical exams, health screenings and risk appraisals, individual and group health counseling, diagnosis and treatment of acute illness and injury, management and monitoring of chronic diseases including, but not limited to asthma, obesity and diabetes, administering immunizations, providing age appropriate reproductive health care as appropriate, laboratory testing and prescribing and administering medications, follow-up and referral to community based health providers or medical home for needed services outside the scope of SBHC practice. Mental/behavioral health services include, but are not limited to: assessment, diagnosis and treatment of psychological, social and emotional problems, crisis intervention, individual/group/family counseling, psycho social education, advocacy and case management, outreach to students at risk and referral to community based providers/organizations to address needs outside the scope of SBHC practice.

CT Title V partners with multiple stakeholders to improve the system of services. Title V staff serve as the Co-Chair of the legislatively led School Based Health Center Strategic Action Group, developing opportunities to refine the existing system as well as opportunities for expansion.

In 2011, the Legislative Program Review and Investigations Committee, a bi-partisan legislative committee tasked with determining whether state programs and policies are effective, continue to serve their intended purposes, are carried out efficiently and effectively, or require modification or elimination conducted an adolescent health study that focused heavily on the SBHCs. Study results and recommendations for the future included adding performance measures to SBHC contracts and requiring a site specific Results-Based Accountability (RBA) report card for each center based on the newly-developed performance measures and targeted outcomes. Contract terms were updated to include standards for mental health screening, BMI monitoring, and that all students with a diagnosis of asthma have an asthma action plan in place. Title V staff provide ongoing technical assistance to individual sites in formulating and populating report cards.

Public Act 13-287 expanded the membership of the school-based health center advisory committee and added to its responsibilities. It requires the committee to advise the Department of Public Health (DPH) Commissioner on matters relating to (1) minimum standards for providing services in SBHCs to ensure that high quality health care services are provided and (2) statutory and regulatory changes to improve health care through access to SBHCs. Title V staff facilitate the advisory. Language and recommendations developed by the advisory were adopted into state statute Public Act 15-59 which established a formal definition for both SBHCs and ESHs, and accommodates the establishment of minimum standards. A list of minimum standards for all SBHCs in CT was also developed by the Advisory and initial plans for adoption into a regulatory structure are underway.

Title V staff participate in both the National School Health Alliance Policy Collaborative and School Health National Quality Initiative – focusing on state policy improvement and the development of national performance measures for SBHCs. In addition, two DPH funded SBHC contractors are engaged in a multi-state partnership with the National Committee for Quality Assurance (NCQA) to formulate and test an alternative model for patient-centered school based health care that will build on the strengths of SBHCs, demonstrate performance improvements in patient care, explore reformed payment models for SBHCs, and advocate among state agencies and policymakers to adopt this new care model as a healthcare innovation.

Adolescent wellness is promoted through additional venues and programs, to include FQHCs. A DPH SBHC staff is the designated State Adolescent Health Coordinator who is a member of the National Network of State Adolescent Health Coordinators (NNSAHC), participates in community of practice calls focusing on different aspects of adolescent health and shares information on best practices, resources and educational opportunities with other state programs within and outside of DPH, SBHC staff, community providers and other interested parties.

Mental health services are a priority within the SBHCs and experienced adolescent health clinical staff who provide medical, mental/behavioral health services are employed. One focus is suicide prevention among adolescents and Title V staff regularly participate in Connecticut Suicide Advisory Board (CT-SAB) meetings. Title V distributes *1 Word 1 Voice 1 Life* suicide prevention awareness campaign materials (developed by the CT-SAB) throughout all programs. Title V participated in the development of the recently released State Suicide Prevention Plan. Title V is collaborating with the president of a local suicide prevention foundation to facilitate the piloting of *Fresh Check Day*, a suicide prevention and mental health promotion event for high school students and plans are in place to expand to other high schools utilizing our partners within the SBHCs. Title V staff provide *Question, Persuade, Refer* suicide prevention training to partners working with adolescents including high schools, SBHCs, DCF foster parents, and numerous care coordination and family advocacy partners.

CT Title V is fully committed to fostering a system that provides all youth including youth with special health care needs the services necessary to make successful transitions to all aspects of adult life including adult health care, work and independence. Activities established through statewide implementation of the HRSA State Implementation Grant for Integrated Community Systems for CYSHCN (“D70” Grant) sustain improved access to quality, family-centered, culturally competent, comprehensive, coordinated, community-based systems of services for successful transition for YSHCN to all aspects of adult life. Many grant initiated activities are incorporated into the Connecticut Medical Home Initiative for CYSHCN (CMHI) system infrastructure. The former “D70” Jumpstart Quality Improvement Project “*Interagency Collaboration on YSHCN Transition Planning Meetings*” is now implemented in each of the CMHI regions. CMHI Care Coordinators in each region work with an individual YSHCN and their family/caregiver to organize and facilitate these meetings. They bring together the critically important individuals in the life of the YSHCN to develop a transition plan. Prior to meeting, a CMHI Care Coordinator meets with the YSHCN and their family/caregiver to establish three critical topics to address with the group and develop of list of who to invite. This can include educators, medical providers, state agencies, insurance company case managers, local support services, vocational resources, legal resources, and recreational resources. To the greatest extent possible, the planning meeting is facilitated by the YSHCN and their family/caregiver with coaching from their Care Coordinator. The transition plan is then implemented and revised as

needed, including reconvening the key members of the group if necessary. To ensure sustainability, DPH has incorporated the transition meetings as a deliverable into all five CMHI Care Coordination Regional Contracts and provides leadership guidance so each region can independently plan and facilitate a minimum of four meetings per year. Providers are also encouraged to engage in a similar process for their adolescent patients who do not have special health care needs.

D70 funding provided the opportunity for “Moving Into Adult Health Care Guides” to be created by CT Kids As Self Advocates and distributed statewide. The booklets offer resources to assist young adults with or without disabilities, their parents, and their primary care providers in preparing for the YSHCN’s transfer to adult health care. The booklets are available on the DPH YSHCN webpage: <http://www.ct.gov/dph/cwp/view.asp?a=3138&q=432684&PM=1>, the Connecticut state page of the National Center for Medical Home Implementation, and the Got Transition? National Health Care Transition Center Youth Resources page.

With an increasing focus on transition in CT, it has been realized that it is important to have key staff focusing on this area. Each CMHI region has now designated a Care Coordinator to serve as their transition resource person. With DPH Title V CYSHCN Program staff, these CMHI Care Coordinators participate in numerous statewide Transition Expos to share information on the importance of planning for health/health care transition from adolescence to youth and young adulthood.

CMHI Care Coordinators are consistently unique resources on health/health care transition. They need vast resources to field questions and concerns associated with transition as families generally are not including health/healthcare in their transition planning. This may be due to the main focus on transition from education and not the intricacies of making health care insurance transition, understanding youth healthcare legal rights, probate court proceedings on health care decision-making, setting up medical-legal guidelines when youth/young adults are out of state, what to research in relation to student health services at institutions of higher education, or how to make judgments about employment based on the environment of the job setting and available health insurance benefits. Initial efforts are being made to extend CMHI Care Coordinator expertise to the SBHC staff in each region.

Strategies are being implemented to address challenges to collaboration around adolescent health and transition; and to extend the model and process for YSHCN to other adolescents. One is the improvement of interdisciplinary communication by promoting inclusion of CMHI Care Coordinators in EHR documentation. This allows entries from multiple specialists to be incorporated into Interdisciplinary Transition Care Coordination Plans without the delay of scheduling phone consultations. Identification of medical home/care coordination champions within hospitals and practice - based providers can help secure access to EHR, as these champions recognize the value of a collaborative care coordination model inclusive of transition planning and implementation. This also encourages health care interns and residents to become familiar with the CMHI model and value it early in their careers, and for other providers to extend the use of the model to adolescents who do not have a special health care need.

An encouraging way to address these challenges is being developed by the CMHI program based at CT Children’s Medical Center (CCMC). With the assistance of a transition physician champion, they have been able to establish the CCMC Transition Task Force within the hospital.

They meet regularly and have developed transition guidelines that providers are encouraged to follow for all adolescents.

Title V staff increase the awareness of personal and environmental health issues related to chronic absenteeism, a key focus of the *Ct State Department of Education Interagency Council for Ending the Achievement Gap* (ICEAG) on which staff serve representing the DPH Commissioner. ICEAG provides assistance in developing and implementing the achievement gap master plan and reporting on it to the CT Lieutenant Governor and the Legislature's Education Committee. Title V supports ICEAG through State Health Improvement Plan activities related to reducing health disparities and to protecting and improving health for all CT students so they are healthy and ready to learn – essential for a successful transition to adulthood, and make the CSHCN transition model and resources available to all interested stakeholders.

## **CYSHCN**

The CT Title V CYSHCN program recognizes that CYSHCN and their families often do not receive effective care coordination and are not linked to the resources available in their communities that address their special needs and also allow them to participate fully in public life. Programmatic strategies emphasize promotion of a medical home model of services, expansion of care coordination resources, integration of primary care and behavioral health, integration of care coordination efforts with an ideal of shared coordination across sectors and providers serving CYSHCN, and promotion of Family and Professional Partnership.

CT's coordinated system of care for Children and Youth with Special Health Care Needs and their families, the CT Medical Home Initiative (CMHI) for CYSCHN, provides community-based, culturally competent care coordination and family support services to more than 8,000 CYSHCN in collaboration with 57 community based Medical Homes (MH) including: community health centers, hospital clinics, pediatric and family practices. CMHI care coordination network contractors included: CT Children's Medical Center (North Central CT), St. Mary's Hospital (Northwest), Stamford Health System (Southwest), Family Centered Services (South Central) and United Community and Family Services, (Eastern). CMHI provides technical assistance (TA) to an additional 16 practices implementing a MH model. Care coordination activities include assessment, care planning, home visits, family advocacy, linkage to specialists and community-based resources, coordination of health financing resources, coordination with school-based services, chronic disease management, integration with behavioral health, provider and family education, administration of extended services and respite funds, provider outreach, family support and transition planning.

The DPH Office of Oral Health partners with CMHI, CT Family Support Network (FSN, a Title V partner in providing family to family support and education), and the CT Dental Health Partnership (the Medicaid Administrative Services Organization for dental services) to connect children, including those with special health care needs, to dental homes. CT Dental Health Partnership resources include a dental special needs coordinator. FSN maintains a link on their webpage with dental resources, including the names of dental providers who self-identify as providing services for CYSHCN.

DPH collaborates with United Way of CT 2-1-1/Child Development Infoline (CDI) to coordinate referrals to the CMHI community-based system. CDI/CMHI regional meetings take place to monitor, evaluate and improve referral to the care coordination system of care for CYSHCN. CDI

serves as a statewide access point to CMHI. DPH staff serve on the CDI Steering Committee. DPH provides CMHI networks TA through participation in Collaborative Care Coordination Partnership Meetings, site visits, quarterly TA care coordinators' meetings, and biweekly conference calls. Conference calls include case scenarios shared to ensure access to community-based resources, to improve referrals and access to CMHI, and to address individual issues with collective experience from care coordinators throughout the system.

Child Health and Development Institute (CHDI) and the CT Family Support Network (FSN) provide statewide outreach and culturally effective education encounters to families on the medical home concept for CYSHCN including information regarding accessing community service systems, and self-advocacy.

The DPH Medical Home Advisory Council (MHAC), comprised of more than 40 representatives including youth representation, state and private agencies, community-based organizations, the state's Medicaid Administrative Service Organizations (ASOs) and parents of CYSHCN, provide guidance to DPH and its partners in their efforts to improve the system of care for CYSHCN. The MHAC remains DPH's chief vehicle for collaborating with state/regional/local agencies to organize easily accessible community-based service systems and maximize linkages with professionals and family organizations. Groups collaborate with MHAC and CMHI to develop and organize universally accessible community-based service systems and maximize linkages for their populations.

DPH partners with organizations serving CYSHCN, including legislatively mandated and other councils, e.g. the CT Family Support Council, Medical Assistance Program Oversight Council, Birth to Three State Interagency Coordinating Council, State Department of Education Bureau of Special Education Transition Task Force, Advisory Council to Division of Autism Spectrum Services, A.J. Pappanikou UCEDD Consumer Advisory Board, CT Developmental Disabilities Council, and SCD Consortium. CMHI access information is distributed among these partners.

DPH and CMHI actively partner with DSS and the state's medical Administrative Services Organization for Medicaid, Community Health Network (CHN) in developing an emerging networked, linked, accessible approach to care coordination for families covered by Medicaid. Informational meetings with regional staff are held and monthly conference calls between CMHI and CHN care coordinators and case managers are in place as a forum for ongoing system analysis and case reviews.

DSS, the state's Medicaid agency, implements a Person Centered Medical Home (PCMH) initiative in which practices and clinics that demonstrate a higher standard of person-centered primary care service delivery qualify for a higher reimbursement. CMHI care coordinators provide support with the most complex CYSHCN for practices on a "Glide Path" option and provide technical assistance to all providers regarding care coordination for complex CYSHCN.

Title V staff facilitate an online CT Medical Home for CYSHCN Training Academy Curriculum (CMHTAC); this training is available to two cohorts of participants per year, is revised annually based on feedback from participants, and has been utilized by partners from across the service array including providers, care coordinators, case managers, FQHC staff, School Based Health Center staff, community based organizations, and family advocates.

DPH Title V staff participate in statewide initiatives to integrate and improve access to behavioral health and primary care. One initiative, Public Act 13-178, directs the Department of

Children and Families (DCF) to develop a comprehensive and integrated children's plan that meets the behavioral health needs of all children in the state and to prevent or reduce the long-term negative impact for children of mental, emotional, and behavioral health issues. DPH Title V staff participated in plan development and serve on the Implementation Advisory Board.

Another DCF initiative, the Connecticut Network of Care Transformation (CONNECT) efforts to expand the network of care in CT to a statewide and regionalized infrastructure that integrates across child-serving sectors, including early childhood, child welfare, mental health, juvenile justice, substance abuse, and education. DPH's contract partner for Family Professional Partnerships, the Child Health and Development Institute (CHDI), serves as the CONNECT Coordinating Center, and works toward implementation of a full network of care expansion driven by youth and families that is feasible, supported, and sustainable. DPH staff participate and are working to include integration of primary care with behavioral health as a consideration.

Title V staff also serve on the State Level Transition Team for CT STRONG (Seamless Transition and Recovery Opportunities through Network Growth) Healthy Transitions Initiative which engages and connects transition age youth and young adults to high quality behavioral health care. The youth served must reside in New London, Milford or Middletown and be at risk for, or have behavioral health disorders. This grant was awarded through a competitive application process to the CT Department of Mental Health and Addiction Services (DMHAS), in partnership with DCF, by the federal Substance Abuse and Mental Health Services Administration (SAMHSA)/Center for Mental Health Services (CMHS). This initiative utilizes innovative approaches to improve rates of service engagement, and outcomes with regard to housing stability; including social marketing and public education approaches such as media campaigns to inform people about mental illness, reduce stigma and discrimination and provide connections to services.

Title V staff serve as the Young Child Wellness Partner for the Elm City Project LAUNCH (Linking Action for Unmet Needs in Children's Health- a SAMHSA funded initiative) in collaboration with DCF, Wheeler Clinic, Yale University, and Clifford Beers Clinic. LAUNCH Elm City's goal is to promote the wellness of young children from birth to 8 years of age, in the Dwight Neighborhood of New Haven, Connecticut, by addressing the physical, social, emotional, cognitive, and behavioral aspects of their development. A major objective of this grant is to strengthen and enhance the partnership between physical health and mental health systems at the federal, state, and local levels. Connecticut's Elm City Project LAUNCH uses a public health approach to promote children's health and wellness with efforts that promote prevention, early identification, and intervention and will be used for replication in other communities.

The CT Title V program for Children and Youth with Special Health Care needs has been involved with the Hartford Care Coordination Collaborative (HCCC) since its inception. HCCC and its partners are vital in maintaining and sharing information, resources and services that are available to families and disseminating that information to families and providers. HCCC meetings focus on expanding knowledge of available services; reducing barriers to resource coordination, interagency communication, and in securing appropriate services in a timely manner. Family-specific interagency approaches are developed to promote accessibility across programs. Members from across the spectrum participate to include medical and behavioral care providers, state and private agencies, medical/legal advocates, Healthcare for Uninsured Kids and Youth (HUSKY), CMHI care coordinators, information/referral coordinators. HCCC has

been a valuable and effective vehicle in a reduction in duplication of services, ACA implementation, and MCH National Performance Measure progress – including MCH Block Grant transformation. The forum has served as an emerging front runner in the development of true shared care coordination and is being used as a model for replication in the other state regions. Care Coordination Collaborative key strategies include:

1. Support for and dissemination of the Care Coordination Collaborative model developed in Hartford to other CYSHCN care coordination regional programs (emerging in all state regions).
2. Integration of Medicaid's PCMH program into the statewide system of care coordination for CYSHCN at the practice, regional and state levels.
3. Expansion of data capabilities and a single point of entry, shared resource – currently the Child Development Infoline database serves in this capacity.

Collaborative outcomes experienced to date include: improved linkage to services for CYSHCN and other vulnerable children; strengthening implementation of PCMH by expanding care coordination capacity of primary care practices that serve CYSHCN, reduction in duplication and increased efficiency of care coordination services; increased cross-sector knowledge of resources for CYSHCN; increased capacity to perform care coordination across more than one sector; increased number of partners engaged in or connected to regional collaboratives; increased funding for care coordination through a blending of public and private resources; and increased family and provider satisfaction with care coordination. CT Children's Medical Center serves as a technical assistance center, providing expertise to other emerging collaboratives in working with medical homes and in establishing evaluation criteria. Funding recently made available through a HRSA D70 integrated services grant will be utilized to fully implement care coordination collaboratives throughout the state, establish an improved shared care coordination resource, and support development of pediatric metrics within the State Innovation Model (SIM).

### **Cross-Cutting or Life Course – Oral health specific**

#### **Plan for Coming Year**

The DPH Office of Oral Health (OOH) and its partners recognize the integral role of maintaining oral health across the lifespan, beginning before a child is born and continuing until the end of life. Poor oral health impacts overall health and well-being, children's ability to learn, grow and thrive, self-esteem, employability and overall quality of life. The "Life Course Theory" conceptual framework points to broad social, economic and environmental factors as underlying causes of inequalities in health, oral health being no exception. The OOH works to advance improvements in oral health by addressing both the risk and protective factors which contribute to reducing oral disease across the lifespan, with an emphasis on the most vulnerable populations.

The two most prevalent oral diseases, dental caries (cavities) and periodontal (gum) disease are chronic, communicable, bacterial infectious diseases that are almost entirely preventable and manageable if detected in the early stages of the disease. Dental caries is the most common, chronic disease in children, five times more common than asthma and seven times more common than hay fever. While these diseases are present across the population, disparities exist in individuals with low-socio economic status and in racial and ethnic minorities.

The OOH convenes the CT Coalition for Oral Health (CTCOH), which consists of representation from diverse dental and non-dental agencies and organizations with a keen interest in addressing the oral health and overall health of all CT residents across the lifespan. The CTCOH workgroups focus their efforts on implementing key strategies included in the State Oral Health Improvement Plan. Six workgroups have been established, focusing on the areas of: Advocacy and Policy, Awareness and Education, Workforce Development, Surveillance, Perinatal and Infant Oral Health and Oral Health for Older Adults.

The Department of Social Services (DSS) has implemented an infant oral health program called the ABC Program (Access for Baby Care to Dental Examinations and Fluoride Varnish). This program is designed specifically for children who may have an increased risk for developing dental decay (caries) and who are covered by the HUSKY Program. Billing codes were added to the Medicaid fee schedule specifically for this program to enable physicians to bill for oral evaluation, counseling and application of fluoride varnish. Training is required before a medical practice can bill for services. Physicians, APRNs, PAs, NPs, RNs, LPNs and medical assistants (LPNs and MAs, under the supervision of a physician) who have received training are allowed to apply fluoride varnish, which can then be billed through the practice. The OOH offers one of the accepted training options, an online training module for medical providers through CT Train. To date, over 700 medical providers have received this training and many have incorporated oral health into their well-child visits.

Oral disease prevention can be achieved through good oral hygiene, maintaining a healthy diet, drinking fluoridated water and visiting a dentist regularly to ensure oral diseases are identified and managed in their earliest stages. Research demonstrates that when parents have preventive dental visits, their children will also visit the dentist more frequently and begin these visits by age one. If a child develops tooth decay at an early age, they are more likely to have a lifetime of pain and suffering from poor oral health. The OOH will continue to work with its partners to increase the awareness of the vital link oral health plays in maintaining health, well-being and quality of life throughout the life span.

### **Annual Report**

A recent initiative the OOH and its partners engaged in included the development of a State Oral Health Improvement Plan, which contains overarching goals to decrease oral health disparities, promote a culturally competent oral health workforce, increase the engagement of health and human service providers in promoting and integrating oral health into their practices and improve the oral health literacy of CT residents. Under these goals, strategies address populations at higher risk for oral disease and its impacts.

The Perinatal and Infant Oral Health Workgroup (PIOHW) is a newly established workgroup for CTCOH, created through the merging of two existing groups focused on perinatal and infant oral health issues in CT. The first group is an oral health workgroup under the DPH Coalition to Improve Birth Outcomes, which recognized the significance of women's oral health as it relates to birth outcomes and the oral health of their children. The second group is the Advisory Committee for a HRSA funded Perinatal and Infant Oral Health Quality Improvement Project (PIOHQI). The CT Dental Health Partnership, the state's dental Medicaid administrative organization, is the recipient of the PIOHQI grant, which focuses on intensive outreach to encourage women to access dental care during their pregnancy. The OOH Director is the Co-



Chair of the PIOHW, which will work collaboratively to promote the importance of early childhood caries prevention and oral health for women during their childbearing years.

The OOH collaborated with the CT State Dental Association, CT ACOG and others in preparing guidelines for dental providers in treating women during pregnancy. These guidelines have been distributed to CT dentists in an effort to dispel any misperceptions about the safety of dental care during pregnancy and stress the importance of ensuring the dental health needs of pregnant women are met.

The OOH Director provided a presentation on the importance of oral health for perinatal women and their families at the Home Visiting Statewide Conference. An educational video produced by the University of Maryland, Healthy Mouths for You and Your Baby, was distributed to all 25 Home Visiting Programs, with the intent that these videos could be played during a home visit and begin the conversation on the importance of oral health for the mother and her children. Additional instructional materials were also distributed and the OOH partnered with the CT Dental Health Partnership to provide oral hygiene supplies and information on dental care coordination. To date, over 100 of these videos have been distributed to MCH programs and plans are to distribute additional copies to Head Start, WIC and other MCH partners.

The OOH worked closely with Title V staff in the preparation of the oral health component of the Pregnancy Risk Assessment Monitoring System (PRAMS). These data will represent the first comprehensive data set to include women’s experience in accessing dental care during their most recent pregnancies, which will inform strategic planning for programs and initiatives for the PIOHW and its members. As a result, oral health will be the first “Data to Action” project for PRAMS.

**Other Programmatic Activities (optional)**

<b>Domain: Women’s and Maternal Health</b>		
<b>State Priority 1: Well woman care/health of women of reproductive age</b>		
<b>Goal 1: All Connecticut women receive timely comprehensive health services.</b>		
<b>Objectives</b>	<b>Strategies</b>	<b>National Performance Measures*</b>
1.1 By 2020, increase by 10% the proportion of all Connecticut women receiving an annual well visit including age appropriate screenings.	1.1.1 Identify and address barriers to access to annual well visits, especially in the uninsured population 1.1.2 Advocate for fewer C-sections among women having a singleton birth. 1.1.3 Advocate for competitive reimbursement rates for annual well visits.	Well-woman visit (Percent of women with a past year preventive medical visit)

<b>Domain: Women’s and Maternal Health</b>		
<b>State Priority 1: Well woman care/health of women of reproductive age</b>		
<b>Goal 1: All Connecticut women receive timely comprehensive health services.</b>		
<b>Objectives</b>	<b>Strategies</b>	<b>National Performance Measures*</b>
1.2 By 2020, increase by 5% the proportion of all Connecticut women receiving an annual dental visit.	1.2.1 Advocate for parity of oral health with physical and behavioral health in practice, policy, and reimbursement. 1.2.2 Identify and address barriers to access to dental services.	

<b>Domain: Perinatal and Infant’s health</b>		
<b>State Priority 2: Preterm births and low birth weight births</b>		
<b>Goal 2: All Connecticut infants achieve optimal birth outcomes.</b>		
<b>Objectives</b>	<b>Strategies</b>	<b>National Performance Measures*</b>
2.1 By 2020, reduce by 5% the proportion of low birth weight among singleton births. 2.2 By 2020, reduce by 1% the proportion of very low birth weight among singleton births. 2.3 By 2020, reduce by 5% the proportion of live singleton births delivered at less than 37 weeks gestation.	2.1.1 Collaborate across sectors to increase social equity (e.g. to increase 4-yr. graduation rate, decrease jobless rate, improve neighborhood safety, etc.) 2.1.2 Improve access to healthcare for women before, during and after pregnancy 2.1.3 Support efforts/programs to improve preconception health (e.g. DPH programs, other statewide....) 2.1.4 Improve/increase enrollment in prenatal care during the 1st trimester and receipt of adequate PNC. 2.1.5 Increase enrollment in WIC during 1st trimester (among WIC eligible women) 2.1.6 Increase co-enrollment in WIC and Medicaid among income-eligible women	Perinatal regionalization (percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU))

<b>Domain: Perinatal and Infant’s health</b>		
<b>State Priority 3: Breastfeeding</b>		
<b>Goal 3: Increase breastfeeding among Connecticut women.</b>		
<b>Objectives</b>	<b>Strategies</b>	<b>National Performance Measures*</b>
3.1 By 2020, increase by 10% the proportion of infants who are ever breastfed.	3.1.1 Increase employee and employer awareness and understanding of their “rights and responsibilities” under State and Federal breast feeding laws. 3.1.2 Provide access to professional and peer support for breastfeeding	Breastfeeding (A. Percent of infants who are ever breastfed and B. Percent of infants breastfed exclusively through 6 months)
3.2 By 2020, increase by 5% the proportion of infants who are breastfed at 6 months.	3.2.1 Provide targeted technical assistance and support to breast feeding friendly work places; schools, hospitals, and medical offices, to ensure compliance with State and Federal workplace lactation accommodation laws. 3.2.2 Provide access to professional and peer support for breastfeeding.	

<b>Domain: Child Health</b>		
<b>State Priority 4: Developmental screening, well-child visits and immunizations</b>		
<b>Goal 4: All Connecticut children receive age appropriate developmental screenings, well-child visits, oral health assessments and ACIP recommended vaccines.</b>		
<b>Objectives</b>	<b>Strategies</b>	<b>National Performance Measures*</b>
4.1 By 2020, increase by 5% the number of developmental screenings conducted by providers with a formal tool.	4.1.1 Advocate for primary care providers to incorporate parental education on developmental milestones 4.1.2 Provide training to primary care providers regarding Developmental Screening, 4.1.3 Communicate benefits of standardized developmental screening tools to parents and providers in primary care settings.	Developmental screening (Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool)
4.2 By 2020, increase by 5% the number of well-child visits and oral health assessments.	4.2.1 Develop and implement an education campaign for parents around patient-centered medical homes (e.g. Text-4-Child and Text-for-Teen). 4.2.2 Explore opportunities to identify cultural barriers to using primary care physicians. 4.2.3 Support school-based health centers, community health centers and other community-based organizations to offer comprehensive health services. 4.2.4 Partner with Access CT to encourage youths under 21 years of age to obtain primary care. 4.2.5 Explore and pursue funding opportunities for “Home by One.” 4.2.6 Provide public education on importance of annual preventive dental services.	

<b>Domain: Child Health</b>		
<b>State Priority 4: Developmental screening, well-child visits and immunizations</b>		
<b>Goal 4: All Connecticut children receive age appropriate developmental screenings, well-child visits, oral health assessments and ACIP recommended vaccines.</b>		
<b>Objectives</b>	<b>Strategies</b>	<b>National Performance Measures*</b>
4.3 By 2020, increase by 5% the number of children that receive age appropriate ACIP recommended vaccines.	4.3.1 Assure costs of vaccines/administration for all ages are covered by all insurers. 4.3.2 Maintain and expand access to Advisory Committee on Immunization Practices (ACIP) recommended vaccines for children (HPV, hepatitis A, rotavirus, influenza, pertussis, pneumonia) 4.3.3 Maintain and enhance CT immunization registry, including across life span; implement comprehensive reminder/recall systems. 4.3.4 Use new and existing data systems to measure vaccine coverage among all populations to identify disparities and target vaccine strategies.	
4.4 By 2020, increase by 1% the number of developmental screenings completed by families.		

<b>Domain: Children with Special Health Care Needs</b>		
<b>State Priority 5: Transition to Adult Health Care</b>		
<b>Goal 5: All CT CSHCN have an optimal transition to adult health care.</b>		
<b>Objectives</b>	<b>Strategies</b>	<b>National Performance Measures*</b>
<p>5.1 By 2020, increase by 5% of the 14-16 year olds, including those with Special Health Care Needs that have a health care transition plan developed.</p> <p>5.2 By 2020, increase by 5% of the 17 year olds, including those with Special Health Care Needs that have an adult primary care provider identified.</p>	<p>5.1.1 Educate medical home providers/staff/care coordinators to ensure that all children, including those with Special Health Care Needs have a transition plan developed by age 14-16.</p> <p>5.1.2 Educate medical home providers/staff/care coordinators to ensure that all children, including those with Special Health Care Needs have an adult primary care provider identified by age 17.</p> <p>5.1.3 Partner with providers, care coordinators, the Department of Education and Community Organizations to support existing and emerging processes to coordinate health care and educational/vocational transition planning for 14-18 year olds including those with Special Health Care Needs.</p>	<p>Transition (Percent of adolescents with and without special health care needs who receive services necessary to make transitions to adult health care)</p>
<p>5.3 By 2020, increase by 5% of the 14-16 year olds, including those with Special Health Care Needs that have an educational/vocational transition plan in place.</p>		

<b>Domain: Children with Special Health Care Needs</b>		
<b>State Priority 6: Medical Home</b>		
<b>Goal 6: All Connecticut children, including those with Special Health Care Needs have access to and participate in a NCQA recognized or Joint Commission Accredited patient-centered medical home.</b>		
<b>Objectives</b>	<b>Strategies</b>	<b>National Performance Measures*</b>
6.1 By 2020, increase by 5% the number of children, including those with Special Health Care Needs who have access to a NCQA recognized or Joint Commission Accredited patient-centered medical home.	6.1.1 Conduct outreach including to the families of CSHCN to educate consumers about the benefits and availability of patient –centered medical homes. 6.1.2 Partner with Community Organizations and stakeholders engaged through the Medical Home Advisory Council to promote the benefits of medical homes to consumers and providers.	Medical home (Percent of children with and without special health care needs having a medical home)
6.2 By 2020, increase by 1% the number of NCQA recognized or Joint Commission Accredited patient-centered medical homes.	6.2.1 Conduct outreach including to the families of CSHCN to educate consumers about the benefits and availability of patient –centered medical homes. 6.2.2 Partner with Community Organizations and stakeholders engaged through the Medical Home Advisory Council to promote the benefits of medical homes to consumers and providers. 6.2.3 Partner with the Department of Social services PCMH program, Community Health Network and others to support providers in pursuing NCQA recognition or Joint Commission Accreditation as patient-centered medical homes.	

<b>Domain: Adolescent Health</b>
<b>State Priority 7: Adolescent Wellness</b>

<b>Goal 7: All Connecticut adolescents achieve optimal wellness.</b>		
<b>Objectives</b>	<b>Strategies</b>	<b>National Performance Measures*</b>
7.1 By 2020, increase by 5% the adolescents receiving well child visits inclusive of behavioral and oral health risk-assessment and anticipatory guidance.	7.1.1 Educate parents on the frequency of and importance of well-child visits 7.1.2 Support school-based health centers that offer comprehensive health services. 7.1.3 Educate/train medical providers and School Based Health Center staff on including behavioral and oral health risk assessments during well child visits. 7.1.4 Partner with students, parents and providers to develop and implement an outreach campaign regarding the importance of a comprehensive adolescent well child visit.	Adolescent well-visit (Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year)
7.2 By 2020, increase by 1% the students that report being physically active at least 60 min/day for more than 5 days, 7 days.	7.2.1 Educate and train school staff (teachers, administrators) on developing and implementing comprehensive school physical activity programs (CSPAP) 7.2.2 Educate district and school administrators and other local stakeholders about creating comprehensive local wellness policies that include creating a healthy school nutrition and physically active environment.	
7.3 By 2020, decrease by 1% the 5-12 yrs. and 9-12th grade students that are overweight ( $\geq$ 85th percentile – 95th percentile)	7.3.1 Educate district and school administrators and other local stakeholders about creating comprehensive local wellness policies that include creating a healthy school nutrition and physically active environment.	
7.4 By 2020, decrease by 1% the students (5-12 yrs. old/9-12th grade) that are obese. ( $\geq$ 95th percentile).	7.4.1 Educate district and school administrators and other local stakeholders about creating comprehensive local wellness policies that include creating a healthy school nutrition and physically active environment.	
7.5 By 2020, increase by 1% the students that report getting an average of 8 or more hours of sleep at night.	7.5.1 Educate students and parents on the importance of adequate sleep on health and academic performance.	



<b>Domain: Adolescent Health</b>		
<b>State Priority 7: Adolescent Wellness</b>		
<b>Goal 7: All Connecticut adolescents achieve optimal wellness.</b>		
<b>Objectives</b>	<b>Strategies</b>	<b>National Performance Measures*</b>
7.6 By 2020, increase by 5% the students that report excellent or very good health.	7.6.1 Educate district and school administrators and other local stakeholders about creating comprehensive local wellness policies that include creating a healthy school nutrition and physically active environment.	

<b>Domain: Cross-Cutting or Life Course Issues</b>		
<b>State Priority 8: Oral health</b>		
<b>Goal 8: Improve oral health of all Connecticut residents.</b>		
<b>Objectives</b>	<b>Strategies</b>	<b>National Performance Measures*</b>
8.1 By 2020, increase by 10% the proportion of CT adults who visited a dentist in the past year.	8.1.1 Increase oral health literacy and promote the value of good oral health as it relates to the overall health and well-being of all CT residents. 8.1.2 Increase care-coordination to oral health provider in the PCMH.	Oral health (A. Percent of women who had a dental visit during pregnancy and B. Percent of children, ages 1 through 17, who had a preventive dental visit in the past year)
8.2 By 2020, Increase by 10% the percentage of children under 3 years of age at greatest risk for oral disease (i.e., in HUSKY A) who receive any dental care.	8.2.1 Maintain oral health education provided to high risk parents through WIC and other MCH programs and initiatives 8.2.2 Maintain care-coordination for children enrolled in HUSKY.	
8.3 By 2020, reduce to 35% the proportion of children in third grade who have dental decay.	8.3.1 Increase oral health literacy and promote the value of good oral health as it relates to the overall health and well-being of all CT residents. 8.3.2 Enhance the concept and utilization of a dental home through enrollment and utilization of HUSKY. 8.3.3 Maintain the State fluoridation statute. 8.3.4 Advocate for parity of oral health with physical health and behavioral (medical) in practice, policy and reimbursement.	
8.4 By 2020, reduce untreated dental decay to 15% in black non-Hispanic children and 12% in Hispanic children in the third grade.	8.4.1 Increase oral health literacy and promote the value of good oral health as it relates to the overall health and well-being of all CT residents.	

<b>Domain: Cross-Cutting or Life Course Issues</b>		
<b>State Priority 8: Oral health</b>		
<b>Goal 8: Improve oral health of all Connecticut residents.</b>		
<b>Objectives</b>	<b>Strategies</b>	<b>National Performance Measures*</b>
8.5 By 2020, reduce by 5% the proportion of adults over 65 who have had all their natural teeth extracted.	8.5.1 Increase oral health literacy and promote the value of good oral health as it relates to the overall health and well-being of all CT residents. 8.5.2 Increase care-coordination to oral health provider in the PCMH. 8.5.3 Maintain the State fluoridation statute. 8.5.4 Advocate for parity of oral health with physical health and behavioral (medical) in practice, policy and reimbursement. 8.5.5 Ensure a strong and sustainable oral health workforce (including medical providers) to anticipate the oral health needs of CT residents.	

Past years Activities, accomplishments, challenges, revisions, and plans for the coming year.  
Title V associated programs

## **2. MCH Workforce Development and Capacity**

The Connecticut Department of Public Health (DPH) developed a Workforce Development Plan which serves as an evolving, five year blueprint for developing employees both professionally and personally, and building capacity to meet the agency's strategic goals and its mission. The Plan identifies competency based training needs and describes how the DPH will manage, deploy, track and evaluate training. It also lays out goals, objectives and initial strategies to begin to address specific workforce priorities such as building subject matter expertise, orienting and mentoring new staff, incorporating succession planning into our work, and improving communication among managers and staff about the current merit system and workforce advancement. The goals, objectives and strategies serve as a work plan that will be updated each year.

The Plan lays out roles and responsibilities for staff at all levels to implement the Plan and institutes use of an annual personal professional development plan as part of the annual review process. The development of onboarding, orientations, and mentoring programs provide support to new employees, and training through formal courses and other low and no cost options such as coaching by subject matter experts, on the job training, cross cutting assignments and volunteer opportunities, provide additional support for learning and development.

Finally, this Plan seeks to build a strong learning culture within the agency that is connected to our agency's quality culture and supportive of both employee development and major agency initiatives such as the quality plan, agency strategic plan, and state health improvement plan.

### **Future workforce**

The public health workforce faces large and unpredictable changes that are challenging but also presents significant opportunity to enhance service capacity and delivery. Participants in DPH's 2014 strategic planning sessions identified numerous external challenges that affect the agency and its workforce including severe fiscal constraints, rapid technology and scientific advances, health system reform, state demographic changes that include an aging and more diverse population, global infectious disease and environmental threats that can affect Connecticut residents, and new national standards for public health department accreditation. Participants identified the agency's workforce as a strategic priority and chose to work on building depth and breadth of subject matter expertise, incorporating succession planning into each section, and providing opportunities for skill enhancement and professional growth.

Related and in support of the workforce strategic priority, recent national surveys and reports identify emerging trends and priorities for developing the public health workforce including some of the essential knowledge, skills and attitudes needed to practice in a changing environment. These include:

- Systems thinking and/or understanding how the health system works

- Leadership skills including change management
- Critical thinking, analytic, and problem solving skills
- Budgeting, priority setting, return on investment.
- Information technology skills and the ability to work with large data sets that aid decision making
- Foundational knowledge in research and science, and the ability to use tools such as policy and law to improve health outcomes.
- Communication skills including the ability to use different technologies to communicate to different audiences.
- A lifelong learning spirit and adaptability to change
- A commitment to population health and social justice

### **Training Needs**

In 2014, CT DPH with assistance from the CT-RI Public Health Training Center at Yale School of Public Health completed a competency-based training needs assessment utilizing the Council on Linkages Core Competencies for Public Health Professionals. Common topics include data and information technology, communicating with linguistic and cultural proficiency, programmatic budgeting, quality improvement, and human relations skills and management.

In 2013, DPH conducted an employee satisfaction survey as part of strategic planning. Most respondents indicated they were extremely dissatisfied to dissatisfied with opportunities for professional growth and development. Respondents also identified the following needs to support performance and enhance job satisfaction:

- Cross Training
- Empowerment
- Professional advancement opportunities
- Training for new employees
- Customer service training

Additional survey information from a national Public Health Workforce Interest and Needs (PH WINS) Survey was prepared and completed by the Association of State and Territorial Health Officials (ASTHO) in February 2015. Survey results are not available at this time, however, it is recommended that the Workforce Development Committee review and consider Connecticut specific results particularly in the areas of job and pay satisfaction, retirements before 2020 and staff planning to leave their current position in the next year, percent of staff that agree their organization is a good place to work, percent of staff that agree creativity and innovation are rewarded, percent of staff that indicated they know how their work relates to the agency's goals and priorities, and specific training gaps.

A strategic priority for the agency is to build depth and breadth of subject matter expertise within each program area of the agency. In doing so, it is necessary to identify qualified individuals with foundational knowledge in research and science, build in supports that allow them to keep current with data, the evidence-base, and provide opportunities to learn on a statewide and national level with colleagues and peers.

### **Other information**

DPH has invested substantial operating funds to provide ongoing Leadership training opportunities for its staff, recognizing that transforming the agency to a culture of quality and learning requires strong leadership and empowered staff. The Leadership Development training is a five day program that explores personality types in the workplace, teaches the five exemplary leadership practices and shares successful strategies for leading change in an organization. Each participant receives a report of their 360 degree evaluation and develops a leadership development plan based on its findings in collaboration with a leadership coach. Participants explore the connection between leadership and quality services and are encouraged to serve as role models for other staff in this area. To date 10 MCH staff has participated. DPH will continue to work with Leadership Greater Hartford to provide this training to all interested staff.

### **3. Family Consumer Partnership**

The CT Title V program recognizes the value and necessity of Family/Professional Partnership and engages families and consumers through the following:

#### **Advisory Committees**

The CT Department of Public Health Medical Home Advisory Council has a Family Experience Workgroup who provides consistent support for bimonthly meetings and offer a gateway to additional family voices through the facilitation of focus groups on behalf of the consumer input section of the MCHBG. Parents representing different organizations are at the table including AFCAMP, the African Caribbean American family organization whose mission is to educate, empower and engage parents and community providers to improve the quality of life for children with special needs and others at risk of education inequity or system involvement.

The Early Hearing Detection and Intervention task force has consumer involvement through the Guide by Your Side Program (GBYS) a service available through CT Hands & Voices. The GBYS Program supported through CT DPH Early Hearing Detection and Intervention funding, offers support to families who infant is deaf or Hard of Hearing without a bias around communication modes or methodology.

#### **Strategic and Program Planning**

The CT Department of Public Health included consumers on the Healthy CT 2020 Plan which included the dissemination of the State Health Assessment and subsequent creation of the State Health Improvement Plan. Performance data is housed in the Health CT 2020 Dashboard residing on the DPH web site. Consumers took part in seven workgroups including; (1) maternal, infant and child health, (2) chronic disease, (3) mental health, alcohol and substance abuse, (4) injury and violence prevention, (5) infectious disease prevention and control, (6) environmental risk factors and health and (7) health status.

## **Quality Improvement**

CT DPH staff facilitates a Family Leader, Action Learning Set for families and professionals who would like improve their knowledge and skills surrounding family/professional partnership. Action learning is a non-traditional, group-oriented, problem-based approach to learning. The process of action learning creates conditions where competent individuals come together to address problems in such a way that everyone learns explicitly from the experience. DPH staff were invited by the Association of Maternal and Child Health Programs (AMCHP) staff to attend an orientation at the national AMCHP Conference and to host a Family Leader Action Learning Set. The group meets virtually two times per month.

## **Workforce Development**

Connecticut Department of Public Health (DPH) Children and Youth with Special Health Care Needs (CYSHCN) Program released the "Medical Home for Children and Youth with Special Health Care Needs Training Academy Curriculum". The Curriculum is designed to enhance the knowledge and skills of those providing care for CYSHCN and their families/caregivers and facilitate development of medical homes across the state. The content consists of four modules: Medical Homes in Connecticut, Care Coordination, Family-Professional Partnerships and Transition to Adulthood.

## **Block Grant Development and Review**

CT DPH has invited and supports consumers of MCH services to read and review the Application/Annual Report and to provide input to strengthen the role of consumer involvement through family leadership for more than 12 years. The reviewer attends two meetings. The first outlines the MCH Programs, the MCH Application, and the importance of the public review process. The reviewer is asked to read the MCH application, complete forms including feedback about performance measures, and to relate comments about his/her experience with access to health care. The reviewer has the opportunity to contact DPH staff as needed. During the second meeting questions from the reviewer are answered. The same reviewer will join DPH staff the day of the Block Grant Review, and will be available to discuss items as needed from the perspective of a consumer of MCH Services. The reviewer is provided a stipend.

The DPH CYSHCN Program partnered with the Family Experience Workgroup of the Medical Home Advisory Council (MHAC) and several community based organizations to conduct consumer focus groups for inclusion in the Public Comment section of the MCHBG. DPH sponsored a one-day facilitator training to expand outreach efforts and include families in the process. DPH utilized a community based facilitator training model. A member of the CT Medical Home Advisory Council who has both a leadership role on the Council and is employed by the CT Council on Developmental Disabilities provided the training. The training, entitled Health Care for Children and Youth in Connecticut, included a PowerPoint Presentation with facilitation guidelines and offered the opportunity to practice facilitation with other trainees.

Six parents of children and youth with special health care needs, who also are Family Representatives of the Medical Home Advisory Council, took part in the training. The six Family Representatives work in teams of two and identify a facilitator and a recorder for each focus group. Each Family Representative is trained to provide either role. The Family Representatives plan to continue to schedule focus groups throughout the coming year.

## **Materials Development**

The CT Department of Public Health Commissioner has a designee on the CT Family Support Council a legislated body, consisting of two-thirds parents, working to establish a comprehensive, coordinated system of family support services, use existing state resources efficiently and effectively, identify and address services that are needed and promote statewide availability of such services. The CT Family Support Council provides an annual report to the Governor and the General Assembly regarding the status of family support services including the implementation of guidelines and recommendations. CT DPH staff assisted in the writing of the report and funded the printing.

Members of the Medical Home Advisory Council Family Experience Workgroup have reviewed and updated two CT Medical Home Initiative brochures; one for providers and one for families.

## **Advocacy**

The CT Title V program employs a full time Family Advocate at the Health Program Associate level to coordinate related activities throughout all MCH programs.

Several organizations working closely with the CT DPH provide advocacy through sharing information about legislative actions with families and consumers and providing education about the legislative process. The Family Support Council has a legislative link that provides information about specific legislative issues or policy concerns a family may like to address. Their web site shows how to find a legislator and the e-mail addresses of individual lawmakers and where a family can find a good source of information about proposed legislation. The legislative website home page also has a link titled "Citizen Guide" and it contains helpful information about how a bill becomes a law, how to testify at a public hearing, "frequently asked questions" and short videos on how to become involved in the legislative process.

AFCAMP provides training, support, and access to resources including; Understanding Special Education Training, Parent Leadership Training, and information on disability laws. AFCAMP has a history of successful collaboration with schools, government agencies, private providers and community stakeholders to ensure that families get the services they need. As a parent voice for systems change, AFCAMP encourages, trains and supports parents to become leaders and active participants in service system reforms.

CT DPH works closely with the CT Autism Action Coalition (CAAC) a group of family organizations, families and community and state agency providers who provide one unified voice to support CT in the development and improvement of service access and quality for all individuals who are affected by Autism Spectrum Disorders. CAAC hosts Autism Awareness Day at the capitol where this April more than 150 autism awareness advocates converged on the Connecticut Capitol to raise awareness for autism programs and rally for funding.



#### 4. Health Reform

Connecticut has experienced great success in the area of Health Reform over the past year, with both a reduction in the number of uninsured and an expansion of quality initiatives. Title V and its partners, including those contracted using state and MCH Block Grant funds have been involved at every level of planning and implementation and have sought to integrate Health Reform efforts across agencies serving the MCH population.

The CT Medical Home Initiative (CMHI) medical home care coordination networks and the contractor for the administration of funds for respite and extended services provided benefits coordination for families of CYSHCN to assist in accessing public/private sources to pay for services needed including the facilitation of eligibility determination and application for Healthcare for Uninsured Kids and Youth (HUSKY). Under HUSKY, children and youth up to age 19 receive a comprehensive health care benefits package, including preventive care, physician visits, prescriptions, vision care, dental care, physicals, mental health/substance abuse services, durable medical equipment, emergency and hospital care. The contractor for the management of extended services and respite funds provided assistance to families in accessing insurance benefits and assisted in the process of filing appeals when claims were denied. Assistance was received from and referrals made to the Office of the Health Care Advocate when needed. United Way Infoline provided MCH information and referral including access to insurance, and conducted presentations and training to community agencies regarding HUSKY. DPH-funded SBHC sites provided the opportunity for increased collaboration between the schools, SBHCs, and other Title V supported programs regarding HUSKY outreach and enrollment. Child Health and Development Institute and FSN will implemented the Provider/Family outreach and education component of the CMHI for CYSHCN with a focus on Family/Professional Partnership. The partnership focus included education for both providers and families of CYSHCN in working to navigate access to insurance and other resources.

DPH staff served on the legislative **Medical Assistance Program Oversight Council (MAPOC)**. The Council is a collaborative body consisting of legislators, Medicaid consumers, advocates, health care providers, insurers and state agencies that advises the Department of Social Services (DSS) on the development and implementation of CT's Medicaid (HUSKY Part A) and SCHIP (HUSKY Part B) program and provides for ongoing legislative and public input in the monitoring of the program. The Council has a legislative mandate to assess and make recommendations to DSS (the state's Medicaid agency) concerning access to and implementation of the HUSKY program. DPH staff also served on the Person Centered Medical Home (PCMH) subcommittee to the MAPOC.

Representatives from DSS and from the Administrative Services Organizations (ASOs) administering HUSKY, including Community Health Network (CHN) – the ASO for medical services, participated in Medical Home Advisory Council (MHAC) meetings, facilitating the incorporation of HUSKY outreach as an integrated part of Connecticut's medical home efforts. CHN ASO staff participated in all *Care Coordination Collaborative Partnership* meetings throughout the state answering eligibility and access questions and working to meet case specific needs.

DPH staff collaborated with the Family to Family (F2F) Health Information Network (administered through Parents Available to Help/Family Voices CT) to disseminate information regarding health finance resources, including public and private insurance. DPH provided

training around medical home for F2F Health Information Specialists working for Parents Available to Help/CT Family Voices, who in turn provided health and resource related trainings for families.

DPH staff and CMHI providers participated in the CT Voices for Children Covering CT's Kids and Families (CCKF) initiative, a statewide coalition of organizations concerned with access to health care for children and their parents <http://www.ctvoices.org/issue-areas/health/covering-kids-families-project> . Coalition activities included technical assistance and support to local outreach efforts; working to maintain and expand HUSKY enrollment and simplification of enrollment process; and supporting DSS to increase the retention of eligible HUSKY families. CT Voices identified a recurring issue with lapse of HUSKY coverage for those turning 18, and initial planning with CCKF occurred to address this issue in the coming year.

DSS expanded ConneCT – an online portal described as “an easy way to get information about your benefits and other DSS programs.” The portal is a consumer friendly tool to check eligibility to receive medical benefits, cash assistance, SNAP, and other services. Applications are available through the portal for all DSS programs. <https://connect.ct.gov/access/accessLogout?fwlat=1382490866023> Information about the portal was disseminated through the CMHI networks.

Progress was made on the DPH Strategic Plan goal to “align efforts of health systems stakeholders to achieve sustainable, equitable and optimal population health” included Access to Health Services as an Area of Concentration - one of the objectives is to increase the percentage of CT residents who have health coverage through either public or private sector to 95-97% by 2020 (through Medicaid/Medicare, Health Insurance Exchange or Employers). The plan included Financing Systems in order to appropriately align and/or increase existing and future funding to meet prevention and population health priorities in the State Health Improvement Plan by leveraging resources, innovation and incentives, partnerships, and coordination of services and programs.

Insurance enrollment through Access Health CT began on October 1, 2013. This state-based health insurance marketplace provides federal premium tax credits and cost-sharing subsidies to assist low- and moderate-income individuals without affordable employer-sponsored insurance in obtaining health coverage. Plans covered Essential Health Benefits and offered pediatric vision and dental coverage. The implementation phase entailed community based partnerships with six Navigators and 298 In Person Assistors for direct consumer outreach through six regions in CT covering all 8 counties, who brought the health coverage marketplace directly to consumers. The Assistors, from health departments, community organizations, nonprofits, faith-based institutions and small businesses, focused on targeted, local, linguistically and culturally sensitive outreach across CT. Access Health CT and HUSKY Health provided points-of-entry, toll-free information and referral services for health care coverage. Both of these programs provide information about the HUSKY program. HUSKY Health and the DSS websites include information about the HUSKY program and enrollment information.

Major changes to Connecticut's Medicaid/HUSKY Health Program took place on January 1, 2014 due to a move to Modified Adjusted Gross Income (MAGI) in calculating income eligibility. This effectively changed the maximum income level to qualify for HUSKY A for children and parents/relative caregivers from 185% to 201% of the federal poverty level (FPL); effectively changed the maximum income level for HUSKY A for pregnant women from 250% to 263% of

FPL; and effectively changed the maximum income level to qualify for subsidized coverage for a child (HUSKY B) from 300% to 323% of FPL.

Healthy Start, Family Planning, CHCs, CMHI care coordinators, SBHCs, WIC staff and programs with a case management component screened families for insurance coverage, and provided support, information and linkages to health care insurance coverage for children.

Following the second Access Health CT open enrollment period (ending February 15, 2015); CT's population was less than 4% uninsured (slightly over 8% prior to October 2013). Newly insured included 110,095 who purchased private insurance through the state-based exchange, and 442,508 newly enrolled in Medicaid.

DSS expanded the Medicaid Person Centered Medical Home (PCMH) initiative in which practices and clinics that demonstrate a higher standard of person-centered primary care service delivery qualify for a higher reimbursement. The DSS PCMH Glide Path option provides financial and technical support for practices pursuing medical home recognition through standards and requirements of the National Committee for Quality Assurance (NCQA). DSS provides technical assistance to Federally Qualified Health Centers (FQHCs) interested in becoming a PCMH through either NCQA recognition or Joint Commission accreditation (FQHCs are excluded from enhanced reimbursement but are eligible for technical assistance). Pediatric and adult quality measures were developed to determine how practices in the Medicaid Medical Assistance Program were performing and for use in the incentive and improvement performance payment programs. As of 5/13/15 there were 348 PCMH approved practice sites and 35 Glide Path practice sites. CMHI care coordinators provided support with the most complex CYSHCN for practices on the Glide Path and provided technical assistance to all providers regarding care coordination for complex CYSHC. There were a total of 1,273 NCQA recognized providers in CT; the DSS Medicaid PCMH initiative covers about one third of all Medicaid members.

CT Title V and their partners were engaged in the emerging State Innovation Model and plan to advance a role in the design of Accountable Care Communities. The model encompasses a strategy to promote shared accountability among key stakeholders and includes the following approaches to improve community health: 1, **Designated Prevention Service Centers (DPSCs)** to strengthen community-based health services and linkages to primary healthcare and 2, **Health Enhancement Communities (HECs)** to target resources and facilitate coordination and collaboration among multiple sectors to improve public health and reduce avoidable health disparities in areas with the highest disease burden, poorest indicators of socioeconomic status and pervasive and persistent health disparities. A cornerstone of the innovation plan is supporting the transformation of primary care to the Advanced Medical Home, a care delivery model comprising five core elements: 1, **Whole-person-centered care** - care that addresses the full array of medical, social, behavioral health, oral health, cultural, environmental, and socioeconomic factors that contribute to a consumer's ongoing health; 2, **Enhanced access** - an array of improvements in access including expanded provider hours and same-day appointments; e-consult access to specialists; non-visit methods for accessing the primary care team; clear, easily accessible information; and care that is convenient, timely, and linguistically and culturally appropriate; 3, **Population health management** - use of population-based data to understand practice sub-populations (e.g., race/ethnicity), panel and individual patient risk, and to inform care coordination and continuous quality improvement, and to determine which AMHs are impacting health disparities, for which conditions and for which populations; 4,

**Team-based coordinated care:** multi-disciplinary teams offering integrated care from primary care providers, specialists, and other health professionals. An essential element in what makes this work is the combination of behavioral healthcare with medical care, whether through co-location, referral linkages, or as part of a virtual team; 5, **Evidence-informed clinical decision making:** applying clinical evidence to healthcare decisions using electronic health record (EHR) decision support, shared decision making tools, and provider quality and cost data at the point-of-care to enable consumer directed care decisions. A key enabler of transformation will be the shift from purely fee-for-service payment, which rewards providers for delivering a greater volume of services, to value-based payment, which rewards providers for delivering high-quality care and a positive consumer experience, while reducing waste and inefficiency. Value-based payment also reduces healthcare costs or better controls the growth in healthcare spending over time. Implementing these payment changes across all payers strengthens the business case for providers to invest in advanced practice and performance improvement, while eliminating conflicting payer incentives. The CT State Innovation Model (SIM) will enter the implementation phase in July 2015. Emerging state CYSHCN Care Coordination Collaboratives, supported through the Title V program will be used to foster Health Enhancement Communities and will serve as an ongoing venue for system integration, shared care coordination, resource development, and reduction in duplication of services.

## 5. Emerging Issues

Emerging issues were identified as those topic areas that were ranked high in importance during the early stakeholder meetings; however, these were not selected as one of the seven to ten state priorities. The two high ranking emerging issues include suicide; and family violence and child abuse/neglect.

Intentional Injury is important because self-inflicted and other-inflicted intentional injuries, including suicides and homicides, are preventable and predictable. Suicide accounts for more than 60% of costs due to violent deaths. It is estimated that suicides result in \$3,056 in medical costs per person, and \$815,963 in work loss costs per person, resulting in a \$26.7 billion in total costs for the US.

Between 2000 and 2010, the number of deaths due to suicide ranged from 242 deaths in 2000 to 269 deaths in 2010 for males, and 61 deaths in 2000 to 72 deaths in 2010 for females. Suicide is the leading cause of injury death in Connecticut. While the number of suicides was higher than homicides in Connecticut, the rate of emergency department visits for homicide or injury intentionally inflicted by others was higher than that for suicide or self-inflicted injury for FFY 2007 through FFY 2011.

Family or domestic violence is a serious public health issue that results in substantial societal and financial costs, and the effects can last a lifetime. Persons who experience domestic violence may experience lost work days, physical injury, mental trauma, and even death. In addition, persons who witness domestic violence are at greater risk of perpetrating violent behavior than those who did not witness domestic violence. While most cases are not reported to the police, nonfatal domestic violence is greatest among females 20 to 24 years of age. The financial costs of intimate partner violence—one type of domestic violence—exceeds \$5.8 billion annually, \$4.1 billion of which is attributed to medical and mental health costs.

In 2011, there were a total of 21,386 family violence arrests in Connecticut. The greatest proportions of arrests associated with family violence were for disorderly conduct, assault, and breach of peace. The number of emergency department (ED) visits due to a domestic violence-related injury varied from 256 in FFY 2008 to 301 in FFY 2012.

Child abuse and neglect is an important public health issue and the effects can last a lifetime. It is estimated that on average, child abuse costs each survivor \$210,012 in childhood health care costs, adult medical costs, productivity losses, and expenses for child welfare, criminal justice, and special education. The estimated lifetime cost of child maltreatment cases that are reported in a single year is \$124 billion.

In FFY 2012, there were 8,151 cases of child abuse or neglect in Connecticut. The rate of substantiated child maltreatment or neglect cases ranged from 11.4 cases per 1,000 children in FFY 2008 to 10.3 per 1,000 children in FFY 2012.

Source: Connecticut Department of Public Health. 2014. Healthy Connecticut 2020. 1: State Health Assessment. Hartford, CT: Connecticut Department of Public Health.

## **6. Public Input**

### **Consumer focus groups**

The DPH CYSHCN Program partnered with the Family Experience Workgroup of the Medical Home Advisory Council (MHAC) and several community based organizations to conduct consumer focus groups if a person is receiving services from programs funded through the Maternal and Child Health Services Block Grant.

DPH sponsored a one-day facilitator training to expand outreach efforts and include families in the process. DPH utilized a community based facilitator training model. A member of the CT Medical Home Advisory Council who has both a leadership role on the Council and is employed by the CT Council on Developmental Disabilities provided the training. The training, entitled Health Care for Children and Youth in Connecticut, included a PowerPoint Presentation with facilitation guidelines and offered the opportunity to practice facilitation with other trainees.

Six parents of children and youth with special health care needs, who also are Family Representatives of the Medical Home Advisory Council, took part in the training. The six Family Representatives work in teams of two and identify a facilitator and a recorder for each focus group. Each Family Representative is trained to provide either role. The Family Representatives plan to continue to schedule focus groups throughout the coming year.

Two focus groups were completed one in Waterbury and one in Hartford. The Waterbury location was comprised of families who receive primary care medical services and utilize children's psychiatric services. The Hartford location was hosted the AFCAMP (African Caribbean American Parents of Children with Disabilities) and included families who regularly attend an AFCAMP family support group. In the satisfaction survey 87.5% of the attendees stated they agreed or strongly agreed that they understood the purpose of the focus group, all items on the agenda were addressed, the time was well spent, their thoughts and opinions were valued and the facilitator was well prepared and organized; overall satisfaction was rated highly satisfied.

In the previous year five focus groups were completed; we observed the following highlights between the two years. For the question that asks, who helps your family find services; there was an increase in the majority percentage from 10% to 28% for the response friend/family member. For chart two; how can finding these services be easier, there was a shift this year to system improvement at 35 % versus doctor/primary care provider response at 24%. For chart number three, who helps you get an appointment, families identified themselves as the number one response last year at 24% but this year they came in a close second at 33% to hospital clinics at 34%. If behavioral or other health services were not working for you the number one response remained change providers; the percentage went from 23% last year to 31% this year. Feeling overwhelmed was the second majority response last year at 23% and was significantly reduced to 6% this year. For the suggestions for change chart; training for parents and providers and outreach made up 76% of the recommendations. Please see attached Public Input Charts.

### **Consumer MCHBG readers**

CT DPH has invited and support consumers of MCH services to read and review the Application/Annual Report and to provide input to strengthen the role of consumer involvement through family leadership for more than 12 years. The reviewer attends two meetings. The first outlines the MCH Programs, the MCH Application, and the importance of the public review process. The reviewer is asked to read the MCH application, complete forms including feedback about the application, and in relevant years, the needs assessment - and to relate comments about his/her experience with access to health care. The reviewer has the opportunity to contact DPH staff as needed. During the second meeting questions from the reviewer are answered. The same review will join DPH staff the day of the Block Grant Review, and will be available to discuss items as needed from the perspective of a consumer of MCH Services. The reviewer is provided a stipend.

During this year for MCHBG transformation 3.0 we identified two reviewers with experience and knowledge of the MCHBG and CT DPH program activities. They are both the Co-Executive Directors of a statewide Family Organization, PATH Parent to Parent/Family Voices of Connecticut (PATH/FVCT). PATH/FVCT is a network of families providing informational and emotional support to others who have a child with developmental or health related needs. PATH/FVCT reaches out to help strengthen families coping with similar situations in Connecticut, and the organizations that serve them to reduce isolation, empower families as advocates for their children and reaffirm their values as parents and caregivers.

For over 27 years, PATH/FVCT has been providing one to one matching, training, advocacy and support to CT families. PATH/FVCT is also the State Affiliate Organization of Family Voices, an Alliance Member of Parent to Parent US and serves as the CT Family to Family Health Information Center.

Carmina Cirioli is Co-Executive Director (2004-present). She is a wife and mother of 3 boys, ages 20, 19 and 17 years old. Her 19 year old son Carlo is diagnosed with Autism Spectrum Disorder. Carmina is a 2013 graduate of Partners in Policy Making. Her professional interests include; Autism Awareness to First Responders and extended Family Members and Collaboration of all Statewide Family organizations, so that parents will be able to access the most information to become the best advocate for their child and to make sure that their child is receiving the utmost services that they can.

Current committees include; Member, Community of Practice Committee; Chair: Family Leadership & Mentoring Committee, Member, and Connecticut Autism Action Coalition.

Nanfi N. Lubogo is Co-Executive Director (2004-present). She is a wife and mother of 3 children ages 22, 16 and 10 years old. Her 15 year old daughter Stephanie is diagnosed with Prader Willi Syndrome, Sleep Apnea and other developmental disabilities. Current committees include: CCMC Family Advisory Council, UCEDD Consumer Advisory Board; Office of Healthcare Innovation SIM Consumer Advisory Board and Practice Transformation Task Force; National Emergency Medical Services for Children (EMSC) Family Advisory Network; Department of Transportation National EMS Advisory Council (NEMSAC); State Affiliate Organization representative to Family Voices Board of Director. MCHP Public Health Leadership Fellow (Maternal and Child Health Leadership) and 2000 Partners in Policy making Graduate.

The readers reviewed and commented on the DPH Needs Assessment document and thought the document was clearly designed but also thought it would make more sense if it aligned to the performance measure. One consumer read and reviewed the needs assessment several times and then it became easier to understand. One reader thought the data became clearer once they understood the data did not align with performance measures. Another consumer thought there was a lot of data, which is great, but would have liked to have seen an explanation about what work is currently being done in Connecticut in response to the data; what issues are being address, and if the measure was met or not, and how Connecticut matches up to national standards.

One reader thought the needs assessment reflected the population as they were aware, another reader was not certain they saw the Asian population represented in the data and were concerned about the Cambodian, Filipino, and Vietnamese since she is aware they are vastly underserved groups particularly regarding health care access. Also mentioned were families from Somali, Kenya and Uganda including families who are refugees from those and other counties.

One reader was excited to see that CT has an excellent record for newborn hearing screening but was concerned about the individuals who developed hearing loss at a later date and wondered if there a way to track the late onset hearing loss.

A reader would have liked to seen a statewide family organization included in the stakeholder involvement section. On several occasions the data was presented in percentages and sometimes it did not seem consistent with other data points. One reader was not aware how a person could be identified as having Autism and then, at a later point in time, no longer identified as having Autism.

A survey of four staff from the statewide family organization representing the towns of Madison, Cromwell, Brookfield, and North Haven showed the following results: for the question; “who helps your family find services”, all answered themselves (mom) and one participant included that the PATH/FV CT staff help. The second part of the question, “how could finding the services be easier”, families answered if pediatricians and schools helped and if all professionals, agencies, and family run organizations are supplied with the appropriate information on the services that are available to families through one’s Life Course, it would assist families and make it much easier for families to find. For example: Community of Practice (Family Mentoring and Leadership Committee) has created a brochure that covers some

agencies and organizations that assist families through one's Life Course. All four moms make doctors' appointments for their family and one family mentioned if it is a specialist, they get a referral from their Pediatrician.

For behavioral health concerns families replied they would talk to their child's pediatrician or psychiatrist working with their child. For finding behavioral health services they would reach out to the child's pediatrician, talk to someone certified in the field, look to an organization such as PATH/FV CT to see if they could be matched with another parent dealing with similar issues to get advice. Recommendations in this area are key, but they would also contact insurance to make sure the people are in the network.

If behavioral health or other health services are not working; what would you do? Responses included they would contact their child's pediatrician, a parent organization, other doctors, hospitals, go to other areas of the state to access resources, and keep searching for the right match; not all behavior therapists work for all kids.

Other comments or suggestions for DPH include: information/communication about children and youth with special health care needs that are accessible across CT such as a quarterly newsletter or updates on social media. One family requested more resources and access to people for support; she shared that with your first child it's hard to tell what normal child behavior is and what isn't. It is tough for parents to know where to start when they have questions.

## **7. Technical Assistance**

During the FFY 2015, CT was fortunate to provide technical assistance in the following area:

Technical assistance was provided by Leadership Greater Hartford to DPH staff to help sustain and enhance leadership development practices among the MCH and DPH workforce. One of the two trainings that were offered focused on how to lead and sustain change in the workplace through an in-depth exploration of the principals and practices described by Richard Axelron in his book, *Terms of Engagement*. These 5 forums, that were presented twice, provided participants with tools and strategies to create an organized culture that supports and encourages inclusive and creative approaches for change. Participants learned to: use tools to help feel more engaged, understand the big picture of their role in accomplishing the Department's goals, align around a common vision, and cultivate accountability, collaboration, and active participation in the Department's work. The second training focused on learning how to facilitate peer coaching-decision making groups. Participants attended three 4 hour train-the-trainer sessions and practiced and learned to facilitate 90 minute Peer Coaching sessions that helped others discuss and explore strategies for resolving problems that are faced in the workplace. MCHBG and DPH staff were encouraged to attend these interactive leadership workshops.

### **Technical Assistance requests for the next year will focus on:**

The Department of Public Health would collaborate with Health Resources in Action, Inc. in order to collect, analyze and complete the 2017 Maternal and Child Health Block Grant application with a particular focus on incorporating ongoing Needs Assessment activities/findings into Annual Update on State Priority Needs; developing Evidence-based or-



informed Strategy Measures (ESMs) for each selected NPM; develop 3-5 SPMs to address priority needs not addressed through the NPMs and ESMs; adding all these to finalize the Five-Year State action Plan Table; and assist with the Narrative Sections of the Application, including presentation of the State's Five-year Action Plan by population health domain.

## II.G. REFERENCES

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- <sup>4</sup> Connecticut Department of Public Health, 2000-2011.
- <sup>5</sup> Connecticut Department of Public Health, Vital Statistics (Registration Reports), 2011.
- <sup>6</sup> Connecticut Department of Public Health, Vital Statistics (Registration Reports), 2011
- <sup>7</sup> Connecticut Department of Public Health, 2010-2011 Connecticut Pregnancy Risk Assessment and Tracking System (PRATS) Survey.
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- <sup>9</sup> Morbidity and Mortality Weekly Reports, *National, State, and Local Area Vaccination Coverage among Children Aged 19-35 Months, United States – 2013*, Table 3; National Immunization Survey.
- <sup>10</sup> Connecticut Department of Public Health, OHCA, January, 2010, *Preventable Hospitalizations in Connecticut: A Current Assessment of Access to Community Health Services*, Table 1.
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- <sup>12</sup> National Survey of Children's Health, 2011-2012
- <sup>13</sup> National and State Vaccination Coverage among Adolescents Aged 13 to 17 Years: United States, 2012. *Morbidity and Mortality Weekly Report (MMWR)* 2013; 62(34): 685-693, Table 3.
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- <sup>15</sup> Connecticut School Health Survey (CSHS), 2005-2011
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- <sup>22</sup> National Survey on Children's Health, 2011-2012.
- <sup>23</sup> Connecticut Voices for Children, *Dental Services for Children and Parents in the HUSKY Program: Utilization Continues to Increase Since Program Improvements in 2008* (Table 1), July 2013.
- <sup>24</sup> Connecticut Voices for Children., 2011.
- <sup>25</sup> National Survey of Children's Health, 2011-2012.