Maternal and Child Health Services Title V Block Grant

Connecticut

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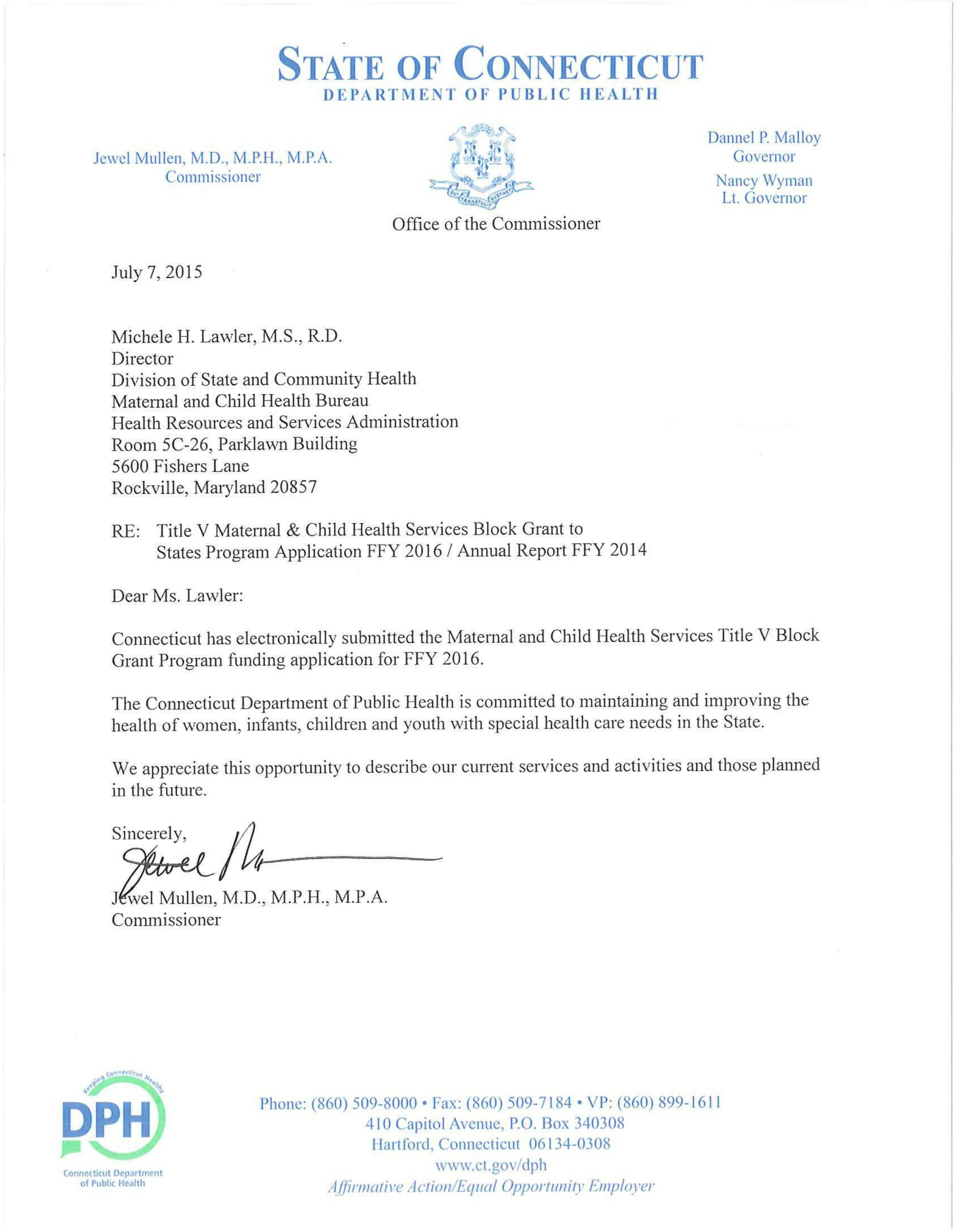
Table of Contents

I. General Requirements

I.A. Letter of Transmittal



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of the Commissioner

July 7, 2015

Michele H. Lawler, M.S., R.D.
Director
Division of State and Community Health
Maternal and Child Health Bureau
Health Resources and Services Administration
Room 5C-26, Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20857

RE: Title V Maternal & Child Health Services Block Grant to
States Program Application FFY 2016 / Annual Report FFY 2014

Dear Ms. Lawler:

Connecticut has electronically submitted the Maternal and Child Health Services Title V Block Grant Program funding application for FFY 2016.

The Connecticut Department of Public Health is committed to maintaining and improving the health of women, infants, children and youth with special health care needs in the State.

We appreciate this opportunity to describe our current services and activities and those planned in the future.

Sincerely,

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

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I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix C of the 2015 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

I.E. Application/Annual Report Executive Summary

INTRODUCTION

As part of the Title V Block Application/Annual Report, the Connecticut Department of Public Health undertakes a statewide Needs Assessment every five years, examining the health status of Title V target populations of pregnant women, mothers, and infants; children and adolescents; and children and youth with special health care needs. This assessment is a systematic examination of the health behaviors, conditions, and risk factors of these populations, using indicators that can be tracked over time for each of the six identified population health domains (Women's/Maternal Health; Perinatal/Infant's Health; Child Health; Children with Special Health Care Needs (CSHCN); Adolescent Health; and Cross-cutting or Life Course). The Connecticut MCH Needs Assessment aims to serve as an important foundation for future data-driven planning efforts in the state.

MCH FIVE-YEAR NEEDS ASSESSMENT

The MCH Needs Assessment and Planning process was integrated within the larger Connecticut State Health Assessment and Planning process (*Healthy Connecticut 2020*) and engaged stakeholders and Connecticut residents throughout the process to understand maternal and child health in its broadest context. A total of 29 key informant interviews were conducted with leaders from state agencies, community service organizations, statewide organizations focused on specific population groups, the state legislature, academia, education, and business. Discussions explored leaders' perspectives on the current and emerging health issues in Connecticut, current state of health data, and feedback on important issues to consider. The list of indicators used for the MCH Needs Assessment was guided by existing initiatives (e.g., Healthy Connecticut 2020, National Prevention Strategy) and shaped by the feedback from stakeholders and partners. Additionally, direct public comment on findings from the State Health Assessment, including those pertaining to maternal and child health, was gathered at 8 county-level public forums. Input from these sessions was used to refine the content and framing of the assessment data.

The Five-Year Needs Assessment resulted in the identification of nine (9) State Selected Priorities: 1) Well woman care/health of women of reproductive age; 2) Preterm births and low birth weight births; 3) Breastfeeding; 4) Developmental screening, well-child visits and immunizations; 5) CSHCN Transition to Adult Health Care; 6) CSHCN Medical home; 7) Bullying; 8) Adolescent Wellness; and 9) Oral health.

KEY FINDINGS AMONG THE SIX POPULATION DOMAINS

The following provides a brief overview of the identified major accomplishments and significant challenges within each population health domain:

Women's/Maternal Health

Nearly three quarters (74%) of women in Connecticut indicated that they had a **preventive medical visit or check-up** in the past year, while nearly 4% indicated it had been five or more years since their last visit.

From 2000 to 2011, there was a significant annual 4.2% decline in the **rate of births per 1,000 teen women (15-19 years)**. 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).

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, 13.0% of pregnant women received **late or no prenatal care.** A significantly greater proportion of black non-Hispanic (20.9%) and Hispanic (19.4%) mothers received late or no prenatal care relative to white non-Hispanic mothers (8.8%).

The proportion of women who received late prenatal care was highest in Hartford, New Haven, Bridgeport, and Stamford, and their surrounding towns, as well as in towns proximate to these towns and in northeastern Connecticut.

Perinatal and Infant's Health

In 2011, the proportion of **preterm births** for black non-Hispanic and Hispanic women was significantly higher than that for white non-Hispanic women. 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.

Preterm birth was more heavily concentrated in and around Waterbury, Hartford, and New Haven and in Northern areas in Connecticut.

Infant mortality rates have continued to decline over the last 20 years (1990-2011) in Connecticut. 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.

There has been a 2.7-fold increase in **neonatal abstinence syndrome** among children born in Connecticut, from 0.27% in 2002 to 0.73% in 2011. The increase in NAS during the past decade largely occurred among white non-Hispanics and children born to women whose expected source of payment for the delivery was Medicaid

In 2010-2011, combined, 88.5% of infants in Connecticut were ever **breastfed**. Overall, 37.1% of infants were breastfed exclusively at three months, while only 12.3% were breastfed exclusively at 6 months.

Child Health

Nine out of ten Connecticut children saw a health care provider for **preventative medical care** in the past year, and the prevalence of **vaccine series completion** among children 19 to 35 months was 78.2. More than nine in ten completed at least one dose of the measles, mumps, and rubella (MMR) vaccine.

Asthma was the leading cause of preventable hospitalization among children, followed by gastroenteritis and urinary tract infections. The rate of preventable pediatric hospitalizations was lowest for white non-Hispanics for most of the leading causes.

From 2002 to 2012, the number of children identified with a **blood lead level** of ≥10+ µg/dL appeared to decline by 70%.

In 2012, the percent of children ever told they have **asthma** ranged from 17.4% among white non-Hispanic children to 21.4% and 23.9%, among black non-Hispanic and Hispanic children, respectively.

From 2007 to 2011, rates **of injury related hospital admissions** were greatest for persons 15 to 19 years of age, followed by those 0 to 4 years of age. In 2012 the rate of injury related hospital admissions for persons age 0 to 4 years eclipsed that of persons age 15 to 19.

Children with Special Health Care Needs

In 2009-2010, 89.5% of children with special health care needs (CSHCN) had **at least one reported health condition**. Approximately 1 in 4 CSHCN had 2 conditions, 11.8% had 3 conditions, and 16.4% had 4 conditions or more.

In 2009-2010, 87.1% of 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.

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%).

Adolescent Health

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. 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, 43.6% of females completed 3 doses of the **HPV vaccine**, while only 8.5% of males completed 3 does 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 vaccine**, and 88.8% received at least one dose of **meningococcal conjugate vaccine**.

The percent of high school students who reported **ever been bullied** on school property ranged from 25.9% of 9th grade students to 19.0% of students in 12th grade. 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%. 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.

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.

Cross-Cutting or Life Course Issues

In 2008-2010, combined, almost one-fifth (19.9%) of children 5 to 12 years of age in Connecticut were **obese** (Figure 76). 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%).

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.

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. 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.

CONCLUSIONS

Connecticut has made significant progress in improving the health of residents across the life course. For example, over the past decade, Connecticut has experienced declines in the rate of births to teen mothers, the infant mortality rate, the number of children identified with blood lead levels of ≥10+ µg/dL, and the prevalence of current cigarette use among middle and high school students. During this same period of health improvements, Connecticut has seen an increase in women experiencing non-adequate prenatal care utilization, neonatal abstinence syndrome among infants, and C-section rates.

The distribution of these health improvements, and persistent and new issues affecting maternal and child health are not equally distributed among subpopulations. Indeed, lower-income residents, black non-Hispanics, and Hispanics generally have less favorable health and health behavior profiles than their counterparts. Additionally, some health patterns among maternal and child health populations vary by sex, town, sexual identity, and special health care need status.

This needs assessment, developed through a participatory planning progress, highlights areas of progress in maternal and child health in Connecticut, as well as health issues necessitating a public health approach to improve the health of all Connecticut residents.

II. Components of the Application/Annual Report

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 (S*ource: 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.

A discussion of how state statutes impact the Connecticut's Title V MCH and CSHCN programs can be found in Attachment #4.

I. Maternal and Child Health Indicators

1. A. 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.

1. B. 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.

1. C. 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.

1. D. Prenatal Care

Among all births in CT during 2012, 13.1% were born to mothers who initiated pregnancy beyond the first trimester (S*ource: 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.

1. E. 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

II.B.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 (See attachment).

II.B.2. Findings

II.B.2.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.[i] 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.[ii] 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.[iii] 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. [iv] 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.[v] 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.[vi] 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.[vii] 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.[viii] 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.[ix]

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%.[x]

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.[xi] 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.[xii] 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.[xiii] Approximately four in ten females (43.6%) completed 3 doses of the HPV vaccine, while only 8.5% of males completed 3 does 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.[xiv]

The prevalence of current alcohol use among students in grades 9-12 ranged from 45.3% in 2005 to 41.5% in 2011[xv]. 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 9th grade students to 19.0% of students in 12th grade.[xvi] 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%.[xvii] 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.[xviii] 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.[xix] 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.[xx] 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.[xxi] 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 3rd 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.[xxii] 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.[xxiii] 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 .[xxiv] 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. [xxv] 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.

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[i] BRFSS, 2013.

[ii] Connecticut Department of Public Health, 2010-2011 Connecticut Pregnancy Risk Assessment and Tracking

System (PRATS) Survey, 2011.
[iii] Connecticut Department of Public Health, 2000-2011.
[iv] Connecticut Department of Public Health, 2000-2011.
[v] Connecticut Department of Public Health, Vital Statistics (Registration Reports), 2011.
[vi] Connecticut Department of Public Health, Vital Statistics (Registration Reports), 2011
[vii] Connecticut Department of Public Health, 2010-2011 Connecticut Pregnancy Risk Assessment and Tracking System (PRATS) Survey.
[viii] National Survey of Children's Health, 2011-2012.
[ix] 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.
[x] Connecticut Department of Public Health, OHCA, January, 2010, *Preventable Hospitalizations in Connecticut: A Current Assessment of Access to Community Health Services*, Table 1.
[xi] Children with Special Health Care Needs Survey, 2009-2010.
[xii] National Survey of Children's Health, 2011-2012
[xiii] 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.
[xiv] National Survey of Children's Health, 2011-2012.
[xv] Connecticut School Health Survey (CSHS), 2005-2011
[xvi] Connecticut School Health Survey (CSHS), 2013.
[xvii] Connecticut School Health Survey (CSHS), 2005-2011.
[xviii] Connecticut School Health Survey (CSHS), 2005-2011.
[xix] Connecticut Department of Public Health, Mortality Tables, 2001-2010.
[xx] Connecticut School Health Survey (CSHS), 2011.
[xxi] Connecticut Department of Public Health, *Every Smile Counts: The Oral Health of Connecticut's Children Report, 2012*.
[xxii] National Survey on Children's Health, 2011-2012.
[xxiii] 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.
[xxiv] Connecticut Voices for Children., 2011.
[xxv] National Survey of Children's Health, 2011-2012.

II.B.2.b Title V Program Capacity

II.B.2.b.i. Organizational Structure

The mission of the DPH is to protect and improve the health and safety of the people of CT by: assuring the conditions in which people can be healthy; promoting physical and mental health, and preventing disease, injury and disability. In 2010 Dannel P. Malloy was elected Governor and in 2011, Jewell Mullen, MD, MPH, MPA became DPH Commissioner. Currently, the DPH has two Deputy Commissioners: Raul Pino, MD, MPH, and Janet Brancifort, MPH.

The Title V Program is located within the Community, Family and Health Equity Section (CFHES). The Title V Program is responsible for the direct or indirect administration of programs carried out with funds from the MCHBG. The majority of CT's activities serving mothers, infants, children, adolescents, and children and youth with special health care needs reside within the CFHES, including: Autism Spectrum Disorder; Children and Youth with Special Health Care Needs including Respite and Extended Services; Family Advocacy; School Based Health Centers; Sickle Cell Disease; Community Health Services; Maternal Mortality Review; Case Management for Pregnant Women; Family Planning; Healthy Choices for Women and Children; Supplemental Nutrition Assistance Program; Birth Defects Registry;

Early Hearing Detection and Intervention; State Systems Development Initiative; Primary Care Office; Pregnancy Risk Assessment Monitoring System; Federal Hartford Healthy Start; Provide Supplemental Nutritious Foods; Breastfeeding promotion and support; and Nutrition education. All of these programs either receive Title V funds or work in collaboration with the Title V Program.

II.B.2.b.ii. Agency Capacity

The mission of DPH is to protect and improve the health and safety of the people of Connecticut. The CFHES is comprised of the following units: 1) Adolescent and Child Health; 2) Women and Reproductive Health; 3) Chronic Diseases; 4) Injury Prevention; 5) Nutrition, Physical Activity and Obesity; 5) Tobacco Control; 6) Maternal and Child Health Epi; 7) Women, Infants and Children (WIC); 8) Cancer; 9) Epidemiology and 10) Asthma. The CFHES also includes the: 1) Genomics Office; 2) Office of Oral Health; and 3) Office of Health Equity. Staff work collaboratively across units and offices to coordinate resources and maximize program capacity.

The Healthy Connecticut 2020 State Health Improvement Plan (SHIP) is closely aligned with the National Prevention Strategy, Healthy People 2020 objectives, and with other existing state plans. The SHIP complements and builds upon other guiding documents, plans, initiatives, and coalitions to improve the health of CT's residents. DPH convenes partners and organizes data to support collective action.

1.Women/Maternal Health

The SHIP identifies 7 health focus areas; the first is Maternal, Infant and Child Health. The goal of this area is to optimize the health and well-being of women, infants, children and families, with a focus on disparate populations. It includes objectives associated with women and maternal health, and addresses: 1) reproductive and sexual health; and 2) preconception and pregnancy care.

Family Planning: promotes decreasing the birth rate to teens, age 15-17, preventing unintended pregnancy, and increasing access to primary reproductive health care. Comprehensive reproductive health services are available in 12 locations with 4 subcontractor locations. Case Management for Pregnant Women: provides comprehensive perinatal and inter-conception services to pregnant and post-partum women, who are alcohol or other drug dependent and at high risk for poor birth outcome. State Healthy Start: provides case management services to pregnant women to: 1) improve CT birth outcomes by reducing the rate of infant mortality, morbidity and low birth weight, 2) increase access to prenatal/postpartum care services, and 3) promote and protect the health of both mother and baby. Federal Healthy Start Program: to promote healthier pregnancies and reduced rates of birth complications among African American women. The program serves pregnant and postpartum women and their children up to two years of age. MCH Information and Referral Service: toll-free hotline for information on health and related services. Pregnancy Risk Assessment Monitoring System (PRAMS): provides the DPH with data about maternal health, experiences, and behaviors during the perinatal period, and advance knowledge about risk and protective factors among CT mothers, and to investigate the associations between these factors, birth outcomes and maternal and infant health. Personal Responsibility and Education Program (PREP): Pregnant teens are at increased risk for health complications including premature birth, delivering low birth weight infants, other serious health problems, and death. The DPH partners with youth services to implement evidence-based programs in schools and other settings. Maternal Mortality Review (MMR): confirms cases of perinatal maternal deaths and develops policy recommendations. The Office of Oral Health works with the American College of Obstetrics and Gynecology and the March of Dimes to address oral health during the prenatal period.

2.Perinatal/Infant Health

Four objectives in the SHIP are associated with perinatal/infant health, and address: 1) birth outcomes; and 2) infant and child nutrition with strategies used by DPH and other agencies.

DPH supports sites for primary care and pregnancy testing at family planning clinics. Outreach services in Hartford engage pregnant women into early and regular care. Breastfeeding provides optimal nutrition for infants and is associated with decreased risk for infant morbidity and mortality and maternal morbidity. CT has a Baby-Friendly hospital initiative. CT birth facilities require further education on adhering to the standard clinical practice guidelines against routine bottle supplementation when breastfeeding.

Connecticut State Law mandates that all newborns delivered in the state be screened for selected genetic and metabolic disorders. The Newborn Screening Program consists of: Testing, Tracking, and Treatment. Specimens are tested at the State Laboratory; all abnormal results are reported to the DPH Tracking Unit who reports the results to the primary care providers and assures referrals are made to the State funded Regional Treatment Centers (RTCs). All babies born in CT are screened prior to hospital discharge or within the first 4 days of life for early identification of increased risk for selected metabolic or genetic diseases so that medical treatment can be promptly initiated to avert complications and prevent irreversible problems and death.

In March of 2013, DPH established a State Coalition to Improve Birth Outcomes (The Coalition). The Coalition developed a State Plan to Improve Birth Outcomes (PIBO). The strategies outlined in the PIBO will serve to reduce perinatal health disparities and improve the health of women and infants across the life course. The strategies outlined in the PIBO will serve to reduce perinatal health disparities and improve the health of women and infants across the life course. The Coalition has been identified by the DPH as the workgroup for the implementation of the focus area Maternal, Infant and Child Health in the SHIP.

3.Child Health

The SHIP includes 3 specific objectives associated with child health, and address: 1) infant and child nutrition, 2) child health and well-being.

The SHIP is objective-specific regarding child health, including the following: 1) increase by 10% the percentage of children up to 19 years of age at greatest risk for poor health outcomes that receive well-child visits; 2) increase by 10% the percentage of children under 3 years of age at greatest risk for oral disease who receive any dental care; and 3) increase by 10% the percentage of parents who complete standardized developmental screening tools consistent with American Academy of Pediatrics guidelines.

DPH will develop and implement educational campaigns for parents around patient-centered medical home. Partnerships and collaborations are venues to explore opportunities to identify cultural barriers to using primary care physicians. The DPH is working with primary care providers to incorporate parental education on developmental milestones, and communicates benefits of standardized developmental screening tools to parents and providers in primary care settings.

The Early Hearing Detection and Intervention (EHDI) Program coordinates data collection, tracking, and surveillance as part of the public health system; and promotion of timely diagnosis of hearing loss and prompt enrollment in Birth-to-Three through partnership building and provider and parent educational initiatives. The goal of this program is to reduce the loss to follow-up/documentation of infants who have not passed a physiologic newborn hearing screening examination prior to discharge from the new born nursery in order to improve quality developmental outcomes for infants identified with hearing loss.

The Immunizations Program distributes vaccines to providers throughout the state, conducts surveillance for vaccine preventable diseases, conducts quality assurance reviews for vaccines for children programs, conducts educational programs for medical personnel and the public, works with providers using the immunization registry to assure that all children in their practices are fully immunized, promulgates rules and regulations related to vaccination requirements for day care, schools, colleges and universities.

4.Children with Special Health Care Needs (CYSHCN)

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

The Connecticut Medical Home Initiative (CMHI) for CYSHCN includes 5 community-based regional medical home care coordination networks; a statewide point of intake, information and referral; provider and family outreach and parent-to-parent support; and access to respite and extended services.

Respite Services: Care provided in or out of the home giving relief to the family/caregiver from the daily responsibilities of care provision for the child/youth with special health care needs. Respite services are family-directed.

Extended services: Deemed medically necessary and appropriate by the medical provider of the CYSHCN, and include durable medical equipment, pharmaceuticals, specialized nutritional formulas and other DPH's approved extended services/goods for families of CYSHCN whose income is less than or equal to 300% of the federal poverty level guidelines and who are not eligible for the CT Medicaid or Healthcare for UninSured Kids and Youth programs.

The DPH established the Medical Home Advisory Council (MHAC) to improve the community-based system of care for CYSHCN by ensuring their connection to a medical home that is accessible, compassionate, comprehensive, coordinated, continuous, culturally effective and family-centered. The MHAC includes representation from parents (families/caregivers) of CYSHCN, partners in the CMHI, service providers, community-based organizations, and public and private agencies.

Neurodevelopment disorders or autism spectrum disorders (ASD) are associated with social impairments, communication difficulties, and the engagement in repetitive or restrictive behaviors. Focus area 6 of the SHIP addresses ASD: Increase by 10% the number of children who are referred to Connecticut Birth to Three System following a failed Modified Checklist for Autism in Toddlers screening.

The DPH is fully committed to fostering a system that provides all YSHCN the services necessary to make successful transitions to adult life including adult health care, work and independence.

5.Adolescent Health

The DPH works with multiple state partners and stakeholders to address the needs of CYSHCN, as well as the health of every adolescent in the state. This includes a firm commitment to increasing access to comprehensive health services offered primarily at community health centers (CHCs) and school based health centers (SBHCs), including an emphasis on prevention and well-child visits.

SBHCs are freestanding medical clinics licensed as outpatient or hospital satellite clinics that are located within or on school grounds. SBHCs provide primary care, mental health services, and health promotion/education/risk reduction activities. Dental care is also available at some sites. The 85 DPH-funded SBHCs are in 28 communities for a total of 96 service sites. Enhance School Health Services (ESHS) vary by site and include, but are not limited to: counseling, health education, health screening, psychosocial care, and prevention services. There are 12 ESHC that receive state funding. School-linked services describe a site that is linked to another SBHC for support.

Mental health services are a priority within the SBHCs and experienced adolescent health clinical staff that provide medical, mental/behavioral health services are employed. One focus is suicide prevention among adolescents.

6.Cross-Cutting/Life Course

The Life Course Theory conceptual framework points to broad social, economic and environmental factors as underlying causes of inequalities in health. The general concept of life course theory is to address early childhood determinants of adult health, before health conditions are realized in adulthood. An extension of the theory is that accumulating years of poor health and multiple risk factors lead to racial and ethnic disparities in adult health status. Connecticut has made progress in the past few years in adhering to this broad philosophy. In addition, Connecticut has been adding the model of the Life Course Theory and examining the effects of social determinants on population health. DPH has recently released key documents that reflect this approach;

The State Health Improvement Plan (SHIP), 2014-2020, in which health equity and the social determinants of health are overarching themes for the entire plan,

Statewide Health Care Facilities and Services Plan through the Office of Health Care Access' (OHCA) with an intent to increase accessibility, continuity and quality of health services; prevent unnecessary duplication of health resources and provide financial stability and cost containment of health care services, and

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.

These documents are directly linked to the overarching goals of the MCH initiatives.

II.B.2.b.iii. MCH Workforce Development and Capacity

Renee Coleman Mitchell, MPH, and Rosa M. Biaggi, MPH, MPA, are Chiefs of the CFHES. Ms. Biaggi is the former Title V Director, and Ms. Coleman-Mitchell has supervised the Director of the state WIC Program. Marcie Cavacas, MS, is the current Title V Director and reports directly to Marjorie Chambers, MS, RD, the Director of the WIC Program. Mark Keenan, RN, MBA, is the Children with Special Health Care Needs Director and reports to Ms. Biaggi. Ann Gionet, MCHBG Family Advocate, reports to Mr. Keenan. Ms. Gionet coordinates the public input section for the block grant application by holding focus groups and contacting individual family readers.

The CFHES employs 90 permanent staff with expertise and skills in various areas of public CFHES have graduate degrees or have experience in nursing, social work, allied health, health education, research, evaluation, epidemiology, law, planning, administration and management. The majority of CT's Title V program activities reside organizationally within the CFHES in the PHI Branch.

The MCHBG supports a full time equivalent in the Health Information Systems and Reporting Section, in the Planning Branch to maintain vital record databases containing information on births, deaths, hospitalizations and risk factors related to maternal and child health. Epidemiologists use vital record information to help direct and evaluate Title V program activity. Funding from the MCHBG also provides support for staff in the Newborn Screening Program, the Fiscal Office and Grants and Contracts.

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

In March of 2013, DPH established a State Coalition to Improve Birth Outcomes (The Coalition). In collaboration with the Governor's Office, the Connecticut Chapter of the March of Dimes, New Haven Healthy Start, and the Department of Social Services, The Coalition developed a State Plan to Improve Birth Outcomes (PIBO). The Coalition, which has over 100 members representing all aspects of maternal and child health, has examined the magnitude of the problem and modifiable risk factors for preterm births, low birth weight, infant mortality, and associated racial/ethnic health disparities, and has knowledge of corresponding existing policies and programs in Connecticut and other states that are addressing these issues. The strategies outlined in the PIBO will serve to reduce perinatal health disparities and improve the health of women and infants across the life course. At the writing of this application, the PIBO has been finalized and is expected to be fully endorsed by the Commissioner’s Office for implementation. The strategies outlined in the PIBO will serve to reduce perinatal health disparities and improve the health of women and infants across the life course. The Coalition recently merged with the former MCH Advisory Group, and commencing in September 2015 will be known as the CT MCH Coalition.

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

Culturally competent approaches in service delivery include: (1) The collection and analysis of data (e.g. Race, ethnicity, language) according to the standards outlined by the DPH Data Collection and Quality Improvement Committee. The purpose of this committee is to ensure adherence to the DPH data collection policy and any data policy documents, to assure that DPH data standards are being met. The Office of Health Equity (OHE), housed within CFHES, works to ensure that health equity is a cross-cutting principle in all agency programs and planning efforts. (2) The OHE program activities focus on the underlying social determinants of health, and federally-funded initiatives focus on promotion and implementation of culturally and linguistically appropriate services in DPH contractor, local health, and community-based organizations. Culturally and linguistically appropriate services are seen as a critical step in addressing long-term health and healthcare disparities confronted by diverse communities throughout the State.

II.B.2.c. Partnerships, Collaboration, and Coordination

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.

DPH CYSHCN program participates on the Birth to Three Interagency Coordinating Council, the CT Council on Developmental Disabilities, the A.J. Pappanikou Center for Excellence on Developmental Disabilities Consumer

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

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1	WELL WOMAN CARE/HEALTH OF WOMEN OF REPRODUCTIVE AGE	New	
2	PRETERM BIRTHS AND LOW BIRTH WEIGHT BIRTHS	New	
3	BREASTFEEDING	New	
4	DEVELOPMENTAL SCREENING, WELL-CHILD VISITS AND IMMUNIZATIONS	New	
5	TRANSITION TO ADULT HEALTH CARE	New	
6	MEDICAL HOME	New	
7	BULLYING	New	
8	ADOLESCENT WELLNESS	New	
9	ORAL HEALTH	New	

The table above lists the State Selected Priorities.

The State Selected Priorities identified are in alignment with the Maternal, Infant, and Child Health Focus Area of the Connecticut State Health Improvement Plan. This plan was created through a statewide, collaborative planning process that engaged partners and organizations to develop, support, and implement the Plan. The Plan was designed to complement and build upon other guiding documents, plans, initiatives, and coalitions already in place to improve the health of Connecticut residents.

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:

- RELEVANCE
    - How Important Is It?
- IMPACT
    - What Will We Get Out of It?

- FEASIBILITY
  - Can We do It?
- APPROPRIATENESS
  - Should We Do It?

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 DPH 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
Women's and Maternal Health	1. Well woman care/health of women of reproductive age
Perinatal and Infant's Health	1. Preterm births and low birth weight births 2. Breastfeeding
Child Health	1. Developmental screening, well-child visits and immunizations
Children with Special Health Care Needs	1. Transition to Adult Health Care 2. Medical home
Adolescent Health	1. Bullying 2. Adolescent Wellness
Cross-Cutting or Life Course Issues	1. Oral health

II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

NPM 1-Percent of women with a past year preventive medical visit

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	68.2	70.0	72.0	74.0	76.0

NPM 3-Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	84.7	87.0	89.0	90.0	93.0

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	78.8	81.0	83.0	85.0	87.0

NPM-4 B) Percent of infants breastfed exclusively through 6 months

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	17.3	17.0	17.0	18.0	18.0

NPM 6-Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives					
	2016	2017	2018	2019	2020

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	26.6	27.0	27.0	28.0	28.0

NPM 10-Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	91.5	93.0	94.0	95.0	96.0

NPM 11-Percent of children with and without special health care needs having a medical home

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	49.6	50.0	51.0	51.0	52.0

NPM 12-Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	44.7	45.0	45.0	46.0	47.0

NPM-13 A) Percent of women who had a dental visit during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	50.9	52.0	53.0	54.0	56.0

NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	86.3	87.0	88.0	89.0	91.0

Domain	State Selected Priorities	National Performance Measure	Rationale for Selection
Women's and Maternal Health	1. Well woman care/health of women of reproductive age	Well-woman visit (Percent of women with a past year preventive medical visit)	The State Selected Priorities and the NPM's are directly correlated. The data from the NPM will clearly support tracking the progress of the selected priority.
Perinatal and Infant's Health	1. 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))	
	1. Breastfeeding	Breastfeeding (A. Percent of infants who are ever breastfed and B. Percent of infants breastfed exclusively through 6 months)	
Child Health	1. 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)	
Children with Special Health Care Needs	1. 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)	
	1. Medical home	Medical home (Percent of children with and without special health care needs having a medical home)	
Adolescent Health	1. Adolescent Wellness	Adolescent well-visit (Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year)	

Domain	State Selected Priorities	National Performance Measure	Rationale for Selection
Cross-Cutting or Life Course Issues	1. 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)	

II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

States are not required to provide a narrative discussion on the State Performance Measures (SPMs) until the FY2017 application

II.F. Five Year State Action Plan

II.F.1 State Action Plan and Strategies by MCH Population Domain

State Action Plan Table

Women/Maternal Health

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
WELL WOMAN CARE/HEALTH OF WOMEN OF REPRODUCTIVE AGE	1.1 By 2020, increase by 10% the proportion of all Connecticut women receiving an annual well visit including age appropriate screenings. 1.2 By 2020, increase by 5% the proportion of all Connecticut women receiving an annual dental visit.	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. 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.	Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Percent of low birth weight deliveries (<2,500 grams) Percent of very low birth weight deliveries (<1,500 grams) Percent of moderately low birth weight deliveries (1,500-2,499 grams) Percent of preterm births (<37 weeks) Percent of early preterm births (<34 weeks) Percent of late preterm births	Percent of women with a past year preventive medical visit		

State Action Plan Table						
Women/Maternal Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
			(34-36 weeks) Percent of early term births (37, 38 weeks) Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births			

Women/Maternal Health

Women/Maternal Health - Plan for the Application Year

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.

The Intimate Partner Violence Prevention Program (IPVPP) as well as the Sexual Violence Prevention Program (SVPP), which provides sexual violence prevention education programs through community based partners, are now administered by the Injury Prevention Program (IPP) within the Community, Family and Health Equity Section. IPVPP promotes intimate partner violence recognition and prevention for incarcerated women recently released to halfway houses, working through community-based agency staff. SVPP is funded through the CDC Rape Prevention and Education Grant, IPVPP was formerly funded through the Preventive Health and Health Services Block Grant. MCH staff are partnering with IPP staff to develop ongoing sustainability for these projects.

Women/Maternal Health - Annual Report

NPM 1 - Percent of women with a past year preventive medical visit

Annual Objectives					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	68.2	70	72	74	76

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 Connecticut Breast and Cervical Cancer Early Detection Program (CBCCEDP) is a comprehensive screening program available throughout Connecticut at any of the 11 funded provider sites for medically underserved and uninsured women. The primary objective of the program is to significantly increase the number of women who receive breast and cervical cancer screening, diagnostic and treatment referral services. Services are offered at no cost to program eligible women. For women who are program ineligible, services are provided through charity care or a mutual payment arrangement where no woman is denied treatment services. 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.

State Action Plan Table

Perinatal/Infant Health

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
PRETERM BIRTHS AND LOW BIRTH WEIGHT BIRTHS	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	Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births	Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)		

State Action Plan Table						
Perinatal/Infant Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		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				
BREASTFEEDING	3.1 By 2020, increase by 10% the proportion of infants who are ever breastfed. 3.2 By 2020, increase by 5% the proportion of infants who are breastfed at 6 months.	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 3.2.1 Provide targeted technical assistance and support to breast	Post neonatal mortality rate per 1,000 live births Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months		

State Action Plan Table						
Perinatal/Infant Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		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.				

Perinatal/Infant Health

Perinatal/Infant Health - Plan for the Application Year

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 20th to 28th week of gestation and ends 1 to 4 weeks after birth.”

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 5th birthday. Breastfeeding services are also provided through hospitals, community-based agencies and maternal and child health programs throughout CT.

With CDC 1305 grant funds, DPH continues to with the CT Breastfeeding Coalition’s (CBC) Ten Steps Collaborative to encourage hospitals to implement evidenced-based maternity care and the 10 Steps for Successful Breastfeeding. Two additional focus groups will be conducted to round out the Southern Connecticut State University report aimed at gaining understanding of both new parents (primarily teen mothers) around Baby -Friendly Hospital Initiative (BFHI) and maternity care practices experienced around the State. Once the final two groups are completed, themes from the sessions will be reviewed and 1 or 2 consumer materials will be developed to promote BFHI and evidenced based maternity care. CT-WIC will continue to participate in the quarterly meetings of the CPQC to assist hospitals in the use of human milk in the newborn/infant population, from healthy newborns to the NICU baby called HI-MOM (Human Infants with Mother's Own Milk).

Through CDC 1305 grant funding the Department will continue to partner with a training consultant from UConn Health Center for Public Health and Health Policy to provide staff at least one Federally Qualified Health Center and various peer support networks such as Breastfeeding USA, Nurturing Families and La Leche League access to the Secrets of Baby Behavior (SBB) training. A webinar through CT Chapter of the American Academy of Pediatrics (CT-AAP) in planned in order to expose the hard-to-reach provider population with SBB messages.

DPH will continue to support worksites voluntary application to the CBC's *Breastfeeding Friendly Worksite Program* via an open letter to businesses, signed by the DPH Commissioner to call attention to the needs of breastfeeding mothers that return to work. Additional outreach efforts includes networking with schools and the CT Business and Industry Association (CBIA) about accommodations for breastfeeding mothers.

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."

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".

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."

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.

Perinatal/Infant Health - Annual Report

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	84.7	87	89	90	93

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	78.8	81.0	83.0	85.0	87.0

NPM-4 B) Percent of infants breastfed exclusively through 6 months

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	17.3	17.0	17.0	18.0	18.0

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.

Using CDC 1305 grant funds, DPH is working with the CT Breastfeeding Coalition's (CBC) Ten Steps Collaborative to encourage hospitals to implement evidenced-based maternity care and the 10 Steps for Successful Breastfeeding. In 2015, Southern Connecticut State University researcher, completed a total of six focus groups, to gain understanding of both new parents (primarily mothers) and maternity care nurses perceptions and knowledge around Baby -Friendly Hospital Initiative (BFHI) and maternity care practices experienced around the State. The final report is forthcoming. CT-WIC breastfeeding staff participated in the quarterly meetings of the CT Perinatal Quality Collaborative (CPQC) which is a statewide hospital collaborative, focused on enhancing the use of human milk in the newborn/infant population, from healthy newborns to the NICU baby called HI-MOM (Human Infants with Mother's Own Milk).

Through CDC 1305 grant funding the Department partnered with a training consultant from UConn Health Center for Public Health and Health Policy to provide staff at two Federally Qualified Health Centers access to the Secrets of Baby Behavior training. The Secrets of Baby Behavior training was developed by the California WIC Program and US Davis Human Lactation Center through a USDA funded, 2009 WIC Special Projects grant. The training aims to assist health care team in providing consistent messages to parents and support people regarding Infant Cues, Crying and Sleep, with the goal of increasing exclusive breastfeeding and reducing supplementation or overfeeding of formula.

The Connecticut WIC Program adapted from Vermont WIC Program and distributed a Breastfeeding Success Checklist to assist moms in planning for both the hospital stay and few weeks after the birth of their child. This checklist is used in all Connecticut WIC Programs as part of breastfeeding education and support. Several hospitals have also asked for copies to use in their childbirth classes.

In 2015 the CBC's *Breastfeeding Friendly Worksite Program* recognized 14 worksites that completed the updated on-line application to verify they comply with both Federal and State lactation accommodation laws. Additionally, a *"What Are Your Rights?"* business card was printed and distributed through CBC, WIC and other organizations that provides information on the state's lactation accommodation laws. DPH, CT-DOL and CBC also collaborated on the development of an educational podcast on state and federal lactation accommodation laws. The podcast is available on the DPH Breastfeeding webpage.

State Action Plan Table

Child Health

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs
DEVELOPMENTAL SCREENING, WELL-CHILD VISITS AND IMMUNIZATIONS	4.1 By 2020, increase by x% the number of developmental screenings conducted by providers with a formal tool. 4.2 By 2020, increase by x% the number of well-child visits and oral health assessments. By 2020, increase by	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.	Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) Percent of children in excellent or very good health	Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool	

State Action Plan Table

Child Health

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs
	5% the number of children that receive age appropriate ACIP recommended vaccines.	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 reproductive health services. 4.2.4 Partner with Access CT to encourage youths under 21 years of age to obtain primary care. 4.2.5 Advocate for more funding for "Home by One." 4.2.6 Provide public education on importance of annual preventive dental services. 4.3.1 Assure costs of			

State Action Plan Table					
Child Health					
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**
		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.			

Child Health

Child Health - Plan for the Application Year

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.

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.

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.

Child Health - Annual Report

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives

	2016	2017	2018	2019	2020
Annual Objective	26.6	27	27	28	28

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. Pappanikou 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.

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.

State Action Plan Table

Adolescent Health

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
ADOLESCENT WELLNESS	8.1 By 2020, increase the % of adolescents receiving well	8.1.1 Educate parents on the frequency of and importance of	Adolescent mortality rate ages 10 through 19 per 100,000	Percent of adolescents, ages 12 through 17, with a		

State Action Plan Table

Adolescent Health

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
	child visits inclusive of behavioral and oral health risk-assessment and anticipatory guidance 8.2 By 2020, increase the % of students that report being physically active at least 60 min/day for more than 5 days, 7 days. 8.3 By 2020, decrease the % of 5-12 yrs. and 9-12th grade students that are overweight (≥ 85th percentile – 95th percentile) 8.4 By 2020, decrease the % of students (5-12 yrs. old/9-12th grade) that are obese. (≥ 95th percentile). 8.5 By 2020, increase the % of students that	well-child visits 8.1.2 Support school-based health centers that offer comprehensive health services. 8.1.3 Educate/train medical providers and School Based Health Center staff on including behavioral and oral health risk assessments during well child visits. 8.1.4 Partner with students, parents and providers to develop and implement an outreach campaign regarding the importance of a comprehensive adolescent well child visit. 8.2.1 Educate and train school staff (teachers,	Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000 Adolescent suicide rate, ages 15 through 19 per 100,000 Percent of children with a mental/behavioral condition who receive treatment or counseling Percent of children in excellent or very good health Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile) Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza	preventive medical visit in the past year.		

State Action Plan Table

Adolescent Health

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
	report getting an average of 8 or more hours of sleep at night. 8.6 By 2020, increase the % of students that report excellent or very good health.	administrators) on developing and implementing comprehensive school physical activity programs (CSPAP) 8.2.2 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. 8.3.1 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.	Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine			

State Action Plan Table						
Adolescent Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		8.4.1 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. 8.5.1 Educate students and parents on the importance of adequate sleep on health and academic performance. 8.6.1 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.				

State Action Plan Table

Adolescent Health

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
BULLYING	7.1 By 2020, decrease the % of students, including those with Special Health Care Needs, that report there are bullies on school property in the past 12 months. 7.2 By 2020, decrease the % of students, including those with Special Health Care Needs, that report being electronically bullied in the past 12 months.	7.1.1 Define bullying and educate parents, School Based Health Center staff, students and school administration on school bullying and how to prevent/control. 7.1.2 Partner with the Department of Education, DMHAS and DCF to support initiatives around bullying prevention. 7.2.1 Define electronic bullying and educate parents, School Based Health Center staff, students and school administration on electronic bullying and how to prevent/control.	Adolescent mortality rate ages 10 through 19 per 100,000 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000 Adolescent suicide rate, ages 15 through 19 per 100,000 Percent of children with a mental/behavioral condition who receive treatment or counseling Percent of children in excellent or very good health Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile) Percent of children 6 months	Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.		

State Action Plan Table						
Adolescent Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		7.2.2 Partner with the Department of Education, DMHAS and DCF to support initiatives around bullying prevention.	through 17 years who are vaccinated annually against seasonal influenza Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine			

Adolescent Health

Adolescent Health - Plan for the Application Year

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 Meeting*s" 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 and 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.

Adolescent Health - Annual Report

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Annual Objectives					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	91.5	93	94	95	96

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 a 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 statue 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.

State Action Plan Table

Children with Special Health Care Needs

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
MEDICAL HOME	6.1 By 2020, increase by X% the number of children, including those with Special Health Care Needs who have access to a NCQA recognized or Joint Commision Accredited patient-centered medical home. 6.2 By 2020, increase by X% the number of NCQA recognized or Joint Commission Accredited patient-centered medical homes.	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. 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	Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system Percent of children in excellent or very good health Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza	Percent of children with and without special health care needs having a medical home		

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		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.	Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine			
TRANSITION TO ADULT HEALTH CARE	5.1 By 2020, increase the % of 14-16 year olds, including those with Special Health Care Needs that have a health care	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	Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system	Percent of adolescents with and without special health care needs who received services necessary to make		

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
	transition plan developed. 5.2 By 2020, increase the % of 17 year olds, including those with Special Health Care Needs that have an adult primary care provider identified. 5.3 By 2020 increase the % of 14-16 year olds, including those with Special Health Care Needs that have an educational/ vocational transition plan in place.	developed by age 14-16. 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. 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.	Percent of children in excellent or very good health	transitions to adult health care		

Children with Special Health Care Needs

Children with Special Health Care Needs - Plan for the Application Year

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.

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).
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.

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.

Children with Special Health Care Needs - Annual Report

NPM 11 - Percent of children with and without special health care needs having a medical home

Annual Objectives					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	49.6	50	51	51	52

NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	44.7	45	45	46	47

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.

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 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.

State Action Plan Table

Cross-Cutting/Life Course

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
ORAL HEALTH	9.1 By 2020, increase by 10% the proportion of CT adults who visited a dentist in the past year (Baseline: 50.9% women who had a dental visit during pregnancy). 9.2 By 2020, Increase by 5% 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 (Baseline: 86.3% children ages 1-17 who had a preventive dental visit in the past year). 9.3 By 2020, reduce to 35% the proportion of children in third grade who have dental decay.	9.1.1 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. 9.1.2 Increase care-coordination to oral health provider in the PCMH. 9.2.1 Maintain oral health education provided to high risk parents through WIC and other MCH programs and initiatives 9.2.2 Maintain care-coordination for children enrolled in HUSKY. 9.3.1 Increase	Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months Percent of children in excellent or very good 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		

State Action Plan Table

Cross-Cutting/Life Course

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
	9.4 By 2020, reduce untreated dental decay to 15% in black non-Hispanic children and 12% in Hispanic children in the third grade. 9.5 By 2020, reduce by 5% the proportion of adults that have had all their natural teeth extracted.	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. 9.3.2 Enhance the concept and utilization of a dental home through enrollment and utilization of HUSKY. 9.3.3 Maintain the State fluoridation statute. 9.3.4 Advocate for parity of oral health with physical health and behavioral (medical) in practice, policy and reimbursement. 9.4.1Increase oral health literacy and promote the value of good oral health as it relates to the				

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		overall health and well-being of all CT residents. 9.5.1 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. 9.5.2 Increase care-coordination to oral health provider in the PCMH. 9.5.3 Maintain the State fluoridation statute. 9.5.4 Advocate for parity of oral health with physical health and behavioral (medical) in practice, policy and reimbursement. 9.5.5 Ensure a strong and sustainable oral health workforce				

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		(including medical providers) to anticipate the oral health needs of CT residents.				

Cross-Cutting/Life Course

Cross-Cutting/Life Course - Plan for the Application 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.

Cross-Cutting/Life Course - Annual Report

NPM-13 A) Percent of women who had a dental visit during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	50.9	52.0	53.0	54.0	56.0

NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	86.3	87.0	88.0	89.0	91.0

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

No content was entered for Other Programmatic Activities in the State Action Plan Narrative section.

II.F.2 MCH Workforce Development and Capacity

Workforce Development Plan Overview

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 Heath 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.

II.F.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 meeting. 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 review will join DPH staff the day of the Block Grant Review, and will be available to discuss items as needed form 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 Heath 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.

II.F.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 implement 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 CYSHCN. 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.

II.F.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.

II.F.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 Heath 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.

II.F.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 though 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.

III. Budget Narrative

	2012		2013	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$ 4,693,379	$ 4,287,280	$ 4,667,308	$ 4,294,483
Unobligated Balance	$ 288,206	$ 288,206	$ 115,099	$ 115,099
State Funds	$ 7,940,000	$ 6,780,181	$ 7,940,000	$ 6,780,181
Local Funds	$ 0	$ 0	$ 0	$ 0
Other Funds	$ 0	$ 0	$ 0	$ 0
Program Funds	$ 0	$ 0	$ 0	$ 0
SubTotal	$ 12,921,585	$ 11,355,667	$ 12,722,407	$ 11,189,763
Other Federal Funds	$ 3,197,317	$ 3,197,317	$ 13,134,792	$ 13,134,792
Total	$ 16,118,902	$ 14,552,984	$ 25,857,199	$ 24,324,555

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$ 4,431,905	$ 4,580,696	$ 4,549,998	$
Unobligated Balance	$ 380,028	$ 380,028	$ 142,365	$
State Funds	$ 6,780,181	$ 6,780,181	$ 6,780,181	$
Local Funds	$ 0	$ 0	$ 0	$
Other Funds	$ 0	$ 0	$ 0	$
Program Funds	$ 0	$ 0	$ 0	$
SubTotal	$ 11,592,114	$ 11,740,905	$ 11,472,544	$
Other Federal Funds	$ 13,296,294	▨	$ 3,047,327	$
Total	$ 24,888,408	$ 11,740,905	$ 14,519,871	$

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2016	
	Budgeted	Expended
Federal Allocation	$ 4,580,696	$
Unobligated Balance	$ 331,753	$
State Funds	$ 6,780,181	$
Local Funds	$ 0	$
Other Funds	$ 0	$
Program Funds	$ 0	$
SubTotal	$ 11,692,630	$
Other Federal Funds	$ 2,390,052	$
Total	$ 14,082,682	$

III.A. Expenditures

FFY 14 Federal Award expenditures totaled $4,580,696 and met the 30%-30%-10% requirement. Expenditures for Preventive and Primary Care for Children totaled $1,488,726 (32.5%), Children with Special Health Care Needs totaled $1,804,794 (39.4%), and $210,712 (4.6%) was Title V Administrative Costs.

The FFY 14 Title V Administrative Costs reported on Form 2 varied from the budgeted amount by more than 10%. Expenditures were higher than the budgeted amount due to: a) the actual percent time for one staff person was slightly higher than projected, and b) the actual salary for one staff person was slightly higher than the projected amount.

The requirement that there be three dollars of State matching funds for each four dollars in federal funding was met in FFY14. State matching funds are met through funding of School-Based Health Centers, the Genetics Diseases Program, and CYSHCN (Medical Homes). In FFY14, these matching funds totaled $3,970,000. In FFY14, the maintenance of effort requirement was met from several sources: Community Health Centers, Family Planning Programs, Waterbury Health Access Program, and the School-Based Health Centers located throughout the state. The State of Connecticut dollars for these programs totaled $6,780,181 in FFY14, which is $2,990 more than the required FFY 1989 base of $6,777,191. In total, the FFY14 Match and Maintenance of Effort amounts totaled $10,750,181.

III.B. Budget

The federal award in FFY 16 is estimated to be $4,580,696. The final FFY 14 federal award amount was used to estimate the award amount because the current (FFY 15) year’s award has not been finalized.

The allocation plan requires that 30% of the FFY allocation be budgeted for Prevention and Primary Care services, as well as 30% for Children with Special Health Care Needs. For the FFY16 award amount, $1,454,777 (31.8%) is allocated for Preventive and Primary Care for Children and $1,914,796 (41.8%) for the CSHCN program. There is an allocation of administrative costs of $260,907 (5.7%) of the projected federal allocation to all programs.

The requirement that there be three dollars of State matching funds for each four dollars in federal funding will be met for FFY16. The projected federal allocation for FFY16 is $4,580,696, which means that the State of Connecticut must match it with at least $3,435,522. In FFY16, these matching funds will total $3,970,000. Maintenance of Effort for FFY16 is in the amount of $6,780,181, which is $2,990 more than the required FFY1989 base of $6,777,191.

The anticipated total Federal-State Title V Block Grant Partnership total for FFY 16 is $11,692,630, which includes the estimated federal award of $4,580,696, the unobligated balance from FFY 15 ($331,753), and the State Maintenance of Effort ($6,780,181).

Other federal grants received by the CT Title V Program that will serve the maternal and child population in FFY16 include: Healthy Start; Primary Care Office; Universal Newborn Hearing Screening; Early Hearing Detection and Intervention; State Systems Development Initiative (SSDI); the Pregnancy Risk Assessment Monitoring System (PRAMS); Personal Responsibility Education Program (PREP); and the State Oral Disease Prevention Program.

There was a substantial decrease ($10,248,967 and $10,886,590, respectively) in the FFY15 and FFY16 Other Federal Funds compared to FFY14. This is mainly due to the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program being transferred from DPH to the CT Office of Early Childhood effective October 1, 2014, resulting in a loss of $9,936,510. In FFY15, there was also a second grant that was no longer included because it ended in FFY14. The remainder of the difference in FFY16 is attributed to two grants moving to another program in DPH and their funds are no longer directly under control of the Title V Program Administrator, and one grant that ended in FFY14.

Other state-funded programs that serve the maternal and child health population include: Community Health Centers, Lead Poisoning Prevention, Asthma, Genetic Sickle Cell Program, Expanded School Health Services, Rape Crisis and Prevention Services, Youth Risk Behavior Surveillance, and Family Planning. In addition to these programs, there are several state-funded DPH personnel who provide support to the maternal and child health programs.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Social Services Connecticut Department of 2011-0306-3 Fully Executed.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - assmt_state_hlth_032514.pdf

Supporting Document #02 - impv_state_hlth_032514.pdf

Supporting Document #03 - CT DPH MCH Comprehensive_Needs Assessment_Report_FINAL.pdf

Supporting Document #04 - State statutes.pdf

Supporting Document #05 - OrgChartandPublicInputCharts.pdf

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Connecticut

	FY16 Application Budgeted	FY14 Annual Report Expended
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 4,580,696	$ 4,580,696
A. Preventive and Primary Care for Children	$ 1,454,777	$ 1,488,726
B. Children with Special Health Care Needs	$ 1,914,796	$ 1,804,794
C. Title V Administrative Costs	$ 260,907	$ 210,712
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 331,753	$ 380,028
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 6,780,181	$ 6,780,181
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	$ 0
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	$ 0
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	$ 0
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 6,780,181	$ 6,780,181
A. Your State's FY 1989 Maintenance of Effort Amount	$ 6,777,191	
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 11,692,630	$ 11,740,905
9. OTHER FEDERAL FUNDS		

Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.

10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 2,390,052	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 14,082,682	$ 11,740,905

	FY14 Annual Report Budgeted
1. FEDERAL ALLOCATION	$ 4,431,905
A. Preventive and Primary Care for Children	$ 1,363,097
B. Children with Special Health Care Needs	$ 1,758,632
C. Title V Administrative Costs	$ 172,409
2. UNOBLIGATED BALANCE	$ 380,028
3. STATE MCH FUNDS	$ 6,780,181
4. LOCAL MCH FUNDS	$ 0
5. OTHER FUNDS	$ 0
6. PROGRAM INCOME	$ 0
7. TOTAL STATE MATCH	$ 6,780,181

	FY16 Application Budgeted
9. OTHER FEDERAL FUNDS	
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI);	$ 100,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS);	$ 146,777
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs;	$ 166,484
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention;	$ 250,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP);	$ 591,034
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start;	$ 625,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Oral Disease Prevent;	$ 315,000

Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State PCO;	$ 195,757

Form Notes For Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**

Field Note:
FFY14 expenditures for Title V Administrative Costs were higher than the projected amount due to: a) the actual percent time for one staff person was slightly higher than projected, and b) the actual salary for one staff person was slightly higher than the projected amount.

Data Alerts:

None

Form 3a

Budget and Expenditure Details by Types of Individuals Served

State: Connecticut

	FY16 Application Budgeted	FY14 Annual Report Expended
I. TYPES OF INDIVIDUALS SERVED		
IA. Federal MCH Block Grant		
1. Pregnant Women	$ 469,057	$ 522,199
2. Infants < 1 year	$ 430,059	$ 503,877
3. Children 1-22 years	$ 1,454,777	$ 1,488,726
4. CSHCN	$ 1,914,796	$ 1,804,794
5. All Others	$ 51,100	$ 50,388
Federal Total of Individuals Served	$ 4,319,789	$ 4,369,984
IB. Non Federal MCH Block Grant		
1. Pregnant Women	$ 730,717	$ 138,123
2. Infants < 1 year	$ 2,192,150	$ 414,368
3. Children 1-22 years	$ 3,518,305	$ 4,696,172
4. CSHCN	$ 339,009	$ 1,531,518
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 6,780,181	$ 6,780,181
Federal State MCH Block Grant Partnership Total	$ 11,099,970	$ 11,150,165

Form Notes For Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts:

None

Form 3b
Budget and Expenditure Details by Types of Services

State: Connecticut

	FY16 Application Budgeted	FY14 Annual Report Expended
I. TYPES OF SERVICES		
IIA. Federal MCH Block Grant		
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 976,856	$ 1,087,622
3. Public Health Services and Systems	$ 3,603,840	$ 3,493,074
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		
Physician/Office Services		
Hospital Charges (Includes Inpatient and Outpatient Services)		
Dental Care (Does Not Include Orthodontic Services)		
Durable Medical Equipment and Supplies		
Laboratory Services		
Direct Services Total		$ 0
Federal Total	$ 4,580,696	$ 4,580,696

IIB. Non-Federal MCH Block Grant

1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 678,018	$ 1,055,881
3. Public Health Services and Systems	$ 6,102,163	$ 5,724,300
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		
Physician/Office Services		
Hospital Charges (Includes Inpatient and Outpatient Services)		
Dental Care (Does Not Include Orthodontic Services)		
Durable Medical Equipment and Supplies		
Laboratory Services		
Direct Services Total		$ 0
Non-Federal Total	$ 6,780,181	$ 6,780,181

Form Notes For Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Connecticut

Total Births by Occurrence	37,648

1a. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Methylmalonic acidemia (methylmalonyl-CoA mutase)	37,557 (99.8%)	170	0	0 (0%)
Methylmalonic acidemia (cobalamin disorders)	37,557 (99.8%)	170	0	0 (0%)
Isovaleric acidemia	37,557 (99.8%)	10	0	0 (0%)
3-Methylcrotonyl-CoA carboxylase deficiency	37,557 (99.8%)	13	0	0 (0%)
3-Hydroxy-3-methyglutaric aciduria	37,557 (99.8%)	13	1	1 (100.0%)
Holocarboxylase synthase deficiency	37,557 (99.8%)	13	0	0 (0%)
ß-Ketothiolase deficiency	37,557 (99.8%)	13	0	0 (0%)
Glutaric acidemia type I	37,557 (99.8%)	65	0	0 (0%)
Carnitine uptake defect/carnitine transport defect	37,557 (99.8%)	22	0	0 (0%)
Medium-chain acyl-CoA dehydrogenase deficiency	37,557 (99.8%)	32	0	0 (0%)
Very long-chain acyl-CoA dehydrogenase deficiency	37,557 (99.8%)	40	0	0 (0%)
Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	37,557 (99.8%)	37	1	1 (100.0%)
Trifunctional protein deficiency	37,557 (99.8%)	37	0	0 (0%)

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Argininosuccinic aciduria	37,557 (99.8%)	20	0	0 (0%)
Citrullinemia, type I	37,557 (99.8%)	20	1	1 (100.0%)
Maple syrup urine disease	37,557 (99.8%)	32	0	0 (0%)
Homocystinuria	37,557 (99.8%)	118	0	0 (0%)
Classic phenylketonuria	37,557 (99.8%)	37	1	1 (100.0%)
Tyrosinemia, type I	37,557 (99.8%)	79	1	1 (100.0%)
Primary congenital hypothyroidism	37,557 (99.8%)	397	7	7 (100.0%)
Congenital adrenal hyperplasia	37,557 (99.8%)	55	2	2 (100.0%)
S,S disease (Sickle cell anemia)	37,557 (99.8%)	13	11	11 (100.0%)
S, βeta-thalassemia	37,557 (99.8%)	19	1	1 (100.0%)
S,C disease	37,557 (99.8%)	6	2	2 (100.0%)
Biotinidase deficiency	37,557 (99.8%)	23	3	3 (100.0%)
Severe combined immunodeficiences	37,557 (99.8%)	123	0	0 (0%)
Classic galactosemia	37,557 (99.8%)	66	2	2 (100.0%)

1b. Secondary RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Methylmalonic acidemia with homocystinuria	37,557 (99.8%)	170	0	0 (0%)
Malonic acidemia	37,557 (99.8%)	0	0	0 (0%)
Isobutyrylglycinuria	37,557 (99.8%)	39	0	0 (0%)
2-Methylbutyrylglycinuria	37,557 (99.8%)	10	0	0 (0%)
3-Methylglutaconic aciduria	37,557 (99.8%)	13	0	0 (0%)
2-Methyl-3-hydroxybutyric aciduria	37,557 (99.8%)	13	0	0 (0%)
Short-chain acyl-CoA dehydrogenase deficiency	37,557 (99.8%)	39	2	2 (100.0%)
Medium/short-chain L-3-hydroxyacl-CoA dehydrogenase deficiency	37,557 (99.8%)	29	0	0 (0%)
Glutaric acidemia type II	37,557 (99.8%)	20	0	0 (0%)
2,4 Dienoyl-CoA reductase deficiency	37,557 (99.8%)	4	0	0 (0%)
Carnitine palmitoyltransferase type I deficiency	37,557 (99.8%)	6	0	0 (0%)
Carnitine palmitoyltransferase type II deficiency	37,557 (99.8%)	6	0	0 (0%)
Carnitine acylcarnitine translocase deficiency	37,557 (99.8%)	6	0	0 (0%)
Argininemia	37,557 (99.8%)	45	0	0 (0%)
Citrullinemia, type II	37,557 (99.8%)	20	0	0 (0%)
Hypermethioninemia	37,557 (99.8%)	118	0	0 (0%)
Benign hyperphenylalaninemia	37,557 (99.8%)	37	4	4 (100.0%)

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Biopterin defect in cofactor biosynthesis	37,557 (99.8%)	37	0	0 (0%)
Biopterin defect in cofactor regeneration	37,557 (99.8%)	37	0	0 (0%)
Tyrosinemia, type II	37,557 (99.8%)	79	0	0 (0%)
Tyrosinemia, type III	37,557 (99.8%)	79	0	0 (0%)
Various other hemoglobinopathies	37,557 (99.8%)	9	3	3 (100.0%)
Galactoepimerase deficiency	37,557 (99.8%)	136	0	0 (0%)
Galactokinase deficiency	37,557 (99.8%)	136	0	0 (0%)
T-cell related lymphocyte deficiencies	37,557 (99.8%)	123	0	0 (0%)

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Newborn Hearing	37,305 (99.1%)	445	65	47 (72.3%)

3. Screening Programs for Older Children & Women

4. Long-Term Follow-Up

The CT DPH Newborn Screening (NBS) program contracts with several regional treatment centers to provide follow-up services in the areas of genetics and sickle cell disease. These centers provide the services of physicians, geneticists, nutritionists, nurse practitioners, nurses, and social workers. Services include review of abnormal NBS results and when appropriate, confirmatory testing, reports of confirmatory testing results to the NBS program, direct treatment or referral for direct treatment, regular follow-up through onsite and satellite clinics, referral and/or coordination with primary care provider/medical home, development of treatment plans, ongoing counseling and nutritional support, case management, immunization and prophylaxis tracking, education and genetic counseling, comprehensive in-patient and outpatient care and the reduction of barriers to optimal health.

Form Notes For Form 4:

None

Field Level Notes for Form 4:

None

Form 5a
Unduplicated Count of Individuals Served under Title V

State: Connecticut

Reporting Year 2014

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	2,670	42.7	14.1	31.0	12.2	0.0
2. Infants < 1 Year of Age	43,326	43.2	0.8	1.7	0.9	53.4
3. Children 1 to 22 Years of Age	143,891	66.1	3.5	21.2	9.2	0.0
4. Children with Special Health Care Needs	34,034	9.1	0.2	2.9	0.2	87.6
5. Others	245,689	46.7	0.2	29.9	12.5	10.7
Total	469,610					

Form Notes For Form 5a:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2014**
	Field Note: Total Infants < 1 served by Title V programs reported in Form 5a is greater by 10% of the total number of birth occurrences due to the fact that data for Form 5a is derived from contractor annual reports who may contribute to duplicate number of infants served.	

Form 5b
Total Recipient Count of Individuals Served by Title V

State: Connecticut

Reporting Year 2014

Types Of Individuals Served	Total Served
1. Pregnant Women	2,690
2. Infants < 1 Year of Age	43,354
3. Children 1 to 22 Years of Age	144,285
4. Children with Special Health Care Needs	34,526
5. Others	246,233
Total	471,088

Form Notes For Form 5b:

None

Field Level Notes for Form 5b:

1.	**Field Name:**	**Infants Less Than One Year**
	Fiscal Year:	**2014**
	Field Note: Total Infants < 1 served by Title V programs reported in Form 5a is greater by 10% of the total number of birth occurrences due to the fact that data for Form 5a is derived from contractor annual reports who may contribute to duplicate number of infants served.	

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Connecticut

Reporting Year 2014

I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	35,969	27,684	4,915	304	391	1,801	0	874
Title V Served	35,969	27,684	4,915	304	391	1,801	0	874
Eligible for Title XIX	15,119	10,421	3,567	75	103	459	0	494
2. Total Infants in State	35,665	27,292	4,956	300	358	1,853	0	906
Title V Served	35,665	27,292	4,956	300	358	1,853	0	906
Eligible for Title XIX	15,119	10,421	3,567	75	103	459	0	494

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	27,615	8,222	132	35,969
Title V Served	27,615	8,222	132	35,969
Eligible for Title XIX	9,793	5,326	0	15,119
2. Total Infants in State	27,513	8,088	64	35,665
Title V Served	27,513	8,088	64	35,665
Eligible for Title XIX	9,793	5,326	0	15,119

Form Notes For Form 6:

None

Field Level Notes for Form 6:

None

Form 7

State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Connecticut

	Application Year 2016	Reporting Year 2014
A. State MCH Toll-Free Telephone Lines		
1. State MCH Toll-Free "Hotline" Telephone Number	(999) 999-9999 x211	(999) 999-9999 x211
2. State MCH Toll-Free "Hotline" Name	MCH Information & Referral Services	MCH Information & Referral Services
3. Name of Contact Person for State MCH "Hotline"	Robin Tousey-Ayers	Robin Tousey-Ayers
4. Contact Person's Telephone Number	(860) 509-8074	(860) 509-8074
5. Number of Calls Received on the State MCH "Hotline"		120,790
B. Other Appropriate Methods		
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	http://ct.gov/dph/cwp/view.asp?a=3138&q=414744	
4. Number of Hits to the State Title V Program Website		
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes For Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Connecticut

Application Year 2016

1. Title V Maternal and Child Health (MCH) Director

Name	Marcie Cavacas
Title	Connecticut Title V Director
Address 1	410 Capitol Avenue
Address 2	MS #11MAT
City / State / Zip Code	Hartford / CT / 06137
Telephone	(860) 509-8074
Email	marcia.cavacas@ct.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director

Name	Mark Keenan
Title	CSHCN Director
Address 1	410 Capitol Avenue
Address 2	MS #11MAT
City / State / Zip Code	Hartford / CT / 06137
Telephone	(860) 509-8074
Email	mark.keenan@ct.gov

3. State Family or Youth Leader (Optional)

Name	Ann Gionet
Title	Family Advocate
Address 1	410 Capitol Avenue
Address 2	MS #11MAT
City / State / Zip Code	Hartford / CT / 06137
Telephone	(860) 509-8074
Email	ann.gionet@ct.gov

Form Notes For Form 8:

None

Form 9
List of MCH Priority Needs

State: Connecticut

Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	WELL WOMAN CARE/HEALTH OF WOMEN OF REPRODUCTIVE AGE	New	
2.	PRETERM BIRTHS AND LOW BIRTH WEIGHT BIRTHS	New	
3.	BREASTFEEDING	New	
4.	DEVELOPMENTAL SCREENING, WELL-CHILD VISITS AND IMMUNIZATIONS	New	
5.	TRANSITION TO ADULT HEALTH CARE	New	
6.	MEDICAL HOME	New	
7.	BULLYING	New	
8.	ADOLESCENT WELLNESS	New	
9.	ORAL HEALTH	New	

Form Notes For Form 9:

None

Field Level Notes for Form 9:

Field Name:

Priority Need 1

Field Note:
NPM #01

Field Name:

Priority Need 2

Field Note:
NPM #03

Field Name:

Priority Need 3

Field Note:
NPM #04

Field Name:

Priority Need 4

Field Note:
NPM #06

Field Name:

Priority Need 5

Field Note:
NPM #12

Field Name:

Priority Need 6

Field Note:
NPM #11

Field Name:

Priority Need 7

Field Note:
NPM #09 does address bullying, however, having identified nine State Priorities and following the rule of selecting eight NPM's out of the fifteen, we chose to make this into an SPM.

Field Name:

Priority Need 8

Field Note:
NPM #10

Field Name:

Priority Need 9

Field Note:
NPM #13

Field Name:

Priority Need 10

Field Note:

Form 10a
National Outcome Measures (NOMs)

State: Connecticut

Form Notes for Form 10a NPMs and NOMs:

Federally Available Data (FAD) was used for the majority of the selected National Performance Measures (NPMs). There were two instances where Connecticut Department of Public Health (CT DPH) data was used to populate the APOs.

NOM-1 Percent of pregnant women who receive prenatal care beginning in the first trimester

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	87.0
Numerator	31,168
Denominator	35,835
Data Source	CT DPH Health Statistics and Surveillance Section
Data Source Year	2013

NOM-1 Notes:

None

Data Alerts:

None

NOM-2 Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	136.8	6.2 %	494	36,111
2011	139.5	6.2 %	514	36,840
2010	133.6	6.0 %	498	37,285

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009	120.0	5.6 %	458	38,168
2008	112.0	5.4 %	439	39,201

Legends:

⚑ Indicator has a numerator ≤10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM-2 Notes:

None

Data Alerts:

None

NOM-3 Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2013	13.9	2.7 %	26	186,509
2008_2012	13.1	2.6 %	25	190,823
2007_2011	12.8	2.6 %	25	195,944
2006_2010	9.5 ⚡	2.2 % ⚡	19 ⚡	200,483 ⚡
2005_2009	9.8	2.2 %	20	204,493

Legends:

⚑ Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM-3 Notes:

None

Data Alerts:

None

NOM-4.1 Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	7.8 %	0.1 %	2,820	36,073
2012	7.9 %	0.1 %	2,868	36,525
2011	7.7 %	0.1 %	2,883	37,262
2010	8.0 %	0.1 %	3,011	37,690
2009	8.0 %	0.1 %	3,127	38,877

Legends:

⚑ Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.1 Notes:

None

Data Alerts:

None

NOM-4.2 Percent of very low birth weight deliveries (<1,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	1.4 %	0.1 %	514	36,073
2012	1.5 %	0.1 %	536	36,525
2011	1.5 %	0.1 %	573	37,262
2010	1.5 %	0.1 %	577	37,690

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009	1.4 %	0.1 %	555	38,877

Legends:

⚑ Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.2 Notes:

None

Data Alerts:

None

NOM-4.3 Percent of moderately low birth weight deliveries (1,500-2,499 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.4 %	0.1 %	2,306	36,073
2012	6.4 %	0.1 %	2,332	36,525
2011	6.2 %	0.1 %	2,310	37,262
2010	6.5 %	0.1 %	2,434	37,690
2009	6.6 %	0.1 %	2,572	38,877

Legends:

⚑ Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.3 Notes:

None

Data Alerts:

None

NOM-5.1 Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	9.3 %	0.2 %	3,357	36,069
2012	9.7 %	0.2 %	3,548	36,515
2011	9.8 %	0.2 %	3,632	37,248
2010	9.9 %	0.2 %	3,728	37,634
2009	10.0 %	0.2 %	3,875	38,868

Legends:

⚑ Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.1 Notes:

None

Data Alerts:

None

NOM-5.2 Percent of early preterm births (<34 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	2.8 %	0.1 %	998	36,069
2012	2.8 %	0.1 %	1,030	36,515
2011	2.9 %	0.1 %	1,088	37,248
2010	3.1 %	0.1 %	1,154	37,634

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009	2.9 %	0.1 %	1,120	38,868

Legends:

⚑ Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.2 Notes:

None

Data Alerts:

None

NOM-5.3 Percent of late preterm births (34-36 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.5 %	0.1 %	2,359	36,069
2012	6.9 %	0.1 %	2,518	36,515
2011	6.8 %	0.1 %	2,544	37,248
2010	6.8 %	0.1 %	2,574	37,634
2009	7.1 %	0.1 %	2,755	38,868

Legends:

⚑ Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.3 Notes:

None

Data Alerts:

None

NOM-6 Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	22.3 %	0.2 %	8,041	36,069
2012	23.0 %	0.2 %	8,384	36,515
2011	22.8 %	0.2 %	8,509	37,248
2010	23.6 %	0.2 %	8,872	37,634
2009	23.8 %	0.2 %	9,262	38,868

Legends:

⚑ Indicator has a numerator <10 and is not reportable

ϟ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-6 Notes:

None

Data Alerts:

None

NOM-7 Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013/Q2-2014/Q1	4.0 %			

Legends:

⚑ Indicator results were based on a shorter time period than required for reporting

NOM-7 Notes:

None

Data Alerts:

None

NOM-8 Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.3	0.4 %	193	36,180
2012	5.8	0.4 %	212	36,619
2011	5.9	0.4 %	222	37,394
2010	5.6	0.4 %	210	37,792
2009	6.3	0.4 %	245	39,004

Legends:

⚑ Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM-8 Notes:

None

Data Alerts:

None

NOM-9.1 Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	4.8	0.4 %	173	36,085

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	5.3	0.4 %	192	36,539
2011	5.2	0.4 %	192	37,281
2010	5.3	0.4 %	200	37,708
2009	5.6	0.4 %	216	38,896

Legends:
⚑ Indicator has a numerator <10 and is not reportable
⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM-9.1 Notes:

None

Data Alerts:

None

NOM-9.2 Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	3.3	0.3 %	118	36,085
2012	4.1	0.3 %	149	36,539
2011	3.6	0.3 %	133	37,281
2010	4.0	0.3 %	149	37,708
2009	4.2	0.3 %	163	38,896

Legends:
⚑ Indicator has a numerator <10 and is not reportable
⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM-9.2 Notes:

None

Data Alerts:

None

NOM-9.3 Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	1.5	0.2 %	55	36,085
2012	1.2	0.2 %	43	36,539
2011	1.6	0.2 %	59	37,281
2010	1.4	0.2 %	51	37,708
2009	1.4	0.2 %	53	38,896

Legends:

⚑ Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM-9.3 Notes:

None

Data Alerts:

None

NOM-9.4 Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	205.1	23.9 %	74	36,085
2012	251.8	26.3 %	92	36,539
2011	182.4	22.1 %	68	37,281

Year	Annual Indicator	Standard Error	Numerator	Denominator
2010	251.9	25.9 %	95	37,708
2009	226.2	24.1 %	88	38,896

Legends:

⚑ Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM-9.4 Notes:

None

Data Alerts:

None

NOM-9.5 Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	66.5	13.6 %	24	36,085
2012	52.0 ⚡	11.9 % ⚡	19 ⚡	36,539 ⚡
2011	51.0 ⚡	11.7 % ⚡	19 ⚡	37,281 ⚡
2010	47.7 ⚡	11.3 % ⚡	18 ⚡	37,708 ⚡
2009	59.1	12.3 %	23	38,896

Legends:

⚑ Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM-9.5 Notes:

None

Data Alerts:

None

NOM-10 The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

FAD Not Available for this measure.

NOM-10 Notes:

None

Data Alerts:

None

NOM-11 The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	10.1	0.5 %	363	36,111
2011	10.1	0.5 %	371	36,840
2010	9.0	0.5 %	334	37,285
2009	8.4	0.5 %	320	38,168
2008	7.6	0.4 %	296	39,201

Legends:

⚑ Indicator has a numerator ≤10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM-11 Notes:

None

Data Alerts:

None

NOM-12 Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM-12 Notes:

None

Data Alerts:

None

NOM-13 Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM-13 Notes:

None

Data Alerts:

None

NOM-14 Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	15.0 %	1.1 %	114,085	762,258

Legends:

⚑ Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-14 Notes:

None

Data Alerts:

None

NOM-15 Child Mortality rate, ages 1 through 9 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	8.7	1.5 %	32	369,636
2012	18.7	2.2 %	70	374,757
2011	16.6	2.1 %	63	379,229
2010	10.1	1.6 %	39	386,665
2009	13.9	1.9 %	54	387,694

Legends:

⚑ Indicator has a numerator <10 and is not reportable
⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM-15 Notes:

None

Data Alerts:

None

NOM-16.1 Adolescent mortality rate ages 10 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	23.9	2.2 %	116	486,018
2012	20.6	2.1 %	101	490,209
2011	19.8	2.0 %	97	490,613
2010	22.4	2.1 %	110	491,099
2009	22.0	2.1 %	109	495,357

Legends:

⚑ Indicator has a numerator <10 and is not reportable
⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM-16.1 Notes:

None

Data Alerts:

None

NOM-16.2 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2013	8.3	1.0 %	63	762,425
2010_2012	8.2	6.3 %	62	759,483
2009_2011	9.0	7.0 %	68	757,495
2008_2010	10.4	8.2 %	79	759,087
2007_2009	11.8	9.5 %	90	761,817

Legends:

⚑ Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM-16.2 Notes:

None

Data Alerts:

None

NOM-16.3 Adolescent suicide rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2013	5.4	3.9 %	41	762,425

Year	Annual Indicator	Standard Error	Numerator	Denominator
2010_2012	5.8	4.2 %	44	759,483
2009_2011	5.7	4.1 %	43	757,495
2008_2010	5.4	3.9 %	41	759,087
2007_2009	6.0	4.4 %	46	761,817

Legends:
⚑ Indicator has a numerator <10 and is not reportable
⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM-16.3 Notes:

None

Data Alerts:

None

NOM-17.1 Percent of children with special health care needs

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	20.4 %	1.2 %	163,219	801,603
2007	20.9 %	1.2 %	169,786	813,675
2003	17.9 %	1.0 %	148,817	832,105

Legends:
⚑ Indicator has an unweighted denominator <30 and is not reportable
⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-17.1 Notes:

None

Data Alerts:

None

NOM-17.2 Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	19.6 %	1.9 %	23,839	121,536

Legends:

⚑ Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-17.2 Notes:

None

Data Alerts:

None

NOM-17.3 Percent of children diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	1.3 %	0.3 %	8,693	693,819
2007	1.2 %	0.3 %	8,224	690,722

Legends:

⚑ Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-17.3 Notes:

None

Data Alerts:

None

NOM-17.4 Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	7.2 %	0.9 %	49,630	692,656
2007	5.2 %	0.7 %	35,744	689,569

Legends:

⚑ Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-17.4 Notes:

None

Data Alerts:

None

NOM-18 Percent of children with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	66.9 % ⚡	5.3 % ⚡	45,149 ⚡	67,472 ⚡
2007	80.2 %	4.8 %	35,382	44,129
2003	76.2 %	4.5 %	38,366	50,361

Legends:

⚑ Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-18 Notes:

None

Data Alerts:

None

NOM-19 Percent of children in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	85.8 %	1.1 %	687,642	801,603
2007	88.2 %	1.0 %	717,021	813,451
2003	87.3 %	0.9 %	726,341	832,105

Legends:

⚑ Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-19 Notes:

None

Data Alerts:

None

NOM-20 Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	29.7 %	2.0 %	111,540	375,787
2007	25.7 %	1.9 %	94,892	368,678
2003	27.3 %	1.7 %	97,615	357,225

Legends:

⚑ Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	32.2 %	0.3 %	7,041	21,886

Legends:

⚑ Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable

⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	26.3 %	1.2 %	41,425	157,768
2011	26.7 %	1.5 %	43,551	163,149
2009	24.5 %	1.3 %	40,073	163,609
2007	25.2 %	1.2 %	41,696	165,232
2005	25.6 %	1.7 %	42,297	164,971

Legends:

⚑ Indicator has an unweighted denominator <100 and is not reportable

⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-20 Notes:

None

Data Alerts:

None

NOM-21 Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	4.1 %	0.4 %	31,898	784,480
2012	3.7 %	0.4 %	29,169	793,378
2011	2.5 %	0.3 %	19,792	802,876
2010	2.9 %	0.3 %	23,909	815,045
2009	3.9 %	0.4 %	31,368	807,442

Legends:

🚩 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-21 Notes:

None

Data Alerts:

None

NOM-22.1 Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	78.2 %	3.5 %	43,810	56,042
2012	77.1 %	2.9 %	43,927	56,955
2011	74.6 %	2.8 %	43,703	58,563
2010	57.9 %	4.1 %	34,813	60,166
2009	34.4 %	4.9 %	21,769	63,243

Legends:
⚑ Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.1 Notes:

None

Data Alerts:

None

NOM-22.2 Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013_2014	70.1 %	1.9 %	532,463	760,115
2012_2013	64.9 %	1.9 %	492,565	758,790
2011_2012	60.8 %	2.3 %	466,401	766,606
2010_2011	61.8 % ⚡	2.6 % ⚡	466,366 ⚡	754,637 ⚡
2009_2010	46.6 %	1.8 %	365,011	783,286

Legends:
⚑ Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.2 Notes:

None

Data Alerts:

None

NOM-22.3 Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Female

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	56.0 %	4.7 %	65,940	117,770
2012	57.6 % ⚡	5.3 % ⚡	68,221 ⚡	118,531 ⚡
2011	60.5 %	4.3 %	72,418	119,620
2010	57.9 %	4.3 %	68,713	118,769
2009	61.2 %	4.3 %	72,498	118,404

Legends:

⚑ Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Male

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	52.3 %	4.7 %	64,477	123,342
2012	20.3 %	3.4 %	25,180	124,246
2011	17.3 %	3.2 %	21,720	125,416

Legends:

⚑ Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.3 Notes:

None

Data Alerts:

None

NOM-22.4 Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	90.8 %	2.2 %	218,850	241,112
2012	89.3 %	2.5 %	216,757	242,778
2011	83.0 %	2.5 %	203,482	245,035
2010	76.2 %	2.6 %	184,939	242,738
2009	68.3 %	3.0 %	165,701	242,690

Legends:
⚑ Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.4 Notes:

None

Data Alerts:

None

NOM-22.5 Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	90.6 %	2.1 %	218,500	241,112
2012	88.8 %	1.9 %	215,628	242,778
2011	81.1 %	2.6 %	198,819	245,035
2010	72.0 %	2.7 %	174,814	242,738

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009	68.1 %	3.1 %	165,356	242,690

Legends:

⚑ Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.5 Notes:

None

Data Alerts:

None

Form 10a
National Performance Measures (NPMs)
State: Connecticut

NPM-1 Percent of women with a past year preventive medical visit

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	68.2	70.0	72.0	74.0	76.0

NPM-3 Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	84.7	87.0	89.0	90.0	93.0

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	78.8	81.0	83.0	85.0	87.0

NPM-4 B) Percent of infants breastfed exclusively through 6 months

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	17.3	17.0	17.0	18.0	18.0

NPM-6 Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives					
	2016	2017	2018	2019	2020

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	26.6	27.0	27.0	28.0	28.0

NPM-10 Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	91.5	93.0	94.0	95.0	96.0

NPM-11 Percent of children with and without special health care needs having a medical home

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	49.6	50.0	51.0	51.0	52.0

NPM-12 Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	44.7	45.0	45.0	46.0	47.0

NPM-13 A) Percent of women who had a dental visit during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	50.9	52.0	53.0	54.0	56.0

NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Annual Objectives

	2016	2017	2018	2019	2020
Annual Objective	86.3	87.0	88.0	89.0	91.0

Form 10b
State Performance/Outcome Measure Detail Sheet
State: Connecticut

States are not required to create SOMs/SPMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10c
Evidence-Based or Informed Strategy Measure Detail Sheet
State: Connecticut

States are not required to create ESMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10d
National Performance Measures (NPMs) (Reporting Year 2014 & 2015)

State: Connecticut

Form Notes for Form 10d NPMs and SPMs

None

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

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	100.0	100.0	100.0	100.0	
Numerator	72	83	80	48	
Denominator	72	83	80	48	
Data Source	CT DPH Newborn Screening Program	CT DPH Newborn Screening Program	CT DPH Newborn Screening Program	CT DPH Newborn Screening Program	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
Source: Data is provisional. Treatment centers are continuing to receive additional test results on children born in 2014 and adding additional confirmed cases on a regular basis

2.	**Field Name:**	**2013**

Field Note:
Source: Seven additional confirmed cases were added for a total of 80. Fatty acid oxidation disorders: Short-chain acyl-CoA dehydrogenase deficiency(1), Medium-chain acyl-CoA dehydrogenase deficiency (1); Biotinidase deficiency (2); Hypothyroid (1); Congenital adrenal hyperplasia,salt-wasting (1); Other Hemoglobin disease: (1)EE. CF results are not tracked or reported by this department.

3.	**Field Name:**	**2012**

Field Note:
Source: CY2011 CT DPH Newborn Screening (NBS) Program supplied the percentage of confirmed cases that also received appropriate follow-up. (For more information on CT's newborn screening procedures/data, see also the detailed note with Form # 6) *As of May 2014, 3 additional confirmed cases added for 2012(1 nonketotic hyperglycinemia, 2 hemoglobinopathies).

4.	**Field Name:**	**2011**

Field Note:
Source: CY2011 CT DPH Newborn Screening Program supplied the percentage of confirmed cases that also received appropriate follow-up. (For more information on CT's newborn screening procedures/data, see also the detailed note with Form # 6) *21 Additional cases confirmed abnormal

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	59.8	70.4	70.4	70.4	70.4
Annual Indicator	70.4	70.4	70.4	70.4	
Numerator					
Denominator					
Data Source	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
Source: For 2011-2014, indicator data came from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes

2.	**Field Name:**	**2013**

Field Note:
Source: For 2011-2014, indicator data came from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease

Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes

3. **Field Name:** **2012**

Field Note:
Source: For 2011-2014, indicator data came from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2011**

Field Note:
Source: For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Annual Performance Objectives for 2012-2016 were updated using the most recent data.

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	48.5	46.0	46.0	46.0	46.0
Annual Indicator	46.0	46.0	46.0	46.0	
Numerator					

	2011	2012	2013	2014	2015
Denominator					
Data Source	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
Source: For 2011-2014, indicator data came from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	**Field Name:**	**2013**

Field Note:
Source: For 2011-2014, indicator data came from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
Source: For 2011-2014, indicator data came from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2011**

Field Note:
Source: For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Annual Performance Objectives for 2012-2016 were updated using the most recent data.

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	61.7	59.6	59.6	59.6	59.6
Annual Indicator	59.6	59.6	59.6	59.6	
Numerator					
Denominator					
Data Source	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
Source: For 2011-2014, indicator data came from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	**Field Name:**	**2013**

Field Note:
Source: For 2011-2014, indicator data came from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
Source: For 2011-2014, indicator data came from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	**Field Name:**	**2011**

Field Note:
Source: For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Annual Performance Objectives for 2012-2016 were updated using the most recent data.

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	89.4	67.8	67.0	66.8	66.8
Annual Indicator	66.8	66.8	66.8	66.8	

	2011	2012	2013	2014	2015
Numerator					
Denominator					
Data Source	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
Source: For 2011-2014, indicator data came from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	**Field Name:**	**2013**

Field Note:
Source: For 2011-2014, indicator data came from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
Source: For 2011-2014, indicator data came from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	**Field Name:**	**2011**

Field Note:
Source: For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Annual Performance Objectives for 2012-2016 were updated using the most recent data.

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	43.3	46.0	46.0	46.0	46.0
Annual Indicator	46.0	46.0	46.0	46.0	
Numerator					
Denominator					
Data Source	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
Source: For 2011-2014, indicator data came from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data.

However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2013**

Field Note:
Source: For 2011-2014, indicator data came from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2011**

Field Note:
Source: For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Annual Performance Objectives for 2012-2016 were updated using the most recent data.

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	89.8	82.0	82.2	82.4	82.6
Annual Indicator	82.0	80.0	82.4	81.5	
Numerator	27,988	26,381	26,105	25,481	
Denominator	34,136	32,969	31,699	31,249	
Data Source	CIRTS	CIRTS	CIRTS	CIRTS	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
Source: Connecticut Immunization Registry and Tracking System (CIRTS), 2011 birth cohort. The CIRTS data provide a more accurate picture regarding childhood immunization coverage rates for CT children. The immunization coverage rate for children born in 2011 was 82% for the 4:3:1:3:3:1 series, The 31,249 children represent 86% of the 36,278 births recorded in Connecticut for 2011. A total of 3,176 children or 9% of the 36,278 births refused registry enrollment.

2.	**Field Name:**	**2013**

Field Note:
Source: Connecticut Immunization Registry and Tracking System (CIRTS), 2010 birth cohort.
The CIRTS data provide a more accurate picture regarding childhood immunization coverage rates for CT children. The immunization coverage rate for children born in 2010 was 82% for the 4:3:1:3:3:1 series, The 31,699 children represent 86% of the 37,010 births recorded in Connecticut for 2010. A total of 3,090 children or 8% of the 37,010 births refused registry enrollment. (This is preliminary data.)

3.	**Field Name:**	**2012**

Field Note:
Source: Connecticut Immunization Registry and Tracking System (CIRTS), 2009 birth cohort.
The CIRTS data provide a more accurate picture regarding childhood immunization coverage rates for CT children. The immunization coverage rate for children born in 2009 was 80% for the 4:3:1:3:3:1 series, The 32,969 children represent 87% of the 37,743 births recorded in Connecticut for 2009. A total of 3,196 children or 8% of the 37,743 births refused registry enrollment. (This is preliminary data.)

4.	**Field Name:**	**2011**

Field Note:
Source: Connecticut Immunization Registry and Tracking System (CIRTS), 2008 birth cohort.
The CIRTS data provide a more accurate picture regarding childhood immunization coverage rates for CT children. The immunization coverage rate for children born in 2008 was 82% for the 4:3:1:2*:3:1 series, The 34,136 children represent 85% of the 40,230 births recorded in Connecticut for 2008. A total of 3,190 children or 8% of the 40,230 births refused registry enrollment. Annual Performance Objectives for 2012-2016 were updated using the most recent data.

Data Alerts:

None

NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

	2011	2012	2013	2014	2015
Annual Objective	10.5	8.3	7.2	7.2	7.2
Annual Indicator	7.4	7.3	6.2	6.2	
Numerator	536	527	445	445	
Denominator	72,814	72,086	71,254	71,254	
Data Source	DPH Vital Statistics	DPH Vital Statistics	DPH Vital Statistics	DPH Vital Statistics	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
Source: CY 2014 not available. CY 2013 Vital Statistics data Provisional.

2.	**Field Name:**	**2013**

Field Note:
Source: CY 2013 Vital Statistics data Provisional.

3.	**Field Name:**	**2012**

Field Note:
Source: CY 2012 Vital Statistics data Provisional.

4.	**Field Name:**	**2011**

Field Note:
Source: CY2011 Vital Statistics data are final.

Data Alerts:

None

NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

	2011	2012	2013	2014	2015
Annual Objective	24.5	23.9	23.9	23.9	23.9
Annual Indicator	23.2	23.2	23.8	20.2	
Numerator	7,183	7,183	6,553	7,347	
Denominator	31,004	31,004	27,572	36,309	
Data Source	CT Dept. of Social Services SCHIP Division	CT Dept. of Social Services SCHIP Division	CT Dept. of Social Services Medicaid Division	CT Dept. of Social Services Medicaid Division	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
Source: Connecticut Department of Social Services Medicaid Division. Numerator: Number of all 8 and 9 year olds enrolled in Medicaid/SCHIP and who received at least one dental sealant on a permanent molar tooth during that year. Denominator: Number of all 8 and 9 year olds enrolled in Medicaid/SCHIP. *Enrollment is based on even 1 day of enrollment during the time period.

2. **Field Name:** **2013**

Field Note:
Source: CT Department of Social Services Medicaid Division. The denominator represents all 8 and 9 year olds enrolled in SCHIP and the numerator represents all 8 and 9 year olds who received at least one dental sealant on a permanent molar tooth.

3. **Field Name:** **2012**

Field Note:
Source: CT Department of Social Services data will be made available at a later date due to data system delay with the data source.

4.	**Field Name:**	**2011**

Field Note:
Source: CT Department of Social Services SCHIP Division. The denominator represents all 8 and 9 year olds enrolled in SCHIP and the numerator represents all 8 and 9 year olds who received dental sealants.

Data Alerts:

None

NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

	2011	2012	2013	2014	2015
Annual Objective	1.0	0.6	0.6	0.7	0.6
Annual Indicator	0.9	0.8	0.8	0.9	
Numerator	6	5	5	6	
Denominator	654,187	654,707	639,273	649,389	
Data Source	DPH Vital Statistics	DPH Vital Statistics	DPH Vital Statistics	DPH Vital Statistics	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
Source: CY 2013 and CY 2014 data are provisional. CT Dept. of Public Health, HISR, Vital Statistics. The annual indicator is a rolling average of 2011, 2012, and 2013 numerator (6, 5, 7) and denominator (654187, 654707, 639,273) CY numbers.

2.	**Field Name:**	**2013**

Field Note:
Source: CY 2013 data are provisional. CT Dept. of Public Health, HISR, Vital Statistics. The annual indicator is a rolling average of 2010, 2011, and 2012 numerator (4, 6, 5) and denominator (664942, 654187, 646004) CY numbers.

3.	**Field Name:**	**2012**

Field Note:
Source: CY 2012 data are provisional.
CT Dept. of Public Health, HISR, Vital Statistics.

The annual indicator is a rolling average of 2009, 2010, and 2011 numerator (5, 4, 6) and denominator (660975, 664942, 654187) CY numbers

4.	**Field Name:**	**2011**

Field Note:
Source: CY 2011 data are Final.
CT Dept. of Public Health, HISR, Vital Statistics.
The annual indicator is a rolling average of 2008, 2009, and 2010 numerator (7, 5, 4) and denominator (667742, 660975, 664942) CY numbers.

Data Alerts:

None

NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.

	2011	2012	2013	2014	2015
Annual Objective	49.8	50.3	48.9	46.0	51.5
Annual Indicator	47.1	48.4	45.6	51.4	
Numerator					
Denominator					
Data Source	CDC National Immunization Survey	CDC National Immunization Survey	CDC National Immunization Survey	CDC National Immunization Survey	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
Source: State-level data reported by the CDC, Breastfeeding Report Card - United States, 2014, from the National Immunization Survey (NIS), based on birth cohort year 2011.
http://www.cdc.gov/breastfeeding/pdf/2014breastfeedingreportcard.pdf Annual performance objective for 2015 has been updated based on the most recent data.

2.	**Field Name:**	**2013**

Field Note:
Source: State-level data reported by the CDC, Breastfeeding Report Card - United States, 2013, from the National Immunization Survey (NIS), based on birth cohort year (2010).
http://www.cdc.gov/breastfeeding/pdf/2013breastfeedingreportcard.pdf Annual performance objectives for 2014-

2018 were updated based on the most recent data.

3.	**Field Name:**	**2012**

Field Note:
Source: State-level data reported by the CDC, Breastfeeding Report Card - United States, 2012, from the National Immunization Survey (NIS), based on birth cohort year (2009).
http://www.cdc.gov/breastfeeding/data/reportcard.htm
Annual performance objectives for 2013-2017 were updated based on the most recent data.

4.	**Field Name:**	**2011**

Field Note:
Source: State-level data reported by the CDC, Breastfeeding Report Card - United States, 2011, from the National Immunization Survey (NIS), based on birth cohort year (2008).
http://www.cdc.gov/breastfeeding/data/reportcard.htm
Annual performance objectives for 2012-2016 were updated based on the most recent data.

Data Alerts:

None

NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.

	2011	2012	2013	2014	2015
Annual Objective	99.3	99.3	99.3	99.0	99.0
Annual Indicator	98.9	98.9	99.1	99.1	
Numerator	37,572	36,899	36,527	37,305	
Denominator	37,988	37,294	36,851	37,648	
Data Source	CT DPH EHDI Program	CT DPH EHDI Program	CT DPH EHDI Program	CT DPH EHDI Program	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
Source: CT DPH Early Hearing Detection and Intervention Program. Denominator data collected April 2015 from Vital Records. Updated 2013 numerator and denominator with final data.

2.	**Field Name:**	**2013**

Field Note:
Source: CT DPH Early Hearing Detection and Intervention Program. Universal newborn hearing screening was implemented in CT on 7/1/00. Denominator data collected May 2014 from Vital Records.

3.	**Field Name:**	**2012**

Field Note:
Source: CT DPH Early Hearing Detection and Intervention Program. Universal newborn hearing screening was implemented in CT on 7/1/00. Denominator data collected on 4/9/2013 from Vital Records. Annual Performance Objectives for 2012-2016 were updated using the most recent data.

4.	**Field Name:**	**2011**

Field Note:
Source: CT DPH Early Hearing Detection and Intervention Program. Universal newborn hearing screening was implemented in CT on 7/1/00. Denominator data collected on 6/15/12 from Vital Records.
Annual Performance Objectives for 2012-2016 were updated using the most recent data.

Data Alerts:

None

NPM 13 - Percent of children without health insurance.

	2011	2012	2013	2014	2015
Annual Objective	4.7	6.0	5.3	3.6	3.6
Annual Indicator	6.0	5.3	3.6	4.3	
Numerator					
Denominator					
Data Source	US Bureau of Census, Current Population Survey	US Bureau of Census, Current Population Survey	US Bureau of Census, Current Population Survey	US Bureau of Census, American Community Survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
Source: US Bureau of Census, American Community Survey, Table HI05: Health Insurance Coverage Status and Type of Coverage by State and age for All people; 2013.

2.	**Field Name:**	**2013**

Field Note:
Source: US Bureau of Census, Current Population Survey, Table HI05: Health Insurance Coverage Status and Type of Coverage by State and age for All people; 2012.

3.	**Field Name:**	**2012**

Field Note:
Source: US Bureau of Census, Current Population Survey, Table HI05: Health Insurance Coverage Status and Type of Coverage by State and age for All people; 2011.

4.	**Field Name:**	**2011**

Field Note:
Source: US Bureau of Census, Current Population Survey, 2010 Table Package, table HI05. Annual performance objectives for 2012-2016 were updated based on the most recent data.

Data Alerts:

None

NPM 14 - Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

	2011	2012	2013	2014	2015
Annual Objective	30.6	31.0	25.0	23.5	30.0
Annual Indicator	31.2	26.7	23.6	30.8	
Numerator	8,671	6,201	5,115	5,073	
Denominator	27,793	23,228	21,663	16,481	
Data Source	CDC's Pediatric Nutrition Surveillance System	CT WIC	CT WIC	CT WIC	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
Source: State of Connecticut, Department of Public Health, WIC Program; Statewide WIC Infor-ma¬tion System (SWIS); based on three (3) nutrition outcome measures: Nutrition Outcome Objective 5a: Overweight in Children 2

to 5 years of age: The prevalence of overweight (BMI ≥ 85th percentile to < 95th percentile) among children 2 - 5 years of age does not exceed 10%. Nutrition Outcome Objective 5b: Obesity in Children 2 to 5 years of age: The prevalence of obesity (BMI ≥ 95th percentile) among children 2 - 5 years of age does not exceed 15%. Combined Overweight/Obesity Objective (BMI ≥ 85th percentile): ≤ 25%. It should be noted that CT WIC recently redesigned its outcome reports to address an error in the coding of its earlier version. This accounts for the significant increase in this year's Annual Indicator compared to the previous two years, and with this year's rate being more in line with the numbers reported in 2010 & 2011 by the CDC's PedNSS reports. Annual performance

2.	**Field Name:**	**2013**

Field Note:
Source: State of Connecticut, Department of Public Health, WIC Program; Statewide WIC Infor-ma¬tion System (SWIS); based on three (3) quarterly nutrition outcome measures:

Nutrition Outcome Objective 5a: Overweight in Children:
The prevalence of overweight (BMI = 85th percentile to < 95th percentile) for children 2 - 5 years of age does not exceed 10%.

Nutrition Outcome Objective 5b: Obesity in Children:
The prevalence of obesity (BMI = 95th percentile) for children 2 - 5 years of age does not exceed 15%.

Combined Overweight/Obesity in Children Objective (BMI = 85th percentile): = 25%.

Annual performance objectives for 2014-2018 were updated based on the most recent data.

3.	**Field Name:**	**2012**

Field Note:
Source: State of Connecticut, WIC Program, Statewide WIC Information System (SWIS), based on three (3) quarterly reports (note: this is a new Outcome Objective for the CT WIC Program).

Nutrition Outcome Objective 5a: Overweight in Children: The prevalence of overweight (BMI = 85th percentile to < 95th percentile) for children 2-4 years of age does not exceed 10%.

Nutrition Outcome Objective 5b: Obesity in Children: The prevalence of obesity (BMI = 95th percentile) for children 2-4 years of age does not exceed 15%.

Combined Overweight/Obesity in Children Objective (BMI = 85th percentile): = 25%.

Annual performance objectives for 2013-2017 were updated based on the most recent data and the change in data source.

Notes: The Centers for Disease Control & Prevention's (CDC), Pregnancy & Pediatric Nutrition Surveillance System (PNSS/PedNSS) reports are no longer being produced. It is important to note that the PedNSS reports included ALL children 2-4 years of age enrolled in WIC, while the WIC Outcome Objective limits its analysis to only those children 2-4 years of age who had been enrolled in WIC for at least one year, serving as a proxy measure for the impact of WIC services.

4.	**Field Name:**	**2011**

Field Note:
Source: Centers for Disease Control & Prevention (CDC), 2011 Pediatric Nutrition Surveillance (PedNSS); Connecticut, Calendar Year 2011 data, Table 2C, run date March 25, 2011. (Note: PedNSS data in Connecticut

come exclusively from WIC.)
Annual performance objectives for 2012-2016 were updated using the most recent data.

Data Alerts:

None

NPM 15 - Percentage of women who smoke in the last three months of pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	0.1	0.1	0.1	0.1	0.1
Annual Indicator	0.2	0.1	0.1	0.1	
Numerator	62	44	39	38	
Denominator	36,648	36,621	35,835	35,523	
Data Source	DPH Vital Statistics	DPH Vital Statistics	DPH Vital Statistics	DPH Vital Statistics	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
Source: CY 2014 are not available. CY 2013 data are provisional. CT DPH, Vital Statistics. Percent is based on the removal of data where prenatal care and tobacco use in the third trimester was unknown. It has been noted that this figure is very low; however, this information is self-reported by the mother on the birth certificate.

2. **Field Name:** **2013**

Field Note:
Source: CY 2013 data are provisional. CT DPH, Vital Statistics. Percent is based on the removal of data where prenatal care and tobacco use in the third trimester was unknown. It has been noted that this figure is very low; however, this information is self-reported by the mother on the birth certificate.

3. **Field Name:** **2012**

Field Note:
Source: CY 2012 data are provisional. CT DPH, Vital Statistics. Percent is based on the removal of data where prenatal care and tobacco use in the third trimester was unknown. It has been noted that this figure is very low; however, this information is self-reported by the mother on the birth certificate.

4. **Field Name:** **2011**

Field Note:
Source: CY 2011 data are final. CT DPH, Vital Statistics. Percent is based on the removal of data where prenatal care and tobacco use in the third trimester was unknown. It has been noted that this figure is very low; however, this information is self-reported by the mother on the birth certificate.

Data Alerts:

None

NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

	2011	2012	2013	2014	2015
Annual Objective	5.5	5.2	5.4	5.8	5.8
Annual Indicator	5.9	5.9	5.9	5.5	
Numerator	15	15	15	14	
Denominator	252,390	253,161	253,161	254,142	
Data Source	DPH Vital Statistics	DPH Vital Statistics	DPH Vital Statistics	DPH Vital Statistics	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
Source: CY 2013 and CY 2014 data are provisional. CT Dept. of Public Health, HISR, Vital Statistics. The annual indicator is a rolling average of 2011, 2012 and 2013 numerator (17, 15, 9) and denominator (252973, 255676, 253776) CY numbers.

2.	**Field Name:**	**2013**

Field Note:
Source: CY 2013 data are provisional. CT Dept. of Public Health, HISR, Vital Statistics. The annual indicator is a rolling average of 2010, 2011 and 2012 numerator (13, 17, 15) and denominator (250834, 252973, 255676) CY numbers.

3.	**Field Name:**	**2012**

Field Note:
Source: CY 2012 data are provisional. CT Dept. of Public Health, HISR, Vital Statistics. The annual indicator is a rolling average of 2009, 2010 and 2011 numerator (15, 13, 17) and denominator (253362, 250834, 252973) CY numbers.

4.	**Field Name:**	**2011**

Field Note:
Source: CY 2011 data are final. CT Dept. of Public Health, HISR, Vital Statistics. The annual indicator is a rolling average of 2008, 2009, and 2010 numerator (14, 15, 13) and denominator (250373, 253362, 250834) CY numbers.

Data Alerts:

None

NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

	2011	2012	2013	2014	2015
Annual Objective	86.6	86.7	88.0	80.0	88.1
Annual Indicator	85.0	86.1	80.3	90.7	
Numerator	488	452	403	441	
Denominator	574	525	502	486	
Data Source	DPH Vital Statistics	DPH Vital Statistics	DPH Vital Statistics	DPH Vital Statistics	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
Source: CY 2014 data are final. CT DPH, Vital Statistics. Eleven of CT's acute care hospitals with self-declared NICU's were included in this survey.

2.	**Field Name:**	**2013**

Field Note:
Source: CY 2013 data are provisional. CT DPH, Vital Statistics. Eleven of CT's acute care hospitals with self-declared NICU's were included in this survey.

3.	**Field Name:**	**2012**

Field Note:
Source: CY 2012 data are provisional. CT DPH, Vital Statistics. Eleven of CT's acute care hospitals with self-declared NICU's were included in this survey.

4.	**Field Name:**	**2011**

Field Note:
Source: CY 2011 data are final. CT DPH, Vital Statistics. Eleven of CT's acute care hospitals with self-declared NICU's were included in this survey.

Data Alerts:

None

NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

	2011	2012	2013	2014	2015
Annual Objective	88.9	87.7	87.7	87.0	87.0
Annual Indicator	86.2	86.6	87.0	87.3	
Numerator	32,131	31,354	31,168	31,012	
Denominator	37,277	36,221	35,835	35,523	
Data Source	DPH Vital Statistics	DPH Vital Statistics	DPH Vital Statistics	DPH Vital Statistics	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
Source: CY 2013 and CY2014 data are provisional, CT DPH Vital Statistics. Annual performance objectives for 2014-2018 have been updated based on the most recent data.

2. **Field Name:** **2013**

Field Note:
Source: CY2013 data are provisional, CT DPH Vital Statistics. Annual performance objectives for 2014-2018 have been updated based on the most recent data.

3. **Field Name:** **2012**

Field Note:
Source: CY2012 data are provisional, CT DPH Vital Statistics.
Annual performance objectives for 2013-2017 have been updated based on the most recent data.

4. **Field Name:** **2011**

Field Note:
Source: CY2011 data are final, CT DPH Vital Statistics.

Data Alerts:

None

Form 10d
State Performance Measures (SPMs) (Reporting Year 2014 & 2015)

State: Connecticut

SPM 1 - Cumulative number of core datasets migrated to the MAVEN application as part of efforts to link high-quality child health data to create a Connecticut comprehensive child health profile.

	2011	2012	2013	2014	2015
Annual Objective	3.0	6.0	7.0	7.0	7.0
Annual Indicator					
Numerator	5	6	6	6	
Denominator	7	7	7	7	
Data Source	EPHT Portal	EPHT Portal	EPHT Portal	EPHT Portal	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2014**

   Field Note:
   Source: The number of databases that have migrated to the MAVEN application. The Children and Youth with Special Health Care Needs database/instance is nearly ready to go into production in the MAVEN system. However, migration of hardware in CT’s main data center will prevent this database/instance from “going live” before the submission date of this application.

2. **Field Name:** **2013**

   Field Note:
   Source: The number of databases that have migrated to the MAVEN application; and their integration through simple data sharing exports/imports of information between databases using the EPHT Portal.

3. **Field Name:** **2012**

   Field Note:
   Source: The number of databases that have migrated to the MAVEN application; and their integration through simple data sharing exports/imports of information between databases using the EPHT Portal.

4. **Field Name:** **2011**

   Field Note:
   Source: The number of databases that have migrated to the MAVEN application; and their integration through simple data sharing exports/imports of information between databases using the EPHT Portal.

Data Alerts:

None

SPM 2 - Percent of students that had a risk assessment with a mental health component conducted during a comprehensive, annual physical exam at a SBHC.

	2011	2012	2013	2014	2015
Annual Objective	60.0	66.0	66.0	85.0	85.0
Annual Indicator	65.1	69.8	81.4	79.4	
Numerator	18,052	14,978	2,995	4,253	
Denominator	27,742	21,458	3,681	5,357	
Data Source	SBHC Year-end Reports	SBHC Year-end Reports	SBHC Year-end Reports	SBHC Year-end Reports	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2014**

Field Note:
Source: An analysis of year-end reports submitted from all SBHC contractors was conducted.

2. **Field Name:** **2013**

Field Note:
Source: An analysis of year-end reports submitted from all SBHC contractors was conducted. The questions asked in the year-end report had been revised to be more specific to reduce inconsistency in data reporting, in doing so data provided was more accurate and specific to screening at the time of annual physical exams.

3. **Field Name:** **2012**

Field Note:
Source: An analysis of year end reports submitted from all SBHC contractors was conducted. All unduplicated medical or mental health visits with a mental health screening component were considered.

4. **Field Name:** **2011**

Field Note:
Source: An analysis of year end reports submitted from all SBHC contractors was conducted. All unduplicated medical or mental health visits with a mental health screening component were considered.

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	31.0	33.0	33.0	35.0	35.0
Annual Indicator	29.2	29.2	49.8	39.9	
Numerator	447	447	1,098	420	
Denominator	1,533	1,533	2,205	1,052	
Data Source	Dept Social Services	Dept Social Services	Dept Social Services	CT Department of Social Services Medicaid Division	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: Source: CT Department of Social Services Medicaid Division. Numerator: Number of child health care providers/dental providers who serve at risk populations that perform dental caries risk assessments, and provide oral health education and risk-based prevention strategies by age one. Denominator: Number of medical and dental providers billing for preventive dental codes on children 36 months and younger.	
2.	**Field Name:**	**2013**
	Field Note: Source: Department of Social Services.	
3.	**Field Name:**	**2012**
	Field Note: Source: Department of Social Services.	
4.	**Field Name:**	**2011**
	Field Note: Source: Department of Social Services.	

Data Alerts:

None

SPM 4 - Increase the redemption rate of fruit and vegetable checks issued to women and children enrolled in the Connecticut WIC program.

	2011	2012	2013	2014	2015
Annual Objective	82.0	83.0	83.0	83.5	83.0
Annual Indicator	82.0	82.7	83.2	82.3	
Numerator	44,535	45,363	521,245	31,377	
Denominator	54,289	54,855	626,327	38,133	
Data Source	CT WIC database (SWIS)	CT WIC database (SWIS)	CT WIC database (SWIS)	CT WIC database (SWIS)	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**

Field Note:
Source: State of Connecticut WIC Program, Statewide WIC Information System (SWIS). Re¬demp¬tion rates for fruit & vegetable checks are used as a proxy measure for consumption. These rates vary by Participant Category, with breastfeeding women continuing to show the highest rate (86.2%) followed by children and pregnant women (83.8%), with postpartum (non-breastfeeding) women (71.2%) demonstrating the lowest redemption rate. For FFY 2014, the Fruit & Vegetable Consumption rates were as follows: women overall: 81.2% [pregnant women: 83.8%; breastfeeding women: 86.2%; and postpartum (non-breast¬feeding) women: 71.2%], and children (12-60 months old): 83.8%. The overall rate of 82.3% for FFY 2014 represents a decrease of 0.9% over last year, and 1.2% below this year’s Performance Objective of 83.5%.

2.	**Field Name:**	**2013**

Field Note:
* Data source: State of Connecticut WIC Program, Statewide WIC Information System (SWIS). Re¬demp¬tion rates for fruit & vegetable checks are used as a proxy measure for consumption. These rates vary by Participant Category, with breastfeeding women continuing to show the highest rate (87.2%) followed by children (84.7%), and with postpartum (non-breastfeeding) women (72.7%) demonstrating the lowest redemption rate.

For FFY 2013, the Fruit & Vegetable Consumption rates were as follows: women overall: 81.4% [pregnant women: 83.1%; breastfeeding women: 87.2%; and postpartum (non-breast¬feeding) women: 72.7%], and children (12-60 months old): 84.7%. The overall rate of 83.2% for FFY 2013 represents an increase of 0.5% over last year, just over this year’s Performance Objective of 83.0%. Each WIC Participant Category improved at least slightly over last year, ranging from 0.2% for breast¬feed¬ing women, to 0.6% for children, and 0.7% for non-breastfeeding postpartum women.

3.	**Field Name:**	**2012**

Field Note:
* Data source: State of Connecticut WIC Program, Statewide WIC Information System (SWIS).
Redemption rates for fruit & vegetable checks are used as a proxy measure for consumption. These rates vary by Participant Category, with breastfeeding women continuing to show the highest rate followed by children, and postpartum (non-breastfeeding) women demonstrating the lowest redemption rate.

For FFY 2012, the rates were as follows: women overall: 80.9% [pregnant women: 82.8%; breastfeeding women: 87.0%; and postpartum (non-breast¬feeding) women: 72.0%], and children (12-59 months old): 84.1%. The overall rate of 82.7% for FFY 2012 represents an increase of 0.7% over last year. Although we fell short of this year's Performance Objective by 0.3%, each WIC Participant Category improved at least slightly over last year [average improvement: 0.6%; range: 0.2% (breastfeeding women) to 0.9% (postpartum women)].

4.	**Field Name:**	**2011**

Field Note:
Source: State of Connecticut WIC Program, Statewide WIC Information System (SWIS).
Redemption rates for fruit & vegetable checks tend to vary by Participant Category, with breastfeeding women generally showing the highest rate, followed by children. For FY 2011, the rates were as follows: children (2-4 yrs): 83.4%; pregnant women: 82.1%; breastfeeding women: 86.8%; postpartum (non-breast¬feeding) women: 71.1%; and, all women: 80.3%. The overall rate of 82.0% for 2011 – an increase of 1.5 percentage points over last year – met this year's Performance Objective.

Data Alerts:

None

SPM 5 - Number of developmental screenings performed for 0-3 year olds participating in the state Medicaid Program (HUSKY - Health Insurance for Uninsured Kids and Youth) within the last twelve months.

	2011	2012	2013	2014	2015
Annual Objective	29.0	28.0	22.0	22.5	23.0
Annual Indicator	26.9	20.9	21.8	25.9	
Numerator	18,406	27,752	10,765	12,596	
Denominator	68,370	132,792	49,471	48,697	
Data Source	Medicaid Claims Data	Medicaid Claims Data	Medicaid Claims Data	Medicaid Claims Data	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**

Field Note:

Source: Medicaid Claims data obtained from the CT Department of Social Services. The measure reported reverted back to 0-3 year olds (instead of 0-6 year olds that was reported in 2012) as reliable data for 0-3 year olds was now available.

2. **Field Name:** **2013**

Field Note:
Source: Medicaid Claims data obtained from the CT Department of Social Services. The measure reported reverted back to 0-3 year olds (instead of 0-6 year olds that was reported in 2012) as reliable data for 0-3 year olds was now available.

3. **Field Name:** **2012**

Field Note:
Source: The measure was changed to include children through six years of age, and is now the total number of screenings indicated in 2012 Medicaid Claims data obtained from the CT Department of Social Services (this is more reliable than data available for the previous measure – the number of 0-3 year olds who received a developmental screening). The Annual Indicator is the number of screenings divided by the number of 0-6 year olds eligible for Medicaid for any length of time. A new baseline is determined as 20.9. This is not comparable to previous years.

4. **Field Name:** **2011**

Field Note:
Source: 2012 Medicaid Claims data obtained from the CT Department of Social Services. There will be a change in data as developmental screening in 2011 was reported to DSS through three MCOs – (requiring significant effort to collect and collate) effective Jan 1, 2012 all data is collected directly by DSS and is expected therefore to be streamlined and consistent going forward. The 2012-2016 Annual Performance Objectives have been updated using the most recent data.

Data Alerts:

None

SPM 6 - The cumulative number of DPH funded Case Management programs whose healthcare professionals complete preconception and interconceptual health screening (including depression) of women.

	2011	2012	2013	2014	2015
Annual Objective	4.0	5.0	2.0	2.0	2.0
Annual Indicator					
Numerator	3	2	2	2	
Denominator	2	2	2	2	
Data Source	Quarterly and annual program reports.	Quarterly and annual program reports.	Quarterly and annual program reports.	Quarterly and annual program reports.	

	2011	2012	2013	2014	2015
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2014**

Field Note:
Source: Case Management tri-annual and annual program reports. The MCHBG funds two case management programs for pregnant women. The Waterbury Health Department serves at risk pregnant and parenting women and their families who are at risk for substance abuse and The Young Adult Services (YAS) Case Management Program serves women of child bearing age who have aged-out of the child welfare system and have significant mental health diagnoses.

2. **Field Name:** **2013**

Field Note:
The MCHBG funds two case management programs for pregnant women. The Waterbury Health Department serves low income pregnant women who are at risk for substance abuse. The services include home visits 2 times/week, screenings for perinatal depression and substance abuse, referrals and linkages to other community services, prepared childbirth classes, breastfeeding support, parenting education using Parents As Teachers adapted and fatherhood initiatives. The program is embedded in the Waterbury community and serves very high risk families. Half of the women enrolled have had prior child welfare involvement. 100% of the women with children were up to date on well-child visits. The program collaborates with a local community college and offers job skill training to women and assistance with childcare. In summer months case managers meet families at local parks, playgrounds and libraries to promote activities outside. Families are linked to summer camps, community food sites and other low cost programs. All postpartum women received one medical visit by 6 months and were accompanied by the case manager

The Young Adult Services (YAS) Case Management Program serves pregnant women who have aged-out of the child welfare system and have an Axis 1 Mental Health diagnosis. The comprehensive services include 2-3 home visits a week, parenting education (Parents As Teachers adapted), preconception and interconception health screenings. On enrollment to YAS, all non-pregnant women are offered a referred for a reproductive health exam. The services are provided by Doula's, who provide case management services and accompany the women to behavioral health and prenatal health appointments and offer support in the delivery room.

3. **Field Name:** **2012**

Field Note:
Source: The 2012-2016 Annual Performance Objectives have been updated using the most recent data. Source: Case Management tri-annual and annual program reports. The DPH concluded the 5-year Case Management for Pregnant Women programs in Waterbury, New Haven and Hartford. The two case management programs funded by the MCHBG serve pregnant women (statewide) with Axis I mental health diagnoses served by the DMHAS' 'Young Adult Services Program and pregnant women in Waterbury.

4. **Field Name:** **2011**

Field Note:
Source: The 2012-2016 Annual Performance Objectives have been updated using the most recent data. The denominator in this measure was changed to reflect the MCH funded case management programs in New Haven,

Hartford and Waterbury. DPH also implemented evidence-based home visiting programs with MIECHV Formula Grant Funding, in four communities (Ansonia/Derby, New London, New Britain, and Windham) identified through the Statewide MIECHV Needs Assessment as in very high need of maternal and infant services.

Data Alerts:

None

SPM 7 - Increase the number of People served by increasing the number and area covered by Health Professional Shortage Area (HPSA) Designations in CT.

	2011	2012	2013	2014	2015
Annual Objective	12.0	15.0	14.0	14.0	14.0
Annual Indicator			10.0	14.0	
Numerator					
Denominator	6	12			
Data Source	ASAPS	ASAPS	ASAPS	Shortage Designation Management System (SDMS)	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2014**

Field Note:
Source: In December 2014, HRSA released a new Geographic Information System (GIS) based mapping system called the Shortage Designation Management System (SDMS) for DPH staff to submit HPSA applications. This system replaced the Application Submission and Processing System (ASAPS).

2. **Field Name:** **2013**

Field Note:
Source: DPH staff uses a Geographic Information System (GIS) based mapping system called Application Submission and Processing System (ASAPS) to submit HPSA applications that can then identify the number of HPSAs in CT.

3. **Field Name:** **2012**

Field Note:
Source: DPH staff uses a Geographic Information System (GIS) based mapping system called Application Submission and Processing System (ASAPS) to submit HPSA applications that can then identify the number of

HPSAs in CT.
Annual Performance Objectives have been updated based on the most recent data.

4.	**Field Name:**	**2011**

Field Note:
Source: Application Submission and Processing System (ASAPS). Five Mental HPSA's were designated during this time. Of the five (5), four (4) were county designations.

Data Alerts:

None

SPM 9 - The extent to which the disparity ratios of key perinatal health measures for non-Hispanic Black/African Americans relative to non-Hispanic Whites have decreased.

	2011	2012	2013	2014	2015
Annual Objective	12.0	12.0	14.0	11.0	12.0
Annual Indicator	8.0	12.0	10.0	17.0	
Numerator					
Denominator					
Data Source	VitalRecords	Vital Records	Vital Records	Vital Records	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**

Field Note:
Source: 2012 and 2013 Vital Statistics This objective was met. There were very small declines in most of the indicators contributing to this calculated measure for 2014, whereas 2013 had very small increases in several of the indicators; this accounts for the significant jump in the indicator between 2013 and 2014 (from 10 to 17). Indicators contributing to this measure include infant mortality, neonatal mortality, post neonatal mortality, and perinatal mortality rates. Because of the relatively small number of annual events, large fluctuations in those rates can occur. Therefore, the changes in the disparity ratios most likely reflect this statistical artifact.

2.	**Field Name:**	**2013**

Field Note:
Source: 2011 and 2012 Vital Statistics

3.	**Field Name:**	**2012**

Field Note:
Source: 2010 and 2011 Vital Statistics

4.	**Field Name:**	**2011**

Field Note:
Source: 2009 and 2010 Vital Statistics

Data Alerts:

None

Form 11
Other State Data

State: Connecticut

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the FY 2016 application and FY 2014 annual report.

State Action Plan Table

State: Connecticut

Please click the link below to download a PDF of the State Action Plan Table.
State Action Plan Table