Maternal and Child Health Services Title V Block Grant

Connecticut

FY 2022 Application/ FY 2020 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Deidre S. Gifford, MD, MPH
Acting Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Community, Family Health, and Prevention Section

August 17, 2021

Christopher Dykton, MA, Acting Director
Division of State and Community Health
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane, Room 18N33
Rockville, Maryland 20857

RE: Title V Maternal & Child Health Services Block Grant to States Program Application FFY 2022
Annual Report FFY 2020

Dear Mr. Dykton:

Connecticut has electronically submitted the Maternal and Child Health Services Title V Block Grant Program funding application for FFY 2022.

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,

Marc Camardo

Marc Camardo, MPH
Title V Director
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 F of the 2021 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 *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: January 31, 2024.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Introduction

The Connecticut Department of Public Health (DPH) has been awarded national accreditation by the Public Health Accreditation Board (PHAB). Earning a five-year accreditation status signifies that DPH has met or exceeded rigorous, nationally recognized, evidence-based public health standards, a distinction that only 31 other states have achieved. A strong public health infrastructure provides the capacity to prepare for and respond to emerging and ongoing threats to the public's health. Key infrastructure components vary both in Connecticut as well as across the nation. These components include a capable and qualified workforce; up-to-date data and information systems; and the capability of assessing and responding to population health concerns. Accreditation through the national Public Health Accreditation Board (PHAB) provides an opportunity to strengthen the infrastructure and improve the quality and performance of governmental public health agencies. Quality standards address delivery of the 10 essential public health services, beginning with routine assessment of population health needs in our communities.

The DPH completed the 2020 update of the State Health Needs Assessment. The report was released as the State Health Improvement Plan (SHIP) coalition launched a series of planning workshops to update the health improvement plan. The DPH Public Health Systems and Equity (PHSE) team worked with partners across the state to design the Healthy CT 2025 State Health Improvement Plan framework. Although the COVID pandemic's guidelines disrupted the planning process by requiring working remotely, the PHSE team completed the plan through multiple virtual meetings and webinars to discuss priority areas and cross-cutting themes. The plan's strategies focus on policy, systems, and environmental changes to address upstream causes of poor health. The priorities under consideration include a) access to health services and primary healthcare, b) economic stability, particularly around issues of poverty and employment, c) access to healthy eating and issues of food security, d) housing quality and stability and e) community resilience as it relates to crime/violence and emergency preparedness. Cross-cutting priorities include education, transportation, and racial discrimination.

In addition to launching Healthy Connecticut 2025, DPH is undergoing preparations for its re-accreditation application due by the first quarter of 2022. CT DPH received its first national public health accreditation in March 2017 and has submitted annual reports to the Public Health Accreditation Board (PHAB). The agency is now preparing documentation that demonstrates a culture of quality improvement and performance management. Additionally, DPH worked to maintain the capacity needed to provide the ten essential services of public health. The agency also worked on developing systems and programmatic functions to narrow gaps identified on an assessment of DPH's current work based on the re-accreditation standards. MICH grant funding makes possible continued progress and allows the agency to conduct the accreditation work across the agency.

The CT (Maternal and Child Health) MCH Coalition is a representative group of state agencies, providers, funders, and advocates working in concert with the state's maternal and child health population. The Coalition has over 120 individuals representing 97 organizations. It serves as a communication and networking vehicle for those working in the field of Maternal and Child Health by holding quarterly meetings and sending out Notes of Interest to Coalition members. The Coalition represents the state's maternal and child health priorities/interests in the State Health Improvement Plan (SHIP), which has established the following priority areas: access to health care; economic stability; healthy food and housing; and community strength and resilience. The Coalition also advocates for health equity and the elimination of racial and ethnic health disparities. A Coalition advocacy initiative, being done in

collaboration with the Every Woman CT Initiative and the March of Dimes, is the establishment of a Reproductive Workgroup. Modeled on the work being done in New York, this workgroup will be looking at the degree and types of disrespect and abuse experienced by women seeking pre/interconception as well as prenatal and postpartum health care. Based on the fact-finding results, the workgroup will propose recommendations to address identified areas of concern.

Key Initiatives

Women/Maternal Health

DPH participates in the Every Woman Connecticut (EWCT) Learning Collaborative, which seeks to increase expertise and self-efficacy in implementing routine pregnancy intention screening and appropriate care, education, and services to ultimately improve birth spacing, increase pregnancy intentionality, and the proportion of Connecticut women who deliver a live birth who report discussing preconception/interconception health with a healthcare worker.

Connecticut Legislation was passed in 2018 to establish a Maternal Mortality Review Committee and program within the department. The Maternal Mortality Review Committee is comprised of both clinical and non-clinical subject matter experts that conduct a comprehensive, multidisciplinary review of each pregnancy-associated death that occurred within one year of the end of a pregnancy, regardless of the outcome. The comprehensive review includes medical records, medical examiner reports, death certificates, vital statistics infant birth, fetal and maternal death files, police reports, informant interviews, obituaries, social media, and other sources of information. The purpose of the Maternal Mortality Review Committee review is to identify contributing factors that may have contributed to the death, and to make recommendations to reduce pregnancy-related morbidity and mortality and disparities. The department's Maternal Mortality Review Program is supported by CDC funding that supports program administration, data collection and analysis of maternal mortality data and an annual Maternal Mortality Evaluation Report.

The Reproductive Health Program is administered by Planned Parenthood of Southern New England, Inc. (PPSNE) and is funded with State and Title V funds through a five-year contract. The program provides services in those areas of Connecticut with a high concentration of low-income women of reproductive age, and with high rates of teen pregnancy.

Perinatal/ Infant Health

The Department's State Physical Activity and Nutrition (SPAN) Program breastfeeding team, along with the State WIC Program staff, continues to partner with the CT Breastfeeding Coalition's (CBC) Ten Step Collaborative to encourage implementation of evidenced-based maternity care and the 10 Steps for Successful Breastfeeding in CT hospitals. In 2020, the "It's Worth It" media campaign that launched in late 2019, was again run in 2020, in targeted areas of the State aimed at increasing the awareness of the campaign's community support message and also documenting stories of diverse populations. Additionally, DPH successfully launched the English version of Ready, Set, Baby (RSB) online website, in partnership with the Carolina Global Breastfeeding Institute in March 2020. Translation of the RSB site into Spanish was completed in May of 2021, with a soft launch planned for July 2021. The Arabic translation will be available in Fall 2021. In partnership with CBC, DPH launched a scholarship program for underrepresented populations in order to improve equity in community lactation support. In September 2020, CBC awarded six individuals (all women of color) funds to pursue their IBCLC. To date, one candidate has taken the exam and the other five are working towards meeting the exam credentials. We anticipate two additional awardees sitting for the exam in early 2022. DPH and CBC, with SPAN funds, plan to support these women through the process and have provided additional financial and moral support through 2021. Four technical assistance sessions were held and an email group was created to facilitate communication among the awardees. In addition, SPAN funded 12 individuals to attend the online Health Children Certified Lactation Counselor course and exam in 2020/2021, based on the scholarship applications.

The Family Wellness Healthy Start (FWHS) program serves pregnant and parenting teens and include interconception services. The FWHS program works to eliminate disparities in infant mortality and adverse perinatal outcomes especially among the target population of African American and Hispanic women in Hartford and New Britain. The Department received a federal grant to expand services which previously included African American women in Hartford to now include African American and Hispanic women in Hartford and New Britain. Services include 1) improving women's health, 2) promoting quality services, 3) strengthening family resilience, 4) achieving collective impact, and 5) increasing accountability through quality improvement, performance monitoring and evaluation.

Child Health

The DPH is working with primary care providers to incorporate parental education on developmental milestones and communicates benefits of standardized developmental monitoring and screening to parents and providers in primary care settings highlighting the CDC's "Learn the Signs. Act Early" materials. CT DPH staff coordinates the CT State Heath Improvement Plan Developmental Screening Workgroup to increase developmental screening through a developmental monitoring and screening education and awareness campaign; training community and healthcare providers to improve screening rates and coordination of referrals and linkage to services; and engaging in cross systems planning and coordination of activities around developmental screening.

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.

The DPH Nutrition, Physical Activity, and Obesity (NPAO) Program has been implementing the Go Nutrition and Physical Activity Self-Assessment for Child Care (Go NAPSACC) initiative with center and home-based early care and education programs (ECEs) to address childhood obesity. Go NAPSACC is an online system that helps ECEs create a healthier environment for the children they serve through a five-step improvement process.

Adolescent Health

DPH supported 92 school health service sites in 27 communities. School health service sites support students in Pre-k through grade 12 and are in elementary, middle and high schools. There are 80 School Based Health Centers (SBHC) that provide access to physical, mental health and limited dental services located throughout the state. There were 12 were Expanded School Health (ESH) sites that provide mental health services. Services provided to students include: diagnosis and treatment of acute injuries and illnesses, managing and monitoring chronic disease, physical exams, administering immunizations, prescribing and dispensing medications, laboratory testing, health education, promotion and risk reduction activities, oral health (in some locations), referral and follow-up for specialty care, and linkages to community based providers.

Mental health services are a priority within the SBHCs and experienced adolescent health clinical staff provide a variety of services such as: assessment, diagnosis and treatment of psychological, social and emotional problems, crisis intervention, individual/group/family counseling, psycho-social education, advocacy and case management.

School-based health services serve as the principle vehicle for promotion of adolescent health services. SBHCs can provide a safe place to talk about sensitive issues such as depression, family problems, relationships and substance abuse. SBHC staff help students by addressing health problems that may interfere with learning, reducing absenteeism, help to keep students out of emergency rooms, and support families by allowing parents to stay at work. Care is delivered in accordance with nationally recognized medical/mental health and cultural and linguistically appropriate standards.

Children and Youth with Special Health Care Needs

The Children and Youth with Special Health Care Needs program's CT Medical Home Initiative provides community-based medical home care coordination networks and collaboratives to support children with special health care needs. Services include a statewide point of intake, information and referral; provider and family outreach and parent-to-parent support. Care coordination services include linkage to specialists and to community resources, coordination with school-based services, and assistance with transition to adult health care and other services. Community Care Coordination Collaboratives support local medical home providers and care coordinators to access state and local resources, and work to resolve case specific and systemic problems (including reduction in duplicity of efforts). The program partners with Child Health and Development Institute of Connecticut, Inc. (CHDI) to conduct Educating Practices training modules on topics including Care Coordination in the Medical Home, Developmental Surveillance Screening and Help Me Grow, and Family Professional Partnership in the Medical Home.

Opioid Update

The Office of Injury and Violence Prevention (OIVP), Opioid and Drug Overdose Prevention Program is helping CT combat the ongoing opioid epidemic. As of March 2021, Connecticut state agency partners, the state Departments of Public Health and Mental Health and Addiction Services, have expanded their network across the state in the areas of real-time opioid and stimulant overdose surveillance, safe storage and disposal of controlled substances and OTC medications, harm reduction, naloxone access, and academic detailing for controlled substance prescriber education. DPH and DMHAS combined elements of the LIVE LOUD (Live Life with Opioid Use Disorder) multi-media campaign with awareness of the high prevalence of fentanyl adulteration and with harm reduction messages. DPH has also been working to improve the statewide spread of the CT Naloxone + Overdose Response App (NORAsaves.com) which has a variety of resources such as how to recognize an opioid overdose and how to administer naloxone. The Change the Script campaign, launched in 2018, is ongoing and all three awareness campaigns point people to 2-1-1 to seek assistance for treatment and to Connecticut's drugfreect.org landing page. CT values interagency collaboration and seeks to ensure sustained statewide, multi-agency education and awareness campaigns that align with the CT Opioid REsponse (CORE) Initiative, a strategic plan which lays out a series of actions designed to rapidly reduce opioid-related overdose deaths in CT. CT's campaigns include a variety of messages focused on prevention, harm reduction, treatment, and recovery and speak to the need to change public perception and thinking about substance use disorder and acknowledge it as a chronic brain disease. The campaigns also seek to address the stigma associated with drug use, which can prevent a person or their loved one from seeking help.

Conclusion

Connecticut has made significant progress in improving the health of residents across the life course. DPH has taken a prominent role in convening partners to address assessment, planning and implementation of activities directly contributing to this improvement.

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. Initiatives and activities are planned to keep diverse populations in mind to begin to address these disparities with a strong emphasis in working to dismantle structural oppression.

These measures, developed through a participatory planning process, highlight areas of progress in maternal and child health in Connecticut, as well as health issues necessitating a public health approach to improve health outcomes.

III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts

The MCHBG is designed to provide quality maternal and child health services for mothers, children and adolescents (particularly of low income families); to reduce infant mortality and the incidence of preventable diseases and disabling conditions among children; and to treat and care for children and youth with special health care needs. The MCHBG is a federal/state program intended to build system capacity to enhance the health status of mothers and children.

Title V funds are an essential component of Connecticut's MCH efforts. State accounts for MCH programs are dedicated primarily to direct or enabling services and allow few staff positions. Federal funds are used to support the leadership, program management, clinical expertise, and data access resources that direct, oversee, develop, and monitor state-funded MCH programs. Title V funded staff are responsible for implementing and monitoring compliance with State mandates and regulations. Title V supports epidemiologists who are essential resources for many data access and performance monitoring activities and Title V funded care coordination staff support quality maternal and child health services for women/mothers, children, adolescents and CYSHCN.

III.A.3. MCH Success Story

United Way of Connecticut's 2-1-1 is a one-stop connection to the local services from utility assistance, food, housing, child care, after school programs, elder care, crisis intervention, and much more. 2-1-1 Infoline is an integral part of the CT Medical Home Initiative, providing a statewide point of entry as well as information and referral. DPH has dedicated MCHBG as well as other federal funding towards improving the United Way resource database and website, thus enhancing access to information for providers and consumers. The improvements include the ability to access information in numerous languages.

United Way has also provided outreach and training to family and community-based organizations regarding how to effectively use the 2-1-1 website. The 2-1-1 Infoline website recorded 2,171,275 visits in the 2020 calendar year. This is a 56% increase from 1,393,352 website visits in the 2019 calendar year. This increase in website visits is evidence that 2-1-1 has made a difference during the COVID-19 pandemic providing connections to critical services.

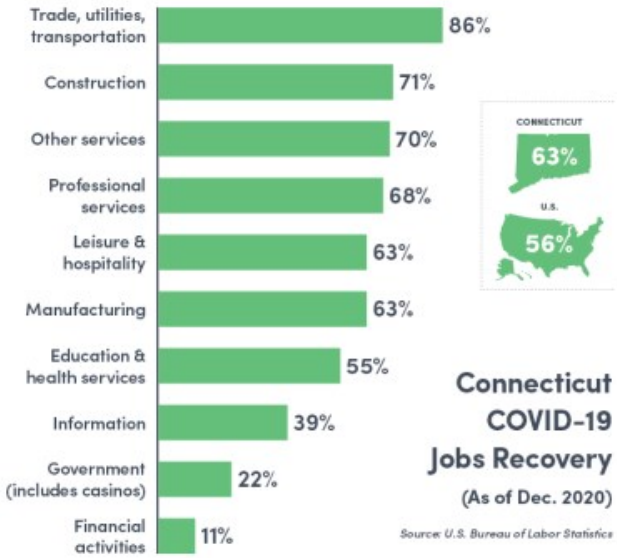
III.B. Overview of the State

Health Status and Demographics

Connecticut (CT) is a small state of about 5,000 square miles and 169 towns, and in 2019 had an estimated statewide population of 3,565,287[1]. Five towns had a population greater than 100,000 and included: Bridgeport (144,399), New Haven (130,250), Stamford (129,638), Hartford (122,105), and Waterbury (108,627)[2]. 17.78% of the state's residents lived in these five towns. The remaining 164 towns had a population of just under one-tenth the size of these large towns (median population size =12,096).

The State of CT is characterized by high social and economic contrasts. From 2014-2019, the state median household income (in 2018 dollars) was $ 76,106. The median household income of the five large towns in CT varied widely from a low of $ 34,338in Hartford, to moderate levels in Waterbury ($41,617), New Haven ($41,142), and Bridgeport ($45,441), and to a high of $89,309 in Stamford[2]. Among the five largest towns in CT from 2010 to 2019, the population of Stamford grew the fastest, with a 5.7% increase, followed by the town of New Haven (.3%) and the town of Bridgeport (.1%). These growth rates were higher than the overall statewide growth rate of -0.2%. The town of Hartford showed a -2.1% change in population, followed by Waterbury (-2.5%), which both showed an overall decrease in population[2].

In December 2020, the seasonally adjusted unemployment rate in Connecticut was estimated to be 8.2% (seasonally adjusted). The US jobless rate in December 2020 was 6.7%. Connecticut has lost 102,700 jobs (6.4% of the workforce) overall for 2020[3].Connecticut has fared better that other New England State and most of the country, but thousands of small businesses had to shut down[4].



In CT during 2019, 65.9% of the population was non-Hispanic White. Among racial and ethnic minorities, the percentages were: 16.9% Hispanic/Latino, 12.2% non-Hispanic Black/African American, 5.0% non-Hispanic Asian, and 2.5% of another race or multi-racial background. CT's largest towns had greater racial and ethnic diversity than CT overall. For example, 37.7% of Hartford's population was non-Hispanic Black/African American, and 35.1% of Bridgeport's population was non-Hispanic Black/African American. The Hispanic population accounted for approximately 44.3% of the population in Hartford, and 40.8% in Bridgeport [5].

In 2019, about one in six residents (16.8%) was 65 years of age or older. About one in five CT residents (20.8%) in

2019 was under 18 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, Waterbury, and Bridgeport, compared to 43.8% statewide. These statistics have policy implications for women of childbearing age and young mothers[2].

Between 2015-2019, 90.6% of CT adults had completed high school or had a GED, and 39.3% had a bachelor's degree or higher. Relative to the state overall, three of the largest towns, Hartford, Bridgeport, and Waterbury, had a greater proportion of adults with the lowest levels of educational attainment[2].

Relative to the general population, a different pattern of demographics exists among children living in CT. In 2019, 14.1% of children under 18 years were living below poverty level in the past 12 months and 19.9% of children under 18 years were living in households with Supplemental Security Income (SSI), cash public assistance income, or Food Stamp/SNAP benefits[5]. 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. It is estimated that the percent of children living below the poverty level in 2019 was 11.5% in Stamford, 31.4% in Bridgeport, 34.9% in Waterbury, and 36.2% New Haven, and 37.4% in Hartford. Other towns, however, also exhibited a high percent of childhood poverty. These towns included: New London (40.0%), Willimantic (39.2%), New Britain (33.4%), Ansonia (20.8%), and Derby (19.8%) 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.

Strengths and Challenges Impacting Health Status

While overall health in Connecticut is very good, sociodemographic disparities persist, shaped by pervasive structural and institutional social determinants of health. For many health indicators, persons of color (anyone other than non-Hispanic White) experience a greater share of adverse health events.

Many of the issues raised from the MCH Block Grant Needs Assessment are therefore driven by the goal of advancing the health of priority populations to the high standards of health obtained by more privileged residents of Connecticut. Based on this assessment, emergent themes in maternal and child health in Connecticut are highlighted by life course stage.

The data contained in the MCHBG NA report indicate major improvements in the health of mothers, infants, and children in Connecticut. However, much remains to be done to achieve optimal outcomes for these populations. The lifetime effects of race, racism, social class, poverty, stress, environmental influences, health policy, and other social determinants of health are reflected in the elevated rates of adverse outcomes and persistent disparities. While we continue to strive to reduce health inequities, these challenges also are apparent at the national level and are not unique to Connecticut. The continuation of evidenced-based programs, coupled with efforts to increase health equity and address social determinants of health (SDOH), are essential to achieving improved birth outcomes and reducing/eliminating disparities for mothers, infants and children in Connecticut.

As we move from assessment to planning, we will look at the common upstream factors of SDOH as cross-cutting themes to identify systemic inequities that impact prioritized health issues. By focusing on these determinants of health, engaging cross-sector partners, identifying alignment of efforts and collaboratively exploring strategic opportunities, we will create a roadmap for collaborative health improvement activities over the next five years and will prioritize health equity for all Connecticut's MCH population.

Maternal and Child Demographics

Overall in 2019, the State of Connecticut was 65.9% non-Hispanic White, 12.2% non-Hispanic Black, 16.9% Hispanic (8% Puerto Rican), 5.0% non-Hispanic Asian, and 2.5% non-Hispanic Other race[2]. At the end of 2020, the unemployment rate was 8.2%[3].

Just over half (53.3%) of women who gave birth in Connecticut in 2019 were non-Hispanic White, one quarter were Hispanic, 13.3% were non-Hispanic Black, and 7.8% were non-Hispanic Other race.

Overall, the State of Connecticut is 65.9% non-Hispanic White. However, non-Hispanic White women make up a smaller percentage of those giving birth, at 53.3. Most women giving birth (90.7%) had over 12 years of education and were married or had an acknowledgment of paternity. A little over a quarter these mothers received Women, Infant, and Children (WIC) benefits (27.6%).

Because of the racial history of the U.S., race/ethnicity is correlated with poverty, which affects access to health insurance. Prior to becoming pregnant, health insurance coverage varied greatly by race/ethnicity for women in Connecticut. In 2019, about 72-82% of women who were non-Hispanic White or non-Hispanic Other races were covered by private health insurance, while only 49.1% of Black and 34.9% of Hispanic women were. About one quarter of Hispanic women were uninsured.

Other socioeconomic characteristics of women delivering live births in Connecticut between 2016-2019 are also not distributed equally by race/ethnicity. Based on data from the CT DPH Office of Vital Records, in which data have been grouped as non-Hispanic Asian, non-Hispanic White, Puerto Rican, non-Hispanic Black, and Other Hispanic, these patterns are apparent. Non-Hispanic Asian women were most likely to have obtained a bachelor's degree or higher (71.8%), followed by non-Hispanic Whites (61.7%), non-Hispanic Blacks (23.1%), other Hispanics (20.4%), and Puerto Rican Hispanics (9.6%). This inequity in educational attainment stems from a history of racism, colonialism (the policy of a country seeking to extend or retain its authority over other people,) and immigration patterns[1]. Unfortunately, lower educational attainment is associated with lower income across the life-course, neighborhood poverty, poorer health status, and poorer health status for infants and children.

Infant Mortality

Connecticut's infant mortality rate was 4.8 deaths per 1,000 live births during the period 2015-2019 down from 5.9 deaths per 1,000 live births in 2005 – a decrease of about 2.5% each year. Connecticut's IMR has consistently remained well below both the US rate and the Healthy People 2020 target of 6 deaths per 1,000 live births since 2010[1].

Reductions in the state IMR are driven by declines across many subgroups. Annual IMRs in both non-Hispanic Black/African American and Hispanic populations also declined for the period 2015-2019, at rates of 2.9% and 2.3% per year, respectively, as they had since 2005. By contrast, there was no evidence of decline in mortality rates among Non-Hispanic White infants between 2015 and 2019.

Progress is being made in reducing Connecticut's IMR and in reducing the disparity between black and white infants. Connecticut was recently cited as ranking eighth among all states for reducing the black-white infant mortality gap over the period 1999-2013.[i] Nonetheless, there is still work to be done. Most recently, and specifically for the period 2015-2019, annual IMRs in Connecticut's non-Hispanic White population averaged 3.2 deaths per 1,000 live births and were significantly lower than those observed for the non-Hispanic Black/African American and Hispanic populations. Annual IMRs for non-Hispanic Black/African American populations averaged 9.8 deaths per 1,000 live births, and those for Hispanic populations averaged 5.6 deaths per 1,000 live births. The averages were 3.1 and 1.7 times higher, respectively, than that for Connecticut's non-Hispanic White population.

Births to Teens

The 2015-2019 annual overall teen birth rates in Connecticut averaged 8.9 (range = 7.7 - 10.1, reported as live births per 1,000 women aged 15-19) and continued an 11-year decline observed to have begun in 2008. The lower limit for the range of teen birth rates during this five-year period of 7.7 births per 1,000 women aged 15-19 represents the lowest teen birth rate observed this century in Connecticut. Declines across all three major race-ethnicity groups are also evident for the period 2015-2019, with annual rates of declines in teen birth rates in the non-Hispanic White,

non-Hispanic Black/African American, and Hispanic populations during this period averaging 12.9%, 11.2%, and 6.6% per year, respectively. In the presence of these significant declines across all three major race-ethnicity groups in Connecticut, however, disparities by race and ethnicity nonetheless exist. For the period 2015-2019, the average annual teen birth rate of Hispanic women of 25.4 births per 1,000 women aged 15-19 was 8.9 times higher than the average rate for non-Hispanic White women of 2.8. The average annual teen birth rate among non-Hispanic Black/African American women of 14.5 births per 1,000 women aged 15- 19 for 2015-2019 was 5.1 times that of non-Hispanic White women.[2]

Prenatal Care

To assure optimal health outcomes for a pregnant woman and her child, preventive care is critical. Early and continuous prenatal care, including oral health care, throughout a woman's pregnancy helps medical providers identify and treat health problems early. Doing so can support the health of the mother and provide unborn babies with as healthy of a start to life as possible.

Beginning prenatal care in the first trimester of pregnancy and following the prescribed visit schedule improves the likelihood of positive health outcomes for mother and baby.[2] Infants whose mothers do not receive prenatal care are three times more likely to be born low birthweight and five times more likely to die compared to infants born to mothers who receive prenatal care.[2] Early and regular prenatal care is protective against maternal and infant adverse outcomes, including infant mortality, low birthweight, and maternal complications. By receiving early and continuous care, early diagnosis, treatment, and prevention of health problems is more likely, and doctors can also discuss topics such as breastfeeding, infant safe sleep environment, and depression to help promote health and well-being in the postpartum period.

Healthy People 2030 aims for 80.5% of women to have early prenatal care. Connecticut has exceeded that goal (84.1% for 2019) and fares better than the U.S. as well (77.6% in 2019).[2, 6] However, caution in comparing rates before and after 2016 is warranted due to changes in collection methods. Due to shifts in rates between 2015 and 2016, reporting of long-term trends for timing of prenatal care initiation is limited to the years prior to 2016.[2] In 2016, Connecticut adopted the 2003 Revision of the US Birth Certificate which included changes to how timing of prenatal care initiation was collected. Specifically, the 2003 Revision collects the date of the first prenatal care visit rather than the month of pregnancy during which prenatal care began. Due to these changes, rates based on prenatal care timing are not directly comparable between Revisions. Internal review by DPH suggests that reporting of date of prenatal care initiation, rather than month, yields more accurate estimates of timing of prenatal care initiation and thus rates for 2016 and later are considered to have slightly higher validity than those released prior to 2016.

Rates of early prenatal care utilization for the entire population of Connecticut have been stable but differ by subgroups of women with 76.5% of Black non-Hispanic women, 88.4% of White non-Hispanic women, 65.4% of women under 20 and 87.0% of women age 30-34 receiving prenatal care in the first trimester in 2019[5].

Singleton Low Birth Weight and Very Low Birth Weight

There was no change in the overall rate of singleton low birth weight (LBW) around an average value of 5.9% (range = 5.8 - 6.1%) for Connecticut, nor for non-Hispanic White and Hispanic populations, for the period 2015-2019. This result is consistent with an observed stable rate of singleton LBW, both overall and in these two race-ethnicities, since the mid-2000s, when rates stopped increasing. Singleton LBW rates for the non-Hispanic Black/African American population, on the other hand, declined during the 2015-2019 period, at a modest rate of 0.08 percentage points per year, as they had since 2003. Disparities among minority race-ethnicity groups have persisted. From 2015 to 2019, the average rate of singleton LBW infants among non-Hispanic Black/African American populations (9.9%) was 2.2 times higher than that among non-Hispanic White women (4.5%). The average rate of singleton LBW among Hispanic women (6.8%) was 1.5 times that of non-Hispanic White women.

Between 2015 and 2019, there was also no change for Connecticut overall in the rate of singleton very low birth

weight (VLBW). There were some minor fluctuations across all three major race-ethnicity groups, but the rates remained largely unchanged and averaged 1.1% for the total population (range=1.0-1.1%). Disparities in rates of VLBW by race-ethnicity in Connecticut were more marked than those for LBW for the period 2015-2019. Average rates of VLBW for the non-Hispanic Black/African American population (2.4%) and Hispanic population (1.3%) were 3.8 and 2.1 times that of the non-Hispanic White population rate of 0.6%, respectively.[7]

State's Systems of Care

The Connecticut Department of Social Services (DSS) is the single state agency for the administration of Connecticut Medicaid and the Children's Health Insurance Program (CHIP). Medicaid and CHIP are collectively described as the HUSKY Health Program. The DSS Division of Health Services as well as Eligibility Policy and field staff support access to and utilization of HUSKY Health. These programs provide person-centered health care coverage to over 800,000 individuals. The vision of Medicaid and CHIP is to represent an effective health care delivery system for eligible people in Connecticut that promotes 1) well-being with minimal illness and effectively managed health conditions; 2) maximal independence, and 3) full integration and participation in their communities. HUSKY Health serves eligible children, their caregivers, older adults, individuals with disabilities and single, childless adults. HUSKY also provides limited coverage to a number of additional small groups (e.g. for family planning and tuberculosis coverage) and helps keep older adults and people with disabilities independent at home through Medicaid "waivers".

Note:

Specific state statutes related to the MCH Block Grant authority (and impact to the state's MCH and CSHCN programs) can be found as an attachment.

The State Health Assessment which serves as a 5-year roadmap for promoting and advancing population health in the State (highlighting the challenges faced around achieving health equity) can be found as an attachment.

The Connecticut Department of Public Health Agency and Section Organizational Chart can be found as an attachment.

1. United States Census Bureau, 2019 Data
2. United States Census Bureau, 2019 Data https://www.census.gov/quickfacts
3. U.S. Bureau of Labor and Statistics
4. The Connecticut Business & Industry Association: https://www.cbia.com/news/media-releases/cbia-response-december-2020-employment-report/
5. American Psychological Association: https://www.apa.org/pi/ses/resources/publications/minorities
6. National Institutes of Health; Eunice Kennedy Shriver National Institute of Child Health and Development. (2017). Pregnancy: About, from https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/prenatal-care
7. US Department of Health and Human Services; Office on Women's Health. (2019). Prenatal Care, from https://www.womenshealth.gov/a-z-topics/prenatal-care

Findings

MCH Population Health Status

Domain 1: Women's and Maternal Health

Just over half of women who gave birth in Connecticut in 2016-2018 were non-Hispanic White, one quarter were Hispanic, 12.2% were non-Hispanic Black, and 10.2% were non-Hispanic Other race. Hispanic and non-Hispanic Black women were disproportionately likely to reside in a female-headed household.

The 2015-2019 annual overall teen birth rates in Connecticut averaged 8.9 (range = 7.7 - 10.1, reported as live births per 1,000 women aged 15-19) and continued an 11-year decline observed to have begun in 2008. However, among all women giving birth, prevalence of unintended pregnancy was high (this includes women who were unsure if they wanted to become pregnant), especially for non-Hispanic Black women (52.4%). This could contribute to racial disparities in maternal morbidity and mortality. For 2019, in the three months *prior to becoming pregnant*, diabetes was most prevalent among non-Hispanic Other race women (3.3%), high blood pressure among non-Hispanic Blacks (6.3%), depression among non-Hispanic Whites (13.6%), poly-cystic ovarian syndrome (PCOS) among non-Hispanic Other race (6.1%), and anxiety among non-Hispanic Whites (26.7%). Non-Hispanic Black and Hispanic women were more likely to be overweight or obese than their non-Hispanic White or non-Hispanic Other race counterparts.

During pregnancy, 13.8% of women in Connecticut developed preeclampsia in 2019, which was highest among non-Hispanic Black women (16.6%) and lowest among non-Hispanic Other race women (8.3%). Overall, 11.9% of women in Connecticut developed gestational diabetes, which was highest among non-Hispanic Other race women (17.0%) and lowest among non-Hispanic Black women (8.5%). The prevalence of gestational diabetes was also strikingly high among the uninsured (20.0%) and is increasingly common with age. Overall, 8.4% of women had thyroid problems, with the highest prevalence's among non-Hispanic Other race women and older women. Approximately eight to ten women die in Connecticut each year, due to pregnancy-related causes.

Following delivery of a live birth in 2019, 11.1% of women in Connecticut reported postpartum depressive symptoms. However, the racial/ethnic patterns shift, with lowest prevalence among non-Hispanic White women (8.5%) and highest among non-Hispanic Black women (18.6%). Among these women, less than half sought help for their symptoms, ranging from 24% of non-Hispanic Other race and non-Hispanic Black women to 40.7% of non-Hispanic White women.

Domain 2: Perinatal and Infant Health

Singleton preterm birth and low birthweight (LBW) rates show persistent racial disparities in Connecticut. In 2015-2019, 6.3% of non-Hispanic White women delivering singletons gave birth preterm, compared to 10.5% of non-Hispanic Black women. Similarly, 6.8% of non-Hispanic White women gave birth to an infant with LBW, compared to 9.9% of non-Hispanic Black women. These patterns have been consistent for nearly 20 years, if not longer. Connecticut's infant mortality rate (IMR) averaged 4.8 per 1,000 live births (range: 4.0 - 5.6) during the period 2015-2019 down from 5.9 deaths per 1,000 live births in 2005 – a decrease of about 2.5% each year. Connecticut's IMR has consistently remained well below both the US rate and the Healthy People 2020 target of 6 deaths per 1,000 live births since 2010. However, disparities persist. Non-Hispanic Black infants were more than three times as likely to die and Hispanic infants were 1.7 times more likely to die than non-Hispanic White infants in Connecticut for the period 2015-2019.

Racial disparities in infant health continue postnatally. Most women in Connecticut reported that their health care

provider had recommended they place their infants to sleep on their backs during 2019. However, fewer women reported putting their infants to sleep on their backs only. Only 61.6% of Black women reported solely back sleeping compared to 90.9% of White women. Breastfeeding practices also vary by race/ethnicity. While 88-94% of women of all race/ethnicities report initiating breastfeeding postpartum, by 8 weeks, only about two-thirds of Hispanic and non-Hispanic Black women are still breastfeeding, compared to 74.6% of non-Hispanic Whites and 80.0% of non-Hispanic Other race women.

An increasing concern in Connecticut is infants born with Neonatal Abstinence Syndrome (NAS) – a condition where a neonate goes through withdrawal from certain drugs that they were exposed to in the womb. Most commonly, NAS is due to chronic maternal opioid exposure. In Connecticut, the number of infants born with NAS increased from 280 in 2010 to 416 in 2015, and then declined to 309 in 2019. Collaborative partnerships have formed in Connecticut between non-governmental professional organizations, multiple state agencies, and public/private professional organizations to address NAS in the state.

Domain 3: Child Health

Overall, 91.4% of children aged 0-17 years old were reported to have excellent or very good health in Connecticut in 2018-2019. However, disparities exist in some manageable and preventable childhood conditions, indicating room for improvement. Just under 9% of children in Connecticut currently had asthma in 2019, with Non-Hispanic Black and Hispanic children disproportionately affected by asthma with higher prevalence rates of 11.2% and 16.1%, respectively. Disparities in utilization of health care have been reported, with Black non-Hispanic children visiting hospitals' emergency departments and hospitalized for asthma at a rate 5 times higher than non-Hispanic White children. Similarly, Hispanic children have asthma-related emergency department visits and hospitalizations rates 4 times that of non-Hispanic White children. Asthma is one of the leading causes of school absenteeism, putting children at risk for poor academic performance. In 2016, 40.6% of children with asthma missed school days in the past 12 months. Children in general, but especially non-Hispanic Black and Hispanic children bear the highest burden of asthma in Connecticut. Families with incomes >$75,000 had the lowest prevalence of children with dental decay (10.9%), while children in families earning <$35,000 had the highest (20.7%). Similar disparities exist by race and insurance coverage for both asthma and dental decay.

The medical home model for children and adults is a proven approach to provide comprehensive and high-quality primary care. In 2018-2019, Connecticut (56.8%) was slightly above the U.S. average (49.0%) in the proportion of children without special health care needs who received coordinated, ongoing, and comprehensive care within a medical home. Connecticut exhibits disparities across race and ethnicity for children receiving care within a medical home. 61.7% of non-Hispanic White children receive care within a medical home, while only 48.3%of non-Hispanic Black children, 41.4% of Hispanic children, and 44.7% of non-Hispanic children of any race did.

The proportion of children with a mental/behavioral health condition who received treatment or counseling declined in both Connecticut and the U.S. between 2011-2012 and 2017-2019. In Connecticut, the proportion declined from 69.9% to 56.6%. Between 2012 and 2019, the proportion of children under three years-old who received a developmental screening rose consistently from 16.2% to 43.9%. However, this is still less than half of the population, indicating that improvement is still needed, but appears promising, given the current trend lines.

Adverse Childhood Experiences (ACEs) are stressful or traumatic events, including abuse, neglect and household dysfunction that occur during childhood. Adverse childhood experiences and trauma are risk factors for depression, anxiety, and post-traumatic stress disorder. In their most extreme form, ACEs can result in death. In 2015-2018, over two out of five deaths due to family violence occurred among Connecticut's youngest residents between 0-17 years of age. Non-Hispanic White residents comprised the largest proportion of deaths related to family violence, followed by non-Hispanic Black and Hispanic residents, respectively. Based on population rates, non-Hispanic Black residents had proportionately higher rates than other race and ethnicity groups. To address the immediate threat of violence, as well as long terms health consequences, the State of Connecticut is engaged in several public

health and policy initiatives.

Domain 4: Children with Special Healthcare Needs

Children and youth with special health care needs (CYSHCN) have or are at increased risk for chronic, physical, developmental, behavioral, or emotional conditions. In addition, they often require more health-related services beyond what is required by children generally. There is a well-documented benefit for children in having health insurance. In 2001, nearly three-quarters of children and youth with special health care needs had private insurance (73%). However, in 2018-2019, the proportion of children and youth with special health care needs who had either private or public insurance was 57.1% and 32.8%, respectively.

Among CYSHCN, Connecticut (40.4%) was slightly below of the U.S. average (42.3%) in the proportion of children who received coordinated, ongoing, and comprehensive care within a medical home in 2018-2019. In contrast, only 52.4% of CYSHCN in Connecticut were reported as receiving needed and effective care coordination, compared to 57.2% of children in the U.S. on average, in the same time period. Connecticut (20.8%) was slightly ahead of the U.S. (18.4%) in the proportion of 12-17-year-old CYSHCN who received the services needed to transition to adult health care. Families of CYSHCN reporting receiving care in a well-functioning system varied greatly by age. In 2018-2019, the proportion was 19.6% for 0-11-year-olds, and 7.3% for 12-17-year-olds. Overall, 8.7% of parents of CYSHCN reported they were usually or always frustrated getting services for their child, compared to only 0.4% of parents of children without special health care needs.

The prevalence of mental/behavioral health conditions has been increasing among children and has been found to vary by geographic and sociodemographic factors. Further, the receipt of treatment is also generally dependent on sociodemographic and health-related factors. Adequate insurance and access to a patient-centered medical home may improve mental health treatment. In Connecticut, a slightly higher proportion of non-Hispanic White children with a mental/behavioral condition received treatment or counseling, compared to Hispanic children with a mental/ behavioral condition (71% and 66%, respectively). Conversely, 29% of non-Hispanic White children and 34% of Hispanic children with a mental/behavioral condition did not receive treatment or counseling. In 2018-2019, 3.1% of children (aged 3-17) in Connecticut had ever been diagnosed with Autism Spectrum Disorder (ASD). This is slightly higher than the national percentage (2.9%). This may speak to more awareness and screening of ASD among Connecticut residents when compared to the US overall.

Domain 5: Adolescent Health

Use and misuse of illicit drugs (e.g. heroin, fentanyl, cocaine), prescription opioid medications and alcohol are major issues nationally and in Connecticut. In recent years illicit drug use among Connecticut high school students has declined. Nonetheless, over 10% of high school students reported ever taking prescription pain medication for non-medical reasons. Prevalence was highest among Hispanics (14.2%) and lowest among Whites (8.0%). Prevalence was notably consistent across grade levels. Only 3.7% of Connecticut high school students currently smoke cigarettes and only 1.3% report frequent use. In contrast, 44.8% report ever using an electronic vaping product, 27.0% report current use, and 8.5% report frequent use.

Bullying is considered a traumatic event, and fighting may be considered either a traumatizing experience or a consequence/outcome of having repeated exposure to trauma. Bullying also indicates disruption in the school setting that impacts school connectedness, which is an important protective factor for substance use, sexual behavior, mental health, and academic success. In recent years, Connecticut females were more likely than Connecticut males to be bullied on school property. In 2019, 21.3% of females and over 14% of males reported being bullied on school property in the past 12 months. Bullying was more common among younger students and among Hispanics and non-Hispanic Whites, compared to non-Hispanic Blacks. The percentage of females being cyberbullied is also consistently higher than the percentage of males in recent years, with 17.3% of females and 11.4% of males reporting the experience in the past 12 months. Youth who identify as lesbian, gay, bisexual, transgender, or queer

(LGBTQ) are more likely to be bullied, both on school property and electronically, when compared to students who identify as heterosexual. The percentage of LGBTQ youth who reported cyberbullying was almost double the percentage of heterosexual youth who reported cyberbullying, 26.9% versus 14.9%.

In the 2019, the prevalence of physical dating violence was 8.7% among students who reported only opposite sex partners, compared to 19.5% among students with partners of the same sex or both sexes. Prevalence of sexual dating violence varied dramatically among high school students, with 8.8% of heterosexual students reporting it, compared to 24.2% of those identified as being gay/lesbian/bisexual, and 25.4% of those "unsure" of their sexual identity. Among Connecticut high school students, 7.5% report being forced to have sexual intercourse in their lifetimes. Prevalence was 4.1% of heterosexual students, compared to 17.9% of gay/lesbian/bisexual students, and 6.1% of those unsure of their identity.

Nationally, suicide contemplation by high school students in the last 12 months was 17.2%. By comparison, Connecticut is below the national average. In 2019, 15.9% of females and 9.3% of males reported considering suicide in the past 12 months. In 2019, 8.3% of females and 5.2% of males attempted suicide. Significantly more Hispanic students (10.1%) attempted suicide compared to Blacks (5.8%) and Whites (5.7%). In 2017, 5.8 youths (aged 10-19 years) per 100,000 died by suicide in Connecticut. In 2018, the rate was 2.8 per 100,000.

Title V Agency

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.

On July 26, 2021 Governor Ned Lamont announced that he is nominating Dr. Manisha Juthani to serve as Commissioner of DPH. Dr. Juthani is an infectious diseases physician at Yale School of Medicine in New Haven, where she specializes in the diagnosis, management, and prevention of infections in older adults. In accepting the nomination, Dr. Juthani will succeed Dr. Deidre Gifford as head of DPH. For the last 14 months, Dr. Gifford has been serving dual roles within the Lamont administration. Although her primary position is as commissioner of the Department of Social Services, in May 2020 she agreed to also serve as Commissioner of the Department of Public Health in an acting capacity while a search was underway to permanently fill the position.

In this new role, Dr. Gifford will be tasked with coordinating a multi-agency approach among the state's nine health and human services agencies to improving health and healthcare in Connecticut. As Senior Advisor to the Governor for Health and Human Services, Dr. Gifford will convene and lead coordination efforts between these agencies, working closely with the Office of Policy and Management, as well as provide the governor with policy input and recommendations that address issues of health, healthcare costs, quality, and disparities.

Dr. Juthani will assume the role as Commissioner on Monday, September 20, 2021.

Leadership:

Rosa M. Biaggi, MPH, MPA and Mark Keenan, RN, MBA are Chiefs of the Community, Family Health, and Prevention Section (CFHPS) and previously served as the Title V Maternal and Child Health Director. Marc Camardo, MPH, is the Title V Director and SSDI Director and reports to Mark Keenan. Ann Gionet is the Children with Special Health Care Needs Director and reports to Mark Keenan. Selma Alves, MPH, is the MCHBG Family Advocate and reports to Ann Gionet.

The Title V Program resides within the CFHPS. The CFHPS works to improve the health of the overall population across the lifespan, especially mothers, infants, children, adolescents and other vulnerable groups, by establishing opportunities that support healthy living habits through education, early detection, access to care and chronic disease prevention. The CFHPS is comprised of the following units: 1) Women's Health and Prevention; 2) Adolescent and Child Health; 3) Maternal and Child Health Epidemiology; 4) Chronic Diseases; 5) Women, Infants

and Children (WIC); and 6) Epidemiology. The CFHPS also includes the: 1) Genomics Office; 2) Office of Oral Health; and 3) Office of Injury and Violence Prevention. Staff work collaboratively across units and offices to coordinate resources and maximize program capacity.

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 CFHPS, 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; 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; Pregnancy Risk Assessment Monitoring System; Family Wellness Healthy Start; Provide Supplemental Nutritious Foods; Breastfeeding promotion and support; and Nutrition education. These programs either receive Title V funds or work in collaboration with the Title V Program.

The CFHPS employs 91 permanent staff with expertise and skills in various areas of public health having graduate degrees or have experience in nursing, social work, allied health, health education, research, evaluation, epidemiology, law, planning, administration and management. Most CT's Title V program activities reside organizationally within the CFHPS. The proposed FFY 2022 plan will maintain overall staff support at 22.0 FTE positions.

The MCHBG supports a full time equivalent in the Health Information Systems and Reporting Section 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, Public Health Systems Improvement, 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 and Violence Prevention.

Number, location and full-time equivalents of staff who work on behalf of the Title V Program

FTE's		FFY 2021	MCH	CSHCN	FY2022	MCH	CSHCN	
Health Program Associate	Alves	100%	25%	75%	45%	15%	30%	Community, Family Health, and Prevention Section
Epidemiologist 2	Budris	50%	50%		10%	10%		Community, Family Health, and Prevention Section
Epidemiologist 3	Davis	100%		100%	100%	15%	85%	Community, Family Health, and Prevention Section
Secretary 1	Douglas	100%	80%	20%	90%	80%	10%	Community, Family Health, and Prevention Section
Health Program Supervisor	Gionet	100%	25%	75%	100%	50%	50%	Community, Family Health, and Prevention Section
Nurse Consultant	Owusu	30%	25%	5%	30%	25%	5%	Community, Family Health, and Prevention Section
Secretary 2	Prevost							Community, Family Health, and Prevention Section
Health Program Associate	Velasquez	50%	50%		50%	50%		Community, Family Health, and Prevention Section
Nurse Consultant	Bailey	100%	25%	75%	100%	25%	75%	Public Health Laboratory
Mircrobiologist 2	Mills	100%	25%	75%				Public Health Laboratory
Secretary 2	Mitchell	100%	25%	75%	100%	25%	75%	Public Health Laboratory
Epidemiologist 3	Vacant/Fill	100%	10%	90%	100%	10%	90%	Health Statistics and Surveillance Section
Associate Accountant	Murray	50%	25%	25%	50%		50%	Fiscal Office
Fiscal Administrative Officer	West	20%	10%	10%				Contracts and Grants Management Section
Office Assistant	Little	100%	100%		100%	100%		Vital Records
Epidemiologist 3	Davis K							Community, Family Health, and Prevention Section
Epidemiologist 2	Prince	50%	40%	10%	45%	35%	10%	Community, Family Health, and Prevention Section
Epidemiologist 4	Camardo	100%	75%	25%	100%	50%	50%	Community, Family Health, and Prevention Section
Health Program Associate	Krusz	10%	10%		10%	10%		Community, Family Health, and Prevention Section
Epidemiologist 3	Hayes	100%	100%		100%	100%		Community, Family Health, and Prevention Section
Health Program Associate	Ortiz/Soto	100%	50%	50%	100%	50%	50%	Contracts and Grants Management Section
Health Program Associate	Touma	50%	20%	30%				Public Health Systems Improvement
Staff Attorney 3	Hansted	25%	15%	10%	25%		25%	Attorney Office
Health Program Associate	Repinecz	75%	75%		100%	50%	50%	Community, Family Health, and Prevention Section
Epidemiologist 2	X. Zheng	25%	25%		25%	25%		Community, Family Health, and Prevention Section
Nurse Consultant	K. Britos-Swain	50%	25%	25%	50%	25%	25%	Community, Family Health, and Prevention Section
Epidemiologist 1	Vacant/Fill							Community, Family Health, and Prevention Section
Health Program Assistant 2	Vacant/Fill							Community, Family Health, and Prevention Section
Epidemiologist 1	T. Fox	100%	85%	15%	100%	85%	15%	Community, Family Health, and Prevention Section
Epidemiologist 3	S. Yurasevecz							Community, Family Health, and Prevention Section
Health Program Assistant 2	J. Squires	80%	60%	20%	80%	60%	20%	Community, Family Health, and Prevention Section
Epidemiologist 2	T. McCarthy	10%	5%	5%	10%	5%	5%	Community, Family Health, and Prevention Section
Health Program Supervisor	E. Conklin	100%	75%	25%	100%	75%	25%	Community, Family Health, and Prevention Section
Connecticut Career Trainee	R. Sterling	100%	45%	55%	100%	45%	55%	Community, Family Health, and Prevention Section
Secretary 2	S. Swegman	100%	75%	25%	100%	75%	25%	Community, Family Health, and Prevention Section
Health Program Assistant 2	C. Fallon	25%	20%	5%	90%		90%	Community, Family Health, and Prevention Section
Secretary 2	Vacant/Fill				100%	90%	10%	Community, Family Health, and Prevention Section
Supervising Nurse Consultant	Vacant/Fill				90%	90%		Community, Family Health, and Prevention Section
TOTAL		22.00	12.75%	9.25%	22.00	12.75%	9.25%	

The State of Connecticut is highly invested in supporting efforts to implement the core public health functions (assessment, policy development, and assurance) and to achieve increased accountability through ongoing performance measurement and supporting an adequately sized and skilled workforce.

Current Initiatives

DPH completed the 2020 update of the State Health Needs Assessment. The report was released as the State Health Improvement Plan (SHIP) Coalition launched a series of planning workshops to update the health improvement plan. The DPH Public Health Systems and Equity (PHSE) team worked with partners across the state to design the Healthy CT 2025 SHIP framework. Although the COVID-19 pandemic disrupted the planning process by requiring working remotely, the PHSE team completed the plan through multiple virtual meetings and webinars to discuss priority areas and cross-cutting themes.

The plan's strategies focus on policy, systems, and environmental changes to address upstream causes of poor health. The priorities under consideration include: a) access to health services and primary healthcare, b) economic stability, particularly around issues of poverty and employment, c) access to healthy eating and issues of food security, d) housing quality and stability, and e) community resilience as it relates to crime/violence and emergency preparedness. Cross-cutting priorities include education, transportation, and racial discrimination.

In addition to launching Healthy Connecticut 2025, DPH is undergoing preparations for its re-accreditation application due by the first quarter of 2022. DPH received its first national public health accreditation in March 2017 and has submitted annual reports to the Public Health Accreditation Board (PHAB). The agency is now preparing documentation that demonstrates a culture of quality improvement and performance management. Additionally, DPH worked to maintain the capacity needed to provide the ten essential services of public health. The agency also worked on developing systems and programmatic functions to narrow gaps identified during an assessment of DPH's current work based on the re-accreditation standards. MCH grant funding makes possible continued progress and allows DPH to conduct the accreditation work across the agency.

The CT Maternal and Child Health Coalition is a representative group of state agencies, providers, funders, and

advocates working in concert with the state's maternal and child health population. The Coalition has over 120 individuals representing 97 organizations. It serves as a communication and networking vehicle for those working in the field of maternal and child health by holding quarterly meetings and sending out notes of interest to Coalition members. The Coalition represents the state's maternal and child health priorities/interests in the State Health Improvement Plan, and also advocates for health equity and the elimination of racial and ethnic health disparities.

A Coalition advocacy initiative, being done in collaboration with the Every Woman Connecticut Learning Collaborative and the March of Dimes, is the establishment of a Reproductive Workgroup. Modeled on work being done in New York, this workgroup will be looking at the degree and types of disrespect and abuse experienced by women seeking pre/interconception as well as prenatal and postpartum health care. Based on the fact-finding results, the workgroup will propose recommendations to address identified areas of concern.

DPH participates in the Every Woman Connecticut Learning Collaborative, which seeks to increase expertise and self-efficacy in implementing routine pregnancy intention screening and appropriate care, education, and services to ultimately improve birth spacing, increase pregnancy intentionality, and the proportion of Connecticut women who deliver a live birth who report discussing pre/interconception health with a healthcare worker.

CT legislation was passed in 2018 to establish a Maternal Mortality Review Committee (MMRC) and program within DPH. The Maternal Mortality Review Committee is comprised of both clinical and non-clinical subject matter experts that conduct a comprehensive, multidisciplinary review of each pregnancy-associated death that occurred within one year of the end of a pregnancy. The comprehensive review includes medical records; medical examiner reports; death certificates; vital statistics infant birth, and fetal and maternal death files; police reports; informant interviews; obituaries; social media and other sources of information. The purpose of the MMRC review is to identify factors that may have contributed to the death, and to make recommendations to reduce pregnancy-related morbidity, mortality and disparities. The department's Maternal Mortality Review Program is supported by CDC funding that provides for program administration, data collection and analysis of maternal mortality data, and an annual Maternal Mortality Evaluation Report.

The Department's State Physical Activity and Nutrition (SPAN) Program breastfeeding team, along with the State WIC Program staff, continues to partner with the CT Breastfeeding Coalition's (CBC) Ten Step Collaborative to encourage implementation of evidenced-based maternity care and the 10 Steps for Successful Breastfeeding in CT hospitals. In 2020, the "It's Worth It" media campaign (launched in late 2019), was again run in targeted areas of the State aimed at increasing the awareness of the campaign's community support message and also documenting stories of diverse populations.

The Children and Youth with Special Health Care Needs Program's CT Medical Home Initiative provides community-based medical home care coordination networks and collaboratives to support children with special health care needs. Services include: a statewide point of intake, information and referral; provider and family outreach; and parent-to-parent support. Care coordination services include linkage to specialists and to community resources, coordination with school based services, and assistance with transition to adult health care and other services. Community Care Coordination Collaboratives support local medical home providers and care coordinators in accessing state and local resources, and work to resolve case specific and systemic problems (including reduction in duplicity of efforts).

The CT State Heath Improvement Plan Developmental Screening Workgroup coordinates their activities with the CT Act Early team to increase developmental screening through the strategies of conducting an education and awareness campaign that targets families and communities on the importance of developmental screening; training community and healthcare providers to improve screening rates and coordination of referrals and linkage to services; and engaging in cross systems planning and coordination of activities around developmental screening.

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.

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. School Based Health Centers were utilized in promoting comprehensive adolescent well visits, inclusive of developmental assessment, risk assessment and behavioral health screening, anticipatory guidance, and body mass index (BMI) screening and intervention.

The DPH Immunization Program oversees the provision of all recommended childhood vaccines to over 680 providers statewide including private physician offices, community health centers, School Based Health Centers, and local health departments. In 2020, nearly 1,000,000 doses of vaccine were distributed and the program universally expanded provision of influenza vaccine for all children up through 18 years of age regardless of insurance status. Adult vaccines, including HPV for uninsured patients 19-45 years of age are provided to local health departments, community health centers, and drug treatment facilities. Uninsured and Medicaid patients 9-18 years of age, as well as privately insured 11 and 12 year olds, are also provided HPV vaccine. All nationally recommended childhood vaccines are provided to School Based Health Centers for children up through 18 years of age free of charge.

DPH’s Lead and Healthy Homes Program (LHHP) evaluates the effectiveness of universal screening laws (i.e., mandated blood lead testing) for children under the age of three by assessing the screening rate. In 2010, the LHHP upgraded its surveillance system to a new, more comprehensive web based system. This has enhanced the ability to merge birth records and comprehensive environmental data with childhood blood lead data. The surveillance system has had a significant positive impact on the program’s capability to utilize surveillance data to enhance child case management efforts. The prevalence of lead poisoning (defined as venous tests ≥ 5 µg/dL) decreased from 1.8% to 1.7% from 2019 to 2020 (1,188 cases versus 1,025 cases), a 13.7% decrease, while the prevalence of lead poisoning decreased by 38.4% from 2017 to 2020 (1,665 cases versus 1,025 cases).

Partnership and Collaborations by Domain

Domain	Partners
1: Women's and Maternal Health	Alliance for Innovation on Maternal Health, CT Perinatal Quality Collaborative, WISEWOMAN, The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Community Health Network of CT, Intensive Perinatal Care program, One Key Question (OKQ), Every Woman Connecticut (EWCT), Department of Mental Health and Addiction Services (DMHAS), and Office of Early Childhood (OEC)
2: Perinatal and Infant Health	OKQ, OEC, Child Fatality Review Committee, MCH Coalition, WIC, Ready Set Baby, and Secrets of Baby Behavior
3: Child Health	United Way of CT/Child Development Infoline (CDI), Help Me Grow Advisory, Office of Early Childhood, University of CT University Center for Excellence in Developmental Disabilities, Connecticut Medical Home Initiative, Connecticut Medical Home Initiative (CMHI), School Based Health Centers, Child Health and Development Institute, Family Wellness Healthy Start, Department of Social Services, Community Health Network of CT, American Academy of Pediatrics, Connecticut Family Support Network, Office of Oral Health, Women Infant Children, and the Nutrition Physical Activity Obesity Prevention Program
4: Children with Special Health Care Needs	Medical Home Advisory Council, DPH Epidemiologists, Department of Social Services (DSS), Community Health Network, CMHI, Mental Health Association of Connecticut (MHAC), Community Health Network (CHN), CT Dental Health Partnership, Office of Oral Health, School Based Health Center (SBHC), Family Wellness Healthy Start, OEC, Maternal and Child Health Coalition, Medical Dental Integration, Catalyst Center, and United Way of CT/CDI
5: Adolescent Health	Jordan Porco Foundation, School Based Health Center Advisory, State Department of Education (SDE), School Nurse Association, Regional Behavioral Health Action Organizations, Alcohol and Drug Policy Council, CT Clearinghouse, Southern CT State University, Question Persuade Refer, SafeTALK or ASIST, CT Suicide Advisory Board, Prevent Suicide CT.org, and the United Way of CT, and CMHI

Five-Year Needs Assessment Summary
(as submitted with the FY 2021 Application/FY 2019 Annual Report)

III.C.2.a. Process Description

Goals, Framework and Methodology

The Connecticut Department of Public Health (DPH) is designated as the principal State agency for the allocation and administration of the Maternal and Child Health Block Grant (MCHBG). Federal legislation mandates that an application be submitted annually, and that an MCH Statewide Needs Assessment be conducted every five years. The Department completed its 2020 MCH Block Grant Needs Assessment, which will be submitted to HRSA with its federal FFY 2021 application in September of 2020. The Five-Year Needs Assessment identified nine (9) State priorities that are addressed with the selection of six (6) National Performance Measures (NPM), four (4) State Performance Measures (SPM), and 6 Evidence Based-or Informed Strategy Measures (ESM).

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 and a health equity lens to explore the upstream factors that influence population health, and a health equity lens to identify differential patterns of health across population groups.

The process for completing the MCHBG Needs Assessment was built upon engagement processes from the 2019 Connecticut State Health Assessment (SHA) with involvement of the Connecticut Maternal and Child Health Coalition. The Connecticut Maternal and Child Health Coalition is a group of almost 200 stakeholders representing all aspects of maternal and child health. Members include health care providers, human services organizations, and advocates who meet regularly to advance the health of mothers and children throughout the State. The group met in March 2020 to discuss data and provide insight into potential MCH priorities in the state.

Planning for Healthy Connecticut 2025 State Health Improvement Plan (SHIP) has been delayed due to COVID-19. Although we were not able to align these processes at this time, we look forward to highlighting areas of alignment in our first annual update for the Title V Block Grant.

Stakeholder Involvement

The MCH chapter of the SHA acts as the core for the MCHBG needs assessment. Community engagement for the SHA included a series of focus groups conducted in collaboration with faculty and students from the University of Connecticut School of Public Health. The purpose of these focus groups was to identify community health concerns, assets and barriers to health; recommendations to address community health priorities; and residents' vision for the future. Maternal, infant, and child health-specific populations represented in focus groups included:

- Black/African American Women
- Families Affected by Autism
- Families of Children with Special Healthcare Needs
- Hispanic Community
- LGBTQ Younger Adults

CT DPH held two data presentations with the Coalition and local health partners to share preliminary findings from the State Health Assessment and solicit feedback on its development. Both presentations occurred in August 2019. In addition, to further ensure that the SHA represents the perspectives and speaks to the most important needs of Connecticut's residents, CT DPH presented a draft of this assessment report on its website for a public comment period in November of 2019.

The input collected from the community via these various means is detailed in a companion document, "Community Engagement." Companion documents are available on the Coalition website.

The MCH Coalition was engaged via a data presentation, discussion, and rating exercise to identify the draft priorities for the MCH Five-Year Action Plan from the emerging themes that came out of the MCH Needs Assessment. Key stakeholders were also engaged via feedback sessions to confirm the draft priorities for the MCH Five-Year Action Plan and gather input on how progress could be measured, and how partners could be engaged. Two feedback sessions were conducted virtually

due to COVID-19 shutdowns, with over 80 stakeholders participating from the Medical Home Advisory Council, and those who worked in the areas of Child Health, Adolescent Health, and Children and Youth with Special Health Care Needs. DPH also engaged internal and external subject-matter experts in each domain to provide input, guidance, and feedback on the priorities as well as the components of the Five-Year Action Plan.

Quantitative and Qualitative Methods

Quantitative and Qualitative methods were employed on the State Health Assessment on data collected through focus groups with MCH stakeholders across the State, public and partner input, Connecticut Department of Public Health (CT DPH) input, and analysis of secondary data. Data sources included the Connecticut School Health Survey, Hospital Discharge Data, the National Survey of Children's Health, the Pregnancy Risk Assessment Monitoring System, Vital Records, and the U.S. Census. This data, along with supplemental stratifiers and indicators, was used to inform the MCH Block Grant Needs Assessment Report.

Data Sources

The list of indicators used for the MCH Block Grant Needs Assessment was guided by existing initiatives (e.g., Healthy Connecticut 2020, National Prevention Strategy) and shaped throughout the process by the feedback from stakeholders and partners. During MCH-focused discussions for the Connecticut SHA, members of the Health Improvement Planning Coalition, Advisory Council, and State Health Assessment Indicators Advisory Group provided data on specific topic areas.

Data for the MCHBG Needs Assessment were from a variety of sources:

- Connecticut School Survey (CSHS)
- Hospital Discharge Data
- National Survey of Children's Health
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- Vital Records
- United States Census

Other sources from which the health indicators were derived include, but are not limited to: Behavioral Risk Factor Surveillance System (BRFSS), National Immunization Survey (NIS), 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, and the Connecticut Department of Energy and Environmental Protection.

A comprehensive Maternal and Child Health Needs Assessment Report can be found in the Supporting Documents section.

Interface between the Needs Assessment data, the state's Title V priority needs and the state's Action Plan

Data from the Needs Assessment was used to identify the emerging MCH priorities across the state, which were used to identify the Title V Priorities for the state's Action Plan.

III.C.2.b. Findings

III.C.2.b.i. MCH Population Health Status

Findings

MCH Population Health Status

Domain 1: Women's and Maternal Health

Just over half of women who gave birth in Connecticut in 2016-2018 were non-Hispanic White, one quarter were Hispanic, 12.2% were non-Hispanic Black, and 10.2% were non-Hispanic Other race. Hispanic and non-Hispanic Black women were disproportionately likely to reside in a female-headed household.

Connecticut has the third lowest teen birth rate in the country. However, among all women giving birth, prevalence of unintended pregnancy was high, especially for non-Hispanic Black women (57.0%). This could contribute to racial disparities in maternal morbidity and mortality. In the three months *prior to becoming pregnant*, diabetes was most prevalent among non-Hispanic Other race women (3.3%), high blood pressure among non-Hispanic Blacks (7.1%), depression among non-Hispanic Whites (10.9%), poly-cystic ovarian syndrome (PCOS) among non-Hispanic Other race (6.2%), and anxiety among non-Hispanic Whites (22.1%). Non-Hispanic Black and Hispanic women were more likely to be overweight or obese than their non-Hispanic White or non-Hispanic Other race counterparts.

During pregnancy, 11.2% of women in Connecticut developed preeclampsia in 2016-2018, which was highest among non-Hispanic Black women (16.3%) and lowest among non-Hispanic Other race women (7.0%). Overall, 10.6% of women in Connecticut developed gestational diabetes, which was highest among non-Hispanic Other race women (16.0%) and lowest among non-Hispanic White women (6.5%). The prevalence of gestational diabetes was also strikingly high among the uninsured (17.1%) and is increasingly common with age. Overall, 7.3% of women had thyroid problems, with the highest prevalence's among non-Hispanic White women and older women. Finally, 3.7% of women had PCOS, with a range of 4.4% among non-Hispanic White women to 2.2% among non-Hispanic Black women. Approximately eight to ten women die in Connecticut each year, due to pregnancy-related causes.

Following delivery of a live birth in 2016-2018, 11.6% of women in Connecticut reported postpartum depressive symptoms. However, the racial/ethnic patterns shift, with lowest prevalence among non-Hispanic White women (9.3%) and highest among non-Hispanic Other race women (19.4%). Among these women, less than half sought help for their symptoms, ranging from 20.8% of non-Hispanic Other race women to 44.6% of non-Hispanic White women.

Domain 2: Perinatal and Infant Health

Singleton preterm birth and low birthweight (LBW) rates show persistent racial disparities in Connecticut. In 2014-2018, 6.2% of non-Hispanic White women gave birth preterm, compared to 10.4% of non-Hispanic Black women. Similarly, 4.4% of non-Hispanic White women gave birth to an infant with LBW, compared to 9.8% of non-Hispanic Black women. These patterns have been consistent for nearly 20 years, if not longer. Connecticut's infant mortality rate (IMR) was 4.6 deaths per 1,000 live births in 2017 down from 5.9 deaths per 1,000 live births in 2005 – a decrease of about 2.4% each year. Connecticut's IMR has consistently remained well below both the US rate and the Healthy People 2020 target of 6 deaths per 1,000 live births since 2010. However, disparities persist. Non-Hispanic Black infants were more than three times as likely to die and Hispanic infants were 1.5 times more likely to die than non-Hispanic White infants in Connecticut in 2017.

Racial disparities in infant health continue postnatally. Most women in Connecticut reported that their health care provider had recommended they place their infants to sleep on their backs during 2016-2018. However, fewer women reported putting their infants to sleep on their backs only. Only 62.2% of Black women reported solely back sleeping compared to 87.0% of White women. Breastfeeding practices also vary by race/ethnicity. While 85-95% of women of all race/ethnicities report initiating breastfeeding postpartum, by 8 weeks, only two-thirds of Hispanic and non-Hispanic Black women are still breastfeeding, compared to 72.9% of non-Hispanic Whites and 82.2% of non-Hispanic Other race women.

An increasing concern in Connecticut is infants born with Neonatal Abstinence Syndrome (NAS) – a condition where a neonate goes through withdrawal from certain drugs that they were exposed to in the womb. Most commonly, NAS is due to chronic maternal opioid exposure. In Connecticut, the number of hospital discharges for infants born with NAS in 2017 (440) was three times higher than the number in 2003 (137). Collaborative partnerships have formed in Connecticut between non-governmental professional organizations, multiple state agencies, and public/private professional organizations to address NAS in the state.

Domain 3: Child Health

Overall, 92.2% of children aged 0-17 years old were reported to have excellent or very good health in Connecticut in 2017-2018. However, disparities exist in some manageable and preventable childhood conditions, indicating room for improvement. Just under 10% of children in Connecticut currently had asthma in 2019, ranging from a prevalence of 8.2% in families earning >$75,000 annually to 14.1% in families earning <$35,000. In 2019, 14.3% of children in Connecticut had dental decay in the past year. However, the proportion varies substantially by sociodemographic subgroups. Families with incomes >$75,000 had the lowest prevalence of children with dental decay (10.9%), while children in families earning <$35,000 had the highest (20.7%). Similar disparities exist by race and insurance coverage for both asthma and dental decay.

The medical home model for children and adults is a proven approach to provide comprehensive and high-quality primary care. In 2017-2018, Connecticut (49.4%) trailed the U.S. average (59.9%) in the proportion of children without special health care needs who received coordinated, ongoing, and comprehensive care within a medical home. Connecticut also exhibits disparities across race and ethnicity for children receiving care within a medical home. Non-Hispanic White children receive care within a medical home 32% more than non-Hispanic Black children, 30% more than Hispanic children, and 14% more than non-Hispanic children of any race.

The proportion of children with a mental/behavioral health condition who received treatment or counseling declined in both Connecticut and the U.S. between 2011-2012 and 2017-2018. In Connecticut, the proportion declined from 69.9% to 56.6%. Between 2012 and 2017, the proportion of children under three years-old who received a developmental screening rose consistently from 16.2% to 39.8%. However, this is still less than half of the population, indicating that improvement is still needed, but appears promising, given the current trend lines.

Adverse Childhood Experiences (ACEs) are stressful or traumatic events, including abuse, neglect and household dysfunction that occur during childhood. Adverse childhood experiences and trauma are risk factors for depression, anxiety, and post-traumatic stress disorder. In their most extreme form, ACEs can result in death. In Connecticut in 2015-2018, over two out of five deaths due to family violence occurred among Connecticut's youngest residents between 0-17 years of age. Non-Hispanic White residents comprised the largest proportion of deaths related to family violence, followed by non-Hispanic Black and Hispanic residents, respectively. Based on population rates, non-Hispanic Black residents had proportionately higher rates than other race and ethnicity groups. To address the immediate threat of violence, as well as long terms health consequences, the State of Connecticut is engaged in several public health and policy initiatives.

Domain 4: Children with Special Healthcare Needs

Children and youth with special health care needs (CYSHCN) have or are at increased risk for chronic, physical, developmental, behavioral, or emotional conditions. In addition, they often require more health-related services beyond what is required by children generally. There is a well-documented benefit for children in having health insurance. In 2001, nearly three-quarters of children and youth with special health care needs had private insurance (73%). However, in 2016, the proportion of children and youth with special health care needs who had either private or public insurance was split relatively evenly (54% and 48%, respectively).

Among CYSHCN, Connecticut (42.7%) was slightly ahead of the U.S. average (39.8%) in the proportion of children who received coordinated, ongoing, and comprehensive care within a medical home in 2017-2018. In contrast, only 50.4% of CYSHCN in Connecticut were reported as receiving needed and effective care coordination, compared to 59.8% of children in the U.S. on average, in the same time period. Connecticut (13.5%) also trailed the U.S. (18.9%) in the proportion of 12-17-year-old CYSHCN who received the services needed to transition to adult health care. Families of CYSHCN reporting receiving care in a well-functioning system varied greatly by age. In 2017-2018, the proportion was 24.0% for 0-5-year-olds, 32.0% for 6-11-year-olds, and 3.3% for 12-17-year-olds. Overall, 11.2% of parents of CYSHCN reported they were usually or always frustrated getting services for their child, compared to only 0.3% of parents of children without special health care needs.

The prevalence of mental/behavioral health conditions has been increasing among children and has been found to vary by geographic and sociodemographic factors. Further, the receipt of treatment is also generally dependent on sociodemographic and health-related factors. Adequate insurance and access to a patient-centered medical home may improve mental health treatment. In Connecticut, a slightly higher proportion of non-Hispanic White children with a mental/behavioral condition received treatment or counseling, compared to Hispanic children with a mental/ behavioral condition (71% and 66%, respectively). Conversely, 29% of non-Hispanic White children and 34% of Hispanic children with a mental/behavioral condition did not receive treatment or counseling. In 2017-2018, 4.0% of children (aged 3-17) in Connecticut had ever been diagnosed with Autism Spectrum Disorder (ASD). This is almost double the national percentage. This may speak to more awareness and screening of ASD among Connecticut residents when compared to the US overall.

Domain 5: Adolescent Health

Use and misuse of illicit drugs (e.g. heroin, fentanyl, cocaine), prescription opioid medications and alcohol are major issues nationally and in Connecticut. In recent years illicit drug use among Connecticut high school students has declined. Nonetheless, over 10% of high school students reported ever taking prescription pain medication for non-medical reasons. Prevalence was highest among Hispanics (14.2%) and lowest among Whites (8.0%). Prevalence was notably consistent across grade levels. Only 3.7% of Connecticut high school students currently smoke cigarettes and only 1.3% report frequent use. In contrast, 44.8% report ever using an electronic vaping product, 27.0% report current use, and 8.5% report frequent use.

Bullying is considered a traumatic event, and fighting may be considered either a traumatizing experience or a consequence/outcome of having repeated exposure to trauma. Bullying also indicates disruption in the school setting that impacts school connectedness, which is an important protective factor for substance use, sexual behavior, mental health, and academic success. In recent years, Connecticut females were more likely than Connecticut males to be bullied on school property. In 2019, 21.3% of females and over 14% of males reported being bullied on school property in the past 12 months. Bullying was more common among younger students and among Hispanics and non-Hispanic Whites, compared to non-Hispanic Blacks. The percentage of females being cyberbullied is also consistently higher than the percentage of males in recent years, with 17.3% of females and 11.4% of males reporting the experience in the past 12 months. Youth who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ) are more likely to be bullied, both on school property and electronically, when compared to students who identify as heterosexual. The percentage of LGBTQ youth who reported cyberbullying was almost double the percentage of heterosexual youth who reported cyberbullying, 26.9% versus 14.9%.

In the 2019, the prevalence of physical dating violence was 8.7% among students who reported only opposite sex partners, compared to 19.5% among students with partners of the same sex or both sexes. Prevalence of sexual dating violence varied dramatically among high school students, with 8.8% of heterosexual students reporting it, compared to 24.2% of those identified as being gay/lesbian/bisexual, and 25.4% of those “unsure” of their sexual identity. Among Connecticut high school students, 7.5% report being forced to have sexual intercourse in their lifetimes. Prevalence was 4.1% of heterosexual students, compared to 17.9% of gay/lesbian/bisexual students, and 6.1% of those unsure of their identity.

Nationally, suicide contemplation by high school students in the last 12 months was 17.2%. By comparison, Connecticut is below the national average. In 2019, 15.9% of females and 9.3% of males reported considering suicide in the past 12 months. In 2019, 8.3% of females and 5.2% of males attempted suicide. Significantly more Hispanic students (10.1%) attempted suicide compared to Blacks (5.8%) and Whites (5.7%). In 2017, 5.8 youths (aged 10-19 years) per 100,000 died by suicide in Connecticut. In 2018, the rate was 2.8 per 100,000.

III.C.2.b.ii. Title V Program Capacity

III.C.2.b.ii.a. 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 2019, Ned Lamont was elected Governor and in May 2020, Governor Lamont appointed Dr. Deidre Gifford to serve as Acting Commissioner of DPH.

The Title V Program is located within the Community, Family Health, and Prevention Section (CFHPS). 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 CFHPS, 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; 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; Pregnancy Risk Assessment Monitoring System; Family Wellness Healthy Start; Provide Supplemental Nutritious Foods; Breastfeeding promotion and support; and Nutrition education. These programs either receive Title V funds or work in collaboration with the Title V Program.

III.C.2.b.ii.b. Agency Capacity

The Title V Program resides within the Community, Family Health and Prevention Section (CFHPS). The CFHPS works to improve the health of the overall population across the lifespan, especially mothers, infants, children, adolescents and other vulnerable groups, by establishing opportunities that support healthy living habits through education, early detection, access to care and chronic disease prevention. The CFHPS is comprised of the following units: 1) Women's Health and Prevention; 2) Adolescent and Child Health; 3) Maternal and Child Health Epidemiology; 4) Chronic Diseases; 5) Women, Infants and Children (WIC); and 6) Epidemiology. The CFHPS also includes the: 1) Genomics Office; 2) Office of Oral Health; and 3) Office of Injury and Violence Prevention. Staff work collaboratively across units and offices to coordinate resources and maximize program capacity.

Leadership:

Rosa M. Biaggi, MPH, MPA, and Mark Keenan, RN, MBA serve as the Section Chiefs in the CFHPS. Marc Camardo, MPH, is the Supervising Epidemiologist and serves as the Title V Director, SSDI Director, and Acting Dental Director and reports to Mark Keenan. Ann Gionet, BBA, is the Children with Special Health Care Needs Director and reports to Mark Keenen. Selma Alves, MPH, is the MCHBG Family Advocate and reports to Ann Gionet.

Title V Capacity to Provide and Assure Services

Domain 1: Women/Maternal Health

Family Planning: promotes decreasing the birth rate to teens, age 15-17, preventing unintended pregnancy, and increasing access to primary reproductive health care. 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. Family Wellness Healthy Start Program: to promote healthier pregnancies and reduced rates of birth complications among African American and Hispanic 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.

Domain 2: Perinatal/Infant Health

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.

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 newborn nursery in order to improve quality developmental outcomes for infants identified with hearing loss.

Domain 3: Child Health

The DPH is working with primary care providers to incorporate parental education on developmental milestones and communicates benefits of standardized developmental monitoring and screening to parents and providers in primary care settings highlighting the CDC's "Learn the Signs. Act Early" materials. The Children and Youth with Special Health Care Needs program coordinates the CT State Heath Improvement Plan Developmental Screening Workgroup and links activities with the CT Act Early team to increase developmental screening through the strategies of conducting an educational and awareness campaign that targets families and communities on the importance of developmental monitoring and screening; training community and healthcare providers to improve screening rates and coordination of referrals and linkage to services; and engaging in cross systems planning and coordination of activities around developmental screening.

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.

The DPH Nutrition, Physical Activity, and Obesity (NPAO) Program has been implementing the Go Nutrition and Physical Activity Self-Assessment for Child Care (Go NAPSACC) initiative with center and home-based early care and education programs (ECEs) to address childhood obesity. Go NAPSACC is an online system that helps ECEs create a healthier environment for the children they serve through a five-step improvement process: best practice assessment, action planning, implementation, training and technical assistance support, and re-assessment to evaluate progress.

Domain 4: Children and Youth 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 five 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.

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.

Domain 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 serve students, Pre-Kindergarten through grade 12, and are in elementary, middle and high schools. SBHCs provide primary care, mental health services, and health promotion/education/risk reduction activities. Dental care is also available at some sites.

Connecticut DPH supports 92 school health services sites in 27 communities throughout the state. Included are 80 School Based Health Centers (SBHC) and 12 Expanded School Health Services (ESHS). Services vary by site and can include diagnosis and treatment of acute injuries and illnesses, management and monitoring of chronic disease, physical exams, administrating immunizations, prescribing and dispensing medications, laboratory testing, counseling, health education, health screening, psychosocial care, and prevention services.

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. Care is delivered in accordance with nationally recognized medical/mental health and cultural and linguistically appropriate standards.

III.C.2.b.ii.c. MCH Workforce Capacity

Rosa M. Biaggi, MPH, MPA and Mark Keenan, RN, MBA are Chiefs of the CFHPS and previously served as the Title V Maternal and Child Health Director. Marc Camardo, MPH, is the current Title V Maternal and Child Health Director, State Systems Development Initiative Director, and Acting Oral Health Director and reports directly to Mark Keenan. Ann Gionet is the Children with Special Health Care Needs Director and reports to Mark Keenan. Ms. Gionet coordinates the public input section for the block grant application by holding focus groups and contacting individual family readers.

The CFHPS employs 91 permanent staff with expertise and skills in various areas of public health having graduate degrees or have experience in nursing, social work, allied health, health education, research, evaluation, epidemiology, law, planning, administration and management. Most CT's Title V program activities reside organizationally within the CFHPS. The proposed FFY 2021 plan will maintain overall staff support at 22.0 FTE positions.

The MCHBG supports a full time equivalent in the Health Information Systems and Reporting Section 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, Public Health Systems Improvement, 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 and Violence Prevention.

Number, location and full-time equivalents of staff who work on behalf of the Title V Program

FTE's		FFY 2020	MCH	CSHCN	FY2021	MCH	CSHCN	
Job Classification	*Incumbent*							
Health Program Associate	Alves	1.00	25%	75%	1.00	25%	75%	Community, Family Health, and Prevention Section
Epidemiologist 2	Budris	0.50	50%		0.50	50%		Community, Family Health, and Prevention Section
Epidemiologist 3	Davis	1.00		100%	1.00		100%	Community, Family Health, and Prevention Section
Secretary 1	Douglas	1.00	80%	20%	1.00	80%	20%	Community, Family Health, and Prevention Section
Health Program Supervisor	Gionet	1.00	25%	75%	1.00	25%	75%	Community, Family Health, and Prevention Section
Nurse Consultant/Public Health Services Manager	Maselli	0.40	40%		0.40	40%		Community, Family Health, and Prevention Section
Nurse Consultant	Owusu	0.75	50%	25%	0.75	50%	25%	Community, Family Health, and Prevention Section
Secretary 2	Prevost	1.00	90%	10%	1.00	90%	10%	Community, Family Health, and Prevention Section
Health Program Associate	Velasquez	0.40	40%		0.40	40%		Community, Family Health, and Prevention Section
Nurse Consultant	Bailey	1.00	25%	75%	1.00	25%	75%	Public Health Laboratory
Microbiologist 2	Mills	1.00	25%	75%	1.00	25%	75%	Public Health Laboratory
Secretary 2	Mitchell	1.00	25%	75%	1.00	25%	75%	Public Health Laboratory
Epidemiologist 3	**Vacant/Fill**	1.00	25%	75%	1.00	25%	75%	Health Statistics and Surveillance Section
Associate Accountant	Murray	0.50	25%	25%	0.50	25%	25%	Fiscal Office
Fiscal Administrative Officer	West	0.20	10%	10%	0.20	10%	10%	Contracts and Grants Management Section
Office Assistant	Little	1.00	100%		1.00	100%		Vital Records
Epidemiologist 3	Davis K	0.20		20%	0.20		20%	Community, Family Health, and Prevention Section
Epidemiologist 2	Prince	0.50	40%	10%	0.50	40%	10%	Community, Family Health, and Prevention Section
Epidemiologist 4	Camardo	1.00	75%	25%	1.00	75%	25%	Community, Family Health, and Prevention Section
Health Program Associate	Krusz	0.30	30%		0.30	30%		Community, Family Health, and Prevention Section
Epidemiologist 3	Hayes	1.00	100%		1.00	100%		Community, Family Health, and Prevention Section
Health Program Associate	Soto	1.00	50%	50%	1.00	50%	50%	Contracts and Grants Management Section
Health Program Associate	Touma	0.50	25%	25%	0.50	25%	25%	Public Health Systems Improvement
Staff Attorney 3	Hansted	0.25	15%	10%	0.25	15%	10%	Attorney Office
Health Program Associate	Repinecz	0.75	75%		0.75	75%		Community, Family Health, and Prevention Section
Epidemiologist 2	X. Zheng	0.25	25%		0.25	25%		Community, Family Health, and Prevention Section
Nurse Consultant	K. Britos-Swa	0.50	25%	0.25	0.50	25%	0.25	Community, Family Health, and Prevention Section
Epidemiologist 1	**Vacant/Fill**	1.00	50%	0.50	1.00	50%	0.50	Community, Family Health, and Prevention Section
Health Program Assistant 2	**Vacant/Fill**	1.00	45%	0.55	1.00	45%	0.55	Community, Family Health, and Prevention Section
Epidemiologist 1	T. Fox	1.00	85%	0.15	1.00	85%	0.15	Community, Family Health, and Prevention Section
TOTAL		**22.00**	**12.75%**	**9.25%**	**22.00**	**12.75%**	**9.25%**	

The State of Connecticut is highly invested in supporting efforts to implement the core public health functions (assessment, policy development, and assurance) and to achieve increased accountability through ongoing performance measurement and supporting an adequately sized and skilled workforce.

In March 2020, the DPH sponsored a Maternal Health Disparities Summit which served as a state-wide opportunity to leverage the great work of providers, community based organizations, and advocates to enhance how we care for Women of Color, with a critical focus on maternal morbidity and mortality. The Vice Admiral Surgeon General Jerome Adams, MD was in attendance and was the keynote speaker. In addition, Charles Johnson, founder and 4kira4moms, worked relentlessly with congress to pass the preventing maternal death act (H.R.1318) presented his testimony. At the Summit, the Governor announced that a Gold Ribbon Commission will be created. The Commission will support the following:

1. Convene and Facilitate a Statewide Commission to Focus on the Causes of Maternal Morbidity and Mortality.
2. Address the Social Determinants of Health and Racial and Ethnic Biases Impacting Women of Color.
3. Create, Enhance, and Strengthen Collaborations between Providers, Community Based Organizations, Networks, State Agencies, Private Agencies, and Advocacy Groups.
4. Explore Innovative Models of Care that Support Health and Wellbeing Across the Life Cycle and Foster Healthy Communities.

III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

HCT2020 State Health Improvement Plan (SHIP)

Maternal, Infant, and Child Health Action Team 2019 Accomplishments

- Partners advocated for Paid Family Medical Leave which passed and went into effect on October 1, 2019. The law will allow employers to provide employees paid, job-protected leave (12 weeks) for health-related reasons.
- Partners collaborated on Connecticut's Screening to Succeed conference to ensure developmental awareness and promotion, developmental screening and connection to services by providing families and providers with knowledge, resources, and tools for effective coordination and community wide implementation.
- Through Maternal and Child Health Services Block Grant (Title V) funding, DMHAS successfully allocated funding for expanding the implementation of One Key Question (OKQ) and supported this effort by offering trainings sponsored by Every Woman Connecticut and Planned Parenthood. OKQ is an initiative that provides women of childbearing age recommendations for either becoming pregnant or preventing pregnancy.

Within DPH, several initiatives are underway to reduce adverse birth outcomes and risk factors associated with poor birth outcomes, and to address disparities in these health indicators. The initiatives listed below may not be directly funded by the MCHBG but are in alignment with the mission of improving the health of the MCH population. These initiatives will continue and include the following:

- DPH completed the 2020 update of the State Health Needs Assessment. The report will be released this summer as the State Health Improvement Plan (SHIP) Coalition launches a series of planning workshops to advance the health improvement plan update. A DPH team is working with partners across the state to design the framework of the Healthy CT 2025 State Health Improvement Plan for its release in 2021. The development of the plan involves multiple virtual meetings and webinars to discuss priority areas and cross-cutting themes. The plan's strategies will focus on policy, systems, and environmental changes to address upstream causes of poor health. The priorities under consideration include: a) access to health services and primary healthcare, b) economic stability, particularly around issues of poverty and employment, c) access to healthy eating and issues of food security, d) housing quality and stability, and e) community resilience as it relates to crime/violence and emergency preparedness. In addition to launching Healthy Connecticut 2025, DPH is undergoing preparations for its reaccreditation application due by the first quarter of 2022.

- The CT MCH Coalition is made up of over 130 stakeholders that meet quarterly and are dedicated to improving the health of mothers, infants and children statewide. The Maternal, Infant and Child Health focus area of the State Health Improvement Plan directly impacts and supports the MCHBG activities in several areas including perinatal/infant health, child health, children with special health care needs, and oral health. The MCH Coalition members support efforts such as: creating a developmental screening media campaign and distributing materials; promoting awareness of developmental screening tools for use in their communities; enhancing school-based dental sealant programs; and increasing the use of fluoride varnish in primary care practice, school-based programs and community access points, to name a few.

- DPH participates in the Every Woman Connecticut (EWCT) Learning Collaborative, which seeks to increase expertise and self-efficacy in implementing routine pregnancy intention screening and appropriate care, education, and services to ultimately improve birth spacing, increase pregnancy intentionality, and the proportion of Connecticut women who deliver a live birth who report discussing preconception/interconception health with a healthcare worker.

- The maternal mortality review program is responsible for identifying maternal death cases in Connecticut and reviewing medical records and other relevant data related to each maternal death case, including, but not limited to, information collected from death and birth records, files from the Office of the Chief Medical Examiner, and physician office and hospital records. Legislation passed in 2018 established a maternal mortality review committee within the DPH to conduct a comprehensive, multidisciplinary review of maternal deaths for purposes of identifying factors associated with maternal death and making recommendations to reduce maternal deaths. Members of the committee represent a wide range of licensed health care professionals. Through the work of the committee, CT identifies and characterizes these maternal deaths as pregnancy-related or pregnancy-associated maternal deaths. The committee is charged with excluding deaths that, though tragic, were not classified in either of these two categories.

- 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.

- 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.

- The Children and Youth with Special Health Care Needs program collaborates with the University of Connecticut, University Center For Excellence in Developmental Disabilities to improve access to comprehensive, coordinated health and related services including trainings on the importance of developmental screening and distribution of the CDC’s “Learn the Signs. Act Early” materials.

- The Developmental Screening workgroup, coordinated by DPH staff, hosted the “Screening to Succeed Conference An Early Childhood Call to Action for Communities to Promote Developmental Awareness and the Power of Community Connections.” With 130 attendees, the call to action was designed to excite conference participants to take the next steps, get inspired and bring back messages and tools shared during the conference to the community. Attendees included parents, family advocates, and care coordinators, along with providers of health care and early care & education programs. Conference presenters worked to help equip communities to increase developmental awareness and promotion, developmental screening, and connecting to services by providing families and providers with the knowledge, resources, and tools for effective coordination and community wide implementation. The conference highlighted that developmental screening is part of a continuum, overview of various screening tools, examples of best practice, and linkages to resources.

Partnership and Collaborations by Domain

Domain	Partners
1: Women's and Maternal Health	Gold Ribbon Commission, Alliance for Innovation on Maternal Health, CT Perinatal Quality Collaborative, WISEWOMAN, The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Community Health Network of CT, Intensive Perinatal Care program, One Key Question (OKQ), Every Woman Connecticut (EWCT), Department of Mental Health and Addiction Services (DMHAS), and Office of Early Childhood (OEC)
2: Perinatal and Infant Health	OKQ, OEC, Child Fatality Review Committee, MCH Coalition, WIC, Ready Set Baby, and Secrets of Baby Behavior
3: Child Health	United Way of CT/Child Development Infoline (CDI), Help Me Grow Advisory, Office of Early Childhood, University of CT University Center for Excellence in Developmental Disabilities, Connecticut Medical Home Initiative, Connecticut Medical Home Initiative (CMHI), School Based Health Centers, Child Health and Development Institute, Family Wellness Healthy Start, Department of Social Services, Community Health Network of CT, American Academy of Pediatrics, Connecticut Family Support Network, Office of Oral Health, Women Infant Children, and the Nutrition Physical Activity Obesity Prevention Program
4: Children with Special Health Care Needs	Medical Home Advisory Council, DPH Epidemiologists, Department of Social Services (DSS), Community Health Network, CMHI, Mental Health Association of Connecticut (MHAC), Community Health Network (CHN), CT Dental Health Partnership, Office of Oral Health, School Based Health Center (SBHC), Family Wellness Healthy Start, OEC, Maternal and Child Health Coalition, Medical Dental Integration, Catalyst Center, and United Way of CT/CDI
5: Adolescent Health	Jordan Porco Foundation, School Based Health Center Advisory, State Department of Education (SDE), School Nurse Association, Regional Behavioral Health Action Organizations, Alcohol and Drug Policy Council, CT Clearinghouse, Southern CT State University, Question Persuade Refer, SafeTALK or ASIST, CT Suicide Advisory Board, Prevent Suicide CT.org, and the United Way of CT, and CMHI

III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

The priorities needs were identified through examination of needs assessment findings, as well as discussion and rating and ranking methodology with both internal and external MCH stakeholders. Fifteen (15) emerging priority areas were presented and further discussion yielded an additional ten (10) priorities for consideration across the domains. A rating tool was used to help participants consider specific selection criteria in an effort to identify their top priorities. Please see the table below for a description of the selection criteria:

Selection Criteria		
Equity	**Impact**	**Feasibility**
Will addressing this issue substantially benefit those most in need?	Can working on this issue achieve both short-term and long-term change?	Is it possible to address this issue given infrastructure, capacity, and political will?

Following the rating exercise, internal DPH MCH staff conducted an additional crosswalk of the highest overall rated priorities against the following additional criteria to reach a final decision:

- 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?

When examining the highest overall rated priorities against all criteria, DPH was able to establish the 9 highest priority needs for the State, that were also best positioned for successful implementation.

Domain	State Selected Priorities
1: Women's and Maternal Health	1: Maternal Morbidity and Mortality 2: Preconception and Interconception Health
2: Perinatal and Infant Health	3: Infant Morbidity and Mortality 4: Breastfeeding Initiation and Duration
3: Child Health	5: Social-Emotional Development and Relationships for Children and Adolescents 6: Preventative Health Care
4: Children with Special Health Care Needs	7: Connections to Medical Home/Dental Home 8: Supports to Address the Special Health Care Needs of Children and Youth
5: Adolescent Health	9: Supports for Health, Safety, and Enhanced Social-Emotional Development

Based on the identified state priorities, six (6) national performance measures and three (3) state performance measures have been selected to address over the five-year Title V program period.

Domain	State Selected Priorities	National and State Performance Measures
1: Women's and Maternal Health	1: Maternal Morbidity and Mortality	NPM #1: Well-woman visit
	2: Preconception and Interconception Health	SPM #1: The proportion of live births conceived within 18 months of a previous birth (percent, females 15–44 years)
2: Perinatal and Infant Health	3: Infant Morbidity and Mortality	SPM #2: The prevalence of unintended pregnancies among women delivering a live-born infant.
	4: Breastfeeding Initiation and Duration	NPM #4: Breastfeeding
3: Child Health	5: Social-Emotional Development and Relationships for Children and Adolescents	NPM #6: Developmental Screening
	6: Preventative Health Care	SPM #3: The proportion of children who drank soda or sugar sweetened drinks at least once daily
4: Children with Special Health Care Needs	7: Connections to Medical Home/Dental Home	NPM #11: Medical Home
	8: Supports to Address the Special Health Care Needs of Children and Youth	NPM #15: Adequate Insurance
5: Adolescent Health	9: Supports for Health, Safety, and Enhanced Social-Emotional Development	NPM #10: Adolescent Well Visit

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 nine (9) state priorities. The two high ranking emerging issues include Technology & Social Development and Paternal Engagement.

Presented	Revised Based on Domain Discussions	Identified via Rating/Voting
Domain 1: Women's and Maternal Health		
a. Disparities in Maternal Morbidity and Mortality b. Disparities in Preconception and Interconception Health c. Mental Health and Help-seeking	c. Mental Health and Help-seeking	9
	e. Health systems Care Coordination (EB Practice)	8
	a. Disparities in Maternal Morbidity and Mortality	8
	b. Disparities in Preconception and Interconception Health	7
	d. Substance Use	3
	f. Paternal Engagement	2
Domain 2: Perinatal and Infant Health		
a. Persistent disparities in LBW and Infant Mortality b. Neonatal Abstinence Syndrome c. Disparities in sleeping and feeding	a. Persistent disparities in LBW and Infant Mortality	15
	c. Disparities in sleeping and feeding	12
	d. Perinatal Oral Health	8
	b. Neonatal Abstinence Syndrome	4
Domain 3: Child Health		
a. Medical Home b. Violence, Adversity, and Mental Health c. Disparities in Manageable/Preventable Childhood Conditions	c. Disparities in Manageable/Preventable Childhood Conditions	10
	b. Violence, Adversity, and Mental Health, and Trauma	9
	a. Medical Home / Dental Home	5
	f. Insurance Equity	5
	d. Developmental Screening	2
	e. Technology & Social Development	1
Domain 4: Children with Special Healthcare Needs		
a. Medical Home b. Adequate/Continuous Insurance Coverage c. Mental Health Treatment/Counseling	c. Mental Health Treatment/Counseling (including school services)	11
	d. Trauma Screening (attention to Trauma)	7
	a. Medical Home / Dental Home	5
	b. Adequate/Continuous Insurance Coverage	4
Domain 5: Adolescent Health		
a. Substance use (vaping, prescription opioids) b. Risk-Taking and Self-Harm (unsafe driving, suicide) c. Bullying and Violence (LGBTQ, sexual violence)	d. Sex Ed / STD's / Teen Birth ages 18-20 (Planning & Programming through age 25)	10
	a. Substance use (vaping, prescription opioids)	7
	b. Risk-Taking and Self-Harm (unsafe driving, suicide)	5
	e. Nutrition/Obesity	5
	c. Bullying and Violence (LGBTQ, sexual violence)	4

III.D. Financial Narrative

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$4,619,707	$4,671,480	$4,620,209	$4,667,875
State Funds	$6,780,181	$6,780,000	$6,777,191	$6,780,000
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$0	$0	$0	$0
SubTotal	$11,399,888	$11,451,480	$11,397,400	$11,447,875
Other Federal Funds	$2,230,004	$2,262,404	$2,267,239	$2,921,641
Total	$13,629,892	$13,713,884	$13,664,639	$14,369,516

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$4,671,480	$4,663,927	$4,663,927	
State Funds	$6,780,000	$6,780,000	$6,780,000	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$0	$0	$0	
SubTotal	$11,451,480	$11,443,927	$11,443,927	
Other Federal Funds	$3,134,618	$3,412,594	$3,443,694	
Total	$14,586,098	$14,856,521	$14,887,621	

	2022	
	Budgeted	Expended
Federal Allocation	$4,663,927	
State Funds	$6,780,000	
Local Funds	$0	
Other Funds	$0	
Program Funds	$0	
SubTotal	$11,443,927	
Other Federal Funds	$3,458,374	
Total	$14,902,301	

III.D.1. Expenditures

The MCHBG (Federal/State funds) significantly supports essential MCH programs/services and the capacity for Connecticut to adequately address its MCH population needs and enhance the health status of mothers and children. The Federal/State funds support quality maternal and child health services for mothers, children and adolescents (particularly of low income families). The MCHBG promotes the development of service systems in States to meet critical challenges in:

- Reducing infant mortality
- Providing and ensuring access to comprehensive care for women
- Promoting the health of children by providing preventive and primary care services
- Increasing the number of children who receive health assessments and treatment services
- Providing family centered, community based, coordinated services for children and youth with special health care needs (CYSHCN)

Connecticut primarily uses MCHBG funds to support grants to local agencies, organizations, and other State agencies in each of the following program areas:

- Maternal and Child Health (including adolescents and all women)
- Children and Youth with Special Health Care Needs

The critical services provided to these populations would be significantly reduced in the absence or reduction of Federal funds. The current fiscal climate of Connecticut would not allow for adequate funding to sustain current services to these populations. The state of Connecticut already budgets state funding for these programs. It would be unable to supplement these services with additional state funding.

For FFY20, the federal allocation funding of $4,663,927 was fully expended. Expenses met the 30%-30%-10% requirement. Expenditures for Preventive and Primary Care for Children totaled $1,411,105 (30.3%), Children with Special Health Care Needs totaled $1,711,055 (36.7%), and $196,597 (4.2%) was Title V Administrative Costs. Expenditures for Pregnant Woman totaled $563,008 (12.1%), Infants totaled $746,262 (16.0%), and All Other individuals served totaled $35,900 (.8%). This is comparable to what had been budgeted for FFY20. Expenditures decreased from what had been budgeted for FFY20 with the $7,553 decrease in federal funding.

The Title V Block Grant funds supported 22.0 FTEs that included a variety of public health professionals including epidemiologists, health program staff, nurses, and a microbiologist. Other staff that are partially funded by the grant include support staff, and administrative staff such as an attorney, an accountant, and contracts management staff. The 22.0 FTEs work directly on different MCH and CYSHCN programs including the CT Medical Home Initiative, Asthma, Maternal Mortality, Newborn Screening, Oral Health, Healthy Start, PRAMS, Sickle Cell, Vital Records, Behavioral Risk Factor Surveillance, School Based Health Centers, Early Hearing Detection and Intervention Program, Health Access Programs, Mother to Baby, and Perinatal Case Management.

The Title V Block Grant Funds support contracts for MCH and CYSCHN programs. The contracts support a variety of necessary programs such as perinatal case management, reproductive health services, care coordination services for CYSHCN throughout the state, family support for CYSHCN, school based primary and behavioral health services, and MCH information and referral services. These contracts are with a variety of Connecticut partners such as other state of CT agencies like the Department of Mental Health and Addiction Services, United Way of Connecticut, hospitals, community health providers, family organizations, and boards of education.

While almost $4.1 million of the Title V Block Grant Funds was spent on staffing and contracts, funds were also used

to pay for the update, translation, and/or printing MCH and CYSHCN materials; Newborn Screening Program Laboratory equipment; AMCHP dues; the “Every Woman Connecticut” Learning Collaborative; and registrations for staff to attend virtual conferences and trainings.

The requirement that there be three dollars of State matching funds for each four dollars in federal funding was met in FFY20. State matching funds are met through funding of School-Based Health Centers, the Genetics Diseases Program, and Childhood Lead Poisoning Program. In FFY20, these matching funds totaled $3,503,610. In FFY20, the maintenance of effort requirement was met from several sources: Reproductive Health Services Programs, Waterbury Health Access Program, and the School-Based Health Centers located throughout the state. The State of Connecticut dollars for these programs totaled $6,780,000.00 in FFY20. The Maintenance of Effort funds were expended as $745,800 (11%) for Pregnant Women, $2,169,600 (32%) for Infants, $3,525,600 (52%) for Prevention and Primary Care for Children 1-21, and $339,000 (5%) for Children with Special Health Care Needs. In total, the FFY20 Match and Maintenance of Effort amounts totaled $10,283,610.

As reported in Forms 5a and 5b, Connecticut used funding to reach MCH populations in the state. Funds were used to reach 34,258 (100%) of Pregnant Women, 35,557 (100%) of Infants, 682,117 (76%) of Children 1 through 21 Years of Age, 143,812 (76%) of Children with Special Health Care Needs, and 605,622 (23%) of individuals that fell into the other category.

Title V funds were not used for any direct services. Title V does not reimburse any direct medical claims.

The State will continue to allocate level or increased funds to each category to support and enhance the services provided.

The MCHBG is assigned to a CT DPH accountant in the agency’s fiscal office as well as a programmatic staff member to monitor expenditures. Budget meetings with the accountant, program staff, and other staff as necessary are conducted as needed to review expenditures, budget redirections if necessary, and projections for the grant. Expenditures are tracked and reviewed for any unallowable or missing charges to the grant and adjustments to appropriate accounts are made. The CT DPH fiscal office maintains budget documentation for MCHBG funding/expenditures for reporting consistent with Section 505(a) and section 506(a)(1) for auditing.

III.D.2. Budget

The federal award in FFY22 is estimated to be $4,663,927. The final FFY20 federal award amount was used to estimate the award amount.

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 FFY22 award amount, $1,406,864 (30.2%) is allocated for Preventive and Primary Care for Children and $1,747,410 (37.5%) for the CSHCN program. There is an allocation of administrative costs of $160,524 (3.4%) of the projected federal allocation to all programs. Funds are also allocated at $674,910 (14.5%) to Pregnant Women, $589,101 (12.6%) to Infants, and $85,118 (1.8%) for all others.

The Title V Block Grant funds will continue to support 22.0 FTEs that include a variety of public health professionals including epidemiologists, health program staff, nurses, and a microbiologist. Other staff that are partially funded by the grant include support staff, and administrative staff such as an attorney, an accountant, and contracts management staff. The 22.0 FTEs work directly on different MCH and CYSHCN programs including the CT Medical Home Initiative, Asthma, Maternal Mortality, Newborn Screening, Oral Health, Healthy Start, PRAMS, Sickle Cell, Vital Records, Behavioral Risk Factor Surveillance, School Based Health Centers, Early Hearing Detection and Intervention Program, Health Access Programs, Mother to Baby, and Perinatal Case Management.

The Title V Block Grant Funds will support contracts for MCH and CYSCHN programs. The contracts support a variety of necessary programs such as perinatal case management, reproductive health services, care coordination services for CYSHCN throughout the state, family support for CYSHCN, school based primary and behavioral health services, and MCH information and referral services. These contracts are with a variety of Connecticut partners such as other state of CT agencies like the Department of Mental Health and Addiction Services, United Way of Connecticut, hospitals, community health providers, family organizations, and boards of education.

Approximately $4.6 million of the Title V Block Grant Funds will be spent on staffing and contracts. The remaining funds will be used to pay for AMCHP dues, registrations for staff to attend virtual and in person conferences and trainings, office supplies, and database maintenance and support.

No MCHBG funding is allocated to direct services. No funds will reimburse any direct medical claims. Funding is allocated at $1,068,481 (22.9%) for Enabling Services and $3,595,446 (77.1%) for Public Health Services and Systems.

The requirement that there be three dollars of State matching funds for each four dollars in federal funding will be met for FFY22. The projected federal allocation for FFY22 is $4,663,927, which means that the State of Connecticut must match it with at least $3,497,945.25. In FFY22, these matching funds will total $3,503,610. Maintenance of Effort for FFY22 is in the amount of $6,780,000, which is above the required FFY1989 base of $6,777,191.

The anticipated total Federal-State Title V Block Grant Partnership total for FFY22 is $11,443,927, which includes the FFY22 federal award of $4,663,927 and the State Maintenance of Effort ($6,780,000).

Other federal grants received by the CT Title V Program that will serve the maternal and child population in FFY22 include: Healthy Start; Universal Newborn Hearing Screening; State Systems Development Initiative (SSDI); the Pregnancy Risk Assessment Monitoring System (PRAMS); Personal Responsibility Education Program (PREP); Preventing Maternal Deaths; the Grant to States to Support Oral Health Workforce Activities; and the State Oral

Disease Prevention Program. For the FFY22, the awards increased from $3,443,694 to $3,458,374. This $14,680 increase is the result of a combination of increased Healthy Start funds and a decrease in PREP funds.

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

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Connecticut

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

The Connecticut Department of Public Health (DPH) is designated as the principal State agency for the allocation and administration of the Maternal and Child Health Block Grant (MCHBG). The Connecticut Title V Program is located in the Community, Family Health and Prevention Section (CFHPS). The CFHPS works to improve the health of the overall population across the lifespan, especially mothers, infants, children, adolescents and other vulnerable groups, by establishing opportunities that support healthy living habits through education, early detection, access to care and chronic disease prevention.

The MCHBG framework includes objectives and strategies to provide quality maternal and child health services for women/mothers, children, adolescents and Children and Youth with Special Health Care Needs (CYSHCN); to reduce infant mortality, low birth weight and the incidence of preventable diseases and disabling conditions among children; and reducing health disparities and health inequities.

The MCH Priority Needs include the following:

1. Maternal Morbidity and Mortality
2. Preconception and Interconception health
3. Infant Morbidity and Mortality
4. Breastfeeding Initiation and Duration
5. Social-Emotional Development and Relationships for Children and Adolescents
6. Preventative Health Care
7. Connections to Medical Home/Dental Home
8. Supports to Address the Special Health Care Needs of Children and Youth
9. Supports for Health, Safety, and Enhanced Social-Emotional Development

The Title V Program serves as a convener, collaborator, and partner in addressing MCH issues. Within DPH, the Title V priorities and performance measure framework provide a unifying vision and strategic plan for individual MCH programs, regardless of funding source or program requirements, which results in improved communication and collaboration, and greater collective impact among discrete MCH programs. The Title V Program also enhances and supports MCH initiatives funded through other sources by increasing a program's capacity or helping to expand its impact and reach. A large portion of federal Title V dollars fund DPH staff, as state funding streams for MCH work allow for few personnel positions. Federal Title V funding is therefore critical to support program managers, epidemiologists, and other expert staff.

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

III.E.2.b.i. MCH Workforce Development

Agency Recruitment & Retention (including Title V Staff)

The DPH is committed to helping strengthen workplace effectiveness and professional profile and recognizes that continuous learning is key to thriving in today's challenging and ever-changing work environments. The Department of Administrative Services and Connecticut's Community College System are partners in providing a wide variety of cost-effective training opportunities to Connecticut State employees. Staff are able to take courses in the Fall, Spring, and Summer of each year that is designed to enhance skills to meet and support agency goals efficiently and with a high level of customer service. DPH employees at all levels are encouraged to participate. Funding from the MCHBG has enabled Title V Staff to participate in these courses. All Title V Staff are given the opportunity to take up to two courses each semester.

The DPH updated the Organizational Strategic Plan in January 2019. DPH continues to prioritize health equity, quality improvement, and workforce development. It has added data quality and access as well as customer service as priority areas of focus. Efforts to address the priority objective “Recruit, Retain and Develop a Competent, Public Health Workforce” are already well underway. Examples of these activities include an improvement effort to effect efficiency of the recruitment summary that continues to be refined. DPH updated the Workforce Development Plan that is in its sixth year of implementation. It is a dynamic document established as a five-year blueprint for developing employees both professionally and personally, focused on building capacity to meet the agency’s strategic direction. 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 address specific workforce priorities such as orientation and onboarding, building institutional memory, specifying roles and responsibilities for workforce development at all levels of the agency, and developing our agency’s learning culture. Other key areas to be addressed include building employee expertise, mentoring new staff, and improving communication about the current merit system and workforce advancement. The goals, objectives and strategies serve as a work plan that is reviewed and updated each year. Finally, this plan serves as a resource to the agency and staff regarding key workforce information and provides the basis for future and ongoing workforce development planning.

In this updated Plan, the DPH Public Health Strategic Team developed a set of organizational competencies that all employees are expected to possess. The Workforce Development Committee (WDC), with staff representation from across the agency, is in the process of conducting a gap analysis to assess the need for professional development and support around the competencies. Identification of roles and responsibilities is critical for plan implementation and the plan is explicit in identifying that staff at all levels play a role in workforce development and training. For example, employees play a key role in their own professional development through communication with their supervisor or other mentor in the agency. The development of onboarding, orientations, and more formal mentoring programs provide support to new employees. Managers seek to find their staff low and no cost options for training and development such as peer coaching, encouraging staff to share their knowledge or skills with others, on the job training, cross cutting assignments, and volunteer opportunities.

This Plan incorporates the value of building a strong learning culture within the agency where opportunities are encouraged for staff to become resources for each other, the collective learning power and thinking capacity of all agency personnel are used, and agency activities are continually reviewed and evaluated to create learning and positive change.

Workforce Plan Implementation

Implementation and updating of the plan is guided by the WDC that meets monthly and is comprised of volunteers from across the agency and includes management, front line staff and key subject matter experts from various programs. The WDC is a standing subcommittee to the Public Health Strategic Team that guides implementation of the agency strategic plan in collaboration with senior managers. Thus, the work of the WDC and the Workforce Development Plan are tied to strategic priorities for the agency including quality and performance management, health equity, reducing health disparities, workforce development and advancement, preparing for re-accreditation, enhancing data indicators and data quality, strengthening internal communications and customer service.

Human Resources leads delivery of an orientation and onboarding program for all new employees that includes modules on performance management and health equity, and completion of minimum training requirements. The WDC has also made available to all DPH, staff tools and guidance for staff in preserving institutional memory for retiring staff or staff that are leaving the agency. One example of this is a template for creating a digital “Legacy Binder” that is available on the DPH intranet. Both initiatives are supported by formal agency policies that are applicable to all staff and implemented by supervisors that orient new staff and process employee separations.

Additionally, the WDC continues to refine updates to the student internship process to enhance agency access to student interns and support development of future public health professionals. As part of enhancing agency access to

students, DPH cooperation with the Yale School of Public Health was highlighted at the first annual 2019 Yale Public Health Expo. As well as highlighting cross institutional cooperation this afforded the DPH internship coordinator the opportunity to interact with students from Yale.

III.E.2.b.ii. Family Partnership

Advisory Committees

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. Parents representing different organizations are at the table including staff from the CT Family Support Network (CTSFN). CTFSN provides direct support to individuals and families in their homes and communities by sharing information and resources that empower people to make their voices heard and to become their own best advocate.

The DPH Medical Home Advisory Council has a Family Experience Workgroup who provides consistent support for quarterly meetings and offers a gateway to additional family voices through the facilitation of focus groups on behalf of the consumer input section of the MCHBG. The Family Experience Workgroup serves as a conduit to ensure a broad representation of family experiences are shared with Council members and to distribute materials and information gathered at MHAC and Family Experience meetings to families statewide.

CT DPH Early Hearing Detection and Intervention Program assists the CT Family Support Network (FSN) through funding to support parents or caregivers of a person who is deaf or hard of hearing. The Early Hearing Detection and Intervention Task Force has consumer involvement through a variety of methods including staff from the CT FSN and families affiliated with Guide By Your Side Program (GBYS) available through CT Hands & Voices. Through DPH funding CT FSN provides support for parents or caregivers of a person who is deaf or hard of hearing. CT FSN offer trainings and presentations on a variety of topics, many useful resources, a voice that reaches the CT State Legislature, family-to-family contacts, an informational distribution list and more.

Strategic and Program Planning

The DPH 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 the following: (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. Consumers including parents of children, youth and young adults with special health care needs are members of the Connecticut Health Improvement Coalition Advisory Council that meets four-times per year to review State Health Improvement Plan progress and discuss ideas for improvement.

DPH kicked off the State Health Improvement Planning for 2020-2025 in September of 2019 with a coalition of stakeholders including but not limited to families, consumers and family advocates who were brought together to consider a selection of findings from the draft State Health Assessment 2.0 and to take the first steps for planning for future health improvement priorities to be included in the State Health Improvement Plan 2.0. “Healthy Connecticut 2025 Healthy People in Healthy, Equitable Connecticut Communities” builds upon the Healthy Connecticut 2020 initiative to advance health promotion and disease prevention through cross-sector partner collaboration and by specifically addressing the social, economic, and environmental determinants of health that create and perpetuate poor health outcomes for Connecticut citizens. The Healthy Connecticut 2025 vision states through effective assessment, prevention, and policy development, the Connecticut Department of Public Health and its stakeholders and partners provide every Connecticut resident equitable opportunities to be healthy throughout their lifetimes and are accountable to making measurable improvements toward health equity. Guided by vision for health equity CT DPH staff, Coalition partners including families and consumers and external stakeholders will collaborate to develop the foundation of the State Health Improvement Plan for 2020-2025.

Workforce Development

CT DPH works closely with CT Family Support Network on several training programs including “Positive Communication: Understanding the Family Perspective.” The training helps to enhance the skills that professionals have in communicating effectively and empathizing with the families they serve. “Now What? You are Not Alone” is a training offered by CT FSN for parents and family members to find out what resources, options, supports are available to help navigate a family’s journey.

Block Grant Development and Review

The 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 17 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 can 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 Beacon Health Options and conducted online consumer focus groups for inclusion in the Public Comment section of the MCHBG. Four online groups were held in English and two online groups were held in Spanish. Some key points from the English focus group are that transportation is a barrier to care; lack of medical interpretation services is another barrier highlighted in the Spanish focus group. The full report and key findings can be found in the consumer section of this application.

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.

Five 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 five 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

All materials related to the CT Medical Home initiative have been updated and are available on the DPH CYSHCN webpage. These materials include the following: CMHI Program application form, CMHI CYHCN Screener complexity referral; Respite family needs checklist, CMHI Universal release of information form and CMHI RSF Request application form.

Advocacy

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 CT General Assembly web site 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 and the CT Family Support Network web site have 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.

Several families support organizations including the CT Family Support Network, African Caribbean American Parents of Children with Disabilities (AFCAMP) and Parents Available to Help/Family to Family Health Information Center (PATH/F2F) provide training, support, and access to resources including; Understanding Special Education Training, Parent Leadership Training, and information on disability laws. These organizations have 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, these organizations encourage, train and support parents to become leaders and active participants in service system reforms.

The 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 in April more than 150 autism awareness advocates converged on the Connecticut Capitol to raise awareness for autism programs and rally for funding. However, due to COVID-19 they did not convene in 2020 at the capital.

Fatherhood Initiative Update

The CT Fatherhood Initiative (CFI) is part of a nationwide, federal initiative that promotes the importance of a father’s involvement and influence in the lives of their children. Through the Initiative, dads are imparted with parenting skills, educational and career guidance, and exposed to the legal rights that are granted to fathers. The Department of Public Health provides the State Initiative with representation, advocacy, joint sponsorship, and funding. Department representatives are actively involved in State-wide counsels, ensure that communication from the Department is publicized using parent-neutral or father inclusive language, and participates in the annual New England States Fathering Conference. As with many conferences, the New England States Fathering Conference was not held in 2020, but CFI accepted a modern approach to reaching its affiliates and all fathers by providing fathering information

and education, virtually. CFI provided numerous webinars beginning in April 2020 and these virtual meeting continue. During Summer 2020, NEFC delivered a free, three-part Webinar Series to support Fatherhood Professionals in New England and beyond.

III.E.2.b.iii. MCH Data Capacity

III.E.2.b.iii.a. MCH Epidemiology Workforce

- **Marc Camardo**, Supervising Epidemiologist, serves as the Title V Director and SSDI Director. Mr. Camardo has an MPH with 14 years of experience at the Department and has dedicated his work to improving the health of women and infants, children and adolescents, and children with special health care needs. In this role, Mr. Camardo provides oversight and direction to the MCH Epidemiology Unit supervising epidemiologists and provides technical assistance in executing the work of the Unit, including surveillance activities, data analyses, and other emerging initiatives. Mr. Camardo also provides leadership by working vertically and cross-functionally with Department and Section management in supporting the coordination of the MCHBG.

- **Dr. Katharyn Baca**, CDC Maternal and Child Health Epidemiology Assignee to Connecticut, has PhD and MPH degrees in Epidemiology, and has 6 years' experience in applied epidemiology in the fields of maternal and child health (MCH) and program evaluation in state, local and federal government settings. Dr. Baca is trained with advanced data management and methodology skills, which she uses to design and implement methodologies to define MCH related indicators, perform linkages across programs, and determine trends by various stratifications. Dr. Baca also coordinates projects and participates in several committees and workgroups in various topics related to MCH, including reproductive justice and substance exposed infants, and has recently joined the CT Pregnancy Risk Assessment Monitoring System (PRAMS) team.

- **Jennifer Morin**, Epidemiologist 3, has an MPH in Epidemiology and has worked as an MCH epidemiologist for 18 years. She has provided key data support to the MCHBG since 2003 including playing a central role in the past 4 MCHBG 5-year Needs Assessments, supported SSDI since 2003 and served as the SSDI Project Coordinator since 2006, and has also served as the CT Pregnancy Risk Assessment Monitoring System (PRAMS) PI, Project Director, Project Coordinator, and analyst since the project was first funded in 2011 and authored the original funding application. Ms. Morin has considerable knowledge and experience in data collection, linkage and analysis, as well as of translation of data into action to support Department of Public Health (DPH) programs and statewide partners in their efforts to improve outcomes for Connecticut's MCH population.

- **Johanna Davis**, Epidemiologist 3, has worked as an DPH epidemiologist for almost 30 years. She has worked with numerous databases, designed by CDC, HRSA, DPH (and others). She has been involved in the planning, designing, converting, linking, and creating of databases. Areas of knowledge include STDs, School Based Health Centers, Primary care office, Family Wellness Healthy Start, Community Health Associations, Birth Defects, Sickle Cell Disease and Birth Defects. She has also provided data support to the MCHBG for the past 15 years including the MCHBG 5-year Needs Assessment. She has created many surveys in Survey Monkey, to collected data and information, including satisfaction surveys. She has also trained and supervised other staff in different areas.

- **Lisa Budris**, Epidemiologist 2, has an MPH in Public Health and an MS in Research, Statistics and Measurements. She has worked as the PRAMS Data Manager since 2012 and serves as a data analyst. Ms. Budris also provides epidemiologic support to the Office of Oral Health and has recently taken on additional responsibilities supporting data reporting for the MCHG. Prior to joining CT PRAMS, Ms. Budris worked within DPH as Health Program Assistant for 2.5 years supporting nutrition, physical activity, and nutrition initiatives' in the Health, Education, Management & Surveillance Section. Prior to DPH, she worked for 4.5 years as a research assistant managing several studies involving women with type 2 diabetes and a history of depression, and was a research coordinator for a behavioral health organization working in several substance abuse clinics around the state.

- **Nicholanna Prince**, Epidemiologist 2, has a MS degree in Molecular and Cellular Biology and worked as an MCH epidemiologist for 5 years. She has provided key data support to the MCHBG since 2016 including providing data support for the Newborn Screening program, Early Hearing and Detection Intervention program, and the Family Wellness Healthy Start program. Ms. Prince has substantial expertise in data collection, analysis, and performing quality control of our online data system for CYSHCN (CT Youth Special Health Care Needs) program and the Family Wellness Healthy Start program (FWHS). She converts and performs electronic uploads for the FWHS program. She runs reports for EHDI (Early Hearing Detection Intervention) program to improve quality of data.

- **Tabitha Fox**, Epidemiologist 1, B.S. Public Health, has provided support to CT PRAMS since 2017 and fulfills some of the PRAMS Data Manager duties related to survey mail operations. She is responsible for

data management and informatics support within the MAVEN: Newborn Screening System and assists in annual data reporting support for ongoing Title V Block Grant.

- **Dr. Laura Estep Hayes**, Epidemiologist 3, serves as liaison between the Title V Program and the Surveillance, Analysis, and Reporting Unit (SAR) in the DPH Health Statistics and Surveillance Section. Dr. Hayes earned a M.S. in Epidemiology and Public Health (Biostatistics Track) from Yale University while serving as an EPA STAR (Science to Achieve Results) Fellow, followed by a doctoral degree in Zoology from Auburn University. Her statistical expertise is the area of linear mixed effect modeling, spatial analysis of geographic public health data, and interpretation and presentation of vital event data analysis results for the general public. Dr. Hayes has served as lead author and co-author of over 30 peer-reviewed manuscripts and state government reports, including, most recently, the Connecticut Registration Report for Vital Events Occurring in 2018.

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

The CT DPH's State Systems Development Initiative (SSDI) is designed to develop, enhance, and expand state Title V MCH data capacity for its needs assessment and performance measure reporting in the Title V MCHBG program. The three SSDI program goals for the FY 2018-2022 project period are to:

1. Build and expand state MCH data capacity to support the Title V MCH Block Grant program activities and contribute to data-driven decision making in MCH programs, including assessment, planning, implementation, and evaluation.
2. Advance the development and utilization of linked information systems between key MCH datasets in the state.
3. Support program evaluation activities around the NPMs that contribute to building the evidence base for the Title V MCH Block Grant program.

One continuing barrier has been in obtaining Medicaid data files. For the past 9 years, Connecticut has not had access to linked birth-Medicaid data. In the past, the Connecticut Department of Social Services (DSS) had provided linked birth data to Medicaid status at the time of delivery; this linkage was completed by a DSS subcontractor. The last birth year for which data were provided was 2012 because DSS's subcontractor was defunded. Marc Camardo, Connecticut Title V MCH Director and SSDI Project Director, worked with staff in the Community, Family Health and Prevention Section, Vital Records, and the DPH Legal Office during Project Year 1 to successfully execute a Memorandum of Understanding (MOU) with DSS, which also serves as the Inter-Agency Agreement required by the MCHBG (Goal 2). While this did enable Connecticut to receive aggregate data for Form 6 for birth years 2013-2017, DSS did not agree to provide the DPH with the linked data set. Mr. Camardo and Jennifer Morin, SSDI Project Coordinator, have initiated discussions with DSS once again and have met with new partners. We are in the process of completing a new DSS Data Request Form that will identify the specific data elements and other changes that we are seeking. Once they have a better sense of the areas within the current MOU that we we'd like to revise or expand, they will connect with us to discuss further. We will use the original MOA that had allowed us linked data up through 2012 as the basis for modifying the current MOU, but we will also make appropriate changes given potential modifications that may have been made to their data system over time. Mr. Camardo and Ms. Morin will continue working with the DSS partners in the upcoming project year to hopefully finalize a new MOU that would allow for data linkage once again.

During July-August 2021, Lisa Budris, MCH Epidemiologist, provided updates to the ongoing needs assessment activities in the Needs Assessment Update section of the Application/Annual Report. This included a brief description of the state's ongoing needs assessment activities (e.g., MCH data collection and analyses, program evaluation, key informant interviews, etc.); noted changes in the health status and needs of the state's MCH population, as compared to the identified priority needs for the MCH Block Grant; noted changes in the state's Title V program capacity or its MCH systems of care and the impact of these changes on MCH services delivery; the breadth of the state's Title V partnerships and collaborations with other federal, state and local entities that serve the MCH population; and efforts undertaken by the state to operationalize its Five-Year Needs Assessment process and findings.

The Every Woman Connecticut (EWCT) evaluator worked with the EWCT Advisory Committee and the EWCT leadership to measure the extent to which the three recommendations from last year's in-depth interviews and evaluation report were incorporated into the EWCT work. Specifically, EWCT and the evaluator worked to: 1) achieve clarity on mission and objectives with a focus on a new website for the initiative; 2) focus on sustainability planning; and 3) create explicit roles and structure for the EWCT Advisory Committee. Additionally, a main focus during the COVID-19 pandemic, which delayed the meetings of the EWCT Advisory Committee, was to work with the Connecticut Department of Mental Health and Addiction Services (DMHAS) to ascertain current data collection

methods and metrics on the implementation of the One Key Question (OKQ) initiative. The EWCT evaluator and the EWCT leadership team met with DMHAS leaders to discuss availability and types of data that could be used for an outcomes evaluation exploring the effectiveness of the OKQ approach on women's health and healthcare. A data collection plan was finalized for execution in the upcoming project year. Because the current evaluator had to leave this project due to new employment during this project year, we met with her and EWCT leadership to develop a transition plan. Since our new CDC MCH Epidemiology Assignee has a great deal of experience with evaluation and is already connected to a lot of the work that we are doing, she will be taking over as the evaluator. The current evaluator will be meeting with the new evaluator to discuss the next steps that were planned for the remainder of this year and the upcoming year. Fortunately, because of her new position, our current evaluator was able to join the EWCT Advisory Committee and will still provide her expertise.

The Connecticut SSDI project has had a longstanding commitment to supporting the implementation of the Pregnancy Risk Assessment Monitoring System (PRAMS) survey to expand and sustain state data capacity. The ongoing study of birth outcomes and associated risk factors has yielded a better understanding of the impact of maternal health and behaviors on the infant and mother during pregnancy and postpartum. Although vital records birth data are available to measure such outcomes of interest as low birth weight, preterm delivery, and the receipt of early and adequate prenatal care, the ability to examine important outcomes and behaviors in-depth had been restricted in Connecticut because of the limited information about key risk and protective factors available from birth certificate data.

PRAMS provides data about maternal health, experiences, and behaviors during the perinatal period, which enhances data capacity surrounding risk and protective factors among Connecticut mothers. The goals of PRAMS are to: 1) Provide statewide data about maternal health, experiences, and behaviors during the perinatal period; 2) Better understand the relationship between maternal risk factors, behaviors, and attitudes and adverse pregnancy and postpartum outcomes; and 3) Investigate racial and ethnic disparities in maternal risk factors, behaviors, attitudes and pregnancy and postpartum outcomes.

Data for the 2013-2020 surveillance years are available, including information from a special opioid survey supplement conducted during the 2019 surveillance year. These data have been provided to numerous programs within DPH, including reporting to the MCHBG, as well as a wide network of MCH partners statewide to support their work. Data dissemination has been achieved via fact sheets, data reports, presentations, and ad hoc data requests. The SSDI Coordinator is also the PRAMS PI, Project Director, Coordinator and primary analyst. She will continue to work with the other PRAMS analyst and the new CDC MCH Epi Assignee on additional data products in addition to fulfilling ad hoc data request. Data collection for the 2020 surveillance year ended in June 2021 and we just received our weighted data in mid-July since we were the first state weighted this year. We not only achieved our highest weighted response rate ever (63.2%), but response rates among all strata (including lower responding groups) also increased.

The 2020 data also includes COVID-19 supplement data that we will analyze and disseminate to our statewide partners. These supplemental questions were an effort to begin collecting population-based data on how the lives of mothers were being impacted by COVID-19 infection and the COVID-19 pandemic. PRAMS data will complement other CDC COVID-19 surveillance efforts by filling gaps in data, including measuring the proportion of women and/or someone in their household infected with COVID-19 during their pregnancy, and also examining interactions with health care providers in person and by telemedicine, barriers to seeking or getting care (prenatal, postpartum and well-baby visits), precautions taken and other experiences related to COVID-19 exposure/infection, hospital experiences during labor and delivery and postpartum, and economic/emotional hardship. We will also be able to divide women into groups that were not at all affected, somewhat affected, or greatly affected by the societal effects

of the pandemic. Taken in conjunction with the rich information that PRAMS already gathers on the lives of women around pregnancy, we may be able to quantify the degree of disruption across many different life domains. For example, are planning on looking at outcomes and health care usage in 2019 vs. 2020. We anticipate potentially seeing an increase in the frequency of maternal anxiety and depression as well as interpersonal violence based on anecdotal reports from our statewide partners who serve pregnant and postpartum women. We'll also examine if there are changes in usage and timing of prenatal care, dental care (which is already a challenge to get people to go because of the misconception it is not safe during pregnancy), postpartum visits, postpartum contraceptive use, and more.

In June 2021, State legislation was passed legalizing adult use of cannabis products. The legislation includes the DPH's role in surveillance. Internal partners from the Tobacco Control Program and Office of Injury Prevention had had a conference call in May 2021 with a national consultant hired to assist the Governor's Office with the legalization process in CT. PRAMS was one of three key data sources identified by the contractor for cannabis surveillance. Subsequently, internal partners convened a meeting to discuss existing data (if available) and how data can be collected moving forward. PRAMS staff have been in discussions with their CDC PRAMS Project Manager and other PRAMS states who are collecting or have collected data on perinatal marijuana use to help identify the best approach for moving forward. Data collected as part of opioid survey supplement in 2019 can provide an initial baseline estimate for marijuana use during pregnancy as there was one question asking about a variety of substances used during pregnancy.

CT PRAMS is in the process of finalizing questions for a survey supplement around marijuana use and the use of Cannabidiol (CBD) products before, during, and after pregnancy; how (e.g., smoked, dabbed, vaped, etc) and why (e.g., relieve nausea, relieve stress or anxiety, etc) women used marijuana products during pregnancy; conversations around marijuana use or recommendations during prenatal care; perceptions of how long someone should wait after using marijuana before breastfeeding or pumping milk for their baby; and if they think the use of marijuana products during pregnancy could be harmful to a baby's health. This supplement will be implemented beginning in Fall 2021 and will continue through the end of the 2022 surveillance year. In 2023, the new PRAMS Phase 9 survey will be implemented and we plan to retain 1-2 questions on the survey for long-term surveillance.

Late in the current project year, we anticipate adding a social determinants of health (SDOH) survey supplement. Currently, it's estimated that the questionnaire will be available from CDC and ready for implementation in October. We plan on implementing both the marijuana and SDOH supplements at the same time to minimize disruptions to operations and maximize efficiency as new survey booklets will need to be printed.

Work on the Phase 9 survey has begun at CDC and CT PRAMS staff have already contributed input, including convening an ad hoc New England PRAMS meeting to discuss what we may want to recommend for changes, as well as the possibility of including one or more questions as a region to look at regional areas of interest. The group expressed interest in continuing to meet and the SSDI Coordinator will serve as the informal convener of the group. As decisions about the Phase 9 Core survey continue at the federal level, CT PRAMS has already begun looking at what changes it might want to make for the other portions of the survey (Standard and state-developed questions). Work on survey content with internal and external partners to ensure Title V MCH data needs are met to the best of our ability will continue into the next project year. The Phase 9 survey is currently slated for deployment with the 2023 surveillance year.

In 2021, the CT PRAMS Director along with key partners at Carey Consulting and the March of Dimes Connecticut Chapter formed a new Reproductive Justice Workgroup that had evolved out of a 2020 PRAMS Data to Action project around discrimination before and during pregnancy. This year and in the upcoming year, activities will include conducting qualitative research in the form of community focus groups with women, partners and doulas, as well as

in-depth interviews with staff working in medical settings (e.g., prenatal care sites, hospitals) who have contact with pregnant and postpartum women to measure experiences of disrespect and mistreatment while receiving these services. We are seeking to replicate the exploratory and formative research that was performed by Columbia University's Averting Maternal Death and Disability (AMDD) project which supported birth justice efforts in NYC. We will explore and expand upon their central research questions, a) how do women describe their experiences of mistreatment or disrespect during facility-based childbirth, and b) what are the individual, institutional, structural, and policy drivers of the treatment that women experience as disrespectful? Our focus will include prenatal care experiences as well as childbirth and immediate postpartum care; in the future, we would like to expand our qualitative research into preconception and interconception care. The purpose of replicating this research is to:

1. Provide specific documentation and examples for CT, which may or may not vary somewhat by region, health system, provider type, or other factors;
2. Provide us with a baseline before/at time work is beginning so we can later evaluate if we've made an impact;
3. Identify specific ways in which providers and all other facility staff, administration, health systems, and others can act and be held accountable for improvement; and
4. Inform a CT PRAMS survey supplement in the future.

III.E.2.b.iii.c. Other MCH Data Capacity Efforts

Birth Defects

DPH is strengthening MCH data surveillance capacity and improving quality of data through data linkage. More specifically, DPH is working on longitudinally linking mothers to their infants born in 2010-2019 (using birth and fetal death data), and then linking each infant and mother to death events and hospitalizations for mothers and infants within a year prior to or up to 3 years following birth (note not all infants will have 3 years' worth of data). The resulting data can be used in several ways, including linking the infant linked data to birth defects surveillance data. Presence and type of birth defects will be compared between birth data, hospital discharge data, and the birth defects surveillance system. Not only can birth defects be evaluated between data sources to determine data quality, but the data can also be used for surveillance purposes for birth defects. Some examples include to determine the topmost common birth defects overall and by region, sex, and by maternal age. As the quality of the surveillance system is improved, the goal is to establish a fully functioning birth defects surveillance system that is timely and accurate.

Vital Records Death

DPH's Health Statistics and Surveillance Section (HSSS) performs the linkage of birth and death data to create annual cohort files. This linkage is done upon the creation of the final mortality file for a calendar year. Infant mortality is a key indicator for MCH programs, so the availability of this linked data set is extremely valuable to Title V programs. Connecticut is in the process of implementing an electronic death registry system (EDRS) that will replace the current paper registry system which has substantial delays in accessing infant death data. The new EDRS is being implemented as a web-based platform and slated for statewide roll-out in Fall 2021. Connecticut has entered all paper death certificates into the new system as of June 2020 which has allowed for some benefits of the new system to be realized. During the current project year, Connecticut has significantly improved our timeliness of death records sent to the CDC National Center for Health Statistics (NCHS) from a few months to a few weeks.

WIC

The co-enrollment of participants in both WIC and Medicaid/HUSKY A has been shown to enhance the timely delivery of key health and nutrition services and to improve birth outcomes. In the past, WIC has entered into data linkage agreements with Vital Records for the purpose of a) determining the percentage of WIC participants co-enrolled in WIC & Medicaid/HUSKY A, and b) identifying and actively recruiting those low-income women and children not already enrolled in both programs. However, the inconsistent labeling of the Primary Insurance Source field in the birth file makes it impossible to accurately determine Medicaid/HUSKY A enrollment and, thus, co-enrollment in WIC and Medicaid/HUSKY A. In addition, the birth file provides only post-delivery hospital data. The absence of data on pregnant women results in WIC's missing the opportunity to intervene during the most critical period in an infant's development - data that are currently only available from the DSS's Medicaid/HUSKY A files.

Given the limitations to linking to the birth file alone, WIC is currently most interested in linking with DSS's Medicaid/HUSKY A dataset so that it can capture eligible women while they are still pregnant, where the Program can have the most impact. The linkage of these files would allow WIC to a) determine co-enrollment in WIC & Medicaid/HUSKY A and, coupled with GIS mapping, pinpoint geographic areas which require a greater focus of recruitment efforts; and b) use it as a QA tool to compare birth-related data in the WIC database vs. the DSS Medicaid file. The challenges to DPH acquiring files from DSS in recent history has been discussed above. However, current work being done by the SSDI Director and Coordinator could potentially facilitate access once again.

Newborn Bloodspot and Newborn Hearing Screening

Creating linkages of high-quality child health information has been a continued priority for Connecticut. Past SSDI project years have included ongoing efforts to implement the web-based MAVEN application, which provides a comprehensive child health profile. The newborn screening module, MAVEN: Newborn Screening System (NSS), has facilitated the linkage of birth and newborn screening records for 8.5 years and will continue to provide access to this information in the new SSDI Project period. Currently, the following databases are integrated into the Maven: NSS - Newborn Bloodspot Screening, Newborn Hearing Screening, Birth Defects Registry, Critical Congenital Heart Disease Screening, Children and Youth with Special Health Care Needs Registry, birth records, Childhood Lead Surveillance System and Family Wellness Healthy Start.

The Maven: NSS application includes an automatic de-duplication algorithm, as well as multiple numeric validation rules that maintains the integrity of the child data records entered into the system. A two-way, automated matching process between ConnVRS and the Maven: NSS is completed 15 days after the system entry date based on an algorithm that achieves a greater than 97% match rate. Prior to ConnVRS, a flag had been included in the automated matching process that would pick up any changes to a particular record within 120 days of birth. For example, if a baby is adopted at 2 months of age, this information will import and update the child's record in Maven:

NSS. Coding for this needs to be built back into the system by the DPH IT Department. Currently, the only records that import, after the initial import at 15 days, are records that are entered late with Vital Records. A new electronic record is automatically created for children born in CT who do not have a matching record in the Maven: NSS from the birth record. These cases are identified and reviewed to make sure they are not duplicate records. With regular monitoring in place, the 2012-2019 NSS birth counts were the closest they have ever been to the former vital records system (EVRS) occurrent birth count.

After EVRS was moved to the new ConnVRS application in January 1, 2016, an updated vital records roster import file was implemented in the Maven: NSS at the end of April 2016. Currently, these records are imported daily. What is not yet included in this new import are any changes made in the Vital Records record within 120 days since birth or any record that was not submitted to Vital Records within 15 days of birth. Originally, it was anticipated that this would be corrected by December 2019. However, due to barriers beyond control the DPH IT Department, it has not yet been completed. This is a critical feature that needs to be added back into the automated import. Several ConnVRS fields have also changed that require changes to the Maven: NSS vital records roster import file to more accurately capture specific demographic changes, such as multiple races. The congenital anomalies section in ConnVRS has also changed and Maven: NSS needs to be remapped to accurately support birth defects reporting. Progress has been made on testing the mapping to receive all fields that map exactly without needing to change the imports. These changes were moved to the Production environment in September 2018. Some of the fields that required the remapping of the data that is captured differently in ConnVRS were updated and remapped so that it will import into Maven NSS. This was completed in March 2019. The mother's education field was remapped and completely reimported for the 2017 birth year and is now part of the daily import. When the other remapping is completed, all ConnVRS files from January 1, 2016 forward will be reimported into Maven NSS. The biggest barriers to this have been lack of resources from the IT department. The staff person that needs to do this from IT has had other priorities with the ConnVRS database that had to be completed. The next step for remapping the Congenital Anomalies section and other sections that are new was anticipated to be completed by March 2020 so that annual birth defects reporting could be completed by the end of May 2020. In March 2020, the CDC and National Birth Defects Prevention Network (NBDPN) changed their focus and moved to collecting data every other year. The 2020 data was pushed back to 2021 so this update to the Congenital Anomalies section was also put on hold by DPH IT.

In February 2018, a new question package was implemented to capture Critical Congenital Heart Disease Screening on every baby that is born in the state of Connecticut. This was implemented to meet a new state statute that went into effect "on or after January 1, 2018."

Information derived from the Maven: NSS application has improved Connecticut's ability to report on the MCHBG providing data for numerous objectives, outcome and performance measures. The CT NBS Program at the State Laboratory (CT NBS) has redesigned several reporting modules, adding fields to capture data points not previously captured. In addition, follow-up modules were developed and implemented that allow the CT NBS to follow-up on outstanding samples and to collect and track outcome data. In addition, an electronic interface was developed between Maven: NSS and the Connecticut Newborn Diagnosis and Treatment Network's (CNDTN) electronic health record (EPIC). This allows for the paperless reporting of presumptive positive NBS results from CT NBS to the CNDTN and the transmission of outcome data (through the age of 21) from the CNDTN to CT NBS. Reports will continue to be built that will simplify the extraction of information from Maven for MCHBG reporting and for entry into to the NewSTEPs National NBS Data Repository.

Maven: NSS has also improved the quality and accessibility of child health information for the CT NBS Program at the State Laboratory, Newborn Hearing Screening, Birth Defects Registry, Children and Youth with Special Health Care Needs, and Lead programs to support their work.

The CT NBS Program is collaborating with the Newborn Diagnosis and Treatment Network to identify disorder specific outcome measures and long-term follow-up reporting processes within Maven: NSS and EPIC, to collect follow-up data on children diagnosed with a disorder identified through NBS through the age of 21.

Hospital Discharge

Starting in 2009, hospitals began reporting emergency department and inpatient hospitalization discharge data directly to DPH. Data from all hospitals is received within 7 months after the end of a calendar year. Previously, data had to be purchased from the Connecticut Hospital Association, which was extremely costly and took additional time because of the contractual process to obtain the data. DPH currently has data up to and including calendar year 2019, and 2020 data is expected to be received in September 2021. These data have been used to report on several measures in the MCHBG Application/Annual Reports. Expanded analyses and/or linkages to other data sources (e.g., birth and death records) can be completed to gain additional information, such as the cost associated with adverse birth outcomes, maternal morbidity and mortality, and neonatal abstinence syndrome. Linkages using birth and hospital discharge data are primarily performed by HSSS staff to meet project-specific needs. However, staff capacity has been overstretched for many years, which has hindered additional linkages. However, now that the

MCH Epidemiology Unit has gained a staff person (CDC MCH Epidemiology Assignee), Mr. Camardo and Ms. Morin have started discussions about future linkages and analyses she can work on involving hospital discharge data. Although linkages have not yet begun, she did recently analyze the rate of Neonatal Abstinence Syndrome (NAS) infants per 1,000 live births and number of NAS-related hospital discharges per calendar year in CT from 2010-2019 using the hospital discharge data. This analysis was completed looking at overall hospital births, as well as by town, insurance type, and race/ethnicity. Average and median length of stay and cost of medical care for NAS infants and newborns overall were calculated by calendar year. This data supported the work of the DPH Office of Injury team and Fetal-Alcohol Spectrum Disorder and Substance Exposed Infants workgroup.

III.E.2.b.iv. MCH Emergency Planning and Preparedness

The Connecticut Title V program staff have provided leadership and support in delivering critical MCH services and in assisting local communities during the COVID-19 pandemic. This includes being proactive in its emergency preparedness planning and to coordinate with partners at the state and local levels to develop emergency preparedness and response plans that include the needs of the MCH population.

The Connecticut Department of Public Health (DPH) is the lead administrative and planning agency for public health initiatives, including public health emergency preparedness. DPH works with federal, state, regional, and local partners to improve the state's ability to respond in emergencies. The Connecticut Public Health Emergency Response Plan (CT PHERP) identifies DPH response activities during a public health emergency. This plan serves as the Emergency Support Function – Public Health and Medical Services component of the state's disaster and emergency operations plans.

The Title V Program has recently engaged with the DPH Public Health Preparedness & Local Health (PHP&LH) Section to assess the Maternal and Child (MCH) epidemiology capacity and the intersection of MCH and emergency preparedness. Specifically, there is interest in looking at the organizational capacity to address the needs of women of reproductive age, especially pregnant and post-partum women, and infants (ages 0-1 years) during public health emergencies. The PHP&LH participate in several committees (that involved planning) around children's health from the government and healthcare system sectors. The Division of Emergency Management and Homeland Security (DEMHS) children's emergency preparedness committee, Emergency Medical Services for Children (EMSC) grant, school safety committees, hospitals (medical surge capacity), DPH Facility licensing & Investigation Section (FLIS) for hospital care, local health departments around vulnerable populations (which include children), and others.

Over the past fifteen months during the COVID-19 pandemic, Title V has supported disaster preparedness planning in DPH and across Connecticut. Title V program staff were involved and consulted in the planning and development of the State's reporting structure for the testing sites available in each region/municipality, and as part of that structure, served as the point person to pull all the information together and provide it to United Way of Connecticut's 2-1-1, the Governor's website, and to the regional coordinators to share with their regions.

III.E.2.b.v. Health Care Delivery System

III.E.2.b.v.a. Public and Private Partnerships

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. Child Health and Development Institute and Connecticut Family Support Network will implement the Provider/Family outreach and education component of the CMHI for CYSHCN with a focus on Family/Professional Partnership.

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.

DSS utilizes 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.

The Connecticut Department of Public Health Strategic Plan 2019-2023 address the Departments Vision for Healthy People in Healthy Communities. DPH's Mission is to protect the health and safety of the people of Connecticut by: assuring the conditions in which people can be healthy; Preventing disease, injury, and disabilities; and Promoting the equal enjoyment of the highest attainable standard of health, which is a human right and a priority of the state.

Health Equity is the foundation of DPH's Strategic Plan. Fundamental to the fair administration of its programs and services is DPH's effort to address the challenges faced by certain populations, to ensure equitable access to resources and high-quality services, and to do no harm. Sec. 19a-4j C.G.S. establishes an Office of Health Equity within the Department of Public Health to improve the health of all Connecticut residents by working to eliminate differences in disease, disability and death rates among ethnic, racial and other population groups that are known to have adverse health status or outcomes. Population groups may be based on, but are not limited to, race, ethnicity, age, gender, socioeconomic position, immigrant status, sexual minority status, language, disability, homelessness, mental illness or geographic area of residence. DPH's health equity policy and procedures help to carry out this mandate and support our mission identified above.

DSS expanded the Medicaid Person Centered Medical Home (PCMH) initiative in 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 January 2020, there were 369 PCMH approved practice sites and 158 Glide Path providers. 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. Connecticut has a total of 1,598 PCMH approved providers; the DSS Medicaid PCMH initiative covers about one third of all Medicaid members.

CT Title V and their partners were engaged with the Office of Health Strategy as all worked to advance health innovation through the ongoing work of the State Innovation Model (SIM) program, a Center for Medicare & Medicaid Innovation (CMMI) initiative to support the development and implementation of state-led, multi-payer healthcare payment and service delivery model reforms that will promote healthier people, better care, and smarter spending in participating states. The CT SIM Vison is to establish a whole-person-centered healthcare system that will: Improve population health through the reduction of statewide rates of diabetes, obesity, and tobacco use; To improve health care outcomes by improved performance on key quality measures, including preventative care and care experience; Promote health equity by closing the health disparity gap between the highest and lowest achieving populations for key quality measures; Reducing healthcare costs by achieving a 1-2% reduction in the annual rate of healthcare growth.

Health Enhancement Communities (HECs) are a component of the health enhancement community framework of Connecticut's State Innovation Model. CT HEC's initiative envisions having sustainable, multi-sector collaboratives in every geography in Connecticut that implement community health, health equity, and prevention strategies in their communities and reduce costs and cost trends for critical health priorities. Specifically, HECs will: be collaboratives that include community members and partners from multiple sectors such as community members, community-based organizations, health care providers, local health departments, local government, social services agencies, schools, housing agencies and providers, transportation agencies, and others; be accountable for improving community health, health equity, and prevention and reducing costs and cost trends for the health priorities; have a defined geographic area that they serve; have formal structures, defined ways of making decisions together, and multiple methods for ensuring community member ownership and involvement; select and implement strategies that address social determinants of health that cause or contribute to poor health, health inequity, and preventable costs; and be sustainable, including through financing that rewards HECs for improving health, preventing poor health, and producing savings and economic value.

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.

III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

The Title V program and Title XIX program share a common goal in working to improve the overall health of the MCH population through affordable health care delivery systems and expanded coverage. Partnership and collaboration between these two programs allow for the effective leveraging of federal and state resources, which yields administrative efficiencies to help ensure that women and children are provided needed preventive services, health examinations, treatments and follow-up care. The Department was recently funded by the CDC (National Initiative to Address Covid 19 Health Disparities Among Populations at High Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities) that will further support current efforts that seek to foster partnership and collaboration between the two programs (with the common goal of establishing a new inter agency agreement/MOA).

The Title V program and Title XIX Medicaid program is working on a Maternal and Child Health (MCH) data integration project to strengthen current data infrastructure and analytic capacity to assess the COVID-19 pandemic's impact on equity measures of maternal and infant health outcomes in the pre-conception, prenatal, delivery, and post-partum periods, and to better characterize the disparities in maternal outcomes among different population groups and the effect of the pandemic on the magnitude of such disparities. This will ensure that Connecticut mothers and children's health in communities that have been disproportionately affected by the pandemic benefit by appropriate and fair service and resource distribution.

The tracking of MCH outcome disparities is critical to assess whether they may have widened due to changes in access and quality of pregnancy care during the pandemic. Connecticut seeks to secure high-quality, stratified data, including race and ethnicity identifiers, to assess the current and future disparities in care of pregnant and parenting women. The goal is to establish the best state's approach to promote and achieve equity care. Monitoring health disparities in all its dimensions is not possible without high-quality data at various levels of stratification. Overlaying multiple data sources and linking data points to build quality indicators and inform reimbursement structures requires the development of a mapping framework that guarantees fidelity and reliability of the combined analyses. DPH proposes to develop a data mapping process that systematically enlists and details the properties of each data source appraised for monitoring MCH status. Sources mapping is an essential step for tracking and monitoring health disparities within the development of an integrated MCH data infrastructure. Therefore, this project seeks to develop a template for data integration with a statewide application for clinical and community-based sources. This includes developing a systematic method of data disaggregation that is equity-oriented that allows rapid and intuitive visualization of MCH outcomes' disparities.

Over the next year, the Title V program and Title XIX Medicaid program seek to do the following:

Activity #1 Creation of Health Equity Measures:

a. Reach out to potential partners

b. Meet with partners to decide what are the benefits and limitations of data integration workgroups (they will be used throughout the process)

c. Establish a new formal partnership between DPH and DSS through an MOA.

d. Establish a workgroup with partners (including DSS, various Sections within DPH, and with non-government organizations) to convene quarterly for brainstorming and to make improvements as needed.

e. Create MOA—key milestone

f. Hire consultants (an actuarial analysis to determine what portion of funding should be tied to equity measures)

h. Creation of a document detailing technical specifications for the quality measures/rule setting—key milestone

Public Health Data Sources: Analysis of MCH data begins with compiling a set of indicators guided by data analysts and with input from partners and stakeholders. DPH features data in a five-year needs assessment document and in a set of public dashboards. Data sources are periodic statewide surveys, census data, state Vital Records, hospital discharge data, and other healthcare provider and state agency records. The following are a few of the primary sources of data used to monitor the health of mothers and children in the state. The Connecticut School Health Survey (CSHS), administered by DPH, is an anonymous and confidential school-based survey of students in grades 9 – 12 from randomly chosen classrooms within selected public schools. DPH also conducts the Pregnancy Risk Assessment Monitoring System (PRAMS) survey in partnership with the CDC. This data provides information about maternal health and women's experiences and behaviors during and after pregnancy, the CT Inpatient and Hospitalization and Emergency Department Visit Dataset (CHIME), and CT Medicaid claims data. DPH compiles registry data from Vital Records in statistical registration reports aligned with Census data and other demographic

analyses. Other sources from which the health indicators are derived include, but are not limited to: the National Survey of Children's Health, Behavioral Risk Factor Surveillance System (BRFSS), National Immunization Survey (NIS), 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, and the Connecticut Department of Energy and Environmental Protection.

Activity #2 Implementation of the Measures

a. Create a data platform that integrates various DPH health equity related data with Medicaid data and to support baseline performance analysis and target setting of the measures.

b. Develop data and quality informed health equity measures.

c. Document detailed technical specifications for the quality measures/rule setting.

d. Research, develop, and test a questionnaire on patient reported outcomes with a plan to incorporate into the bundle in the future.

e. Implementation of the quality informed equity measures - research/design/test patient reported outcomes with a sustainability plan to incorporate into the bundle in the future.

Process for Implementation: DPH and DSS will blend the clinical and public (population) health analytics of MCH data of both the low-income and general population while tracking the effect of equity solutions on clinical and community health outcomes. With integrated and high-quality data collection, the public health and healthcare systems can analyze how changes in policies, programs, and practices during the pandemic have affected selected outcomes. DPH seeks to partner with DSS to pair data collection with critical assessments of policies, practices, and supports that may improve or worsen inequities and access to culturally and linguistically effective care. Connecticut is well-positioned to advance the MCH Data Infrastructure Integration project due to a strong partnership between public and private payers, healthcare providers, and state agencies. The state will ensure that all necessary maternal health care data is collected and create a data sharing platform that allows stakeholders to identify, understand, and remedy deficiencies and inequities in the health care system. Connecticut Medicaid is currently undertaking a transformation in how maternity care is paid for through a health equity focused maternity bundle. The goal is to embed health equity throughout the implementation phase of the maternity bundle development and align DPH and DSS maternity work in the process.

Activity #3: Evaluation of the Measures:

Evaluation:

a. Develop measures, implement health equity measures to drive who gets the bundle payments, evaluate if the approach works, if it does not work then change the approach using data.

b. Claims analysis to support baseline performance and target setting of the measures.

c. Ongoing evaluation and monitoring of outcomes of maternal/child inequities after the bundle is launched.

III.E.2.c State Action Plan Narrative by Domain

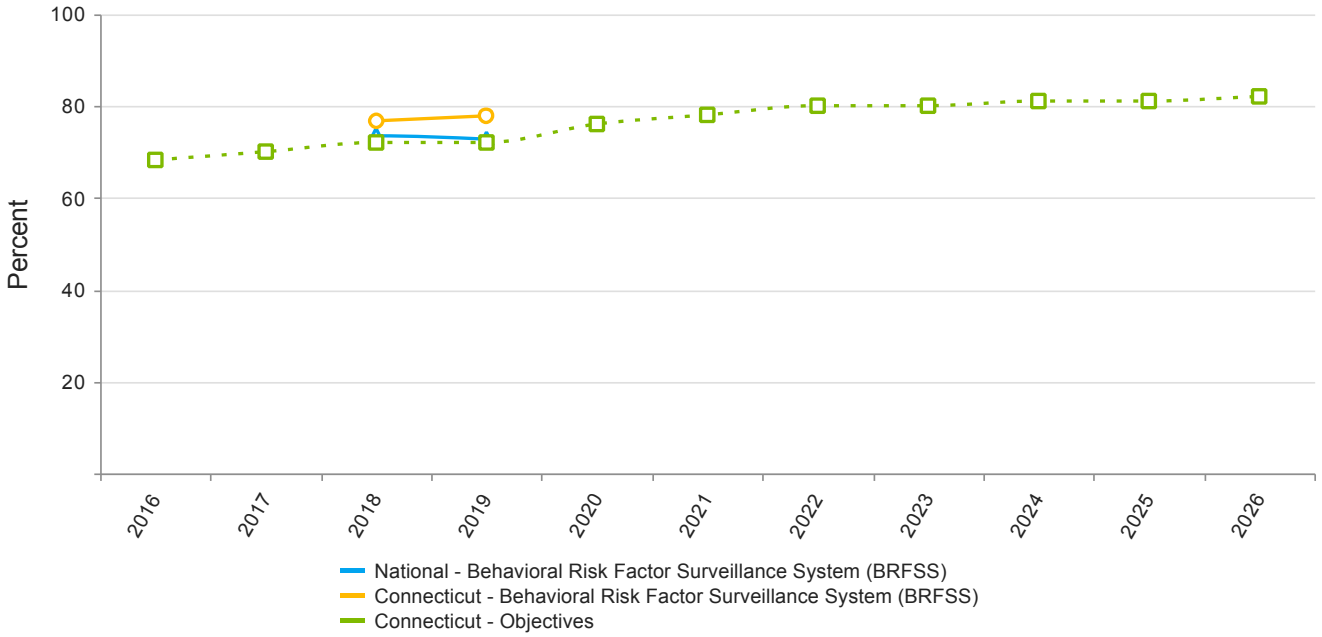
Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2018	87.6	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2015_2019	14.2	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2019	7.8 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2019	9.4 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2019	25.5 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2018	5.2	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	4.2	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2018	3.1	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	1.2	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2018	161.3	NPM 1
NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy	PRAMS-2019	9.0 %	NPM 1
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations	SID-2018	8.3	NPM 1
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2018_2019	9.1 %	NPM 13.1
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	14.8 %	NPM 13.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	91.4 %	NPM 13.1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	7.7	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2019	11.1 %	NPM 1

National Performance Measures

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Indicators and Annual Objectives



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective					76
Annual Indicator				76.7	77.9
Numerator				459,058	460,616
Denominator				598,556	591,657
Data Source				BRFSS	BRFSS
Data Source Year				2018	2019

Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	78.0	80.0	80.0	81.0	81.0	82.0

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Percent of clients receiving an annual preventative reproductive health exam that receive a PAP test and/or will be current with receiving the recommended PAP screening schedule, as per ACOG and USPSTF Guidelines

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		97.3	90	90.2	90.4
Annual Indicator	97.3	89.8	97.2	97.8	99.2
Numerator	11,472	10,442	5,256	5,005	4,877
Denominator	11,796	11,623	5,406	5,115	4,917
Data Source	Annual contract reports	Annual contract reports	Annual contract reports	Annual contract reports	Annual contract reports
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	90.6	90.8	91.0	91.2	91.4	91.6

ESM 1.2 - Percent of mothers enrolled in MIECHV-funded home visiting programs prenatally or within 30 days after delivery who received a postpartum visit with a healthcare provider within 8 weeks (56 days) of delivery?

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	77.3	78.2
Numerator	163	161
Denominator	211	206
Data Source	MIECHV-funded programs	MIECHV-funded programs
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	74.0	74.5	75.0	75.5	76.0	76.5

State Performance Measures

SPM 1 - The proportion of live births conceived within 18 months of a previous birth (percent, females 15–44 years).

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		37.7	37.1	25.7	25.5
Annual Indicator	26.5	25.4	25.9	26.6	25.8
Numerator	5,207	4,945	5,057	5,090	4,804
Denominator	19,642	19,437	19,537	19,154	18,654
Data Source	DPH Health Statistics and Surveillance	DPH Health Statistics and Surveillance	DPH Health Statistics and Surveillance	DPH Health Statistics and Surveillance	DPH Health Statistics and Surveillance
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	25.3	25.1	24.9	24.7	24.5	24.3

State Action Plan Table

State Action Plan Table (Connecticut) - Women/Maternal Health - Entry 1
Priority Need
Maternal Morbidity and Mortality
NPM
NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Objectives
1.1: By 2025, reduce the Maternal Mortality Ratio (MMRatio) by 10%.
1.2: By 2025, increase the number of birth hospitals who have a severe maternal morbidity review committee to 2.
1.3: By 2025, reduce the prevalence of cardiovascular disease in women of childbearing age by 5%.

Strategies
1.1.1: Explore innovative models of care that support health and wellbeing across the life cycle and foster healthy communities.
1.1.2: Address the Social Determinants of Health and racial and ethnic biases that impact women of color.
1.1.3: Address implicit bias in healthcare that would likely improve patient-provider interactions, health communication, and health outcomes.
1.1.4: Support the work of the Gold Ribbon Commission to ensure that its members have the infrastructure and resources needed to carry out its charge.
1.1.5: Support fatherhood initiatives to increase social support within the family and home environment.
1.2.1: Participate in the Alliance for Innovation on Maternal Health (AIM) project initiatives undertaken by the Connecticut Perinatal Quality Collaborative (CPQC) to expand the adoption of evidence-based patient safety bundles.
1.2.2: Support the work of the Gold Ribbon Commission to ensure that its members have the infrastructure and resources needed to carry out its charge.
1.2.3: Support advocacy through the Connecticut Perinatal Quality Collaborative (CPQC) and Title V Program collaborations.
1.2.4: Assess the burden of maternal morbidity in Connecticut.
1.3.1: Work with the WISEWOMAN program to increase the percent of women who receive risk reduction counseling and healthy behavior support.
1.3.2: Promote education and awareness of cardiovascular risk factors.
1.3.3: Support WIC initiatives that address access to healthy food through nutrition assessments and food packages that meet health needs.
1.3.4: Support the work of the Community Health Network of Connecticut to increase availability of blood pressure cuffs and increase participation in the Intensive Perinatal Care program.
1.3.5: Identify and address barriers to access annual well visits especially in the uninsured population.

ESMs	Status
ESM 1.1 - Percent of clients receiving an annual preventative reproductive health exam that receive a PAP test and/or will be current with receiving the recommended PAP screening schedule, as per ACOG and USPSTF Guidelines	Active
ESM 1.2 - Percent of mothers enrolled in MIECHV-funded home visiting programs prenatally or within 30 days after delivery who received a postpartum visit with a healthcare provider within 8 weeks (56 days) of delivery?	Active

NOMs

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

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

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

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

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

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

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

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

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

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

State Action Plan Table (Connecticut) - Women/Maternal Health - Entry 2

Priority Need

Preconception and Interconception Health

SPM

SPM 1 - The proportion of live births conceived within 18 months of a previous birth (percent, females 15–44 years).

Objectives

2.1: By 2025, decrease the percent of unintended pregnancy by 3%.

2.2: By 2025, increase the percent of women who have had a discussion with a doctor, nurse or other healthcare worker about how to improve their health before a pregnancy by 5%.

2.3: By 2025, increase the number of community-based organizations that are participating in the Every Woman CT initiative by 10%.

Strategies

2.1.1: Sustain and expand the use of the One Key Question (OKQ) screening tool by establishing formal relationships between EWCT and state agencies (DPH, DMHAS, OEC, etc.) that use OKQ in their programs as well as with regional entities that can serve as a hub for supporting the use of OKQ (such as Bridgeport Prospers and New Haven Healthy Start).

2.1.2: Provide evidence-based teen pregnancy prevention education to youth through collaborations with the PREP grant.

2.1.3: Increase the availability and use of Long Acting Reversible Contraception (LARC) in women of childbearing age who would like to postpone pregnancy.

2.1.4: Promote provider education focused on patient centered birth control including patient education on LARCs.

2.1.5: Expand Every Woman CT programming to include WIC staff throughout the state.

2.2.1: Sustain and expand the use of the One Key Question (OKQ) screening tool by establishing formal relationships between EWCT and state agencies that use OKQ in their programs (DPH, DMHAS, OEC, etc.) as well as with regional entities that can serve as a hub for supporting the use of OKQ (such as Bridgeport Prospers and New Haven Healthy Start).

2.2.2: Increase public awareness about the importance of discussing with your doctor how to improve your health prior to becoming pregnant.

2.2.3: Increase provider awareness about the importance of preconception health discussions in all health settings.

2.2.4: Improve access to healthcare for women before, during and after pregnancy.

2.2.5: Integrate into provider training mental health, social stressors, and trauma education relevant to infants and families.

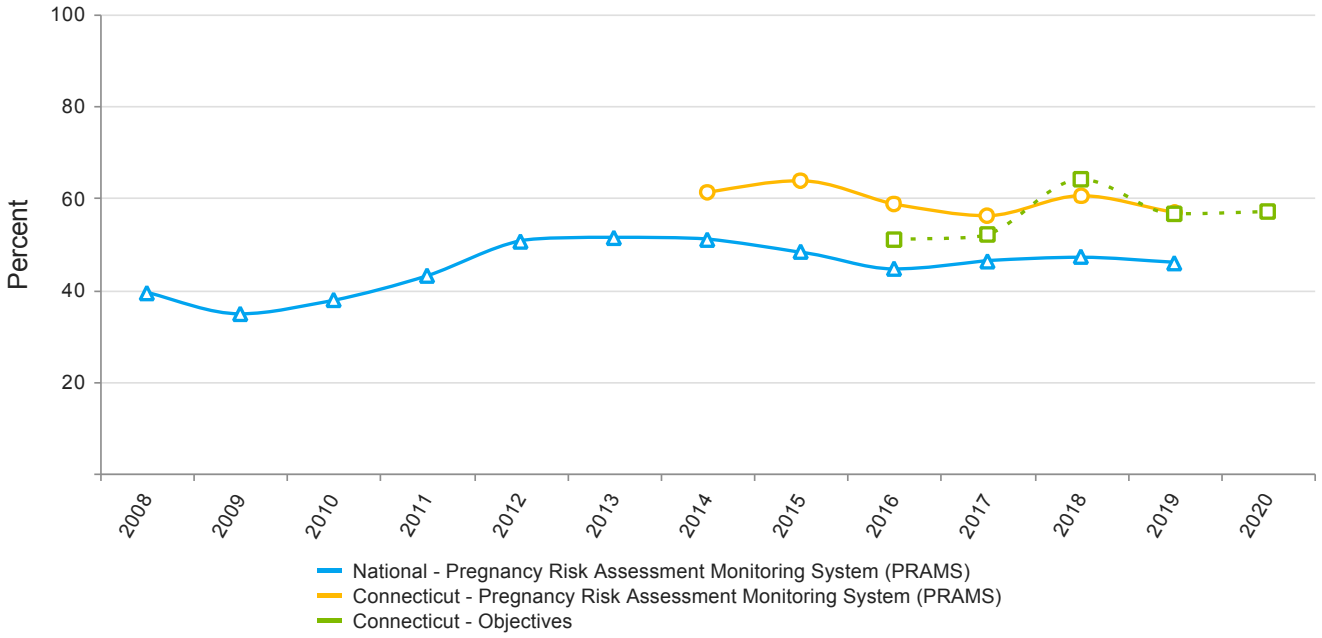
2.3.1: Recruit community-based organizations to participate in EWCT's trainings.

2.3.2: Increase the awareness about EWCT/OKQ among providers in different health care settings statewide.

2.3.3: Utilize Title V funds, when possible, to facilitate the expansion of EWCT/OKQ.

2016-2020: National Performance Measures

2016-2020: NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy
Indicators and Annual Objectives



Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2017	**2018**	**2019**	**2020**
Annual Objective	52	64	56.5	57
Annual Indicator	63.8	56.1	60.3	56.9
Numerator	21,607	18,660	19,795	18,485
Denominator	33,879	33,268	32,808	32,508
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2017	2018	2019

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 13.1.1 - Percent of dental or other health care workers providing information on how to care for teeth and gums during pregnancy

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		61.3	64	62	62.5
Annual Indicator	63.8	59.8	60.8	59.2	60.1
Numerator	21,607	20,219	19,930	19,231	19,303
Denominator	33,879	33,831	32,776	32,509	32,141
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Pre-/Interconception Health

Preconception health counseling has been identified and endorsed by the Centers for Disease Control and Prevention as a strategy to improve maternal health and birth outcomes, as well as to reduce unplanned pregnancies. Starting in May 2016 under the auspices of the MCH Coalition and the March of Dimes, who provided the financial support, Every Women Connecticut (EWCT) and the Every Women Connecticut Learning Collaborative (EWCTLC) were established. The main goal of this initiative is to increase provider expertise and self-efficacy in implementing routine pregnancy intention screening and appropriate care, education, and services to ultimately improve birth spacing, increase pregnancy intentionality, as well as the proportion of Connecticut women who deliver a live birth and report discussing pre-/interconception health with a healthcare worker.

EWCT, which established and manages the EWCTLC, now operates under the auspices and support of the Connecticut Women's Consortium (CWC), which is a statewide policy, training, and advocacy organization specializing in women's behavioral health. This, combined with the guidance of the EWCT Advisory Committee, has helped to stabilize the work of EWCT.

In order to strengthen relationships with new partners, representatives from the State Department of Mental Health and Addictions Services (DMHAS) and the Connecticut Coalition Against Domestic Violence (CCADV) have joined the EWCT Advisory Committee. This group of well-known and respected individuals representing partner organizations, including state agencies; the state's Medicaid ASO; the state's Medicaid dental and behavioral health carve-outs; state-level private non-profits; and direct service providers, continue to guide EWCT's efforts in increasing a general awareness around pre/interconception care and specifically around the One Key Question (OKQ) screening tool and in addressing social determinants of health and health equity.

The EWCTLC has representatives from clinical and community-based providers in communities throughout the state and has expanded to include a cohort of the Department of Mental Health Addictions Services (DMHAS) providers.

The trainings done during this time frame continued the partnership with DMHAS, which is requiring the use of OKQ in their programs serving women and men in their childbearing years. Trainings for staff at DMHAS funded program were as follows:

- On July 2, July 22, and September 16, 2019 EWCT and DMHAS co-sponsored and the CWC hosted a workshop entitled *Pregnancy Intention Screening, Sexual Health, Optimal Birth Spacing, and Effective Contraceptive Counseling.* This workshop was conducted by Dr. Jordana Frost, Co-Chair of EWCT and Sarah Gannon from Planned Parenthood of Southern New England (PPSNE). This training for implementers of OKQ focused on optimal birth spacing, an overview of different effective birth control methods, and ways in which staff can counsel women and their partners while ensuring a culturally sensitive and trauma-informed approach.

- In addition to the three trainings conducted by Dr. Frost and Sarah Gannon, another workshop, co-sponsored by EWCT and DMHAS and hosted by CWC, was a day-long session held in August 2019 on implicit bias and microaggressions. The trainer was Dr. Lisa Worcester Rozas from the UConn School of Social Work.

- A workshop requested by EWCTLC members on human trafficking originally scheduled for March 2020 was canceled due to COVID. It was held in August 2020.

While these trainings were for DMHAS funded programs others, including Ashley Starr Frechette representing CCADV on the EWCT Advisory Committee, were also able to attend. CCADV is the membership organization of Connecticut's 18 domestic violence service agencies that provide critical support to victims including counseling, support groups, emergency shelter, court advocacy, safety planning, and lethality assessment, among other services. Due to a major internal and external expansion of CCADV services the opportunity to present OKQ to the advocates and direct service staff of CCADV's member agencies has been delayed.

EWCT supports the Department of Public Health's State Health Improvement Plan (SHIP) through the participation of Jordana Frost and Marijane Carey on the SHIP Advisory Council. Jordana Frost is a member of the Advisory Council representing the March of Dimes and Marijane Carey attends and participates in Council meetings as the Co-Lead (along with Dr. Frost) of the Maternal, Infant and Child Action Team. Specific collaborative activities included advocating for Paid Family and Medical Leave (PFML) and supporting Judith Dicine, an attorney in the State's Attorney Office and member of the SHIP's Chronic Disease Action Team, in advocating for a statewide Uniform Property Maintenance Code. Note: After 7 years of educating on and advocating for PFML, PFML legislation was passed during the 2018 legislation and signed into law in June 2019.

Jordana Frost and Marijane Carey, Co-Chairs of Every Woman CT, presented a poster session at the annual AMCHP conference held in March 2019. In April Dr. Frost presented at the CWC-sponsored on Reproductive Health, Birth and Trauma.

Reproductive Health Services

Planned Parenthood of Southern New England provided reproductive healthcare services to 35,151 clients regardless of their ability to pay, of these, 26,997 (77%) were low income; 4,902 (14%) were teens; (8,761 (25%) were 21 or under), and 22,595 (64%) were women of color. The race and ethnicity breakdown of those served is as follows: 36% were white non-Hispanic/Latinx; 28% were Hispanic/Latinx; 27% were Black/African American non-Hispanic/Latinx; 2% were Asian; and 8% were "other" (Native American, mixed race, unknown/declined, etc.), all of whom had incomes at or below 250% of the federal poverty level. The majority of patients (88%) served were females and more than half (55%) were between the ages of 22 and 34. Forty nine percent (49%) of the program participants were covered by Medicaid; 29% were covered by private insurance; and 22% were uninsured and were charged according to PPSNE's income-based sliding fee scale.

The program provided 10,322 pregnancy tests with options for counseling; 771 Herpes tests, 29,424 chlamydia tests, 30,011 gonorrhea tests, 11,898 syphilis tests, and 12,406 HIV tests. These numbers are lower than last year, due to lower patient visit volume during the COVID-19 pandemic and restrictions on health care visits. Seventy four percent of patients ages 15-25 received a screening for chlamydia and gonorrhea in the last year. This is short of our goal of 90%, but still well above national screening rates. Thirty three percent of patients received an HIV test and referral for care as indicated in our goal of 65%. Seventy seven percent (77%) of the family planning clients received reproductive health care services regardless of ability to pay (goal, 60%). Ninety nine percent (99%) of female clients receiving a comprehensive reproductive health exam received a Pap test or were current with their Pap screening schedule. Ninety-eight percent (98%) received a clinical breast exam (goal, 90%); and 99.9% discussed reproductive life plan with clinic staff (Goal, 90%).

PPSNE's education and training department reached 811 teens and young adults, 644 of whom were teens (goal of 1,000) with outreach and education in a variety of settings and venues, including in multi-session workshops to at-risk teens. Utilization of PPSNE Education and Training programs was greatly affected by the COVID-19 social distancing requirements and lack of in-person educational opportunities. The COVID-19 pandemic proved extremely challenging for PPSNE, but throughout the agency remained committed to providing sexual and reproductive health

care and primary care to as many people as possible and as safely as possible. PPSNE continued to provide essential services in person and other services through telehealth, which was quickly implemented at the beginning of the pandemic.

Teen pregnancy and childbearing are at historic lows in CT. The teen birth rate in CT declined 77% between 1991 and 2016 and. Teen birth rates have fallen for all racial and ethnic groups, and in some cases the gap in teen birth rates by race/ethnicity has narrowed, but disparities remain.

Connecticut teen birth rates have been on a continuous decline since 2010. In 2015 the teen birth rate was 10.1 per 1,000 and decreased to 8.9 per 1,000 in 2018 in all race and ethnicities. Although overall teen birth rates have decreased, 2018 births to African American (13.2/1,000) and Hispanic teens (23.8/1,00 exceed the state rate of 8.9 per 1,000 births. The number of abortions among women under 20 has dropped even faster (67%) between 2006 and 2016.

The City of New Britain had the 2nd highest teen birth rate in the state at 33.7 per 1,000 women ages 15-19 in 2011-2015 and the highest repeat teen pregnancy rate in the state. The Family Wellness Healthy Start Program used this data to expand services in New Britain when the grant renewed in 2019.

Breast and Cervical Cancer

During the program period for fiscal year 2021 the Breast and Cervical Cancer Early Detection program enrolled and screened 3818 women while the WISEWOMAN program screened 784 women despite closure and delays due to the COVID-19 Pandemic. This year, the CEDPP added the Colorectal Cancer Screening Program (CRC) to its integrated services. The program continues to provide funding for 12 Community Health Workers (CHW) who navigated women to no-cost screening programs for cancer screening and cardiovascular screening. These CHWs also provide baseline cardiovascular services (blood pressure, blood glucose, cholesterol, height and weight) using a mobile equipment, connected participants with abnormal readings to providers and supported participants to improve their lifestyles to reduce their risk of cancer and heart diseases. An additional 3 CHWs will be added this year to implement the new CRC screening program services.

Genomics

The Genomics Office continued to increase public awareness of the importance of knowing their family health history and sharing this information with their family and healthcare practitioners, promoted the use of Family Health History collection by promoting the US Surgeon General's "My Family Health Portrait" tool; continued partnering with CEDPP and the mandatory collection of patient and family B&C health history, provision of free patient information resources, and encouraging staff healthcare provider genomics education through online training on hereditary cancer syndromes such as Hereditary Breast and Ovarian Cancer (HBOC) and Lynch Syndrome, and the appropriate use of genetic services.

Oral Health

Covid-19 modestly impacted preventative dental services as offices closed statewide temporarily (Spring to late summer 2020) to mitigate spread. Only emergency dental services were provided. Full preventative services resumed in the Fall of 2020. Despite delays by covid-19, the Office of Oral Health (OOH) continued working on the State Oral Health Improvement Plan with community partners through virtual meetings. Covid-19 reinforced the needs for collaboration, support to providers, and general updates to the providers and public.

The OOH serves on the CT Maternal and Child Health Coalition (MCH) and attended quarterly meetings, including an annual (virtual) conference. The OOH remains a member to ensures oral health is represented as a critic function of overall wellness.

The OOH continued efforts on two federal funding opportunities: A Center for Disease Control and Prevention (CDC), and one from the Health Resources and Services Administration (HRSA). Grant efforts and funds including hiring two new DPH OOH staff. The two grants assist CT's efforts to decrease dental caries, reduce oral health disparities, and other chronic diseases co-morbid and conduct ongoing surveillance of oral health. The CDC grant includes two components:

Component One (3 strategies)

1. implement and expand school-based sealant programs,

Two large city school systems (Hartford and New Haven) continued to offered sealant services to students through their school-based health centers (SBHS). Family/student engagement efforts remains consistent by SBHS staff despite COVID-19 and school attendance fluctuation. Ongoing promotion of the value of dental sealants was also promoted via DPH's social media during Child Dental Health Month (February)and on an ongoing basis. A Sealant Advisory met quarterly and is well attended.

2. support and increase access to community water fluoridation,

The OOH along with DPHs Drinking Water Section (DWS) conducted an annual training in December (virtual) to provide CEU to drinking water operators around the state. Presenters included CDC Dept of Oral Health and UConn's school of Dentistry, among other presenters.

3. conduct oral health surveillance.

Planning began for the surveillance project, Every Smile Counts, conducted every 3 years of kindergarten and 3rd grade students across the state. This is conducted in collaboration with our partners at the CT State Depart of Education (CSDE). The survey was postponed a year due to covid-19 but will be implemented in the 2021-2022 school year. An older adult version of the survey is scheduled for early 2022.

Component Two

The OOH implemented a medical-dental integration pilot program (MDIP) at the state's largest federally qualified health center organization, Community Health Center, Inc. (CHC)). Pilot features innovative, systems level changes to improve common risk factors for childhood obesity and dental caries by integrating nutrition screening, counseling, referral, and care coordination in the dental setting. Implemented was conducted in the Spring of 2021 at five of CHC's 32 sites with intent to expand.

Extensive, comprehensive planning was involved: development of a screening toolkit for providers, modifications to the CHC electronic medical records, to flow of referrals internally. A comprehensive 8-hour Motivation Interviewing training was conducted for CHC medical and dental staff in February. Train the Trainor model utilized for long term sustainability. Evaluative tools utilized at all levels of the pilot. An MDIP Advisory was also established and met for the first time in May made up of statewide stakeholders in both medical and dental. Meeting are held quarterly to provide best practices and guidance for sustainability and best practices.

Personal Responsibility Education Program

The Personal Responsibility Education Program (PREP) delivered evidence-based and evidence-informed

prevention programs to high risk youth ages 13 to 25 by trained facilitators in high schools (Waterbury, Bridgeport), middle schools (Bridgeport), alternative high schools Capitol Regional Education Council (CREC), community-based programs, Bridgeport Detention Facility, and in child welfare community and residential programs. The Be Proud! Be Responsible!, Making Proud Choices, and Reducing the Risk programs have been showed through rigorous evaluation to reduce risk-taking behavior, delay sexual activity, increase condom or contraceptive use for those who are sexually active, and reduce unintended pregnancy, and range in length from 6 to 16 hours. Streetwise to Sexwise is a three-hour evidence informed program delivered to youth in the Detention Center. From 2019-2020 the PREP programming was delivered to 682 youth and young adults. The average age of youth was 15.7 years, with a range between 11-25 and about half said English was the only language spoken at home.

Deidentified entry and exit surveys are collected from each participant immediately prior to starting the program and upon completion and are used to measure behavior change. The entry surveys identified that almost half of the youth reported that they were sexually active at one point in their lives, 30% of the sexually active youth reported that they used a condom all of the time with sexual intercourse, only 51% reported that they used a condom at last sex, and 21% used no contraception at all. Following the program, the exit surveys reported that 45% of youth said they were much or somewhat more likely to abstain from sex, 74% said they were much more likely to use a condom, and 66% of the sexually active youth reported that they were much or somewhat more likely to use birth control. The Department provides Facilitator training, the curriculum, educational materials, ongoing technical assistance, and training on trauma, gender and identity, birth control and motivational interviewing. The program sites are monitored for fidelity to assure that all program delivery is trauma informed, medically accurate, inclusive, age appropriate and implemented with fidelity. The program educates youth on adult preparation subjects such as healthy relationships, Adolescent development and healthy life skills, necessary for transition into adulthood.

In May 2020, as a result of COVID and schools doing remote learning, the Department converted all PREP programming to virtual learning and trained the health teachers and other facilitators. Electronic entry and exit surveys were provided to sites to collect participant pre and post data.

Women/Maternal Health - Application Year

Pre/Interconception Health

Every Women Connecticut (EWCT) and the Every Woman Connecticut Learning Collaborative (EWCTLC) will be working toward addressing and increasing awareness around health equity, social drivers of health and social justice. A major vehicle for this work has been the recently established Reproductive Justice Workgroup (RJW), which is a collaborative effort among EWCT, the MCH Coalition, PRAMS, and the March of Dimes. With guidance from Columbia University's Averting Maternal Death and Disability (AMDD) project, The RJW's 2021-22 activities will focus on conducting statewide focus groups with women who have experienced disrespect and abuse during their pregnancy, partners, and doulas, as well as in-depth interviews with staff working in medical settings (e.g., prenatal care sites, hospitals) who have contact with pregnant and postpartum women.

The RJW will explore and expand upon Columbia's central research questions, a) how do women describe their experiences of mistreatment or disrespect during facility-based childbirth, and b) what are the individual, institutional, structural, and policy drivers of the treatment that women experience as disrespectful? Our focus will include prenatal care experiences as well as childbirth and immediate postpartum care. The purpose of replicating these focus groups is to:

- Provide specific documentation and examples for CT, which may or may not vary somewhat by region, health system, provider type, or other factors;
- Provide us with a baseline before/at time work is beginning so we can later evaluate if we've made an impact;
- Identify specific ways in which providers & all other facility staff, administration, health systems, and others can act and be held accountable for improvement; and
- Inform a potential CT PRAMS survey supplement in the future.

The RJW will be working on expanding statewide efforts and developing recommendations and standards for respectful care during pre/interconception time frames as well as prenatally, during childbirth and during the postpartum period. The workgroup will focus on policy, delivery systems, advocacy, training, and public information. Through data collection and Results Based Accountability the Workgroup will report out on the impact of our efforts, which will inform our recommendations.

Internal work within EWCT will focus on updating the OKQ manual to include new data on pre and inter-conception care outcomes in Connecticut as well as exploring opportunities to build out One Key Question to become more inclusive of all persons of childbearing age. EWCT has established relationships with the Director of Real Dads Forever and the Office of Early Childhood. We will be working with them to identify ways to expand OKQ to include men. EWCT will also work with local experts to update OKQ training language and content to better meet the needs of the LGBTQ population served with the goal of becoming all-inclusive regardless of gender, sex, or orientation.

EWCT will also be holding a One key Question training conducted by EWCT Co-Charis and a human sexuality and reproductive health trainings by Planned Parenthood of Southern New England in the second half of 2021. These trainings will be open to the community.
Externally, EWCT is strategically planning to maximize its reach by establishing or continuing relationships with other organizations and entities. The specific groups are:

- The Women's Services Practice Improvement Collaborative (WSPIC)

WSPIC is co-sponsored by the Department of Mental Health and Addiction Services (DMHAS) and the CT Women's Consortium. Collaborative members are the Department's treatment programs for women. WSPIC is a conduit for a rapid response by EWCT to needs identified WSPIC members.

- The Medicaid Strategy Group (MSG)

MSG is a coalition of health advocates working together to improve and protect the quality and reach of HUSKY/Medicaid programs in Connecticut through administrative and legislative advocacy.

- Health Equity Solutions, COVID-19 Outreach and efforts to eliminate racism

This on-going outreach effort is collecting information about the impact on COVID-19 on underserved communities to help center health equity in Connecticut's response and recovery efforts.

Health Equity Solutions was the lead advocate for passage SB1: An Act Equalizing Comprehensive Access to Mental, Behavioral and Physical Health Care in Response to The Pandemic. Sections of this bill: requires hospitals to offer implicit bias training for people who provide direct care during pregnancy and the postpartum period; requires the maternal mortality review committee to annually report to the Public Health Committee with recommendations on eliminating disparities in maternal health; and defines "culturally humility" and requires the Office of Higher Education to evaluate recruitment and retention of people of color in health care programs and make recommendations. EWCT will work with Health Equity Solutions and other partners in doing administrative advocating for the implementation of this legislation in the spirit it is intended.

- CSTAR (formerly known as the ACES Task Force)

This Task Force was convened by the CT Women's Consortium and Bridgeport Prospers, a national STRIVE Initiative, to support efforts to address racism in trauma.
Participation in these groups expands partnership potential as it increases EWCT's platform for addressing pre/interconception health care, health equity and racism from a comprehensive and holistic perspective.
Participation in WSPIC strengthens EWCT relationship with DMHAS, which includes the Department offering, for the past three years, EWCT-sponsored workshops on OKQ/human sexuality/reproductive health and on implicit bias as well as creating an on-line OKQ training module.

- CT Coalition Against Domestic Violence (CCADV)

CCADV has invited EWCT to introduce OKQ at staff meetings of residential staff and child and family advocates. If this introduction of OKQ leads to programs implementing this screening tool, EWCT will offer on-going training and support to support successful implementation. These programs will also be part of the EWCTLC allowing additional support from other OKQ implementers.

- The Mom and Baby Action Network(M-BAN), an initiative of the March of Dimes

EWCT is also partnering on a national level with M-BAN, which is building cross-sector partnerships to address the root causes of inequities in maternal and infant health. This relationship provides access to national leaders in the field and opportunities to participate in the M-BAN workgroups, webinars, conferences, and legislative advocacy on the national level. M-BAN also provides EWCT and other CT efforts national visibility.
EWCT's newly designed user-friendly website will supplement EWCTLC efforts to increase provider expertise and self-efficacy in implementing routine pregnancy intention screening and appropriate care, education, and services to ultimately improve birth spacing, increase pregnancy intentionality, as well as the proportion of Connecticut women who deliver a live birth and report discussing pre-/inter-conception health with a healthcare worker.
In a continued effort to support implementers of OKQ, EWCT will be conducting a survey of the EWCTLC on their current implementation efforts of One Key Question, identifying strengths and areas of need, and potential implementation opportunities moving forward.
Currently there are over 350 EWCTLC members consisting of OKQ implementers and/or those who have attended an EWCT sponsored training. EWCTLC members will receive at least quarterly Notes of Interest via e-mail. Opportunities for local networking and one on one meetings will also be offered virtually until it is safe to resume in person meetings.

Reproductive Health Services

Reproductive health services are funded with State and Title V funds through a five-year contract with Planned Parenthood of Southern New England (PPSNE). The program provides services in those areas of Connecticut with high concentration of low-income women of "reproductive age," and with high rates of teen pregnancy. CT's

Medicaid program offers expanded reproductive health services, which affords presumptive Medicaid eligibility for those uninsured and under 250FPL to receive reproductive health and STD services at no cost. Sliding-fee scale services are also offered and pregnancy testing, counseling visits, referrals for prenatal care, contraceptive service visits, breast and cervical cancer screenings, STD and HIV screenings and counseling, and other medical services visits are also provided as appropriate. The plan for this year is to continue to offer women the Expanded Medicaid Family Planning Limited Benefit and if they qualify, with presumptive eligibility if they are eligible.; Due to the impact of COVID-19 and loss of Title X funding, PPSNE closed two centers in Danielson and Old Saybrook and provided telehealth services. The plan for this year is to continue to provide telehealth services or in-person visits for all clients and refer clients from Old Saybrook and Danielson to nearby centers for in-person care. PPSNE also plans to work closely with Federally Qualified Health Centers (FQHCs) in implementing the Association of State and Territorial Health Officials (ASTHO's) Learning Community goal of Increasing Access to Contraception for Medicaid clients. The reproductive health care services provided by PPSNE are in accordance with nationally recognized standards of care. Chlamydia and gonorrhea testing will be encouraged as a standard procedure for all patients between the ages of 15-25.

Planned Parenthood will continue to assure that all clients who receive a reproductive health exam participate in the development of a Reproductive Life Plan. The discussions are conducted by a licensed healthcare provider and the client. The Program will also seek to decrease the prevalence of unintended pregnancies through health education.

The Personal Responsibility Education Program (PREP), funded by the Administration on Children and Families, Family and Youth Services Bureau, will continue to deliver evidence-based programming to high-risk youth in Bridgeport middle and high schools, East Hartford high schools. CREC alternative high schools, and in community-based and residential programs serving youth with child welfare involvement. The New London school district was recruited during COVID and the program will be delivered this school year by health teachers. The Be Proud! Be Responsible! and Reducing the Risk programs will be delivered to high school youth in the health class, as well as community youth, and Making Proud Choices will be delivered to middle school youth. In the late Spring of 2020, due to COVID-19, the CT PREP program developed virtual programming and trained facilitators in the delivery. This year the plan is to resume in-person education, but COVID data and Governor mandates will determine the need to revert to virtual learning. Entry and exit surveys will be collected from all participants and will be used to evaluate behavior change and reduction in risk-taking behavior.

Pregnancy Risk Assessment and Monitoring System (PRAMS)

PRAMS data is used by DPH and other statewide partners by providing them with data to inform their work in addressing the strategies outlined in this section. PRAMS provides statewide data on a variety of topics that are not available from any other data source, including preconception health and education, pregnancy intention, contraception methods, perinatal depression, oral health, social support, postpartum maternal and infant care, discrimination, and father involvement. Since receiving our first weighted data set in late October 2015, 71 data requests from internal and external partners have been fulfilled; numerous publications and other products have been produced; and PRAMS staff have collaborated on various efforts to address state MCH priorities, as well as statewide plans, needs assessments, and initiatives to reduce low birth weight, infant mortality, and health disparities.

Currently, eight years of data (2013-2020) are available for analysis, including data from the 2019 opioid supplement. Data collection for the 2020 surveillance year ended in June 2021 and we received our weighted data by mid-July since we were the first state weighted this year. We not only achieved our highest weighted response rate ever (63.2%), but response rates among all strata (including lower responding groups) also increased. The 2020 data includes COVID-19 supplement data that we will analyze and disseminate to our statewide partners.

These supplemental questions were an effort to begin collecting population-based data on how the lives of mothers were being impacted by COVID-19 infection and the COVID-19 pandemic. PRAMS data will complement other CDC COVID-19 surveillance efforts by filling gaps in data, including measuring the proportion of women and/or someone in their household infected with COVID-19 during their pregnancy, and also examining interactions with health care providers in person and by telemedicine, barriers to seeking or getting care (prenatal, postpartum and well-baby visits), precautions taken and other experiences related to COVID-19 exposure/infection, hospital experiences during labor and delivery and postpartum, and economic/emotional hardship. We will also be able to divide women into groups that were not at all affected, somewhat affected, or greatly affected by the societal effects of the pandemic. Taken in conjunction with the rich information that PRAMS already gathers on the lives of women around pregnancy, we may be able to quantify the degree of disruption across many different life domains. For example, are planning on looking at outcomes and health care usage in 2019 vs. 2020. We anticipate potentially seeing an increase in the frequency of maternal anxiety and depression as well as interpersonal violence based on anecdotal reports from our statewide partners who serve pregnant and postpartum women. We'll also examine if there are changes in usage and timing of prenatal care, dental care (which is already a challenge to get people to go because of the misconception it is not safe during pregnancy), postpartum visits, postpartum contraceptive use, and more.

As evidenced above, PRAMS is uniquely positioned to provide population-based data on maternal behaviors and experiences among recent postpartum women, including emerging areas of concern. In addition to core operations, PRAMS periodically implements survey supplements to collect data to address emerging needs. In June 2021, State legislation was passed legalizing adult use of cannabis products. The legislation includes the DPH's role in surveillance. Internal partners from the Tobacco Control Program and Office of Injury Prevention had had a conference call in May 2021 with a national consultant hired to assist the Governor's Office with the legalization process in CT. PRAMS was one of three key data sources identified by the contractor for cannabis surveillance. Subsequently, internal partners convened a meeting to discuss existing data (if available) and how data can be collected moving forward. PRAMS staff have been in discussions with their CDC PRAMS Project Manager and other PRAMS states who are collecting or have collected data on perinatal marijuana use to help identify the best approach for moving forward. Data collected as part of opioid survey supplement in 2019 can provide an initial baseline estimate for marijuana use during pregnancy as there was one question asking about a variety of substances used during pregnancy. CT PRAMS is in the process of finalizing questions for a survey supplement around marijuana use and the use of Cannabidiol (CBD) products before, during, and after pregnancy; how (e.g., smoked, dabbed, vaped, etc) and why (e.g., relieve nausea, relieve stress or anxiety, etc) women used marijuana products during pregnancy; conversations around marijuana use or recommendations during prenatal care; perceptions of how long someone should wait after using marijuana before breastfeeding or pumping milk for their baby; and if they think the use of marijuana products during pregnancy could be harmful to a baby's health. This supplement will be implemented beginning in Fall 2021 and will continue through the end of the 2022 surveillance year. In 2023, the new PRAMS Phase 9 survey will be implemented and we plan to retain 1-2 questions on the survey for long-term surveillance.

In the upcoming year, we also anticipate adding a social determinants of health (SDOH) survey supplement. Currently, it's estimated that this questionnaire will be available from CDC and ready for implementation in October 2021. We plan on implementing both the marijuana and SDOH supplements at the same time to minimize disruptions to operations and maximize efficiency as new survey booklets will need to be printed.

Work on the Phase 9 survey has begun at CDC and CT PRAMS staff have already contributed input, including convening an ad hoc New England PRAMS meeting to discuss what we may want to recommend for changes, as well as the possibility of including one or more questions as a region to look at common areas of interest. The group

expressed interest in continuing to meet and the CT PRAMS Director/SSDI Coordinator will serve as the informal convener of the group. As decisions about the Phase 9 Core survey continue at the federal level, CT PRAMS has already begun looking at what changes it might want to make for the other portions of the survey (Standard and state-developed questions). Work on survey content with internal and external partners to ensure Title V MCH data needs are met to the best of our ability will continue into the upcoming year. The Phase 9 survey is currently slated for deployment with the 2023 surveillance year.

In 2021, the CT PRAMS Director along with key partners at Carey Consulting and the March of Dimes Connecticut Chapter formed a new Reproductive Justice Workgroup that had evolved out of a 2020 PRAMS Data to Action project around discrimination before and during pregnancy. The workgroup currently consists of 24 members including persons with lived experiences, local and State government agencies, and community organizations. In the upcoming year, activities will include conducting qualitative research in the form of community focus groups with women, partners and doulas, as well as in-depth interviews with staff working in medical settings (e.g., prenatal care sites, hospitals) who have contact with pregnant and postpartum women to measure experiences of disrespect and mistreatment while receiving these services. We are seeking to replicate this exploratory and formative research that was performed by Columbia University's Averting Maternal Death and Disability (AMDD) project which supported birth justice efforts in NYC. We will explore and expand upon their central research questions, a) how do women describe their experiences of mistreatment or disrespect during facility-based childbirth, and b) what are the individual, institutional, structural, and policy drivers of the treatment that women experience as disrespectful? Our focus will include prenatal care experiences as well as childbirth and immediate postpartum care; in the future, we would like to expand our qualitative research into preconception and interconception care. The purpose of replicating this research is to:

1) Provide specific documentation and examples for CT, which may or may not vary somewhat by region, health system, provider type, or other factors;
2) Provide us with a baseline before/at time work is beginning so we can later evaluate if we've made an impact;
3) Identify specific ways in which providers and all other facility staff, administration, health systems, and others can act and be held accountable for improvement; and
4) Inform a CT PRAMS survey supplement in the future.

NYC PRAMS had also developed and implemented a birth justice survey supplement and they presented the results alongside Columbia's research at a CDC PRAMS webinar in August 2020. Their supplement had explored a) how common is it for women to experience mistreatment or disrespect during childbirth, and b) if it is more common among some communities or some social/ethnic/racial groups than others. Because NYC PRAMS is in the process of refining their tool, we will connect with them in the future about the possibility of using their supplement in CT to further expand our data capacity around this critical area.

In addition to the qualitative research, the Reproductive Justice Workgroup will be working on expanding and unifying statewide efforts and developing recommendations and standards for respectful care with the intent to reduce maternal morbidity and mortality. The workgroup will focus on policy, delivery systems, advocacy, training, and public information. Our partner at the March of Dimes also will be leading the group through data collection, monitoring and reporting on the impact of our efforts along the lines of RBA.

Breast and Cervical Cancer

The CT Breast and Cervical Cancer Early Detection Program (CBCCEDP) is funded through the Centers for Disease Control & Prevention (CDC) and state of CT funds. The program provides comprehensive screening to Connecticut women ages 21 to 64 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 screened for breast and cervical cancer and referred for diagnostic testing and treatment. For the program year of 2020-2021, the WISEWOMAN Program (WWP) received CDC funding to provide cardiovascular screening services to women receiving breast and cervical cancer services. The WWP serves the same target population as CBCCEDP, specifically women between the ages of 40-64; Wellness checks are provided in the form of Body Mass Index (BMI), waist circumference, blood pressure monitoring, along with Cholesterol and Blood glucose monitoring for participants. Those found with at risk values in need of improvement can be supported by Health Coaching and specific Lifestyle Programs to better assist the participant in reaching their health and wellness goals. The Colorectal Cancer Program (CRC) received CDC funding to provide colorectal cancer screening, diagnostic, and treatment referral services for persons who qualify over the age of 45. Together the CBCCEDP, WWP, and CRC programs create the Connecticut Early Detection & Prevention Program (CEDPP), providing a whole-body approach to improving the health of CT Women. During this program period, CEDPP continued to provide services at 6 health care systems, consisting of 21 hospitals to reach more CT women. These hospitals sub-contracted with 14 FQHCs, 14 clinics and 15 Planned Parenthood clinics. CEDPP contracted health systems partnered with several organizations to provide Community Wellness Day events for women and families where services were provided where they live and work and appointments were given for further follow-up visits. CEDPP collaborated with area CT Walmart Stores, CT Cosmetologists Association, and CT Physicians for Women to conduct outreach and 17 wellness days across the state, reaching over 316 women. CEDPP Wellness days provides, at a minimum, patient education, health assessment, clinical screening and clinical referral. CEDPP continued to collaborate with Knox Garden, Snap-Ed program, Sardili's Produce, Joan Dauber Food Bank, and Women's Empowerment Center to provide community garden opportunities to program participants and improve food security, healthy nutrition, and physical activities to reduce the risk of cancer and heart diseases to participants in the Hartford Community.

Oral Health

The Office of Oral Health (OOH) and its partners will continue to implement the State Oral Health Improvement Plan 2019 - 2024 (SOHIP). Focusing on prevention, access/utilization, medical and dental integration, and data collection and analyses. The OOH is dedicated to ensuring access to oral health services for all residents regardless of race ethnicity, education, or class background. The SOHIP aims to decrease oral health disparities; promote a culturally competent oral health workforce, continue and increase community engagement of partners to establish practices; and improve the oral health literacy of CT residents.

The OOH program activities will continue to initiate addressing oral health workforce gaps in dental health professional shortage areas (DHPSAs) and other underserved areas in Connecticut and coordinating a continuum of oral health education services for CT residents, with an emphasis on underserved populations. Community based prevention efforts continues with the community water fluoridation and dental sealant programs. Action steps over the next year will include activities around increasing inter-professional collaboration across disciplines, including dental and primary medical care to develop best practices to improve service coordination and delivery.

The OOH and CT DPH Drinking Water Section (DWS) will continue to support CT water operators and local health departments to comply with the current CT state water fluoridation statute. Activities will include a water fluoridation principles and practice training, maintaining optimally fluoridated water levels in public water systems, conducting a community water fluoridation aging equipment survey, and continuing to provide data to CDC.

The CT Dental Health Partners (CTDHP), the state's Medicaid/CHIP dental Administrative Service Organization (ASO), will continue to focus on intensive outreach to underserved residents with efforts to secure a dental home. Outreach efforts will continue to pregnancy and post pregnancy. In 2020 the CTDHP established an evaluation

workgroup (The Affinity Group) which seeks to explore the potential for an initiative allowing the application of dental sealants in pediatric settings by a crossed trained medical-oral health staff. This is to encourage early child oral health screening, improve partnership between medical and dental providers, and establish early dental homes. The OOH is a member of this working group and efforts are ongoing.

The OOH will conduct the Every Smiles Counts (ESC) oral health surveillance survey for kindergarten and third graders students across the CT in the 2021-2022 academic year. Schools are selected randomly to capture a cross section of state demographics. In-person screening will be conducted with a goal to screen 8,000 students.

The OOH will continue to implement the Medical-Dental Integration Pilot (MDIP) at five of the Community Health Center, Inc, federally qualified health centers.

Pilot efforts to screen for risk factors for childhood obesity and dental caries through nutritional screening, counseling, referral, and care coordination will continue between medical and dental staff. Evaluative tools continue to be utilized at all levels of the pilot. The MDIP Advisory, established in 2021 will meet quarterly to provide guidance and establish best practices. Train the trainer model will continue to be applied for increased sustainability.

The OOH continues to promote and share bi-lingual oral health educational information, resources, public services announcement (PSA)s for the general public and MCH population. This is conducted via DPH’s social media, the OOH webpages, and through community partners.

Perinatal/Infant Health

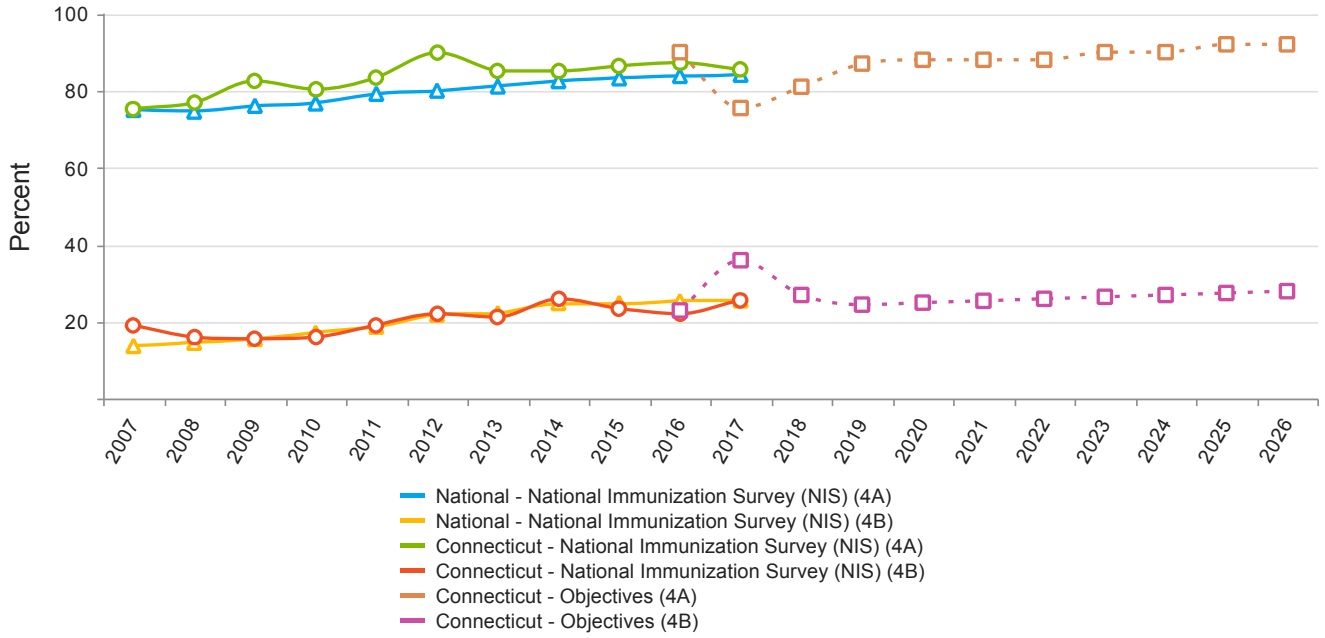
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2018	5.2	NPM 3
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	4.2	NPM 3 NPM 4
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2018	3.1	NPM 3
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	1.2	NPM 4
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2018	161.3	NPM 3
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	63.4	NPM 4

National Performance Measures

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Indicators and Annual Objectives



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	90	75.5	81	87	88
Annual Indicator	85.2	84.9	86.3	87.1	85.4
Numerator	28,285	29,601	29,023	30,307	24,877
Denominator	33,201	34,879	33,627	34,787	29,144
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	88.0	88.0	90.0	90.0	92.0	92.0

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

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	23	36	27	24.5	25
Annual Indicator	21.4	26.1	23.6	22.3	25.7
Numerator	6,776	8,941	7,650	7,555	7,393
Denominator	31,727	34,213	32,386	33,879	28,711
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	25.5	26.0	26.5	27.0	27.5	28.0

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Number of pregnant and postpartum WIC clients served by breastfeeding peer counselors

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	1,423	1,318
Numerator		
Denominator		
Data Source	Connecticut WIC Program	Connecticut WIC Program
Data Source Year	2018	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	1,500.0	1,550.0	1,600.0	1,650.0	1,700.0	1,750.0

State Performance Measures

SPM 2 - The prevalence of unintended pregnancies among women delivering a live-born infant.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	20.6	21
Numerator	6,707	6,801
Denominator	32,572	32,352
Data Source	CT Pregnancy Risk Assessment Monitoring System	CT Pregnancy Risk Assessment Monitoring System
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	20.6	20.4	20.2	20.0	19.8	19.6

State Action Plan Table

State Action Plan Table (Connecticut) - Perinatal/Infant Health - Entry 1	
Priority Need	
Breastfeeding Initiation and Duration	
NPM	
NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	
Objectives	
4.1: By 2025, increase the percent of infants who are breastfed or receive breast milk at 6 months to 3% (Data source: CDC National Immunization Survey).	
4.2: By 2025, increase by 5% the proportion of Hispanic women and non-Hispanic Black women breastfeeding at 8 weeks (Data source: PRAMS).	
Strategies	
4.1.1: Support work environments to accommodate breastfeeding mothers through lactation rooms, etc.	
4.1.2: Support policies on breastfeeding in the workplace (e.g., establishing minimum criteria for lactation rooms and how to have discussions with supervisors/managers).	
4.1.3: Engage WIC peer counselors for pregnant and postpartum women.	
4.1.4: Promote Ready. Set. Baby. (RSB) online module to increase prenatal education on breastfeeding that is consistent in the state.	
4.1.5: Continue to provide Secrets of Baby Behavior (SBB) training to ensure parental competence around cues, crying and sleep.	
4.2.1: Support work environments to accommodate breastfeeding mothers through lactation rooms, etc.	
4.2.2: Support policies on breastfeeding in the workplace (e.g., establishing minimum criteria for lactation rooms and how to have discussions with supervisors/ managers).	
4.2.3: Train women in the community as lactation peer support counselor.	
4.2.4: Engage WIC peer counselors for pregnant and postpartum women.	
ESMs	Status
ESM 4.1 - Number of pregnant and postpartum WIC clients served by breastfeeding peer counselors	Active

NOMs

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

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

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

State Action Plan Table (Connecticut) - Perinatal/Infant Health - Entry 2

Priority Need

Infant Morbidity and Mortality

SPM

SPM 2 - The prevalence of unintended pregnancies among women delivering a live-born infant.

Objectives

3.1: By 2025, decrease the percent of unintended pregnancy for women who have delivered live births by 3%.

3.2: By 2025, increase the percent of mothers who report practicing safe sleep habits for their infants by 3%.

3.3: By 2025, decrease the disparity ratio between singleton preterm births among non-Hispanic Black- and non-Hispanic White women by 3%.

Strategies

3.1.1: Sustain and expand the use of the One Key Question (OKQ) screening tool by establishing formal relationships between EWCT and state agencies (DPH, DMHAS, OEC, etc.) that use OKQ in their programs as well as with regional entities that can serve as a hub for supporting the use of OKQ (such as Bridgeport Prospers and New Haven Healthy Start).

3.1.2: Provide evidence-based teen pregnancy prevention education to youth through collaborations with the PREP grant.

3.1.3: Increase the availability and use of Long Acting Reversible Contraception (LARC) in women of childbearing age who would like to postpone pregnancy.

3.1.4: Promote provider education focused on patient centered birth control including patient education on LARCs.

3.1.5: Expand Every Woman CT programming to include WIC staff throughout the state.

3.2.1: Partner with the Child Fatality Review Committee, MCH Coalition, and other statewide partners to expand safe sleep education and messaging.

3.2.2: Increase social supports and education for mothers on safe sleep practices.

3.2.3: Support fatherhood initiatives to increase social support within the family and home environment.

3.3.1: Explore innovative models of care that support health and wellbeing across the life cycle and foster healthy communities.

3.3.2: Address the Social Determinants of Health and racial and ethnic biases that impact Women of Color.

3.3.3: Address implicit bias in healthcare that would likely improve patient-provider interactions, health communication, and health outcomes.

3.3.4: Improve access to healthcare for women before, during and after pregnancy.

3.3.5: Support fatherhood initiatives to increase social support within the family and home environment.

3.3.6: Integrate into provider training mental health, social stressors, and trauma education relevant to infants and families.

2016-2020: National Performance Measures

2016-2020: NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
Indicators and Annual Objectives

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	84.7	87	87	89	89
Annual Indicator	86.9	83.6	88.2	83.3	88.7
Numerator	464	428	404	384	384
Denominator	534	512	458	461	433
Data Source	Health Statistics and Surveillance	Health Statistics and Surveillance	Health Statistics and Surveillance	Health Statistics and Surveillance	Health Statistics and Surveillance
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Provisional

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 3.1 - Number of communities participating in Every Woman Connecticut

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		8	8	9	9
Annual Indicator	8	8	8	8	9
Numerator					
Denominator					
Data Source	Every Woman Connecticut Initiative	Every Woman Connecticut Initiative	Every Woman Connecticut Initiative	Every Woman Connecticut Initiative	Every Woman Connecticut Initiative
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Every Woman Connecticut

Preconception health counseling has been identified and endorsed by the Centers for Disease Control and Prevention as a strategy to improve maternal health and birth outcomes, as well as to reduce unplanned pregnancies. Starting in May 2016 under the auspices of the MCH Coalition and the March of Dimes, who provided the financial support, Every Women Connecticut (EWCT) and the Every Women Connecticut Learning Collaborative (EWCTLC) were established. The main goal of this initiative is to increase provider expertise and self-efficacy in implementing routine pregnancy intention screening and appropriate care, education, and services to ultimately improve birth spacing, increase pregnancy intentionality, as well as the proportion of Connecticut women who deliver a live birth and report discussing pre-/interconception health with a healthcare worker.

EWCT, which established and manages the EWCTLC, now operates under the auspices and support of the Connecticut Women's Consortium (CWC), which is a statewide policy, training, and advocacy organization specializing in women's behavioral health. This, combined with the guidance of the EWCT Advisory Committee, has helped to stabilize the work of EWCT.

In order to strengthen relationships with new partners, representatives from the State Department of Mental Health and Addictions Services (DMHAS) and the Connecticut Coalition Against Domestic Violence (CCADV) have joined the EWCT Advisory Committee. This group of well-known and respected individuals representing partner organizations, including state agencies; the state's Medicaid ASO; the state's Medicaid dental and behavioral health carve-outs; state-level private non-profits; and direct service providers, continue to guide EWCT's efforts in increasing a general awareness around pre/interconception care and specifically around the One Key Question (OKQ) screening tool and in addressing social determinants of health and health equity.

The EWCTLC has representatives from clinical and community-based providers in communities throughout the state and has expanded to include a cohort of the Department of Mental Health Addictions Services (DMHAS) providers.

The trainings done during this time frame continued the partnership with DMHAS, which is requiring the use of OKQ in their programs serving women and men in their childbearing years. Trainings for staff at DMHAS funded program were as follows:

- On July 2, July 22, and September 16, 2019 EWCT and DMHAS co-sponsored and the CWC hosted a workshop entitled *Pregnancy Intention Screening, Sexual Health, Optimal Birth Spacing, and Effective Contraceptive Counseling.* This workshop was conducted by Dr. Jordana Frost, Co-Chair of EWCT and Sarah Gannon from Planned Parenthood of Southern New England (PPSNE). This training for implementers of OKQ focused on optimal birth spacing, an overview of different effective birth control methods, and ways in which staff can counsel women and their partners while ensuring a culturally sensitive and trauma-informed approach.

- In addition to the three trainings conducted by Dr. Frost and Sarah Gannon, another workshop, co-sponsored by EWCT and DMHAS and hosted by CWC, was a day-long session held in August 2019 on implicit bias and microaggressions. The trainer was Dr. Lisa Werkmeister Rozas from the UConn School of Social Work.

While these trainings were for DMHAS funded programs others, including Ashley Starr Frechette representing CCADV on the EWCT Advisory Committee, were also able to attend. CCADV is the membership organization of Connecticut's 18 domestic violence service agencies that provide critical support to victims including counseling,

support groups, emergency shelter, court advocacy, safety planning, and lethality assessment, among other services. Due to a major internal and external expansion of CCADV services the opportunity to present OKQ to the advocates and direct service staff of CCADV's member agencies has been delayed.

EWCT supports the Department of Public Health's State Health Improvement Plan (SHIP) through the participation of Jordana Frost and Marijane Carey on the SHIP Advisory Council. Jordana Frost is a member of the Advisory Council representing the March of Dimes and Marijane Carey attends and participates in Council meetings as the Co-Lead (along with Dr. Frost) of the Maternal, Infant and Child Action Team. Specific collaborative activities included advocating for Paid Family and Medical Leave (PFML) and supporting Judith Dicine, an attorney in the State's Attorney Office and member of the SHIP's Chronic Disease Action Team, in advocating for a statewide Uniform Property Maintenance Code. Note: After 7 years of educating on and advocating for PFML, PFML legislation was passed during the 2018 legislation and signed into law in June 2019.

Jordana Frost and Marijane Carey, Co-Chairs of Every Woman CT, presented a poster session at the annual AMCHP conference held in March 2019.

In April Dr. Frost presented at the CWC-sponsored on Reproductive Health, Birth and Trauma.

Family Wellness Healthy Start Program

The Family Wellness Healthy Start Program (FWHS) provided services to 227 pregnant women, 226 infants and children up to age 18 months during the period 7/1/19 to 6/30/20. There was a total of 226 live births to enrolled women, and 30 infants were low birth weight. There were 141 women who identified as Hispanic and 96 who identified as African American. The percentage of pregnant participants who received prenatal care beginning in the first trimester was 70%. The percentage of women who had an ongoing source of primary and preventive care was 78%. The percentage of infant and child participants who received coordinated, ongoing, comprehensive care within a medical home was 91%. There were 198 pregnant and 76 inter-conception women screened for risk factors and the most frequent risk factors were high stress, low social support, and mental health risk.

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and 1807 cooperative agreement (SPAN) Initiatives

DPH continued to partner with the CT Breastfeeding Coalition's (CBC) Ten Step Collaborative to encourage implementation of evidenced-based maternity care and the 10 Steps for Successful Breastfeeding in CT hospitals. Developed a media campaign, building on the It's Worth It messages, to be released during August 2019 that featured diverse families in targeted areas. Mall ads, targeted billboards, radio buys, tabling at community events and outreach to providers were included. Developed a new moms' postcard to provide information to expectant parents on the Breastfeeding: It's Worth It (IWI) messages. Media campaign release was delayed due to internal department approvals. Campaign was delayed until October 2019. Ran in same media markets with compressed timeline. Will consider a limited run in 2020. Post campaign received and filled orders from medical offices and hospitals requesting IWI resources.

COVID-19 impacted CT-WIC's sponsorship of local agency staff at CT La Leche League Conference which was cancelled.

Sponsored 50 diverse individuals for the Healthy Children Certified Lactation Counselor (CLC) training week of June 24-28, 2019 in New Haven. Half of the attendees passed the exam, the remaining attendees, were provided opportunities to retake the exam and/or retake the course during 2019 and 2020. An in-person retake was held in

November 2019, two more passed. Then, 14 more people decided to retake in March 2020, but then COVID happened. These individuals were able to get online access to retake the exam during the reporting period, but results were not yet available by June 2020. In addition, 4 individuals were enrolled to attend the in person CLC training in March 2020 as new participants, but again COVID happened. CT WIC and SPAN Breastfeeding staff developed a "Kick-Off" training to Fall 2019/Spring 2020 CLC online training cohort to assist with course and exam success. DPH planned and a technical assistance webinar to June 2019 cohort on CLC scope and opportunities and IBCLC pathways.

DPH focused on improving access to culturally competent community lactation support through partnership with the CT Breastfeeding Coalition (CBC) to draft scholarship process and application to support diverse candidates to attend the Certified Lactation Counselor (CLC) training and/or pursue the International Board Certified Lactation Consultant (IBCLC) certification and exam. Planned to launch scholarship opportunity in August 2020. Developed a breastfeeding module with the Child Health Development Institute (CHDI) that was added to their existing Educating Practices program. Module implemented in two pilot sites (one FQHC and a one private practice). Pilot sites received IWI materials and will be offered SBB training. Feedback from the pilot helped inform project improvements before statewide implementation occurs in October 2020.

DPH partnered with the UConn Health Center for Public Health and Health Policy training consultant to provide Secrets of Baby Behavior (SBB) trainings to a variety of community partners including the Department of Mental Health and Addiction Services-Women's Programming.

DPH continued to support worksites voluntary application to the CBC's Breastfeeding Friendly Worksite Program. Due to COVID-19 unable to complete tabling at various events La Leche League and Connecticut Business and Industry Association (CBIA) in 2020.

Disseminated COVID-19 and Breastfeeding education opportunities via IWI listserv, CBC Facebook page, WIC distribution list, CPQC listserv and Ten Step Collaborative. Informally surveyed hospital lactation programs about COVID practices in order to inform families re: expectation and plans for breastfeeding.

WIC staff participated in CT-ESF workgroup to offer information and breastfeeding resources in midst of COVID pandemic. Assisted staff of Office of Early Childhood (OEC) in their plan to distribute formula to families via home visitors. Reviewed and provided feedback on staff training materials, assessment and formula safety recommendations.

Worked with CT PRAMs Team to develop presentation on results from PRAMS data on maternity care practices and breastfeeding duration for WIC staff and Ten Step Collaborative (hospitals).

Pregnancy Risk Assessment and Monitoring System (PRAMS)

PRAMS has significantly increased perinatal data capacity in CT, providing ongoing statewide data on a variety of topics that are not available from any other statewide data source, including preconception health and education, pregnancy intention, perinatal anxiety and depression, oral health, social support, postpartum maternal and infant care, safe sleep, discrimination, and father involvement. During this reporting period, six years of data (2013-2018) were available for analysis. PRAMS staff completed and disseminated several publications, including fact sheets and data reports. CT PRAMS supported DPH and other statewide programs by providing them with data to inform their work addressing the strategies outlined in this section. Staff fulfilled 17 data requests from internal and external partners throughout the course of the year, including presenting data at external meetings, including the DPH-

sponsored *Connecticut 2020 Summit: Disparities in Maternal Child Health* where Vice-Admiral Surgeon General Jerome Adams, MD was the keynote speaker. PRAMS also supplied data for nearly 100 indicators to the Title V program for the MCHBG 5-year Needs Assessment process. PRAMS is also used to report on numerous state and national measures annually, including providing FAD on 6 NPM/NOMs.

PRAMS data have been integrated into efforts to address state MCH priorities, as well as statewide plans and initiatives to reduce low birth weight, infant mortality, and health disparities. Some recent examples of how PRAMS data has been translated into public health policy or practice include:

- Collaborating with statewide partners to form a new Reproductive Justice Workgroup that had evolved out of a 2020 PRAMS Data to Action project around discrimination before and during pregnancy. This workgroup will be focusing on expanding and unifying statewide efforts and developing recommendations and standards for respectful care with the intent to reduce maternal morbidity and mortality. The workgroup will focus on policy, delivery systems, advocacy, training, and public information.
- Supporting DPH's State Health Assessment (SHA) which establishes the health status of the state and will inform the prioritization and development of the next Healthy Connecticut 2025 State Health Improvement Plan (SHIP). This plan will serve as a 5-year roadmap for promoting and advancing population health in CT and provides a framework for health promotion and disease prevention in the current decade, with overarching themes of health equity and social determinants of health. Maternal, Infant and Child Health was one of several domains addressed by the SHA and the SHIP. Data from CT PRAMS was provided to support the development of the SHA and will be used for the upcoming SHIP. Moving forward, CT PRAMS will be a data source for several SHA and SHIP measures.
- Supporting statewide efforts to enhance and expand the adoption of the Ten Steps to Successful Breastfeeding. Data demonstrated the impact of these practices on breastfeeding duration, clearly illustrating the 10 steps' value in supporting breastfeeding at 4 and 8 weeks. These data have and will continue to be used by the Connecticut Breastfeeding Program to help direct and prioritize activities around hospital breastfeeding support, including incorporating CT PRAMS data in discussions with local agencies about hospital practices.
- Collaborating with local and statewide fatherhood efforts to support their initiatives and to increase public awareness around the importance of fathers in improving perinatal outcomes for mothers and infants. In the future, we are interested in expanding the knowledge base through a full fatherhood supplement to the PRAMS survey.
- Supporting Every Woman Connecticut (EWCT), a statewide initiative that addresses preconception health by working with many different types of providers who serve women of childbearing age. This is intended to make sure a woman is healthy before becoming pregnant, which will improve birth outcomes. Data on unplanned pregnancy, contraceptive use, and misconceptions around fertility were recently presented to the EWCT Advisory Committee and the EWCT Learning Collaborative. At the request of project implementers, the insights gained by the addition of qualitative data around misconceptions around fertility are going to be integrated into staff trainings. These and other MCH indicators continue to be shared with EWCT as new data become available to inform their work.

Nationally, CDC PRAMS provided data to HRSA MCHB on safe sleep, fetal alcohol exposure during pregnancy, postpartum depressive symptoms, and teeth cleaning during pregnancy to support the federally available data (FAD) for the MCHBG. Numerous requests for the PRAMS Analytic Research File are made from researchers annually, allowing them to analyze data from multiple states or nationwide, thus contributing to the overall MCH knowledge

base. This file is maintained and disseminated by CDC staff.

In addition to core operations, PRAMS implemented CDC's opioid survey supplement. Supplements to the PRAMS survey allow the CDC, state health departments, and others to respond to emerging issues that arise during the data collection cycle, including responses to emergency surveillance needs. The purpose of this supplement was to use the existing PRAMS infrastructure to measure maternal behaviors and experiences related to the use of prescription pain relievers and other opioids among recent postpartum women in the US. PRAMS data complemented other CDC opioid surveillance efforts by filling gaps in data, including information about opioid and other substance use by the mother, reason for use (including assessment of prescription pain reliever misuse), interactions with health care providers related to prescribing and counseling, and need for and access to treatment services. Data from this effort will inform state health departments, clinical providers, CDC, and other federal agencies on programs and policies to mitigate the risk of opioid exposure during pregnancy and to ensure access to recommended clinical care. Data collection began in April 2019 and was funded for 6 batches of data collection, but CT PRAMS committed to completing 12 batches in order to provide more robust data. Data collection was completed in June 2020 when data collection for the 2019 surveillance year ended. CDC was able to extract mini datasets to publish initial data and later analyze the complete surveillance period and publish findings, contributing to the national knowledge base. When CT PRAMS received its 2019 weighted data, data were analyzed and results from the supplement were disseminated to our internal and external partners who we have been working with on opioid-related issues in the MCH population.

Early Hearing Detection & Intervention Program

Effective January 1, 2016, Connecticut state law requires hospitals to test all newborns, who fail their newborn hearing screening, for congenital Cytomegalovirus (cCMV) and report the results to the CT DPH. Congenital CMV is considered the leading cause of nonhereditary sensorineural hearing loss in children. Starting in July 2015, Connecticut began a cCMV initiative which included birth facility education and technical assistance, resource development (including a re-designed brochure for parents of infants who do not pass newborn hearing screening, and fact sheets for pediatric healthcare and obstetric providers), database enhancements, and, as needed, collaboration with infectious diseases physicians and the Connecticut chapter of the American Academy of Pediatrics (AAP). To date, most of these activities are maintained as needed, but have largely been replaced by vigorous tracking and surveillance activities. In CY2019, 93.1% (461) of Connecticut-born infants in need of a testing received it, an increase of .50 percent over CY 2018. Of the 461 infants, there were 4 newborns diagnosed with congenital CMV in CY2019. CT DPH EHDI will continue to aggressively track cases, conduct birth facility outreach, and work with the Connecticut AAP chapter champion.

Connecticut Newborn Screening Program (CT NBS)

The Connecticut Newborn Screening Program (CT NBS) added a follow-up module in Maven for the collection of short-term follow-up data on infants with results that were reported to CT Newborn Diagnosis and Treatment Network (CNDTN) following a presumptive positive newborn bloodspot screen. These modules allow for the future expansion to collect long-term follow-up data on infants who confirm positive for a disorder identified through NBS through the age of 21. Other modules were implemented that simplify the tracking of outstanding specimens, and results of repeat specimens. CT NBS has also enhanced existing modules in Maven and has developed multiple reports to simplify the extraction of data from Maven for program use, NewSTEPs reporting and MCHBG grant reporting.

CT NBS Program contracts with Connecticut Children's Medical Center (CCMC) to oversee the CT Newborn Diagnosis and Treatment Network (CNDTN) which responds to presumptive positive newborn screening results reported by the state laboratory and begins diagnostic work-up and treatment as necessary in conjunction with Yale

New Haven Hospital and School of Medicine. CNDTN established a registry for measuring, tracking, and reporting of disorder specific outcomes from birth to age 21. In early 2019, CT NBS began electronic reporting of results and demographic information to the CNDTN through a newly developed interface between Maven and CCMC's electronic medical record, Epic. In early 2020 CT NBS Program began receiving data through this interface into the newly developed follow-up module as described above.

CT NBS worked with CNDTN to refine information exchanged via the interface for disorders added to the CT NBS panel in 2020 and early 2021 including Adenosine Deaminase Deficiency Severe Combined Immunodeficiency (ADA SCID) and Spinal Muscular Atrophy (SMA), Glutaric Acidemia Type I (GA I) and Pompe disease.

All of these efforts help to ensure that CT infants with presumptive positive screens receive appropriate, timely work-up, to increase the percentage of diagnosis-confirmed infants whose care adheres to best-practice treatment, to reduce rates of morbidity and premature mortality for affected infants and enhance provision of cost-effective, reliable newborn testing and management.

Perinatal/Infant Health - Application Year

Every Woman Connecticut

Every Women Connecticut (EWCT) and the Every Woman Connecticut Learning Collaborative (EWCTLC) will be addressing and responding to the impact of COVID-19 and the increased awareness around health equity, social justice, and social determinants of health. With guidance from EWCT Advisory Committee members and implementers of OKQ, lessons learned from providing clinical and non-clinical services during the perinatal period in a pandemic will be shared with EWCTLC, the MCH Coalition and the SHIP Advisory Council.

This work will be done under the auspices of the CT Women's Consortium.
Consulting services will continue to be provided by Marijane Carey of Carey Consulting. Carey Consulting will be charged with managing the Advisory Committee, expanding partnerships, responding to the evaluation recommendations and engaging members of EWCTLC to increase provider knowledge and self-efficacy in delivering , promising and evidence-based education, care, and services related to pregnancy intentionality, optimal birth spacing, and pre-/interconception health. Dr. Jordana Frost, the Co-Chair of EWCT since the inception of this initiative, has moved into a national position at the March of Dimes. Once her CT position is filled, the March of Dimes' essential contribution to the work of EWCT will continue.

Based on the evaluation report prepared for the Advisory Committee by Dr. Megan Smith through Elevate, a policy lab at Yale School of Medicine, beginning this year evaluation recommendations will be addressed. The recommendations are: 1) clarifying EWCT's mission and objectives; 2) clarifying the role of Advisory Committee members and other involved in EWCT's work; 3) sustainability planning; and 4) measuring impact.

Internal work will also include updating the OKQ manual to include information and guidance on providing care during a pandemic and how federal and state legislation, The Child Abuse Prevention and Treatment Act (CAPTA) and the Comprehensive Addiction Recovery Act (CARA), impacts women who deliver an infant believed to have been substance exposed and/or displays withdrawal symptoms. The manual update will be informed by the information and resources presented in the two EWCT-sponsored workshops on CAPTA and CARA.

Externally EWCT is strategically planning to maximize its reach by establishing relationships with other organizations and entities. The specific groups are:

- The Women's Services Practice Improvement Collaborative (WSPIC)
  WSPIC is co-sponsored by the Department of Mental Health and Addiction Services (DMHAS) and the CT Women's Consortium. Collaborative members are the Department's treatment programs for women. WSPIC is a conduit for a rapid response by EWCT to needs identified WSPIC members.
- The Women and Opioid Workgroup
  This is another DMHAS sponsored group designed to communicate and coordinate services for women dealing with opioid use.
- The Medicaid Strategy Group (MSG)
  MSG is a coalition of health advocates working together to improve and protect the quality and reach of HUSKY/Medicaid programs in Connecticut through administrative and legislative advocacy.
- Health Equity Solutions, COVID-19 Outreach
  This on-going outreach effort is collecting information about the impact on COVID-19 on underserved communities to help center health equity in Connecticut's response and recovery efforts.
- The ACES Task Force
  This Task Force was convened by the Women's Consortium to support efforts to address racism in trauma.

Participation in these groups expands partnership potential as it increases EWCT's platform for addressing pre/interconception health care, health equity and racism from a comprehensive and holistic perspective.

Participation in WSPIC and the Women and Opioids Workgroup supports and strengthens EWCT relationship with DMHAS, which includes the Department offering, for the past two years, EWCT-sponsored workshops on OKQ/human sexuality/reproductive health and on implicit bias as well as creating an on-line OKQ training module.

CT Coalition Against Domestic Violence's (CCADV) representative on the EWCT Advisory Committee will help to facilitate opportunities to present OKQ to CCADV member agencies.

EWCT will use the EWCT Learning Collaborative (EWCTLC) has the major vehicle to increase provider expertise and self-efficacy in implementing routine pregnancy intention screening and appropriate care, education, and services to ultimately improve birth spacing, increase pregnancy intentionality, as well as the proportion of Connecticut women who deliver a live birth and report discussing pre-/interconception health with a healthcare worker and to support implementers of OKQ. Currently there are over 350 EWCTLC members consisting of OKQ implementers and/or those who have attended an EWCT sponsored training. EWCTLC members will receive at least quarterly Notes of Interest through Constant Contact supported emails and at least two trainings on topics identified by EWCTLC members or through the groups identified above (WSPIC, the Women and Opioid Workgroup, Health Equity Solutions' COVID-19 Outreach, and the ACEs Task Force). Opportunities for local networking and one on one meetings will also be offered virtually until it is safe to resume in person meetings.

Family Wellness Healthy Start Program (FWHS)

In the Project Period 2021, the Family Wellness Healthy Start Program (FWHS) will continue to provide services to Connecticut's low-income pregnant and parenting teens, women, infants up to 18 months of age, and other family members in the cities of Hartford and New Britain, The goal of all Federal Healthy Start Program is to eliminate racial and ethnic disparities in perinatal health outcomes such as low birth weight, premature birth and infant mortality among the target population of Hartford and New Britain's African American/Hispanic female teenagers and women. Direct services are provided by Care Coordinators/ Case Managers at Community Health Services Inc., Charter Oak Health Center Inc., St. Francis Hospital and Medical Center, Women's Clinic; the Hispanic Health Council; the City of Hartford Health and Human Services; and the Community Health Center, Inc. (CHC Inc). Outreach services are provided by Outreach Workers at the Urban League of Greater Hartford, and CHC Inc. Fatherhood activities are provided by a Fatherhood Coordinator at Catholic Charities, Archdiocese of Hartford Family Centers in the Asylum Hill, and Northeast areas of Hartford. Nurse Practitioner clinical services are also provided to participants in the city of New Britain through a contract with CHC Inc. In the upcoming grant year FWHS will provide services to at least 700 program participants including pregnant women, infants, preconception and interconception women. The services will include: case management; prenatal, inter-conception, depression and intimate partner violence screenings, referral and follow-up; fatherhood services; health education on nutrition, breastfeeding, birth spacing, infant and child care and developmental milestones; and available resources such as HUSKY, WIC, food pantries, housing and shelters, education, employment, smoking cessation, child care, counseling and maternity needs. The benchmarks that will be measured for the program goals include: assessment for preventative medical well-woman visits, increase the proportion of infants who are breastfed at 6 months, increase the proportion of program participants who practice safe sleep, and reduce the proportion of women who conceive within 18 months of a previous birth.

Pregnancy Risk Assessment and Monitoring System (PRAMS)

PRAMS data is used by DPH and other statewide partners by providing them with data to inform their work in

addressing the strategies outlined in this section. PRAMS provides statewide data on a variety of topics that are not available from any other data source, including preconception health and education, pregnancy intention, contraception methods, perinatal depression, oral health, social support, postpartum maternal and infant care, discrimination, and father involvement. Since receiving our first weighted data set in late October 2015, 71 data requests from internal and external partners have been fulfilled; numerous publications and other products have been produced; and PRAMS staff have collaborated on various efforts to address state MCH priorities, as well as statewide plans, needs assessments, and initiatives to reduce low birth weight, infant mortality, and health disparities.

Currently, eight years of data (2013-2020) are available for analysis, including data from the 2019 opioid supplement. Data collection for the 2020 surveillance year ended in June 2021 and we received our weighted data by mid-July since we were the first state weighted this year. We not only achieved our highest weighted response rate ever (63.2%), but response rates among all strata (including lower responding groups) also increased. The 2020 data includes COVID-19 supplement data that we will analyze and disseminate to our statewide partners. These supplemental questions were an effort to begin collecting population-based data on how the lives of mothers were being impacted by COVID-19 infection and the COVID-19 pandemic. PRAMS data will complement other CDC COVID-19 surveillance efforts by filling gaps in data, including measuring the proportion of women and/or someone in their household infected with COVID-19 during their pregnancy, and also examining interactions with health care providers in person and by telemedicine, barriers to seeking or getting care (prenatal, postpartum and well-baby visits), precautions taken and other experiences related to COVID-19 exposure/infection, hospital experiences during labor and delivery and postpartum, and economic/emotional hardship. We will also be able to divide women into groups that were not at all affected, somewhat affected, or greatly affected by the societal effects of the pandemic. Taken in conjunction with the rich information that PRAMS already gathers on the lives of women around pregnancy, we may be able to quantify the degree of disruption across many different life domains. For example, are planning on looking at outcomes and health care usage in 2019 vs. 2020. We anticipate potentially seeing an increase in the frequency of maternal anxiety and depression as well as interpersonal violence based on anecdotal reports from our statewide partners who serve pregnant and postpartum women. We'll also examine if there are changes in usage and timing of prenatal care, dental care (which is already a challenge to get people to go because of the misconception it is not safe during pregnancy), postpartum visits, postpartum contraceptive use, and more.

As evidenced above, PRAMS is uniquely positioned to provide population-based data on maternal behaviors and experiences among recent postpartum women, including emerging areas of concern. In addition to core operations, PRAMS periodically implements survey supplements to collect data to address emerging needs. In June 2021, State legislation was passed legalizing adult use of cannabis products. The legislation includes the DPH's role in surveillance. Internal partners from the Tobacco Control Program and Office of Injury Prevention had had a conference call in May 2021 with a national consultant hired to assist the Governor's Office with the legalization process in CT. PRAMS was one of three key data sources identified by the contractor for cannabis surveillance. Subsequently, internal partners convened a meeting to discuss existing data (if available) and how data can be collected moving forward. PRAMS staff have been in discussions with their CDC PRAMS Project Manager and other PRAMS states who are collecting or have collected data on perinatal marijuana use to help identify the best approach for moving forward. Data collected as part of opioid survey supplement in 2019 can provide an initial baseline estimate for marijuana use during pregnancy as there was one question asking about a variety of substances used during pregnancy. CT PRAMS is in the process of finalizing questions for a survey supplement around marijuana use and the use of Cannabidiol (CBD) products before, during, and after pregnancy; how (e.g., smoked, dabbed, vaped, etc) and why (e.g., relieve nausea, relieve stress or anxiety, etc) women used marijuana products during pregnancy; conversations around marijuana use or recommendations during prenatal care;

perceptions of how long someone should wait after using marijuana before breastfeeding or pumping milk for their baby; and if they think the use of marijuana products during pregnancy could be harmful to a baby's health. This supplement will be implemented beginning in Fall 2021 and will continue through the end of the 2022 surveillance year. In 2023, the new PRAMS Phase 9 survey will be implemented and we plan to retain 1-2 questions on the survey for long-term surveillance.

In the upcoming year, we also anticipate adding a social determinants of health (SDOH) survey supplement. Currently, it's estimated that this questionnaire will be available from CDC and ready for implementation in October 2021. We plan on implementing both the marijuana and SDOH supplements at the same time to minimize disruptions to operations and maximize efficiency as new survey booklets will need to be printed.

Work on the Phase 9 survey has begun at CDC and CT PRAMS staff have already contributed input, including convening an ad hoc New England PRAMS meeting to discuss what we may want to recommend for changes, as well as the possibility of including one or more questions as a region to look at common areas of interest. The group expressed interest in continuing to meet and the CT PRAMS Director/SSDI Coordinator will serve as the informal convener of the group. As decisions about the Phase 9 Core survey continue at the federal level, CT PRAMS has already begun looking at what changes it might want to make for the other portions of the survey (Standard and state-developed questions). Work on survey content with internal and external partners to ensure Title V MCH data needs are met to the best of our ability will continue into the upcoming year. The Phase 9 survey is currently slated for deployment with the 2023 surveillance year.

In 2021, the CT PRAMS Director along with key partners at Carey Consulting and the March of Dimes Connecticut Chapter formed a new Reproductive Justice Workgroup that had evolved out of a 2020 PRAMS Data to Action project around discrimination before and during pregnancy. The workgroup currently consists of 24 members including persons with lived experiences, local and State government agencies, and community organizations. In the upcoming year, activities will include conducting qualitative research in the form of community focus groups with women, partners and doulas, as well as in-depth interviews with staff working in medical settings (e.g., prenatal care sites, hospitals) who have contact with pregnant and postpartum women to measure experiences of disrespect and mistreatment while receiving these services. We are seeking to replicate this exploratory and formative research that was performed by Columbia University's Averting Maternal Death and Disability (AMDD) project which supported birth justice efforts in NYC. We will explore and expand upon their central research questions, a) how do women describe their experiences of mistreatment or disrespect during facility-based childbirth, and b) what are the individual, institutional, structural, and policy drivers of the treatment that women experience as disrespectful? Our focus will include prenatal care experiences as well as childbirth and immediate postpartum care; in the future, we would like to expand our qualitative research into preconception and interconception care. The purpose of replicating this research is to:

Provide specific documentation and examples for CT, which may or may not vary somewhat by region, health system, provider type, or other factors;
Provide us with a baseline before/at time work is beginning so we can later evaluate if we've made an impact;
Identify specific ways in which providers and all other facility staff, administration, health systems, and others can act and be held accountable for improvement; and
Inform a CT PRAMS survey supplement in the future.

NYC PRAMS had also developed and implemented a birth justice survey supplement and they presented the results alongside Columbia's research at a CDC PRAMS webinar in August 2020. Their supplement had explored a) how common is it for women to experience mistreatment or disrespect during childbirth, and b) if it is more common among some communities or some social/ethnic/racial groups than others. Because NYC PRAMS is in the process

of refining their tool, we will connect with them in the future about the possibility of using their supplement in CT to further expand our data capacity around this critical area.

In addition to the qualitative research, the Reproductive Justice Workgroup will be working on expanding and unifying statewide efforts and developing recommendations and standards for respectful care with the intent to reduce maternal morbidity and mortality. The workgroup will focus on policy, delivery systems, advocacy, training, and public information. Our partner at the March of Dimes also will be leading the group through data collection, monitoring and reporting on the impact of our efforts along the lines of RBA.

Early Hearing Detection & Intervention Program

Effective January 1, 2016, Connecticut state law requires hospitals to screen newborns who do not pass newborn hearing screening for congenital Cytomegalovirus (CMV) and report the results to the Connecticut Department of Public Health (DPH). Congenital CMV is considered the leading cause of nonhereditary sensorineural hearing loss in children. Starting in July 2015, Connecticut began a CMV initiative which included birth facility education and technical assistance, resource development (including a re-designed brochure for parents of infants who do not pass newborn hearing screening, and fact sheets for pediatric healthcare and obstetric providers), continued database enhancements, and, as needed, collaboration with Infectious Diseases physicians and the Connecticut Chapter of the American Academy of Pediatricians.

With regards to CMV, in addition to our aggressive lost to follow-up tracking protocols, CT EHDI will also begin work on ensuring that all Connecticut-born infants who fail their newborn hearing screening be tested for CMV before 21 days of age. Enhancements will be made to the data system to better identify cases and facilities that need more training.

Connecticut Newborn Screening Program (CT NBS)

The focus for the upcoming year will be to identify disease specific long-term follow-up data points to be collected through the electronic interface with CNDTN, add fields in Maven to receive this data and to develop reports to extract long-term follow-up data. In addition, it is anticipated that in upcoming months the Newborn Screening Laboratory will implement a new Laboratory Information System (LIMS). This will require the integration of the Maven NSS and the new LIMS.

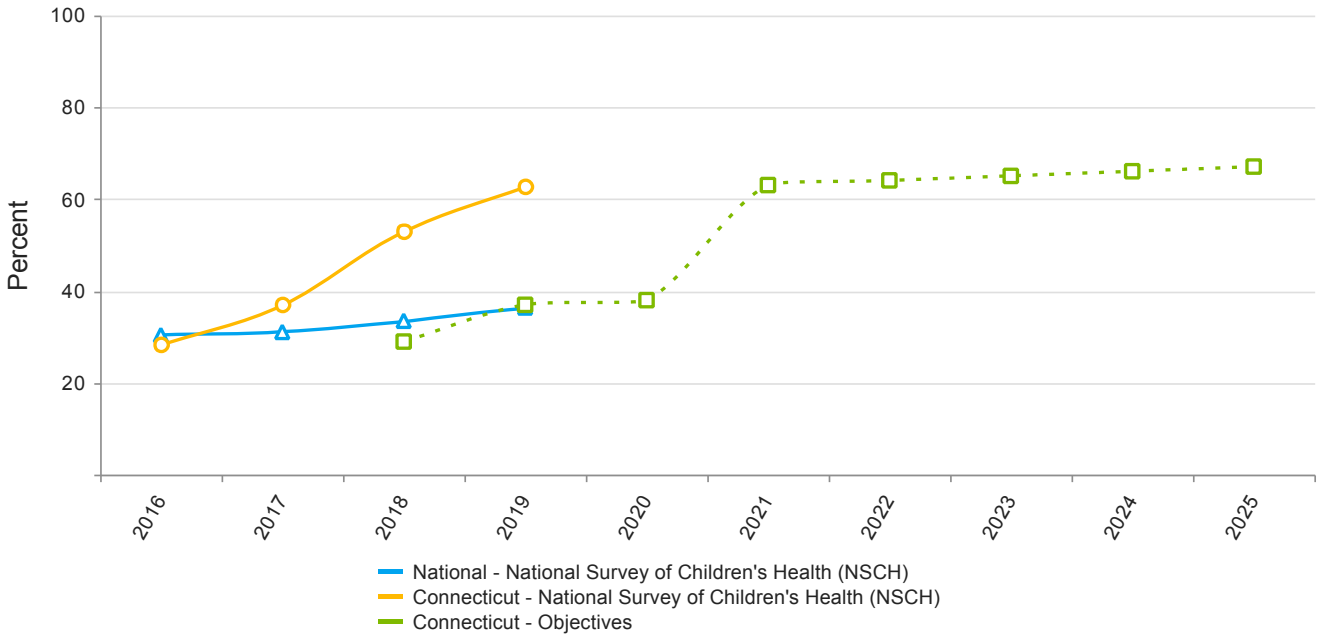
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available or Not Reportable	NPM 6
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2018_2019	9.1 %	NPM 13.2
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	14.8 %	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	91.4 %	NPM 6 NPM 13.2

National Performance Measures

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			29	37	38
Annual Indicator		28.3	36.9	53.0	62.6
Numerator		24,674	30,265	36,846	44,868
Denominator		87,268	82,092	69,503	71,670
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	63.0	64.0	65.0	66.0	67.0	68.0

Evidence-Based or –Informed Strategy Measures

ESM 6.1 - Percent of children less than 3 years old (1-2 years 364 days old) who receive a developmental screening according to claims code 96110

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		33	40	43.5	45
Annual Indicator	32.9	39.8	42.1	44	44.1
Numerator	25,473	31,022	32,576	33,573	32,613
Denominator	77,344	77,998	77,321	76,362	73,956
Data Source	CT Department of Social Services	CT Department of Social Services	CT Department of Social Services	CT Department of Social Services	CT Department of Social Services
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	45.5	46.0	46.5	47.0	47.5	48.0

State Performance Measures

SPM 3 - The proportion of children who drank soda or sugar sweetened beverages at least once daily.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	28.3	26.4
Numerator	141,491	142,122
Denominator	500,206	537,895
Data Source	Behavioral Risk Factor Surveillance System	Behavioral Risk Factor Surveillance System
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	28.0	27.0	26.0	25.0	24.0	23.0

State Action Plan Table

State Action Plan Table (Connecticut) - Child Health - Entry 1
Priority Need
Social-Emotional Development and Relationships for Children and Adolescents
NPM
NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
Objectives
5.1: By 2025, increase by 5% the number of developmental screenings conducted using a validated screening tool.
5.2: By 2025, increase by 5% the number of social-emotional screenings conducted.
5.3: By 2025, increase referrals to appropriate services for positive screening results by 5%.
5.4: By 2025, disseminate educational information on positive social-emotional and relationship skills for children.

Strategies
5.1.1: Collaborate with stakeholders to promote the use of CT 2-1-1 Child Development Infoline's Ages and Stages Child Monitoring Program and mobile developmental screening applications such as Sparkler.
5.1.2: Initiate data collection for children including those with special health care needs to include what developmental screenings are being used and the results.
5.1.3: Assist parents in the completion of developmental screening tools.
5.1.4: Coordinate and provide developmental screening trainings to medical providers and childcare providers.
5.2.1: Determine baseline for social-emotional screenings completed by providers based on Department of Social Services claims codes.
5.2.2: Promote for increased social-emotional screenings by providers.
5.2.4: Explore the utilization of telehealth to conduct social-emotional screening tools.
5.2.4: Assist parents in the completion of social-emotional screening tools.
5.3.1: Determine the baseline of positive screenings leading to referrals.
5.3.2: Document follow up on referrals from positive screenings.
5.3.3: Engage pediatricians, child health providers, infant mental health consultants, and home visitors to improve screening and referrals.
5.4.1: Provide educational materials, webinars, and trainings to students, parents, and faculty about positive social-emotional and relationship skills.
5.4.2: Partner with the Office of Early Childhood and CT American Academy of Pediatrics to train pediatric providers on early positive social-emotional and relationship skills.
5.4.3: DPH Connecticut Medical Home Initiative to conduct family support group sessions both in person and virtually about positive social-emotional and relationship skills to share educational materials and provide a forum for discussion.

ESMs	Status
ESM 6.1 - Percent of children less than 3 years old (1-2 years 364 days old) who receive a developmental screening according to claims code 96110	Active

NOMs
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Connecticut) - Child Health - Entry 2

Priority Need

Preventative Health Care

SPM

SPM 3 - The proportion of children who drank soda or sugar sweetened beverages at least once daily.

Objectives

6.1: By 2025, increase by 5% the number of children who receive a well-child exam annually.

6.2: By 2025, increase by 5% the number of children who receive a dental visit annually.

6.3: By 2025, reduce by 3% the number of children with BMI's that are in the categories of overweight or obese.

6.4: By 2025, decrease by 5% children who drink sugar sweetened beverages at least once daily.

Strategies

6.1.1: Document well-child exams for children in the Connecticut Medical Home Initiative.

6.1.2: Establish baseline via data obtained from Department of Social Services on the percentage of children 3 years old to 18 years old who receive yearly well-child exams.

6.1.3: Promote annual well-child exams including scheduled immunizations.

6.1.4: Promote the use of telehealth for components of the well-child exam when appropriate.

6.2.1: Promote the provision of dental services in School Based Health Centers.

6.2.2: Promote the benefits of school-based sealant programs.

6.2.3: Support families in taking an active role in establishing and maintaining good oral health for their child.

6.3.1: Collect data to gather information about factors that contribute to an unhealthy weight.

6.3.2: Promote the use of healthy diet and activity (5-2-1-0 American Academy of Pediatrics) programs.

6.3.3: Work with early care and education providers to implement policies and best practices at their site that encourage the adoption of healthy eating and physical activity behaviors among young children.

6.3.4: Deliver evidence-based obesity-prevention education to low income SNAP-eligible preschool children and their families.

6.4.1: Determine the baseline of children including those with special health care needs who drink sugar sweetened beverages at least once daily.

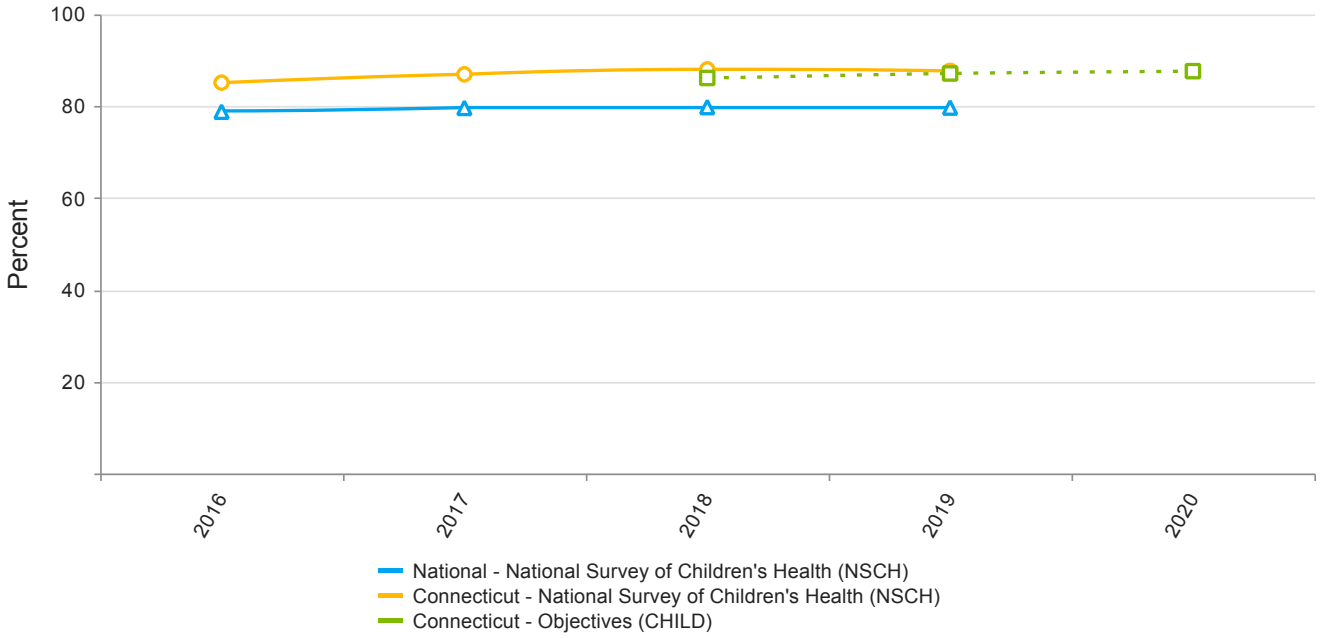
6.4.2: Work with early care and education providers to implement policies and best practices at their site that encourage young children to decrease consumption of sugar sweetened beverages and increase consumption of plain drinking water.

6.4.3: Deliver evidence-based obesity-prevention education to low income, SNAP-eligible preschool children and their families.

6.4.4: Distribute nutrition education materials to School Based Health Centers on reducing sugar sweetened beverage consumption.

2016-2020: National Performance Measures

2016-2020: NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year
Indicators and Annual Objectives



2016-2020: NPM 13.2 - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			86	87	87.5
Annual Indicator		85.1	86.9	87.9	87.7
Numerator		611,017	619,404	623,473	611,844
Denominator		717,846	712,489	709,257	697,889
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 13.2.1 - Percent of high risk children, ages 1 through 17, who have had a preventive dental visit in the past year

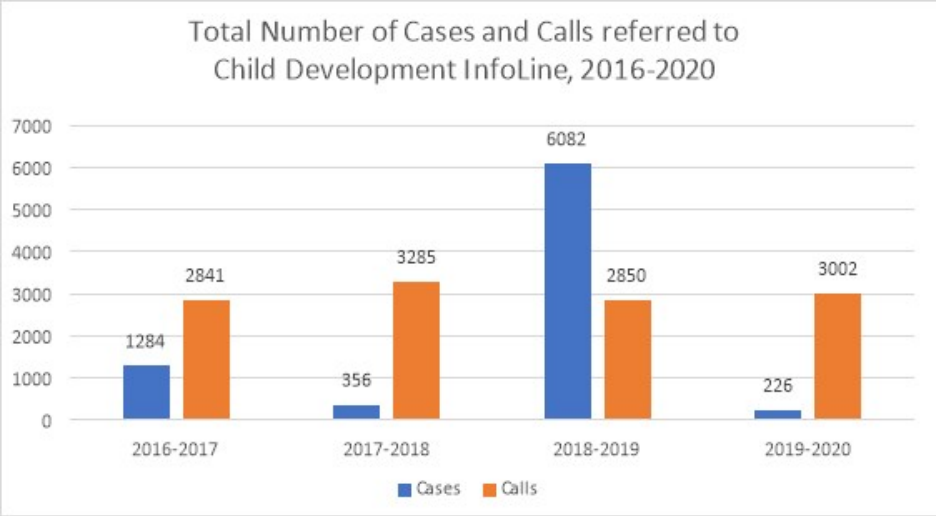
Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		62.2	63.2	65	65.5
Annual Indicator	62.6	67.4	64.8	65	65
Numerator	197,734	204,743	206,207	212,030	212,030
Denominator	315,978	303,632	318,066	326,061	326,061
Data Source	Connecticut Dental Health Partnership	Connecticut Dental Health Partnership	Connecticut Dental Health Partnership	Connecticut Dental Health Partnership	Connecticut Dental Health Partnership
Data Source Year	2016	2017	2018	2019	2019
Provisional or Final ?	Final	Final	Final	Final	Final

When compared to other states across the county, Connecticut is a healthy state, with numerous successes to celebrate. Connecticut has experienced high levels of immunizations, a decline in teen births, and a decrease in infant mortality. The health of all of Connecticut's youngest residents is not equal across all populations. To maximizing potential, quality early childhood healthcare, development, and family services must be equally accessible. CT DPH will continue to work closely with a variety of partners including families, state agencies, and community providers to promote the healthy development of children, to offer comprehensive early childhood systems, to improve early identification and treatment of developmental delays, to increase access to dental health services, and promote a healthy diet and physical activity.

Developmental screening is a priority area for the CT Department of Public Health State Health Improvement Plan Advisory Council and the Maternal and Child Health Coalition. The Developmental Screening Workgroup includes a group of stakeholders committed to developmental screening, made up of community providers, representatives from family organizations, state agency representatives, the group meets quarterly. The Developmental Screening Workgroup's Action Agenda contains three strategies.

The first strategy is to conduct an education and awareness campaign that targets families and communities on the importance of developmental screening. The Developmental Screening Workgroup is supporting the media campaign message which includes information on and the promotion of developmental screening, a focus on families & relationships, and the Strengthening Families' Protective Factors. The success of the campaign is monitored through the counting of several screening and referrals items available through Child Development Infoline and are tracked overtime. Ages and Stages Questionnaires (ASQ) new enrollments 1,688; ASQ Screenings Completed 4,866; Birth to Three referrals 9,244; ASQ web hits 2,581; ASQ enrollment from web hits 872; total ASQ enrollments 8,415, Promote awareness and use of Child Development Infoline. Total number of Child Development Infoline and Help Me Grow (CDI/HMG) calls is 3,002; CDI/HMG cases related to monitoring a child's development 571; Help Me Grow Referrals 2,743. Expand the number of "Learn The Signs. Act Early." materials distributed statewide to families and community providers 226; "Learn The Signs. Act Early." web hits at Child Development Infoline 136.

The second strategy is to train community and healthcare providers to improve screening rates and coordination of referrals and linkages to services within the state. Success will be tracked through a variety of Educating Practices trainings. The Education Practices program offers 23 training topics to help pediatric practices across Connecticut improve delivery of child health services. From July 1, 2019 to June 30, 2020, 57 trainings were completed at 38 pediatric practices. The program was able to have some of the trainings which were completed remotely because of the COVID-19 closures and social distancing measures put in place. Due to the COVID-19 Pandemic, CT Association for Infant Mental Health (CT-AIMH) offered one (1) virtual statewide conference for 179 people and offered four (4) different virtual CT-AIMH infant and toddler audience-specific training series that included 179 people, for a total of 358 trained.

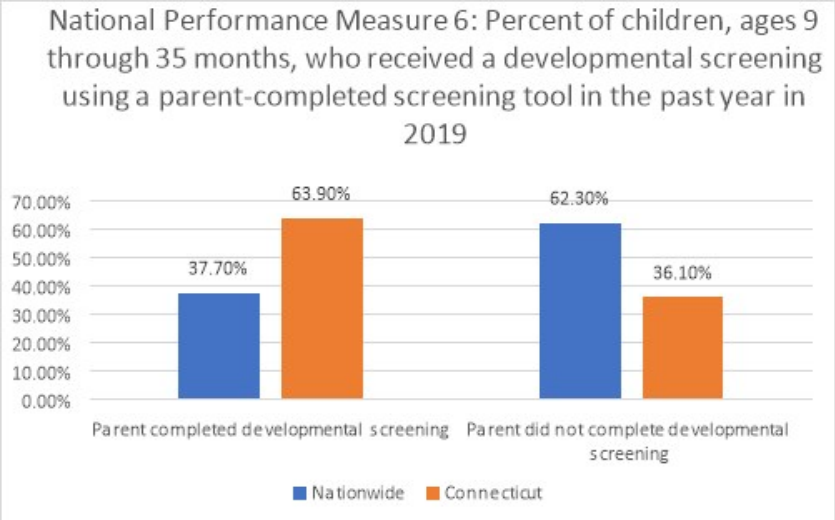


Data Source: CDI/HMG Data 2016-2020

According to Child Development Infoline/Help me Grow Data the total number of Child Development Infoline and Help Me Grow (CDI/HMG) calls between 2016-2020 was 2,841; 3,285; 2,850; and 3,002 and the number of cases between 2016-2020 was 1,284; 356; 6,082; 226. Due to Covid the number of cases were relatively low in 2019.

Resources at 2-1-1 Infoline allows for phone and digital access to educational information, screening resources and connectivity to support services; expansion of parent participation at the state level young child wellness council and linkage to national parenting activities; and partnering with local schools around initiatives that support family strengthening. Information is available on a variety of resources including: Text4baby a free service for pregnant and new moms that offers tips on baby development, pregnancy, and childcare; Milestone Tracker Mobile app to track your child's development from age 2 to 5 months which includes tips on development and what to do if you are ever concerned; support from the Early Childhood Consultation Partnership that provides early childhood mental health promotion, prevention and intervention services to children who are at risk of suspension or expulsion from early care and education settings due to behavioral and mental health concerns; and Vroom an app that provides parents with science-based tips and tools to give a child a great start in life.

The third strategy is to engage in cross system planning and coordination of activities around developmental screening. Members of the Developmental Screening Workgroup joined state level groups to support communication among and coordination of statewide efforts around developmental screening and the promotion of healthy development through the Help Me Grow Advisory Council, the CT Medical Home Initiative Medical Home Advisory Council, the Integrated Care for Kids (InCK) State Agency Advisory, and the Children's Behavioral Health Council.

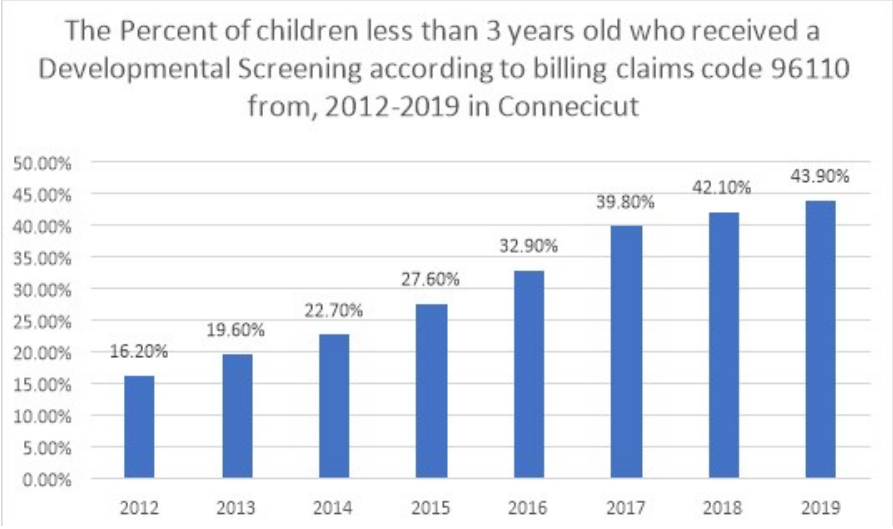


Data Source: National Survey of Children's Health, Health Resources and Services Administration, Maternal and Child Health Bureau. https://mchb.hrsa.gov/data/national-surveys

According to the National Survey of Children's Health, Health Resources and Services Administration, Maternal and Child Health Bureau, the percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in 2019 was 37.70% Nationwide and 63.90% in Connecticut. In contrast to 62.30% for parents who did not complete a developmental screening tool and 36.10% in Connecticut. Connecticut's percentage is much higher than the national average.

DPH staff edited the "Learn the Signs.Act Early" Milestones Moments Booklets in both English and Spanish to include Connecticut specific information for referral to 2-1-1 Child Development Infoline. The logos of "Learn the Signs.Act Early", 2-1-1 Child Development Infoline, CT Department of Public Health, Healthy From Day One, UCONN Center for Excellence in Developmental Disabilities, and the Office of Early Childhood were added to reflect the collaborative efforts to support developmental monitoring, screening and referral in CT. Combined funding allowed the printing of 7,500 of English and 7,500 Spanish "Learn the Signs.Act Early" Milestone Moments Booklet and Track Your Child's Developmental Milestones Brochures. Finally, 100 "Learn the Signs.Act Early" Candy Land mats were printed along with 50 mat carrying bags. Printed materials were shared with all partners for distribution through their community networks and materials are available from 2-1-1 Child Development Infoline for statewide distribution.

Regional Screening to Succeed Community Education Session identified developmental awareness and screening activities to focus on in the coming year some examples include the following; improve outreach to families with an emphasis on fathers, ensure cultural competence, enhance support for screening in Primary Care settings, provide screenings at Family Resource Centers, and complete Ages and Stages Questionnaires (ASQ) at enrollment.



Source: Connecticut Billing Claims Data for claims code 96110 between 2012-2019

Connecticut has tracked the percent of children less than 3 years old (1-2 years and 354 days old) who received a developmental screening according to billing claims code 96110 beginning in 2012 at 16.2% and grew to 19.6% in 2013, then 22.7% in 2014, continued to 27.6% in 2015 and 32.9% in 2017, 42.1% in 2018 and most recently 43.9% in 2019.

The Help Me Grow Advisory Council continued its mission to ensure screening and follow-up services are accessible and fully integrated and to build capacity of the system to respond to increased need for referrals and services. The Help Me Grow Advisory Council developed out of the Early Childhood Comprehensive Systems grant that had an Action Plan that utilized national materials shared at the CT Act Early meeting including the adoption of objectives such as establishing a statewide learning collaborative and creating a marketing message to emphasis the promotion of good health/development. The council has been working with Sparkler, which is an evidenced-based, mobile family engagement platform, available in English and Spanish, promoted by the Connecticut Office of Early Childhood and 2-1-1 Child Development to help all Connecticut families with young children ages birth to 5-years-old. Sparkler offers Tracking tools to monitor children's social-emotional, cognitive, communication, and physical development, including the Ages & Stages Questionnaires. It encompasses messaging tools to give parents/caregivers advice and support.

CT DPH and the UCEDD continued our shared partnership to promote the Center for Disease Control and Prevention (CDC's) "Learn the Signs. Act Early" campaign. Bethanne Vergean, Early Childhood Technical Assistant from the UCEDD, was selected as Connecticut's Ambassador. The program aims to improve early identification of children with developmental disabilities including autism to raise awareness of the importance of screening and early identification through the distribution of materials for parents and professionals working with young children. "Learn the Signs. Act Early." trainings were provided statewide to Early Childhood-10; State Agencies (DCF)-32; and Community Providers – 6. The "Learn the Signs. Act Early" Connecticut Face Book Page has 586 followers and 507 likes. They also partnered with Reach out and Read at CT Community Health Centers to provide 1,650 Baby Busy Day, CDC Books.

In additional the UCEDD was awarded funding from the Association of University Center on Disabilities (AUCD) and the Center for Disease Control and Prevention (CDC) Early Childhood State Systems Through the Act Early Network to Support Recovery and Strengthen Resilience Skills, Behaviors, and Resources of Children, Families, and Communities. The focus of the application was to develop a stakeholder group and conduct a needs assessment to identify the barriers of early identification during the COVID-19 pandemic. Other grant objectives include develop, implement, and evaluate a plan to address the identified barriers; evaluate strategies to improve resiliency of very young children (ages birth to five) and their families by supporting well-child healthcare, developmental promotion, and timely referral. Connecticut Department of Public Health will continue to support developmental monitoring, screening, and promotion activities along with the development of materials that will improve resiliency among families with young children during COVID-19 response and mitigation efforts.

The MAVEN online reporting system is available to care coordinators within the CT Medical Home Initiative for Children and Youth with Special Health Care Needs (CMHI) with enhanced 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.

Title V continues to partner with Child Health and Development Institute (CHDI) and the Office for Community Child Health at CT Children's Medical Center (CCMC) to conduct a variety of Educating Practices modules including care coordination, Lead Screening and Behavioral Health Screening, medical home and more that focus on the education of the office team including nurses, physicians, and administrative staff to promote a team approach to practice change and support for the change is made possible by state and local resources and policies.

A comprehensive service resource guide was placed online 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. DPH staff serve as the liaison for the comprehensive resource guide initiative and the training initiative. The Autism Services & Resources Connecticut houses the user-friendly clearing house on their website at ct-asrc.org/professional-resources-guide.

The DPH Nutrition, Physical Activity, and Obesity (NPAO) Program has been working with Early Care and Education (ECEs) Sites to provide nutrition and physical activity education and support the creation of healthier environments for the children and families they serve for over 10 years. Over the years, these efforts have expanded with the receipt of new funding and development of new partnerships, including other DPH programs addressing children's health and wellness.

In 2017, the NPAO Program partnered with the DPH Office of Oral Health to create Water First for Your Thirst! (WFFYT) initiative for ECE sites to increase the availability of fluoridated drinking water in ECE sites and promote fluoridated drinking water as the primary beverage for young children (birth to 5 years old). The WFFYT initiative was developed as a result of a group of partner organizations that wanted to improve sugary drink intake in young children and as an extension of an existing marketing and communications campaign developed by UConn Health. The WFFYT initiative focused on providing training and support to ECE providers, including a self-directed toolkit, a training on implementation, and resources to use in classroom and on-site. The WFFYT website provides consumer information and resources on the value of drinking and cooking with fluoridated water and healthy food choices. From 2017-2019, the WFFYT initiative was successfully implemented in 11 center-based and 66 home-based ECEs serving 1,014 children. Starting in 2019, the NPAO Program shifted to include the WFFYT initiative tools and resources as part of the Go Nutrition and Physical Activity Self-Assessment for Child Care (Go NAPSACC) initiative.

Go NAPSACC implementation began in 2019 with center and home-based ECEs to address childhood obesity with funding from the Centers for Disease Control and Prevention (CDC) State Physical Activity and Nutrition Program (SPAN) and U.S. Department of Agriculture (USDA) Supplemental Nutrition Assistance Program-Education (SNAP-Ed) funding. Go NAPSACC is an evidence-based online platform that helps ECEs create a healthier environment for the children they serve through a five-step improvement process: best practice assessment, action planning, implementation, training and technical assistance support, and re-assessment to evaluate progress. Best practices include policy, systems, and environmental changes to support healthy behaviors and are grouped into seven modules: Breastfeeding & Infant Feeding, Child Nutrition, Farm to ECE, Oral Health, Infant & Child Physical Activity, Outdoor Play & Learning, and Screen Time. ECEs that opt to work on the Oral Health module will also receive the WFFYT toolkit and resources described earlier.

Recruitment occurs on a rolling basis throughout the year, and participating ECEs complete the selected module(s) at their own pace. Implementation of one or more modules typically occurs over a six to nine-month period, depending on the number of action items identified, the ECE site's time, and any barriers faced during implementation. From October 1, 2019 to September 30, 2020, 32 sites were actively working through Go NAPSACC, reaching 1,626 children. The Oral Health module specifically addresses reducing sugary beverages and increasing plain fluoridated drinking water access in ECE sites. During the reporting period, none of the 32 ECE sites selected the Oral Health module as their focus for implementation. Because of COVID-19, many programs that enrolled to participate either dropped out or were delayed in completing the module(s) selected. The NPAO Program continues to work with TAs to ensure sites that start the process complete the full Go NAPSACC implementation process, including a second self-assessment to measure changes in best practice attainment.

The NPAO Program, in partnership with the University of St. Joseph (USJ) is also implementing Coordinated Approach to Child Health (CATCH) Early Childhood (CEC) in ECE sites with SNAP-Ed funding. Modeled after the nationally recognized CATCH Program for grades K-12, CEC is an obesity prevention intervention designed to increase physical activity and promote healthy eating in children ages 3-5. ECE staff are trained to deliver CEC curriculum in their classrooms, which includes nutrition and gardening lessons and 30 minutes of daily physical activity in the classroom. From October 1, 2019 to September 30, 2020, the NPAO Program sponsored a three-day CEC training conducted by a master trainer from CATCH. The CEC training included 1) a two-day CEC Training Academy to train CEC trainers, which included NPAO Program staff, contractors, and interested ECE site staff, and

2) a one-day CEC implementation training for CEC trainers and staff from 14 ECE sites. In addition, 14 additional ECE sites that received training the previous year were implementing CEC during this timeframe, for a total of 28 ECE sites implementing reaching a reported 2,316 children and 737 staff during the reporting period.

Funded by SNAP-Ed, the NPAO Program in collaboration with USJ delivers evidence-based nutrition and physical activity education sessions and workshops for the parents/caregivers of young children with the goal of improving overall nutrition and increasing physical activity of families. Parents/caregivers are targeted as they have the most influence on food choices and are able to enforce healthy messages within their families. The educational content is based on Eating Smart • Being Active, a curriculum developed at Colorado State University and University of California at Davis for low-income adults with young children. The program curriculum has eight different topics: Get Moving, Plan Shop Save, Fruits and Veggies Half Your Plate, Make Half Your Grains Whole, Build Strong Bones, Go Lean with Protein, Make a Change, and Celebrate! Eat Smart and Be Active. ECE sites participating in Go NAPSACC and CEC are targeted for these sessions and workshops to employ a layered approach to obesity prevention. From October 1, 2019-September 30, 2020, 104 sessions and workshops were delivered to 743 participants.

The NPAO Program has been working with MCH Block Grant staff to develop a one-page handout for School Based Health Center staff outlining existing nutrition education materials for distribution to students and their families on reducing sugary drinks. The content has been compiled and will be organized in an easy to read and use format in the upcoming year.

Child Health - 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 developmental promotion, developmental monitoring, early screening, evaluation, and intervention.

CT activities around developmental screening continue to address together shared strategies including: conducting an education and awareness campaign that targets families and communities on the importance of developmental screening; train community and healthcare providers to improve screening rates and coordination of referrals and linkage to services within the state; and engage in cross systems planning and coordination of activities around developmental screening.

Cross system planning and coordination of activities include a Title V staff member to continue to attend the Help Me Grow Advisory Council meeting that focused on developmental screening efforts including a focus on establishing a statewide learning collaborative to bring together developmental screening initiatives to increase understanding of screening practices and create an informed system of developmental promotion, developmental monitoring, early detection, linkage, and referral.

Screening to Succeed regional call to action efforts will continue through the increase of developmental awareness and promotion, developmental screening, and connecting to services by providing families and providers with the knowledge, resources, and tools for effective coordination and community wide implementation. Staff from Department of Public Health, University Center for Excellence in Developmental Disabilities, Child Development Infoline, Wheeler Clinic, Office of Early Childhood, Help Me Grow Advisory Committee and the Developmental Screening Workgroup of the State Health Improvement Plan will continue to support efforts to expand developmental screening through the implantation of community action plans.

DPH staff will work with CT Medical Home Initiative partners to distribute CT customized (LTSAE) materials in English and Spanish 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.

Child Development Infoline (CDI) has an updated family friendly web site that offers the Ages and Stages Questionnaires online along with developmental milestones. CDI has a supply of “Learn the Signs. Act Early.” Materials available on site for distribution for families and providers available in both English and Spanish. CT DPH has updated the Where is Bear? Book in English and Spanish to include CT referral information to United Way 2-1-1 Child Development Infoline.

CMHI will continue to work with staff from CT Children’s Medical Center Autism Spectrum Assessment Program (ASAP) as the program offers parents, families, and medical providers a direct line from the autism diagnosis to needed services and community supports.

School Based Health Centers actively ensure that immunizations are updated, and numerous SBHC have chosen immunizations as a Results Based Accountability outcome measure as well. Title V staff and our partners will work with the DPH Immunizations Program to disseminate information, including Advisory Committee on Immunization Practices (ACIP) guidelines and to promote the necessity of adhering to immunization schedules; and to advocate for the coverage of vaccines by all insurers. In addition, SBHCs perform oral health screenings and referral.

The Connecticut Department of Public Health Immunization Program provides all recommended childhood vaccines to over 680 providers statewide including private physician offices, community health centers, school-based health centers, and local health departments. In 2020, nearly 1,000,000 doses of vaccine were distributed and the Program universally expanded provision of Influenza vaccine for all children up through 18 years of age in Connecticut regardless of insurance status. Adult vaccines including HPV for uninsured patients 19-45 years of age are provided to local health departments, community health centers, and drug treatment facilities. Uninsured and Medicaid patients 9-18 years of age, as well as privately insured 11- and 12-year old’s, are also provided HPV vaccine. All nationally recommended childhood vaccines are provided to School Based Health Centers for children up through 18 years of age free of charge. The Immunization Program also partners with the WIC program to promote timely immunizations and well childcare at WIC locations statewide. Nine local Immunization Action Plan (IAP) Contracts (Hispanic Health Council, Ledge Light Health District, Naugatuck Valley Health District, New Britain Heath Department, New Haven Health Department, Norwalk Health Department, Southwestern AHEC (Area Health Education Center), Torrington Area Health District, Waterbury Health Department) worked with providers, maternal and child health partners, and local WIC agencies to ensure that all children have a medical home and access to age appropriate vaccinations.

IAP Coordinators and state immunization program Epidemiologists conduct site visits called IQIP (Immunization Quality Improvement for Providers) with providers as a continuous quality improvement process developed by the Centers for Disease Control and Prevention (CDC) to raise immunization coverage rates, reduce missed opportunities to vaccinate, and improve standards of practice at the local level.

The Connecticut Immunization Information System (IIS) called CT WiZ tracks children statewide from birth up through age eighteen as reported from providers enrolled in the Connecticut Vaccine Program (CVP), as will be described below. CT WiZ can capture vaccines throughout the lifespan. All children born in Connecticut are automatically enrolled through State Vital Records and their provider offices, unless the parent opts out. CT WiZ enables providers to report electronically which reduces data entry and enables CT WiZ to capture timely data on children up through age eighteen and beyond.

The Connecticut Vaccine Program (CVP) is funded through a combination of state and federal monies. The state monies are from an assessment tax on all health insurers doing business in the state of Connecticut. This assessment allows the program to provide the majority of all nationally recommended vaccines for privately insured children up through 18 years of age free of charge.

Pediatric outpatient visits and routine childhood vaccination have declined during the COVID-19 pandemic, leaving children and communities at risk for outbreaks of vaccine-preventable diseases. In response, the CT DPH Immunization Program has supported providers to remind parents that vaccinations are safe and important through activities including: Surveying providers on their ability to provide catch-up and coordinating with the State Department of Education on recommendations for health assessment records; Sending memos and resources to pediatric providers via Everbridge mass communication system and posting on: https://portal.ct.gov/DPH/Immunizations/CVP---Information-for-Providers; Posting on CTDPH social media sites to promote vaccine catch up; Sharing resources and social media toolkits with providers and local Immunization Action Plan (IAP) Contractors conducting outreach and education to raise immunization rates; Preparing and posting a letter encouraging providers to onboard with CT WiZ as a strategy for real-time reporting and utilizing reminder recall reports; Continuing to onboard providers with CT WiZ; Promoting and posting the updated reminder recall reports training on the CT WiZ Training website: https://portal.ct.gov/DPH/Immunizations/CT-WiZ-Patient-Management; Sharing AAP and CDC messaging/webinars/resources on routine catch up reminding parents to take kids to their pediatrician.

The Connecticut Department of Public Health Office of Oral Health tracks the number of children who receive a dental visit annually through the CT Behavioral Risk Factor Surveillance Survey. The most recent data available is from 2019 and it shows 86.2% of Connecticut children between the ages of 0 and 17 receive a dental visit. Other data captured includes “dental visit among children aged 1-17 years with special health care needs” from National Survey of Children’s Health and it shows that Connecticut has 93.1% which is above the national percentage of 85.4% in 2019. Connecticut can also capture “preventive dental visit among children aged 1-17 years enrolled in Medicaid/SCHIP” via CMS-416 and Connecticut’s percentage is 82.8% in 2019.

The Office of Oral Health (OOH) continues to promote the benefits of sealants through its school-based sealant programs, other community partners, and other health promotion channels. In the last year the Office of Oral Health created a Communications Plan for school-based dental sealant programs which included strategies to foster community awareness, develop bilingual resources, and promote them via the website and social media. The OOH continues to facilitate the CT Dental Sealant Advisory, a statewide stakeholder group that meets quarterly to provide guidance and technical assistance to the SEAL CT! program. Despite covid, the group maintained strong attendance and participation, meeting virtually. Resources to promote sealants and the safety of preventative visits during covid were created in English and Spanish and shared with partners for broad utilization. A 30 second public service announcement (PSA) was created to promote sealants.

The OOH will support the Dental Sealant Advisory in hosting the annual workshop in the Fall of 2021 which bring together sealant partners to discuss the benefits, challenges, and best practices. This year’s workshops will be focused on re-engagement of families to further promote sealants. Due to covid, there is general hesitancy about resuming preventative dental services. This workshop will best around be sharing best practices and lessons learned. The OOH is also planning to conduct the oral health surveillance of kindergarten and 3rd grade students in CT as part of a long-term surveillance strategy. Randomly selected school are chosen by the CDC and in partnership with the CT State Department of Education. The survey will be conducted in the 2021-2022 school year. Active planning with partners was conducted in 2020-2021.

The survey is conducted every 4 years to provide an update of the oral health status of children in CT so that the OOH, along with partners can make appropriate recommendations of intervention, health education and policy recommendations. Through a HRSA grant the OOH is working with the Community Health Center, Inc (CHCI) to implement a medical dental integration pilot that addresses common risk factors for child obesity. Referrals between dental and medical providers within the CHCI system is aimed to address risk factors, provide nutritional counseling,

and access to other resources. A CDC grant will address the adult component for those at risk for diabetes. CHCI staff received comprehensive training including Motivational Interviewing and a Provider Toolkit to assist the pilot implementation at five sites in May 2021.

The Nutrition, Physical Activity, and Obesity (NPAO) Program will continue to expand the existing Early Care and Education (ECE) site initiatives by working with new and existing partner organizations.

Go NAPSACC: The NPAO Program plans to recruit a minimum of 60 ECE sites for participation in the Go NAPSACC initiative from October 1, 2021 to September 30, 2022. Recruitment will be supported by state and local partners, including the partnering organizations that provide training and technical assistance to most of the participating ECE sites: the Regional Education Service Centers (RESC) Alliance; All Our Kin, a family child care home network; and the City of Hartford Department of Children, Families, and Recreation. As ECE sites recover from the COVID-19 pandemic, the NPAO Program plans to work with ECE sites and their TAs to promote full completion of the Go NAPSACC process with a goal of at least 50% of enrolled sites completing both the pre and post assessment to measure best practice attainment.

Early Childhood (CEC): The NPAO Program plans to implement CEC in at least 15 ECE classrooms from October 1, 2021-September 30, 2022. Because of COVID-19, NPAO Program and University of St. Joseph (USJ) staff will need to be recertified to conduct training on CEC, which requires the three-day Training Academy with the CATCH master trainer. Each of the selected ECE classrooms will identify a two-person CEC team, consisting of one administrator and one lead or senior teacher, who will coordinate CEC implementation for a total of 60 staff trained.

Nutrition and Physical Activity Education: The NPAO Program, with USJ, plans to conduct at least 105 sessions and workshops from October 1, 2021-September 30, 2022 for a total of 788 participants. The NPAO Program plans to finalize the handout for School Based Health Center staff which will outline reliable nutrition education information for students and their families on reducing sugary drink consumption. The information included is sourced from nationally recognized websites (National Institutes of Health, American Academy of Pediatrics, CDC, USDA, and so forth) and includes content in English, Spanish, and other available languages.

Adolescent Health

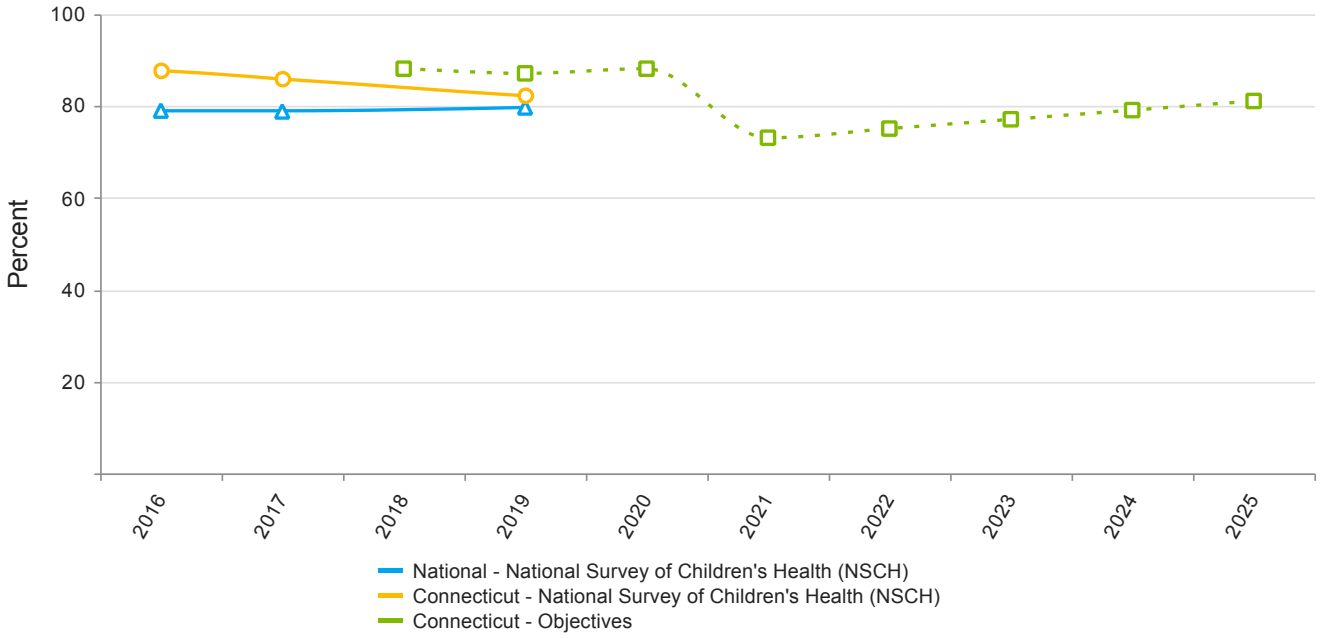
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2018_2019	9.1 %	NPM 13.2
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2019	21.4	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2017_2019	6.6	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2017_2019	8.0	NPM 10
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	14.8 %	NPM 10 NPM 13.2
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	53.9 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	91.4 %	NPM 10 NPM 13.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2018_2019	13.3 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2018	14.5 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2019	14.4 %	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2019_2020	78.0 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2019	70.6 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2019	96.5 %	NPM 10

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2019	93.7 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	7.7	NPM 10

National Performance Measures

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



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			88	87	88
Annual Indicator		87.6	85.8	85.8	82.1
Numerator		227,911	224,493	224,493	220,463
Denominator		260,320	261,660	261,660	268,575
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017	2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	73.0	75.0	77.0	79.0	81.0	83.0

Evidence-Based or –Informed Strategy Measures

ESM 10.1 - Percent of adolescents 12 through 17 with at least one completed BMI at time of medical visit at all school-based health centers

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		99.1	89	84	89
Annual Indicator	78.8	88.2	83	88.8	80.7
Numerator	10,197	12,278	10,826	10,886	8,946
Denominator	12,946	13,924	13,045	12,256	11,091
Data Source	CT DPH SBHC Database	CT DPH SBHC Database	CT DPH SBHC Database	CT DPH SBHC Database	CT DPH SBHC Database
Data Source Year	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	89.0	89.5	89.5	90.0	90.0	90.5

ESM 10.2 - Percent of adolescents 12 through 17 with a depression screening at the time of medical visit at all school-based health centers

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		37.3	71	72	73
Annual Indicator	33.7	70.4	71.1	41	71
Numerator	4,369	9,804	9,273	6,438	7,873
Denominator	12,946	13,924	13,045	15,703	11,091
Data Source	Funded School Based Health Centers database	Funded School Based Health Centers database	Funded School Based Health Centers database	Funded School Based Health Centers database	Funded School Based Health Centers database
Data Source Year	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	74.0	75.0	76.0	77.0	77.0	78.0

State Action Plan Table

State Action Plan Table (Connecticut) - Adolescent Health - Entry 1
Priority Need
Supports for Health, Safety, and Enhanced Social-Emotional Development
NPM
NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
Objectives
9.1: By 2025, increase by 15% the number of DPH funded School Based Health Center (SBHC) sites who are conducting Adverse Childhood Experiences (ACEs) screenings.
9.2: By 2025, increase the number referrals by DPH funded SBHCs to appropriate services in response to positive ACEs screening results by 5%.
9.3: By 2025, increase by 5% the number of adolescent well visits.
9.4: By 2025, reduce by 5% the number of adolescents who report using substances including vaping, prescription drugs, and illicit drugs.
9.5: By 2025, reduce by 0.5% the number of adolescents who report attempted suicide.

Strategies
9.1.1: Increase the number of School Based Health Center (SBHC) staff who are trained to conduct ACEs screenings.
9.1.2: Provide educational materials, webinars, and trainings with SBHC coordinators to increase the rate of ACES screenings completed.
9.1.3: Require SBHC to report on CPT billing codes for ACES and other social-emotional screening tools.
9.2.1: Encourage SBHC behavioral health staff to join and attend Regional Care Collaboratives.
9.2.2: Promote documenting referrals from positive screens and their outcomes.
9.2.3: Provide educational materials, webinars, and trainings about promoting strong connections to family and community supports to encourage resilience.
9.3.1: Employ outreach and engagement strategies to increase awareness of SBHC services including the adolescent well visits annually.
9.3.2: Encourage SBHCs to increase the number of signed consent forms for access to services including adolescent well visits.
9.3.3: Provide educational materials, webinars, and trainings to get adolescents in for a well visit, to set the stage for a successful well visit, and to engage the adolescent as a health care consumer.
9.3.4: Promote primary prevention programs to strengthen resiliency in high school students though school-based programs, such as 4 What's Next.
9.4.1: Provide educational materials, webinars, and trainings for school staff around vaping, prescription drugs, and illicit drugs.
9.4.2: Identify gaps in preventive messaging and materials on vaping, prescription drugs, and illicit drugs being used by youth-serving organizations and address through development of updated messages and materials for distribution.
9.4.3: Develop curriculum materials for vaping cessation that are age-appropriate, and make available to school districts and organizations that serve youth in CT.
9.5.1: Promote primary prevention programs to strengthen resilience in high school students through school-based programs, such as 4 What's Next.
9.5.2: Expand gatekeeper training for parents, schools and other youth serving organizations (Question Persuade Refer).
9.5.3: Provide educational materials and events, including promoting awareness of mobile crisis resources in CT and the National Suicide Prevention Crisis Lifeline phone and text numbers.

ESMs	Status
ESM 10.1 - Percent of adolescents 12 through 17 with at least one completed BMI at time of medical visit at all school-based health centers	Active
ESM 10.2 - Percent of adolescents 12 through 17 with a depression screening at the time of medical visit at all school-based health centers	Active

NOMs

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

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

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

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

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

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

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

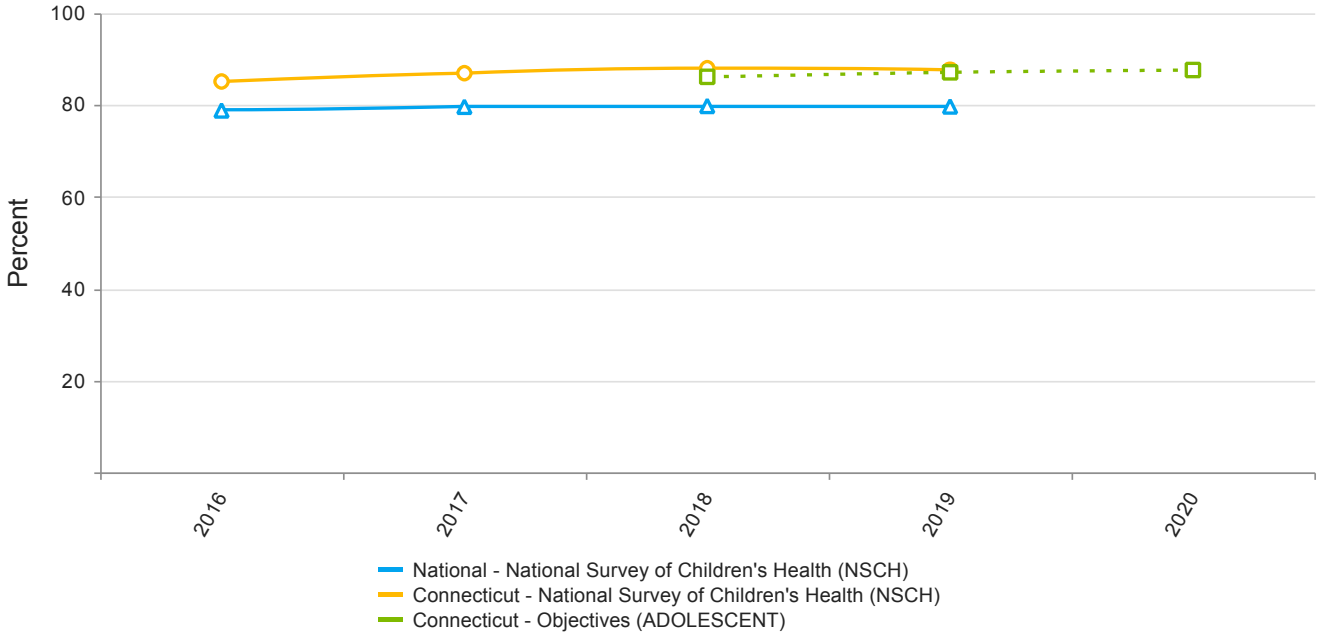
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

2016-2020: National Performance Measures

2016-2020: NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year
Indicators and Annual Objectives



2016-2020: NPM 13.2 - Adolescent Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			86	87	87.5
Annual Indicator		85.1	86.9	87.9	87.7
Numerator		611,017	619,404	623,473	611,844
Denominator		717,846	712,489	709,257	697,889
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 13.2.1 - Percent of high risk children, ages 1 through 17, who have had a preventive dental visit in the past year

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		62.2	63.2	65	65.5
Annual Indicator	62.6	67.4	64.8	65	65
Numerator	197,734	204,743	206,207	212,030	212,030
Denominator	315,978	303,632	318,066	326,061	326,061
Data Source	Connecticut Dental Health Partnership	Connecticut Dental Health Partnership	Connecticut Dental Health Partnership	Connecticut Dental Health Partnership	Connecticut Dental Health Partnership
Data Source Year	2016	2017	2018	2019	2019
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: State Performance Measures

2016-2020: SPM 1 - The rate (per 100,000) of suicide deaths among youth aged 10 through 19.

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		3.7	4	3.9	3.6
Annual Indicator	3.2	5.8	3	3.3	5.1
Numerator	15	27	14	15	23
Denominator	470,268	465,119	465,119	459,801	453,134
Data Source	Health Statistics and Surveillance	Health Statistics and Surveillance	Health Statistics and Surveillance	Health Statistics and Surveillance	Health Statistics and Surveillance
Data Source Year	2015	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Provisional	Final	Provisional

2016-2020: SPM 2 - Percent of adolescents in grades 9-12 who report being bullied at school in the past year.

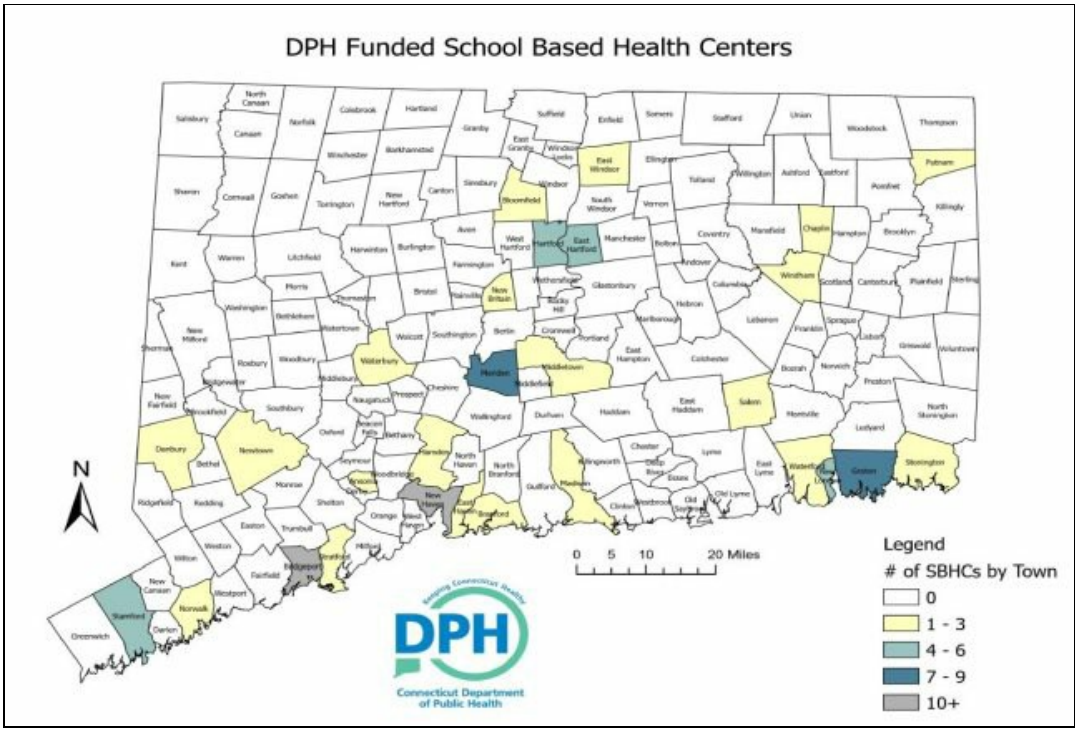
Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		18.6	18	17.7	17.7
Annual Indicator	19	18.1	22.2	17.8	17.8
Numerator	447	435	435	359	359
Denominator	2,349	2,397	1,962	2,015	2,015
Data Source	Youth Risk Behavior Survey (YRBS)	Youth Risk Behavior Survey (YRBS)	Youth Risk Behavior Survey (YRBS)	Youth Risk Behavior Survey (YRBS)	Youth Risk Behavior Survey (YRBS)
Data Source Year	2015	2016	2017	2019	2019
Provisional or Final ?	Final	Final	Final	Final	Final

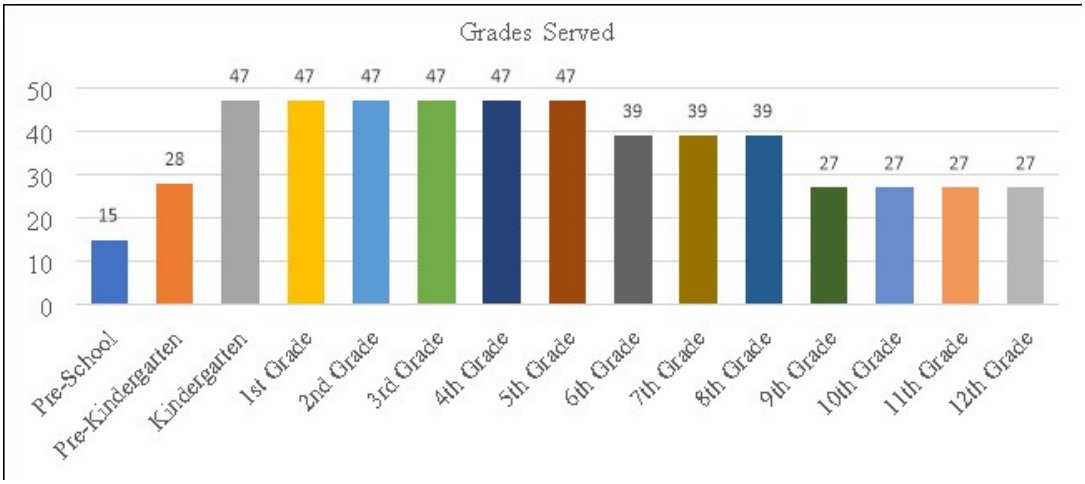
Adolescent Health - Annual Report

The CT Title V program recognizes the value of providing adolescents with appropriate, comprehensive, and timely health care. We also recognize the importance of effective 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. The School Based Health Centers were used as an infrastructure in promoting comprehensive adolescent well child visits, developmental assessment, risk assessment and behavioral health screening, anticipatory guidance, and Body Mass Index (BMI) screening and intervention.

DPH supported 92 school-based health service sites in 27 communities statewide through a state budget line item as well as MCHBG funds. Included are 80 School Based Health Centers (SBHC) and 12 Expanded School Health (ESH) sites. SBHCs serve students, Pre-Kindergarten through grade 12, and are in elementary, middle and high schools. SBHCs provide access to medical, mental health and dental (in some locations) services to students enrolled in the school regardless of their ability to pay. Services provided to students include but are not limited to: diagnosis and treatment of acute injuries and illnesses, managing and monitoring chronic disease, physical exams, administering immunizations, prescribing and dispensing medications, laboratory testing, health education, promotion and risk reduction activities, crisis intervention, individual, group and family counseling, outreach, oral health (in some locations), referral and follow-up for specialty care, and linkages to community based providers. Being able to treat students while at school reduces absenteeism, saves money by keeping children out of emergency rooms, and supports families by allowing parents to stay at work. Care is delivered in accordance with nationally recognized medical/mental health and cultural and linguistically appropriate standards.

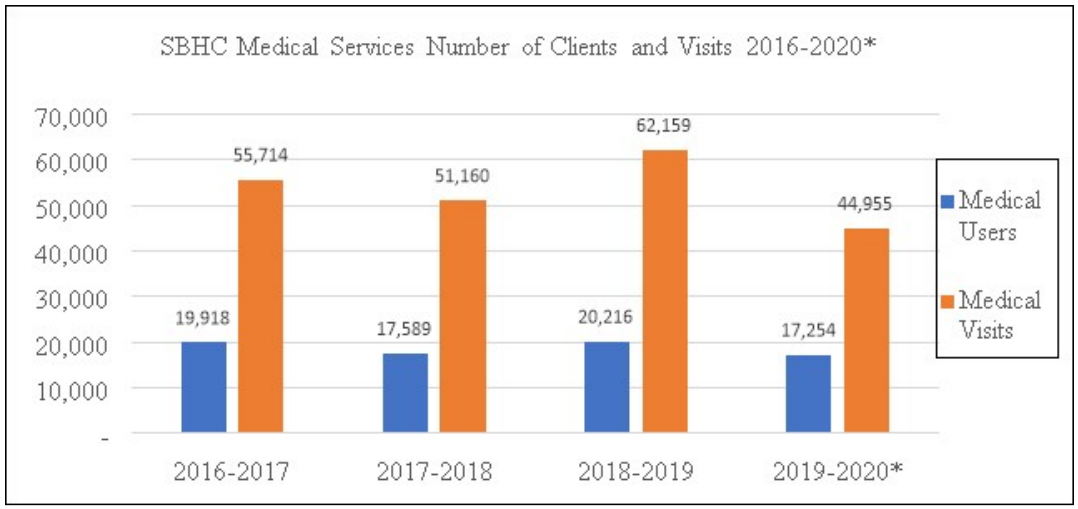
Mental health services are a priority within the SBHCs and experienced adolescent health clinical staff who provide mental/behavioral health services. Mental/behavioral health services include, but are not limited to - assessment, diagnosis and treatment of psychological, social and emotional problems, crisis intervention, individual/group/family counseling, psycho-social education, advocacy and case management, outreach to students at risk and referral to community-based providers to address needs outside the scope of SBHC practice.



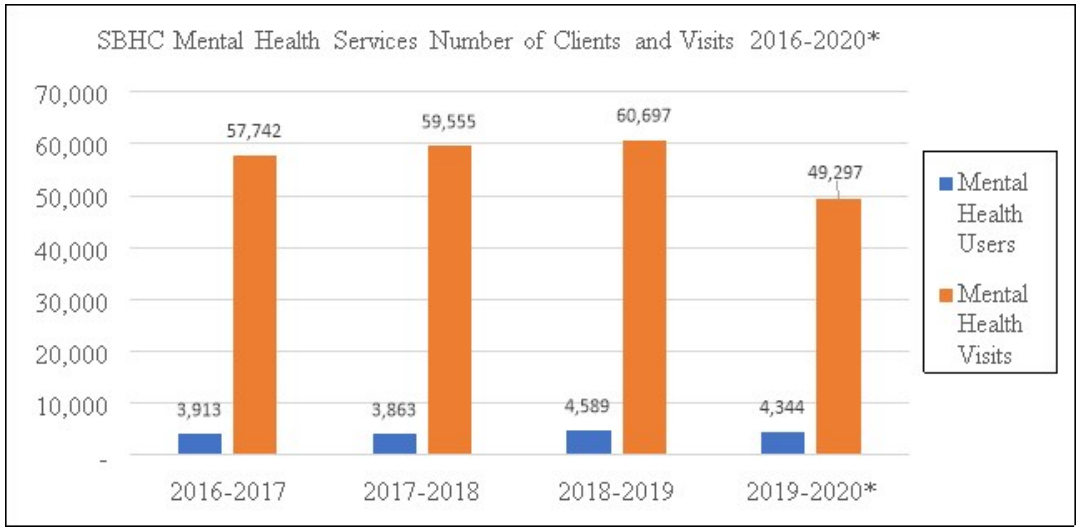


Source: 2020-2021 DPH SBHC 1st Period Report

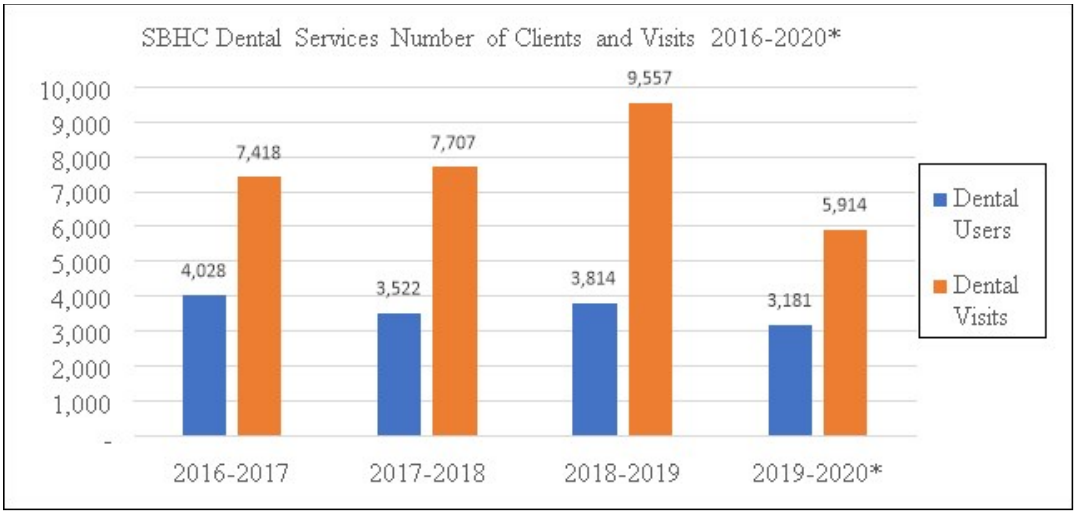
The school-based health centers serve as the principal vehicle for promotion and improvement of adolescent health services with more than 20,000 students receiving one or more service visit per year (approximately 29% of the student population). The number of visits to the SBHCs total more than 100,000 per year. In 2019-2020, a total of 17,254 students made 44,955 medical visits, an average of 2.6 visits per student. A total of 4,344 students made a total of 49,297 mental/behavioral health visits, an average of 11.3 visits per student. A total of 3,181 students made 5,914 dental visits, an average of 1.9 visits per student.



Source: 2019-2020 DPH SBHC Year End Reports. * 2019-2020 Numbers are severely reduced due to COVID-19 and school closures mid-March

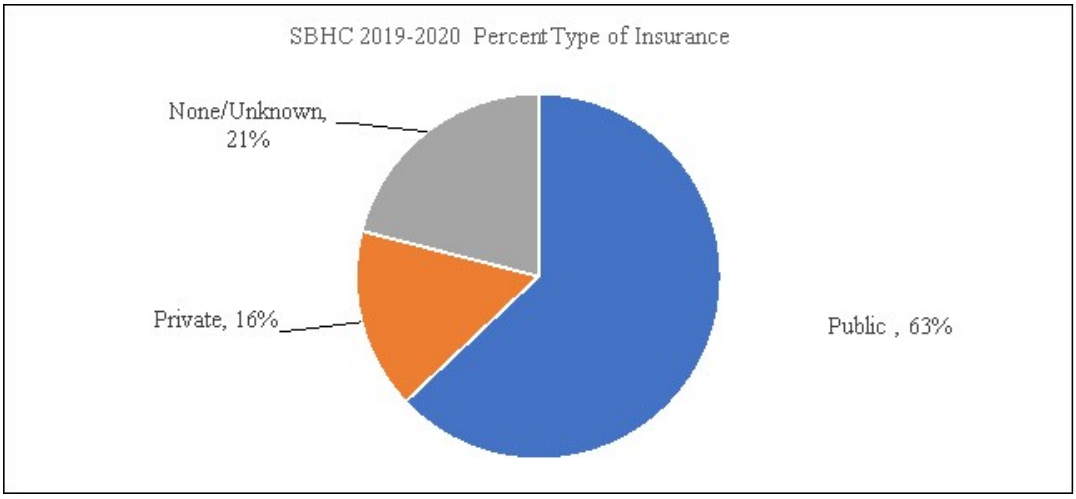


Source: 2019-2020 DPH SBHC Year End Reports. * 2019-2020 Numbers are severely reduced due to COVID-19 and school closures mid-March



Source: 2019-2020 DPH SBHC Year End Reports. * 2019-2020 Numbers are severely reduced due to COVID-19 and school closures mid-March

79% of client's have public or private insurance and the SBHC can bill and may be reimbursed for these client's services.



Source: 2019-2020 DPH SBHC Year End Report

In March 2020, all of CT schools were closed due to COVID-19. This had an immense impact on the schools' SBHCs, which also had to close their doors and all services were shut down temporarily. As the schools started to do remote learning the clinics also started to do telehealth visits. These are some of their obstacles, trends, and successes that they experienced.

For Mental health visits that could be done remotely, the transition did not go easily for most of the schools. Students didn't have devices to use for classes or Mental Health visits, and many didn't have access to a stable Wi-Fi connection. The shutdown left a lot of families with difficulty accessing school and other necessities, like food a result of being unable to get free lunch.

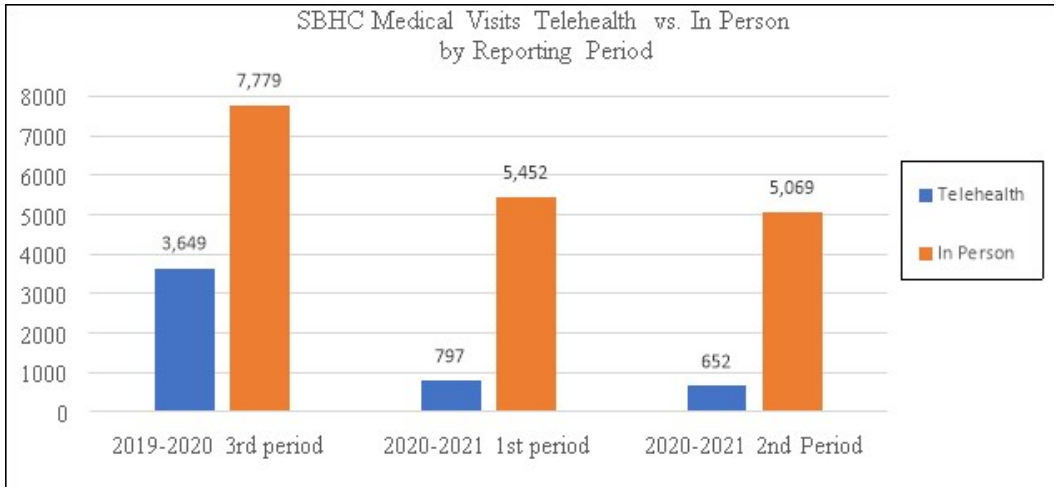
There were some difficulties related to telehealth. Contact information was not accurate, telephones out of service, parents not answering phones, and blocked numbers. Connecting with students took time as parents/students

access to this system had to be learned and services then provided. Students and parents were overwhelmed with the learning curve for technology and were often to burnt out after a day of online learning to log in again to a counseling session. Parents had difficulty helping their children to participate in telehealth due to other parental responsibilities and clinicians were stunned by the lack of schedules the students kept since they were at home full time and had a hard time with engaging students for morning appointments. There was a much higher no-show rate with telehealth and decrease in referrals than in the school as families forgot or got distracted with other things without a firm structure to their weeks. Students expressed having difficulty with telehealth visits and privacy. Many opted out of services altogether and some opted for only phone calls where they could have more privacy.

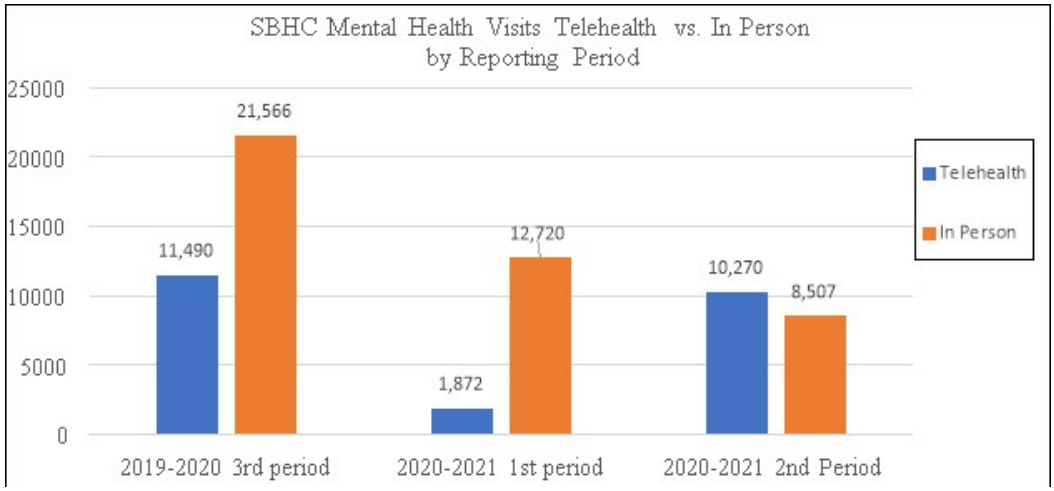
Closing the schools had a lot of negative effects on the students. Many reported symptoms of depression, anxiety, and loneliness due to the uncertainty of the COVID-19 pandemic.
Students experienced anxiety and stress around managing online learning and navigating the online learning world as well as personal/family issues during covid. Students often worried about their relatives getting sick and students expressed their concerns about the violence in their own community and nationally. Students struggled with not being able to see friends, ending the school year early, and missing end of year activities which caused isolation, loneliness and for some suicidal ideation. Students lacked energy and motivation to engage in schoolwork, were frustrated, distracted, and developed behavioral issues related to distance learning. It was especially difficult for a lot of the students in the bilingual program to adapt to distance learning. The lack of fluency of English, deficits in technology knowledge, and limited access to good internet connection made the process of distance learning frustrating for many students and parents.

Medical visits were even more difficult to maintain since there is only so much that could be done remotely through telehealth. There was a decrease in the number of vaccinations given, which also lead to having vaccines that were going to expire and what to do with them. Some schools that are linked with a Community Health Center could refer the student to one of their other sites, but getting there could be difficult, because of lack of transportation. There were few physicals done and PCPs were also working on limited schedules making it even harder for the students to get services. Some SBHCs held flu vaccination clinics and other primary care services outside for students and their families. SBHC staff also assisted with COVID activities in the community.

SBHCs did have some successes when it came to COVID-19. After initial set up, many telehealth visits were successful with no breaks in coverage for the students. The ability to reach parents through the phone or computer increased parent contact and involvement in treatment planning. Parents engaged more frequently by text with the providers. Some students thrived in quarantine since in person school was the source of their anxiety. Many schools resumed free lunch and students could go and pick up meals daily. Several SBHCs opened before the 2020-2021 school year to provide physicals to students who need them.



Source: DPH SBHC 2019-2020 3rd Period Reports through 2020-2021 2nd Period Reports.



Source: DPH SBHC 2019-2020 3rd Period Reports through 2020-2021 2nd Period Reports.

A statewide virtual school-based health conference sponsored by the Connecticut Association of School Based Health Centers (CASBHC) was held in the fall of 2020. The event "Healing From The Inside Out", was attended virtually by more than 180 participants including: school personnel, nurses, physicians, mental health clinicians, state agency personnel, and other stakeholders with an interest in adolescent health. The keynote speaker, Kevin Hines, "Cracked Not Broken" author spoke about his true story of surviving and thriving after a suicide attempt off the Golden Gate Bridge. Other breakout workshop topics included: mindfulness, PREP, eating disorders, human trafficking, PANDAS, violent encounters, motivational interviewing and suicide risk assessment and intervention.

Suicide prevention had been a focus among adolescents, and more recently to a broader group of youth and young adults ages 10 to 24 years old. Injury and Violence Prevention and Surveillance staff regularly participated in CT Suicide Advisory Board (CT-SAB) meetings (virtual meetings as of March 2020) and shared information with Title V staff. The statewide 1 Word 1 Voice 1 Life campaign, developed by the CT-SAB, is intended to educate Connecticut residents on how to recognize the warning signs of suicide, how to find the words to have a direct conversation with someone in crisis, and where to find professional help and resources, including the preventsuicidect.org web site and the Suicide Prevention Crisis Line at 2-1-1 (text 741-741). Title V distributes 1 Word suicide prevention awareness campaign materials throughout all programs. DPH worked with the United Way of CT to distribute the 1 Word campaign via animated video PSAs and print messaging in various venues such as youth

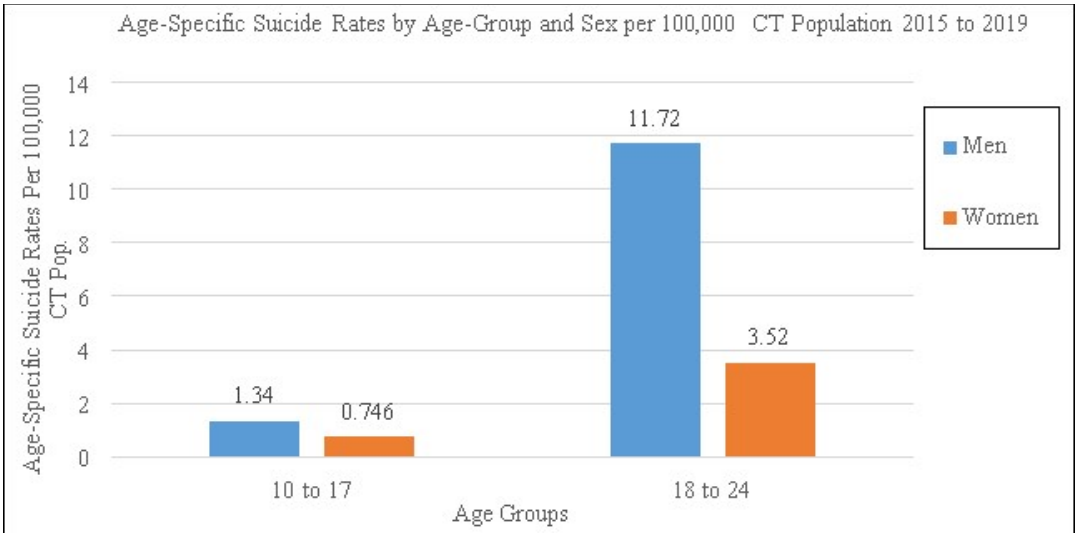
and social services agencies and college campuses around the state as well as outdoor advertising at Yard Goats minor league baseball games at Dunkin' Donuts Park.

DPH continued to partner with Child Health and Development Institute and CT Children's Medical Center to promote Educating Practices training on suicide prevention for pediatric providers.

DPH staff were involved with the CT-SAB during 2019-2020 in updating the CT statewide Suicide Prevention Plan 2020-2025 and worked on a CDC grant application for Comprehensive Suicide Prevention in Connecticut, which was ultimately awarded in August 2020. Two of the targeted vulnerable populations for the grant project will be 10 to 17 year old's and 18 to 24 year old's, who both have higher suicide attempt rates compared to the rest of the population.

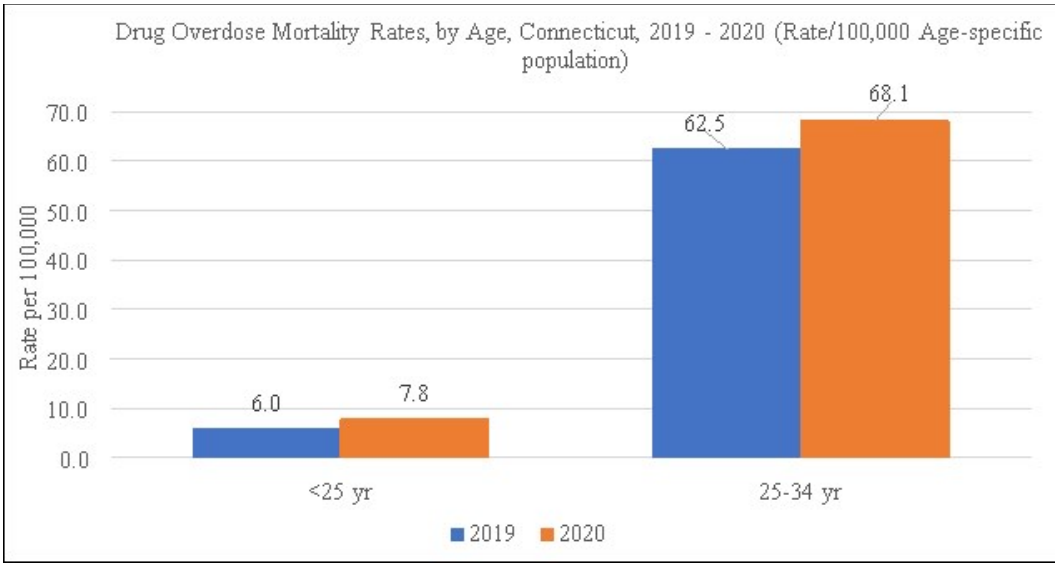
The Suicide Crisis phone and text line was posted on additional high suicide risk locations (bridges and on railways). In July 2019, a letter was sent to 10 communities' Town Manager, Elected Official, Director of Health, and Local Prevention Council from the Lethal Means subcommittee of the CT-SAB and CT Department of Transportation (DOT) asking for support to install signs on a bridge in their city. To date, two communities successfully posted signage on local bridges. Several other communities are pursuing signage and working with the DOT to apply for an encroachment permit. Also, radio ad space for suicide prevention was purchased on three CT radio stations WDRC- AM, WDRC-FM, and WMRQ-FM HD2 from 12/09/2019 - 06/30/2020 and continued through the remainder of 2020.

DPH supports the suicide-crisis information and referral line through United Way's 211 Infoline and partnered with Department of Mental Health and Addiction Services (DMHAS) and Department of Children and Families (DCF) to provide sustainability to crisis line services, of critical importance related to the national Zero Suicide model. Additionally, DPH in consultation with the CT-SAB worked with Wheeler Clinic to plan trainings that address the risk factors related to suicide ideations and the reduction of stigma in mental health help seeking. Similar to last year's activities, Wheeler Clinic planned to offer one training course of "Assessing and Managing Suicide Risk: Core Competencies for Behavioral Health Professionals (AMSR)," a one-day 6.5 hr. training for behavioral health professionals, and two suicide prevention webinar trainings, "Recognizing and Responding to Suicide Risk: Essential Skills for Primary Care Practitioners (RRSR-PC)" for primary care providers of adults, young adults (18-24), and youth (RRSR-PC-Y). RRSR-PC-Y webinar participants will learn how to work with parents of at-risk youth. These trainings were postponed, partly due to COVID-19, and are planned to start up again July/August 2021.



Source: CT Violent Death Reporting System

The DPH Office of Injury and Violence Prevention (OIVP), Opioid and Drug Overdose Prevention Program is helping CT combat the ongoing opioid epidemic. In April 2019, Governor Ned Lamont and the Commissioners of DMHAS and DPH launched two additional statewide resources, the LIVE LOUD (Live Life with Opioid Use Disorder) multi-media campaign (liveloud.org) and a CT Naloxone + Overdose Response App (NORAsaves.com). In the Fall and Winter of 2019/2020, DPH worked with DMHAS to combine the LIVE LOUD campaign with Fentanyl risk awareness and harm reduction. In CT, opioids are involved in 95% of the drug overdose deaths, and among all opioid-involved deaths, about 90% of those are caused by Fentanyl overdose. These fentanyl percentages are higher in CT that most parts of the U.S., so much education and awareness is needed to those with opioid use disorder. The statewide public awareness campaign, called Change the Script, which launched in February 2018 to help communities, health care providers, pharmacists and individuals address the opioid crisis, is also ongoing and points people to drugfreect.org. CT values interagency collaboration and seeks to ensure sustained statewide, multi-agency education and awareness campaigns that align with the CT Opioid REsponse (CORE) Initiative, a strategic plan which lays out a series of actions designed to rapidly reduce opioid-related overdose deaths in CT. Change the Script was chosen as the theme of the campaign to speak to the need to change public perception and thinking about drug dependence and acknowledge addiction as a chronic brain disease. The campaign also seeks to address the stigma associated with opioid misuse, which often prevents a person or their loved ones from seeking help. A variety of marketing strategies were developed to address several different demographic audiences, including adolescents. Change the Script messages were and continue to be disseminated across the state through a variety of mass media mediums. The Connecticut Interscholastic Athletic Conference (CIAC) is delivering Change the Script messaging to target student athletes and their families. The CIAC represents the largest youth agency in the state of CT and serves all CT public and parochial high schools and K-8 schools through its umbrella organization, the CT Association of Schools. The CIAC is the sole provider of access to CT's student athletes for championship games, which attract huge numbers of adolescents and their families. In the past year, CIAC ran multiple events that included the campaign messages as well as providing outreach to coaches, athletic directors, school administration and staff. CIAC is utilizing all Change the Script communications materials provided by DPH including but not limited to banners, PA announcements, print and electronic programs, press conferences, the CIAC Monthly News-blast, and annual website exposure on the CIAC website. Since COVID-19 hit the state in March 2020, many of the awareness and marketing activities with CIAC converted to online and digital advertising.



Source: Office of the Chief Medical Examiner, Connecticut

One area of interest is Neonatal Abstinence Syndrome (NAS) surveillance and related education and targeted interventions. Title V and OIVP staff sit on the CT Perinatal Quality Collaborative, led by the CT Hospital Association, which focused on NAS education and cross system collaboration as well as participating in the Substance Exposed Infants-Fetal Alcohol Spectrum Disorder working group. Additional work around prenatal substance exposure and NAS will continue in the coming grant year.

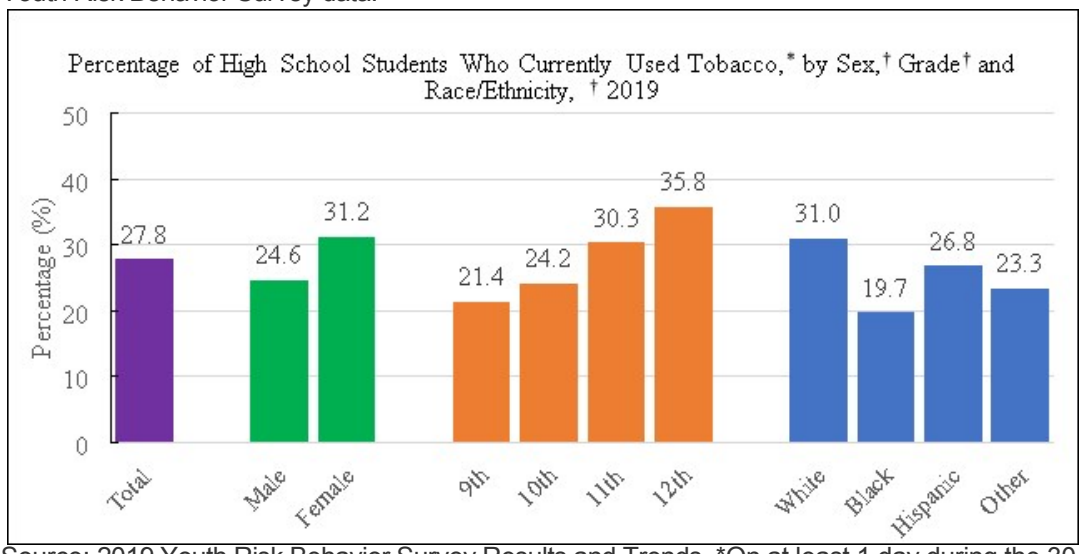
The CT Youth Risk Behavior Survey (YRBS), which is administered as the "Connecticut School Health Survey" (CSHS) is a school-based surveillance system designed by the Centers for Disease Control and Prevention and collects data on substance use and abuse including alcohol, mental health, well-visits, physical activity and nutrition, obesity and overweight, sleep, violence and injury, sexual behaviors, as well as positive or protective factors. The CSHS was administered during the spring of 2019 to high school students in grades 9 through 12. Results were prepared for dissemination in early 2020, including annual estimates, a trend report, a health and academics report, sexual minority risk report. Reports were posted online and shared with stakeholders and partners. Results from the CSHS can be found at www.ct.gov/dph/CSHS.

Adolescent health data from the CSHS continues to support the work of adolescent health programs within DPH, as well as programs in other organizations that promote adolescent well-being, including the CT Department of Education, Department of Mental Health and Addiction Services, and Department of Children and Families and non-governmental agencies such as the Connecticut Alliance to End Sexual Violence, Connecticut Coalition to End Homelessness, the Suicide Advisory Board, and the CT Children's Injury Prevention Center.

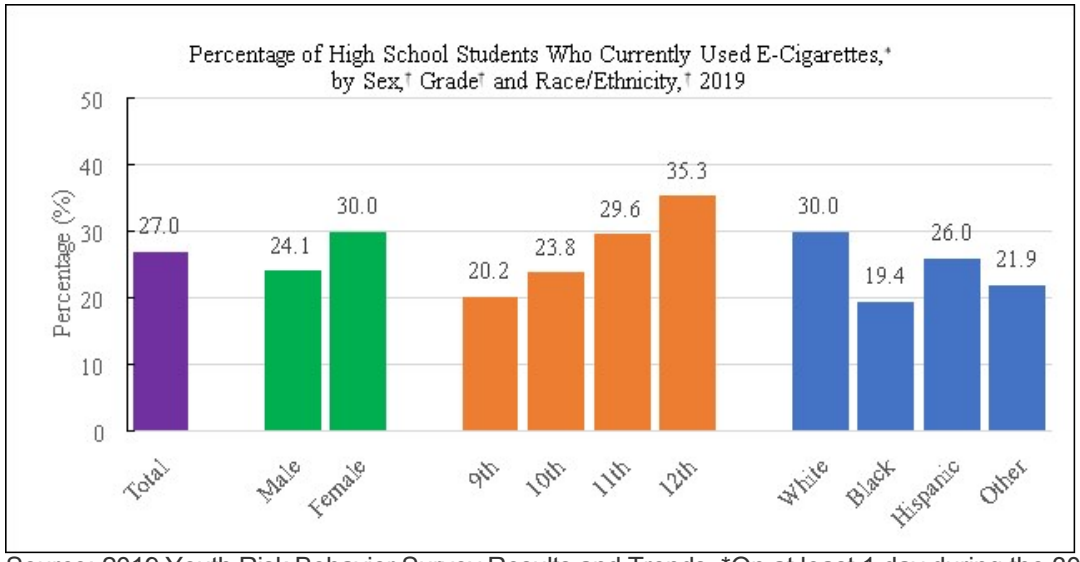
In the spring of 2020, the CDC released a funding opportunity to YRBS funded states to help increase knowledge about Adverse Childhood Experiences (ACEs) using the YRBS data. Connecticut DPH applied for this supplemental funding and was awarded to supplement the next administration of the survey in 2021 with a panel of ACEs-related questions. Subsequently, in May 2020, the CDC announced a competitive funding opportunity through the Preventing Adverse Childhood Experiences (PACE) Data to Action grant. An application was developed by a multi-agency team including CT DPH, the CT Office of Early Childhood, Department of Children and Families, University of Connecticut, Department of Mental Health and Addiction Services and was awarded for project period starting August 2020.

About 44,000 Connecticut high school students use at least one tobacco product, including e-cigarettes, which are

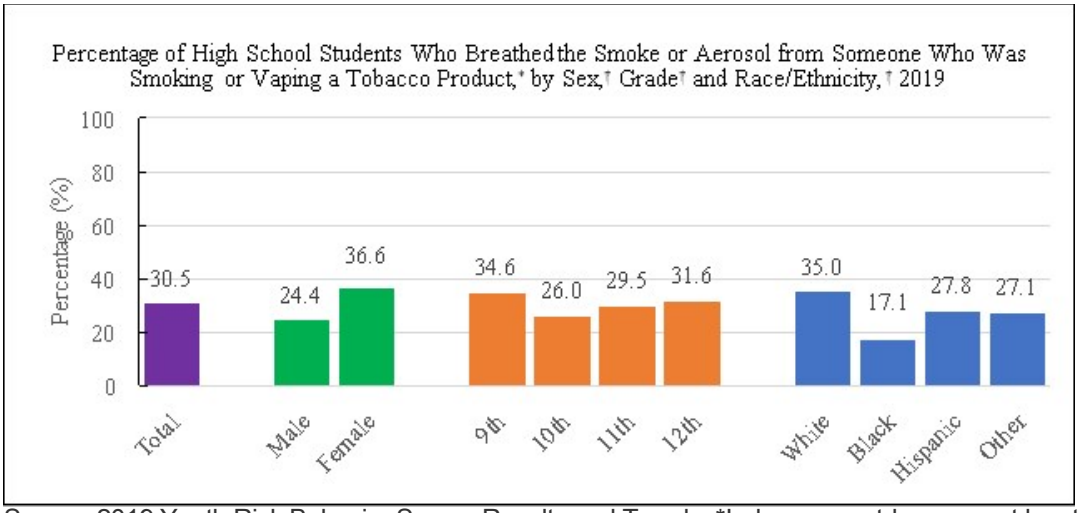
the most common type of tobacco products used by high school students in CT. Every year in CT, 800 youth under 18 years of age become new daily smokers, and nearly 5,000 Connecticut adults die prematurely from their own smoking. Vaping has been marketed to youth as a safer alternative to cigarettes and other tobacco products. As a result, while cigarette smoking among CT high school students decreased from 25.6% in 2000 to 3.7% in 2019, the use of vaping products, such as e-cigarettes, more than tripled from 7.2% in 2015 to 27% in 2019, according to CT Youth Risk Behavior Survey data.



Source: 2019 Youth Risk Behavior Survey Results and Trends. *On at least 1 day during the 30 days before the survey; "tobacco" includes cigarettes, cigars, e-cigarettes, hookahs (waterpipes), chewing tobacco, snuff, snus, dip and pipes. †F>M; 11th>9th, 12th>9th, 12th>10th; W>B, H>B, W>O (Based on t-test analysis, $p < 0.05$). Note: This graph contains weighted results.

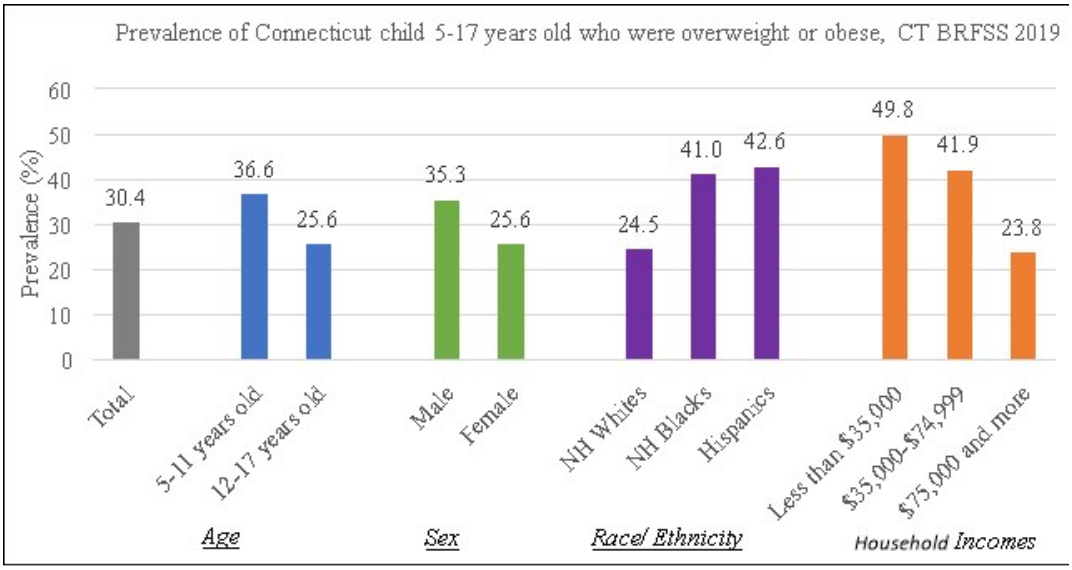


Source: 2019 Youth Risk Behavior Survey Results and Trends. *On at least 1 day during the 30 days before the survey; includes e-cigarettes and other vaping products. †F>M; 11th>9th, 12th >9th, 12th>10th; W>B, H>B, W>O (Based on t-test analysis, $p < 0.05$). Note: This graph contains weighted results.



Source: 2019 Youth Risk Behavior Survey Results and Trends. *Indoors or outdoors, on at least 1 day during the 7 days before the survey. †F>M; 9th>10th; W>B, H>B, O>B, W>H, W>O (Based on t-test analysis, $p < 0.05$). Note: This graph contains weighted results.

The CT Behavioral Risk Factor Surveillance System (BRFSS) concluded data collection for calendar year 2019 and prepared results for release in 2020. Both the 2019 and 2020 CT BRFSS collected child health information (age 0 to 17 years) from an adult proxy on the following topics: child's dental visit, dental decay, and dental sealants; breastfeeding; physical inactivity (screen time including television viewing, use of electronic devices); nutrition; and self-reported height and weight to calculate BMI, obesity, and overweight. Results from the CT 2019 BRFSS were released in late 2020 and posted to the DPH CT BRFSS web page which can be found at www.ct.gov/dph/BRFSS.



Source: 2019 Youth Risk Behavior Survey Results and Trends.

Adolescent Health - Application Year

Adverse Childhood Experiences (ACEs) are stressful or traumatic events, including abuse, neglect and household dysfunction that occur during childhood. These events can affect people of all backgrounds and are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan. ACEs can have lasting, negative effects on health, well-being, and opportunity. These experiences can increase the risks of injury, sexually transmitted infections, maternal and child health problems, teen pregnancy, involvement in sex trafficking, and a wide range of chronic diseases and leading causes of death such as cancer, diabetes, heart disease, and suicide. ACEs and associated conditions, such as living in under-resourced or racially segregated neighborhoods, frequently moving, and experiencing food insecurity, can cause toxic stress (extended or prolonged stress). Toxic stress from ACEs can change brain development and affect such things as attention, decision-making, learning, and response to stress. Children and adolescents growing up with toxic stress may have difficulty forming healthy and stable relationships. They may also have unstable work histories as adults and struggle with finances, jobs, and depression throughout life. These effects can also be passed on to their own children. Some children may face further exposure to toxic stress from historical and ongoing traumas due to systemic racism or the impacts of poverty resulting from limited educational and economic opportunities.

DPH sponsored a virtual technical assistance opportunity for SBHC coordinators, staff, and school personnel called Adverse Childhood Events, Trauma-Informed Care, and School-Based Health Center Considerations for Screening. Over 140 partners participated. Objectives of the training were to understand Adverse Childhood Experiences and their impact on development, describe trauma-informed care, understand the importance of trauma-informed care in SBHCs, identify screening measures to operationalize in SBHCs, and to explain protocols and implementation considerations for SBHC practice. During the upcoming school year DPH plans to hold a technical assistance meeting with SBHC coordinators and stuff to discuss how they have implemented ACES screeners into their practice. The training was also recorded and will be posted to the DPH SBHC webpage for SBHC staff to view. DPH will be keeping track of views and conduct pre and posttest surveys.

DPH funded SBHCs report programmatic data and information three times a year through survey monkey. Information on the number of individuals who received an ACEs screener, the number of individuals found to be at risk, and the number of individuals that were found at risk that were referred for follow up will continue to be collected. The survey monkey report will be modified to collect information related to reimbursement specifically to see if SBHCs are receiving any for administering trauma screenings and which ones and if reimbursement is being provided for treatment. DPH will also ask specifically which social emotional screening tools are being used in the SBHCs, if students have been referred for service based on the screening and if there was follow through with students going to their referred appointments.

In the coming years DPH plans to distribute the 4 What's Next program to the high schools funded by DPH that have a SBHC. The 4 What's Next Program was purchased through a MCHBG Technical Assistance funding. Technical assistance was provided to the SBHCs from the Jordan Porco Foundation. The 4 What's Next curriculum is a primary prevention program that builds resilience in high school students by giving them the tools to handle stress and distress now and in their future. Over the course of 5 modules, students learn and understand what distress looks like for them and develop or strengthen an internal focus of control related to their mental health and emotional wellbeing. They will gain skills for psychological resiliency such as coping skills and help-seeking and learn how to apply these skills to better manage conflict, time, and money as examples.

AMCHP's Innovation Hub (formerly Innovation Station) is an online platform that provides MCH professionals with tools and resources to explore, build, and share successful and effective practices from the maternal and child health

(MCH) field. It is home to the MCH Innovations Database, a searchable repository of "what's working" in the field that improves the health and well-being of MCH populations. Practices in the database are assessed along a continuum and receive a designation of Cutting-Edge, Emerging, Promising, or Best practices depending on the amount of evidence demonstrating their work's impact, among other criteria. In the Summer of 2020, our 4 What's Next program model and implementation strategy was accepted as a Cutting-Edge practice. Cutting-edge practices are generally housed in Innovation Station for two years.

Also, AMCHP began piloting a technical assistance cohort to support cutting-edge practices and work with individuals and organizations to help move the practice along the continuum to an Emerging, Promising, or Best Practice to stay in the database permanently. There are two main components to this TA opportunity: 1) One-on-one check-ins between AMCHP staff and individual practices to track progress and provide tailored support, and 2) Training webinars on topics related to Innovation Station's criteria, with opportunities for peer-sharing. This training cohort is open to anyone supporting/working with their practice. This TA opportunity began in early 2021 and one of our MCH staff is taking part in this TA opportunity.

DPH will partner with the School Based Health Centers to develop strategies to educate parents on the importance of well-child visits, including sending flyers/brochures out with annual enrollment packets and dissemination of information through local SBHC advisory boards. DPH will also partner to ensure SBHCs are engaged in health education activities on the individual and group levels and will provide direction and training regarding adherence to Bright Futures as a required standard for all DPH funded SBHCs. Outreach and health education through the School Based Health Centers will be inclusive of nutrition and physical activity. Strategies will be implemented to promote adolescent well-child visits, principally through the School Based Health Centers. DPH Title V will partner with the Medical Home Advisory Council, the CT Association of School Based Health Centers, and the School Based Health Center Advisory Committee to develop strategies to 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. Information will be shared with SBHCs on Medical Home Initiative extended services and respite in order to connect families to the services they may need for their children. A list of minimum standards for all SBHCs in CT was developed by the Advisory and initial plans for adoption into a regulatory structure are underway.

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. SBHC staff also participate on a number of calls with the National SBHC Alliance and state partners. Trainings and resources from national and local partners will be sent out to SBHC staff regularly.

Due to COVID-19 CT schools and SBHCs have been operating in different ways this past school year. Some were open, others had a hybrid model or distance learning was used full time. SBHCs continued to see students through telehealth visits and in person visits when they could. For the 2021-2022 school year, schools plan to be open for all students and distance learning may be an option in some schools. SBHCs will continue working hard to provide medical and mental health services through telehealth and in person visits and assist with community need around COVID-19 testing and vaccination. DPH anticipates a reduction in visit numbers during this uncertain time.

The Connecticut Department of Public Health (DPH), in collaboration with the Connecticut State Department of Education (CSDE), has received federal funding and plans to offer a no-cost weekly pooled COVID-19 screening testing to schools. Through this program DPH and SDE are hoping to provide, with the help of a testing partner, weekly pooled testing to all unvaccinated K-12 students and staff in both public and private schools in several identified high-risk areas and weekly pooled testing to all unvaccinated K-6 students and staff in all public schools in

the rest of the state. Through testing cases may be identified sooner when screening testing is utilized, weekly surveillance testing of students and staff can help increase the time students spend in the classroom and reduce the number of days/times they are required to quarantine, screening testing reduces the risk of school-based COVID-19 transmission, and it allows parents, staff, and students to have confidence in school learning. The DPH SBHC program and staff will assist with linking this testing program with SBHCs as needed.

CT Medical Home Initiative (CMHI) for CYSHCN Care coordinators will work with School Based Health Center staff to ensure families are accessing needed resources. Some care coordinators are embedded in pediatric practices while others spend time working to engage new practices with medical home and provide ongoing engagement with other involved practices. Care coordinators help families get appointment with specialists including dental services, acquire transportation to appointments, get respite funds, and facilitate insurance coverage for services. The coordinators help each family prioritize the specific needs, link them to support groups and food pantries if necessary, in the area, help set up home therapy, and help with any difficulties or confusion the families might be having in getting services at school, including attending meetings at the school to help set up 504 plans. CMHI Care Coordinators along with staff from the CT Medical Home Initiative at FAVOR will reach out to School Based Health Centers staff to ensure they are connected to community resources, extended service funds for pharmaceutical and nutritional products, respite and other family identified needs.

Care Coordination Collaboratives are comprised of care coordinators from all the sectors related to children: health, early care and education, family advocacy, law, home visiting programs, state agencies, and more. They come together to learn from one another, identify areas of shared need, develop inter-agency solutions to common problems, discuss emerging challenges and connect with others engaged in improving access to services for Children and Youth with Special Health Care Needs and vulnerable, at risk children and their families. Connecticut has five regional care collaboratives. The Collaborative range from meeting in their regions bimonthly to quarterly with some of the regions hosting electronic meetings for their group. The Collaborative meetings host speakers that highlight a wide range of topics as they related to CYSHCN, children and adolescents. These meetings also are a time where care coordinators can discuss some complex medical needs cases to help link to other services in the community. DPH will connect SBHC staff to their regional care collaboratives. SBHC staff identified will be invited to attend the collaborative meetings in order to engage with other professionals and to gain knowledge on how to better connect the student they are seeing with resources in their community.

DPH Health Survey Unit staff will continue to represent the agency on the Preventing Adverse Childhood Experiences (PACE) Data to Action steering committee and data surveillance committee. Staff collaborated with UConn Center for Prevention Evaluation and Statistics to develop the Adverse and Positive Childhood Experiences (ACE/PCE) Surveillance Capacity Assessment Technical Report. This point-in-time surveillance capacity assessment was conducted as a foundational activity of CT PACE Data to Action initiative. The goals of the assessment were to identify the data and indicators proposed for CT's statewide adverse and positive childhood experiences (ACE/PCE) surveillance system, including exposure/incidence, risk and protective factors, subpopulations at risk, and social determinants of health (SDOH), as well as data access and sharing.

DPH Health Survey Unit staff will continue to represent the agency on the Connecticut Suicide Advisory Board (CTSAB) which meets monthly and continue to co-chair the Data to Action committee of the CTSAB, which meets quarterly. In hopes that in-person learning resumes statewide following the worst of the pandemic, DPH staff will resume their role with the Student Wellbeing committee of the CTSAB during this project year.

The Office of Injury and Violence Prevention (OIVP), Opioid and Drug Overdose Prevention Program is helping CT combat the ongoing drug overdose epidemic, including conducting ongoing statewide surveillance of fatal and nonfatal drug overdoses. Injury and violence epidemiologists from the Injury and Violence Surveillance Unit (IVSU) disseminate local-level and statewide data reports to a broad array of state partners and stakeholders that capture drug overdose trends in CT in order to support the design of targeted community prevention strategies and evaluate

state-level interventions. State stakeholders will include School-Based Health Centers, school districts, and college campuses.

CT saw a steep rise in deaths from prescription drug and opioid overdoses between 2012 and 2020 and ranked among the top ten states with the highest rates of opioid-related overdose deaths. The impact of addiction on families is immeasurable. According to CT School Health Survey data, illicit drug use among Connecticut high school youth has significantly decreased over the last 10 years (2009-2019). This downward trend was observed for marijuana use, age at first marijuana use (younger than 13 years of age), cocaine, heroin, methamphetamines, and ecstasy. The percentage of students who were offered, sold, or given illegal drugs on school property significantly declined from 28.9% in 2009 to 19.2% in 2019. Just over 10% of high school students reported ever taking a prescription pain medicine without a doctor's prescription or taking it differently than how a doctor told them to use it. In 2019, the prevalence for inappropriate use of a prescription pain medicine was highest for Hispanic youth and was significantly higher than non-Black students (14.3% compared to 8.0% (White) and 4.3% for non-Black Other Race). In the coming grant year, the OIVP will continue to share prevention messaging and materials on youth and young adult use of prescription and illicit drugs with Title V staff and programs in order to address health disparities by sex, race, ethnicity, sexual orientation and gender identity.

Interagency collaboration has been the hallmark of the efforts by state agencies in CT working towards the goal of reducing opioid related deaths and overdoses. CT DPH will continue to work together with its partners to reduce of the impact of prescription and illicit drug misuse in CT by utilizing:

1) Existing CT campaigns to reach adolescents: Over the last four years, CT has learned that opioid overdose prevention and awareness communications campaigns are best leveraged through the work of multiple state agencies and partners. Examples of complementary CT campaigns include: 1) the CT 'Change the Script' campaign focused on primary prevention as well as messages around naloxone; 2) the new LIVE LOUD/Harm Reduction campaign that explicitly educates on the dangers of Fentanyl is a statewide platform for messaging addressing opioid use disorder, including prevention, treatment, and recovery; and 3) the DPH Naloxone + Overdose Response App (NORAsaves.com), a progressive website developed to be an interactive educational tool for CT residents to help advance the use of naloxone, provide education on opioids, and help prevent overdose deaths in the state.

2) Interagency advisory bodies to assess resource gaps: The CT Alcohol and Drug Policy Council (ADPC) is a legislatively mandated body comprised of representatives from all three branches of State government, consumer and advocacy groups, private service providers, individuals in recovery from addictions, and other stakeholders in a coordinated statewide response to alcohol, tobacco and other drug (ATOD) use in CT. The Council, co-chaired by DMHAS and the Department of Children and Families (DCF), is charged with developing recommendations to address substance-use related priorities from all state agencies on behalf of CT citizens across the lifespan and from all regions of the state. The meetings are convened every other month at the CT Legislative Office Building. The Prevention subcommittee of the ADPC meets on a monthly basis. Staff from the DPH OIVP and IVSU regularly participate in this group. This is a statewide, multidisciplinary workgroup with a mission of recommending programs, and services to prevent the onset of illegal drug use, prescription drug misuse and proper disposal; and to promote effective substance misuse prevention practices that enable communities and other organizations to apply prevention knowledge effectively.

3) Support for the CT Interscholastic Athletic Conference (CIAC) to deliver prevention campaign messaging to target student athletes and their families. The CIAC is the sole provider of access to CT's student athletes for championship games, which attract huge numbers of adolescents and their families. CIAC will include the CT Change the Script, opioid misuse and overdose prevention, campaign messages at events and provide outreach to coaches, athletic directors, school administration, and staff.

Connecticut has a growing number of state and local agencies involved in suicide prevention, intervention, and response. CT has multi-pronged, coordinated suicide prevention efforts that cross programs at the CT DPH, CT Department of Mental Health and Addiction Services (DMHAS), CT Department of Children and Families (DCF), Wheeler Clinic, and United Way of CT/2-1-1 which operates the statewide suicide crisis lifeline (CT-NSPL). In 2020, CT DPH was awarded a 5-year CDC Comprehensive Suicide Prevention grant that used the Public Health Approach for suicide prevention. As part of this project, CT DPH will continue these integrated collaborations, work to sustain the statewide 1 Word, 1 Voice, 1 Life awareness campaign and comprehensive statewide websites: preventsuicidect.org and www.Gizmo4MentalHealth.org, and implement the newly updated statewide five-year suicide prevention strategic plan, Connecticut's Suicide Prevention Plan 2020-2025 (PLAN 2025). In recent years, the statewide CT Suicide Advisory Board (CTSAB) has branched out to include five (5) Regional Suicide Advisory Boards (RSABs). Each RSAB is unique and self-autonomous but supports the overall vision of the statewide CTSAB and provides the local and regional infrastructure for activities. As part of the CDC-funded project, local health agencies will connect with their region's RSABs and local prevention councils to support suicide prevention, intervention, and response in their local jurisdictions.

According to CT Violent Death Reporting System data, the under 25-year-old age group comprises 10% of suicide decedents, but according to Emergency Department and hospitalization data, represent a large proportion of people who seek emergency medical treatment for suicide attempts (SA) and self-directed violent (SDV) behaviors. About three-times higher number of females (75%) under 20 years old incurred SA and SDV-related ED visits and in-patient stays (IPs) compared to males (25%) and past data have shown that nonfatal suicide risk is higher in Hispanic female adolescents. When looking at trends over time from 2016 through 2018, there was an upward trend for Hispanic youth, for both males and females under 20 years old.

Injury and Violence prevention and surveillance staff regularly participates in CT Suicide Advisory Board (CT-SAB) meetings and share information with Title V staff. Title V will work to build its connection to the CT-SAB and increase awareness of SBHCs as a resource for suicide prevention and intervention.

PLAN 2025 is aligned with the National Strategy for Suicide Prevention and Healthy People 2020 and be designed to be accessible to everyone. Individuals, communities, institutions, and organizations are encouraged to use the plan as their working template to guide their efforts to prevent suicide attempts and deaths in CT. PLAN 2025 was launched in September 2020, and the vulnerable populations of focus include youth and young adults, in addition to middle-aged persons. Title V staff will familiarize themselves with the PLAN and disseminate it to MCH stakeholders, including SBHCs.

Title V staff will work with injury and violence epidemiologists to identify higher risk school districts based on rates of suicide/SA/SDV and behavioral health needs, and link school-based health center (SBHC) staff to their respective RSAB. The five (5) RSABs currently help strengthen regional, community, and partnering sector infrastructure, capacity, readiness, resources, and relationships to support mental health promotion and suicide prevention, intervention, and response. The RSABs promote the use of evidence-based practices, including the state suicide prevention campaign (1 Word 1 Voice 1 Life) co-branded with the National Suicide Prevention Lifeline (NSPL), to prevent SAs and deaths. The CT RSABs can help connect SBHCs to gatekeeper training for parents, school staff, and other youth serving organizations in the community. CT has extensive QPR training capacity, including in-person and virtual offerings and modules designed for custom audiences, such as law enforcement, schools and other youth serving organizations, and medical providers. All QPR trainings include mobile crisis and NSPL resources, and there is adequate capacity to respond to increased help-seeking behaviors that often follow gatekeeper training.

The statewide 1 Word 1 Voice 1 Life campaign, developed by the CT-SAB, is intended to educate CT residents on how to recognize the warning signs of suicide, how to find the words to have a direct conversation with someone in crisis, and where to find professional help and resources, including the preventsuicidect.org web site, NSPL, and how to access statewide mobile crisis services. United Way has recently produced video PSAs that speak to suicide prevention among selected population groups, including one for Teens and is available in both English and

Spanish. Title V distributes 1 Word suicide prevention awareness campaign materials throughout all programs. DPH will work with the United Way of CT to identify at least two strategies per year to disseminate the 1 Word campaign with a focus on reaching adolescents.

For the federally funded CT DPH Comprehensive Suicide Prevention grant project, extensive strategic planning has identified youth 10-17 years of age and young adults 18-24 years of age as most at-risk for nonfatal suicide attempts and self-directed violence. The strategies that have been selected to be implemented in September 2021 are the Gizmo Mental Health Promotion curricula in selected elementary and middle schools in CT (4-6th grades) and the 4-What's Next program in 7-8th graders and 11th-12th graders to help build resilience in navigating and coping with major transitions in the youths' lives.

The Tobacco Control Program will continue to provide information and data to community and education partners in efforts to inform adolescents, youth, and young adults as well as their parents and educators about the hazards of vaping. This information will include the latest available research and data on the use of various substances. Materials to be provided include both generalized educational materials and state-specific data and resources that are available for use by Connecticut residents. DPHs Tobacco Control Program will also work with various community organizations to review and revise materials, answer questions, and offer technical assistance upon request. Through participation on the Vaping Resource Committee of the Prevention, Training, and Technical Assistance Service Center funded by the Department of Mental Health and Addiction Services, materials have been developed and disseminated for use by the regional behavioral health action organizations who in turn share with various local prevention councils, youth service bureaus, and community groups. The Tobacco Control Program has developed materials and presentations that are available for a variety of audiences including schools, parent-teacher organizations, youth organizations and other interested parties. During the 2020-2021 school year, a youth cessation curriculum was made available to organizations including school staff, and also provided tobacco treatment specialist training free of charge for those interested in offering programs to CT youth.

The Connecticut School Health Survey will continue to collect public health surveillance data to inform various child and adolescent health programs within CT DPH and external partners too. The school-based survey (known nationally as the YRBS) collects information on ACEs and positive experiences to help inform Objectives 9.1 and 9.2 under Goal 9; adolescent well visit information to help inform Objective 9.3; tobacco and vaping behaviors to help inform Objective 9.4; and suicide risk and attempt data to help inform Objective 9.5. Results from the 2021 CSHS will be posted online and shared with many stakeholders and data users within and outside of CT DPH.

The CSHS will continue to collect self-reported data on many topics including in-school and electronic bullying; dental visits; physical activity level; sedentary behavior; height and weight to calculate BMI, obesity, and overweight; alcohol, marijuana and illicit drug use, adequate sleep; and self-rated health status.

The Behavioral Risk Factor Surveillance System (BRFSS) will continue to collect child and adolescent health information (age 0 to 17 years) from an adult proxy on a variety of topics including: child's dental visit, dental decay, and dental sealants; breastfeeding history; physical inactivity (screen time including television viewing, use of electronic devices); nutrition; and self-reported height and weight to calculate BMI, obesity, and overweight.

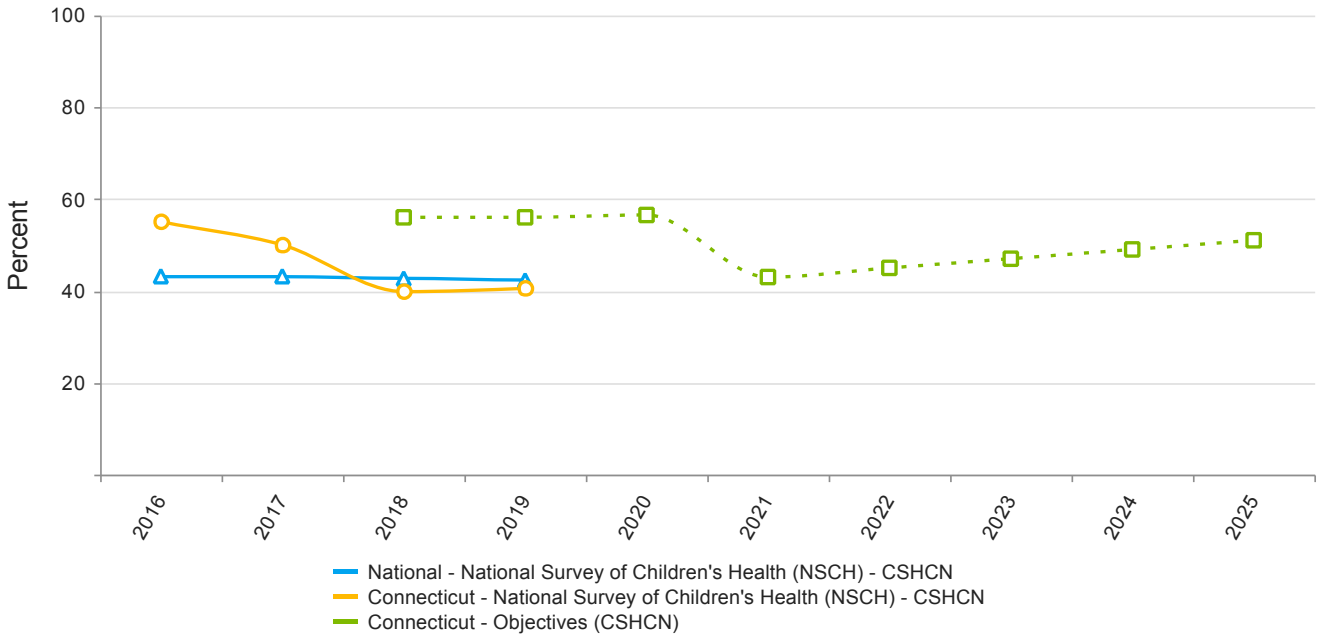
Children with Special Health Care Needs

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	14.8 %	NPM 11 NPM 12 NPM 15
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	53.9 %	NPM 11 NPM 15
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	91.4 %	NPM 11 NPM 15
NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months	NIS-2016	76.3 %	NPM 15
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2019_2020	78.0 %	NPM 15
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2019	70.6 %	NPM 15
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2019	96.5 %	NPM 15
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2019	93.7 %	NPM 15
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	NSCH-2018_2019	1.6 %	NPM 11 NPM 15

National Performance Measures

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home
Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			56	56	56.5
Annual Indicator		55.1	49.8	39.8	40.4
Numerator		85,553	78,583	59,419	60,412
Denominator		155,167	157,677	149,426	149,716
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	43.0	45.0	47.0	49.0	51.0	53.0

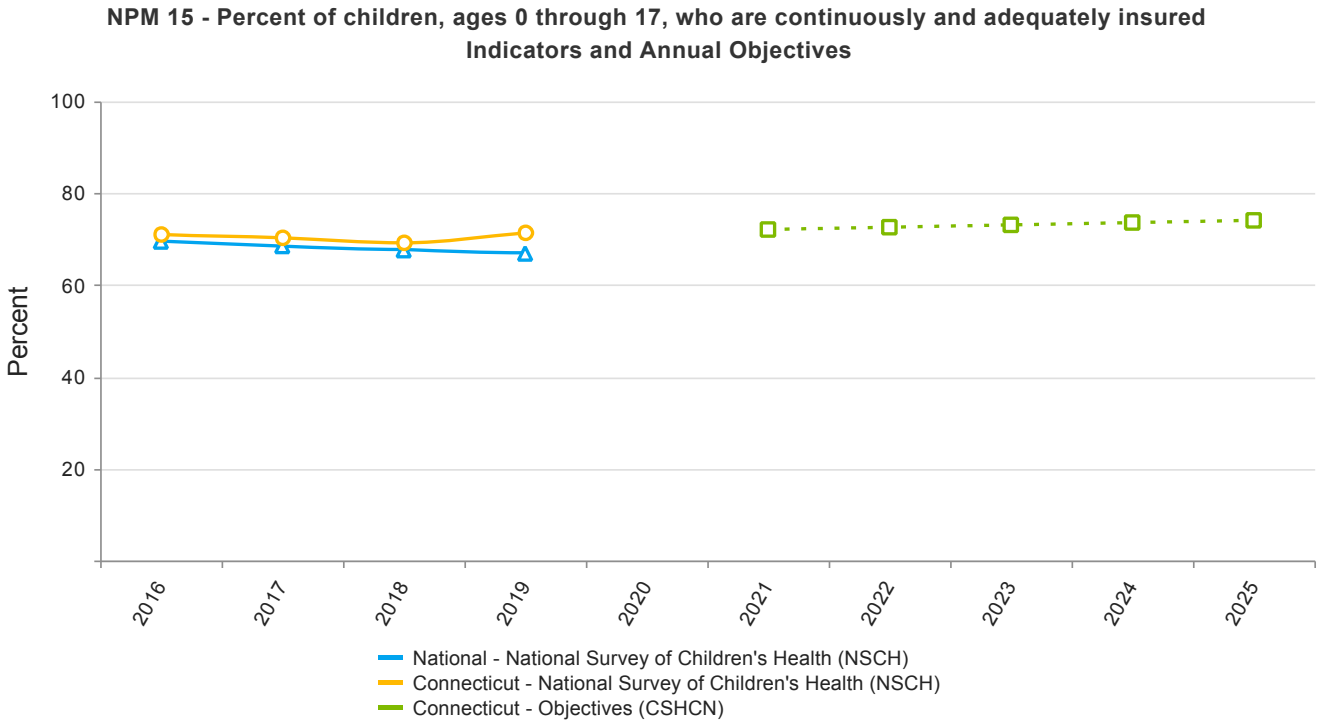
Evidence-Based or –Informed Strategy Measures

ESM 11.1 - Percent of CYSHCN who have a comprehensive care plan in place as evidence that they are receiving care in a well-functioning system

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		19	25	25.5	34
Annual Indicator	18.7	24.8	25.1	32.7	74.2
Numerator	534	510	513	600	1,151
Denominator	2,854	2,059	2,042	1,835	1,551
Data Source	DPH Connecticut Medical Home Initiative Care Coord	DPH Connecticut Medical Home Initiative Care Coord	DPH Connecticut Medical Home Initiative Care Coord	DPH Connecticut Medical Home Initiative Care Coord	DPH Connecticut Medical Home Initiative Care Coord
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	34.5	35.0	35.5	36.0	36.5	37.0



NPM 15 - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2019	**2020**
Annual Objective		
Annual Indicator	69.2	71.3
Numerator	515,486	522,367
Denominator	745,033	732,761
Data Source	NSCH	NSCH
Data Source Year	2017_2018	2018_2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	72.0	72.5	73.0	73.5	74.0	74.5

Evidence-Based or –Informed Strategy Measures

ESM 15.1 - The number of community organizations who help families understand what services are available and covered by insurance for all children including those with special health care needs

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	321	365
Numerator		
Denominator		
Data Source	United Way 2-1-1 database	United Way 2-1-1 database
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	370.0	375.0	380.0	385.0	390.0	395.0

State Action Plan Table

State Action Plan Table (Connecticut) - Children with Special Health Care Needs - Entry 1
Priority Need
Connections to Medical Home/Dental Home
NPM
NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home
Objectives
7.1: By 2025, increase by 1% the number of National Committee for Quality Assurance (NCQA) recognized or Joint Commission Accredited patient-centered medical homes.
7.2: By 2025, increase by 5% the number of children, including those with special health care needs, who have a National Committee for Quality Assurance (NCQA) recognized or Joint Commission Accredited Patient-Centered Medical Home (PCMH).
7.3: By 2025, increase by 5% the number of children, including those with special health care needs, who have a dental home.
Strategies
7.1.1: Partner with community organizations and stakeholders engaged through the CT Medical Home Advisory Council to promote the benefits of medical home to providers.
7.1.2: Determine the percentage of Primary Care Providers whose practices are NCQA or equivalent recognized as Patient-Centered Medical Homes.
7.1.3: Partner with the Department of Social Services Person-Centered Medical Home, Community Health Network, and others to support providers in pursuing NCQA or Joint Commission Accredited patient-centered medical home recognition.
7.2.1: Conduct outreach including to the families of children including those with special health care needs to educate consumers about the benefits and availability of patient-centered medical homes.
7.2.2: Partner with community organizations and stakeholders engaged through the Connecticut Medical Home Advisory Council to promote the benefits of medical home to consumers.
7.2.3: Contact providers and health care facilities that are not recognized and share education materials on the benefits of becoming a Patient-Centered Medical Home.
7.3.1: Establish a mechanism of measuring the number of dental homes through Medicaid data.
7.3.2: Educate families on the importance of dental homes.
7.3.3: Promote interagency and community-based partnerships to improve coordination between medical and dental services.

ESMs	Status
ESM 11.1 - Percent of CYSHCN who have a comprehensive care plan in place as evidence that they are receiving care in a well-functioning system	Active

NOMs
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

State Action Plan Table (Connecticut) - Children with Special Health Care Needs - Entry 2

Priority Need

Supports to Address the Special Health Care Needs of Children and Youth

NPM

NPM 15 - Percent of children, ages 0 through 17, who are continuously and adequately insured

Objectives

8.1: By 2025, increase by 3% the number of children including those with special health care needs who are insured.

8.2: By 2025, conduct an environmental scan of comprehensive health care services for children including those with special health care needs.

8.3: By 2025, increase the number of partner organizations who help families understand what services are available and covered by insurance for children including those with special health care needs 5%.

Strategies

8.1.1: Support trainings for providers working with children including those with special health care needs, to ensure knowledge of insurance coverage.

8.1.2: Offer insurance application assistance through community organizations.

8.1.3: Use social media for targeted information for families including families of those with special health care needs.

8.2.1: Use the CT 2-1-1 Child Development Infoline resource database for comprehensive health care services for all children including those with special health care needs.

8.2.2: Collaborate with partners and community organizations to identify gaps in services.

8.2.3: Collaborate with state agencies regarding insurance coverage.

8.3.1: Work with Care Coordination Collaboratives to increase the number of partner organizations.

8.3.2: Provide information on insurance access to partner organizations.

8.3.3: Provide education or assistance to families in navigating health insurance financing options in their language.

8.3.4: Work with CT 2-1-1 Child Development Infoline to provide training to community partners on generating resource lists for families of children, including those with special health care needs.

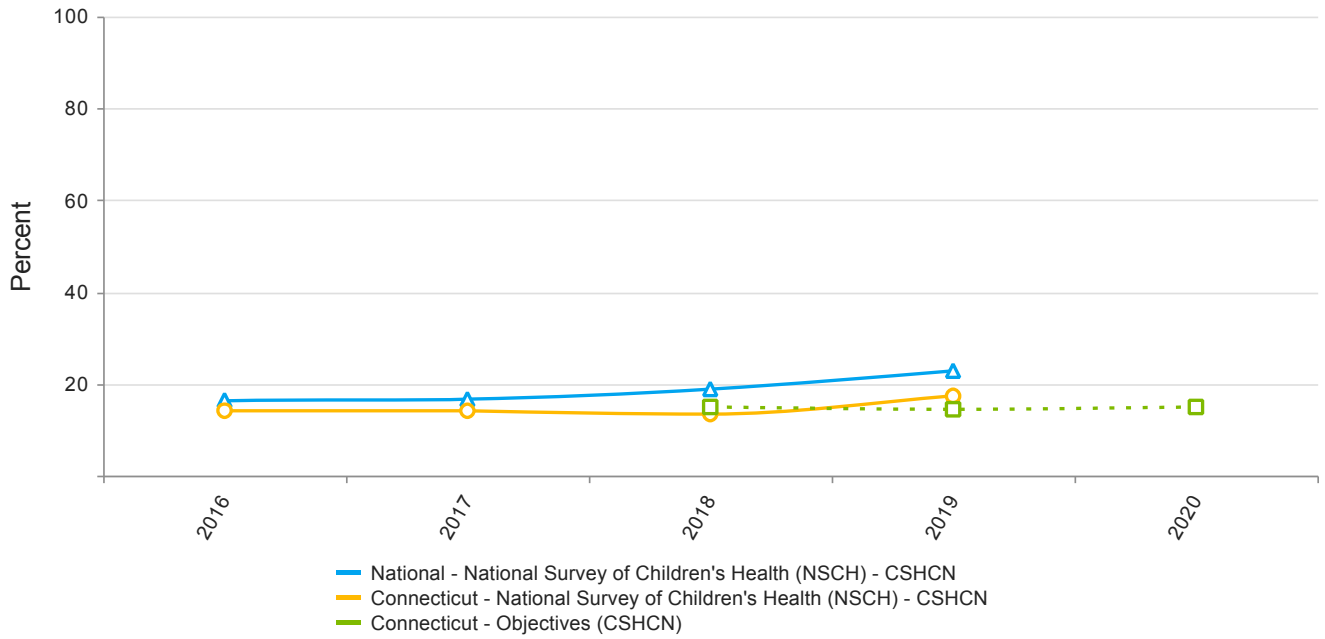
ESMs	Status
ESM 15.1 - The number of community organizations who help families understand what services are available and covered by insurance for all children including those with special health care needs	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

2016-2020: National Performance Measures

2016-2020: NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care
Indicators and Annual Objectives



2016-2020: NPM 12 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			15	14.5	15
Annual Indicator		14.3	14.1	13.5	17.3
Numerator		9,623	10,208	8,513	10,137
Denominator		67,324	72,478	63,050	58,555
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 12.1 - Percent of CYSHCN who have transition plans to adult health care in place by age 14

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		52.3	42	42.5	43
Annual Indicator	50.3	41.9	40.7	27.2	20.6
Numerator	374	206	211	126	89
Denominator	744	492	518	463	432
Data Source	MAVEN, the Department's web-based reporting portal	MAVEN, the Department's web-based reporting portal	MAVEN, the Department's web-based reporting portal	MAVEN, the Department's web-based reporting portal	MAVEN, the Department's web-based reporting portal
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

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 CYSHCN, provided community-based, culturally competent care coordination and family support services to 9,500 CYSHCN in collaboration with 81 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).

CT DPH awarded new funding through a five-year RFP that had three separate components that all are involved with the CMHI. New contracts were developed and executed to seven different contractors. The three components included Care Coordination services, Family Professional Partnerships, and the Respite and Extended Service Funds program. The Care Coordination program provides culturally sensitive, developmentally appropriate, statewide services in community based pediatric practice settings for CYSHCN determined to be eligible under the CT CYSHCN program guidelines. These contractors work with medical home providers, the inclusion of protective factors within the framework of pediatric and other services, integration of behavioral health with primary care, and measuring progress via social networking tools. The five contractors also coordinate regional collaborative meetings. These Collaborative meetings provide a way to identify what gaps in services are happening throughout the state. Contractors focus on reaching out to organizations in their communities to increase the number of partner organizations in their Collaboratives, including providers from Federally Qualified Health Centers (FQHC) and School Based Health Centers (SBHC).

Funding provided through the Family Professional Partnership Services component of the RFP ensures that DPH will continue to provide statewide outreach and culturally effective education encounters for families on the medical home concept for CYSHCN including information regarding accessing community service systems and self-advocacy.

Funding provided through the Respite and Extended Service Funds component of the RFP, which is all state funds, ensures that the awarded contractor will implement and maintain a program to manage respite and extended service funds for children/families deemed eligible for the CYSHCN program. The contractor issues payments to providers who furnish services and provides assistance to consumers in accessing health financing resources from all available sources. It also provides assistance to eligible consumers in accessing available respite funding and service providers.

The CT Title V Program for CYSHCN has been working with contractors to support Community Care Coordination Collaboratives (CCC) in each region. Care Coordination Collaboratives members are vital to maintaining and sharing information, resources and services available to families and disseminating information to families and providers. Meetings focus on expanding knowledge of available services; reducing barriers to resource coordination, interagency communication, and securing appropriate services in a timely manner. Family-specific interagency approaches are developed to promote accessibility across programs. Members from across the spectrum participate including 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. Care Collaboratives are an effective vehicle in reducing duplication of services and MCH National Performance Measure progress.

Community Care Coordination Collaboratives are uniquely positioned to work on both the individual and policy or system level. On the individual level, these Collaboratives focus on families seeking assistance and the care

coordinators who work with them. The goal on this level is to maximize the use of available, appropriate and affordable services for children and their families. Collaboratives achieve this goal by clarifying referral processes; coordinating the services available from collaborative members, documenting activities both during and between meetings; and collecting data that document collaborative efforts and the results of those efforts. This work helps the Collaborative identify policy and/or systems issues that make it difficult for families to obtain the services and support needed and for care coordinators to help them. This information can influence decisions made by program administrators, legislators, state agencies, advocates, and funders. The goal on the systems-level is to change systems and policies so that families can easily obtain needed services.

The CCC Collaboratives serve as resources for the DSS Person-Centered Medical Home (PCMH) program based on the National Committee for Quality Assurance (NCQA) PCMH model. Participation includes PCMH Community Practice Transformation Specialists (CPTS) and Intensive Care Management (ICM) Nurses and Community Workers who are organized under Community Health Network of CT (CHNCT) – CT's Medical Administrative Services Organization (ASO) for the HUSKY Health Program.

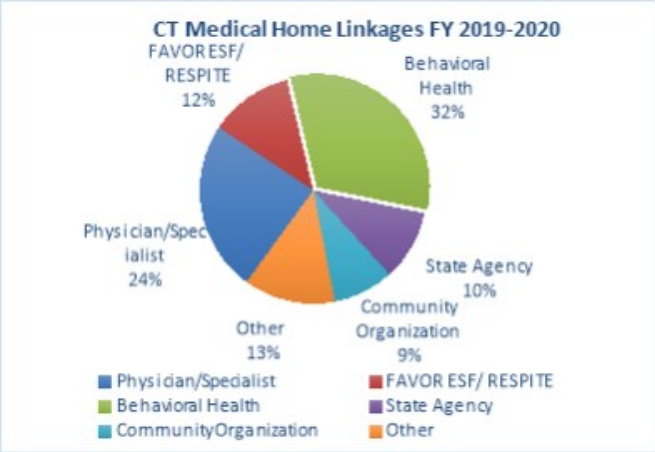
Continued expansion of the Collaboratives which support local medical home providers and care coordinators to access state and local resources, as well as serving to resolve case specific and systemic problems (including reduction in duplicity of efforts) have moved forward, with improvement in both expansion and quality. The Collaboratives range from meeting in their regions bimonthly to quarterly. As a result of the COVID-19 pandemic, all regions held meetings virtually. Some of the regions had already utilized electronic meetings before the pandemic started. The Collaborative meetings hosted speakers that highlighted a wide range of topics as they related to CYSHCN such as the following: intimate partner violence, food insecurity, education during a pandemic including special education and distance learning, and mental health and wellness resources and supports. These meetings also are a time where care coordinators can discuss some complex medical needs cases to help link to other services in the community.

During this federal year, DPH and the Office of Early Childhood (OEC) continued to work together on the integration of CMHI Care Coordination Collaboratives and Help Me Grow Community Collaboratives. We held a meeting in February to discuss what this collaboration among all the programs should look like. It was a time for each Collaborative to discuss upcoming meetings and how to move forward. Each CMHI region has a specific OEC staff member identified to work with. Three of the five regions were able to join together immediately while the other two regions had a harder time due to staff turnover and unfilled positions in the OEC. This integration will focus on improving communication, reviewing and improving data collection and sharing resources.

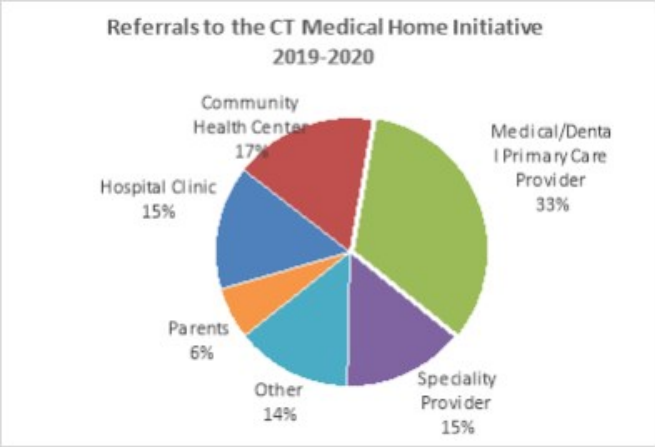
Care coordinators for each region provide a variety of services for CYSHCN in Connecticut. Some care coordinators are embedded in pediatric practices while others spend time working to engage new practices with medical home and provide ongoing engagement with other involved practices. Care coordinators had to shift focus this year because of the pandemic. While they continued to help families get appointments with specialists including dental services, acquire transportation to appointments, get respite funds, and facilitate insurance coverage for services; they also had to help families navigate accessing services virtually and helping direct families to aid for virtual learning. The coordinators help each family prioritize the specific needs, link them to support groups (some of which transitioned to virtual groups because of the pandemic) and food pantries in the area, help set up home therapy, and help with any difficulties or confusion the families might be having in getting services at school, including attending meetings at the school to help set up 504 plans.

One of the goals of the CMHI is to link CYSHCN and their families to any services or providers that they need. In the 2020 contract year, CMHI Care Coordination staff in the five state regions, provided over 9,200 linkages to multiple services and providers. Almost 3,000 CYSHCN were linked to important behavioral health services, which made up

32% of all the linkages provided. Over 2,200 CYSHCN were linked with a necessary primary care physician, specialist, or dentist, which made up 24% of all linkages. Families were also helped by linking them with respite services, other state agencies, insurance providers, community organizations, legal services, and educational services.



Several different organizations and providers recognize the value of the CT Medical Home Initiative. This is evident from the number of referrals to the program throughout the state. Over 400 CYSHCN were referred by medical and dental primary care providers, which was 33% of all referrals. Specialists referred 178 CYSHCN (15%). Community Health Centers referred over 200 patients (17%) and hospital clinics referred 183 patients (14%).



The CMHI meets periodically in different areas of the state for an opportunity for all the contractors and care coordinators funded by the MCHBG and the state of CT to come together to discuss the needs and successes in their region. In FFY20, before the pandemic started, we had speakers that discussed what programs are available in libraries for children and families, including CYSHCN. We also had the Executive Director of True Colors, Inc, who provided information about services and programs they provide to the LGBTQ+ population and their families. We had virtual meetings to discuss what issues and needs the care coordinators were seeing and hearing from the families they serve once the pandemic had started. We also had a presentation about ADHD in Connecticut.

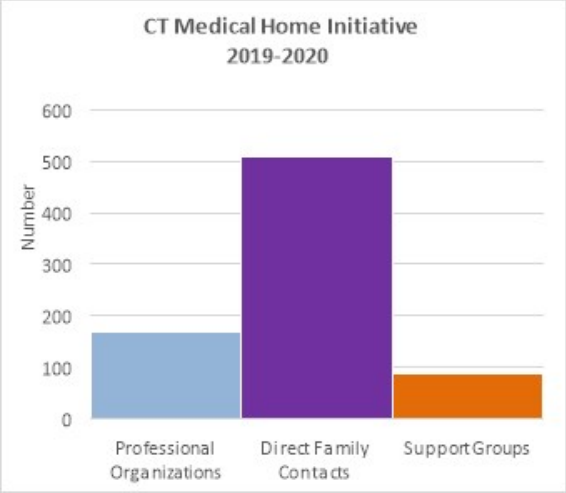
The DPH Medical Home Advisory Council (MHAC), comprised of more than 40 representatives including state and private agencies, community-based organizations, the state's Medicaid Administrative Service Organizations (ASOs) and parents/caregivers of CYSHCN, provides guidance to DPH and its partners in 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. This year the MHAC meetings were active with in depth conversations and presentations about programs in Connecticut such as the Educating Practices Program, which has 21 modules for information to medical providers, and the Connecticut Dental Health Partnership, which is the dental plan for HUSKY Health (Medicaid/CHIP). The MHAC was also very active in helping develop the Needs Assessment and strategies, objectives and goals for CT.

DPH partners with organizations serving CYSHCN, including legislatively mandated and other councils, e.g. the Medical Assistance Program Oversight Council, CT Interagency Birth-to-Three Coordination Council, State Department of Education Bureau of Special Education Transition Task Force, Autism Spectrum Disorder Advisory Council, A.J. Pappanikou University Center for Excellence in Developmental Disabilities Consumer Advisory Council, CT Council on Developmental Disabilities, Maternal Infant and Child Health Coalition, Help Me Grow Advisory, and Sickle Cell Disease Consortium. CMHI access information is distributed among these partners.

Child Health and Development Institute (CHDI) and the CT Family Support Network (CTFSN) provided statewide outreach and culturally effective education encounters for families on the medical home concept for CYSHCN including information regarding accessing community service systems and self-advocacy. This included hosting multiple social media pages and groups specific to different needs, such as a Facebook groups for Spanish speaking parents/caregivers of CYSHCN, parents/caregivers of CYSHCN with potty training difficulties or special diets, or parents/caregivers of CYSHCN for support and self-care. The social media groups and pages had over 9,000 members and followers in total, with Facebook having the highest number of followers. The social media pages reached a total of 221,649 people who can see the posts. The pages were active with over 36,000 post engagements in the forms of reactions, comments, shares, and clicks of links. The CTFSN posted 14 videos to their YouTube channel during the year. There are also several Google group distribution lists, with over 700 members in the statewide group, a few hundred in each of 6 regional groups, and over 50 in very specific groups related to deaf/hard-of-hearing or creative housing groups.

CHDI and FSN provided 57 training sessions for the Educating Practices program on topics such as, but not limited to, Care Coordination, Behavioral Health Screening, Suicide Prevention and ADHD in multiple child health sites. Over 90% of those practices said they would implement changes to their programs. The annual One Voice Conference that was supposed to be held in March 2020 was postponed due to the pandemic. FSN was able to utilize their YouTube channel to post several virtual trainings during the pandemic. Staff reported an increase in views and attendees at virtual trainings and support groups. During the 2019-2020 year, CTFSN worked with 167 professional organization, 509 direct family contacts, including 38 families where English was not the primary language, and held 87 support groups.



CT Title V is 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 are established through statewide implementation of a quality, youth-centered, and culturally competent, comprehensive, coordinated, community-based systems of services for successful YSHCN transition to all aspects of adult life. CHDI and FSN provide information on transition to parents through support groups, social media, and telephone calls. CMHI Care Coordinators in each region work with an individual YSHCN, their family/caregivers and other critically important individuals in the life of the YSHCN to develop a transition plan. A CMHI Care Coordinator meets with the YSHCN and their family/caregiver to establish three critical topics to address. Topics may need the input and support of 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 communication is directed by the YSHCN and their family with coaching from their Care Coordinator.

The transition plan is then implemented and revised as needed, including communicating with 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 contracts and provides leadership guidance. Each region has a Care Coordinator identified as a transition resource person. The CMHI program based at CT Children's Medical Center (CCMC) continues to work with CCMC Transition Task Force within the hospital. This includes a transition physician champion and providers from different medical and behavioral health backgrounds who meet regularly and provide transition guidelines that providers are encouraged to follow for all adolescents.

"Moving Into Adult Health Care Guides" created by CT Kids As Self Advocates were 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.

Children with Special Health Care Needs - 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 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 CYSHCN and their families, the CT Medical Home Initiative (CMHI) for CYSHCN, provides community-based, culturally competent care coordination and family support services to 9,500 CYSHCN in collaboration with 81 community based Medical Homes (MH) including: community health centers, hospital clinics, pediatric and family practices. CMHI care coordination network contractors include: 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).

DPH will continue to convene the DPH Medical Home Advisory Council (MHAC), including convening the MHAC Family Experience Workgroup. MHAC is 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/caregivers of CYSHCN, and provides 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, identify gaps in medical and dental services, 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 will continue to partner with organizations serving CYSHCN, including legislatively mandated and other councils, e.g. the Medical Assistance Program Oversight Council, CT Interagency Birth-to-Three Coordination Council, Help Me Grow Collaborative, State Department of Education Bureau of Special Education Transition Task Force, Autism Spectrum Disorder Advisory Council, A.J. Pappanikou UCEDD Consumer Advisory Council, CT Council on Developmental Disabilities, Maternal Infant and Child Health Coalition, and Sickle Cell Disease Consortium. CMHI access information is distributed among these partners.

CT DPH will work with 7 different contractors that were awarded funding in July 2020 through a five-year RFP that had three separate components that all are involved with the CMHI. The three components were Care Coordination services, Family Professional Partnerships, and the Respite and Extended Service Funds program. The Care Coordination program provides culturally sensitive, developmentally appropriate, statewide services in community based pediatric practice settings for CYSHCN determined to be eligible under the CT CYSHCN program guidelines. These contractors work with medical home providers, the inclusion of protective factors within the framework of pediatric and other services, integration of behavioral health with primary care, and measuring progress via social networking tools. The five contractors also coordinate regional collaborative meetings. These Collaborative meetings provide a way to identify what gaps in services are happening throughout the state. Contractors will focus on reaching out to organizations in their communities to increase the number of partner organizations in their Collaboratives, including providers from Federally Qualified Health Centers (FQHC) and School Based Health Centers (SBHC).

Care coordination activities include assessment, care planning, home visits, family advocacy, linkage to specialists, dental services 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 including dental providers, family support and transition planning, and navigating telehealth and electronic services that developed as a response to the COVID-19 pandemic.. Collaborative outcomes experienced to date include: improved linkage to services for CYSHCN and other vulnerable children; strengthened implementation of Person Centered Medical Home 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.

Funding provided through the Family Professional Partnership Services component of the RFP will ensure that DPH will continue to provide statewide outreach and culturally effective education encounters for families on the medical home concept for CYSHCN including information regarding accessing community service systems, navigating insurance access, and self-advocacy. The contractor will provide several options for social media access and workshops, trainings, and education videos on topics that are important for CYSHCN and their families, including insurance access and the importance of having a dental home. The contractor will continue to provide virtual and in person support groups to help families.

A final component of the CMHI CYSHCN RFP provided state funding for Respite and Extended Service Funds. The five care coordination contractors, the family professional partnership contractor, and Child Development Infoline will all continue to work with and refer CYSHCN and their families to this contractor who will provide assistance to consumers in accessing health financing resources from all available sources. It will also provide assistance to eligible consumers in accessing available respite funding and service providers. This contractor will also provide their clients with information about the CMHI care coordination program and the family professional partnerships contractor.

In the upcoming year, for all seven (7) contracts that were awarded through the RFP, DPH staff will work with the contractors as they submit Results Based Accountability Report Card documents for the first time, and streamlining data collection and reporting to help improve efficiency.

DPH staff and the CMHI contractors will continue to be involved with highlighting the importance of developmental screening through workshops and webinars throughout Connecticut, aimed at giving information and support to providers such a home visitors, pediatricians, preschool programs, and kindergarten readiness programs to provide screenings such as Ages and Stages Questionnaire. The meetings and webinars will focus on individualized resources and needs of the communities to ensure the success of all young children through promotion, developmental awareness, and the power of community connections.

DPH will continue to work with the Office of Early Childhood on the integration of CT Medical Home Initiative Care Coordination Collaboratives and Help Me Grow Community Collaboratives. Integration of community collaborative will focus on improving communication, reviewing and improving data collection and sharing resources. Expansion and coordination across the regions, as well as getting feedback from care coordinators and families, will help to refine the model and implement effective care coordination practices around the state.

DPH staff will continue to work with CT 2-1-1 Child Development Infoline to develop an updated resource database for comprehensive health care services for all children, including CYSHCN. CT 2-1-1 currently has an interactive ALICE (Asset Limited, Income Constrained, Employed) web tool available and an online database for families to search for resources by their community. CT 2-1-1 also provides a yearly ALICE report to DPH which gives data by

15 service regions in Connecticut. DPH will also continue to work with CT 2-1-1 on their Navigator Benefits Screener which is an anonymous tool that allows a person to answer a question to generate a list of some state and federal assistance programs that could be of help, what they may qualify for, and how to apply for them. CT 2-1-1 will also continue to work with DPH and community providers to make sure that all the CT 2-1-1 databases stay up to date for individuals and families to access information on a variety of services such as employment assistance, transportation, housing, utilities, mental health services, COVID-19 resources, and basic needs. DPH will also work with them to provide training to community partners on generating resource lists for families of children, including CYSHCN. As a result of the large increase in web-based searches and calls to 2-1-1 from the COVID-19 pandemic, we will working with CT 2-1-1 Child Development Infoline to monitor and respond to the community needs.

DPH staff will also continue to work with the Integrated Care for Kids (InCK) grant to improve child health outcomes, reduce avoidable out of home placement and inpatient stays and create sustainable alternative payment models to support provider accountability for cost and quality outcomes. The Connecticut grant will focus on the city of New Haven, with services to be provided by a mental health outpatient clinic. The goal is to increase access to services and reduce disparities in health outcomes for Medicaid and CHIP-enrolled children up to age 21, as well as pregnant women by providing comprehensive screenings and assigning children to a service integration level that is based on the screening results. Children, including CYSHCN and their families will receive culturally and linguistically appropriate support, including scheduling and transportation assistance and connections to community resources.

Title V staff will also with the National Catalyst Center on NPM #15 to improve financing of care and health insurance coverage for CYSHCN. The Catalyst Center will help staff identify innovative strategies to help finance services and improve reimbursement for services used by CYSHCN. Focus will be on continued access to telemedicine as a result of the COVID-19 pandemic and working with those negatively impacted because of lack of access to computers. The Catalyst Center is a Health Resources and Services Administration funded National Center on insurance access.

The Office of Oral Health (OOH) serves as a primary source of oral health information to CT, promoting the importance of having a dental home and overall health and wellness. This is achieved through ongoing updates to resources on the website, social media messaging, federally funded grant programs, and community and inter-agency partnerships. Sharing and creating new data and resources, including bilingual content, is ongoing.

The OOH will continue to strengthen community partnerships. CT's Dental Health Partnership (DHP), the dental administration for Medicaid works closely with the OOH to promote finding a dental home and access to Medicaid "HUSKY" dental insurance. In the Fall of 2020, DHP invited the OOH to be part of a work group (The Affinity Group) as they explored implementing a medical dental integration concept: medical staff applying dental sealants in pediatric setting during the well- child visits. The goal being to reduce extra visits, reduce transportation barriers, assist families in finding a dental home, and facilitate partnership between medical and dental providers as part of overall wellness. This work group will continue through the 2022 federal fiscal year.

Through a partnership with FQHCs in CT, Community Health Center, Inc, (CHC), the OOH implemented a medical dental integration pilot program (MDIP) at seven CHC sites in March 2021. The pilot features bi-directional referral between the CHC medical and dental staff in effort to reduce child obesity for children, heart disease for adults, and promote oral health as well. An MDIP Advisory was developed in March consisting of stakeholders around the state. Quarterly meetings are held to provide guidance and technical assistance to the project and ensure sustainability.

The OOH along with the support of the CT State Department of Education (CSDE) is planning to conduct Every Smiles Counts (ESC) oral health surveillance during the 2021-2022 academic year. The ESC survey conducted

every three (3) years screens kindergarten and third grade students at randomly selected school in CT as a part of ongoing evaluation of the state's oral health. The survey originally planned for 2020 was postponed a year due to COVID-19 and schools being remote.

Cross-Cutting/Systems Building

Cross-Cutting/Systems Builiding - Annual Report

No content was entered for the Cross-Cutting/Systems Building - Annual Report in the State Action Plan Narrative by Domain section.

Cross-Cutting/Systems Building - Application Year

No content was entered for the Cross-Cutting/Systems Building - Application in the State Action Plan Narrative by Domain section.

III.F. Public Input

Consumer Focus Groups

Six consumer focus groups were completed this year in collaboration between DPH staff and Family Representatives of the Medical Home Advisory Council for a total of thirty-six participants. The focus groups were conducted virtually with consumers identified as utilizing MCH services. There was a total of 36 participants: 11 men, 24 women, and 1 unknown. At least 11 of the women were Hispanic and participated in the 2 Spanish speaking focus groups. Three groups had 6 participants, two had 7 participants, and the last group had 4. Nine questions were asked this year, an increase from seven questions last year. Some of the questions from last year were removed or reworded. There are two new questions at the end which specifically relate to the COVID-19 pandemic.

Chart #1: "What type of services do you need or require?" (previous question was "Who helps your family find services?")

This year, rather than asking who helps the families find services, participants were asked what services they actually needed. The most popular responses tied with 17% were "special education" and "making services more available." For the second most popular answers, there were three that tied at 12%: "transportation," "behavioral/mental services," and "specialty services." "Help accessing services" and "interpretation services" both received 9%. "Homeless services" and "young adult services" both received 6% of responses.

Chart #2: "How can finding these services be easier?" (same question as previous year)

The number one answer was "make services easier and more friendly" with 32%. This is very similar to the "centralized services" answer from last year that got 30%. The second most popular answer is connected to this with 23% - "more information available and up to date." A new response this year, with 14% was "more HUSKY providers." "Translation," "peer support," and "help from providers" fills out the rest of the pie with 9% each. Translation has been an ongoing issue with 20% of responses last year and 12% the year before.

Chart #3: "Who helps you get appointments?" (same question as previous year)

"Self" continues to be at the top of responses with 39%. There was a 3-way tie for 2nd with 19% "doctor/staff," "family/friend," and "clinic/hospital/agency." Previously, all three of these had 11%. "Translator" was mentioned in the previous years coming down from 11% to only 4% this year.

Chart #4: "Who would you talk to if you had concerns about your child's behavior?" (same question as previous year)

Although this is the same question asked in the previous year, the answers are quite different. "Medical provider" was the top response with 23%. There were 3 answers with 20%: "specialist," "community agency," and "school professional." "School professional" was the only common answer given in the prior year. "Family or friends" had 11%, which was also a previously given response. The last two with 3% each were "child" and "self."

Chart #5: "Based on your concerns about your child's behavior has the conversation about evaluation ever come up? (new question)

This is a new question this year. Only 14% of the participants responded that they had conversations with a provider

or the school about getting the child evaluated.

Chart #6: "What would you do if behavioral or other health services were not working for you?" (same as question #5 in previous year)

Most participants (55%) said they were not sure. This was a new response not given previously. This could be due to the extremely different circumstances brought about because of the pandemic. Unlike last year when no one said this, participants may now be looking into what options are available instead of making a quick decision. Two of the answers with 18% were to consult the school system or other agencies. In previous years 20% of parents said they would ask a doctor or care coordinator for advice. Seeking out doctor's advice got only 9% this year. No one gave the answer "give up" which got 32% 2 years ago and last year they switched to "don't give up." This could be considered a more positive outlook on the parents part.

Chart #7: "If you do not have insurance available through your employer, Medicaid, or the Insurance exchange, how would you access health insurance coverage?" (previous question was "How do you get Health Care Services if you can't get Insurance?")

Although this question is worded differently, the answers seem to still be geared to what they would do for services without insurance rather than how would they access insurance. The answers were very similar to the previous year. Last year "FQHCs" got 29% while this year they got 22%. "ER" stayed at 22%. The remaining answers were fairly specific but were all examples of other places to get help: "free bed funds" (21%), "2-1-1" (14%,) and the last 3 all getting 7% were "DSS," "talk to doctor," and "self-pay." Going back to responses two years ago and more, parents were saying "go without. This could be considered a good change that the parents are not saying that anymore. Another positive trend is that only 7% said "self-pay." Last year, that response was 24%. Lastly no one said "don't know" which was an answer previously given.

#8. "During the pandemic, has your child been receiving medical services?" (new question)

This new question was aimed at finding out if children are getting the medical care that they need during the pandemic. Although 62% said yes, many stated that they had problems getting the care. This may be something to explore in more detail. The 38% that did not get care also should be followed up with the question of were they trying to get care and could not or they just did not need services during that time period.

#9. "Are you receiving telehealth or Tele-audio services?" (new question)

Also, a new question because of the pandemic. Since telehealth was made reimbursable, many providers used this as a way to reach clients. 73% of participants said they had telehealth services, 15% had only audio, and 12% said no. A follow up question was asked what the participants liked and or did not like about telehealth services. People enjoyed that there was no travel involved, they did not have to take out their children in cold weather, and some were able to have all the services/visits they needed. Some of the complaints about telehealth were muffled sounds, not knowing how to use the technology, the doctor not being able to see the body part that was causing the issue, or the lack of privacy because of the need to have a family member translate.

Title V Consumer Reader – Tesha Tramontano-Kelly
Biography

The MCHBG Consumer Reader has over seventeen years' experience in grassroots advocacy and nonprofit

leadership. She worked with a Connecticut nonprofit for over 16 years, eight as the Executive Director. The nonprofit assisted families that are raising children with special needs. Currently the reader is the Director of Operations for a New Haven based nonprofit that works with the community to bridge the digital divide while offering free technology classes and opportunities to help the participants learn computer skills that will help them with their education and career path. The reader also started a consulting agency that works with organizations and businesses to assist them to build a strong leadership team with the goal of creating a tailored business plan that will suit their needs. The reader believes that effective communication is the key to successful relationships in both personal and professional associations.

Pg. 41- DPH is committed to helping strengthen workplace effectiveness and professional profile and recognizes that continuous learning is key to thriving in today's challenging and ever-changing work environments. The Department of Administrative Services and Connecticut's Community College System are partners in providing a wide variety of cost-effective training opportunities to Connecticut State employees. Staff are able to take courses in the Fall, Spring, and Summer of each year that is designed to enhance skills to meet and support agency goals efficiently and with a high level of customer service. Funding from the MCHBG has enabled Title V Staff to participate in these courses. I suggest adding the number of DPH staff that has taken advantage of this educational opportunity.

Pg. 43- DPH Medical Home Advisory Council has a Family Experience Workgroup who provides consistent support for quarterly meetings and offers 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 Family Experience Workgroup serves as a conduit to ensure a broad representation of family experiences are shared with Council members and to distribute materials and information gathered at MHAC and Family Experience meetings to families statewide.

Is the above mention of AFCAMP still, correct? I suggest adding that family members also help to plan, organize and implement Focus Groups. I see that this is mentioned on pg. 44, but I think at least once sentence mentioned here would be beneficial. Also, depending on the time frame of this reporting, mention that a focus groups were held virtually due to the pandemic.

DPH works closely with CT Family Support Network on several training programs including “Positive Communication: Understanding the Family Perspective.” The training helps to enhance the skills that professionals have in communicating effectively and empathizing with the families they serve. “Now What? You are Not Alone” is a training offered by CTFSN for parents and family members to find out what resources, options, supports are available to help navigate a family’s journey. Be sure that the above-mentioned opportunities are up to date and still being offered by CTFSN.

Pg. 44- 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

Women/Maternal Health

Pre/Interconception Health. Pg. 69.

It is impressive to see all the different collaborations of clinical and community base providers. This section mentions the outreach to increase provider expertise, but it is not clear if what outreach is done for consumers/communities.

Reproductive Health Services. Pg. 70.

The data provided is very precise and easy to follow along. All this information is helpful in seeing where CT was, but nothing mentioned about next steps for the future. The way that this section is written just informs the reader on what Planned Parenthood has done but does not state the partnership that DPH has with Planned Parenthood.

Pg. 74- This is the information that I was looking for on pg. 70. This was very confusing to me. As I was reading, I was realizing that I already read the same named section earlier.

Same question for other sections that are listed here as well. I found myself scrolling back and forth to follow along. It would make sense to have these sections together. When I am reading them, I was looking for this information and did not realize that is was listed a few pages away.

Pg. 70- The City of New Britain has the 2nd highest teen birth rate in the state at 44.2 per 1,000 women ages 15-19 and the highest repeat teen pregnancy rate in the state, and the family Planning Center that provided part-time reproductive health services closed. Why not mention the highest city/town and then mention New Britain and the rest of the information? It does not flow with starting with the 2nd highest.

Personal Responsibility Education Program.

This sounds like a great program. Is there any data to include to show the success of the program? Is there any follow up to the 1,127 youth that were part of the program after the exit questionnaires? Is there a plan for the program to continue?

Perinatal/Infant Health

I find this section the same as previous section. This would read much easier if each section was placed together. All the data and narrative provided is well written but broken up. Again, I found myself scroll back and forth looking for information.

Child Health

I am going to re-enforce what I stated below. Maybe if some program names were put in bold, it will be helping to differentiate the programs that are be written about in each paragraph or section. Lots of great information. Some of the paragraphs are long and hard to read because of all the information, but still able to follow along. The sections that have an underlined title were much easier to read as I knew right away what that section was going to be about.

Immunizations, Oral Health, NPAO all were easy to follow along and showed the outcome and closed with how the program would continue.

Adolescent Health

School Based Health Centers

I read this section a few times as there was a lot of information and I wanted to be sure I did not miss any data that I was looking for. I feel this section really did highlight the great work that is being done within the SBHC. Pg. 127-

DPH partnered with Child Health and Development Institute and CT Children's Medical Center to promote Educating Practices training on suicide prevention for pediatric providers. The above mentioned showcases the continued partnership but should include how many of these EP's were provided on suicide prevention and outcomes from the evaluations.

This was the first time that I heard of the Change the Script program. I was very impressed to learn of the partnership with the CIAC. This is a great partnership to have as they have a very large outreach and audience.

There are two sections that mention the SBHC staff viewing the film Resilience. Pg. 130 and pg. 126. There's repetitive information on pg. 130 and 131 regarding the SBHC's.

As I stated earlier about other sections. The information would be easier to read if the sections were combined to show what was done, data and future plans.

Children with Special Health Care Needs

Correct acronym for Connecticut Family Support Network to CTFSN.

Pg. 147 mentions the regional collaborative meetings. I would suggest including data on how often they meet and attendance and maybe some of the guest speakers.

The information given regarding MHAC was very comprehensive. I suggest also adding that the co-chairs are always a parent/family member and a provider. I think it will show the commitment to keep parents/families involved and not just at the table.

There is also some repetitive information and again too broken up.

III.G. Technical Assistance

The DPH Title V Program is requesting TA through a trainer such as AMCHP or Georgetown University to facilitate a series of virtual or in person sessions on Health Inequity/Disparities for Title V Program staff within the Department. The intent is to foster state specific trainings and discussions for up to twelve (12) Title V staff.

Specifically, the Title V Program is requesting that the sessions include the following topics:

1. The Impact of Racism on Health and Birth Outcomes - A foundational overview of applying an equity lens to improving all aspects within MCH.

Learning Objectives:

- Build a clear understanding of key concepts such as racial equity and structural racism;
- Learn to talk about race constructively within organizations and with key stakeholders and communities;
- Gain tools and practices for counteracting racial bias in work and practices; and
- Identify opportunities and next steps for applying concepts and strategies to advance racial equity

2. Building the Capacity of MCH to Advance Racial Equity (Putting Concepts into Action) - Strategies to advance racial justice and expand knowledge of structural racism and its operation in systems and organizations.

Learning Objectives:

- Learn how to effectively frame and message the structural determinants of health to multiple stakeholders and convey health as a human right;
- Gain strategies and learn tools for authentically engaging partners and communities in social justice work;
- Understand the major components of a racial equity initiative;
- Review several tools and materials used by other state health departments in their health equity work, and explore how the agency could adopt them; and
- Identify the next steps needed to implement health equity components fostering structural change within the Department.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - DPH_DSS_IAA-MOU_FINAL.pdf

V. Supporting Documents

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

Supporting Document #01 - Focus group charts for 2022 application_TVIS FINAL.pdf

Supporting Document #02 - MCH SHA.pdf

Supporting Document #03 - State statutes.pdf

Supporting Document #04 - 2019-2020 Fatherhood Brief_TVIS FINAL.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - Combined Agency and Section ORG Chart.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Connecticut

	FY 22 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 4,663,927	
A. Preventive and Primary Care for Children	$ 1,406,864	(30.1%)
B. Children with Special Health Care Needs	$ 1,747,410	(37.4%)
C. Title V Administrative Costs	$ 160,524	(3.5%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 3,314,798	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 6,780,000	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 6,780,000	
A. Your State's FY 1989 Maintenance of Effort Amount $ 6,777,191		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 11,443,927	
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)	$ 3,458,374	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 14,902,301	

OTHER FEDERAL FUNDS	FY 22 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health	$ 400,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 559,911
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 235,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 300,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	$ 570,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 149,342
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	$ 1,144,121
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000

	FY 20 Annual Report Budgeted		FY 20 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 4,671,480		$ 4,663,927	
A. Preventive and Primary Care for Children	$ 1,414,593	(30.3%)	$ 1,411,105	(30.2%)
B. Children with Special Health Care Needs	$ 1,834,351	(39.3%)	$ 1,711,055	(36.6%)
C. Title V Administrative Costs	$ 298,128	(6.4%)	$ 196,597	(4.3%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 3,547,072		$ 3,318,757	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 6,780,000		$ 6,780,000	
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)	$ 6,780,000		$ 6,780,000	
A. Your State's FY 1989 Maintenance of Effort Amount $ 6,777,191				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 11,451,480		$ 11,443,927	
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)	$ 3,134,618		$ 3,412,594	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 14,586,098		$ 14,856,521	

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 100,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	$ 1,070,000	$ 1,070,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 171,141	$ 171,141
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	$ 570,000	$ 570,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000	$ 235,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 573,477	$ 566,453
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health	$ 400,000	$ 400,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees		$ 300,000

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: There will be unfilled administrative positions that use MCHBG funds.	

Data Alerts:

- The value in Line 1C, Title V Administrative Costs, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please add a field level note indicating the reason for the discrepancy.

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Connecticut

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 674,910	$ 563,008
2. Infants < 1 year	$ 589,101	$ 746,262
3. Children 1 through 21 Years	$ 1,406,864	$ 1,411,105
4. CSHCN	$ 1,747,410	$ 1,711,055
5. All Others	$ 85,118	$ 35,900
Federal Total of Individuals Served	$ 4,503,403	$ 4,467,330

IB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 745,800	$ 745,800
2. Infants < 1 year	$ 2,169,600	$ 2,169,600
3. Children 1 through 21 Years	$ 3,525,600	$ 3,525,600
4. CSHCN	$ 339,000	$ 33,900
5. All Others	$ 0	$ 0
Non-Federal Total of Individuals Served	$ 6,780,000	$ 6,474,900
Federal State MCH Block Grant Partnership Total	$ 11,283,403	$ 10,942,230

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

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
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	$ 1,068,481	$ 1,016,612
3. Public Health Services and Systems	$ 3,595,446	$ 3,647,315
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		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Federal Total	$ 4,663,927	$ 4,663,927

IIB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
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	$ 678,000	$ 678,000
3. Public Health Services and Systems	$ 6,102,000	$ 6,102,000
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Non-Federal Total	$ 6,780,000	$ 6,780,000

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: 34,986 **Data Source Year: 2020**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	34,911 (99.8%)	1,649	120	120 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Hearing Loss	Holocarboxylase Synthase Deficiency
Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency
Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Mucopolysaccharidosis Type 1	Primary Congenital Hypothyroidism	Propionic Acidemia
S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1
ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Newborn Hearing Screening	34,715 (99.2%)	448	88	85 (96.6%)

3. Screening Programs for Older Children & Women

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Childhood Lead Screening	74,593	1,404	1,188	7

4. Long-Term Follow-Up

The CT Newborn Diagnosis & Treatment Network (the Network), formed in 2019 to respond to reports of presumptive positive newborn screens (NBS) made by the CT NBS Program Follow-up Unit based at the State Laboratory. Established through an initiative of the CT NBS Program, the Network is funded through DPH and administered by CT Children's Medical Center and begins the diagnostic work-up & provides support to the health care team and family as needed. For infants who confirm positive for a disorder identified through NBS, the Network coordinates treatment & long-term follow-up for the condition working with PCPs, hospitals and specialists statewide. The Network established an electronic registry for patients diagnosed through the Network that will enable application of population health principles and tools to provide the highest level of care & optimal health outcomes for the population. The Network measures, tracks & reports on developmental and behavioral health from birth - age 21.

Form Notes for Form 4:

Newborn Hearing Screening- Receive at least one Screen
The mission of the CT EHDI program is to ensure that all CT-born infants receive the appropriate hearing screenings, Cytomegalovirus (CMV) screenings, diagnostic hearing evaluations, early intervention services, family support and mentoring services to maximize developmental outcomes without bias towards communication modes and methods. Additionally, EHDI supports Healthy People 2030 goal.
The program operates under the following authority:
Universal Newborn Hearing Screening legislation passed in 2000, see C.G.S. Sec. 19a-59; CMV testing legislation, passed in 2016. C.G.S. Sec. 19a-55; Referral to Early Intervention, see 17a-248d.

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2020**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: Data for indicators were provided by the DPH Health Statistics and Surveillance Section, May 19, 2021. Data for 2020 are provisional and should be cited as provisional.	
2.	**Field Name:**	**Data Source Year**
	Fiscal Year:	**2020**
	Column Name:	**Data Source Year Notes**
	Field Note: Data for indicators were provided by the DPH Health Statistics and Surveillance Section, May 19, 2021. Data for 2020 are provisional and should be cited as provisional.	
3.	**Field Name:**	**Newborn Hearing Screening - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: 34,715 of Connecticut-born infants were screened for possible hearing loss.	
4.	**Field Name:**	**Newborn Hearing Screening - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: 448 infants failed newborn hearing screening.	
5.	**Field Name:**	**Newborn Hearing Screening - Total Number Confirmed Cases**

	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: 88 had a diagnosed hearing loss.	
6.	**Field Name:**	**Newborn Hearing Screening - Total Number Referred For Treatment**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: 85 diagnosed hearing loss cases were referred Birth to Three.	
7.	**Field Name:**	**Childhood Lead Screening - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2020**
	Column Name:	**Older Children & Women**
	Field Note: Number Receiving at Least One Screen: 74,593 - 2020 data is currently not available, these numbers are for 2019.	
8.	**Field Name:**	**Childhood Lead Screening - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: Number Presumptive Positive Screens: 1404 Capillary >=5 mcg/dL; 1122 of the 1432 received a follow-up confirmatory venous test >=5 mcg/dL	
9.	**Field Name:**	**Childhood Lead Screening - Total Number Confirmed Cases**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: 1,188 Number Confirmed Cases	
10.	**Field Name:**	**Childhood Lead Screening - Total Number Referred For Treatment**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: Number Referred for Treatment: 7 chelations	

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Connecticut

Annual Report Year 2020

Form 5a – Count of Individuals Served by Title V (Direct & Enabling Services Only)

		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	5,139	37.0	0.0	58.0	5.0	0.0
2. Infants < 1 Year of Age	5,334	37.0	0.0	58.0	5.0	0.0
3. Children 1 through 21 Years of Age	134,628	34.0	0.0	62.0	4.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	28,384	36.0	0.0	57.0	7.0	0.0
4. Others	394,971	18.0	0.0	75.0	7.0	0.0
Total	540,072					

Form 5b – Total Percentage of Populations Served by Title V (Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	34,258	Yes	34,258	100.0	34,258	5,139
2. Infants < 1 Year of Age	35,557	Yes	35,557	100.0	35,557	5,334
3. Children 1 through 21 Years of Age	897,522	Yes	897,522	76.0	682,117	134,628
3a. Children with Special Health Care Needs 0 through 21 years of age^	189,226	Yes	189,226	76.0	143,812	28,384
4. Others	2,633,140	Yes	2,633,140	23.0	605,622	394,971

^Represents a subset of all infants and children.

Form Notes for Form 5:

Connecticut DPH does not currently have a mechanism in place to correctly identify or accurately estimate the types of individuals served in Form 5a (i.e. inclusion of unduplicated, direct enabling, non-reimbursed individuals served). We acknowledge this limitation and are working toward solutions.

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2020**
	Field Note: Reference data includes the amount of the total Federal/State partnership expended on enabling services. No funds were used for direct services. Reference data was used to populate the percentages for the primary source of coverage.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2020**
	Field Note: Reference data includes the amount of the total Federal/State partnership expended on enabling services. No funds were used for direct services. Reference data was used to populate the percentages for the primary source of coverage.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Reference data includes the amount of the total Federal/State partnership expended on enabling services. No funds were used for direct services. Reference data was used to populate the percentages for the primary source of coverage.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Reference data includes the amount of the total Federal/State partnership expended on enabling services. No funds were used for direct services. Reference data was used to populate the percentages for the primary source of coverage.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**
	Field Note: Reference data includes the amount of the total Federal/State partnership expended on enabling services. No funds were used for direct services. Reference data was used to populate the percentages for the primary source of coverage.	
6.	**Field Name:**	**Total_TotalServed**
	Fiscal Year:	**2020**
	Field Note: Reference data includes the amount of the total Federal/State partnership expended on enabling services. No funds were used for direct services. Reference data was used to populate the percentages for the primary source of coverage.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2020**
	Field Note: Data Source: National Vital Statistics System – Resident Live Births, 2019	
2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2020**
	Field Note: Data Source: National Vital Statistics System – Occurrent Live Births, 2019	
3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Data Source: US Census Bureau Population Estimates, 2019	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Data Source: National Survey of Children's Health CSHCN Prevalence Estimates 0-17 (2018-2019) multiplied by US Census Bureau Population Estimates 0-21, 2019	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**
	Field Note: Data Source: US Census Bureau Population Estimates, 2019	

Data Alerts: None

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

State: Connecticut

Annual Report Year 2020

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	35,130	18,615	4,046	9,236	43	2,112	6	864	208
Title V Served	35,130	18,615	4,046	9,236	43	2,112	6	864	208
Eligible for Title XIX	18,216	3,304	2,320	3,438	60	397	23	0	8,674
2. Total Infants in State	34,987	18,554	4,017	9,206	42	2,105	6	862	195
Title V Served	34,987	18,554	4,017	9,206	42	2,105	6	862	195
Eligible for Title XIX	17,425	1,170	962	1,577	8	155	6	0	13,547

Form Notes for Form 6:

Data for indicators were provided by the DPH Health Statistics and Surveillance Section, June 3, 2021. Data for 2020 are provisional and should be cited as provisional.

Field Level Notes for Form 6:

None

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Connecticut

A. State MCH Toll-Free Telephone Lines	2022 Application Year	2020 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 203-1234 x211	(800) 203-1234 x211
2. State MCH Toll-Free "Hotline" Name	MCH Information & Referral	MCH Information & Referral
3. Name of Contact Person for State MCH "Hotline"	Selma Alves	Selma Alves
4. Contact Person's Telephone Number	(860) 508-8251	(860) 509-8251
5. Number of Calls Received on the State MCH "Hotline"		5,987,573

B. Other Appropriate Methods	2022 Application Year	2020 Annual Report Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	https://portal.ct.gov/DPH/Family-Health/Maternal--Child-Health-Block-Grant/Maternal--Child-Health-Block-Grant	https://portal.ct.gov/DPH/Family-Health/Maternal--Child-Health-Block-Grant/Maternal--Child-Health-Block-Grant
4. Number of Hits to the State Title V Program Website		366
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

1. Title V Maternal and Child Health (MCH) Director	
Name	Marc Camardo
Title	Supervising Epidemiologist & Title V Maternal and Child Health Director
Address 1	410 Capitol Avenue
Address 2	
City/State/Zip	Hartford / CT / 06134
Telephone	(860) 509-8251
Extension	
Email	marc.camardo@ct.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Ann Gionet
Title	Health Program Supervisor & CYSHCN Director
Address 1	410 Capitol Avenue
Address 2	
City/State/Zip	Hartford / CT / 06134
Telephone	(860) 509-8251
Extension	
Email	ann.gionet@ct.gov

3. State Family or Youth Leader (Optional)	
Name	Selma Alves
Title	Health Program Associate
Address 1	410 Capitol Avenue
Address 2	
City/State/Zip	Hartford / CT / 06134
Telephone	(860) 509-8251
Extension	
Email	selma.alves@ct.gov

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Connecticut

Application Year 2022

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Maternal Morbidity and Mortality	New
2.	Preconception and Interconception Health	New
3.	Infant Morbidity and Mortality	New
4.	Breastfeeding Initiation and Duration	New
5.	Social-Emotional Development and Relationships for Children and Adolescents	New
6.	Preventative Health Care	New
7.	Connections to Medical Home/Dental Home	New
8.	Supports to Address the Special Health Care Needs of Children and Youth	New
9.	Supports for Health, Safety, and Enhanced Social-Emotional Development	New

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Maternal Morbidity and Mortality	New
2.	Preconception and Interconception Health	New
3.	Infant Morbidity and Mortality	New
4.	Breastfeeding Initiation and Duration	New
5.	Social-Emotional Development and Relationships for Children and Adolescents	New
6.	Preventative Health Care	New
7.	Connections to Medical Home/Dental Home	New
8.	Supports to Address the Special Health Care Needs of Children and Youth	New
9.	Supports for Health, Safety, and Enhanced Social-Emotional Development	New

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10
National Outcome Measures (NOMs)

State: Connecticut

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

The 2019 number that was provided last year was 486. This number has been updated due to being able to de-duplicate the site and organizations. In the past, we received only a number from United Way, this year they sent us a spreadsheet for 2019 and 2020, so we were able to correct the 2019 number. Moving forward, the counts will be more accurate.

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	84.7 %	0.2 %	28,832	34,034
2018	84.0 %	0.2 %	28,907	34,414
2017	84.4 %	0.2 %	28,904	34,262
2016	84.1 %	0.2 %	29,479	35,035

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	87.6	5.1	297	33,889
2017	75.9	4.7	262	34,510
2016	74.6	4.6	261	34,999
2015	75.1	5.4	197	26,215
2014	62.0	4.2	217	35,022
2013	65.6	4.4	229	34,891
2012	56.3	4.0	200	35,506
2011	70.2	4.4	254	36,186
2010	59.3	4.0	217	36,612
2009	62.9	4.1	237	37,674
2008	54.2	3.8	210	38,720

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
2015_2019	14.2	2.8	25	175,965
2014_2018	11.8	2.6	21	177,992

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 - 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
2019	7.8 %	0.1 %	2,657	34,250
2018	7.6 %	0.1 %	2,641	34,710
2017	8.1 %	0.2 %	2,845	35,209
2016	7.8 %	0.1 %	2,813	35,999
2015	7.9 %	0.1 %	2,836	35,730
2014	7.6 %	0.1 %	2,763	36,275
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% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	9.4 %	0.2 %	3,208	34,244
2018	9.4 %	0.2 %	3,251	34,716
2017	9.5 %	0.2 %	3,338	35,195
2016	9.4 %	0.2 %	3,375	35,819
2015	9.3 %	0.2 %	3,340	35,733
2014	9.2 %	0.2 %	3,347	36,268
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% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - 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
2019	25.5 %	0.2 %	8,727	34,244
2018	24.6 %	0.2 %	8,544	34,716
2017	23.7 %	0.2 %	8,341	35,195
2016	23.7 %	0.2 %	8,499	35,819
2015	22.9 %	0.2 %	8,185	35,733
2014	22.5 %	0.2 %	8,159	36,268
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

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, 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
2019/Q1-2019/Q4	1.0 %			
2018/Q4-2019/Q3	1.0 %			
2018/Q3-2019/Q2	1.0 %			
2018/Q2-2019/Q1	1.0 %			
2018/Q1-2018/Q4	1.0 %			
2017/Q4-2018/Q3	2.0 %			
2017/Q3-2018/Q2	1.0 %			
2017/Q2-2018/Q1	1.0 %			
2017/Q1-2017/Q4	2.0 %			
2016/Q4-2017/Q3	2.0 %			
2016/Q3-2017/Q2	3.0 %			
2016/Q2-2017/Q1	3.0 %			
2016/Q1-2016/Q4	3.0 %			
2015/Q4-2016/Q3	3.0 %			
2015/Q3-2016/Q2	3.0 %			
2015/Q2-2016/Q1	3.0 %			
2015/Q1-2015/Q4	3.0 %			
2014/Q4-2015/Q3	3.0 %			
2014/Q3-2015/Q2	3.0 %			
2014/Q2-2015/Q1	3.0 %			
2014/Q1-2014/Q4	3.0 %			
2013/Q4-2014/Q3	4.0 %			
2013/Q3-2014/Q2	3.0 %			
2013/Q2-2014/Q1	4.0 %			

Legends:

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
2018	5.2	0.4	182	34,816
2017	5.0	0.4	178	35,307
2016	5.1	0.4	184	36,092
2015	6.1	0.4	220	35,839
2014	5.0	0.4	182	36,362
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
2018	4.2	0.4	146	34,725
2017	4.5	0.4	159	35,221
2016	4.8	0.4	172	36,015
2015	5.7	0.4	202	35,746
2014	4.8	0.4	175	36,285
2013	4.8	0.4	173	36,085
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
2018	3.1	0.3	106	34,725
2017	3.0	0.3	107	35,221
2016	3.6	0.3	129	36,015
2015	3.9	0.3	141	35,746
2014	3.5	0.3	127	36,285
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
2018	1.2	0.2	40	34,725
2017	1.5	0.2	52	35,221
2016	1.2	0.2	43	36,015
2015	1.7	0.2	61	35,746
2014	1.3	0.2	48	36,285
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
2018	161.3	21.6	56	34,725
2017	195.9	23.6	69	35,221
2016	216.6	24.6	78	36,015
2015	293.7	28.7	105	35,746
2014	203.9	23.7	74	36,285
2013	205.1	23.9	74	36,085
2012	251.8	26.3	92	36,539
2011	182.4	22.1	68	37,281
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 - 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
2018	63.4	13.5	22	34,725
2017	59.6	13.0	21	35,221
2016	50.0	11.8	18	36,015
2015	56.0	12.5	20	35,746
2014	57.9	12.6	21	36,285
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 - Percent of women who drink alcohol in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	9.0 %	1.1 %	2,880	32,134
2018	7.5 %	0.9 %	2,463	32,624
2017	8.7 %	1.1 %	2,866	33,102
2016	10.9 %	1.1 %	3,693	34,006
2015	7.7 %	1.2 %	2,620	33,849
2014	7.8 %	1.1 %	2,700	34,482

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	8.3	0.5	283	34,025
2017	9.9	0.5	343	34,490
2016	10.2	0.5	358	35,216
2015	9.7	0.6	257	26,466
2014	9.5	0.5	335	35,389
2013	8.9	0.5	310	34,975
2012	7.4	0.5	262	35,625
2011	7.5	0.5	277	36,725
2010	6.6	0.4	245	37,355
2009	6.1	0.4	234	38,440
2008	5.0	0.4	198	39,538

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)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

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

Federally available Data (FAD) for this measure is not available/reportable.

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 year

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	9.1 %	1.3 %	63,158	693,901
2017_2018	7.1 %	1.1 %	50,058	702,800
2016_2017	7.6 %	1.1 %	53,874	706,555
2016	8.2 %	1.3 %	58,259	710,443

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable 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**
2019	9.1	1.6	31	341,823
2018	12.2	1.9	42	344,032
2017	13.0	1.9	45	347,469
2016	11.7	1.8	41	351,028
2015	8.1	1.5	29	356,910
2014	10.2	1.7	37	362,832
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
2019	21.4	2.2	97	453,134
2018	21.1	2.1	97	459,801
2017	22.8	2.2	106	465,119
2016	18.5	2.0	87	470,268
2015	20.0	2.1	95	476,078
2014	18.9	2.0	91	482,093
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
2017_2019	6.6	1.0	48	725,857
2016_2018	5.0	0.8	37	734,411
2015_2017	5.4	0.9	40	742,842
2014_2016	5.2	0.8	39	750,032
2013_2015	7.4	1.0	56	756,382
2012_2014	7.7	1.0	59	761,723
2011_2013	8.3	1.0	63	762,425
2010_2012	8.2	1.0	62	759,483
2009_2011	9.0	1.1	68	757,495
2008_2010	10.4	1.2	79	759,087
2007_2009	11.8	1.3	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
2017_2019	8.0	1.1	58	725,857
2016_2018	6.8	1.0	50	734,411
2015_2017	6.7	1.0	50	742,842
2014_2016	5.5	0.9	41	750,032
2013_2015	5.0	0.8	38	756,382
2012_2014	5.3	0.8	40	761,723
2011_2013	5.4	0.8	41	762,425
2010_2012	5.8	0.9	44	759,483
2009_2011	5.7	0.9	43	757,495
2008_2010	5.4	0.8	41	759,087
2007_2009	6.0	0.9	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 (CSHCN), ages 0 through 17

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	20.3 %	1.6 %	149,716	736,693
2017_2018	20.0 %	1.7 %	149,426	745,342
2016_2017	20.9 %	1.5 %	157,677	755,638
2016	20.4 %	1.6 %	155,167	760,866

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable 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), ages 0 through 17, who receive care in a well-functioning system

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	14.8 %	3.1 %	22,138	149,716
2017_2018	13.8 %	3.3 %	20,649	149,426
2016_2017	17.4 %	3.4 %	27,406	157,677
2016	17.7 %	3.7 %	27,480	155,167

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, 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
2018_2019	3.1 %	0.8 %	19,551	639,351
2017_2018	4.0 %	1.1 %	25,578	640,386
2016_2017	4.3 %	1.1 %	27,016	632,438
2016	3.1 %	0.9 %	19,979	639,426

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, 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
2018_2019	11.2 %	1.4 %	70,765	634,220
2017_2018	10.0 %	1.4 %	63,463	636,725
2016_2017	10.3 %	1.3 %	64,943	631,278
2016	11.1 %	1.5 %	70,191	634,206

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, 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
2018_2019	53.9 %	5.6 %	54,680	101,479
2017_2018	56.6 %	6.4 %	57,155	100,909
2016_2017	67.4 %	5.6 %	60,273	89,414
2016	65.5 %	6.3 %	55,241	84,339

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, 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
2018_2019	91.4 %	1.3 %	672,715	735,784
2017_2018	92.2 %	1.4 %	685,457	743,591
2016_2017	92.7 %	1.2 %	698,883	753,996
2016	93.1 %	1.1 %	707,444	759,626

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	14.5 %	0.3 %	2,598	17,937
2016	14.4 %	0.3 %	2,696	18,748
2014	15.3 %	0.3 %	3,041	19,839
2012	16.6 %	0.3 %	3,632	21,860
2010	17.1 %	0.3 %	3,925	22,988
2008	16.8 %	0.3 %	3,079	18,321

Legends:

Indicator has a denominator <50 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	14.4 %	1.2 %	21,094	146,363
2017	12.7 %	1.0 %	19,322	152,622
2015	12.3 %	1.1 %	18,806	153,386
2013	12.3 %	1.1 %	19,421	157,768
2011	12.5 %	1.3 %	20,470	163,149
2009	10.2 %	1.0 %	16,698	163,609
2007	12.2 %	0.8 %	20,092	165,232
2005	11.1 %	1.2 %	18,299	164,971

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	13.3 %	1.9 %	46,600	351,465
2017_2018	11.5 %	1.9 %	41,641	361,240
2016_2017	11.9 %	1.9 %	39,836	334,568
2016	13.4 %	2.2 %	43,244	322,706

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	3.5 %	0.3 %	25,257	727,424
2018	2.6 %	0.4 %	19,257	734,788
2017	3.1 %	0.3 %	22,820	742,035
2016	2.5 %	0.3 %	18,566	748,701
2015	3.5 %	0.4 %	26,996	762,252
2014	3.9 %	0.4 %	30,434	773,218
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 >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	76.3 %	4.4 %	28,000	37,000
2015	75.1 %	4.1 %	28,000	37,000
2014	74.9 %	3.7 %	28,000	38,000
2013	77.0 %	3.5 %	30,000	38,000
2012	76.1 %	3.8 %	29,000	38,000
2011	75.0 %	3.5 %	29,000	39,000

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	78.0 %	1.4 %	543,486	696,777
2018_2019	73.8 %	1.7 %	519,908	704,101
2017_2018	71.3 %	1.7 %	507,693	711,966
2016_2017	68.6 %	1.6 %	494,619	720,914
2015_2016	70.6 %	1.8 %	520,851	738,272
2014_2015	67.1 %	1.9 %	500,233	745,726
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 because the relative standard error is >0.3.

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) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	70.6 %	3.4 %	157,868	223,658
2018	70.5 %	3.3 %	159,627	226,552
2017	71.3 %	3.1 %	164,717	231,174
2016	62.2 %	3.2 %	145,769	234,322
2015	68.0 %	2.9 %	161,139	236,879

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable 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) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	96.5 %	1.2 %	215,795	223,658
2018	95.4 %	1.5 %	216,135	226,552
2017	94.9 %	1.2 %	219,339	231,174
2016	93.9 %	1.7 %	219,999	234,322
2015	93.8 %	1.5 %	222,074	236,879
2014	94.8 %	1.6 %	226,244	238,616
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 width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable 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) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	93.7 %	2.0 %	209,523	223,658
2018	92.1 %	2.2 %	208,693	226,552
2017	94.9 %	1.4 %	219,312	231,174
2016	93.9 %	1.6 %	220,088	234,322
2015	93.5 %	1.6 %	221,376	236,879
2014	94.9 %	1.5 %	226,535	238,616
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
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 width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	7.7	0.3	902	117,276
2018	8.3	0.3	988	118,377
2017	8.8	0.3	1,053	119,770
2016	9.4	0.3	1,136	120,856
2015	10.2	0.3	1,241	122,000
2014	11.5	0.3	1,420	123,333
2013	12.9	0.3	1,606	124,470
2012	15.0	0.4	1,889	125,874
2011	16.1	0.4	2,020	125,629
2010	18.4	0.4	2,274	123,484
2009	21.2	0.4	2,605	123,044

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	11.1 %	1.1 %	3,543	31,966
2018	11.7 %	1.1 %	3,752	32,188
2017	12.7 %	1.1 %	4,180	32,842
2016	10.5 %	1.0 %	3,541	33,868
2015	10.4 %	1.2 %	3,504	33,575
2014	11.1 %	1.1 %	3,798	34,316

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	1.6 %	0.5 %	12,098	735,638
2017_2018	1.6 %	0.7 %	11,555	742,622
2016_2017	1.4 %	0.5 %	10,760	752,423
2016	1.8 %	0.5 %	13,402	758,633

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Connecticut

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective					76
Annual Indicator				76.7	77.9
Numerator				459,058	460,616
Denominator				598,556	591,657
Data Source				BRFSS	BRFSS
Data Source Year				2018	2019

Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	78.0	80.0	80.0	81.0	81.0	82.0

Field Level Notes for Form 10 NPMs:

None

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	90	75.5	81	87	88
Annual Indicator	85.2	84.9	86.3	87.1	85.4
Numerator	28,285	29,601	29,023	30,307	24,877
Denominator	33,201	34,879	33,627	34,787	29,144
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	88.0	88.0	90.0	90.0	92.0	92.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	23	36	27	24.5	25
Annual Indicator	21.4	26.1	23.6	22.3	25.7
Numerator	6,776	8,941	7,650	7,555	7,393
Denominator	31,727	34,213	32,386	33,879	28,711
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	25.5	26.0	26.5	27.0	27.5	28.0

Field Level Notes for Form 10 NPMs:

None

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			29	37	38
Annual Indicator		28.3	36.9	53.0	62.6
Numerator		24,674	30,265	36,846	44,868
Denominator		87,268	82,092	69,503	71,670
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	63.0	64.0	65.0	66.0	67.0	68.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			88	87	88
Annual Indicator		87.6	85.8	85.8	82.1
Numerator		227,911	224,493	224,493	220,463
Denominator		260,320	261,660	261,660	268,575
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017	2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	73.0	75.0	77.0	79.0	81.0	83.0

Field Level Notes for Form 10 NPMs:

None

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			56	56	56.5
Annual Indicator		55.1	49.8	39.8	40.4
Numerator		85,553	78,583	59,419	60,412
Denominator		155,167	157,677	149,426	149,716
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	43.0	45.0	47.0	49.0	51.0	53.0

Field Level Notes for Form 10 NPMs:

None

NPM 15 - Percent of children, ages 0 through 17, who are continuously and adequately insured - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2019	**2020**
Annual Objective		
Annual Indicator	69.2	71.3
Numerator	515,486	522,367
Denominator	745,033	732,761
Data Source	NSCH	NSCH
Data Source Year	2017_2018	2018_2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	72.0	72.5	73.0	73.5	74.0	74.5

Field Level Notes for Form 10 NPMs:

None

Form 10
National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)

State: Connecticut

2016-2020: NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	84.7	87	87	89	89
Annual Indicator	86.9	83.6	88.2	83.3	88.7
Numerator	464	428	404	384	384
Denominator	534	512	458	461	433
Data Source	Health Statistics and Surveillance	Health Statistics and Surveillance	Health Statistics and Surveillance	Health Statistics and Surveillance	Health Statistics and Surveillance
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Provisional

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: CY2016 Final, CT DPH Health Statistics and Surveillance Section.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: CY2017 Final, CT DPH Health Statistics and Surveillance Section.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: CY2018 Final, CT DPH Health Statistics and Surveillance Section. At this time, Connecticut Resident statistics do not include women who delivered out of state but are residents of CT. We continue to experience delays in importing out of state records into ConnVRS.	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: CY2019 Provisional, CT DPH Health Statistics and Surveillance Section. At this time, Connecticut Resident statistics do not include women who delivered out of state but are residents of CT. We continue to experience delays in importing out of state records into ConnVRS.	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: CY2020 Provisional, CT DPH Health Statistics and Surveillance Section. At this time, Connecticut Resident statistics do not include women who delivered out of state but are residents of CT. We continue to experience delays in importing out of state records into ConnVRS.	

2016-2020: NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			15	14.5	15
Annual Indicator		14.3	14.1	13.5	17.3
Numerator		9,623	10,208	8,513	10,137
Denominator		67,324	72,478	63,050	58,555
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Field Level Notes for Form 10 NPMs:

None

2016-2020: NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2017	**2018**	**2019**	**2020**
Annual Objective	52	64	56.5	57
Annual Indicator	63.8	56.1	60.3	56.9
Numerator	21,607	18,660	19,795	18,485
Denominator	33,879	33,268	32,808	32,508
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2017	2018	2019

Field Level Notes for Form 10 NPMs:

None

2016-2020: NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			86	87	87.5
Annual Indicator		85.1	86.9	87.9	87.7
Numerator		611,017	619,404	623,473	611,844
Denominator		717,846	712,489	709,257	697,889
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Field Level Notes for Form 10 NPMs:

None

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Adolescent Health

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Connecticut

SPM 1 - The proportion of live births conceived within 18 months of a previous birth (percent, females 15–44 years).

Measure Status:	Active				
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		37.7	37.1	25.7	25.5
Annual Indicator	26.5	25.4	25.9	26.6	25.8
Numerator	5,207	4,945	5,057	5,090	4,804
Denominator	19,642	19,437	19,537	19,154	18,654
Data Source	DPH Health Statistics and Surveillance	DPH Health Statistics and Surveillance	DPH Health Statistics and Surveillance	DPH Health Statistics and Surveillance	DPH Health Statistics and Surveillance
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	25.3	25.1	24.9	24.7	24.5	24.3

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: CY2016 FIVE LEVELS Interpregnancy Intervals For Women Aged 15 to 44 With A Prior Pregnancy For Selected Risk Factors: SINGLETONS Source: CT DPH Health Statistics and Surveillance	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: CY2017 FIVE LEVELS Interpregnancy Intervals For Women Aged 15 to 44 With A Prior Pregnancy For Selected Risk Factors: SINGLETONS Source: CT DPH Health Statistics and Surveillance	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: CY2018 FIVE LEVELS Interpregnancy Intervals For Women Aged 15 to 44 With A Prior Pregnancy For Selected Risk Factors: SINGLETONS Source: CT DPH Health Statistics and Surveillance	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: CY2019 FIVE LEVELS Interpregnancy Intervals For Women Aged 15 to 44 With A Prior Pregnancy For Selected Risk Factors: SINGLETONS Source: CT DPH Health Statistics and Surveillance	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: FIVE LEVELS Interpregnancy Intervals For Women Aged 15 to 44 With A Prior Pregnancy For Selected Risk Factors: SINGLETONS Source: CT DPH Health Statistics and Surveillance	

SPM 2 - The prevalence of unintended pregnancies among women delivering a live-born infant.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	20.6	21
Numerator	6,707	6,801
Denominator	32,572	32,352
Data Source	CT Pregnancy Risk Assessment Monitoring System	CT Pregnancy Risk Assessment Monitoring System
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	20.6	20.4	20.2	20.0	19.8	19.6

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
This does not include women who answered “not sure”, and also is not reflective of pregnancies that ended in abortion or fetal loss.

SPM 3 - The proportion of children who drank soda or sugar sweetened beverages at least once daily.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	28.3	26.4
Numerator	141,491	142,122
Denominator	500,206	537,895
Data Source	Behavioral Risk Factor Surveillance System	Behavioral Risk Factor Surveillance System
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	28.0	27.0	26.0	25.0	24.0	23.0

Field Level Notes for Form 10 SPMs:

None

Form 10
State Performance Measures (SPMs) (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 1 - The rate (per 100,000) of suicide deaths among youth aged 10 through 19.

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		3.7	4	3.9	3.6
Annual Indicator	3.2	5.8	3	3.3	5.1
Numerator	15	27	14	15	23
Denominator	470,268	465,119	465,119	459,801	453,134
Data Source	Health Statistics and Surveillance	Health Statistics and Surveillance	Health Statistics and Surveillance	Health Statistics and Surveillance	Health Statistics and Surveillance
Data Source Year	2015	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Provisional	Final	Provisional

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: CY2015 Final, CT DPH Health Statistics and Surveillance Section.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: CY2016 Final, CT DPH Health Statistics and Surveillance Section.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: CY2017 Provisional, CT DPH Health Statistics and Surveillance Section.	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: CY2018, CT DPH Health Statistics and Surveillance Section.	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: CY2019, CT DPH Health Statistics and Surveillance Section.	

2016-2020: SPM 2 - Percent of adolescents in grades 9-12 who report being bullied at school in the past year.

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		18.6	18	17.7	17.7
Annual Indicator	19	18.1	22.2	17.8	17.8
Numerator	447	435	435	359	359
Denominator	2,349	2,397	1,962	2,015	2,015
Data Source	Youth Risk Behavior Survey (YRBS)	Youth Risk Behavior Survey (YRBS)	Youth Risk Behavior Survey (YRBS)	Youth Risk Behavior Survey (YRBS)	Youth Risk Behavior Survey (YRBS)
Data Source Year	2015	2016	2017	2019	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: 2015 Youth Risk Behavior Survey (YRBS), Health Statistics and Surveillance Section	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: 2016 Youth Risk Behavior Survey (YRBS), Health Statistics and Surveillance Section	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: 2017 Youth Risk Behavior Survey (YRBS), Health Statistics and Surveillance Section	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: 2019 Youth Risk Behavior Survey (YRBS), Health Statistics and Surveillance Section	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 2020 Youth Risk Behavior Survey (YRBS) is not available	

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Connecticut

ESM 1.1 - Percent of clients receiving an annual preventative reproductive health exam that receive a PAP test and/or will be current with receiving the recommended PAP screening schedule, as per ACOG and USPSTF Guidelines

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		97.3	90	90.2	90.4
Annual Indicator	97.3	89.8	97.2	97.8	99.2
Numerator	11,472	10,442	5,256	5,005	4,877
Denominator	11,796	11,623	5,406	5,115	4,917
Data Source	Annual contract reports	Annual contract reports	Annual contract reports	Annual contract reports	Annual contract reports
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	90.6	90.8	91.0	91.2	91.4	91.6

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: The slight decrease is due to the difficulty ensuring that the “date of last Pap” was properly recorded in their data system as a result of challenges with working with a relatively new EMR system at one of the delegate agencies.	

ESM 1.2 - Percent of mothers enrolled in MIECHV-funded home visiting programs prenatally or within 30 days after delivery who received a postpartum visit with a healthcare provider within 8 weeks (56 days) of delivery?

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	77.3	78.2
Numerator	163	161
Denominator	211	206
Data Source	MIECHV-funded programs	MIECHV-funded programs
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	74.0	74.5	75.0	75.5	76.0	76.5

Field Level Notes for Form 10 ESMs:

None

ESM 4.1 - Number of pregnant and postpartum WIC clients served by breastfeeding peer counselors

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	1,423	1,318
Numerator		
Denominator		
Data Source	Connecticut WIC Program	Connecticut WIC Program
Data Source Year	2018	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	1,500.0	1,550.0	1,600.0	1,650.0	1,700.0	1,750.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
FY 2020 is 10/1/2019 through 9/30/2020.
The Hartford Program was not active starting 10/1/19 so this may have impacted the number. Further, the estimates for future years may need to be revisited based on the fact 3 programs were not executed during FY21 as planned.

ESM 6.1 - Percent of children less than 3 years old (1-2 years 364 days old) who receive a developmental screening according to claims code 96110

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		33	40	43.5	45
Annual Indicator	32.9	39.8	42.1	44	44.1
Numerator	25,473	31,022	32,576	33,573	32,613
Denominator	77,344	77,998	77,321	76,362	73,956
Data Source	CT Department of Social Services	CT Department of Social Services	CT Department of Social Services	CT Department of Social Services	CT Department of Social Services
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	45.5	46.0	46.5	47.0	47.5	48.0

Field Level Notes for Form 10 ESMs:

None

ESM 10.1 - Percent of adolescents 12 through 17 with at least one completed BMI at time of medical visit at all school-based health centers

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		99.1	89	84	89
Annual Indicator	78.8	88.2	83	88.8	80.7
Numerator	10,197	12,278	10,826	10,886	8,946
Denominator	12,946	13,924	13,045	12,256	11,091
Data Source	CT DPH SBHC Database	CT DPH SBHC Database	CT DPH SBHC Database	CT DPH SBHC Database	CT DPH SBHC Database
Data Source Year	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	89.0	89.5	89.5	90.0	90.0	90.5

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: The numerator is the number of adolescents ages 12-17 that had a BMI completed during a medical visit. The denominator is the number of adolescents ages 12-17 that had a medical visit.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: The numerator is the number of adolescents ages 12-17 that had a BMI completed during a medical visit. The denominator is the number of adolescents ages 12-17 that had a medical visit.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: The numerator is the number of adolescents ages 12-17 that had a BMI completed during a medical visit. The denominator is the number of adolescents ages 12-17 that had a medical visit.	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: The numerator is the number of adolescents ages 12-17 that had a BMI completed during a medical visit. The denominator is the number of adolescents ages 12-17 that had a medical visit.	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The numerator is the number of adolescents ages 12-17 that had a BMI completed during a medical visit. The denominator is the number of adolescents ages 12-17 that had a medical visit.	

ESM 10.2 - Percent of adolescents 12 through 17 with a depression screening at the time of medical visit at all school-based health centers

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		37.3	71	72	73
Annual Indicator	33.7	70.4	71.1	41	71
Numerator	4,369	9,804	9,273	6,438	7,873
Denominator	12,946	13,924	13,045	15,703	11,091
Data Source	Funded School Based Health Centers database	Funded School Based Health Centers database	Funded School Based Health Centers database	Funded School Based Health Centers database	Funded School Based Health Centers database
Data Source Year	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	74.0	75.0	76.0	77.0	77.0	78.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: The numerator is the number of behavioral health screenings done on the 12-17 year olds at the time of medical visit. The denominator is the number of 12-17 year olds that had a medical visit.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: The numerator is the number of behavioral health screenings done on the 12-17 year olds at the time of medical visit. The denominator is the number of 12-17 year olds that had a medical visit. The increase this year is due to the fact that the change in criteria recommends that everyone who has had a medical visit should have a behavioral health screening.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: The numerator is the number of behavioral health screenings done on the 12-17 year olds at the time of medical visit. The denominator is the number of 12-17 year olds that had a medical visit. The increase this year is due to the fact that the change in criteria recommends that everyone who has had a medical visit should have a behavioral health screening.	

ESM 11.1 - Percent of CYSHCN who have a comprehensive care plan in place as evidence that they are receiving care in a well-functioning system

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		19	25	25.5	34
Annual Indicator	18.7	24.8	25.1	32.7	74.2
Numerator	534	510	513	600	1,151
Denominator	2,854	2,059	2,042	1,835	1,551
Data Source	DPH Connecticut Medical Home Initiative Care Coord	DPH Connecticut Medical Home Initiative Care Coord	DPH Connecticut Medical Home Initiative Care Coord	DPH Connecticut Medical Home Initiative Care Coord	DPH Connecticut Medical Home Initiative Care Coord
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	34.5	35.0	35.5	36.0	36.5	37.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: The numerator is the number of new CYSHCN with a comprehensive care plan. The denominator is the number of new CYSHCN.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: The numerator is the number of new CYSHCN with a comprehensive care plan. The denominator is the number of new CYSHCN.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: The numerator is the number of new CYSHCN with a comprehensive care plan. The denominator is the number of new CYSHCN.	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: The numerator is the number of new CYSHCN with a comprehensive care plan. The denominator is the number of new CYSHCN.	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The numerator is the number of new CYSHCN with a comprehensive care plan. The denominator is the number of new CYSHCN.	

ESM 15.1 - The number of community organizations who help families understand what services are available and covered by insurance for all children including those with special health care needs

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	321	365
Numerator		
Denominator		
Data Source	United Way 2-1-1 database	United Way 2-1-1 database
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	370.0	375.0	380.0	385.0	390.0	395.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
In the past, we received only a number from United Way, this year they sent us a spreadsheet. Moving forward, the counts will be more accurate.

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 3.1 - Number of communities participating in Every Woman Connecticut

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		8	8	9	9
Annual Indicator	8	8	8	8	9
Numerator					
Denominator					
Data Source	Every Woman Connecticut Initiative	Every Woman Connecticut Initiative	Every Woman Connecticut Initiative	Every Woman Connecticut Initiative	Every Woman Connecticut Initiative
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 4.1 - Number of hospitals participating in the CT Breastfeeding Coalition's (CBC) Ten Steps Collaborative to implement evidenced-based maternity care and the 10 Steps for Successful Breastfeeding

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		10	10	10	10
Annual Indicator	10	10	10	10	10
Numerator					
Denominator					
Data Source	CT WIC	CT WIC	CT WIC	CT WIC	CT WIC
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: The reality about maintaining 10 Baby Friendly Hospitals is uncertain due to current budget projections and probable cuts to health care.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: The reality about maintaining 10 Baby Friendly Hospitals is uncertain due to current budget projections and probable cuts to health care.	

2016-2020: ESM 4.2 - Number of Federally Qualified Health Centers (FQHCs) and/ or peer networks that were provided the Secrets of Baby Behavior (SBB) training

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		2	2	9	10
Annual Indicator	2	2	9	9	9
Numerator					
Denominator					
Data Source	CT WIC	CT WIC	CT WIC	CT WIC	CT WIC
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: The Secrets of Baby Behavior initiative has funding that allows for two hospitals per year. However, "after 2018, we do not have guaranteed funds."	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: The Secrets of Baby Behavior initiative has funding that allows for two hospitals per year. However, "after 2018, we do not have guaranteed funds."	

2016-2020: ESM 12.1 - Percent of CYSHCN who have transition plans to adult health care in place by age 14

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		52.3	42	42.5	43
Annual Indicator	50.3	41.9	40.7	27.2	20.6
Numerator	374	206	211	126	89
Denominator	744	492	518	463	432
Data Source	MAVEN, the Department's web-based reporting portal	MAVEN, the Department's web-based reporting portal	MAVEN, the Department's web-based reporting portal	MAVEN, the Department's web-based reporting portal	MAVEN, the Department's web-based reporting portal
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: The numerator is all new CYSHCN clients age 14 and older that have a transition plan. The denominator is all of the new CYSHCN clients age 14 and older for that year.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: The numerator is all new CYSHCN clients age 14 and older that have a transition plan. The denominator is all of the new CYSHCN clients age 14 and older for that year.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: The numerator is all new CYSHCN clients age 14 and older that have a transition plan. The denominator is all of the new CYSHCN clients age 14 and older for that year.	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: The numerator is all new CYSHCN clients age 14 and older that have a transition plan. The denominator is all of the new CYSHCN clients age 14 and older for that year.	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The numerator is all new CYSHCN clients age 14 and older that have a transition plan. The denominator is all of the new CYSHCN clients age 14 and older for that year.	

2016-2020: ESM 13.1.1 - Percent of dental or other health care workers providing information on how to care for teeth and gums during pregnancy

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		61.3	64	62	62.5
Annual Indicator	63.8	59.8	60.8	59.2	60.1
Numerator	21,607	20,219	19,930	19,231	19,303
Denominator	33,879	33,831	32,776	32,509	32,141
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 13.2.1 - Percent of high risk children, ages 1 through 17, who have had a preventive dental visit in the past year

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		62.2	63.2	65	65.5
Annual Indicator	62.6	67.4	64.8	65	65
Numerator	197,734	204,743	206,207	212,030	212,030
Denominator	315,978	303,632	318,066	326,061	326,061
Data Source	Connecticut Dental Health Partnership	Connecticut Dental Health Partnership	Connecticut Dental Health Partnership	Connecticut Dental Health Partnership	Connecticut Dental Health Partnership
Data Source Year	2016	2017	2018	2019	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
2020 data is not available at this time.

Form 10
State Performance Measure (SPM) Detail Sheets

State: Connecticut

SPM 1 - The proportion of live births conceived within 18 months of a previous birth (percent, females 15–44 years).
Population Domain(s) – Women/Maternal Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the proportion of women with a live birth who report having had a preconception health care discussion with a health care provider.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>The number of second- or higher-order singleton births where the date of the previous live birth occurred within 18 months.</td></tr>
<tr><td>Denominator:</td><td>The number of second- or higher-order singleton births.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>DPH Health Statistics and Surveillance Section</td></tr>
<tr><td>Significance:</td><td>The timing between a live birth and the next pregnancy, termed the interpregnancy interval (IPI), may affect the risk of pregnancy complications, such as preterm birth, low birthweight, and small gestational age (birthweight that is small for a given gestational age). While there is no consensus on optimal IPI, research has shown that short intervals (less than 18 months) and long intervals (60 months or more) were associated with higher risks of adverse health outcomes. Factors such as maternal age and socioeconomic status may affect IPI patterns. Health care providers have emphasized the importance of providing information about and access to reproductive health services during the postpartum period to reduce adverse outcomes associated with short IPI. Moreover, evidence suggests a relationship between long IPI and perinatal complications, but these mechanisms are less well understood.

Reference: http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_03.pdf</td></tr>
</table>

SPM 2 - The prevalence of unintended pregnancies among women delivering a live-born infant.
Population Domain(s) – Perinatal/Infant Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To reduce the percent of unintended pregnancies among women delivering a live-born infant.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Women who answered “I wanted to be pregnant later” or “I didn’t want to be pregnant then or at any time in the future"</td></tr>
<tr><td>Denominator:</td><td>Women who answered the question, “Thinking back to just before you got pregnant with your new baby, how did you feel about becoming pregnant”</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Pregnancy Risk Assessment Monitoring System (PRAMS)</td></tr>
<tr><td>Significance:</td><td>Certain maternal behaviors and experiences (e.g., unintended pregnancy, late entry into prenatal care, smoking cigarettes during pregnancy, and physical abuse during pregnancy) might be related to adverse reproductive outcomes (e.g., low birthweight, infant morbidity and mortality, and maternal morbidity). Information on the prevalence of these behaviors and experiences is needed to monitor trends over time, to increase understanding of maternal behaviors and experiences and their relation to perinatal and maternal outcomes, and to develop and assess programs and policies designed to reduce these adverse outcomes among pregnant women and their infants.</td></tr>
</table>

SPM 3 - The proportion of children who drank soda or sugar sweetened beverages at least once daily.
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	To reduce the number of children who drink soda or sugar sweetened beverages at least once daily
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of children who drank soda or sugar sweetened drinks at least once daily **Denominator:** The total number of children responding whether drank soda or sugar sweetened drinks at least once daily
Data Sources and Data Issues:	Connecticut Behavioral Risk Factor Surveillance System (CT BRFSS)
Significance:	Consumption of soda and other sugar-sweetened beverages (SSBs) is associated with obesity in children. (footnote #1 Ludwig below). Adult proxy respondents report how many glasses, bottles, or cans of soda or other SSBs the randomly selected child drinks on an average day. Sugar-sweetened beverages (SSBs) or sugar drinks are the leading sources of added sugars in the American diet. Frequently drinking sugar-sweetened beverages is associated with weight gain/obesity, type 2 diabetes, heart disease, kidney diseases, non-alcoholic liver disease, tooth decay and cavities, gout, a type if arthritis. (footnote #2) Limiting the amount of SSB intake can help individuals maintain a healthy weight and have a healthy diet. Ludwig, DS, Peterson, KE, Gortmaker, SL (2001) Relation Between Consumption of Sugar-sweetened Drinks and Childhood Obesity: A Prospective, Observational Analysis. Lancet, 357(9255):505-508. https://www.cdc.gov/nutrition/data-statistics/sugar-sweetened-beverages-intake.html

Form 10
State Performance Measure (SPM) Detail Sheets (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 1 - The rate (per 100,000) of suicide deaths among youth aged 10 through 19.
Population Domain(s) – Adolescent Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To eliminate self-induced, preventable morbidity and mortality.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Rate</td></tr>
<tr><td>Unit Number:</td><td>100,000</td></tr>
<tr><td>Numerator:</td><td>The number of suicide deaths among youth aged 10 through 19</td></tr>
<tr><td>Denominator:</td><td>The number of youth aged 10 through 19</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2020 Objective:</td><td>Related to Mental Health and Mental Disorders (MHMD) Objective 1: Reduce the suicide rate. (Baseline: 11.3 suicides per 100,000 in 2007, Target: 10.2 suicides per 100,000)
Related to Mental Health and Mental Disorders (MHMD) Objective 2: Reduce suicide attempts by adolescents. (Baseline: 1.9 suicide attempts per 100 occurred in 2009, Target: 1.7 suicide attempts per 100)</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>DPH Health Statistics and Surveillance Section, 2014 Mortality Data
CT Office of Chief Medical Examiner</td></tr>
<tr><td>Significance:</td><td>Suicide is the second leading cause of death for ages 10 through 24, and the third leading cause of death for college age youths and ages 12 through 18. In the U.S. each day, there are an average of more than 5,400 suicide attempts by young people grades 7-12.

In Connecticut 15 youths ages 10 to 19 died by suicide in 2014 (DPH Health Statistics and Surveillance Section, 2014 Mortality Data).</td></tr>
</table>

2016-2020: SPM 2 - Percent of adolescents in grades 9-12 who report being bullied at school in the past year.
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	To reduce the number of adolescents who are bullied.
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of adolescents in grades 9-12 who report being bullied at school in the past year.</td></tr><tr><td>**Denominator:**</td><td>The number of survey respondents in grades 9-12.</td></tr></table>
Healthy People 2020 Objective:	Related to Injury and Violence Prevention (IVP) Objective 35: Reduce bullying among adolescents. (Baseline: 19.9%, Target: 17.9%)
Data Sources and Data Issues:	Connecticut School Health Survey/Youth Behavior Component
Significance:	Bullying, particularly among school-age children, is a major public health problem. Current estimates suggest nearly 30% of American adolescents reported at least moderate bullying experiences as the bully, the victim, or both. Specifically, of a nationally representative sample of adolescents, 13% reported being a bully, 11% reported being a victim of bullying, and 6% reported being both a bully and a victim. Studies indicate bullying experiences are associated with a number of behavioral, emotional, and physical adjustment problems. Adolescents who bully others tend to exhibit other defiant and delinquent behaviors, have poor school performance, be more likely to drop-out of school, and are more likely to bring weapons to school. Victims of bullying tend to report feelings of depression, anxiety, low self-esteem, and isolation; poor school performance; suicidal ideation; and suicide attempts. Evidence further suggests that people who are the victims of bullying and who also perpetrate bullying (i.e., bully-victims) may exhibit the poorest functioning, in comparison with either victims or bullies. Emotional and behavioral problems experienced by victims, bullies, and bully-victims may continue into adulthood and produce long-term negative outcomes, including low self-esteem and self-worth, depression, antisocial behavior, vandalism, drug use and abuse, criminal behavior, gang membership, and suicidal ideation.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Connecticut

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Connecticut

ESM 1.1 - Percent of clients receiving an annual preventative reproductive health exam that receive a PAP test and/or will be current with receiving the recommended PAP screening schedule, as per ACOG and USPSTF Guidelines
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percent of women with a preventative reproductive health exam who received a PAP test and/or are current with receiving their recommended PAP screening schedule.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td># of women with a preventative reproductive health exam who received a PAP test and/or are current with receiving their recommended PAP screening schedule</td></tr>
<tr><td>Denominator:</td><td>Total number of women that received a preventative reproductive health exam</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Annual contract statistical reports.
Centers for Disease Control (http://www.cdc.gov/cancer/cervical/basic_info/screening.htm)
American College of Obstetrics and Gynecology (ACOG) Guidelines (2014)
U.S. Preventive Services Task Force (USPSTF) Position Statement (2012)</td></tr>
<tr><td>Significance:</td><td>The American College of Obstetricians and Gynecologists Committee (ACOG) Opinion (2014) states that the annual health assessment should include screening, evaluation and counseling, and immunizations based on age and risk factors and should include a physical examination. The physical examination will include obtaining standard vital signs, determining body mass index, palpating the abdomen and inguinal lymph nodes, and making an assessment of the patient’s overall health.

The ACOG guidelines for cervical cytology screening published in May 2009 recommend beginning cervical cancer screening at age 21 years, irrespective of sexual activity of the patient. This is based on the current understanding of human papillomavirus infection in the adolescent patient and the pathophysiology of invasive cervical cancer.

The CDC reports that cervical cancer is the easiest gynecologic cancer to prevent, with regular PAP and HPV screening tests and follow- up. The Pap test looks for precancerous cell changes on the cervix that might become cervical cancer if they are not discovered early and treated appropriately. The HPV test looks for the human papilloma virus that can cause these cell changes.

Health disparities exist in CT, as they do nationally. At risk populations have higher rates of teen births, STDs, HIV, and chronic disease and often lack access to care. Evidence-based reproductive health services were provided in accordance with national standards, regardless of the patient’s inability to pay. The 12 CT RHS centers are geographically located in the state’s largest cities and areas of high teen birth rates. The services are inclusive, gender neutral and patient friendly.</td></tr>
</table>

ESM 1.2 - Percent of mothers enrolled in MIECHV-funded home visiting programs prenatally or within 30 days after delivery who received a postpartum visit with a healthcare provider within 8 weeks (56 days) of delivery?
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To increase the number of mothers enrolled in MIECHV-funded home visiting programs prenatally or within 30 days after delivery who received a postpartum visit with a healthcare provider within 8 weeks (56 days) of delivery
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of mothers enrolled in home visiting prenatally or within 30 days after delivery who received a postpartum visit with a healthcare provider within 8 weeks (56 days) of delivery **Denominator:** Number of mothers who enrolled in home visiting prenatally or within 30 days after delivery and remained enrolled for at least 8 weeks (56 days) after delivery
Data Sources and Data Issues:	Connecticut Maternal, Infant and Early Childhood Home Visiting (MIECHV) This measure includes all women who reached the point of being due for their postpartum visit who were enrolled prenatally or within 30 days of delivery. Methods: • Question asked of index parent when baby is 3 months, or 3 months post enrollment – “Did you receive any postpartum care visit with a healthcare provider within 8 weeks of delivery?”
Significance:	This measure is based on ACOG guidelines for postpartum care, which recommends thinking of postpartum care as an ongoing process beginning with a visit within three weeks of delivery.

ESM 4.1 - Number of pregnant and postpartum WIC clients served by breastfeeding peer counselors
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To improve breastfeeding initiation rates and have an impact on breastfeeding rates at 1 and 3 months post-partum.
Definition:	**Unit Type:** Count **Unit Number:** 100,000 **Numerator:** Number of pregnant and postpartum WIC clients served by breastfeeding peer counselors **Denominator:**
Data Sources and Data Issues:	McCoy, M. B., Geppert, J., Dech, L., & Richardson, M. (2018). Associations between peer counseling and breastfeeding initiation and duration: an analysis of Minnesota participants in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Maternal and child health journal, 22(1), 71-81. Chapman, D. J., Damio, G., Young, S., & Pérez-Escamilla, R. (2004). Effectiveness of breastfeeding peer counseling in a low-income, predominantly Latina population: a randomized controlled trial. Archives of pediatrics & adolescent medicine, 158(9), 897-902.
Significance:	Peer counselor interventions appear to be effective and are more likely to influence initiation than exclusivity at 6 months. Programs based on this strategy are likely to work. This strategy has been tested more than once and results trend positive overall.

ESM 6.1 - Percent of children less than 3 years old (1-2 years 364 days old) who receive a developmental screening according to claims code 96110
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>All Connecticut children receive age appropriate developmental screenings, well-child visits, oral health assessments and ACIP recommended vaccines.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of developmental screening claims code 96110 for children less than 3 years old (1-2 years 364 days old)</td></tr>
<tr><td>Denominator:</td><td>Number of children less than 3 years old (1-2 years 364 days old) in HUSKY</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: Department of Social Services Claims Data for developmental screening according to claims code 96110 (developmental screening). Claims data provides a good method to track screening.</td></tr>
<tr><td>Significance:</td><td>As many as one in four children between the ages of zero and five is at a moderate or high risk for a developmental, behavioral or social delay. (The Health and Well-Being of Children: A Portrait of States and the Nation, 2011-2012)

The American Academy of Pediatrics, Recommendations for Preventive Pediatric Health Care, Bright Futures/American Academy of Pediatrics, 2017 recommends that children be screened for developmental delays or disabilities during the 9-month, 18-month, and or 30-month well-child visits (Identifying Infants and Young Children with Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening) and specifically for autism spectrum disorders at 18 and 24 months (Screening Should Occur per "Identification and Evaluation of Children with Autism Spectrum Disorders).

Screening for healthy development can help identify potential delay areas for further evaluation and diagnosis, and reduce the likelihood of developing other delays. (Pediatrics 2001; 108(1), 192-196).

The rising incidence of autism spectrum disorder and developmental disabilities and heightened focus on early identification and intervention has led to an increased demand on states to develop and improve systems of care to assure all children receive early developmental screening and those with ASD/DD receive timely identification, diagnosis and intervention services. (AMCHP Environmental Scan: State Strategies and Initiatives to Improve Developmental and Autism Screening and Early Identification Systems, August 2014)

Developmental screening, consistent with the AAP Guidelines, is highlighted in the Action Agenda for the Connecticut State Health Improvement Plan (SHIP) as part of the Maternal, Infant and Child Health Workgroup. The State Health Improvement Plan is a roadmap for improving the state’s health and ensuring that all people in Connecticut have the opportunity to attain their highest potential.</td></tr>
</table>

ESM 10.1 - Percent of adolescents 12 through 17 with at least one completed BMI at time of medical visit at all school-based health centers
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percent of adolescents 12-17 who have a BMI measured at the time of a medical visit.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of adolescents 12-17 with at least one completed BMI at the time of a well visit at all School Based Health Centers (Physical)</td></tr>
<tr><td>Denominator:</td><td>Number of students 12-17 who had at least one well visit at all School Based Health Centers (Physical)</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Funded School Based Health Centers database and annual contractual program reports.

Annual School Based Health Centers Medical Results Based Accountability Report Cards.

National NQI data portal.</td></tr>
<tr><td>Significance:</td><td>The U.S. Preventive Services Task Force recommends that clinicians screen children ages 6 to 18 years for obesity and refer them to programs to improve their weight status. The recommendations are explained in the special article, “Screening for Obesity in Children and Adolescents: US Preventive Services Task Force Recommendation Statement,” in the February 2010 issue of Pediatrics.

The American Academy of Pediatrics (AAP) recommends that periodic measurement of BMI be performed as part of a comprehensive approach to prevention of pediatric overweight, and recommends that BMI be calculated and documented once a year for all children and adolescents.
BMI screening and well child visits have been included as clinical outcome measures for the School Based National Quality Initiative - with School Based Health Center sites in Connecticut participating in the national pilot to establish national quality standards for School Based Health Centers.</td></tr>
</table>

ESM 10.2 - Percent of adolescents 12 through 17 with a depression screening at the time of medical visit at all school-based health centers
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percent of adolescents 12-17 who receive depression screenings during a preventive medical visit.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of students 12-17 who had a depression screening during a medical visit at all School Based Health Centers (All visits)</td></tr>
<tr><td>Denominator:</td><td>Number of students 12-17 who received a medical visit at all School Based Health Centers (All visits)</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Funded School Based Health Centers database and annual contractual program reports. We are using “well visit” as the preventive medical visit.

CDC Youth Risk Assessment Survey.

Annual School Based Health Centers Behavioral Health Results Based Accountability Report Cards.</td></tr>
<tr><td>Significance:</td><td>The 2017 Recommendations for Preventive Pediatric Health Care (Periodicity Schedule) have been approved by the American Academy of Pediatrics (AAP) and represents a consensus of AAP and the Bright Futures Periodicity Schedule Workgroup. Each child and family is unique; therefore, these recommendations are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest variations from normal.</td></tr>
</table>

ESM 11.1 - Percent of CYSHCN who have a comprehensive care plan in place as evidence that they are receiving care in a well-functioning system
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percentage of CYSHCN receiving care coordination services (beyond simple information and referral) through the Connecticut Medical Home Initiative for CYSHCN (CMHI) who have a comprehensive care plan in place.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td># of CYSHCN receiving care coordination through CMHI with a comprehensive care plan documented in the MAVEN reporting database</td></tr>
<tr><td>Denominator:</td><td># of CYSHCN receiving care coordination through CMHI documented in the MAVEN reporting database</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>DPH Connecticut Medical Home Initiative Care Coordination MAVEN database.

DPH care coordination contractual program statistical reports.

DPH conducted Family Medical Home Survey.</td></tr>
<tr><td>Significance:</td><td>The American Academy of Pediatrics (AAP) proposed a definition of the medical home in a 1992 policy statement. A 2002 AAP statement contained an expanded and more comprehensive interpretation of the concept and an operational definition of the medical home. The AAP developed the medical home as a model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective to every child and adolescent. A pediatric medical home is a family-centered partnership within a community-based system that provides uninterrupted care with appropriate payment to support and sustain optimal health outcomes and is a standard to maintain in a well-functioning system for Children & Youth with Special Health Care Needs (CYSHCN).

The 2015 National Committee for Quality Assurance (NCQA) Patient-Centered Medical Homes (PCMH) Evidence Report indicates that PCMHs are saving money by reducing hospital and emergency department visits, reducing health disparities, and improving patient outcomes. The Connecticut Medical Home Initiative (CMHI) works to expand the number of NCQA level 2 and 3 recognized medical homes in CT.

DPH conducts a Family Medical Home Survey on an ongoing basis as a validation of data reported by care coordinators to include questions regarding family involvement in care planning.</td></tr>
</table>

ESM 15.1 - The number of community organizations who help families understand what services are available and covered by insurance for all children including those with special health care needs
NPM 15 – Percent of children, ages 0 through 17, who are continuously and adequately insured

Measure Status:	Active
Goal:	To increase the number of community organizations who help families understand what services are available and covered by insurance for all children including those with special health care needs.
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** The number of community organizations who help families understand what services are available and covered by insurance for all children including those with special health care needs. **Denominator:**
Data Sources and Data Issues:	United Way 2-1-1 database, the statewide toll-free information line, provides a description of services and contact information for community organizations including those that help families understand services that are available and covered by insurance for all children including those with special health care needs.
Significance:	American Academy of Pediatrics highlighted the importance of continuous and adequate insurance with a policy statement. The major problems cited were cost-sharing requirements were too high, benefit limitations, and inadequate coverage of needed services. Inadequately insured children are more likely to have delayed or forgone care, lack a medical home, be less likely to receive needed referrals and care coordination, and receive family-centered care. Reference: https://www.mchevidence.org/tools/npm/15-adequate-insurance-coverage.php

Form 10
Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 3.1 - Number of communities participating in Every Woman Connecticut
2016-2020: NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active
Goal:	Implement Every Woman CT Learning Collaborative to give babies across CT a healthy start and ensure that all women and men are as healthy as they can possibly be throughout the course of their life whether they want to start a family or not.
Definition:	**Unit Type:** Count **Unit Number:** 169 **Numerator:** # of communities participating in Every Woman CT **Denominator:**
Data Sources and Data Issues:	Baseline data collected through assessment survey prior to implementation of One Key Question (OKQ). Survey will assess organizational needs and goals surrounding upcoming implementation of OKQ, as well as baseline data for current services provided related to pregnancy intention screening, pre-/inter- conception health care, and birth spacing/contraception care. 30, 60, and 90-day opportunities for sites to receive targeted technical assistance informed by optional PDSA cycles. PDSA worksheet data will be collected from participating sites and shared on a quarterly basis with members of the collaborative during sharing opportunities (webinars/conference calls/training sessions). Mid-project assessment survey (for comparison with baseline data, identification of outstanding training and technical support needs) End of project assessment survey will be administered to assess changes in practice and successful integration of pregnancy intention screening into regular practice and program workflow. Statewide population data indicators will also be monitored to inform future directions (Inter-Pregnancy Interval, early entry into PN care, unplanned pregnancies, premature birth, and LARC utilization rates). ~ A project of CT MCH Coalition, supported by the March of Dimes CT and Western MA.
Significance:	Nearly 3 out of 10 pregnancies in Connecticut in 2013 were unplanned. Only 56.6% of women who were not trying to get pregnant at the time, were using some form of birth control at the time they got pregnant. 40.7% of postpartum women using birth control, were using less or least effective methods of birth control. Only 27.4% of women reported having a “preconception health” discussion with their health care provider prior to becoming pregnant, to help them prepare for a healthy pregnancy. 48.5% of women were overweight or obese prior to becoming pregnant. 19.8% of women were taking medication other than birth control prior to becoming pregnant. 12.8% of mothers received late or no prenatal care, while 22.9% received inadequate prenatal care. Non-Hispanic Blacks, Hispanics, younger women (<20 and 20-24 years), and women who were on Medicaid or uninsured were disproportionately affected by poor health status before, during, and after a pregnancy, unintended pregnancies, and poor birth outcomes. (PRAMS data from Every Woman CT Fact Sheet)

2016-2020: ESM 4.1 - Number of hospitals participating in the CT Breastfeeding Coalition's (CBC) Ten Steps Collaborative to implement evidenced-based maternity care and the 10 Steps for Successful Breastfeeding NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase number of hospitals participating in the CT Breastfeeding Coalition's Ten Steps Collaborative to implement evidence-based maternity care and the 10 Steps for Successful Breastfeeding to increase the percent of infants who are ever breastfed.
Definition:	**Unit Type:** Count **Unit Number:** 29 **Numerator:** # of hospitals that have implemented the 10 Steps for Successful Breastfeeding **Denominator:**
Data Sources and Data Issues:	mPINC (Maternity Practices in Infant Nutrition and Care)data (Breastfeeding Report Card) and Self-report of hospitals' from Baby-Friendly USA The SHAPe (Strategic Health Asset Planning and Evaluation) performance measures detail the current # of Baby-Friendly Hospital Initiative (BFHI) Designated Hospitals in CT and both short and long term goals.
Significance:	With CDC 1305 grant funds, DPH continues to work 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. Focus groups were conducted aimed at gaining understanding of new parents around Baby-Friendly Hospital Initiative (BFHI) and maternity care practices experienced around the State. A report was completed and themes from the sessions were reviewed to develop consumer materials will be targeted to promote BFHI and evidenced based maternity care to the general public. In partnership with CBC, a consumer campaign seeking new mom's "it's worth it" story about breastfeeding is in development. The goal of which is to communicate peer and community support messages so new and prospective parents understand elements and importance of BFHI i.e. skin to skin, rooming in, developing a birth plan, community support resources.

2016-2020: ESM 4.2 - Number of Federally Qualified Health Centers (FQHCs) and/ or peer networks that were provided the Secrets of Baby Behavior (SBB) training
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the number of FQHCs/peer networks that were trained in the Secrets of Baby Behavior to increase the percent of infants breastfed exclusively through 6 months.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>17</td></tr>
<tr><td>Numerator:</td><td>The # of Federally Qualified Health Centers (FQHCs) and/ or peer networks that were trained in the Secrets of Baby Behavior (SBB)</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>There are 17 FQHC’s in CT. Federal funding is secured through 2018 to support this initiative.</td></tr>
<tr><td>Significance:</td><td>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 Federally Qualified Health Centers (FQHCs) and various peer support networks such as Breastfeeding USA, Nurturing Families and the La Leche League access to the Secrets of Baby Behavior (SBB) training. Resources allow up to 2 FQHC’s and at least 1 peer support network.

A webinar was conducted in December 2015 in partnership with CT Chapter of the American Academy of Pediatrics (CT-AAP) to expose the hard-to-reach provider population with SBB messages.</td></tr>
</table>

2016-2020: ESM 12.1 - Percent of CYSHCN who have transition plans to adult health care in place by age 14
2016-2020: NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percentage of CYSHCN with a formal transition plan in place by age 14.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>The number of CYSHCN 14+ year olds with a transition care plan to adult health care</td></tr>
<tr><td>Denominator:</td><td>The number of CYSHCN 14+ year olds</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source is MAVEN, the Department’s web-based reporting portal for CYSHCN. This web-based internet platform is an automated system that CT Medical Home Initiative for CYSHCN contractors utilize to enable collection, storage and transmission of data electronically to the Department. This includes data on the development of transition plans. CT School-Based Health Centers with Department Contracts will begin including data on transition plans for medical care after graduation in their 2015-2016 SBHC year-end report. The Department works closely with the State Department of Education (SDE) to encourage inclusion of health care goals and objectives in students’ transition Individual Education Plans. This data is monitored by SDE.</td></tr>
<tr><td>Significance:</td><td>A Census Statement on Health Care Transition for Young Adults with Special Health Care Needs was drafted by the AAP, AAFP and ACPASIM and published in Pediatrics Vol. 110 No. 6 December 2012. It states that all young people with special health care needs have an identified health care provider who attends to the unique challenges of transition and assumes responsibility for current health care, care coordination and future health care planning. This starts with having a written health care transition plan in place by age 14 done together with the YSHCN and family.
This is not limited to having appropriate providers in place. It also includes insurance, prescription plan, transportation, office hours, employer co-operation, and hospital of preference. For YSHCN entering college, this will mean assuring that college health services are adequate including: access for filling prescriptions; nutritional requirements; specialists; hospital of preference, if needed; having appropriate legal documents in place so home based providers can communicate with college based providers; and authorizing someone to make healthcare legal decisions if that becomes necessary.
A well-timed transition from child-oriented to adult-oriented health care allows young people to optimize their ability to assume adult roles and functioning.</td></tr>
</table>

2016-2020: ESM 13.1.1 - Percent of dental or other health care workers providing information on how to care for teeth and gums during pregnancy
2016-2020: NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

Measure Status:	Active
Goal:	Increase oral health literacy and promote the value of good oral health and the importance of dental visits during pregnancy.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of dental or other health care workers providing information on how to care for teeth and gums during pregnancy **Denominator:** The total number of women who completed the survey
Data Sources and Data Issues:	Pregnancy Risk Assessment Monitoring System (PRAMS)
Significance:	The Office of Oral Health Program (OOH), along with CT Coalition for Oral Health (CTCOH) and community stakeholders have a strong collaborative partnership toward improving perinatal and infant oral health outcomes in CT. The three strategies to achieve the oral health objective include increasing dental care provided by pediatric primary care providers directly and through referral; encouraging Pediatric PCPs to include oral health in the well child visits for children under three and for those high caries risk patients under three, the application of therapeutic topical fluoride varnish application; and advocate for funding and sustainability of the Home by One program.

2016-2020: ESM 13.2.1 - Percent of high risk children, ages 1 through 17, who have had a preventive dental visit in the past year
2016-2020: NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	Increase preventive dental visits among high risk children.
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>The number of children, ages 1 through 17 eligible for HUSKY(Medicaid) who had a preventive dental visit in the past year</td></tr><tr><td>**Denominator:**</td><td>The number of children ages 1-17 that were eligible for HUSKY(Medicaid) services in the past year</td></tr></table>
Data Sources and Data Issues:	CMS database (Medicaid population ages 1-17)
Significance:	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; a child'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, with 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 the 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. 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. While these diseases are present across the population, disparities exist in individuals with low-socio economic status and in racial and ethnic minorities.

Form 11
Other State Data

State: Connecticut

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
MCH Data Access and Linkages

State: Connecticut

Annual Report Year 2020

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Annually	12		
2) Vital Records Death	Yes	Yes	Annually	12	No	
3) Medicaid	No	No	Less Often than Annually	60	No	
4) WIC	Yes	Yes	Annually	12	No	
5) Newborn Bloodspot Screening	Yes	Yes	Annually	12	No	
6) Newborn Hearing Screening	Yes	Yes	Annually	12	No	
7) Hospital Discharge	Yes	Yes	Annually	12	No	
8) PRAMS or PRAMS-like	Yes	Yes	Annually	12	No	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None