Maternal and Child Health Services
Title V Block Grant

State Narrative for Connecticut

Application for 2013
Annual Report for 2011

Document Generation Date: Friday, July 13, 2012

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The assurances and certifications are on file at the Connecticut Department of Public Health and are available from:

Director, Office of Affirmative Action
Connecticut Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

Methodology

Public Input was provided using two methodologies: consumer interviews and hardcopy surveys. Initially, input was to be gathered through a process of individual consumer interviews followed by a focus group. The goal was to assemble all consumer participants in a dynamic environment where they could interact with each other to stimulate conversation and ideas regarding maternal and child health services and the block grant process. An outside consultant was retained to conduct the focus group; the expectation was that the consumer participants would be more relaxed and forthcoming in their comments with an external moderator.

The consumer review meetings were scheduled in two sites: Hartford and Waterbury. The sites were selected based on what was considered to be "easy-access" for the selected participants. The objective was to meet with consumers in an "office/business" setting instead of the "home/community" setting that was used in previous years to achieve the goal of having one focus group with all readers.

Due to problems experienced with consumer attendance, the initial plan was modified to eliminate the focus group and supplement the interview process with a survey-only group of consumers. Consumers were unable to attend their sessions due to reasons such as illness, childcare problems, and conflict with work schedules. In retrospect, given the consumer population that was selected (mothers with young children still in school and some with special healthcare needs) future reviews and interviews could be more successful and appropriately conducted with a flexible schedule that is geared to the consumers' schedules and community locations.

Conducting some sessions on weekends and evenings rather than during business hours could increase participation.

Two consumers provided input by reading and reviewing the Maternal and Child Health Services 2012 Block Grant (MCHBG) application and 2010 Annual Report. These reviewers attended two meetings. The first meeting outlined the MCH Programs, the block grant process, and the importance of the public review process. Readers were asked to read the report and complete forms with their feedback on national and state performance measures and to relate comments about their experience with access to healthcare. Reviewers had the opportunity to contact the Family Advocate (FA) as needed before the next meeting. During the second meeting, reviewer input was gathered and questions were answered. The Readers were provided a stipend for their participation.

An additional six reviewers provided input by completing a consumer survey in lieu of consumer interviews. The survey was originally developed as a web-based tool; for this review, it was implemented in hardcopy due to lack of reliable consumer access to personal computers.
Consumer Background

Reviewers were identified from DPH programs serving consumers participating in the Healthy Start Program or a School Based Health Center (SBHC).

The first interviewee was a 22 year old single mother of three children from Hartford, CT. One son, age 3 1/2, has severe eczema, allergies, and asthma. His conditions require weekly hospital visits for treatment. The reviewer is currently looking for employment and is involved in volunteer mentoring programs for teen moms.
The second interviewee was a 26 year old single mother of two children (a 9 year old son and a 5 year old daughter). Working since she was 16, she is currently working two jobs to support herself and her family. She also helps to support her sister and her sister's children, including a sick nephew. She is having difficulty getting insurance coverage for herself and her children due to administrative issues involving the Medicare status of her ex-husband.

The six survey-only consumers submitted their responses anonymously.

Consumer Comments

The programs and services that the consumers have used include: Head Start, Food Stamps, Medicaid, Birth to Three, Medical Homes for Children with Special Health Care Needs, Infoline/211, WIC, School Based Health Centers, Intimate Partner Violence Counseling/Intervention, and Healthy Start. When asked if the programs and services met their needs, half of the respondents indicated that "Most of the time" they did. The other half indicated that they did "Some of the time".

The readers of the MCH Block Grant reported that it was difficult to find the time to read the document due to family and job requirements. They also stated that it was hard to read and confusing because of the extensive use of acronyms (readers were provided a list of acronyms). The readers stated that participating in the review process made them aware of additional services and gave them insight into the process. They indicated they would like the process promoted and expanded to more consumers. They suggested that the report should be translated into a shorter, more consumer-friendly pamphlet that could be used in the review process in place of the full document.

One reader stated that she is not satisfied with the level and quality of care that her son receives; she believes that her access to good doctors is limited due to practitioners' reluctance to treat patients with HUSKY insurance.

Mental Health/Behavioral Services: Four participants indicated that Community Health Centers

(CHC) and the SBHCs do not do well at providing services to women, children, and adolescents. Some of the suggestions for improvement included: focus on the family as a whole, provide in-home therapy and outpatient services, compensate doctors appropriately to increase their participation, provide parents with information regarding availability of mental health services, have more access to specialty care and specialists who accept all insurance, and provide classes for parents on how to identify signs of mental health problems and how to respond to problems. Two of the participants commented that they liked the fact that the health care services made them feel like "they care" when providers sit with them "1-on-1" and let them know that "they matter".

Dental Health Services/Healthy Lifestyles: Two participants indicated that it was easy for them to get dental health services when they needed them; two participants indicated that it was hard. Half of the participants indicated that if they were given WIC vouchers, they would buy more fruits and vegetables. Three participants said that they did not attend any of the WIC dental health workshops because they did not know about them. Two participants did not have a child developmental screening through Husky because they were not aware of the service. Of the participants receiving dental services through Husky, two said that their needs were addressed "somewhat well" and two said that they were addressed "very well". Some of the participants said that the WIC program was very important to them and they would like to see it expanded.

Some of the suggestions for how the State could make it easier for women and children to use dental health services included: provide more education on the risks/benefits of not getting/getting proper dental care, provide better access to qualified doctors and orthodontists, give referrals that are accurate (one participant indicated that often referred providers are at their quota for Husky patients and will not take new clients), have the primary care physicians provide dental referrals, supply more assistive services such as transportation to dental appointments, increase the age for WIC participation from age 5 to age 8, and increase the amount of WIC vouchers so participants can buy more fruits and vegetables.

Maternal and Child Related Services: All participants felt that the State should be doing more to address the priority needs of maternal and child populations; four participants felt that the State does "somewhat well" in addressing their priority health needs overall. Two participants indicated that CHCs did "somewhat well" in providing services for the health of women; one participant indicated that they did "not well". Two participants indicated that SBHCs did "somewhat well" in providing services for the health of young women. Two participants indicated that Healthy Start did "very well" in providing services for the health needs of pregnant women. One of the participants expressed concern over the funding of state programs. Another participant commented that the customer service provided by Medicaid is terrible, unpleasant, and inaccurate. Another participant commented that she had to wait over two weeks for an appointment for treatment of her son's broken finger because it was difficult to find a doctor who would accept her Husky insurance; she has experienced other problems getting appointments on a timely basis.

Some of the suggestions for how the State could improve access to health care services and care for women and children included: provide education on good health care practices, increase parent-to-parent connections to provide sharing of experience from trusted sources, expand Birth to 3 to Birth to 5, provide parenting education -- especially for first-time mothers, support Medical Home initiatives, have more service providers that are in the network to provide better quality service and help eliminate large provider waiting lists, conduct mailings to families to make them aware of available services, provide programs and support for children with Autism Spectrum Disorders, provide programs to help pregnant women quit smoking, provide a rent assistance program for single moms (possibly something where community service is exchanged for financial assistance), and provide counseling for teens regarding birth control services and options.

Consumer Suggestions for the Feedback Process: Most of the participants ranked individual

interviews as one of their top choices for providing feedback to the MCHBG process. Other choices in order of number of participant selection are: focus groups/roundtable discussion, public forums, meetings or conferences throughout the year, comments submitted through the DPH web site, email communication, and community listening sessions.
DPH Reflection: DPH will address three identified consumer issues in the coming year with our community partners; (1) how to identify signs of mental health and respond to problems; (2) support the Medical Home Initiative, and (3) provide programs and services for children with ASD.

Public input for the coming year will integrate lessons learned and will begin earlier in the year, target established groups that represent the MCH population during regularly scheduled meetings, provide a first meeting to outline the process and a second meeting that would be an individual interview, conduct a focus group or round table discussion format.

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

Changes in the population strengths and needs in the State Priorities

The five-year Needs Assessment conducted for the FFY 2011 MCHBG application identified nine State Priorities that were very similar to those identified in the needs assessment completed in 2005. These nine State Priorities remain the same for FFY 2013 application.

1) Enhance Data Systems
2) Improve Mental/Behavioral Health Services
3) Enhance Oral Health Services
4) Reduce Obesity among the three target MCH populations
5) Enhance Early Identification of Developmental Delays, Including Autism
6) Improve the Health Status of Women, related to depression
7) Improve Linkages to Services/Access to Care
8) Integrate the Life Course Theory throughout all state priorities
9) Reduce Health Disparities within the three MHC target populations

Changes in the State MCH program or system capacity in those State priorities

Only one of the State Performance Measures (SPMs) has been revised for this FFY 2013 application:

• SPM #01: Cumulative number of core datasets migrated to the MAVEN application as part of efforts to link high-quality child health data to create a Connecticut comprehensive child health profile.

On-going NA activities that enable the State to continue to monitor and assess on an on-going basis its priority needs and its capacity to meet those needs

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A brief description of any activities undertaken to operationalize the NA, such as establishing an

advisory group to monitor State progress in addressing the findings and recommendations resulting from the NA.

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III. State Overview

A. Overview

Connecticut (CT) is a small state of about 5,000 square miles and 169 towns, and has an estimated statewide population of 3,501,252 (July 1, 2008). The average town population is about 20,000. Five towns have a population greater than 100,000: these are the towns of Bridgeport (136,405), Hartford (124,062), New Haven (123,669), Stamford (119,303), and Waterbury (107,037). In 2008, there were 41 towns that had high unemployment rates, of which18 had populations that exceeded the average. The need for social services in the state is not limited to towns of high population.

CT is characterized by high social and economic contrast and racial and ethnic diversity. It is the third smallest state in the U.S. in terms of area, but it has the 29th highest population and is the fourth most densely populated state. Approximately 88% of CT's population lives in urban areas. While CT is one of the wealthiest states in the country, several cities have high rates of poverty. With a median household income of $68,595, CT was ranked third highest in the nation in 2008.

Racial and ethnic disparities exist across town lines, and between urban and rural populations. Racial and ethnic diversity is increasing in CT. From 2000-2007, the state's Asian population increased by 38.2%, the native Hawaiian or other Pacific-Islander population increased by 29.3%, and the Hispanic/Latino population increased by 24.8%. Hispanics or Latinos have shown the most growth of any CT racial or ethnic subgroup in terms of overall numbers during this period. (The CT Health Disparities Report, 2009). In 2007, the Hispanic or Latino population comprised 11.5% of the CT population, black or African Americans 9.3% and Asian 3.4%. These differences have engendered the concept of two CT's -- one comprising people who live in the wealthiest state in the nation, and the other consisting of those who live in some of the most severe and concentrated pockets of poverty in the U.S. The overall health of CT's people varies between its wealthiest and poorest communities.

According to the U.S. Census Bureau (2006), one in ten (10.3 percent) CT children under 18 (84,000) lived in a household with income below the federal poverty level ($20,516 for a family of four). That's down from the 2004 level (12.4 percent) but represents no improvement from the 2003 level (10.1 percent), according to the U.S. Census Bureau's Current Population Survey (CPS). One in four (25.8 percent) CT children lived in a household with income below 200 percent of the federal poverty level in 2006, according to CPS data (The 2004 level was 23.9%). According to a second measure that uses a larger sample, 10.7 percent of CT children under 18 (86,000 children) in 2006 lived in a family with income below the federal poverty level. This data from the U.S. Census Bureau's American Community Survey represents no improvement from the 2004 level (10.1 percent). ***/2013/ In 2010, 10.1% of CT residents had incomes under the FPL, up from 9.4% in 2009. Among CT children under age 18, 12.8% lived in families with incomes under the FPL in 2010. - CT experienced one of the largest declines in income (6.1%), second only to Nevada. (American Community Survey-CT Voices for Children September 2011) //2013//***

Employment levels in CT have plummeted since the start of the recession in December 2007. One year since the CT economy began losing jobs; it has already shed 95 percent of the total jobs lost during all three years of the previous recession. CT lost 58,000 jobs, (3.4 percent decline in total jobs), between March 2008 and March 2009 (CT Department of Labor (DOL), April 2009. This level of job loss is similar to the national employment decline of 3.5 percent. The Initial claims for unemployment insurance jumped 75.5% from 16,268 to 28,551, the highest number since the 1991-1992 recession (The CT Economic Digest, January 2010). ***/2013/ Between 1990 and 2010, CT cities (i.e., Bridgeport, Hartford, New Haven, New London, Norwich, Stamford, and Waterbury) lost almost 90,000 jobs (19.6 percent), while the number of jobs in the state remained relatively constant. CT's lack of public transportation between cities and suburbs makes some suburban jobs inaccessible for urban residents who don't own a***

car. http://library.constantcontact.com/download/get/file/1103087853419-26/Reversing_Job_Losses.pdf //2013//

/2013/In 2010, the US Census Bureau's Current Population Survey data indicated that, an estimated 49,000 CT children under 18 (6.0%) were uninsured for the entire year (http://www.census.gov/prod/2011pubs/p60-239.pdf). //2013//

I. Maternal and Child Health Indicators

1.A. Maternal and Child Demographics
In 2008, there were 40,106 births to CT residents. Of these births, 23,406 were to non-Hispanic White/Caucasian mothers, 5,017 were to non-Hispanic Black/African American mothers, and 8,662 births were to women of Hispanic/Latino ethnicity. Seventeen percent of the births to non-Hispanic White/Caucasian mothers, 57% of the births to non-Hispanic Black/African American mothers and 54% of the births to Hispanic mothers were paid by public insurance. Thirteen percent of the births to Hispanic mothers were either self-paid or were uninsured vs. 2% for non-Hispanic White/Caucasian mothers.

Many maternal and child health indicators of health within CT compare favorably with the United States as a whole. High-risk groups experience a disproportionate burden of adverse health risk factors and outcomes. These disparities are documented in more detail in the Needs Assessment. To address racial and ethnic disparities in the state is a priority. Reducing the disparities in maternal and child health indicators remains one of the major challenges facing the public health community.

1.B. Infant Mortality
Approximately 260 babies die annually in CT, of whom about 200 die within the first month of life. Approximately 50% of these deaths are associated with low birth weight (LBW). Analysis of the 2000-2004 birth cohort, broken down into Perinatal Periods of Risk (PPOR) categories, indicates that fetal and infant deaths for babies of very LBW among non-Hispanic Black/African American mothers is nearly 4 times higher that that among non-Hispanic White/Caucasian mothers. Also significantly elevated are deaths to babies with higher birth weights.

The racial/ethnic disparity seen in feto-infant mortality rates reflects the consistently higher prevalence among the non-white population for risk factors, such as birth rates among teenage women, lack of adequate prenatal care, and low birth weight. Focusing prevention programs on groups showing a high rate of low and very LBW infants (such as women in the urban centers or the state's African American/Black population) may produce the greatest effect on reducing the overall risk factors among the nonwhite infant population in the state.

DPH programs intended to reduce infant mortality start before conception and continue through the prenatal and postnatal periods. Preconception interventions aimed at school-aged audiences and women of childbearing age include primary care services, health education programs, outreach and case-finding to link individuals and families to primary and preventive services. Efforts are focused on getting mothers into regular care early in the pregnancy and keeping both regular and specialty care appointments as directed by their health care provider. Postnatal efforts include medical testing for genetic disorders and maintaining good health for healthy infants and their mothers. Programs that include home visiting services funded by the Maternal and Child Health Block Grant (MCHBG) have been implemented to provide special care to pregnant women at high risk for adverse infant health. In 2009, DPH received federal funding to establish a Healthy Start community in Hartford, joining the New Haven Healthy Start program. These programs include outreach services to the Black/African American communities of the state.

1.C. Births to Teens
Teen birth rates in the state have decreased since calendar year 2000, but remained high in 2008

within the Hispanic/Latino community, where the teen birth rate was nearly ten times higher than that within the non-Hispanic White/Caucasian community. The teen birth rate within the non-Hispanic Black/African American community was over four times higher that that within the non-Hispanic White/Caucasian community. Among all the towns in CT, teen birth rate was highest within New Britain, where one in every 13 teen gave birth during the calendar year (birth rate 75.6 per 1,000). This rate was three times higher than the statewide average of 25.0 per 1,000 women, and nearly two times higher than the 2007 U.S. rate of 42.5 per 1,000.

Teen pregnancy is considered a public health problem for reasons related to the health of both the mother and newborn. Early sexual activity can result in a higher risk for sexually transmitted diseases, which could harm the fetus and impair the future fertility and health of the mother. Preventive interventions to address teen pregnancy through CT's Title V programs include programs to delay the onset of sexual activity, promote abstinence as the social norm, reduce the number of adolescents who have sex at young ages, and increase the number of sexually active adolescents who use contraceptives effectively. Programs such as the Case Management Program for Pregnant Women and Parenting Teens, Healthy Choices, and Healthy Start (state and federal) serve pregnant and parenting teens. These programs provide case management services with emphasis on promoting positive pregnancy outcomes and positive parenting. The DPH FHS implemented a new Case Management for Pregnant Women program in three large cities with high rates of teen births. The program targets pregnant females and teens under the age of 20 who are at greatest risk for poor birth outcomes. This is a coordinated, culturally-sensitive approach to providing individualized client services through intensive case management and home visitation. The services are provided during the perinatal and interconceptional periods, with a focus on all aspects of achieving a healthy birth outcome, as well as building social supports, providing education, promoting birth spacing, family planning, referral to ongoing medical care, and building social supports promoting client self-efficacy.
The DPH recently submitted a grant proposal for funding in teen pregnancy prevention programs. If funded, the program will bring much needed intervention into high need communities, including the town of New Britain.

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

1.E. Low Birth Weight (LBW)
LBW (with weights less than 2,500 grams, or 5.5 pounds) is a major risk factor of infant mortality and long-term health problems. The impact of LBW on infant mortality occurs primarily during the first 28 days of life (the neonatal period), when LBW infants are about 32 times more likely than normal weight infants to die.

LBW rates among all singleton births in CT have not changed significantly since calendar year 2000. In 2008, low birth rate among non-Hispanic White/Caucasian mothers was 4.5 per 100 live births, 10.5 per 100 among non-Hispanic Black/African American mothers, and 6.5 per 100 live births among women of Hispanic/Latino ethnicity. LBW events were most concentrated in six towns: Hartford, New Haven, Bridgeport, Waterbury, New Britain, and East Hartford. Recent media campaigns focused on the African American and Hispanic communities of Hartford, New

Haven and Bridgeport with funding from the federal First Time Motherhood Initiative. Additional efforts to address LBW in the state include a strategic plan within the FHS, state legislation to monitor LBW as a consequence of the recession, and a recent emphasis on LBW within the Women's Health Subcommittee of the Medicaid Managed Care Council, suggest that efforts surrounding LBW will continue in the future.

1.F. Maternal Depression

Information about maternal depression prevalence in CT is not readily available. Results of a point-in-time survey conducted in 2003, probed a variety of social risk factors for adverse births. The survey was conducted with women two to four months postpartum. Results of the survey revealed disparities in how women experienced their most recent pregnancy. Relative to non-Hispanic White/Caucasian women, three-times more non-Hispanic Black/African American women indicated that their pregnancy was one of the worst times in their life. These results do not explore the reasons why women of minority race and ethnicity experience more difficulty, but recent publications indicate that social support structure is an important component to healthy maternal and birth outcomes. A new survey will be initiated within the next few months, and questions contained in the survey may further explore maternal depression in the state.
DPH contracted with Yale University to conduct training session of health care providers (obstetricians, family practitioners, pediatricians, social workers, nurses, mental health care professionals) about perinatal depression including perinatal risk factors, screening, diagnostic questionnaires, barriers to patient care, medications and service referral. This was a successful collaboration demonstrated by training 465 health care professionals in SFY 2008; toolkits were distributed to over 169 locations and 659 individuals that practices can use on an ongoing basis to educate, screen, and refer women and families. All Child Development Infoline (MCH Information and Referral Service) staff were trained regarding perinatal depression screening. Some practices and hospitals have adopted use of the screening tool as part of their assessment of pregnant women at their first prenatal visit. Trainings of health care professionals are continued in SFY10.

1. G. Oral Health

Dental caries (tooth decay) is an infectious disease process affecting both children and adults. During childhood, tooth decay is the single most common chronic disease, five times more common than asthma.

A 2007 oral health assessment of preschool (2-4 years old), kindergarten (5-6 years old and third grade (8-9 years old) students in CT determined the following: 1) dental decay is a significant public health problem for CT's children; 2) many children in CT do not get the dental care they need; 3) one in every 4 preschool children have experienced dental decay; 4) more than 60 percent of children in CT do not have dental sealants, a well accepted clinical intervention to prevent tooth decay in molar teeth; 5) there are significant oral health disparities in CT with minority and low-income children having the highest level of dental disease and the lowest level of dental sealants; 6) forty-one (41%) of third grade children have experienced dental decay and of those with decay experience, 18 percent have untreated decay. ***/2013/ The 2010-2011 CT school year survey data showed there has been significant improvements in the oral health status of preschool children but that dental decay is still a significant problem. There was a slight improvement in the prevalence of dental sealants, but no improvements in decay experience in the kindergarten and third grade children.//2013//***

The Office of Oral Health has initiated the Home by One program to build integrated partnerships with the early childhood community at the state and local levels that focus on oral health as essential to the overall health and well-being of children in CT. ***/2013/The Home by One program brought early dental care issues to the forefront of several CT initiatives addressing early childhood health and development. The program provided oral health and advocacy training to more than 150 parents in the WIC program and almost 500 child health providers. More than 40 dental homes have been established where dentists have been educated in and provide age one dental visits to children. In 2008, 14% of children in***

this age range received preventive services, whereas 32% received these services in 2010.//2013//

1.H. Breastfeeding

Breastfeeding provides optimal nutrition for infants and is associated with decreased risk for infant morbidity and mortality as well as maternal morbidity (US Dept of Health and Human Services, Agency for Healthcare Research and Quality; 2007). Maternity practices in hospitals and birthing centers can influence breastfeeding behaviors during a period critical to successful establishment of lactation. All of CT's birth facilities have the option of reporting on the mother's intent to breastfeed. Since some mothers have not decided to breastfeed within twenty-four hours of birth, the hospital staff often leave this question unreported or report intent as "undecided".

CT has a Baby-Friendly hospital initiative in place and currently has three hospitals designated as Baby-Friendly. Baby-Friendly Designation is a globally recognized symbol of world-class maternity care, endorsed by the United States Breastfeeding Committee, the World Health Organization, and UNICEF. The pathway to designation provides maternity facilities the opportunity to improve health outcomes for mothers and babies; improve patient satisfaction, elevate reputation and standards of care, and increase market share; enhance a professional environment of competence; demonstrate a commitment to quality improvement; and build leadership and team skills among staff. All CT hospitals report breastfeeding data to the CDC's Maternity Practices in Infant Nutrition and Care (mPinc) project. DPH and CT Breastfeeding Coalition (CBC) assist the birth facilities through the initial discovery and development phase of the process. A program consultant will help the birth facilities complete at least five of the ten steps towards designation, by offering 40 hours of consultation with an International Board Certified Lactation Consultant (IBCLC) with Baby-Friendly experience, and a two day training course. CT has an agreement with the Connecticut Breastfeeding Coalition through ARRA funding, to support ten (10) hospitals in earning the "Baby Friendly Hospital" designation.

In FFY09, the twelve regional CT WIC sites reported breastfeeding rates that exceeded the WIC goal of > 55%, yet only two of the twelve sites met or exceeded the HP 2010 objective of 75%. CT birth facilities require further education on adhering to the standard clinical practice guidelines against routine bottle supplementation when breastfeeding. Nine percent of CT hospitals have comprehensive breastfeeding policies as recommended by the Academy of Breastfeeding Medicine. Nine percent of CT hospitals provide patients with post-discharge telephone or opportunity for a follow-up visit. DPH's Immunization Program now includes breastfeeding educational materials in the hospital discharge packet in all birth facilities. The information provides contact information for support and referral.

Most WIC nutrition staff are Certified Lactation Counselors (CLC), trained to provide individualized support for breastfeeding mothers and each site has a dedicated Breastfeeding Coordinator to provide breastfeeding support, education and referrals. CT WIC continues to provide annual training for nutritionists to become CLCs and renew their certification.

The CT WIC program has expanded the Hispanic Health Council/Hartford Hospital Breastfeeding: Heritage and Pride (BHP) breastfeeding peer counseling program to Yale-New Haven Hospital (YNHH). YNHH has a number of breastfeeding initiatives underway that demonstrate its unique suitability for successfully implementing a breastfeeding peer counseling program, including: initiation of a breastfeeding clinic, providing an alternate location for peer counselors to meet with their clients to provide follow up and support, with access to a Lactation Consultant or physician, integration of the peer counseling program into the administrative structure of the Yale Primary Care Center (PCC) as well as inpatient maternity services. The Yale PCC serves largely African American individuals and this segment of the population has lower breastfeeding duration rates that its White or Latino counterparts. The provision of this evidence-based service to the YNHH population is consistent with national and state health objectives to reduce or eliminate racial and ethnic disparities.

1.I. Obesity
Obesity is the second leading cause of preventable death in the United States after smoking (Wee, American Journal of Public Health, 2005). According to the 2008 Pediatric Nutrition Surveillance System, which assesses weight status of children from low income families participating in WIC, 31.2% of low income children age 2-5 are overweight or obese in CT. One in four (26%) CT high school students are obese (12.3%); are overweight (13.3%) (2007 YRBS). Adolescents who are overweight have an 80% chance of being obese as adults. One in five CT high school students (21.5%) eats the recommended five or more daily servings of fruits and vegetables (2007 YRBS).

1.J Immunizations
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. Beginning August 1, 2010 all incoming CT college freshman (full-time or matriculating) will be required to show proof of 2 doses of measles, mumps and rubella vaccine and 2 doses of varicella (chickenpox vaccine). Beginning September 1, 2010 all children born on or after January 1, 2009 who attend a child day care center, group day care home, or family day care home ages 12-23 months are required to have one dose of the Hepatitis A vaccine; two doses are required for those aged 24 months and older. By January 1, 2011 and each January 1 thereafter, children aged 6-59 months attending a child day care center, group day care home, or family day care home are required to receive at least one dose of influenza vaccine between September 1 and December 31 of the preceding year. The Immunization's staff facilitates the Vaccine Purchase Advisory Committee (VPAC) that makes recommendations to the State Department of Public Health on issues related to the use of publicly purchased vaccines for childhood and adolescent vaccinations.***/2013/ A consultant conducted a feasibility study to estimate operational costs and impact to staff time, supplies, equipment and training required to implement a provider choice policy. The provider choice program will be implemented October 2012.//2013//***

II. Other Indicators

II.A. Socioeconomic Indicators in CT
CT is a small state of about 5,000 square miles and 169 towns, with a July 1, 2008 estimated statewide population of 3,501,252. The average town size is about 20,000, and only five towns have a size greater than 100,000. These five towns are Bridgeport (population 136,405), Hartford (124,062), New Haven (123,669), Stamford (119,303), and Waterbury (107,037).

41 towns had high unemployment rates reported in 2008, with Hartford having the highest at 10.9%. Eighteen towns with high unemployment rates had populations that exceeded the average town size. These data indicate that the need for social services in the state is not limited to towns of high population.

II.B. Health Care Delivery Environment in Connecticut
CT's direct health care services are delivered through a range of providers including, but not limited to, school based health centers (SBHC), community health centers (CHC), outpatient clinics, physicians offices for primary care services; free-standing and hospital-based outpatient surgical centers for diagnostic or minor surgical procedures; acute care hospitals for emergency care, routine outpatient or inpatient services; long term care facilities for chronic care or rehabilitative service; and increasingly non-institutional settings, such as the home, for services ranging from intravenous infusion of medications to physical therapy. To date, 11 "Minute Clinics" have been established at local CVS pharmacies. These clinics are staffed with licensed Nurse Practitioners and Physician Assistants and serve clients ages 18 months of age and older. The

licensure or certification of health care facilities and health care professionals guides delivery of health care and services. Utilization of services is dependent upon a variety of demographic, economic, social and environmental factors, all of which are considered when planning the delivery of Title V programs, services and activities.

Perinatal Care in CT is provided through a network of Healthy Start Providers. The goal of the state Healthy Start Program is to promote positive birth outcomes and maternal and infant health among at-risk, low-income families in CT. To complement the Healthy Start program, CT also has a Nurturing Families Network, which operates in all 29 birthing hospitals in the state. It provides parent education and support for first time parents. Unlike the Healthy Start program, families are enrolled in the Nurturing Families Network when they are expecting or have just given birth to their first child.

II.C. Safety Net Providers

Safety Net Providers are part of the system of care that addresses the needs of individuals who experience barriers when accessing the traditional health care system. Some of these barriers include financial, transportation, cultural and linguistic differences, etc. Populations targeted by safety net providers include uninsured, underinsured, immigrants, and the homeless. The safety net providers in CT include CHC, SBHC, Visiting Nurse Associations (VNA), Local Health Departments (LHD) and Family Planning Clinics. In the past year, federal stimulus funding allowed community health centers to cover costs associated with treating additional patients, develop infrastructure, and allowed existing CHC to add sites. Three CHC obtained 330 Federally Qualified Health Center (FQHC) funding (Community Health and Wellness Center of Greater Torrington, Norwalk Community and Family Services, Inc., and the Greater Danbury CHC). State bonding dollars have been made available to CHC and SBHC to continue to build their capacity as a safety net provider.

II.D. Health Insurance

As of May 2009, 9,671 CT residents were enrolled in the Charter Oak Plan (CT's universal health coverage plan, available to all consumers on an income-based sliding scale). Another 4,927 were eligible but not enrolled.

HUSKY (Healthcare for UninSured Kids and Youth) is CT's health insurance plan for children and families. In 1997 when the federal government created the State Children's Health Insurance Program, CT renamed part of its Medicaid program that serves children and low-income families "HUSKY A" and established the "HUSKY B" program for uninsured children with family income that exceeds the HUSKY A limits. HUSKY A and B are managed care programs, administered through the Department of Social Services (DSS) and private health plans. HUSKY A covers pregnant women (with income under 250% of the FPL and children in families with income under 185% of the FPL. Parents and relative caregivers can also obtain comprehensive benefits. The basic HUSKY package includes preventive care, outpatient physician visits, inpatient hospital and physician services, outpatient surgical facility services, short-term rehabilitation and physical therapy, skilled nursing facility care, home health care and hospice care, diagnostic x-ray and laboratory tests, emergency care, durable medical equipment, eye care and hearing exams.

Mental and behavioral health services; and dental services are carved out and administered through Administrative Service Organizations (CT Behavioral Health Partnership, and CT Dental Health Partnership). Pharmaceuticals are administered directly through the Department of Administrative Services.

HUSKY B provides health care for children without employer-sponsored coverage for a sliding fee. As part of HUSKY B, HUSKY Plus provides supplemental benefits for Children and Youth with Special Health Care Needs enrolled in HUSKY B. Services include Multidisciplinary teams (Pediatricians, Advanced Practice Nurses, Benefits Specialists, Family Resource Coordinators and Advocates) who work with families to identify their child's care needs and the resources to meet those needs. Community-based mental health and substance abuse services to children

and youth with intensive behavioral health needs are also offered under HUSKY Plus.

HUSKY gives families the flexibility to choose one of three participating managed health care plans: Aetna Better Health, AmeriChoice by United Healthcare, or Community Health Network of CT. ***/2013/Since January 1, 2012, new applicants and current HUSKY members are no longer enrolled in a managed health plan or in HUSKY Primary Care. Community Health Network (CHN) of CT has been chosen to be the single, statewide HUSKY Health Administrative Services Organization (ASO) and will provide case management, benefit information, member services, and quality management. Fee for service remains an option for providers.//2013//***

A fee for service option, HUSKY Primary Care, Connecticut's Primary Care Case Management (PCCM) program, is now available to HUSKY A members in the Hartford, New Haven, Waterbury, and Windham areas. In HUSKY Primary Care, the primary care provider has a greater role in coordinating health care on a Per Member Per Month (PMPM) reimbursement basis. The providers in HUSKY Primary Care offer the same services offered by a managed care health plan, such as health education, reminders about immunizations and well-child visits, and help in scheduling appointments. ***/2013/PCCM has been discontinued in favor of an emerging Person Centered Medical Home (PCMH) program implemented through CHN.//2013//***

There are 378,571 persons, including 249,156 children under 19 enrolled in HUSKY A as of June 1, 2010. HUSKY B provides health care for children without employer-sponsored coverage for a sliding fee. There are 15,476children under 19 in HUSKY B as of June 1, 2010 (CT Voices for Children; web site www.ctkidslink.org).

DPH has provides policy guidance and technical assistance to the HUSKY program through:

- DPH medical home care coordination, extended services, and respite fund administration contractors provide benefits coordination for families of Children and Youth with Special Health Care Needs (CYSHCN) to assist in accessing public/private sources to pay for services needed.
- Participation in the Covering CT's Kids coalition, a network of organizations involved in HUSKY outreach (including DSS, and MCH Information and Referral Service),
- Partnering in the work to expand Katie Beckett waiver and other related DSS waiver applications to support access to comprehensive care for children and youth,
- Working with the State Medicaid Managed Care Council to promote outreach for prenatal access in first trimester and Medicaid reimbursement of care coordination services to improve access to pediatric primary health care under Early Periodic Screening and diagnostic and Treatment Services,
-Working to facilitate access to PCCM as well as to the Medicaid Managed Care plans.
- Working with the State Commission on Children, HUSKY and other CT key stakeholders in promoting home visitation for mothers with newborns, particularly at risk mothers using Healthy Start and Nurturing Families Programs,
- Providing care coordination and respite care as well as family support services to children with special health care needs in HUSKY.
- Developing linkages between HUSKY and state public health programs such as WIC, childhood immunizations, Medical Home Learning Collaborative of primary care physicians, SBHC, CHC, Family Support Council, and other essential community services and Title V funded programs.
- Utilizing existing services to create access points for referral or applications to enhance outreach and enrollment; and
- Implementing quality improvement activities and evaluation

/2013/The Charter Oak Health Plan had 9,727 members in 2011. The HUSKY program for medical services transitioned from a managed care based system to an ASO system utilizing CHN with billing directly through DSS. The PCCM program was replaced by a PCMH program, participation is dependent upon level two NCQA certification and enhanced reimbursements linked to specific outcomes. The Medicaid Managed Care Council is now the Medical Assistance Program Oversight Council (MAPOC).//2013//

II.E. Racial and Ethnic Disparities
In 2007, the Hispanic or Latino population comprised 11.5% of the CT population. Hispanics represented 35.1% of uninsured CT adults (2004-2006 CT BRFSS). Hispanics represented 17.5% of all reported Chlamydia cases (2001-2005). Hispanics represented 35.1% of all reported HIV/AIDS cases (2001-2005). In 2005, about 22% of Connecticut doctors reported that they felt unprepared to treat patients with limited English proficiency (Hispanic Health Council 2006, 31-32).

Among the Black/African American population, age-adjusted death and premature mortality rates of Black/African Americans CT residents are significantly higher than those of the White, non-Hispanic Connecticut residents for the following leading causes of death - heart disease, cancer, cerebrovascular disease, HIV, and diabetes (2000-2004 data). African Americans have 1.2 times the age-adjusted death rate for all causes, 1.2 times the age-adjusted death rate for heart disease, 1.1 times the age-adjusted death rate for cancer, 1.4 times the age-adjusted death rate for cerebrovascular disease (stroke), 2.5 times the age-adjusted death rate for diabetes, and 14.9 times the age-adjusted death rate for HIV/AIDS compared with White, non-Hispanic CT residents. (The CT Health Disparities Report, 2009)

The Title V programs have incorporated contract language that requires providers to deliver culturally competent services and demonstrate this by: developing a mission statement committing to cultural diversity, develop materials in languages reflecting the needs of the patient population, policies and procedures to address the needs of the patient population, taking into account factors such as race, ethnicity, age, gender, hearing impairment, visual impairment, physical disability, mental illness, developmental disability and sexual orientation.

The DPH Office of Multicultural Health (OMH) is responsible for providing leadership in promoting, protecting, and improving the health of all CT residents by eliminating differences in disease, disability, and death rates among ethnic, racial and culturally diverse populations. The Office promotes access to quality health education and health care services; facilitates presence of diverse populations in health planning, program development, policy formation, and outreach and awareness initiatives. OMH functions largely through collaboration with statewide partners, and recommends policies, procedures, activities, and resource allocations to improve health among the states' underserved and diverse populations, and to eliminate health disparities.

OMH leads state and local partners in addressing multicultural health issues and eliminating health disparities by focusing on the goals of: 1) Improving Language proficiency; 2) Promoting Cultural Competency; 3) Increasing Workforce Diversity; and 4) Enhancing Awareness, Access to Health Care and Health Education.

II.F. Rural Health
The CT definition of rural uses the 2000 U.S. Census data and OMB designations. All towns in a designated Micropolitan Statistical Area with a population less than 15,000 and those towns in Metropolitan Statistical Areas with a population of less than 7,000 are designated rural for the State of CT. Of the 169 towns in CT, there are 52 with populations of less than 7,000 as of 2008. Specific concerns identified for rural CT include: emergency medical services, transportation, recruitment and retention of adequate workforce, a decreasing social services safety-net, mental health, oral health, and others. Currently there are 7 of CT's rural towns, which are designated as Medically Underserved Areas/Populations (MUA/Ps). The Title V program will continue to support the Primary Care Office (PCO) now located in the Family Health Section (FHS), to continue to assess and designate Connecticut's rural communities collaborating with the ORH. The DPH has representation on the Office of Rural Health (ORH) Advisory Board.***/2013/ The CT Office of Rural Health (CT-ORH) updated the list of rural towns it serves using the 2010 U.S. Census data in 2011. There were 61 of 169 towns in CT designated as rural Concerns identified for rural CT include: emergency medical services, transportation, recruitment and retention of adequate workforce, a decreasing social services safety-net, mental***

health, oral health, and others. Seven (7) of CT's rural towns are designated as MUA/Ps.//2013//

The CT ORH identifies data sources, analyze and report the key health care issues impacting rural CT. The overall goal is to gain a better understanding of the health status of rural residents and develop a supporting rural health database. Results from a survey indicated concerns regarding transportation service in rural communities, adequate services for substance abuse, domestic violence, oral health care and mental health services. The report can be found at www.ruralhealthct.org/report.htm.

CT DPH Injury Prevention Program and MCH staff are collaborating with the CT-ORH on the Region 1 Rural Injury Community of Practice initiative facilitated by the Children's Safety Network. An analysis of rural and non-rural injury-related mortality and hospitalizations for leading causes of injury was recently completed. The next step is to look at additional sources of data on rural injuries, identify existing prevention efforts/partnerships and develop a rural focus for these efforts as needed.

II.G. Other Vulnerable Populations
DPH is interested in the health needs of vulnerable women and children, many of whom face financial, language, and cultural barriers to care. These populations include the uninsured, single mothers transitioning from welfare to work, homeless mothers and children, incarcerated women, adolescents who are concerned with confidentiality (parent involvement in their health care), and immigrant and undocumented populations. Safety net providers, such as community health centers and school based health centers, as well as case management programs, help address the needs of vulnerable populations.

Incarcerated Women's Health: The DPH collaborated with DOC and a community-based agency to continue to provide intimate partner violence/trauma training to inmates onsite at York Correctional Institute (YCI), CT's only female prison. In addition, plans are underway to provide this training to recently released women at halfway houses and resettlement programs. The goal is to help this vulnerable population understand what intimate partner violence is, prevent repeated trauma, seek appropriate resources and supports, and develop healthy relationships.

Male Involvement: The FHS recognized that the health of fathers and men impacts the health of women, children and families. The Title V Program is an active participant on the DSS Fatherhood Initiative Council that develops and disseminates consumer and provider educational materials regarding the importance of men's health and the impact on maternal and child health. This workgroup is comprised of members from DCF, DSS, DOC, and community based organizations. DPH is contracting with Real Dads Forever, Inc. who will pilot, conduct and evaluate a train-the-trainer training of its recently developed health education curriculum for male partners to providers in the Hartford Healthy Start Program. The goal of the training to men is to increase involvement between fathers/family men ages 15 through 30+, single or married, and their children. The training will provide strategies directed at male partners to support women during pregnancy by providing strategies that reduce stressors in their relationships and that positively impact lifestyles in support of the child.
DPH supports and partially funds the annual New England Fatherhood Conference, which reaches out to birth fathers, fatherhood practitioners, child welfare leaders, and community-based staff workers to participate in the conference and share information in both formal and informal venues.

DPH also was a signatory in a Memorandum of Understanding among the State Departments of Social Services, Children and Families, Mental Health and Addiction Services, Correction, Labor, and Education, and the Judicial Branch to collectively develop an annual report to be presented to the Fatherhood Advisory Council to provide information on expenditures and programmatic/statistical activities.

III. Health Priorities

III.A. MCH Priorities
The nine identified state priority needs are: 1) Enhance Data Systems; 2) Improve Mental/Behavioral Health Services; 3) Enhance Oral Health Services; 4) Reduce Obesity among the three target MCH populations; 5) Early Identification of Developmental Delays, Including Autism; 6) Improve Health Status of Women, particularly related to depression; 7) Improve Linkages to Services/Access to Care; 8) Integrate the Life Course Theory throughout all state priorities; and 9) Reduce Health Disparities within the three MCH target populations

III.B. CYSHCN Priorities
The DPH requires that the CYSHCN community based networks: 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.

DPH is the state's lead agency for implementation of the State Early Childhood and Comprehensive System's (SECCS) grant, called Early Childhood Partners (ECP), which supports all CT families to ensure that children arrive at school healthy and ready to succeed. ECP has collaborated with the Children's Trust Fund to build provider capacity as it relates to identifying and referring children with developmental delays. ECP funds are leveraged to conduct annual Ages and Stages Questionnaire (ASQ) trainings for health care providers.

/2013/ DPH will address three identified consumer issues in the coming year with our community partners; (1) how to identify signs of mental health and respond to problems; (2) support the Medical Home Initiative, and (3) provide programs and services for children with ASD. A number of recent activities within the FHS of the DPH have been implemented to address adverse birth outcomes and disparities in outcomes, under the leadership of Commissioner J. Mullen and Title V Director which include policy initiatives, funded programs and surveillance. DPH is committed to incorporating health equity into its strategic plan, and into the goals and objectives of Healthy CT, its state health improvement plan, which will be completed by December 2012. During the next year, DPH will undertake a self-assessment of its institutional capacity to address health equity.//2013//

DPH is a board member of the CT Association for Infant Mental Health (CT-AIMH). CT-AIMH promotes social emotional health and development of infants, young children and their families.

III.C. Data and MCH Impact
Consistent with the HP 2010 objectives, CT gives priority to MCH surveillance through the creation of a comprehensive linked database containing high-quality, record-level, child health data (HIP-Kids), a database for CYSHCN, Fetal and Infant Mortality Review, and Vital Records data collection and analysis. The HIP-Kids database project is located in the FHS and holds information of newborns on lab screening tests, hearing tests, and birth defects reported by birth facilities through the electronic reporting system. The HIP-Kids project is being migrated to a web-based application called MAVEN and includes a planned electronic link to the Electronic Birth Record followed by a link to the death record system. All Title V activities and programs are designed to promote and protect the health of CT's mothers, children and adolescents, and children with special health care needs.

Additional activities include the completion of the PRATS survey in 2009 to obtain information about the experiences and health behavior of pregnant women before, during and after their most recent pregnancy. The first Birth Defects Registry Report for 2001-2004 has been released and

is posted on the DPH website. The Birth Defects Registry submitted data on 6/18/10 to the Centers for Disease Control (CDC) and National Birth Defects Prevention Network for children born in 2007 in June 2010. The 2005-2007 registry report has data for children born with 45 reportable birth defect conditions. Data for year 2008 is being analyzed and will be published in 2011. The Birth Defects Registry is working closely with the Environmental Public Health Tracking System and has submitted birth defects data through the birth cohort 2007. ***/2013/ CT was one of only three new states funded by the CDC for a 5-year project period to conduct the Pregnancy Risk Assessment Monitoring System (PRAMS) survey. //2013//***

The birth defects epidemiology staff received notification that the New England Genetics Collaborative (NEGC) Innovative Project Awards, 2010-2011 application for the Development & initiation of a New England Birth Defects Consortium (NEBDC) was funded for a second year in June 2010. New Hampshire is the lead in this six-state consortium. The Consortium is working to: 1) Implement routine data sharing among member states; 2) Support research into the causes of birth defects in New England; and 3) Prevent Birth Defects in New England by engaging members in a pilot project to standardize a prevention campaign among all states in the NEBDC.

The need to strengthen data linkages was identified in the five-year needs assessment. The Title V program will be taking a lead role in securing a contract with the CT Hospital Association to obtain hospital discharge data. The acquisition of this data set will enhance case ascertainment for the maternal mortality surveillance program, enhance the Crash Outcome Data Evaluation System (CODES) database and provide additional data for the Asthma and other MCH programs both at the state and local levels. A data management module for the in-patient hospitalization and ED data was created and will be placed on DPH's Public Health Information Network (PHIN) to facilitate the creation of data extracts for various DPH programs that have requested access to this secondary data source. In-patient hospitalization & ED data for its placement on PHIN was provided. Under the authority of the DPH Commissioner, all 31 acute care hospitals are now required to submit annual in-patient hospitalization & Emergency Department (ED) data to the agency starting with the CY 2006 & 2007.

In March 2009, an MOU was signed between DPH and the Department of Developmental Services (DDS). The purpose of this MOU is for early detection and intervention for infants with hearing impairments, or with other medical conditions that have a high probability of resulting in developmental delay. The Birth Defects Registry monthly identifies children born weighing less than 1,000 grams and/or born at 28 weeks gestation or less with the Birth to Three System.

IV. Conclusion

It is the role of CT's Title V program, through funding of direct/enabling, population-based, and infrastructure building services, to address prioritized needs and gaps in services for the target populations. Community based programs are funded to provide direct and enabling services, such as case management and outreach. Population-based services include disease prevention and education. Infrastructure building services include needs assessment, policy development, quality assurance, development and management of information systems, and training.

The Title V Program determines factors that impact services in the State, through: 1) conducting statewide assessments (MCH five-year needs assessment); 2) reviewing and analyzing Title V programs quarterly reports submitted by all contractors, which include quantitative and qualitative information; 3) technical assistance meetings with the MCH contractors; 4) analyzing data from various sources; and 5) continuous feedback from stakeholders through advisory groups.

The Title V Program has taken a more data driven approach to its prioritization of MCH program design and implementation, and is committed to use resources effectively to address health disparities. As a result, the need to enhance our data collection system and integrate information becomes very apparent to support continued assessment, evaluation, research, and development of public health policy for the MCH population.

/2012/ Jewell Mullen, MD, MPH, MPA became DPH Commissioner in 2011.
As a former member of the National Health Service Corps and Director of the Bureau of Community Health and Prevention at another state health department, she brings to her role the recognition that efforts to improve the health of individuals and communities must be informed by an understanding of the social context which determines their behaviors and their access to resources. The Commissioner's leadership and commitment to promote a seamless relationship between state government and local communities is supported by the increased collaboration and partnerships that have developed over the last year to address maternal and child health.

The Title V Director partnered with the New Haven Health Department, the Community Foundation for Greater New Haven Healthy Start Program, and Hartford Health Department to submit an application for a Partnership to Eliminate Disparities in Infant Mortality (PEDIM). This Action Learning Collaborative has been funded by CityMatCH, AMCHP, and NHSA (June 2011)./***2013/The Collaborative will be holding a 2-day workshop on all six phases of Perinatal Periods of Risk (PPOR). National experts from the CDC and CityMatCH will be conducting the training.//2013//***

The Medicaid Care Management Oversight Council's Women's Health Committee in collaboration with the March of Dimes, DPH, DSS, Lily's Kids, Inc., Community Health Center, Inc. and other stakeholders held a forum to discuss Woman's Health Before, During and After Pregnancy in November 2010. The focus of the forum was to identify strategies to 1) improve prenatal care/postpartum care, 2) Reduce low birth weight/prematurity, 3) Reduce disparities in prenatal care, birth outcomes and infant mortality and 4) Integrate preconception/inter-conception care into practice. Carol Stone, PhD, MPH, MPA, MAS provided a presentation on The Epidemiology of Poor Birth and Infant Outcomes in Connecticut and Rosa Biaggi, MPH, MPA, State Title V MCH Director provided an overview of DPH initiatives that address low birth weight and prenatal care initiatives.

DPH serves as the lead in a collaborative partnership with DCF, SDE, and Department of Mental Health and Addiction Services (DMHAS) on the development and implementation of CT's Personal Responsibility Education Program (PREP) plan. The goal of this project is to provide education and training to the DCF system that supports behavior change in youth in foster care, in an effort to delay sexual activity and associated risks, reduce planned or unplanned pregnancy, and increase access to reproductive health care. The target population are youth (ages 13-19) served by DCF, who are in an out of home setting.
During the past year, DPH convened a group of stakeholders to conduct the Statewide Needs Assessment for Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Programs submitted in September 2010. It can be found at:
http://www.ct.gov/dph/lib/dph/needs_assessment_complete_091510.pdf .
Another Advisory Committee was convened to assist in the development of the updated state home visiting plan which has been submitted to HRSA./***2013/ The MIECHV program serves pregnant women and families at high risk for adverse maternal, infant, and early childhood outcomes in areas of the State with the greatest need (2010 Needs Assessment). Funding from Formula grant was used to serve Windham, New London, New Britain, and Ansonia/Derby. The competitive Home Visiting grant award the DPH received in April 2012 will allow support to other towns that were described in the Needs Assessment as being very high need by expanding the Parents as Teachers (PAT) and ChildFIRST home visiting models.//2013//***

CT received two awards at the NIC in Washington D.C. from Dr. Regina Benjamin, Surgeon General, U.S. Public Health Service and Dr. Anne Schuchat, Assistant Surgeon General and Director of the National Center for Immunization and Respiratory Diseases, in recognition of CT's outstanding achievement in improving adolescent immunization coverage by 16% from 2008-2009 for three vaccines that have been recommended for adolescents to protect them from serious diseases such as meningitis, cervical cancer, and pertussis (Whooping Cough) The

second award was in recognition of CT's extraordinary achievement of 55.6% coverage of influenza vaccination among children by December 2010. Connecticut was also among the top states in the country for overall teen vaccination with an average coverage rate of 73 percent. Connecticut's immunization coverage rate was third only to Massachusetts and Rhode Island, and well above the national average of 58 percent.

The Connecticut General Assembly (CGA) has adopted Results-Based Accountability (RBA) approach as a critical planning and policy tool for the Appropriations Committee. FHS staff received RBA training to use when reporting about the impact of state funded programs. RBA enables policy makers, funders and program administrators to identify how well a program is doing against an historical trend line and to judge progress in terms of whether they are "turning the curve" or beating the baseline. The FHS has used the RBA process to provide a detailed report on the status of: SBHC, CHC and the Immunizations programs. The RBA process was utilized when reporting to CGA's Appropriations Committee to for use in the budgeting process. DPH held two half-day training workshops, Performance Management and Quality Improvement applications for state public health agencies for managers, directors and Branch Chiefs in spring 2011. The workshops were facilitated by the Public Health Foundation covering Quality Improvement (QI) methods and tools. As a recipient of a Component 1 grant through the National Public Health Improvement Initiative supported through the Prevention and Public Health Fund of the Affordable Care Act, DPH wants to enhance its workforce capacity to apply QI tools and methods in order to improve work efficiencies and increase effectiveness. Other employee groups will be included in educational sessions later this year.

One of Connecticut's most pressing challenges is trying to maintain and improve programs and services for the MCH population while working with reductions in state and federal funding. DPH is committed to examine all opportunities to work collaboratively with our stakeholders to leverage existing state and federal funds to maximize programs and services and explore no cost or low cost initiatives. FHS will continue to apply for additional funds as they become available and work synergistically with providers and MCH state and community leaders so that services are coordinated, efficient, and effective resulting in the MCH population having access to and receiving quality preventive and primary services throughout the life course.//2012//

/2013/State FY13 Immunizations funding was increased to provide Hepatitis A and Pneumococcal Conjugate vaccines universally for all children regardless of insurance status. The increase in funding will come from an assessment on any domestic insurer or health care center doing health insurance business in the state.//2013//

/2013/ PA 12-116 An Act Concerning Education Reform was signed by the Governor and provided funding to establish or expand a minimum of twenty school-based health clinics that are located in alliance districts.//2013//

B. Agency Capacity

Authority for the Maternal, Infant, and Child and Adolescent Health Programs is derived from the CT General Statutes and Title V Federal Grant Program Requirements. The following describes the statutes that support DPH authority for MCH programs.

The statutory basis for maternal and child health services in Connecticut originates from the statute passed in 1935, SS19a-35 PA 35-240 authorizing the Department of Public Health to receive Title V funds for its existing maternal and child services. Statute SS19a-59b PA 83-17(1983) established the Maternal and Child Health Protection Program (MCHPP) to provide outpatient maternal health services and labor services to needy pregnant women and to children less than 6 years of age; and SS19a-7i PA 97-1 (1997) extended coverage under the Maternal and Child Health Block Grant.

Statutes passed to provide maternal and child care include: SS19a-7c PA 134(1990) subsidized non-group health insurance for pregnant women; SS19a-90 PA 41-255(1941) blood tests of pregnant women for syphilis; SS19a-59c PA 88-72(1988) special supplemental food program for women, infant and children (WIC); SS19a-59a PA 82-355(1982) low protein modified food products and amino acid modified preparations for inherited metabolic disease; SS19a-55 PA 65-108(1965, 2002) newborn infant screening; SS19a-59 PA 81-205(1981) newborn infant screening for hearing impairment; SS19a-49(1961) and SS19d-55b PA 09-21(2009) screening and care for infants and children for cystic fibrosis; SS19a-7f PA 91-327(1991) and SS19a-7h PA 94-90(1994) childhood immunization schedule and registry; SS19a-54 PA 33-266(1933) and SS19a-52(1981) physically handicapped children registration and equipment; SS19a-53 PA 33-318(1933) childhood physical defects; SS19a-50 PA 39-142 PA 37-430(1937, 1939) and SS19a-51 PA 63-572(1963) children crippled or with cardiac defects; SS19a-48(1949) care for children with cerebral palsy; SS19a-53 PA 33-318(1933) physical defects of children; SS19a-56a PA 89-340(1989) and SS19a-56b PA 89-340(1989) birth defects surveillance and confidentiality; SS19a-60 PA 45-462(1945) and SS19a-38 PA 156(1965) dental services for children and fluoridation of public water; SS19a-110 PA 71-22(1971) lead poisoning; SS19a-62a(2000) pediatric asthma; and SS47-48 PA 06-188(2006) Medical Home Pilot Program. ***/2013/PA 12-13(2012) Critical Congenital Heart Disease Screening for Newborn Infants and PA 12-116 (2012 An Act Concerning Education Reform to establish or expand a minimum of twenty school based health clinics.//2013//***

Other statutes exist to provide regulatory authority for Title V related services that include: SS10-206 PA 04-221(1940-2004) health assessments of school pupils; SS14-100a PA 05-58(2005) child restraint systems; SS19a-7a PA 90-134(1990) availability of appropriate healthcare to all CT residents; SS19a-4j PA 98-250(1998) addressing disparity of disease in racial, ethnic, and cultural groups; SS19a-4i PA 93-269(1993) injury prevention; SS19a-7 PA 75-562(1975) public health planning; SS19a-17b PA 76-413(1976) peer review; SS19a-25 PA 61-358(1961) confidentiality of records; SS4-8 (1949) transfer Title V funds to Department of Social Services; SS19a-32(1949) authority to receive, hold, invest, and disperse assets; SS19a-2a PA 93-381(1993) powers and duties of Commissioner of DPH in the prevention and suppression of disease; SS51 PA06-195 to establish a School Based Health Center ad hoc committee.

Program Capacity in CT

The mission of DPH is to protect and improve the health and safety of the people of Connecticut. Within DPH, the Family Health Section (FHS) is part of the Public Health Initiatives (PHI) Branch. The FHS is comprised of five units: 1) Primary Care and Prevention, 2) Children and Youth with Special Health Care Needs, 3) Program Development, 4) Immunizations, and 5) Registry. ***/2013/The Immunizations Program is now part of the Infectious Disease Section. The FHS is comprised of four units: 1) Community Health and Support, Oral Health, Maternal, Infant and Child Health, and Child and Adolescent Health.//2013//***

The focus of programs within the FHS is to promote community based, coordinated, culturally competent, family centered services to pregnant women, mothers and infants, children and adolescents (including CYSHCN) through the life course. Staff within the units work collaboratively to coordinate resources and maximize program capacity.

Programs supported with MCH Title V funds provide direct services, enabling services, population based services and/or infrastructure building services. CT's Title V Program focuses on three main populations: 1) Pregnant Women, Mothers and Infants (PWMI), 2) Children and Adolescents (CA), and 3) Children and Youth with Special Health Care Needs (CYSHCN).

Title V Partnership Programs for Pregnant Women, Mothers and Infants

Breastfeeding Initiative: DPH is developing internal mechanisms and evaluating capacity to collect population-based breastfeeding data. The Electronic Newborn Screening Database

collects data from all birthing hospitals on the mother's intent to breastfeed.

Case Management for Pregnant Women: provides comprehensive, integrated case management services during the perinatal and interconceptional periods to pregnant and post partum teenagers and women in an effort to improve birth outcomes. The program is offered in three towns/cities and includes the partners of pregnant women.

Centering Pregnancy: Two Centering Pregnancy programs in New Haven provide services to women who are most at-risk for delivering low birth weight infants, so as to achieve outcomes that include: 1) empowerment and community-building among pregnant group members, 2) increased satisfaction of pregnant women with prenatal care, 3) reduction in premature or preterm births, and 4) increased breastfeeding of infants by their mothers. The Centering Pregnancy model includes three "care components" of assessment, education, and support, which are provided within a group setting and facilitated by a credentialed health provider and a co-facilitator. /2012/ Programs are now financially self-sustaining.//2012//

Community Health Centers receive state funds to provide primary and preventive health services across the lifespan.

Family Planning: promotes decreasing the birth rate to teens, age 15-17, preventing unintended pregnancy, and increasing access to primary reproductive health care. Through its contract with Planned Parenthood of Southern New England (formerly Planned Parenthood of CT, Inc.), comprehensive reproductive health services are available in 12 locations with 4 subcontractor locations across the state.

Fetal and Infant Mortality Review (FIMR): to identify and address contributing factors to fetal and infant mortality. The state budget did not include funding for the FIMR program in state fiscal year 2010. Funding to the former FIMR contractors was restored in State fiscal year 2011. /2012/Funding was rescinded for FIMR in State fiscal year (FY 2011). //2012/ ***//2013/State funds have been allocated for Fiscal Year ending June 2013, to develop a plan for statewide implementation of a program to address fetal and infant mortality in the state.//2013//***

Healthy Choices for Women and Children (HCWC): provides intensive case management services to low income, pregnant and postpartum women in the City of Waterbury or surrounding communities, who abuse or are at risk for abusing substances (or whose partner abuses substances), and their children from birth to age three. Services include case management with intensive home visiting, prevention education, parenting education, domestic violence, planning, and assistance with housing and transportation. /2012/A Request for Proposal for this program will be released in State FY 2012.//2012// ***/2013/State funding will continue for this Program through September 2017//2013//***

State Healthy Start: provides case management services to eligible pregnant women for the purpose of 1) improving CT birth outcomes by reducing the rate of infant mortality, morbidity and low birth weight, 2) providing access to prenatal/postpartum care services through CT's HUSKY A healthcare program, and 3) promoting and protecting the health of both mother and baby. This program is offered through a MOA with the DSS.***/2013/State Healthy Start screens and refers eligible pregnant women for case management and home visiting services.//2013//***

Federal Healthy Start Program: designed to increase the number of low-income black African American pregnant women who enter early prenatal care to promote healthier pregnancies and reduced rates of birth complications such as infant morbidity and mortality. DPH secured federal funding to address racial and health disparities in the city of Hartford. /2012/Program serves pregnant and postpartum women and their children up to two years of age.//2012//

Maternal and Child Health Information and Referral Service: administers the toll-free MCH hotline that provides information on health and related services. Services are accessible to non-English

speaking callers and to speech/hearing impaired callers. DPH contracts with the United Way of CT for the service.

First-Time Motherhood/New Parent Initiative: an Infant Mortality Social Marketing Campaign in Hartford, New Haven, and Bridgeport to increase awareness of and linkages to existing preconception/interconception, prenatal care and parenting resources as well as to increase the likelihood of a healthy pregnancy. The HRSA grant supporting this initiative ends August 2010. /2012/Grant ended in 2010.//2012//

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.

The 2007-2011 State Systems Development Initiative (SSDI) Project goals are to: 1) improve and increase the availability of quality data for the MCHBG and MCH programs, and 2) develop data dissemination systems of analytic reports and presentations to help inform public health programs at the state and local level.

CT is focusing on 3 main activities to achieve these goals: 1) implementing HIP-Kids, a comprehensive linked database containing high-quality, record-level, child health data; 2) linking birth records with WIC enrollment and visit data, and to include a linkage with the state Medicaid eligibility files; and 3) conducting a PRAMS-like survey of postpartum women in CT.***/2013/ CT has been awarded funds by the Centers for Disease Control and Prevention for a 5-year project period to conduct the Pregnancy Risk Assessment Monitoring System (PRAMS) survey that will monitor the social, emotional, and behavioral experiences of women before, during, and immediately after pregnancy CT was one of only three new states funded. //2013//***

Injury Prevention: focuses on the "reduction of the factors associated with intentional, unintentional and occupational injury". The Injury Prevention Program, following National recommendations for intentional and unintentional injury prevention, conducts community-based programs to address risk and resiliency factors and implements strategies to decrease injury.

/2012/ Maternal, Infant, and Early Childhood Home Visiting:
DPH was designated by the Governor as Lead Agency for the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program. An Advisory Committee was convened to work with DPH on this project. A State Needs Assessment (September 2010), State Plan (June 2011), and competitive grant application (July 2011) were submitted to HRSA. //2012// ***/2013/The MIECHV program's Statewide Plan was accepted by the U.S. Health Resources and Services Administration. DPH received notice that the Competitive MIECHV grant submitted in the summer of 2011 was funded for a three-year period.//2013//***

/2012/ Personal Responsibility and Education Program: focuses on teen pregnancy prevention, particularly among young men and women transitioning out of the foster care system within the State. An Advisory Committee was convened in 2011 to work with DPH on this project and a State Plan was submitted and approved by the Administration for Children and Families.//2012// ***/2013/Prevention activities continue for youth in foster care. Youth in 41 DCF group homes will participate in the Teen Talk program. The DPH entered into an MOU with DCF to develop a data sharing plan to identify youth in and aging out of foster care who are pregnant or parenting. //2013//***

/2013/ The DPH has partnered with the New Haven (Federal) Healthy Start program, and New Haven Health Department, to address systemic and institutional racism that leads to adverse birth outcomes in the City of New Haven. This initiative is supported through City Match, a nonprofit organization of urban areas of the country with high rates of adverse birth outcomes. The Title V Director has the lead role.//2013//

/2013/Staff prepared a proposal to address the ASTHO President's Challenge to reduce preterm birth by 5% in CT by 2014 working in partnership with the State March of Dimes. The proposal is designed to leverage existing program activity including those from the Hartford Healthy Start, Fetal and Infant Mortality Review Program, Pregnancy Risk Assessment Monitoring System, National Leadership Academy of the Public Health, Strong Start initiative, and the Action Learning Collaborative.//2013//

/2013/A State Policy Action Team on Integrating Quality Home Visiting Services in State Early Childhood Systems has been established with members from DPH (Title V Director), DSS (Children's Trust Fund), CT Head Start State Collaboration Office, the Commission on Children, and Child FIRST (Child Family Interagency Resource, Support and Training). The Policy Action Team is working on designing policy actions to achieve: 1) high quality programs; 2) strong linkages and comprehensive services; and 3) supportive governance and policy.//2013//

/2013/The DPH was selected to participate in the National Leadership Academy for the Public's Health (NLAPH), a leadership training program offered by the CDC. DPH has partnered with representatives from a CHC, a local health department, and the CT Hospital Association (CHA) and others to receive training and support to promote the adoption of a Medicaid maternity care Pay-for-Performance Initiative, under construction by the DSS. The initiative will initially focus on New London County, and link the delivery of evidence-based prenatal care performance measures to HUSKY reimbursement rates.//2013//

/2013/The CT DPH FHS partnered with the State Medicaid Agency, the March of Dimes and eleven service providers across the state to apply for the Strong Start for Mothers and Newborns federal funding opportunity to support implementation of two models of prenatal care designed to improve perinatal outcomes while reducing overall costs for women enrolled in Medicaid and/or Children's Health Insurance Program. The project would provide enhanced prenatal care services to a total of 19,541 during the three year period, approximately one-half of the state's perinatal Medicaid population, with a racial and ethnic distribution that represents the entire state's Medicaid birth cohort. The application deadline was delayed; the revised guidance was released on July 3, 2012.//2013//

Title V Partnership Programs for Children and Adolescents, Age 1 - 22 years

State Healthy Start: As described above.

School Based Health Centers (SBHC): DPH funds 75 SBHC in 23 communities. Licensed as outpatient facilities or hospital satellites, they offer services addressing the medical, mental and oral health needs of youth.
/2012/DPH funds 71 SBHC that provide comprehensive services in 20 communities, 11 expanded school health services in 3 communities, and one school-linked site.//2012// ***/2013/The CT legislature appropriated more than 1.3 million dollars for the Department of Public Health to establish or expand a minimum of twenty SBHCs that are located in alliance districts.//2013//***

Expanded School Health Services (ESHS): DPH funds 3 ESHS projects at 10 sites. One site focuses on preventing and improving mental health status and service referral for children and youth in a regional school system, and one site provides access of physical and behavioral health services to preschool children and families who are at risk for learning. An additional ESHS program provides mental health and dental services to students in eight elementary schools in a high need community. /2012/ESHS provide limited services such as counseling, health education, health screening, and prevention services to enhance existing school health services. Two Madison sites and one Chaplin site provide mental health services in a regional school system,

and eight Meriden sites provide mental and dental health services.

School-linked services: A school-linked site is linked to another existing SBHC for support. DPH funds one school-linked health center in New London that provides medical and behavioral health services to preschool children.//2012//

Family Planning: A special effort is made to target services to teens and provide STD screening and treatment, HIV/AIDS screening, and contraception services. Other services include free pregnancy tests and counseling for adolescents at or below 150% federal poverty level, outreach, teen life conferences, reproductive health and STD prevention literature, and community educational programs to teens at risk.

Healthy Choices for Women and Children (HCWC): As described above.

Maternal and Child Health Information and Referral Service (MCH I&R): As described above.

Case Management for Pregnant Women: As described above.

/2012/Federal Hartford Healthy Start: As described above.//2012//

The Early Childhood Partners (ECP) Initiative: funded through the HRSA Early Childhood Comprehensive Systems Grant, works to develop a comprehensive statewide system to support all CT families so their children attain optimum health and school readiness by age five. ECP efforts include expanding the number of pediatric practices and clinics providing medical homes for all children and especially CYSHCN; increasing the number of parents and providers trained and participating in their communities as advocates for children; meeting the developmental needs of children through access to comprehensive health, mental health and education consultation for families and early care and education providers; and meeting the developmental needs of children through the increase of perinatal depression screenings among postpartum mothers. The CT Early Childhood Cabinet serves as the State Advisory Council on early education.

The DPH Injury Prevention Program (DPH-IP): The CT Young Worker Safety Team, a collaboration of DPH and State Departments of Labor and Education, federal and local agencies, promotes safety of adolescents in the workplace through awareness, education and training activities. DPH-IP collaborates with partners to facilitate the Interagency Suicide Prevention Network, and participates in the Youth Suicide Advisory Board.***/2013/The Interagency Suicide Prevention Network, and Youth Suicide Advisory Board have merged into the CT Youth Suicide Advisory Board, DPH participates on the Board.//2013//***

/2012/ Maternal, Infant, and Early Childhood Home Visiting: As described above.//2012//

Title V Partnership Programs for Children with Special Health Care Needs

The CYSHCN program provides care coordination, advocacy and family support to CYSHCN regardless of enrollment financial status. A review of the CYSHCN program resulted in a new infrastructure and capacity building strategy to meet the Healthy People 2010 goals of parent partnership, comprehensive care within a medical home, adequacy of insurance, screening for special needs, community-based systems and transition to all aspects of adult life. There are an estimated 133,000 CYSHCN in CT.***/2013/There are now 139,000 CYSHCN in CT.//2013//***

The Connecticut Medical Home Initiative (CMHI) for Children and Youth with Special Health Care Needs: enhances capacity for medical homes in the five state regions to screen children; and assists medical homes through community-based health care systems while enhancing access to services. The five networks providing co-located and/or embedded care coordination on a regional basis are: 1) CT Children's Medical Center (north central), 2) St. Mary's Hospital

(northwest), 3) Stamford Health System (southwest), 4) Coordinating Council for Children in Crisis, Inc. (south central), and 5) United Community and Family Services, Inc. (eastern). Services include: administration of extended services and respite funds, medical home care coordination, provider and family education, outreach and family support.

Children with an identified chronic condition and are either uninsured or underinsured may be eligible for payment of durable medical equipment, prescriptive pharmacy and special nutritional formulas through CYSHCN/CMHI. The CYSHCN program offers a limited respite program based on available funds, and transition services to adult care. The CT Lifespan Respite Coalition is the statewide administrator of extended services and respite funds for CMHI, and serves as an additional statewide point of entry.

/2013/The DPH-facilitated MHAC now serves as the ongoing vehicle for partnership and alignment of the Title V Care Coordination system and the emerging Person Centered Medical Home system administered through Community Health Network under the Medicaid program.//2013//

CYSHCN program surveillance, planning and evaluation: DPH epidemiology staff developed a Microsoft Access database to assure that information was collected and the database is utilized by each of the five regional care coordination networks. DPH is working with developers to migrate the CYSHCN database to a web-based platform. This will allow for integration of data with other databases at DPH, and allow for future connection to Electronic Medical Records. The system will allow information from families; medical home based care coordinators, and other stakeholders to be integrated.

The United Way's (2-1-1) (the MCH Information and Referral Service) Child Development Infoline (CDI): serves as a statewide point of entry to CMHI and for information and resource referral for CYSHCN. CDI caseworkers make referrals to the CT Birth to 3 System, Help Me Grow, Preschool Special Education, and/or CYSHCN/CMHI. The 2-1-1component of MCH Information and Referral Service works closely with the CMHI on their resource information updates.

The Child Health and Development Institute (CHDI): provides a statewide family outreach and education component of the CMHI with a focus on Family/Professional Partnership. Family/Professional partners provide training to families in linking to resources and work in partnership with primary care providers./2012/CHDI will provide outreach to pediatricians of children diagnosed with hearing loss to strengthen the role of the medical home in promoting the healthy development of children with hearing loss.//2012//

Adult and Maternal Phenylketonuria Program (PKU): The 2 Regional Genetic Treatment Centers (UConn Health Center (UCHC) and Yale) maintain current records on all adolescent and adult females in CT with PKU, and serve as genetics consultants for primary care providers throughout the state. Genetic and nutritional counseling and high-risk pregnancy care is provided to adolescent and adult females in CT with PKU.

Genetics: The 2 Regional Genetic Treatment Centers provide access to genetic services for all residents. These services include confirmation testing for newborns identified with abnormal metabolic screening results, prenatal testing, genetic counseling, and ongoing treatment, support for adults with PKU, and high risk pregnancy care for the maternal PKU clients.

Oral Health: The Office of Oral Health addresses the oral health needs of CYSHCN through health promotion activities, particularly early childhood caries prevention. Oral health promotion and disease prevention is an integral part of the goals, objectives and educational activities of the CYSHCN program The Home by One Program partners with DDS and the Family Support Network to implement oral health educational activities of the CYSHCN program.

Pregnancy Exposure Information Services (PEIS): a toll-free telephone line supported by the

UCHC Genetics Program. During 2009, this line provided information to 841 pregnant women who were concerned about exposure to toxic substances during pregnancy and the possible effect(s) to their baby.

School Based Health Centers: provide primary and preventive physical and behavioral health care to CYSHCN who are mainstreamed in school settings. SBHC coordinate care with a child's primary physician and/or specialist.

The Sickle Cell Disease Community Outreach and Support Program: services include Sickle Cell Disease education, screening, trait testing and referral, and case management services including: advocacy, family support, systems navigation, and transition services. The program is contracted to the Hospital for Special Care, which collaborates with providers and hospitals to facilitate access for individuals with Sickle Cell, and subcontracts with The Sickle Cell Disease Association of America Southern CT Chapter and Citizens for Quality Sickle Cell Care.

Universal Newborn Screening (UNBS): a population-based program to test, track and treat all newborns. All newborns are screened for the disorders as listed in the document attached to this section, "CT Newborn Screening Panel." Infants with abnormal screening results are referred for comprehensive testing and treatment services. Counseling and education are provided to the parents of these children. The program provides increased public health awareness of genetic disorders, public health education, and referrals.***/2013/Legislation was passed that requires all health care institutions caring for newborn infants to test them for critical congenital heart disease, unless, as allowed by law, their parents object on religious grounds starting January 1, 2013. //2013//***

Universal Newborn Hearing Screening (UNHS): All 31 CT birthing facilities participate in a legislatively mandated UNHS program. Standardized equipment is used to screen all newborns prior to discharge. Hospitals notify the primary care providers of all infants in need of follow-up audiologic testing. Tracking and follow-up of children are conducted at the state level. A web-based reporting system tracks screening results from the birth hospitals. A database is used to track infants referred to audiologists for further evaluation. Those with hearing loss are enrolled in the CT Birth to Three Program. The Early Hearing Detection and Intervention (EHDI) program works with eleven diagnostic audiology centers that provide follow-up testing from the hearing screens conducted at birth.

/2013/ A CT Chapter of Hands and Voices was formally established in March 2012 fostering strong family/professional partnership in support of children who are deaf or hard of hearing.//2013//

Federal Hartford Healthy Start -- as described above.

Cultural Competency

The Title V programs have incorporated contract language that requires providers to deliver culturally competent services and demonstrate this by: developing a mission statement committing to cultural diversity, develop materials in languages reflecting the needs of the patient population, policies and procedures to address the needs of the patient population, taking into account factors such as race, ethnicity, age, gender, hearing impairment, visual impairment, physical disability, mental illness, developmental disability and sexual orientation. The Title V Program will continue to address health disparities based on data by race and ethnicity to identify and allocate resources.

The Office of Multicultural Health (OMH) promotes access to quality health education and health care services, facilitates presence of diverse populations in health planning, program development, policy formation, and outreach and awareness initiatives. The OMH functions largely through collaboration with statewide partners. The Office recommends policies,

procedures, activities and resource allocations to improve health among the state's underserved and diverse populations, and to eliminate health disparities.

The FHS received technical assistance from the National Center for Cultural Competence for Title V staff at DPH and to MCH community providers over two days in May 2010.***/2013/In consultation with the National Center for Cultural Competence and in collaboration with DPH, Parents Available to Help provides cultural competence training and outreach specific to families and providers of children with ASD.//2013//***

DPH is a participant on the newly formed Commission on Health Equity (Public Act No. 08-171), which mission is to eliminate disparities in health status based on race, ethnicity and linguistic ability, and improve the quality of health for all of the state's residents./2012/The Commission's First Annual Report was shared (September 2010).//2012//

/2012/The Hartford Healthy Start program seeks to reduce racial and ethnic disparities in low birth weight and infant mortality within Hartford, particularly within the Black/African American community. Enhanced outreach and recruitment of pregnant and postpartum women and their children up to two years of age.//2012//

C. Organizational Structure

Governor M. Jodi Rell has been CT's Governor since July 2004. J. Robert Galvin, MD, MPH, MBA, DPH Commissioner since December 2003, serves as the leading health official in CT and advisor to the Governor on health-related matters. Dr. Galvin brings experience in the fields of medicine and public health, as well a strong commitment to serving the people of CT. DPH is the center of a comprehensive network of public health services, and is a partner to local health departments for which it provides advocacy, certification and training, technical assistance, consultation and specialty services. 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.
/2012/Dannel P. Malloy was elected Governor in 11/10 and in 2/11, Jewell Mullen, MD, MPH, MPA became DPH Commissioner.//2012// ***/2013/Lisa A. Davis, RN, BSN, MBA, has been appointed to Deputy Commissioner (DC). In the fall of 2011 a second DC, Leonard Lee, was hired. He left the DPH at the end of June 2012.//2013//***

/2013/ Dr. Mehul Dalal joined DPH as the Chronic Disease Director. Dr. Dalal will provide clinical support and programmatic leadership and guidance to the PHI Branch programs. Dr. Dalal most recently worked as a primary care physician at the Fairhaven Community Health Center in New Haven. Prior to that he was the Medical Director of Quality Improvement at the New York City Department of Health Cardiovascular Disease Prevention and Control Program.//2013//

The Office of Health Care Access merged with the DPH and became a branch within DPH in SFY 2010. As a result, DPH is now comprised of nine Branches. The majority of the Title V activities are located in the Public Health Initiatives (PHI) Branch and a detailed description follows:

The Title V Program is located within the FHS, which is part of the Public Health Initiatives (PHI) Branch. The majority of CT's Title V program activities reside within the FHS. Other MCH-related programs such as oral health, childhood lead poisoning prevention, diabetes, tobacco, obesity prevention and asthma are in other sections within the DPH. Other branches within DPH work cooperatively with Title V funded programs and provide support to programs that promote maternal and child health in the state of CT. The Title V Program is responsible for the administration (or the supervision of the administration) of programs carried out with funds from the MCHBG.
/2012/Reorganization shifted programs among units. The CYSHCN Unit added the MCH

Information and Referral Program. The Program Development Unit added Case Management/Parenting Programs, Centering Pregnancy, State Healthy Start and Family Planning. //2012// ***/2013/ DPH is now comprised of eight Branches. The Maternal, Infant and Child Health Unit provides representation to the federal Office on Women's Health -- Region I, Department of Health and Human Services (DHHS). //2013//***

CT's 31 birthing facilities send blood specimens collected from all newborns to the Laboratory Branch for genetic screening. Following specimen analysis, the laboratory staff forwards all abnormal screening results to the Newborn Screening Tracking Program (NBST) for rapid short-term follow-up. NBST is partially funded by the MCHBG. /2012/CT's 30 birthing facilities send blood specimens collected from all newborns to the State Laboratory for genetic and metabolic screening. All abnormal screening results are forwarded to the Newborn Screening Tracking Program (NBST) for rapid short-term follow-up. NBST is partially funded by the MCHBG.//2012//

Block Grant funds support a full time equivalent in the Health Information Systems and Reporting Section, in the Planning Branch to maintain vital record databases containing information on births, deaths, hospitalizations and risk factors related to maternal and child health. Epidemiologists use vital record information to help direct and evaluate Title V program activity.

The Primary Care and Prevention (PCP) Unit promotes health care to the Maternal and Child Health population, including women of childbearing age, pregnant and postpartum women, and their partners and children. Access to care is promoted through support of safety net providers. Contractors provide: (1) case management services for pregnant women and teens (including secondary teen pregnancy prevention and parenting programs) to promote good birth outcomes; (2) comprehensive primary care services through community health centers; (3) family planning; (4) rape prevention education and crisis intervention and the prevention of intimate partner violence; (5) medical and mental health services to children and adolescents in School Based Health Centers (SBHC); and (6) perinatal depression training to health care providers.

Programs supported in this unit include 1) Case Management/Parenting Programs, 2) Centering Pregnancy, 3) First Time Motherhood/New Parents Initiative, 4) State Healthy Start, 5) Healthy Choices for Women and Children, 6) Perinatal Depression Training, 7) MCH Information and Referral Service, 8) Intimate Partner Violence Prevention, 9) Rape Prevention Education and Crisis Intervention, 10) Community Health Centers, 11) Family Planning, 12) School Based Health Centers/Expanded School Health, and 13) Waterbury Health Access Program. /2012/First Time Motherhood ended 8/10 and Healthy Choices for Women & Children will terminate all services as of 6/30/11.//2012//

This unit provides representation to the federal Office on Women's Health -- Region I, Department of Health and Human Services.***/2013/ The Supervisor of the Primary Care and Prevention Unit retired and resulted in a renaming and shifting of programs among units. //2013//***

The Registry and Program Support Unit provides data and analytical support to the FHS programs, including the provision of required information for the MCHBG and the Preventive Health and Health Services Block Grant national and state performance measures. This unit also coordinates the State Systems Development Initiative grant (the infrastructure grant related to the MCHBG). The Birth Defects Registry and the CT Immunization Registry and Tracking System (CIRTS) staff are in this unit. CIRTS collaborates with the Immunization Program activities. This unit seeks to identify and collect population-based MCH data, as well as create new data systems to complement existing data that will enhance the section's ability for program planning, evaluation and surveillance.***/2013/ The Registry and Program Support Unit is now called the Community Health and Support Unit. This Unit added the following programs: CHC, Intimate Partner Violence Prevention, Rape Prevention Education and Crisis Intervention, Health Access Programs, and Early Hearing Detection and Intervention Program. //2013//***

The Children and Youth with Special Health Care Needs (CYSHCN) Unit includes: 1) the Medical Home Initiative, 2) the Early Hearing, Detection and Intervention (EHDI) Program, 3) Sickle Cell Disease Program, and 4) State Implementation grants for Integrated Community Systems for CYSHCN. The goal of the Medical Home Program is to build the state infrastructure to: 1) reach more CYSHCN and their families and assist them with access and coordination of multiple systems of care and resources; 2) assist the Pediatric Primary Care Providers (PCPs) to identify CYSHCN with high severity needs who need care coordination; 3) link with regional family support networks; 4) provide respite planning and funding for respite family-based services; 5) provide benefits coordination for families to access durable medical equipment, prescriptive medications and specialized formulas; 6) assist PCPs to identify youth with special health care needs to receive the services necessary to make transitions to all aspects of adult life, and 7) liaison with Child Development Infoline (MCH Information and Referral Services for CYSHCN). The EHDI Program ensures early hearing detection and intervention for infants identified with a hearing loss. The goal of the EHDI program is to assure quality developmental outcomes for infants identified with hearing loss. The Sickle Cell Disease Program provides comprehensive coordination of adults with Sickle Cell Disease (SCD) and Trait by improving adult SCD healthcare services and improving transition from pediatric to adult SCD healthcare services. The program also provides advocacy for optimal use of state and federal resources. ***/2013/ The CYSHCN Unit is now called the Child and Adolescent Health Unit and added the SBHC program.//2013//***

The Immunizations Unit's main focus is to prevent disease, disability and death from vaccine-preventable diseases, through surveillance, case investigation and related control, and by monitoring immunization levels in infants and children through annual daycare and school surveys, provision of vaccines for all children and selected adults, support to local health departments for immunization coordination and outreach, and conducting professional and public education. Programs include 1) Vaccines for Children Program, 2) Immunization Action Plan, 3) Vaccines for Preventable Diseases Surveillance, and 4) Adult Immunization Program.***/2013/ The Immunizations Unit has become part of the Infectious Diseases Section.//2013//***

The Program Development Unit performs public health surveillance and research on MCH topics, prepares reports and other communications. The unit supports administration of the Title V Block Grant, manages other federally funded grants in the Section, and seeks new funding for evidence-based and theory-driven interventions that address emerging MCH needs. Initiatives include 1) the Pregnancy Risk Assessment Tracking System (PRATS), 2) Early Childhood Comprehensive Systems, 3) federal Hartford Healthy Start, and 4) Primary Care Office. /2012/ The FHS applied for and received ACA funding to implement the PREP and the MIECHV Program. //2012// ***/2013/ The FHS applied for and received a 5-year grant to conduct the Pregnancy Risk Assessment Monitoring System survey. The Program Development Unit is now called the Maternal, Infant and Child Health Unit.//2013//***

The Office of Oral Health has been transitioned to the Local Health Administration Branch. A strong collaborative relationship exists with the MCH programs and the Office of Oral Health. ***/2013/The Office of Oral Health has become part of the FHS.//2013//***

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

The CT Department of Public Health is comprised of nine Branches. The Title V Program is located within the FHS, which is part of the Public Health Initiatives (PHI) Branch. Lisa A. Davis, RN, BSN, MBA, is the Chief of the Public Health Initiatives (PHI) Branch.***/2013/ The DPH is currently divided into eight Branches: Office of Healthcare Access, Planning, Laboratory, Public Health Initiatives, Regulatory Services, Operations, Health Care Systems, and Administration. Lisa A. Davis, RN, BSN, MBA, has been promoted to Deputy***

Commissioner (DC); a second DC --Leonard Lee --was hired in the fall of 2011. The Chief of the Family Health Section reported directly to DC Lee. DC Lee left the DPH at the end of June 2012. //2013//

Rosa M. Biaggi, MPH, MPA, is the Chief of the Family Health Section (FHS) and the State MCH Title V Director. Ms. Biaggi began working in the FHS in 2009. Janet M. Brancifort, MPH, became the Public Health Services Manager for the FHS in March 2007. ***/2013/ On June 1, 2012, Linda Ferraro became the Director of the Office of Oral Health, and is now a Public Health Services Manager also in the FHS.//2013//***

Administrative support to the Section management is provided by an Administrative Assistant and a Secretary 2.***/2013/The Administrative Assistant has been re-assigned to another Section). //2013//***

The Family Health Section employs 54 permanent staff with expertise and skills in various areas of public health and MCH related fields. Most of the professional staff within the Family Health Section have graduate degrees or have experience in nursing, social work, allied health, health education, research, evaluation, epidemiology, law, planning, administration and management. The majority of CT's Title V program activities reside organizationally within the FHS in the PHI Branch. ***/2013/ The Family Health Section(FHS) employs 35 permanent staff, the Immunization Program became part of the Infectious Disease Section on June 1.//2013//***

Sharon Tarala, RN, JD, Supervising Nurse Consultant, supervises the Primary Care & Prevention (PCP) Unit and serves as the State Women's Health Coordinator. There are seven staff in the unit: two (2) Nurse Consultants, one (1) Social Work Consultant, two (2) Health Program Assistant 1, one (1) Health Program Assistant 2, and one (1) vacant CT Career Trainee position and is in the process of being filled.
/2012/Seven staff consist of (1) Nurse Consultant, (1) Social Work Consultant, (1) Health Program Associate, and (3) Health Program Assistant 1. //2012// ***/2013/ Sharon Tarala, RN, JD, Supervising Nurse Consultant retired October 1, 2011, creating the opportunity to re-organize staff and programs.//2013//***

Marcia Cavacas, MS, supervises the Registry and Program Support Unit. There are seven staff in the unit: two (2) are Epidemiologist 2; one (1) Epidemiologist 3, one (1) Health Program Associate, two (2) Health Services Workers, and one (1) Office Assistant. ***/2013/The Registry and Program Support Unit is now called the Community Health and Support Unit. There are ten staff in the unit: one (1) Epidemiologist 3, three (3) Epidemiologist 2, two (2) Nurse Consultants, one (1) Health Program Associate, two (2) Health Program Assistant 1, and one (1) vacant Health Program Assistant 2.//2013//***

Mark Keenan, RN, MBA, Supervising Nurse Consultant, serves as the state's Title V CYSHCN Director and leads the CYSHCN Unit. There are seven staff in the unit: one (1) is a nurse consultant, three (3) are Health Program Associates, two (2) Health Program Assistant 1 and one (1) Secretary 1. One of the Health Program Assistant positions is vacant and is in the process of being filled. One (1) Health Program Associate serves as the agency Family Advocate and is a parent of children with special health care needs. This staff member provides consultation regarding family issues ensuring that a family-centered, culturally competent perspective is maintained. /2012/Vacant Health Program Assistant 1 position in the CYSHCN Unit is eliminated.//2012// ***/2013/The Unit is now called the Child and Adolescent Health Unit. There are seven (7) staff in the unit: one (1) Social Work Consultant, three (3) Health Program Associates, two (2) Health Program Assistant 2, and one (1) vacant Health Program Assistant 2.//2013//***

Vincent Sacco, MS, Epidemiologist 4, supervises the Immunizations Program. There are 20 staff in the unit: three (3) Epidemiologist 3, six (6) Epidemiologist 2, one (1) Health Program Assistant 1, three (3) Clerk Typists, one (1) Health Program Associate, two (2) data entry clerks, one (1)

Information Technology Analyst 2, one (1) Materials Storage Handler, one (1) Secretary 2, and one (1) Assistant Program Coordinator. /2012/The Assistant Program Coordinator is a CDC employee.//2012// ***/2013/The Immunization Program has been merged into the Infectious Disease Section within the Public Health Initiatives Branch.//2013//***

Carol Stone, PhD, MPH, MAS, MA, Epidemiologist 4, supervises the Program Development Unit. There are five (5) staff in the unit: two (2) are Epidemiologist 3, One (1) Health Program Associate, one (1) Health Program Assistant 1, and one (1) Epidemiologist 1. /2012/ Effective 7/10, the unit consists of 2 Epidemiologist 3, 2 Nurse Consultants, 1 Health Program Assistant 1 and 1 Epidemiologist 1.//2012// ***/2013/This Unit is now called the Maternal, Infant and Child Unit. There are six (6) staff in the unit: two (2) Nurse Consultants, one (1) Epidemiologist 3, one (1) Epidemiologist 2, one (1) Health Program Associate, and one (1) Health Program Assistant 2.//2013//***

/2013/The Oral Health Unit has been integrated into the Family Health Section. Linda Ferraro, R.D.H., B.S. is the Director of the Office of Oral Health. There one (1) part-time Secretary 1 and three vacant positions, one(1) Epidemiologist 2, one (1) Health Program Associate, and one (1) Health Program Assistant 2.//2013//

Funding from the MCHBG also provides support for staff in the Newborn Screening Program, Health Information Systems (Vital Records), the Fiscal Office and Grants and Contracts.

Staff from other programs within the DPH collaborate and/or provide support to the Title V staff. These programs include: Obesity, Asthma, WIC, Environmental Health, STD, HIV, Vital Records, State Laboratory (Newborn Screening) and Tracking Units, Oral Health, Tobacco, Nutrition, Facility Licensing, and Injury Prevention. /2012/Staff collaborate with Healthcare Quality, Statistics and Analysis within DPH.//2012//.***/2013/ The Office of Oral Health is now part of the Family Health Section.//2013//***

An attachment is included in this section. IIID - Other MCH Capacity

E. State Agency Coordination

CT's Title V Program works with other state agencies and within its own programs to ensure coordination of services. The narrative below describes the most important of those collaborations.

Under the state's Medicaid program, grants are made to hospitals, clinics, departments of health and other organizations to expand and enhance health services to low income pregnant women and children, and to assist women in obtaining Medicaid coverage for themselves and their children. Healthy Start contracts are jointly administered by the DSS and the DPH.

CT Maternal-Child Health Advisory Committee offer a networking opportunity for MCH providers to share relevant information and resources available to the state's MCH populations and coordinate efforts in order to maximize resources and services available to Connecticut's women, children and families. The Committee meets on a quarterly basis.

/2012/Program Development staff provides representation on the Women's Health Subcommittee of the CT Medicaid Care Management Oversight Council whose mission is to improve the health status of pregnant and postpartum women and their infants.//2012//

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

program.

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

A State Implementation Grant for Integrated Community Systems for CYSHCN activities focusing on transition of youth with special health care needs to adult services has resulted in MOUs with the DCF, the SDE- Bureau of Special Education, and DSS-Bureau of Rehabilitation Services.

The CYSHCN program partners with United Way of CT/2-1-1 Infoline (CT's MCH Information and Referral Service), DDS (Birth to Three), and the Children's Trust Fund (Help Me Grow) in supporting United Way's Child Development Infoline (CDI) to serve as the statewide point of entry and referral for all CYSHCN. CDI implements a referral and coordination of services model to assess and refer appropriate CYSHCN to Birth to Three, Ages and Stages, Help Me Grow and CT Medical Home Initiative for CYSHCN resources (including referral to community based medical homes). CYSHCN staff serve on the CDI steering Committee.

The CYSHCN program and the CT Lifespan Respite Coalition, Inc. (CLRC) have partnered to create and disseminate a two-section "Get Creative About Respite" manual.

The CYSHCN program staff work with partners implementing the CT Medical Home Initiative for CYSHCN that includes family and professional partnership and support staff, respite and extended services administration, and community based medical home staff.

The CYSHCN program partners with contractors associated with the CT Medical Home Initiative for CYSHCN to distribute "Directions: Resources for Your Child's Care" an information organizer for families, available in English, Spanish, and Portuguese.

The Early Hearing Detection and Intervention program staff work with the 31 CT birthing facilities, State Laboratory, Audiology Diagnostic Centers, the Regional Treatment Centers and individual medical homes to assure the testing, tracking, and treatment components of the Universal Newborn Hearing Screening and Laboratory Programs. /2012/Facilities refers to 30 Birthing Facilities and one Home Birthing Agency.//2012// ***/2013/EHDI staff have begun recruiting team members for the National Initiative for Children's Healthcare Quality (NICHQ) Improving Hearing Screening and Intervention Systems (IHSIS) Learning Collaborative. The IHSIS Learning Collaborative brings together teams to improve care in a specific disease category or topic area, in this case, follow-up after newborn hearing screening. State teams work together to learn how to test changes within their EHDI system on a small scale. Each team collects and reports data on a monthly basis throughout the collaborative to track improvement and identify successful change strategies that can then be spread more widely. Learning is accelerated as the collaborative teams work together and share their experiences through regular calls and in-person meetings.//2013//***

CYSHCN/EHDI program staff are active members of the CT Early Hearing Detection and Intervention (EHDI) Task Force. The Task Force members include representatives from the DSS, DDS, birth hospital nurse managers, UConn Division of Family Studies, neonatologists and audiologists. The group meets monthly to plan and coordinate activities across state and other

agencies, that promote optimal outcomes for infants and children through age 5 identified with hearing loss. The EHDI program has a data sharing MOU in place with DDS Birth to Three to facilitate outreach.

Quarterly meetings are held with a Genetic Advisory Committee (GAC), comprised of the Sickle Cell, Genetics and Metabolic specialty treatment centers and Newborn Screening Program staff from the FHS and DPH State Laboratory, as well as a consumer representative from the Citizens for Quality Sickle Cell Care, Inc. /2012/ Changes to the external Newborn Screening (NBS) Program Advisory Committee (formerly GAC), includes the addition of the Sickle Cell Disease Association of America and replacement of FHS with Laboratory Management and NBS Program staff representing DPH. //2012//

The CT Expert Genomics Advisory Panel advises the Commissioner on the development of a Genomics Statewide Plan. This committee is comprised of representatives with expertise in genetics, law and bioethics; individuals from industry, insurance and academia; medical providers, genetic counselors; and consumer advocates.

Family Health Section staff participates in the Sickle Cell Consortium, working to implement the statewide sickle cell plan. The consortium is comprised of advocacy groups, sickle cell associations, hospitals, treatment centers, and providers. The plan has been widely disseminated to nine other states and the National Sickle Cell Disease Association. The consortium is finalizing an emergency department protocol for the management of Sickle Cell crisis to be implemented statewide. /2012/The emergency department protocol has been finalized for dissemination.//2012//

Health professionals of the DPH Newborn Screening Program and the Regional Treatment Centers participate on various state, regional, and national committees and resource groups such as: the CT PKU Planning Group, NE Mothers Resource Group, New England Consortium of Metabolic Programs, NERGG, Inc., National Newborn Screening Genetic Resource Center, and the National Newborn Screening Advisory Committee. Participation on these committees provides the opportunity to network with experts and consumers, participate in educational conferences, and keep abreast of advances in genetics and newborn screening as they impact public health. Program staff participates in the UConn MPH Program and provide NBS educational sessions to students as part of the Genetics course curriculum.

CT SBHC have formed a non-profit independent organization, the CT Association of SBHC, Inc., to advocate for this service delivery model. The epidemiologist supporting the SBHC program convenes conference calls with a Data Steering Committee that identifies technical, data quality and other issues that need resolution. The committee members are peer mentors for other sites requiring assistance./***2013/ The Children's Hospital Colorado and the University of Colorado provided notice that the Clinical Fusion(r) software utilized to support SBHCs will no longer be sold or supported. There will be no new licenses or technical support provided after July 1, 2012. One of the FHS Epidemiologist has worked with program staff and representatives from several SBHCs to develop a new Access database that will be used to replace Clinical Fusion for the start of the new school year.//2013//***

Seventy-five SBHC in 23 communities are partially funded by DPH serving students in elementary, middle and high schools. SBHC are licensed as outpatient facilities and staffed by both a licensed primary care provider and licensed mental health clinician. They offer an array of services addressing the medical, mental and oral health needs of youth, including crisis intervention, health education, social services, outreach, and substance abuse prevention services. The practitioners coordinate the care they provide with a child's primary providers and/or specialists, while integrating the needs of the child with other school personnel. There are 10 Expanded School Health Service programs in three communities, which vary by site and do not provide the full compliment of services provided through traditional SBHC. Services are available to all enrolled students in the school. All expanded school health services programs are

currently providing mental health services. Eight offer oral health care. /2012/Seventy-one SBHC, 11 Expanded School Health Service Programs, and one school-linked service exist in 23 communities.//2012// ***/2013/The CT legislature appropriated more than 1.3 million dollars for the Commissioner of Public Health to establish or expand a minimum of twenty school-based health clinics that are located in alliance districts.//2013//***

A SBHC Ad Hoc Committee was formed with the goal of improving health care through access to SBHC, particularly by under- or uninsured people or Medicaid recipients.

Community Health Centers (CHC) provide comprehensive primary and preventive health care and other essential public health services at over 150 sites in CT. DPH funds 13 of the 14 community health center corporations in CT, and 12 of the 13 are members of the Community Health Center Association of CT (CHCACT). All centers are located in HPSA and/or Medically Underserved Areas and operate in accordance with Federally Qualified Health Center Guidelines. In FY09, 242,034 people were served with a wide variety of comprehensive services, including EPSDT. The CHC also work with Family Planning, WIC, SBHC, Infoline and many community-based organizations that provide other health care and social services. /2012/In calendar year (CY) 08, 242,034 clients were served in 13 DPH funded CHCs. In CY 09, 289,395 clients were served in the 13 CHCs.//2012// ***//2013//The State Budget for FY13 includes funding for an additional CHC in the City of Danbury that in 2009 received funds from the American Recovery Reinvestment Act (ARRA).//2013//***

DPH and CHCACT work together on a number of important initiatives to promote, inform policy, and develop community based systems of care for the state's most vulnerable populations and to support CHC. Among these are National Health Service Corps recruitment and retention activities and immunization program initiatives. ***/2013/The PCO was awarded federal funding to evaluate the effectiveness of retention activities of provider sites and the impact of ARRA funding on reducing primary care workforce shortages and improving access to health care services in underserved communities.//2013//***

The statewide family planning program is implemented through a contract with Planned Parenthood of Southern New England (formerly Planned Parenthood of CT, Inc.) in 16 sites. The services provided include comprehensive preventive and primary reproductive health care for adolescents and adults. During FY 2009, 35,015 clients received services; of those, 32,210 were women, 7,593 were teens, 17,630 were women and men of color, and 26,171 were low-income. The program goals and activities include education in a variety of forums for youth, parents, teachers, social workers and clergy. Forums are held in schools, churches, community-based social service offices and recreational programs. The prevention focus includes the prevention of pregnancy, sexually transmitted infections, Hepatitis and HIV/AIDS.

The DPH participates on the CT Breastfeeding Coalition (CBC), which includes representatives from the state and local WIC program, La Leche League, AAP, Hospitals, CHC, Health Management Organizations (HMO), Universities, independent Lactation Consultants, Medela Corporation and consumers. The Coalition meets on a monthly basis and has 4 active committees: Policy and Advocacy, Data, Provider Education, and Public Awareness. The goals of CBC are to increase public awareness and support for breastfeeding statewide and promote breastfeeding as the social norm. The FHS continues to work closely with the WIC program to promote and support breastfeeding in the state. The CBC includes representatives from breast pump manufacturers, and provides information and input on breastfeeding in the legislative arena.

As part of the Women's Health Initiative, DPH staff actively participates in the Office of Women's Health Region 1 Workgroup to increase the focus on women's health, foster collaboration, and encourage the development of women's health activities in the state and in the New England region.

During National Women's Health week, DPH collaborated with the CT Sexual Assault Crisis Services (Connsacs) and other DPH initiatives to raise awareness about sexual assault prevention, nutrition, cardiovascular disease and HIV/AIDS. Community based forums that addressed these topics were conducted in New Haven, Bridgeport, Hartford and at a shopping mall.

The SBHC staff participate participates in Regional Adolescent Health Coordinators monthly conference calls.

The MOU between DPH and DSS regarding data exchange exists to improve public health service delivery outcomes for low-income populations through the sharing of available Medicaid, HUSKY Part B and Plus, and Title V data. The initial MOU addresses the linkage of birth and Medicaid data, childhood lead screening and Medicaid data, and data on Children Receiving Title V Services and Medicaid data. The DPH-DSS MOU was amended to include the Department of Children and Families.

DPH worked the Governor's Collaboration for Young Children to establish the Healthy Child Care CT (HCC-CT) initiative. Its goal is to achieve optimal health and development for all children in childcare by guiding and supporting service integration between the childcare community and health care providers. DPH participates on the HCC-CT leadership team. HCC-CT also works closely with the national Healthy Child Care America campaign, which is coordinated by the AAP with support from the DHHS Child Care and MCH Bureaus. As part of the HCC-CT initiative, DPH contracted with the CT Nurses Association (CNA) to conduct child care health consultant workshops for day care health consultants, education consultants and directors of day care facilities, and will coordinate with DSS and CNA to offer medication administration training. DPH will allow HCC-CT access to its learning management site, CT TRAIN, to facilitate workshop enrollment and track participant's CEUs.

The DPH-Local Health Administration Branch assists and advises local health districts in the state in planning, providing, and advocating for public health services on the local level. The services provided include prenatal and family planning clinics, child health clinics, nutrition services, immunizations, communicable disease surveillance and control, HIV counseling and testing and other services. DPH's Local Health Branch administers state funding for local health departments and districts.***/2013/The Local Health Section of DPH has become part of the Regulatory Services Branch.//2013//***

The Early Childhood Partners (ECP) Initiative, funded through the Early Childhood Comprehensive Systems grant, works to develop a comprehensive statewide system to support all CT families so their children attain optimum health and school readiness by age five. Staff serve on the Fatherhood Initiative, facilitated by DSS, and as alternate to the DPH Deputy Commissioner on the State Early Childhood Advisory Council. /2012/With the retirement of the Deputy Commissioner, the ECP project director was selected to serve on the Council.//2012// ***/2013/The ECP Project Director passed away and the DPH representation was transferred to Deputy Commissioner Lee. Deputy Commissioner Lee left the DPH at the end of June. The DPH Commissioner is in the process of designating the new DPH member to these councils. //2013//***

To address intentional and unintentional injuries, the DPH Injury Prevention Program (DPH-IP) collaborates with the CT Department of Transportation (DOT), SDE, DCF, DSS, OCA, Court Support Services Division (CSSD), and other public, private, and community-based organizations. State and local SAFE KIDS Coalitions (membership includes health care, EMS, Police, Fire and community service providers) address motor vehicle injuries. DPH-IP facilitates the CT Young Worker Safety Team, a collaboration that includes the CT and US Departments of Labor and the CT SDE. The group promotes awareness and training to decrease adolescent work related injuries. DPH-IP facilitates the Interagency Suicide Prevention Network, an interagency, interdisciplinary collaboration that has completed a statewide, comprehensive

suicide plan and works with collaborators to address intentional injury issues including suicide prevention, violence prevention, domestic/dating violence prevention and child maltreatment. DPH-IP participates in the Northeast Injury Prevention Network, which includes State Health Injury Prevention Programs from Regions I and II, university-based injury research centers and representatives from federal regional offices. The Network collaborates on injury prevention initiatives of relevance to both the region and the individual states. DPH-IP is also collaborating with MCH and the Connecticut Office of Rural Health on a rural injury initiative focused on motor vehicle and self-inflicted injury.

The Immunization's staff facilitates the Vaccine Purchase Advisory Committee (VPAC) that makes recommendations to the State Department of Public Health on issues related to the use of publicly purchased vaccines for childhood and adolescent vaccinations. Membership of committee includes the AAP, CHCACT, CT Association of Public Health Nurses, and CT Association of School Nurses. The committee also includes representatives of the vaccine manufacturers, medical directors, and medical insurers. The VPAC is open to the public.***/2013/The Immunization Program monitored the loss of vaccine in the aftermath of Tropical Storm "Irene" (September 2011) and winter storm "Alfred" (October 2011) that resulted in statewide power outages, each lasting several days. //2013//***

/2012/ The federal Hartford Healthy Start program partners with organizations in Hartford that serve pregnant women and their children, including the Hartford Health Department, Hispanic Health Council, St. Francis Hospital, Charter Oak Health Center, and Community Health Services. //2012//

/2012/ A group of stakeholders was convened to conduct the Statewide Needs Assessment for Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Programs submitted in September 2010. It can be found at: http://www.ct.gov/dph/lib/dph/needs_assessment_complete_091510.pdf . //2012//

/2012/ DPH convened an Advisory Committee to assist in the development of the state's updated state home visiting plan which has been submitted to HRSA.//2012//

/2013/DPH received notice that the Competetive MIECHV grant submitted in the summer of 2011 was funded for a three-year period.//2013//

/2012/ DPH serves as the lead in a collaborative partnership with DCF, SDE, and Department of Mental Health and Addiction Services (DMHAS) on the development and implementation of CT's Personal Responsibility Education Program (PREP) plan. The goal of this project is to provide education and training to the DCF system that supports behavior change in youth in foster care, in an effort to delay sexual activity and associated risks, reduce planned or unplanned pregnancy, and increase access to reproductive health care. The target population are youth (ages 13-19) served by DCF, who are in an out of home setting.//2012//

/2013/ The DPH has partnered with the New Haven (federal) Healthy Start program, and New Haven Health Department, to address systemic and institutional racism that leads to adverse birth outcomes in the City of New Haven. This initiative is supported through City Match, a nonprofit organization of urban areas of the country with high rates of adverse birth outcomes. The Title V Director has the lead role. //2013//

F. Health Systems Capacity Indicators

Significant challenges were encountered in obtaining current data from sources used for the Health Status Capacity Indicators including information from the Department of Social Services (DSS), Vital Statistics and hospitalization data. However, data from Vital Statistics and hospitalization data from the asthma program have reported that revised information will be

available in September 2012 at which time the HSCIs will be updated.

DSS, the state's Medicaid agency, has reported that data previously available for HSCIs reporting are no longer available. The difficulties encountered include: "the CMS 416 report specs changed significantly" and, "SCHIP is not included in the CMS 416 report and this measure is not separately tracked". Other HSCI data from DSS was reported to have questionable validity. Going forward, the reorganization of the state Medicaid system to a single Administrative Services Organization (in effect since January 2012) will allow for data to be reported directed to DSS resulting in the availability of more accurate and applicable data. DSS is in the process of implementing an entirely new data system allowing for enhancement to the agency's capability in reporting data.

The Memorandum of Agreement executed in June 2011 with DSS continues to be in place to link birth data to Medicaid eligibility data on an annual basis.

There have been two positive developments regarding the HSCIs data. The first is the availability of a more accurate data source for HSCI #08: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program. The second is Connecticut's recent success in being one of only three states funded by the CDC for a 5-year project to conduct the Pregnancy Risk Assessment Monitoring System (PRAMS) survey.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Connecticut (CT) Department of Public Health (DPH), Family Health Section (FHS) utilized the framework included in the Title V Application Guidance (engaging stakeholders, assessing needs and identifying desired outcomes and mandates, examining strengths and capacity, selecting priorities, seeking resources, establishing performance objectives, developing an action plan, allocation of resources, monitoring impact on outcomes, and reporting back to stakeholders) to ensure all steps in the needs assessment were addressed to identify needs for 1) preventive and primary care services for pregnant women, mothers and infants up to age one; 2) preventive and primary care services for children; and 3) services for Children with Special Health Care Needs (CSHCN) from October 2008 -- May 2010. The MCH needs assessment was designed to be population-based, community focused, and framed within a family context.

The MCH Title V Program established an MCH Needs Assessment Planning Committee to assist in the oversight and direction of the needs assessment. The Planning Committee included staff from the various MCH programs.

The Planning Committee determined that the needs assessment process would include a DPH Internal Needs Assessment, a Community Centered Needs Assessment, and a Stakeholders Committee that would assist with selecting State priority areas.

Each Internal Needs Assessment workgroup was instructed to recommend up to 5 priority needs for a total of 15 priority needs to be considered by the Stakeholders Committee. In the Community Centered Needs Assessment, both qualitative and quantitative methods were used to inform the comprehensive needs assessment process. Additional feedback on the health needs of women and children was obtained from providers and consumers. Engaging the various stakeholder groups facilitated the inclusion of their insights and experience of their practical experiences and served as a valuable reality check. A concerted effort was made to engage providers, advocates and consumers in both identifying priority needs and successful solutions to identified problems.

The Stakeholders Committee met in May 2010, to review the identified priority needs from the Internal and Community Centered Needs assessments and to select 7-10 priority areas to improve maternal and child health. The Stakeholders Committee selected 9 priority areas.

DPH established state performance measures for each priority area.

/2012/Five of the State Performance Measures (SPMs) have been revised:
• Improve Mental/Behavioral Health Services-Percent of students that had a risk assessment with a mental health component conducted during a comprehensive, annual physical exam at a SBHC.
• Enhance Oral Health Services-Percent of child health providers/dental providers who serve at risk populations that perform dental caries risk assessments and provide oral health education and risk based preventive strategies by age one.
• Reduce Obesity among the three target MCH populations -- Increase the redemption rate of fruit and vegetable checks issued to women and children enrolled in the Connecticut WIC program.
• Improve the Health Status of Women, including Depression -- The percent of pregnant and postpartum women who receive preconception and interconceptional health screening (including depression) and education in DPH-funded case management/Home Visiting programs.
• Reduce Health Disparities within the three MHC target populations --the extent to which the ratios of key perinatal health measures for non-Hispanic Black/African Americans relative to non-Hispanic Whites has changed.//2012//

/2013/One of the State Performance Measures (SPM #01) has been revised:

Cumulative number of core datasets migrated to the MAVEN application as part of efforts to link high-quality child health data to create a Connecticut comprehensive child health profile.//2013//

B. State Priorities

Through the Needs Assessment process completed for the 2011 Application, DPH identified nine State priority needs.

1. Enhance Data System

The goal is to increase the number of core databases integrated into the Health Informatics Profile for CT Kids (HIP-Kids), a data warehouse containing a comprehensive child health profile created by linking disparate databases into a single comprehensive system. There is no National Performance Measure that addresses this need and the rationale for creating a State Performance Measure.

Insufficient data and research are available to adequately support MCH program development and the evaluation of existing programs, especially in terms of obtaining new funding and reporting the appropriate information for existing grants and initiatives. Databases containing child health information are housed in different areas of the agency. These data are currently not linked, and they are analyzed in isolation of one another, thus limiting essential public health functions. The Health Informatics Profile for CT Kids (HIP-Kids), a data system of linked child health information at the record level, is currently under development to address this problem. The seven (7) core datasets identified for inclusion in HIP-Kids are not yet integrated completely. The fully developed HIP-Kids data warehouse will support the agency's public health assurance, assessment and evaluation activities; interdivisional public health research activities and initiatives, and inform public health policy.

2. Improve Mental/Behavioral Health Services

Annually, about one out of every five CT children has a mental health or substance abuse problem. Fewer than half get any treatment. In 2008-2009, mental health as a primary diagnoses accounted for more than one third (37%) of all SBHC clinic visits. There is no National Performance Measure that addresses this need and the rationale for creating a proxy State Performance Measure to attempt to measure improvement in mental health services provided to adolescents. The proxy measure is intended to monitor the SBHC students that visited a SBHC clinic that received a risk assessment with a Mental Health component who come in for intake physical exams or children referred by parents, teachers, etc.

3. Enhance Oral Health Services

Dental caries is the single most common chronic childhood disease, 5 times more common than asthma and 7 times more common than hay fever. Prolonged lack of treatment can lead to tooth loss, systemic infection, and the entry of toxins and by products of inflammation into the bloodstream. Dental disease in a young child can affect their development, school readiness, and attendance. While National Performance Measure #09 addresses children receiving dental sealants, there was a strong consensus that more preventive activities needed to be monitored.

This resulted in the goal to reduce the prevalence of dental caries through increased recognition of the importance of early dental caries prevention prior to tooth eruption, dental visits beginning at age one, fluoride varnish applications (where appropriate) and the importance of optimal oral health for the mother. A new State Performance Measure was created to expand on monitoring prevention activities completed by dental care providers.

4. Reduce Obesity among the three target MCH populations

The association between the consumption of fruits and vegetables and preventing or reducing obesity prevalence has been established. There is no National Performance Measure that addresses this need and the rationale for creating a proxy State Performance Measure to attempt to measure improvement in reducing obesity among the three target MCH populations. Offering fruit and vegetables vouchers to WIC participants works as incentives for participants to purchase more fresh fruits and vegetables. With increased availability and access to fresh fruits and vegetables, it is hoped that the participants would change their dietary habits and increase their consumption of fruits and vegetables. By increasing the consumption of fruits and vegetables, participants would be in a better position to combat obesity or prevent becoming obese.

5. Enhance Early Identification of Developmental Delays, Including Autism

The five National Performance Measures addressing the needs of the CYSHCN population do not directly address this aspect of the life of a CYSHCN. The 2005/2006 National Survey of CSHCN revealed that 3.8% of Connecticut's CSHCN population, or roughly 5,057 children were diagnosed with Autism Spectrum Disorder (ASD). Early identification is a component of meeting the needs of CYSHCN, including those with ASD, and the focus will be on the 0-3 population and provider education. A State Performance Measure was created to increase awareness and recognition of the importance of early identification of developmental delays on the part of providers as evidenced by an increase in the percentage of 0 to 3 year olds receiving a developmental screening within the last twelve months; thereby facilitating subsequent evaluation and referral to services.

6. Improve the Health Status of Women, including depression

A woman's health across the lifespan includes her reproductive years, as well as pre-reproductive and post-reproductive years. Use of a culturally-sensitive and evidence-based preconception screening tool can address many risk factors (including depression) for pregnancy and birth complications before a woman becomes pregnant, and needs to be encouraged as a best-practice protocol among professional service providers who serve women. There is no National Performance Measure that addresses this need and the rationale for creating a proxy State Performance Measure to measure the number of DPH funded Case Management programs whose healthcare professionals complete preconception health screening (including depression) of women.

7. Improve Linkages to Services/Access to Care

There is no National Performance Measure that addresses this need. DPH's PCO works to identify medically underserved areas in CT that may qualify for a federal designation as Medically Underserved Area or Population or Health Professional Shortage Area as underserved areas for primary care, dental or mental health care. Identifying needy areas in the state and then obtaining a federal designation are the first steps toward getting the necessary resources to improve health care services and access in local communities. A State Performance Measure was created using the information available from the PCO to promote and provide access to health care programs and services especially among the underserved populations by increasing the number of Health Professional Shortage Area (HPSA) designations in the State.

8. Integrate the Life Course Theory throughout all state priorities

There is no National Performance Measure that addresses this need. The general concept of life course theory is to address early childhood determinants of adult health, before health conditions are realized in adulthood. Interventions are needed in childhood that decrease the risk factors of poor health in adulthood and that maximize protective factors. A paradigm shift is needed to focus public health initiatives on children, with the intention of curbing poor health in adulthood. A

State Performance Measure was created to monitor the extent to which DPH has incorporated public health interventions that address early childhood determinants of adult health into programmatic action plans.

9. Reduce Health Disparities within the three MCH target populations

There is no National Performance Measure that addresses this need. Improvements in the quality of data collected will further increase our statewide capacity to accurately monitor and devise plans to reduce health disparities. The goal is to increase the availability of racial/ethnic data in the context of the other eight State Priority needs based on Federal and State data collection standards. With adequate resources and attention, a number of documented gaps in health status can be narrowed. Improvements in the quality of data The 2009 Connecticut Health Disparities Report (Stratton, Alison, Margaret M. Hynes, and Ava N. Nepaul. 2009, Connecticut Department of Public Health.), collected will further increase our statewide capacity to accurately monitor and devise plans to reduce health disparities.

/2013/ The intent to create linkages of high-quality child health information continued to be a focus for the Family Health Section during 2012. Seven core databases were selected as part of the project to create a comprehensive child health profile in CT, and had been planned to be located in a data warehouse, called HIP-Kids. The databases originally included the Newborn Laboratory Screening, Newborn Hearing Screening, Children and Youth with Special Health Care Needs (CYSHCN) Registry, Birth Defects Registry, birth Records, death Records, and the Immunization Registry. Progress on the HIP-Kids data warehouse continued with activities to migrate three of the seven core databases to a new web-based application called MAVEN. However, a major shift in the Information Technology (IT) infrastructure to use the web-based application MAVEN to house the individual core databases resulted in major changes to the plan for when and how to link the seven core databases. The plans shifted from completing the linkages between databases and housing them in a data warehouse (HIP-Kids) to a plan of migrating each of seven core databases to the MAVEN application separately and then linking the databases. An additional change was to replace the death record database with the Childhood Lead Surveillance System as one of the core databases because the death record registry is in the process of a major database system change, whereas the Childhood Lead Surveillance System has already migrated to MAVEN.

The ability of the MAVEN application to provide comprehensive child health information will greatly enhance public health assurance and assessment activities within CT. Enhanced assurance activities will include: 1) better coordination of medical services to all children, especially CYSHCN, through linkages with qualified medical home environments; 2) reduced health disparities among childhood disease prevention activities, though better outreach to the "hard-to-reach" populations; and 3) reduced need to disclose confidential information that is now necessary to generate local database linkages. Enhanced assessment activities will include: 1) increased ability to evaluate population-based health activities within DPH; 2) improved data quality through better data validation and coordinated data improvement efforts; 3) enhanced comprehensive data accessibility to support grant activities, health programming, and to support data requests from sources outside DPH; and 4) enhanced analyzing, interpreting, monitoring, and reporting activities by staff because less time would be needed to manage data.//2013//

C. National Performance Measures

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	55	77	68	54	51
Denominator	55	77	68	54	51
Data Source		CT DPH Newborn Screening Program	CT DPH Newborn Screening Program	CT DPH Newborn Screening Program	CT DPH Newborn Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	100	100	100	100	100

Notes - 2011
Source: CY2011 CT DPH Newborn Screening Program supplied the percentage of confirmed cases that also received appropriate follow-up. (For more information on CT's newborn screening procedures/data, see also the detailed note with Form # 6)

Notes - 2010
Source: CY2010 CT DPH Newborn Screening Program supplied the percentage of confirmed cases that also received appropriate follow-up. (For more information on CT's newborn screening procedures/data, see also the detailed note with Form # 6)

Notes - 2009
Source: CY2009 CT DPH Newborn Screening Program supplied the percentage of confirmed cases that also received appropriate follow-up. (For more information on CT's newborn screening procedures/data, see also the detailed note with Form # 6)

a. Last Year's Accomplishments
This objective was met, 100% of infants screened as positive received follow-up to definitive diagnosis and treatment. In 2011, 98% of the 37,985 occurring births were screened prior to discharge or within the first week of life. 37,273 babies received at least one screen. There were a total of 3,639 presumptive suspect positive screens, 51 confirmed cases and 51 newborns that needed treatment received it. There were 25 hemoglobinopathies and 941 hemoglobin traits identified.

Treatment centers that provide universal Cystic Fibrosis (CF) testing collect CF statistics and

report it to the National Newborn Screening Information System (NNSIS). 390 newborns had unsatisfactory specimens; all but three (lost to follow-up) were resolved with repeat testing. 11 CT State waivers for refusal of screening were submitted to the lab due to conflicts with religious tenets. Of these, 4 newborns had specimens later obtained by their PCP.

The NBST Program set up the Missing Scan Report internal system to track specimens delivered to the DPH Lab from birthing facilities, there were 846 missed scan specimens and over 130 specimens needed tracking and follow-up in 2010.

The UCHC Genetics Program continued to offer the PEIS toll-free phone line. Referrals for follow-up were made to UCHC Genetics. In 2010, 841 pregnant women called the line concerned about exposure to toxic substances and the possible effect(s) to their baby.

DPH NBST continued to ensure early identification of infants at increased risk for over 40 selected metabolic or genetic disorders. We plan to add testing by validating new assays. A research technician went to the CDC to attend a one week course about new test implementation.

The GAC agreed to restructure the clinical and technical components of the NBS program. The NSPAC, formerly GAC, adopted a mission and purpose statement. It will provide structure that will be governed by By-Laws, officers and expansion of the NSPAC membership.

Due to the increase in abnormal results in 2010, NBS program reviewed the Clinical and Laboratory Standards Institute's "Newborn Screening for Preterm, Low Birth Weight, and Sick Newborns; Approved Guidelines." The state birthing facilities' neonatologists and treatment center physicians met to develop a newborn screening schedule for Neonatal Intensive Care Unit and Sick Baby Nursery babies. Implementation is planned for spring 2011. The newborn CLSI guidelines are now in use at several hospitals.

A Nurse Consultant is working full time on short term-follow-up and is the NBS representative to the statewide SCD Consortium.

Staff provided technical and phone assistance to Hartford Hospital, neonatologists around the state, and birthing facilities to ensure timely and accurate collection of NBS specimens and compliance standards.

Treatment Centers are in year 2 of a 3 year level funded contract until June 30, 2012. Collaboration between NBS, CYSHCN programs and NSPAC was planned on grant applications to ensure care coordinated connections to pediatric treatment centers.

NBS program and CYSHCN program submitted an application to the Maternal and Child Health Bureau, Division of Services for Children with Special Health Needs, Genetic Services Branch for the SCD NBS Program, Follow-up Network grant funds.

The Supervising Biologist and NBS Program Supervisor attended the Association of Public Health Laboratories meeting on Severe Combined Immunodeficiency (SCID) screening. The legislature has mandated that SCID be included as a disorder on the CT screening panel, with implementation date of Jan. 2012. The SCID assay was fully validated and added to the NBS screen on January 1st, 2012. The SCID assay is now run on a routine basis.

A Nurse Consultant participated on the DPH Genomics Office's (DPH-GO), Council of Genomics (COG), the Expert Genetic Advisory Panel (EGAP), New England Consortium of Metabolic Disorders (NECMD), the New England Regional Genetics Group (NERGG), and as a board member of the Public Health Genomics Committee and the Citizens for Quality Sickle Cell Care.

MAVEN consultant continued to meet with LIMS and Laboratory Screening to advance the

development and intersection of the web-based reporting system with the LIMS through HL7 messaging. NBST staff developed the birthing facility and disease workflow (including missed scan report) specifications and corresponding reports and letters. The NBS component of Maven is now fully functional.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participate in the quarterly Genetics Advisory Committee (GAC) meetings.				X
2. Work with other groups to provide education on Genetics and NBS.		X		
3. Screen all infants for selected metabolic or genetic disorders.			X	
4. Refer newborns with abnormal screening results for appropriate services.			X	
5. Development of treatment center services on the expanded NBS panel.				X
6. Update educational programs to reflect the expansion of the NBS testing panel.				X
7. Participate in various State, Regional, and National conferences.				X
8. Support families identified with genetic and metabolic disorders.		X		
9. Enhancing data collection technology for electronic reporting.				X
10. Quality Assurance Measures to track blood specimens.				X

b. Current Activities

NBST screens for early identification of infants at increased risk of selected metabolic or genetic diseases to allow prompt initiation of treatment. Newborns with suspect positive results are referred for confirmation testing, treatment, follow-up, genetic and nutritional counseling, and education.

NBST continued to: 1) monitor and collect data on unsatisfactory NBS specimens, refusal waivers, and missing scan reports from the birthing facilities; 2) meet with the LIMS and MAVEN staff for the development and implementation of the web-based reporting system; 3) train birthing facility NBS staff to use the web-based system; 4) monitor activities on NBS education; 5) advocate for increased funding; and 6) meet with the NSPAC.

NBST Nurse Consultants provide technical assistance to selected birthing facilities on the NBS process.
NBST staff meet with the NSPAC to discuss data system challenges, quality assurance, statistical reporting, and emerging genetic issues.

Case and protocol reviews foster timely and accurate screening reporting. The NBLS Testing and Tracking program monitors the implementation of CLSI guidelines and the NBS Screening Schedule proposed by Yale New Haven Hospital. The Yale CLSI guideline is now in use at several hospitals.

A Nurse Consultant participates on the DPH-GO, COG, EGAP, NECMD, and NERGG.

c. Plan for the Coming Year

DPH NBST will ensure that newborns at increased risk are screened for early identification of selected metabolic or genetic diseases, allowing for prompt initiation of treatment to avert complications and prevent irreversible problems or death. All newborns with suspect positive results will be referred to state Regional Treatment Centers for confirmation testing, treatment & follow-up, and genetic and nutritional counseling & education.
NBST will continue to: 1) monitor and collect data on unsatisfactory NBS specimens, refusal waivers, and missing scan reports from the birthing facilities; 2) meet with the LIMS System Coordinator and the MAVEN Consultant to proceed with the web-based reporting system; 3) train birthing facility NBS staff to use the web-based system; 4) monitor activities on NBS education through grand rounds conferences at birthing hospitals and medical schools, increased NBS follow-up and care coordination capacity building; 5) advocate for increased funding for the PEIS hotline, daily patient referrals and comprehensive treatment services for patients and their families; 6) meet quarterly with the NSPAC.

NBST will: 7) implement at least one of the Healthy People 2020 Initiatives in the NBST program; 8) identify, discuss and act on issues related to Lab NBS, protocols, confirmed disorders, consumer concerns, and proposed NBS legislative bills; 9) continue case and protocol reviews with appropriate staff to foster timely and accurate reporting and to decrease false positive and false negative screening results.

NBSLT staff will meet to discuss data systems challenges, quality assurance, statistical reporting, and genetic issues.

If Sickle Cell Disease Newborn Screening Program, Follow-up Network (SCDNSFN) grant funds are obtained, the NBS program will be able to enhance newborn screening capacity and communication between NBSLT staff and pediatric genetic treatment centers and build upon existing SCD service infrastructure to establish a comprehensive SCDNSFN.

NBST Nurse Consultants will provide technical assistance to selected birthing facilities to assess the NBS process from data entry at the birth of the baby through collection of the specimen and receipt of the laboratory report. The Nurse Consultants will educate birthing facilities' Neonatal Intensive Care Unit Nurse Managers and Primary Care Providers on the "Newborn Screening for Preterm, Low Birth Weight, and Sick Newborns; Approved Guidelines."

A NBST Nurse Consultant will participate on the DPH-GO's COG and EGAP, and regional committees and advisory groups.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**37985**			
Reporting Year:	**2011**			
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**	**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**

	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	37273	98.1	33	0	0	
Congenital Hypothyroidism (Classical)	37273	98.1	719	6	6	100.0
Galactosemia (Classical)	37273	98.1	88	7	7	100.0
Sickle Cell Disease	37273	98.1	25	18	18	100.0
Biotinidase Deficiency	37273	98.1	130	3	3	100.0
Congenital Adrenal Hyperplasia	37273	98.1	255	0	0	
Hemoglobin Traits	37273	98.1	941	0	0	
Hemoglobinopathies	37273	98.1	25	7	7	100.0
Maple Syrup Urine Disease	37273	98.1	47	1	1	100.0
Tyrosinemia Type I	37273	98.1	86	0	0	
Methylmalonic Acidemia (MMA)	37273	98.1	63	1	1	100.0
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	37273	98.1	16	0	0	
Isovaleric Acidemia	37273	98.1	41	0	0	
Propionic Acidemia	37273	98.1	43	0	0	
Carnitine Uptake Defect	37273	98.1	67	0	0	
3-Methylcrotonyl-CoA Carboxylase Deficiency	37273	98.1	5	1	1	100.0
Ornithine Transcarbamylase Deficiency (OTC)	37273	98.1	138	0	0	
Carnitine/Acylcarnitine Translocase Def. (CACT)	37273	98.1	12	0	0	
Carnitine Palmitoyl Transferance I (CPT I)	37273	98.1	47	0	0	
Carnitine Palmitoyl Transferance II (CPT II)	37273	98.1	11	0	0	
Glutaric Acidemia II (GA II)	37273	98.1	25	0	0	
Glutaric Acidemia Type I	37273	98.1	35	1	1	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	37273	98.1	26	0	0	
Homocystinuria Hypermethionemia	37273	98.1	223	1	1	100.0
Multiple CoA Carboxylase Def. (MCD)	37273	98.1	5	0	0	
Short-Chain ACYL-CoA Dehydrogenase Deficiency (SCADD)	37273	98.1	60	5	5	100.0

Hyperammonemia-Hyperornithinemia-Homocitrullinemia Syndrome (HHH)	37273	98.1	49	0	0	
Malonic Aciduria	37273	98.1	86	0	0	
Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency/Trifunctional Protein Deficiency	37273	98.1	20	0	0	
Citrullinemia or Argininosuccinic Acid Synthetase Deficiency (ASD)	37273	98.1	39	0	0	
2, 4, Dienoyl CoA Reductase Def. (DCR)	37273	98.1	2	0	0	
Beta-Ketothiolase Deficiency and 2M3HBA	37273	98.1	3	0	0	
Long-Chain Acyl-CoA Dehydrogenase Def. (LCADD)	37273	98.1	0	0	0	
3-Hydroxy 3-Methylglutaryl-CoA Lyase Def. (HMG)	37273	98.1	46	0	0	
Noketotic Hyperglycinemia (NKH)	37273	98.1	66	0	0	
Muliple Acyl-CoA Dehydrogenase Deficiency (MADD)	37273	98.1	25	0	0	
Argininosuccinic aciduria (ASA) / Argininosuccinase Lyase (ADL)	37273	98.1	11	0	0	
Argininemia - Arginase Deficiency (Arg)	37273	98.1	103	0	0	
Short-Chain 3-Hydroxyacyl-CoA Dehydrogenase Def. (SCHADD)	37273	98.1	23	0	0	

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	59.8	59.8	59.8	59.8	59.8
Annual Indicator	57.8	57.8	57.8	57.8	70.4
Numerator					
Denominator					
Data Source		National	National	National	National

		Survey of CSHCN	Survey of CSHCN	Survey of CSHCN	Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	70.4	70.4	70.4	70.4	70.4

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

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

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

Notes - 2010
Source: Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009
Source: Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
This measure was met. Connecticut 70.4% vs. the national average of 70.3%.

CT's Title V System of Care for CYSHCN, The CT Medical Home Initiative (CMHI) CYSHCN provided a community-based, coordinated system of care for children and families. Services in the following categories were provided to 8,020 CYSHCN: administration of extended services and respite funds, care coordination, provider and family education, outreach and family support.

The Child Health and Development Institute (CHDI) and their subcontractor the Family Support Network (FSN) implemented provider and family outreach, education, and family support for the CMHI for CYSHCN. FSN and CHDI provided training to families about linking to resources, and worked to educate primary care providers through Educating Practices in the Community (EPIC) modules including modules on family and professional partnership and Family-Centered Care, Care Coordination for CYSHCN, Early Hearing Detection, Oral Health, and Autism Spectrum Disorders. FSN provided information and education encounters to 4,316 families of CYSHCN and 2,731 providers. CT FSN established a Facebook Page and a statewide Yahoo ListServe.

Results of the CT DPH Medical Home Family Survey through August 2011 indicated that of 502 respondents receiving services through CMHI, 88% reported their medical provider "always" listened to their concerns with 9% indicating they "sometimes" listened. In addition, 84% indicated their provider and staff "always" showed commitment to provide quality care and family support, with 13% indicating "sometimes." Results of the survey were used to plan EPIC and other trainings for CMHI associated providers and staff.

The Early Hearing Detection and Intervention (EHDI) program strengthened family and professional partnerships through the establishment of a Deaf and Hard of Hearing Outreach Coordinator as part of the FSN. The Coordinator created an electronic list of statewide resources for families with children who are deaf or hard of hearing.

Information about Hands & Voices (H & V), a national organization to provide unbiased communication options, was shared with over forty community stakeholders including families of children who are deaf or hard of hearing and providers. (CT was granted provisional H & V Chapter status in March 2011).

In June 2011, Patti Silva, Deaf and Hard of Hearing Outreach Coordinator, attended the National H & V Leadership Conference in Maine. Patti attended workshops, networked with families and professionals, and received advice for the CT H & V Chapter.

DPH and CMHI partners assisted the Department of Social Services (the state's Medicaid agency) in obtaining family input to the newly established Person Centered Medical Home Medicaid system of services through facilitation of focus groups for CYSHCN and Adolescents.

The FSN hosted a forum in September 2011 titled One Voice designed to bring parents and caregivers together to network, exchange valuable resources, learn about legislation and empower families to work to effect change. More than 150 families/caregivers from diverse communities, cultures and socio-economic levels attended the forum. FSN released the "One Voice" newsletter to represent the collective thoughts and priorities of hundreds of parents and professionals who are part of the FSN.

Eight family representatives served as voting members of the Medical Home Advisory Council (MHAC) and were compensated for travel and childcare expenses. Family representatives participated in three MHAC workgroups, including a Family Experience workgroup. DPH provided stipends to assist families in participation on either Council and/or work group activities. Teleconferencing was available for all meetings.

A FSN Family Advocate attended the 2011 AMCHP National Conference in Washington D.C. as part of her year-long training awarded as family scholar. Tesha Imperati, along with CHDI staff, presented at the conference, and shared medical home related information, including family support opportunities with child health providers established through EPIC presentations.

DPH partnered with key stakeholders to implement and support the HRSA grant for the CT Family-to-Family Health Information Network. The project assists families and providers in navigating public and private health care financing service delivery systems, and strategies to improve these systems.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Encourage families to participate in family forums, CMHI meetings, Medical Home Advisory Council, Block Grant review, and Family Support Council and meetings as appropriate.				X

2. Support families to participate through training and mentoring and compensate for time and knowledge.				X
3. Provide trainings for families on statewide and local supports, link families to existing trainings and other resources.				X
4. Have families provide training for all stakeholders and encourage sharing lessons learned.				X
5. Assure families from diverse backgrounds are involved.				X
6. Distribute family surveys.		X		X
7. Assure establishment and growth of family/professional partnerships.				X
8. Provide families with tools such as “Get Creative About Respite” and “Directions”.		X		
9.				
10.				

b. Current Activities
Family support services, including education for families of CYSHCN, are offered statewide through the FSN to enable families to acquire skills necessary to access medical and related support services and become empowered, competent supporters for their children.

The Medical Home Family Survey, available in English and Spanish, is posted online and is being distributed through the CMHI.

CTFSN is implementing a training workshop - Meeting Halfway: Positive Communication with Families, designed for professionals who work directly with parents to assist professionals in their ability to understand a parent's perspective, actively listen and build quality parent/professional partnership.

CT H & V has recently been granted official Chapter status.

Work provided by the Deaf and Hard of Hearing Outreach Coordinator is being complemented by CHDI and Dr. Brenda Balch, the AAP EHDI Chapter Champion, through a MD to MD Project. The project brings "Just In Time" information to pediatric providers and families who have an infant recently identified with hearing loss.

DPH is providing funding for 15 scholarships for fathers to attend the 13th Annual New England Fathering Conference which brings together federal, state and local professionals and parents to share information and gain knowledge about the significant role fathers play in raising healthy, happy children.

c. Plan for the Coming Year
DPH and CMHI will support and enhance a family-centered Medical Home concept through statewide outreach and culturally competent education to pediatric primary care providers and families. CHDI and the FSN will continue to implement Family/Professional Partnership education and outreach. CMHI partners and contractors, including the Child Development Infoline of 2-1-1-United Way, will connect families to support, advocacy, and resources.

Families will be members of the MHAC, its workgroups and subcommittees, and will be compensated for their time through stipends. Family participation will continue on the legislated Family Support Council, the CT Lifespan Respite Coalition, and Family Voices organizations.

Implementation of the CHDI contract expansion will further enhance family involvement in the CT DPH EHDI process and improve awareness and availability of information for families of children

in CT who are deaf or hard of hearing and will further promote family-professional partnerships within the CT EHDI System.

DPH will monitor, enhance and revise the statewide respite system available through CMHI. DPH will distribute the Get Creative About Respite manual through community activities, and disseminate Directions: Resources for Your Child's Care an information organizer that includes sections on medical home and connecting parents and families to services (available in English, Spanish and Portuguese). These documents are available in hardcopy and through the DPH website.

DPH will promote the partnering of families in decision making for CYSHCN. Activities will include, but not be limited to: compensation for families to review CT's MCH Block Grant (MCHBG) application, invitation for families to comment at the MCHBG public hearings or focus groups, and provision and support of an Access database to manage and report information on CYSHCN.

DPH will work with key stakeholders and family and consumer agencies, including FSN, CHDI, and Parents Available to Help/Family Voices CT, with a primary outcome to improve access to Medical Home and related services including family support.

DPH will participate as an active member of the CT Family-to-Family Health Information Network to assist families and providers in navigating the public and private health care financing service delivery systems and develop appropriate strategies and policies to improve these systems.

Additional outreach activities will include collaboration with the FatherWorks Program through the Village for Families and Children in the Hartford area with a primary focus of supporting fathers of CYSHCN in becoming involved in accessing and coordinating services for their children. The collaboration will support teenage fathers and include those who are YSHCN themselves. Activities will include health literacy education.

The DPH Family Advocate will be available to the public and all MCH programs within DPH.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	56.9	48.5	48.5	48.5	48.5
Annual Indicator	48.5	48.5	48.5	48.5	46
Numerator					
Denominator					
Data Source		National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	46	46	46.2	46.2	46.3

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

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

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

Notes - 2010
Source: Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2009
Source: Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments
This objective was not met; however, CT at 46.0% remains above the national average of 43.0%.

The DPH Medical Home Advisory Council (MHAC) comprised of more than 40 representatives including youth representation from CT Kids as Self Advocates, state and private agencies, community-based organizations, and parents of CYSHCN, provided guidance to DPH and its partners in their efforts to improve the system of care for CYSHCN by ensuring connections to medical homes and between services.

CT's system of care for CYSHCN, The CT Medical Home Initiative (CMHI) for CYSCHN, provided a community-based, culturally competent, coordinated system of care for children and families. CMHI provided community-based care coordination and family support services to 8,020 CYSHCN through 47 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), Coordinating Council for Children in Crisis (South Central) and United Community and Family Services, (Eastern). CMHI provided technical assistance (TA) to an additional 16 practices implementing a MH model. Care coordination activities included: assessment, care planning, home visits, family advocacy, linkage to specialists and community-based resources, coordination of health financing resources, coordination with school-based services, chronic disease management, family education and transition planning. CMHI utilized a resource guide to train agency staff, care coordinators and case managers throughout the system providing services to CYSHCN -- the guide was made available to public and private sector agencies including third party payers.

DPH provided CMHI networks technical assistance (TA) through participation in Collaborative Partnership Meetings, site visits, quarterly TA care coordinators' meetings, and biweekly conference calls. Conference calls included case scenarios shared to ensure access to community-based resources, to improve referrals and access to CMHI, and to address individual issues with collective experience from care coordinators throughout the system.

A summary report of a MH pilot project implemented in three practice sites was provided to the General Assembly. Findings included confirmation that: establishment of protocols facilitates care coordination, MH care coordination improves care delivery, and sustainability is ensured through provider recognition of MH value to consumers.

Results of the CT DPH Medical Home Family Survey through August 2011 indicated that of 502 respondents receiving services through CMHI; 86% reported they "always" had access to their primary medical provider when needed with 11% indicating they "sometimes" had access when needed. In addition, 85% indicated their provider and staff "always" were knowledgeable about and understood their child's condition, medical concerns and history, with 12% indicating "sometimes". Families reported care plans were in place 55% of the time (previous survey results indicated 44%, with a baseline of 23%); 78% reported they were actively involved in writing the care plan; 96% reported they understood the care plan. Responses indicated care coordinators "always" helped link families to resources 87% of the time with 9% reporting they received help accessing resources "sometimes". 71% of respondents with children over the age of 13 indicated they received assistance in addressing health care needs moving towards adult services. Access database information confirmed the findings and indicated 68% of children served by the program were linked to services outside the MH.

DPH staff and the SW CMHI presented a poster session - 'Reduction in Hospitalization for CYSHCN' at the American Public Health Association annual meeting - October 2011; the session provided the analysis of a cohort of CYSHCN receiving care coordination services over a three year period with measurable reduction in frequency and length of hospitalizations.

DPH partnered with the Department of Social Services (DSS) to provide assistance and input to a new paradigm of Medicaid Services incorporating Person Centered Medical Home (PCHM). Partnering included participation on a pediatric providers' workgroup and initial discussions regarding the future alignment of CMHI with the new DSS program.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Implement, monitor and evaluate CT Medical Home Initiative.				X
2. Assist the CT Medical Home Initiative with expanding the medical home provider network.				X
3. Work with CT Medical Home Initiative and the Family Support Network to facilitate family-professional partnerships.				X
4. Participate on Medical Home Advisory Council and workgroups.				X
5. Provide families with tools such as "Get Creative About Respite" and "Directions".		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities
CMHI provides community-based, culturally competent medical home care coordination services.

Mark Keenan, CT's Title V CYSHCN Director, in collaboration with community partners from Stamford CT, including the SW CMHI, presented two poster sessions at the Association of Maternal and Child Health Programs annual conference in February. The sessions - 'Macro Medical Home Model: Stamford's Community Childhood Blueprint, and Stamford's Successful Community Approach to Childhood Obesity' provided details of successful strategies used to focus on specific outcomes while integrating available resources and coordinating various "care coordinators" working within complementary community systems.

DPH and MHAC partners are actively collaborating with Community Health Network (CHN) and DSS to fully integrate the CMHI care coordination networks with the newly established CHN programs under Medicaid in order to maximize available resources, avoid duplication of services, and provide support for emerging Medical Homes and Health Homes.

Access database reporting through CMHI is being enhanced to include the ability to easily identify participants in CHN's programs; and to incorporate the ability to provide specific details regarding developmental screening.

Initial steps are being taken to integrate the state School Based Health Center (SBHC) system with the CMHI networks, with strategies being developed to link care coordinators and to assess the SBHCs regarding implementation of MH.

c. Plan for the Coming Year
CMHI will provide community-based MH care coordination services and provide technical assistance to practices engaged in medical home implementation.

DPH will provide TA to CMHI care coordinators and other partners through support of and participation in Collaborative Partnership Meetings (ongoing community based meetings involving care coordinators and service providers from various agencies sharing information and strategizing to resolve both case specific and systems level challenges to access and resource identification); site visits, biweekly conference calls, and quarterly TA care coordinators' meetings.

DPH contracts with existing CMHI care coordination networks will be extended for an additional two years; allowing for continuity of services.

The Access Database utilized by CMHI care coordinators will be migrated to a web-based platform, allowing for web-based reporting, integration with other databases utilized by DPH (Birth Defects Registry, Newborn Screening and Early Hearing Detection and Intervention), and will ensure future linkages to electronic medical records. The system will allow information from medical home care coordinators and others providing services to be integrated in support of CYSHCN program surveillance, planning and evaluation. On-site training at CMHI medical homes will be conducted and TA will be provided in support of the new data reporting system. Additional national and state level presentations in promotion of MH will be made, and the MHAC Strategic Plan developed in 2010 will be fully implemented.

The North Central Care Coordination Collaborative (Collaborative Partnership Meeting) will expand to include local providers either engaged or interested in MH implementation in order to assess the feasibility of the collaborative serving as a regional source of technical assistance open to all providers.

The CMHI service system will be aligned and integrated with the DSS Medicaid PCMH system,

identifying synergies between the systems and supporting the emergence of medical homes, including the provision of support and education of providers to implement medical home.

The MHAC and other stakeholders will be utilized to provide input to the development of a statewide Request for Proposals (for implementation in two years) that will redefine the role of the CT Medical Home Initiative in order to maintain assistance for CYSHCN in accessing care within medical homes, while promoting and supporting the emergence of new medical homes and health homes.

Opportunities to partner and collaborate with DPH chronic disease programs will be explored and developed, including the incorporation of disease specific outcome measures for the CYSHCN population served through CMHI.

Specific training opportunities for SBHC staff will be developed regarding medical home implementation within the SBHCs.

The Medical Home Training Academy CT specific curriculum will be posted and available online to all providers and stakeholders.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	61.3	61.7	61.7	61.7	61.7
Annual Indicator	61.7	61.7	61.7	61.7	59.6
Numerator					
Denominator					
Data Source		National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	59.6	59.6	59.6	59.6	59.6

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

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as

survey design flaws, respondent classification and reporting errors, and data processing mistakes.

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

Notes - 2010
Source: Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009
Source: Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
This objective was unmet as Connecticut 59.6% is slightly below the national average of 60.6%.

The CT Medical Home Initiative (CMHI) medical home care coordination networks and the contractor for the administration of funds for respite and extended services provided benefits coordination for families of CYSHCN to assist in accessing public/private sources to pay for services needed including the facilitation of eligibility determination and application for Healthcare for UninSured Kids and Youth (HUSKY). Under HUSKY, children and youth up to age 19 receive a comprehensive health care benefits package, including preventive care, physician visits, prescriptions, vision care, dental care, physicals, mental health/substance abuse services, durable medical equipment, emergency and hospital care. The CT Lifespan Respite Coalition (CLRC), the contractor for the management of Extended Services and Respite funds, provided assistance to families in accessing insurance benefits and assisted in the process of filing appeals when claims were denied.

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.

The number of participants in the Katie Beckett Waiver remained at 200. The Katie Beckett Waiver enables children to receive an institutional level of care at home and bases eligibility for Medicaid on income and assets without counting the income and assets of legally liable relatives.

In April 2011, DSS released a Request for Proposals to programmatically change the existing Medicaid Managed Care HUSKY structure. The change will result in full implementation of a revised system of care that will utilize an Administrative Services Organization (ASO) structure to change local service delivery to support the emergence of medical homes, health homes, and integrated care organizations. Community Health Network (CHN) was identified as the ASO for the program and initial implementation went into effect on January 1, 2012. DPH collaborated with DSS and later CHN to provide input for the design of the program, including: facilitation of focus groups, facilitation of input from the DPH Medical Home Advisory Council (including family representatives), participation in a pediatric providers workgroup, and participation on the Person Centered Medical Home (PCMH) MAPOC subcommittee.

In September 2011, Mark Keenan Title V CYSHCN Director presented at Making "Cents" of it All, CT HealthCare Summit 2011, a workshop for providers and families of children and youth with

special health care needs interested in and effected by insurance changes taking place in the state. The forum was hosted by PATH Parent-to-Parent Family Voices of CT, CT's Family-to-Family Health Information Network. Presenters also included Carol Tobias and Beth Dworetzky of the Catalyst Center, Dr. Robert Zavoski (DSS Medical Director), and Laura Morris from the CT Office of the Health Care Advocate.

Representatives from DSS, as well as representatives from the MCOs administering HUSKY and later CHN, participated in Medical Home Advisory Council (MHAC) meetings, facilitating the incorporation of HUSKY outreach as an integrated part of Connecticut's medical home efforts. HUSKY MCO staff, and later CHN ASO staff, participated in all Care Coordination Collaborative Partnership meetings, answering eligibility and access questions, and working to meet case specific needs.

DSS staff participated on CMHI biweekly technical assistance conference calls, providing updates and assistance with eligibility regarding complex family needs.

DPH, DSS and CMHI staff collaborated with the CT Family-to-Family Health Information Network to update and distribute the HUSKY eligibility manual -- disseminated in hard copy, electronically and on flash-drives. Dissemination to consumers included channels through CT SCD Consortium and CT EHDI Task Force partners.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assess family's insurance status.		X		
2. Provide education on benefits/services provided by insurance/other programs.				X
3. RMHSC and Medical Homes identify CYSHCN and provide care coordination including access to private/public insurance.		X		
4. Coordinate with HUSKY Infoline.		X		
5. Work with Medicaid Managed Care Council and DSS to ensure CYSHCN population is identified, provided all needed services, and providers are reimbursed for identification and care coordination services.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CMHI care coordinators provide coordination of and facilitate access to health care financing resources, including public insurance. Referrals are made to HUSKY Infoline, and assistance is provided in filling out applications. The CT DPH Title V CYSHCN Program continues integration and improvement of strategies for CYSHCN and their families in accessing public/private insurance sources and assists families with eligibility determination and application for HUSKY.

DPH, DSS, MHAC members and CMHI staff are collaborating with CHN to integrate the CYSHCN system of services with the new ASO Medicaid system in order to maximize all available resources, avoid duplication of services, and to identify and eliminate gaps in services.

The resources and experience of DPH and CMHI staff, as well as the MHAC membership are available to DSS and the ASO to ensure consumers, including CYSHCN, experience continuing

improvement in access to both medical homes and insurance.

Strategies are being developed to assist CHN and providers in implementing PCMH -- which requires National Committee for Quality Assurance (NCQA) level two medical home recognition. CHN is implementing a glide path for providers to achieve recognition for participation in the program with enhanced reimbursement based on specific clinical outcomes. DPH and CMHI staff have taken initial steps to assess how they can best assist providers and CHN's Practice Transformation Specialists in ensuring successful implementation of PCMH.

c. Plan for the Coming Year

CMHI community-based medical home care coordinators will provide coordination of and facilitate access to health care financing resources, including insurance.

The CLRC, the contract grantee for the management of extended services and respite funds, will assist families in accessing existing insurance benefits and in the process of filing appeals.

DPH staff will serve on the MAPOC and the PCMH subcommittee, providing ongoing input to the Medicaid ASO restructure.

DPH will facilitate access to PCMH as well as to HUSKY and private insurance. Additional efforts will be made to identify private insurers interested in NCQA requirements and Medical Home implementation in order to partner in dissemination of information available on private plans to consumers, and to promote the alignment of services within medical practices.

Connecticut DPH and DSS representatives will attend MHAC and workgroup meetings and respond to issues concerning eligibility determination, access, application process and related issues. DSS staff will participate in CMHI for CYSHCN contractors' technical assistance conference calls to address insurance issues and questions.

CHN ASO staff will be invited to participate in all Care Coordination Collaborative Partnership meetings, and an invitation for ongoing participation in the MHAC will be extended to CHN.

Child Health and Development Institute and FSN will implement the Provider/Family outreach and education component of the CT Medical Home Initiative for CYSHCN with a focus on Family/Professional Partnership. The partnership focus will include education for both providers and families of CYSHCN in working to navigate access to insurance.

DPH will partner with the A.J. Pappanikou Center for Excellence in Developmental Disabilities (the state's UCEDD) to provide an educational presentation to care coordinators, providers and families regarding potential gaps in future coverage for CYSHCN as a result of restructuring due to the Affordable Care Act (ACA). The presentation will include potential differences in coverage and strategies to ensure families understand differences between employer based, public, and exchange based plans when making decisions in selecting a plan.

Additional forums, including Family Support Network and Family-to-Family forums, will be used to disseminate access and eligibility resource materials. DPH will assist Family-to-Family to disseminate the HUSKY eligibility manual electronically and on flash drives through additional partners, including the CF Foundation, Epilepsy Foundation, and other disease specific support organizations. Information will also be disseminated throughout the CT School Based Health Center (SBHC) system.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	76.8	89.4	89.4	89.4	89.4
Annual Indicator	89.4	89.4	89.4	89.4	66.8
Numerator					
Denominator					
Data Source		National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	67.8	67	67	67.2	67.2

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

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

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

Notes - 2010
Source: Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2009
Source: Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for NPM05.

a. Last Year's Accomplishments

This objective was not met; however, CT at 66.8% remains above the national average of 65.1 %.

CT's System of Care for CYSHCN and the CT Medical Home Initiative (CMHI) for CYSHCN, provided a community based, coordinated system of care for CYSHCN and families. Contractors provided services for 8020 CYSHCN in the following categories: medical home care coordination, administration of extended services and respite funds, provider and family education, outreach, and family support.

Five community-based medical home network contractors provided care coordination services statewide: Stamford Health System (Southwest); St. Mary's Hospital (Northwest); United Community & Family Services (Eastern); Coordinating Council for Children in Crisis (South Central); and CT Children's Medical Center (North Central). Each network contractor affiliated with and provided embedded care coordination for numerous clinical sites. Care coordination was co-located in community based clinical practices, making care coordination services easier to access for families.

CHDI and the CT Family Support Network (FSN) provided statewide outreach and culturally effective education to 4,316 families on the medical home concept for CYSHCN including information regarding accessing community service systems.

DPH collaborated with United Way of CT 2-1-1/Child Development Infoline (CDI) to coordinate referrals to the CMHI community-based system. CDI/CMHI regional meetings took place to monitor, evaluate and improve referral to the care coordination system of care for CYSHCN. CDI served as a statewide entry point to CMHI. DPH staff served on the CDI Steering Committee.

CT Lifespan Respite Coalition (CLRC) managed the administration of DPH approved extended service funds and respite funds. Respite and extended services were accessible directly through CLRC; referral from CMHI care coordinators, or through referral from CDI. CLRC served as an additional statewide entry point to CMHI.

DPH expanded partnerships with organizations serving CYSHCN and their families. DPH participated on legislatively mandated and other councils, e.g. the CT Family Support Council, Medical Assistance Program Oversight Council, Birth to Three State Interagency Coordinating Council, State Department of Education Bureau of Special Education Transition Task Force, Advisory Council to Division of Autism Spectrum Services, A.J. Pappanikou UCEDD Consumer Advisory Board, CT Developmental Disabilities Council, and Sickle Cell Disease Consortium. CMHI access information was distributed among these partners and ongoing collaboration included efforts to identify strategies to promote ease of access across service systems.

The Medical Home Advisory Council remained 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 collaborating with CMHI to develop and implement community based medical home care coordination for their populations included: DSS HUSKY Medicaid; Sickle Cell Disease Consortium; School Based Health Center Association; Parents Available to Help/CT Family Voices-CT's F2F Health Information Center, CT Family Support Network.

Outreach efforts included collaborative presentations by DPH and CMHI care coordinators providing CMHI access information and linking counseling and case management services to medical home care coordination.

DPH and CMHI Care Coordinators collaborated with agencies serving youth with special health care needs providing outreach statewide through conferences, panel discussions and expos on resources for successful transition from youth to young adulthood. These collaborations heightened awareness of the importance of health for success in school, work and the community. Through efforts initiated through the State Implementation Grant for Integrated

Community Systems for CSHCN; DPH established new partnerships with the State Board of Education and community organizations including Family Advocacy Organization for Children's Behavioral Health (FAVOR) and CT Kids as Self Advocates. CMHI and other programmatic access information was routinely distributed through these new partnerships.

The CT DPH Home by One Program identified 40 dental homes and linked them to WIC sites statewide. Additionally, 17 dental providers were found who self-identified as providing services to CSHCN.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement, monitor and evaluate CT Medical Home Initiative for Children and Youth with Special Health Care Needs.				X
2. Implement, monitor and evaluate referral and coordination of services system with United Way of Connecticut 2-1-1 Infoline/Child Development Infoline.				X
3. Work with contractors to survey families regarding access to community-based service systems.				X
4. Develop trainings to enhance families' ability to access community-based service systems.		X		X
5. Enhance public/private partnerships with agencies and organizations serving CYSHCN and their families.				X
6. Implement recommendations from Medical Home Advisory Council strategic planning process.				X
7.				
8.				
9.				
10.				

b. Current Activities

The CMHI community-based system of care reaches more CYSHCN and families by assisting with systems of care coordination; training and support to enhance quality of care and optimize health of CYSHCN; PCP care coordination support for CYSHCN with high severity needs; and PCP and specialists coordination.

CMHI Care coordination is co-located or embedded in 47 community based medical homes. An additional 16 medical homes receive some level of support. CDI and CLRC serve as statewide system access points for linking families with public and private services.

Care Coordination Collaborative Partnerships are focusing on services available; barriers to resource coordination, interagency communication; obstacles to securing appropriate services in a timely manner. Meetings include developing family specific interagency care plans and accessibility across agencies.

DPH is piloting a revised process to obtain public input to the MCH Block Grant and programs. Family representatives now participate in the MCH Block Grant review and the process for public input is being revised to include the use of online tools (and hardcopies thereof) to assist families to organize written responses to the MCH Block Grant application. A third party is being utilized to organize initial written responses into a focus group format for consumers who are engaged as "Block Grant Readers". Specific questions regarding how the service system could be organized to facilitate ease of use are being included.

c. Plan for the Coming Year
DPH will actively partner with Community Health Network to provide a networked approach to medical home care coordination for CYSHCN covered by the CT Children's Health Insurance Plan (HUSKY). DPH will work in collaboration with families and community partners to develop a RFP to reorganize CMHI in the following year in order to align the program with services available through the Medicaid program, maximize available resources, avoid duplication of services, and improve ease of use for consumers.

DPH will collaborate with Parents Available to Help, CT's Family-to-Family Health Information Center grantee to develop strategies to improve access to health financing resources and services. Trainings will be provided to care coordinators and families at numerous workshops, will include cultural competency training, and will target communities with identified health disparities.

Through efforts initiated through the State Implementation Grant for Improving the System of Services for Children with ASD and Other Developmental Disabilities, DPH will establish new working relationships with ASD specific family support organizations and providers, and will disseminate CMHI and other programmatic access information through these new partnerships.

Directions: Resources for Your Child's Care, a family information organizer will be updated and available in hard copy and electronically in English, Spanish and Portuguese. Sections include: accessing systems of services, medical home, health plan information, emergency preparedness, transition, and parenting CYSHCN. The second CT edition in Spanish is expected to be available by fall 2012.

Recent state legislation supports the establishment of 20 additional School Based Health Centers in the next year within communities identified with the lowest performing schools or districts.

The FHS is considering implementing a contract administrative pilot project that will include assigning contracts for CMHI care coordination, School Based Health Centers, and Community Health Centers within the same communities to a single contract liaison/manager at DPH. The project will leverage existing connections between providers serving the same families while fostering collaboration and communication on an ongoing basis and will serve to reduce fragmentation across systems by aligning programs. Priority will be given to communities with identified health disparities. Local community partners will be identified to provide outreach and culturally competent training to families and providers.

The CT MCH consumer survey utilized as part of the MCH five year needs assessment will be reposted online for additional consumer input.

DPH will collaborate with the CT Dental Health Partnership (DHP) to coordinate dental services for CSHCN; DHP maintains a designated coordinator to assist CSHCN on Medicaid to find dental services. The Family Support Network will partner with DPH to coordinate outreach in finding dental services for CSHCN.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and	2007	2008	2009	2010	2011

Performance Data					
Annual Performance Objective	5.8	43.3	43.3	43.3	43.3
Annual Indicator	43.3	43.3	43.3	43.3	46
Numerator					
Denominator					
Data Source		National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	46	46	46	46	46

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

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

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

Notes - 2010
Source: Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2009
Source: Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for NPM#06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments

This measure was successfully met (CT 46.0% vs. national 40.0%).

In order to ensure completion and full implementation of goals and objectives for the HRSA State Implementation Grant for Integrated Community Systems for CYSHCN (D70 Grant), the CT Title V CYSHCN Program was granted a no cost extension. The primary outcome of the project is to assist youth with special health care needs (YSHCN) and their families/caregivers to overcome barriers to successful transition to all aspects of adulthood, including healthcare, work and independence.

CYSHCN Program staff continued to develop and revise the Connecticut Medical Home Training Academy Curriculum (CMHTAC). The CMHTAC is a CT specific version of the American Academy of Pediatrics "Every Child Deserves a Medical Home" curriculum. The CMHTAC includes four modules: Background and Current Context of Medical Homes in CT, Care Coordination, Family-Professional Partnerships and Transition to Adulthood. CT D70 project consultants Patti Hackett, Umbereen Nehal M.D., and Richard Antonelli M.D. reviewed each module, provided edits and suggested resources to enhance the CMHTAC.

In May 2011 the DPH CYSHCN Program hosted a conference titled "Launching Into Adulthood: It's Not Like It Used to Be!". Guest speakers included: John G. Reiss, PhD, Associate Professor, University of Florida Gainesville; Keith Jones, disability rights advocate and national public speaker; Deborah Allen, ScD, Director of the Bureau of Child, Adolescent and Family Health at the Boston Public Health Commission; and Mallory Cyr, National Youth Program Manager at Got Transition? Nation Center. Topics discussed included: transitioning from pediatric to adult health care; closing health disparities gaps, students with intermittent absenteeism, youth panel discussion on how health/wellness impact transition; Life Course Theory and the role of life stressors for YSHCN in their transition process. Over two hundred students/young adults, parents and providers attended the all-day statewide conference.

In May 2011 the DPH CYSHCN Program hosted a forum titled "Correlating Health with All Aspects of Transitioning to Adulthood: Successful Health Care Transition for YSHCN" Dr. John Reiss met with CT Medical Home Initiative (CMHI) Care Coordinators and D70 Grant community partners. The group discussed lessons learned from "Launching Into Adulthood: It's Not Like It Used to Be!" conference and the critical need to identify adult medicine practitioners who are willing to serve YSHCN in their practices.

In July 2011, Nordia Grant, MPH and Transition Specialist for the D70 Grant, participated on a "Families and Youth as Critical Agents of Change and Sustainability Panel" at the annual State Implementation Grantee Meeting. Connecticut presented information on their YSHCN Transition Project and a poster presentation on their Regional Interagency Care Coordination Collaboratives on YSHCN Transition to Adulthood.

In September 2011, CYSHCN Program Staff participated on the State Department of Education Bureau of Special Education "Back to School Meeting" state agency transition panel. This is a meeting that Special Education Directors from across the state attend yearly. CYSHCN staff shared information on transition to adulthood services that the CT Title V CYSHCN Program offers.

In December 2011, CYSHCN staff participated in the "School Days to Pay Days: Launching into Adulthood" transition conference. This conference was a collaborative effort among Connect-Ability/the Bureau of Rehabilitation Services, the CT State Department of Education, the Department of Developmental Services, and the State Education Resource Center. The conference included the most popular sessions offered at the DPH CYSHCN Program's "Launching Into Adulthood: It's Not Like It Used To Be" and the Department of Developmental Services "School Days to Pay Days" transition conferences. CYSHCN staff facilitated the "Addressing Students with Intermittent Absenteeism" session, manned a DPH vendor table and disseminated CYSHCN and transition information to conference participants. CYSHCN staff

arranged for Deborah Allen to present two sessions at this conference (one for students & parents and one for providers) on Lifecourse Theory and Transition. Over three hundred young adults, parents and providers attended the all-day statewide conference.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identify youth with special health care needs.			X	
2. Identify and strengthen relationships with schools, community-based organizations and State Agencies.				X
3. Provide children and families individualized transition packets.		X		
4. Identify and provide training for adult health care providers interested in serving YSHCN transitioning to adult health care.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Mark Keenan, RN, MBA, Title V CYSHCN Director and Dr. Madhu Mathur, Southwest CMHI Physician Champion, presented a session at the 2012 Association of Maternal Child Health Programs Annual Conference titled "Connecticut's Collaborative Model for YSHCN Transition to Adulthood. Challenges and Successes". The workshop discussed lessons learned of CT's care coordination life course transition model for YSHCN developed in collaboration with the Southwest CMHI program, youth, parents and community partners.

Although recruitment of primary care practitioners to support transition of YSHCN to medical homes has been a difficult barrier to overcome, CYSHCN staff are vigilant in pursuing opportunities to engage and recruit adult practitioners who are willing to care for YSHCN.

CYSHCN program staff are revising the fourth module of the CMHTAC. All four curriculum modules will be posted online (including pre and post test questions) by September 2012. This online version will be available to providers (including participants in the state's Medicaid Person Centered Medical Home Program) as an introductory course on medical homes and health homes.

CYSHCN program staff participate in statewide collaborative opportunities (e.g. presenting to agency staff, parents and school personnel) and share information about the importance of considering health in transition to adulthood for YSHCN, CYSHCN program information, YSHCN resources, and answer questions.

c. Plan for the Coming Year

The Connecticut Economic Resource Center has provided a written report on DPH's progress towards achieving the goals and objectives of the D70 Grant. The report will be used as a framework for developing a sustainability plan which includes development of ongoing MOUs with state agencies, continued participation in monthly calls, ongoing technical assistance from National Initiative for Children's Healthcare Quality, investigating funding opportunities to translate materials into Spanish and collaborating with non-traditional partners such as Federally Qualified Health Centers (FQHCs) by developing protocols giving providers a blue print to follow when

transitioning YSHCN from private pediatric to adult services through a FQHC.

Three CMHI CYSHCN care coordination contractors will routinely and independently plan and facilitate Interagency Collaboration on Care Coordination & Transition Planning Meetings. The meetings develop a youth-driven, culturally competent transition plan for the youth and their families/caregivers, in collaboration with key state agencies and community-based partners. CYSHCN staff will work with two remaining CMHI care coordination contractors towards future independent implementation of meetings in the additional two area networks.

DPH and the Department of Children and Families (DCF) has partnered with D70 project consultant Patti Hackett, MEd, to develop a curriculum for use by DCF social workers titled "Making the Connections--Changing the Outcomes". The curriculum will be implemented with a mixed audience of CMHI care coordinators and regional DCF social workers.

The state School Based Health Centers Program is now situated within the same DPH unit as the CYSHCN Program. This will allow for a unique opportunity to closely collaborate on health care transition of YSHCN.

DPH and CMHI will distribute educational materials such as the three "Moving Into Adult Health Care Guides" created by CT Kids As Self Advocates. The booklets offer strategies and resources to help young adults with or without disabilities, their parents, and their primary care providers to prepare for the transition to adult health care process. The booklets are now available on the YSHCN webpage http://www.ct.gov/dph/cwp/view.asp?a=3138&q=432684&PM=1.

DPH staff will continue to serve on the SDE/BSE (State Department of Education/Bureau of Special Education) Transition Task Force (TTF), bringing awareness to the importance of health care transition. The TTF supports the SDE/BSE in promoting positive postsecondary outcomes in education, training, employment and independent living for students with disabilities.

CYSHCN staff will disseminate transition resources and CYSHCN Program information to CT school social workers, counselors and psychologists through an electronic listserv developed by SDE/BSE and DPH.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	88.6	89	89.4	83.6	89.8
Annual Indicator	83.4	83.2	83.1	85.0	82.0
Numerator	29765	29207	29091	30019	27988
Denominator	35674	35111	35000	35309	34136
Data Source		CIRTS	CIRTS	CIRTS	CIRTS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

	2012	2013	2014	2015	2016
Annual Performance Objective	82	82.2	82.4	82.6	82.8

Notes - 2011
Source: Connecticut Immunization Registry and Tracking System (CIRTS), 2008 birth cohort. The CIRTS data provide a more accurate picture regarding childhood immunization coverage rates for CT children. The immunization coverage rate for children born in 2008 was 82% for the 4:3:1:2*:3:1 series, The 34,136 children represent 85% of the 40,230 births recorded in Connecticut for 2008. A total of 3,190 children or 8% of the 40,230 births refused registry enrollment. Annual Performance Objectives for 2012-2016 were updated using the most recent data.

Notes - 2010
Source: Connecticut Immunization Registry and Tracking System (CIRTS), 2007 birth cohort. The CIRTS data provide a more accurate picture regarding childhood immunization coverage rates for CT children. The immunization coverage rate for children born in 2007 was 85% for the 4:3:1:2*:3:1 series, The 35,309 children represent 85% of the 41,413 births recorded in Connecticut for 2007. A total of 17,829 children or 43% of the 41,413 births are also enrolled in Medicaid and 3,924 children or 9% of the 41,413 births refused registry enrollment.

*2006-2007 Birth Cohort, Schedule 4,3,1,2,3,1: 4 DTaP, 3 IPV, 1 MMR, 2 Hib, 3 Hep B, 1 Varicella (Schedule reflects 2 Hib due to the Hib shortage and Feb. 2008 to July 2009 Hib booster dose deferment.)

Notes - 2009
Source: Connecticut Immunization Registry and Tracking System (CIRTS), 2006 birth cohort. The CIRTS data provide a more accurate picture regarding childhood immunization coverage rates for CT children. The immunization coverage rate for children born in 2006 was 83.1% for the 4:3:1:2*:3:1 series, which represents 35,000 children or 87% of the 40,260 births recorded in CT.
*2 Hib were measured instead of 3 Hib due to the February 2008-July 2009 Hib shortage and deferment of the Hib booster dose.

a. Last Year's Accomplishments
CT did not meet the annual objective in 2011. In 2011, CT's 4:3:1:2*:3:1 coverage rate (based on the modified Hib schedule of 2 doses) of 82% was lower than the 2011 national estimate of 83.4% (based on the modified Hib schedule of 0 doses). The Hib vaccine shortage that occurred from December 2007 to September 2009 continues to impact overall immunization coverage rates. The CIRTS registry data provide a more accurate picture regarding childhood immunization coverage rates for CT children. The immunization coverage rate for children born in 2008 was 82% for the 4:3:1:2*:3:1 series, which represents 34,136 children or 85% of the 40,230 births recorded in CT.*2 Hib were measured instead of 3 Hib due to the December 2007 to September 2009 Hib shortage and deferment of the Hib booster dose. The national estimate is based on a sample of CT residents from a random digit dialing survey and did not include Hib in their schedule.

The availability of one-time ARRA (American Recovery and Reinvestment Act) funds in September 2009 enabled the Immunization Program to begin replacement of CT's outdated DOS-based immunization registry with a web-based immunization registry and tracking system. In 2010, a Project Manager Consultant experienced in Project Management methodologies and web-based technologies was hired to assist in implementation of a vendor-based immunization registry and tracking system. A contract was established in October 2010 with a vendor (Consilience Software, Inc.) to build a new web based immunization registry using their MAVEN registry application product. The Immunization program also established a partnership in September with the MA Immunization program, who is also using the MAVEN application as the base for their immunization registry, to share application development documents, training

information, etc. Most of 2010 was spent on completing the System Development Methodology (SDM) documents required by the CT Department of Administrative Services Bureau of Enterprise Systems and Technology (BEST), formerly called DOIT, for DPH business requirements and general design phase for the registry application.

The Healthy Start and HCWC programs provided case management to pregnant women and their children and encouraged and educated parents regarding the importance of keeping well child care visits. The programs assessed immunization status and linked children with primary care providers to maintain up-to-date immunizations. All CHC follow national guidelines for administration of childhood immunizations. Chart reviews are used to assure that infants and children are in compliance.

The CYSHCN program assessed children for required immunizations and referred them to appropriate resources. Care coordination is used to support families in accessing services.

The WIC Program encouraged parents and caregivers to obtain well child care and referred participants to eligible programs. The CT WIC certification form includes a check-off box for the health care provider to indicate if the child is up-to-date on immunizations, which then enables the WIC nutritionist to reinforce the importance of obtaining missed immunizations.

The Immunization Program provided funding to support: the CT Immunization Registry and Tracking System (CIRTS), 12 contractors to conduct immunization activities and procuring and distributing publicly funded childhood vaccines. Contractor activities consisted of: performing clinic immunization assessments to monitor immunization coverage rates for preschool children; coordinating and providing outreach and referrals for children identified by CIRTS who are behind in their immunizations; conducting immunization education campaigns that are culturally appropriate for pregnant women, new parents, and new immigrants; and providing training and support to medical providers who utilize the CIRTS.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitor infants and children for compliance with immunization schedules.	X			
2. Outreach and identify infants and children for up to date immunizations.		X		
3. Provide support, information and linkage to necessary services.		X		
4. Procure and provide publicly purchased vaccines.		X		
5. Provide funding and technical support to health care providers to improve childhood immunization levels.				X
6. Provide WIC check box to identify up to date immunization status.			X	
7.				
8.				
9.				
10.				

b. Current Activities

The Immunization Program provides funds to support: the CIRTS, 12 contractors to conduct immunization activities, and procuring and distributing publicly purchased childhood vaccines. Contractor activities consist of: performing clinic immunization assessments to monitor immunization coverage rates for preschool children; coordinating and providing outreach and

referrals for children identified by CIRTS who are behind in their immunizations; conducting immunization education campaigns that are culturally appropriate for pregnant women, new parents, and new immigrants; and provide training and support to medical providers who utilize the CIRTS. The program established a project steering committee to develop a new web based registry utilizing ARRA funding and completed the System Development Methodology (SDM) documents required by BEST including the: Business Requirements, Design, Construction, Testing, and Implementation Phases.

All Title V programs (CYSHCN, case management programs for pregnant women) assess the immunization status of the infants/children and refer them as necessary to their medical home/primary care provider for any needed immunizations. Those without a designated PCP are referred to CHC.

c. Plan for the Coming Year
The immunization program will: 1) continue to assess and monitor immunization rates for children enrolled in the CIRTS; 2) procure and distribute childhood vaccines: 3) continue efforts to implement MAVEN registry application by completing implementation and begin rollout to providers by June 2012; 4) convene local advisory/planning groups in all 11 Immunization Action Plan funded sites to improve immunization services for children in high risk areas; 5) partner with community organizations, coalitions, businesses and public and private professional and civic organizations to promote childhood immunizations and vaccine safety; and 6) strive to achieve the Healthy People 2020 goal of enrolling > 95% of children under age six in our immunization registry.

The case management programs for pregnant women (and their children), will ensure that the children are current with their immunizations and refer to the medical home/PCP as necessary to ensure compliance.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	12.3	12.2	11.9	11.5	10.5
Annual Indicator	12.0	11.7	10.7	8.4	8.4
Numerator	885	846	766	620	620
Denominator	74029	72503	71840	74039	74039
Data Source		DPH Vital Statistics	DPH Vital Statistics	DPH Vital Statistics	DPH Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**

Annual Performance Objective	8.3	8.3	8.2	8.2	8.1

Notes - 2011
Source: CY2011 Vital Statistics data are not available.
CY2010 Vital Statistics data are provisional.

Notes - 2010
Source: CY2010 Vital Statistics data provisional.
Annual performance objectives for 2011-2015 were updated using these more recent data.

Notes - 2009
Source: Final CY2009 Vital Statistics data as of Sept 2011. The 2005 and 2006 annual objective fields are "locked in" and will not allow us to change the objective to reflect our most recent experience. If we were able to change these fields we would have modified the objective for 2005 to read 12.8 and for 2006 to read 12.3.
Annual performance objectives for 2010-2014 were updated using these more recent data.

a. Last Year's Accomplishments
This measure was met. SBHC staff continued to address teen pregnancy through risk assessments and provision of reproductive health services including: individual/group counseling, health education sessions, student empowerment activities, and referrals to community-based reproductive health care providers. Counseling and education were also provided to pregnant and parenting teens on numerous topics, including prevention of additional pregnancies. Seven SBHC clinical staff attended an adolescent health conference that featured presentations on contraceptive management for adolescents. SBHCs in the southwestern part of the state conducted a regional conference entitled, The Legal Rights of Adolescents.

DPH funded two adolescent confidentiality teleconferences for community-based health care professionals. A total of 660 individuals registered.

The DPH funded three Case Management for Pregnant Women programs in Waterbury, New Haven and Hartford targeting low income pregnant women under the age of 19. The program provided a comprehensive system of case management and home visitation that included risk assessments, perinatal depression screening, screening and referral for tobacco cessation, parenting education, promotion of breastfeeding, family planning, child development education, and establishing support systems. The case management services were provided in the perinatal and interconceptional periods in an effort to improve birth outcomes, reduce fetal and infant mortality and improve maternal health and well-being.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide risk assessments and referrals for reproductive health services.			X	
2. Implement teen pregnancy prevention programs.		X		
3. Collaborate with traditional and nontraditional teen pregnancy prevention partners.				X
4. Develop curriculum for addressing adolescent paternity for at-risk youth.				X
5. Convene the interagency adolescent workgroup.				X
6. Provide education opportunities to key stakeholders on best practices in teen pregnancy prevention and youth development.				X
7. Establish an “Implementation Team” to address reproductive				X

health and sexuality strategic issues identified as a priority in the State Adolescent Health Plan (activities will promote teen pregnancy, STD, and HIV prevention).				
8.				
9.				
10.				

b. Current Activities
SBHCs address teen pregnancy through risk assessments & provision of reproductive health services including: individual/group counseling, health education sessions, student empowerment activities & referrals to community-based reproductive health care providers.

The Case Management program provides intensive case management, parenting education, assessments & referrals to at risk women. Enrolled families receive birth spacing education. Fatherhood initiatives are included at all sites and educate fathers about interconceptional care and the benefit of birth spacing.

Planned Parenthood of Southern New England (PPSNE) provides reproductive health education & prevention services to women and men at 12 centers in towns with high rates of teen pregnancy. They provided reproductive health services to 28,917 people; of those, 5,248 were teens (ages 14-19). This year, 1,535 at-risk teens attended educational presentations given by PPSNE and its subcontractors.

DPH manages the Personal Responsibility Education Program (PREP) grant. PREP is an HIV, STD and pregnancy prevention program targeting youth in foster care. Activities include participation in Teen Talk program for youth ages of 13-19 in 21 group homes, trainings for DCF, group home staff & foster parents on "How to Be an Effective Sex Educator." A Youth Advisory was supported through grant funding to engage youth in the child welfare system to become peer advocates for other youth in foster care on decreasing risky behavior.

c. Plan for the Coming Year
SBHC staff will continue to address teen pregnancy through implementation of risk assessments and provision of reproductive health services including: individual/group counseling, health education sessions, student empowerment activities and referrals to community-based reproductive health care providers. The State Adolescent Health Coordinator will participate in monthly regional conference calls and will provide information on adolescent health, including updates on the new federal teen pregnancy prevention program with SBHCs and other relevant DPH programs.

Title V supports programs such as Healthy Start and case management programs including teens (both female and male) and provides interconceptional counseling. The Hartford Healthy Start project will provide care coordination and outreach services to pregnant and postpartum women.

PPSNE will continue to provide reproductive health, prevention services and education to males and females throughout the state. The life-course theory approach was embedded into their services.

DPH will continue the activities and initiatives aimed at reducing teen pregnancy and risk taking behavior among youth in, and, aging out of foster care. Youth in 22 group homes will participate in the Teen Talk program. Youth with cognitive and/or developmental delays in DCF Short Term Assessment and Respite (STAR) programs will receive a one-day training on reproductive health and prevention. DCF staff, group home contractors and foster parents will be trained on "How to Be an Effective Sex Ed Educator."

DPH has entered into a memorandum of agreement with the Department of Mental Health and Addiction Services to provide support and pregnancy prevention education and referrals to women with Axis I mental health diagnoses served by the Family Services Program. Doula's will be assigned to pregnant women enrolled in the program and case management services will be provided.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	12	38	34	23.9	24.5
Annual Indicator	38.0	18.0	26.1	29.2	23.2
Numerator	1687	4276	6147	6867	7183
Denominator	4440	23747	23535	23544	31004
Data Source		CT Dept. of Social Services SCHIP Division	CT Dept. of Social Services SCHIP Division	CT Dept. of Social Services SCHIP Division	CT Dept. of Social Services SCHIP Division
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	23.9	23.9	23.9	23.9	23.9

Notes - 2011
Source: CT Department of Social Services SCHIP Division. The denominator represents all 8 and 9 year olds enrolled in SCHIP and the numerator represents all 8 and 9 year olds who received dental sealants.

Notes - 2010
Source: CT Department of Social Services SCHIP Division. The denominator represents all 8 and 9 year olds enrolled in SCHIP and the numerator represents all 8 and 9 year olds who received dental sealants.
Annual performance objectives for 2011-2015 were updated using these more recent data.

Notes - 2009
Source: CT Department of Social Services SCHIP Division. The denominator represents all 8 and 9 year olds enrolled in SCHIP and the numerator represents all 8 and 9 year olds who

received dental sealants.
Annual performance objectives for 2010-2014 were updated using the most recent data.

a. Last Year's Accomplishments
This measure was not met. Though more 8 to 9 year old children participating in the state Medicaid/CHIP received a dental sealant during this timeframe, the percentage relative to the number of children enrolled decreased.

The Office of Oral Health (OOH) focused on three major initiatives: "Home by One", the CDC Cooperative Agreement, and the Basic Screening Survey for pre-school and elementary school children. Through "Home by One," the OOH is developing a statewide infrastructure to increase early childhood oral health interventions. Training modules for child health providers and dental professionals will be made available through web-based curricula.
The CDC Cooperative Agreement identifies eight core activities on which the OOH should focus: 1) ensuring appropriate staffing for the office, 2) building collaborations with internal/external partners, 3) developing a state oral health plan, 4) ensuring community water fluoridation, 5) creating a statewide oral health coalition, 6) increasing the number of school-based dental sealant programs, 7) enhancing surveillance, and 8) creating an evaluation component. CT has a state oral health plan, strong partnerships, and a mandate that any community water system serving over 20,000 people fluoridate their water supply. The OOH has developed a statewide dental sealant pilot program, an oral health coalition that meets the requirements of the CDC, a state dental sealant plan and conducted the second training session for community water operators on the benefits of water fluoridation.

The Basic Screening Survey for the 2010-2011 school year included height and weight collection in addition to the oral health status data, to describe the BMI of the children assessed. More than 750 children in Head Start and 8,300 children in kindergarten and third grade were screened and the findings showed that while there was a significant improvement in the oral health of CT's Head Start children, dental decay continues to be a significant problem for CT's children overall.

A statewide oral health conference was held in June to: 1) inform oral heath stakeholders on coalition building; 2) provide updates from or to the CT Coalition for Oral health on state plan implementation; and 3) enhance the medical/dental partnership and cultural competencies for dental professionals.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop a strategic plan for enhancing DPH data and information systems to improve the monitoring of dental sealants' prevalence.				X
2. Continue OPENWIDE training of non-dental providers.				X
3. Continue Home by One activities.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The OOH continues to work on eight core activities for the CDC Cooperative Agreement. OOH is conducting its second surveillance survey of the oral health status of children.

OOH conducted its third training session for community water operators on the benefits of water fluoridation and held a statewide oral health conference to advise oral health stakeholders, health care reform, the interdisciplinary approach to oral health care and the development of the new state oral health improvement plan.

The CT Coalition for Oral Health expanded to include members beyond its core group. Focus areas and activities to implement the CT Oral Health State Plan 2007-2012 objectives were identified. Discussions to develop an updated plan for the next five years began.

A dental sealant demonstration pilot ends in Sept 2012 for existing school-based/linked dental programs to use specific software to collect dental sealant data delivered in a school setting. Funding and technical assistance was provided to participating programs and an evaluation will be developed to address the effectiveness and feasibility of the pilot activities.

A no cost extension was awarded for the "Home by One" program to continue to work toward its goal for children to have a dental visit and dental home by age one. Training for health providers on age one dental visits, oral health risk-assessment and fluoride varnish applications is self-sustaining with on-line courses and network development follow-up.

c. Plan for the Coming Year

The OOH will continue to work on the eight core recipient activities for the CDC Cooperative Agreement. The CT Coalition for Oral Health will implement strategies to improve the oral health and overall health of CT residents. Collaboration with the DPH Drinking Water Section will be maintained to promote optimal water fluoridation. More emphasis will be placed on collaboration with MCH programs, as well as with the DPH Chronic Diseases Programs.

Upon availability of funds from the CDC Cooperative Agreement, a dental sealant data collection tool will be developed, in the event that the evaluation of the pilot proves the SEALS software was not appropriate for the eight participating school-based/linked dental programs.

If funding is available, under this Cooperative Agreement a dental sealant campaign will be developed to increase the awareness of the safety and benefits of this proven evidence-based dental caries prevention intervention. This campaign will be targeted to dental professionals, and the general public, with a strong emphasis on vulnerable populations.

The Home by One program will continue to be self-sustaining; trainings for medical and dental providers on age one dental visits, fluoride varnish application and oral health risk-assessments will be offered online.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	1.4	1.3	1.2	1.2	1
Annual Indicator	1.3	1.0	0.8	0.6	0.6
Numerator	9	7	5	4	4

Denominator	672521	667742	660975	664942	664942
Data Source		DPH Vital Statistics	DPH Vital Statistics	DPH Vital Statistics	DPH Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	0.6	0.6	0.6	0.6	0.6

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

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

Notes - 2009
Source: CT Dept. of Public Health, HISR, CY 2009 final Vital Statistics.
The annual indicator is a rolling average of 2007, 2008, and 2009 numerator (10, 6, 6) and denominator (668663, 668663, 668663) original numbers.
Annual performance objectives for 2010-2014 were updated using these most recent data.

a. Last Year's Accomplishments
This measure was met in 2011. Compared to an annual performance objective of 1.0, the annual indicator was 0.8 per 100,000 children. CT addressed this NPM through Title V and non-Title V programs and collaborations to reduce deaths and non-fatal injuries due to motor vehicle crashes.

The Injury Prevention Program, using MCHBG funding, developed a three year contract with Safe Kids Connecticut to conduct child passenger safety programs. Target audiences included parents, caregivers and healthcare, childcare and community service providers. During the first contract year, Safe Kids conducted 13 workshops/educational events serving 201 adults and 253 children and one 4-day child passenger safety technician certification course which trained 13 new technicians. The programs included booster seat education and "giveaway" programs for low-income families with booster seat age (4-8 years) children and provided booster seats to those who needed them. These served 69 adults and 86 children, with 86 booster seats provided. Additional programs included car seat "clinics" where trained technicians checked car seats, provided education on correct use and replaced unsafe seats, and educational presentations for families and providers. These served 132 adults and 167 children, with 53 car seats replaced. The new best practice recommendations from the American Academy of Pediatrics and the National Highway Traffic Safety Administration were promoted at all programs. Programs were conducted throughout the state; communities included New Britain, Waterbury, Haddam, Meriden, Southington, New London, Windham, Norwich, Plainfield, and Hartford.

Partners and event locations included family resource centers, WIC programs, schools, police and fire departments, local Safe Kids Coalitions, car dealerships, hospitals, health clinics and community health centers. The Injury Prevention Program, the FHS, and the CT Office of Rural Health continued to partner on the Children's Safety Network's (CSN) facilitated New England Rural Injury Community of Practice, which focused on types of injuries with higher rates in rural areas, including motor vehicle injuries. The Injury Prevention Program participated in several initiatives that address motor vehicle injuries and deaths among children, including the CT Department of Transportation's Safe Routes to School, the CT Safe Teen Driving Partnership, the Capitol Region Council of Governments (CRCOG) Pedestrian-Bicycle Committee, the Safe Kids Connecticut Coalition, and the Emergency Services for Children Advisory Committee.

One local health department used Preventive Health and Health Services Block Grant (PHHSBG) funding for motor vehicle injury prevention activities.

The Injury Prevention Program (IPP) provided TA on issues related to motor injuries to units within DPH, individuals, and community-based programs.

The CT Crash Outcome Data Evaluation System (CODES) Project, funded by the National Highway Traffic Safety Administration (NHTSA), completed linkage of eleven years of police crash reports, injury-related hospitalization and emergency department data. Based on previous analyses showing higher motor vehicle injury and death rates for children and adolescents residing in rural towns, CT CODES data was analyzed to provide additional information. Compared to crashes occurring in Connecticut's urban towns, rural crashes were more likely to involve teens as drivers or passengers, involve alcohol and result serious injury or death.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide technical assistance, resources, and funding to support to motor vehicle injury prevention activities.				X
2. Provide linkages to motor vehicle injury prevention resources.		X		
3. Provide screening, risk assessment and anticipatory guidance in Title V funded programs.	X			
4. Provide guidance and support for policy development regarding motor vehicle related mortality in children.				X
5. Participate in statewide coalitions and collaborations addressing motor vehicle injury prevention through public and professional education, policy change and system enhancements.				X
6. Utilize injury-related data to guide planning for state and community based programs and policy development.				X
7.				
8.				
9.				
10.				

b. Current Activities

During the second year of the MCHBG funded contract, Safe Kids Connecticut is conducting at least 14 child passenger safety workshops, presentations or trainings. There is a continued focus on low income families with children of booster seat age, since l studies continue to indicate that this age group is least likely to be appropriately restrained while traveling in a motor vehicle. The American Academy of Pediatrics' recent best practice recommendation for safe travel for children of all ages will also be promoted. Educational programs for parents and other family members

and continuing education updates for child passenger safety technicians are being conducted or planned.

The CT CODES Project, funded by NHTSA, continues to link additional years of crash, hospital and emergency department data for use in planning motor vehicle injury prevention initiatives. Through Preventive Health and Health Services Block Grant Funding, one local health department is conducting motor vehicle injury prevention activities during the SFY 2012.

DPH-funded case management programs, CHCs and SBHCs, continue to provide guidance and resources on motor vehicle injury prevention.

c. Plan for the Coming Year
Through the third year of the MCHB funded contract, Safe Kids will provide 14 child passenger safety programs for parents, caregivers and healthcare, childcare and other community service providers.

DPH-funded case management programs for women and children will work to enhance activities and identify resources to reduce the death rate for children age 14 years and under caused by motor vehicle crashes.

SBHCs will have motor vehicle safety as an integral focus of events and services. Community Health Centers, as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) providers, will continue to provide guidance about age-appropriate risk assessments and injury prevention information related to motor vehicle safety.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	39	48	49	45	49.8
Annual Indicator	43	42.9	41.9	49.3	47.1
Numerator					
Denominator					
Data Source		CDC National Immunization Survey	CDC National Immunization Survey	CDC National Immunization Survey	CDC National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year			Yes	Yes	Yes

moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	50.3	50.3	50.8	51.3	51.8

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

Notes - 2010
Source: This measure monitors the rate of breastfeeding at 6 months of age using information from the National Immunization Survey based on the year of the birth cohort. The birth cohort reported is the CY 2007. Websource: www.cdc.gov/breastfeeding/data/reportcard2.htm
Annual performance objectives for 2011-2015 have been updated using this more recent data.

Notes - 2009
Source: This measure monitors the rate of breastfeeding at 6 months of age using information from the National Immunization Survey based on the year of the birth cohort. The birth cohort reported is the CY 2006. Websource: www.cdc.gov/breastfeeding/data/report_card2.htm
Annual performance objectives for 2010-2014 have been updated using this more recent data.

a. Last Year's Accomplishments
This measure was not met, however many past and current activities are ongoing to ensure that in future years we meet annual performance measures.

The Connecticut Department of Public Health (DPH), Commission on Human Rights & Opportunities (CHRO), the CT Department of Labor (DOL) and the Connecticut Breastfeeding Coalition (CBC) developed and made available via website a guidance document for employees and the public about public accommodation for breastfeeding and lactation accommodation in the workplace. http://www.breastfeedingct.org/images/handouts/faq_breastfeeding_joint_10-2-11-1.pdf

Due to limited funds, "What Are Your Rights" flyers about CT's breastfeeding laws were not updated in 2011 but it is planned to update the electronic versions by Sept 2012.
http://www.breastfeedingct.org/images/handouts/your_rights_english.pdf

DPH, CBC, and the Connecticut WIC Program collaborated on an outreach activity during World Breastfeeding Week (WBW) in 2011 to update libraries on appropriate and current resources for the community. The CBC purchased the revised LLL's Womanly Art of Breastfeeding and the WIC program purchased children's books and donated 24 copies each to libraries near local WIC programs. Local WIC Breastfeeding Coordinators were encouraged to network with their area libraries to support them in updating their holdings and partnering on WBW events.
http://www.breastfeedingct.org/images/breastfeeding%20week%20aug%202011%20final.pdf

DPH-WIC's Breastfeeding Unit facilitates meetings of the WIC Breastfeeding Committee. Four breastfeeding content sheets aimed at ensuring consistent staff messaging were completed. Topics include: exclusive breastfeeding, building and maintaining a milk supply, pumping for medical reasons, and pumping for short separations. Additionally, updates to the breast pump policies and working with the state's Department of Social Services (DSS) liaison for WIC breast pump coverage continued through 2011.

The Connecticut WIC Program continues to fund the Hartford Hospital-based, Hispanic Health Council's Breastfeeding: Heritage and Pride (BHP) breastfeeding peer counseling program, in Hartford. WIC also funds its expansion in New Haven at Yale-New Haven Hospital (YNHH). The Yale BHP Program targets the African American population. A pilot WIC Peer Counseling program was launched in March of 2011 at three local WIC agencies at the following sites: TVCCA (Norwich site), New Haven WIC Program (Fair Haven Community Health Center) and ACCESS agency (Day-Kimball Hospital site). Activities included revision of BHP program protocols, training of four peer counselors, updating of forms, and the purchase and development of outreach materials.

WIC funded recertification of 31 WIC lactation counselors and funded the attendance of 107 State and local WIC program staff at the annual Healthcare Provider Seminar organized by La Leche League of Connecticut.

The Nutrition, Physical Activity & Obesity (NPAO) and WIC program staff within DPH continued its administration and oversight of the Connecticut Breastfeeding Initiative (CBI), a CDC-, CPPW-, and ARRA-funded project to assist 10 maternity facilities achieve 5 of the 10 steps to achieve Baby-Friendly Hospitals status.

DPH/WIC continued its collaboration with the CT Chapter of the American Academy of Pediatrics (CT-AAP) to educate physicians on breastfeeding topics. WIC continued to fund two DPH/CT-AAP teleconferences: The Journey to Successful Breastfeeding Series - Part V and VI, "To Pump or Not to Pump" and "Infant Tongue Tie". DPH/WIC staff worked to plan two additional calls for 2012. http://www.ct-aap.org/ctaap-teleconferences-2011.php

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Attend and participate in the monthly CBC meetings.				X
2. Identify and track breastfeeding data sources to further build infrastructure.				X
3. Promote provider and consumer education and awareness through training and education.				X
4. Implement recommendations of provider survey and consultant analysis of disparities in breastfeeding rates in African American women as appropriate.				X
5. Promote and support the WIC Breastfeeding Peer Counseling Program.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Created breastfeeding committee within DPH to coordinate breastfeeding support services and provide referrals to families.

A Nursing Mothers Policy was developed and endorsed by the Commissioner. DPH was featured as a business that supports breastfeeding employees for a CBC federally funded grant project.

NPAO/WIC staff continued administration of the CBI. A Sustainability conference and Lessons Learned teleconference were held.

The CBI project evaluation was completed and submitted to the CDC for review. DPH staff and CBC presented at several national and state meetings. One CBI hospital achieved Baby-Friendly Designation on November 4, 2011.Nine hospitals were in Dissemination (phase) by project end. The newest Baby-Friendly Hospital was recognized by the DPH Commissioner at a ceremony in February designating it as the fourth Baby-Friendly hospital in CT. The WIC breastfeeding unit conducts local agency breastfeeding visits, quarterly breast¬feeding coordinators' meetings, and provides oversight for three WIC peer counseling pilots and two BHP peer programs.
DPH participates in monthly CBC meetings.

Education materials are distributed via DPH's Immunization Program's hospital discharge packets and other appropriate vehicles.

Participate in the implementation of The Business Case for Breastfeeding with CBC.

CT-AAP physician education teleconference: The Role for the Pediatrician in a Baby-Friendly Hospital Initiatives was conducted to continue DPH support for the CBI

c. Plan for the Coming Year
The DPH breastfeeding committee will continue to meet to ensure coordination of breastfeeding support services, including an emphasis on Child Day Care facilities.

Training and implementation of the DPH Nursing Mothers Policy lactation support program will continue. Supervisor training and supervisor support for breastfeeding employees will be emphasized. Outreach to other state agencies on workplace accommodation is also planned.

CBI momentum in CT will be supported per the DPH sustainability plan. DPH and CBC staff plan to collaborate to write a journal article based on the project findings. Opportunities to incorporate evidence-based maternity care practices in hospital perinatal regulations will be explored.

State WIC breastfeeding unit staff will continue to assess baseline local agency breastfeeding promotion and support practices via scheduled technical assistance visits and quarterly breastfeeding coordinators' meetings.

Preliminary data from the WIC Peer Counseling pilot program will be reviewed and incorporated into quality improvement. The USDA Peer Counseling training platform will be incorporated into a statewide training manual for WIC peer counselors.

DPH will continue to participate in monthly CBC meetings and in committee meetings, as appropriate. World Breastfeeding Week and CT Breastfeeding Awareness Month activities will be planned and implemented.

Distribution of consumer education materials will continue via DPH's Immunization Program hospital discharge packets and other appropriate vehicles. DPH will continue participation in the implementation of The Business Case for Breastfeeding with CBC and will focus on marketing the Breastfeeding Friendly Employer Designation statewide.

Efforts to secure additional resources remain ongoing to further implement the recommendations of the Surgeon General's Call to Action to Support Breastfeeding released in 2011, to address racial and ethnic disparities in breastfeeding rates, and to improve access to breastfeeding information and support for all families.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	99.1	99.2	99.3	99.4	99.3
Annual Indicator	99.1	99.4	99.0	99.3	98.8
Numerator	41889	40672	39070	38254	37546
Denominator	42266	40930	39481	38538	37985
Data Source		CT DPH EHDI Program	CT DPH EHDI Program	CT DPH EHDI Program	CT DPH EHDI Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	99.3	99.3	99.3	99.3	99.3

Notes - 2011
Source: CT DPH Early Hearing Detection and Intervention Program. Universal newborn hearing screening was implemented in CT on 7/1/00. Denominator data collected on 6/15/12 from Vital Records.
Annual Performance Objectives for 2012-2016 were updated using the most recent data.

Notes - 2010
Source: CT DPH Early Hearing Detection and Intervention Program. Universal newborn hearing screening was implemented in CT on 7/1/00. Denominator data collected on 6/14/11 from Vital Records.
Annual performance objectives for 2011-2015 were updated using these more recent data.

Notes - 2009
Source: CT DPH Early Hearing Detection and Intervention Program. Universal newborn hearing screening was implimented in CT on 7/1/00. Numerator data collected on 6/16/10.

a. Last Year's Accomplishments
This measure was not met, as CT's hearing screening rate for CY 2011 was 98.8%, falling short of the Performance Objective of 99.3%. Tracking and follow-up continues on babies born in late 2011, and the provisional rate may improve once final data is available.

CT hospitals have electronically reported newborn screening data to the DPH since 2002. Newborn Screening System (NSS) records are matched to the Electronic Vital Records System (EVRS). A DPH Newborn Screening Project Team worked with the contractor, Consilience Software, to develop an improved newborn screening web-based reporting system, Maven. During the Summer and Fall of 2011, final testing and data migration phases were completed, a written training manual was developed, and off-site training of all 30-birth facilities and the one midwife practice was conducted. The Maven: NSS went into production on 1/18/2012.

The EHDI Program's goal is to identify infants with hearing loss as early as possible to minimize speech/language and other delays by linking them to early intervention (EI) services. EHDI has a proactive tracking and follow-up system in place to ensure: 1) all babies are screened at birth; 2) those who do not pass receive timely diagnostic follow-up; and 3) those diagnosed with a hearing loss are enrolled in EI. To reduce the number "lost to follow-up" (LTF) after an infant fails to pass the newborn hearing screening, letters are sent and follow-up phone calls made to the mother and primary care provider of any child who fails the hearing screen and for whom DPH does not have a diagnostic audiological evaluation documented. EHDI is in regular communication with audiology centers about children who were referred from newborn hearing screening. Sixty-eight infants with hearing loss were identified in 2010. Enrollment into EI is confirmed for each newborn diagnosed with a hearing loss, and infants with a permanent mild and/or unilateral hearing loss are automatically eligible for CT's IDEA, Part C, EI program (Birth to Three). In 2010, 68% of infants diagnosed with a hearing loss were eligible for Birth to Three services and 87% of eligible infants were enrolled before 6 months of age.

DPH EHDI staff attend monthly CT EHDI Task Force meetings to discuss issues relevant to infant hearing, early identification and habilitation.

EHDI has allocated funds to support the goal of increasing parent involvement in the CT EHDI process. EHDI staff facilitated regular participation of parent leaders/parent of child who is deaf or hard of hearing in monthly EHDI Task Force meetings and disseminated Hands & Voices materials to incite discussion regarding a CT Chapter. CT Child Health and Development Institute (CHDI) subcontractor, the CT Family Support Network (FSN), hired a Deaf and Hard of Hearing Resource Coordinator who is working to establish a formalized parent-to-parent support group for families of children who are deaf or hard-of-hearing in the state.

The existing contract with the CHDI was amended to include: 1) development and presentations of an Educating Practices in the Community (EPCI) module on EHDI with the intent to improve quality of care related to hearing loss among pediatric-age patients in the primary care setting, 2) work with the CT FSN to improve information availability and parent-to-parent support for families of children who are deaf or hard-of-hearing, and 3) collaboration with the CT AAP EHDI Chapter Champion to deliver a physician to physician pilot project to provide technical assistance and consultative services to PCPs who see young children who are deaf or hard of hearing in their practice.

EHDI is distributing two resources developed by the National Center for Hearing Assessment & Management: "Communicate with Your Child" pamphlet for parents of a newly diagnosed young child, and a Newborn Hearing Screening Training Curriculum DVD designed to assist birth facilities with ongoing competency-based training.

In February 2011, EHDI staff attended and presented at the National EHDI Conference in Atlanta, GA, to share the latest information and collaborate with other experts in the field of early hearing loss.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Improve state data tracking system.				X
2. Improve follow-up on missed or abnormal screens.				X
3. Improve follow-up on infants lost to diagnostic follow up.				X
4. Improve tracking on follow up program for infants at risk for hearing loss.			X	
5. Educate primary care providers on genetic factors associated with hearing loss.				X

6. Distribute culturally sensitive educational materials to parents.			X	
7. Assure linkage to a medical home.		X		
8. Hire support staff to assist with tracking and follow-up.				X
9.				
10.				

b. Current Activities
EHDI staff conduct ongoing tracking and follow-up to ensure infants are screened at birth and receive audiological follow up by 3-months of age and are enrolled in EI by 6-months. The new Maven: NSS keeps a running list of babies without screening results in the system, which is available to hospitals for quality assurance purposes. Phone and on-site TA is provided to hospital staff and audiology centers as needed.

A revised Diagnostic Audiology Reporting Form for reporting diagnostic testing or rescreening results to DPH was distributed to the 11 diagnostic centers in CT. The new form included modified degree of hearing loss categories.

The existing NSS was replaced by a web-based reporting system (Maven) on 1/18/12.

As of 3/12, CT has an official Chapter of Hands & Voices, a parent driven, non-profit organization dedicated to providing unbiased support to families with children who are deaf or hard of hearing.

DPH distributes two parent brochures entitled: "Listen Up!" and "A Parent's Guide to Diagnostic Hearing Testing of Infants," in English and Spanish to birth facilities to make available to newborns' parents.

In 3/12, two EHDI staff attended the National EHDI Conference in St. Louis, MO, for training on best practices in early hearing detection and presented on: Engaging the Medical Home in Connecting Babies with Hearing Loss to Early Intervention, Family Support and Specialty Services, which included discussion about the physician to physician pilot project.

c. Plan for the Coming Year
EHDI will continue its focus on educating hospital staff, pediatric healthcare providers, and families about the importance of follow-up audiological testing of infants who did not pass newborn hearing screening within 3-months of age as well as investigating opportunities to expand partnerships with midwives performing home deliveries in CT.

In collaboration with pediatric experts and other stakeholders, CHDI will continue to present the EHDI EPIC module to practices in each of the state's five CYSHCN Program service areas, and provide each practice with tools and resources to ensure better outcomes in the medical home for children who are deaf or hard of hearing. In collaboration with DPH, CHDI will also continue working with CT Children's Medical Center physicians to provide physician to physician technical assistance and consultative services to PCPs, including "just in time" educational materials to support access to care and links to the three statewide EI programs serving infants and toddlers who are deaf or hard of hearing and the CT FSN as well as other needed resources.

The EHDI Program will hire a 1.0 FTE Health Program Assistant 1 -- Newborn Hearing Screening Tracking and Systems Enhancement Liaison (NHS-TSE Liaison), who will provide Maven: NSS technical assistance to birth facilities, including ongoing day-to-day technical and programmatic support. This position was created to: increase newborn hearing screening capacity, to realize process improvements, to ensure connections to pediatric audiological diagnostic follow up and entry into early intervention services, and to decrease infants lost to follow up.

EHDI will strengthen collaborative relationships with other established early childhood programs

to expand the current EHDI infrastructure in the state and to facilitate timely and appropriate audiological follow-up for infants who do not pass newborn hearing screening and early intervention for infants who are deaf or hard of hearing: by working with the Maternal and Child Health Home Visiting Program to provide educational resources regarding early childhood hearing screening, by partnering with the University of Connecticut to examine early head start and head start hearing screening practices in CT, and by collaborating with Birth to Three (IDEA Part C EI) to revitalize data collection initiatives aimed at ensuring infants identified with an eligible hearing loss are enrolled in an EI program by 6 months of age

The EHDI Program will assemble a team of stakeholders to participate in the next National Initiative on Child Health Quality (NICHQ) Learning Collaborative in order to identify and test small change strategies with the goal of reducing loss to follow-up after failure to pass newborn hearing screening.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	7.6	5.9	5.1	5	4.7
Annual Indicator	6	5.2	5.4	7.7	6
Numerator					
Denominator					
Data Source		US Bureau of Census, Current Population Survey	US Bureau of Census, Current Population Survey	US Bureau of Census, Current Population Survey	US Bureau of Census, Current Population Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	6	5.8	5.8	5.7	5.7

Notes - 2011
Source: US Bureau of Census, Current Population Survey, 2010 Table Package, table HI05.
Annual performance objectives for 2012-2016 were updated based on the most recent data.

Notes - 2010

Source: US Bureau of Census, Current Population Survey, 2009 Table Package, Table HI05. Annual performance objectives for 2011-2015 were updated based on the most recent data.

Notes - 2009
Source: US Bureau of Census, Current Population Survey, 2008 Table Package, Table HI05. Annual performance objectives for 2010-2014 were updated based on the most recent data.

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

Infoline provided MCH information and referral services including access to insurance, and conducted presentations and training to community based agencies and groups regarding 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.

DPH staff served on the legislative Medical Assistance Program Oversight Council (MAPOC). The Council has a legislative mandate to assess and make recommendations to DSS (the state's Medicaid agency) concerning access to and implementation of the HUSKY program.

DPH-funded SBHC sites provided the opportunity for increased collaboration between the schools and the SBHCs regarding HUSKY outreach and enrollment.

DPH staff collaborated with the Family to Family (F2F) Health Information Network to disseminate information regarding health finance resources, including public and private insurance. DPH provided training around medical home and health financing resources for newly hired F2F Health Information Specialists working for Parents Available to Help/CT Family Voices, who in turn provided health and resource related trainings for families of CYSHCN.

DPH staff and CMHI providers participated in the CT Voices for Children Covering CT's Kids and Families (CCKF) initiative, a statewide coalition of organizations concerned with access to health care for children and their parents. Coalition activities included technical assistance and support to local outreach efforts; working to maintain and expand HUSKY enrollment and simplification of enrollment process; and supporting DSS to increase the retention of eligible HUSKY families.

A CT Voices for Children analysis of 2008-2009 enrollment data (conducted in May 2011) indicated four of every ten babies lost Medicaid (HUSKY) coverage when they turned one year old. Similar analysis indicated a large number experienced gaps in coverage at age 18. DPH staff and CMHI network coordinators provided education to potentially effected consumers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide outreach, screening and referral to sources of health insurance.		X		
2. Provide advocacy and liaison to assist families in obtaining health care coverage.		X		
3. Provide education regarding resources to consumers and community-based providers.				X
4. Support the state's information and referral services as a point of access for insurance coverage.			X	

5. Provide follow-up and assistance with insurance application process.		X		
6. Develop capacity with local organization as resources for outreach and enrollment.				X
7. Provide education regarding resources to consumers and community-based providers.				X
8.				
9.				
10.				

b. Current Activities
Healthy Start, Family Planning, CHC, HCWC, Case Management for Pregnant Women and Teens, CMHI care coordinators and WIC staff screen families for insurance, and provide support, information and linkages to health care insurance coverage for children.

Infoline serves as the state's single-point-of-entry, toll-free (24 hours/day, 7 days/week) information and referral service for health care coverage. Infoline has a HUSKY line to provide information about the HUSKY program. Both Infoline and the DSS websites include information about the HUSKY program.

The DSS Administrative Services Organization (ASO) structure is now in effect for all HUSKY participants and includes a Person Centered Medical Home program. DPH collaborates with DSS and the ASO (Community Health Network) to facilitate access to plans under HUSKY.

Care coordinators located in CYSHCN medical homes provide families with information about insurance for their children. Care coordinators assist families with insurance/HUSKY applications.

CT Lifespan Respite Coalition, the CMHI contractor for Respite and Extended Services, provides information to families about insurance for their children.

c. Plan for the Coming Year
Infoline will provide MCH information and referral services including access to insurance, and conduct presentations and training to community based agencies and groups regarding the HUSKY program.

Case Management for Pregnant Women and Teens Program will provide services in the city of Waterbury to women who do not qualify for other programs and will provide consumers with appropriate assistance in accessing the state's Medicaid program. Other programs such as State Healthy Start and the Hartford and New Haven federally funded Healthy Start programs will assist with access to health insurance for children.

DPH will collaborate with Connecticut's F2F Information Grantee, Parents Available to Help/CT Family Voices (PATH); and will support community outreach efforts and statewide forums sponsored by PATH.

DPH staff and CMHI providers will participate in the CT Voices for Children Covering CT's Kids and Families (CCKF) initiative.

DPH will work with DSS and other CCKF participants to develop information in a Frequently Asked Questions format regarding actions required to avoid gaps in coverage following the first and eighteenth birthdays.

Information will be disseminated through all MCH programs, including WIC, Healthy Start, and the Home Visiting Program.

Strategies will be implemented to outreach to families with children who are close to one year old as well as to consumers who are 17 (and approaching 18 years old) -- age cohorts in the state most at risk for experiencing a lapse in HUSKY coverage. Additional outreach to the Birth to Three (early intervention) system will be made through the Early Hearing Detection and Intervention program, who will provide communication to Birth to Three providers concerning the potential lapse and the necessity for families to provide information for redetermination prior to a child's first birthday (the child of a mother who is a HUSKY participant automatically qualifies for HUSKY until their first birthday). Communication will also be made through the state's Head Start State Collaboration Office to reach Early Head Start Programs.

The topic of a potential lapse in coverage for adolescents at their eighteenth birthday (additional redetermination information is required on or before the eighteenth birthday to ensure continuation of coverage) will be the topic of a statewide SBHC Technical Assistance meeting and information regarding the need for consumers to provide the additional information in a timely manner will be distributed through the SBHC system.

DPH and Medical Home Advisory Council partners will outreach to major private insurers to develop strategies to provide families information regarding access to private plans; and will disseminate eligibility and premium information to consumers.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	9.2	32.1	32	31.9	30.6
Annual Indicator	32.2	31.0	31.4	30.7	31.2
Numerator	7521	7944	8928	8719	8671
Denominator	23356	25623	28432	28401	27793
Data Source		CDC's Pediatric Nutrition Surveillance System	CDC's Pediatric Nutrition Surveillance System	CDC's Pediatric Nutrition Surveillance System	CDC's Pediatric Nutrition Surveillance System
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

	2012	2013	2014	2015	2016
Annual Performance Objective	31	30.8	30.6	30.4	30.2

Notes - 2011
Source: Centers for Disease Control & Prevention (CDC), 2011 Pediatric Nutrition Surveillance (PedNSS); Connecticut, Calendar Year 2011 data, Table 2C, run date March 25, 2011. (Note: PedNSS data in Connecticut come exclusively from WIC.)
Annual performance objectives for 2012-2016 were updated using the most recent data.

Notes - 2010
Source: Centers for Disease Control & Prevention (CDC), 2010 Pediatric Nutrition Surveillance (PedNSS); Connecticut, Calendar Year 2010 data, Table 2C, run date March 25, 2011. (Note: PedNSS data in Connecticut come exclusively from WIC.)
Annual performance objectives for 2011-2015 were updated using these more recent data.

Notes - 2009
Source: Centers for Disease Control & Prevention (CDC), 2009 Pediatric Nutrition Surveillance (PedNSS); Connecticut, Calendar Year 2009 data, Table 2C, run date March 23, 2010: 15.4% of 2-to-5-year old children enrolled in the Connecticut WIC Program in Calendar Year 2009 had a BMI = 85th and < 95th percentile, and 16.0% had a BMI = 95th percentile, for a combined prevalence of overweight of 31.4% (BMI at or above the 85th percentile).

a. Last Year's Accomplishments
This measure was not met. With the new WHO growth charts, nutrition education guidance and lesson plans, and implementation of the upcoming new BMI/obesity objective, we anticipate slow improvement in obesity rates over time.
The local WIC programs in CT continued to use the automated BMI calculation feature in the (SWIS) as a tool for assessing growth, and for teaching parents and care providers about their children's growth patterns. Local WIC nutrition staff continued to provide individual nutrition counseling and group education to participants.

During 2011, WIC VENA implementation continued in quality nutrition assessment, participant focused education, standardized nutrition documentation and procurement of standardized educational materials. Educational guidance and materials on promoting fruits and vegetables and age appropriate physical activity and play for children via individual education or group classes for use by all local WIC agencies were developed and/or procured. These resources were presented to all local WIC nutritionists and coordinators at the September 2011 statewide WIC meeting.

The New York State WIC Office presented their Fit WIC Program to the local WIC agencies in December 2010. This educational program provides information, teaching tools and resources on nutrition and physical activity for children. A presentation on the new Dietary Guidelines was also provided to the local agencies in June 2011.

The Physician's Outreach Initiative (POI), continued in FY 2011. Health Care Provider Newsletters were revised to reflect current information and posted on the CT WIC Website. The POI's purpose is to update health care providers about the WIC Program and the rationale/benefits of the new WIC food packages, inform them of WIC Program requirements, coordinate referrals and networking, and collaborate with them on providing consistent messages with the purpose of best serving our mutual clients.

The CT State WIC Office continued to collaborate with the SNAP-Ed Program in an initiative providing "Loving Your Family, Feeding Their Future" group education classes/educational displays at local WIC agencies. A follow-up presentation by SNAP-Ed in fiscal year 2011 was postponed until FY2012 due to other SNAP Ed priorities. The SNAP-Ed Program also provided

the local WIC agencies with large supplies of low-cost recipe cards to distribute to WIC participants. These recipes were adapted to include CT WIC-approved foods and designed to promote consumption of fruits and vegetables.

Preliminary planning was started toward implementing a new BMI/obesity outcome objective for 2-5 year olds that all local WIC agencies will be required to include in their local agency plans.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Automate WIC database to generate BMI.				X
2. Develop/implement new BMI/Obesity Objective.				X
3. Training of WIC providers in using BMI.				X
4. Collaboration with WIC local agency ReNEW 2.0 (formerly VENA) committee.				X
5. WIC Physician's Outreach Initiative.				X
6. Collaboration with SNAP –Ed program.				X
7. Promote the positive changes in new WIC food packages.				X
8. Develop/provide WIC educational resources promoting fruits/veg and low fat milk.				X
9. Develop/provide WIC educational resources promoting physical activity/play in young children.				X
10.				

b. Current Activities

The VENA committee continued work on quality nutrition assessment, participant focused education, standardized nutrition documentation and materials procurement. A Nutrition Education Lesson Plans workshop was provided to local WIC staff in March 2012. Two lesson plans promote fruits/vegetables and physical activity/play for children. The State WIC Office and SNAP-Ed Program Initiative "Loving Your Family, Feeding Their Future continues. Due to decreased SNAP Ed funding, the frequency of classes/displays at local WIC agencies was decreased, with more emphasis placed on displays. The State WIC Office provided local agencies with MyPlate SNAP Ed recipes. SNAP Ed staff developed and provided Spanish recipes to local staff with input from the Local WIC Agency Spanish Resource Team.

Local agency WIC staff were trained and policies updated on the revised WIC nutrition risk criteria, which require use of the WHO growth standards for infants and children ages 0-24 months, and on new terminology for childhood overweight and obesity. The Physician's Outreach Initiative continues, with plans to share WIC's use of the new WHO growth charts/revised child overweight/obese terminology with CT AAP. The new State WIC BMI/obesity outcome objective will be finalized. Training will be provided to local agencies for incorporation into their 2013 local agency plans.

Connections between breastfeeding promotion/support and obesity prevention are in place. See NPM #11 for more information.

c. Plan for the Coming Year

With VENA policies, procedures, training and implementation in place but with a desire by state and local WIC staff to continue joint efforts on providing quality nutrition and customer service, the committee was renamed ReNEW 2.0, with the purpose of expanding on the VENA theme and to pick up on some of the work done in a previous grant (Project ReNEW) emphasizing quality

nutrition education and quality assurance in nutrition services. The committee will continue work on quality nutrition assessment, participant-focused education, standardized nutrition documentation, and procurement of standardized educational materials. Nutrition education guidance for each category served and for specific topics based on priority will continue to be developed. In addition, developing marketing messages to promote the benefits of nutrition education in the WIC Program, clarifying policies and revising various State WIC Plan components are also projects that are/will be worked on as well.

Monitoring local agencies for appropriate use and consistent implementation of the WHO growth standards and related WIC childhood anthropometric risk criteria is planned through Sept 2013. When indicated, technical assistance will be provided to local WIC agencies.

Dependent on funding, continued collaboration is anticipated with the SNAP-Ed program on providing "Loving Your Family, Feeding Their Future" group education classes and/or displays at local WIC agencies.

Newly developed nutrition education guidance documents will be incorporated into the State WIC Plan.

Implementation of the CT State WIC new BMI/obesity nutrition outcome objective in children 2-5 years of age will occur. All local WIC agencies will have to include this objective in their 2013 local agency plans.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	0.2	0.2	0.1	0.1	0.1
Annual Indicator	0.2	0.2	0.1	0.1	0.1
Numerator	79	65	54	42	42
Denominator	40969	39854	38362	37028	37028
Data Source		DPH Vital Statistics	DPH Vital Statistics	DPH Vital Statistics	DPH Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	0.1	0.1	0.1	0.1	0.1

Notes - 2011
Source: CY 2010 data are provisional. CY 2011 data are not available.
CT DPH, Vital Statistics. Percent is based on the removal of data where prenatal care and tobacco use in the third trimester was unknown. It has been noted that this figure is very low; however, this information is self-reported by the mother on the birth certificate.

Notes - 2010
Source: CY 2010 data are provisional.
CY2009 final data, CT DPH, Vital Statistics. Similar to 2006 and 2007 calculations, percent is based on the removal of data where prenatal care and tobacco use in the third trimester was unknown. It has been noted that this figure is very low; however, this information is self-reported by the mother on the birth certificate.

Notes - 2009
Source: CY2009 final data as of Sept 2011, CT DPH, Vital Statistics. Similar to 2005, 2006 and 2007 calculations, percent is based on the removal of data where prenatal care and tobacco use in the third trimester was unknown. It has been noted that this figure is very low, however, this information is self-reported by the mother on the birth certificate.

Note: The 2005 column was based on the removal of data where prenatal care and tobacco use in the third trimester was unknown. The calculations reported a numerator of 89 and a denominator of 41,086 resulting in an annual indicator of 0.2%. This column is locked and so these updates are not possible to this form.

a. Last Year's Accomplishments
This measure was met. The CT Quitline registered 4,552 callers for Quitline services that included counseling and nicotine replacement therapy, as appropriate. The Quitline offers counseling services and nicotine replacement therapy products of patches, gum or lozenges to CT residents that sign up for the program and when medically appropriate. Medicaid participants and the uninsured are able to receive up to eight weeks of products.

Quitline materials continued to be distributed through health care providers, community health centers, state and local libraries, and other community programs. Health care providers are encouraged to use a fax referral system that is in place to refer their patients to the Quitline for services.

During this period, stimulus funding was used to establish a specialized counseling program for pregnant women, that includes additional calls and support after the baby is born to try to lower the rate of recidivism in postpartum women.

The Tobacco Control Program also continued to provide funding to community agencies for tobacco use cessation programs that offer face-to-face cessation counseling and pharmacotherapies, with a variety of programs being offered.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide cessation counseling and referral through the CT Quitline.	X			
2. Educate health care professionals and providers in cessation intervention and treatment.				X
3. Educate public about the effects of tobacco use and secondhand smoke.			X	
4. Screen and refer women to smoking cessation programs.		X		
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities
The DPH Tobacco Use Prevention and Control Program provides ongoing training and technical assistance for community providers as well as funding tobacco use prevention and cessation programs. An independent evaluation is underway that continues to collect data and results to determine the effectiveness and cost efficiency of each DPH-funded program. The results will be used for our ongoing planning efforts and to make any programming changes.

Program staff is working with the Department of Social Services to implement an incentives program that will encourage Medicaid clients to participate in tobacco use cessation counseling, including accessing Quitline services. In addition, cessation counseling is now covered for CT Medicaid clients beginning January 1, 2012.

c. Plan for the Coming Year
The Tobacco Use Prevention and Control Program will continue to work to establish successful tobacco use cessation and prevention programs statewide, to conduct media campaigns that encourage Connecticut residents to reduce their exposure and use of tobacco products, and to encourage all clinic and health care provider locations to screen and refer patients for cessation services. The availability of telephone, online, and face-to-face programs will provide any Connecticut resident who wishes to quit using tobacco with the opportunity to have the necessary support for their quit. Programs will be funded at least through December of 2012.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	3.8	6.4	6.3	5.5	5.5
Annual Indicator	5.2	5.6	5.9	5.2	5.2
Numerator	13	14	15	13	13
Denominator	249493	250373	253362	251523	251523
Data Source		DPH Vital Statistics	DPH Vital Statistics	DPH Vital Statistics	DPH Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	5.2	5.2	5.1	5.1	5

Notes - 2011

Source: CY 2010 data are provisional. CY 2011 data are not available. CT Dept. of Public Health, HISR, Vital Statistics. The annual indicator is a rolling average of 2008, 2009, and 2010 numerator (14, 15, 9) and denominator (250373, 253362, 250834) CY numbers.

Notes - 2010
Source: CY 2010 data are provisional. CT Dept. of Public Health, HISR, CY 2008 final Vital Statistics. The annual indicator is a rolling average of 2008, 2009, and 2010 numerator (14, 15, 9) and denominator (250373, 253362, 250834) CY numbers.

Notes - 2009
Source: Final CY2009 data as of Sept 2011, CT Dept of Public Health, Vital Statistics.
The annual indicator is a rolling average of 2007, 2008, and 2009 numerator (13, 14, 14) and denominator (250994, 250053, 250053) original numbers.
Annual Performance Objectives for 2010-2014 have been updated based on the most recent data.

a. Last Year's Accomplishments
This measure was met. Community Health Centers (CHC) provided mental health services through assessment, direct care, and referrals. Services were ensured through direct provision via onsite clinicians such as social workers, psychiatrists and psychologists and through referrals to community agencies such as local hospitals, child guidance centers and mental health centers. CHCs work in collaboration with child guidance centers across CT. A number of CT's child guidance centers are actually operated by CHCs.

School Based Health Centers offered anticipatory guidance, age appropriate mental health risk assessments, crisis intervention, individual, family, group counseling, referral and follow-up for specialty care and health promotion/education activities that directly/indirectly address suicide prevention.

Healthy Choices for Women and Children provided comprehensive assessment of consumers, including the need for mental health services. (Healthy Choices for Women and Children is designed to address the multiple health and social needs of pregnant and postpartum women and their families who use or are at risk of using substances; and reside in the City of Waterbury). This program identified and referred clients who are at risk for suicide to appropriate resources.

A suicide/crisis information and referral line was maintained through 211 Infoline; a consultative perinatal depression hotline for healthcare professionals was also maintained.

The DPH Injury Prevention Program provided guidance related to suicide prevention information, data and resources to other DPH programs.

DPH staff participated in the Women's Health Subcommittee of the CT Medicaid Medical Assistance Program Oversight Council (MAPOC). The Subcommittee's focus was on issues related to perinatal depression.

The Case Management for Pregnant Women and Teens Program screened consumers for perinatal depression. This program provides services in the cities of Hartford, New Haven and Waterbury. Perinatal depression screening occurs in the state Healthy Start programs and the Hartford Healthy Start program (the programs provide case management services for pregnant women at or below 185% of the FPL).

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Provide suicide prevention training to students.				X
2. Provide suicide prevention training to providers and other adults.				X
3. Provide technical assistance and guidance for MCH programs.				X
4. Provide anticipatory guidance and risk assessments in Title V funded programs, especially SBHCs.		X		
5. Provide mental health services through assessment, direct care and/or referrals in SBHCs, CHCs and other MCH programs.	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DPH staff participate on the legislatively mandated CT Suicide Advisory Board (the charge of the board is to increase public awareness of the existence of youth suicide, to promote means of prevention and to make recommendations to the Commissioner of the Department of Children and Families regarding the prevention of youth suicide). The board recently launched a statewide campaign to increase public awareness of suicide and suicide prevention through distribution of their 1 Word, 1 Voice, 1 Life campaign -- designed to address suicide prevention among youth. Strategies are being developed to disseminate campaign materials through MCH and other public health programs. www.preventsuicidect.org

Other activities include maximizing available resources through networking with other members of the board and participating in the strategic planning process to update the 2005 CT Suicide Prevention Plan. The 2005 plan is available at http://www.ct.gov/dph/lib/dph/Suicide_Prevention_Plan.pdf

SBHCs offer anticipatory guidance, age appropriate mental health risk assessments, crisis intervention, individual, family, group counseling, referral and follow-up for specialty care and health promotion/education activities that directly/indirectly address suicide prevention. Community Health Centers provide mental health services through screening, assessment, primary care, and referrals.

c. Plan for the Coming Year

DPH will promote the early identification and intervention for treatment of depression and other mood disorders to provide clients with necessary supports and services to avert suicide.

Perinatal depression screening efforts will include: the Case Management for Pregnant Women program in the City of Waterbury for at risk Black and Hispanic, low income pregnant teens that will screen all women for perinatal depression on enrollment and at regular intervals throughout the perinatal period; Maternal, Infant and Early Childhood Programs (Home Visiting) in New Britain, Windham, New London and Ansonia/Derby for pregnant women in at-risk communities will screen for depression on enrollment and at regular intervals throughout the perinatal period; the state Healthy Start Program, under a newly revised DPH contract, will include perinatal depression screening for all women on referral to Healthy Start; the federal Hartford Health Start Program will screen enrollees. Women who screen positive will be referred to their primary care provider for services. Case managers and home visitors will conduct follow-up to ensure referral completion and access to supports. DPH will build on initial steps taken in discussion with Planned Parenthood of Southern New England to implement perinatal depression screening.

Healthy Choices for Women and Children will provide comprehensive assessment of consumers,

including the need for mental health services.

SBHCs will offer anticipatory guidance, age appropriate mental health risk assessments, crisis intervention, individual, family, group counseling, referral and follow-up for specialty care and health promotion/education activities that directly/indirectly address suicide prevention.

CHCs and SBHCs will provide mental health services through assessment, direct care, and/or referrals. SBHCs will provide mental health screening and appropriate referrals at the time of all physical examinations.

DPH staff will serve on the CT Suicide Advisory Board. A plan will be developed and implemented to disseminate suicide public awareness and education campaign materials through MCH funded and other public health programs including the Community Health Centers, School Based Health Centers, the CT Medical Home Initiative for Children and Youth with Special Health Care Needs, Healthy Start, and other programs. Additional avenues for dissemination will include community partners including FAVOR (Family Advocacy Organization for Behavioral Health), the Family Support Network, and Parents Available to Help/CT Family Voices.

DPH staff will participate in the Women's Health Subcommittee of the CT Medicaid Medical Assistance Program Oversight Council (MAPOC).

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	87.4	87.5	87.6	86.5	86.6
Annual Indicator	84.9	86.6	85.6	86.3	86.3
Numerator	541	529	475	485	485
Denominator	637	611	555	562	562
Data Source		DPH Vital Statistics	DPH Vital Statistics	DPH Vital Statistics	DPH Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	86.7	86.8	86.9	87	87.1

Notes - 2011
Source: CY 2011 data are not available.
CY2010 data are provisional, CT DPH, Vital Statistics. Eleven of CT's acute care hospitals with self-declared NICU's were included in this survey.

Notes - 2010

Source: CY2010 data are provisional, CT DPH, Vital Statistics. Eleven of CT's acute care hospitals with self-declared NICU's were included in this survey.
Annual performance objectives for 2011-2015 have been updated based on the most recent data.

Notes - 2009
Source: Final CY2009 data as of Sept 2011, CT DPH, Vital Statistics. Eleven of CT's acute care hospitals with self-declared NICU's were included in this survey.
Annual performance objectives for 2011-2015 have been updated based on the most recent data.

a. Last Year's Accomplishments
This objective was not met. CT has 30 birthing hospitals statewide and one birthing center located in Danbury, CT, contiguous to the New York State border. There are 11 "self-defined" Level III Neonatal Intensive Care Units in CT.

The State Perinatal Health Advisory Committee, which is now part of the MCH Advisory Committee, met quarterly as scheduled. One plan recommendation identifies the need to reduce pregnancy and birth related risk factors by facilitating maternal transfers to tertiary perinatal/neonatal centers for high-risk antepartum, intrapartum and postpartum care.

The Title V-funded programs, including State Healthy Start, Case Management for Pregnant Women, and Family Planning provided outreach, screening, assessment and referral for women at risk for having a poor birth outcome. Women enrolled in the case management programs received screening, assessments and referrals for services such as WIC, family planning, mental health care, healthcare access, education and support in an attempt to promote better maternal and child health birth outcomes.

A Strategic Plan within the FHS was developed May 2008, and later updated in February 2009. The plan addresses low birth weight and its disparities. The following activities have been completed: 1) two community-based health care centers were funded to initiate the CenteringPregnancy model of group prenatal care; 2) a statewide infant mortality campaign was expanded to incorporate life course theory; 3) dissemination of a brochure about fish consumption during pregnancy was broadened; 4) recommendations of an agency-wide workgroup to address disparities in low birth weight within Hartford; 5) DPH applied and received funding to build a Healthy Start community within Hartford; 6) DPH developed an MOA to share low birth weight records with the state's Birth-to-Three program; 7) the FHS included life course theory in its MCHBG state priorities, and 8) using a TA grant with HRSA funding, the FHS conducted a statewide symposium to address disparities in the CT's perinatal system of care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide outreach, identification and referral of high-risk pregnant teens.		X		
2. Provide intensive case management and supports to promote positive pregnancy outcomes.		X		
3. Provide culturally competent and linguistically appropriate care to high-risk populations.	X			
4. Collaborate with tertiary care centers that provide specialized delivery and neonatal care.				X
5. Collaborate with the members of the State Perinatal Health Advisory Committee to implement the plans goals and objectives.				X
6.				

7.				
8.				
9.				
10.				

b. Current Activities
The MCH Advisory Committee meets quarterly. The MCH Advisory Committee is the vehicle for discussing and implementing the recommendations from the State Perinatal Plan, and specifically reviewing the activities and resources needed to better address this NPM.

Recommendations identified in the recently developed Strategic Plan for Addressing Low Birth Weight in CT, include the need to coordinate with medical providers to ensure that high-risk pregnancies deliver in tertiary care hospitals.

c. Plan for the Coming Year
DPH entered into a new MOU with DSS to provide administration and oversight of the State's Healthy Start Program. Pregnant women referred will continue to be screened on referral using the REID screen for eligibility into a home visiting program; and all eligible women will get expedited referral and enrollment into HUSKY A to promote early access to prenatal care in an effort to promote the health of the mother and infant

The MCH Advisory Committee will continue to meet and identify resources to develop and implement strategies to address this objective.

A more in-depth epidemiological review of the birth data will be conducted to better assess where (which facilities) the VLBW are occurring, and look for any trends or other indicators that might better explain this gradual decrease.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	87	87.3	87.6	88.5	88.9
Annual Indicator	86.5	87.6	88.1	87.5	87.5
Numerator	35424	34898	33792	32401	32401
Denominator	40969	39845	38362	37028	37028
Data Source		DPH Vital Statistics	DPH Vital Statistics	DPH Vital Statistics	DPH Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**

Annual Performance Objective	87.7	88	88.3	88.6	88.9

Notes - 2011
Source: CY2011 data are not available. CY2010 data are provisional, CT DPH Vital Statistics.
Annual performance objectives for 2012-2016 have been updated based on the most recent data.

Notes - 2010
Source: CY2010 data are provisional, CT DPH Vital Statistics.
Annual performance objectives for 2011-2015 have been updated based on the most recent data.

Notes - 2009
Source: Final CY2009 data as of Sept 2011, CT DPH Vital Statistics.
Annual performance objectives for 2010-2014 have been updated based on the most recent data.

a. Last Year's Accomplishments
The objective was not met. In 2010, 88.1% of women received early prenatal care, not exceeding the objective of 88.5%. State Healthy Start, Hartford Healthy Start, Family Planning, HCWC, Case Management for Pregnant Women, WIC, CHC, and SBHC, encourage pregnant women to obtain early and continuous prenatal care.

Recommendations from the LBW Strategic Plan were initiated, and included: 1) facilitating case management services pregnant women; 2) coordinating with medical providers to ensure evidence-based treatment for pregnancies at risk of preterm-birth; 3) advertising the use of Infoline 2-1-1 to assure referrals for early and regular prenatal care; 4) documenting that all DPH-funded initiatives address language, culture, diversity and health literacy; and 5) continuing to provide TA to the Hartford Health Department in support of their federally-funded Healthy Start Program.

DPH received Maternal, Infant and Early Childhood Home Visiting grant funding and conducted a statewide MCH Needs Assessment that identified towns with greatest need for MCH services. DPH utilized the needs assessment for program planning to target case management and home visiting programs to serve pregnant women in those at risk communities. The home visiting programs conduct education and outreach and strive to enroll women in the first trimester of pregnancy. Eligible pregnant women are referred to HUSKY with expedited eligibility and linked to a healthcare provider and receive other services, referrals and follow-up.

DPH case management programs provide case management services to women at risk for poor birth outcomes and conduct outreach to enroll women in the first trimester of pregnancy.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide outreach and case management to identify and enroll clients in early prenatal care.		X		
2. Provide culturally and linguistically appropriate services to decrease barriers to prenatal care services.	X			
3. Provide outreach to targeted populations (i.e. pregnant substance users).		X		
4. Provide support, information and advocacy to pregnant teens.		X		
5. Promote early enrollment into prenatal care as a linkage from programs such as WIC.		X		
6. Provide/promote comprehensive services to encourage women of reproductive age to enter prenatal care early.		X		

7. Continue to analyze and disseminate PRATS Survey data.			X	X
8.				
9.				
10.				

b. Current Activities

Title V-funding helps support programs such as the State Healthy Start, Family Planning, Case Management Program for Pregnant Women and Parenting Teen, and SBHC that provide outreach and identification of pregnant women to promote early entry into prenatal care. HCWC (state funded) provides outreach and case management for pregnant women at risk for substance abuse and promote early entry into prenatal care. Other programs such as Community Health Centers and WIC, promote early entry into prenatal care. Hartford Healthy Start is also performing active outreach in Hartford to women in early pregnancy. The State Healthy Start program refers pregnant women to a home visiting program in their community, assists with applying to HUSKY and identifying a primary care provider, which promotes early access to healthcare.

c. Plan for the Coming Year

Title V-funding will continue to support programs such as the State Healthy Start, Family Planning, Case Management Program for Pregnant Women and Parenting Teens, and SBHC that provide outreach and identification of pregnant women to promote early entry into prenatal care. Other programs such as Community Health Centers and WIC will continue to promote early entry into prenatal care. Hartford Healthy Start will also perform active outreach in Hartford to women in early pregnancy.

The four CT Maternal, Infant and Early Childhood Home Visiting Program(s) will also support early entry into prenatal care. DPH plans to expand the home visiting programs to an additional 14 high-risk towns.

DPH will provide Title V funding to the Department of Mental Health and Addiction Services (DMHAS) to provide intensive case management and education to women with Access 1 mental health diagnoses. Case management, parenting education and home visiting services will facilitate improved access to prenatal care in the first trimester.

D. State Performance Measures

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					3
Annual Indicator				2	5
Numerator				2	5
Denominator				7	7
Data Source				HIP-Kids	EPHT Portal
Is the Data Provisional or Final?					Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	6	7	7	7	7

Notes - 2011
The number of databases that have migrated to the MAVEN application; and their integration through simple data sharing exports/imports of information between databases using the EPHT Portal.

Notes - 2010
FFY 2012 application is the first year of reporting on this new SPMs. The 2010 Annual performance objective is 2.

a. Last Year's Accomplishments
Progress on the HIP-Kids data warehouse continued with activities to migrate three databases to a new web-based application called MAVEN. The intent to create linkages of high-quality child health information continued to be a focus for the Family Health Section during 2011. However, a major shift in the Information Technology (IT) infrastructure to use the web-based application MAVEN to house the individual core datasets resulted in major changes to the plan for when and how to link the seven core datasets. The plans shifted from completing the linkages between datasets and housing them in a data warehouse (previously called HIP-Kids) to a plan of migrating each of the core datasets to the MAVEN application separately and then identify how to link the datasets once each was in a MAVEN instance. An additional change was to replace the death record database with the Childhood Lead Surveillance System as one of the core datasets as the death record registry is in the process of a major database system change while the Childhood Lead Surveillance System has already migrated to a MAVEN instance.

The Newborn Screening System (NBS) and the CT Immunization Registry and Tracking System (CIRTS) completed various implementation phases with the goal of a MAVEN production system for each database by the end of 2011. The Childhood Lead Surveillance System (LSS) had already completed all phases needed for a MAVEN production version of the LSS that was functional as of July 2010. The Childhood Lead Poisoning Prevention Program staff completed further efforts to offer access to the LSS to local health departments. The system security was reconfigured to allow DPH sharing the system with local health departments in a confidential and safe manner. The LSS is being used by 24 Local Health Departments/Districts.

Most of last year's activities for the NBS migration were related to the Newborn Screening Lab Tracking (NBST) component since the Early Hearing and Birth Defects components had completed most of the needed steps for a production version of the MAVEN application. By mid-June 2011, NBS team staff had planned trainings for hospital users with a proposed MAVEN production date of September 1, 2011. During July and August NBS Team staff conducted user acceptance testing (UAT) of the staging environment and documented identified errors and solutions to the system through multiple rounds of UAT. In August, the NBS team, DPH Information Technology (DPH IT) staff, consultant developers for the state lab's Laboratory Information System (LIMS), and Consilience Software met to discuss roll out of the MAVEN: NBS since it had become obvious from UAT results that the production date would need to be after September 1, 2011. Additional UAT was identified as a critical need before a production version could be released.

On 9/20/2012, the DPH Newborn Screening System (NBS) staff finalized the training schedule for birthing hospitals. Training for the new NBS was held at DPH during the first two weeks of October. During training, each hospital received a manual along with the electronic version that was placed on the DPH website.

The CIRTS completed all of the required phases for migration to the MAVEN application. User acceptance testing was started by DPH Immunization staff in the fall of 2011.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Complete the documentation of the business needs of the Genetic/Laboratory component of the NSS.				X
2. Move into production of the Newborn Screening System.				X
3. Continue to identify funding for the HIP-Kids project.				X
4. Identify future methods for data integration/linkage of the newly created child health database systems as MAVEN instances.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
MAVEN: NBS trainings for hospital users were conducted at DPH or at individual hospitals.

During October-December 2011, activities included the implementation of HL7 messaging between MAVEN: NBS and the LIMS; data migration from the legacy system; and implementation of an import of vital records birth data. Several updates were implemented each needing UAT. Planning took place to strategize for deployment of the production version of the system. A "mock" production was conducted during the last week of December 2011 that identified new issues. These issues were corrected and tested during the first two weeks of January 2012.

The MAVEN: NBS went into production on Thursday, Jan 19, 2012.

After the system was in production, 24-hour technical support was provided to the hospital users through the end of January. The NBS Team continued to work on various post-production activities including technical assistance to birth facilities. Most post-production issues were related to the complicated process of integrating the MAVEN: NBS with LIMS. Several enhancements were implemented. The NBS Team conducted another round of training for hospital users in April 2012 to educate them on these changes.

The CT Immunization Registry is nearly 95% complete in its migration to the MAVEN application. Legacy data from 1993- 2011 was migrated over to the new application and internal DPH users began entering "live" data during the week of April 30, 2012.

c. Plan for the Coming Year
There are a few known processes that are planned to be monitored in the coming year. The NBS Team in collaboration with DPH IT and the State Lab IT staff will continue to enhance and monitor HL7 messaging between MAVEN: NBS and the Laboratory Information Management System (LIMS) as this functionality can be impacted when upgrades are made to any part of the complex IT infrastructure existing between these two applications. The NBS Team and DPH IT will also assure the successful implementation of the Electronic Vital Records System (birth records) import process with continued monitoring of the correct matching of birth record information to MAVEN: NBS child case records. The NBS Team will also continue to monitor the creation of duplicate child case records and eliminate duplicates using a de-duplication process.

There are two known enhancements to the MAVEN: NBS that are being planned for the coming year. The first is the addition of a module, or in MAVEN application terminology, a question package for the Children and Youth with Special Health Care Needs being seen in the five

CYSHCN Medical Homes. These children are currently being tracked through a Microsoft Access database but will benefit from being added to the MAVEN: NBS as there is potential for integration and linkage of children across the life span if they are included the MAVEN: NBS. The second enhancement to the MAVEN: NBS that is planned is the addition of a question package to track newly legislated screening of newborns for Critical Congenital Heart Disease (CCHD). This screening is very similar to newborn hearing and birth defects screening in that birth facilities conduct the actual testing and DPH will track the results and conduct surveillance activities for infants who do not pass the screening test(s).

The ability to achieve the sharing and access to child health databases has been greatly enhanced by the success of the Environmental Public Health Tracking (EPHT) Network in establishing use of Microsoft(r) Business Intelligence technology (SharePoint, Presentation Point and SQL server) to support the EPHT Portal. The plan for the coming year is to work a consultant firm, Infusion Software, to move MAVEN application information into the EPHT to allow secure access to more detailed data to DPH users who have defined user roles and permissions. The plan is to begin with information from the MAVEN: NBS in the fall of 2012. This will be followed by other MAVEN application information depending on the stability and readiness of each database that has migrated to MAVEN.

State Performance Measure 2: *Percent of students that had a risk assessment with a mental health component conducted during a comprehensive, annual physical exam at a SBHC.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					60
Annual Indicator				58.5	65.1
Numerator				17158	18052
Denominator				29307	27742
Data Source				Survey of SBHCs in 2011	SBHC Year-end Reports
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	66	66	67	68	68

Notes - 2011
Source: An analysis of year end reports submitted from all SBHC contractors was conducted. All unduplicated medical or mental health visits with a mental health screening component were considered.

Notes - 2010
Source: A survey was sent to all SBHCs in CT to collect initial information about usage of risk assessments with a mental health component during annual physical exams. This was used as a baseline for 2010.

a. Last Year's Accomplishments
This measure was met. FHS staff developed and emailed a survey to all 19 School Based Health Center contractors to obtain baseline information regarding utilization of risk assessments with a mental health component. All 19 contractors responded. DPH followed up to clarify some responses. The survey showed that 63.2% of SBHC used risk assessments with a mental health component for pre-kindergarten through high school. Of those that used a risk assessment, 42% used the GAPS tool while others used a variety of other tools. Risk assessments were administered 57.9% of the time to students who came for an annual physical exam, 73.7% of the

time to student walk-ins with a self-identified mental health issue, and 73.7% of the time for students who were specifically referred to the clinic. DPH staff added questions regarding utilization of a risk assessment with a mental health component to the annual year-end report. Analysis of the reports indicated data was reported inconsistently across contractors and across individual clinical sites. The reports indicated 65.1 % of unduplicated medical and mental health visits included mental health screening.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Develop and administer an electronic reporting database to obtain data regarding utilization of a risk assessment tool with a mental health component.				X
2. Monitor use of current risk assessment tools with a mental health component during comprehensive, annual physical exams.				X
3. Survey SBHCs operating outside of the state program to assess mental health services available.				X
4. Provide technical assistance to SBHCs to assure best practices.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The electronic data reporting format in place at the SBHCs is being replaced with an Access database written specifically for the SBHC program. The new electronic data format will allow for comprehensive analysis and monitoring of mental health screening and follow up. Data will be available by individual clinical site and will be monitored throughout the year. As SBHC contracts are renewed, language is being incorporated requiring mental health and risk assessment screening with physical exams using standardized tools. The new data reporting format will be in place at all sites by the start of the 2012-2013 school year.

A student intern is conducting a survey of all SBHCs that are not state funded contractors to ascertain the scope of services available, including information on risk assessment and mental health screening. The survey will be completed in the Fall 2012.

c. Plan for the Coming Year

DPH will provide technical assistance and training to SBHC staff regarding the necessity of consistent reporting of mental health and risk assessment screening using the revised electronic format.

Risk assessment with a mental health component conducted during a comprehensive, annual physical exam will be the topic of a quarterly technical assistance meeting for SBHC clinical staff. Additional assistance will be provided during the time of site visits.

DPH will collaborate with the CT Association of School Based Health Centers to promote collaboration and discussion that will help better define best practices for conducting risk assessments with a mental health component in the SBHC setting.

DPH will collaborate with SBHC staff to ensure that mental health staff is available at SBHC clinics and to troubleshoot issues that may arise.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					31
Annual Indicator				29.2	29.2
Numerator				447	447
Denominator				1533	1533
Data Source				Dept Social Services	Dept Social Services
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	33	33	35	35	35

Notes - 2011
Source: Data will not be available until a later date due to system delays with the data source, Department of Social Services.

Notes - 2010
New state performance measure for FFY 2012.
Source: Department of Social Services 2010 data sets combined of child health providers enrolled in Medicaid/SCHIP/HUSKY A and HUSKY B,eligible to bill dental codes on children 23 months and younger. Dental providers enrolled in Medicaid/SCHIP/HUSKY A and HUSKY B billing preventive dental codes on children 23 months and younger. Medicaid/SCHIP billing codes for caries risk assessments,oral health education and fluoride varnish applications.

a. Last Year's Accomplishments
A Medical Dental Partners conference brought medical and dental professionals together in a workshop entitled "Infant and Toddler Oral Health: Building Effective Networks between the Dental and Medical Professions." Medical and dental providers worked together in a "hands on" portion of the workshop, applying fluoride varnish to children under age three who volunteered from the WIC programs. Anticipatory guidance and oral health education was delivered to the children's parents. Of the 935 child health professionals trained in fluoride application, 262 have received full billing credentials. Fluoride varnish start-up kits, including mirrors, toothbrushes for both child and parent, educational materials for distribution to parents, puppets and anticipatory guidance resources were shared with 935 medical providers, through funds to the CT DPH from the Samuel Harris Fund for Children's Dental Health Grants Program of the American Dental Association Foundation for 2010-2011.
Fluoride varnish Application for Pediatric Medical Providers: Home by One course on CT TRAIN launched as a video on demand webinar which meets the criteria for training requirements of the DSS ABC dental program, allowing medical providers to train and credential to bill for preventive dental codes during a well-child visit.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**

	DHC	ES	PBS	IB
1. Continue to educate dental and medical professionals in providing dental caries risk assessments, oral health education and appropriate risk-based preventive strategies to children by age one.				X
2. Continue to identify funding for the Home by One Program.				X
3. Expand the number of dental practices and clinics providing dental homes for children beginning at age one.	X			
4. Expand the non-dental workforce competent in preventive dental strategies.	X			
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Though HRSA funding ended for this program and the program coordinator left state service, the Home by One Program continues. A no cost extension was awarded which will be utilized to continue to promote the activities of the program. Dental and medical providers continue to train in proficiency of assessing the dental caries of children by age one utilizing an on-line training tool. DPH staff continues to educate the public on the importance of utilizing early preventive dental services in order to reduce the burden of oral disease in CT's children. The Home by One Program will have an evaluation report completed on the first four years of the Program funded through a 4-yr HRSA targeted MCH Oral Health Services Systems grant 2007-2011.

c. Plan for the Coming Year

Funding opportunities will be sought to expand the Home by One Program to address the oral health of pregnant women in the WIC programs. Studies have found that many pregnant women do not access dental care for several reasons and this time in a women's life presents an opportunity to educate them on the importance of good oral health for themselves and their babies. Poor oral health in a mother can increase the likelihood of her child developing Early Childhood Caries, the disease that causes dental cavities, which is both progressive and destructive. Bacteria that cause dental cavities can be transmitted from the mother's mouth to her baby through day to day contact with her child. This condition can lead to a lifetime of decay and suffering for the child. In addition, some studies show that poor oral health during pregnancy may have a negative impact on birth outcomes. Education on the importance of good oral health during pregnancy will be provided and care coordination for dental care will be an additional component of this expansion. OB/GYN providers will receive training on the importance of oral health and their role in encouraging their patients to seek dental care. Dentists will also receive education in the safety of treating pregnant women, as many have reservations or fears to treating women while they are pregnant.

Dental providers and medical providers will continue to train in proficiency of assessing the dental caries of children by age one utilizing the on-line training tool. DPH staff will continue to educate the public on the importance of utilizing early preventive dental services in order to reduce the burden of oral disease in CT's children.

State Performance Measure 4: *Increase the redemption rate of fruit and vegetable checks issued to women and children enrolled in the Connecticut WIC program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					82
Annual Indicator				80.5	82.0
Numerator				43494	44535
Denominator				54045	54289
Data Source				CT WIC database (SWIS)	CT WIC database (SWIS)
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	83	83	83.5	84	84.5

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

Notes - 2010
Source: CT WIC Program, Statewide WIC Information System (SWIS).
Note: The exact wording of this SPM has been updated for FFY 2012 as described in the detail sheet. Data for this measure has only been collected since October 2010 and the percentage only reflects 5 months of data available as of June 13, 2011.

a. Last Year's Accomplishments
The new WIC Food packages were implemented in October 2009. Participant women and children aged 1 to 5 years are now issued cash-value checks which enable them to purchase fresh fruits and vegetables valued at $10 per month for women and $6 per month for each child. Local WIC agencies were trained on and provided with several nutrition education resources promoting fruits and vegetables. Farmers Markets now redeem WIC checks at their stands for purchase of fresh produce.

The Physician's Outreach Initiative (POI) continued in FY 2011. Health Care Provider Newsletters were revised to reflect current information and posted on the CT WIC Website. The POI's purpose is to update health care providers about the WIC Program and the rationale/benefits of the new WIC food packages, inform them of WIC Program requirements, coordinate referrals and networking, and collaborate with them on providing consistent messages with the ultimate purpose of best serving mutual clients.

Effective October 2010, Value Enhanced Nutrition Assessment (VENA), a national USDA initiative to improve nutrition services in the WIC Program, was implemented. Its guiding principle is to "strengthen and redirect WIC nutrition assessment from eligibility determination to individualizing nutrition education in order to maximize the impact of WIC nutrition services. CT WIC activities include collaboration with the VENA core committee with representation from all local agencies, revisions of policies and forms, and continuing education for local WIC staff. Local WIC nutrition staff continued to provide individual nutrition counseling and group education to participants. During FY 2011, WIC VENA implementation continued in quality nutrition assessment, participant focused education, standardized nutrition documentation and procurement of standardized educational materials. Educational guidance and materials on promoting fruits and vegetables for children via individual education or group classes for use by

all local WIC agencies were developed and/or procured. These resources were presented to all local WIC nutritionists and coordinators at the September 2011 statewide WIC meeting.

The New York State WIC Office presented their Fit WIC Program to the local WIC agencies in December 2010. This educational program provides information, teaching tools and resources on nutrition and physical activity for children. A presentation on the new Dietary Guidelines was also provided to the local agencies in June 2011.

The CT State WIC Office continued to collaborate with the SNAP-Ed Program in an initiative providing "Loving Your Family, Feeding Their Future" group education classes/educational displays at local WIC agencies. This collaboration began with the implementation of the new WIC Food Package in FFY2010, and fosters a comprehensive, statewide approach at the local agency level, where SNAP-Ed leads facilitated group discussions with participants to promote increased fruit and vegetable consumption. These discussions include a produce food demonstration with subsequent tasting opportunity. The fruit and vegeta¬ble message is expanded to a larger audience with interactive display boards in the WIC lobby areas. The SNAP-Ed program developed and disseminates fruit and vegetable recipe cards that highlight items in the WIC food package. These recipes were adapted to include CT WIC-approved foods and designed to promote consumption of fruits and vegetables. A follow-up presentation by SNAP-Ed in fiscal year 2011 was postponed until FY2012 due to other SNAP Ed priorities.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Promote fruit and vegetable consumption among WIC participants.				X
2. Continue the WIC Physician's Outreach Initiative.				X
3. SNAP Ed to pursue funding to continue its nutrition education activities in partnership with WIC.				X
4. Continue to work with the VENA committee on standardizing nutrition education materials and providing educational resources.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The VENA committee continued work on quality nutrition assessment, participant focused education, standardized nutrition documentation and materials procurement. A Nutrition Education Lesson Plans workshop was provided to local WIC staff in March 2012. One of the lesson plans promotes fruits/vegetables among children.

The State WIC Office and SNAP-Ed Program Initiative "Loving Your Family, Feeding Their Future continues. Due to decreased SNAP Ed funding, the frequency of classes/displays at local WIC agencies was decreased, with more emphasis placed on displays. The State WIC Office provided local agencies with MyPlate SNAP Ed recipes. SNAP Ed staff developed and provided Spanish recipes to local staff with input from the Local WIC Agency Spanish Resource Team.

The Physician's Outreach Initiative continues. In addition to a potential CT AAP teleconference on the new growth charts, plans to explore consistent nutrition education messaging to shared

clients are also being considered.

USDA is in the process of revising their MyPyramid guide for young children to reflect the new dietary guidelines MyPlate logos and recommendations. Once revised, these materials, which include promoting fruits and vegetables, will be incorporated into CT WIC nutrition educational resources, with training and guidance documents provided to local agencies to support their implementation of the new Dietary Guidelines.

c. Plan for the Coming Year

Key activities planned for FY 2013 include:
With VENA polices, procedures, training and implementation in place but with a desire by state and local WIC staff to continue joint efforts on providing quality nutrition and customer service, the committee was renamed ReNEW 2.0, with the purpose of expanding on the VENA theme and to pick up on some of the work done in a previous grant (Project ReNEW) emphasizing quality nutrition education and quality assurance in nutrition services. The committee will continue work on quality nutrition assessment, participant-focused education, standardized nutrition documentation, and procurement of standardized educational materials. Nutrition education guidance for each category served and for specific topics based on priority will continue to be developed. In addition, developing marketing messages to promote the benefits of nutrition education in the WIC Program, clarifying policies and revising various State WIC Plan components are also projects that are/will be worked on as well.

Dependent on funding, continued collaboration is anticipated with the SNAP-Ed program on providing "Loving Your Family, Feeding Their Future" group education classes and/or displays at local WIC agencies.

Newly developed nutrition education guidance documents, which include the promotion of fruits and vegetables among young children, will be incorporated into the State WIC Plan.

The Physician's Outreach Initiative will continue in FY2013 and will explore the development of consistent messages and resources for our mutual client bases, with promotion of fruits and vegetables under consideration as one of the potential topics.

State Performance Measure 5: *Percent of 0-3 year olds participating in the state Medicaid Program (HUSKY - Health Insurance for Uninsured Kids and Youth) who received a developmental screening within the last twelve months.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					29
Annual Indicator				26.2	26.9
Numerator				14462	18406
Denominator				55100	68370
Data Source				Medicaid Claims Data	Medicaid Claims Data
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	28	28	29	29	30

Notes - 2011

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

Notes - 2010
FFY 2012 is the first year for the new state SPMS.
Source: 2010 Medicaid Claims data obtained from the CT Department of Social Services. In 2009, Developmental screening became billabe at the same time as well child visits. This lead to an increase in uptake of screenings due to this change in payment structure.

a. Last Year's Accomplishments
In August 2011, CT was awarded the HRSA State Implementation Grant for Improving Services for Children and Youth with Autism Spectrum Disorders and other Developmental Disabilities (SIG ASD/DD) to improve access to comprehensive, coordinated health and related services. The three year federal grant is a collaborative project between DPH -- the state's Title V agency and A.J. Pappanikou Center -- the state's University Center for Excellence on Developmental Disabilities (UCEDD). Proposed outcomes of the project include: (1) implementation of the CT State Autism Plan, with activities that strengthen stakeholders awareness of early signs of ASD; knowledge about and access to evidenced-based, individualized and timely screening; diagnostic assessment and interventions implemented by a competent workforce; (2) engage ASD specific family support and training organizations to provide information and education on ASD; (3) work with the AAP, pediatric primary and family care providers, and the CT Medical Home Initiative for CYSHCN (CMHI) providers to expand practices proving family-centered, comprehensive coordinated health care and related services including screening, linkage to diagnosis, and transition to evidence-based interventions.

The 2009/2010 National Survey of CSHCN estimated that 7.8% of CT's CYSHCN population, or roughly 10,435 children ages 2-17 were diagnosed with Autism Spectrum Disorder (ASD). Early identification is recognized as an important component of meeting the needs of CYSHCN, including those with ASD, and therefore SIG/ASD/DD activities focused on the 0-3 population, provider and family education. Review of the DPH CYSHCN database confirmed that ASD was one of the most prevalent conditions among children who received CMHI services.

CMHI contractors provided services to 8,020 CYSHCN between July 1, 2010 and June 30, 2011; referral sources for CMHI included the Department of Social Services (DSS) and the Birth to Three System.

In April of 2010, CT stakeholders representing early intervention and early childhood providers were invited by CT's UCEDD to take part in the Region 1 ‘Act Early' Summit, held in Providence, RI. The outcome of this meeting included the creation of a Connecticut State Plan which focused on stakeholders' awareness of the early signs of ASD, improved knowledge of screening, diagnostic assessments and interventions. CT's Act Early team continues to meet periodically. Last year's work focused on three activities (1) create a roadmap for families with children who are newly diagnosed with ASD or DDs; (2) address disparities in terms of screening, identification and services; and (3) developing best practice diagnostic guidelines for ASD clinicians.

A statewide CMHI for CYSHCN Care Coordinators meeting in June 2011 focused on developing strategies to increase developmental screening. The meeting included training on the new state performance measures, an introduction to Results Based Accountability, and specific strategies to address State Performance Measure number 5 (Percent of 0-3 year olds participating in the state Medicaid Program-HUSKY-who received a developmental screening within the last 12 months).

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Partner with Child Health and Development Institute (CHDI) to identify strategies to support an increase in developmental screening.				X
2. An overview of CHDI's Educating Practices In the Community (EPIC) Developmental Screening training module will be shared with CMHI networks.				X
3. CMHI network will coordinate developmental disabilities screening trainings for two pediatric practices in each of five state regions.				X
4. DPH staff will increase awareness of the Centers for Disease Control and Prevention's (CDC) "Learn the Signs. Act Early" campaign.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In April 2012 DPH staff met with Dr. Thyde Dumont-Mathieu from the University of Connecticut to discuss opportunities for collaboration. Dr. Dumont-Mathieu discussed the Early Detection Study (EDS), a screening study for detecting Autism in pediatric practices at age 18-24 months using the Modified Checklist for Autism in Toddlers --Revised (M-CHAT- R). CMHI contractors are participating in the study.

SIG ASD/DD staff presented an overview of Learn the Signs. Act Early (LTSAE) materials to DPH Women, Infants and Children (WIC) program coordinators and daycare (centers and family day care) frontline staff in June 2012. The purpose of LTSAE materials is to improve early identification of ASD and other DD so that children and their families can get the supports and services they need. Both programs agreed to disseminate LTSAE materials to daycare providers, who will in turn, distribute materials to parents.

The CMHI Access database is undergoing enhancement to include fields specifically related to developmental screening. Fields will include whether the child has received a developmental screening, screening results, confirmation of screening results and referrals made. This mandatory data entry will require gathering information from parents on developmental screening of all CYSHCN under the age of four who are currently being served by CMHI contractors. The enhanced fields will be fully implemented and in use by all CMHI sites by the end of July 2012.

c. Plan for the Coming Year

DPH will partner with Child Health and Development Institute (CHDI) to create two Educating Practices In the Community (EPIC) training modules that build upon the American Academy of Pediatrics (AAP) recommendation of formal screening at 9, 18 and 24 (30) months of age. One training module will focus on the follow-up questions to the M-CHAT. The second module will describe the maintenance of certification credit available through the American Board of Pediatrics (ABP) for pediatricians participating in an ASD screening practice based quality improvement activity.

DPH staff will work with the ASD "Physician Champion" to implement ASD screening protocols in fifteen CMHI network medical homes. Screening protocols will focus on the importance of detecting and treating developmental delays as early as possible and linking families to appropriate resources. In addition, the ASD "Physician Champion" will enhance the Connecticut Medical Home Training Academy's "Medical Homes in CT" module to include information on developmental screening and surveillance. The enhanced module will be used to train pediatricians and other providers located in the five CMHI network regions.

DPH will work with the Act Early team to implement the State Autism Plan. The first goal is to raise awareness of the importance of screening and early identification by promoting and disseminating the Learn the Signs. Act Early (LTSAE) materials. A second goal of the state plan is to develop guidelines for a diagnosis of ASD that provide a consistent and comprehensive source of information for evaluating whether a child has a clinical diagnosis of ASD. DPH will disseminate the group's "Guidelines for a diagnosis of ASD" to practices in each of the five CMHI network regions.

DPH staff will work with an ASD "Action Team" consisting of a family leader, ASD "Physician Champion", a nurse or social worker, and A.J. Pappanikou staff assigned to the LEND Program to provide technical assistance to CMHI care coordinators and providers on ASD awareness, screening, diagnosis and intervention.

SIG ASD/DD staff have customized (LTSAE) materials with the Child Development Infoline (CDI), (a specialized call center of CT United Way 2-1-1, that helps families with children who are at risk for or experiencing developmental delays or behavioral health issues find appropriate services) toll free number and will present to CDI staff on LTSAE materials and the SIG ASD/DD Grant.

DPH will work with Child Development Infoline to expand their current listing of ASD resources so that it includes statewide comprehensive listings of ASD resources and supports. The outcome will be an improved, unduplicated, seamless and unified CDI database that includes a comprehensive listing of CT ASD resources and supports to refer families and providers.

State Performance Measure 6: *The cumulative number of DPH funded Case Management programs whose healthcare professionals complete preconception and interconceptual health screening (including depression) of women.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					4
Annual Indicator				3	3
Numerator				3	3
Denominator				8	8
Data Source				Quarterly and annual program reports.	Reports
Is the Data Provisional or Final?					Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	5	5	6	6	7

Notes - 2011
Source: Case Management quarterly and annual program reports. The 2012-2016 Annual Performance Objectives have been updated using the most recent data.

Notes - 2010
The programs that provide Case Management are undergoing a re-structuring during 2011.

a. Last Year's Accomplishments
This measure was not met. Perinatal depression education (FFY 9 and 10) and training sessions were provided to health care providers (obstetricians, pediatricians, social workers, nurses, psychologists and psychiatrists) in CT. The training was provided by mental health and Psychiatry experts from the Yale School of Medicine. The training sessions included the following areas: 1) risk factors for perinatal depression; 2) screening and diagnostic questionnaires; 3) barriers to care; 4) medications for treatment and 5) referral to services. Attendees were provided with toolkits developed during the first year of the project and with CD-ROMs of the content for all training sessions. It is expected that --once trained -providers incorporate perinatal depression screening into their practices.

DPH funded three contracts that provided Case Management Programs. All women enrolled received periodic perinatal depression screening and were referred for services if they screened positive. All women enrolled received interconceptional screening and education.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Percent of women who receive preconception screening and education.	X			
2. Percent of women enrolled in Case Management programs who receive interconceptional screening and education.	X			
3. Percent of women enrolled in Case Management programs who are screened for depression screening.	X			
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
DPH funded three contracts that provided Case Management Programs. All women enrolled in the MCH Funded programs received periodic perinatal depression screening and are referred for services if they screen positive. All women enrolled receive interconceptional screening and education. Three of the Case Management contracts will expire on 9/30/12.

c. Plan for the Coming Year
DPH will incorporate language in all case management and home visiting contracts that require pregnant and postpartum women to receive preconception and interconceptional health screening for depression and interconceptional screening/education. Contractors will be required to report the number of women screened on an annual basis.

State Performance Measure 7: *Increase the number of People served by increasing the number and area covered by Health Professional Shortage Area (HPSA) Designations in CT.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					12
Annual Indicator					
Numerator					
Denominator			3	6	5
Data Source			ASAPS	ASAPS	ASAPS
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	15	18	21	24	27

Notes - 2011
Source: Application Submission and Processing System (ASAPS). Five Mental HPSA's were designated during this time. Of the five (5), four (4) were county designations.

Notes - 2010
Source: DPH staff was trained to use a Geographic Information System (GIS) based mapping system called Application Submission & Processing System (ASAPS) to submit HPSA applications. that can then identify thenumber of HPSA's in CT.

Notes - 2009
Source: DPH staff had started their training to use a Geographic Information System (GIS) based mapping system called Application Submission & Processing System (ASAPS) to submit HPSA applications. that can then identify thenumber of HPSA's in CT.

a. Last Year's Accomplishments
PCO staff mailed out cover letters containing a link to complete a web-based survey (SurveyMonkey) to more than eight-thousand (8,000) Primary Care Providers and two-thousand (2,000) Dentists throughout the state. PCO staff is currently in the process of making phone calls to those who did not respond. PCO staff has collaborated with the Practitioner Licensing Section to obtain information collected at the time of license renewals for physicians. The data collected from Licensing has been incorporated into the newly developed PCO Primary Care database. In September 2011, working with the Connecticut State Dental Association (CSDA) and Connecticut Dental Health Partnership (CDHP), the PCO was successful in surveying all Dentists in the state to update the dental piece in the Application Submission and Processing System (ASAPS). The Dentist database has been updated and has been uploaded into ASAPS. Connecticut now has the ability to expand Dental Health Professional Shortage Area (HPSA) designations.

During this time frame, two Primary Care HPSA's (Groton and New London) and four Mental Health HPSA's (Litchfield County, New London County, Windham County, and Danbury) were approved.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Provide technical assistance to organizations/communities seeking HPSA designation.				X
2. Provide relevant state data to organizations/ communities seeking HPSA designation.				X
3. Identify HPSA's for designations or re-designation.				X
4. Submit HPSA applications to HRSA.				X
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities
The Primary Care database is expected to be finalized this upcoming year. PCO staff is currently in the process of making phone calls to those who did not respond. The database will be sent to Health Resources & Services Administration (HRSA) so that the data can be uploaded into ASAPS. Once the data is uploaded into ASAPS, DPH staff will have the opportunity to focus their efforts to expand the number of HPSA applications for Primary Care. A fully updated physician database will enable DPH staff to identify more high need HPSA areas in the state. So far this year, twenty-one (21) Primary Care, three (3) Mental Health, and thirteen (13) Dental Care HPSA applications have been approved with a total of thirty-seven (37) HPSA Designations. A major accomplishment was the approval of Middlesex County for Mental Health. Connecticut now has five (5) Mental Health County designations. Submitting applications and obtaining federal designations will continue to serve as the necessary step toward obtaining the resources to improve health care services and access throughout Connecticut.

c. Plan for the Coming Year
The Primary Care database is expected to be finalized this upcoming year. The database will be sent to Health Resources & Services Administration (HRSA) so that the data can be uploaded into ASAPS. Once the data is uploaded into ASAPS, DPH staff will have the opportunity to focus their efforts to expanding the number of HPSA applications for Primary Care that are sent to HRSA. A fully updated physician database will enable DPH staff to identify high need HPSA areas in the state. PCO staff will continue to submit renewal and new HPSA applications to obtain federal designations.

State Performance Measure 8: *Integrate the Life Course Theory (LCT) throughout all state priorities. Increase the number of state priorities that have incorporated LCT into their programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					2
Annual Indicator					
Numerator				13	20
Denominator				8	8
Data Source				2010 Semi-decennial needs assessment	2011 Self Report
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	3	3.5	4	4.5	5

Notes - 2011
Source: Information from Carol Stone, CT DPH Family Health Section.

Notes - 2010
Information from Carol Stone, CT DPH Family Health Section. Detailed data source described in Form 16.

a. Last Year's Accomplishments

In the absence of a formal assessment for the fiscal year (FY) ending September 30, 2009, it is assumed that all state priorities were at Stage 1, or Pre-Contemplation. During the FY, activities designed to increase awareness about LCT were limited to those supported by the Knowledge-to-Practice translational grant funded to Boston University. This grant was funded to work with the Region 1 states and support a broader base of knowledge about LCT and how it could be used in the MCH field. A symposium conducted throughout the region and within CT of statewide MCH experts was followed up during FY2009 with another conference. The state-specific topic was childhood obesity and how a medical home could be used to incorporate LCT. This conference was conducted by real time audio-visual feed, and CT participants convened at the University Connecticut (UConn) School of Medicine audio-visual feed room, with funding from the DPH Obesity program. Participants in CT included Mark Keenan and Johanna Davis of the CT CYSHCN program; Sharon Tarala, Supervising Nurse Consultant within DPH, and Stephanie Rendoulic and Mario Garcia of the DPH Obesity program. In addition, Paula Liebovitz, Community Healthcare Center, Inc., and Director of a federal Living Healthy/Living Fit grant, attended the conference. During the state-specific discussion, CT participants identified five future activities that could be implemented within medical homes.

In May 2011, the DPH CYSHCN Program hosted a conference titled "Launching Into Adulthood: It's Not Like It Used to Be!". Guest speakers included: John G. Reiss, PhD, Associate Professor, University of Florida Gainesville; Keith Jones, disability rights advocate and national public speaker; Deborah Allen, ScD, Director of the Bureau of Child, Adolescent and Family Health at the Boston Public Health Commission; and Mallory Cyr, National Youth Program Manager at Got Transition? Nation Center. Topics discussed included: transitioning from pediatric to adult health care; closing health disparities gaps, students with intermittent absenteeism, youth panel discussion on how health/wellness impact transition; Life Course Theory and the role of life stressors for YSHCN in their transition process. Over two hundred students/young adults, parents and providers attended the all-day statewide conference.

CYSHCN staff arranged for Deborah Allen to present two sessions at this conference (one for students & parents and one for providers) on Lifecourse Theory and Transition. Over three hundred young adults, parents and providers attended the all-day statewide conference.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Seek learning opportunities among DPH program staff and among other state and community leaders.				X
2. Pursue technical assistance to incorporate LCT action steps into program plans.				X
3. Assist with grant seeking and other funding opportunities that incorporate LCT into program activities.				X
4. Pursue technical assistance and provide MCHBG and MCH Epidemiologic support to evaluate program activities related to LCT.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The overall stage of change was 2.5, above the objective of 2.0. Two of the state priorities remain at Stage 1 with no activity related to LCT and limited understanding of LCT among key

stakeholders. Two state priorities are at Stage 2, with an understanding of LCT but limited understanding how to incorporate LCT into their program. Two priorities are at Stage 3 with inclusion of LCT into an action plan; these priorities are SPM 2 and SPM 5. Two state priorities report being at Stage 4, with implementation of a LCT action plan. These two priorities are SPM 6 and SPM 9. Topics on LCT have been incorporated into written materials, including the Sickle Cell Disease Transitional grant, and the Needs Assessment for Maternal, Infant and Early Childhood Home Visiting Program. With funds from federal the Hartford Healthy Start, the "Someday" campaign was re-issued in Hartford during Spring, 2012. Staff within the FHS are members of the MCH Lifecourse Research Network and participate in periodic webinars.

c. Plan for the Coming Year
During the FY ending September 30, 2013, DPH will continue efforts to move SPM toward change that incorporates LCT. With available funding, DPH will seek technical assistance to conduct an agency-wide seminar by Dr. Bernard Guyer, to discuss how the agency can incorporate LCT into its programs and policies. Oral presentations will be focused on state priorities related to SPM 3 and SPM 4, which currently report being at State 1. A focus in the upcoming year will be to move all state priorities away from Stage 1. Efforts will continue to assist all state priorities with incorporation of a LCT action step into current strategies. These efforts may be facilitated with mentoring by those programs that have reached Stage 4. Epidemiology staff will continue to participate on the MCH Lifecourse Research Network.

State Performance Measure 9: *The extent to which the ratios of key perinatal health measures for non-Hispanic Black/African Americans relative to non-Hispanic Whites has changed.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					12
Annual Indicator				10	8
Numerator					
Denominator					
Data Source				VitalRecords	VitalRecords
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	12	14	16	18	20

Notes - 2011
Source: 2009 and 2010 Vital Statistics

Notes - 2010
Source: 2008 and 2009 Vital Statistics

a. Last Year's Accomplishments
Title V-funded programs that serve to reduce racial and ethnic disparities in perinatal outcomes included Case Management for Pregnant Women, Centering Pregnancy, Community Health Centers, Family Planning, Healthy Choices for Women and Children (HCWC), State Healthy Start, Hartford Healthy Start, and Maternal, Infant, and Early Childhood Home Visiting; these programs and activities have been described elsewhere in the application.

The DPH participated on the CT Commission on Health Equity, which mission is to eliminate health disparities and inequities based on race, ethnicity and linguistic ability, and improve the quality of health for all CT residents. The FHS continued its collaboration with the Office of Multicultural Health, described elsewhere in the application.

FHS epidemiologists collected, analyzed, and disseminated perinatal data to monitor and investigate racial and ethnic disparities in perinatal outcomes, and assist in enhancing/developing strategies to reduce these disparities.

Data collection for CT's PRAMS-like survey, PRATS, was completed, which will provide essential information to further quantify and investigate perinatal disparities. A special set of questions were included regarding perceived discrimination to determine its effects on health-seeking behavior and birth outcomes. FHS was awarded PRAMS funding in September 2011, which will allow for the annual collection of these data.

FHS applied for and was selected to be part of a national Action Learning Collaborative (ALC) to Eliminate Disparities in Infant Mortality. DPH co-leads the ALC with the New Haven Health Department and New Haven Healthy Start Program. The ALC Team began work to identify community partners to design strategies to address racism and its impact on disparities in infant mortality in the city of New Haven.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide outreach, referral, and case management to high-risk populations.		X		
2. Provide intensive case management and supports to promote positive pregnancy outcomes.		X		
3. Provide pregnancy testing, reproductive health education, counseling and linkage to healthcare providers.	X			
4. Provide/promote comprehensive services to encourage early entry into prenatal care.		X		
5. Provide culturally competent and linguistically appropriate services.	X			
6. Provide/promote comprehensive services, support, information and advocacy to optimize preconception health among women of childbearing age.	X	X	X	
7. Collect, analyze, and disseminate perinatal data to monitor and investigate racial and ethnic disparities in perinatal outcomes.				X
8. Investigate and address social determinants of health related to perinatal outcomes.			X	X
9. Develop strategies to address racism and health inequities.			X	X
10.				

b. Current Activities

Title V-funded programs that serve to reduce racial and ethnic disparities in perinatal outcomes, described above and elsewhere in the application, continue to be implemented.

The DPH continues its participation on the CT Commission on Health Equity and collaboration with Office of Multicultural Health, described elsewhere in the application.

FHS epidemiologists continue to collect, analyze, and disseminate perinatal data to monitor and investigate racial and ethnic disparities in perinatal outcomes, and assist in enhancing/developing strategies to reduce these disparities.

PRATS survey data was weighted and are now being analyzed. Results will be disseminated to

DPH and statewide partners to inform efforts to address racial and ethnic disparities and health inequities. FHS has been completing PRAMS surveillance protocol development activities in conjunction with CDC. PRAMS data collection will begin in Sept. 2012.

The Title V Director and FHS epidemiologist continue to partner with representatives from the New Haven Health Department, New Haven Healthy Start Program, and community partners in New Haven to identify and design strategies to address racism and its impact on disparities in infant mortality. FHS is co-sponsoring a 2-day PPOR workshop in September to engage community stakeholders in New Haven and prioritize action steps.

c. Plan for the Coming Year

Title V-funded programs that serve to reduce racial and ethnic disparities in perinatal outcomes, described above and elsewhere in the application, will continue to be implemented. State funds have been allocated to develop a plan for statewide implementation of a program to address fetal and infant mortality in the state.

The DPH will continue its participation on the CT Commission on Health Equity and its collaboration with Office of Multicultural Health, described elsewhere in the application.

FHS epidemiologists will continue to collect, analyze, and disseminate perinatal data to monitor and investigate racial and ethnic disparities in perinatal outcomes, and assist in enhancing/developing strategies to reduce these disparities.

PRATS survey data will continue to be analyzed and disseminated to DPH and statewide partners to inform efforts to address racial and ethnic disparities and health inequities.

The Title V Director and FHS epidemiologist will continue to partner with representatives from the New Haven Health Department, New Haven Healthy Start Program, and community partners in New Haven to design and implement strategies to address racism and its impact on disparities in infant mortality. Based on the results of the PPOR workshop, the team will plan for and implement appropriate action steps.

E. Health Status Indicators

Similar to the Health Status Capacity Indicators, obtaining Vital Statistics and hospitalization data for this FY 2013 application was a challenge. However, FHS staff will update these indicators in September 2012 when these data become available.

There has been little or no change in the rate of low birth weight or very low birth weight births over the last four years.

It does appear that there has been a decrease in the death rate of unintentional injuries among children aged 14 years and younger over the past four years including those due to motor vehicle crashes. This unfortunately is in contrast to no identifiable decreasing trend in the death rate of unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.

Further positive outcomes show the decrease in the rate of nonfatal injuries due to motor vehicle crashes among both children aged 14 years and younger as well as among youth aged 15 through 24 years.

The rate of Chlamydia appears to have reversed an increasing trend in the 15-19 year age group

over the last few years but unfortunately continues an increasing trend in the 20-44 year old age group.

A review of the demographic data in the 0 - 24 year age group continues to show a potential shift in this population with an increased representation in ethnic and racial minorities. This is accompanied by Black/African American mothers giving birth at a younger age than other racial populations; and Hispanic/Latino mothers giving birth more often in the teen years.

It was also found that children 0 - 19 years old living in high risk households are more likely to be of ethnic and racial minority populations.

All public health interventions within the state need to be culturally and linguistically sensitive, and conscious of the belief systems and other environmental factors among the different age groups within the MCH population.

F. Other Program Activities

Many other programs within DPH affect the MCH population but are not funded through MCHBG. Some of these are listed below:

The Asthma Program's mission is to reduce asthma-associated morbidity and mortality and improve the quality of life for people with asthma. The Asthma Program and FHS staff collaborated to assess Title V program data to evaluate appropriate asthma diagnosis and medical management and patient self-management education for children diagnosed with asthma.

The Connecticut Breast and Cervical Cancer Early Detection Program provides screening, and diagnostic and treatment referral services through 14 major health care facilities and over 350 clinical subcontractors throughout the state. The Program also provides case management, patient and public education and outreach targeting uninsured and underinsured Connecticut women, as well as professional education and quality assurance.

The Childhood Lead Poisoning Prevention and Control Program operates a comprehensive lead surveillance system, provides professional and community education services and operates 2 regional lead treatment centers. The DPH laboratory provides blood lead testing. CLPPCP also provides regulatory oversight and consultative services, and funding support for two Regional Lead Treatment Centers. The program's major goal is to eliminate elevated blood lead levels (>10mcg/dL) in children less than 6 years of age in CT by 2010.

Chlamydia Infertility Prevention provides free chlamydia screening and treatment services to females and their partners who attend targeted Planned Parenthood clinics. Free services are available at clinics to uninsured sexually active females 25 years of age and younger and their sexual partners.

Comprehensive STD Prevention Systems Projects provides services to reduce the transmission and incidence of STDs including surveillance to monitor the trends facilitating individual case intervention.

Enhanced Perinatal HIV Surveillance receives CDC funding to conduct surveillance. All perinatal HIV exposures (approximately 75 infants per year) are followed-up with medical record reviews to collect information about maternal HIV testing, prenatal care, risk factors, treatment compliance, etc.

"Five-a-Day" Head Start Project focuses on providing direct nutrition education to Food Stamp eligible families in CT with the "Captain 5-A-Day" program for children and the "Supermarket

Smarts" program for parents and families. These programs are delivered through workshops by state nutrition staff and provide education on food budgeting and developmentally appropriate feeding practices, and encourage dietary behavior modification including the purchase and consumption of fruits, vegetables and other low-fat foods.

DPH worked with the Governor's Collaboration for Young Children to establish the Healthy Child Care CT (HCC-CT) initiative. Its goal is to achieve optimal health and development for all children in childcare by guiding and supporting service integration between the childcare community and health care providers. DPH participates on the HCC-CT leadership team, which has established a regional Core Committee representing organizations that play a key role in the planning and delivery of childcare and health care for children and their families. HCC-CT also works closely with the national Healthy Child Care America campaign, which is coordinated by the AAP with support from the DHHS Child Care and MCH Bureaus.

The Immunization Program: Activities are designed to prevent disease, disability and death from vaccine-preventable diseases in infants, children, adolescents and adults through surveillance, case investigation and control, vaccination, monitoring of immunization levels, provision of vaccine and professional and public education. The Immunization Action Program funds local health departments, health districts, and a regional community provider to conduct activities to raise immunization rates. The Vaccines for Children (VFC) provides free vaccines to over 600 health care providers. The CT Immunization Registry and Tracking System records and tracks all CT children's immunizations.

DPH contracts with the Connecticut Women's Consortium, Inc. to provide intimate partner violence prevention curricula to incarcerated women at the York Correctional Institute (YCI), to women recently released from YCI who live in halfway houses and resettlement programs, and to staff of these community based agencies.

Perinatal Hepatitis B Prevention: All hepatitis B positive pregnant women and their providers are contacted to provide education about the implications of hepatitis B infection in pregnancy, offer testing and vaccination to family members and ensure that the infant receives appropriate immunization and testing.

Ryan White Care Act: Provides federal support for comprehensive health and support services for people living with HIV/AIDS, including women, infants and children.

Sexual Assault Prevention and Intervention Services: DPH contracts with the CT Sexual Assault Crisis Services, Inc., to coordinate primary prevention education and direct services to victims of rape and other sexual assaults. DPH is implementing the Sexual Violence Prevention Plan (2009-2017).

The WIC Program: Serves approximately 60,000 participants through 12 agencies located throughout the State. The program provides food, nutrition, breastfeeding and health education, and referral services for individuals found to be at nutritional and/or medical risk. Eligible clients are defined as pregnant, breastfeeding and postpartum women, and infants and children up to age five.

WISEWOMAN (The Well-Integrated Screening and Evaluation for Women Across the Nation Program): Provides cardiovascular disease risk reduction screening and lifestyle modification intervention services to uninsured and underinsured women at health care provider sites.

/2013/ FHS staff represents DPH at Child Fatality Review Panel (CFRP) meetings under the auspices of the Office of the Child Advocate. The CFRP reviews deaths of children from birth to 17 that are unexpected or unexplained, and primarily focuses its investigations on the fatalities of children involved in state systems.//2013//

/2013/DPH will address three consumer identified issues with community partners; (1) how to identify signs of mental health and respond to problems; (2) support the Medical Home Initiative, and (3) provide programs and services for children with Autism Spectrum Disorders (ASD). Community partners will include 2-1-1 Infoline who has resources to address these issues with; (1) Suicide Hotline accredited by the American Association of Sociology; (2) Child Development Infoline who provide a link to the DPH CT Medical Home Initiative; and (3) resources on programs and services available for children identified with ASD. DPH is also committed to incorporating health equity into its strategic plan and is conducting a self-assessment of its institutional capacity to address health equity across multiple domains, including: institutional commitment; evidence-based approaches to public health; accessible data for planning, monitoring and evaluation; recruiting, hiring and training staff; broad-based partnerships; and transparent and inclusive communication with partners. Partners include state agencies, local health departments, non-profit agencies, community based organizations, for-profit health related organizations and businesses, and professional associations.//2013//

G. Technical Assistance

During the FFY 2012, CT was fortunate to receive technical assistance in the following areas:

1. Adolescent Health
Technical assistance was received from the Adolescent Health Resource Center at the Konopka Institute for Best Practices in Adolescent Health utilizing funding available through the State Department of Education and the Coordinated School Health Initiative. The one day workshop "Adolescence through a Developmental Lens" in May 2012 enhanced the knowledge of current issues and concerns regarding program planning and implementation for Adolescents. Program staff and community partners, including School Based Health Center providers participated in the training.

Technical Assistance requests for the next year will focus on:

1. CYSHCN
Contracted community based medical home partners have varying levels of knowledge regarding Health Reform, the Affordable Care Act, and the potential impact on health financing resources available to CYSHCN. This TA will utilize expertise (possibly through the Catalyst Center) to provide a workshop for the purpose of strengthening the knowledge of medical home care coordinators and other community partners.

2. Chronic Disease and MCH
Multiple Chronic Disease and MCH Programs serve the same consumers and/or are operational within the same communities with limited alignment and limited sharing of resources. This TA will provide training regarding strategies to integrate the approach to services and will serve as a forum to dialogue around the issues impacting the provision of services.

3. Pregnant Women
This TA will inform a possible future action plan to address low birth weight in the state. Focus groups of 12-15 pregnant women each will be convened across the State of Connecticut in both rural and urban areas of low and high socioeconomic status. Areas at high risk for adverse birth outcomes will also be included and will be determined by zip code-level area assessment. The focus groups will be conducted to understand current perceptions of prenatal care and explore how prenatal care might be improved statewide. Information from the focus groups will be used to inform future activities in the state, existing programs within DPH, and a possible statewide prenatal care plan.

A second TA is needed to conduct a statewide conference, tentatively planned for November,

2012, with a focus on obstetric providers, public health professionals, community-based health centers and hospitals to raise awareness about promising innovative state and institutional policies to improve maternity care in Connecticut. Discussions may include the 39-week initiative, maternity home model of care, and Centering Pregnancy model of group prenatal care. Invited presentations may include: 1) DPH Commissioner Mullen, 2) ASTHO president and previous Texas Commissioner of Health David Lakey, 3) March of Dimes national representative, 4) North Carolina Department of Public Health, 5) Chair of the Connecticut legislative Public Health Committee, 6) Chair of the Women's Health Committee of the Council on Medical Assistance Program Oversight, and 7) Department of Social Services Medicaid Director Mark Schaefer from DSS. Additional speakers may be drawn from state and local legislators, and may include a presentation from Angela Blackwell and/or Fleda Mask Jackson about the need to address racial and ethnic disparities in adverse birth outcomes. Discussion may also include urban and rural areas of the state with high rates of low birth weight and infant mortality.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	4748137	4563402	4693379		4667308	
2. Unobligated Balance *(Line2, Form 2)*	166438	166438	288206		115099	
3. State Funds *(Line3, Form 2)*	7095000	6780181	7940000		7940000	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	0	0	0		0	
7. Subtotal	12009575	11510021	12921585		12722407	
8. Other Federal Funds *(Line10, Form 2)*	2284695	2284695	3197317		13134792	
9. Total *(Line11, Form 2)*	14294270	13794716	16118902		25857199	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	772130	785208	856774		747469	
b. Infants < 1 year old	1230464	1138002	1084061		1128215	
c. Children 1 to 22 years old	5810242	5375425	7037242		6973358	
d. Children with	3917316	3959361	3647950		3607791	

Special Healthcare Needs						
e. Others	45827	39717	48354		49475	
f. Administration	233596	212308	247204		216099	
g. SUBTOTAL	12009575	11510021	12921585		12722407	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	100000		100000		100000	
c. CISS	0		0		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	750000		750000		750000	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	582991		306016		855269	
j. Education	0		0		0	
k. Home Visiting	0		0		10244349	
k. Other						
ECP	132000		140000		150000	
EHDI	299874		300000		300000	
PCO	119830		149788		138734	
PREP	0		596440		596440	
Home Visiting	0		855073		0	
CYSHCN Integration	300000		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011		**FY 2012**		**FY 2013**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	4487936	4280846	4514936		4513435	
II. Enabling Services	2230771	2157885	2247454		2265056	
III. Population-Based Services	952809	810027	764366		792683	
IV. Infrastructure Building Services	4338059	4261263	5394829		5151233	
V. Federal-State Title V Block Grant Partnership Total	12009575	11510021	12921585		12722407	

A. Expenditures

There were several overall factors that impacted the actual expenditures in comparison to the FFY2011 budget. Details specific to any significant (>10%) expenditure variations on each of the Budget Forms are described below.

Form 4
FFY11 All Others expenditures were less than the budgeted amount due to the reallocation of carryover funds to activities that had a slightly different focus compared to our original plans.

Form 5
FFY11 Population-Based Services expenditures were less than the budgeted amount due to the reallocation of personnel and carryover funds to activities that had a slightly different focus compared to our original plans.

B. Budget

State matching funds are met through funding of School-Based Health Centers, The Genetics Diseases Program, and the CYSHCN (Medical Homes). These matching funds will total $3,970,000 for FFY2013. For FFY2011, the maintenance of effort requirement was met from several sources: Community Health Centers, Family Planning Programs, Waterbury Health Access Program and the School-Based Health Centers located throughout the state. The State of Connecticut dollars for these programs totaled $6,780,181 for FFY2011. The Maintenance of Effort and Match amount for FFY2011 was $10,750,181.

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

The requirement that there be three dollars of State matching funds for each four dollars in federal funding is met for FFY2013. The projected federal allocation for FFY2013 is $4,667,308, which means that the State of Connecticut must match with at least $3,520,481. Maintenance of Effort for FFY2013 is in the amount of $6,780,181, which is $2,990 more than the required FFY1989 base of $6,777,191.

Other federal grants received by the Family Health Section that serve the maternal and child population will include: Healthy Start; Primary Care Office; Rape Prevention and Education; Universal Newborn Hearing Screening; State Systems Development Initiative (SSDI); the Pregnancy Risk Assessment Monitoring System (PRAMS); Personal Responsibility Education Program (PREP); Maternal, Infant, and Early Childhood Home Visiting; and ECP, CT's CECCS program.

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 FFY2013 award amount, $1,448,929 (31.04%) is allocated for Preventive and Primary Care for Children; and $1,798,056 (38.52%) for the CSHCN program. There is an allocation of administrative costs of $216,099 (4.63%) of the projected federal allocation to all programs.

In FFY2013, the federal allocation is $4,667,308 plus using $115,099 of the carry forward from FFY2011 funds for a total of $4,782,407 of federal funding. When combined with the state funds of $7,940,000 there is a federal-state block grant partnership total of $12,722,407.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.