



State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (<http://www.mchdata.net>).

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I. COMMON REQUIREMENTS FOR APPLICATION AND ANNUAL REPORT

1.4 Overview of the State

Connecticut is a relatively small state of 5,006 square miles and 3.3 million persons. Although sprinkled with farms, the state's economy is supported predominantly by services (40%), manufacturing (17%) and retail trade (16%) industries. Many indicators of maternal and child health within Connecticut compare favorably with the United States as a whole (see Table 1 and Table 4), however, there are high risk groups within Connecticut which experience a greater share of the burden of adverse health risks and outcomes. Within the State, it is the poor, the minorities, and those who live in the larger urban areas who experience higher rates of disease (see Figure 1). During the period 1994 to 1996 an African American/Black baby was almost three times more likely to die within its first year of life than a White baby, and more than twice as likely to be born with low birthweight. Additionally, although teen birth rates have been declining during the past decade, an African American/Black or Hispanic baby born between 1994-1996 was approximately 5 times more likely to have a teenager as a mother than a White baby.

Our Title V programs within Connecticut exist to serve all of the citizens in the State but focus on those who are most in need of the services they provide. The Connecticut Department of Public Health undertook a needs assessment of the Maternal and Child Health population that is presented later in this application. The needs assessment provides detailed information on many health indicators and helped establish our priority needs for this application. Some of the information from the needs assessment is summarized in this Overview.

Table 1 Selected Health Indicators for the United States and Connecticut, 1997

	United States	Connecticut
Infant Mortality Rate per 1,000 live births	7.2	7.2
Low Birthweight percent	7.5	7.3
Prenatal care in 1st trimester percent	82.5	89.2
Teen Birth rate per 1,000 teens age 15-19	59.2	36.2

Source: National Vital Statistics Reports. <http://www.cdc.gov/nchs/fastats/prenatal.htm> and CT Vital Records

Demographic Information

While the total Connecticut population changed little since 1990, the proportion of minorities in the population has been increasing. The Hispanic, Asian/Pacific Islander, and African American/Black population has increased approximately 26, 57, and 7 percent respectively since the 1990 census, while the White population has decreased 4 percent. Table 2 presents a breakdown of the Connecticut population with age grouping to reflect the Maternal and Child Health Populations of infants, children and adolescents and women of child bearing age. The estimate of the population of children with special health care needs is based on the National Health Interview Survey on Disability. This estimate indicated that approximately 143,000 of the almost 800,000 children less than 18 have special health care needs.ⁱ

Figure 1 Selected Health Indicators in Connecticut by Race and Hispanic Ethnicity, 1994-1996

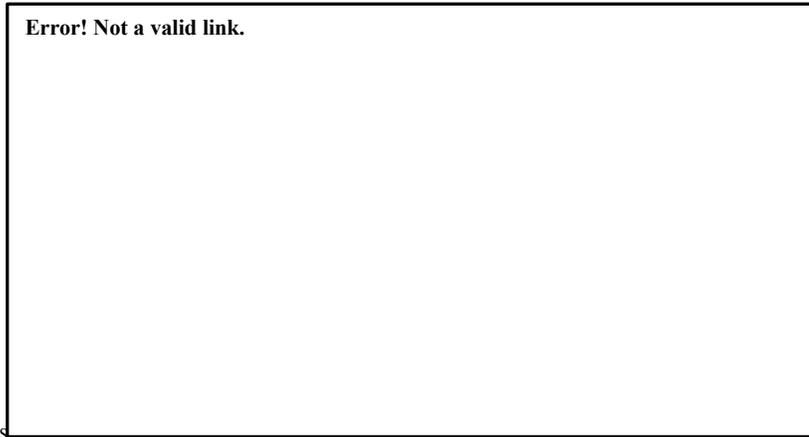


Table 2 Estimated Connecticut Population by Age, Gender, Race and Hispanic Ethnicity for 1998

	Race (Non-Hispanic Ethnicity)								Hispanic Ethnicity		Total
	White		African American/Black		Asian/Pacific Island		Other		Male	Female	
	%of total		%of total		%of total		%of total				
Age Group	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
<1	15,602	14,863	2,154	2,020	666	688	40	40	3,190	2,994	42,257
1-14	235,548	224,620	34,064	32,828	8,719	8,530	611	574	39,681	37,753	622,928
15-19	78,671	73,897	11,737	11,153	2,913	2,823	228	202	11,826	11,155	204,605
20-44	480,671	478,542	54,232	60,015	16,632	18,675	1,335	1297	53,664	57,440	1,222,503
Total	1,285,357	1,358,750	132,139	146,648	36,970	39,780	3,012	3074	131,129	137,210	3,274,069

Source: US Census Population Estimates <http://www.census.gov/population/estimates/state/sasrh/sasrh98.txt>

The population in Connecticut is primarily located within the major cities and along the major transportation routes. Map 1 and Map 2 present the cities and towns within Connecticut and the population density of the State. Connecticut is a fairly small state, geographically, and although distance to medical providers may not be a barrier, transportation services are not always available and access to health care facilities can be difficult.

Socioeconomic Indicators in Connecticut: Sociodemographic indicators are crucial to understanding factors contributing to morbidity and mortality risks. Socioeconomic status (SES) is strongly related to health insurance coverage, which influences access to and quality of medical care. SES is also related to health behavior, the quality of the living environment, and health status.

As with the entire United States, the economy has improved in Connecticut during the past few years. Unemployment has dropped to only 3.4 percent statewide in 1998. However, some areas of unemployment are higher in the state, including the largest urban areas. For example, in 1998, unemployment in Hartford was 6.7 percent, almost twice the state average.ⁱⁱ Connecticut still ranks near the top in the nation in per capita income, but also

exceeds most other states in cost of living. Nationally, in 1996, 13.7 percent of the population lived in poverty, however, in Connecticut the poverty rate is lower at 8.7 percent.ⁱⁱⁱ Within Connecticut income varies greatly by geographic area. The larger cities have much lower per capita income (PCI) than the wealthy cities and towns near New York City. For example, the PCI for Bridgeport is \$21,581 while Darien has a PCI of \$90,669.ⁱⁱ

Educational level is widely used as an indicator of socioeconomic status and is associated with infant and adult mortality. Striking racial-ethnic disparities in educational and income level are evident in Connecticut (Table 3), as in the entire U.S.

Table 3 Sociodemographic Data Connecticut, 1990

Indicator	Race/Ethnicity			
	White	African American/Black	Hispanic ^a	All Races
Education level of persons aged 25+:				
High school graduate (%)	80.9%	67.0%	53.5%	79.2%
College graduate or higher (%)	28.5%	12.3%	12.1%	27.2%
Median household income (\$)	\$43,407	\$28,011	\$29,310	\$41,721
Persons with income below federal poverty level (%)	4.6%	19.8%	15.5%	6.8%
Housing indicator:				
More than 1 person per room (%)	1.3%	8.1%	15.0%	2.3%

^a The "Hispanic" category in this table overlaps with the other two categories, because Hispanics can be of any "race" (white, black or other); some Hispanics consider their "race" to be Hispanic. Source: 1990 Census data.

Much of the racial/ethnic disparity in various health indicators can be explained by social class differences, but residual disparities often exist that may reflect other factors such as discrimination. For many developed countries including the U.S., and for Connecticut, the inequality in income distribution has been increasing; that is, a decreasing proportion of the population holds a growing proportion of the country's wealth. This trend is due in part to the increase in the number of single-parent families and greater growth of salaries among college graduates than persons with little education.

In Connecticut, as in the nation, the health status of minority groups is notably different from that of whites. In 1998 African Americans/Blacks represented 8.5 percent of the total population and Hispanics 8.2 percent, however they showed higher rates than whites for many adverse health outcomes. Information on the disparities between whites and other racial and ethnic groups is presented in more detail in the needs assessment portion of this application.

CT's Health Care Delivery Environment:

Direct health care services are delivered to residents through a wide range of providers including, but not limited to, school based health centers, community health centers, outpatient clinics, and 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. Promotion of high quality health care and services is guided by the licensure or certification of health care facilities and health care professionals. 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.

Connecticut is part of the national trend in the delivery of health care services in which managed care has expanded and has become the dominant financing mechanism. The Connecticut care delivery system is challenged by managed care and the lack of sufficient services for the uninsured. These new methods of financing affect not only the availability and delivery of services but also the quality of patient outcomes, with the promise, but not the guarantee, of greater efficiency. Hospital mergers have occurred in Connecticut, length of stays in hospitals have decreased, as has the rate of hospitalizations. From 1991 to 1995 the hospitalization rate decreased from 114.7 to 112.1 per 1,000 population and the median length of stay dropped from four to three days. This trend is expected to continue, as an emphasis of managed care is to keep people out of the hospital. ^{iv}

Health insurance: Health insurance is generally believed to be an important component of access to health care. People without health insurance are less likely to receive the basic health care services that the insured receive. The uninsured are more likely to delay medical treatment and preventive health care until an emergency arises, subsequently requiring a higher and more expensive level of care. ^v

The Connecticut Office of Health Care Access (OHCA) has a primary agency goal to improve access to health care for all Connecticut citizens. In 1995, in order to provide baseline data prior to the implementation of Medicaid Managed Care and the passage of the Children's Health Initiative, OHCA conducted the Connecticut Family Health Care Access Survey. In the 1995 survey almost 70 percent of Connecticut residents reported having private insurance. Nearly 25 percent were covered by Medicaid or Medicare. However, over 7 percent of Connecticut's residents said they had no health insurance coverage.

According to the Census Current Population Survey conducted in 1998, 44.3 million people or 16.3 percent of the population nationally was without health insurance coverage. For Connecticut, the Census estimates that 12.6 percent of the population was without health insurance in 1998. Nationally, those factors that reduce the likelihood of having health insurance in 1998 were identified as age 18 to 24, African American/Black, Hispanic origin, foreign-born, worked part-time, lower household income, and lower educational attainment. ^{vi}

OHCA also conducted a study based on evaluation of hospital discharge records to estimate the uninsured on a state level. Newborns, appendicitis and heart attacks were the indicator "conditions" used in the analysis because these conditions were considered to be non-discretionary and therefore would be unrelated to insurance status or racial/ethnic category. Approximately 242,000 (7.5 percent) of Connecticut residents were estimated to be uninsured in 1997 (which is lower than the Census estimate). The methodology produced similar results to the survey OHCA conducted in 1995, prior to the implementation of Medicaid Managed Care. Those most likely to be without health insurance were age 20-24 with an uninsured rate of nearly 15 percent in 1997. OHCA reported a variety of reasons why individuals did not receive care, enroll in insurance plans, or apply for public funding for which they are qualified including:

- Immigrants may fear that receiving Medicaid, HUSKY (Healthcare for Uninsured Kids and Youth) or other benefits will affect their ability to become a permanent resident or result in deportation.
- Many uninsured can not afford the cost of health insurance.

- Employer coverage has decreased due to the rapid rise in health care costs.

HUSKY: One year after passage of welfare reform, the Congress established State Children's Health Insurance Program (SCHIP), an optional health insurance program for children in families with incomes above the federal poverty level who do not qualify for Medicaid. In Connecticut this program is known as HUSKY (Health Care for Uninsured Kids and Youth). The plan is administered by the Connecticut Department of Social Services and is funded through federal SCHIP Title XXI funds and state dollars. Implementation of HUSKY began in June of 1998. HUSKY provides insurance coverage for children age 18 and under in families with incomes too high to qualify for Medicaid, but too low to afford private health insurance. The HUSKY program combined two federal approaches to increase health insurance coverage. It increased coverage by expanding Medicaid eligibility for children and creating a new program to subsidize private insurance for children.^{vii} The basic HUSKY package includes preventive care, outpatient physician visits, prescription medicines, inpatient hospital and physician services, outpatient surgical facility services, mental health and substance abuse 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, eyecare and hearing exams, and dental care.^v

The Medicaid portion of HUSKY is referred to as Part A, while the insurance program is referred to as Part B. Both HUSKY part A and B utilize contracted services through managed care plans. HUSKY part A reflects Medicaid coverage for children through age 18 in families with incomes up to 185% of the federal poverty level (FPL). For HUSKY part B, children with family incomes between 185 % to 300% of the FPL are eligible for insurance coverage by paying a sliding fee. Children enrolled in HUSKY B with family incomes between 185% and 300% of the FPL are also able to apply for HUSKY Plus, a supplemental health coverage for children with special behavioral or physical needs. The HUSKY Plus benefits provide expanded coverage through contracts with Connecticut Children's Medical Center in Hartford , and the Department of Pediatrics at the Yale University School of Medicine in New Haven.^{viii}

As the Title V agency in Connecticut, DPH has contributed policy guidance and technical assistance to the HUSKY program regarding:

- children with special health care needs and filling gaps in care;
- the development of linkages between HUSKY and state public health programs such as WIC, childhood immunizations and Title V funded programs, (including an MOU with DSS regarding these linkages). SBHCs were named as the only essential community providers in the DSS waiver application, resulting in all SBHCs having contracts with all managed care plans for Husky A and B. CT is the only state in the nation that has accomplished this.
- Community Health Centers/Connecticut Primary Care Association and SBHCs were both awarded statewide outreach grants for Husky B.
- the use of existing services to create access points for referral or applications to enhance outreach and enrollment;
- the identification and development of needed enabling services through work with other providers and local health departments; and the implementation of quality improvement activities and evaluation.

The overall goal of Connecticut's Title V Federal-State Partnership Program is to improve the health of all women and children, including children with special health care needs. The Title V program is particularly concerned about the health needs of vulnerable women and children, many of whom face barriers to care which are not addressed by Connecticut's managed care system. These populations include the uninsured, the many single parent mothers transitioning from welfare to work who are faced with issues of quality child care and restricted work release policies, adolescents who are concerned with confidentiality and have issues regarding policies that required parental involvement, the immigrant and undocumented populations, and infants who experience delays in newborn eligibility determination. Additional concerns of the Title V program include the new availability of providers who have previously worked in the private health insurance market, and are therefore not prepared to deal with the multiple social and economic problems facing many low income families. Hence, it is likely that many needs go unmet.

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 enabling services, such as case management and outreach. Population-based services include disease prevention, education, and the empowering of MCH populations about health and health related issues. Infrastructure building services include needs assessment, policy development, quality assurance, information systems development and management, and training that supports individual, agency, and community health efforts. Each of these efforts is described more fully throughout this document.

Health Needs of the Entire State's Population: In response to Objective 22.1 of Healthy People 2000, a consensus set of 18 health indicators was developed at the national level in 1991 which allow for a state to compare itself to both the U.S. as a whole and to each of the individual states. Based on this consensus set of indicators for 1996 (the latest year for which such comparisons are available), the overall health status in Connecticut is comparatively good. Connecticut compared well with the United States as a whole for fourteen of the eighteen indicators. Exceptions where CT exceeded US rates included: Breast cancer mortality per 100,000 women (CT=21, U.S.=20.2), AIDS incidence per 100,000 population (CT=34, U.S.=25.2), and air pollution (proportion of persons living in counties which exceeding national ambient air quality standards) (CT=37.6, U.S.=33.3). Three of the subcategories also showed a worse experience in CT than for the nation as a whole. These were: infant mortality rate per 1,000 live births for Blacks (CT=15.1, U.S.=14) and Hispanics (CT=8.3, U.S.=6.1), and percent Very Low Birthweight (CT=1.5, U.S.=1.4).

Comparing Connecticut with the other states, CT ranked among the ten best for five of the eighteen consensus indicators and one of the subcategories. (See Table 4). The CT favorable performance indicators include: 1) motor vehicle mortality (CT= rank 5 among the 50 states), 2) work-related injury mortality (CT= rank 4 among the 50 states), 3) suicide mortality (CT= rank 7 among the 50 states), 4) Percent of all births with adolescent mothers (CT= rank 8 among the 50 states), 5) Percent of mothers lacking early prenatal care (CT= rank 5 among the 50 states), and 6) white infant mortality rate (CT= rank 10 among the 50 states).

Table 4 Consus Health Status Indicators, 1996

Consensus Health Status Indicators, Comparison of CT with Other States:, 1996

(Reporting only those indicators where CT ranked in best or worst ten states)

Health Status Indicators	Best State	Best Rate	CT Rate	CT Rank
Race/ethnicity-specific infant mortality as measured by the rate (per 1,000 live births) of deaths among infants under one year of age -White	Maine	4.2	5.3	10
Motor vehicle crash deaths per 100,000 population. (ICD-9 nos. E810-E825)	Massachusetts	7.3	10.1	5
Work-related injury deaths per 100,000 population.	New Hampshire	0.9	1.1	4
Suicides per 100,000 population. (ICD-9 nos. E950-E959)	New Jersey	6.7	8.5	7
Reported incidence (per 100,000 population) of acquired immuno-deficiency syndrome.	Wyoming	1.5	34	46
Births to adolescents (ages 10-17 years) as a percentage of total live births.	New Hampshire	2.5	3.4	8
Prenatal care as measured by the percentage of mothers delivering live infants who did not receive care during the first trimester of pregnancy.	Maryland	10	12	5

SOURCES: National Vital Statistics System, CDC, NCHS.(Indicators #1,3,5,15 and 16)
 Census of Fatal Occupational Injuries, Department of Labor, Bureau of Labor Statistics.(Indicator #4)
 AIDS Surveillance System, CDC, NCID. (Indicator #10)
 Current Population Survey, U.S. Bureau of the Census.(Indicator #17)

The Department of Public Health prepared an extensive report entitled Looking Toward 2000^{iv} That report identified the most significant problems affecting the public's health in Connecticut and set specific priorities for policy and program development for the future. Twenty five public health priorities were selected for promoting the increased expectancy and quality of life for state residents. The priorities are divided into three groups; health status, health services, and essential public health programs and are listed as follows

HEALTH STATUS PRIORITIES

1. Prevention and cessation of tobacco use.
2. Further determination and reduction of the factors associated with intentional, unintentional, and occupational injuries.
3. Improvement in rates of breast, cervical, and colorectal cancer screening and follow-up.
4. Improvement in rates of hypertension detection and control.
5. Improvement in rates of diabetes monitoring and control.
6. Improvements in diet and rates of blood cholesterol monitoring and control.
7. Further determination and reduction of the factors associated with adverse pregnancy outcomes.
8. Reduction of risky sexual behavior that leads to acquisition of HIV/AIDS, STDs, and unwanted pregnancy.
9. Reduction of physical inactivity.
10. Reduction of alcohol abuse.
11. Reduction of illicit substance use and substance use practices associated with transmission of infectious disease.

HEALTH SERVICES PRIORITIES

1. Reinforce and strengthen the public health infrastructure.
2. Focus resources on the collection, analysis, interpretation, and dissemination of health systems data and information for better monitoring of the health care delivery system.

3. Promote the development of adequate programs and services for persons aged 65 years and older.
4. Monitor the growth and development of managed care and its impact on the delivery and utilization of personal health care services.
5. Expand access to affordable health insurance and primary and preventive health care services to the uninsured and underinsured.

ESSENTIAL PUBLIC HEALTH PROGRAMS

1. Monitoring and control of all infectious diseases.
2. Investigation of outbreaks of infectious diseases and food poisoning.
3. Immunization programs.
4. Setting and enforcing standards for preventive health care and professional provider qualifications and provider and facility quality assurance.
5. Protection of food and water through setting and enforcing quality standards.
6. Lead abatement in housing and testing of children for blood lead levels.
7. Setting and enforcing standards for preventive health care.
8. Assuring the provision of health care services to underserved populations.
9. Family nutrition programs.

MATERNAL AND CHILD HEALTH PRIORITIES

In addition to the above listed priorities, the following priorities were identified through the Maternal and Child Health Needs Assessment for this application. These are described in more detail in the Needs Assessment Section of this application.

1. Enhance CSHCN services
2. Reduce the health disparities between whites and other racial/ethnic groups.
3. Encourage the adoption of healthy habits among children and adolescents.
4. Reduce teen pregnancy.
5. Reduce the frequency and or severity of injuries to children and adolescents.
6. Improve access to and quality of care for mothers and children.
7. Improve data capacity related to Maternal and Child Health issues.
8. Improve access to dental health services.
9. Enhance referrals for mental health services.
10. Improve recognition, diagnosis, and case management for asthma.

The delivery of Title V services in Connecticut are intended to address these priority areas. The Children with Special Health Care Needs program regards the priority areas specific to this population in its program design. Infant mortality and morbidity reduction, and the reduction of racial disparity is addressed through a variety of programs, including Healthy Start/Comadrona and Healthy Choices for Women and Children. Improvement in the

health status of children and adolescents is the focus of the School Based Health Programs, and the Oral Health Program as well. Teen pregnancy reduction is addressed through the Adolescent Pregnancy Prevention/Young Parents Program and also crosses over into other program areas. Asthma prevalence has been increasing and Title V programs will be working to improve recognition, diagnosis and case management for asthma. The issue of access to services is addressed programmatically as well as administratively through DPH participation in a variety of statewide processes, such as the CT HUSKY program, for example. Consistent with the HP 2010 objectives, Connecticut gives priority to MCH surveillance through such activities as Pregnancy Related Mortality Surveillance, Fetal and Infant Mortality Review, and Vital Records data collection and analysis, to name a few. Emphasis is being placed on the necessity to develop better linkages among our many sources of data. All Title V activities and programs are designed to promote and protect the health of Connecticut's mothers, children and adolescents, and children with special health care needs.

1.5 The State Title V Agency

1.5.1 State Agency Capacity

1.5.1.1 Organizational Structure

There have been no changes to the Department of Public Health's organizational structure in the past year. Beth Weinstein has assumed the role of the Title V Director and the Director of the Family Health Division under the direction of Ardell A. Wilson, DDS, MPH, Chief of the Bureau of Community Health. The majority of Connecticut's Title V program activities reside organizationally within the Family Health Division in the Bureau of Community Health.

See Supporting Documents for the DPH Organizational Charts and Table 5 for Divisions and Programs within the Bureau of Community Health.

Table 5 Programs identified in Bold are part of the Title V Federal/State Partnership

Bureau of Community Health	
DIVISIONS	PROGRAMS
<p><i>Family Health Services</i></p> <p><i>Director: Beth Weinstein</i> <i>Title V MCH Director</i></p>	<p>I. <u>Maternal and Child Health Unit (MCH):</u></p> <ul style="list-style-type: none"> • Abstinence Only Education • Adolescent Pregnancy Prevention/Young Parents • Child Health Access Project • Children with Special Health Care Needs • CT Healthy Start/Comadrona • Genetics Services • Healthy Choices for Women and Children • Maternal PKU • MCH Referral and Information Services • Pregnancy Exposure Information Service • Pregnancy Related Mortality Surveillance • Sickle Cell Services • Statewide Systems Development Initiative • Sudden Infant Death Syndrome • Universal Newborn Hearing Screening • Universal Newborn Screening <p>II. <u>School and Primary Health Unit (S&PH)</u></p> <ul style="list-style-type: none"> • Community Health Centers • Cooperative Agreement for Primary Care • Expanded School Health Services • Family Planning • Farmworker Health • NHSC SEARCH (National Health Service Corps; Student/Resident Experiences and Rotation Community Health) • Oral Health • Pediatric Primary Care • School Based Health Centers • Sexual Assault Prevention and Intervention • State Loan Repayment • Women's Health
<p><i>Program Support and Contract Management</i></p> <p><i>Julianne Konopka, Director</i></p>	<ul style="list-style-type: none"> • Fetal Infant Mortality Review • Behavioral Risk Factor Surveillance System • MCH Block Grant Application • PHHS Block Grant Application • Contract Development and Management • TB Billing • Health Professional Shortage Designations (HPSAs)

<p><i>Health Education and Intervention</i></p> <p><i>Nancy Berger, Director</i></p>	<ul style="list-style-type: none"> • Health Promotion • Cardiovascular Disease Prevention • Breast and Cervical Cancer Early Detection • Nutrition/Physical Activity, 5 a Day, Folic Acid, Osteoporosis Prevention • Injury Prevention • Diabetes • Tobacco Control • Special Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) • Chronic Disease Control
<p><i>Environmental Epidemiology and Occupational Health</i></p> <p><i>Mary Lou Fleissner, Director</i></p>	<ul style="list-style-type: none"> • Toxic Hazards Assessment • Childhood Lead Poisoning Prevention • Connecticut Birth Defects Prevention and Surveillance Program (CBDSP) • Occupational Health & Special Projects • Childhood Asthma surveillance and Control
<p><i>Infectious Diseases</i></p> <p><i>James Hadler, Director</i></p>	<ul style="list-style-type: none"> • AIDS Epidemiology and Perinatal Infectious Disease Program • Epidemiology Program • Immunization Program • Sexually Transmitted Diseases Program • Tuberculosis Control Program • Lyme Disease Surveillance and Prevention • Hepatitis B Perinatal Prevention • Emerging Infections and Bioterrorism Surveillance
<p><i>AIDS Programs</i></p> <p><i>Beth Weinstein, Director</i></p>	<ul style="list-style-type: none"> • HIV/AIDS Prevention & Intervention programs

Authority for the Maternal, Infant, and Child and Adolescent Health Programs is derived from the General Statutes of the State of Connecticut and Title V Federal Grant Program Requirements. Table 6 represents the statutes that support the Bureau’s authority for Connecticut’s Maternal, Infant, Child and Adolescent Health related programs.

Table 6 Maternal and Child Health Related Statutes

Sec 19a-2a PA 93-381 (1993)	Powers and duties. The Commissioner of Public Health shall employ the most efficient and practical means for the prevention and suppression of disease and shall administer all laws under the jurisdiction of the DPH and the Public Health Code. He shall have responsibility for the overall operation and administration of the Department of Public Health. The powers and duties are further defined.
Sec. 19a-4i PA 93-269 (1993)	Office of Injury Prevention. There shall be, within the Department of Public Health, an Office of Injury Prevention, whose purpose shall be to coordinate and expand prevention and control activities related to intentional and unintentional injuries. The duties of the Office are further defined.
Sec. 19a-4j PA 98-250 (1998)	Office of Multicultural Health. There is established within the Department of Public Health, an Office of Multicultural Health. The responsibility of the office is to improve the health of all Connecticut residents by eliminating difference in disease, disability and death rates among ethnic, racial and cultural populations. Further responsibilities of the office are defined.
Sec. 19a-7	Public Health Planning. The Department of Public Health shall be the lead agency for

<i>PA 75-562 (1975)</i>	public health planning and shall assist communities in the development of collaborative health planning activities which address public health issues on a regional basis or which respond to public health needs having state-wide significance. Further requirements for the development of a multiyear state health plan are defined.
<i>Sec. 19a-7a PA 90-134 (1990)</i>	State goal to assure the availability of appropriate health care to all state residents. The General Assembly declares that it shall be the goal of the state to assure the availability of appropriate health care to all Connecticut residents, regardless of their ability to pay.
<i>Sec. 19a-7c PA 90-134 (1990)</i>	Subsidized nongroup health insurance product for pregnant women. The commissioner of Public Health, in consultation with the Department of Social Services, may contract, within available appropriations, to provide a subsidized nongroup health insurance product for pregnant women who are not eligible for Medicaid and have incomes under two hundred percent of the federal poverty level. Further details of the product are defined.
<i>Sec. 19a-7f PA 91-327 (1991)</i>	Childhood immunization schedule. The standard of care for immunization for the children of this state shall be the recommended schedule for active immunization for normal infants and children published by the committee on infectious diseases of the American Academy of Pediatrics or the schedule published by the National Immunization Practices Advisory Committee, as determined by the Commissioner of Public Health. An immunization program shall be established by the commissioner; the parameters of that program are further defined and include that the program shall provide vaccine at no cost to health care providers in Connecticut to administer to children so that cost of vaccine will not be a barrier to age-appropriate vaccination in this state..
<i>Sec. 19a-7h PA 94-90 (1994)</i>	Childhood immunization registry. Regulations. The commissioner of Public Health or his designee may, within the limitations of available resources, establish and maintain for the purpose of assuring timely childhood immunization an ongoing registry of all children who have not begun the first grade of school including all newborns. The registry shall include such information as is necessary to accurately identify a child and to assess current immunization status. Further reporting information and requirements are described.
<i>Sec. 19a-7I PA 97-1 (1997)</i>	Extension of coverage under the maternal and child health block grant. Within available appropriations, the Commissioner of Public Health shall extend coverage under Title V of the Social Security Act for families up to three hundred percent of the federal poverty level to cover underinsured children with family incomes between two hundred percent and three hundred percent of the federal poverty level. If allowed by federal regulations, such expansion may be included for reimbursement under Title XXI of the Social Security Act.
<i>Sec. 19a-25 PA 61-358 (1961)</i>	Confidentiality of records procured by the DPH or directors of health of towns, cities or boroughs. Describes the restricted use and confidentiality of all information, records of interviews, written reports, statements, notes, memoranda or other data procured by the Department or its representatives for the purpose of reducing the morbidity or mortality from any cause or condition and states that such information shall be confidential and shall be used solely for the purposed of medical or scientific research and for disease prevention and control.
<i>Sec. 19a-32 (1949)</i>	Department authorized to receive gifts. The Department of Public Health is authorized to receive, hold and use real estate and to receive, hold, invest and disburse money, securities, supplies or equipment offered it for the protection and preservation of the public health and welfare by the federal government or by any person, corporation or association, provided such real estate, money, securities, supplies or equipment shall be used only for the purposes designated by the federal government or such person, corporation or association. Said department shall include in its annual report an account of the property so received, the names of its donors, its location, the use made thereof and the amount of unexpended balances on hand.
<i>Sec. 19a-35 PA 35-240 (1935)</i>	Federal funds for health services to children. The Department of Public Health is designated as the state agency to receive and administer federal funds which may become available for health services to children.

<i>Sec. 19a-48 (1949)</i>	Care for Children with Cerebral Palsy. The Department of Public Health shall furnish services for children who have cerebral palsy or who are suffering from conditions which lead to cerebral palsy, such services to include the locating of such children, the providing of medical, surgical, corrective and allied services and care, and the providing of facilities for hospitalization and aftercare.
<i>Sec. 19a-49 (1961)</i>	Services for Persons with Cystic Fibrosis. The Department of Public Health shall establish and administer a program of services for children and adults suffering from cystic fibrosis.
<i>Sec. 19a-50 PA 39-142 PA 37-430 (1937 & 1939)</i>	Children crippled or with cardiac defects. The Department of Public health is designated as the state agency to administer a program of services for children who are crippled or suffering from conditions which lead to crippling or suffering from cardiac defect or damage and to receive and administer federal funds which may become available for such services.
<i>Sec. 19a-51 PA 63-572 (1963)</i>	Pediatric Cardiac Patient Care Fund. There shall be a Pediatric Cardiac Patient Care Fund to be administered by the Department of Public Health and to be used exclusively for medical, surgical, preoperative and postoperative care and hospitalization of children, residents of this state, who are or may be patients of approved cardiac centers in this state.
<i>Sec. 19a-52 (1981)</i>	Purchase of equipment for handicapped children. ...the Department of Public Health...may, within the limits of appropriations, purchase wheelchairs and placement equipment directly and without the issuance of a purchase order, provided such purchases shall not be in excess of six thousand five hundred dollars per unit purchased. Further information about such purchases are described.
<i>Sec. 19a-53 PA 33-318 (1933)</i>	Reports of physical defects of children. Each person licensed to practice medicine, surgery, osteopathy, midwifery, chiropractic, natureopathy, podiatry or nursing or to use any other means or agencies to treat, prescribe for, heal or otherwise alleviate deformity, ailment, disease or any other form of human ills, who has professional knowledge that any child under five years of age has any physical defect shall, within forty-eight hours from the time of acquiring such knowledge, mail to the Department of Public Health a report, stating the name and address of the child, the name and address of this parents or guardians, the nature of the physical defect and such other information as may reasonably be required by said department.
<i>Sec. 19a-54 PA 33-266 (1933)</i>	Registration of physically handicapped children. Each institution supported in whole or in part by the state shall report to the Department of Public health, the name and address of each child under twenty –one years of age who is physically handicapped for whom application is made for admission, whether such child is admitted or rejected.
<i>Sec. 19a-55 PA 65-108 (1965)</i>	Newborn infant health screening. The administrative officer or other person in charge of each institution caring for infants shall cause to have administered to every such infant in its care an HIV-related test, as defined in section 19a-581, a test for phenylketonuria, hypothyroidism, galactosemia, sickle cell disease, maple syrup urine disease, homocystinuria, biotinidase deficiency, congenital adrenal hyperplasia and such other tests for inborn errors of metabolism as shall be prescribed by the Department of Public Health. The tests shall be administered as soon after birth as is medically appropriate. If the mother has had an HIV-related test pursuant to section 19a-90 or 19a-593, as amended by this act, the person responsible for testing under this section may omit an HIV-related test. The Commissioner of Public Health shall (1) administer the newborn screening program, (2) direct persons identified through the screening program to appropriate specialty centers for treatments, and (3) set the fees to be charged to institutions to cover all expenses of the comprehensive screening program including testing, tracking and treatment. The Commissioner shall adopt regulations specifying the abnormal conditions to be tested for and the manner of recording and reporting results.
<i>Sec. 19a-56a PA 89-340 (1989)</i>	Birth defects surveillance program. There is established a birth defects surveillance program, within available funds, in the Department of Public Health. The program shall monitor the frequency, distribution and type of birth defects occurring in Connecticut on an annual basis. The Commissioner of Public Health shall establish a system for the collection

	of information concerning birth defects and other adverse reproductive outcomes. Further specifics regarding the Birth Defects Surveillance Program are defined.
<i>Sec. 19a-56b PA 89-340 (1989)</i>	Confidentiality of birth defects information. All information collected and analyzed pursuant to section 19a-56a shall be confidential insofar as the identity of the individual patient is concerned and shall be used solely for the purposes of the program. Access to such information shall be limited to the Department of Public Health and persons with a valid scientific interest and qualifications as determined by the Commissioner of Public Health, provided the department and such persons are engaged in demographic, epidemiologic or other similar studies related to health and agree, in writing, to maintain confidentiality. Further details regarding confidentiality are described.
<i>Sec.19a-58 PA 79-287 (1979)</i>	Pamphlet Concerning Hearing Impairments in Infants. The Department of Public Health shall develop a pamphlet which (1) Specifies the indicators for high risk of hearing impairment in infants; (2) explains the diagnostic procedures which should be carried out to determine whether a hearing impairment actually exists or may potentially develop and where such diagnostic services are available; (3) alerts parents to the resources available for the treatment and education of infants and children that develop hearing impairments, and (4) contains any other information the department deems necessary. Further information about the pamphlet distribution and availability, and the development of regulations defining indicators of high risk of hearing impairment are defined.
<i>Sec 19a-59 PA 81-205 (1981)</i>	Program to Identify Newborn Infants at Risk for Hearing Impairment. Each institution, as defined in section 19a-490, that provides childbirth service shall, not later than July 1, 2000, include a universal newborn hearing screening program as part of its standard of care and shall establish a mechanism for compliance review. The Department of Public Health shall establish a plan to implement and operate a program of early identification of infant hearing impairment. The purpose of such a program is further defined.
<i>Sec. 19a-59a PA 82-355 (1982)</i>	Low Protein modified food products and amino acid modified preparations for inherited metabolic disease. Prescription required. Purchase by department...The Department of Public Health, in carrying out its powers and duties under this section, may within available appropriations, purchase prescribed special infant formula, amino acid modified preparations and low protein modified food products directly and without the issuance of a purchase order.
<i>Sec. 19a-59b PA 83-17 (1983)</i>	Maternal and child health protection program. The Commissioner of Public Health shall establish a maternal and child health protection program. He shall contract, for purposes of the program, annually, within available appropriations, with local providers of health services to provide outpatient maternal health services and labor and delivery services to needy pregnant women and child health services to children under six years of age. Eligibility requirements and further description of the program are defined.
<i>Sec. 19a-59c PA 88-172 (1988)</i>	Administration of federal Special Supplemental Food Program for Women, Infants and Children in the state. The Department of Public Health is authorized to administer the WIC program in the state, in accordance with federal law and regulations.
<i>Sec. 19a-60 PA 45-462 (1945)</i>	Dental services for children. The Department of Public Health may, on request, furnish dental services for children in areas of the state where adequate dental service shall be furnished free of charge to all children where the cost of necessary service would be a financial hardship to their parents. Such dental service may be furnished to children of parents who are financially able to pay parent or all of the cost of dental services received by their children. Said department is authorized to charge for dental service in such cases, but in no case more than the actual cost of such service and materials.
<i>Sec.19a-61 PA 78-196 (1978)</i>	Services for Children Suffering from Diabetes. The Department of Public Health shall establish and administer a program of services for children suffering from diabetes. Diabetic centers for children shall be geographically located so as to conveniently serve the population of the state. Further details of such centers are defined.
<i>Sec. 4-8</i>	Qualifications, Powers and Duties of Department Head. This statute authorizes the

<i>(1949)</i>	transfer of Title V funds to the Department of Social Services (DSS).
<i>Sec. 19a-90 PA 41-255 (1941)</i>	Blood tests of pregnant women for syphilis. Each physician giving prenatal care to a pregnant woman in this state during gestation shall take or cause to be taken a blood sample of each such woman within thirty days from the date of the first examination and during the final trimester between the twenty-sixth and twenty-eighth week of gestation or shortly thereafter subject to the provisions of this section, and shall submit such sample to an approved laboratory for a standard serological test for syphilis.
<i>Sec. 19a-110 PA 71-22 (1971)</i>	Report of lead poisoning. Defines reporting requirements to the Department of Public Health regarding blood lead levels equal to or greater than 10 micrograms per deciliter of blood or any other abnormal body burden of lead.
<i>Sec. 19a-111a-e PA 87-394 (1987)</i>	Lead poisoning prevention program. The Commissioner of Public Health shall establish a lead poisoning prevention program. Such program shall provide screening, diagnosis, consultation, inspection and treatment services, including, but not limited to, the prevention and elimination of lead poisoning through research, abatement, education and epidemiological and clinical activities.
<i>Sec. 17b-277 PA 88-217 (1988)</i>	Medical assistance for needy pregnant women and children. Presumptive eligibility. The Commissioner of Social Services shall provide, in accordance with federal law and regulations, medical assistance under the Medicaid program to needy pregnant women and children up to one year of age whose families have an income up to one hundred eighty-five percent of the federal poverty level. The commissioner shall implement presumptive eligibility for appropriate applicants for the Medicaid program with an emphasis on pregnant women. Such presumptive eligibility determinations shall be in accordance with applicable federal law and regulations. The commissioner shall provide such presumptive eligibility determinations on a pilot basis, in one district office beginning June 1, 1991, and shall provide them statewide effective September 1, 1991.

1.5.1.2 MCHB Partnership Program Capacity

A discussion of the capacity of Connecticut's Title V program to meet the needs of pregnant women, mothers and infants, children and adolescents, and children with special health care needs requires a description of Title V funded service delivery (programs), the workforce, and the support services currently in place. The settings in which services are delivered and the strategies used to address the needs of each target population have to be considered when discussing program capacity as well. Table 7 presents Connecticut's Title V Partnership Programs by level of the pyramid of health care services (direct care, enabling, population based, and infrastructure) and by population group served (pregnant women, mothers, and infants; children and adolescents, and children with special health care needs).

The workforce that contributes to the Title V capacity includes both the staff at the Connecticut Department of Public Health (MCHBG partnership funded) and the staff responsible for administering programs that serve the target population at the community level. Organizations responding to Requests for Proposals and those receiving DPH contracts must file a Workforce Analysis form to delineate the racial, ethnic and gender make-up of their staff. In this way DPH assures an organization's cultural diversity and its capacity to reflect the community where it is located and the population it serves. In order to assure the cultural competence of the Title V staff within the Department of Public Health, the Family Health Division plans to undertake the following activities regarding cultural literacy:

- * training in the concepts of cultural literacy,
- * role playing exercises to demonstrate problems that arise when programs are not culturally competent, and,
- * the distribution of appropriate reading material among state and local staff.

DPH staff provide grantees with technical assistance, training, information technology and other infrastructure-building services that enhance the ability of community based programs and services to address the needs of the three target populations.

The majority of the partnership sponsored programming in the Connecticut Department of Public Health, Bureau of Community Health, is located in the Family Health Division. The MCH Director is also the Division Director and serves as the state's Primary Care Officer. Along with the traditional MCH/CSHCN program, the Division is responsible for administering the Abstinence-Only Education Program, the Family Planning program, Rape Crisis, and Community Health Center program. In addition, the Oral Health CISS Project and the SSDI Initiative are housed in the Family Health Division. This broad range of responsibilities allows for close partnerships and collaboration among programs serving similar and related MCH populations. (See organization structure for more details.)

Table 7 Connecticut's Title V Partnership Program in CT - July 2000

Program/Activity	LEVELS OF THE PYRAMID				■	TARGET POPULATIONS		
	Direct Medical	Enabling	Population Based	Infrastructure		■	Women & Infants	Children & Adolescents
APP/YPP		75%		25%	■	30%	70%	
CSHCN	20%	50%		30%	■			100%
FIMR				100%	■	100%		
Genetics	40%	40%		20%	■			100%
Healthy Choices		80%		20%	■	70%	30%	
Healthy Start/ Comadrona		70%		30%	■	60%	40%	
MCH Information & Referral		40%		60%	■	75%	20%	5%
Maternal Mortality			10%	90%	■	100%		
SIDS		20%	50%	30%	■			100%
Universal Newborn Screening		10%	50%	40%	■			100%
UNBHS		10%	50%	40%	■			100%
Oral Health	15%	15%	35%	35%	■	30%	65%	5%
Pedi Primary Care (CHCs)		80%		20%	■	20%	80%	
SBHCs	40%	20%	10%	30%	■		90%	10%
ESHCs	50%	20%	10%	20%	■		90%	10%
Family Planning	70%	10%		20%	■	60%	35%	5%

Pregnant Women, Mothers and Infants

DPH programs that address the needs of Pregnant Women, Mothers and Infants through contracts with local providers for direct care services, enabling, population-based and/or infrastructure building services include:

- Adolescent Pregnancy Prevention/Young Parents Program (APP/YPP)
- Family Planning Program (FP)
- Fetal and Infant Mortality Review (FIMR)
- Healthy Choices for Women and Children (HCWC)
- Healthy Start (HS)/Comadrona
- Maternal Child Health Information and Referral Service (MCH I&R)
- Oral Health Program (OHP)
- Pregnancy Related Mortality Surveillance (PRMS), and
- Pediatric Primary Care

Title V services are provided to pregnant women and infants in community-based health and social service organizations such as visiting nurse associations, schools, local health departments, community health centers and hospitals. Strategies utilized in service delivery include primary and preventive care, care management, outreach and follow-up, risk assessment, education and support services. Most of these strategies are also directed at women of childbearing age since many factors that impact the health of the pregnant woman or her infant are best addressed before she becomes pregnant.

The *Adolescent Pregnancy Prevention/Young Parents Program* is described under services for Children and Adolescents below.

Connecticut provides *Family Planning* services and reproductive health care, including pregnancy testing, to women and adolescents through its contract with Planned Parenthood of CT, Inc. Comprehensive reproductive health services are available in sixteen locations across the state. These sites have been determined, by needs assessment, to be areas with high concentration of low income women, men and adolescents of reproductive age. Their target population is defined as all individuals seeking reproductive health care, and having some limitation in their ability to pay the full service fee.

Family Planning promotes decreasing the birth rate to teens aged 15-17, prevent unintended pregnancy, and increase access to primary reproductive health care. Direct reproductive health care provided by the contractors include health promotion and disease prevention through educational programs, contraception services, preconception counseling, pregnancy testing, pregnancy options counseling, referral for prenatal care, screening for sexually transmitted diseases and treatment, HIV/AIDS and breast and cervical cancer screening, counseling to address identified risk factors, referrals and follow up services, nutrition counseling, and outreach. Enabling services provided through contracts between DPH and PPC include translation for non-English speaking clients, outreach, health education, referrals to Healthy Start and WIC, and coordination with Medicaid as appropriate.

Six high risk communities are currently funded to implement *Fetal and Infant Mortality Review (FIMR)* projects. In each community, the FIMR process brings a community team together to examine confidential, de-identified cases of infant deaths. (Information is obtained from case record reviews and from a maternal interview.) The purpose of these reviews is to understand how a wide array of local social, economic, public health, educational, environmental and safety issues relate to the tragedy of infant loss. Having gained a comprehensive understanding of these issues from the case reviews, a broad forum of interested community members/leaders, elected officials, providers, agencies, advocates and consumers--are able to reason together and act to improve services and resources

It is anticipated that through FIMR, the awareness of health care professionals and other individuals who provide care to women and infants will be heightened to the issues that drive fetal and infant mortality and morbidity. Communities will be empowered in their efforts to enhance services, influence policy, and direct efforts that are intended to ultimately lower fetal and infant mortality rates. As service systems and resources continue to improve through FIMR, the future for local women, infants and families will be better.

The Connecticut *Healthy Start (HS)* Program is a statewide system composed of 23 sites that provide community-based, culturally sensitive enabling services to pregnant women and children. The goal of Healthy Start is to improve access and availability to comprehensive health and health related services for eligible pregnant women and children which contributes to the reduction of infant mortality and morbidity and improved health status. Contracts for the Healthy Start program are administered by the Department of Social Services, and the program is a collaboration between DSS and DPH. Services are co-located in agencies that provide direct primary, preventive, and support services to the target population. All clients receive a standardized risk assessment that provides the basis for determining essential care management services. These services include linkage with primary and preventive care services, support services, advocacy services, and referrals to other community resources including wrap-around services like transportation. Care management also involves coordination of services to prevent duplication.

The Healthy Start/Healthy Families Partnership, part of the DSS/DPH Healthy Start collaborative, is an initiative developed as a result of legislation passed in 1997. This component was initially funded in FY 97, and, although modeled after the Hawaii Healthy Families Initiative, program implementation varies depending on the needs of the community. The partnership is designed to achieve a variety of objectives, specifically:

- * To link families with programs that meet their identified health and related needs.
- * Provide intensive and long term case management and home visiting services to assist families in: identifying their own strengths; enhancing their ability to advocate for themselves; and by promoting their own health, safety and well-being.
- * Provide employment to former welfare recipients in response to the state's Welfare to Work initiative.

The *Comadrona* Program is a culturally sensitive, nationally recognized model for intensive case management which demonstrates the ability to link and assure that all prenatal clients receive appropriate and continuous prenatal care and are enrolled in Medicaid and other programs for which they are eligible, based upon individual and cultural needs. Additionally children born to program clients have identified pediatric care and receive immunizations and other related preventative services as indicated.

The *Healthy Choices for Women and Children (HCWC)* program offers home visiting services to a specific target population--pregnant, eligible residents in the city of Waterbury, and their children. Clients have a history of, or are current substance abusers, or live in a substance abusing household. The program uses a comprehensive community team approach to provide intensive case management services and linkage to needed services and supports.

The *Maternal Child Health Information and Referral Service (MCH I & R)* is Connecticut's response to the Title V requirement for provision of a toll-free, statewide information and referral service, and has been in place since 1991. This free telephone access point provides information on health care and support services for the state's pregnant women, parents, and their children. The MCH I&R maintains extensive information on services and programs available in the state, including those which serve the Title V target populations. Reports are generated quarterly to reflect MCH service requests, client demographics and gaps/barriers related to the MCH population in Connecticut. In addition to the telephone information and referral service, the MCH I & R Program, through the 5 MCH staff liaisons, provides public awareness activities regarding MCH issues and services.

The MCH I & R is available in all 169 Connecticut towns. Callers who access the toll-free number are referred to services in their local communities. Services are accessible to non-English speaking callers via trained interpreters who are bilingual and sensitive to the cultural needs of the callers. Telephone services are also available to speech/hearing impaired.

The *Oral Health* Program's CISS-CT Community Oral Health Systems Development Project (CCOHP) continues to help develop community based pilot site work groups dedicated to the development of oral health care delivery systems and the integration of oral health into existing MCH and other health and human services programs. These work groups are enabling enhanced access to dental services in their communities through a variety of innovative means. In addition to clinical services, the CCOHP sites provide oral health education in prevention of baby bottle tooth decay to women, mothers, and infants. The Oral Health Program has developed a draft Early Childhood Caries prevention program to educate health professionals and the public about the oral health care issues and needs of infants. Although presently in developmental stages, it is estimated that, once operational, these efforts will enable provision of dental services to approximately 25,000 women, mothers and infants.

The *Pregnancy Related Mortality Surveillance (PRMS)* is a population based program that will be administered via a Memorandum Of Agreement, by the University of Connecticut Health Center, Department of Obstetrics and Gynecology. OB/GYN staff will conduct mortality reviews. Based on review findings, physician education will be provided to prevent future maternal deaths and to increase case reporting to the committee.

Pediatric Primary Care projects, providing services to infants in four communities, are described under services for Children and Adolescents below.

Children and Adolescents

A large number of Connecticut children, especially adolescents, who are un and underinsured, do not have access to basic medical care. Other barriers to care include cost, lack of transportation, concerns about confidentiality, cultural competence, lack of availability of services and lack of knowledge about available services

and the importance of preventive care and some local agency policies that require parental involvement. In Connecticut's survey of middle and high school students, "The Voice of Connecticut Youth", nearly one third of the students reported that they had not received medical care when they should have in the past year.

DPH programs that address the needs of children and adolescents through contracts with local providers to provide direct care services, enabling, population-based and/or infrastructure building services include:

- Adolescent Pregnancy Prevention/Young Parents Program (APP/YPP)*
- Family Planning Program (FP),
- Healthy Choices for Women and Children
- Healthy Start (HS)/Comadrona
- Maternal Child Health Information and Referral Service (MCH I&R)
- Oral Health Program (OHP)
- Pediatric Primary Care projects
- School Based Health Centers (SBHC), and
- Expanded School Health Services (ESHS)

Strategies utilized to address the needs of children and adolescents include primary and preventive physical and behavioral health care, immunizations, screenings, nutrition services, injury prevention, health education, outreach and follow-up, transportation, and social and support services. Behavioral and mental health services for youth include initiatives to reduce unhealthy risk behaviors, including suicide, unprotected sexual activity, and substance abuse. Settings in which these services are provided include community-based health and social service organizations, including visiting nurse associations, schools, local health departments, Community Health Centers and hospitals.

The *Adolescent Pregnancy Prevention/Young Parents Program* provides intensive care management and social services, including support services, advocacy, and health education services to pregnant and parenting teens in 50 towns via sites in hospitals, schools and community-based organizations. Through these services, pregnant/parenting teens are linked with health, educational, social and other essential community-based services in order to prevent low birthweight births and second pregnancies as well as to encourage self-sufficiency and positive parenting skills in these young people. The program also links the infants and children of teen parents with primary care services and monitors the compliance with their immunization schedules.

Connecticut provides *Family Planning* services and comprehensive reproductive health care to adolescents through its contract with Planned Parenthood of Connecticut, Inc. (PPC). The services provided are described in the previous section on women and infants. A special effort is made by the contractor to target services to teens by providing sexually transmitted disease screening and treatment, HIV/AIDS screening, and contraception services including condoms. Other services targeted specifically to teens include free pregnancy tests and counseling visits for adolescents at or below 150% federal poverty level, outreach efforts at health fairs, teen life conferences, and concerts across the state to provide reproductive health and STD prevention literature as well as conducting community educational programs to teens at risk.

The ***MCHI&R*** is a statewide information and referral service, maintaining an extensive database on services and programs available in the state, including those which serve children and adolescents. People calling the hotline number are provided with information about the array of community based services available to address their concerns. See a more extensive program description under services for Pregnant Women, Mothers, and Infants above.

The Oral Health Program's CISS-CT Community Oral Health Systems Development Project (CCOHP) continues to help develop community based pilot site work groups dedicated to the development of oral health care delivery systems and the integration of oral health into existing MCH and other health and human services programs. These work groups are enabling enhanced access to dental services in their communities through a variety of innovative means, with the potential, to enable access to dental services for approximately 50,000 children statewide. The Oral Health Program continues to develop its health promotion and disease prevention program, addressing such issues as oral hygiene, sports-related injuries, and dental sealants. Through health centers, health fairs and collaborative activities with the CT State Dental Association, these programs help change health risk behavior and improve children's health.

In addition, the Oral Health Program has taken significant steps this past year to enhance the State's capacity to conduct oral health needs assessments and surveillance for children. A partnership with the Yale-Griffin Prevention Research Center has established the oral health Innovative/Integrated Use of Data for Evaluation, Assessment and Surveillance (IDEAS) Project. The Oral Health Survey and Needs Assessment for Second Grade School Children has been completed and analysis and final reports are being prepared.

Pediatric Primary Care projects are supported within the Community Health Center Program in four areas of especially high need in Hartford, New Haven, Middletown and Waterbury. Emphasis is placed on the provision of outreach, health education, case management, transportation assistance, multilingual/multicultural services, in addition to support for basic health services for uninsured and underinsured children. This comprehensive package of services is designed to improve the health status of the children served. Development and support of linkages with community based programs serving children have been encouraged. These programs include Healthy Start, WIC, Birth to Three, Family Planning, APP/YPP, SBHC and CSHCN Programs.

School Based Health Centers (SBHC) are comprehensive primary health care facilities located within or on the grounds of schools. In Connecticut, DPH funds 57 SBHCs in sixteen communities, serving students in grades Pre-K through 12. All students attending a school where a SBHC is located are eligible to enroll in the SBHC with parental permission.

In Connecticut, SBHCs are licensed as outpatient facilities or hospital satellites. They offer a wide range of services addressing the medical, mental and oral health needs of youth. These include crisis intervention, health education, social services, outreach, and substance abuse prevention services. In SBHCs, young clients can receive extensive health education on issues related to puberty, violence prevention, sexuality, reproduction and sexually transmitted diseases. Reproductive health care, including routine gynecological care, sexually transmitted disease counseling, diagnosis, and treatment, and pregnancy testing are available at more than 35 middle and high school

sites throughout the state. SBHCs provide counseling services to pregnant teens, assist them in linking with community providers of prenatal care, and provide ongoing support throughout a teen's pregnancy.

School Based Health Centers make primary and preventive physical and behavioral health care available to children with special health care needs who are mainstreamed in school settings. In such cases, they coordinate the care provided with a child's primary and specialty caregivers, and provide support while the child is in school.

Expanded School Health Services (ESHS) projects are designed to address the community defined unmet needs of students, or gaps in school health services. All students attending a school in which an Expanded School Health Services project is located are eligible to receive services. There are currently five ESHS projects funded by the CT DPH. Three sites focus on prevention and improving mental health status of youth, one site provides physical and behavioral health services to preschool aged children, and one site addresses improving the organization and delivery of school nursing services.

Children with Special Health Care Needs

DPH programs that address the needs of the CSHCN population through direct care at the state and community level, as well as enabling, population-based and infrastructure building services include the following programs:

- Children with Special Health Care Needs (CSHCN)
- Genetics Program (GP)
 - * Pregnancy Exposure Information Services (PEIS)
 - * Sickle Cell Program
 - * Adult and Maternal Phenylketonuria Program (PKU)
 - * Universal Newborn Screening
- Sudden Infant Death Syndrome (SIDS)
- Universal Newborn Hearing Screening (NBHS)
- Family Planning Program (FP)
- MCH I&R
- Oral Health
- School Based Health Centers (SBHC)

Settings in which Title V services are provided to children with special health care needs include tertiary care facilities and outpatient settings (including Community Health Centers and School Based Health Centers). Strategies utilized include primary and preventive care, specialty care, care coordination, outreach and follow-up, education and support services.

The Children with Special Health Care Needs Program (CSHCN) is a statewide delivery system that allows families to access much needed specialized services and supports. The CT CSHCN program is operated in participation with two regional centers: the Connecticut Children's Medical Center (CCMC) located in Hartford and

the Yale Center for Children with Special Health Care Needs located in New Haven. The CSHCN program coordinates specialty care services, provides advocacy and support, and payment for certain services including but not limited to: adaptive and specialty equipment, specialty medical pharmacy and special nutritional formulas, transdisciplinary team conferences, etc. Both Centers subcontract with community based facilities throughout the state, which increases access for families who do not live in Hartford or New Haven. The CSHCN Centers are responsible for providing services to children receiving Supplemental Security Income (SSI) benefits who meet program eligibility criteria.

The statewide **Universal Newborn Screening** (UNBS) program is a population-based program composed of 3 components: testing, tracking, and treatment for all newborns. Connecticut State law mandates that all newborns delivered in Connecticut are screened for eight disorders: biotinidase deficiency, congenital adrenal hyperplasia, congenital hypothyroidism, galactosemia, homocystinuria, maple syrup urine disease, phenylketonuria and hemoglobinopathies. The goal of universal newborn screening is early identification of infants at increased risk for selected metabolic or genetic diseases, so that medical treatment can be promptly initiated to avert complications and prevent irreversible problems. Infants with abnormal screening results are referred to one of the two Regional Treatment Centers for comprehensive testing, counseling, education, and treatment services. Newborns identified with endocrine disorders are referred for confirmation testing and specialty care to Pediatric Endocrinologists at CCMC and Yale University School of Medicine. The programs provide increased public health awareness of genetic disorders, public health education, and referrals.

The two state funded Regional **Genetic Services** programs, located at Yale University in New Haven and the University of CT Genetics program at the CCMC in Hartford, provide access to genetic services for all residents of CT. These services include, but are not limited to, 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. The Centers also 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. In collaboration with the University of Connecticut and Yale School of Medicine, the Maternal PKU Program provides genetic and nutritional counseling, high risk pregnancy care, and maintenance of current records on all adolescent and adult females in CT with PKU.

The two State funded Regional Sickle Cell Programs, located at Yale University in New Haven and St. Francis Hospital and Medical Center in Hartford, provide comprehensive care programs that include confirmation testing, counseling, education and treatment for newborns identified with hemoglobinopathies through the NBS program.

The Sickle Cell Association of America, CT Chapter is located in Hartford, with satellite facilities in New Haven and New London to serve families with sickle cell disease and provide educational programs to increase community awareness of sickle cell disease and trait. The **Sickle Cell Transition** program is a multi-faceted program in New Haven and Hartford that provides support, education, and assistance with transition from pediatric to adult health care for adolescents with sickle cell disease.

The Pregnancy Exposure Information System (PEIS), based at the University of CT Health Center Genetics Program, provides information and referral services to pregnant women and health care providers concerning the potential teratogenic effects of drugs, maternal illness, occupational exposure, etc., via a statewide toll-free telephone number.

The Sickle Cell Association of America, CT Chapter is located in Hartford, with satellite facilities in New Haven and New London to serve families with sickle cell disease and provide educational programs to increase community awareness of sickle cell disease and trait. The *Sickle Cell Transition* program is a multi-faceted program in New Haven and Hartford that provides support, education, and assistance with transition from pediatric to adult health care for adolescents with sickle cell disease.

As of July 1, 2000, all 30 hospitals and birthing facilities in the state are mandated to implement a *Universal Newborn Hearing Screening* program. This is a population-based service that provides for the hearing screening of all newborns prior to discharge. All hospitals are utilizing standardized hearing screening equipment and will conduct the initial screens. Hospital staff will notify the primary care providers of all infants who refer from the initial screens and are in need of follow-up audiologic testing for subsequent diagnostic evaluation. Tracking and follow-up of children who refer from the initial screens will be conducted at the state level. The DPH has purchased the Hi Track data management system in order to track infants screened, those referred to audiologists for further diagnostic evaluation, and those enrolled in the CT Birth to Three Program.

The Connecticut *SIDS* Center provides population-based bereavement services to families that have experienced a sudden infant death. Services are offered to every family with a SIDS death based on referrals from the Office of the Chief Medical Examiner, including an in home visit, referral and follow-up. Previously, the Center also conducted public awareness and training activities for health care professionals, day care providers, community groups, emergency medical personnel, police, and other first responders, in collaboration with the Office of Emergency Medical Services (OEMS) and other DPH programs. These activities (prevention, provider education) will now be conducted by DPH staff. In addition, the DPH has established a SIDS surveillance database and will be responsible for tracking SIDS events statewide.

The Connecticut *SIDS* Center provides population-based bereavement services to families that have experienced a sudden infant death. Services are offered to every family with a SIDS death based on referrals from the Office of the Chief Medical Examiner, including an in home visit, referral and follow-up. Previously, the Center also conducted public awareness and training activities for health care professionals, day care providers, community groups, emergency medical personnel, police, and other first responders, in collaboration with the Office of Emergency Medical Services (OEMS) and other DPH programs. These activities (prevention, provider education) will now be conducted by DPH staff. In addition, the DPH has established a SIDS surveillance database and will be responsible for tracking SIDS events statewide.

Reproductive health, health education and *Family Planning* services are available to adolescents with special health care needs and developmental disabilities through DPH's contract with Planned Parenthood of CT, Inc. A description of these services is provided in previous sections.

As described in the previous sections, the *MCHI&R* is a statewide information and referral service maintaining an extensive database on services and programs available in the state. Callers may call the MCHI&R on behalf of children with special health care needs.

The *Oral Health Program* activities that impact women, infants and children (described above) have been inclusive and, in many cases, specifically address the oral health needs of children with special health care needs. In addition, oral health promotion and disease prevention has been integrated into the goals, objectives and educational activities of the CSHCN program.

School Based Health Centers provide primary and preventive physical and behavioral health care to children with special health care needs who are mainstreamed in school settings. In such cases, they coordinate the care they provide with a child's primary and specialist caregivers, and provide support while the child is in school. A discussion of the scope of services provided by SBHCs is provided in the previous section.

Workforce

Currently there are 33 filled Title V funded positions and 5 vacant positions within the Department of Public Health. (See Table 5 State Title V Staff). Title V staff in the Family Health Unit who have responsibility for the administration of programs that address the needs of the target populations include Social Workers, Nurse Consultants, Epidemiologists, Research Assistants, and a Dentist. A part time Parent Advocate is supported by MCH block grant funds through a contract between the Connecticut Children's Medical Center and DPH. Administrative support is provided by clerical staff. Resumes for the following staff members can be found in the Supporting Documents Section of this application: Beth Weinstein, Director, Family Health Division, Julianne Konopka, Director, Program Support and Contracts Management, Lisa Davis, Supervising Nurse Consultant, and Stanton Wolfe, Oral Health Director.

The Adolescent Pregnancy Prevention/Young Parents Program (APP/YPP) and the *Pregnancy Related Mortality Surveillance (PRMS)* program, is coordinated by a Master's prepared Nurse Consultant with experience and education in nurse-midwifery, teen pregnancy, maternal child and public health. DPH staff responsible for *Healthy Start, Healthy Choices for Women and Children* and *MCHI&R* programs are all Nurse Consultants with education and experience commensurate with the responsibilities of managing these programs. Several of these staff have Master's degrees and some have education beyond the Master's level. All are familiar with both clinical and programmatic issues in the delivery of services to the target populations.

The School and Primary Health Unit Supervisor is also the State Oral Health Director, an Oral & Maxillofacial Surgeon with a Masters degree in Public Health. The *Oral Health Program* is also staffed with a Master's prepared Health Program Assistant 2.

Staff responsible for the *Pediatric Primary Care/Community Health Centers (CHC)* program include a Master's prepared Nurse Consultant with experience in pediatrics, health care access, and related issues. DPH staff responsible for the *SBHC and ESHS* programs include a Nurse Consultant with pediatric, school and adolescent

health and research expertise, Social Work Consultants with clinical and social service backgrounds, and Epidemiologists with expertise in data management and analysis. Most of the staff are prepared at the Master's level.

The MCH Unit in the Family Health Division oversees the *Children with Special Health Care Needs Program* (CSHCN) activities. DPH staff responsible for this program include Nurse Consultants, a Social Work Consultant, a doctorally prepared MCH Epidemiologist and a part time Parent Advocate whose education and experience qualifies them for the responsibilities of managing this program. Several of these staff have Master's degrees. All are familiar with both clinical and programmatic issues in the delivery of services to children with special health care needs. The Parent Advocate offers valuable insight into family/consumer issues for the program staff. Program policies and any proposed changes in services are reviewed by the Parent Advocate, to ensure that a family centered, culturally competent perspective is always maintained. The Parent Advocate may interface directly with families served through the CSHCN program, in order to facilitate coordination of services, while also providing support, information and assistance to the Yale CSHCN program and the CCMC program as well. A Nurse Consultant is responsible for triaging and referring SSI applicants, less than 18 years of age, to the CSHCN Centers for rehabilitative services.

Genetic services staff consist of one Master's prepared Nurse Consultant, two Bachelor's prepared Nurse Consultants, a part time Research Assistant and clerical support. All three Nurse Consultants have expertise in maternal and child health and program management. In addition, the Nurse Consultants' attendance and participation at various genetic and metabolic conferences and educational programs on the state, regional and national levels are maintained in order to keep abreast of the rapid growth in the field of genetics.

Community based staff of *CHCs*, *SBHCs* and *ESHS* includes a wide range of well qualified staff such as Advanced Practice Nurse Practitioners, Physician Assistants, Nurses, Physicians, Dentists, Master's prepared Social Workers and Mental Health clinicians, health educators, Dental Hygienists, Medical Assistants, outreach workers and Nutritionists, many of whom are bilingual/bicultural. These sites are also regularly used as clinical placement sites for nurse practitioner students, nursing students, social work students, medical students and others.

The DPH staff person responsible for the *SIDS* program is prepared in social work at the Master's level. The *SIDS* program funds a part-time Director at the local level who holds a Master's degree in Human Services Administration and coordinates bereavement the services to families of infants who have suffered a sudden infant death.

MCHI & R caseworkers are familiar with both clinical and programmatic issues in the delivery of services to the population groups. In addition, MCH liaisons who represent each of the 5 geographic regions of the state are familiar with community resources, as well as the clinical and programmatic issues necessary to promote public awareness of MCH services.

APP/YPP Program Coordinators at the community level are prepared in Social Work (BSW, MSW), Community Work, Outreach and Counseling (both marriage/family and general).

Recruitment and retention of community responsive, culturally competent primary care providers can be difficult due to sometimes less than desirable work locations and working conditions, and lower than market place salaries and benefits. To overcome these difficulties, all CHCs participate in a DPH supported statewide recruitment

and retention program, utilize National Health Service Corps (NHSC) scholars and loan repayees, and participate in the State Loan Repayment Program (SLRP). Through the SLRP, graduates of professional clinical health programs provide primary care services in CHCs in return for salary and funds for the repayment of their student loans, thus enhancing the workforce in these settings. Certified nurse midwives and specialists in obstetrics and gynecology are included in these programs in addition to family practice, internal medicine and pediatric providers, physicians assistants and dentists. The NHSC Student Experiences and Rotations in Community Health (SEARCH) Program encourages health professionals students to complete clinical placements and community projects in CHCs. Lastly, the J1-Visa Waiver Program also assists in encouraging physicians, from other countries, to practice in health professional shortage areas.

Title V partnership staff and non-partnership staff housed in the Program Support and Contracts Management Unit (PSCM) manage a variety of program support and data analysis activities for the MCH Program. The Fetal and Infant Mortality Review Program (FIMR) is coordinated by a Nurse Consultant in the PSCM Unit. The development of the Title V document is coordinated by staff in PSCM. The PSCM Director, a Nurse Consultant, and two Epidemiologists (one full time and one half time) provide ongoing support for this activity. The methodology for the five year needs assessment was defined by PSCM Unit staff, and the implementation of the needs assessment was coordinated by Program Support staff as well.

Title V staff in the Contracts Management section of the Bureau of Community Health assist with the contract development process. Compliance with contract terms is one means by which the Department holds its grantees accountable as they carry out Title V programmatic responsibility.

Title V funding supports two positions in the Office of Program Planning and Evaluation (OPPE), which facilitates the development of CT's Annual Registration Report. This report is an important source of information for assessing the health of pregnant women, infants and children. Data and analytical support to MCH programs such as FIMR and teen pregnancy prevention are provided by OPPE staff. Support is also provided to the Vital Records Office in assessing the quality and completeness of the Vital Records database and the Birth-Death Match database.

Title V partnership funds also support a position in the DPH Vital Records Section of OPPE. Data management activities regarding maternal health/risk factors, birth outcomes, and infant mortality in Vital Records include entry of medical/statistical data extracted from approximately 44,000 birth certificates per year from hospitals. Data on the medical risk factors of the mother, congenital anomalies of the child, abnormal conditions of the newborn, complications of labor/delivery, number of prenatal care visits, and site(s) of prenatal care visits, among other information, is data entered. This data is utilized to compile the CT's Annual Registration Report of Vital Statistics, while the cause of fetal and infant deaths is data entered into MICAR (Mortality Medical Indexing, Classification and Retrieval) system.

Table 8 State Title V Staff

(33 filled positions; ½time Parent Advocate [Contractual]; 5 Vacancies)

Employee Name and Position Title	LEVELS OF THE PYRAMID					TARGET POPULATIONS			
	Direct Medical	Enabling	Population Based	Infrastructure		Women & Infants	Children & Adolescents	CSHCN	Administration
D. Aye Epidemiologist 4		100%				50%	25%	25%	
M.J. Mitchell Epidemiologist 3				100%		50%	25%	25%	
B. Silverman Epidemiologist 3				100%				100%	
S. Wolfe Oral Health Director			50%	50%		30%	60%	10%	
R. Schreiber Hlth Prgm Associate				100%		100%			
F. Morton Hlth Program Asst 2			50%	50%		30%	60%	10%	
B. Jung Hlth Prgm Associate		100%				50%	40%	10%	
C. Farrelly Hlth Prgm Assoc 2				100%					100%
L. Davis Sup. Nurse Consult	10%	35%	30%	25%		70%	20%	10%	
T. Kalbaugh Nurse Consultant		70%		30%				100%	
S. Tarala Nurse Consultant		60%	30%	10%		20%	20%	60%	
A. Scott Nurse Consultant		60%		40%		60%	30%	10%	
A. Mascia Nurse Consultant		70%		30%		70%	35%		
E. Medeiros Nurse consultant		70%		30%		70%	30%		

Employee Name and Position Title	LEVELS OF THE PYRAMID					TARGET POPULATIONS			
	Direct Medical	Enabling	Population Based	Infrastructure		Women & Infants	Children & Adolescents	CSHCN	Administration
P. Delage Nurse Consultant				100%		50%	25%	25%	
L. Daniels Nurse consultant		755		25%		67%	33%		
D. Trebisacci Nurse Consultant	40%	40%		20%				100%	
F. Larson Nurse Consultant		10%	50%	40%				100%	
D. Masselli Nurse Consultant			50%	50%				100%	
L. Mills Lab Asst 2			100%					100%	
M. Tom Med S. W. Consult		70%	30%					100%	
H. Colon Med S.W. Consult		100%					90%	10%	
H. Ziewacz Assoc. Accountant (50% charged to Title V)				100%					100%
F. Amadeo Assoc. Research Analyst				100%					100%
S. Pickney Research Asst (40% charged to Title V)				100%				100%	
J. Andrews Secretary 2	10%	35%	30%	25%		40%	20%	40%	
F. Battagler Office Assistant				100%					100%
N. Dickman Office Assistant				100%		40%	20%	20%	20%

Employee Name and Position Title	LEVELS OF THE PYRAMID					TARGET POPULATIONS			
	Direct Medical	Enabling	Population Based	Infrastructure		Women & Infants	Children & Adolescents	CSHCN	Administration
K. Krusz Secretary 1	10%	35%	30%	25%		20%	10%	70%	
J. Douglas Clerk Typist		34%	33%	33%		50%	25%	25%	
N. Sinkfield Secretary 2	10%	35%	30%	25%		50%	25%	25%	
K. Gaherty Secretary 2		100%				50%	40%	10%	
M. Fountain Secretary 1		34%	33%	33%		50%	40%	10%	
A. Gionett part time Parent Advocate/ Contractual									
VACANT POSITIONS									
Supervising Nurse Consultant									
Nurse Consultant									
Health Program Supervisor									
Health Program Assistant 1									
Research Analyst									
Secretary 1									

Gaps in Capacity

DPH staff have identified issues and factors that affect the Title V program capacity to meet the needs of the three target populations. These gaps in capacity include the following:

- Access issues, such as confidentiality, acceptability of services, cultural and social insensitivity, and geographic barriers to services continue, despite availability of Husky A(Title 19), Husky B (Title 21) and private insurance. DPH grantees are provided ongoing technical assistance and support in negotiating the existing systems and seeking appropriate policy changes. The DPH continues to address these issues through its representatives on the Medicaid Managed Care Council and its sub-committees as well as through various advocacy groups.
- There continues to be a need to enhance seamless integration of Title V program goals and objectives throughout the activities of the agency and with our community partners. Examples include enhancement of oral health, women's health, minority health, perinatal health and adolescent health. The Title V Program has focused on this need by working collaboratively and through community based systems development and health integration initiatives.
- Racial and ethnic as well as cultural, social and economic disparities in health status exist across all three population groups in Connecticut. This problem needs to be better addressed through review of data and technical assistance to local providers to enhance their ability to deliver culturally competent interventions. Recently, through legislation, DPH was granted funding for an Office of Minority Health. We plan to work cooperatively with this Office to develop a plan for impacting this issue. We will also provide technical assistance to our community grantees to assure that services are provided in a meaningful way to the population(s) they serve. Additionally, a nurse consultant has been assigned to work on multicultural and immigrant health issues in the School & Primary Health Unit.
- Title V funded programs vary in their capacity to collect and analyze data necessary to enhance program development and evaluation. DPH is striving to develop consistency among grantees by providing technical assistance and ongoing support around improving information technology and the development of enhanced data collection systems. DPH needs to increase its capacity to carry out MCH surveillance, analyze data provided by grantees, and utilize this data to inform program and policy development.

1.5.1.3 Other Capacity

Maternal and Child Health issues in Connecticut are addressed in DPH by Title V partnership as well as non-partnership programs and services. These include community health centers, nutrition, WIC, immunizations, sexually transmitted diseases, Hepatitis B perinatal prevention, childhood lead poisoning prevention, breast and cervical cancer early detection, tobacco use prevention, diabetes control, intentional and unintentional injury prevention, youth violence prevention, youth suicide prevention, domestic violence and family violence prevention, and HIV/AIDS prevention activities. Some examples of MCH related activities are as follows.

The Abstinence Only Education Initiative (AOI) has funded 3 community based education programs, and in addition, 2 media campaigns have been produced. A full time coordinator and an Evaluator are also funded by this initiative.

The State *WIC* program administers the federally mandated program funded through the United States Department of Agriculture (USDA) and is part of the Health Education and Intervention Division. The state program funds 21 local programs that are located in local health departments, hospitals, community health care centers, and community action programs. These agencies provide direct services to pregnant women and children up to the age of five, including nutritional risk assessment, nutrition education, supplemental foods, and referrals to health and social service programs. In addition, local *WIC* agencies provide breastfeeding promotion and support, screening for tobacco and substance abuse, outreach, coordination of services with local health agencies/services, and preventive education on lead poisoning, immunization and other topics which impact the health of pregnant women, new mothers, infants, and children.

Community Health Centers (CHC), provide primary and preventive health services to the three target populations, and are available to all persons in CT, regardless of age, insurance or economic status, and race/ethnicity. These centers are family-oriented, community-based, often have extended hours of operation, and are fully handicapped accessible. They are administered by thirteen corporations which provide services to children and adolescents at more than 25 sites throughout the state.

Prenatal services are available through 10 CHCs. Care management for pregnant women is provided, especially in sites where nurse midwives are employed. Enabling services vary by site but may include health education, parenting assistance, translation services, transportation and outreach. Perinatal care is available through all CHCs and may include prenatal and postpartum education and well infant visits. A particular focus on women's health services include breast and cervical cancer screening, domestic violence, and cardio-vascular screening, diagnosis, treatment and follow-up.

Through the *Connecticut Birth Defects Prevention and Surveillance Program (CBDPSP)*, the frequency, distribution and type of birth defects occurring in Connecticut is monitored. The information may be used to determine associations that may be related to preventable causes of birth defects. The 1993, 1994, and 1995 databases have been finalized. Base prevalence rates for major birth defects have been established. Progress and findings have been presented to a meeting of the local health directors, the Connecticut Chapter of the American College of Obstetricians and Gynecologists and the Connecticut Perinatal Association. Additionally, the CBDPSP has participated with the UConn School of Pharmacy in a project that assembled a folic acid packet for distribution to consumers.

The Connecticut Folic Acid Task Force is a multidisciplinary group committed to increasing public and professional knowledge about prevention of neural tube defects through the use of folic acid. The Task Force is co-chaired by Jann Dalton-Moody, MSW, Director of Program Services, March of Dimes Birth Defects Foundation, Connecticut Chapter, and Kathy Cobb, MS, RD, CD-N, Senior Nutrition Consultant, DPH. The DPH is represented by Ms Cobb, Susan Jackman, MS, RD, CD-N, (Senior Nutrition Consultant- DPH), and Bonnie Lang Silverman, Ph.D., (Epidemiologist III – DPH).

Since its inception the Task Force has sponsored a state-wide conference for professionals, and members have presented to the CT Pharmacists Association (June 1999), CT Dietetic Association (Fall 1999), American Dietetics Association (Fall 1999), and Association of Jewish Registered Nurses (Fall 1999). A state wide survey of obstetricians and certified nurse midwives was conducted to assess professionals' knowledge base and health education practice concerning folic acid. The Task Force has educated the public through participation in the Hispanic Health Council's Health Fair, March of Dimes Folic Acid Café at the Star Chef's Auction, and an educational outreach campaign targeting beauty salons. In the future the Task Force plans to continue to reach both professionals and consumers through culturally appropriate venues as well as develop a means of measuring the effects of this health education.

Since 1996 Connecticut has had a *Perinatal HIV Prevention Plan* to guide our efforts to eradicate HIV transmission from infected women to their babies. The Department of Public Health participates in a partnership with the Academy of Obstetricians and Gynecologists to educate providers and women about HIV prevention for women and for their babies. The New England AIDS Education Training Center at Yale is funded by the Department to run a training program for health care providers caring for pregnant women. A state law passed in 1999 requires that health providers counsel pregnant women about HIV and offer them the HIV test. It further requires that babies born to women who have not been tested during pregnancy or during delivery be tested to ensure that the babies get treatment to give them the best possible chance of avoiding HIV infection. Since 1994, the number of babies born with HIV infection each year has dropped significantly.

Women have specific needs for educational materials. DPH responded to this need over that past six years by contracting for the development of materials and media for women. This included broadcast media on radio and development of specifically targeted high-quality materials such as intake and discharge materials for female inmates that included HIV education materials, and brochures for pregnant women to inform them about HIV testing.

Innovative multi-session group HIV prevention workshops for young women at risk for HIV infection began in 1995 (for young Latinas) and in 1998 for young African Americans. They are held in six community-based organizations across the state and use very culturally competent curricula specially developed for these young women. The workshops inform the young women about HIV/AIDS, motivate them to change the behaviors that put them at risk, and teach them the skills they need to keep themselves safe.

Project Athena was developed recently by behavioral scientists at AIDS Project Hartford with funding from DPH to help HIV + women infected mostly through injection drug use to avoid risky behavior. Avoidance of risk behavior is important both so that they do not infect others and so that they can stay as healthy as possible. Through the *Local Health Administration* Unit, DPH provides state general fund grants in aid to local health departments and health districts to assure that quality public health services are available to residents of every community in the state, 24 hours a day. Activities must be conducted in each of the eight core public health functions, one of which is Maternal and Child Health. Department staff provide orientation for new health directors, technical assistance, opportunities for professional education and information sharing, and complaint investigation. Many local health departments operate or have strong linkages with Healthy Start and WIC Programs, School Based Health Centers, Community Health Centers and Oral Health Programs.

1.5.2 State Agency Coordination

Linkages with a variety of state human service agencies are maintained by the Title V Program. (See Table 9 below and Supporting Documents for detailed description.)

New this past year, the Connecticut Department of Education, in collaboration with the Department of Public Health, received a technical assistance grant to develop a Coordinated School Health program for the State of Connecticut. The nurse consultant with the DPH School Based Health Center Program has been participating in these interagency meetings along with consultant in the Health Education and Intervention Division in the Department's Bureau of Community Health.

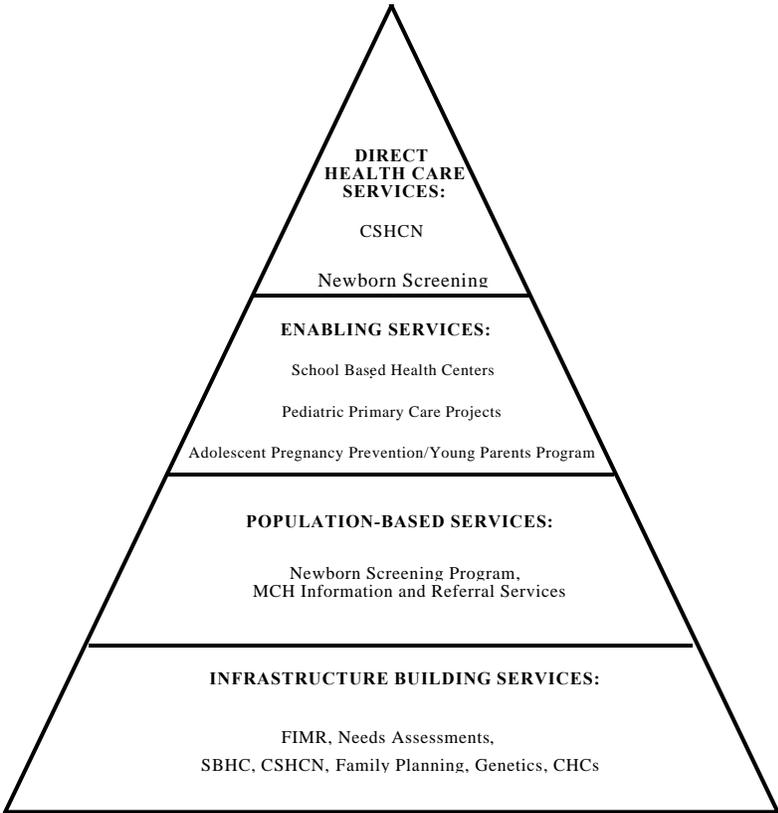
Table 9 State Agency Coordination

Other State Agencies and Committees/Cabinets	Department of Social Services (DSS)	DSS SSA Disability Determination Unit	Department of Mental Retardation	Department of Education
Department of Insurance	Department of Children and Families	Office of the Child Advocate	Department of Mental Health and Addiction Services	Commission on the Deaf and Hearing Impaired
Office of Policy and Management	Office of the Governor	Commission On Children	Permanent Commission on the Status of Women	
Local and Federally Funded Agencies and Health Centers	31 Hospitals/Birthing Facilities	Local Health Departments	Community Health Centers	Planned Parenthood of Connecticut
School Based Health Centers	Healthy Families/Wheeler Clinic			
Associations and Organizations	Teen Pregnancy Prevention Council of CT	Connecticut Association of Health Maintenance Associations	Office of Women's Health Region One Workgroup	CT HUSKY Plus Behavioral Steering Committee
Birth to Three Public Awareness and Medical Advisory Committee	Birth to Three Interagency Coordinating Council	Genetics Advisory Committee	CT PKU Group	Maternal PKU Planning Group
New England Regional Genetics Group	CT Infant Screening Task Force	CT Family Support Council	MCH I&R Advisory Committee/Infoline	State Court Support Services for Gender Responsive Programming Committee
CT HM/HB Coalition	CT Chapter March of Dimes	CT Association of School Based Health Centers	Family Resource Coalition of America	State Adolescent Health Coordinator's Network
NASW	National Assembly on School Based Health Care	ACOG/NFIMR	Children's Health Council	American Academy of Pediatrics/DHHS Child Care
Connecticut Primary Care Association	Youth Suicide Advisory Board	Robert Wood Johnson Foundation	CT Coalition to Stop Underage Drinking/Drugs Don't Work	Connecticut Association for Human Services
Connecticut State Dental Association	Connecticut Association of Dental Hygienists	Hispanic Health Council		
Tertiary Care Facilities and Universities	Yale University	University of Connecticut	Connecticut Children's Medical Center	Regional Genetics Treatment Centers
Boston University School of Public Health	Griffin Hospital (Yale-Griffin Prevention Research Center)	St. Francis Hospital and Medical Center		

Figure 2 Core Public Health Services

Figure 1

**CORE PUBLIC HEALTH SERVICES
DELIVERED BY CT DPH**



II. REQUIREMENTS FOR THE ANNUAL REPORT

2.1 Annual Expenditures

Please refer to Forms 3, 4 and 5.

Expenditures from FFY 98 to FFY 99 increased from \$4,500,062 to \$4,616,140. This is the result of salary and fringe increases in FFY 99 of \$358,851. Several positions were filled instead of being vacant as in FFY 98. This was offset by a late payment of \$121,529 being made in the Healthy Start program for FFY 99 (paid in FFY 2000), with a late payment in FFY 97 for another \$121,529 (paid in FFY 98). The actual time of payment of the contract affected reductions seen in Infants < 1 and Enabling Services expenditures.

CSHCN expenditures were \$1,473,387 (31.9% of expenditures), and expenditures for Preventive & Primary Care for children totaled \$1,588,952 (34.4% of expenditures). The 30% requirement was met for each of these population groups. The 10% administrative cost limitation was met for FFY 1999 with \$314,675 (6.8% of \$4,616,140) being expended.

\$3,607,703 of state matching fund expenditures exceeded the minimum requirements (three dollars of state match for every four dollars of federal dollars expended). Maintenance of effort expenditures totaled \$7,880,507, exceeding the FFY 89 required maintenance of effort of \$6,777,191.

2.2 Annual Number of Individuals Served

Please refer to Forms 6, 7, 8, and 9

2.3 State Summary Profile

Please refer to Form 10

2.4 Progress on Annual Performance Measures

1. 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.

Status of Annual Performance Indicator: 4.2%

Indicator has: Improved Stayed the same Not Improved
(Increased from 1.7% to 4.2%)

Objective Met/Exceeded: Yes No (An increase from 1.7% to 4.5% was projected)

Population Served: CSHCN

Level of the Pyramid: Enabling

Activities within Title V: The State CSHCN Program triaged SSI beneficiaries for CSHCN eligibility for children up to age 18. Those children deemed eligible were referred to one of the two Regional Programs located at the Connecticut Children's Medical Center (CCMC) in Hartford or the Yale-New Haven Children's Hospital where direct rehabilitative services were provided. Client referrals were based on geographic location.

The Fiscal Year for the CSHCN Program is defined as July 1 through June 30 of any given year. In July of 1998, the CSHCN Program's clinical and financial eligibility guidelines were expanded, which increased the number of SSI beneficiary referrals from DPH to the two Centers from 238 in FY98 to 556 in FY99. However, the FY98 data was based on children up to age 18 while the FY99 data is based on children less than age 16. In 1998, 80 out of 4,600 SSI beneficiaries less than 16 in the state or, 2.0%, were enrolled in the CSCHN Program. In 1999, 204 out of 4,900 SSI beneficiaries less than age 16 in the state, or 4.2%, were enrolled in the CSHCN Program.

Technical assistance to both Centers has improved the tracking and reporting of the SSI database to DPH. Centers reported SSI beneficiary data quarterly beginning in 1999. On 5/1/99, DPH began utilizing an SSI database in Access for tracking and reporting. Excel data from 1997 to 5/1/99 was merged with this database. DPH met biannually with SSA representatives to discuss relevant issues regarding SSI beneficiaries and the CSHCN Program, such as interpretation of the SSI referral form to clarify the SSI beneficiaries, updating of the impairment code list, and refining the process of referral to DPH.

Note: Although the goal for 1999 was 36.5% enrollment, and the actual percentage obtained was 4.2%, the methodology utilized to obtain the percentage in 1999 was revised in order to be more reflective of the actual SSI beneficiaries in the state. The FY99 numerator (204) is from the centers' electronic databases and represents the number of SSI beneficiaries *less than 16* at the end of FY99 who were initially *enrolled in any fiscal year who are still actively enrolled at the end of FY99*. The FY99 denominator (4,900) is the actual number of *SSI beneficiaries less than 16 in the state* from any referral source based on a 10% sample file for calendar year 1999 as published in a federal report by the Social Security Administration, Office of Research, Evaluation and Statistics. In order to explain why only 204 out of 4,900 SSI beneficiaries were enrolled, it is important to note that 64% of the 4,900 SSI beneficiaries in the state have mental health diagnoses which are ineligible for services under the Title V CSHCN Program, others are clinically ineligible based on other diagnoses, and some are ineligible due to receipt of income from certain sources.

In order to be more consistent, the 1998 percentage was adjusted using the new methodology applied to the percentage for 1999. With the previous methodology, in 1998, the Centers reported that 85 out of the 238 SSI beneficiaries up to age 18 referred by DPH, or 35.7%, were enrolled in the CSHCN Program. The FY98 numerator was supplied by the centers and represented the actual number of SSI beneficiaries *less than age 18* who subsequently were *enrolled in the CSHCN Program in FY98*. The FY98 denominator was supplied by DPH's database and represents a subset of the SSI referrals received from Disability Determination Services or the *number of SSI beneficiaries less than 18 presumed eligible for the CSHCN Program and referred by DPH to the center for possible enrollment*.

require that all enrolled children have a medical home (identified primary care provider). The designation of this responsibility has continued to be based upon the initial evaluation and ongoing assessment and, in consort with the child's clinical needs and family wishes. During site visits to the Centers, MCH program staff review client records to assure that clients have an identified primary care provider, or are linked with one, to assure enrolled Title V CSHCN clients have a designated medical home.

4. Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases) (combined).

Status of Annual Performance Indicator: 99.98%

Indicator has: Improved Stayed the same Not Improved
(Increased from 98% to 99.98%)

Objective Met/Exceeded: Yes No
((An increase from 98% to 99% was projected)

Population Served: CSHCN / Pregnant women, mothers and infants **Level of the Pyramid:** Population Based

Activities within Title V: CT Legislation required the population based service of Newborn Screening for phenylketonuria, hypothyroidism, galactosemia, sickle cell, maple syrup urine disease, homocystinuria, congenital adrenal hyperplasia, and biotinidase deficiency be provided to all newborns delivered in CT. Newborns were to be screened prior to discharge from the hospital or within the first seven days of life.

In CY 1999, 44,391 initial newborn screens were performed at the CT State Laboratory for eight disorders mandated by Legislature. Of these initial screens, 226 were presumptive positive screens for diseases, and 775 sickle cell traits were identified. All newborns with presumptive positive screens for diseases were referred to the designated Regional Treatment Centers for confirmation testing, treatment and follow up. Genetic, metabolic and endocrinology services are provided at Yale (New Haven) and UCONN Genetics at CT Children's Medical Center (Hartford). Newborns identified with presumptive positive screens for sickle cell were referred to the two designated Sickle Cell Services Centers at Yale (New Haven) and St. Francis (Hartford).

Presently, a computer linkage of the CT State Laboratory Newborn Screening data and the Vital Record's Birth Record data to verify testing of all newborns is lacking. A manual match was conducted through collaboration of the CT State Laboratory, Maternal Child Health Unit and Data Processing staff to determine the percentage of newborns that have been screened for the eight diseases. This was performed through Title V Program participation in the federally sponsored initiative known as the State Systems Development Initiative (SSDI) and their goal of assisting states to improve their reporting requirements related to the MCH Block Grant Application and Annual Report. This match was previously performed in 1996. Three months of birth data (Oct., Nov., & Dec. 1999), and 4 months of lab data (Oct., Nov., Dec. 1999 & Jan. 2000). January 2000 data was needed to capture records for those infants born in December but not tested until January. This match confirmed the following: 99.98 % of the infants born in CT from Oct. - Dec. 1999 were screened for the eight mandated diseases, 95.17 % of the specimens were collected within the first four days of life and the unsatisfactory specimen rate was 0.26%.

The DPH is currently in the process of instituting an electronic reporting system in all the birthing facilities. This will enable electronic transmission of biographical and newborn screening specimen information to the CT State Laboratory and the DPH, Data Processing information system. This system will generate reports documenting newborns that did not have a specimen forwarded to the CT State Laboratory for testing.

The DPH, MCH, Newborn Screening Tracking Unit staff continues to monitor all birthing facilities to assure compliance of screening all newborns prior to their discharge. Collaboration is ongoing between all three components of the Newborn Screening Program's testing, tracking and treatment through quarterly meetings of the Laboratory/Tracking Unit staff and Genetic Advisory Committee members. The meetings provide an opportunity to present, review and discuss the program statistics, emerging issues, and the Newborn Screening Program Guidelines and Protocols. Revisions are made to the Guidelines and Protocols and distributed to birthing facilities and primary care providers accordingly. The tracking unit continues to provide technical assistance to birthing facilities and primary care providers to promote an optimal quality newborn screening program and healthy children.

5. Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.

Status of Annual Performance Indicator: 89.8%

Indicator has: Improved Stayed the same Not Improved
(Increased from 87% to 89.8%)

Objective Met/Exceeded: Yes No (An increase from 87% to 90% was projected)

Population Served: Pregnant women, mothers and infants; Children **Level of the Pyramid:** Population Based

Activities within Title V: During the grant year of 7/1/98 to 6/30/99, 89 of 91 children (98%) receiving services in the Healthy Choices for Women and Children program were age appropriately immunized.

The community based Healthy Start providers encouraged and educated parents regarding the importance of keeping well child care visits to assure compliance with the EPSDT periodicity schedule. A contract outcome measure requires the providers to assess all case managed children and to assist them in compliance with the EPSDT schedule. The 23 providers assessed the children enrolled in the program and achieved a 92.19% compliance rate with the outcome measure.

As part of a program of comprehensive primary and preventive care, age appropriate immunizations are administered and will continue to be administered at all Community Health Center sites, including the four Title V supported Pediatric Primary Care program sites. Over ninety percent of the two year olds served at CHC sites have been appropriately immunized. Strategies that will continue to be used to achieve these high levels of immunization rates include documentation of walk-in immunizations given, scheduling of immunization clinics and scheduling of follow up immunization appointments with parents before they leave the clinic. All of these efforts fall under outreach, education and case management.

Other Interventions/Influences: The DPH Immunization Program is responsible for all statewide surveillance related to vaccine preventable diseases and for activities geared to improve childhood immunization levels and to reduce the occurrence of vaccine preventable diseases. These latter activities include outbreak investigation and control, procurement and provision of publicly purchased vaccines, distribution of funding and provision of technical support for local health departments and other groups for activities to improve early childhood immunization levels, establishment of a statewide immunization registry and tracking system, and assessment of childhood immunization levels.

Organizationally, the state Immunization Program consist of four units: a) Epidemiology/Surveillance unit, b) Immunization Action Program (IAP)/ Contract unit, c) Vaccines for Children (VFC) unit and d) Connecticut Immunization Registry and Tracking System (CIRTS) unit.

Epidemiology/Surveillance Unit Activities include population based assessments (daycare, school and college students) including assessments of immunization coverage of patients at both public and private provider sites delivering immunization services, vaccine-preventable disease and adverse events surveillance, disease investigation, outbreak control and containment, public information and education to enhance awareness among the public about the importance of immunizing children, adolescents, and adults according to recommended immunization schedules (i.e. educational seminars targeting parents and caregivers, community groups, providers, etc.), professional information and education to provide current professional immunization information, education and training to health care providers both in public and private sectors.

Immunization Action Program (IAP)/Contract Unit provides resources to allow local health departments to take an active role in evaluation, planning and outreach in support of vaccine providers in their areas. DPH funds 16 full time health departments (13 municipalities and 3 health districts) to conduct immunization activities that include:

- performing clinic immunization assessments to monitor immunization coverage rates for preschool children in their community,
- establishing and convening local advisory and planning groups,
- coordinating and providing outreach and referrals for children identified by the state immunization registry as being behind in their immunizations,
- conducting immunization education campaigns that are culturally appropriate to target pregnant women, new parents and new immigrants in their service delivery area, and
- providing training and support to providers who utilize the Connecticut Immunization Registry and Tracking System (CIRTS).

Vaccines for Children Program (VFC) Unit Connecticut is a universal vaccine purchase and distribution state. We provide all recommended childhood vaccines at no cost to health care providers in the state to administer to children (regardless of health insurance) so that the cost of vaccine will not be a barrier to age-appropriate vaccination. Our VFC Unit ships vaccines on a monthly basis to over 500 health care providers statewide. Additional vaccine management activities include: ordering, storage, handling, packing, shipping, accountability and disposal of vaccines including continual recruitment and annual re-enrollment of providers in the VFC program.

CIRTS (State Immunization Information System) In the spring of 1994, the CT General Assembly passed Public Act 94-90 enabling the Commissioner of the CT Department of Public Health to establish an immunization registry for children statewide. Building upon an existing computerized registry established in the greater Hartford area in 1993, in 1996 CIRTS expanded to include all children enrolled in Medicaid Managed Care statewide. In 1998, CIRTS expanded again to include all infants born on or after January 1, 1998. The current registry system is predominately a paper driven system with very little electronic online reporting by provider practices. However, DPH has been working with a vendor to rollout a new enhanced registry system that will enable providers to electronically link to a state registry database and report patient immunization information online. However, due to a series of delays and technical issues the new system delivery date is behind schedule. We hope that by the end of this year we will be able to rollout the new system to providers statewide.

In 1999, five organizations/insurance companies in CT had contracts with the CT Department of Social Services (DSS) to provide Medicaid services to young children. The number with contracts in 2000 is four. As required by their contracts with DSS, all Medicaid providers collect and report immunization data on Medicaid patients. This initiative has been a model means of assessing the performance of Medicaid Managed Care in CT and has been a critical intermediate step in the statewide expansion of CIRTS.

In the past year, Immunization Action Plan Coordinators (IAP's) located in the sixteen largest towns/cities in CT were linked to the old CIRTS system and were trained in its use. These sixteen are either local health department employees or are subcontracted by local health departments. The linking of the IAP's was done to facilitate outreach to and updating of information on children identified as late by the current CIRTS computerized system or by local pediatric practices which report to CIRTS by paper.

CIRTS accomplishments include:

- enrolling approximately 78% of all children born in CT in 1998 and 1999 regardless of source of insurance into CIRTS.
- established a reporting system with all pediatric provider sites in CT which ensures that all practices provide immunization histories to the registry, and
- established a mechanism for providing HEDIS reports for all CT children enrolled in Medicaid Managed Care.

Additionally, Connecticut's Children's Health Council/Project provides a monthly report to each Medicaid Managed Care Plan which identifies Medicaid enrolled children who are due or overdue for their immunizations, or who have been enrolled in MMC for 6 months and have not yet received any well child care. Once the health plan is notified of their enrolled children who are due for their immunizations, the plans have the option to follow up with the primary care provider or with the family to enable receipt of services. The Children's Health Council/Project pays special attention to those children who have not received immunizations or well child visits and are part of the Department of Children and Families system. DCF is notified that these children have not received care in accordance with the EPSDT/AAP periodicity schedule, and follow-up by DCF with these families/providers is expected.

6. The birth rate (per 1,000) for teenagers aged 15 through 17 years.
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Status of Annual Performance Indicator: 21.4

Indicator has: Improved Stayed the same Not Improved
(Decreased from 22.4 to 21.4)

Objective Met/Exceeded: Yes No
(A decrease from 22.4 to 22.2 was projected)

Population Served: Pregnant women, mothers and infants; Children/Adolescents **Level of the Pyramid:** Population Based/Enabling

Activities within Title V: The APP/YPP program, through its 12 sites, placed heavy emphasis on preventing subsequent pregnancies among the pregnant/parenting teen clients it served. Intensive case management, linking clients with educational, health and social services, education in life skills and family planning and advocacy for these young clients were the primary interventions used with 1,217 clients served during FY 99.

The Department of Public Health (DPH) has funded ten Planned Parenthood of CT sites and six subcontractors to provide contraceptive services, comprehensive reproductive health care, education, and counseling to enhance responsible sexual decision making and prevent unintended pregnancies in teens. Adolescents in need of these services have been identified through SBHCs, APP/YPP programs, high schools, and community groups. Services have been provided to approximately 12,500 adolescents. Family planning and reproductive health services are also provided to adolescents with special health care needs. In FFY 99, Planned Parenthood of Connecticut (PPC) and its subcontractors provided family planning services to 79,382 clients, 35,721 of who were adolescents. Many of the staff at the sites have received in-service training in working with adolescents with special health care needs. PPC has seven locations with adaptive examination tables to accommodate clients with disabilities. Information is being reported to the DPH through quarterly reports. DPH provides technical assistance to the grantee as needed, and conducts quality assurance reviews through chart audits at all sites.

In FFY 99, DPH funded 54 School Based Health Centers in sixteen communities. A variety of services provided through these SBHCs addressed reproductive health issues. All DPH funded SBHCs were required to provide age appropriate reproductive health education to students. More than 6,500 students received classroom or small group education sessions. Topics ranged from “know your body” classes for fourth graders and puberty education workshops for fifth and sixth graders, to more targeted sessions for older students on topics including adolescent sexuality, STDs and contraceptives, and pregnancy prevention workshops. In addition, students identified through health risk appraisals as being at high risk for sexual activity were provided targeted reproductive education or small group interventions. Students who tested negative for pregnancy were provided with reproductive health education and referrals for contraceptive services.

Other interventions/ influences: The federally funded Abstinence-Only Education initiative (HRSAs) is managed within the same unit as the APP/YPP programs. This initiative, now heading into its 4th year, has produced a media campaign in the first year and funded 3 community-based education programs during the next two years. In 1999 a fourth program applied and is in the process of contract negotiations with DPH. A contract has been awarded to an evaluator who has worked with the community-based sites in developing and implementing pre- and post-program

surveys. An evaluation of the first media campaign has been conducted. In 2001, a second media campaign, due to be aired in May, 2000, will be evaluated also

In addition to DPH's Title V activities, The CT Department of Social Services funds 9 primary prevention programs focused on prevention of teen pregnancy. The Teen Pregnancy Prevention Council of CT, newly restructured, serves as a state-wide data repository, education and advocacy group that focuses on teen pregnancy prevention.

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

Status of Annual Performance Indicator: 26%

Indicator has: Improved Stayed the same Not Improved
(Increased from 25.1% to 26.0%)

Objective Met/Exceeded: Yes No (An increase from 25.1% to 30% was projected)

Population Served: Children (Third grade children in the State [44,276: DOE, 8/97]) **Level of the Pyramid:** Population Based

Activities within Title V: The original plan to develop a statewide program to increase the prevalence of dental sealants had been modified based upon a change in the scope of the project. Instead of narrowly focusing on data collection involving only sealants, the focus has been broadened to include other oral health measures. This will allow for the planning of more integrated and efficient programs to increase the number of third grade children with dental sealants while also addressing other oral health needs.

The oral health program has taken the lead in the development and implementation of a regional pilot project to enhance and modify the health status data system infrastructure to include oral health status measures. Included in this initiative will be data collection involving sealants, assessment of risk factors for dental decay.

Once this pilot project has been completed, steps will be taken to expand the scope of data collection to include the entire state. This comprehensive set of data will make targeted efforts to increase sealants initiatives easier to plan.

During the period covered by this annual report, the Department of Public Health initiated a process to award \$25,000 to enhance school based dental services, including such preventive measures as dental sealants.

In order to effectively plan efforts to increase the number of children receiving dental sealants, a survey and needs assessment was initiated among local health departments, home health and public health nursing agencies, and school systems. As part of this assessment, respondents were asked to indicate whether their agency currently provides dental sealant application and, if not, whether they plan on doing so in the future. This assessment was initiated at the end of the period covered by this annual report.

8. The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.

Status of Annual Performance Indicator: 2.8

Indicator has: Improved Stayed the same Not Improved
(Decreased from 3.0 to 2.8)

Objective Met/Exceeded: Yes No

Population Served: Children/Adolescents **Level of the Pyramid:** Population Based

Proposed Activities within Title V: Healthy Start and Comadrona Programs collaborated with the Health Education and Intervention (HEI) Division to provide HS Coordinators with information that was shared with clients regarding injury prevention, including proper restraints use for infants and children, as well as home safety. Case Managers from the Healthy Choices for Women and Children program attended a car seat in-service training by a certified car seat specialist which enhanced their ability to provide anticipatory guidance and injury prevention information to clients regarding proper restraints for infants and children when riding in a motor vehicle. The program provided car seats and booster seats to clients who were in need along with the instruction on the proper use of the seat.

The APP/YPP program worked with teen parents through peer-support group educational sessions which emphasized home and family safety. Enabling teen parents to access appropriate child safety restraints and other child safety equipment is a major intervention of these programs.

In FFY 99, School Based Health Centers and Expanded School Health Services (ESHS) projects funded by DPH provided a range of injury prevention and safety education activities. Educational sessions ranged from small classroom presentations on safety, to a “pre-prom” assembly for more than 1,000 students on motor vehicle safety and substance abuse. More than 4,000 students participated in these activities. In addition, SBHCs participated at health fairs in their schools and in their communities, distributing information on safety as well as on health promotion.

Other interventions/ influences: The Preventive Health & Health Services Block Grant (PHHSBG) does not have any dedicated funding presently for motor vehicle injury prevention activities, and the DPH Injury Prevention Program (IP) does not currently receive any other funding for this issue. To address motor vehicle injury prevention, the program works closely with other agencies and organizations.

DPH has a Crash Outcome Data Evaluation System (CODES) project which linked police crash reports with medical data. This linked data system provides a much more complete picture of motor vehicle crashes in Connecticut and will be valuable in planning and evaluating both statewide and community-based interventions. CODES data has already been used by several communities for program planning and preparing grant applications.

Local Health Departments receive an annual allocation of PHHSBG funds which they may use to address a range of public health issues, including motor vehicle injury prevention. The Injury Prevention Program provides technical assistance to those local health departments electing to use their PHHSBG funding for motor vehicle injuries. Program activities are designed to increase the correct use of child safety seats, safety belts and awareness of pedestrian safety measures. During FY 99, three local health departments (Norwalk, Uncas and Chesprocott) conducted programs.

The IP Program works with a network of Connecticut child passenger safety advocates, including CT SAFE KIDS, CT Dept. of Transportation (DOT), state and local police, hospitals and health departments to promote child passenger safety awareness and conduct car seat safety “check up” clinics to educate parents and caregivers on correct installation. During 1999, over 74 “check up” events were held statewide with over 3,500 car seats checked. Approximately 96% of these seats arrived at the events incorrectly installed.

The IP Program collaborated with CT SAFE KIDS, CT Trial Lawyers Association and local police and health departments to distribute bicycle helmets and provide bike safety education through schools. During April, 1999, approximately 3,000 helmets (donated by the CTLA) were distributed to elementary schools in 13 communities.

The IP Program collaborates with the National Highway Traffic Safety Administration (NHTSA) and CT DOT to promote the development of “Safe Communities” in Connecticut. CT has two Safe Community initiatives; Lower Naugatuck Valley Coalition (lead agency - Seymour Ambulance) and Norwich (lead agency - Uncas Health District). Both have received national recognition as model programs. The NHTSA “Safe Communities” concept involves development of an injury profile using local data and formation of a coalition to address identified injury problems.

The IP Program prepared a grant application on behalf of the CT Public Health Association (CPHA) for APHA/NHTSA “Buckle Up America” funds. CPHA received a \$10,000 mini-grant and is working with DPH, CT SAFE KIDS, CT DOT and local health and police departments to increase child passenger safety (CPS) awareness in Spanish speaking populations. Training will be provided to staff at community agencies that serve Spanish speaking clients to enable them to serve as effective CPS educators. Two pilot communities are Waterbury and New London. The overall project goal is to develop a model for involving community agencies in CPS education that can be replicated in other communities.

9. Percentage of mothers who breastfeed their infants at hospital discharge.

Status of Annual Performance Indicator: 64.3%

Indicator has: Improved Stayed the same Not Improved
(Decreased from 65.5% to 64.3%)

Objective Met/Exceeded: Yes No (An increase from 65.5% to 67% was projected.)

Population Served: Pregnant women, mothers, and infants **Level of the Pyramid:** Population Based

Activities within Title V: As part of the prenatal services provided by the Healthy Start and Comadrona program, clients were provided with health education regarding the health benefits of breastfeeding infants after delivery. Reinforcement of these benefits was provided during prenatal care coordination contacts with specific referrals to local resources depending on client preferences. Local breastfeeding resources are variable by community; Comadrona and some Healthy Start sites are co-located within agencies that offer specific programs. Healthy Start and Comadrona staff participated in an in-service program provided by a lactation consultant.

Other interventions/ influences: The breastfeeding initiation rate among infants enrolled in the WIC Program was 42%. The WIC Breastfeeding Committee was reconvened during FY 99. Bimonthly meetings were held and priorities for the group were established. The first task was to develop an inventory of local agency breastfeeding activities. The Women's Health Subcommittee of the state's Medicaid Managed Care Council began deliberations regarding lactation issues during this period. The Director of the Health Education and Intervention Division represents the Department of Public Health on the subcommittee and participated in the development of several recommendations. The WIC Nutrition Coordinator assisted in this process.

10. Percentage of newborns who have been screened for hearing impairment before hospital discharge.

Status of Annual Performance Indicator: Will be reported beginning in FY 2001.

Indicator has: Improved Stayed the same Not Improved
 Objective Met/Exceeded: Yes No

Population Served: Pregnant women, mothers and infants **Level of the Pyramid:** Population Based

Activities within Title V: During FY99, the Department of Public Health worked collaboratively and met monthly with the CT Newborn Hearing Screening Task Force. The Task Force developed recommendations of what tests the pediatric audiologists should be able to conduct as part of the test battery required for initial diagnostic testing and those required for follow-up treatment and management. The Task Force assisted Universal Newborn Hearing Screening program staff in developing a standardized reporting form for audiologists to report results to the Department of Public Health. In addition, the DPH developed Guidelines for the Universal Newborn Hearing Screening Program, which were distributed to all birthing facilities. Universal Newborn Hearing Screening brochures were developed in both English and Spanish for distribution to parents by birthing facilities and other health care providers. The Department of Public Health purchased copies of a Universal Newborn Hearing Screening program video produced by the CT Perinatal Association and the American School for the Deaf that explains the screening process and distributed them to all birthing facilities in the state to use for patient/staff education. The Department of Public Health has had ongoing meetings with birthing facility staff, audiologists, primary care providers and other health care professionals to provide technical assistance and guidance in their program implementation.

11. Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care.

Status of Annual Performance Indicator: 97.5%

Indicator has: Improved Stayed the same Not Improved
 (Increased from 94.4% to 97.5%)
 Objective Met/Exceeded: Yes No

(An increase from 94.4% to 95% was projected)

Population Served: CSHCN

Level of the Pyramid: Infrastructure Building

Activities within Title V: As part of the intake assessment for children enrolling in the CSHCN Program, a source of insurance for primary and specialty care has continued to be identified. With the HUSKY Programs serving the uninsured children, Title V has shifted its focus to the enrollment eligible underinsured population. The Steering and Advisory Committee for Children with Special Health Care Needs and HUSKY Plus Physical (SASH) was formed to pull together statewide representation from all agencies in the state that serve children with special needs. SASH is comprised of representation from the Departments of Public Health, Social Services, Education, Mental Retardation, Children and Families, and Insurance. Also included is representation from the HMO Association and the Family Advisory Subcommittee. This statewide collaboration between departments has enhanced the program's ability to link with insurance providers and other state agencies which has resulted in an increased CSHCN enrollment.

12. Percent of children without health insurance.

Status of Annual Performance Indicator: 6.2%

Indicator has: Improved Stayed the same Not Improved
(Increased to 6.2% from 5.9%)

Objective Met/Exceeded: Yes No (6.1% was projected)

Population Served: Children/Adolescents

Level of the Pyramid: Infrastructure Building

Activities within Title V: Healthy Start and Comadrona programs screened all clients for health insurance status and assisted clients with the completion of applications. These programs provided 7260 children with liaison and advocacy services which included assisting clients to obtain health care coverage, and linking clients to other Title V programs that will address their health needs. HCWC staff participated in a training program to maintain their knowledge of the state's SCHIP program (HUSKY). The program staff worked closely with the Department of Social Services liaison worker who is stationed at the Waterbury Department of Health to register eligible children in HUSKY.

The Department of Public Health has funded ten Planned Parenthood of CT sites and six subcontractors to provide family planning services. The grantee identifies uninsured adolescents, services and gaps in service provision. Under Title X, uninsured adolescents are charged a fee according to their income. Also, uninsured clients/youth are referred to appropriate sources of coverage, including HUSKY.

SBHC enrollees who lack insurance were routinely identified at the time of registration. Initially only three communities had outreach staff dedicated to the task of following up with the families of these students. During this year, the Connecticut Association for School Based Health Centers, comprised of all DPH funded SBHC grantees, secured a \$100,000 grant from the Department of Social Services to provide outreach services in support of HUSKY enrollment. With the DSS grant, now all SBHCs perform these services for their enrollees as well as others in their communities.

SBHC outreach staff have directly facilitated the enrollment of more than 100 youth in the HUSKY program. In addition, more than 30,000 individuals and families were contacted via phone, mailings and leaflets.

MCH Liaisons, employed by Infoline, the MCH Information and Referral Service, provide HUSKY presentations and trainings to providers, agencies and community groups throughout the state.

Other interventions/ influences: (The following excerpts are taken from the Children's Health Council Report *ENSURING HUSKY COVERAGE FOR CHILDREN; Recent Evidence Shows Gaps in Coverage, November 15, 1999*). Enrollment in Connecticut's Medicaid managed care program for children and families steadily increased from July 1998 through June 1999. However, since June, there had been a decrease in enrollment. As of November 1999, there were 170,866 individuals under age 19 enrolled in HUSKY A managed care plans compared to 171,062 in June 1999. Although this decline was not large, it occurred despite significant outreach activities that had taken place throughout the state, including a number of activities that took place in September 1999, as children returned to school.

A decline in Medicaid enrollment despite significant outreach efforts is not a phenomenon unique to Connecticut. Other parts of the country have seen even greater declines in enrollment. Families USA released a report on enrollment in Medicaid and CHIP programs from 1996-1999 in 12 states with almost two-thirds of the uninsured children in the United States. In 1999, fewer children in these states were enrolled in federally funded children's health programs than were enrolled in Medicaid alone in 1996.

Recently released national census data show that the percentage of children in families with income below the federal poverty level participating in the Medicaid program has declined from 62.6 percent in 1996 to 57.8 percent in 1998. This represents 643,000 poor children who have lost Medicaid coverage. Thus, even as states have worked on expanding eligibility and increasing the availability of coverage for children in low income working families, coverage of poor children has declined. More information on insurance coverage is presented in section 1.4 Overview of the State, page 4, and 3.1.2.2 Direct Health Care Services and Enabling Services, page 95.

13. Percent of potentially Medicaid-eligible children who have received a service paid by the Medi aid Program.

Status of Annual Performance Indicator: 38.1%

Indicator has: Improved Stayed the same Not Improved
(Increased from 36.1% to 38.1%)

Objective Met/Exceeded: Yes No
(An increase from 36.1 to 37% was projected)

Population Served: Children/Adolescents

Level of the Pyramid: Infrastructure Building

Activities within Title V: Although the HCWC program does not utilize income guidelines to provide services nor do they charge for services, the entire population served was low income. Families without health care coverage are referred to the Department of Social Services for health care coverage and parents are provided with information on

how to access health care. Staff will advocate for families within the healthcare system and if necessary accompany families as they obtain care.

Healthy Start and Comadrona provided services to over 7,000 children who were eligible for Medicaid services by acting as liaison with DSS, educating parents on the Medicaid Managed Care System and advocating for clients within the health care system. The staff also assisted undocumented parents of approximately 200 US citizen children to access the health care services to which they were entitled.

Ten funded Planned Parenthood of CT sites and six subcontractors have provided pregnancy testing, access to contraceptive services, and reproductive health care, counseling and education to clients. Funded sites have documented the number of adolescents receiving services, and have identified Medicaid eligible youth without coverage and made appropriate referrals.

All SBHCs are required to contract with Medicaid Managed Care Organizations to directly provide a comprehensive range of primary and preventive physical and behavioral health services. Services provided to Medicaid clients included physical examinations and health screenings, immunizations, treatment of acute injuries and illnesses, prescription and dispensing of medications, laboratory testing, diagnosis and treatment of sexually transmitted diseases, nutrition counseling and weight management, individual, family and group counseling, oral health screenings, and health education. In addition, at 12 SBHCs provided full dental care to students. Nine SBHCs regularly provide transportation services to students and their families to appointments with community providers. The SBHC clinicians collaborate with school health staff who provide state mandated vision and hearing screening.

DPH staff have continued to monitor, through regular reports and site visits, the progress of the Medicaid contract/billing process. DPH provided technical assistance as needed on issues such as appropriate documentation and record keeping to SBHC grantees to increase their capacity to do this successfully. As noted above, all SBHCs are providing outreach services to students identified as lacking health insurance at time of enrollment. Under their contract with DSS, they provide consumers with information and facilitate referrals to EDS, the organization currently charged with determining eligibility.

Other interventions/ influences: See #12 above.

14. The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.

Status of Annual Performance Indicator: 72.2%

Indicator has: Improved Stayed the same Not Improved
Objective Met/Exceeded: Yes No (An increase from 72% to 77.8% was projected)

Population Served: CSHCN

Level of the Pyramid: Infrastructure Building

Activities within Title V: A paid part-time employee who is a mother of a child with special health care needs is staff to the CSHCN Program. She has continued to be available to other Maternal and Child Health programs as well as to both CSHCN regional centers.

The Steering and Advisory Committee for Children with Special Health Care Needs and HUSKY Plus Physical (SASH) has a family representative who was voted in by the Family Advisory Subcommittee. The Family Advisory Subcommittee has continued to advise and assist SASH regarding family issues and information flows back and forth between the two entities. Families also participated on the following SASH subcommittees: covered services, data and quality assurance, authorization and outreach. The Family Advisory Subcommittee assisted in the design of the new respite services which recently became available on a limited basis to CSHCN enrolled families. Families participated in the planning and implementation of “Keeping it All Together”, a follow-up conference which included a re-introduction of the “Keeping it All Together “ notebook and included a session provided by the Department’s Office of Emergency Medical Services which highlighted emergency medical services and respite. Title V families also provided testimony at the Block Grant Public Hearing and participated in a public parent, providers and stakeholders meeting sponsored by the Connecticut Association of Human Services to describe the Title V Block Grant to elicit input for the final application.

As part of the Child Health Access Project (CHAP), the Connecticut Association for Human Services (CAHS) facilitated a series of six meetings with an advisory group that made recommendations to improve the delivery of home health care services for all children, including children with special health care needs, and adolescents. The group’s composition included families of children with special health care needs, home health care providers, advocates, representatives of several state agencies, and representatives from the Medicaid Managed Care Council to form an Institute on Home Health Care. Some of the recommendations included enhancing the home care delivery system to coordinate benefits and offer increased choice of home care providers, verifying the inadequacy and shortage of home care workers, increasing the supply of pediatric home health care providers available to families, and improving information dissemination to families who have children with special health care needs.

15. Percent of very low birth weight live births.

Status of Annual Performance Indicator: 1.7%

Indicator has: Improved Stayed the same Not Improved
(Increased from 1.6% to 1.7%)

Objective Met/Exceeded: Yes No (A decrease from 1.6% to 1.5% was projected)

Population Served: Pregnant women, mothers and infants; Children/Adolescents **Level of the Pyramid:** Infrastructure/Enabling

Activities within Title V: Healthy Choices for Women and Children (HCWC) staff link clients of the program with a variety of community agencies such as alcohol/drug treatment or WIC to increase the possibility of a normal birth weight infant. Of the 50 babies born to women in the HCWC program, 48 were born weighing greater than 5 pounds eight ounces; the remaining two babies weighed 5 pounds, 4 ounces and 4 pounds four ounces. There were no very low birth weight infants born to mothers enrolled in HCWC. APP/YPP programs spent over 12% of their individual educational encounters (and almost 10% of group encounters) on nutrition and its relation to healthy pregnancy outcomes. In addition, programs counseled and referred clients for smoking cessation and intervention for other

unhealthy behaviors and lifestyles. The percent of low birthweight births for program clients has been lower than the statewide percentage for three consecutive years.

The Healthy Start program provided outreach activities and encouraged pregnant women to begin care early in the pregnancy and linked clients with the necessary community programs/agencies (WIC, mental health services, etc.) to increase the opportunity for the prenatal client to have an infant of normal birthweight. In the Healthy Start program 74 of 3735 births (2.2%) were very low birth weight.

Planned Parenthood of CT provided pregnancy testing, STD testing and treatment, reproductive health education and counseling as well as prenatal care linkages to community providers to eligible pregnant women and adolescents. Planned Parenthood of CT links eligible clients to WIC, Healthy Start, and other entitlement programs. SBHCs provided 1,835 pregnancy related visits to 1,038 enrollees in FFY 99, including a wide spectrum of services from pregnancy testing to postpartum care. Although SBHCs are not a primary source of prenatal care for pregnant teens, the majority of middle and high school sites provide support services, including groups for pregnant and parenting teens, and reproductive health education. More than 6,500 students received some form of this education. As part of DPH quality assurance, all SBHCs receive a yearly site visit. Chart audits performed at this time document the appropriateness of referrals for needed care or support services. At least four high school SBHCs run ongoing groups for pregnant teens where they learn about their own needs during pregnancy as well as about delivery, child development and infant care.

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

Status of Annual Performance Indicator: 9.3

Indicator has: Improved Stayed the same Not Improved
(Increased from 4.5 to 9.3)

Objective Met/Exceeded: Yes No (No change from 4.5 was projected)

Population Served: Children and Adolescents **Level of the Pyramid:** Infrastructure Building

Activities within Title V: Mental health services were provided at 54 SBHCs and three ESHS sites during FFY 99. DPH required all programs to have policies and procedures in place to address suicidal ideation or attempts. In addition, all sites are required to maintain policies for the provision of a risk appraisal for students within one month of beginning mental health services. DPH staff reviews these policies at yearly site visits, and document that all SBHC staff provide written acknowledgement of their familiarity with the policies and procedures. During this year, DPH social work consultants provided technical assistance to several communities to improve their documentation of mental health services, including the development of psychosocial assessment forms and treatment plans. In addition, DPH staff provided assistance to one community to strengthen its suicidal ideation policy.

Other interventions/ influences: One suicide prevention program, funded through the Preventive Health and Health Services Block Grant provided services to 34 youth and young adults in alternative school and teen center settings in FY 99.

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

Status of Annual Performance Indicator: 85.9%

Indicator has: Improved Stayed the same Not Improved
(Increased from 81.6% to 85.9%)

Objective Met/Exceeded: Yes No
(An increase from 81.6% to 82.2% projected)

Population Served: Pregnant women, mothers, and infants. **Level of the Pyramid:** Infrastructure Building

Activities within Title V: The HCWC program does not provide prenatal care, however, the case managers worked collaboratively with OB clinicians and clients for those infants determined to be high risk to ensure that the infant was born at an appropriate birthing facility. During the most recent grant year, there were no very low birth weight babies born to women enrolled in the HCWC program. Clients of the HCWC program are assisted in accessing and maintaining compliance with the prenatal care schedule. If the client feels the need for staff support during prenatal visits staff will accompany the client.

Healthy Start/Comadrona prenatal clients that are identified as high risk are closely monitored and are referred to appropriate birthing facilities that are equipped to handle the delivery of the at risk infant. In addition to implementing a standardized risk screening tool for all clients entering Healthy Start/Comadrona, a levels system was initiated to categorize client by low and mod/high risk which determined the extent of care coordination services needed. Data system programming has been proposed to identify the numbers served at each level. CT never adopted a formal regionalization model for intrapartum services. This will continue to be a challenging performance measure especially in light of managed care and its emphasis on in-plan services.

MCH Liaisons, employed by Infoline, the MCH Information and Referral Service provide suicide prevention presentations and training to providers, agencies, community groups and students in the state.

Other interventions/ influences: Infoline’s 211, or (800) 203-1234 phone number serves as a Suicide Prevention Hotline and 24 hour statewide referral resource. Other Suicide Prevention Hotlines are listed on the inside cover of Connecticut telephone directories.

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

Status of Annual Performance Indicator: 82.5%

Indicator has: Improved Stayed the same Not Improved
(Decreased from 89.1% to 82.5%)

Objective Met/Exceeded: Yes No (No change from 89.1% was projected)

Population Served: Pregnant Women, mothers and infants; Children/Adolescents **Level of the Pyramid:** Infrastructure/Enabling

Activities within Title V: HCWC accepts referrals of pregnant women who are at risk of or who abuse substances from community agencies that are already providing prenatal care to this population. The staff encourage clients to adhere to the prenatal care schedule. If the client requests, the staff will accompany clients who are scared or need assistance in understanding the information being provided at the visit.

Healthy Start, Comadrona and HCWC, through intensive case management services to pregnant women strongly encouraged early registration in prenatal care and compliance with prenatal visits and provider recommendations. An outcome measure in the Healthy Start providers' contract stated that 80% of the women enrolled in the program would begin care in the first trimester. In the past year 73.8% of the babies born were to women who began care in the first trimester.

APP/YPP programs that do not receive client referrals from prenatal care providers place heavy emphasis on early entry into prenatal care. Teens are supported in their enrollment in care and their communications with their families and the care environment. Transportation is provided or facilitated.

DPH contracts with Planned Parenthood of CT and its subcontractor sites to provide a variety of services including pregnancy testing, STD testing and treatment, reproductive health education and counseling, and prenatal care linkages to community health providers to ensure first trimester prenatal care. In addition, pregnant women and adolescents have been linked to other entitlement programs such as WIC and Healthy Start. The Department of Public Health conducts quality assurance through the review of quarterly reports.

SBHCs provided 1,835 pregnancy related visits to 1,038 enrollees in FFY 99, including a wide spectrum of services from pregnancy testing to postpartum care. Although SBHCs are not a primary source of prenatal care for pregnant teens, the majority of middle and high school sites provide support services, including groups for pregnant and parenting teens, and reproductive health education. More than 6,500 students received some form of this education. As part of DPH quality assurance, all SBHCs receive a yearly site visit. Chart audits performed at this time document the appropriateness of referrals for needed care or support services.

Through advocacy and public education, CAHS worked to improve access to health care for pregnant women, mothers, and infants, especially those from low-income families or those with special needs. CAHS staff made site visits and met with OB/GYN clinic providers at Yale-New Haven, Hartford, St. Mary's, and St. Francis Hospitals and convened a workgroup to identify specific access to health care issues. Topics pursued included repeat teen pregnancy, health care access for uninsured and undocumented populations, treatment for pregnant substance abusing teens, lack of mental health services for low-income Latino women, and Medicaid Managed Care access to care. Increased access to prenatal care is an expected result of this effort to expand access to health care for pregnant women.

SP#19. Tobacco Use During Pregnancy

Status of Annual Performance Indicator: 8.7%

Indicator has:

- Improved Stayed the same Not Improved
(Decreased from 9.7% to 8.7%)

Objective Met/Exceeded: Yes No
(A decrease from 9.7% to 9.6% was projected)

Population Served: Pregnant women, mothers and infants; Children/Adolescent **Level of the Pyramid:** Population-Based/Enabling

Activities within Title V: The staff of HCWC assessed clients for their health and health related needs including tobacco and other substance use and provided intensive case management services to meet the clients needs. Clients were counseled regarding the potential health risks to the unborn child and were encouraged to discontinue use of tobacco during the pregnancy. Those who expressed an interest in discontinuing tobacco use were referred for smoking cessation assistance. HCWC provided intensive case management services to pregnant tobacco users, substance users or those at risk for substance use. The program reported that 100% (62 clients) who requested case management for their needs accessed the necessary services.

All APP/YPP clients are assessed for smoking, alcohol use and other substance use during pregnancy. Clients are counseled and/or referred to tobacco cessation programs.

All Planned Parenthood and Family Planning sites offer a range of reproductive health education services including targeting women and youth that use tobacco during pregnancy. Women and youth identified as at risk of pregnancy or who are pregnant received smoking cessation/prevention counseling.

Healthy Start and Comadrona , through its risk-screening tool, identified and linked pregnant smokers to cessation services. The number of clients provided screening and referral to smoking cessation programs will be able to be quantified once proposed data programming changes are effected and are anticipated to be available for report commencing in FY2001

DPH funded SBHCs provided tobacco education services to more than 400 students in FFY 99. In addition, more than 75 students participated in smoking cessation groups. SBHC policies indicate that students seen for physical examinations received health risk assessments including appraisal use of tobacco. DPH chart audits performed at the time of yearly site visits monitored the implementation of this policy.

Connecticut Association for Human Services (CAHS) staff met with Chairs and Co-Chairs of the Public Health Committee and the Human Services Committee to discuss legislation and funding for smoking cessation efforts targeted at low income pregnant women. Information on rates of tobacco and drug use among pregnant women was obtained from 10 clinic sites across the state and subsequently presented to the Co-Chair of the Public Health Committee.

Other interventions/ influences: During 1999, smoking cessation programs for pregnant women were offered by at least two hospitals and one non-governmental organization (American Cancer Society). These programs are subject to funding availability and at least one was a research project that had specific entry criteria. The Department of Public Health's Tobacco Use Prevention Control Program (TPCP) did not address this high-risk population directly. Because of limited funding, the TPCP has taken a strategy that targets policies change rather than individual behavioral change. Currently, the TPCP funds initiatives which address social norm changes by encouraging policies that denormalize and deglamorize tobacco use. The TPCP funds numerous programs that must address one or more of the following goals:

- Preventing initiation among youth,
- Promoting cessation among adults and youth,
- Eliminating exposure to environmental tobacco smoke, and
- Addressing disparities in tobacco use.

SP#20. Number of children /adolescents needing care for cognitive, emotional and child/adolescent /parent functioning who are assessed and receive appropriate counseling.

Status of Annual Performance Indicator: 4455

Indicator has: Improved Stayed the same Not Improved
(Increased from 4105 to 4455)

Objective Met/Exceeded: Yes No
(An increase from 4105 to 4146 was projected)

Population Served: Children and Adolescents **Level of the Pyramid:** Enabling

Activities within Title V: Children of the women enrolled in the HCWC program are assessed for growth and development utilizing the Ages and Stages Developmental Screen. Twenty six children were screened and two were referred for further evaluation and are receiving services from the Birth to Three program. All APP/YPP clients are assessed for cognitive, psychosocial and family factors that contribute to their functioning during pregnancy and parenthood.

The primary care provider for appropriate growth and development monitors all children enrolled in the Healthy Start and Comadrona program. Those children with identified needs are referred to the Birth to Three program for further testing and evaluation. Those infants of parents enrolled in the Healthy Start/Healthy Families Partnership and the HCWC programs were assessed utilizing the Ages and Stages screening tool.

In FFY 99, 54 SBHCs and 3 Expanded School Health Services projects in 19 communities provided comprehensive mental health services to students in elementary, middle and high school settings. These services included psychosocial assessments. Students with identified needs received individual, family and/or group counseling, as well as referral and follow-up services when appropriate. SBHCs provided 29,990 visits related to mental health issues, counseling or referral to 4,455 enrollees. As was identified last year, visits related to mental health accounted for the largest proportion of visits during the year. For mental health services at SBHCs, information is reported through the SHO! data collection system. ESHS projects served an additional 400 students.

DPH provided several training opportunities to SBHC and ESHS staff to enhance their diagnostic and treatment skills. More than 25 SBHC staff participated in the University of Connecticut Master Therapist workshop on "Treating Depression and Anxiety in Children and Adolescents". Other sessions included a full day conference for more than 80 participants on sexual assault issues, a workshop on psychopharmacology and a full day workshop entitled, "The Care and Support of the HIV Affected Child".

DPH staff continued to work in collaboration with DSS to facilitate contracting between SBHCs and Medicaid Managed Care behavioral health carve-outs. Joint meetings were held to educate plans about the services provided in SBHCs, quality assurance measures taken by the SBHCs, and their unique ability to enable access to care for students. By the end of FFY 99, the majority of plans and SBHCs were finalizing negotiations for these behavioral health contracts.

SP#21. Prevalence of children with blood lead levels \geq 10 micrograms per deciliter.

Status of Annual Performance Indicator: 3.1%

Indicator has: Improved Stayed the same Not Improved
(Decreased to 3.1% from 4.4%)

Objective Met/Exceeded: Yes No
(A decrease from 4.4% to 4.3% was projected)

Population Served: Children

Level of the Pyramid: Population Based/Enabling/
Infrastructure

Activities within Title V: Healthy Start, Comadrona and HCWC assessed children for EPSDT compliance which also includes lead screening. Available department resources were shared in the form of resource materials, consultation, promoting linkages to the available resources at the community level.

Other interventions/ influences: The Connecticut Lead Poisoning Prevention Program (CLPPP) continues to make progress towards the establishment of an updated statewide screening plan. Currently, in accordance with CDC's Guidelines and the HCFA mandate for screening Medicaid beneficiaries, the CLPPP recommends screening all children at one and two years of age if they have not been previously screened.

The CLPPP Case Manager is responsible to assure that local health departments and other individual jurisdictions provide case management and follow-up as needed. To better accomplish the goal a case management protocol is being developed that will be utilized by local health departments. In order to evaluate case management activities at the local level an audit protocol and checklist is being developed. Four hundred and eighteen (418) children under the age of six had elevated blood levels exceeding 20 $\mu\text{g}/\text{dL}$ during the 1999 calendar year. The Case Manager focuses on those children with blood lead levels exceeding this level. The Case Manager contacted local health departments to assure that notification of elevated blood lead levels and follow-up was conducted for 295 children during the period of 7/1/99-1/31/00.

In 1998, the first stage of a pilot project by the CLPPP, under the auspices of the Division Director of the Environmental Epidemiology and Occupational Health Division, (EEOH) and the Department of Social Services (DSS), was conducted. Based upon the 1995 birth cohort, a subset of the Hartford Medicaid Managed Care population was merged with the lead-surveillance system data in order to determine the feasibility of identifying children on Medicaid that have been screened for lead poisoning. Results of this study indicated that 93% of the subset of Medicaid Managed Care children in Hartford had been screened.

A continuation and expansion of this study is being conducted in five other cities of the state; Hartford, Bridgeport, New Haven, Waterbury and one rural/suburban area, (Norwich-Montville). Preliminary results of the study show that approximately 80% of Medicaid Managed Care children have been screened within the recommended time schedules.

Through an Memorandum of Agreement the CLPPP will determine the number of screenings done on children aged 0-6 who were part of Medicaid Managed Care in FFY 1999. This will provide information on screenings throughout the state and identify areas where outreach efforts need to be increased.

During 1999 the CLPPP was active in a number of statewide and municipal public and professional lead education initiatives. Major emphasis focused on assurance that children are screened at 1 and 2 years of age. Program staff have expanded these efforts and continued to provide expertise to several health departments and districts to assist their efforts in coalition building, community outreach and targeted education campaigns. The "Comprehensive Care Document", which continues to be distributed to local physicians, remains a valuable resource. This document has been designed as the core reference document for local health directors, environmental staff, medical practitioners and providers. Program staff developed standardized education packets that include core educational materials to be given to parents of children with elevated blood levels, ($\geq 10\mu\text{g/dL}$). These materials have been provided to local health departments throughout the state.

The Program is developing a "Health Education Intervention Needs Assessment" which focuses on those communities with highest risk of lead poisoning. Six towns were identified with the largest number of children under 6 years old and the highest percentage of pre-1950 housing. The needs assessment will examine the level of lead hazard knowledge within each community, the type of educational materials and the form in which the educational information will be best received by the community, and the perceived need for lead poisoning education. The CLPPP quarterly newsletter, "Lead Lines" continues to be distributed throughout the state to full time and part time health directors, lead program coordinators, medical providers and community groups. The current distribution per edition is 1250 copies.

Two quarterly meetings with average attendance of 50-60 individuals have been presented to date. These meetings were conducted primarily for lead poisoning prevention personnel at the local level and serve to provide current primary prevention initiatives, legislative happenings, program events and regulatory information. The CLPPP has developed a web page for public viewing on the DPH website and the Bureau of Community Health also maintains an Intranet site which provides educational materials that can be easily accessed by bureau personnel.

SP#22.) (Revised to SP#03 in the 2001 Annual Plan) Pediatric Mortality Due to Injury (Death rate for children 1-19 caused by unintentional and intentional injury)

Status of Annual Performance Indicator: 14.5

Indicator has: Improved Stayed the same Not Improved
(Decreased from 16.7 to 14.5)

Objective Met/Exceeded: Yes No
(No change from 16.7 was projected)

Population Served: Children and Adolescents

Level of the Pyramid: Population Based/Enabling/
Infrastructure

Activities within Title V: All clients enrolled in the HCWC program are provided with injury prevention and home safety information. As part of this educational service, staff provide and instruct parents in the use of safety plugs, medication measuring spoons and a refrigerator magnet that lists emergency numbers. Through educational interventions related to parenting, APP/YPP programs work with young parents in areas such as child development, discipline and related safety issues.

Healthy Start providers were surveyed on injury prevention training and resource needs. The majority of injuries to children < 5 years of age occur in the home; this topic was identified as a training need in the needs assessment survey. To respond to this need, in collaboration with the Health Education and Intervention Division, an in-service was conducted for all community based Healthy Start program staff. An overview of injury prevention issues was presented as were strategies for obtaining and furnishing educational materials for clients served in their programs and linkages to state level resources for accessing ongoing consultation regarding related issues.

Some Healthy Start sites offered “Safety Parties” which included educational sessions and distribution of safety devices such as electric socket plugs or cabinet latches. The Healthy Start /Healthy Families partnership provided intensive home visiting to first time parents with an educational emphasis on injury prevention. As a result, approximately 200 families were served.

DPH SBHCs and ESHS provided safety related health education sessions to more than 3,000 students in FFY 99. Sessions included classroom-based workshops on issues such as “stranger danger” and bicycle safety, child safety education for teen mothers, and motor vehicle safety activities noted in Performance Measure 8. DPH staff provided training for more than 80 SBHC and ESHS professionals on understanding child sexual assault and child abuse. A DPH Social Work Consultant actively participated in an interagency committee focusing on reducing injuries to adolescents in the workplace, helping to develop policy recommendations.

Other interventions/ influences: The Preventive Health & Health Services Block Grant (PHHSBG) does not have any dedicated funding presently for unintentional injury prevention, and the Injury Prevention Program (IP) does not receive any other funding for this issue. To address unintentional injury prevention the program works closely with other agencies and organizations.

The IP Program is a member of the Emergency Medical Services for Children (EMSC) Committee and has collaborated with the DPH EMSC Program on a series of regional workshops designed to involve EMS providers in childhood injury prevention activities. The workshops provide overview of “essential knowledge” including the magnitude, causes, and costs of injury, strategies for injury prevention and potential roles for EMS providers in injury prevention. The workshops also provided training on specific activities that EMS providers could implement in their communities.

The IP Program is involved in a collaboration with the DPH School Based and Primary Health Unit, the Environmental Epidemiology and Environmental Health Program and the CT Departments of Labor and Education on

an initiative addressing teen occupational injuries. The CT Young Worker Safety Team is working to increase awareness of teen worker safety issues among teens, parents, educators and health care providers.

The Injury Prevention Program is a member of the steering committee for CT SAFE KIDS Coalition. Coalition membership includes police, fire, EMS, hospitals, local health departments, and other community service providers. The Coalition works to foster community level unintentional injury prevention activities. As a member of the steering committee, the Program is also involved with distribution of mini-grants from the "Keep Kids Safe" License plate fund. Mini-grants of up to \$1,500 are available for communities to implement childhood injury prevention activities. Local Health Departments, Healthy Start and YPP/APP Programs have been past recipients of these grants. Unfortunately sufficient funding is only usually available to fund 12 projects out of an average of 70 applications received.

The Program co-sponsors and assists in planning the Annual CT Fire and Life Safety Educators Conference with the CT Commission on Fire Prevention and Control. The Conference's objective is to broaden the role of the fire service in prevention and public education activities.

The Program provides technical assistance, information and training for other programs within DPH, including MCH and Day Care Licensing Section. Articles on injury prevention are provided for issues of the quarterly "All Children Considered" newsletter which reaches 20,000 child care providers, educators and health care providers

The Injury Prevention Program provides data, technical assistance and resource materials to communities on implementation and evaluation of injury prevention activities

In FY 99, with Preventive Health and Health Services Block Grant funding, six local health departments/districts provided violence prevention programs to their communities. These modest programs served more than one thousand youth and adults. Most contractors reported that program participants surveyed were able to identify non-violent alternatives to fighting. Additionally, the youth violence prevention training contractor provided multi-session training programs which reached 100 youth in a shelter, after-school program and community based agencies. The contractor reported that 86-100% of youth participants surveyed were able to identify non-violent alternatives to fighting.

SP#23. Percent of Medicaid enrolled children and adolescents who received an EPSDT service during the past year.

Status of Annual Performance Indicator: 51.4%

Indicator has: Improved Stayed the same Not Improved
(Decreased to 51.4% from 60.2)

Objective Met/Exceeded: Yes No (An increase from 60.2% to 61% was projected)

Population Served: Children and Adolescents

Level of the Pyramid: Infrastructure Building

Activities within Title V: HCWC reported that 98% of the children whose mothers are enrolled in the program were in compliance with the immunization schedules.

The community-based Comadrona and Healthy Start program monitored and encouraged compliance for infants and children with the EPSDT periodicity schedule. This program is administered jointly with CT's Medicaid agency (lead for EPSDT).

All SBHCs are required to contract with Medicaid Managed Care Organizations to directly provide a comprehensive range of primary and preventive physical and behavioral health services. EPSDT preventative health care screenings are provided at the 54 SBHCs through physical examination and at 12 dental clinics through dental screenings. The SBHC clinicians collaborate with school health staff who provide state mandated vision and hearing screening. SBHCs document the number of children who receive physical examinations, risk appraisals, dental screenings and dental care, although they are not documented as EPSDT screenings.

As noted above, all SBHCs are providing outreach services to students identified as lacking health insurance at time of enrollment, and facilitate referrals to appropriate sources of coverage.

Other interventions/ influences: The Children's Health Project has reported that the percentage of on time screens for children enrolled in Medicaid managed care varies by health plan and County within the State. Younger children are more likely to receive on time screens than are older children and adolescents. (See Needs Assessment; *EPSDT on time visit rates* for further discussion.)

SP#24. (Revised to SP#08 in the 2001 Annual Plan)
Percent of community-based public health care facilities that provide comprehensive dental services for needy or vulnerable children and their families.

Status of Annual Performance Indicator: 33.3

Indicator has: Improved Stayed the same Not Improved
(Increased from 28.8 % to 33.3%)

Objective Met/Exceeded: Yes No (An increase from 28.8% to 35% was projected)

Population Served: Children and Adolescents **Level of the Pyramid:** Infrastructure

Activities within Title V: In Fiscal Year 1999, one (1) Community Health Center, Community Health Center, Inc. in New Britain, opened a dental clinic. This clinic currently offers a full range of preventive and treatment services. With the opening of this clinic a total of thirteen (13) out of (28) Community Health Centers provide dental services to needy and vulnerable children and their families. This represents forty six percent (46%) of the community health centers in the state. In addition to the centers, fourteen (14) hospitals, fifteen (15) local health and ten (10) home health/public health nursing agencies provide dental services. Services vary somewhat, with only preventive services being offered by some agencies while a full range of dental services are offered by others. Services are available to all people regardless of their ability to pay.

As part of the current Fiscal Year 2000 Budget, the Connecticut Department of Public Health awarded \$100,000 worth of grants to four Community Health Centers in the amount of \$25,000 each to increase and enhance oral health services. These grants are expected to be renewed for an additional year.

For Fiscal Year 1999, the Department did not receive appropriations for the enhancement of dental services in school based health centers. Therefore, no additional sites were added during this period.

Due to changes in operational plans, the oral health program chose not to conduct a follow-up survey of community-based health facilities during this year. It was decided that this survey, following so closely to the initial baseline survey, would show little differences and that it would be more appropriate and cost effective to conduct follow-up surveys every three (3) years.

**SP#25. (Revised to SP#01 in the 2001 Annual Plan)
The percentage of CSHCN clients enrolled in the State CSHCN program that have a written care service plan.**

Status of Annual Performance Indicator: 75%

Indicator has: Improved Stayed the same Not Improved
(Decreased from 84.1% to 75%)

Objective Met/Exceeded: Yes No (An increase from 84.1% to 85% projected)

Population Served: CSHCN

Level of the Pyramid: Infrastructure Building/Enabling

Activities within Title V: The two CSHCN regional Centers located at the Yale-New Haven Children's Hospital and Connecticut Children's Medical Center, have continued to strive toward providing every CSHCN child with a comprehensive, interdisciplinary, family centered, written care service plan. DPH staff conducted on site chart reviews to monitor the Centers' compliance in completing care plans for all enrolled clients.

Table 10 Accomplishments of the Title V Program (Outside of the Performance Measures)

	Pregnant Women and Infants	Children and Youth	CSHCN
Direct/Enabling	<p>MCH I&R provided information and referrals for all three population groups to DPH programs such as the two CSHCN Centers, CHCs, Family Planning, Healthy Start, HUSKY, PEIS, SBHCs, Rape Crisis, SIDS, WIC, and APP/YPP.</p> <p>MCH I&R made 572 prenatal care referrals.</p>	<p>MCH I & R instituted and advertised the 211 hotline in 1999 which resulted in a 100% increase in the number of MCH Service Requests received across the three population groups.</p> <p>MCH Liaisons coordinated public awareness and education activities via 96 training sessions, 173 presentations, 198 networking/facilitation activities, and 75 health fairs.</p> <p>To address unmet needs of teens, MCH Liaisons have provided training to new DCF staff, developed Youth Yellow Pages as a resource specifically designed for teens, and offered training regarding MCH services.</p>	MCH I&R
Infrastructure Building	<p>FIMR program established in 6 high risk communities. (see Outcome Report Supporting Documents)</p> <p>APP/YPP programs implemented individual client level database, collecting information on client characteristics, program interventions, outcomes, and follow-up.</p>	<p>The Hartford Health Department closed the Women's Health Center on 8/13/99 and Planned Parenthood of CT Inc. opened a new facility on 8/16/99.</p>	

	Pregnant Women and Infants	Children and Youth	CSHCN
Infrastructure Building	<p>The HCWC program sponsored a conference for 180 service providers entitled "Working with Substance Abusing Pregnant Women/Long-Term Impact on Children" with Dr. Ira Chasnoff, a nationally recognized speaker, researcher and author.</p> <p>HCWC Staff were participants in the Melanie Reiger Violence Prevention Conference and the Youth Violence Prevention conference. All clients of the program are screened for domestic violence. Seven women (100%) identified to be at risk for physical abuse by their partners were provided with safety plans.</p> <p>Genetics/Newborn Screening Program contracted consulting services to develop and install a new database for the Newborn Screening Program. This database has enhanced the tracking Unit's data and surveillance system for all abnormal newborn screening results for the eight diseases mandated by the Legislature.</p>		

2.5 Progress on Outcome Measures

Please refer to Form 12

Outcome Measure #1 – The infant mortality rate per 1,000 live births.

Status of Annual Outcome Indicator: 7.0

HP 2010: 5

Indicator Has: Improved Not Improved

Objective Met/Exceeded: Yes No

Source of Data: CT DPH, Vital Statistics, 1998

Outcome Measure #2 – The ratio of black infant mortality rate to white infant mortality rate.

Status of Annual Outcome Indicator: 3.2

HP baseline 1995: 1.92

(Estimation based on targeted 34.2% reduction stated for total IMR) HP 2010 goal: 1.26

Indicator Has: Improved Not Improved

Objective Met/Exceeded: Yes No

Source of Data: CT DPH, Vital Statistics, 1998

Outcome Measure #3 – The neonatal mortality rate per 1,000 live births.

Status of Annual Outcome Indicator: 5.1

HP 2010: 3.3

Indicator Has: Improved Not Improved

Objective Met/Exceeded: Yes No

Source of Data: CT DPH, Vital Statistics, 1998

Outcome Measure #4 – The postneonatal mortality rate per 1,000 live births.

Status of Annual Outcome Indicator: 1.9

HP 2010: 1.7

Indicator Has: Improved Not Improved

Objective Met/Exceeded: Yes No

Source of Data: CT DPH, Vital Statistics, 1998

Outcome Measure #5 – The perinatal mortality rate per 1,000 live births.

Status of Annual Outcome Indicator: 11.2 *HP 2010: 7.7*

Indicator Has: () Improved (X) Not Improved

Objective Met/Exceeded: () Yes (X) No

Source of Data: CT DPH, Vital Statistics, 1998

Outcome Measure #6 – The child death rate per 100,000 children aged 1-14.

Status of Annual Outcome Indicator: 16.9 *HP 2010: 30 (ages 1-4)
: 17(ages 5-14)*

Indicator Has: (X) Improved () Not Improved

Objective Met/Exceeded: (X) Yes () No

Source of Data: CT DPH, Vital Statistics, 1998

Connecticut compares favorably with the nation for all of the outcome measures except measure #2, the ratio of black IMR versus white infant mortality. Connecticut's child fatality rate has achieved the Healthy People 2010 Objective, and our postneonatal rate is very close to achieving the Healthy People objective. A trend comparison within CT shows three of the measures improved, and three with worse outcomes than the prior year. The three measures with worsening outcomes are:

- #2 Ratio of black to white infant mortality rate,
- #4 Postneonatal mortality rate, and
- #5 Perinatal mortality rate. This measure fell the shortest from its goal with a rate of 11.2 vs. the objective of 10.0.

III. REQUIREMENTS FOR APPLICATION

3.1 Needs Assessment of the Maternal and Child Health Population

3.1.1 Needs Assessment Process

To assist in the overview and direction of the Needs Assessment, the MCH director established a Steering Committee within the CT DPH comprised of supervisors and staff from the various MCH programs, epidemiologists from the Office of Policy Planning and Evaluation (OPPE), and staff from the Program Support and Contract Management Unit. The Steering Committee determined the process to be used for the Needs Assessment and established three workgroups based on the MCH populations: pregnant women, mothers and infants; children and adolescents; and children with special health care needs.

Each of the workgroups was comprised of approximately 10 members and met 7 to 10 times over a five month period from September, 1999 to January, 2000. At these meetings the workgroup members identified sources of information relevant to the population group including existing programmatic information, reports, data sources, and existing needs assessments. Staff volunteered to review the information and present it to the workgroup. When appropriate, persons outside the workgroup presented information. (For example an epidemiologist from the Sexually Transmitted Disease Section of DPH presented information to workgroups on STD incidence among adolescents and women.) The source of information was reviewed for its validity and value to the Needs Assessment and how it could help assess the need for direct health care, enabling, population-based, and infrastructure building services. Existing programs were discussed including how they address the identified needs and where there may be gaps in services. *Strengths* of the existing programs were identified as well as gaps and needs. All of the needs that were identified were grouped under several major headings.

A matrix was developed to bring closure to the workgroup discussions and to assist in the final identification and prioritization of needs. The matrix approach was suggested by Eugene Declercq of Boston University during a technical support training session held in January of 2000 and sponsored by MCHB and also outlined in an MCHB publication.^{ix} The matrix considered the following factors: severity and prevalence of the condition, the ability of DPH to effect a change, whether DPH has an existing program in place, and whether there was an impact on the quality of life. The matrix was *not* intended to be the final way to prioritize the identified needs, but it was intended to help us bring our discussions and reviews to closure for the needs assessment. The identified needs were then presented to supervisors within the DPH for their final review and comments.

It is important to emphasize that selection as a priority need was based on the severity of the health impact, the number of persons affected, whether it was within the statutory authority of DPH, whether programs were already in place, and, the potential DPH could actually bring about an improvement in health status.

After the priority needs were identified, the MCH staff then met to discuss how the program activities should be altered to respond to the priority needs, how to incorporate activities into the annual plan, and how to track progress through state performance measures. For example, asthma has been identified as a priority need. Staff met to discuss how Title V programs could incorporate improvements in education, diagnosis, and case management for

asthma. These activities were incorporated into the annual plan, and then a performance measure reflecting these programmatic activities was developed.

Public input was brought into the process in a number of ways including: family surveys of the CSHCN, summary of calls to the MCH Infoline, and four focus group meetings. Also, the draft Needs Assessment was reviewed by parent groups, available for public comment during the public hearing, and will be available for review on the internet.

The strength of our Needs Assessment process was that it involved all programmatic staff, epidemiologists, and managers in discussing the quality of information and the programmatic implications of the information.

Use of Geographic Information Systems (GIS)

One innovation of the Needs Assessment was the use of GIS. The GIS enables computerized mapping of data and enables spatial analysis of information. Where possible, data used in the Needs Assessment was geocoded for incorporation into the GIS. For example address information from the matched birth/death (1994-1996) cohort file was assigned latitude and longitude coordinates using Matchmaker 2000. This enabled the generation of maps that displayed health outcome and risk factor information from the cohort file. Spatial modeling techniques were used to present information without respect to political boundaries such as town lines. Additionally, Title V funded program locations (such as School Based Health Centers, Community Health Centers) were geocoded and mapped in relation to appropriate health outcome and risk factor information. This allowed staff to review program location and risk factor and health outcome information simultaneously.

These maps are located at the end of the needs assessment section and should be viewed in their original color format. Unfortunately, when the maps are photocopied they lose detail and become a less valuable tool in visualizing data.

3.1.2 Needs Assessment Content

3.1.2.1 Overview of the Maternal and Child Health Population's Health Status

Although the majority of indicators of the health of the citizens of Connecticut are good in comparison to the United States as a whole, there are many higher risk groups within Connecticut which experience a greater share of the burden of adverse health risks. Within the State, it is the poor, the minorities, and those who live in the larger urban areas who experience higher rates of disease. Our Title V programs within Connecticut exist to serve all of the citizens in the State but focus on those who are most need of the services they provide.

Demographic Information

Estimates from the Census Bureau indicate that in 1998 Connecticut's population of about 3.3 million included 2.6 million whites, 279,000 African Americans/Blacks, 268,000 Hispanics, 77,000 Asian-Pacific Islanders, and 6,000 classified as American Indians or others. While the total Connecticut population changed little since 1990, the proportion of minorities in the population have been increasing. Recent complete estimates of the racial and ethnic distributions are not available for all of the cities in the state, however, Table 11 presents the proportion of the population by race and Hispanic ethnicity for six major cities in comparison to the State. While Connecticut

population is almost 80 percent white, these cities have a much greater percentage of minority populations. Map 1 presents the State with town names for reference. Map 2, Map 3, and Map 4 present the overall population density, the percent of the population that are African American, and the percent of the population that are Hispanic.

Table 11 Percent Population Distribution by Race and Ethnicity

	Connecticut	Bridgeport	Hartford	New Haven	New London	Waterbury
White non-Hispanic	78.8	40.1	25.4	43.5	63.5	68.7
African American non-Hispanic	8.5	26.6	37.2	37.2	17.7	13.7
Hispanic	8.1	30.2	35.5	15.8	15.2	16.2
Other	4.6	3.2	4.1	3.5	3.6	1.3

Economic Data

The variation of economic conditions within the State of Connecticut provides the main backdrop for the variations in health status among the citizens of the State. Sociodemographic indicators are crucial to understanding factors contributing to morbidity and mortality risks. Socioeconomic status (SES) is strongly related to health insurance coverage which influences access and quality of medical care. SES is also related to health behavior, the quality of the living environment, and health status. The distribution of wealth within Connecticut varies greatly by geographic area. The Per Capita Income(PCI) in 1998 for the State was \$33,875; however the PCI had a wide range within the cities and towns. Hartford had the lowest PCI in the State at \$17,274, while New Canaan, a wealthy suburb near the New York border had a PCI of \$91,777.^x

As with the entire United States, the economy has improved in Connecticut during the past few years. Unemployment has dropped to only 3.4 percent statewide in 1998. However, some areas of unemployment are higher in the state, including the largest urban areas. For example, in 1998, unemployment in Hartford was 6.7 percent, almost twice the state average.^{xi} Educational attainment also varies throughout the State. Education level is widely used as an indicator of SES and is associated with many health outcomes including infant mortality. Only 4.6 percent of students drop out of high school in Connecticut (lower than the 15 percent drop out rate nationally), however, this rate is much higher in the urban areas with Hartford having a drop out rate of 25 percent.

The proportion of persons with income below the poverty level is useful because it takes into account the size of the household. The term “two Connecticuts” is sometimes used to indicate the disparities in income and the quality of life in Connecticut. Table 12 presents selected economic indicators for Connecticut and selected cities. With a healthy economy the poverty rate nationally and in CT has decreased somewhat in recent years. The March, 1999 Current Population Survey conducted by the US Census indicated that the Connecticut poverty rate of 9.9 percent for the three year period of 1996-1998 was lower than the national average rate of 13.2 for the same period.^{xii} Poverty is an important consideration for the MCH population. While Connecticut specific data are not available for 1998, nationally, the poverty rate for children was 18.9 percent in 1998. Poverty becomes more severe among related children under age 6 living in families with a female householder (no husband present) with a poverty rate of 54.8 percent which is more than five times the rate than the children of their married counterparts.^{xiii}

Table 12 Selected Economic Indicators for Connecticut and Selected Cities

	Connecticut	Bridgeport	Hartford	New Haven	New London	Waterbury
Per Capita Income for 1996*	\$ 33,875	\$ 21,581	\$ 17,274	\$ 21,884	\$ 21,283	\$ 23,248
April, 2000 percent unemployment**	2.1	4.1	4.4	3.2	3.7	3.5
% poverty (1990)	6.6	17.1	27.5	21.3	15.2	12.1
% High School Drop out [^]	4.6	7.1	23.4	10.3	9.3	15.9

Data source: *CT Dept of Economic Development <http://www.state.ct.us/ecd/research/ceis/income/pci.html>

** <http://www.ctdol.state.ct.us/lmi/laus/lmi123.htm>

[^] <http://www.state.ct.us/ecd/research/townprof98/98townhtml.html>

Maternal and Infant Health

The DPH report Looking Toward 2000 provided a great deal of information on Maternal and Infant Health which is presented here. The overall condition of maternal and infant health is relatively good in Connecticut in comparison with national figures. Infant mortality rate was low (7.0/1,000) in 1998, meeting the year 2000 target objective (7.0/1,000). In 1998 only 12.2% of Connecticut women did not receive early prenatal care in accordance with the recommended guidelines of the American College of Obstetricians and Gynecologists (about half the U.S. rate). In contrast, the percentage of low birthweight deliveries, which is an important risk factor and a predictor of infant mortality, has not improved for ten years and remains a major challenge for maternal and child health programs in Connecticut.^{xiii}

While the overall rates for maternal and child health indicators compare favorably with national statistics, significant health status disparities exist within Connecticut. Rates for selected indicators by race and Hispanic ethnicity are presented below.

Infant Mortality

From 1986 to 1998, Connecticut's infant death rate fell from 9.0 to 7.0 deaths per 1,000 live births. Infant mortality includes neonatal (less than 28 days old) and postneonatal (29 to 365 days old) mortality figures. Neonatal deaths are frequently associated with circumstances related to conditions of the pregnancy and delivery, whereas postneonatal deaths are associated with environmental conditions, risk exposures, and access to health care during the first year of life. The decline in Connecticut's infant mortality rate was due largely to decreasing neonatal mortality rates. In contrast, the postneonatal death rate has not dropped during the same period.

The infant mortality rates for African American/Blacks exceeded the rates for whites in all years from 1986 to 1996 (see Figure 3). This gap reflects the consistently higher prevalence among African American/Blacks for other risk factors, such as birth rates among teenage women, lack of adequate prenatal care, and low birthweight. The infant mortality rate also varies by geographic region. Table 13 and Map 5 present the infant mortality rate throughout the State. The major cities have higher infant mortality rates, but this map demonstrates that even outside the urban centers there are portions of Connecticut which experience elevated rates of infant mortality.

Figure 3 Infant Mortality Rates by Race and Ethnicity

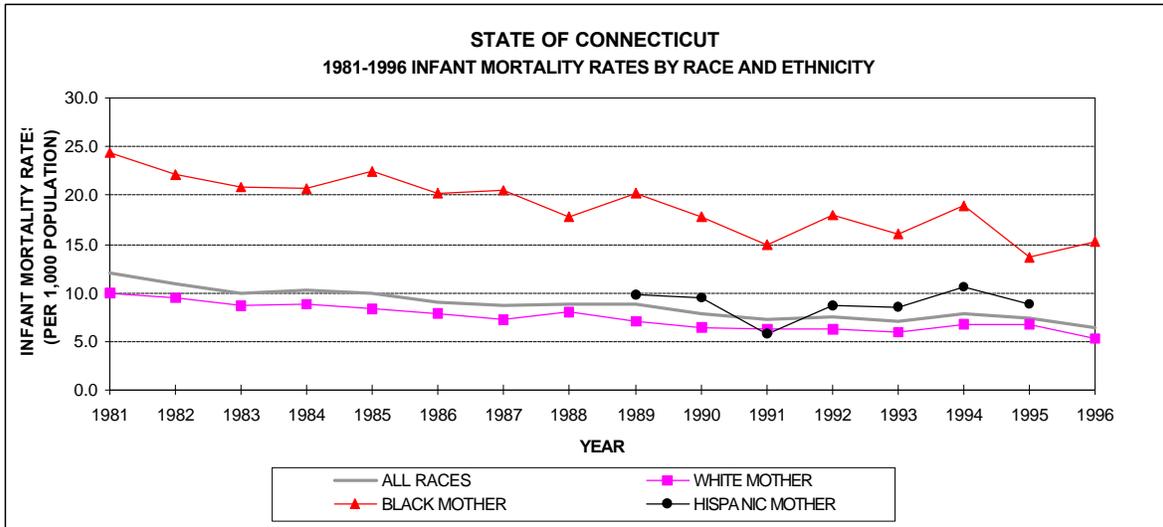


Table 13 Infant Mortality Rate per 1,000 Live Births for Connecticut and Selected Cities, by Race and Ethnicity 1994-1996

	Connecticut	Bridgeport	Hartford	New Haven	New London	Waterbury
White non-Hispanic	5.23	9.79	9.45	7.09	7.78	8.36
African American non-Hispanic	15.09	14.49	19.54	15.77	11.28	13.37
Hispanic	9.31	7.67	13.27	11.29	3.64	8.92
Other	6.40	9.97	0.00	11.36	17.24	8.77

While this country has not seen any improvements in the incidence of preterm birth and the rates of low birthweight overall, there has been a significant improvement in the survival rates for preterm infants. Through advances in neonatal intensive care for very low birthweight infants (< 1,500 grams at birth) and better obstetrical management of preterm and other high risk deliveries, the birthweight specific survival rates in the U. S. are among the best in the world.^{xiv} Improvements in the infant mortality rate are believed to be due to the efficacy of newborn intensive care units, with improved survival mainly for infants of moderately low birthweight. For example, corticosteroid therapy administered to the mother prior to birth is effective in reducing respiratory distress syndrome, intracranial hemorrhage, and mortality in the premature newborn.^{xiv} Further reductions in infant mortality and morbidity will require new strategies to modify the behaviors and lifestyles that affect birth outcomes, such as smoking, drinking, drug use, and utilization of prenatal care services. Efforts such as improved prenatal care by means of comprehensive programs to improve pregnancy outcomes can reduce neonatal mortality. Studies have indicated that screening for risk factors such as bacterial vaginosis may have an effect in reducing preterm delivery.^{xv} Targeting prevention programs to groups showing a high rate of low and very low birthweight infants (such as the

urban centers or the state's African American/Black population) may produce the greatest effect on reducing the overall neonatal mortality rate in the state.

Leading causes of postneonatal death include birth defects, sudden infant death syndrome, infections, and injuries. Interventions aimed at linking newborns with accessible, on-going, and culturally-sensitive primary care can provide effective education and services to avoid or minimize the effects of these threats to the postneonate.

A large percentage of fetal deaths is attributed to lethal malformations. Better medical evaluation of fetal deaths with genetic screening and counseling may help to prevent fetal deaths. Interventions to address known causes of fetal death include improved prenatal diagnosis and treatments of maternal morbidities, such as hypertension and maternal-fetal infections, and efforts to reduce maternal cigarette smoking and the use of illegal drugs.

Programming within DPH to reduce infant mortality is aimed at the period before conception, along with the prenatal and postnatal periods. Pre-conception interventions aimed at school-aged audiences and women of childbearing age include: primary care services; targeted health education programs; and outreach and case-finding to link individuals and families to primary and preventive services. Prenatal 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 physician. Postnatal efforts include medical testing for genetic disorders and maintaining good health for normal infants and their mothers. The WIC program (Special Supplemental Food Program for Women, Infants and Children), for example, promotes breast feeding of infants for at least the first three months of life.

Births to teens

Teen mothers are more likely to have unplanned, unwanted pregnancies, and to become single parents. Being a young single parent imposes extra demands on the mother, which may result in her being less likely to complete high school, to find adequate employment and to have enough time to interact with her child. Teen mothers are at an increased risk of having a low birthweight baby, and the risk of infant mortality may also be elevated, particularly for young teenage mothers. In 1995, women aged 15-19 had the greatest risk of delivering a low birthweight baby. The risk diminished as women aged, until ages 35-39 years, when it gradually began increasing.

Teen pregnancy is considered a public health problem for several reasons related to the health of both 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 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 numbers of sexually active adolescents who use contraceptives effectively.

Connecticut ranked 12th in the nation for its teen pregnancy rate for 15-17 year olds in 1997 with a rate of 22 births per 1,000 females age 15-17. The rate of births to teens varies throughout the State as presented in Map 3. Also the percentage of births to teens varies greatly throughout the State as presented in Table 14 with cities having a greater percent of birth to teens than the State overall. The percent of births to teens also varies by race and ethnicity. Figure 4 shows that the overall percent of births to teens has dropped in the last decade, especially among African American/Blacks. However, there remain a greater percentage of pregnancies among teens in the African

American/Black and Hispanic populations. During 1994-1996 an African American/Black or Hispanic baby was approximately 5 times more likely to have a teenager as a mother than a White baby.

The percentage of births that are low birthweight (< 2,500 gm.) has remained fairly level with a slight increase since 1985. In 1997, the percentage of low birth weight births to teens in Connecticut was 11.9 (compared to a statewide percentage of 7.3). The 1997 percent of preterm births to the state was 10.0, while that to teens was 15.3. Therefore, teens are at a greater risk of having a baby preterm or with low birthweight.

Table 14 Percent Births to Teenage Mothers (<=19) Connecticut and Selected Cities, 1994-1996

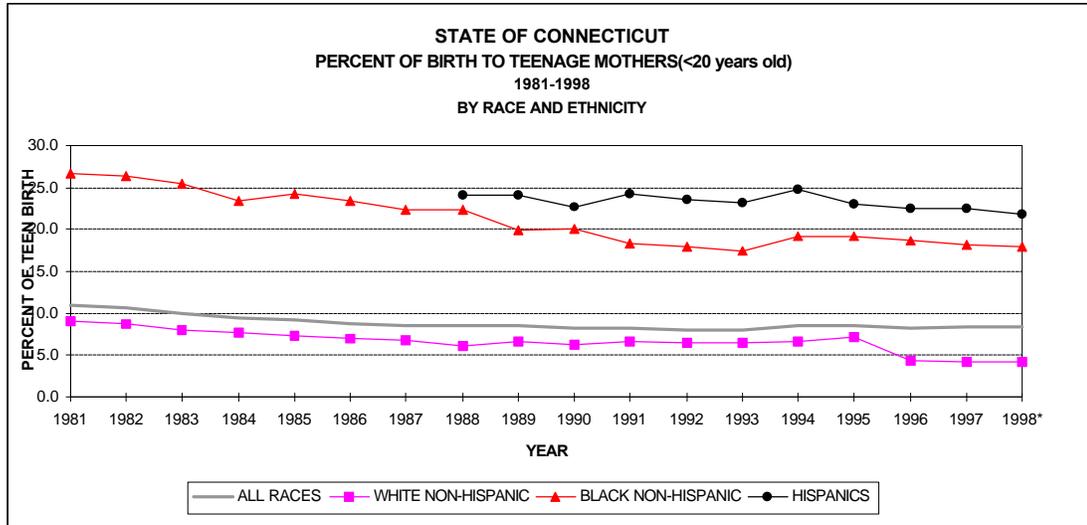
	Connecticut	Bridgeport	Hartford	New Haven	New London	Waterbury
White non-Hispanic	4.36	8.29	11.97	6.85	10.89	7.49
African American non-Hispanic	19.18	20.12	23.64	22.82	22.18	20.16
Hispanic	23.44	26.16	32.08	24.63	26.55	26.02
Other	4.67	10.96	12.96	1.14	8.62	13.16

Child abuse, domestic violence and other injuries to children can be more prevalent in the homes of young parents. Children of teen mothers are more likely to be recipients of reported child abuse and more likely to be placed in foster care than children of older mothers although it is unclear how much of this effect is the result of the stresses of poverty. There are racial/ethnic disparities in the number of teens who become pregnant and have children.

State-sponsored specialized programs such as the APP/YPP (Adolescent Pregnancy Prevention/Young Parents' Program) programs provide both contraceptive services and prenatal care for teens. Teen planning grants, a new initiative in 1997, targeted teen pregnancy prevention in the ten communities in the state with the highest teen birth rates.

State programs are also directed towards preventing repeat births among teenage mothers. One of the goals of the programs is to maximize the health of its participants, while trying to promote healthy social/economic future for the teens. One way this is accomplished is by joining forces with the educational system to encourage teen mothers to finish high school.

Figure 4 Percent of Births to Teenage Mothers



Prenatal care

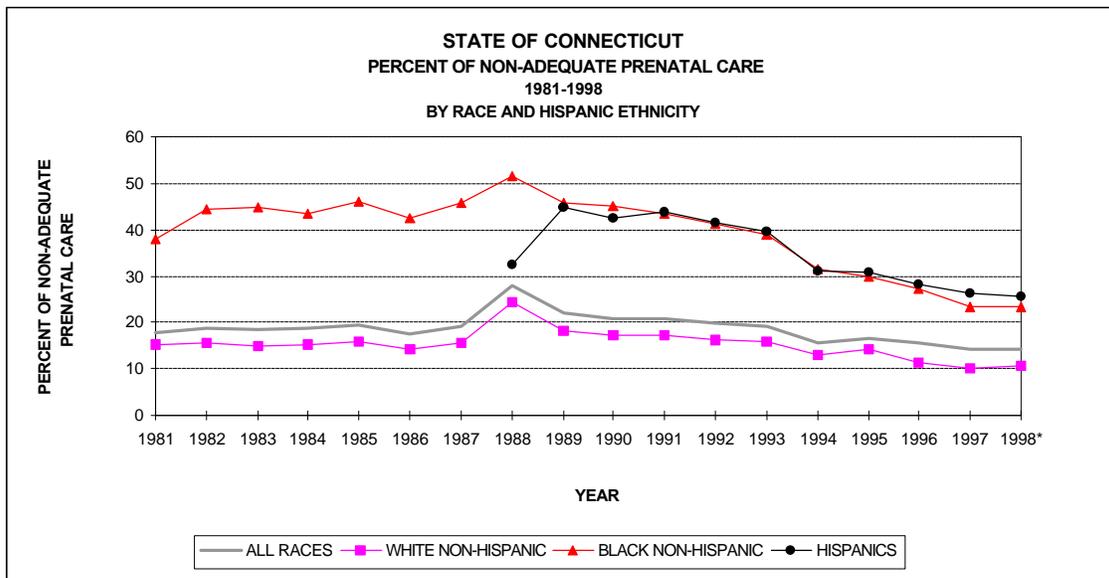
Non-adequate care, is a composite index (a modified Kessner Index has been used by DPH for years), reflecting both the time of the first prenatal visit and the number of visits. Non-adequate prenatal care is a summary measure of prenatal care initiation and the number of prenatal visits. The “non-adequate” grouping includes both “inadequate” and “intermediate” care as defined in the Kessner Index of prenatal care.^{xvi} In Connecticut, the elimination of non-adequate care could reduce infant mortality by an estimated 15% overall.^{xvii} Among African/Black American infants, non-adequate care is more common, and its elimination could result in an estimated 24% infant mortality reduction.^{xviii} Adequacy of prenatal care has improved during the past decade, however adequate prenatal care is less often achieved by African American/Black and Hispanic women as shown in Figure 5 and Table 15. Table 15 and Map 7 also demonstrate that mothers in the cities are less likely to receive adequate prenatal care.

Prenatal care should be initiated during the first trimester of pregnancy. Prenatal care utilization has been quite good in Connecticut. In 1998 only approximately 12.2% of Connecticut women did not receive early care (about half the U.S. percentage).

Table 15 Percent non-Adequate Prenatal Care for Connecticut and Selected Cities, by Race and Ethnicity 1994-1996

	Connecticut	Bridgeport	Hartford	New Haven	New London	Waterbury
White non-Hispanic	10.32	16.81	13.07	13.62	20.22	22.12
African American non-Hispanic	24.34	22.27	16.46	27.60	37.22	40.74
Hispanic	23.48	20.71	17.02	22.16	33.09	42.97
Other	16.96	18.60	17.59	19.89	32.76	27.19

Figure 5 Percent of non-Adequate Prenatal Care by Race and Ethnicity



Good prenatal care is a cornerstone of prevention for both infant mortality and morbidity. An expectant mother with no prenatal care is three times more likely than mothers with appropriate care to have a low birthweight baby. Low birthweight is associated with a variety of medical problems and increased risk of mortality, especially for the pre-term infant. Ensured access to care, together with comprehensive approaches to prenatal care that include “flexible combinations of education, psychosocial and nutritional services, and certain clinical interventions such as a low threshold for hospitalization, careful screening for medical risks, and rapid response to signs of early labor,”^{xix} hold the promise of considerable improvement in birth outcomes and in the health of both mother and child.

DPH has tried to improve access to prenatal care through several strategies, such as supporting sites for primary care and free pregnancy testing at family planning clinics. At these sites, patients are appropriately referred for early prenatal care, in keeping with established protocols.

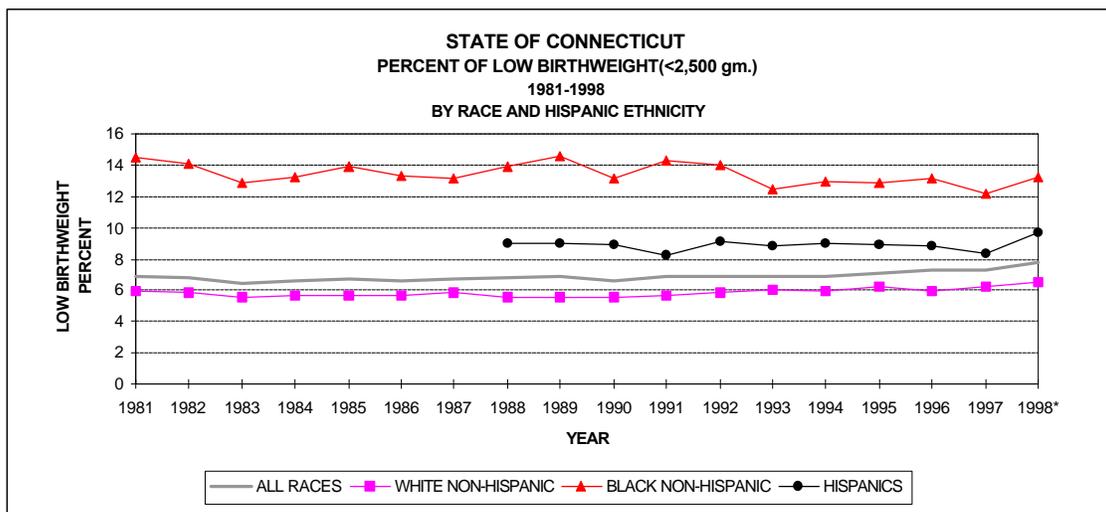
Low birthweight

Prematurity and low birthweight are major risk factors for infant mortality. Nearly 70 percent of all infant mortality is associated with low birthweight, as are about one-third of all handicapping conditions.^{xiv} Low birthweight refers to infants weighing less than 2,500 grams (about 5.5 pounds) at delivery. Birthweight in general is a measure of the adequacy of fetal growth during pregnancy, and low birthweight can result from prematurity (gestational age <37 weeks), intrauterine growth retardation, or other factors. Low birthweight is a major cause of infant mortality and long-term health problems, and decreasing birthweights under 2,500 grams are associated with increasing risk of death within the first year of life. Low birthweight infants account for less than 7% of all live births in the United States, but they account for nearly 60% of all infant deaths.^{xx} The impact of low birthweight on infant mortality occurs primarily during the first 28 days of life (the neonatal period), when low birthweight infants are

about 40 times more likely than normal-weight infants to die. For very low birthweight infants (less than 1,500 grams or 3 lbs. 3 oz.) the risk of death is 200 times higher than among normal-weight newborns.

For the 1994-1996 birth cohort Connecticut figures are even more pronounced, with low birthweight accounting for about 7% of births and 68% of infant deaths. Relative to normal weight babies in Connecticut, low weight increased the risk of neonatal death over 50 times (from 1.1 to 59.8 deaths per 1,000 births), and over 225 times among very low birthweight deliveries. Low birthweight occurred more frequently among deliveries where Medicaid was the payer. During 1996, in 10.4 percent of deliveries paid for by Medicaid, the baby had low birthweight compared to 6.2 percent among non-Medicaid deliveries. Low birthweight is more common among infants of African American/Black and Hispanic mothers as shown in Figure 6. Table 16 and Map 8 demonstrate that low birthweight is a more common health problem in the cities..

Figure 6 Percent of Low Birthweight by Race and Ethnicity



In addition to increased risk of mortality, low and very low birthweight are associated with increased risk of disability, such as mental retardation, cerebral palsy, and vision and hearing disabilities. Advances in neonatal medicine have increased the survival of low and very low birthweight infants. While many of these low birthweight survivors will lead normal lives, it is clear that “serious questions remain about how these infants will develop and whether they will have normal productive lives. Given the increasing number of survivors of extreme prematurity and the high health care and educational costs involved, it is crucial that we appreciate the full extent of any adverse outcomes.”^{xxi} Low birthweight is, however, a preventable condition. By improving maternal health before conception using appropriate family planning and prenatal care services, many of the conditions that lead to the slow growth and/or prematurity of a low-birthweight infant can either be reduced.

Table 16 Percent Low Birthweight for Connecticut and Selected Cities, by Race and Ethnicity 1994-1996

	Connecticut	Bridgeport	Hartford	New Haven	New London	Waterbury
White non-Hispanic	6.91	6.90	7.24	6.93	6.53	7.81
African American non-Hispanic	13.42	11.80	15.07	14.15	9.77	13.48
Hispanic	9.76	8.99	11.94	8.47	5.82	9.52
Other	9.30	7.97	7.41	9.67	15.52	11.40

Prevention of low birthweight is considered to be a major objective of public health and medical interventions whose goal is to reduce infant mortality. Six risk factors for low birthweight birth are:

- Demographic characteristics, such as low socioeconomic status, low level of education, nonwhite race (particularly African American/Black), childbearing at extremes of the reproductive age span, and being unmarried;
- Medical risks that can be identified before pregnancy, such as a poor obstetric history, certain diseases and conditions, and poor nutritional status;
- Problems that are detected during pregnancy, such as poor weight gain, bacteriuria, toxemia/pre-eclampsia, short inter-pregnancy interval, and multiple pregnancy;
- Behavioral and environmental risks, such as smoking, alcohol and other substance abuse, and exposure to various toxic substances;
- Health care risks of absent or inadequate prenatal care; and
- Evolving concepts of risk, such as stress, uterine irritability, certain cervical changes detected before the onset of labor, some infections, inadequate plasma volume expansion, and progesterone deficiency.^{xxii}

Increasing access to prenatal care and improving the content of care remain key concerns. Improvements in these factors should affect other modifiable risk factors favorably. Sexually transmitted diseases during pregnancy, infection of the lower (vagina and cervix) and upper female reproductive tract (amniotic fluid and chorioamnion), and a specific condition called bacterial vaginosis are strongly associated with spontaneous preterm birth and other adverse pregnancy outcomes.^{xiv}

Also, cigarette smoking is an important modifiable risk factor for low birthweight and infant mortality. Interventions to diminish cigarette smoking in pregnant women could have far-reaching benefits for both mother and child.

Birth Defects

Connecticut has a Birth Defects Prevention and Surveillance Program (BDPSP). The BDPSP gathers information from birth certificates, death certificates, and hospital discharge records. State and local maternal and child health workers need a birth defects surveillance system to monitor the prevalence and incidence of birth defects, to understand the causes and impacts of various birth defects, and to develop effective strategies for prevention.^{xxiii} Connecticut data are now available from 1993 and 1994.^{xxiv}

Immunizations

During the 20th century, substantial achievements have been made in the control of many vaccine-preventable diseases. A recent CDC report documented the decline in morbidity from nine vaccine-preventable diseases and their complications as a result of immunizations.^{xxv}

Vaccines are responsible for the control of many infectious diseases that were once common in this country. However, the viruses and bacteria that cause vaccine-preventable disease and death still exist and can be passed on to people who are not protected by vaccines. Vaccine-preventable diseases have a costly impact, resulting in doctor's visits, hospitalizations, and even premature deaths.

In the past the following vaccine-preventable diseases disabled and killed millions of American children. Thanks to high childhood immunization coverage levels in the United States, these diseases are now very uncommon.

- Diphtheria
- Haemophilus influenzae type b (Hib)
- Hepatitis A
- Hepatitis B
- Measles
- Mumps
- Pertussis (whooping cough)
- Polio
- Rubella (German measles)
- Tetanus (lockjaw)
- Varicella (chickenpox)

Vaccines are one of the greatest achievements of biomedical science and public health. Despite remarkable progress, several challenges face the U.S. vaccine-delivery system. The infrastructure of the system must be capable of successfully implementing an increasingly complex vaccination schedule. Over 40,000 children are born each year in Connecticut, each requiring 15-19 doses of vaccine by age 18 months in order to be protected against 11 childhood diseases. The DPH has developed an immunizations registry to assist with the tracking of immunizations among CT children. Connecticut has consistently achieved high rates of immunization coverage within the State. The National Immunization Survey for July 1998 to June 1999 indicated that Connecticut had an immunization coverage rate of 88 percent, the fourth highest rate in the U.S. This coverage rate is for the most critical series (4:3:1:3) of childhood vaccines covering diphtheria, pertussis, tetanus, poliovirus, measles, and *Haemophilus influenzae* type b with a national average of 79 percent. Among the children receiving WIC, the coverage was 81.4 percent.^{xxvi} Within the children on Medicaid, 76.7 percent were known to be up to date with immunizations.^{xxvii}

Asthma

Asthma is the most common chronic condition among children and is a leading cause of school absenteeism. Each year in Connecticut there are approximately 1,400 hospital admissions and 6,000 emergency room visits with a primary diagnosis of asthma in children less than 15 years of age. While asthma cannot be cured, the debilitating

effects of asthma, including hospitalizations and emergency room visits, can be reduced through proper asthma management. According to data from the CT Office of Health Care Access, the median charge **per** hospital admission is approximately \$3,085, translating into approximately \$4,319,000 per year-just for admissions among children with a primary diagnosis of asthma.

Surveillance activities at the Connecticut Department of Public Health indicate that children living in urban areas have much higher rates of hospitalization and emergency room visits. Significant differences are also seen among racial/ethnic groups.

Hospital admission rates for children 0-14 in Connecticut are much higher among African American/Black and Hispanic children when compared to white children. The average annual hospital admission rate for Hispanic children for the seven year period from 1992-1998 is 55/10,000, five times higher than the annual average for white children, of 12/10,000. Significant differences in the rates of hospitalization and emergency room visits are seen in our urban centers. While Bridgeport, Hartford, New Haven, Stamford and Waterbury comprise approximately 20 percent of the children age 0-14 in the State, these cities account for 50 percent of all hospitalizations and emergency room visits for asthma among children. Table 17 presents Asthma data for Connecticut and selected cities by race and Hispanic ethnicity.

Table 17 Annual Average Hospital Admission Rate per 10,000, Primary Diagnosis of Asthma, Children 0-14, for Connecticut and Selected Cities by Race and Hispanic ethnicity 1992-1998

	Connecticut	Bridgeport	Hartford	New Haven	Waterbury
White non-Hispanic	11.7	12.38	10.35	30.35	15.17
African American non-Hispanic	58.4	39.17	43.10	91.90	62.26
Hispanic	55.3	39.91	77.70	111.21	69.86

The prevalence of asthma among Medicaid clients is highest in Connecticut cities. In 1997, the prevalence of asthma among Medicaid clients in Connecticut was 7.3 percent compared to the cities of Bridgeport 8.9 percent, Hartford 10.3 percent, New Haven 8.4 percent and Waterbury 8.6 percent. Twenty-seven percent of the Medicaid clients identified with asthma were white, 27 percent were African American and 45 percent were Hispanic.

During the 1998 and 1999 Behavioral Risk Factor Surveillance System survey, Connecticut added questions about asthma. Nineteen percent of all households surveyed reported at least one person with asthma. Eighteen percent of white households, 22 percent of African American/Black households and 31 percent of Hispanic households reported having at least one person with asthma. In the households with children, 16.5 percent reported at least one child in the household with asthma. Twenty-two percent of the Hispanic households with children reported at least one child with asthma compared to 15 percent of white households.

Lead Poisoning Prevention

Although there has been a decline in lead exposure nationwide, lead poisoning continues to be an important public health issue in Connecticut. Childhood lead poisoning is one of the most common pediatric public health

problems today and is totally preventable. In response to this need the DPH Childhood Lead Poisoning Prevention Program (CLPPP) has many program activities including surveillance, education, and environmental management. The CLPPP is funded through federal grants and State funding.

The existence of a large segment of housing built prior to 1950, combined with the high proportion of rental housing, ranks Connecticut among the top 15 states with the highest levels of at-risk housing. According to the 1990 US Census, 35 percent of Connecticut’s housing stock was built before 1950, compared to the US with 19.6 percent. Every town in Connecticut has some pre-1950 housing with the urban areas having higher proportions of older housing and rental units.

In order to decrease the effects of lead poisoning in children, children who are at risk need to be identified early so that interventions can be instituted in a timely manner. Analysis of the lead test results data for the 1995 birth cohort indicated that approximately five percent were screened prior to six months of age and 34 percent prior to one year. In addition, another 13 percent were screened after two years of age. Table 18 presents data on lead screening activities in Connecticut. Data from the Lead Surveillance System does not have sufficient data on race or ethnicity to enable that information to be reported. However, the cities in Connecticut show a higher percentage of screening activity and a higher percent of children with elevated blood lead levels.

Table 18 Percent of Children with Elevated Blood Lead Level for Connecticut and Selected Cities, 1999

	Connecticut	Bridgeport	Hartford	New Haven	New London	Waterbury
Number of children <age 6	272,294	14,013	14,245	12,076	2,377	10,139
Percent of children <age 6 screened for EBL	23.9	41.1	45.2	38.7	37.3	42.3
Percent of children 10-19 ug/dl	2.5	8.7	4.2	6.7	0.8	2.1
Percent of children 20-45 ug/dl	0.6	1.8	0.9	2.3	0.0	1.0
Percent of children >45 ug/dl	0.05	0.14	0.11	0.12	0.24	0.07

Data source: DPH Lead Surveillance System

Injury (intentional and unintentional).

Injuries are the leading cause of death for Connecticut children and adolescents, as well as young adults between the ages of 1-34 years and a major cause of hospitalization. More children and adolescents die each year from unintentional injuries than from all other childhood diseases combined. Most risk factors are specific to the type of injury, however several general factors are common to many types of injuries including: alcohol and substance abuse; risk taking behavior, especially among children, adolescents, and young adults; the perception that injuries are “accidents” and are a normal part of life; and low socioeconomic status. Table 19 and Table 20 show that death rates due to injury vary by race and Hispanic ethnicity. Even though other agencies may address one specific type of injury or some aspect of injury prevention, DPH is the only agency that looks at the entire spectrum of injury prevention.

Motor vehicle-related injury prevention.

Children are injured in motor vehicle crashes as vehicle occupants, pedestrians and bicyclists. Child passenger safety is just one of the issues that should be addressed. Pedestrian injuries are one of the leading causes of injury related death and hospitalization for children 5-14 years in CT. Adolescents and young adults are at highest risk of dying of motor vehicle injuries.

Table 19 Death Due to Selected Causes in Connecticut and the United States, 1995-1997

	Injury		Motor Vehicles	
	US	CT	US	CT
White non-Hispanic	29.1	24.5	16.2	10.7
African American non-Hispanic	36.7	33.9	16.7	12.1
Hispanic	28.8	28.0	16.0	11.0

Data Source: NCHS

Table 20 Death Due to Selected Causes in Connecticut and the United States, 1995-1997

	Firearms		Homicide		Suicide	
	US	CT	US	CT	US	CT
White non-Hispanic	10.6	5.6	4.9	2.8	11.6	8.6
African American non-Hispanic	28.1	22.7	30.4	25.8	6.6	6.5
Hispanic	13.5	10.0	12.6	11.4	6.7	5.6

Data source: NCHS

Violence prevention

Domestic violence is the leading cause of injury among women, and is linked to other health care problems including depression, drug abuse, and suicide. Children who are victims of violence or witness violence in the home are more likely to be involved in violent behavior as adults. Child victims of abuse or neglect comprise at least 70 percent of men in the criminal justice system. Domestic violence is also often related to sexual assault.

Firearm safety

Firearms cause nearly one of every five injury deaths in Connecticut. In 1994, 293 Connecticut residents were shot to death; 49 percent of the firearms deaths were homicides, 48 percent were suicides and the remainder were unintentional shootings. In Connecticut, more than one-third of all homicide victims are between 15 and 24 years of age. Eighty seven percent of the firearms deaths occurred to males with the mortality rate for African American/Blacks being four times higher than for whites. A gun at home is much more likely to be used to kill a family member or friend than a criminal intruder. Although homicide may be associated with criminal acts, the majority of homicides occur during personal arguments or fights.^{xxviii}

Work related injury prevention for adolescents

Adolescent workers are defined as individuals between the ages of 14-17 who are employed. There are approximately 165,000 youths between the ages of 14-17 in Connecticut. According to the Bureau of Labor Statistics, 51 percent of 16-19 year olds work and account for 6 percent of the civilian work force. There currently are no statistics regarding the percentage of 14-15 year olds that work.

Behavioral Data

Two major sources of information will be reported here. One source is the Voice of Connecticut Youth, a survey done in 1996 that gathered information on adolescent health. The other is the Behavioral Risk Factor Surveillance System (BRFSS) which collects data from randomly selected non-institutionalized adults aged 18 and older through monthly telephone surveys. During 1998, 3,129 Connecticut adults were surveyed and in 1999, 3,500 interviews were conducted for the BRFSS. Where possible, data for the two years were combined to yield a total sample size of 6,600.

MCHBG needs assessment identified the need for a comprehensive adolescent health survey, focusing on health, risk and protective factors, as early as 1989. In response to that need the Voice of Connecticut Youth (VCY) survey was conducted in 1996. The VCY survey provides comprehensive information on adolescent health status that is both reliable and valid. Major areas addressed included school, future aspirations, physical health, nutrition, emotional health risks, health care access, sexual behavior, substance abuse, delinquency risks, personal protective factors, family risk and protective factors, and community risk and protective factors. The inclusion of some of these areas, including access to health care and the presence of protective factors, goes beyond what is included in most other youth risk surveys. The goals of the survey were to reap reliable and valid baseline statewide information for rational planning and resource allocation; and to provide data meaningful to local communities, including educators, providers, families and advocates. The Survey was intended to be a baseline, with replication at 3-5 year intervals

The selection process was based upon Educational Reference Groups (ERGs are groupings of cities and towns based on similar demographic factors). For purposes of reporting, the nine ERG groups were combined into five (ERG AB, CD, EF, GH, I) and vocational and technical schools included in the study were treated as a sixth ERG. Care was taken to represent all ERG groups. Responses from 11,383 students in 7th, 9th, and 11th grades comprised the survey.

The Voice of Connecticut Youth (VCY) survey included questions on a wide range of issues affecting adolescents in 7th, 9th and 11th grades and helps to identify the major health problems among this population group.

Exercise, Nutrition and Diet

Adequate exercise and nutrition are important for adolescents' overall health as well as their school performance. For girls, more than one-third reported only exercising twice or less per week, compared to one in five boys (see Table 21). While about half of the boys exercised six or more times a week, only one-quarter of the girls did the same. Nearly half of all girls and one-third of all boys usually skipped breakfast. Diets were often reported to be high in fat and low in calcium and protein. Nearly one in five younger students and one-third of older students did not have any fruit the previous day.

Table 21 Percent of students who reported exercising twice or less per week by race, Hispanic ethnicity, grade and gender Connecticut, 1996

	7	9	11
Girls			
White non-Hispanic	28.3	31.4	39.9
African American non-Hispanic	50.0	51.0	65.0
Hispanic	54.2	59.4	58.5
Boys			
White non-Hispanic	17.9	16.2	24.6
African American non-Hispanic	27.0	24.9	30.8
Hispanic	27.1	29.3	22.6

Data: Voice of Connecticut Youth, 1996

Tobacco, Alcohol, and Drugs

The proportion of students who reported weekly or daily use of cigarettes quadrupled between 7th and 11th grade; from 6 percent of 7th graders to 18 percent of 9th graders to 25 percent of 12th graders (see Table 22). While nearly 66 percent of 7th graders reported never using alcohol in the past year, only 40 percent of 9th graders and 30 percent of 11th graders reported the same (see Table 23). Thirty two percent of 11th grade boys and 22 percent of 11th grade girls reported getting drunk once or more in the past week.

Marijuana use, like alcohol use, increased with age. The overwhelming majority of 7th graders (91 percent of girls, and 86 percent of boys) reported never using marijuana in the past year, compared to 70 percent of girls and 66 percent of boys in 9th grade and 61 percent of girls and 56 percent of boys in 11th grade. Cocaine use was minimal across all grades with 95-98 percent reported they had never used cocaine in the past year.

Table 22 Percent of students who reported weekly or daily use of cigarettes by race, Hispanic ethnicity grade and gender Connecticut, 1996

	7	9	11
Girls			
White non-Hispanic	5.4	21.4	28.1
African American non-Hispanic	3.6	6.2	6.9
Hispanic	7.7	10.9	15.8
Boys			
White non-Hispanic	6.5	20.1	28.0
African American non-Hispanic	6.4	6.9	8.6
Hispanic	5.1	14.2	14.0

Data: Voice of Connecticut Youth, 1996

Table 23 Percent of students who reported never using alcohol in the past year by race, Hispanic ethnicity, grade and gender Connecticut, 1996

	7	9	11
Girls			
White non-Hispanic	71.1	40.9	28.1
African American non-Hispanic	69.6	41.8	41.8
Hispanic	55.0	43.6	29.3
Boys			
White non-Hispanic	63.3	37.5	29.3
African American non-Hispanic	61.4	54.7	32.8
Hispanic	65.8	41.9	32.3

Data: Voice of Connecticut Youth, 1996

Sexual behavior

Nearly one third of all students surveyed (31.9%) said they had already had sexual intercourse, including 15.3% of 7th graders, 32.1% of 9th graders and 49.4% of 11th graders. Boys were more likely than girls to have had sex (35.1% vs. 28.8%) overall, but not in grade 11 where rates were equal for both genders. Results were significantly different by race/ethnicity and by grade as shown in Table 24. These differences were reflected in rates across ERG, with the rate increasing from 21.2% of those in ERGs A/B (towns and suburbs) to 44.8 percent in ERG I (major cities). Many of these students were at risk for pregnancy and/or HIV/AIDS or other STDs, as only 53.9% of those who were sexually active reported they always used some form of birth control and 15.8% never used birth control. Hispanic youths were least likely to use birth control, with 27% reporting they never used it, compared with

13% of whites and 14.6% of African American/Blacks who were sexually active. Birth control use among the sexually active was not significantly related to ERG.

Table 24 Percent of students who have had sex by grade and gender Connecticut, 1996

	Grade 7	Grade 9	Grade 11
Girls			
White non-Hispanic	7.1	20.5	46.4
African American non-Hispanic	21.3	54.4	68.6
Hispanic	10.9	35.5	53.7
Boys			
White non-Hispanic	15.6	26.2	44.5
African American non-Hispanic	49.0	73.4	80.7
Hispanic	32.7	65.0	71.7

Data: Voice of Connecticut Youth, 1996

Students in grades 9 and 11 were asked additional questions about sexual behavior, including whether or not they had been pregnant or gotten someone pregnant. Based on the data for sexual activity and use of birth control, the results on pregnancy should not be surprising. Three percent of all 9th graders and 5.2% of all 11th graders had been pregnant/gotten someone pregnant and an additional 2.2% in each grade weren't sure. Rates were much higher for minority students than for white students: 8.7% of African American/Black students and 5.9% of all Hispanic students had been pregnant/gotten someone pregnant. These are percents of all students, not just those who were sexually active. Among *sexually active* 9th and 11th graders, 12.8% of girls and 6.7% of boys had been pregnant or responsible for a pregnancy.

Students in all three grades were asked about the likelihood they would become parents by age 18. A total of 10.8% of all students in the three grades reported there was at least a 50-50 chance of becoming a parent by age 18, including 2.7% who said it "will happen". If this latter rate is applied across all grades from 7-12, this figure represents 5,500 Connecticut teenagers currently in school becoming parents by age 18. The rates for minority students were more than twice as high as rates for non-Hispanic white students; 20.2% of African American/Black and 21.4% of Hispanic students reported at least a 50-50 chance of being a parent by age 18, compared with 7.9% of white students. Over one in every 20 minority students (5.1% for African American/Blacks and 5.8% for Hispanics) said it "will happen" compared with 1.8% of white students. Again, these results were reflected in the results for ERG, with rates of "it will happen" ranging from 1.4% in ERGs A/B (the towns and suburbs) to 5.1% in ERG I (representing the major cities).

Questions were asked in the BRFSS (of non-institutionalized adults aged 18 and older), to measure the prevalence of "risky sexual behavior that leads to HIV/AIDS or STDs". Seven percent of sexually active adults gave responses that indicated they were at risk for acquiring a sexually transmitted disease or HIV. High risk groups of those who were sexually active included men, 18-24 year olds, low income persons, and residents of the mid-sized

cities, the racial differences were greater and African American/Blacks were more likely to be at risk. Young persons 18-24 years of age were still the most likely to report risky behavior.

Table 25 Groups at High Risk for HIV/AIDS/STDs

Groups at High Risk for HIV/AIDS/STDs Among Sexually Active 18-64 year olds		
Group	n	% at risk
18-24 year olds	208	18%
Uninsured	125	13%
Income <\$25,000	183	13%
African Americans	113	13%
Men	916	8%
All sexually active 18-64 yrs.	1,783	7.0%

Data from BRFSS

Unwanted pregnancy

In 1998 the Connecticut BRFSS included two questions about the use of birth control that were asked of all male and female respondents 18-44 years of age. Respondents were asked if they or their partners currently used any form of birth control (including having tubes tied, vasectomy, the pill, condoms, diaphragm, foam, rhythm, Norplant, shots or any other way to keep from getting pregnant) and if not, why not. One in four sexually active at risk young Connecticut adults were not using birth control. Among at risk young women, 22.6 percent were not using birth control, which represents 96,500 women. Among all 18-44 year old women, not just those who were sexually active, 5.2 percent reported they were trying to get pregnant, representing 41,300 women, and an additional 3.6 percent (or 23,500 women) reported they were already pregnant. For comparison, there are about 43,000 live births and about 10,000 abortions in Connecticut each year to women aged 18 and older. As shown in Table 26 below, high risk groups for unwanted pregnancy include young black and Hispanic women and women in the urban and mid-sized city regions (Hartford, Bridgeport, New Haven, Waterbury and Norwalk, New Britain, and Meriden).

Table 26 Women at High Risk for Unwanted Pregnancy

Women at High Risk for Unwanted Pregnancy		
Group	n	% of At Risk* Women aged 18-44 yrs. not Using Birth Control
Uninsured women	42	39%
African American women	50	37%
Hispanic women	57	31%
All at risk women 18-44 yrs.	534	22.6%

* At risk women: Sexually active, not pregnant or trying to get pregnant, or not unable to get pregnant.

Access to care:

Two thirds of all students reported through the VCY that they had a routine checkup in the past year, and another 24% reported having one within 2 years, with similar results for dental exams. Nearly all had a usual source

of health care, with over 60% reporting a doctor's office or HMO, 16.1% using a clinic, 13.9% using more than one place, 5.4% using an ER and 3.9% reporting no usual source of care. This varied considerably across ERG, with 11% of students in ERG I (cities) using an ER for care, only 35.4% using a doctor's office, and 30.2% using a clinic. This compares with 65.7% of those in ERGs A/B (towns and suburbs) using a doctor's office, 11.6% using a clinic, and only 2.1% using an ER.

However, nearly one third (31.3%) of all students reported there was a time in the past year when they felt they should have gone to a doctor but didn't go. The most commonly reported reason for this was thinking that the problem would go away, reported by 68.6%. The next most common reasons for not getting care were "other" (49.1%), afraid of what doctor would say or do (39.8%), didn't want parents to know (36.5%), couldn't get there (25.8%), and didn't think doctor could help (25.2%). Lack of insurance or cost issues were lower on the list, with 14-20% reporting those as a reason. Students in ERG I (cities) were twice as likely as those in A/B (towns and suburbs) to report not having insurance (20.4% vs. 10.0%) and were the least likely to think the problem would go away (59%). A more extensive discussion of the issues affecting foregone health care among adolescents was drawn from a large national survey.^{xxix} The authors conclude that adolescents who forgo health care are at increased risk for a number of physical and mental health problems. For example, smokers, frequent users of alcohol, the sexually active, those with symptoms suggesting serious mental and physical problems, and disabled students were all more likely than comparison groups to report foregone health care.

A series of questions on the BRFSS address health insurance. Combining responses to the two questions reduces the prevalence of lack of insurance in Connecticut from 8.8% for the single question to 7.3% when results for both questions are considered.

In 1998, about 84% of all adults in Connecticut indicated they had one or more usual places to go if they were sick or needed advice about their health. A majority were able to identify the place they went most often, with two thirds of all respondents (not just those who had a usual source of care) indicating a doctor's office or HMO as that place. Six percent of all respondents indicated they used a health center, including 3% who named one of the DPH funded CHCs, and 3% who used some other clinic or health center.

Table 27 Source of Health Care as Indicated in BRFSS, Connecticut 1999

Group	n	Source of Health Care				
		no source of care	MD/HMO	CHC	Other clinic	Other source
Uninsured	220	35%	33%	5%	6%	21%
18-24 yr. olds	338	26%	47%	7%	8%	12%
Hispanics	202	23%	45%	10%	4%	17%
<\$25,000 income	521	17%	56%	4%	4%	18%
Big city region	403	15%	58%	8%	4%	15%
African American	185	12%	57%	8%	4%	19%
All adults	3,129	17%	66%	3%	3%	12%

As shown in Table 27, the uninsured were the least likely to have a usual source of care, and also to have a doctor's office or HMO as their usual source. Younger persons - who were also less likely to be insured - were more likely to report no source of care or a source other than a doctor/HMO.

All respondents were also asked in 1998 how difficult it was for them to get needed health care services. Overall, the percent of those who said it was so difficult they didn't go was only 0.8% and in almost every sub-group this percent was 1% or less. The significant exception was the uninsured, where 7% indicated that accessing health care was so difficult they didn't go.

Mental and emotional health:

One in every eleven students surveyed in the Voice of Connecticut Youth in grades 7, 9, and 11 reported they had tried to kill themselves in the past 12 months; 11.6% of girls and 6.3% of boys. Hispanic students were the most likely to report suicide attempts, with 15% of them reporting one or more attempts in the past year. Feelings of hopelessness were very common, with 39.6% of girls and 24.9% of boys reporting feeling so sad, discouraged or hopeless in the past 12 months that it bothered them, including 6.5% of all students who said it was to the point they had almost given up. Among Hispanic students, 40.8% reported feeling hopeless, including 10.7% who seemed about to give up. Serious personal, emotional, or mental health problems were reported by 28.6% of all respondents, with the highest rates among Hispanic and "other" race groups, where 32.7% and 34.9% respectively reported problems. Over 10% of all Hispanic and "other" race students and 10% of all girls surveyed reported a problem that they never got help for. This rate was not related to ERG.

One measure from each of the three areas above were also examined by outside factors including whether or not the student lived with two parents, whether they worked, and the educational attainment of their mothers. These were selected as only some of the factors that might affect students behaviors and health risks. Students not living in two parent households were more likely to have had sex, to have felt sad and/or hopeless in the past year, and to report not going to a doctor when they should have. Students who worked 20 or more hours a week seemed to be at especially high risk, even when the fact they were older was taken into account. They were much more likely to have not seen a doctor when they should have (43.2%) and to feel hopeless or sad (39.7%, including 9.3% who had about given up). About two thirds of 9th and 11th grade students who worked 20 hours or more had had sex, compared with 30% of non-working 9th graders and 41.4% of non-working 11th graders. Students whose mothers did not complete high school were more likely to plan to drop out themselves and also were the most likely to feel hopeless. Nearly half of these students (47.5%) had had sex, compared with only 23% of students whose mothers had graduated from college.

Sexually Transmitted Disease

Sexually transmitted diseases (STDs) can have devastating consequences, particularly among women and children, including pelvic inflammatory disease, infertility, adverse pregnancy outcomes, low birthweight babies, neonatal infections, and even death for the fetus. Additionally, studies have shown that the presence of STDs can facilitate the transmission of HIV.^{xxx}

The rate of primary and secondary syphilis has decreased in recent years, while the rates of gonorrhea and chlamydia have increased. The increase in Chlamydia incidence may be partially due to enhanced reporting due to increased efforts to provide urine based screening at various sites around the State. Urine based testing is a non-invasive laboratory test that has a greater sensitivity than traditional testing methods. Table 28 demonstrates that

overall, the rates of STDs are much greater within the cities. The rates of STDs among the African American and Hispanic populations are much greater than the white population as shown in Table 29.

Table 28 Gonorrhea, Chlamydia and Primary and Secondary Syphilis Case rates per 100,000 for Connecticut and Selected Cities 1998

	Connecticut	Bridgeport	Hartford	New Haven	New London	Waterbury
Gonorrhea	105	387	526	498	301	301
Chlamydia	229	563	1073	840	554	476
Primary and Secondary Syphilis	0.8	0.7	9.1	1.6	0	1.9

Source: DPH STD program

Table 29 Estimated Gonorrhea, Chlamydia, and Primary and Secondary Syphilis case rates per 100,000 population for Connecticut by Race and Hispanic Ethnicity 1998

	Gonorrhea	Chlamydia	Primary and Secondary Syphilis
White non-Hispanic	14	51	0.03
African American non-Hispanic	885	1,390	6.2
Hispanic	262	1,014	3.3

Table 30 presents selected age specific rates for gonorrhea and chlamydia. Adolescents in the larger cities of the state continue to be most affected by gonorrhea and chlamydia.

Table 30 Selected Age Specific Case Rates for Gonorrhea and Chlamydia per 100,000 population for Connecticut, 1998

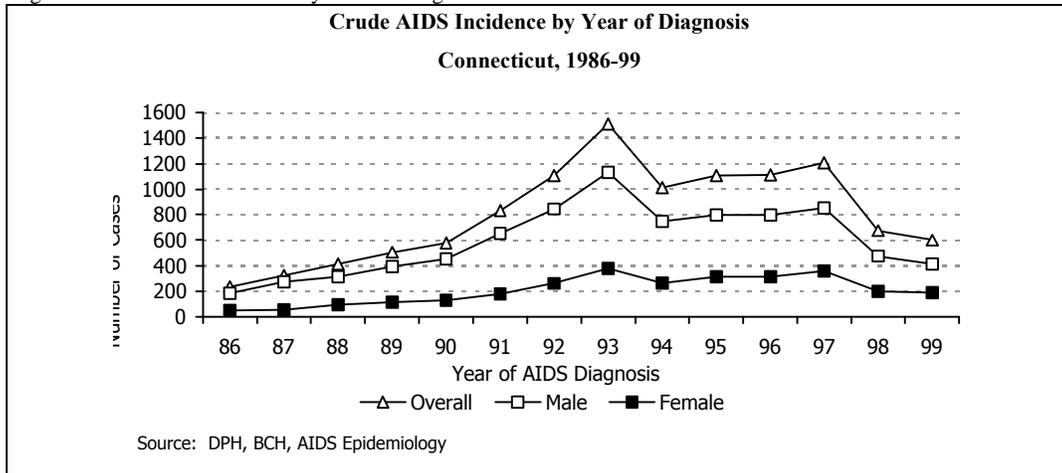
	10-14	15-19	20-24	25-29	30-34	35-39
Gonorrhea	19	433	382	190	129	93
Chlamydia	87	1427	969	338	145	63

HIV/AIDS

Since the early 1980's, when Acquired Immunodeficiency Syndrome (AIDS) was first recognized in Connecticut, surveillance efforts have targeted adults who develop AIDS and children who develop HIV infection and AIDS. In addition, the prevalence of HIV infection in women giving birth in Connecticut and the mortality rates from AIDS have been used to help determine the magnitude and the impact of the HIV/AIDS epidemic.

The number of newly diagnosed AIDS cases has been declining in recent years (Figure 7). In 1998, 242 deaths were reported representing the lowest number of deaths since 1988. In the past few years, trends in AIDS incidence have changed. The percentage of cases who are white increased to 39.2 percent and the percentage of cases who are African American continued to decrease from 35.9 in 1998 to 30.7 percent in 1999.

Figure 7 Crude AIDS Incidence by Year of Diagnosis



In spite of the positive trends, the magnitude and epidemiology of AIDS continue to pose a major challenge to prevention efforts. While injection drug use remains a leading means of HIV transmission, heterosexual contact is an important means of HIV transmission. In 1998, 58.7 percent of Hispanic women had heterosexual risk, compared with 49.4 percent of African American women, and 43.6 percent of white women.

The incidence of AIDS remains higher among African American/Black and Hispanic populations than among whites for both males and females as shown in Table 31.

Table 31 AIDS Incidence Rates per 100,000 population by Gender, Race, and Hispanic Ethnicity, Connecticut, 1999

	Male	Female
White non-Hispanic	13.5	4.3
African American non-Hispanic	85.0	51.3
Hispanic	96.4	43.0

A former component of HIV/AIDS surveillance was a serosurvey of all childbearing women for HIV infection. For the serosurvey, samples of blood taken from newborns for required genetic screening were blinded as to identity and tested for the presence of maternal antibody to HIV. The results reflected the magnitude of the HIV epidemic among women and related trends, and provided a direct measure of how many newborns were exposed to HIV each year. The sixth period of the Survey of Childbearing Women (SCBW) in Connecticut was completed in 1995. For the sixth survey period (1994-95), 101 samples tested positive for HIV, with the prevalence for the period being 0.24%. This was the lowest percentage of births testing HIV positive since the survey began, and continued a downward trend which began in the fourth survey period (Table 32). Of the total tested (266,673), the number of infants born to HIV-infected mothers from April 1, 1989 through March 31, 1995 was 765 (0.29%). The HIV seroprevalence (percentage positive) of childbearing women in Connecticut was associated with race/ethnicity, reflecting the state's race-specific AIDS case incidence rates. African American/Black non-Hispanic women had the highest seroprevalence in all survey periods.

Table 32 Survey of Childbearing Women Summary Connecticut Residents, 1989-95

Survey Period	Total No. Women Tested	HIV+ Women	Percent HIV+ Births
1 (4/89-3/90)	45,890	138	0.30
2 (4/90-3/91)	46,750	143	0.31
3 (4/91-3/92)	44,915	149	0.33
4 (4/92-3/93)	43,264	123	0.28
5 (4/93-3/94)	43,054	111	0.26
6 (4/94-3/95)	42,800	101	0.24

Source: DPH, BCH, AIDS Epidemiology

In CT many program activities are geared toward HIV prevention in pregnant woman including activities conducted to educate providers and the public regarding HIV counseling and testing of pregnant women. Prenatal brochures for patients summarizing all the tests required during pregnancy and emphasizing behaviors which will enhance a healthy pregnancy were developed through Concerned Citizens for Humanity in conjunction with the Prenatal Morbidity and Mortality Committee of the Connecticut Medical Society. The project resulted from focus groups conducted with various providers. A second piece developed was a chart for providers summarizing testing and treatment of infectious diseases in a pregnant woman.

Connecticut was one of two states selected by the American College of Obstetricians and Gynecologists (ACOG) for a Provider's Partnership to work on training and education regarding perinatal transmission of HIV. DPH staff met with state and national representatives of ACOG and a task force was formed. As a result, information on provider training in HIV counseling and testing skills was mailed to the department heads of all hospitals providing labor and delivery services. A sample packet of free information for pregnant women and providers, with directions for ordering, was mailed to the ACOG membership, nurse midwives, and family practitioners.

Material on the counseling and testing of pregnant women was included in Connecticut's new Healthy Start Manual. Providers of the Healthy Start and WIC Programs who work with women of childbearing age were educated as to the importance of HIV counseling of and testing of pregnant women and provided with materials for their clients. Articles on a healthy pregnancy and the importance of HIV counseling and testing were prepared through a collaboration of the AIDS Division and Healthy Start for the Medicaid managed care consumer and provider news letters. The AIDS Division of DPH has contracts with hospitals in the three cities in the state with the most AIDS cases, to provide HIV counseling and testing in their prenatal clinics.

Summary of Overview

Data presented in the overview section has demonstrated that health risks are not evenly distributed among the residents of Connecticut. While the majority indicators of the health of the citizens of Connecticut are good, there are many higher risk groups within Connecticut which experience a greater share of the burden of adverse health risks. Within the State, it is the poor, the minorities, and those who live in the larger urban areas who experience higher rates of disease. Public health programs are intended to help those in greatest need. The Title V programs within Connecticut are located in areas where the public health risk are the greatest and these programs can serve the people in greatest need. Map 9, Map 10, and Map 11 present the locations of many programs developed to serve the needs of the Maternal and Child populations. Map 12, Map 13, and Map 14 present MCH programs and risk factors

at the same time. These maps show that the MCH programs are located in geographic areas of the state where the need has been identified to be the greatest.

3.1.2.2 Direct Health Care Services and Enabling Services

Connecticut Provider Data

An overview of selected providers of health care in the State of Connecticut indicate sufficient numbers of health care providers are licensed to practice in the State in comparison to the United States ratios per 100,000 population. Table 33 presents available CT and US data for many health care professions:

Table 33 Ratios of Various Health Providers per 100,000 Population, CT 1999 and US 1992*

Provider Type	CT Ratio '99	US Ratio '92*
1. Physicians & Surgeons	306	201
2. Primary Care Physicians	169	91
3. Dietitians/Nutritionists	13	unknown
4. Registered Nurses	1228	726
5. Advanced Practice Registered Nurses	47	11
6. Licensed Nurse Midwives	3	2
7. Physician Assistants	19	7
8. Social workers	100	unknown
9. Dentists '92	81	61
10. Audiologists	5	unknown
11. Speech pathologists	47	unknown
12. Reg. Physical therapists, 1993	82	45
13. Occupational therapists, 1994	35	16

CT Data Source: CT Dept. of Public Health, Bureau of Regulatory Services. (data are for CY1999)

US Data Source: Pew Health Professions Commission, State Health Personnel Handbook, University of California at San Francisco, pp. 6-14, 70-77, March, 1995. *(data are for CY 1992 unless otherwise noted)

The strength of the DPH licensure database is its universality, Connecticut General Statutes require that all who practice in regulated professions must be licensed by the Department of Public Health. This “strength” becomes a weakness when looking for counts of physicians serving CT residents because it actually results in over counts of persons truly practicing in the state (As illustrated in Table 34, in 1999, only 79% of MD’s with CT licenses listed a CT address.) The current licensure data base includes persons: a) now residing outside the state who want to maintain an active license in case they want to practice if they live in CT again; b) retired; c) working in academia or research; and d) temporarily on leave from their practice.

The categories of professionals enumerated in the Title V guidance are not a perfect match with the types of licensing and certifications that are offered by DPH. For those provider categories not counted within the department’s licensure database, outside sources were researched for this data. The address of professionals maintained through DPH licensing records has not been useful for mapping access to care studies since there is no indication 1) that the individual licensed is actually actively practicing her/his profession full-time, 2) taking new patients, or 3) that the address provided is a practice site, teaching location, or residence. Beginning in 2000, DPH will be implementing provider profiles of physicians as part of a survey document mailed with annual license renewals that will contain some of this information. Expanded information gathered on these paper surveys, could be entered into a database to ascertain details relating to physician practice site(s), FTE hours of practice, board certification, and

such access to care issues as: sliding fee scale or translation services offered. This additional information would enable a better understand access to care issues in Connecticut.

Table 34 Distribution of CT Physician Licensees by Residence, 1999

MD License Address	Number of Licensees	% of all Licensees
Connecticut	10,008	78.9%
Bordering States(RI, NY,MA)	1,404	11.1%
Other U.S. States	1,199	9.5%
Outside the United States	62	0.5%
Total All CT Physician Licensees	12,673	100.0%

Source: CT Department of Public Health, Bureau of Regulatory Services, 1999

A commercially available database was purchased from Folio to provide information on active medical professionals. Map 15 presents the office locations of providers who listed Pediatrics (family practice, neonatal-perinatal medicine, or pediatrics) or Obstetrics and Gynecology (gynecology, pediatric gynecology, maternal and fetal medicine, obstetrics, obstetrics and gynecology) as their primary, secondary, or tertiary speciality. There are some areas of the State that have few providers. These areas tend to be the less populated areas of Connecticut.

Federal Shortage Designations, namely, Health Professional Shortage Areas and Medically Underserved Populations/Areas, are two cases-in-point where examination of sub areas of Connecticut’s population document serious needs in accessing primary care, dental or mental health services for a defined group. Mapping of the state shows these designated areas are frequently, though not exclusively, in urban areas of Connecticut. DPH, through both federal and state funds, promotes the continuation and expansion of these designations as well as several other programs to enhance access to care and provider placements in needy areas. Map 16 presents medically underserved areas and medically underserved populations.

Federal Shortage Area Data

Federal Shortage Designations are a) not determined state-wide, nor do they b) represent a pure measurement of provider FTE’s. Both HPSA’s (Health Professional Shortage Areas) and MUA’s (Medically Underserved Areas), (the two major types of designations) are a good reflection of need and under-service in the area/group under study, but variables other than MD FTE’s are also factored into designation decisions. For example, a town could have a scarcity of physicians (1MD serving 40,000 people), but not qualify as a HPSA because it doesn’t have >30% of its population under 200% of the federal poverty limit. Thus, looking only at designated shortage areas in CT represents an undercount of the communities with physician shortages because: a) there may be many other CT communities that could qualify for a federal shortage designation but have not yet been studied to submit the requisite data for federal determination, and b) some communities deemed not eligible for a federal shortage area could still have a need for providers, but may not meet one of the other criteria for HPSA/MUA designation. Map 17, Map 18, and Map 19 present the HPSAs.

Oral Health

To a large extent, lack of access to oral health care, particularly to preventive dental services, is a major contributing factor to the high prevalence of dental disease in uninsured and underinsured populations. Critically low numbers and lack of distribution of dental providers for uninsured and underinsured populations are largely responsible for limited access to care.

The CT Department of Public Health 1996 report, “Present and Projected Dental Provider Participation in the Connecticut Medicaid Managed Care Program: Impact on Access to Oral Health Care”, predicted that up to 30 percent of the already relatively low number of dental providers under State managed Medicaid would resign from participation under Medicaid managed care. The report also revealed that 80 percent of Medicaid providers would not accept any additional Medicaid enrolled children as new patients. These projections have, for the most part, been confirmed by very recent reports from the Connecticut Department of Social Services and the Children’s Health Council. Enrollment of dentists in the Medicaid managed care program has slowly declined from 1995 to the present.

The number and distribution of providers is not the only issue. Although lack of an adequate dental care provider network is a critical factor, dental care access is highly complex and multifaceted. It included obstacles and issues that exist on the provider level, administrative and systems management level, as well as on the client level. Map 17 presents HPSAs for dental, and Map 20 presents offices and clinics of dentists and active Medicaid dentists in Connecticut. It is clear from Map 20 that many areas of the State lack active Medicaid dentists.

Pregnant Women, Mothers and Infants

Medicaid

With the delinking of cash assistance and Medicaid it has been feared that many persons potentially eligible to maintain Medicaid coverage would not realize that they were still eligible for Medicaid and no longer participate in the program. In Connecticut several actions have occurred to try to ensure that eligible children and families continue to receive Medicaid. Connecticut is one of nine states with waivers from the federal government that allow for changes in the federally-defined transitional Medicaid benefit. In Connecticut, families who stop receiving Transitional Family Assistance (TFA) may be eligible for two years of transitional Medicaid benefits. Benefits may continue if:

- An adult in the family is working when cash assistance ends; or
- An adult starts work within the first six months after cash assistance ends; or
- Cash assistance ends because of child support.

Connecticut families receive the full two years of transitional coverage regardless of the amount of their income and assets. The simplicity of Connecticut’s program, along with the fact that it extends for two years regardless of the amount of a family’s income and assets, has allowed many more families to continue their health insurance coverage when their welfare benefits end.^{xxxii} Ninety four percent of families eligible for transitional Medicaid have participated in the program in Connecticut. According to a General Accounting Office report, between 1995 and 1997, Medicaid enrollment declined nationwide, but substantially less than welfare participation. Overall, Medicaid enrollment among the nonelderly and nondisabled adults and children declined by 1.7 million , or 7 percent, compared with a 3.1 million, or 23 percent decline in welfare participation¹. In Connecticut during the same period there was only a 1 percent drop in Medicaid enrollment, and a 11.5 percent drop in welfare.

In Connecticut, the Children’s Health Council has been involved in many activities including tracking the enrollment in the Connecticut’s Medicaid managed care program for children and families. The Council has found during a ten month period from September 1998 to June 1999 the number of participants in the cash assistance coverage group decreased by about 14,250. During the same period the number of participants in the transitional

Medicaid coverage group increased by about 11,350 suggesting that most families leaving TFA in Connecticut are moving into the transitional Medicaid program.^{xxxix} Total enrollment in HUSKY A Managed Care Plans grew from approximately 220,000 to over 230,000. However, as thousands of families reach the end of the two-year periods of transitional coverage and as thousands of children reach the end of continuous eligibility coverage periods, there are indications for a significant increase in the number of uninsured children.^{xxxix} As predicted by Children's Health Council since June, 1999 there has been a decrease in enrollment to slightly more than 228,000. The decline occurred in spite of extensive outreach activities that have been taking place throughout the state.^{xxxix}

An initiative funded by the Robert Wood Johnson Foundation called "Covering Connecticut's Kids" is an effort to enroll eligible children into the HUSKY program. In spite of efforts to maintain eligibility, examples of calls to the Children's Health Infoline demonstrate that confusion still exists regarding the linking of HUSKY with cash assistance and sometimes gaps in coverage occur when they should not occur. The Children's Health Council has made recommendations that emphasis be placed on the development of appropriate training for DSS staff and educational materials for the public to ensure that everyone understands eligibility for HUSKY. Also, there should be improvements to the automated eligibility process and improved communication among all parties.^{xxxix}

The Children's Health Council recently created a longitudinal database that allows for tracking enrollment over time. The Council is conducting more extensive examination of why children are moving in and out of the HUSKY program and providing recommendation to DSS on how to maintain and increase HUSKY participation. Analysis of the longitudinal database has indicated that net gains in enrollment are least among African American children in Hartford, suggesting targeted outreach efforts may need to be enhanced among this group.^{xxxix}

Children and Adolescents

EPSDT on time visit rates

The Children's Health Project reported on the percentage of children who receive required EPSDT screens within the appropriate time period.^{xxxix} From the third quarter of 1996 to the second quarter of 1999 the percentage of children receiving on time EPSDT screens varied between 24.1 and 44.2 percent with the most recent quarter of data reported at 38.6 percent. Younger children are more likely to receive on time screens than older children and adolescents. The percentage of on time screens varied by health plan and County within the State. Many children are not receiving appropriate screening services in a timely fashion.

Dental health services

A study of dental utilization was conducted by the Children's Health Project, to identify areas of need. Medicaid eligibility files supplied by the Department of Social Services (DSS) were used to provide information on the utilization of dental services. The study sample included all children who were age 3-19 and enrolled in the program for at least 11 months between the period July 1997 to June 30 1998. Thirty seven percent of the study sample had a record of at least one preventive dental visit during the study period, 21 percent had a record of a dental treatment visit and 45 percent had a record of at least one dental visit of any type. Children under age 12 were more likely to have been to the dentist than older children. Differences in utilization associated with demographic and enrollment factors suggest that children do not have uniform access to preventive dental services. The lowest rates of utilization

were evident among older children age 15-19, African American children, children residing in Fairfield, Tolland, and Windham, counties and children who changed health plans.^{xxxv}

Mental health services

Mental health disorders are identified as the major cause of hospitalizations among adolescents. School Based Health Centers report that visits for mental health services or substance abuse accounted for 24,523 visits or approximately one third of the 73,836 total visits for the 1997 to 1998 school year. DPH has identified the need to identify appropriate standards for screening, assessment, referrals and linkages to mental health services and supports for the Title V programs.

Children with Special Health Care Needs

Supplemental Security Income (SSI)

Eligibility changes have caused some confusion for children with special health care need families in Connecticut. The population is concerned over the changing eligibility criteria and the impact it has on their family. Efforts are made to maintain coordination between SSI and the children with special health care need population in Connecticut. Many families are concerned about losing some of the only family-directed dollars they may receive for their child's special care.

Affordable Home Health Care

Availability of affordable home health care within Connecticut has been identified as a serious problem, especially for families with children with special health care needs. There is a lack of qualified professionals, no back up service, and families have little choice of who works in the home due to a lack of available home health care providers. Families have also identified the need for respite services. Often the majority of the care for the children with special health care needs falls on the family, leaving little ability to have simple family activities. Although some Title V funds are available for respite care, the funding falls far short of the need.

Home Health Care

The Connecticut Association for Human Services (CAHS) convened a group of individuals from around Connecticut to form an Institute on Home Health Care with funding from DMR and the Council on Developmental Disabilities. The Institute consisted of home health care providers, families of children with disabilities, advocates and representatives of several state agencies. Five sessions, consisting of round table discussions, were held from September 1998 through November 1998. Further studies and collaboration with appropriate state agencies is needed and recommended by the Institute in order to analyze key gaps.

Care Coordination

The CSHCN program does offer care coordination to any child with a special health care need regardless of enrollment and insurance status, however, care coordination as a continues as a need.

Behavioral Health Services

Identifying and accessing behavioral health services for children with special health care needs is a major problem in Connecticut. The Department of Children and Families (DCF) is the lead agency for children's mental health. The Department of Mental Retardation through its Birth to Three Program does address some of the needs of children, however, these services cease as soon as the child ages out of the program and is transitioned to an

educational setting. The Department of Social Services (DSS) through HUSKY Plus Behavioral covers the cost of behavioral health services to uninsured children with special health care needs. Such services, however, have historically focused on the more severe cases. The program has been in the process of reviewing the eligibility criteria which may result in services for a wider range of children. The issue of behavioral health services for Title V recipients remains. DPH is trying to address this concern through partnerships with other state and community providers.

In 1998, Family Voices and Brandeis University conducted a national survey of 2,220 families of children with special health care needs in 20 states. The survey was sent out to randomly-selected families in state Maternal and Child Health Programs for Children with Special Health Care Needs, and families on the mailing lists of Family Voices.^{xxxvi} Some of the findings from this survey are listed below.

- Children with autism (9 percent), mental health problems (other than autism) (7 percent), or behavioral problems (other than mental health or autism) (17 percent) constituted a significant group within the sample of children with special health care needs (one-third of the sample for this study).
- Nearly half (48 percent) of the families of children with mental health, behavioral problems, or autism reported problems in accessing mental health services. The most common problems were finding providers with needed skills and experience, getting referrals for specialty care, getting appointments for specialty care, and coordination of care between the child's mental health specialist and other providers of care.
- Parents of these children were significantly more likely to report problems finding skilled and experienced mental health clinicians, and in coordinating services between the child's mental health provider and other clinicians than parents of children without these conditions who used mental health services.

A New England survey was conducted in 1997.^{xxxvii} The purpose of the data collection effort was to gather information about the recent experiences of families and primary care providers in accessing and delivering quality managed care for children with chronic health conditions. Four surveys were developed; Family Survey, Primary Care Provider Survey, two surveys of managed care plans one for organizational and descriptive information and one for staff level information.

Access to families using managed care plans was provided by the Children with Special Health Care Needs programs within the Connecticut, New Hampshire and Vermont Departments of Public Health, and through family support or advocacy organizations in each of these states. Access to primary care physicians was facilitated by state chapters of the American Academy of Pediatrics in Connecticut, New Hampshire, Vermont and Rhode Island. One copy of the Organizational and Descriptive Information survey and multiple copies of the Staff Level Information survey were sent to 31 managed care plans in New England. In two states (Massachusetts and Connecticut) access was facilitated by the state association of managed care organizations.

Families reported their highest levels of overall dissatisfaction with mental health services. While the sample of families responding to these items was smaller (ranging from 29 responding to inpatient psychiatric care to 118 responding to an item about out-patient services) satisfaction ratings were significantly lower than those reported in other areas.

Providers reported generally high levels of dissatisfaction in the area of ability to make referrals for appropriate mental health services. The “not satisfied” ratings for these items ranged from a low of 36 percent for out-patient diagnosis services to a high of 52 percent “not satisfied” for family support groups. None of the five items in this domain received a “very satisfied” rating above 15 percent. Findings from the managed care staff surveys also supported the overall concerns with access to appropriate mental health services that was reported by both families and providers.

3.1.2.4 Population Based Services

Pregnant Women, Mothers and Infants

and

Children with Special Health Care Needs

Genetics

With the rapid expansion in the field of human genetics it becomes difficult for public health officials, policymakers, health practitioners, etc., to keep abreast of new information and its potential implications. In order to respond to the expansion of genetics information, the following emerging issues and needs have been identified:

- A Statewide Genetics Needs Assessment should be done to evaluate Primary Care Providers’ knowledge and understanding of genetics, accessibility of Genetic Specialists, capacity of present Regional Treatment Centers, and resources needed. This would lead to the development of a Statewide CT Genetics Plan to address the identified needs and issues. A State Performance Measure regarding this Plan has been developed for this application.
- Transition services are needed to assist adolescents in establishing a relationship with adult primary and specialty care services. Presently, follow up care continues with pediatric specialty care services that leads to non-compliance with follow up care. Screening in CT began in 1964 with PKU and continued to expand through the past thirty-three years to include eight disorders. To date there has been approximately 7,000 confirmed abnormal tests identified through the newborn screening program. Many individuals have approached adulthood or are adolescents approaching adulthood both in need of establishing a relationship with adult primary and specialty care services. DPH currently lacks data for those clients that are not followed by the designated regional Genetic Treatment Centers who may also need to transition for adult specialists (e.g. cardiology, neurology, PCP’s).
- Outreach Programs are needed to assist young women of childbearing age with PKU back into genetic specialty services. Long term tracking of affected women is not available if they are not being followed by the regional genetic treatment centers. Education and specialty follow up services will assure maintenance of their special dietary needs prior to and during pregnancy as preventative measures to decrease the risk factors to the unborn infant. Education of obstetrical, gynecological, and other healthcare professionals regarding protocols and guidelines for women of child-bearing years and prenatal care for individuals with PKU, homocystinuria and hypothyroidism to assure optimal health of the newborn is needed. (Educational brochures, inservices, etc.).

- Computer linkage needs to be established between the Vital Records Birth Certificates database and the Laboratory NBS database to assure that all newborns born in CT are screened for the eight mandated disorders. Prompt identification of infants at risk for metabolic or genetic diseases enables medical treatment to avert complications and prevents irreversible problems. A targeted match of NBS Laboratory records and Vital Records Birth Certificates was performed to determine the percentage of newborns born between October 1st through December 31st 1999 who had a satisfactory specimen submitted and tested. The verified that 99.98% were screened. This shows an improved rate over previous targeted matches done in 1994 (98.8%) and 1995 (98%). Much integration of various data sources and numerous hours of tedious work is necessary to conduct the match review that was time specific. Computer linkage would enable an ongoing verification process to assure that all CT newborns are screened for all diseases mandated by State statute.
- Educational services need to be provided to PCP's, Pediatricians, Obstetrician's, Midwives, and Family Practice physicians regarding Genetics and Newborn Screening in order to prevent disease and improve health. This will promote compliance with the State statute assuring that all CT newborns are screened. Presently, all hospitals/birthing facilities, pediatric Primary Care Provider's and Family Practitioners are provided with Newborn Screening Guidelines and/or Protocols and technical assistance is provided by the MCH Tracking Unit. It remains evident through telephone communications that knowledge and understanding of genetic and metabolic disorders is lacking.
- Further study and assessment is needed regarding the potential expansion of the NBS Program screening panel to include metabolic disorders using tandem mass spectrometry technology.

Children and Adolescents

Information from the Voice of Connecticut Youth survey conducted in 1996 is very similar to information collected from the national Youth Risk Behavior Surveillance conducted in 1977. Both of these surveys of youth indicate that a significant proportion of our youth engage in behavior that is hazardous to their health. Detailed information is presented in the section 3.1.2.1 Overview of the Maternal and Child Health Population's Health Status sections on Injury, Behavioral Data, and Sexually Transmitted Disease starting on page 85.

These sources of behavioral data indicate the importance of providing targeted education and programmatic activities aimed at promoting healthy habits among children and adolescents. These messages must come from all sources possible including our Title V funded programs.

3.1.2.5 Infrastructure Building Services

Pregnant Women, Mothers and Infants

and

Children and Adolescents

Collaboration

DPH has a strong, functional intra and interagency infrastructure for collaborative activities currently in existence. For example, the Supplemental Security Income (SSI) program works collaboratively with DPH surrounding families who apply for SSI and their possible access to services and supports from the Children with

Special Health Care Needs Program. Some Ryan White and Title IV AIDS programs are housed at the Department of Public Health. Maternal and Child Health staff work collaboratively with social services, special education and early intervention programs through a variety of methods, such as; interagency councils, training workshops such as *Making Room at the Table*, conference planning and implementation such as *Together We Will* and the interagency celebration of families in Connecticut called *Family Day*. MCH staff and vocational rehabilitation staff work together on issues facing children with special health care needs in Connecticut. SSDI, Healthy Child Care Connecticut, and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) are located in the Bureau of Community Health (See Section 1.5.2 State Agency Coordination, page 38, and Supporting Documents, Section 5.3, page SD 39 for further details).

Data Base Issues

At present, data relative to the MCH population are maintained in distinct and isolated databases across Divisions, Bureaus, and Agencies that often contain similar data elements. A comprehensive, population-based source of MCH data is needed if CT is to respond to performance measures, estimate incidence and prevalence of MCH outcomes, provide appropriate referrals, and track and evaluate the effectiveness of programs funded under Title V. Further information on this is provided in the Priority Needs Section.

Children with Special Health Care Needs

CSHCN Registry

An important issue facing those trying to serve the Children with Special Health Care Needs (CSHCN) population is to identify and count the children. Depending on the definition used, and the level of severity of a condition, the estimates of the number of CHSCN will vary. Using data from a study on the prevalence of chronic conditions^{xxxviii} a needs assessment of the CSHCN population conducted for the DPH estimated the number of CSHCN in Connecticut to be between 38,000 to 226,000 of the children under 18 in the State.^{xxxix} Another estimate of the number of CSHCN is based on the National Health Interview Survey on Disability indicated that approximately 142,963 of the almost 800,000 children are less than 18.^{xl} Recently the DPH has initiated a process to explore the feasibility to establish a registry of CSHCN. This is based on the statutory authority found in Connecticut General Statutes Section 19a-54. In an effort to improve planning of CSHCN services and to get an accurate count of the number of children with special health care needs in the state, the Department has made the registry a top priority and a consultant has been hired to assess internal and external capacity.

Health Insurance for the Underinsured

The implementation of the HUSKY programs has provided a source of insurance for uninsured children with special health care needs. This has enabled Title V to focus on the underinsured. A source of insurance for primary and specialty care is identified as part of the intake assessment for children enrolling in the program. According to the 1999 CSHCN Annual Report, 97.5 percent of the children in the CSHCN program had a source of insurance for their primary and specialty care. Future plans include continuing present activities and further maximizing outreach opportunities.

Service System Constructs for CSHCN

State program collaboration

DPH staff participate in numerous interagency collaborative groups. The CSHCN program shares an interagency advisory committee with the HUSKY Plus physical program called SASH (Steering and Advisory committee for children with Special Health care needs and HUSKY Plus Physical). This group includes representatives from DSS, Department of Insurance, Department of Children and Families, Office of the Child Advocate, Department of Mental Retardation, Department of Education, and DPH, and providers of CSHCN and HUSKY Plus Physical programs, and families of these services. The CSHCN staff and DSS staff have a strong partnership in overseeing the CSHCN and HUSKY Plus Physical programs. The two group's work together to create and maintain a seamless system where families of CSHCN receive wrap around services in a coordinated manner. Both DSS and DPH recently took part in a review from the Health Care Financing Administration of these coordinated programs.

The Children's Health Council is the organization chosen by the DSS to administer a survey of satisfaction to families of CSHCN enrolled in the HUSKY program. The DPH CSHCN staff reviewed the design of the survey.

State support for communities

The CT CSHCN program is operated in participation with two regional centers. The Connecticut Children's Medical Center (CCMC) is located in Hartford and the Yale Center for Children with Special Health Care Needs is located in New Haven. The CSHCN program coordinates specialty care services, provides advocacy and support, and payment for certain services including but not limited to adaptive and specialty equipment, specialty medical pharmacy and special nutritional formulas, transdisciplinary team conferences, etc. Both Centers subcontract with community based facilities throughout the state, which increases access for families who do not live in Hartford or New Haven. The CSHCN Centers are responsible for providing services to children receiving Social Security Insurance (SSI) benefits who meet program eligibility criteria. DPH provides technical assistance consultation, education, training, common data protocols and financial resources for systems development.

Coordination of health components of community based systems

Yale and CCMC provide coordination of health care services in the areas of primary care, rehabilitation, other specialty medical, mental health and home health care. Though the CSHCN program is the payor of last resort, the two centers must determine if families can benefit from participation in any other service or support. The CSHCN program does offer care coordination to any child with a special health care need regardless of enrollment and insurance status, however care coordination continues as a problem.

Coordination of health services with other services at the community level

Through a variety of sources the State provides coordination and service integration among programs serving children with special health care needs. A paid parent advocate assists by keeping information flowing from the program level to the State level. INFOLINE, the State's toll-free line reports information from the community level. Public hearings allow community programs to provide input to the Title V programs.

3.2 Health Status Indicators

Many of the Health Status Indicators have proved useful in assessing the Maternal and Child Health Needs in Connecticut. However, we are unable to report information for Core Health Status Indicator #6. This indicator requires the comparison of health status indicators for Medicaid, non-Medicaid and all populations in the State. At the present time DPH does not link vital records data with the DSS Medicaid files, and therefore, the required data are not accurately available. DPH recognizes the need to establish the relationships necessary for data sharing and has begun the development of an MOU with DSS regarding the sharing of information between the two agencies. It is hoped that in the near future we will be able to report on the comparison of health status indicators for Medicaid, non-Medicaid and all populations in the State.

3.2.1 Priority Needs

Through the needs assessment process DPH identified ten areas of priority needs. These ten areas are described below

1. Enhance CSHCN services

CSHCN Registry

Sec 19a-53 of the Connecticut Statutes refers to the development of a registry of children with special health care needs. Although this activity is mandated, the Department has not had the financial and technical resources to move forward. In an effort to improve planning of children with special health care needs services and to get an accurate count of the number of children with special health care needs in the state, the Department has made the registry a top priority for 2001. A new state performance measure has been added and a consultant has been hired to assess internal and external capacity.

Health Insurance for the Underinsured

The implementation of the HUSKY programs has provided a source of insurance for uninsured children with special health care needs. This has enabled Title V to focus on the underinsured. Performance Measure #11 responds to efforts to address the insurance for the underinsured issue. A source of insurance for primary and specialty care has been and will continue to be identified as part of the intake assessment for children enrolling in the program. According to 1999 CSHCN Annual Report, 97.5% of the children in the CSHCN program had a source of insurance for their primary and specialty care. Future plans include continuing present activities and further maximizing outreach opportunities.

Case Management and Care Coordination

Although the CSHCN program does offer care coordination to any child with a special health care need regardless of enrollment and insurance status, the 1999 Family Support Council's report to the Governor on the Status of Family Support in Connecticut and the draft Report on Connecticut's Care for Children With Special Health Care Needs/ Developmental Disabilities put forth by the Child Advocate's Task Force cite care coordination as a continuing problem. The CSHCN program had made several efforts to address the issue of care coordination. In 1998 and 1999, conferences geared specifically to families addressed the care coordination concern by providing information and tools to help families be their own care coordinator. A notebook entitled "Keeping It All Together"

was disseminated and continues to be provided to enrolled families. The notebook provides a means of organizing medical, educational and emergency information, a section on record keeping and a listing of available resources. The CSHCN program is planning another family empowerment related conference slated for Fall 2000.

Behavioral Health Services

The issue of behavioral health services for Title V recipients is clear. DPH is trying to address this concern through partnerships with other state and community providers. Connecticut is not alone in its quest of quality behavioral health services. The Surgeon General released the first report on mental health in late 1999 stating that “mental health should be part of the mainstream of health”.

In a New England survey findings pointed to the need for increased attention to measuring the quality of mental health services. Gaps in access to specialized and appropriate mental health service for children with ongoing health conditions were highlighted by both families and providers. In addition, the reported need by primary care providers for additional supports in managing psychological or emotional needs of children and their families identifies another critical aspect of primary care for this population that can contribute to mental health. Also necessary is increased attention to measures of care coordination and communication among providers and including families. Well-integrated and coordinated services that are delivered across a wide range of providers, in multiple settings, remain the hallmarks of quality family-centered care for children with special health care needs. Quality measures for this population must focus on monitoring the indicators of effective communication and information exchange among all providers, including the family.^{xxxvii}

Available Home Health Care

The availability of pediatric home health care for children with special health care needs remains an issue according to the 1999 Report to the Governor on the Status of Family Supports, The 1999 Child Advocate’s Task Force draft Report on Connecticut’s Care of Children With Special Health Care Needs/ Developmental Disabilities, results of the CSHCN and Family Voices surveys, discussions with CSHCN staff and other sources. Home health agencies are not able to hire sufficient staff to fill all the hours of home health care authorized. Low pay scales, no benefits, travel and lack of appropriate training were cited as reasons for the “home health care crisis” the state is currently experiencing. To address this concern, the Connecticut Association for Human Services (CAHS) with funding from DMR and the Council on Developmental Disabilities convened a group of individuals to form an Institute on Home Health Care. The group, which consisted of: advocates, home health care providers, families of children with special health care needs and state agency representatives, had, as it’s goal the creation of a comprehensive, informed list of recommendations for policymakers, practitioners and providers, and families that would improve the delivery of home care services for all children and adolescents.

Quality and Inclusive Education

The 1999 Report to the Governor on the Status of Family Supports states that families of children with disabilities still have to struggle for quality inclusive education. Local education school districts look for ways to cut costs by limiting specialty services needed by children with special health care needs.

Other Respite Services

The 1999 Report to the Governor on the Status of Family Supports cite the need for other respite services. According to the Child Advocates Task Force Report, partial funding for respite is available. The CSHCN program also has a respite program. The amount of funding, however, is insufficient compared to the degree of need.

Day Care Services

According to the 1999 Report to the Governor on the Status of Family Supports, families of children with special health care needs have difficulty accessing quality childcare. Lack of providers skilled in caring for a child with a special health care need, daycare sites that are not accessible to children with disabilities, and fear are a few of the barriers faced by families with children with special health care needs. To address these difficulties, the Department is exploring the possibility of providing education and training to day care providers regarding children with special health care needs.

State Performance Measure

Two State Performance Measures have been developed in response to needs identified in the children with special health care needs population. SP #01, placed in the Direct Services level of the pyramid, measures the percentage of children with special health care needs clients enrolled in the State CSHCN program that have a written care service plan. SP #09, placed in the Infrastructure Building Services level of the pyramid, measures the degree to which DPH has the infrastructure in place to collect and report information on all children with special health care needs in the State.

2. Reduce the health disparities between whites and other racial/ethnic groups.

Many disparities exist between the health of the white population and that of the African American and Hispanic populations within Connecticut. The DPH recently completed a comprehensive report detailing health disparities within Connecticut.^{xxviii} It is striking how consistently these disparities exist across so many health indicators. Whether it involves infant health, lead poisoning, sexually transmitted disease, or violence, a greater proportion of adverse health outcomes are borne by our African American and Hispanic populations. Many health disparities are outlined in section 3.1.2.1 Overview of the Maternal and Child Health Population's Health Status beginning on page 73. This problem is not unique to Connecticut, but action must be taken at the State level to address these disparities.

Epidemiologic review of CT specific information for identification of risk factors

While research on health disparities must take place at the Federal level, DPH needs to improve its ability to address racial and ethnic disparities at the State level. CT's Title V programs need to consistently gather race and ethnicity information. Analysis of vital records and program data should be conducted for better identification of risk factors that may be specific to racial and ethnic groups within Connecticut. For example, risk factors for low birthweight and preterm deliveries among Connecticut women should be more completely analyzed using available databases.

Targeted education and programmatic activities aimed at reducing racial/ethnic disparities

CT's Title V programs that address the health outcomes such as: infant mortality, low birthweight, prenatal care, teen pregnancy, STDs, lead poisoning, and asthma need to target participation among African American and

Hispanic populations. One of the new State Performance Measures this year is aimed at assessing participation among African American and Hispanic populations to ensure that these groups are receiving appropriate Title V services. Educational messages and program content must be appropriate and culturally sensitive.

Program activities need to ensure that recent information regarding specific risk factors for African American or Hispanic populations are incorporated into the standards of care delivered at Title V programs. For example if screening for bacterial vaginosis reduces preterm delivery and low birthweight among higher risk mothers, then screening must be incorporated into the Standards of Care for prenatal care.

State Performance Measure

State Performance Measure #04, placed in the Population based Services level of the pyramid, measures the degree to which Title V programs target services to racial and/or ethnic groups with disparities in pregnancy outcomes. Title V programs will focus on increasing outreach and other activities to ensure service to populations at highest risk for poor outcomes.

3. Encourage the adoption of healthy habits among children and adolescents.

CT's Title V programs need to continue to provide targeted education and programmatic activities aimed at promoting healthy habits among children and adolescents.

Unprotected sexual activity

Unprotected sexual activity results in increases in unwanted teen pregnancies. It also increases the risk of sexually transmitted diseases. Behavioral data from the Voice of Connecticut Youth Survey detailed in section 3.1.2.1 Overview of the Maternal and Child Health Population's Health Status on Behavioral Data starting on page 87 indicate that nearly one third of all students surveyed said they had already had sexual intercourse. Also, adolescents are experiencing high rates of STDs. Young persons in the larger cities of the State continue to be most affected by gonorrhea and chlamydia (see Table 30 on page 94).

Tobacco, Alcohol and Drug use

The proportion of students who reported weekly or daily use of cigarettes quadrupled between 7th and 11th grade; from 6 percent of 7th graders to 18 percent of 9th graders to 25 percent of 12th graders. While nearly 66 percent of 7th graders reported never using alcohol in the past year, only 40 percent of 9th graders and 30 percent of 11th graders reported the same. 32 percent of 11th grade boys and 22 percent of 11th grade girls reported getting drunk once or more in the past week.

Marijuana use, like alcohol use, increased with age. The overwhelming majority of 7th graders (91 percent of girls, and 86 percent of boys) reported never using marijuana in the past year, compared to 70 percent of girls and 66 percent of boys in 9th grade and 61 percent of girls and 56 percent of boys in 11th grade. Cocaine use was minimal across all grades with 95-98 percent reported they had never used cocaine in the past year.

Driving safety

Deaths and injuries due to motor vehicle accidents remain an important public health problem among adolescents. Children are injured in motor vehicle crashes as vehicle occupants, pedestrians and bicyclists. Child passenger safety is just one of the issues that should be addressed. Pedestrian injuries are one of the leading causes of

injury related death and hospitalization for children 5-14 years in CT. Adolescents and young adults are at highest risk of dying of motor vehicle injuries.

Physical activity and Nutrition

Adequate exercise and nutrition are important for adolescents' overall health as well as their school performance. For girls, more than one-third reported exercising twice or less per week compared to one in five boys. While about half of the boys exercised six or more times a week, only one-quarter of the girls did the same. Nearly half of all girls and one-third of boys usually skipped breakfast. Diets were often reported to be high in fat and low in calcium and protein. Nearly one in five younger students and one-third of older students did not have any fruit the previous day.

4. Reduce teen pregnancy.

Teen Mothers are less likely to complete high school than their classmates and are more likely to end up on welfare. The children of teen mothers are more likely to perform poorly in school, at greater risk of abuse and neglect, more likely to be placed in foster care, and more likely to engage in criminal activity as adolescents and young adults, and less likely to be economically and socially successful as adults. Daughters of teen mothers are more likely to repeat the cycle and to become teen mothers themselves.^{xii}

Some social indicators may predict a future increase in teen pregnancy in Connecticut. Literature on teen pregnancy prevention cites the child poverty rate as a strong predictor of teen pregnancy (9 years subsequent to the given rate). Connecticut's child poverty rate has been on a steady rise since the 1980s. In 1996, Connecticut was 23rd in the US for the percent of children living in poverty.

There are communities in Connecticut where the teen pregnancy, birth and repeat birth rates are higher than both Connecticut's statewide rate and that of the US. Communities with consistently high rates include Hartford, Bridgeport, New Haven, New London, Norwich, New Britain, Plainfield, Waterbury, West Haven and Windham.

The Connecticut Department of Social Services awards grants to 9 Teen Pregnancy Prevention programs in Connecticut. Bridgeport, Hartford, New Britain, New Haven, New London, Northeast District Department of Health, Norwalk, Stamford and Waterbury. These are focused on primary prevention and are gradually implementing programs based on the Carrera (Children's Aid Society, New York) model of teen pregnancy prevention.

The Connecticut Department of Education funds several Young Parent programs within high schools in the state. These programs provide childcare for teen parents attending school and accredited parenting classes. The Teen Pregnancy Prevention Council of Connecticut, recently restructured, is a not-for profit statewide data repository, information disseminator, education, and advocacy council. The Connecticut Department of Public Health (DPH) funds ten Planned Parenthood of CT sites and six subcontractors to provide comprehensive reproductive health care, education, counseling, and contraceptive services. Special outreach is targeted to teens throughout the state. DPH has funded 13 Adolescent Pregnancy Prevention/Young Parent Programs (APP/YPP) since the 1980s. These programs, while all involved in community-wide and group prevention efforts, focus primarily on teens that are already pregnant and/or parenting. Through vigorous outreach and intensive case management, pregnant teens are identified, supported and referred to essential social, legal and health services. Support and health education are provided in a peer group environment; advocacy and mobilization of support systems are also major components of these programs.

Goals of the APP/YPP programs include: healthy birth outcomes, continuing or re-entering school and completion of high school, positive parenting and prevention of child neglect/abuse, and prevention of subsequent teen pregnancies. Since one of the strongest risk factors for teen pregnancy is already having had a teen pregnancy, the last goal receives strong emphasis from a number of interventions within these programs.

These programs have consistently achieved the following outcomes:

- Early entry into prenatal care (2/3 enter in first trimester);
- Lower percentage of low birth weight infants than that statewide (10.0 vs. 11.9);
- Substantially lower percentage of repeat pregnancies than in national reports and literature (< 10% in one year vs. 34%);
- Low numbers of referrals to child protective services for suspected child neglect/abuse (< 5%); and
- Good school completion/GED rates (> 80%).

An individual client-level database has been implemented in these programs and is being phased in. Data are currently available about client characteristics on intake into the APP/YPP programs for most programs and for program interventions, outcomes, and follow-up for a few programs. These data will be used for description of the programs and their clients and for program evaluation in terms of both short-term (e.g., birth weight) and long-term (e.g. timing of repeat pregnancies) outcomes.

DPH also administers the Abstinence-Only Education grant. To date, a media campaign and three community-based education programs have been funded under these monies. A fourth program is under negotiation. The evaluation is in progress and will not have data regarding effectiveness of the programs for at least a year.

5. Reduce the frequency and or severity of injuries to children and adolescents.

Injury (both intentional and unintentional).

Injuries are the leading cause of death for Connecticut children and adolescents, and young adults between the ages of 1-34 years and a major cause of hospitalization. More children and adolescents die each year from unintentional injuries than from all other childhood diseases combined

Motor vehicle-related injury prevention.

Children are injured in motor vehicle crashes as vehicle occupants, pedestrians and bicyclists. Child passenger safety is just one of the issues that should be addressed. Pedestrian injuries are one of the leading causes of injury related deaths and hospitalizations for children 5-14 years in CT. Major interventions for the three types of motor vehicle related injuries include:

- Occupant protection including correctly installed child safety seats, booster seats for children 40-80 lb. in weight and safety belts for older children and adults.
- Teaching and practicing pedestrian safety skills, supervision, especially for children under 10 yrs, and providing safe pedestrian and play areas.
- Bicycle helmets (correctly fitted and worn), safe riding skills, supervision for younger children and providing safe bicycling areas away from traffic all play a role in prevention bicycle injuries.

Adolescents and young adults are at highest risk of dying from motor vehicle injuries. One of the most promising interventions for reducing young driver crashes is implementing comprehensive “Graduated Licensure” legislation. Graduated licensure allows young drivers to practice skills and gain maturity under controlled situations before “graduating” to full driver privileges. A comprehensive graduated licensure program includes driving with adult supervision for an extended period of time, “zero tolerance” for alcohol, and restrictions on nighttime driving and number and ages of passengers.

DPH has a Crash Outcome Data Evaluation System (CODES) project which can provide a much more complete picture of motor vehicle crash related injuries to children and adolescents in Connecticut. CODES links police crash reports with medical data including hospitalization and trauma data from the CT Hospital Association and death certificates from DPH.

The Injury Prevention Program within DPH has already been working with the MCH Healthy Start Program to incorporate injury prevention into the services provided by Healthy Start Grantees. Healthy Start Providers were surveyed regarding training needs and several in-service training programs have been provided. New information and resource materials are disseminated regularly to the grantees and technical assistance is provided as requested to individual grantees.

The DPH Injury Prevention Program can provide technical assistance to MCHBG Programs on the injury prevention issues including:

- Assistance with identification/design of training programs and resources for health care providers and grantees.
- Assistance with development of “Standards of Care” on injury prevention for providers.
- Assistance with identification/development/implementation of injury prevention programs targeting specific populations.
- Assistance with design/planning of education materials, conferences etc.

Violence prevention

In recent years, the impact of youth violence has become the focus of national concern. Several high profile incidents have directed attention to an issue that has long been acknowledged by the public health community as having a significant impact on health. According to the Center for the Study and Prevention of Violence, intentional violence accounts for one-third of all injury deaths in the United States. Intentional interpersonal violence disproportionately involves young people as both victims and perpetrators. Minority youth, in particular, are at high risk of injury or death from violence.

According to the 1999 Connecticut Youth Risk Behavior Survey of high school students, 7.3 percent of girls and 23.3 percent of boys reported carrying a weapon at some time within the previous 30 days. In addition, 32.5 percent of youth reported engaging in a physical fight, 5.2 percent reported being injured in a fight, and 13.1 percent reported being physically hurt by a boyfriend or girlfriend on purpose. Close to one out of ten students (9.7 percent) reported feeling too unsafe to go to school.

While violence has historically been addressed primarily within the justice system, there is an increasing emphasis on the need to utilize a public health approach to identify and implement effective prevention strategies.

Several DPH Title V programs provide injury prevention services as part of their comprehensive health promotion and risk reduction activities, including School Based Health Centers and APP/YPP programs.

Work related injury prevention for adolescents

Because young workers lack training, work experience, maturity, and knowledge of their rights, they are at high risk of injury and disease. These injuries and diseases may disable them or follow them into adulthood. The HEI/Injury Prevention Program is also working with representatives from Family Health, EEOH and the CT Depts. of Labor and Education on the issue of teen worker safety. There is a real need for expanded efforts to educate health care providers, educators, teens and parents on young worker safety issues.

State Performance Measure

State Performance Measure #03, placed in the Population Based Services level of the pyramid, addresses the need to reduce the death rate for children aged 1-19 caused by unintentional and intentional injury. This measure hopefully will reflect the impact of injury prevention activities aimed at the pediatric population.

6. Improve access to and quality of care for women and children.

Health insurance for the underinsured

As stated earlier in the Overview Section, estimates of the Connecticut population that are without health insurance range from 7.5 percent (Connecticut Office of Health Care Access) to 12.6 percent (US Census estimate). There are a variety of reasons why individuals do not receive care, enroll in insurance plans, or apply for public funding for which they are qualified including that immigrants may fear that receiving Medicaid, HUSKY or other benefits will affect their ability to become a permanent resident or result in deportation, or that many uninsured can not afford the cost of health insurance. Other reasons for lack of health insurance include

- Employer coverage has decreased due to the rapid rise in health care costs.
- Those in temporary positions may not qualify for insurance benefits.
- Mothers of children on HUSKY may not have health insurance.
- Families leaving welfare may not realize that they are still eligible for Medicaid

Welfare reform has created some confusion regarding eligibility for health insurance and some families may assume that they have lost health coverage because they no longer were eligible for cash assistance from the Transitional Family Assistance (TFA) program. Currently all families receiving TFA benefits also receive HUSKY A coverage. About one-quarter of the families leaving the TFA program are discontinued because their earned income is over the federal poverty level. These families are automatically transferred to the Medicaid extension and they do continue receiving Medicaid benefits for up to 24 months. Similarly, families with earned income who are discontinued because of the time limit also receive extended benefits. However, an average of about 1,000 families a month lose TFA benefits for "other" reasons, including failure to complete the redetermination process. Many of these families are also losing HUSKY Part A coverage even though they may still be eligible. (Children's Health Council 11/15/99)

"Safety net" programs funded through Title V exist to help individuals receive health care. The Connecticut Healthy Start program, which provides health care enrollment and care management services to pregnant women and their children up to 185 percent of the poverty level, enrolled 7,128 children from 7/1/98 to 6/30/99. The Connecticut

Healthy Start program enrolled 6,492 previously uninsured pregnant women in Title 19. Of these women, 12 percent (or 780) were illegal aliens who were provided Extended Eligibility Coverage, which at a minimum covered the labor and delivery costs. Uninsured pregnant women and children are eligible to obtain care on a sliding scale at the 15 community health centers located around the State. Additionally there are more than 40 school based health centers situated in elementary, middle and high schools which provide comprehensive health services to children who are enrolled in the school regardless of insurance coverage.

Family planning

BRFSS data indicate that many pregnancies may not be planned. One in four sexually active at risk young Connecticut adults were not using birth control. Among at risk young women, 22.6 percent were not using birth control, which represents 96,500 women. Among all 18-44 year old women, not just those who were sexually active, 5.2 percent reported they were trying to get pregnant, representing 41,300 women, and an additional 3.6 percent (or 23,500 women) reported they were already pregnant. As shown in Table 26 on page 91, high risk groups for unwanted pregnancy include young black and Hispanic women and women in the urban and mid-sized city regions.

The DPH sponsors services at 16 Family Planning Clinics. Services provided include health promotion/disease prevention, contraception, preconceptual counseling, pregnancy options counseling, STD screening and HIV/AIDS counseling and testing. The services are available to women and teens whose income and family size places them at 100 percent of the federal poverty level and who have no other payor. For women and teens whose income is less than 250 percent of the federal poverty level, services are offered at a discount. Special outreach is targeted to teens, minority women and homeless women.

Genetic testing and counseling

Prompt identification of infants at risk for metabolic or genetic diseases enables medical treatment to avert complications and prevents irreversible problems. Identified needs related to genetics services are presented in section 3.1.2.4 Population Based Services on Genetics located on page 103. Some of the needs include ongoing education and training for health professionals as well as transition services to assist adolescents in establishing a relationship with adult primary and specialty care services. Also, outreach programs are needed to assist young women of childbearing age with PKU back into genetic specialty services.

Prenatal care

Nationally, while the percentages of both African American and white women receiving non-adequate prenatal care have declined since 1990, the percentage of African American women receiving non-adequate prenatal care has consistently been more than twice as high as the percentage of white women receiving non-adequate prenatal care.

Prenatal care should be initiated in the first trimester. The DPH has tried to improve access to prenatal care by supporting sites for primary care, free pregnancy testing at family planning clinics, and through programs such as Healthy Start, Healthy Choices for Women and Children, and APP/YPP. While in the overall population of pregnant women in Connecticut only 12.2 percent did not receive early care, there are sub populations who have a larger percent who did not start care early. In 1998, 20 percent of African American pregnant women and 21 percent of pregnant Hispanic women started care late. In the Healthy Start population whose income and family size place them

at or below 185 percent of the federal poverty level, 25 percent of the women began care after the first trimester. In Stamford, the Healthy Start program provided services to 334 pregnant women who were illegal aliens. Sixty one percent of these women started care late. There is a continued need for the outreach, education, and advocacy activities of the 23 Healthy Start programs to reach pregnant women who are at risk for starting care late.

Perinatal infectious disease prevention

Current prenatal care standards of practice recommend testing pregnant women for a variety of infectious diseases including syphilis, hepatitis B (HBV), rubella, group B streptococcus (GBS), and HIV. The DPH Perinatal Infectious Disease Prevention Program have several projects including:

- Case management of HBV infected pregnant women,
- Investigation of preventability of HIV transmission among children exposed at birth,
- Investigation of preventability of early onset GBS, and
- Evaluation of prenatal care provider policies and testing rates.

Pregnancy Related Mortality

Maternal mortality surveillance utilizes review of a computer listing of all deaths occurring in females of reproductive age reporting ICD-9 codes (#630-679.9) as the cause of death and additional active surveillance through contacting hospitals and requesting information on any suspected maternal mortality. Pregnancy-related death is a death of any woman that occurs while pregnant or within one calendar year of termination of pregnancy resulting from 1) complications of the pregnancy itself, 2) the chain of events initiated by the pregnancy that led to death, or 3) aggravation of an unrelated condition by the physiologic or pharmacologic effects of the pregnancy that subsequently caused death.

In a report completed in 1995 regarding the surveillance of maternal mortality for the period 1980 to 1990, an overall pregnancy mortality ratio of 9.9 per 100,000 live births was reported.^{xlii} These data indicate that Connecticut failed to reach the 1990 national goal of < 5 maternal deaths per 100,000 births. The maternal mortality ratio is consistently greater for nonwhite than white women. For the decade 1980 to 1990 the nonwhite women were 5.5 times more likely to die than white women. The maternal mortality ratio for nonwhite women was 33.2 deaths per 100,000 live births versus 6.0 for white women. The most common cause of death was due to cardiac problems.

State Performance Measure

Two State Performance Measures were developed in relation to pregnant women, mothers and infants. SP #05, although referencing Population Based Services, is placed in the Infrastructure building Services level of the pyramid, as it refers to the development of an infrastructure within DPH to develop and implement a Statewide Genetics Plan. SP #06, also placed in the Infrastructure Building level of the pyramid, evaluates the degree to which the DPH has the infrastructure in place to collect and report accurate information on pregnancy related mortality.

7. Improve data capacity related to Maternal and Child Health issues.

At present, data relative to the MCH population are maintained in distinct and isolated databases across Divisions, Bureaus, and Agencies that often contain similar data elements. A comprehensive, population-based source of MCH data is needed if CT is to respond to performance measures, estimate incidence and prevalence of MCH

outcomes, track and evaluate the effectiveness of programs funded under Title V and provide appropriate referrals. This database should be both secure (to maintain confidentiality) yet accessible to designated staff.

Data Source and Data Issues:

At present, databases that currently track the MCH population in CT and their location include:

- Vital Records- within DPH, OPPE
- Universal Newborn Hearing Screening- within DPH, FH Division
- Newborn Screening (laboratory screening)- within DPH, FH Division
- Medicaid- DSS
- Healthy Start- within DPH, FH Division
- WIC- within DPH, HEI Division
- Lead Poisoning- within DPH, EEOH Division
- Birth Defects Registry- within DPH, EEOH Division

Systems in development include:

- Immunization Registry- within DPH, Infectious Diseases Division
- PRATS (Pregnancy Risk Assessment Tracking System)- proposed for implementation within DPH, FH Division
- CSHCN Registry, which will provide population-based estimates for children with special health care needs, based upon the case definition adopted by MCHB: *Children with special health care needs are those who have, or are at increased risk of having a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally (McPherson et al., 1998).*

Systems needed to be included:

- Hospitalization data- within Connecticut Hospital Association (CHA)

These databases reside within DPH with the exception of the Medicaid database, which is maintained by DSS and hospitalization data, which is collected by the CHA. Ideally DPH should use these data sources to create a committed MCH database that will track subgroups of the MCH population. Linkages will need to be established between systems via a core group of data elements consisting of a basic set of demographic data as well as data specific to that reporting system (i.e., the childhood lead screening program would report core demographic data as well as blood lead levels). This effort is an excellent opportunity for cross-divisional and inter-agency cooperation.

Significance:

At present it is impossible to estimate the prevalence of children with special health care needs in CT. This lack of denominator data has hampered our ability to respond to Core Performance Measure # 3 (% of CSHCN with a medical home; #5 (% of children immunized); #12 (% of children without health insurance); #13 (% of potentially Medicaid eligible children who have received a Medicaid paid service). Furthermore, this lack of denominator data about children with special health care needs, which estimate disease burden, has hampered health service planning.

It is also difficult to investigate risk factors associated with adverse maternal child health outcomes, as well as to evaluate the effects of programs that are designed to respond to other Core Performance Measures [#15 (% of

VLBW births); #17 (% of VLBW infants delivered at high risk facilities; #18 (% of infants born to pregnant women receiving prenatal care in the 1st trimester); #21 (prevalence of children with elevated Blood Lead Levels); and #23 (% of Medicaid children receiving an EPSDT)]. When linked with the PRATS database, the comprehensive MCH database will contribute significant information about risk factors. Measurement of the effect of participation in multiple programs (HS, HCWC, APP/YPP, WIC, etc) on birth outcomes will be facilitated. A comprehensive, population-based source of MCH data will also assist us in building infrastructure for reporting pregnancy related mortality and investigating associated risk factors.

8. Enhance Oral Health Services

Background

Dental disease and lack of access to oral health care for children and their families is a serious public health concern. The former Surgeon General, C. Everett Koop, stated that "...without oral health there is no health." According to the CDC, dental disease is the most prevalent of all preventable diseases. Dental caries and periodontitis are infectious disease processes that progressively become more serious, difficult and expensive to treat, and can become severely painful and debilitating. Dental disease has been reported as one of the most common health reasons for absence from school and time lost from work. Poor oral health has been linked to cardiovascular disease, cancer, diabetes, lead poisoning, growth and development impairment, and low birth weight.

A Connecticut Department of Public Health statewide survey of second grade school children (ages 6-9) revealed that 40 percent of children in the sample have active untreated dental decay (Healthy People 2000 goal is 20 percent) and 57 percent of the children have experienced dental decay (HP 2000 goal is 35 percent).

The 1997 survey found that 70 percent of low-income children, age 6-9 years, have a higher rate of dental disease than 6-9 year olds from higher income families. Poor and minority children are at even greater risk for dental disease, experiencing disproportionately extensive caries. Seventy percent of socioeconomically disadvantaged children, age 6-9 years, have untreated dental disease. Poor and minority children, who make up 20 percent of the population, experience between 60 and 75 percent of total dental disease. This population is growing relatively more rapidly than the majority population, nationally as well as in Connecticut, with a concomitant projected overall rise in the prevalence of dental disease in children.

To a large extent, lack of access to dental care, particularly to preventive dental services, is a major contributing factor to the high prevalence of dental disease in uninsured and underinsured populations. Critically low numbers and lack of distribution of dental providers for uninsured and underinsured populations are largely responsible for limited access to care.

The CT Department of Public Health 1996 report, "Present and Projected Dental Provider Participation in the Connecticut Medicaid Managed Care Program: Impact on Access to Oral Health Care", predicted that up to 30 percent of the already relatively low number of dental providers under State managed Medicaid would resign from participation under Medicaid managed care. The report also revealed that 80 percent of Medicaid providers would not accept any additional Medicaid enrolled children as new patients. These projections have, for the most part, been confirmed by very recent reports from the Connecticut Department of Social Services and the Children's Health Council. Enrollment of dentists in the Medicaid managed care program has slowly declined from 1995 to the present.

The number and distribution of providers is not the only issue. The 1996 CT Department of Public Health report referenced above demonstrated that, although lack of an adequate dental care provider network is a critical factor, dental care access is highly complex and multifaceted, including obstacles and issues that exist on the provider level, administrative and systems management level, as well as on the client level.

DPH Resources & Activities

The DPH Oral Health Program is currently engaged in numerous activities to enhance oral health and oral health care access in CT, including:

- creating state wide public-private collaborations in support of oral public health,
- providing technical assistance and funding for CHC and SBHC dental services,
- developing an oral health integration and training program for *non*-dental health professionals,
- creating an early childhood caries prevention educational and training program,
- exploring means to expand the SEARCH program to increase the number of dental students and residents working in public settings,
- enhancing data and data systems to improve oral health assessment, surveillance and evaluation.

The above and all other Oral Health Program activities are carried out by the DPH State Oral Health Director and a Health Program Assistant 2, whose salaries are supported by the MCHBG. The CT Community Oral Health Systems Development Project is supported by a federal grant award (DHHS/HRSA/MCH) and funds a part time (10-hour per week) contract consultant. The Innovative/Integrated use of Data for Evaluation, Assessment and Surveillance (IDEAS) Project is a joint endeavor between DPH and the Yale Prevention Research Center, the project grant awardee (DHHS/CDC).

Oral Health Program Needs

The Oral Health Program has not been able to *fully* implement and/or successfully complete several important goals and objectives, such as:

- a state wide institutionalized system for oral health surveillance and assessment,
- adequate expansion and enhancement of dental safety net facilities,
- increased recruitment of and incentives for dental public health service providers,
- a state wide dental sealants program,
- an early childhood caries prevention educational and promotional program,
- an oral health integration training program for non-dental health professionals, and
- an oral-facial injury prevention program.

State Performance Measure

State Performance Measure #08, which is placed in the Infrastructure building level of the pyramid, evaluates the percent of community-based public health care facilities that provide comprehensive dental services for needy or vulnerable children and their families. Lack of dental services has been identified as a need, and this performance measure reflects the importance of providing dental services at the “safety net” providers.

9. Enhance referrals for mental health services.

In Connecticut and nationally, mental health concerns have become recognized as an important component of overall health. Earlier this year, the report "Mental Health: A Report of the Surgeon General," was released and provided major conclusions about children's mental health and provided an excellent summary of the nature of mental health and disability in children, and best approaches for treating these health problems.

Childhood is a period of rapid development. It is critical to assess the mental health of children in a developmental context that takes into account family, community, and cultural expectation about age-appropriate thoughts, emotions, and behaviors.

- Approximately one in five children experience the signs and symptoms of a disorder during the course of a year, and five percent experience "extreme function impairment".
- Children at greatest risk include those with physical problems; intellectual disabilities (retardation); low birth weight; family history of mental and addictive disorders; multigenerational poverty; and caregiver separation or abuse and neglect.
- Primary care and the schools are major settings for the recognition of mental disorders, yet trained staff are limited, as are options for referral to specialty care.
- Families are essential partners in the delivery of mental health services to children.
- Culturally appropriate services improve access to services, but are not widely available.
- The multiple problems associated with "serious emotional disturbance" are best addressed with a "systems" approach in which multiple service sectors work in an organized, collaborative way.^{xliiii}

State policy makers and practitioners are increasingly concerned about children in Connecticut who have serious emotional or behavioral problems, as are the families of these children. Providing appropriate and effective services to meet their needs is a high priority. The State of Connecticut invests an estimated \$207 million annually in behavioral health services for children enrolled in HUSKY, the state health insurance program. Behavioral health services, however, are administered by more than five agencies and a myriad of local agencies and the schools. The result is a complex and fragmented system that leaves families confused about where to turn when they recognize that their children need help. A report to the General Assembly entitled, "Delivering and Financing Children's Behavioral Health Services in Connecticut" outlined many important mental health issues in the State including:

- 70 % of all behavioral health dollars are spent for psychiatric hospitals and residential treatment, serving 19% of all HUSKY children receiving services.
- Acute Care Psychiatric Hospitals, the most intensive and expensive level of services, serve an estimated 1,067 children a year and cost the state \$41.1 million.
- Residential treatment and other out of home placements serve an estimated 3,000 children per year and cost \$104.2 million.
- Community-based services serve about 18,200 children (82% of the children served) with a state investment of \$61.3 million (about 30% of the resources).

- Insufficient mechanisms exist for effective coordination of care between levels and across systems for children and their families.
- Community-based resources and treatment alternatives must be better developed.
- Funding is allocated by program and agency, each having its own requirements and incentive structure. This system fragmentation must be reduced.
- Families must have a greater role in planning services for their children and in system planning and oversight.

Current resources may not be sufficient, but a redistribution of existing resources and taking fuller advantage of federal financing mechanisms could go a long way toward supporting a more effective system of behavioral health services for children.

Recommendations of the report were to:

- Expand and enhance local systems of care as the mechanism for coordinating and delivering behavioral health services for children.
- Design, develop, and implement a blended funding approach to support these comprehensive, integrated community-based systems of care.
- Establish a coordinating and administrative structure to direct and implement the expanded system of care model.
- Form a state-level Interagency Committee for strategic planning and support for the development and implementation of the expanded system of care, with representation from the Departments of; Social Services, Children & Families, Education, Mental Health and Addiction Services, Public Health and the Office of Policy Management.

In direct response to this report Connecticut Legislators have responded with a \$ 3.4 million dollar budget for a program called Connecticut Community KidCare that will provide mental health services to children. This program will provide important early intervention services that can prevent issues from escalating into acute conditions, as well as community-based services to help those children who are ready to leave acute care but still need a lesser level of care.

State Performance Measure

Although DPH is not the primary agency responsible for mental health issues, as the lead MCH agency it is important for DPH to improve access to mental health services and supports. State Performance Measure (SP #02), which is placed in the Enabling Services level of the pyramid, was added to assess and improve access to mental health screening, assessment, referrals and linkages in Title V funded programs. Some Title V funded programs, such as School Based Health Centers, already screen and assess clients' mental health needs. They provide direct services and /or refer clients to community resources, following up to assure that clients become linked to those services whenever possible. Other programs may need to review and/or develop policies and procedures for incorporating mental health screenings into their practice, and for assuring that assessment and provision of supports and services occur as appropriate.

10. Improve recognition, diagnosis, and case management for asthma.

Asthma is the most common chronic illness of children. People who have asthma experience periods of breathlessness, wheezing, coughing and chest tightness; these periods are called attacks or exacerbations. Sometimes these attacks can be life threatening. The number of people with asthma has more than doubled in the last 18 years and more significant increases have been seen in poor, inner city residents.

The specific cause(s) of asthma are not known. However, people with asthma can lead normal, productive lives with effective asthma management and control of asthma symptoms. Asthma that is not controlled has a significant impact on the person with asthma, their family, caregivers and others. Asthma is the leading cause of missed days from school and can result in missed days of work, visits to the hospital, interrupted sleep, limited physical activity and the disruption of family and care giver routines. The health care costs associated with poorly managed asthma are significant as a result of avoidable emergency room visits and hospital admissions. Indirect costs associated with lost work, missed school and poor quality of life are significant but not easily enumerated.

Controlling asthma requires a comprehensive approach including: consistent and appropriate medical treatment, patient compliance with drug regimens; comprehensive patient and family education, and; reduction of risk factors that exacerbate asthma.

Childhood asthma surveillance within the CT DPH indicates that inner city children and minority children are at greater risk of visiting the emergency room for their asthma and are at greater risk of being hospitalized for their asthma. Both hospital admissions and emergency room visits can be indicators of asthma that is not well managed. Populations that are disproportionately represented in these surveillance data need to be targeted for asthma intervention strategies that will improve their asthma management and control.

Access to primary care, culturally sensitive asthma education, and access to resources necessary to reduce environmental asthma triggers are all factors that may contribute to the number of emergency room visits and hospitalizations by inner city minority children.

Controlling asthma requires a comprehensive approach including: consistent and appropriate medical treatment, patient compliance with drug regimens; comprehensive patient and family education, and; reduction of risk factors that exacerbate asthma.

Strategies are needed that will improve provider and patient management, patient understanding of the disease and compliance. This will result in reductions of hospitalizations, emergency room visits and school and work absences due to asthma.

Asthma issues transcend all bureaus within the agency. Maintaining an in-house asthma workgroup of all bureau representatives will be necessary to ensure coordination and integration of asthma activities. Numerous mechanisms are currently available within the department to disseminate public health messages about asthma. These include regularly issued public health reports, newsletters, public education materials and fact sheets. These mechanisms will be explored for use in disseminating information about asthma. In addition, many existing programs including WIC, School and Community-Based Health Centers and Day Care licensing may provide mechanisms for targeted asthma activities.

Surveillance

Central to a statewide asthma program is a successful surveillance effort for identifying at-risk groups, monitoring trends and evaluating program effectiveness. Connecticut has begun to establish a surveillance system composed of hospital discharge and emergency room data. These data sets are useful in evaluating disease management and health care access issues. CT DPH has used Medicaid encounter data and the Behavioral Risk Factors Surveillance System (BRFSS) to assess prevalence.

Other data sources need to be evaluated to determine if they will increase the understanding of asthma and its impact on the state. Additional sources of information on asthma include schools, School Based Health Centers, Community Health Centers, Managed Care organizations and enhanced use of Medicaid Managed Care data. In addition, our current surveillance efforts need to be standardized to better support an ongoing and sustainable surveillance effort.

Environmental Triggers

Through the use of a Healthy Home model, environmental asthma triggers including dust mites, cockroaches, second hand smoke and pets can be identified and appropriate control strategies applied. In-home assessments are necessary because the reduction of environmental risk factors have been shown to enhance the management of asthma.^{xliv,xlv,xlvi} There are many barriers, especially among inner city families, to implementing environmental control measures. Trained staff can more appropriately identify those things likely to exacerbate asthma in the home and provide appropriate remedies. In addition, home visits in conjunction with reinforced education about asthma self management have been shown to improve asthma control. DPH through their HUD lead abatement program and coordination with local health departments has experience with implementing this type of program but to date has not had the resources to establish it as part of any comprehensive asthma initiative.

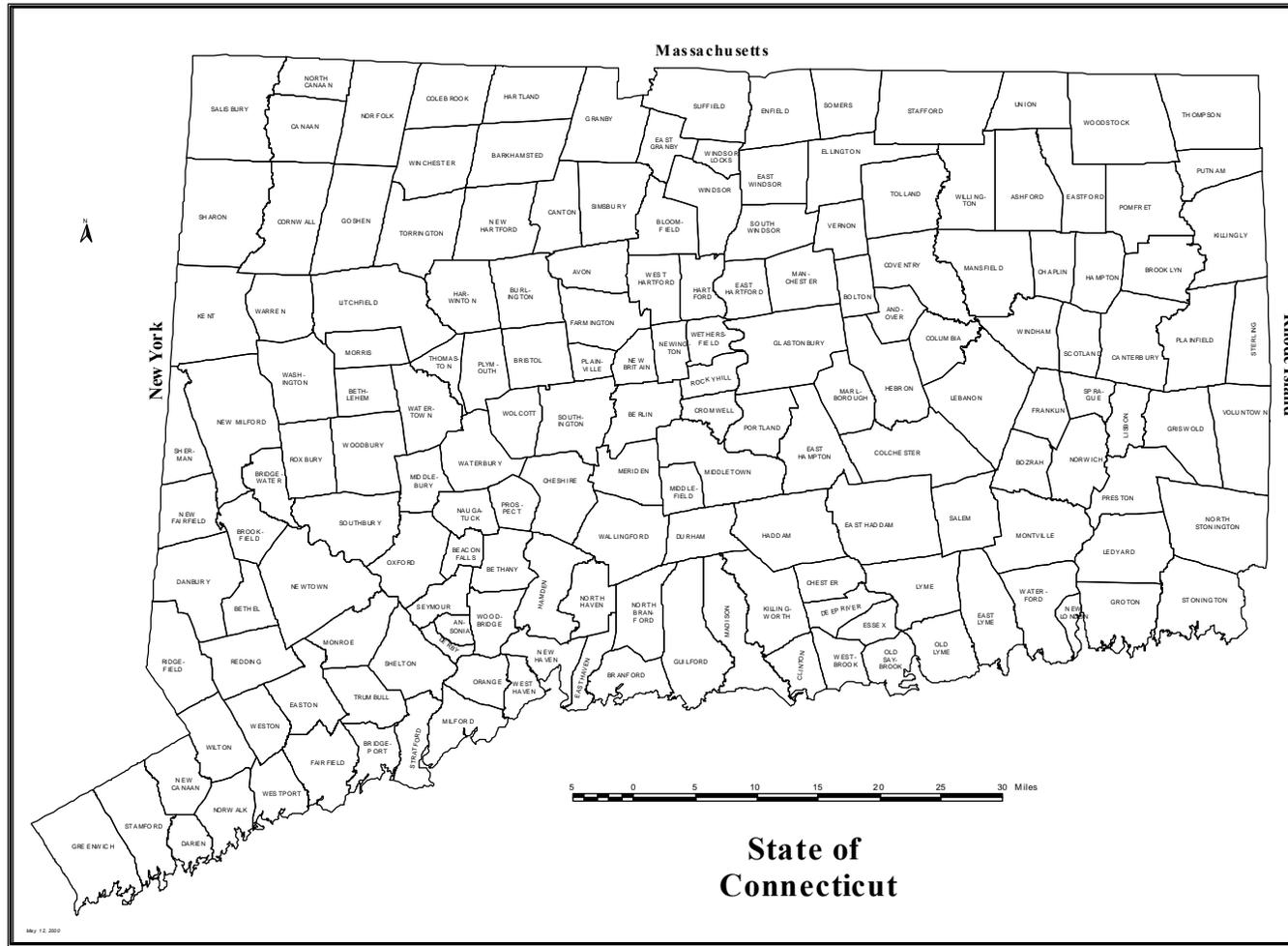
Education

Targeted asthma education activities need to be developed for a broad spectrum of audiences including the general public, health care providers, local health departments, schools, child care providers and others. When and if appropriate, educational initiatives need to correspond with other asthma initiatives including environmental and medical management components.

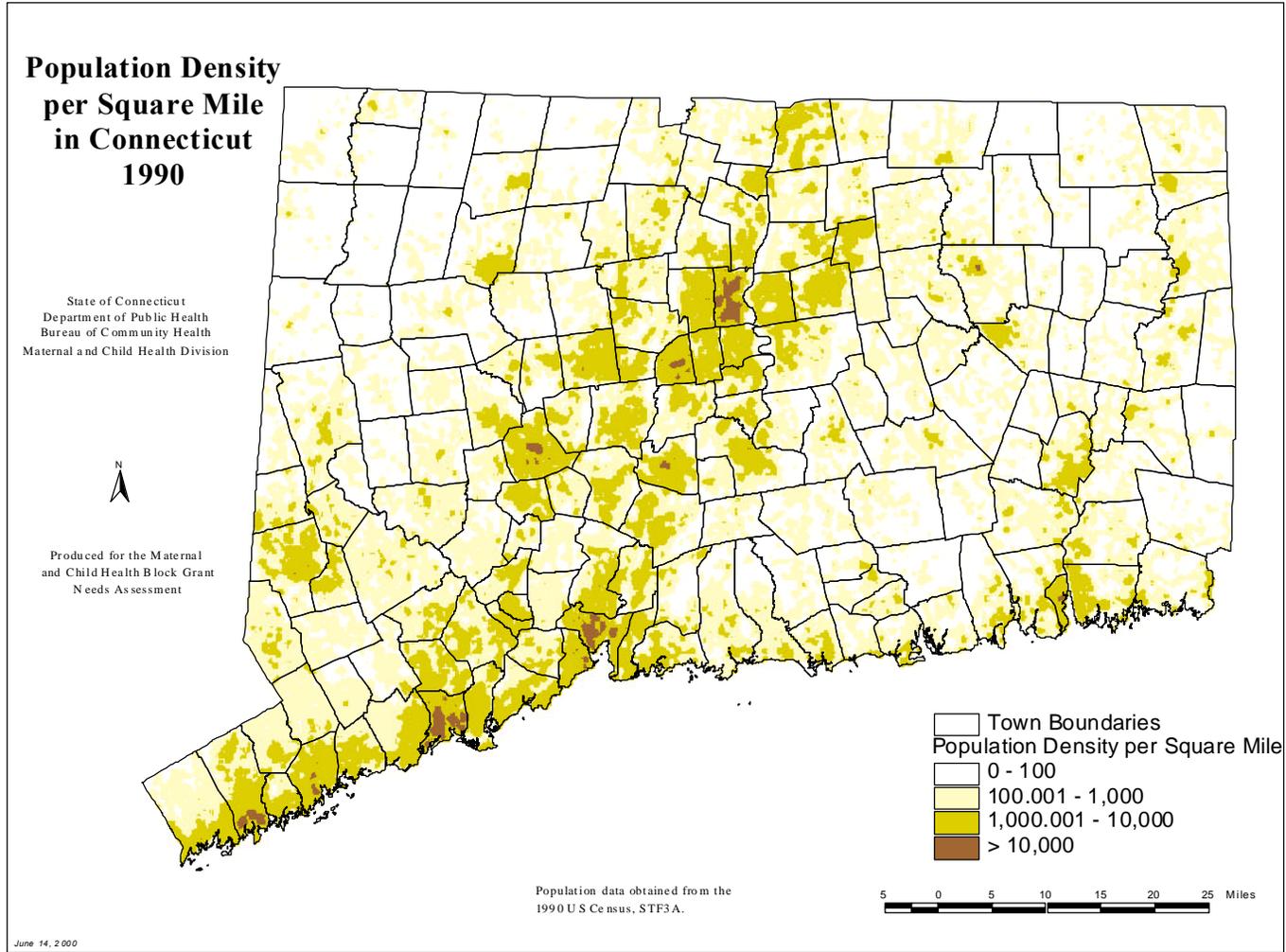
State Performance Measure

State Performance Measure #07, which crosses both the Population Based and Infrastructure Building levels of the pyramid, was developed to measure the degree to which DPH improves education, diagnosis, and case management for asthma. This performance measure will evaluate activities including: the implementation of data collection and evaluation methods in Title V funded programs to determine whether children with a diagnosis of asthma have an asthma management plan, CSHCN programs will assess case managers' knowledge of asthma management including control of triggers of asthma in the home, the Open Airways Program will be implemented, and, surveillance activities will be enhanced.

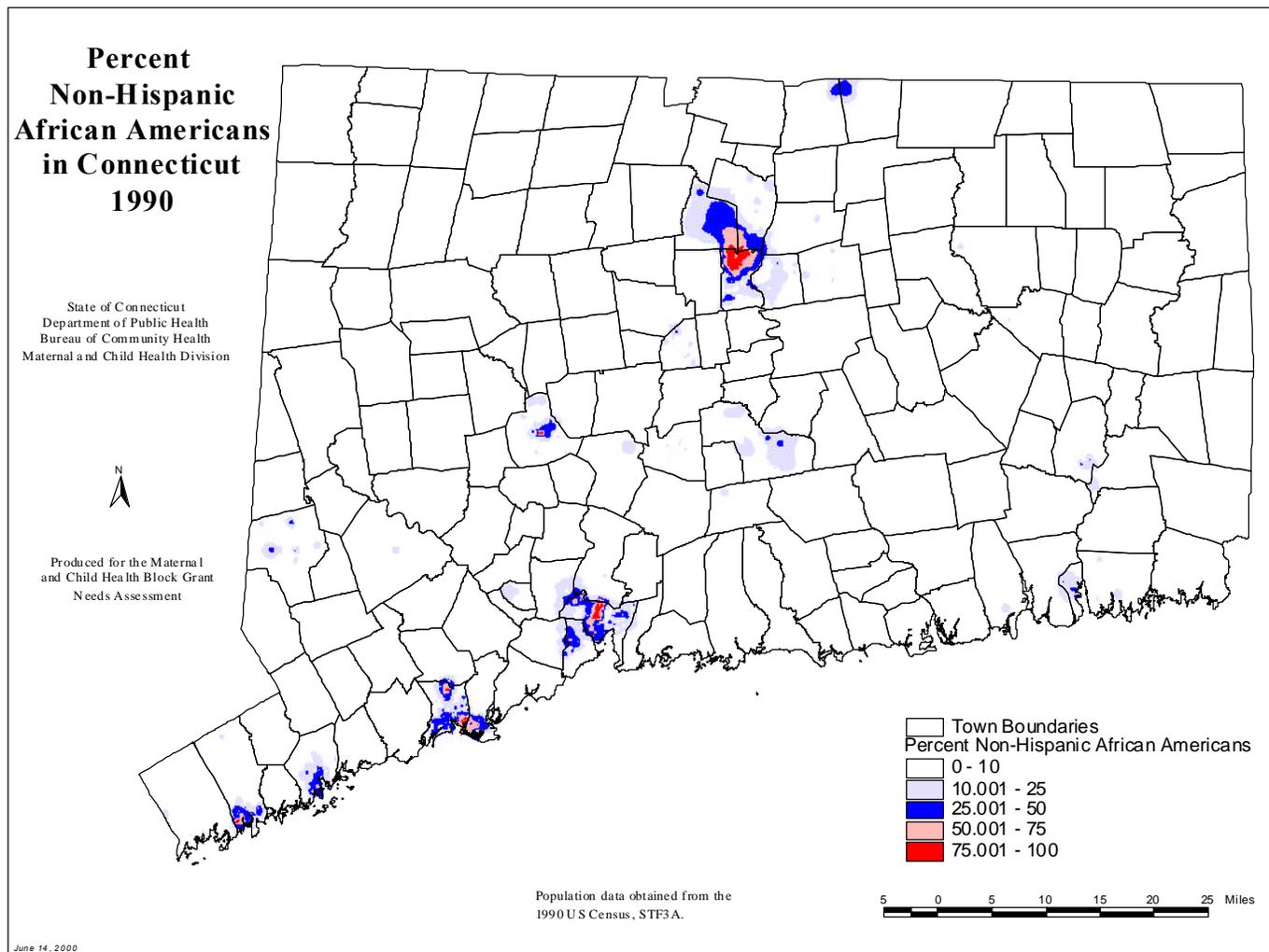
Map 1 Connecticut with Town Names



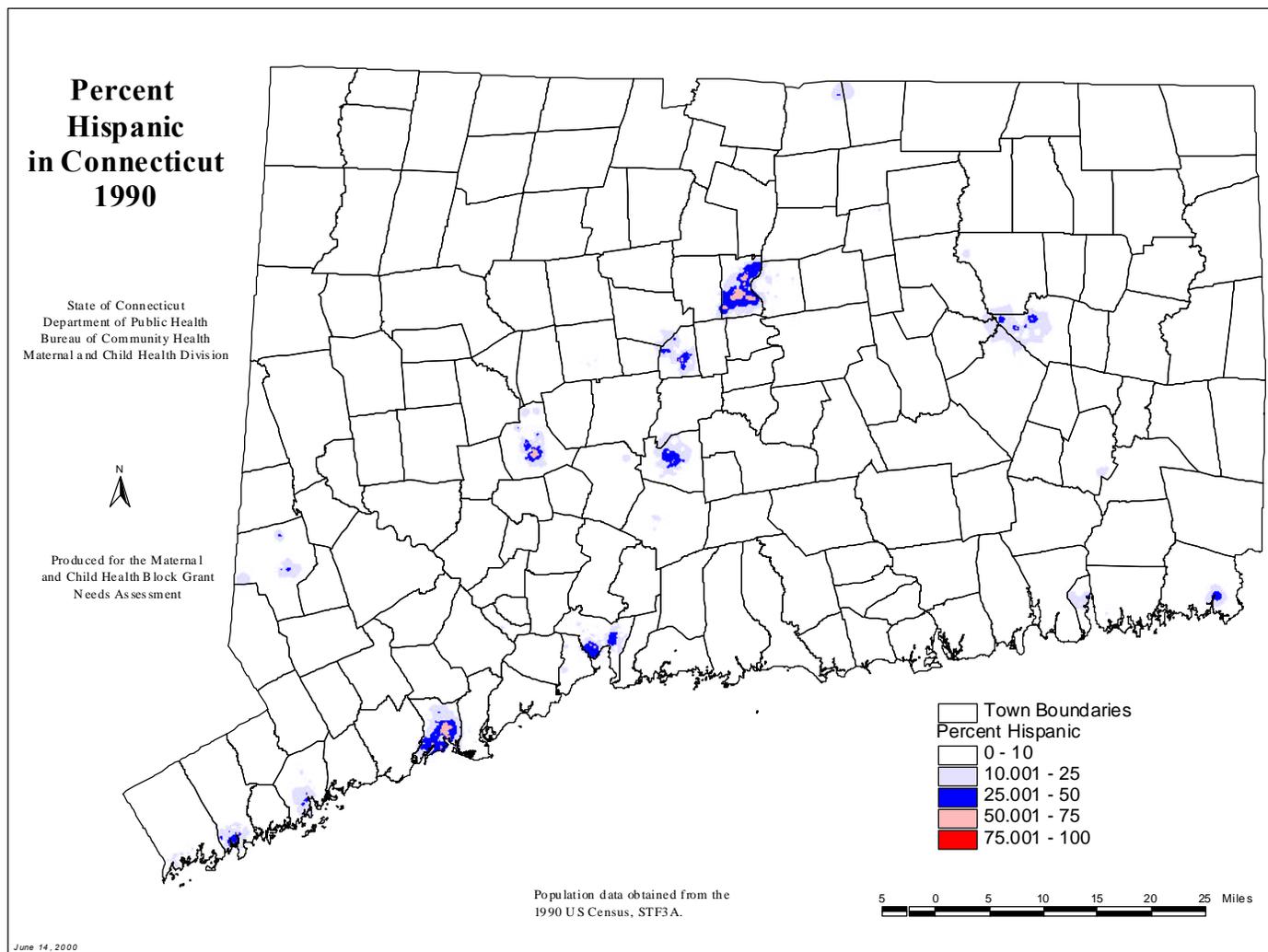
Map 2 Population Density per Square Mile in Connecticut, 1990



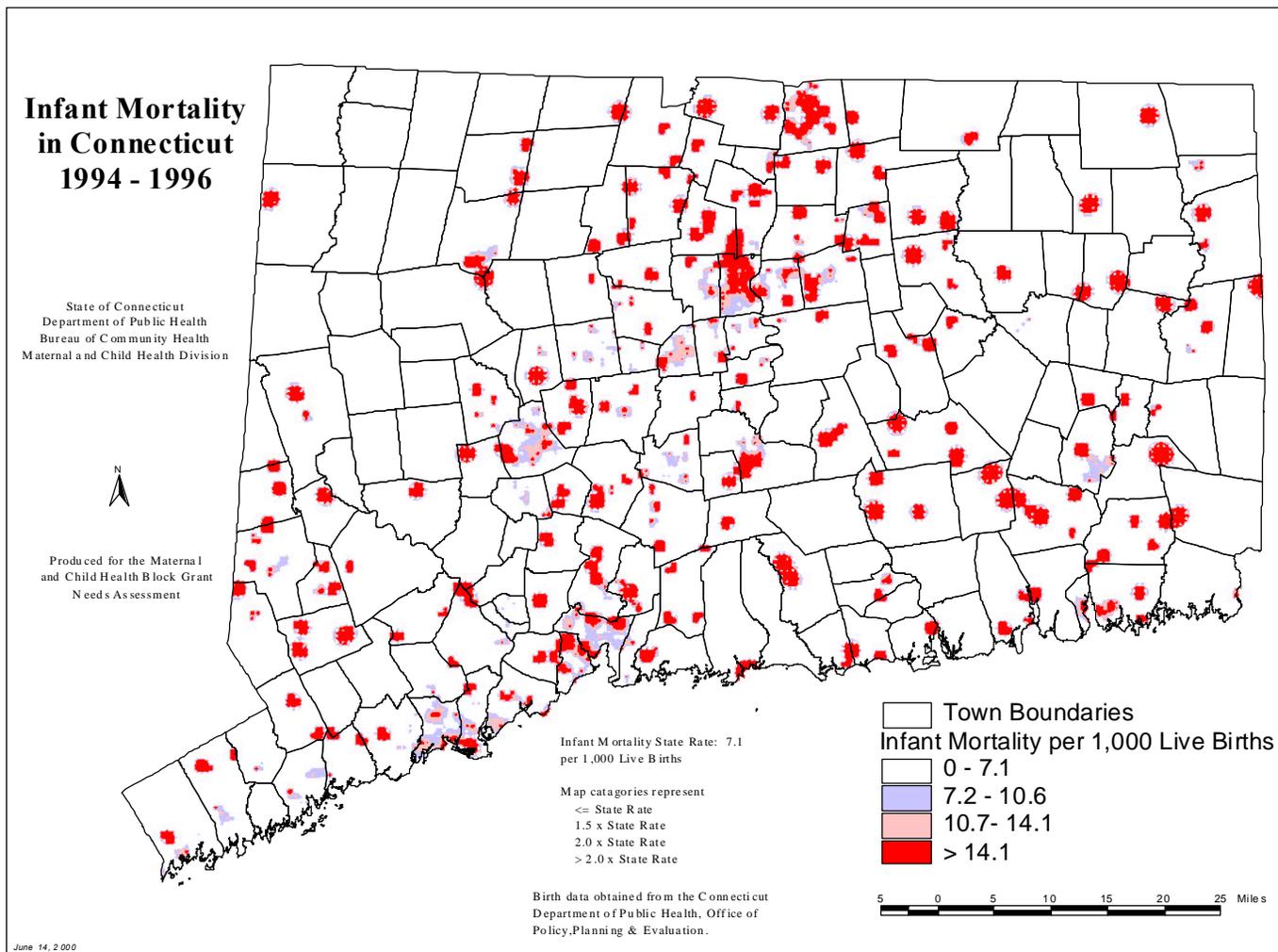
Map 3 Percent Non-Hispanic African Americans in Connecticut, 1990



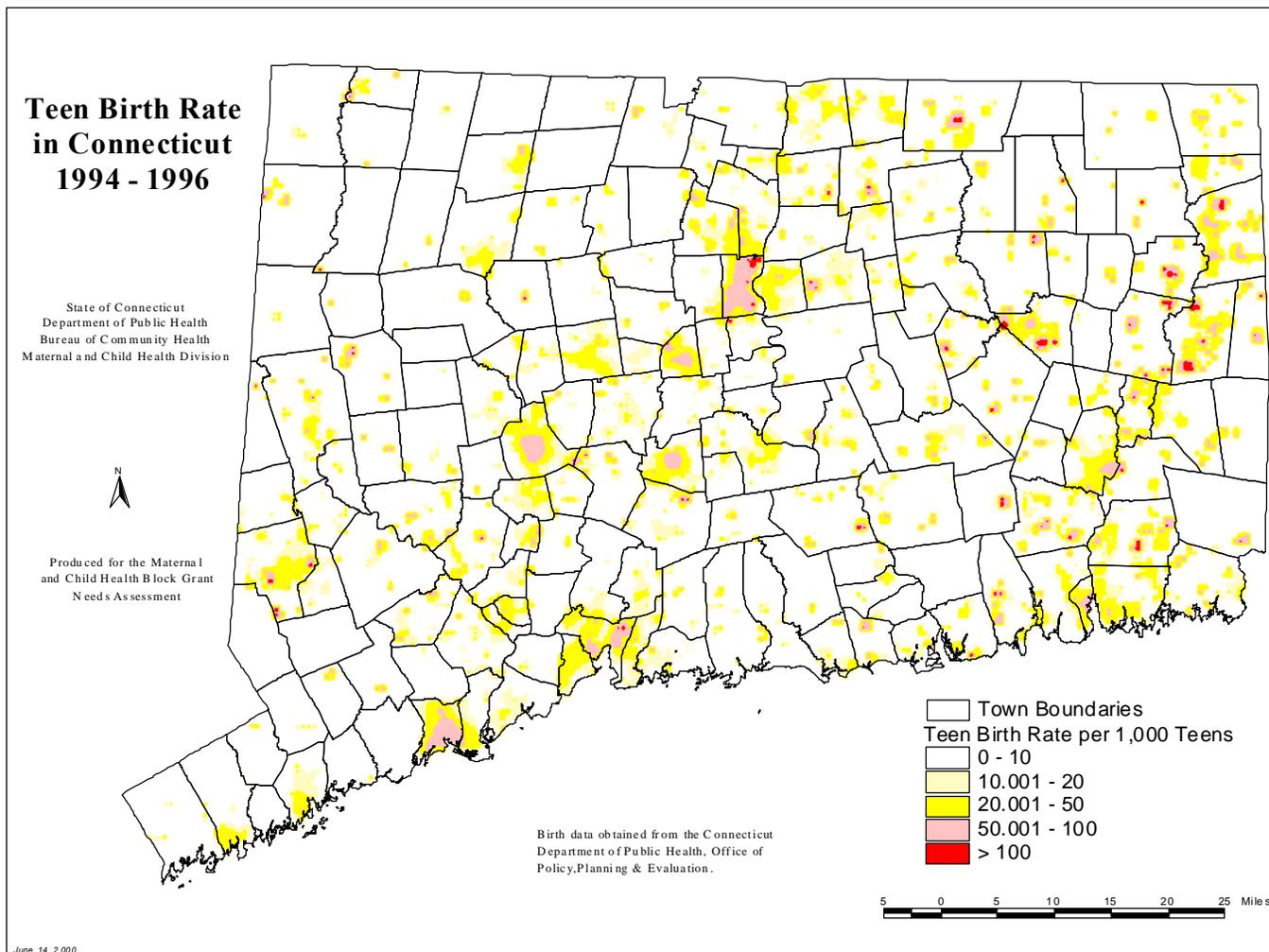
Map 4 Percent Hispanic in Connecticut, 1990



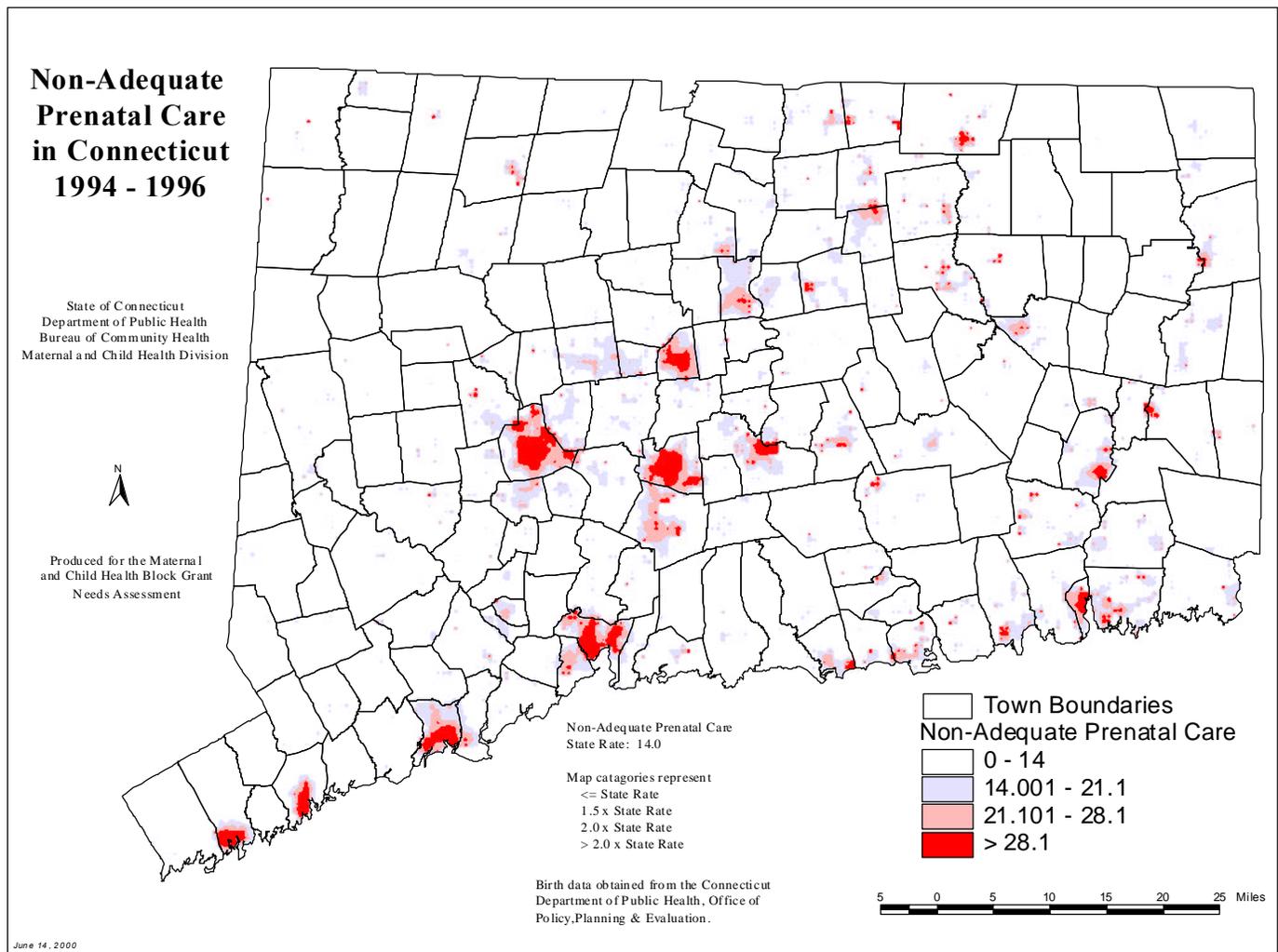
Map 5 Infant Mortality in Connecticut, 1994 - 1996



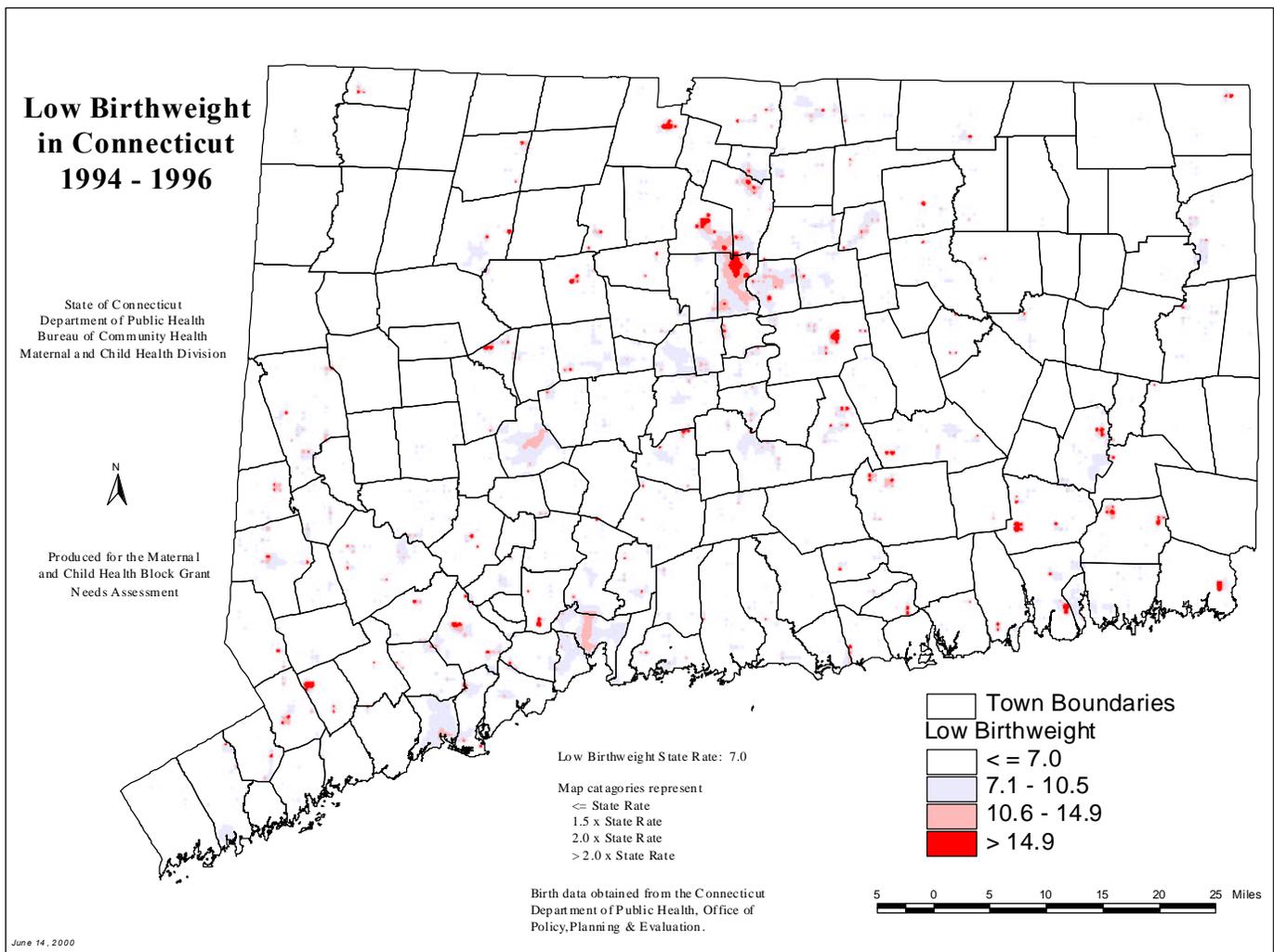
Map 6 Teen Birth Rate in Connecticut, 1994 - 1996



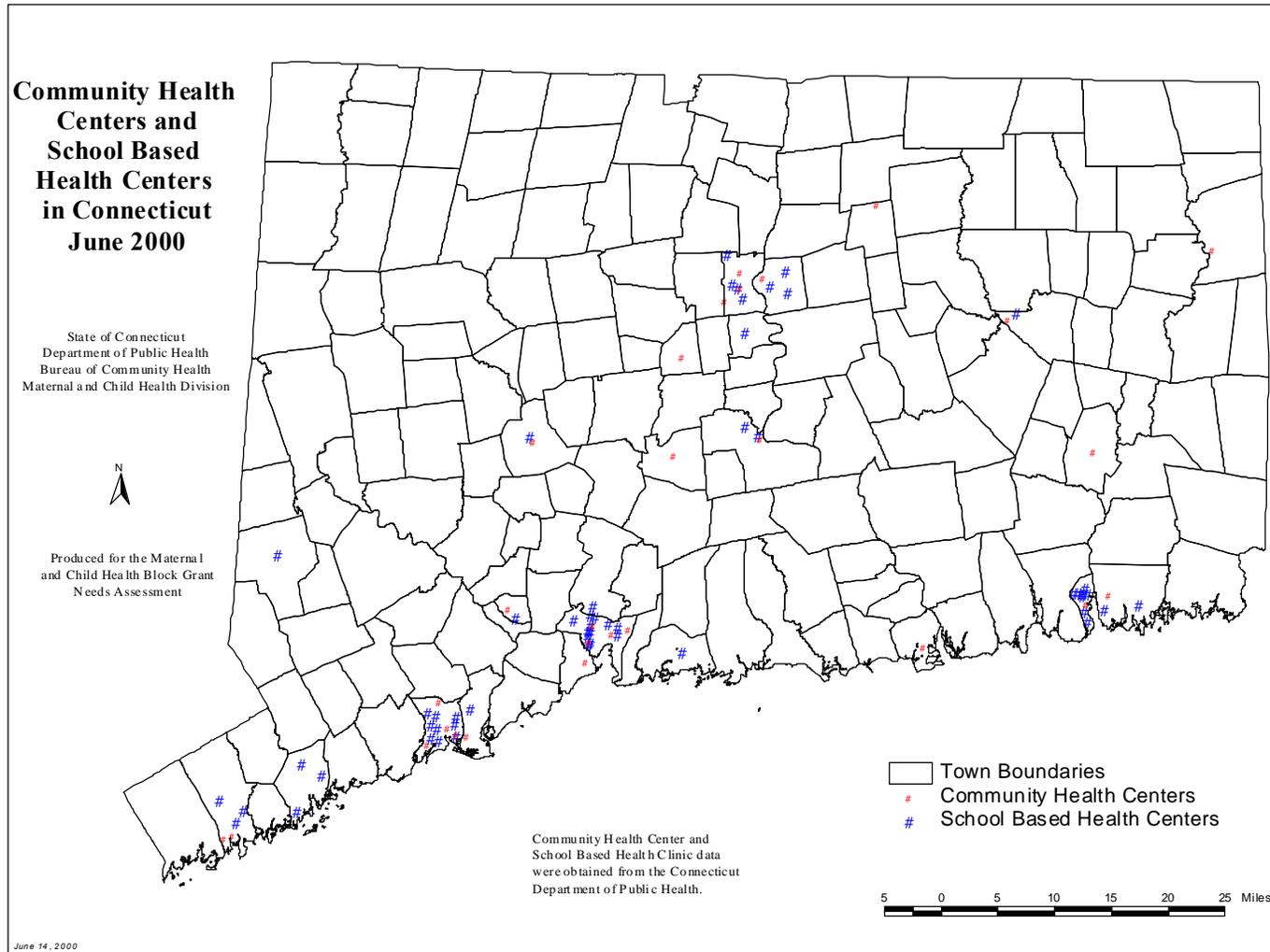
Map 7 Non-Adequate Prenatal Care in Connecticut, 1994 - 1996



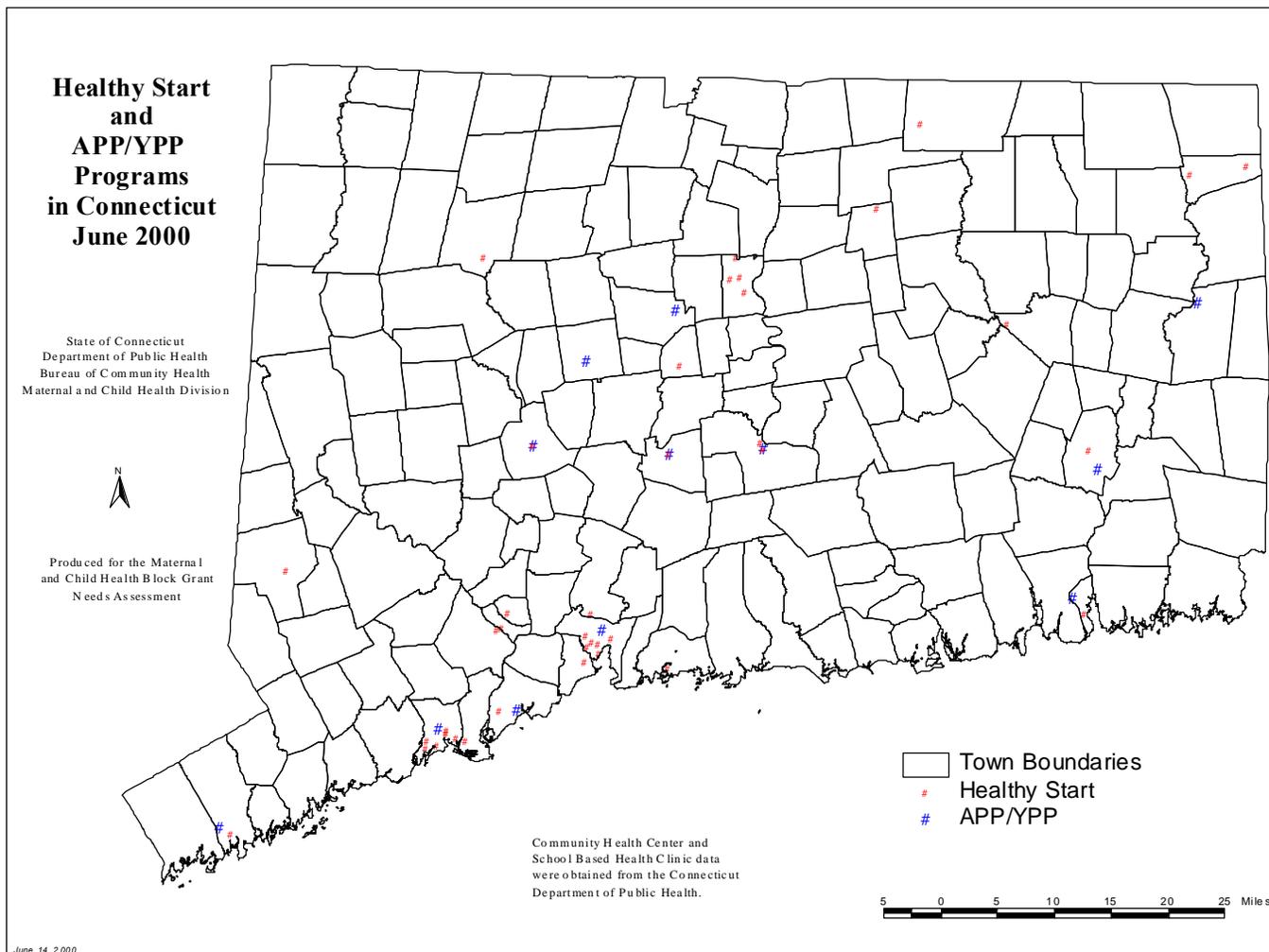
Map 8 Low Birthweight in Connecticut, 1994 - 1996



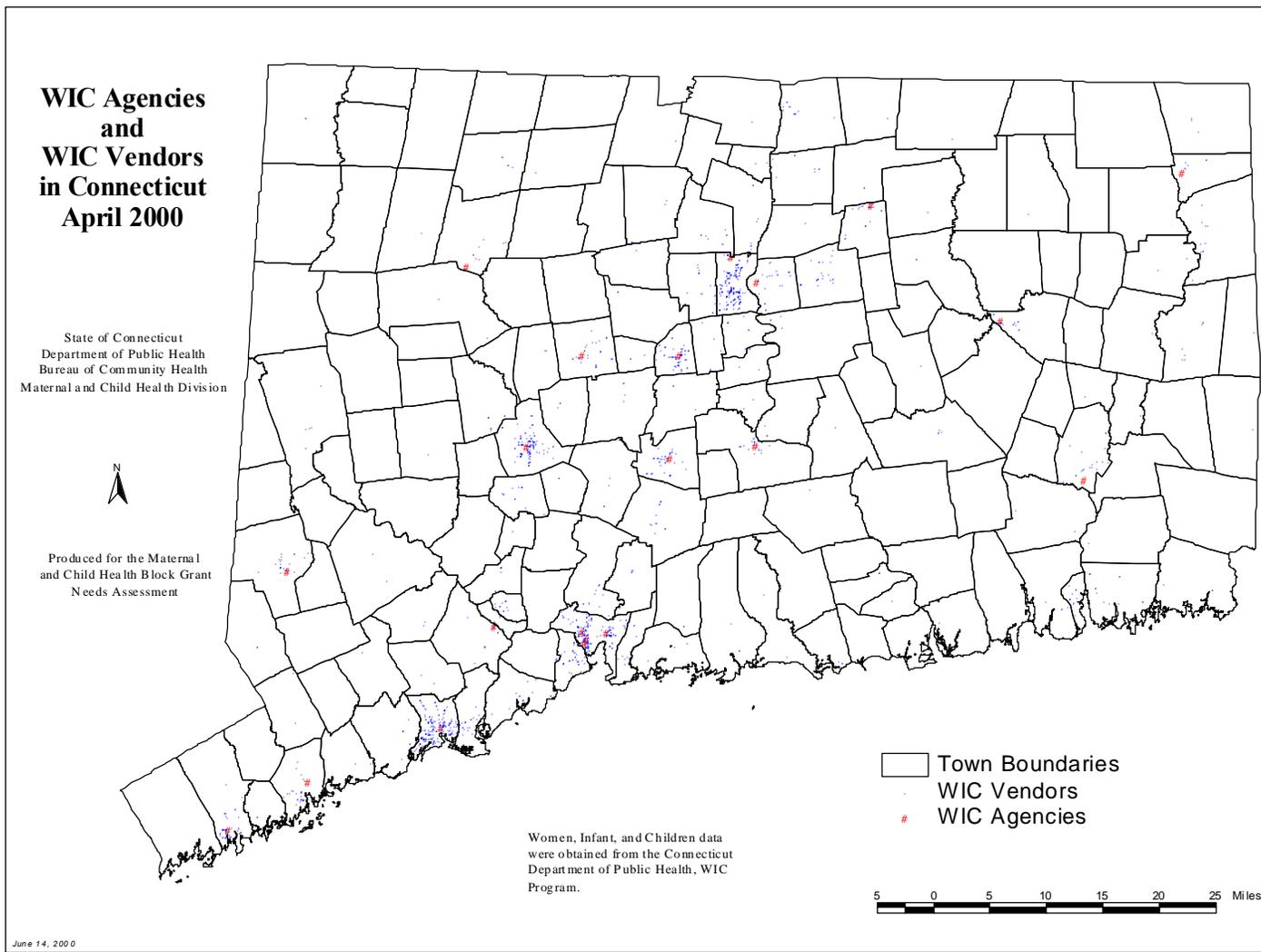
CTMap 1 Community Health Centers and School Based Health Centers in Connecticut, June 2000



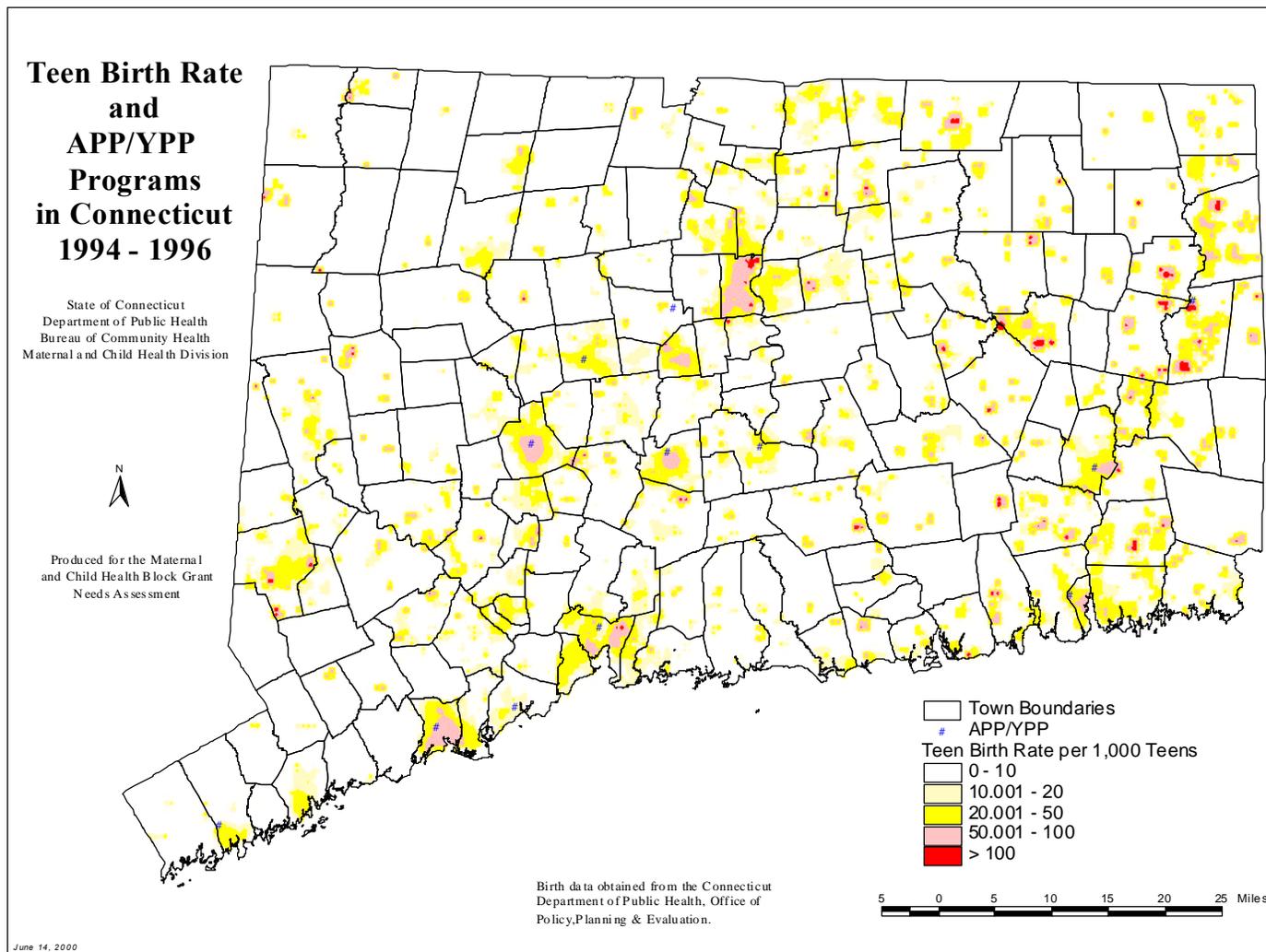
Map 2 Healthy Start and APP/YPP Programs in Connecticut, June 2000



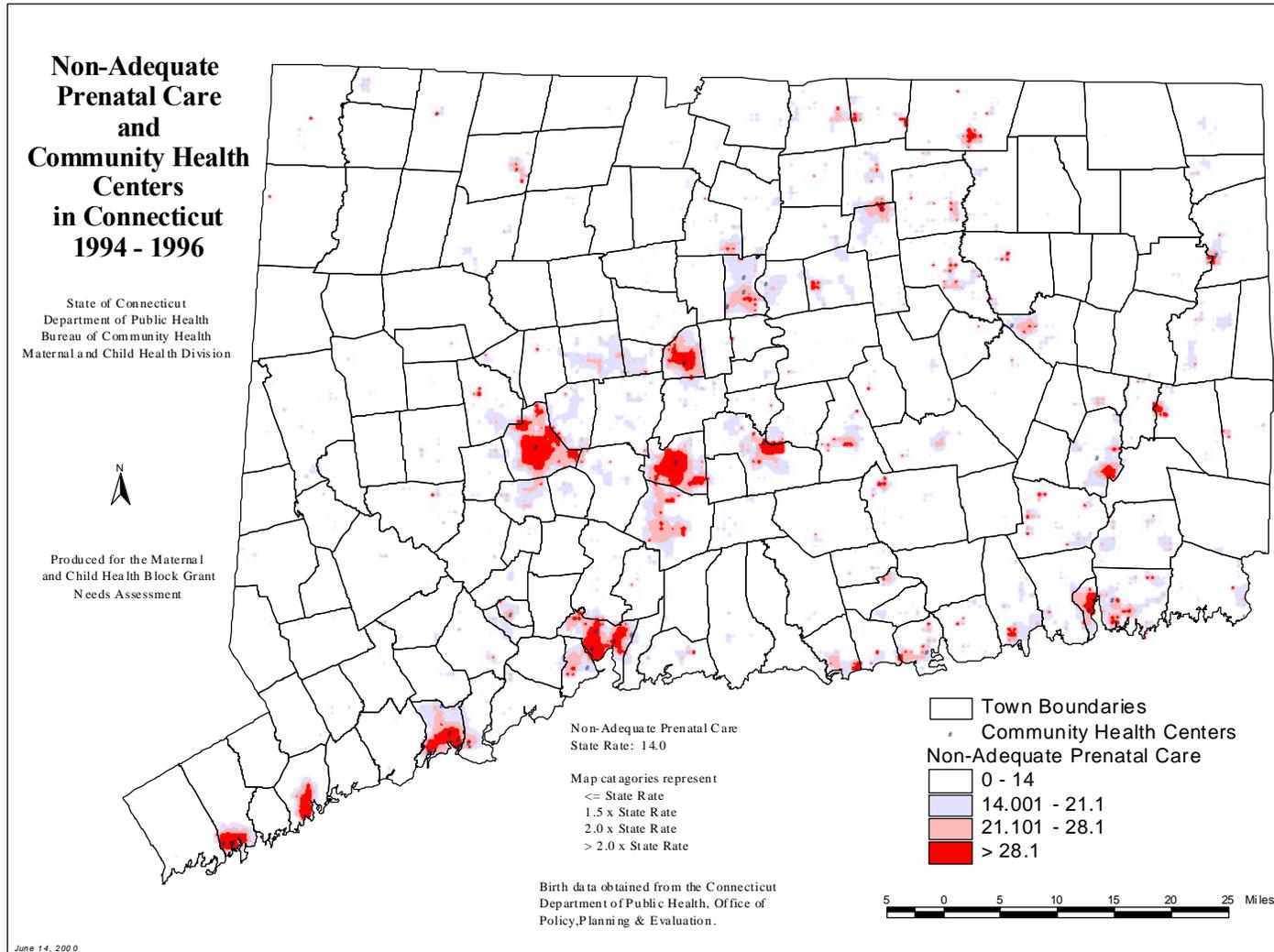
Map 3 WIC Agencies and WIC Vendors in Connecticut, April 2000



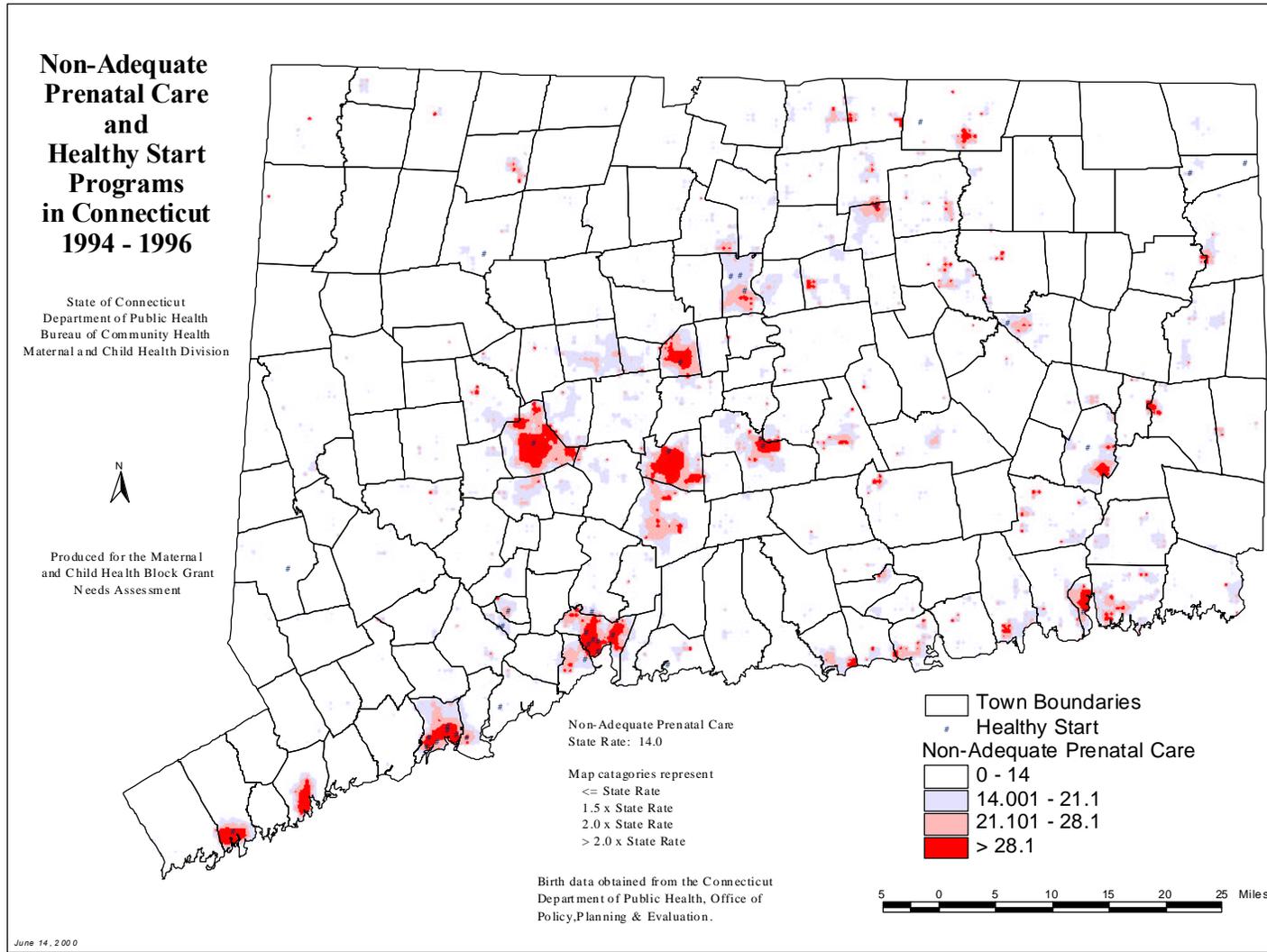
Map 4 Teen Birth Rate and APP/YPP Programs in Connecticut 1994 - 1996



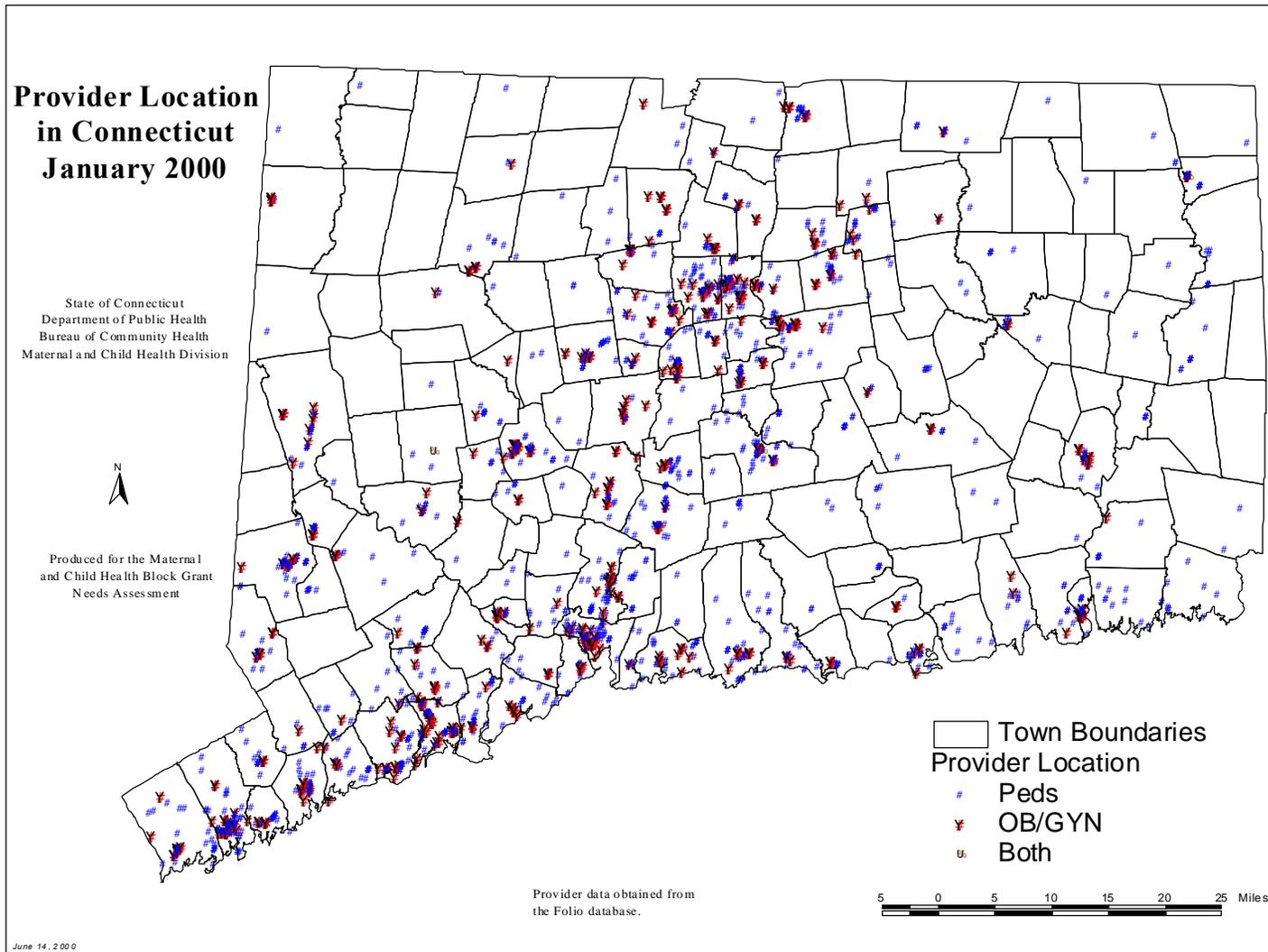
Map 5 Non-Adequate Prenatal Care and Community Health Centers in Connecticut 1994 - 1996



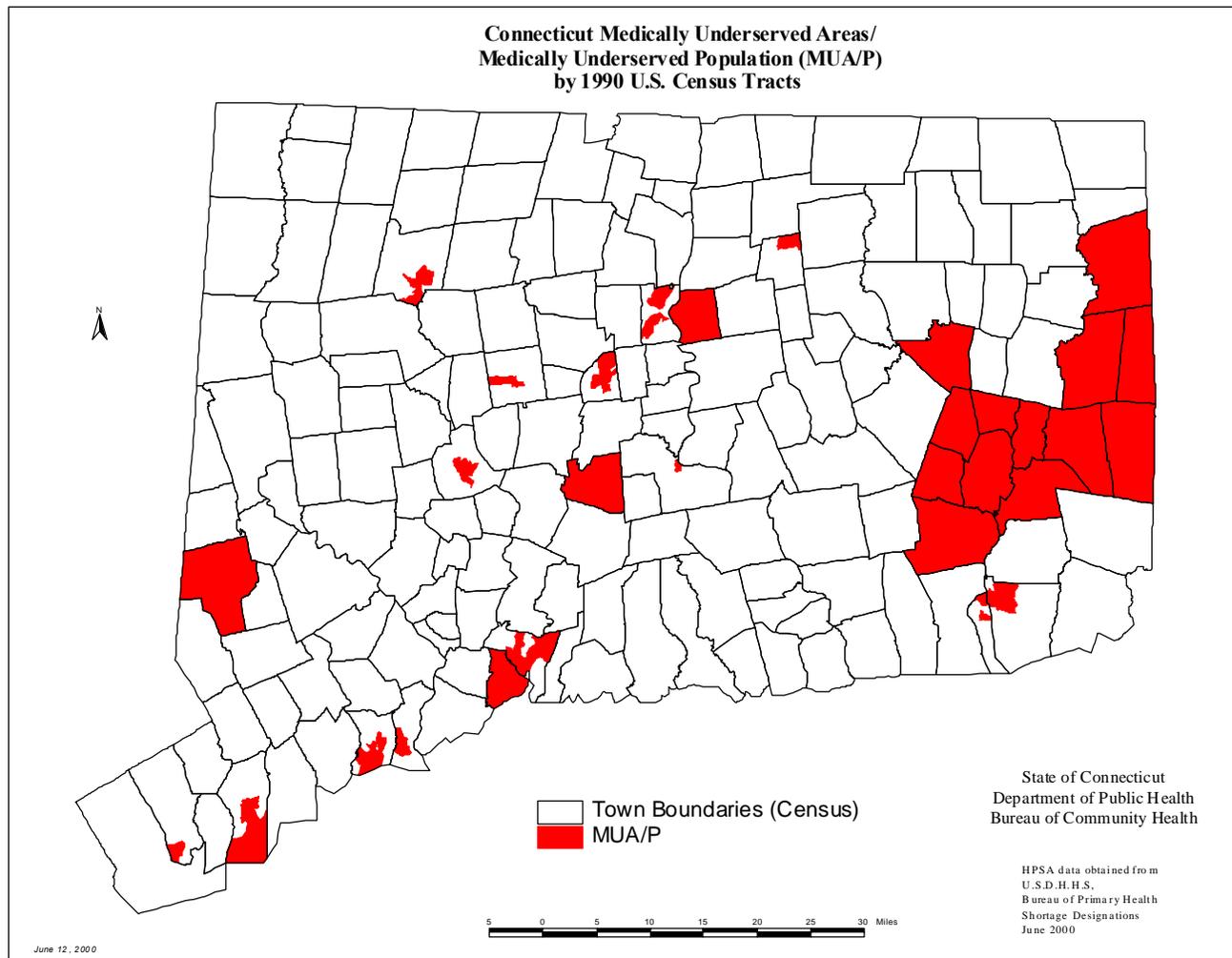
Map 6 Non-Adequate Prenatal Care and Healthy Start Programs in Connecticut 1994 - 1996



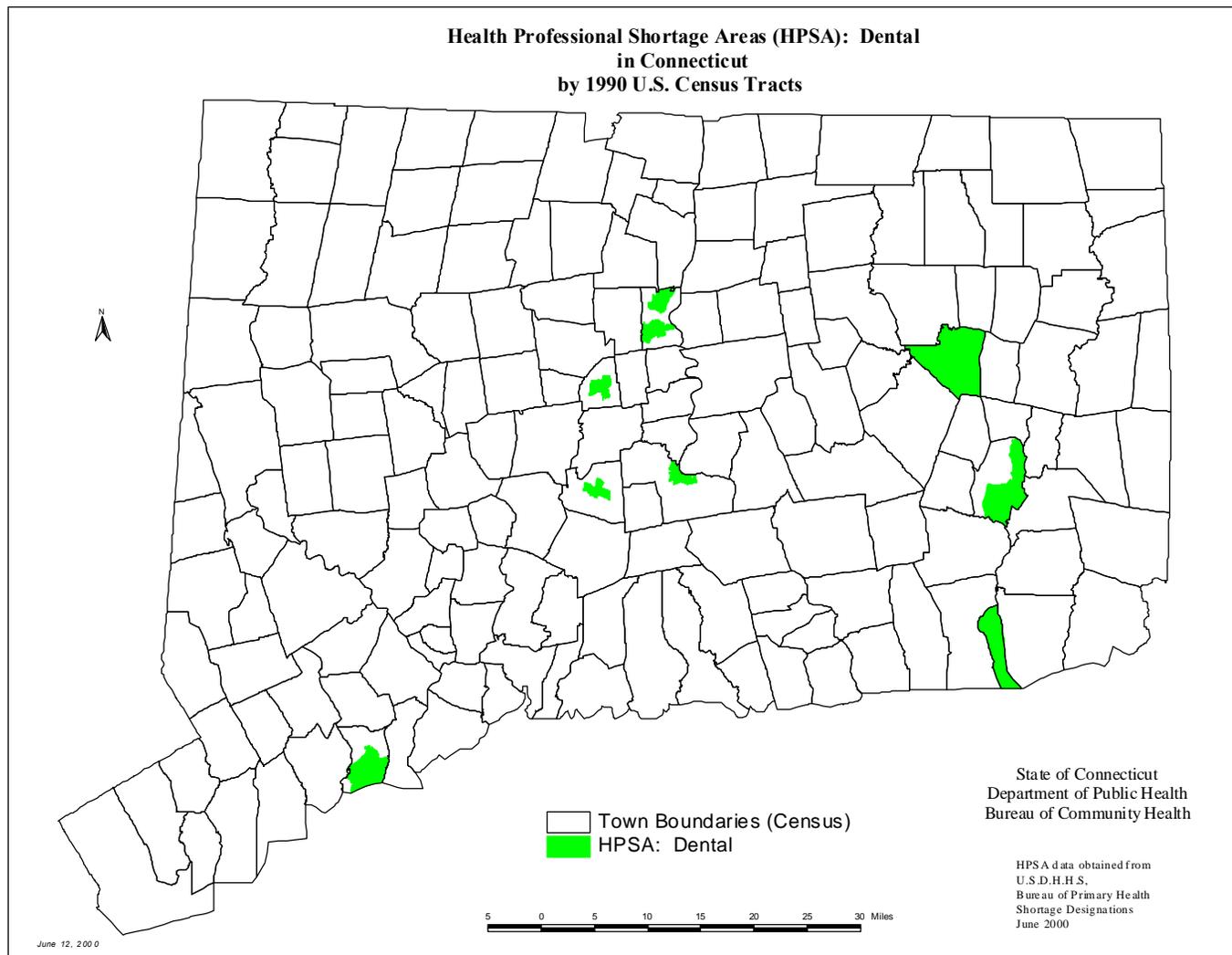
Map 7 Provider Location in Connecticut, January 2000



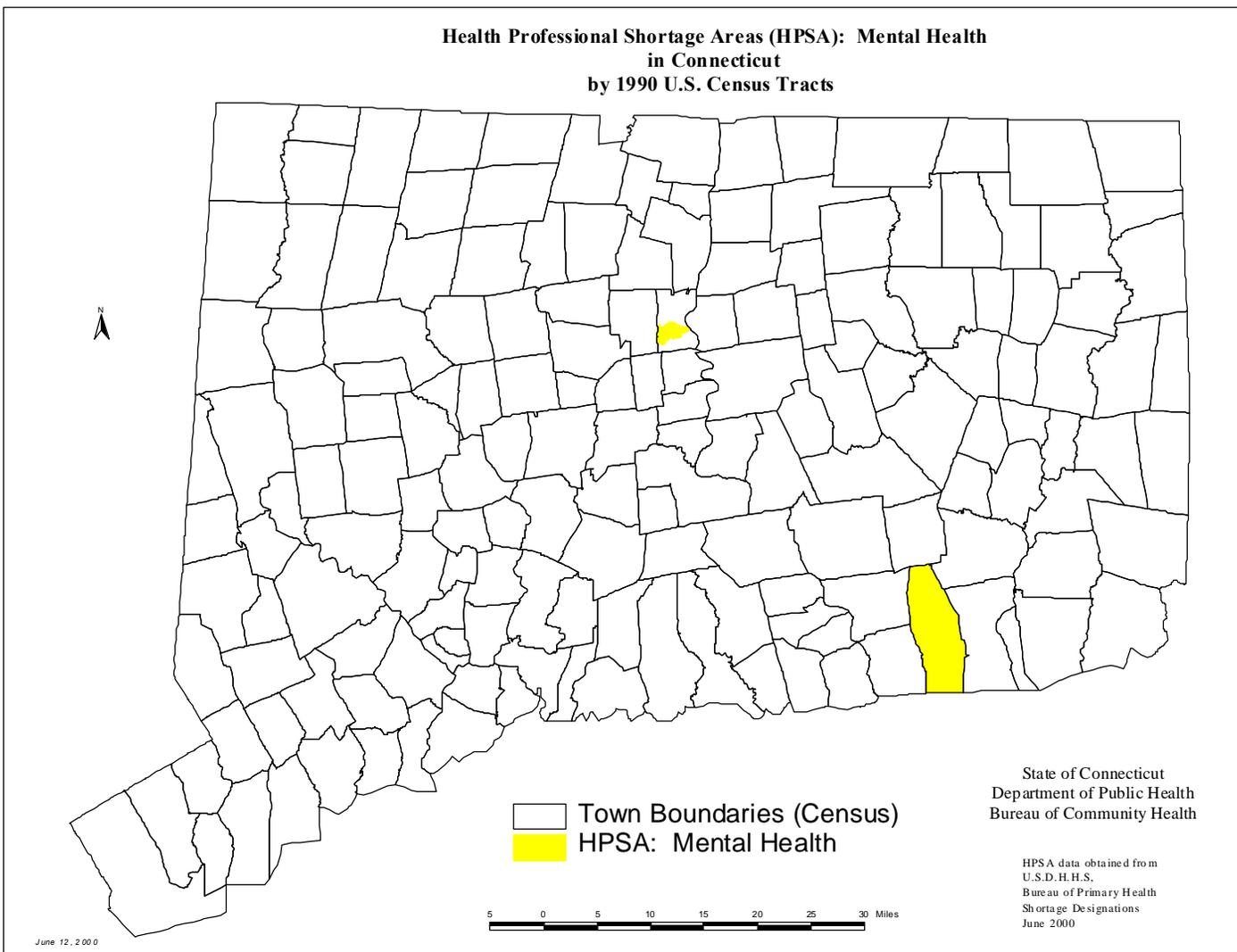
Map 16 Connecticut Medically Underserved Areas/Medically Underserved Population (MUA/P) by 1990 U.S. Census Tracts



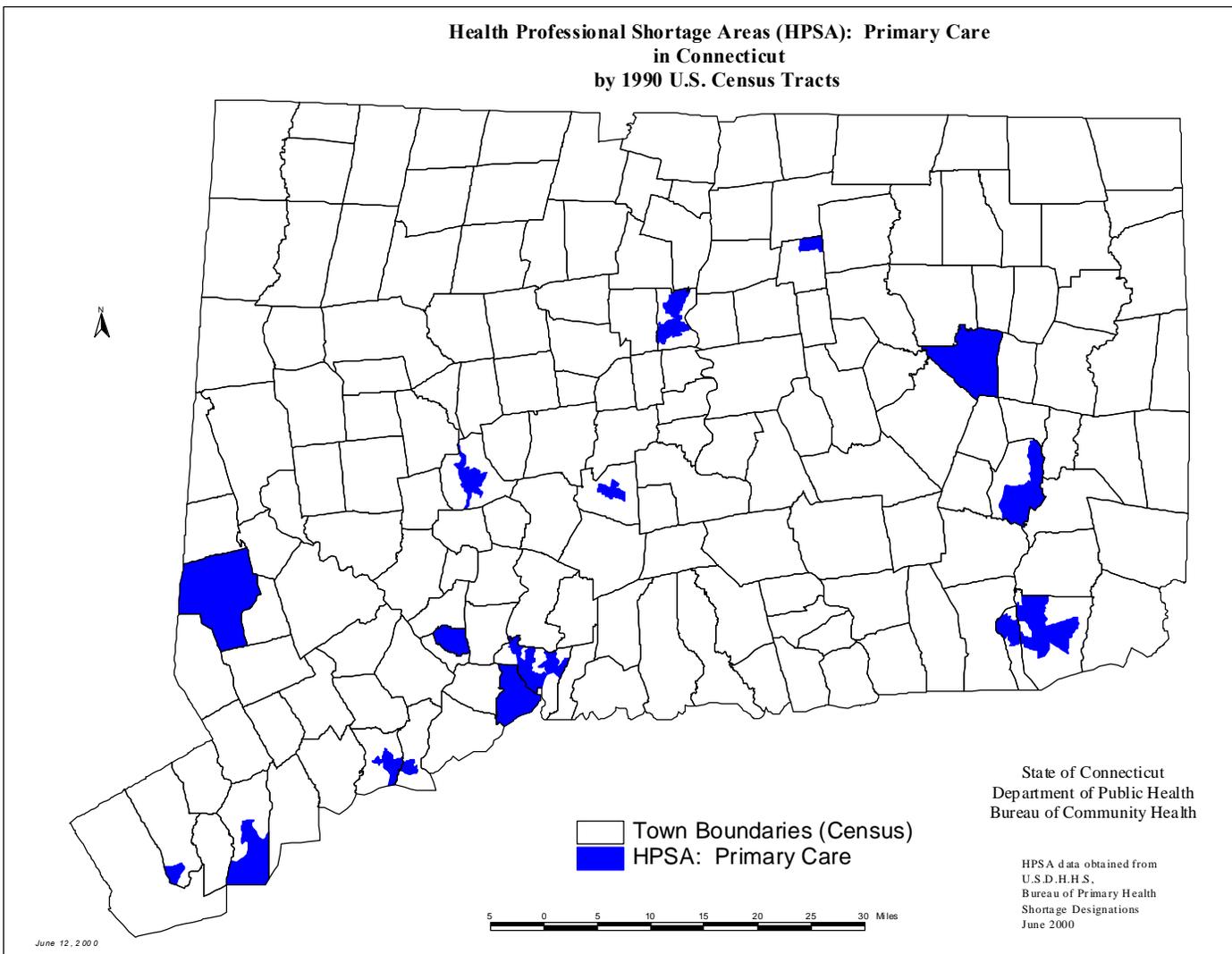
Map 17 Health Professional Shortage Areas (HPSA): Dental in Connecticut by 1990 U.S. Census Tracts



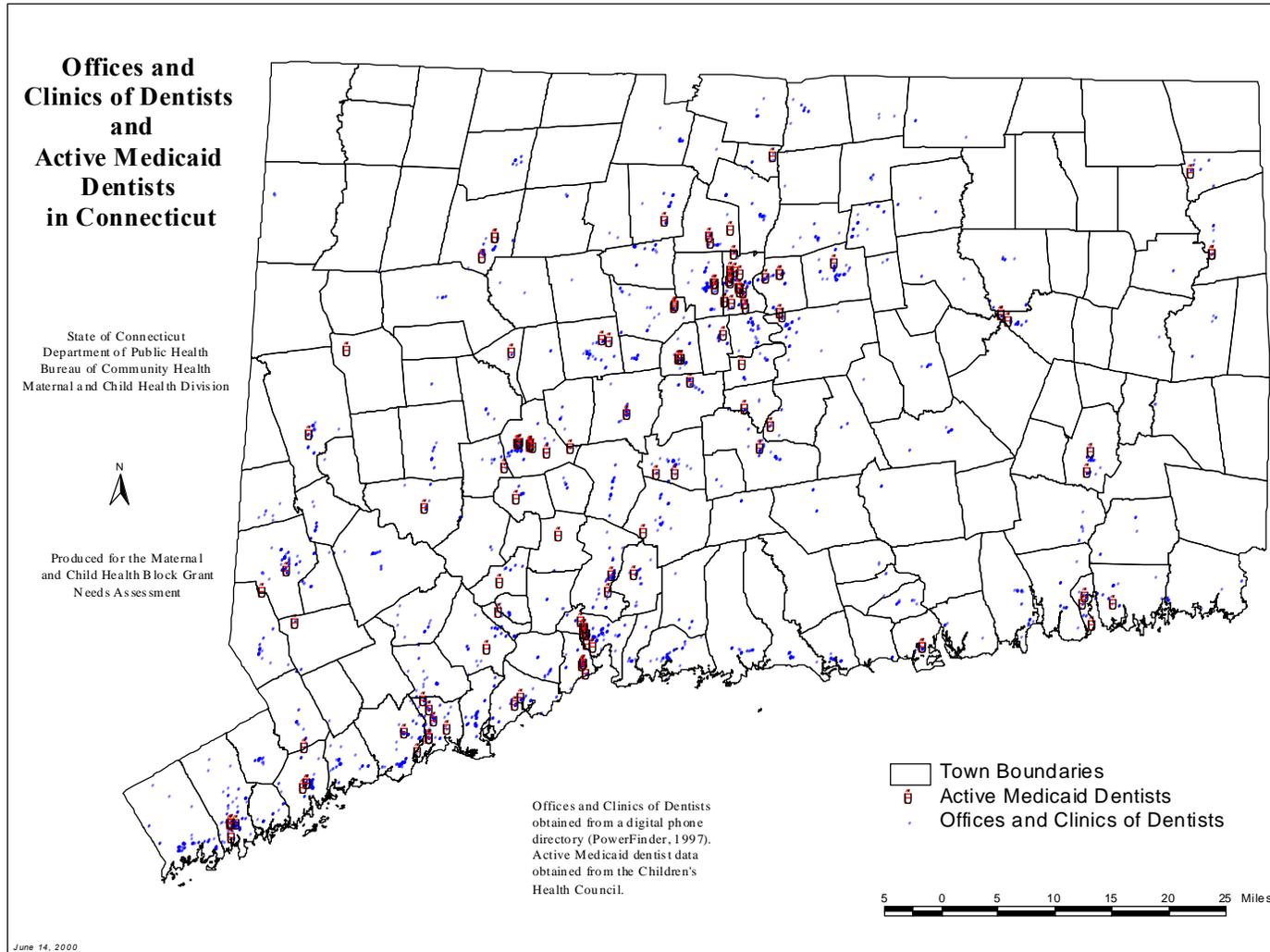
Map 18 Health Professional Shortage Areas (HPSA): Mental Health in Connecticut by 1990 U.S. Census Tracts



Map 19 Health Professional Shortage Areas (HPSA): Primary Care in Connecticut by 1990 U.S. Census Tracts



Map 20 Offices and Clinics of Dentists and Active Medicaid Dentists in Connecticut



3.3 Annual Budget and Budget Justification

3.3.1 Completion of Budget Forms

See Forms 2, 3, 4, and 5 for FY 2001.

3.3.2 Other Requirements

A total budget of \$5,250,436 has been prepared for FFY 2001 based on level funding of \$4,874,049 and using \$376,387 in carryover. Budgeted expenditures were reviewed to insure that CSHCN and Preventive and Primary Care requirements for children will be met. A primary reason for the budget reduction in this proposal is that \$135,000 is budgeted for special projects for Children with Special Health Care Needs in FFY 2000.

There is a total projected carryover of \$853,235 available. The remaining \$476,848 will be needed for cost increases/projects in future years. This carryover is fairly consistent with last year's budget before the implementation of special projects. Because DPH has initiated a dialogue with the two largest providers of CSHCN services to permit them to use funds to their best advantage, estimate carryovers should be reduced in the future.

The requirement that there be three dollars of State matching funds for every four dollars in Federal funding spent is met for FFY 2000 projections with \$4,087,761 in State match and an additional \$5,240,179 in overmatch budgeted. Administrative costs are budgeted for \$353,214 (7.25% of the projected Federal allocation).

3.4 Performance Measure

3.4.1 National "Core" Five Year Performance Measures

3.4.1.1 Five Year Performance Objectives

See Form 11, Supporting Documents Section 5.8 and National Core Performance Measure Detail Sheets, Supporting Documents Section 5.9

Table 35 Performance Measures Summary Sheet

Core Performance Measure	Level of the Pyramid				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1. 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.	X				X		
2. The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3. The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home."		X			X		
4. Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases) (combined).			X				X
5. Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6. The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7. Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8. The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9. Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10. Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11. Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care.				X	X		
12. Percent of children without health insurance.				X	X		
13. Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				X		X	
14. The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.				X		X	
15. Percent of very low birth weight live births.				X			X
16. The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
17. Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				X			X
18. Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				X			X

State Added Performance Measures							
SP# 01. The percentage of CSHCN clients enrolled in the state CSHCN program that have a written care service plan.	X						X
SP# 02. The degree to which Title V families have access to mental health screening, referral, assessment, and linkages SP#01.		X					X
SP# 03. The death rate for children aged 1-19 caused by unintentional and intentional injury (Pediatric Mortality Due to Injury).			X				X
SP# 04. The degree to which Title V programs target services to racial and/or ethnic groups with disparities in pregnancy outcomes.			X				X
SP# 05. The degree to which the Department of Public Health has developed and implemented a statewide genetics plan.				X			X
SP# 06 The degree to which the Connecticut State Department of Public Health has the infrastructure in place to collect and report accurate information on pregnancy related mortality.				X	X		
SP# 07 The degree to which the State of Connecticut, Department of Public Health improves education, diagnosis, and case management for asthma.				X		X	
SP# 08 Percent of community-based public health care facilities that provide comprehensive dental services for needy or vulnerable children and their families.				X	X		
SP# 09 The degree to which the Connecticut State Department of Public Health has the infrastructure in place to collect and report information on all children with special health care needs in the state.				X	X		

NOTE: DHC=Direct Health Care ES=Enabling Services PBS=Population Based Services IB=Infrastructure Building C = Capacity P = Process RF = Risk Factor

3.4.2 State “Negotiated” Five Year Performance Measures

3.4.2.1 Development of State Performance Measures

See State Performance Measure Detail Sheet, Supporting Documents Section 5.10

3.4.2.2 Discussion of State Performance Measures

The following is a listing of the State Performance Measures, why each was chosen, how each one relates to the priority needs, and its relationship to the outcome measures.

State Performance Measure SP #01

The percentage of CSHCN clients enrolled in the State CSHCN program that have a written health care service plan.

SP #01, placed in the Direct Services level of the pyramid, measures the percentage of children with special health care needs clients enrolled in the State CSHCN program that have a written care service plan. Coordination of care is important for all persons, but especially for children with special health care needs. Children with chronic and disabling conditions receive services by a multitude of sub specialty providers. A written health care plan helps to

maximize the delivery of health care services by coordinating and assuring the provision of necessary and quality health care services. This performance measure has no direct link to the outcome measures, however, the written care service plan may have an impact on Outcome Measures #01 and #06 by reducing infant and child mortality.

State Performance Measure SP #02

The degree to which the Connecticut State Department of Public Health improves mental health screening, assessment, referral and linkages to services and supports in Title V funded programs.

SP #02, which is placed in the Enabling Services level of the pyramid, was added to assess and improve access to mental health screening, assessment, referrals and linkages in Title V funded programs. Mental health is an important health concern in Connecticut and the nation. Earlier this year, the report "Mental Health: A Report of the Surgeon General," was released and provided major conclusions about children's mental health. Nationally, approximately one in five children experience the signs and symptoms of a disorder during the course of a year, and five percent experience "extreme function impairment". In Connecticut, mental health issues are an important reason for hospitalizations and for visits to School Based Health Centers.

Although DPH is not the primary agency responsible for mental health issues, as the lead MCH agency it is important for DPH to improve access to mental health services and supports. Some Title V funded programs, such as School Based Health Centers, already screen and assess clients' mental health needs. They provide direct services and /or refer clients to community resources, following up to assure that clients become linked to those services whenever possible. Other programs may need to review and/or develop policies and procedures for incorporating mental health screenings into their practice, and for assuring that assessment and provision of supports and services occur as appropriate. This performance measure has no direct link to the outcome measures, however, appropriate mental health services may have an impact on Outcome Measure # 06 by reducing child mortality.

State Performance Measure SP #03

Pediatric Mortality due to injury

State Performance Measure #03, placed in the Population Based Services level of the pyramid, addresses the need to reduce the death rate for children aged 1-19 caused by unintentional and intentional injury. Injuries account for three out of four deaths to children age 1-19 (186 of 250 deaths in Connecticut in 1995). This measure hopefully will reflect the impact of injury prevention activities aimed at the pediatric population and will effect Outcome Measure # 06 by reducing child mortality.

State Performance Measure SP #04

The degree to which Title V programs target services to racial and /or ethnic groups with disparities in pregnancy outcomes.

State Performance Measure #04, placed in the Population based Services level of the pyramid, measures the degree to which Title V programs target services to racial and/or ethnic groups with disparities in pregnancy outcomes. Many disparities exist between the health of the white population and that of the African American and

Hispanic populations within Connecticut and the United States. The DPH recently completed a comprehensive report detailing health disparities within Connecticut. It is striking how consistently these disparities exist across so many health indicators. Whether it involves infant health, lead poisoning, sexually transmitted disease, or violence, a greater proportion of adverse health outcomes are borne by our African American/Black and Hispanic populations. Many health disparities are outlined in section 3.1.2.1 Overview of the Maternal and Child Health Population's Health Status beginning on page 73. Title V programs will focus on increasing outreach and other activities to ensure service to populations at highest risk for poor outcomes.

This performance measure may have an impact on Outcome Measures #02 by reducing the ratio of the black infant mortality rate to the white infant mortality rate.

State Performance Measure SP #05

The degree to which the Connecticut Department of Public Health has developed and implemented a Statewide Genetics Plan

SP #05, although referencing Population Based Services, is placed in the Infrastructure building Services level of the pyramid, as it refers to the development of an infrastructure within DPH to develop and implement a Statewide Genetics Plan. Prompt identification of infants at risk for metabolic or genetic diseases enables medical treatment to avert complications and prevents irreversible problems. Identified needs related to genetics services are presented in section 3.1.2.4 Population Based Services located on page 103. Some of the needs include ongoing education and training for health professionals as well as transition services to assist adolescents in establishing a relationship with adult primary and specialty care services. Also, outreach programs are needed to assist young women of childbearing age with PKU back into genetic specialty services.

This performance measure has no direct link to the outcome measures, however, improved genetics services may have an impact on Outcome Measures #01, #03, and #05 by reducing infant, neonatal, and perinatal mortality.

State Performance Measure SP #06

The degree to which the Connecticut Department of Public Health has the infrastructure in place to collect and report accurate information on pregnancy related mortality

SP #06, also placed in the Infrastructure Building level of the pyramid, evaluates the degree to which DPH has the infrastructure in place to collect and report accurate information on pregnancy related mortality. Connecticut failed to reach the 1990 national goal of < 5 maternal deaths per 100,000 births and the maternal mortality ratio is consistently greater for nonwhite than white women. This performance measure has no direct link to the Outcome Measures.

State Performance Measure SP #07

The degree to which the Connecticut Department of Public Health improves education, diagnosis and case management for asthma

Asthma is the most common chronic illness of children. The number of people with asthma has more than doubled in the last 18 years and more significant increases have been seen in poor, inner city residents. Controlling asthma requires a comprehensive approach, including consistent and appropriate medical treatment, patient compliance with drug regimens; comprehensive patient and family education, and; reduction of risk factors that exacerbate asthma. Access to primary care, culturally sensitive asthma education, and access to resources necessary to reduce environmental asthma triggers are all factors that may contribute to the number of emergency room visits and hospitalizations by inner city minority children. State Performance Measure SP #07 will evaluate DPH efforts to improve education, diagnosis, and case management for asthma. This performance measure has no direct link to the outcome measures, however, improvement in asthma management may have an impact on Outcome Measures #06 by reducing child mortality.

State Performance Measure SP #08

Percent of community-based public health care facilities that provide comprehensive dental services for needy or vulnerable children and their families.

State Performance Measure #08, which is placed in the Infrastructure Building level of the pyramid, evaluates the percent of community-based public health care facilities that provide comprehensive dental services for needy or vulnerable children and their families. Studies reveal that the dental provider network in Connecticut is inadequate to meet the oral health care needs of economically disadvantaged children and their families. Community-based public health care facilities have historically proven to be effective “safety net” providers in meeting the medical and dental needs of these vulnerable populations. This performance measure will evaluate the percent of community health centers, school-based health centers, and hospital clinics that provide dental services. This performance measure has no direct link to the Outcome Measures, but will improve child morbidity.

State Performance Measure SP #09

The degree to which the Connecticut State Department of Public Health has the infrastructure in place to collect and report information on all children with special health care needs in the State.

State Performance Measure SP #09, placed in the Infrastructure Building Services level of the pyramid, measures the degree to which DPH has the infrastructure in place to collect and report information on all children with special health care needs in the State. An important issue facing those trying to serve the population of children with special health care needs is to identify and count the children. Depending on the definition used, and the level of severity of a condition, the estimates of the number of CHSCN will vary. In an effort to improve planning of children with special health care needs services and to get an accurate count of the number of children with special health care needs in the state, the Department has made the registry a top priority for 2001. This performance measure has no direct link to the Outcome Measures.

Former State Performance Measures

Several State Performance Measures that were in last year's application were not included in the application for this year. They are listed below with the rationale for being not included in this application:

Former SP #19 – Tobacco use During Pregnancy.

Although tobacco use is an important risk factor for adverse pregnancy outcome and poor maternal health this measure was not included in the application because the data available from the birth certificate is not considered complete.

Former SP #20 - Number of children/adolescents needing care for cognitive, emotional and child/adolescent/parent functioning who are assessed and receive appropriate counseling.

This Performance Measure was replaced with State Performance Measure SP #02 - The degree to which the Connecticut State Department of Public Health improves mental health screening, assessment, referral and linkages to services and supports in Title V funded programs. The new performance measure was made more inclusive in its approach to mental health.

Former SP #21 – Prevalence of children with blood lead levels equal or greater to 10 micrograms per deciliter.

While lead poisoning continues to be an important public health problem among children, the measure was dropped from this year's list of performance measures, as we had successfully met our objectives.

Former SP # 23 – Percent of Medicaid enrolled children and adolescents who received an EPSDT service during the past year.

DPH activities through Title V programs work to enhance access to care and receipt of services through Medicaid. It was felt, however, that this was more a measure of the activities that are the primary responsibility of the Connecticut Department of Social Services rather than those of DPH.

3.4.2.3 Five Year Performance Objectives

See Form 11, Supporting Documents Section 5.8

3.4.2.4 Review of State Performance Measures

3.4.3 Outcome Measures

See Form 12 and Outcome Measure Detail Sheet, Supporting Documents Section 5.11

IV. REQUIREMENTS FOR THE ANNUAL PLAN

4.1 Program Activities Related to Performance Measures

1. 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.

Population Served: CSHCN

Level of the Pyramid: Enabling

Planned Activities within Title V: In July 2000, the State CSHCN Program anticipates initiation of a 6 month pilot project to send all SSI referrals for children up to 18 years of age received from Disability Determination Services (DDS) to one of the two CSHCN Centers for evaluation of eligibility into the Program. In the past, we triaged SSI referrals and sent the Centers only those clients deemed eligible based on age and diagnostic criteria supplied by DDS. The Regional Programs, located at the Connecticut Children's Medical Center (CCMC) in Hartford or the Yale-New Haven Children's Hospital, will evaluate each client for eligibility into the Program where direct rehabilitative services are provided. Client referrals will be based on geographic location. This effort is expected to expand the number of children referred and deemed eligible for the CSHCN Program and/or care coordination.

We will continue to track the number of SSI referrals received from DDS in our SSI database. However, the percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the CSHCN Program will be based on electronic data supplied by the Centers as well as data published in a federal report by the SSA, Office of Research, Evaluation, and Statistics. We will continue to provide technical assistance to the Centers to increase accuracy of reportable data.

In addition, DPH plans to continue biannual collaborations with DDS representatives in order to discuss relevant issues regarding SSI beneficiaries and the CSHCN Program, such as exploration of ways to increase public awareness to SSI applicants of the CSHCN Program.

The universal newborn screening and genetics services will continue to identify potential diseases, that if not identified early in life, may result in a child with special health care needs who may be an SSI beneficiary who requires rehabilitative services at one of the two Regional Centers.

2. The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.

Population Served: CSHCN

Level of the Pyramid: Enabling

Planned Activities within Title V: **Planned Activities within Title V:** The CSHCN Program, through its contracts with the CSHCN Centers located at the Yale Center for Children with Special Health Care Needs and the Connecticut Children's Medical Center will continue to pay for specialty and subspecialty services including care coordination.

The HUSKY programs (Connecticut's CHIP) will continue to serve the uninsured population and Title V will continue to focus on the underinsured. Care coordination will continue to be available to any child with a special health care need regardless of insurance and enrollment status. The CSHCN program provides all the specialty services identified on the performance measure checklist, except for early intervention services thus scoring 8 out of 9 total points. The program actively collaborates with the Department of Mental Retardation, (DMR) which houses the Birth to Three Program (B-3). It is anticipated that the CSHCN Director will be appointed to the Interagency Coordinating Council (ICC) and staff will continue to represent the agency on various Birth-to-Three subcommittees. Also, a representative from DMR will continue to participate on the Steering and Advisory Committee for Children

with Special Health Care Needs and Husky Plus Physical (SASH). It is anticipated that this level of collaboration will continue and we will continue to score 8 out of 9 total points with no increase anticipated.

Other interventions/ influences: In addition, the program actively collaborates with the Department of Social Services (SCHIP program) and other state agencies such as the Department of Education (SDE), the Department of Insurance (DOI), the Department of Children and Families (DCF), Department of Mental Retardation and the Office of Child Advocate (OCA) in coordinating and administering services to the special needs children and their families. With the development and implementation of a CSHCN registry, the program will be able to identify children early and link families to early intervention services. DPH will be collaborating with the Department of Mental Retardation, Birth to Three System to develop a Memorandum of Agreement to address stronger collaborations for families enrolled in both the Title V CSHCN and Birth to Three programs. This will include a formalized transition for families from the Birth to Three system to the Children with Special health Care Needs program, and one comprehensive, multidisciplinary, global plan of care.

**3. The percent of Children with Special Health Care Needs (CSHCN) in the State who have :
“medical/health home.”**

Population Served: CSHCN

Level of the Pyramid: Enabling

Planned Activities within Title V: As a requirement of its contracts with the CSHCN Centers, the state will continue to assure that all enrolled children have a primary care provider (PCP) or medical home. The identification of the PCP/medical home is determined upon the initial evaluation/program enrollment, and is updated on an annual basis. In addition, specialty and subspecialty subcontractors are now required to report this information to the Centers on a quarterly basis. If the child does not have a primary provider/medical home, the care coordinator works with the family to identify and link the client to a primary care provider, pediatric specialist or sub-specialist. In 1999, 75% of enrolled clients were identified as having a medical home/PCP. It is anticipated that this number will continue to increase as the Centers continue to report this information on a quarterly basis. Centers will continue to be expected to assure that verification of a PCP is documented in the client record. We anticipate convening meetings with other programs that serve children with special needs (SBHCs, CHCs, lead etc.), to identify if the documentation of a medical home can be collected and reported for future years in addressing this measure.

The University of Connecticut Family Studies was awarded a MCHB Medical Home grant. Grant recipients will be presenting their medical home project at the September SASH meeting and efforts will be made to develop on-going collaboration between this project and the Title V CSHCN program.

****NOTE:** We anticipate that, in the future, with the completion of the federal SLAITS survey, our denominator will change and will more accurately reflect the prevalence of children with special needs in Connecticut as opposed to using the national prevalence of 18%.

Other interventions/ influences: The future development and implementation of a statewide CSHCN registry will enhance the identification of all children in the state with special needs including the identification of those children

without a medical home (PCP). Continued and enhanced interagency collaboration and education of agencies on the necessity of capturing this information will assist the DPH in providing more complete information next year. A survey will be developed and distributed to the members of SASH, to ascertain if this information can be collected (from other agencies which serve children with special needs) and reported to the DPH to enhance this measure.

4. Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases) (combined).

Population Served: CSHCN / Pregnant women, mothers and infants **Level of the Pyramid:** Population Based

Planned Activities within Title V: The Newborn Screening Program's Tracking Unit staff will continue to monitor compliance of all 30 hospitals/birthing facilities to assure that all CT newborns are screened for the eight disorders mandated by Legislation (PKU, congenital hypothyroidism, galactosemia, hemoglobinopathies, maple syrup urine disease, homocystinuria, congenital adrenal hyperplasia, and biotinidase deficiency). The program staff will continue to: develop quality improvement reviews, review and revise guidelines and protocols, provide education and technical assistance to healthcare providers to promote an optimal quality program.

The electronic Newborn Screening System will be implemented statewide. This electronic transmission of biographical and laboratory newborn Screening information on all CT newborns will expedite processing of laboratory results and provide informational reports for tracking and surveillance.

The Genetics/Newborn Screening Program Tracking Unit staff will continue to: collaborate with the GAC (Genetic Advisory Committee) physician specialists, attend Genetics and Public Health conferences to research and explore opportunities to expand the laboratory testing panels through TMS (Tandem Mass Spectrometry). The rapid growth in the field of genetics and the Human Genome Project will have a major impact on Public Health. The expansion of Genetic testing for adults including cardiovascular syndromes, connective tissue disorders, cerebrovascular hereditary coagulation disorders, elderly onset neurological disorders and cancer genetics are public health concerns which are impacted by genetic testing capabilities. The DPH will continue to explore and address the needs of the adult population to access medical genetics information and services to promote optimal levels of health and prevention.

5. Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.

Population Served: Pregnant women, mothers and infants; Children **Level of the Pyramid:** Population Based

Planned Activities within Title V: The APP/YPP programs, through intensive case management, link pregnant and parenting teens to essential services. One priority of this program is to assure that the infants of teen parents are registered for primary care and are current in their immunizations. The program will continue this assurance. The community based Healthy Start providers will continue to encourage and educate parents regarding the importance of

keeping well child care visits to assure compliance with the EPSDT periodicity schedule. HCWC will continue to monitor infants and children to age three for their immunization status and will assist parents to obtain the necessary services to maintain their children's immunization status. As part of enrollment procedures for the State CSHCN Program, children will be assessed for required immunizations and referred to appropriate resources, as has been the procedure in the past. Care coordination activities will be utilized to provide support for those families in need of assistance in accessing those services.

Four pediatric primary care projects will continue to be supported at Community Health Centers in four urban areas of high need, -Middletown, New Haven, Hartford and Waterbury. Emphasis will continue to be placed on serving children who are hard to reach, including the uninsured, underinsured, homeless children, and newly arrived and undocumented immigrants. As part of a program of comprehensive primary and preventive care, assuring age appropriate immunization status for all children served is a priority. Strategies which will continue to be used to achieve high immunization rates include outreach, autodialer systems, parent aides, case management and health education.

Other Interventions/Influences: Community Health Centers serve thousands of children and adolescents throughout the state each year. Assuring age appropriate immunization status is a priority for all of them. In addition to their basic package of services, they often operate Healthy Start Programs, serve as EPSDT providers and participate in various state and national immunization initiatives.

The DPH Immunization Program will continue its efforts as described in the Annual Report.

6. The birth rate (per 1,000) for teenagers aged 15 through 17 years.

Population Served: Pregnant women, mothers and infants; Children/Adolescents

Level of the Pyramid: Population Based/Enabling

Planned Activities within Title V: APP/YPP programs, primarily through case management and counseling interventions with pregnant teens, will continue to place heavy emphasis upon the prevention of second pregnancies among these teens through encouragement of school completion and contraception education. A program evaluation initiative, using client-specific data, will be implemented through a phase-in process. Follow-up information will include data on timing of subsequent pregnancies up to two years following initial birth.

HCWC and the Healthy Start providers through case management and health promotion education work with teens to prevent repeat pregnancies during the teen-age years.

The Department of Public Health (DPH) will continue to fund 10 Planned Parenthood of CT, Inc. and six sub-contractors to provide contraception, STD prevention, diagnosis, and treatment, comprehensive reproductive health care services, education, and counseling surrounding sexual decision making to prevent unintended

pregnancies in teens. Services will be provided to at least 6,000 adolescents. Adolescents in need of such services will be identified through SBHCs, APP/YPP programs, high schools, and community groups. Information will be reported to the DPH through quarterly reports. DPH will provide technical assistance to the grantee, and will provide quality assurance reviews through chart audits at all sites.

As part of the comprehensive model of service, all SBHCs will provide age appropriate reproductive health education to approximately 6,000 students. Students seen for mental health services or physical exams will be given a health risk appraisal. Students at high risk for sexual activity will be provided more targeted reproductive education and/or group interventions. All high school level SBHCs provide reproductive health services, including pregnancy tests. Students who test negative will be treated as high risk for future pregnancy. At least 3,500 students will receive these reproductive health services.

Other interventions/influences: Now heading into its fourth year, DPH's abstinence-only initiative plans to fund several new community-based abstinence-only education programs, targeting those Uniform Service Regions currently without programs. Data will be analyzed from the first year of operation of community-based programs. The CT Department of Social Services will continue to fund primary prevention programs that are focused on prevention of teen pregnancy. The Teen Pregnancy Prevention Council of CT will continue to serve as a state-wide data repository and education and advocacy group for teen pregnancy prevention issues.

Community Health Centers are often located in areas where the rate of births to teens is a significant problem. Behavioral risk assessments for sexual activity are completed for adolescents between the ages of 12 and 19 served by health centers. Treatment plans are developed and implemented for those determined to be at risk. Reproductive health care including contraceptives and STD diagnosis and treatment are offered. Many health centers operate parenting/parent aide programs, participate in Teen Pregnancy Prevention Programs, and collaborate with other local and statewide initiatives designed to reduce the number of births to teens. These activities will continue during FFY 2001. For expanded discussion see 3.2.1 Priority Needs section on page 111.

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

Population Served: Children (Third grade children in the State [44,276: DOE, 8/97]) **Level of the Pyramid:** Population Based

Planned Activities within Title V: There are presently sixteen (16) health clinics in schools with third grade children that offer dental services. In addition, there are three (3) local health departments, one (1) additional school and three (3) health agencies that provide sealants. Working with this agency base, the Department will conduct a needs assessment among the agencies to determine; 1) their specific practices regarding sealants; 2) barriers to providing sealants; 3) ways the Department can encourage the application of more sealants; and 4) resources they would like to see the Department provide.

With this information, the Department will develop a comprehensive plan for the establishment of a sealant promotion project. Such project will be planned in light of the above needs assessment and will also include a comprehensive public awareness effort aimed at caregivers and clinicians.

To measure the impact of the project, the Agency will encourage and support the development of a centralized, standardized data system to measure the presence of sealants and the general oral health status of children through; 1) the establishment of a statewide data system which includes oral health status; and 2) the development of a uniform oral health screening form and encouragement of its use.

In addition to the above activities, the agency will, in the future, make sealant application a high priority when awarding funds to local community and school based health agencies to enhance/increase dental services. The Agency will support the establishment and integration of school based dental services in Connecticut through; 1) offering funding opportunities with measurable objectives for the creation and expansion of clinical dental services in school settings; 2) supporting the work of clinical school based dental services by providing information, collaboration and networking opportunities for staff; 3) clinical chart reviews to help school based dental clinics assure appropriate standards of care; 4) and process reviews to help identify ways of enhancing and integrating services offered.

The Connecticut Oral Health Systems Development Project (CCOHP) is a federal Community Integrated Service Systems (CISS) grant program administered by the Agency. This program is designed to enhance oral health and oral health care access statewide through the activities of community-based oral health work groups. Each work group seeks to develop and integrate oral health promotion, disease prevention, and health care delivery systems within its own community. Among the objectives of the CISS-CCOHP are the conducting of community-based oral health needs assessments and, based on such assessments, the planning, implementation, and evaluation of oral disease prevention programs and interventions. There are presently ten (10) active CCOHP workgroups.

Other interventions/ influences: All Community Health Centers provide some preventive dental services. The availability of on site treatment services varies, with the larger centers offering a full complement on site and the smaller ones offering dental services through referral to private providers and/or other dental programs in their areas. On site services are available to all people regardless of their ability to pay. Insurance coverage is accepted and sliding fee scales are available. Often when referrals to private providers are necessary, services may be provided free or at reduced cost.

8. The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.

Population Served: Children/Adolescents

Level of the Pyramid: Population Based

Planned Activities within Title V: APP/YPP programs, through educational and case management interventions will work with teen parents to enhance parenting skills in young parents. Child safety is a priority issue and includes use of infant auto restraints as well as other safety behaviors.

Healthy Start, Comadrona and the HCWC programs will continue to provide anticipatory guidance and injury prevention information to clients regarding proper restraints for infants and children when riding in a motor vehicle. HCWC will continue to provide car seats to families in need.

DPH will fund 57 SBHCs in 16 communities and Expanded School Health Services (ESHS) projects in three additional communities. As part of the comprehensive model of service these grantees will provide injury prevention education activities at health fairs, at bicycle safety training programs, in the classroom and through other group activities. Several high school level SBHCs and ESHS projects will provide targeted safety education activities during the spring prom/graduation season to increase awareness of the dangers of drinking and driving. Quarterly reports generated by the grantees will provide information as to number of participants and levels of activities. Staff will coordinate with other DPH programs to facilitate obtaining resource materials, as well as provide training and technical assistance as needed.

Injury prevention is a priority area for the Pediatric Primary Care Projects. All children and/or their caregivers will receive age appropriate risk of injury assessments, anticipatory guidance and injury prevention information, in accordance with the American Academy of Pediatrics standards, as part of a comprehensive package of primary and preventive health care services. Appropriate use of infant/child safety seats, safety belts and bicycle helmets will be emphasized. Information provided will be reinforced on a regular basis through the use of support services, including home visitors, parent aides and health educators.

Other interventions/ influences: Child safety/injury prevention activities are conducted by Community Health Centers in various ways. Risk assessments, anticipatory guidance and health education materials are provided on an individual basis for children and/or their caregivers who are served by the health center. Information is also provided at health fairs, school education programs, and other community/neighborhood events.

(Depending on availability of funding) Child Passenger Safety: Child safety seats, when correctly installed, are extremely effective at protecting children in crashes. Safety seats reduce the risk of fatal injury by 71% for infants less than one year and 54% for children 1-4 years. However incorrect installation can significantly lower or negate their effectiveness. National surveys have found the majority of seats installed incorrectly and of the 3,500 seats checked during 1999 in CT, 96% were misused.

There is also a major need to increase awareness that children between 40-80 pounds (typically 4-8 years) should ride in booster seats. Safety belts are designed to protect adult occupants and do not provide adequate protection for young children. On a child the lap belt rides up over the stomach which can cause severe or fatal injuries in a crash. The shoulder belt may cut across the neck, leading the child or parent to put the belt under the arm or behind the back, both of which practices can also lead to serious injuries. When children outgrow their regular safety seat they should graduate to a booster seat which will position the lap/shoulder belt system properly. Nationally surveys have found that only 5% of 4-8 year old children ride in booster seats.

Health care providers, including health educators, home visitors ,and out reach workers have a very important role in providing child passenger safety education to families and care givers. However, agencies need to ensure that they are providing accurate education and materials to clients. The child passenger safety field has changed dramatically in recent years. Recommendations and educational materials as recent as 2 years old may be

inaccurate. Due to the large number of safety seat and car models, proper selection, installation and use of safety seats can be a difficult and complex process. Health care providers need to be aware of these issues if they are providing education and guidance to families.

The current national training standard is NHTSA's four day Standardized Child Passenger Safety Training Course which leads to national certification as a CPS technician. The course was designed for persons who interact directly with parents, caregivers and the public. The course was developed to ensure that CPS education and materials are accurate and consistent. To date, the majority of the trained and certified Child Passenger Safety Technicians in CT come from the Law enforcement community.

Two-day training programs are also being piloted in Connecticut for family educators to enable them to provide basic essential child passenger safety education.

Potential activities:

- Provide training for health care providers on child passenger safety including child safety seat use and installation. This training will enable them to incorporate accurate child passenger safety education into childbirth education classes, home visits, parent education programs, and regular preventative health visits.
- Provide funding to communities to make child safety seats and booster seats available free or at low cost to low income families through hospitals, community health centers, health departments and other community agencies. Agencies providing seats would also be required to educate families on correct use of seats.
- Work with Healthy Child Care CT, School Readiness Initiatives, Collaboration for CT Children and other related initiatives to provide access to child safety seats and incorporate training, education, and up to date resource materials on child passenger safety and other childhood injury prevention issues.

Pedestrian/Bicycle Safety: Pedestrian injuries are one of the leading causes of injury-related death and hospitalization for 5-14 years olds in CT. Bicycle related injuries are also a significant cause of injury related hospitalization.

Potential Activities:

- Community education and public awareness campaigns that:
 - encourage walking and bicycling as healthy forms of exercise.
 - educate pedestrians of all ages and drivers on pedestrian safety measures.
 - educate bicyclists on safe bicycling and correct use of helmets.
- Educate parents on the importance of supervision for children, especially under the age of 10, around traffic. Even if children receive pedestrian and bicycle safety education, they are typically not ready to understand and deal with traffic.
- Pedestrian safety curriculums that teach pedestrian skills to children. Research indicates that the crucial component these programs is actual real world practice of skills.
- Bicycle safety programs that teach safety skills and "rules of the road".
- Distribute free or low cost bicycle helmets to low income families accompanied by education on correct fit of helmets and bicycle safety education.

- Assist communities in conducting surveys to assess the “walkability” of their community, and identify barriers and hazards to pedestrians.
- Encourage community collaboration to develop sidewalks, walking and biking paths and other safe environments for recreation and exercise.

9. Percentage of mothers who breastfeed their infants at hospital discharge.

Population Served: Pregnant women, mothers, and infants **Level of the Pyramid:** Population Based

Planned Activities within Title V: APP/YPP programs will encourage and teach breastfeeding methods to teen mothers who are motivated to breastfeed.

Comadrona programs will be provided health education regarding the health benefits of breastfeeding infants after delivery as part of the prenatal services.

Other interventions/ influences: The WIC Program will continue to promote breastfeeding to all pregnant participants, unless medically contraindicated. The breastfeeding initiation rate among infants enrolled in the Connecticut WIC Program is 43.3 %. While this figure is still well below the Healthy Connecticut 2000 and Healthy People 2010 target of 75%, it is up from 30% in 1991. The WIC Program has been represented on the Breastfeeding Committee of the Connecticut Chapter of the American Academy of Pediatrics since 1998. In addition to its annual conference, the committee has designated a liaison to the Connecticut WIC Program to provide information and technical assistance. Continuing education on breastfeeding will be provided to local WIC Nutritionists during FY 2001, and additional resources will be sought to establish a training initiative, including breastfeeding education for all local WIC staff. The WIC Breastfeeding Committee will continue its development of breastfeeding promotion and support strategies.

10. Percentage of newborns who have been screened for hearing impairment before hospital discharge.

Population Served: Pregnant women, mothers and infants **Level of the Pyramid:** Population Based

Planned Activities within Title V: Legislation was passed in Connecticut for all birthing facilities to implement a Universal newborn Hearing Screening program, as a part of its standard of care, as of July 1, 2000. It is anticipated that those infants that refer from the initial hearing screen will be referred to a pediatric audiologist for diagnostic testing within one month of the initial screen. The Department of Public Health Universal Newborn Hearing Screening program staff will monitor the infants from the initial screen to ensure follow-up testing, and will track the numbers of infants referred and enrolled into early intervention services. The Maternal and Child Health Information and Referral Service (Infoline) will refer callers to appropriate referral sources, as needed.

The DPH will continue to work collaboratively with the CT Newborn Hearing Screening Task Force, the Commission on the Deaf and Hearing Impaired, and the Birth to Three System. These groups continue to be actively involved in the implementation of the program.

The Department of Public Health will continue to work collaboratively with the State Department of Information Technologies in creating an electronic reporting system for hearing screening results. The newborn screening laboratory as well as hearing screen results will be transmitted to the Department of Public Health via an Internet based virtual private network. This computer linkage between the laboratory and hearing screening programs will enable program staff to generate reports documenting the newborns that did not have a hearing screen conducted.

Other interventions/ influences: Children with diagnosed hearing impairments will be referred to the Connecticut Department of Mental Retardation, lead agency for the state's Birth to Three System Program, for early intervention services and advocacy. Infants and families may be referred to the Children with Special Health Care Needs Program for evaluation, support and advocacy, as needed.

11. Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care.

Population Served: CSHCN

Level of the Pyramid: Infrastructure Building

Planned Activities within Title V: As part of the intake assessment for children enrolling in the CSHCN program, a source of insurance for primary and specialty care will continue to be identified.

In 1999, the Centers reported that 97.5 % of clients enrolled in the CSHCN program had a source of insurance for primary and specialty care. We anticipate a slight increase as the result of continued outreach activities and the transfer of children from Title V to HUSKY Plus Physical. The Centers will continue to reach out to potential CSHCN families through agency newsletters, mass mailings to targeted families, and participation in community health fairs, as well as through various other community awareness activities. The Centers will continue to strengthen existing partnerships with the HMOs for early identification of children with special needs. In addition, a representative from the HMO Association and the Department of Insurance will continue to participate on SASH thus providing an opportunity to continue linkages at the Center and state level.

Other interventions/ influences: With the future development of a CSHCN registry we will have the capacity to track the insurance status of those children identified with special needs.

12. Percent of children without health insurance.

Population Served: Children/Adolescents

Level of the Pyramid: Infrastructure Building

Planned Activities within Title V: Healthy Start, Comadrona and HCWC programs will screen all clients for health insurance status. Children identified without health insurance will receive assistance in applying for Medicaid benefits, and/or will be linked to other Title V programs that will address their health needs.

The Department of Public Health (DPH) will continue to fund 10 Planned Parenthood of CT, Inc. sites and six sub-contractors. DPH will require the grantee to identify uninsured adolescents, services and gaps in service provision as well as refer uninsured clients/youth to appropriate sources of coverage.

DPH SBHC contract terms will continue to require grantees to identify uninsured youth, refer uninsured youth to appropriate sources of healthcare coverage e.g., Medicaid, HUSKY, and SSI. SBHC registration and individual counseling will be two methods of revealing the source of need. In addition, several communities will provide outreach services to actively identify such youth. Legislation proposed last year would have allowed SBHCs to enroll students under presumptive eligibility. Although this legislation did not pass, SBHCs will continue to negotiate with DSS and their subcontractor, EDS, to fund SBHCs as Husky/Medicaid enrollment sites.

MCH Liaisons, employed by Infoline, the MCH I&R Service, will continue to provide HUSKY presentations and trainings to providers, agencies, and community groups within the State.

Other interventions/ influences: The Department of Social Services has developed a work plan to address a number of factors that are adversely affecting client eligibility determinations for HUSKY A (family Medicaid) as well as the transition between HUSKY A and HUSKY B, (referenced in the annual report section of this document). The critical danger points taken into consideration when developing this plan include the end of cash assistance, the end of the 2-year Extended Eligibility Period, the end of Continuous Eligibility Period, and the Redetermination Process for both HUSKY A and B.

The Department of Social Services plans to implement changes to its Eligibility Management System (EMS) in order to support expanded coverage and adjust coverage group tracking systems to identify children who are coming up for redetermination of eligibility. DSS staff training will be developed and implemented, to address problems identified by Children's Health and HUSKY Health Infolines as well as those related to EMS changes outlined above. A marketing strategy will be developed to enhance outreach to potentially eligible families and other caretaker relatives not on the program, inviting them to request assistance. The HUSKY redetermination processes will be changed to include a mail-in option for those families no longer requiring cash assistance or food stamps, and a shorter redetermination form will be used for HUSKY only clients. The text on notices will be improved. Notices sent to clients will inform them to call the toll free line if they wish to continue HUSKY coverage for their children when their cash or other assistance is discontinued. All other notices will be reviewed for content to improve clarity regarding HUSKY enrollment, redetermination, and reinstatement. Plans are also in place to improve the HUSKY application and redetermination forms.

In order to improve the transition of clients from HUSKY A to B, DSS will run a weekly report of all HUSKY A cases that are closed or have become spenddown cases and include children under 19. Copies will be distributed to DSS staff and Benova who will identify cases for automatic transition into HUSKY B in order to minimize the risk of gaps in coverage. A new notice and HUSKY application form will be mailed to clients who are receiving continuous eligibility at the beginning of the 2nd to last month of coverage. Clients will be advised to submit the form to Benova in order to maintain coverage.

It has been a longstanding DSS policy to not have the post office forward mail sent to their recipients. In this way DSS has been able to maintain accurate addresses and could be assured that clients are still residents of

Connecticut. However, because of this, clients who do not inform the department of address changes often miss critical notices and have their benefits terminated for non-compliance with procedural requirements. This policy will be re-examined.

13. Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

Population Served: Children/Adolescents

Level of the Pyramid: Infrastructure Building

Planned Activities within Title V: DPH will continue to fund 10 Planned Parenthood sites and six sub-contractors. Funded sites will provide pregnancy testing, access to contraceptive services, reproductive health care, and counseling/education to clients. Funded sites will document the number of adolescents receiving services, and will identify Medicaid eligible youth without coverage and refer appropriately.

All DPH funded SBHCs will continue to be required to contract with Medicaid Managed Care Organizations for reimbursement of physical and behavioral health services. The location of SBHCs within school grounds will help to eliminate barriers to care created by the lack of good public transportation in many of our communities. SBHCs will document the number of children

Through intensive case management services, APP/YPP programs will link pregnant and parenting teens with needed health, educational, and social services. These include Medicaid/HUSKY coverage for all eligible mothers and children. Healthy Start providers will screen clients for Medicaid/HUSKY eligibility and assist clients in accessing identified needed services. HCWC provides services to low income (less than or equal to 185% FPL) pregnant women and their children. The clients who are eligible will be assisted with the application process.

The Title V CSHCN Program is the payer of last resort, and as part of the intake process, clients are screened and referred to other possible funding sources including Healthy Start, HUSKY, and WIC. Care coordination and advocacy services are provided to assist clients in accessing these programs.

The Comadrona program will screen clients for Medicaid eligibility and assist clients in accessing identified needed services. The Oral Health program's CT Community Oral Health Systems Development Project has as a goal, increased access to oral health care for Medicaid-eligible children and entry into long-term comprehensive dental care.

Other interventions/ influences: Community Health Centers serve all people regardless of ability to pay. Many CHCs have Medicaid/HUSKY Eligibility Workers on site. CHCs report to DPH quarterly on the units of service provided to children which are paid for by HUSKY

14. The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.

Population Served: CSHCN

Level of the Pyramid: Infrastructure Building

Planned Activities within Title V: A paid part-time family member who is staff to the CSHCN program will continue to be available to other Maternal and Child Health programs as well as to both regional Centers. SASH has a family

representative from the Family Advisory Committee who will continue to advise and assist SASH regarding family issues. Information will continue to flow back and forth between the two entities. Families will continue to participate on the following SASH subcommittees: covered services, data and quality assurance, authorization and outreach. The Family Advisory Committee will also continue its efforts to expand and diversify its membership. Families will be encouraged to participate in the planning and implementation of the CSHCN annual conference and will continue to implement and monitor respite services. The Department of Public Health will continue to afford families the opportunity to review the Block Grant application and provide testimony at the Block Grant Public Hearing. The Centers will also continue to support family advocates on the community-based level.

Other Interventions/Influences: Connecticut has organized a chapter of Family Voices, a national grass roots organization of families and friends who speak on behalf of children with special health care needs. Family Voices, partly funded through the Maternal and Child Health Bureau, can assist in assuring programs are comprehensive, coordinated and culturally sensitive. The Family Opportunity Act 2000 has the potential to create state health resource centers staffed by families of children with special health care needs that will assist families in the coordination of services as well as provide strong family to family supports.

15. Percent of very low birth weight live births.

Population Served: Pregnant women, mothers and infants; Children/Adolescents

Level of the Pyramid: Infrastructure/Enabling

Planned Activities within Title V: The Healthy Start program encourages early entry into prenatal care, and will link clients with necessary community programs/agencies (WIC, mental health services, etc.) in an effort to increase the opportunity for the prenatal client to have an infant that is of normal birthweight. Comadrona provides culturally sensitive, community based services that encourages early entry into prenatal care, and will link clients with necessary community programs/agencies (WIC, mental health services, etc.) in an effort to increase the opportunity for the prenatal client to have an infant that is of normal birthweight.

HCWC encourages and tracks compliance of pregnant client's prenatal care, and will link clients with necessary community programs/agencies (WIC, Healthy Start, mental health services, drug treatment facilities, etc.) in an effort to increase the opportunity for the prenatal client to have an infant that is of normal birthweight

APP/YPP programs, through intensive case management, counseling and educational input with pregnant teens will encourage appropriate weight gain during pregnancy, cessation of smoking and other substance use during pregnancy, and early and regular prenatal care to help prevent low birthweight births. A program evaluation initiative, using client-specific data, will be implemented on a phased-in basis; data will be collected on the time and type of educational content provided by these programs as well as birth outcomes like weight gain and birth weight of infants of program clients.

DPH will continue to fund 10 Planned Parenthood sites and six sub-contractors. Planned Parenthood of CT, Inc (PPC) will provide pregnancy testing, STD prevention, diagnosis, and treatment, comprehensive reproductive health education and counseling, as well as prenatal care linkages to community providers to eligible pregnant women and adolescents. In addition, PPC will link eligible clients to WIC, Health Start, and other entitlement programs.

DPH funded SBHCs will provide, to identified middle and high school students, age appropriate reproductive health education, pregnancy testing (per local decision), STD diagnosis and treatment, counseling and referrals to APP/YPP programs, WIC, Healthy Start and other relevant community providers. At least 1,500 students will receive such services.

The Fetal and Infant Mortality Review program, which is replicating the national model in high risk communities in the state, is include the review of individual cases of very low birthweight deliveries as part of its case review procedure in the town of Windham. The addition of very low birthweight reviews beyond the reviews of infant deaths may provide important insight for community based interventions being proposed to impact the incidence of low birthweight deliveries.

Other interventions/ influences: Efforts to enroll women in the WIC Program during their first trimester are ongoing.

Pregnant women served by Community Health Centers may be at significant risk of delivering low birthweight babies, because of their income status, age, late entry into prenatal care and/or substance abuse. Comprehensive prenatal care is provided on site or through referral to other appropriate providers. Risk assessments are completed and a care plan developed. Extensive use of support services, such as case management, outreach, and home visitors, help assure compliance with the care plan.

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

Population Served: Children and Adolescents

Level of the Pyramid: Infrastructure Building

Planned Activities within Title V: As part of the comprehensive model of mental health service, all DPH funded SBHCs and three ESHS projects will provide age appropriate mental health services to children and adolescents at risk of suicide. The SBHCs evaluate, treat and/or refer to community providers when students at risk of suicide are identified. The ESHS projects provide a variety of age appropriate primary prevention activities.

MCH Liaisons, employed by Infoline, the MCH I&R Service, will continue to provide suicide prevention presentations and trainings to providers, agencies, community groups, and students within the State.

Other interventions/ influences: Community Health Centers provide mental health services and will provide assessment, treatment and referrals for follow-up mental/behavioral health services

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

Population Served: Pregnant women, mothers, and infants.

Level of the Pyramid: Infrastructure Building

Planned Activities within Title V: Healthy Start prenatal clients that are identified as high risk will be closely monitored and referred to appropriate birthing facilities that are equipped to handle the delivery of the at risk infant. These activities will continue in the coming fiscal year. Comadrona clients that are identified as high risk are also closely monitored and referred to appropriate birthing facilities that are equipped to handle the delivery of the at risk infant; these activities will also continue. Although the HCWC program does not provide direct medical services, the case managers will continue to work collaboratively with the OB clinician and clients to ascertain that the delivery of any infant that may be deemed high risk is handled by an appropriate birthing facility.

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

Population Served: Pregnant Women, mothers and infants; Children/Adolescents

Level of the Pyramid: Infrastructure/Enabling

Planned Activities within Title V: The Healthy Start and Comadrona programs conducted outreach activities such as distribution of flyers, door to door campaigns or health fairs to reach pregnant women and to encourage access to health care. Healthy Start, Comadrona and HCWC, through intensive case management services to pregnant teens, strongly encourage early registration in prenatal care and compliance with prenatal visits and provider recommendations.

DPH will continue to fund 10 Planned Parenthood sites and six sub-contractors. Contracts will reflect services e.g., pregnancy testing, reproductive health education, counseling and prenatal linkages to community health providers to ensure first trimester prenatal care. In addition, pregnant women and adolescents will be linked to other entitlement programs such as WIC and Healthy Start. DPH will monitor services through review of quarterly reports.

SBHCs will identify pregnant women and following established protocols, conduct age appropriate reproductive health education, counseling and referrals of these women to APP/YPP programs, WIC, Healthy Start and other relevant community providers.

Other interventions/influences: Evaluation studies have shown that women who participate in the WIC Program receive prenatal care earlier. The WIC Program seeks to enroll pregnant women in the program during their first trimester so that they may benefit from the supplemental foods and nutrition education as long as possible. The first trimester WIC enrollment rate in Connecticut as of April 2000 is 46.4% statewide; local agencies are required to develop and implement action plans to improve this rate.

Because Community Health Centers serve a predominantly low income minority population and are located in areas with high infant mortality rates and high numbers of low birthweight babies, early identification of pregnancy, and early and continuous prenatal care are priorities. The larger centers provide obstetrical services on site, often using nurse midwives as part of their programs, and smaller centers refer their patients to other local providers. All health centers are Healthy Start providers or are closely linked with the Healthy Start program in their area if it is operated by another agency.

SP#01. The percentage of CSHCN clients enrolled in the State CSHCN program that have a written care service plan.

Population Served: CSHCN

Level of the Pyramid: Direct/Enabling

Planned Proposed Activities within Title V: The two CSHCN regional centers will continue to strive toward providing every CSHCN child enrolled in the program with a comprehensive, interdisciplinary, family centered, written care plan. During routine site visits, DPH will continue to review care service plans to assure a multidisciplinary professional approach, family involvement etc. DPH, in concert with the HUSKY Plus Program at DSS, is in the process of developing and implementing a standardized, comprehensive, family centered written care service plan for all CSHCN children. This activity includes providing technical assistance to Center staff through a series of in-services and workshops. Information regarding the presence of a care plan continues to be reported to DPH on a quarterly basis.

Other interventions/ influences Interagency collaboration will continue and will be a critical component in the development of a comprehensive, multidisciplinary care plan.

SP#02. The degree to which Title V families have access to mental health screening, referral, assessment, and linkages.

Population Served: Pregnant women, mothers and infants, Children and adolescents, CSHCN.

Level of the Pyramid: Enabling

Planned Activities within Title V: There is increasing awareness of the need for improved systems of mental health services. The recent Surgeon General's Report on Mental Health clearly stated that mental health is fundamental to overall health. The report also recognizes that mental disorders are real health conditions, and mental health programs in the United States, like general health programs, are rooted in a population-based public health model. The Surgeon General's Report defined mental health as the successful performance of mental functions, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. From early childhood until late in life, mental health is the springboard of thinking and communicating skills, learning, emotional growth, resilience, and self-esteem. DPH has identified the need to improve access to mental health services and supports as a priority for Title V programs in the coming five years.

In the next five years we intend to establish the identification of mental health needs and linkages to mental health services as a seamless component of health care, delivered by public health programs for the good of the population in general. By the end of the five-year period we will have institutionalized a process where Title V programs routinely address the mental health needs of the population they serve. We will have identified program needs, provided standards and protocols, training and technical assistance, identified community supports and funding options, and collected annual data on the progress of Title V funded programs.

First year activities will include the convening of a workgroup of DPH staff, representatives from other public and private organizations, and Title V grantees to identify the capacity to screen, assess, refer and link Title V recipients to mental health services and supports. The workgroup will identify appropriate standards for screening (identifying

potential need for mental health supports or services) and assessment (a more in-depth process to determine specific diagnoses, needs and develop a treatment or care plan). In addition, the group will identify providers of mental health supports and services and possible funding streams to enhance program capacity.

Some Title V funded programs, such as School Based Health Centers, already screen and assess clients' mental health needs. They provide direct services and/or refer clients to community resources, following up to assure that clients become linked to those services whenever possible. Other programs may need to review and/or develop policies and procedures for incorporating mental health screenings into their practice, and for assuring that assessment and provision of supports and services occur as appropriate. In this first year we will establish a baseline rate of activity for each program currently reporting on their mental health activities. For those programs not collecting this data, a reporting system will be put in place with baselines being set after one full year of reporting. Following establishment of baselines, we will collect and analyze data to identify changes in the number of people served. We will expect a 5% increase per year over baseline for mental health screening. We expect that 100% of those who are screened and found to be at risk will be assessed, referred and/or linked to supports and services.

We will provide technical assistance and support to programs based upon the assessment of their levels of need, as well as their capacity for recording and reporting information to the Department on these services.

Other interventions/ influences: In Connecticut, mental health services and supports are beginning to receive renewed attention from state agencies and other public and private organizations. The cry from families and providers for additional supports and services for mental health issues is being heard. Numerous reports identifying strengths and weaknesses of the current system of care for mental health service are available or will soon be available. The State has legislatively mandated parity in HUSKY A and HUSKY B coverage for behavioral health care effective January 1, 2000. In February 2000, the State Department of Social Services presented an interagency report to the Connecticut General Assembly on Delivering and Financing Children's Behavioral Health Services in Connecticut. The report addressed a request by the legislature for recommendations for improving the quality and integration of these services for Connecticut's children, and will be the foundation for major change in the provision of children's behavioral health care in the State of Connecticut. The report identifies the importance of including DPH in future discussions around this integration.

DPH staff is already linked to a variety of statewide activities addressing access to mental health care. DPH Family Health Division staff represent the Department at the HUSKY Plus Behavioral Health Steering committee, which sets policy and monitors implementation of the Department of Social Service's SCHIP program for children with special behavioral health care needs. The Commissioner is representing the Department on the newly established Governor's Blue Ribbon Commission on Mental Health. DPH staff regularly report to the Medicaid Managed Care Council's Behavioral Health Subcommittee on issues related to the implementation of behavioral health managed care contracts with School Based Health Centers.

SP#03. The death rate for children aged 1-19 caused by unintentional and intentional injury (Pediatric Mortality Due to Injury).

Population Served: Children and Adolescents

Level of the Pyramid: Population Based /

Infrastructure Building

Planned Activities within Title V: APP/YPP programs, through counseling, support and educational services, will teach parenting skills to teen parents; these skills will include heavy emphasis on child development, age-appropriate discipline, child safety (and home) safety.

Healthy Start and Comadrona programs will continue to provide anticipatory guidance and injury prevention information to clients regarding proper restraints for infants and children when riding in a motor vehicle as well as safety in the home. HCWC will continue to provide anticipatory guidance and injury prevention information to clients regarding proper restraints for infants and children when riding in a motor vehicle. Through the intensive home visiting component, education will be provided to parents regarding safety in the home.

Children are at higher risk of injuries in the home environment than the general population (with the exception of older adults.) These injuries include falls, fire/burns, poisoning, drowning, and choking/suffocation/strangulation. Contributing factors may include:

- hazardous products such as old cribs, baby walkers, drawstrings on clothing etc.
- lack of safety devices such as smoke detectors, stair gates, child resistant packaging.
- unsafe environments such as substandard housing, hot water temps >120 degrees, unsafe firearm storage in the home.
- lack of parental/caregiver awareness and lack of supervision for children.

Modifying the home environment, using safe products, correcting hazards, and educating parents, family members and caregivers can all play a major role in reducing the risk of injuries.

Potential activities:

- Provide anticipatory guidance, educational materials and safety devices during regular preventive care visits.
- Conduct safety assessments during home visits to identify and correct hazards.
- Provide/install safety devices such as smoke and carbon monoxide detectors, stair gates cabinet locks, anti scald devices.
- Provide parents and care givers with ongoing education, reinforcement, and referrals to community resources.

Inter-generational Safety

Older adults and children under the age of five have the highest risks for unintentional injuries in the home environment. The safety needs of both children and older adults should be considered in households where grandparents and older family members are full or part-time caregivers for young children.

Playground Safety

Nationwide over 200,000 children are injured seriously enough each year to require medical treatment. Most injuries occur on municipal or school play areas. Although play ground related injuries are less common in the day care setting the majority of injuries occur in day cares are playground related.

Potential Activities:

- Provide training on recognition of playground hazards, safe playground design, maintenance, and supervision.

- Encourage community collaboration to repair/replace unsafe playgrounds or build new playgrounds that conform to the US Consumer Product Safety Commission’s Recommendations for Public Playgrounds. Many communities do not have the resources for repair or replacement and so will simply remove unsafe equipment, leaving children with no safe play areas.

Adolescent Occupational Injuries

Increasing numbers of teenagers are working and many do not receive any type of safety training. Many teens, parents and health care providers are unaware of safety risks and of the provisions in the CT Labor laws that are designed to protect young workers. There is a real need to educate health care providers, educators, teens and parents on young worker safety issues.

The HEI/Injury Prevention Program is part of a CT Young Worker Safety Team that includes representatives from Family Health, EEOH and the CT Depts. of Labor and Education. The team is developing its expertise in young worker safety issues, and developing a state group of “Train the Trainers” for an existing young worker safety curriculum.

Potential Activities:

- Provide training on young worker health and safety issues to health care providers including school based health centers, educators, community agencies and youth serving organizations.
- Provide resource materials on occupational health and safety issues and labor laws to adolescents, parents, schools, employers, and community and youth agencies.
- Incorporate occupational health and safety training into for students participating in Connecticut’s School to Career Program and other occupational training programs.

Motor Vehicle Crash-Related Injuries

One of the most promising interventions for reducing young driver crashes is implementing comprehensive “Graduated Licensure” legislation. Graduated licensure allows young drivers to practice skills and gain maturity under controlled situations before “graduating” to full driver privileges. A comprehensive graduated licensure program includes driving with adult supervision for an extended period of time, “zero tolerance” for alcohol, and restrictions on nighttime driving and number and ages of passengers. CT driver laws currently include some of the above provisions but are by no means comprehensive. Parents should be encouraged to implement their own “graduated Licensure” provisions.

Youth Violence Prevention

Through the Preventive Health and Health Services Block Grant, The Youth Violence and Suicide Prevention Program, in the Health Education and Intervention Division of DPH will continue to competitively fund youth violence prevention programs to provide services to middle and high school aged youth in community-based settings in three communities. Staff from the HEI division will also facilitate programs for those local health departments and districts in Connecticut who elect to use the local health allocation for youth violence prevention activities.

Additional plans include increased collaboration between MCHBG, PHHSBG and categorically funded programs which work with children and youth.

SP#04. The degree to which Title V programs target services to racial and/or ethnic groups with disparities in pregnancy outcomes.

Population Served: Pregnant women, mothers and infants.

Level of the Pyramid: Population Based/Infrastructure Building

Planned Activities within Title V: Over the next five years, an interdisciplinary workgroup will be established to mount a statewide, coordinated, Perinatal Initiative to develop strategies to reduce poor perinatal outcomes in specific populations that display disparities in outcomes, including those related to racial and/or ethnic subpopulations. This workgroup will include representation from disciplines, agencies, and organizations invested in the outcomes (e.g., obstetrics, pediatrics) and with knowledge and experience in the risks associated with these outcomes (e.g., substance abuse, access to care, and social issues). These strategies may indicate changes or reallocation of existing resources within the Title V programs.

Assessment of current status of programs related to racial and/or ethnic and other risk factors for poor perinatal outcomes is a prerequisite to strategy development. Subsequently, Title V programs will focus on increasing outreach or other activities that will ensure service to populations at highest risk for poor outcomes. During year one, an interdivisional workgroup will be established to assess baseline proportions of racial and/or ethnic groups served in Title V programs. In addition, this workgroup will assess the penetration of Title V programs into specific geographic locations with an excess of poor perinatal outcomes (i.e., infant mortality, low birthweight).

Other interventions/ influences: The Connecticut Perinatal Association (CPA) has long been invested in these issues. The CPA has provided education and awareness programs and has collaborated with the Connecticut Chapter of the March of Dimes Birth Defects Foundation (MOD) on some initiatives. In June of 2000, a regional perinatal meeting that included members from the Connecticut association as well as people from similar associations in New York, New Jersey and Pennsylvania was held. Staff from the Family Health Division participated in a panel relating to Title V activities within Connecticut. The MOD has used data available from the Connecticut Department of Public Health in its three-year perinatal needs assessment. These informal relationships need to be formalized so that future collaboration is possible.

SP#05. The degree to which the Department of Public Health has developed and implemented of a Statewide Genetics Plan.

Population Served: Pregnant women, mothers and infants.

Level of the Pyramid: Infrastructure Building

Planned Activities within Title V: The Maternal Child Health Genetics Program, in collaboration with a specially convened workgroup, will develop an infrastructure whereby a Statewide Genetics Plan will be designed and implemented. With the rapid expansion in the field of human genetics, it becomes difficult for public health officials,

policymakers, healthcare providers, and the general public to keep abreast of new information and its potential implications. Therefore, a Statewide Genetics Plan is needed to address the multitude of issues related to the advancement of genetic medicine so as to prevent disease and improve health.

In the first year, data will be gathered and analyzed from a number of available surveys. Strengths, weaknesses, gaps and barriers related to genetic education and health care delivery services will be identified and prioritized.

In the next phase, a collaborative effort will be to assure that a mechanism is in place for the exchange and dissemination of genetic information. The workgroup will develop partnerships at state and local levels with community, academic and medical associations. By utilizing the Newborn Screening Program current model of testing, tracking and treatment, expansion of genetic services will be explored.

The final phases of the plan will be dedicated to genetics awareness and education. As the infrastructure evolves, and the field of genetics expands, the plan will be evaluated and adjusted accordingly to meet the needs of the people of Connecticut.

Other interventions/influences: Legislation may be needed to address the confidentiality and discrimination issues predicted to develop as the result of this rapid expansion in the field of genetics. Cultural, social, educational and economic indicators will need to be considered in all phases of the infrastructure development.

SP#06. The degree to which the Connecticut State Department of Public Health has the infrastructure in place to collect and report accurate information on pregnancy related mortality.

Population Served: Pregnant Women, mothers, and infants **Level of the Pyramid:** Infrastructure Building

Planned Proposed Activities within Title V: The Department plans to award a new contract to the University of Connecticut Department of Obstetrics and Gynecology for investigation and reporting of cases of suspected pregnancy-related mortality, since the previous obstetrical consultant is no longer able to meet contract requirements. A statewide conference will be held, in partnership with the grantee, to present information about pregnancy-related mortality to obstetrical providers in Connecticut. A mechanism (currently in progress) will be fine-tuned, in collaboration with the Office of Policy, Planning and Evaluation, to match deaths of women of reproductive age with live birth and fetal death certificates in order to improve accuracy of surveillance of pregnancy related deaths. A ten-year (1991-2000) summary of pregnancy-related deaths in Connecticut will be prepared.

Other interventions/ influences: The Office of Vital Records is undergoing transition to new technology for its databases. This transition is expected to take at least a year. This may influence our ability to track and match live and fetal death certificates. In addition, the Office of Vital Records does not intend to modify the state death certificate to include a check box for a pregnancy within one year until after the national model is published in 2000. Both will influence collection of accurate data on pregnancy-related mortality in Connecticut.

SP#07. The degree to which the State of Connecticut, Department of Public Health improves education, diagnosis, and case management for asthma.

Population Served: Children and Adolescents

Level of the Pyramid: Infrastructure Building

Planned Activities within Title V: Asthma is the most common chronic condition among children and is a leading cause of school absenteeism. Reducing asthma associated morbidity and improving the quality of life for children with asthma requires a comprehensive approach including: consistent and appropriate medical treatment, patient compliance with drug regimens; comprehensive patient and family education, and; reduction of risk factors that exacerbate asthma.

The Connecticut Department of Public Health is committed to working with health care providers, community health centers, school based health centers, Managed Care Organizations, local health departments, people with asthma and their families, and caregivers to develop comprehensive asthma initiatives. DPH has begun to establish an ongoing surveillance system to define high risk populations and monitor trends in asthma. Additionally plans are underway to develop and implement comprehensive educational initiatives that inform the public and health care providers about diagnosis and proper management of asthma, and programs that will identify and reduce environmental risk factors that exacerbate and trigger asthma attacks.

An asthma workgroup within DPH has been established to inventory existing program initiatives around asthma and identify potential opportunity for coordination within existing programs. Staff from the School and Primary Health Unit will participate in this asthma initiative. This inter-division collaboration will assist in building the capacity within Title V programs to enhance asthma awareness, diagnosis, treatment and management.

A written asthma management plan is a very important part of effective asthma management. To improve the use of this very important asthma management tool, data collection and evaluation methods within Title V funded programs will be implemented to determine whether, or the extent to which children with a diagnosis of asthma have an asthma management plan.

The evaluation of the home environment and the identification and reduction of environmental asthma triggers is also an important part of effective asthma management. This service is not routinely offered. The CSHCN case managers provide a mechanism to ensure that this type of service is being conducted for CSHCN children with asthma. CSHCN programs will be required to develop a process of assessing CSHCN case managers' knowledge of asthma management and control including evaluation and control of triggers of asthma in the home. CSHCN case managers will be trained to assess knowledge of asthma management in the home and will implement a process of evaluation of asthma triggers in homes of CSHCN diagnosis with asthma. CSHCN case managers may also serve to coordinate these activities in the event that there are other case managers. The case managers also will assist with education regarding asthma management for the child and family when appropriate.

Providing children with the knowledge to understand and manage their asthma has been demonstrated as effective in improving the quality of life of children with asthma and reducing exacerbations of their disease. A new activity proposed would be to implement the "Open Airways Program" (an asthma education program for 4th and 5th graders developed by the American Lung Association) for schools in Connecticut. (Note: this would potentially

involve development of an RFP for the Block Grant to fund schools to implement the “Open Airways Program” in their school.)

Enhancing asthma surveillance in Title V funded programs is a critical for the identification of children at increased risk of severe asthma outcomes, those who should be targeted for interventions and monitoring trends in asthma among this population.

Other interventions/ influences: School and Primary Health Staff within the Family Health Division will participate in the newly formed Coordinated School Health Program to enhance asthma activities within schools in Connecticut (Coordinated School Health is an interagency program with the State Department of Education as lead agency).

SP#08. Percent of community-based public health care facilities that provide comprehensive dental services for needy or vulnerable children and their families.

Population Served: Children and Adolescents

Level of the Pyramid: Infrastructure

Planned Proposed Activities within Title V: As of October 31, 1999, thirteen (13) out of a total of (28) Community Health Centers provide comprehensive dental services to needy and vulnerable children and their families. School Based Health Centers also provide dental services, sixteen (16) out of fifty four (54) provide comprehensive services. Therefore, the percent of community-based public health care facilities that provide comprehensive dental services for needy or vulnerable children is 35%.

In order to encourage the expansion and enhancement of dental services offered by “safety net” facilities, the agency will conduct a needs assessment among safety net providers. This assessment will identify barriers to dental service expansion and will determine what support the department could provide to encourage and enhance services.

With this information, the agency will establish a strategic plan to encourage the growth, expansion and support of safety net provider dental services.

Comprehensive dental services also include health promotion and disease prevention activities. Two major priorities for oral health education and oral health promotion are the prevention of early childhood caries and the integration of oral health services into the larger health care field.

To enhance activities in this area the agency will develop a scientifically sound and culturally valid early childhood caries prevention program. This effort, while geared toward the entire public, will extensively involve community health centers and the other safety net facilities.

In addition to this program, the agency will develop a training program for non-oral health clinicians working in safety net facilities. This training will be aimed at non oral health professionals. The training content will emphasize the importance of oral health, stress its strong interconnection with health problems and overall health status, educate practitioners about current issues and trends in oral health, and help them to identify ways they can participate in promoting the oral health of their clients. A clinical workforce properly trained in this area will enhance and encourage development of oral health services.

SP#09. The degree to which the Connecticut State Department of Public Health has the infrastructure in

place to collect and report information on all children with special health care needs in the State.

Population Served: CSHCN

Level of the Pyramid: Infrastructure Building

Planned Activities within Title V: The CSHCN Program, through its contract with a data consultant, will develop a registry to enumerate the population of children with special health care needs in the state. Under CT General Statutes, all licensed health care professionals are required to report to the DPH any child with either a “physical defect” (Sec 19a-53) or who is “physically handicapped (Sec 19a-54). Amendments have been proposed to the statutory language which will more accurately reflect the current MCHB definition of children with special health care needs. During this first year, a multidisciplinary workgroup will be convened to operationalize the definition of children with special health care needs. In collaboration with our data consultant, DPH CSHCN staff will specify required data elements for construction of a database module and Windows application.

Initially, data will be gathered at birthing facilities using a module built onto the electronic reporting system for mandatory newborn screening programs. In the next phase, we will explore the feasibility of expanding the electronic reporting network to include pediatric provider sites. A statewide educational program for providers will be developed to facilitate reporting. Methods for referral to state early intervention and Title V CSHCN programs will be established.

Other interventions/ influences: Data linkages will be established with internal and external programs to increase case ascertainment, for quality assurance and referral to early intervention.

4.2 Other Program Activities

Maternal and Child Health (MCH) Information and Referral Services

The state will continue to contract for MCH Information and Referral Services. A Nurse Consultant in the MCH Unit of DPH will continue to provide technical assistance related to the collection and reporting of data on all of the hotlines that receive MCH-related service requests. The goal is to provide information and referrals on identified needs to at least 98% of clients, as well as to track demographics and types of MCH Service Requests. We will continue to collect data on all of the hotlines that receive MCH-related requests and will continue to report in the MCHBG application and annual report specifically the number of requests generated by the MCH component of the MCH I&R.

DPH program staff will continue to provide inservices to the MCH Liaisons in order to expand their knowledge and linkage with DPH programs. We will work with the MCH Liaisons and provide suggestions on ways to enhance public awareness activities, as well as to improve training and presentations to the community. Technical assistance will be provided to improve reporting on gaps/barriers in each region of the state, as well as the number of prenatal care referrals.

DPH will continue to promote ongoing meetings with MCH I&R staff, including MCH Advisory Committee meetings held by Infoline, in order to promote stronger liaisons and educate staff on MCH-related issues. The MCH Advisory Committee meetings will focus at least one topic annually on the MCH component of the MCH I&R.

Coordination with SSA

DPH staff will continue to track SSI referrals received from DDS in an Access database. Both Centers will submit quarterly data electronically, which will be queried annually to obtain the numerator for the performance measure. Technical assistance will continue to be provided to improve accuracy of reporting. The federal report published by the SSA, Office of Research, Evaluation, and Statistics will be used for the denominator. DPH staff will continue to interface with DDS staff in order to improve tracking, communication, and increase public awareness of the CSHCN Program.

Family Support Programs

The Department of Public Health's Title V program will continue to be actively involved with Family Support Connecticut, formerly known as Connecticut's STATES Initiative (State Training and Technical Assistance for Effective Systems). This initiative is a collaborative effort of state and local agencies, direct service providers, advocate groups and others who are building a voice for Family Support in this state. Technical assistance is provided to the state from the Family Resource Coalition of America (FRCA), located in Chicago. Connecticut has worked diligently on this effort over the past four years, and has success in developing its definition of family support as well as an active state agency linkage team. In spite of continued efforts, changes in the initiative's leadership over the past year have limited its success in building a network of family support providers across the state, as was originally planned. Despite these setbacks, family and consumer involvement continues to be a top priority of the initiative. Efforts are currently underway to plan for the third annual implementation of Connecticut's Family Day activities to honor families and to educate the public about the philosophy of family support through many organized events throughout the state.

EPSDT

The MCH Unit staff will continue to work with the Department of Social Services on revising their EPSDT periodicity schedule. Written comments will be provided to DSS and staff will participate meetings with DSS as deemed necessary.

Healthy Child Care Connecticut

A Nurse Consultant from the MCH Unit will be representing the Family Health Division on the Healthy Child Care Connecticut Initiative. The goal of Connecticut's Healthy Child Care Initiative is to achieve optimal health and development for all children receiving Child Care by guiding and supporting service integration between the child care community and health providers. Inherent in the philosophy is the belief that service provision and integration is reflective of families' needs. Representation from the Family Health Division and on-going collaboration among the agencies involved in the initiative is critical since our Title V programs serve the Healthy Child Care Connecticut target population.

4.3 Public Input

An effort was made this year to identify five families to assist the department in reading and commenting on the Block Grant. Activity began in late March to identify a team of readers. Two parents were identified through the

Torrington Healthy Mothers/Healthy Babies coalition, a group of community providers, agency representatives, and families who meet monthly to share information and strengthen community supports. One Block Grant reader is a mom of five children; one foster child (aged 13) and four natural children (ages 14, 12, 4 and 2). The second Block Grant reader has two children ages 4 and 7.

There were two moms from the New Haven area who were recommended from Hill Health, a Community Health Center; both are bilingual. One Block Grant reader is a client of a school based health center. The second Block Grant reader was recommended from the perinatal department at Hill Health.

We have one parent reading who is of African-American descent and who has two children, one of whom has special health care needs.

The Family Advocate from the Maternal and Child Health Bureau set up two meeting dates for each of the readers. The first two-hour meeting was designed to provide readers with background information on the Maternal and Child Health Bureau, reasons why the department asks for input, and a general overview of the Block Grant. A second two-hour meeting was arranged approximately one week later for the purpose of gathering comments and answering reader's questions. Readers were assured that they would be able to access the Family Advocate with questions at any time during the process. Block Grant readers were provided with a stipend for participating in this process.

The goal of this activity was to convene a diverse group of families from various areas of the state to comment on the Block Grant and to expand our efforts in the area of family participation.

Four focus groups, attended by consumers and providers, were held this year, as part of the Needs Assessment Process. The format and questions addressed in the focus groups was driven by the Needs Assessment guidance, and was consistent throughout the groups. The information obtained has been incorporated in the findings of the assessment and in the identification of the priority needs. The approximately 30,000 MCH service requests from the population served by Infoline, the MCH Information and Referral Service, also supported the findings and of our assessment activities.

A Public Hearing was held on June 22, 2000, and attended by twenty constituents, including parent consumers and community providers. Verbal and written testimony was received regarding the value of the bereavement services received through the Connecticut SIDS Center, as well as the need for sensitivity training of first responders. The benefits of the direct and enabling services received through the Connecticut's CSHCN program, particularly the respite funds received by families, was acknowledged, while the need for greater mental health assistance by this population was emphasized. Additional testimony included the need to continue support services for at risk teens and pregnant females who are served through the community based Title V funded programs. The need to identify the reason why some teen mothers experience repeat pregnancies while others do not was emphasized, and a request to continue funding to support the FIMR projects in communities with significant rates of infant mortality was also received.

4.4 Technical Assistance

(See Form 15)

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- ⁱ Newcheck PQ, Strickland B, Shonkoff JP. An epidemiologic profile of children with special health care needs. *Am Acad of Pediatrics*. 1998;102:117-123.
- ⁱⁱ Department of Economic and Community Development. 1998 Connecticut Town Economic Data / 1997 to 1998 % changes. State of Connecticut, Department of Economic and Community Development. Accessed May 31, 2000. <http://www.state.ct.us/ecd>.
- ⁱⁱⁱ US Census Bureau. State Estimates for People of All Ages in Poverty for US: 1996. Accessed on May 31, 2000 <http://www.census.gov>.
- ^{iv} Department of Public Health. Looking Toward 2000. State of Connecticut, Department of Public Health. Hartford, CT. February, 1999.
- ^v Office of Health Care Access. *Report on Connecticut's Insured and Uninsured The Connecticut Family Health Care Access Survey Baseline Results*. State of Connecticut, Office of Health Care Access, Hartford, CT, April, 1998.
- ^{vi} US Census Bureau. *Health Insurance Coverage*. US Dept of Commerce. Washington, D.C. October, 1999.
- ^{vii} Office of Health Care Access. *The Uninsured in Connecticut: A Supplemental Analysis*. State of Connecticut, Office of Health Care Access. Hartford, CT, November, 1999.
- ^{viii} Mattocks K. The HUSKY Program: An Opportunity to Insure Connecticut's Children. *Connecticut Medicine*. 1999;63:95-97.
- ^{ix} Peoples-Sheps MD, Farel A, Rogers MM. *Assessment of health status problems*. 1996. Maternal and Child Health Bureau.
- ^x Department of Economic Development. *Economic Data*. State of Connecticut Department of Economic Development data accessed June 8, 2000 <http://www.ctecd.state.ct.us>
- ^{xi} Department of Economic and Community Development. 1998 Connecticut Town Economic Data / 1997 to 1998 % changes. State of Connecticut, Department of Economic and Community Development. Accessed May 31, 2000. <http://www.state.ct.us/ecd>.
- ^{xii} Dalaker, J, US Census Bureau. Current Population Reports, Series P60-207, *Poverty in the United States: 1998*, US Government Printing Office, Washington, DC, 1999. <http://www.census.gov/hhes/www/poverty.html>
- ^{xiii} American College of Obstetricians and Gynecologists. *Standards for Obstetric-gynecologic Services*, 7th Edition. Washington, D.C.: 1989.
- ^{xiv} Goldenberg RL. *Low birthweight in minority and high-risk women patient outcomes research team (PORT) final report*. 1998. Agency for Health Care Policy and Research.
- ^{xv} Goldeberg RI, Iams JD, Mercer BM et al. The preterm prediction study: the value of new vs standard risk factors in predicting early and all spontaneous preterm births. *Am J Public Health* 1998;88:233-238.
- ^{xvi} Kessner, D.M., J. Singer, C.E. Kalk, and E.R. Schlesinger. Infant death: An analysis by maternal risk and Health care. *Contrasts in Health Status, Vol. 1*. Washington, D.C: Institute of Medicine, National Academy of Sciences. 1973
- ^{xvii} Institute of Medicine, National Academy of Sciences. *Preventing Low Birthweight*. Washington, DC: National Academy Press. 1985
- ^{xviii} Mueller LM, "Estimated impact of eliminating non-adequate prenatal care toward lowering infant mortality in Connecticut," Connecticut Department of Public Health, March 1990
- ^{xix} Institute of Medicine, National Academy of Sciences, *Preventing Low Birthweight*. Washington, DC: National Academy Press. 1985
- ^{xx} U.S. Public Health Service, *Health United States (1989)*, (PHS #90 - 1232), Hyattsville, MD, p 12
- ^{xxi} Hack M, Klein N, Taylor HG. *Long term developmental outcomes of low birthweight infants*. The Future of Children 1995 Spring;5(1):176-193.
- ^{xxii} Institute of Medicine, National Academy of Sciences. *Preventing Low Birthweight*. Washington, DC: National Academy Press. 1985.
- ^{xxiii} Walker DK Integrating birth defects surveillance in Maternal and child health at the state level. *Teratology* 2000; 61:4-8.
- ^{xxiv} Birth defect surveillance data from selected states, 1989-1996. *Teratology*. 2000; 61:86-158.
- ^{xxv} CDC. Achievements in Public Health, 1900-1999 Impact of Vaccines Universally Recommended for Children --United States, 1990-1998. *MMWR* April 02, 1999 / 48(12):243-248
- ^{xxvi} CDC. Immunization coverage levels with the 4:3:1:3 series by state. National Immunization Survey. July 1998 to June 1999. Accessed on 6/27, 2000 <http://www.cdc.gov/nip/prog/asthoap3.jpg>.
- ^{xxvii} HEDIS. Report on MMC Children born in 1966. September 15, 1999
- ^{xxviii} Hynes MM, Mueller LM, Bower CE, Hofmann MJ. *Multicultural Health*. 1999 Connecticut Department of Public Health. Hartford, CT.
- ^{xxix} JAMA 282:2227-2234, 1999
- ^{xxx} STD Program. *Sexually Transmitted Diseases. 1998 Surveillance Summary*. 1999. Connecticut Department of Public Health. Hartford, CT.
- ^{xxxi} Children's Health Council. Ensuring HUSKY coverage for children: protecting children from gaps in Coverage. June 16, 1999. Hartford, CT.
- ^{xxxii} Children's Health Council. Ensuring HUSKY coverage for children: recent evidence shows gaps in coverage. November 14,

-
1999. Hartford, CT.
- ^{xxxiii} Solomon J. *Tracking HUSKY enrollment*. Children's Health Council. April 14, 2000. Hartford, CT
- ^{xxxiv} Children's Health Project. Quarterly report to the Children's Health Council on EPSDT on-time visit rates. February, 10, 1999. Hartford, CT
- ^{xxxv} Children's Health Project. Utilization of dental services by children enrolled in medicaid managed care. November, 14, 1999. Hartford, CT
- ^{xxxvi} Wells N, Krass M.W, Anderson B, Gulley S, Leiter V, O'Neil M, Martin L, Cooper J. *What Do Families Say About Health Care for Children with Special Health Care Needs? Your Voice Counts!!* The Family Partners Project Report to Families..2000 Unpublished manuscript. Boston, MA: Family Voices at the Federation for Children with Special Health Care Needs.
- ^{xxxvii} Epstein S, Taylor A, Turnbull N, Halberg A, Klein Walker D, Gardner J, Crocker A. Assessing the Quality of Managed Care for Children with Special Health Care Needs Summary of a Regional Survey of Families, Primary Care Providers & Managed Care Organizations in New England., March 1997
- ^{xxxviii} Newacheck PW, Taylor WR. Childhood chronic illness:prevalence, severity, and impact. *Am J of Public Health*. 1992;82:364-371.
- ^{xxxix} CT Department of Public Health. Identifying the need for services for children with special health care needs. Hartford, CT. 1997.
- ^{xl} Newacheck PQ, Strickland B, Shonkoff JP. An epidemiologic profile of children with special health care needs. *Am Acad of Pediatrics*. 1998;102:117-123.
- ^{xli} Card JJ. Teen pregnancy prevention:do any programs work? *Ann Rev Public Health*. 1999;20:257-85.
- ^{xlii} Ramirez PR. Pregnancy-Related Mortality Surveillance in the State of Connecticut: 1980-1990. Connecticut Department of Public Health. Hartford, CT. November, 1995.
- ^{xliii} USDHHS. *Mental Health: A Report of the Surgeon General*. U.S. Department of Health and Human Services, 1999, Washington D.C. accessed on June 27, 2000. <http://www.surgeongeneral.gov/library/mentalhealth/index.html>
- xliv Huss, Karen, et. al., Home environmental risk factors in urban minority asthmatic children. *Annals of Allergy* 1994; 72:173-177.
- xlv Etzel, Ruth, Indoor Air Pollution and Childhood Asthma: Effective Environmental Interventions. *Environmental Health Perspectives* 1995; 103 Sppl. 6:55-58.
- xlvi Schneider, Susan et. al., Moving Health Care Education into the Community. *Nursing Management* 1997; 28:40-43.

V. SUPPORTING DOCUMENTS

5.1 Glossary

Glossary

Adequate prenatal care – Prenatal care where the observed to expected prenatal visits is greater than or equal to 80% (the Kotelchuck Index).

Administration of Title V Funds – The amount of funds the state uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment – (see “Needs Assessment”)

Capacity – Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, “What does the State need to achieve the results we want?”

Capacity Objectives – Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for Children With Special Health Care Needs (CSHCN, see definition below) – those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. *[Title V Sec. 501 (b) (3)]*

Carryover (as used in Forms 2 and 3) – The unobligated balance from the previous years MCH Block Grant Federal Allocation.

Case Management Services – For pregnant women – those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one – those services that assure access to quality preventive and primary care services. *(Title V Sec.501 (b) (4)*

Children – A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) – (For budgetary purposes) Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. *(For planning and systems development)* – Those children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) – Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations

States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. State Support for Communities

State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education, and training, common data protocols, and financial resources for communities engaged in systems development to assure that the unique needs of CSHCN are met.

3. Coordination of Health Components of Community-Based Systems

A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. Coordination of Health Services with Other Services at the Community Level

A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals – authorized persons to be served with Title V funds. See individual definitions under “Pregnant Women”, “Infants”, “Children with Special Health Care Needs”, “Children”, and “Others”.

Community – a group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care – services provided within the context of a defined community.

Community-based Service System – an organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive – the recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent – the ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries – women who received a medical care procedure (were provided prenatal, delivery or postpartum care) associated with the delivery or expulsion of a live birth or fetal death.

Direct Health Care Services – those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient, and outpatient medical services allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support – by directly operating programs or by funding local providers – services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services – Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with

Medicaid, WIC, and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential – for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

EPSDT – Early and Periodic Screening, Diagnosis and Treatment – a program for medical assistance recipients under the age of 21, including those who are parents. The program has a Medical Protocol and Periodicity Schedule for well-child screening that provides for regular health check-ups, vision/hearing/dental screenings, immunizations and treatment for health problems.

Family-centered Care – A system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) – The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GRPA) – Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System – The entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants – Children under one year of age not included in any other class of individuals.

Infrastructure Building Services – The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Jurisdictions – As used in the Maternal and Child Health block grant program: the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Palau.

Kotelchuck Index – An indicator of the adequacy of prenatal care. See *Adequate Prenatal Care*.

Local Funding (as used in Forms 2 and 3) – Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income – an individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.[Title V. Sec. 501 (b)(2)]

MCH Pyramid of Health Services – (see “Types of Services”)

Measures – (see “Performances Measures”)

Needs Assessment – A study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is to aimed at determining:

- 1) What is essential in terms of the provision of health services;
- 2) What is available; and,
- 3) What is missing

Objectives – The yardsticks by which an agency can measure its efforts to accomplish a goal.
(See also “Performance Objectives”)

Other Federal Funds (Forms 2 and 3) – Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include but are not limited to: WIC, EMSC, Healthy Start, SPRANS, HIV/AIDS monies, CISS funds. MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) – Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives – Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and usually expressed in terms of morbidity and mortality.

Outcome Measure – The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, “Why does the State do our program?”

Performance Indicator – The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - A narrative statement that describes a specific maternal and child health need or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: “The rate of women in [State] who receive early prenatal care in 19_.” This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement – The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives – A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services – Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

PRAMS – Pregnancy Risk Assessment Monitoring System –a surveillance project of the Centers for Disease Control and Prevention (CDC) and State health departments to collect State-specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy.

Pregnant Woman – A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus

Preventive Services – Activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care – the provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual’s or family’s health care services.

Process – Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, “Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?”

Process Objectives – The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) – Funds collected by State MCH agencies from sources generated by the state’s MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives – Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, “Why should the State address this factor (i.e., what health outcome will this result support)?”

State – As used in this guidance, includes the 50 States and the 9 jurisdictions. (See also, Jurisdictions)

State Funds (as used in Forms 2 and 3) – The State’s required matching funds (including overmatch in any given year.

Systems Development – Activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) – The process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration and, identification of core public health issues.

Title XIX, number of infants entitled to – The unduplicated count of infants who were eligible for the State’s Title XIX, (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to – The number of pregnant women who delivered during the reporting period who were eligible for the State’s Title XIX (MEDICAID) program.

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants rolled under – The duplicated count of infants provided a direct service by the State’s Title V program during the reporting period.

Total MCH Funding – All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block grant allocation, the *Applicant’s* funds (carryover from the previous year’s MCH Block Grant allocation – the unobligated balance). The *State* funds (the total matching funds for the Title V allocation – match and overmatch), *Local* funds (total of MCH dedicated funds from local jurisdictions within the state), *Other* federal funds (monies other than the Title V Block Grant that are under control of the person responsible for administration of the Title V program) and *Program Income* (those collected by state MCH agencies from insurance payments, MEDICAID, HMO’s etc.).

Types of Services – The major kinds or levels of health care services covered under Title V activities. See individual definitions under “Infrastructure Building”, “Population Based Services”, and “Direct Medical Services”.

Connecticut Specific Glossary of Acronyms

AAP: American Academy of Pediatrics
AFDC: Aid to Families with Dependant Children
APHA: American Public Health Association
APP/YPP: Adolescent Pregnancy Prevention/Young Parents Program
BDPSP: Birth Defects Prevention and Surveillance Program
BRFSS: Behavioral Risk Factor Surveillance System
CAHS: Connecticut Association for Human Services
CBDPSP: Connecticut Birth Defects Prevention and Surveillance Program
CCMC: Connecticut Children's Medical Center
CCOHP: Connecticut Community Oral Health Systems Development Project
CHAP: Child Health Access Project
CHCs: Community Health Centers
CIRTS: Connecticut Immunization Registry and Tracking System
CLPPP: Connecticut Lead Poisoning Prevention Program
CODES: Crash Outcome Data Evaluation System
CPS: Child Passenger Safety
CTLA: Connecticut Trial Lawyers Association
DCF: Department of Children and Families
DDS: Disability Determination Services
DOT Department of Transportation
DPH: Department of Public Health
DSS: Department of Social Services
EEOH: Environmental Epidemiology and Occupational Health
EMS: Emergency Medical Services
EMSC: Emergency Medical Services for Children
EPSDT:
ERGS: Educational Reference Groups
ESHC: Expanded School Health Centers
FAC: CSHCN Family Advisory Committee
FIMR: Fetal and Infant Mortality Review
FP: Family Planning
GIS: Geographic Information Systems
HCWC: Healthy Choices for Women and Children
HEI: Health Education and Intervention
HPSA: Health Professional Shortage Areas
HUSKY: Healthcare for Uninsured Kids and Youth (CT's CHIP program)

IAP: Immunization Action Plans
IP: Injury Prevention
MCH I&R: Maternal and Child Health Information and Referral
MICAR: Mortality Medical Indexing, Classification and Retrieval
NBS: Newborn Screening
NHSC: National Health Service Corps
NHTSA: National Highway Traffic Safety Administration
OEMS: Office of Emergency Medical Services
OHCA: Office of Health Care Access
OPPE: Office of Program, Planning and Evaluation
PEIS: Pregnancy Exposure Information System
PHHSBG: Preventive Health & Health Services Block Grant
PPC: Planned Parenthood of Connecticut
PRMS: Pregnancy Related Mortality Surveillance
PSCM: Program Support and Contracts Management
SASH: Connecticut Steering and Advisory Committee for Children with Special Health Care Needs and HUSKY Plus Physical
SBHC: School Based Health Centers
SCHIP: State Children's Health Insurance Program
SES: Socioeconomic Status
SHO!: School Healthcare Online!
SLRP: Mortality Medical Indexing, Classification and Retrieval
SSI: Supplemental Security Income
TFA: Transitional Family Assistance
UCONN: University of Connecticut
UNBHS: Universal Newborn Hearing Screening
UNBS: Universal Newborn Screening
VCY: Voice of Connecticut Youth
VFC: Vaccines for Children

5.2. Assurances and Certifications

ASSURANCES – NON-CONSTRUCTION PROGRAMS

NOTE: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age of Discrimination Act of 1975, as amended (42 U.S.C. Sects. 6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 360 1 et seq.), as amended, relating to the non-discrimination in the sale, rental, or financing of housing; (I) any other non-

discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and
(j) the requirements of any other non-discrimination statute(s) which may apply to the application.

Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 9-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

Will comply with the provisions of the Hatch Act (5 U.S.C. Sects. 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect. 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.

Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.

Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects. 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems.

Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16U.S.C. Sects. 469a-1 et seq.)

Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.

Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of knowledge and belief that it and its principals:

are not presently debarred, suspended proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

have not within a 3-year period preceding this proposal been convicted of or had a civil judgement rendered against them for commission or fraud or criminal judgement in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

are not presently indicated or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and

have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurance page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled "Certification Regarding Debarment, Suspension, In-eligibility, and Voluntary Exclusion – Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractor) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certified that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

Establishing an ongoing drug-free awareness program to inform employees about-

The dangers of drug abuse in the workplace;

The grantee's policy of maintaining a drug-free workplace;

Any available drug counseling, rehabilitation, and employee assistance program; and
The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
Abide by the terms of the statement; and
Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant offer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or
Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).
For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, DC 20201

CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the

Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total cost (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

The undersigned shall require that the language of this certification be included in the award documents for all subawards and all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsibility entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

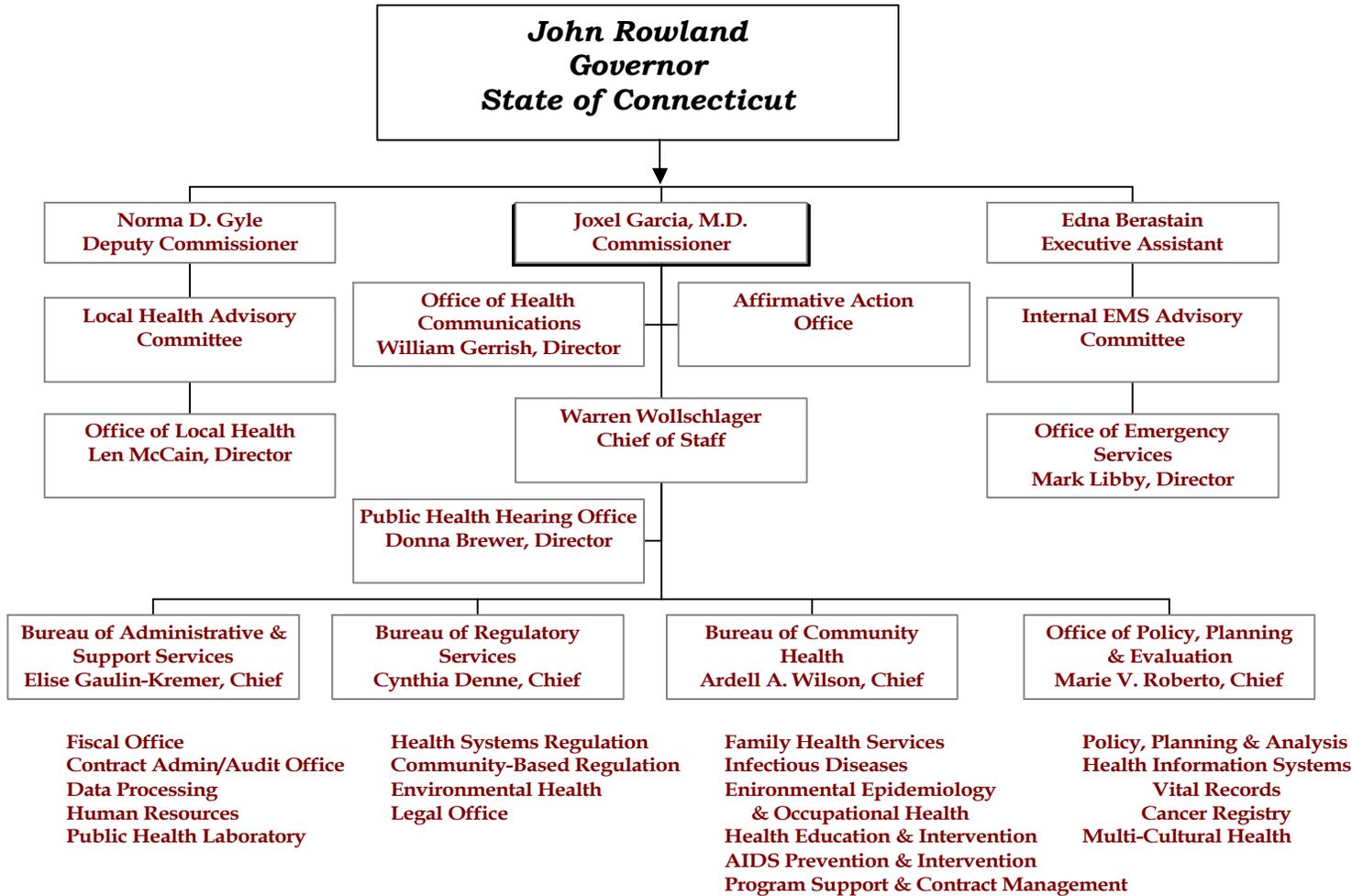
The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for the children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages will grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

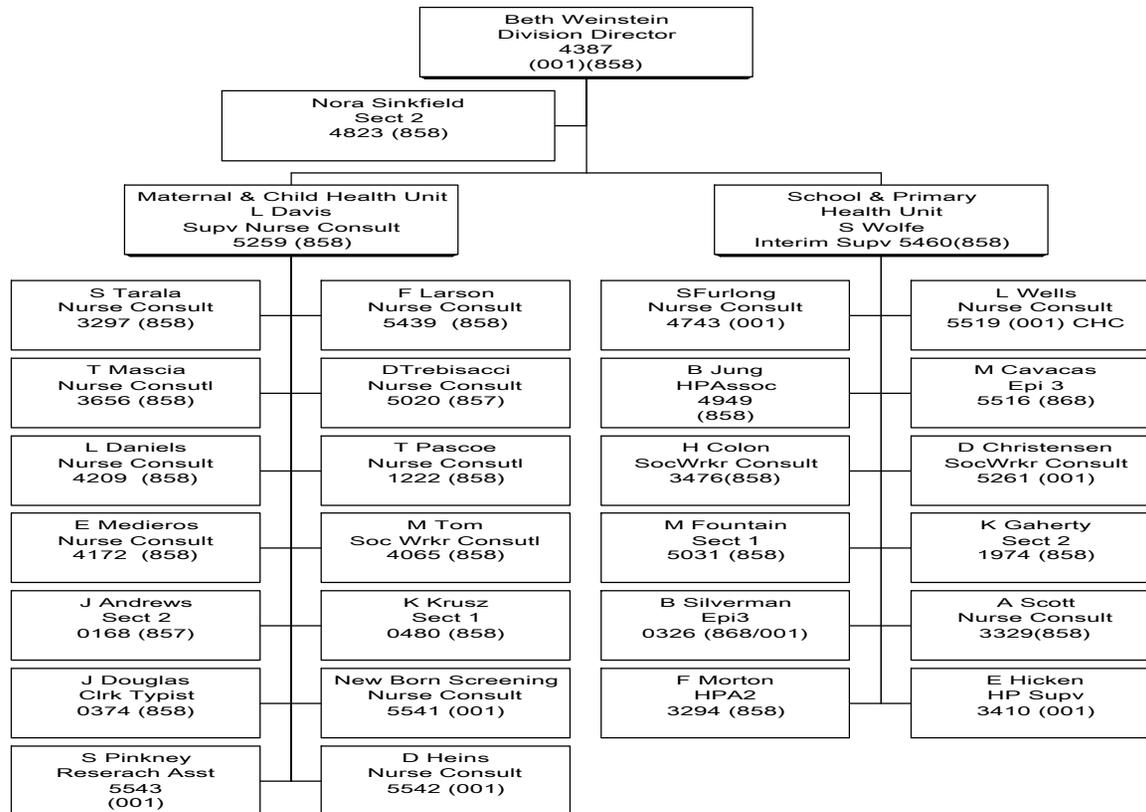
5.3 Other Supporting Documents

ORGANIZATIONAL CHARTS

Department of Public Health



FAMILY HEALTH DIVISION



RESUMES

BETH WEINSTEIN

150 Selden Hill Drive
West Hartford, CT 06107

EDUCATION

Yale University, M.P.H. (Master of Public Health), 1973

Barnard College, B.A., 1971

EMPLOYMENT

Connecticut Department of Public Health

Director, Family Health Division (Jan. 2000 to present)

Direct the division, which includes programs such as Title V Healthy Start, Children with Special Health Care Needs, genetic services, community health centers, school based health centers, adolescent pregnancy programs, family planning, and oral health.

Director, AIDS Division (Nov. 1987 to present)

Reorganized and direct the AIDS Division, including hiring, obtaining funding, designing studies and programs, and managing \$20 million budget, 70 contracts, and 25 staff members.

Responsible for policy development on AIDS issues, served as principle investigator of epidemiology, prevention and health care cooperative agreements with the Centers for Disease Control and Prevention and the Health Resources and Services Administration.

Acting Director, Chronic Disease and Injury Prevention Division (Sept. 1993 to Sept. 1994)

Directed this Division in addition to the AIDS Division. Established and obtained federal funding for the Injury Control Program. Supervised staff in the areas of hypertension, breast and cervical cancer, nutrition and physical activity.

Director, Preventable Diseases Division (Nov. 1985 to Nov. 1987)

Directed Department activities including infectious diseases, environmental health, chronic diseases, drinking water, cancer control, and the state Tumor Registry.

Assistant Chief, Bureau of Health Promotion (Jan. 1985 to Nov. 1985)

Assisted in administration of the Bureau, which included the Preventable Diseases Division, the

Community Health Division (maternal and child health), and the Laboratory Division.

Assistant Director, Preventable Diseases Division (Sept. 1982 to Jan. 1985)

Assisted division director in administration of programs described above.

Block Grant Coordinator (Aug. 1981 to Aug. 1982)

As a consultant to the Department, supervised planning and approval process for new federal block grants for preventive health and maternal and child health.

Connecticut Office of Policy and Management, Consultant, Comprehensive Planning Division (Sept. 1979 to July 1981)

Directed the Institutional Care Study, an analysis of health care for the mentally ill and other institutionalized populations. Prepared the work program of the HUD 701 awarded to the state for the purpose of implementing strategies to help urban areas.

Citizen/Government Transportation Planning Center, Staff Director, Aug. 1976 to June 1978)

Directed the operation of the center and worked with volunteer board on transportation issues in

the Capitol Region.

Connecticut Citizen Research Group, Director, Health Project (Dec. 1975 to July 1976)

Coordinated efforts to increase citizen input into health systems agencies being formed in the state.

Connecticut Department of Environmental Protection, Senior Environmental Analyst, Air Compliance Unit (July 1973 to Nov. 1975)

Directed planning for new air quality regulations and analyzed health impacts of state and federal emission standards.

PUBLICATIONS

Weinstein, B, and Melchreit, RM. Economic evaluation and HIV prevention decision making: the state perspective. Handbook of Economic Evaluation of HIV Prevention Programs. Plenum Press, 1998, 153-161.

Weinstein B, Toce P, Katz D, Ryan LL. Peer education of Pharmacists and supplying pharmacies with IDU packets to Increase injection drug users access to sterile syringes In Connecticut. Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology, 1998;18 (suppl 1):S146-147.

Wright-DeAguero L, Weinstein B, Jones TS, Miles J. Impact of the change in Connecticut syringe prescription laws on pharmacy sales and pharmacy managers' practices. Journal of

Acquired Immune Deficiency Syndromes and Human Retrovirology

1998;18 (Suppl 1): S102-110.

Diaz T, Chu SY, Weinstein B, Mokotoff E, Jones TS, the SHAS Project Group. Injection and syringe sharing among HIV-infected injection drug users: implications for prevention of HIV transmission. Journal of Acquired Immune Deficiency

Syndromes and Human Retrovirology 1998;18 (Suppl 1): S76-S81.

Weinstein, B. Commentaries: The National Institutes of Health Consensus Development Conference Statement on Interventions to Prevent HIV Risk Behaviors: Commentaries on Reaching Consensus. Public Health Department Perspective. AIDS and Behavior 1997;1, no.3, 205-206.

Valleroy LA, Weinstein B, Jones TS, et al. Impact of increased legal access to needles and syringes on community pharmacies' needle and syringe sales - Connecticut, 1992-1993. Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology 1995;10: 73-81.

Groseclose, SL, Valleroy LA, Weinstein B, Jones TS, Fehrs LJ, Kassler WJ. Impact of increased legal access to needles

and syringes on practices of injecting-drug users and police

officers - Connecticut, 1992-1993. Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology 1995;10: 82-9.

Centers for Disease Control and Prevention. Impact of New Legislation on Needles and Syringe Purchase and Possession - Connecticut, 1992. MMWR 1993;42:145-8.

Checko, PJ, Weinstein, B. Community Awareness and Use of HIV/AIDS Prevention Services Among Minority Populations - Connecticut, 1991. MMWR 1992;43:825-9.

ACADEMIC POSITIONS

Lecturer in Public Health, Yale University School of Medicine, Department of Epidemiology and Public Health (1976 to 1980)

PROFESSIONAL AFFILIATIONS

Member, Executive Committee, National Alliance of State and Territorial AIDS Directors

Member, HIV Committee, Association of State and Territorial Health Officers, 1989-1995.

Member, American Public Health Association and Connecticut Public Health Association

Member, 1990 Class of Leadership Greater Hartford

AWARDS

Connecticut AIDS Action Council Leadership Award, 1990 and
1995

National Alliance of State and Territorial AIDS Directors
Nicholas A. Rango Leadership Award, May 1996

Julianne Konopka

14 Carillon Drive

Rocky Hill, Connecticut 06067

Home: (860) 563-1058

Office: (860) 509-7658

OBJECTIVE

A senior management position within the Department of Public Health.

PROFESSIONAL EXPERIENCE

AUGUST, 1997 **DEPARTMENT OF PUBLIC HEALTH**
to PRESENT

Director of Program Support and Contracts Management Section

In addition to the duties described as Director of Program Support and Information Management Section below, this position includes management and oversight of approximately 400 contracts, management of the Bureau Quarterly Reporting System, coordination of fiscal aspects of block grant development (allocation plans, annual reports, etc.), tracking of operating expenses for the Bureau, management of bureau purchase requisitions and the Tuberculosis billing process.

JUNE 1994 **Director of Program Support and Information Section**

JULY, 1997 Within the Bureau of Community Health, responsible for the management of preventive and MCH block grant planning and reporting, planning coordination, program and resource development, data gathering and management and data analysis.

1979 to 1994 **CONNECTICUT ALCOHOL AND DRUG ABUSE COMMISSION**

Director of Planning and Development **1988 to 1994**

Implemented planning mandates under CGS 17a-635, including development of a multi-year state plan for alcohol and other drug abuse problems, development of annual plans to implement the multi-year plan, acted as staff to the State Plan Steering Committee, conducted annual regional public hearings and an annual state survey, managed the agency's Regional Action Council (RAC) system, which involved technical assistance and trouble shooting, as well as coordination with the agency's overall planning activities; managed the development of programmatic reporting requirements for the state general fund (i.e. Program measures, budget options) and the Substance Abuse Block Grant (ie. Application, Annual Report and Allocation Plan); developed requests for proposals for new and expanded

programming; managed the completion of national and state substance abuse surveys; supervised the work of agency planning staff and the work of ad hoc consultants.

Senior Planning Analyst

1982 to 1988

Chaired an intra-agency group which revised the agency's automated Client Information Collection System (CICS) and ensured coordination of all agency divisions relative to client data and clinic reporting; developed major sections of the State Plan for Alcohol and Other Drug Abuse; developed a validation procedure for review of client records for use by program monitors; completed an annual national survey of state alcohol and drug abuse agencies; completed program measures and budget options for the Governor's Budget; designed and implemented a quarterly reporting system for homeless shelter programs.

Planning Analyst II

1980-1982

Assisted in the development of the State Plan for Alcohol and Other Drug Abuse; prepared topic-specific reports on issues related to alcohol and other drug abuse; chaired an intra-agency work group which coordinated the data needs of staff in agency divisions; represented CADAC on the Department of Human Resources Advisory Council; conducted evaluations of model substance abuse programs (i.e. long term care, triage, social setting detoxification); implemented, analyzed and prepared results of a statewide substance abuse survey.

Planning Analyst I

1979-1980

Assisted in the development of the State Plan for Alcohol and Other Drug Abuse; provided technical assistance to other state agencies and substance abuse providers in the area of program development and evaluation; completed agency information for the Office of Policy and Management's Institutional Care Study; analyzed social, economic and other data related to alcohol and other drug abuse.

1977 to 1979

CONNECTICUT STATE DEPARTMENT OF LABOR

Assistant Employment and Training Specialist 1978-1979

Prepared written and graphic materials related to the state employment and training plan; established and maintained relationships with program operators through the provision of technical assistance; conducted an evaluation of agency-funded programs; and served as liaison between the Office of Employment and Training and Connecticut's State Manpower Planning Council.

Career Trainee

1977-1978

Gathered and analyzed economic information pertinent to employment and training programs; analyzed statistical information on program effectiveness.

1973-1977

PETER R. AMATO, M.D.,P.C.

Hartford, Connecticut

Under the direction of an R.N., responsible for patient billing, insurance claims, patient appointments, lab work and assistance with patient care.

EDUCATION

Bachelor of Science - Central CT State College (1973)

Major in Elementary Education, Concentrate in Reading

MBA - Rensselaer Polytechnic Institute, Hartford Graduate Center

Quality Point Average: 3.867

REFERENCES

Available on request.

Lisa A. Davis
PO Box 174
Glastonbury, CT 06033
(860) 659-8931

Career Objective

To obtain a management level position within a growing and diverse health or social service organization.

Professional Experience

Nov. 1997 - Present: State of Connecticut, Department of Public Health
Supervising Nurse Consultant, MCH Unit

Responsible for programmatic and budgetary oversight of the programs in the MCH Unit which include:
Genetics/Newborn Screening, Adolescent Pregnancy

Prevention and Young Parents Program (APP/YPP), CT Healthy Start, Abstinence-Only Education,
SIDS, Newborn Hearing Screening, Children with Special Health Care Needs, Sickle Cell Transition,
Healthy Choices for Women and Children, Pregnancy Related Maternal Mortality Surveillance and
numerous personal service agreements.

Responsible for providing direct supervision to 17 professional and support staff.

Responsible for writing the Federal State Systems Development Initiative (SSDI) Grant and the Maternal
and Child Health Block Grant.

1995 - Nov. 1997: State of Connecticut, Department of Public Health
Nurse Consultant

Responsible for contract negotiation and monitoring of Department funded School Based Health Centers
statewide. Chairperson for the SBHC training committee and Robert Wood Johnson Communication
Subcommittee.

1987 - 1995: Community Health Services, Inc. Hartford, CT
Assistant Clinical Director

Responsible for coordinating and monitoring of clinical activities at an urban community health center. Assisted in the development, implementation and follow-up of patient satisfaction surveys and other QA activities. Provided direct supervision to 30 staff (administrative and clinical).

1984 - 1987: **St. Francis Hospital and Medical Center, Hartford, CT**
Staff/Charge Nurse

Responsible for direct patient care of acutely ill patients on a medical/surgical and orthopedic unit. Trained as a preceptor for new staff nurses.

EDUCATION

1987 - 1993 **The Hartford Graduate Center, Hartford, CT**
Degree: MBA
Awarded by Rensselaer Polytechnic Institute; Troy, NY

1979 - 1983 **University of Connecticut, Storrs, CT**
Degree: BSN

PROFESSIONAL ORGANIZATIONS

Member: **Chi Eta Phi Nursing Sorority**
Hartford Graduate Center Alumni Association
University of Connecticut Alumni Association
New England Public Health Association (NEPHA)
Coalition of State Genetic Coordinators

LICENSES/CERTIFICATIONS

Current: **State of Connecticut Registered Nurse License**

References: **Available upon request**

Work

Experience:	School & Primary Health Unit Supervisor	State of Connecticut, Department of Public Health	1999 – present
	Supervisory and oversight responsibility for the professional staff, contract and budget development (approx. \$15,000,000), and program implementation for: School-Based Health Centers, Community Health Centers, Family Planning, Sexual Assault Prevention & Intervention, Recruitment & Retention, Cooperative Agreement for Primary Care, & others.		
	State Oral Health Director	State of Connecticut, Department of Public Health	1995 – present
	Oral & Maxillofacial Surgeon	Private clinical practice, Connecticut	1979 – 1995
	Assistant Professor	University of Connecticut, School of Medicine & Dentistry	1977 – 1979

Education:

Master in Public Health (MPH)	University of Connecticut, School of Medicine	1995
Oral & Maxillofacial Surgery	Fellowship & Residency, Johns Hopkins Hospital & Medical Center	1997
Doctor of Dental Surgery (DDS)	New York University, College of Dentistry	1974
Bachelor of Science (BS)	City University of New York, Brooklyn College	1970

Professional

Experience:	Director Oral Health Programs	Yale-Griffin Prevention Research Center, Yale School of Medicine	1999 – present
	Advisory Committee	Preventive Medicine Residency Program, Yale School of Medicine	1999 – present
	Chairman	Association of State & Territorial Dental Directors, Policy Committee	1999 – present
	Steering Committee	Graduate Program in Public Health, University of Connecticut, School of Medicine	1993 – present
	Medicaid Managed Care Council	Subcommittee on Access / EPSDT, Connecticut State Legislature	1996 – present
	Tobacco Use Cessation Coalition	Mobilize Against Tobacco for Children’s Health (MATCH), CT statewide coalition	1996 – 1999

Mayor's Child Abuse Prevention Coalition	City of Hartford	1996 – 1999
Health Care Access Commission	Connecticut Legislature	1991 – 1993
President CSDA	Connecticut State Dental Association	1991 – 1992

Professional

Boards: Diplomat American Board of Oral & Maxillofacial Surgery 1979 -present

Licensure: Dentistry Connecticut, Massachusetts, New York

Memberships: Association of State & Territorial Dental Directors
American Association of Public Health Dentistry
American Dental Association
American Board of Oral & Maxillofacial Surgery
Connecticut State Dental Association

Awards &

Honors: Surgeon General's Report on *Healthy People 2000*, Teleconference: selected as "expert panelist."
New England Public Health Association: "Exceptional Best Practices" in Public Health: for development of community based collaborations to enhance oral health care access.
Commissioner's AIDS Leadership Award, State of Connecticut.
American Dental Association Golden Apple Award, for the Connecticut State Dental Association's Infection Control Program.
Pierre Fauchard Academy, National Dental Honor Society.
Award of Special Merit, American Dental Association, for developing a preventive dentistry program for the Native American school systems of the Northwest United States.

Professional

Presentations: Featured speaker at numerous state, regional & national health conferences: full list available upon request.
[REPRESENTATIVE SAMPLE]

- Developing Community Collaborations to Enhance Health Care Access.*
- School Based Health Centers: an Answer to Enhanced Health Care Access.*
- Infection Control & Hazardous Waste Management in the Clinical Setting.*
- Oral Health & General Health: Findings of the Behavioral Risk Factor Surveillance Survey.*

HIV/AIDS: the Oral Public Health Perspective.

[Note: Dr. Wolfe is also a noted expert in Pain & Anxiety Management, and in the Prevention & Treatment of Medical Emergencies, in Clinical Practice; list of professional presentations available upon request.]

Research & Grants:

[REPRESENTATIVE SAMPLE]

Project Director, Innovative & Integrated Use of Data for Surveillance, Evaluation and Assessment, Yale-Griffin Prevention Research Center, Yale School of Medicine, federal grant (CDC), 1999-2001.

Principal Investigator, Connecticut Oral Health Survey and Needs Assessment, CT DPH, ongoing.

Principal Investigator, Present and Projected Dental Provider Participation in the Connecticut Medicaid Managed Care Program: Impact on Dental Care Access, CT DPH, 1966.

Publications:

[REPRESENTATIVE SAMPLE]

Wolfe, SH, Present and Projected Dental Provider Participation in the Connecticut Medicaid Managed Care Program: Impact on Dental Care Access, CT DPH, December 1996.

Wolfe, SH, *Preparing the Patient for Painless Dentistry*. Jour Calif Dent Assoc, 24(8):21 (1996).

Wolfe, SH, *Local Anesthesia Revisited: Update, Selection, Eliminating Failures, Trouble-Shooting*, in Clark's Clinical Dentistry, Hardin JF, ed. JB Lippincott Company, Philadelphia. 1(24A):1 (1993).

Mehlisch D, Wolfe SH, et al, Clinical Comparison Of Zomepirac With APC-Codeine Combination In The Treatment Of Pain After Oral Surgery, Jour Clin Pharm, 20(1):271 (1980).

Wolfe SH, Teeth Can Last Forever: A Preventive Dentistry Activity Book for Children. NYU Press, New York (1972).

STATE AGENCY COORDINATION

State Agency Coordination

The Department of Public Health and The Department of Social Services (DSS) continue to provide joint funding and program management for 23 statewide Healthy Start Programs. Program staff from both agencies meet periodically to assure coordination of services. The Departments of Public Health and Social Services continue to work with Healthy Families Connecticut in partnership to link Healthy Start and Healthy Families to promote outreach and home visitation to high risk families. The funding supporting this partnership also provides entry level employment opportunities for individuals who are transitioning from welfare to work.

The APP/YPP program coordinator represents the Department of Public Health on the Teen Pregnancy Prevention Coalition of Connecticut, a statewide coalition of individuals and organizations dedicated to the prevention of teen pregnancy. The Supervisor of the School and Primary Health Unit and the Nurse Consultant participate

The Children with Special Health Care Needs (CSHCN) program advisory committee membership includes representation from the Departments of: Public Health (DPH), Social Services (DSS), Mental Retardation(DMR), Education (DOE), Insurance (DOI), Connecticut Association of Health Maintenance Associations, Children and Families (DCF), and Office of the Child Advocate. The CT HUSKY Plus Physical program, which is modeled after the Title V CSHCN program, utilizes the same advisory group and providers as well. The state Title V Director is also a member of the CT HUSKY Plus Behavioral Steering Committee. The CSHCN program collaborates with the Social Security Administration/Disability Determination Unit at DSS to identify and refer potential clients to the CSHCN Program. Staff from DPH and both CSHCN Regional Centers participate on the Department of Children and Families Advisory Committee for Medically Fragile Children in Foster Care. Additionally, staff actively participate on the Department of Mental Retardation's Birth to Three Public Awareness and Medical Advisory Committee and represent the Department on the planning committee for the annual statewide early intervention conference for families and providers serving children in specialized programs. The CSHCN program will be serving on CT's Birth to Three Interagency Coordinating Council.

The Genetics Services and Universal Newborn Screening Programs have working relationships with all thirty-one hospitals/birthing facilities in the State, the CT State Laboratory and the designated state-funded Regional treatment centers to fulfill the testing, tracking and treatment components of the Universal Newborn Screening Program.

Genetic services are supported by three tertiary centers: Yale University, the University of CT Health Center and St. Francis Hospital and Medical Center. The Genetics Advisory Committee (GAC) is comprised of physician specialists for Genetics, Metabolics, Endocrinology and Hematology; Social Workers, Clinical Nurse Specialists, Nurse Consultants, Director of the State Laboratory and Supervisors, as well as DPH program staff. The GAC meets on a quarterly basis to discuss protocols, guidelines, emerging issues, program outcomes and needs. Universal Newborn Screening program staff attend and represent the DPH on various state and regional committees and resource groups. Presently, DPH representation has been included on the following: CT PKU Group, New England Maternal PKU Planning Group, New England Consortium of Metabolic Centers and New England Regional Genetics Group (NERGG). NERGG participation includes representation on the Steering Committee,

Newborn Screening Committee and the Sickle Cell Committee. Participation on these committees and groups has provided staff the opportunity to: network with multiple disciplines of medical professionals regarding program needs, plans and emerging public health issues; participate in educational conferences/workshops; and gain support and resources for DPH staff, clients and their families.

In an effort to address the provision of universal newborn hearing screening, the Department is working in collaboration with and has representation on both the Commission on the Deaf and Hearing Impaired, and the CT Infant Hearing Screening Task Force, and the Birth to Three System.

MCH program staff continue to represent the Department on the CT Family Support Council which assists state agencies to evaluate/coordinate and identify emerging issues to address service needs and promote statewide access to services. Representation continues on the MCH Information and Referral Service Advisory Committee to provide ongoing evaluation and planning to meet Connecticut's OBRA 89' requirements. In fostering linkages between Title V and the court system the Department is represented on the State Court Support Services for Gender Responsive Programming Committee which deals with program development needs for females who are either pregnant or parenting and receiving services from the judicial system.

As part of the Women's Health Initiative (WHI), DPH staff actively participate in the Office of Women's Health Region One Workgroup. This workgroup is a means 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.

Connecticut's Healthy Mothers/Healthy Babies Coalition is jointly chaired by a staff member within the Title V program and the Connecticut Chapter of the March of Dimes. The mission of the Connecticut Healthy Mothers/Healthy Babies Coalition is to promote the health and well being of women and children in the State of Connecticut, through leadership, collaboration, and resource sharing. Quarterly meetings are held; each meeting presents a speaker on a topic of interest to the MCH community address an expressed area of need, as well as an opportunity for networking and information sharing among providers.

This year, the Robert Wood Johnson Foundation (RWJF) grant to institutionalize School Based Health Centers (SBHCs) as an integral part of the health care delivery system for youth is ending. This grant was guided by the Making the Grade (MTG) in CT RWJ Steering Committee, and provided many opportunities for collaborative efforts among DSS, SDE, DCF, Corrections, OPM, and DPH.

Site Coordinators of SBHCs across the state meet bi-monthly with DPH staff to address grantee issues, training and technical assistance, information and resource sharing and input on overall project direction. CT SBHCs have formed a non-profit independent organization-The CT Association of SBHCs, Inc., to advocate for this service delivery model.

SBHC program staff participate on the Youth Suicide Advisory Board, an interagency committee which advises DCF on policy and program planning regarding youth suicide. Staff also work closely with the State Department of Education (SDE) on the Coordinated School Health Program. A Social Work Consultant with DPH's SBHC program is an active member of the State Adolescent Health Coordinator's Network which is a

national association of all state and territorial Adolescent Health Coordinators, as well as a member of NASW, and a member of the National Assembly on School Based Health Care.

The Department of Public Health has partnered with the Office of the Governor, through the Governor's Collaboration for Young Children, to establish The Healthy Child Care Connecticut initiative. This project is a state and federal collaborative effort, supported by the Maternal Child Health Bureau. Its goal is to achieve optimal health and development for all children in child care, by guiding and supporting service integration between the child care community and health care providers. Healthy Child Care Connecticut is guided by a five member Leadership Team; DPH provides staff to the position of project director and co-chair, along with the executive director of the Children's Health Council. The team has established a Core Committee consisting of over 55 people representing organizations that play a key role in the planning and delivery of child care and health care for children and their families. Healthy Child Care Connecticut also works very closely with the national Healthy Child Care America campaign, which is coordinated by the American Academy of Pediatrics with support from the DHHS Child Care and MCH Bureaus.

The MCH Director represents the Department on the board of CT's Commission on Children. This Commission, legislatively created in the early 1980's, sets the agenda for issues relating to children's health in the state. Some of the priority issues have revolved around youth violence, fatherhood, parent leadership, school readiness, literacy, child care, adoption reform and child safety.

The CT Coalition to Stop Underage Drinking, designed to curb under age drinking, involves all state agencies and advocacy groups across the state. The coalition is headed by the Governor's Partnership Project, Drugs Don't Work!, and is funded by the RWJ Foundation.

The MCH Supervisor has met with staff from the Department of Mental Health and Addiction Services. Additional meetings are scheduled to enhance collaboration between DPH and DMHAS. In addition, we are planning to sponsor regional meetings for grantees to discuss access to mental health services for women.

Community Health Centers (CHCs) make up a significant portion of the public health delivery system. Twelve corporations provide comprehensive primary and preventive health care and other essential public health services at 28 sites. All centers are located in Health Professional Shortage Areas and/or Medically Underserved Areas and operate in accordance with Federally Qualified Health Center Guidelines. Approximately 120,000 people are served annually. Over six million state and federal dollars from the Department of Public Health support the Community Health Center infrastructure, services to the uninsured, and special projects to improve access and facilitate entry into care in areas of especially high need. State bond funds are available periodically to support capital projects.

Most Community Health Centers in Connecticut are members of the Connecticut Primary Care Association (CPCA). The Department of Public Health and CPCA work together on a number of important initiatives to promote, advocate for, and develop community based systems of care for the state's most vulnerable populations and to support CHCs. Among these are the Connecticut River Valley Farmworker Health Program (in conjunction with the Massachusetts League of CHCs), CHC Recruitment and Retention activities, State Loan Repayment

Program, National Health Service Corps SEARCH Program, Immunization Program initiatives, Pediatric AIDS Program, Breast and Cervical Cancer Screening and Domestic Violence Prevention.

Local Health departments/districts in the state play a critical role in planning, providing, and advocating for public health services on the local level. The services provided may include but are not limited to: 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 Office of Local Health administers state funding for local health departments and districts. Input is provided by a panel of department staff including a representative from the Title V program.

Connecticut is one of eight states chosen by the Family Resource Coalition of America to partner with them on the STATES initiative (State Training and Technical Assistance for Effective Systems), a national initiative to promote a Family Support agenda. Our STATES initiative, now entitled Family Support Connecticut has included many diverse partners including the Office of the Governor, The State Departments of Public Health, (represented by staff from the Title V program), Children and Families, Community & Economic Development, Education, Mental Health & Addiction Services, Mental Retardation, Office of the Child Advocate, Office of Policy and Management, Office of Protection and Advocacy, Social Services, Commission on Deaf and Hearing Impaired, and others, as well as community-based agencies including the CT Association for Foster and Adoptive Parents, CT Chapter for the Prevention of Child Abuse, CT Parent Teacher Association, Graustein Memorial Fund, Southern Connecticut Library Services, Manchester Hospital Family Support and Resource Center, United Way of CT, and WVIT Channel 30. This list is not all inclusive; the initiative has been successful in reaching as many partners as possible.

Representatives from some of the above agencies meet to work on various activities related to the goals of the CT initiative such as Family Day and development of the CT Family Support Network. The partners represent a broad spectrum of socio-economic and culturally diverse groups as well as a wide geographic area in Connecticut who work to carry out the vision of this initiative: a Connecticut in which all of us...families, communities, government, social service and health care systems, businesses, educational and faith communities work together to provide healthy, safe and stimulating environments for all children and families.

CONNECTICUT
Fetal and Infant Mortality Review Programs
OUTCOMES TO DATE

CONNECTICUT FIMR PROGRAM OUTCOMES TO DATE

In the 12 months (and in some cases, less) since the FIMR programs have been doing case reviews, there have been some significant findings across each of the FIMR projects. These include:

- Lack of follow-up care for medical and bereavement services, no referral to VNA for follow-up
- Ineffective linkages between Community Services and Private Physicians.
- No preconception planning--no medical intervention prior to becoming pregnant.
- More case management needed
- Translation services are needed
- Poor medical record documentation exists in clinics and hospitals

Findings specific to each FIMR project are listed below, followed by a listing of community response for change. It is anticipated that, with continuation funding for the next 2 years, the projects will be able to successfully implement some of the recommendations that have come out of the Community Action Teams. Additionally, it is feasible to believe that over time the information obtained through the home interview process and the medical record review will substantiate the implementation of these changes.

Hartford

- Lack of follow-up care for medical and bereavement services
- Lack of referral to other needed health/social services by private physicians
- No referral to VNA for follow-up
- Missed signs of domestic violence in a variety of settings
- Seatbelt not worn during pregnancy
- No preconception planning
- Limited case management services
- Numerous stressful events in the mother's life around the time of pregnancy
- Large percentage of women are over 30 years of age.
- Obesity as a risk factor

System Changes

1. Create a system of follow-up care for women and families that have suffered a fetal or infant loss.

Women and their families need follow-up information regarding medical information related to the death.

Women and their families need bereavement counseling.

The anticipated outcome of this system would be that some women would not try to have another baby immediately and therefore would reduce the risk of another poor outcome.

Action Team: Silvana Flattery, Leticia Lacomba, Jann Moody, Amy Sampson, Kelly Sanders

A Perinatal Loss Conference was held to educate providers about the issues specific to the bereavement needs of families that have suffered a perinatal loss. This conference was held in Hartford and was attended by sixty people from across the state. The conference was sponsored by the CT SIDS Center and the CT March of Dimes, the Greater Hartford Prenatal Care Continuum, and the Hartford Primary Care Consortium.

Work continues on this recommendation.

2. Increase screening for Domestic Violence

The anticipated outcome of this intervention would be to identify and offer supports to pregnant women in Domestic Violence situations. An Action Team has not yet been identified for this recommendation. The City Health Department will hear a presentation in March to decide if there should be a call to action on Domestic Violence in the City of Hartford. This would create a greater and more coordinated focus on the issue, and would create the possibility for more funding on this issue.

3. Educate prenatal providers about resources available for the women they serve.

The anticipated outcome of this recommendation is that private physicians will make more referrals to needed services. Further discussion is necessary to develop the plan to address this issue.

Action Team: David Polk, Paula Gilberto, Jann Moody

4. Lack of seatbelt use in pregnant women can easily lead to a fetal or infant demise.

A recommendation regarding this issue has not been brought to the Community Action Team yet.

A physician from the Case Review Team has become active in a group that is already addressing this issue and will update the Case Review Team on the status of this campaign.

5. Lack of a referral for VNA services following a perinatal loss.

This is being addressed by Case Review Team members at their own institutions. FIMR staff have begun to see cases with this referral made.

6. Obesity

A student from the UCONN School of Allied Health has assessed the nutrition status of all the women identified by FIMR. The findings of this assessment will be presented to the Case Review Team in January for discussion.

Other Accomplishments: FIMR staff have presented to the Women's Ambulatory Center at Hartford Hospital and have been asked to present at other facilities with a variety of providers. These presentations are currently being scheduled. FIMR staff have developed three brochures; one for families, one for lay persons, and one for providers. The brochures and presentations are mechanisms for educating the community and providers about the FIMR program and about some of the factors that may be contributing to fetal/infant mortality.

New Britain

- Inconsistent patient follow-up.

The Case Review Team identified a pattern of inconsistent patient follow-up after an infant/fetal loss (e.g., for bereavement counseling and support; for family planning and pregnancy spacing, genetic counseling/testing). In addition, improvement of monitoring and follow-up for women experiencing preterm labor was also identified as a need.

- Ineffective linkages between Community Services and Private Physicians. The Case Review Team identified the need to improve communication and linkages between private obstetrician-gynecologists and relevant community services, particularly for women covered by Medicaid Managed Care. It appeared as though women receiving prenatal care from private physicians did not always receive other needed services that are available to them.

System Changes

1. New Britain General Hospital maternity unit implemented changes in discharge procedures for patients experiencing an infant or fetal loss. Home visits with a visiting nurse are now routinely arranged within two or three days of discharge. This allows the visiting nurse to make an assessment of the patient's need for a range of follow-up services, as well as provide counseling, support and education.
2. More aggressive follow-up has been instituted by the hospital for women telephoning with concerns about possible premature labor. Patients are now routinely instructed to report back by phone, (or be called back) whether or not they continue to experience contractions (rather than only if they believe the contractions are continuing.)
3. The need for more extensive bereavement services has been discussed, but no formal plan has yet been instituted.

4. A private obstetrician-gynecologist from one of the largest local medical groups has been recruited to participate on the Case Review Team. It is anticipated that this relationship will provide an opportunity for ongoing, honest communication.

5. The Community Action Team will develop and implement an outreach effort to educate private physicians about existing community services currently available to all women and families--including their patients. A subcommittee of the CAT will formulate the outreach plan and present it to the Community Action Team at its March 2000 meeting.

6. The FIMR Coordinator will present and overview of FIMR to all New Britain obstetrician-gynecologists at their regularly scheduled grand rounds/business meeting, held at New Britain General Hospital. These meetings are well attended and will provide an opportunity to educate physicians about FIMR activities, findings and related issues.

New Haven

- Stable housing may be a significant factor in birth outcomes.
- Poor medical record documentation exists in clinics and hospitals
- No bereavement services are provided post-discharge.
- No post-partum follow-up at home.
- Inadequate culturally appropriate translation services available in clinics, labor, and delivery.
- Fragmented services exist across agencies and organizations.
- New Haven's large undocumented population receives late or no prenatal care.
- Although the number of infant deaths is decreasing, the number of fetal deaths and low birthweight babies is steadily increasing. This points to the fact that new and different prevention programs must be identified and implemented.

System Changes

1. Established a collaborative relationship between a variety of community organizations, to assist in the identification of high-risk pregnant women pre-conceptually.

2. The Health Department has hired a bi-lingual MANOS outreach worker who will have responsibility for case finding and providing follow-up care coordination (bereavement, access to health care, family planning, mentoring, etc.). She will become part of a team, (VNA, hospitals, clinics, CBO's), that will implement a system of referral and follow-up post-hospital discharge.

3. VNA has applied for a 2000/01 City of New Haven Community Development Block Grant (CDBG) funding to implement a program of post-partum visits and bereavement services in conjunction with the New Haven Health Department.
4. Health Department has applied for 2000/01 CDBG funding to augment the FIMR program.
5. A plan is underway to target outreach toward undocumented residents needing prenatal care.
6. Efforts to increase enrollment of pregnant women in the Healthy Start program are being enhanced.

New London

- Lack of bereavement services, no directory of such services
- Inadequate follow-up services
- Case management services need to be strengthened
- Private physicians need to be educated about referral resources
- There is a need to enhance prenatal/pre-pregnancy education
- Translation services are required to assure receipt of accurate information

System Changes

1. Establish a post-discharge grief counseling service for families. These services need to begin in the acute care setting at the time of the loss episode/event. The development and implementation of these coordinated bereavement services require follow-up at one month, six months and one year at a minimum. These services need to involve community lay personnel and professionals who are sensitive to cultural and religious beliefs.
2. Strengthen relationships among providers, especially with physicians who will encourage more appropriate and timely referrals for moms (particularly nutritional counseling). These services need to extend beyond the current WIC services, need to address women of all socio-economic levels and need to be creative in delivery (e.g. address the working women's needs and perhaps meet during lunch times, etc.)
3. Develop and implement better preconception and prenatal education programs that emphasize the importance of women's health, prenatal care and prevention, including use of harmful and addictive substances, i.e. drug abuse. Partnership with schools is one suggested avenue for implementation.

4. Develop and maintain an easily accessible and user friendly resource directory for women regarding maternal child health providers, and bereavement services.
5. Increase and improve translation services for health care delivery, especially for the Asian population and other under-represented minority populations and immigrants.
6. Work with acute care facilities and other professionals involved with maternal and child health to improve documentation in the medical records. Suggest better identification of the provider's name, title, and care delivered.
7. Explore the development and implementation of a single universal record for each client to increase continuity of care and decrease duplicative efforts and gaps in services.
8. Explore a system to evaluate the continuity of care and follow-up between the pre-assessment and post-discharge plan (it appears that there is inadequate follow-up with moms.)
9. Develop and implement care protocols for deliveries that occur outside the hospital and are transported to the hospital for follow-up.

Windham:

- Lack of grief counseling services and support groups, and information
- Poor birth outcomes as a result of maternal substance abuse.
- Late entry into prenatal care
- Lack of family planning resulting in unplanned pregnancies
- Lack of sensitivity among ER physicians regarding infant death
- Need for universal screening of all patients upon entry into prenatal care systems (private and public)
- Mental health issues and lack of prenatal care

System Changes

1. A subcommittee to address bereavement issues has been convened.
2. A list of Windham Bereavement Resources has been developed and distributed to key locations.
3. A list of burial services for fetal and infant deaths has been developed.
4. The Bereavement Support Group (Share) at the hospital has been reactivated.

5. A subcommittee to promote family planning to stem the increase in unplanned pregnancies has been established.
6. FIMR was instrumental in establishing a sensitivity training for ER doctors concerning SIDS deaths.
7. The hospital billing system has been reviewed in order to provide for parents who have suffered an infant or fetal death and who are uninsured or financially unable to pay for medical services.
8. An education program has been developed on the OB floor in order to educate patients before they leave the hospital after giving birth, about future pregnancies.
9. A CAT subcommittee will examine the prevalence of maternal substance abuse in Windham and is looking at the lack of treatment centers for the maternal population.

Bridgeport

- Communication between prenatal OB/GYN, patient, and delivering OB/GYN needs to be enhanced.
- Communication between insurance companies and providers need to be enhanced to flag high risk clients.
- Risk assessments in the physicians office need to be improved.
- Counseling and education services need to be enhanced, especially regarding signs and symptoms of preterm labor.
- Women should be referred for needed services. Services should be case managed and coordinated.
- Missed appointments are not followed-up by the clinician.
- There is no bereavement or follow-up post hospital discharge.
- Medical record documentation is incomplete.

System Changes

1. Determine the hospitals' methods of follow-up after delivery regarding; family planning, genetic and grief counseling, bereavement services, etc.; policies and procedures regarding these matters should be developed as well as a mechanism for QA regarding adherence to the same.
2. Development of a system to flag a history of high-risk pregnancies in the event a mother becomes pregnant again.

3. Determine what assistance the hospitals can offer to patients without health insurance (what are the federal guidelines, mandates?) Educate providers in the system regarding the same.
4. Education of mother/parents regarding signs and symptoms that indicate reason for concern during pregnancy (decreased fetal movement, preterm labor).
5. Determine available resources to support performance of an autopsy where personal financial resources are unavailable.
6. Develop the system of case management and care coordination during the prenatal, peri-natal and post-partum periods.
7. Work with HMO's to develop a system of care coordination between services provided by the HMO and the health care providers.
8. Improve documentation in medical records.
9. Educate private physicians regarding pregnancy related services in Bridgeport.

**Family Readers of the
Maternal and Child Health Services 2001 Block Grant Application,
1999 Annual Report, and
Connecticut's Needs Assessment**

**Family Readers of the
Maternal and Child Health Services 2001 Block Grant Application,
1999 Annual Report, and
Connecticut's Needs Assessment**

WHO

Five families participated by reading the Maternal and Child Health Services 2001 Block Grant application and 1999 Annual Report as well as Connecticut's Needs Assessment. The goal was to bring together a diverse group of families, representing different geographic locations, who utilize a variety of Maternal and Child Health programs to read and comment on Connecticut's information. A profile of the families reveal two families were referred through Healthy Mother's/Healthy Babies, a coalition of agencies, providers, and families to support mothers and young children. These two families were located in the northern region of the state. One family had a combination of three natural children and one foster child starting from age 2 and continuing to age 13. The other family had two children ages 4 and 7. Two families were from the New Haven area. One family was a new mom who had just accessed Healthy Start. The other mom had two children who utilized School Based Health Centers. The two families from New Haven were bilingual as well as bicultural. One family of African-American decent was from the Hartford area. She and her husband have two children, one with special health care needs. All families were paid a stipend to assist us in reading and commenting on Connecticut's Block Grant, Annual Report and Needs Assessment.

HOW

Two meetings were requested with the families and scheduled at least a week apart. During the first of these two-hour meetings an overview of a number of topics was presented including; Maternal and Child Health Programs, the Block Grant process, and general information as to why we are requesting the review. Families had the ability to start reading materials at this meeting and were provided the ability to contact the department with questions before the next scheduled meeting date. The second two-hour meeting allowed for gathering of family information regarding the Block Grant review and the answering of questions.

WHAT WAS SAID

❖ *Distribution of program information*

One item mentioned by all families was they were not aware the Department of Public Health, Maternal and Child Health Programs provided such an extensive array of services. All believed information about these programs was not common knowledge. Many provided ideas and suggestions as to how to distribute the information including: brochures, flyers, information set up in locations where families gather, information mailed to families homes, public awareness campaigns, free booklets at clinics, and materials at doctor's offices.

One family highlighted the INFOLINE MCH liaison position as increasing the presentations to the community to promote program awareness as important. One family commented that state support for communities was 'lacking'.

❖ *Cultural Competence*

Numerous families noted translation services and culturally competent/sensitive staff as missing in the programs. Comments such as 'very lacking', 'much needed', 'none', 'NEVER' were utilized in the areas discussing these services. Some large city hospitals and community health centers were named as having no assistance in this area. It is possible that these locations do have translation services available but they were never offered to the families nor did the families know to request. Discussed under the FIMR program in New Haven was the hiring of a MANOS bilingual outreach worker who will have the responsibility for case finding and providing follow-up care coordination. Families thought there should be more of these positions available.

Safety

A concern was voiced by a few of the readers that car seat safety information needs to take into account children with special health care needs who may need special seating as well as children who are older, possibly young teens, who may still weigh under 80 pounds.

A request was made to see if the Department could publish a flyer on recalled items (toys, car seats, and clothing) in regards to the childhood injury prevention performance measure.

❖ *Access*

As the Block Grant discusses maternal and child health issues, the subject of general health access came up and two families were concerned over the practice of limiting referrals based upon the insurance plan.

One family felt information regarding Performance Measure #3, the percentage of Children with Special Health Care Needs in the state who have a "medical/health home", was overstated. This person did not believe all families had access to a quality 'medical/health home' one that provides all the necessary services and supports a family may need.

Other items mentioned of concern included why Connecticut was ranked as one of the 10 worst states for measles incidence, AIDS incidents, and substandard air quality.

❖ *What families liked about Maternal and Child Health Programs*

Families commented positively on many efforts including: asthma initiative, providing testimony at the Block Grant public hearing, valued the needs assessment process, Community Health Centers, importance of mental health supports, family-centered care, impressed with the River Valley Farm Worker Program's ability to link families with health care providers and transfer health record.

CLOSING COMMENTS

All families stated they learned much by reading the Block Grant. All said they would be interested in reading a second time. One family would like to have additional families of African-American heritage read the Block Grant in the future.

5.4 Core Health Status Indicator Forms

5.5 Core Health Status Indicator Detail Sheets

5.6 Developmental Health Status Indicator Forms

5.7 Developmental Health Status Indicator Detail Sheets

5.8 All Other Forms

5.9 National “Core” Performance Measure Detail Sheets

5.10 State “Negotiated” Performance Measure Detail Sheet

5.11 Outcome Measure Detail Sheets

5.12 NOTES

5.13 APPENDIX

**NEW STATE ADDED PERFORMANCE MEASURES DETAIL SHEETS
IN WORD FORMAT**

State Performance Measure # 02

Mental Health

The degree to which the Connecticut State Department of Public Health improves access to mental health screening, assessment, referral and linkages to services and supports in Title V funded programs.

TYPE:	Process
CATEGORY:	Enabling
GOAL:	To improve access to screening, assessment, referral and linkages to mental health supports and services for families in Title V
MEASURE:	Percent score of the number of indicators in place to support mental health screening, assessment, referrals and linkages.
DEFINITION:	Numerator: Total number of points checked in seven(7) indicator boxes. Denominator: Total possible number of points in seven indicator boxes (21).
HEALTH PEOPLE 2010 OBJECTIVES:	6-2 Reduce the proportion of children and adolescents with disabilities who are reported to be sad, unhappy, or depressed. 18-6 (Developmental) Increase the number of persons seen in primary health care who receive mental health screening and assessment. 18-7 (Developmental) Increase the proportion of children with mental health problems who receive treatment.
DATA SOURCE and DATA ISSUES:	Existing Family Health Division programs with activity (current or potential) in this area: School based Health Centers, Community Health Centers, APP/YPP, Children with Special Health Care Needs. SBHC database contains encounter data on more than 20,000 mental health/social service visits per year. APP/YPP developed a new database, which tracks relevant activities including mental health referrals. Intake protocols address mental health and psychosocial needs of population. CSHCN programs develop care plans for children served- may potentially include activities to address psychosocial needs. Family Health Division provides training and workshops to improve the capacity of our providers to meet the mental health needs of the population

SIGNIFICANCE:

There is an increasing emphasis on the federal and state levels for improved systems of mental health services. In the fall, the Surgeon General's Report on Mental Health clearly defined that mental health is fundamental to health, that mental disorders are real health conditions, and in the United States, mental health programs, like general health programs are rooted in a population-based public health model. Mental health must be defined broadly. The Surgeon General's Report defined mental health as the successful performance of mental functions, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity; from early childhood until late life, mental health is the springboard of thinking and communicating skills, learning, emotional growth, resilience, and self-esteem.

Discussion taken from Healthy People 2010 Conference edition under measure 18-7: For many children aged 18 years and under, life-long mental disorders may start in childhood or adolescence. For many other children, normal development is disrupted by biological, environmental, and psychosocial factors, which impair their mental health, interfere with education and social interactions, and keep them from realizing their full potential as adults.

Mental Health Performance Measure Checklist

The degree to which State of Connecticut Department of Public Health improves mental health screening, assessment, referral and linkages to services and supports in Title V funded programs.

0 1 2 3 <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	1. Convene a mental health workgroup to assess mental health related activities within Title V programs.
0 1 2 3 <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2. Identify appropriate standards for screening, assessment, referrals and linkages to mental health services and supports that are scientifically sound and culturally valid.
0 1 2 3 <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	3. Assess current mental health related practices within Title V funded programs, and identify baseline rates of activity for each program.
0 1 2 3 <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	4. Provide training and technical assistance to Title V funded programs to implement and/or enhance appropriate mental health screening, assessment, referrals and linkages.
0 1 2 3 <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	5. Collect and analyze data from Title V programs on an ongoing basis to determine the extent to which mental health screening, assessment, referrals and linkages occur.
0 1 2 3 <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	6. Increase screening, assessment, referrals and linkages to mental health services and supports in Title V funded programs by 5% per year over the baseline.

0= Not met; 1=Partially met; 2=Mostly met; 3=Completely met

State Performance Measure # 04

Racial Disparities

The degree to which Title V programs target services to racial and/or ethnic groups with disparities in pregnancy outcomes.

TYPE: Risk Factor

CATEGORY: Infrastructure

GOAL To reduce disparities among racial and/or ethnic groups in the occurrence of poor birth outcomes (i.e., low birth weight, infant mortality).

MEASURE Percent score of the number of indicators demonstrating a focus, within Title V programs, on racial and/or ethnic populations with disparities in birth outcomes (i.e., low birth weight, infant mortality).

DEFINITION **Numerator:** Total number of points checked in seven (7) indicator boxes.

Denominator: Total possible number of points in seven (7) indicator boxes (21).

OBJECTIVE Title V Services are targeted to racial/ethnic populations with increased likelihood of poor birth outcomes (e.g., low birth weight, infant mortality).

HEALTHY PEOPLE 2010

OBJECTIVES

Related to 9.0

Increase the proportion of pregnancies that are intended.

Related to 9.2

Reduce the proportion of births occurring within 24 months of a previous birth.

Related to 16-1

Reduce fetal and infant deaths.

Related to 16-4

Reduce maternal deaths.

Related to 16-6

Increase the proportion of women who receive early and adequate prenatal care.

Related to 16-10

Reduce low birth weight (LBW) and very low birth weight (VLBW).

Related to 16-14

Reduce the occurrence of developmental disabilities.

Related to 16-17

Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women.

DATA SOURCE and DATA ISSUES

Data from quarterly reports on number of clients seen and proportions of those who are of racially/ethnically disparate groups for obstetric outcomes from the following programs: APP/YPP, Healthy Start, Family Planning. There are no data on penetration of Title V programs into communities/populations with disparities in outcomes.

SIGNIFICANCE

The disparities in pregnancy outcomes between whites and other racial/ethnic groups parallel other disparities among the same groups: lead poisoning, sexually transmitted diseases, asthma and other health problems that are related to the physical and socio-economic environments in which people live. Population groups who are at risk for most or all of these should be given high priority for Title V services to help narrow these disparities.

Racial/Ethnic Disparities Performance Measure Checklist

The degree to which Title V programs and services are focused on reducing disparities in birth outcomes among racial and/or ethnic groups.

0 1 2 3

1. Establish an interdisciplinary workgroup to mount a coordinated statewide perinatal initiative that develops strategies to reduce poor perinatal outcomes, including those related to racial and/or ethnic disparities.

0 1 2 3

2. Assess penetration of Title V programs into geographic locations with racial and/or ethnic disparities in perinatal outcomes.

0 1 2 3

3. Assess and ensure that clients served in Title V programs targeting at-risk, pregnant or parenting teens exceed racial and/or ethnic proportions of teen births in target communities by 5%.

0 1 2 3

4. Assess and ensure that clients served in Title V programs exceed racial and/or ethnic proportions of low birth weight births in target communities by 5%.

0 1 2 3

5. Assess and ensure that clients served in Title V programs exceed racial and/or ethnic proportions of the infant mortality rate in target communities by 5%.

0 1 2 3

6. Assess and ensure that Title V programs providing services designed to decrease disparities in birth outcomes among racial and/or ethnic groups do so with culturally competent and developmentally appropriate strategies.

0 1 2 3

7. Racial and/or ethnic disparities in birth outcomes in Title V programs are reduced by 5%.

0 = Not met

1 = Partially met

2 = Mostly met

3 = Completely met

State Performance Measure # 05

Genetics Plan

The degree to which the Connecticut Department of Public Health has developed and implemented a Statewide Genetics Plan.

Type: Capacity

Category: Infrastructure Building

GOAL	Develop an infrastructure whereby a Statewide Genetics Plan will be developed and implemented.
MEASURE	Number of benchmark indicators in place to support development and implementation of a Statewide Genetics Plan.
DEFINITION	<p>Numerator: Total number of points checked in six (6) indicator boxes</p> <p>Denominator: Total possible number of points, eighteen (18), in six (6) indicators boxes</p>
DATA SOURCE DATA ISSUES	Survey and research projects: -New England Genetics/Metabolic Survey -CT Hospital Genetic Services Survey -The Future of Pediatric Education II Project -Qualitative documentation of process reflected in indicator boxes
SIGNIFICANCE	With the rapid expansion in the field of human genetics it becomes difficult for public health officials, policymakers, healthcare providers, and the general public to keep abreast of new information and its potential implications. Therefore, a Statewide Genetics Plan is needed to address the multitude of issues related to the advancement of genetic medicine so as to prevent disease and improve health.

State Performance Measure # 05

Checklist

GENETICS Awareness / Education

The degree to which the Department of Public Health, Bureau of Community Health, Family Health, Maternal Child Health Unit Genetics Program develops a Statewide Genetics Plan by convening a workgroup to:

0 1 2 3

1. Analyze data from available surveys (i.e., the New England Metabolic Consortium Survey '99, and CT Department of Public Health Genetic Services Survey 6/00), to identify the State's genetic educational needs and capacity to provide genetic services.

0 1 2 3

2. Develop partnerships with CT Chapters & Associations (American College of Obstetricians and Gynecologists, American Academy of Pediatrics, CT Medical Society Committees & CT Hospital Association) as well as academic institutions.

0 1 2 3

3. Assess need for and expand the current Newborn Screening Program to accommodate advances in screening capabilities.

0 1 2 3

4. Develop a forum for the exchange of genetic information between consumers, healthcare professionals, policymakers and educators.

0 1 2 3

5. Develop a genetics awareness and educational plan incorporating the needs of all stakeholders in the state affected by the field of genetics.

0 1 2 3

6. Assure that a mechanism is in place to implement, evaluate and revise the Statewide Genetics Plan.

0 = Not Met; 1 = Partially Met; 2 = Mostly Met; 3 = Completely Met

State Performance Measure # 07

Asthma

The degree to which the State of Connecticut, Department of Public Health improves education, diagnosis, and case management for asthma:

TYPE: Process

CATEGORY: Infrastructure Building

GOAL: To improve education, diagnosis, and case management for asthma.

MEASURE: Percent score of the number of indicators in place to support a more comprehensive asthma program.

DEFINITION: **Numerator:** Total number of points checked in eight (8) indicator boxes.

Denominator: Total possible number of points in eight (8) indicator boxes (24).

HEALTHY PEOPLE 2010: Under evaluation

DATA SOURCE and DATA ISSUES: We will work to enhance the current asthma surveillance system which includes hospital discharge data and census information. Also, this will require that we evaluate and modify Title V data systems so that they capture appropriate information on asthma.

SIGNIFICANCE: A more comprehensive asthma program will help ensure that children are diagnosed, receive proper education, and case management services where necessary.

Asthma Performance Measure

The degree to which the State of Connecticut, Department of Public Health improves education, diagnosis, and case management for asthma:

0 1 2 3

0. Participate in a DPH asthma workgroup to build the capacity within Title V programs to enhance asthma awareness, diagnosis, treatment, and management.

0 1 2 3

2. Assess asthma related activities (including direct services, education, data collection) within the Title V programs

0 1 2 3

3. Implement data collection and evaluation methods within Title V funded programs to determine whether children with a diagnosis of asthma have an asthma management plan

0 1 2 3

4. Assess CSHCN case manager knowledge of asthma management and control including evaluation and control of triggers of asthma in the home

0 1 2 3

5. Implement evaluation of asthma triggers in homes of CSHCN diagnosed with asthma by the CSHCN case manager. The case manager also will assist with education regarding asthma management for the child and family when appropriate.

0 1 2 3

6. Participate in the newly formed Coordinated School Health Program (DPH with the Connecticut Department of Education) to enhance asthma activities within schools in Connecticut.

0 1 2 3

7. Implement the "Open Airways Program" (an asthma education program for 4th and 5th graders developed by the American Lung Association) for schools in Connecticut.

0 1 2 3

8. Enhance asthma surveillance activities by DPH.

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State Performance Measure # 09

CSHCN Registry

The degree to which the Connecticut State Department of Public Health has the infrastructure in place to collect and report information on all children with special health care needs in the State.

TYPE: Capacity

CATEGORY: Infrastructure Building

GOAL: To enhance program planning and development in order to work toward the improved health and well-being of children with special health care needs in the State.

MEASURE: Percent score of the number of indicators in place to support the collection and reporting of accurate information on children with special health care needs.

DEFINITION: **Numerator:** Total number of points checked in seven (7) indicator boxes.

Denominator: Total possible number of points in seven (7) indicator boxes (21).

HEALTHY PEOPLE 2010: OBJECTIVES

12.02: Reduce the prevalence of serious developmental disabilities arising from events in the prenatal and infant periods.

14.00: (Developmental) Increase the proportion of State and local public health agencies that meet performance standards for the essential public health services.

DATA SOURCE and DATA ISSUES: This requires data from multiple sources to be determined by the external data consultant. Under CGS §09a-53 and 09a-54, all licensed healthcare professionals must report any child with a special health care need to the Department of Public Health.

SIGNIFICANCE: A CSCHN registry will provide data on the total number of children with special health care needs in the state. This data will allow improved planning and implementation of services and will increase knowledge by providers of children with special health care needs.

CSHCN Performance Measure Checklist

CSHCN Registry

The degree to which the Connecticut State Department of Public Health has the infrastructure in place to collect and report information on all children with special health care needs (CSHCN) in the State:

- | | |
|---|--|
| 0 1 2 3
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> | 1. Contract with a data consultant to develop a database for the CSHCN registry. |
| 0 1 2 3
<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | 2. Assess internal and external data capabilities and develop a database application for the CSHCN registry. |
| 0 1 2 3
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> | 3. Establish a workgroup to define and operationalize the definition of children with special health care needs. |
| 0 1 2 3
<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | 4. Develop and implement a training and educational program for licensed health care professionals on the application of the CSHCN database. (e.g., workshops, one on one training, newsletter etc.) |
| 0 1 2 3
<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | 5. Develop a pilot project on select groups of licensed health care professionals in Connecticut prior to full implementation. |
| 0 1 2 3
<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | 6. Begin statewide implementation of the CSHCN registry. |
| 0 1 2 3
<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | 7. Conduct a one year post-implementation review and evaluation of CSHCN registry. |

0 = Not Met; 1 = Partially Met; 2 = Mostly Met; 3 = Completely Met