

STATE TITLE V BLOCK GRANT NARRATIVE

STATE: CT

APPLICATION YEAR: 2005

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I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

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

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

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

A Public Hearing for the MCH Block Grant was held on May 12, 2004. Although representatives from two community provider agencies were present, this year no families were able to attend. A Notice of Public Hearing for the Block Grant and Title V application was posted, together with an invitation for written testimony, in two CT newspapers (New Haven Register and the Hartford Courant), via email to providers and contractors, as well as through several CT family Listserv newsgroups on the internet.

This year, written testimony was received from a mother of two adult daughters with sickle cell disease. She is also board member of the Citizens for Quality Sickle Cell Care, Inc (CQSCC) in New Britain, CT. She is concerned that a decrease in funding and a concentration in certain services will cause a lack of services for those infants and families living with sickle cell disease.

In May 2004, three families were paid to read and review CT's block grant application. This report can be found as an attachment to this section.

II. NEEDS ASSESSMENT

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

Connecticut is a relatively small state of about 5,000 square miles and 3.4 million persons. The state's economy is supported predominantly by services (44%), manufacturing (15%) and retail trade (11%) industries. While the total Connecticut population increased only 3.6 percent since 1990, the proportion of minorities in the population has been increasing at a greater rate. It is clear that the population in Connecticut has become more diverse during the past decade. The Hispanic, Asian, and African American/black population has increased approximately 50, 68, and 13 percent respectively since the 1990 census, while the white population has decreased 4 percent. The white non-Hispanic population comprised 83.8 percent of the Connecticut population in 1990, but that percentage dropped to 77.5 in 2000. See Table 1 in the document attached to the Overview Section.

/2004/The economic recession that began in March of 2001 has suffered further since the terrorist attacks of September 11, 2001. The downturn in the economy has led to increased unemployment, state budget cuts, layoffs of state employees, reduction in state services, and increases in taxes. In times of economic trouble it is often the poor who suffer the most and the services supported through the Maternal and Child Health Block Grant are needed the most.//2004//

/2005/Connecticut has not experienced the national jobs recovery, losing 2,000 jobs since December 2003. It is expected that in the next two years, job growth in Connecticut will be modest. For the most recent historical period (April 2001 through June 2003), the CT Department of Labor is reporting that Connecticut replaced only one-third of every 100 jobs lost, while the U.S. economy replaced two-thirds of every 100 jobs lost(1).//2005//

Maternal and Child Health Indicators

Many indicators of maternal and child health within Connecticut compare favorably with the United States as a whole, however, there are high risk groups which experience a greater share of the burden of adverse health risks and outcomes. The overall infant mortality rate has declined in the United States and Connecticut during the past two decades(2). See Table 2 in the document attached to the Overview Section. However, African American/black babies consistently have had higher infant mortality rates than white and Hispanic populations in Connecticut and in the U.S. In 2001, an African American/black baby was two and a half times more likely to die within its first year of life than a white baby, twice as likely to have non-adequate prenatal care, and twice as likely to be born with low birthweight.

/2004/Teen birth rates declined dramatically during the past decade, the birth rate for teens age 15-19 dropped from 62.1 to 45.8 per 1,000 teens nationally between 1991 and 2001. In Connecticut during the same period, the rate dropped from 40.4 to 29.4 infants born per 1,000 female teens(3).//2004// An African American/black or Hispanic baby born in 2000 was approximately 4 to 5 times more likely to have a teenager as a mother than a white baby(4). Reducing the disparities in maternal and child health indicators remains one of the major challenges facing the public health community. These disparities are documented in more detail in the Needs Assessment that was completed as part of the 2001 MCHBG application.

/2004/In January of 2003, the Children's Health Council released a report on Births to Mothers in HUSKY A (<http://www.childrenshealthcouncil.org/briefs/policy/retention.pdf>). There were 43,075 births to Connecticut residents in 2000, with 22.4 percent or 9,630 of the mothers enrolled in Healthcare for Uninsured Kids and Youth - HUSKY A. The HUSKY Plan is designed to help all women and children who do not have health insurance. It includes services under the traditional Medicaid program (now known as HUSKY Part A). It also provides health services for children in higher-income families (called HUSKY Part B). This report by the Children's Health Council utilized a linking of Connecticut Department of Public Health (DPH) birth certificate information with the Connecticut Department of Social Services (DSS) Medicaid data for the year 2000 birth cohort. In comparison to all mothers, HUSKY A mothers tended to be younger (average age 24 versus 31), and more likely to be Black

non-Hispanic (24 versus 8 percent) or Hispanic (33 versus 10 percent). Mothers living in the largest cities and towns also were more likely to be covered by HUSKY A.

Mothers who were covered by HUSKY A were also more likely to have a baby with low birth weight (9.6 vs. 6.8 percent), experience preterm delivery (13.2 vs. 11.1 percent) and have late or no prenatal care (2.9 vs. 1.5 percent). The Children's Health Project of the Children's Health Council completed the linking of the two data sources. Unfortunately, the Children's Health Project was eliminated early in 2003 due to budget cuts. We are hopeful that a memorandum of understanding with DSS will enable these data linkages to continue to occur in future years.//2004//

/2005/A memorandum of understanding was signed effective October 3, 2003 between DPH and DSS for sharing of data. Specifically the MOU establishes a mechanism for linking of data sets for a variety of projects with goals to evaluate prevalence of conditions and program effectiveness. The MOU is flexible to allow expansion into additional data linkage projects as the needs arise. The first project involves the linking vital records from the 2002 birth file from DPH with the DSS Medicaid file to enable analysis of risk factors and birth outcomes among women covered by Medicaid and enrolled in managed care during pregnancy. The linkage of these data will allow the evaluation of access to care and quality of care for the Medicaid/non-Medicaid populations and the comparison of prenatal care utilization and pregnancy outcomes among high-risk groups. Another project involves reviewing asthma data among HUSKY enrollees. The HUSKY information will estimate the prevalence of asthma among this population and to look at the patterns and distribution of the disease (by gender, race/ethnicity and geography). These estimates will be used, in conjunction with other asthma data sources, to provide a picture of the burden of asthma in Connecticut and help direct program interventions. Also, two projects involve linking with the HUSKY files. One projects involves the linking of data from the Childhood Lead Poisoning Prevention Program Surveillance System at DPH with the HUSKY files to ensure that the HUSKY children have received appropriate lead screening. The second project involves linking data on children enrolled at the CSHCN centers to ensure that the medical needs of these children are being met.//2005//

Infant Mortality

/2004/From 1981 to 2001, Connecticut's infant death rate fell from 12.0 to 6.1 deaths per 1,000 live births. However, the infant mortality rates for African Americans/blacks in 2001 was 16.5 and substantially exceeded the rates for whites in all years from 1981 to 2001. See Figure 1 in the document attached to the Overview Section.//2004// This gap reflects the consistently higher prevalence among African Americans/blacks for other risk factors, such as birth rates among teenage women, lack of adequate prenatal care, and low birthweight. Targeting prevention programs to groups showing a high rate of low and very low birthweight infants (such as women in the urban centers or the state's African American/black population) may produce the greatest effect on reducing the overall infant mortality rate in the state.

Programming within the 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 healthy infants and their mothers.

Births to Teens

/2004/According to the National Center for Health Statistics final birth data for 2001, Connecticut ranked seventh in the nation for its teen pregnancy rate for 15-19 year olds in 2001, with a rate of 29.4 births per 1,000 females ages 15-19 in comparison to the national rate of 45.8(3). The percent of

births to teens varies by race and ethnicity. The overall percent of births to teens has dropped in the last decade, especially among African Americans/blacks. However, there remain a greater percentage of pregnancies among teens in the African Americans/black and Hispanic populations when compared to white teens. See Figure 2 in the document attached to the Overview Section.//2004//

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 through Connecticut's Title V programs include programs to delay the onset of sexual activity, promote abstinence as the social norm, reduce the number of adolescents who have sex at young ages, and increase the numbers of sexually active adolescents who use contraceptives effectively. State-sponsored specialized programs such as the Right from the Start Program serve pregnant and parenting teens. This program provides intensive case management services with emphasis on promoting positive pregnancy outcomes, positive parenting and breastfeeding. /2004/The Abstinence-Only Initiative provides education to 9-14 year old youths with the goal of reducing sexually active teens, teen pregnancy, and transmission of STDs. During FY 01 to FY 02, 344 youth enrolled in 24 Abstinence-Only Programs located in 5 regions of Connecticut. Programs were held at a total of 12 sites across 8 cities. In the regions of: Hartford, Waterbury, New Haven, Bridgeport, and Windham Co.//2004//

Prenatal Care

Non-adequate prenatal care is a composite measure, reflecting both the time of the first prenatal visit and the number of visits. The "non-adequate" grouping includes both "inadequate" and "intermediate" care as defined in the Kessner Index of prenatal care(5). 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. See Figure 3 in the document attached to the Overview Section. /2004/In 2001, only 1.9 percent of women received late or no prenatal care in comparison to 3.7 percent nationally. Only three states had lower rates of late or no prenatal care(3).//2004//

The Connecticut Department of Public Health (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

Low birthweight (under 2,500 grams) is a major cause of infant mortality and long-term health problems. 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. /2004/(See Figure 4 in the document attached to the Overview Section). In 2001, 7.4 percent of births had low birthweight in Connecticut in comparison to 3.7 percent nationally(3).//2004// While there have been improvements in the infant mortality rates, low birthweight has remained relatively stable for the past two decades. Low birthweight is more common among infants of African American/black and Hispanic mothers. Likewise, twins and multiple births have a higher frequency of low and very low birthweights compared with singleton newborns.

Maternal and Child Health Demographics

As Census 2000 information has been released, it provides a more detailed picture of Connecticut and the United States. Data collected on the Census 2000 Supplemental Population Survey provides information on residents of Connecticut in comparison to the United States. (See Tables 3 and 4 in the document attached to the Overview Section) Residents of the major cities (Bridgeport, Hartford,

and New Haven) tend to be younger, unmarried, poorer, less educated, more likely to be unemployed, on public assistance, and be Hispanic or black than the state as a whole. These comparisons are in stark contrast to the demographics of some wealthy suburbs such as Darien and New Canaan.

/2004/The State and Local Area Integrated Telephone Survey (SLAITS) was conducted between October 2000 and April 2002. It provides us with population based data on children with special health care needs. From SLAITS we have learned that there are approximately 120,000 children with special health care needs in Connecticut representing 14 percent of the population.//2004//

Socioeconomic Indicators in Connecticut

In Connecticut, the 1990's saw the disparity between the wealthiest and poorest citizens widen. While Connecticut is one of the wealthiest states in the country, several cities have high rates of poverty. Hartford experienced an increase in the poverty rate during the past ten years, and is one of the poorest cities in the country (6). Many families in Connecticut enjoyed improvements in their standard of living over the 1990s as median family income and the wages of median-wage workers grew. However, low-wage workers saw their wages decline over the 1990s. The poverty rate and income inequality in Connecticut grew over the 1990s(7). The poverty rate in Connecticut grew during the 1990s, from 3.5% in 1987-88 to 9.1% in 1997-98. However, the poverty rate in Connecticut in the late 1990s was lower than the national rate (13.0% in 1997-98)(8).

/2004/The unemployment in Connecticut has risen to 5.3 percent in comparison to 6.0 percent nationally(9).//2004// According to the Census Bureau, Connecticut has the fourth highest median household income in the US behind Alaska, Minnesota, and Maryland. The average median household income for 2000-2001 in the US was \$42,695 while in Connecticut the median family income was \$52,460 for the same period. /2004/The median family income for the United States and Connecticut dropped 1.2 and 0.4 percent respectively from the previous two-year reporting period (10).//2004// Within Connecticut, however, the median family income and other characteristics recorded in the 2000 Census vary within the State and its large cities, and New York suburbs. The economic disparity experienced by the cities is mirrored in differing maternal and child health statistics.(See Table 5 in the document attached to the Overview Section).

/2005/Connecticut reported an increase in unemployment to 5.5 percent for 2003 and the Real Personal Income of Connecticut residents barely grew in the last three years showing the weakest growth in the 13 years since 1990(11). However, some positive socioeconomic indicators which tend to signal future economic conditions are being seen in Connecticut. For example, new housing permit activity increased for the second year, the number of new automobile registrations increased to an all time high indicating that consumers took advantage of the low interest rates, making these major purchases. Also, the number of initial claims for unemployment finally fell last year, after having risen for two consecutive years (11).//2005//

Legislation

The Governor signed Public Act No. 02-113 AN ACT REQUIRING THE SCREENING OF NEWBORNS FOR METABOLIC DISEASES into law on June 7, 2002. The language of this bill amends the language in Sec. 19a-55 Newborn infant health screening in the General Statutes of Connecticut. This legislation requires that the State Newborn Screening Program will test for amino acid disorders, organic acid disorders and fatty acid oxidation disorders, including, but not limited to, long-chain 3-hydroxyacyl CoA dehydrogenase (LCHADD) and medium-chain acyl CoA dehydrogenase (MCADD). /2004/The start date for this program was intended to be on or before January 1, 2003, however, budget problems with resulting layoffs in the DPH laboratory have resulted in lack of trained laboratory personnel and a delay in the anticipated start date to the fall of 2003.//2004//

/2005/Newborn screening for the fatty acid disorders, 3-hydroxy long-chain ACYL-CoA

dehydrogenase (LCHADD) and medium-chain acyl CoA dehydrogenase (MCADD) and the amino acid disorder, Tyrosinemia were added on May 1, 2004./2005//

/2004/ A Sub-Committee of the Genetics Advisory Committee is meeting to plan for the expansion of the Newborn Screening panel. Two Tandem Mass Spectrometers were installed in the Public Health Laboratory. The committee has decided to begin testing for the markers for long-chain 3-hydroxyacyl CoA dehydrogenase (LCHADD) and medium-chain acyl CoA dehydrogenase (MCADD) in 2003 and will continue to add other markers as other reference ranges are validated. The committee identified and discussed the educational needs for primary care providers, obstetricians, other health care providers, and the general public. Plans to address the needs of all three components of testing, tracking, and treatment were included. Implementation of expanded testing has been delayed because of budget cutbacks and layoffs in the DPH laboratory. It is anticipated that the expanded testing will be implemented during the summer of 2003./2004//

/2005/The above testing for LCHADD, MCADD, and Tyrosinemia are inclusive of the Newborn Screening panel. The laboratory has one Tandem Mass Spectrometer (TMS) functioning and is validating the second TMS. The second phase of identifying other disorders to the Newborn Screening panel is presently occurring./2005//

Health Care Delivery Environment in Connecticut

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

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 methods of financing affect not only the availability and delivery of services, but also the quality of patient outcomes. Hospital mergers have occurred in Connecticut and length of stays in hospitals have decreased, as has the rate of hospitalizations(12).

Health Insurance

Health insurance is 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, leading to a higher and more expensive level of care(13). A Connecticut Office of Health Care Access survey 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. These reasons include that 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, and, some uninsured families can not afford the cost of health insurance.

According to the Census Current Population Survey conducted in 2000, 38.7 million people or 14.0 percent of the non-elderly population in the United States was without health insurance coverage. For Connecticut, the Census estimates that 8.5 percent of the population was without health insurance in 2000(14). Nationally, those factors associated with lack of health insurance in 2000 were identified as age 18 to 24, Hispanic origin, foreign-born, worked part-time, lower household income, and lower educational attainment(14). The proportion of children who were uninsured declined from 15.4 to 11.6

percent nationally between 1998 and 2000(14).

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 (DSS) 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 increased coverage by expanding Medicaid eligibility for children and creating a new program to subsidize private insurance for children (15). 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, eye care and hearing exams, and dental care(13).

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 use 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). In an effort to expand health insurance, legislation passed by the Connecticut General Assembly in 2000 extended eligibility for HUSKY A to parents with incomes up to 150 % of the federal poverty level. This expanded eligibility took effect January 1, 2001. This family coverage promotes continuity and integration of care for parents and their children (16). From January 2001 to January 2002, enrollment of adults aged 19 and over increased by 35 %, from 55,170 to 74,453. Previously, most adults in HUSKY A were families that received Temporary Family Assistance benefits(17).

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 whose family incomes are between 185% and 300% of the FPL are also able to apply for HUSKY Plus, a supplemental health coverage program 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(18).

State and local outreach efforts have been successful in enrolling thousands of new children in the State's HUSKY health insurance program. In July 1998, when the HUSKY program began, there were 158,568 children in the Medicaid (HUSKY A) program. The HUSKY B program had just begun. As a result of the outreach efforts, there were a total of 196,439 children enrolled in HUSKY in January 2002, with 185,733 in HUSKY A and 10,706 in HUSKY B, for a total of 37,871 more children covered (19). /2004/Unfortunately, part of the budget reduction plans adopted in Connecticut in February, 2003 included reducing the eligibility limit for parents and caretaker relatives from 150 percent of poverty to 100 percent of poverty. This means that fewer parents of children covered by HUSKY will be receiving benefits. There had been a suit to extend these benefits, but that suit failed and these benefits end as of June 30, 2003. However, families now receiving HUSKY whose earned income goes above the HUSKY A income eligibility level of 100 percent of the federal poverty level still receive a two-year extension of benefits (transitional medical assistance or TMA).

Continuous eligibility has also been eliminated. Under continuous eligibility, a child who was eligible for HUSKY A or HUSKY B was covered for a year, regardless of any changes in income or family size. The Children's Health Council is developing fact sheets to help the estimated 20,000 parents and 5,500 children affected by these changes understand the impact (<http://www.childrenshealthcouncil.org/covering/index.htm>)./2004//

As new children enter the HUSKY program, other families have left. A survey conducted to understand why families left the program indicated that the main reasons children are no longer enrolled in HUSKY A had to do with obtaining employer-sponsored coverage (42%) and the child reaching the age of 19(11%). Most children (67%) who are no longer enrolled in HUSKY A are insured. However, the survey also indicated that there remains confusion among parents regarding the length of coverage and that children must be re-enrolled each year. Efforts have been made to increase retention of HUSKY coverage so that children do not lose their health coverage. DSS has simplified forms, increased efforts to get correct addresses, and developed postage-paid address change forms. A legislative change in July, 2001 should help with retention. Families may self-declare income, the change makes it so families no longer have to supply documentary proof of income at the time of application or renewal.

In an effort to boost enrollment in HUSKY, the Covering Connecticut's Kids coalition, a network of organizations involved in HUSKY outreach (including DSS, Benova, and Infoline), collaborated on the 2001 Back-to-School campaign. From September to November, 2001 enrollment increased by 2,705 children compared to 309 during the same period the previous year(20).

/2004/It appears that outreach efforts have been effective. The Husky A enrollment has continued to grow. In January, 2003 the Children's Health Council reported that enrollment had increased to 203,000 children. This increase in numbers served by HUSKY A is due not only to newly enrolled children, but also because children have remained enrolled(21). //2004//

/2005/During SFY 2003, HUSKY A enrollment peaked at 208,624 children in May, before falling back to 205,520 children at the end of the state fiscal year. The decline in eligibility reflects the legislative elimination of the 'continuous eligibility' coverage group. State funding for local outreach projects has been eliminated due to this year's budget crisis In a cost cutting effort to help balance the State budget the Connecticut General Assembly passed a law in August, 2003 to require the DSS to ask the federal government for a waiver that would make changes to HUSKY A. If approved these changes would apply to all of the approximately 210,000 children in HUSKY A requiring co-payments for medical services and medication. EPSDT standards are also slated for elimination (22).

As many as 40,000 children with special health care needs will be at risk if Connecticut eliminates Medicaid's guarantee of necessary health care services for children and charges co-payments for their care. Children's visits to health care providers might possibly decline by as much as 30 percent. An estimated 2,000 pregnant women can lose coverage if monthly premiums are implemented for the period of pregnancy and 60 days after birth. They will then have difficulty in obtaining early prenatal care for their infant, nor will the infant be automatically covered for timely well-baby care and immunizations(23).//2005//

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)
- ? School Based Health Centers (SBHC) 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
- ? 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.

Two Community Access Programs were funded in Connecticut with the intent of improving access to health care, coordination of services, and reduction in the duplication of services. The Women's Health Access Program was awarded approximately \$1,000,000 to target underinsured and uninsured women in the Naugatuck River Valley, including the communities of Ansonia, Beacon Falls, Derby, Naugatuck, Oxford, Seymour, and Shelton. The Program will develop a referral system for provision of care among the health care providers in the area. Community outreach will be increased, educational materials will be developed and a computer information system will be initiated. As part of the CAP grant, the hospital developed the Women's Health Coordination Center and received its formal designation as a National Community Center of Excellence in women's health.

In January, 2002 Middlesex Health System, which includes five safety net health care facilities in the New Haven area, received \$922,000 in funding from HRSA to improve health coordination among adults. The project will develop a Community Health Information Network to improve cases management and tracking of patients, especially for the underinsured or uninsured. The network partners are the Fair Haven Community Health Center, Hill Health Center, New Haven Health Department, Hospital of Saint Raphael, and Yale-New Haven Hospital. The intent of the project is to insure that patients have a primary care provider and that medical records are shared among the facilities so that information is more readily available and duplication of services is reduced. Both of these programs will work to improve the provision of health care to women in Connecticut.

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 require 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.

It is the role of Connecticut'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 support individual, agency, and community health efforts.

Health Priorities

In 1999, the Department of Public Health prepared an extensive report entitled, "Looking Toward 2000"(12). 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 increased life 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 DPH priorities, the following priorities were identified through the Maternal and Child Health Needs Assessment for the year 2001 Application and are described in more detail in the Needs Assessment. The State Performance Measures were developed as part of the year 2001 Application in a direct effort to help address these needs. They are:

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

/2004/A more detailed description of the Maternal and Child Health Priority Needs is presented in the MCHBG Needs Assessment available from DPH. How these MCH priority needs were translated into State Negotiated Performance Measures is presented in Section IV B State Priorities. The delivery of Title V services in Connecticut is intended to address these priority areas.

The Children with Special Health Care Needs program includes the priority areas specific to this population in its program design. In order to enhance CSHCN services, the Family Health Division (FHD) within DPH has redesigned the program by requiring the Center to operate a program that is family-centered with family participation and satisfaction; performs early and continuous screenings; improves access to affordable insurance; coordinates benefits and services to improve access to care; participates in spreading and improving access to medical home and respite service; participates in developing a community-based service system of care, and promotes transition services for youths with special health care needs.

Infant mortality and morbidity reduction and the reduction of racial disparity are addressed through a variety of programs, including Right from the Start, Comadrona and Healthy Choices for Women and Children. In addition, the state's Hispanic Health Council was contracted to perform a quick ethnographic study on the street to assess cultural factors associated with high Latina teen pregnancy rate. Similarly an ethnographic study was conducted to identify cultural factors leading to poor oral health in targeted community areas. The Family Health Division plans to implement culturally appropriate interventions based on the findings from these studies to reduce the health disparities. Changes have been made to the FHD's contracts to enforce cultural competency measures.

Improvement in the health status of children and adolescents is the focus of the school based health centers and the oral health program. Teen pregnancy reduction will be addressed through the Right from the Start Program and other program areas. The FHD is participating in the National Initiative for Child Health Quality (NICHQ) Medical Home Learning Collaborative as one of the mechanisms to improve access to quality of care for mothers and children, particularly CSHCN. Asthma prevalence has been increasing and Title V programs are 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 Connecticut HUSKY program.

In addition, the Bureau contracted with an independent public health consulting firm to assess and evaluate the health care access infrastructure for the Homeless population in order to enhance their access to health services. A statewide Homeless Health Advisory group, including governmental, public/non-for-profit, private, faith based, and advocacy organizations, was formed to guide this evaluation study. This study involved needs assessment of shelters, and their health care systems/infrastructure for the homeless population, and key informant interviews. The study is completed and the agency is exploring necessary intervention strategies to promote and enhance the health status of homeless population.

//2005/As a result of this report, which identified the need to have health care providers and shelter staff collaborate, the DPH sponsored the "Health Care for the Homeless" conference, which was attended by over 125 providers, shelter staff and the general public. The purpose of the conference was to bring together health care providers and shelter staff to help address the health care needs of this special population. Through an RFP process, the DPH issued grants to three community health centers to enhance their infrastructure to address the needs of homeless persons in Connecticut.//2005//

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.

The FHD has developed a System Navigation Tool to assist Medicaid, SCHIP and low-income population with important information on how to access dental services through the health care delivery system, their rights and tips to prevent their children from having oral disease. Also, brochure

on oral health relationship with other systemic diseases is developed to educate medical professionals and improve access to dental health services. The Bureau is developing a partnership with the Departments of Children and Families and Social Services to enhance referrals and track mental health services for children and youth with behavioral health problems. There will be an ongoing and enhanced efforts to improve recognition, diagnosis and case management for asthma in compliance with our state asthma plan.//2004//

/2005/ During the past year there has been emphasis placed in some new and expanding areas:

The FHD has recognized that the health of fathers and men impacts the health of the women, children and families. In collaboration with the New Haven Family Alliance, Male Involvement Network two brochures are being developed. One brochure will focus male specific health issues and accessing services to address those issues and the other brochure, for health care providers, will identify strategies for engaging and sustaining men in the health care delivery system.

There is growing emphasis on the development of data systems and linkages. As mentioned earlier, SEQA staff of epidemiologists are coordinating the Memorandum of Understanding (MOU) between DPH and DSS regarding data exchanges. The purpose of this MOU is to improve public health service delivery and public health outcomes for low-income populations through the sharing of available Medicaid, HUSKY Plan Part B, HUSKY Plus and Title V data. The initial MOU included three addenda addressing the linkage of birth and Medicaid data, childhood lead screening and Medicaid data, and on Children Receiving Title V Services and Medicaid data. Linked data will be analyzed and used to guide MCH programs.

SEQA staff implemented the Connecticut Birth Defects Registry on January 1, 2004. Five hospitals have been visited to conduct an educational presentation and to emphasize the importance of reporting. Hospital compliance in reporting birth defects information has improved from 23 to 28 (of a total 31 birthing hospitals). There were 128 cases reported from October 2002 to December 2003, and has increased to 255 as of June 2004. The completeness of reporting birth defect cases is estimated to be 61.7%.

Also, there has been an increasing emphasis placed on care coordination and the implementation of the medical home model for children with special health care needs. The two CSHCN Centers will be replaced with five Regional Medical Home Support Centers. These Centers will enable DPH to reach more children with special health care needs with MCHBG funding.//2005//

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B. AGENCY CAPACITY

The CSHCN program contracts with two regional centers: the Connecticut Children's Medical Center (CCMC) located in Hartford, and the Yale University Medical School located in New Haven. The CSHCN program provides care coordination, advocacy and family support to any child with special health care need regardless of enrollment financial status. Enrolled children, those that meet the medical and financial guidelines, may receive payment for certain services including: adaptation and specialty equipment, special prescriptions, specialty and sub-specialty care and occupational/physical/speech therapies that are not covered by their insurance. The CSHCN program also offers a limited respite program based on available funds, and transition services to adult care. ***//2005/Children may also receive payment for special nutrition formulas if they qualify as uninsured or underinsured.//2005//***

Both Centers subcontract with statewide community-based facilities such as Easter Seals in New London, the Feroletto Center in Trumbull and a primary care center in Danbury, which increase access for families not residing in the Hartford or New Haven areas. The CSHCN Centers are responsible for providing services to children receiving Supplemental Security Income (SSI) benefits who meet program eligibility criteria.

A review of the CSHCN program began in December 2002, with an interagency work group. The purpose of the review was to evaluate the present format of CSHCN services with the President's Freedom Initiative and the 2010 goals. Infrastructure and capacity building strategies have been identified regarding a community-based services system for easy access, medical home, respite and family support. A survey is presently being conducted to identify the needs of families regarding respite care and to target a regionalized respite system.

/2005/The survey of families and primary care providers was conducted. Strategies were identified and a transition plan was developed for CSHCN, with a goal to develop a community-based system of care for CSHCN in CT./2005//

The United Way's INFOLINE (211) beginning in July 2003, will be utilized as a single point of entry for screening and referral of children with special health care needs to appropriate services. The two CSHCN Centers will continue to enroll families who need extensive care coordination activities and family advocacy, while also expanding linkage to primary care providers. The Centers will also continue to pay for extended services to eligible families. Three primary pediatric centers are presently enrolled in the National Institute of Child Health Quality's (NICHQ) Medical Home Learning Collaborative. The purpose of this Learning Collaborative is to improve care and to narrow the gap for the growing population of children with special health care needs by implementing the Medical Home concept.

/2005/As of October 2003, INFOLINE now includes CSHCN with the Child Development Infoline (CDI). It will serve as a single point of entry for screening and referral to programs or Centers for care coordination. The Centers will continue service where the medical home or specialized services are unable to provide community-based support./2005//

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

Sec 19a-2a PA 93-381(1993) Powers and duties. The Commissioner of DPH 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 DPH. All Title V Programs are impacted by this statute.

Sec. 19a-4j PA 98-250 (1998) Office of Multicultural Health. The responsibility of the office is to improve the health of residents by eliminating difference in disease, disability and death rates among ethnic, racial and cultural populations. All Title V Programs are impacted by this statute. Note: The Office was eliminated by layoffs in January, 2003.

Sec. 19a-7 PA 75-562 (1975) Public Health Planning. The DPH shall be the lead agency for public health planning and shall assist communities in the development of collaborative health planning activities. All Title V Programs are impacted by this statute.

Sec. 19a-7a PA 90-134 (1990) State goal to assure the availability of appropriate health care to all state residents. The goal of the state is to assure the availability of appropriate health care to all residents, regardless of their ability to pay. All Title V programs are impacted by this statute.

Sec. 19a-7c PA 90-134 (1990) Subsidized non-group health insurance product for pregnant women. DPH with DSS, may contract to provide a subsidized non-group health insurance for pregnant women who are not eligible for Medicaid and have incomes under two hundred percent of the federal poverty level. CT Community Healthcare Initiative, Comadrona, Family Planning, Community Health Centers are the programs most affected by this statute.

Sec. 19a-7f PA 91-327 (1991) Childhood immunization schedule. An immunization program shall be established by DPH, cost of vaccine will not be a barrier to age-appropriate vaccination. Community Health Centers and School Based Health Centers are the programs most affected by this statute.

Sec. 19a-7h PA 94-90 (1994) Childhood immunization registry. The registry shall include information to accurately identify a child and to assess current immunization status. Community Health Centers and School Based Health Centers are the programs most affected by this statute.

Sec. 19a-7i PA 97-1 (1997) Extension of coverage under the maternal and child health block grant. DPH 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. CSHCN Centers are the programs most affected by this statute.

Sec. 19a-17b, PA76-413 (1976) Peer Review: definitions, immunity; discovery permissible from proceedings. There shall be no monetary liability against any person who provides testimony, information, records, etc. The proceedings of a medical review committee shall not be subject to discovery or introduction into evidence in any civil action for or against a health care provider arising out of the matters which are subject to evaluation and review by such committee. Fetal and Infant Mortality Review (FIMR) and Pregnancy Related Mortality Surveillance are the programs most affected by this statute.

Sec. 19a-25 PA 61-358 (1961) 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 DPH or its representatives for the purpose of reducing the morbidity or mortality from any cause 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. All programs are influenced by this statute. FIMR and Pregnancy Related Mortality Surveillance are the programs most affected.

Sec. 19a-32 (1949) Department authorized to receive gifts. DPH 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 assets shall be used only for the purposes designated. All Title V Programs are impacted by this statute.

Sec. 19a-35 PA 35-240 (1935) Federal funds for health services to children. The DPH is designated as the state agency to receive and administer federal funds which may become available for health services to children. Title V Programs serving children are the programs most affected by this statute.

Sec.19a-48 (1949) Care for Children with Cerebral Palsy. DPH shall furnish services for children who have cerebral palsy including locating the children, providing medical, surgical, corrective and allied services and care, and providing facilities for hospitalization and aftercare. CSHCN programs are most affected by this statute.

Sec.19a-49 (1961) Services for Persons with Cystic Fibrosis. DPH shall establish and administer a program of services for children and adults suffering from cystic fibrosis programs. CSHCN programs are most affected by this statute.

Sec. 19a-50 PA 39-142 PA 37-430 (1937 & 1939) Children crippled or with cardiac defects. DPH is designated to administer a program of services for children who are crippled or suffering from cardiac defect and to administer federal funds which may become available for such services. CSHCN programs are most affected by this statute.

Sec.19a-51 PA 63-572 (1963) Pediatric Cardiac Patient Care Fund. There shall be a Pediatric Cardiac Patient Care Fund to be administered by DPH and to be used exclusively for medical, surgical, preoperative and postoperative care and hospitalization of children, residents, who are or may be patients of cardiac centers in this state. CSHCN programs are most affected by this statute.

Sec. 19a-52 (1981) Purchase of equipment for handicapped children. DPH may, purchase wheelchairs and placement equipment directly. CSHCN programs are most affected by this statute.

Sec. 19a-53 PA 33-318 (1933) Reports of physical defects of children. Each health care provider, who has professional knowledge that any child under five years of age has any physical defect shall, mail to DPH a report, stating the name and address of the child, the nature of the physical defect and such other information. The CSHCN Registry is supported by this statute.

Sec. 19a-54 PA 33-266 (1933) Registration of physically handicapped children. Each institution supported in whole or in part by the state shall report to the DPH, 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. The CSHCN Registry is supported by this statute.

Sec. 19a-55 PA 65-108 (1965 revised 2002) Newborn infant health screening. Each institution caring for infants shall cause to have administered to every infant in its care an HIV-related test, 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 DPH. The tests shall be administered as soon after birth as is medically appropriate. This bill was amended in June, 2002 to expand testing to amino acid disorders, organic acid disorders and fatty acid oxidation disorders, including, long-chain 3-hydroxyacyl CoA dehydrogenase (L-CHAD) and medium-chain acyl CoA dehydrogenase (MCAD).

Sec. 19a-56a PA 89-340(1989) Birth defects surveillance program. The program shall monitor the frequency, distribution and type of birth defects occurring in Connecticut on an annual basis. DPH shall establish a system for the collection of information concerning birth defects and other adverse reproductive outcomes. The CSHCN Registry is supported by this statute.

Sec. 19a-56b PA 89-340 (1989) 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. The CSHCN Registry is supported by this statute.

Sec 19a-59 PA 81-205 (1981) Program to Screen Newborn Infants for Hearing Impairment at Birth. Each institution, 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 DPH shall establish a plan to implement and operate a program of early identification of infant hearing impairment. Newborn Hearing Screening Program is supported by this statute.

Sec. 19a-59a PA 82-355 (1982) Low Protein modified food products and amino acid modified preparations for inherited metabolic disease. The DPH, may purchase prescribed special infant formula, amino acid modified preparations and low protein modified food products directly. CSHCN programs are supported by this statute.

Sec. 19a-59b PA 83-17 (1983) Maternal and Child Health Protection Program (MIHPP). DPH shall establish a maternal and child health protection program 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. Comadrona, Right from the Start, and CT Community Healthcare Initiative are supported by this statute.

//2005/CT Community Healthcare Initiative is now known as Healthy Start.//2005//

Sec. 19a-59c PA 88-172 (1988) Administration of federal Special Supplemental Food Program for Women, Infants and Children in the state. The DPH is authorized to administer the WIC program in the state, in accordance with federal law and regulations. WIC is supported by this statute.

Sec. 19a-60 PA 45-462 (1945) Dental services for children. The DPH may furnish dental services for children free of charge where the cost of necessary service would be a financial hardship to their parents. Community Health Centers and School Based Health Centers are affected by this statute.

Sec. 4-8 (1949) Qualifications, Powers and Duties of Department Head. This statute authorizes the transfer of Title V funds to the Department of Social Services (DSS).

Sec. 19a-90 PA 41-255 (1941) Blood tests of pregnant women for syphilis. Each physician giving prenatal care to a pregnant woman in this state shall take a blood sample within thirty days from the date of the first examination and during the final trimester, and shall submit such sample for a standard serological test for syphilis. Family Planning, Community Health Centers and School Based Health Centers are affected by this statute.

Sec. 19a-110 PA 71-22 (1971) Report of lead poisoning. Defines reporting requirements to the DPH regarding blood lead levels equal to or greater than 10 micrograms per deciliter of blood or any other abnormal body burden of lead. Community Health Centers and School Based Health Centers are affected by this statute.

Sec. 19a-62a (2000) Pilot program for early identification and treatment of pediatric asthma. DPH with DSS, shall establish pilot program for the early identification and treatment of pediatric asthma. The DPH Asthma Program is impacted by this statute.

Title V Partnership Programs for Pregnant Women, Mothers and Infants

Breastfeeding Initiative: Through the SSDI Initiative and in-kind support, staff are working to develop internal mechanisms to collect breastfeeding data. One goal is to collaborate with Vital Records to collect breastfeeding initiation rates upon hospital discharge. The other goal is to work with the Immunizations Program to assess our ability to collect breastfeeding duration rates.

/2005/In January 2004, the Electronic Newborn Screening Database started to collect data from all birthing hospitals on the mother's intent to breastfeed. Since software issues prevented Vital Records from collect breastfeeding data on the birth certificate worksheet the capacity of the Immunization Program database to collect breastfeeding data will be evaluated./2005//

Comadrona: The DPH contracts with the Hispanic Health Council of Hartford to provide culturally appropriate intensive case management services to pregnant Latina and African-American women and their children.

CT Community Healthcare Initiative (CCHI): This statewide collaboration between DSS and DPH has as its goal to reduce infant mortality and morbidity and low birthweight, and to improve healthcare coverage and access for children and eligible pregnant women.

/2005/This program is now known as Healthy Start./2005//

Family Planning: Through its contract with Planned Parenthood of CT, Inc., comprehensive reproductive health services are available in 16 locations across the state. Family Planning promotes decreasing the birth rate to teens aged 15-17, preventing unintended pregnancy, and increasing access to primary reproductive health care.

Fetal and Infant Mortality Review (FIMR): Six high-risk communities are currently funded to examine confidential, de-identified cases of infant deaths. The purpose of these reviews is to understand how local social, economic, public health, educational, environmental and safety issues relate to the tragedy of infant loss in order to improve community resources and service delivery.

/2005/Several high-risk communities are now currently funded./2005//

Healthy Choices for Women and Children (HCWC): HCWC provides intensive case management services to low income, pregnant and postpartum women who abuse substances or are at risk for abusing substances, or whose partner abuses substances, and their children who reside in the city of

Waterbury or surrounding communities. Referrals and linkages to community-based health and health related services are provided.

Maternal and Child Health Information and Referral Service (MCHI&R): The DPH contracts with the United Way of CT to administer the toll-free MCH hotline that provides information on health and related services. Services are accessible to non-English speaking callers and to speech/hearing impaired callers. MCH specialists provide public awareness activities on priority health issues identified by the DPH, such as SIDS, asthma, and breastfeeding, in order to heighten awareness, education, and effect behavior changes in the MCH population.

//2005/More information on INFOLINE is noted above. //2005//

Oral Health Unit (OHU): The Oral Health Unit has a health promotion and disease prevention program that is part of a comprehensive public health strategy for the prevention of dental decay, oral diseases and disorders in CT's children and their families.

//2005/The Oral Health Unit is working collaboratively with the American College of Obstetrics and Gynecology and the March of Dimes to address oral health during the prenatal period. The unit collaborated with the Yale Research Prevention Center on a CDC grant application to address oral health during the perinatal period.//2005//

Pediatric Primary Care Project: Funding for Community Health Centers in Hartford, Middletown, Waterbury and New Haven is provided for outreach, health education, case management, transportation assistance, multilingual/ multicultural services, in addition to support for basic health services for uninsured and underinsured infants and children.

//2005/This funding will be redirected as of June 30, 2004 into the regionalized medical home support centers proposal, due to begin in October 2004.//2005//

Pregnancy Related Mortality Surveillance (PRMS): The UConn OB/GYN staff conduct maternal mortality reviews and, based on findings, provides education to medical providers to prevent future maternal deaths.

//2005/In April 2004, a DPH contractor conducted PRMS activities.//2005//

Right from the Start (RFTS): Provides intensive case management services to pregnant and/or parenting teens. Services provided by community-based contractors must include: 1) intensive case management; 2) outreach and case-finding activities; 3) promotion of breastfeeding; 4) integration of the USPHS/Smoke Free Families Smoking Cessation Intervention model; and 5) public awareness activities. Services must be comprehensive, culturally appropriate, community-based and family centered.

SSDI: Through this federally funded initiative, CT is focusing on three main activities: linking WIC and Vital Records databases; developing the infrastructure to collect statewide breastfeeding data (initiation and duration rates); and conducting a population-based survey (like PRAMS) of new mothers to collect data regarding their behaviors and experiences during the perinatal period.

//2005/An additional focus now includes evaluating DPH database systems to enhance the ability to report on the MCHBG performance measures and other outcome measures.//2005//

State Mortality & Morbidity Review Support Program (M & M): Through this federally-funded initiative, DPH has convened an interdisciplinary state case review team to review the maternal deaths. Using the FIMR model this review will provide a more comprehensive, review of maternal deaths. In addition, the FIMR and Maternal Mortality review processes will be coordinated and findings shared between members of all committees.

//2005/DPH convened a interdisciplinary Fatality Workshop. The grant funding this program ended on May 31, 2004.//2005//

Title V Partnership Programs for Children and Adolescents

Comadrona: As described above.

CT Community Healthcare Initiative (CCHI): As described above.
/2005/This program is now known as Healthy Start./2005/

Expanded School Health Services (ESHS): The DPH funds three ESHS projects. Two sites focus on preventing and improving mental health status of youth and one site provides physical and behavioral health services to preschool aged children.

/2005/DPH continues to fund two projects, and funding for the third site was merged with additional state funding to begin a SBHC in the same community./2005/

Family Planning: A special effort is made to target services to teens and provide STD screening and treatment, HIV/AIDS screening, and contraception services. Other services 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 events across the state to provide reproductive health and STD prevention literature, as well as conducting community educational programs to teens at risk.

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

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

Oral Health Unit: As described above.

Pediatric Primary Care Project: Funding for Community Health Centers in Hartford, Middletown, Waterbury and New Haven is provided for: outreach, health education, case management, transportation assistance, and multilingual/multicultural services, in addition to support for basic health services for uninsured and underinsured children.

/2005/See changes as described above./2005/

Right from the Start: Provides intensive case management services to pregnant and/or parenting teens under 20 years of age. Services provided by community-based contractors must include but are not limited to: 1)intensive case management; 2)outreach and case-finding activities; 3)promotion of breastfeeding; 4)integration of the USPHS/Smoke Free Families Smoking cessation Intervention model; and 5)public awareness activities. Services provided must be comprehensive, culturally appropriate, community-based and family centered.

School Based Health Centers (SBHC): DPH funds 61 SBHCs in 18 communities, serving students in grades pre-K-12. SBHCs are licensed as outpatient facilities or hospital satellites. They offer a wide array 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.

/2005/The Early Childhood Partners is the planning and implementation stage of the State Early Childhood Comprehensive Systems./2005/

Title V Partnership Programs for Children with Special Health Care Needs

Children With Special Health Care Need (CSHCN): The CSHCN program contracts with two regional centers: the Connecticut Children's Medical Center, Center for Children with Special Health Care Needs, (CCMC) located in Hartford, and the Yale Center for Children with Special Health Care Needs located in New Haven. The CSHCN program provides care coordination, advocacy and family support to any child with a special health care need regardless of enrollment status. Enrolled children, those that meet the medical and financial guidelines and have a form of insurance (including Medicaid (HUSKY A), may receive payment for certain services including: adaptive and specialty equipment, special pharmacy prescriptions, specialty and sub-specialty care, occupational/physical/speech therapy and special nutrition formulas. The CSHCN program also offers a limited respite program based on available funds, and transition services to adult care.

Both Centers subcontract with statewide community based facilities such as Easter Seals in New London and the Feroletto Center in Trumbull which increases access for families not residing in the Hartford or New Haven areas. The CSHCN Centers are responsible for providing services to children receiving Supplemental Security Income (SSI) benefits who meet program eligibility criteria.

/2005/The Pediatric Center (Stamford) and St. Mary's Hospital (Waterbury) partner in the development of Medical Homes in CT./2005//

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

Genetics: The two state funded Regional Genetic Services programs, located at Yale University and the University of CT Genetics program, provide access to genetic services for all residents. These services include confirmation testing for newborns identified with abnormal metabolic screening results, prenatal testing, genetic counseling, and ongoing treatment, support for adults with PKU, and high risk pregnancy care for the maternal PKU clients.

Pregnancy Exposure Information Services (PEIS): PEIS provides information and referral services via a statewide toll-free telephone number to pregnant women and health care providers concerning the potential teratogenic effects of drugs, maternal illness, and occupational exposure.

Sickle Cell Program: The two State funded Regional Sickle Cell Programs, located at Yale University 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 Transition program is a multi-faceted program in New Haven, Hartford, and New London that provides support, education, and assistance with transition from pediatric to adult health care providers for adolescents with sickle cell disease. The Sickle Cell Disease Association of America has satellite facilities in New Haven and New London and serves families with sickle cell disease and provide educational programs to increase community awareness of sickle cell disease and trait.

/2005/Yale University with Connecticut Children's Medical Center in Hartford are now the state funded Regional Sickle Cell Programs./2005//

Universal Newborn Screening: The statewide Universal Newborn Screening (UNBS) program is a population-based program for all newborns with three components: testing, tracking, and treatment. All newborns are screened for eight disorders: biotinidase deficiency, congenital adrenal hyperplasia, congenital hypothyroidism, galactosemia, homocystinuria, maple syrup urine disease, phenylketonuria and hemoglobinopathies. This list will be expanded to test for amino acid disorders, organic acid disorders and fatty acid oxidation disorders, including, but not limited to, long-chain 3-hydroxyacyl CoA dehydrogenase (L-CHADD) and medium-chain acyl CoA dehydrogenase (MCADD) in the fall of 2003. Infants with abnormal screening results are referred for comprehensive testing, counseling, education, and treatment services. The program provides increased public health awareness of genetic disorders, public health education, and referrals.

/2005/As of May 1, 2004 newborns are now screened for eleven disorders./2005//

Oral Health Unit (OHU): The Oral Health Unit activities are inclusive for all population groups 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 (SBHC): 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.

Sudden Infant Death Syndrome (SIDS): DPH provides bereavement services to families statewide 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 home visits, referrals to other community-based services, and follow-up.

//2005/An RFP was issued to conduct a statewide assessment of cultural appropriateness of bereavement services. Upon completion, additional MCHBG funding will be allocated to support bereavement services for infant mortality, including SIDS events.//2005//

Universal Newborn Hearing Screening (UNHS): As of July 1, 2000, all 30 hospitals and birthing facilities in the state implemented a Universal Newborn Hearing Screening program. Standardized hearing screening equipment is used to screen all newborns prior to discharge. Hospital staff notify the primary care providers of all infants who are in need of follow-up audiologic testing for subsequent diagnostic evaluation. Tracking and follow-up of children who refer from the initial screens are conducted at the state level. The DPH has developed an MS Access program that has replaced 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.

Cultural Competency

"Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda" was included in the Request for Proposals for our new Right From the Start Program. This document will provide a foundation and guidance for our new grantees. ***//2005/Recommendations were used to develop a self-assessment tool and guidance for Title V providers and new contractors. Cultural Competence language is now standard for Title V funded contracts as of July 1, 2003.//2005//***

FHD staff remain committed to addressing cultural competency during site visits to our contractors and staff has developed a cultural competent assessment tool to assure that our contractors are providing culturally appropriate services. The assessment tool contains key items to be discussed and reviewed during the site visit (i.e., recruitment/retention of diverse staff, provision of cross-cultural training, etc.). Also, a check box has been placed on the DPH's Site Visit Monitoring Tool, to remind staff to discuss and address cultural competency during site visits.

The CSHCN Centers are in the process of furthering efforts in the area of cultural competency. Both Centers employ bilingual staff including Latino outreach workers and family advocates who are an integral part of the Spanish-speaking community. In addition to providing individual families with translation services and support, they link with other service agencies to educate their staff about the Latino community and the specific needs of Latino families of children with special health care needs. They also advocate on behalf of families regarding accessible housing and other pertinent issues. The outreach workers and family advocates are familiar with the available resources for Latino families in their community and statewide. In addition to facilitating an on-going in-house support group for Latino families, they link families to self advocacy groups such as Padres Abriendo Puertas, the Panitas Program, Juntos Podemos (a Latino Support group) and to service agencies such as: Latino Youth, Hispanic Health Council, San Juan Center and Casa Boricua.

C. ORGANIZATIONAL STRUCTURE

//2004/Governor John G. Rowland appointed Dr. Joxel Garcia as Commissioner of Public Health in May 1999. Dr. Garcia serves as the leading health official in the State of Connecticut and advisor to the Governor on health-related matters. However, Dr. Garcia will be leaving the Department of Public Health (DPH) as of July 14, 2003. A new Commissioner has not yet been appointed, however, the current Deputy Commissioner of DPH, Norma Gyle, RN, PhD, is expected to serve as Acting Commissioner.//2004//

//2005/In November 2003, Governor Rowland named J. Robert Galvin, M.D., to serve as Commissioner of the Connecticut Department of Public Health. Dr. Galvin brings experience in

the fields of medicine and public health, as well a strong commitment to serving the people of Connecticut. He started with the Department on December 1, 2003.

Effective July 1, 2004, M. Jodi Rell is now serving as Governor of Connecticut.//2005//

/2004/The DPH is the center of a comprehensive network of public health services, and is a partner to local health departments for which it provides advocacy, certification and training, technical assistance, consultation and specialty services. DPH is a source of health information used to monitor the health status of Connecticut's residents, set health priorities and evaluate the effectiveness of health initiatives. The agency is a regulator of the health community, focusing on health outcomes while maintaining a balance between health status and administrative burden. DPH works to prevent disease and promote wellness through community-based education and programs.

There have been some changes to the organizational structure of DPH in the past year. Other changes have been proposed, but not yet implemented, awaiting the appointment of a new Commissioner. With expansions involving bioterrorism prevention the Bureau of Community Health was split into two components. A new Bureau, the Bureau of Public Health Science, was formed and is comprised of the Infections Diseases Epidemiology Programs including Immunizations, Sexually Transmitted Diseases, and AIDS surveillance and some components of Environmental Epidemiology including Community Hazards Assessment and Occupational Health.//2004//

//2005/In February of 2004, the Department consolidated the five Bureaus into four. The functions of the Bureau of Public Health Science have been absorbed by other organizational units of DPH.//2005//

/2004/Within the Bureau of Community Health, a new Director of Family Health was recruited. Since July, 2002, Martha Okafor, PHC, MA, CSM, MPA, has been serving as the Director of the Family Health Division (FHD) and as the Title V Director under the supervision 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, however, there is support for many Title V programs from other areas within the DPH. For example, the DPH Laboratory analyzes blood specimens from newborns for genetic screening, and the Office of Health Care Quality (OHCQ) maintains vital record data bases containing information on births, deaths, hospitalizations and risk factors related to maternal and child health. Epidemiologists within OHCQ and the Bureau of Community Health use vital record information to help direct and evaluate Title V program activity. Other MCH related programs such as Childhood Lead Poisoning Prevention, and Asthma are located organizationally in other Divisions within the Bureau of Community Health. These programs work cooperatively with Title V funded programs in the Family Health Division to promote maternal and child health in the state of Connecticut.//2004//

//2005/The Bureau of Community Health, under Dr. Ardell Wilson's leadership, realigned its programs and assumed new programmatic responsibilities. The AIDS and Chronic Diseases Divisions integrated the Department's cardiovascular health efforts, including diabetes, tobacco, and obesity prevention. The Health Information Systems and Reporting Division, under the direction of Julianne Konopka, assumed responsibility for Health Care Quality, Statistics, Analysis, and Reporting, Chronic Disease Surveillance, and Survey Research and Reporting. The Health Education, Management and Surveillance Division, took on additional responsibility for the Nutrition Program.//2005//

/2004/The Family Health Division was reorganized into four units in the fall of 2002. These include the Women, Men, Aging & Community Health; Child, Adolescent & School Health; Oral Health unit, and Surveillance, Evaluation & Quality Assurance. Programs within each unit are defined in the organizational charts attached to this document. This reorganization enables the Family Health Division to focus on and improve the health status of individual member of a family as a cohesive unit. The Women, Men, Aging & Community Health (WMACH) unit focuses on the adult members of a family and their public health primary care access point. The Child, Adolescent & School Health unit focuses on the pediatric members of a family and their public health primary care access point. The Oral Health unit focuses on improving oral health access and integrating oral health as part of general

health for all individuals and members of a family. The Surveillance, Evaluation and Quality Assurance [SEQA] unit is structured to focus on supporting the programs with necessary data analyses, program evaluation to track and measure results and ultimately assure that we meet set objectives/objectives and provide quality care/services to our clients.

In conjunction with this reorganization, the Family Health Division has strategically examined their business functions within existing resources and mandates, and has identified their mission as ?improving the health of Connecticut's resident across lifespan through culturally appropriate: surveillance, public education, family-centered interventions and community-based capacity building.' The Division's core purpose is ?to optimize the health of families' with a vision that ?all individuals and families achieve optimal health through appropriate and comprehensive health services.' The Division's two core priority foci areas are: (1) improve perinatal health (within the framework of women health, which includes inter-conceptual, wellness, healthy behaviors and relationship involving men, parenting and social support systems); (2) improve child and adolescent primary health (within the framework of prevention and family-centered health strategies). The Family Health Division will develop crucial business alliance and work with both internal and external stake holders as partners to optimize the health of families.

Lisa Davis, RN, BSN, MBA is the supervisor of the Women, Men, Aging and Community Health Unit. Staff in this unit work on the following programs: Abstinence Only Education, Comadrona, Community Health Centers, Family Planning, Fetal and Infant Mortality Review Program, Healthy Choices for Women and Children, MCH Referral and Information Services, Pregnancy Related Mortality Surveillance, Right from the Start, State Mortality and Morbidity Review Support Program, Sexual Assault Prevention and Intervention.

/2005/Program changes include the conclusion of the grant for the State Mortality and Morbidity Review Support Team and change in responsibility for the State Loan Repayment Program. The Arthritis Program, Primary Care Office and Intimate Partner Violence programs are now located in the WMACH Unit./2005//

Dorothy Pacyna, MS, RN is the supervisor of the Child, Adolescent & School Health Unit. The programs served by these staff are: Expanded School Health Services, Pediatric Primary Care Program, School Based Health Centers, Children with Special Health Care Needs, Genetics Services, Maternal PKU, Pregnancy Exposure Information Service, Sickle Cell Services, Sickle Cell Transition Program, Sudden Infant Death Syndrome, Universal Newborn Hearing Screening, Universal Newborn Screening.

/2005/Program changes in this unit will include the transfer of activities from the Pediatric Primary Care Program to under the new Medical Home Support Center./2005//

The Oral health unit is supervised by Stanton Wolfe, DDS, MPH. All oral health activities including the Openwide program are coordinated within this Unit.

/2005/Recruitment is underway to refill the Director of the Oral Health Unit vacated by Dr. Wolfe./2005//

The supervisor position for the Surveillance, Evaluation & Quality Assurance Unit was recently filled with the transfer of Lisa McCooley, MPH, Epidemiologist 4 to lead that Unit. The programs within this unit are: Child Health Access Project, Cooperative Agreement for Primary Care, NHSC SEARCH Program, State Loan Repayment Program, Statewide Systems Development Initiative (SSDI), and the Children with Special Health Care Needs Registry, and non-Title V funded injury prevention activities.

/2005/Programs in this unit now include Child Health Access Project, Statewide Systems Development Initiative (SSDI), the Children with Special Health Care Needs Registry, and both Title V and non-Title V funded injury prevention activities. The Primary Care Office, responsible for the Cooperative Agreement for Primary Care has been relocated to another unit within the Family Health Division./2005//

Coordination of the development of the Title V document and fiscal administration of the Maternal and Child Health Block Grant is supervised by Julianne Konopka, Director of the Program Support and

Contracts Management Division (PSCM). It is a collaborative between the Family Health Division and the PSCM Division on all aspects of the Block Grant development and fiscal oversight of its implementation. Development of many DPH funded grants and contracts have been centralized within the Program Support and Contracts Management Division to assist the program staff with administrative issues and to allow the staff to focus their efforts on program activities. Staff also provide epidemiological support to the FHD.

/2005/The former Program Support and Contract Management Unit has been reorganized into two different divisions, including the Division of Health Information Systems and Reporting within the same Bureau and still led by Director Julianne Konopka, and the Contracts Management Division, now in the Bureau of Administrative Support Services.//2005//

Resumes are attached to the "Other MCH Capacity" section and are on file at DPH for Martha Okafor, Lisa Davis, Lisa McCooley, Dorothy Pacyna and Julianne Konopka. Department of Public Health Organizational charts are attached to this section.//2004//

D. OTHER MCH CAPACITY

Within the Bureau of Community Health, Family Health Division (FHD) there are many staff who work on Title V programs. Martha Okafor, PHC, MA, CSM, MPA, is the Director of the FHD and the Title V Director. Her Administrative Assistant is Nora Sinkfield.

Lisa Davis, RN, BSN, MBA is the supervisor of the Women, Men, Aging and Community Health Unit. Administrative support is provided by clerk typist Jackie Douglas. Staff within this unit are four nurse consultants; Lois Daniels, RN, MSN, CNM, Donna Fox, RN, MA, Anthony Mascia, MSN, RN and Sharon Tarala, RN, JD. Health Program Associate Deanna Bergeron also reports to Lisa Davis. These staff work on the following programs: Comadrona, Community Health Centers, Family Planning, Fetal and Infant Mortality Review Program, Healthy Choices for Women and Children, MCH Referral and Information Services, Pregnancy Related Mortality Surveillance, Right from the Start, State Mortality and Morbidity Review Support Program, Sexual Assault Prevention and Intervention. ***/2005/Staff changes within this unit include the retirement of Lois Daniels and her position as Nurse Consultant will not be re-staffed. Clerical support is now provided by Joy Andrews. Marilyn Binns joined this unit as an additional Health Program Associate. Program changes include the conclusion of the grant for the State Mortality and Morbidity Review Support Team and change in responsibility for the State Loan Repayment Program. The Arthritis Program, Primary Care Office and Intimate Partner Violence programs are now located in the WMACH Unit. //2005//***

Dorothy Pacyna, MS, RN is the supervisor of the Child, Adolescent & School Health Unit. This Unit is comprised of five nurse consultants; Melissa Hofilena, Donna Heins, RN, BS, Fay Larson, RN, MSHA, Donna Maselli, RN, BS and Tina Pascoe, BSN, MHA, JD. Social Worker Meryl Tom, and Family Advocate Ann Gionet also report to Ms. Pacyna. There is one vacant Health Program Associate position in this Unit. The programs served by these staff are: Abstinence Only Education, Expanded School Health Services, Pediatric Primary Care Program, School Based Health Centers, Children with Special Health Care Needs, Genetics Services, Maternal PKU, Pregnancy Exposure Information Service, Sickle Cell Services, Sickle Cell Transition Program, Sudden Infant Death Syndrome, Universal Newborn Hearing Screening, Universal Newborn Screening.

/2005/Staff changes in this unit include the vacancy of two Nurse Consultant positions previously staffed by Melissa Hofilena and Tina Pascoe. Meryl Tom transferred to another unit within the Division of Family Health. Rose Marie Mitchell provides secretarial support to Dorothy Pacyna. Recruitment continues for Nurse Consultants, a Health Program Assistant and Health Program Associate for the Newborn Screening Program. Robin Tousey-Ayers and Linda Burns have joined this unit to fill the other vacant Health Program Associate positions.//2005//

The oral health unit is supervised by Stanton Wolfe, DDS, MPH. Health program associate Pamela Painter, RDH, MS, and social worker consultant, Hector Colon report to Dr. Wolf. All oral health activities including the Openwide program are coordinated within this Unit.

//2005/Recruitment has begun to refill the Director of the Oral Health Unit vacated by Stanton Wolfe. Pamela Painter continues her duties in this unit. The Social Worker Consultant position is also vacant due to Hector Colon's retirement. Lisa Davis is providing interim supervision to the Oral Health Unit until the Oral Health Director's position is filled. //2005//

The supervisor position for the Surveillance, Evaluation & Quality Assurance Unit was recently filled with the transfer of Lisa McCooey, MPH, Epidemiologist 4. Administrative support is provided by Secretary Joy Andrews. Epidemiologist 3, Marcie Cavacas, MS, nurse consultant Dottie Trebisacci, and health program associate Vine Samuels, MPH are the current staff. There are two vacant epidemiologist positions within this unit. The programs within this unit are: Child Health Access Project, Cooperative Agreement for Primary Care, NHSC SEARCH Program, State Loan Repayment Program, Statewide Systems Development Initiative (SSDI), the Children with Special Health Care Needs Registry, and non-Title V funded injury prevention activities.

//2005/Staffing changes in this unit include clerical support provided by secretary Jackie Smith Douglas. New Epidemiologists are Chun-Fu Liu (Epi 3), Jennifer Morin (Epi 2), Shila Kanakamadela (Epi 2). Social Worker Meryl Tom joined this unit as well as Health Program Associates Marian Storch, Margie Hudson and Kevin Sullivan. Programs in this unit now include Child Health Access Project, Statewide Systems Development Initiative (SSDI), the Children with Special Health Care Needs Registry, and both Title V and non-Title V funded injury prevention activities.//2005//

The Program Support and Contract Management Unit within the Bureau of Community Health provides administrative support through contract management and the preparation of the MCHBG application. Staff also provide epidemiological support to the FHD. Epidemiologist 4 Diane Aye, MPH, PhD, Epidemiologist 3 Marijane Mitchell, MS, and health program associate Africka Hinds are funded by the MCHBG and there is one vacant health program assistant position. Other DPH staff funded by the MCHBG are research analyst Federico Amadeo, MPA in the Office of Health Care Quality who works on maintaining and analyzing vital records, , lab assistant (newborn screening) L Mills, office assistant F. Batteglar in Vital Records, and administrative assistant Kathy Graff in the Bureau of Science.

//2005/The former Program Support and Contract Management Unit has been reorganized into two different divisions, including the Division of Health Information Systems and Reporting within the same Bureau, still led by Director Julianne Konopka, and the Contracts Management Division, now in the Bureau of Administrative Support Services. Changes in staff include a vacancy for the contract support from the Health Program Associate previously staffed by Africka Hinds and the hiring of Celeste Jorge as the Health Program Assistant with duties including the MCHBG application preparation. Administrative Assistant Kathy Graff is no longer funded by the grant.//2005//

Resumes are attached to this section and are on file at DPH for Julianne Konopka, Martha Okafor, Lisa Davis, Lisa McCooey, and Dorothy Pacyna.

E. STATE AGENCY COORDINATION

Connecticut's Title V Program has established working relationships with the following organizations listed below.

State Agencies and Committees/Cabinets

Birth to Three Interagency Coordinating Council (ICC)

Birth to Three Public Awareness and Medical Advisory Committee

Commission on the Deaf and Hearing Impaired
Commission on Children
Council on Developmental Disabilities
Department of Social Services (DSS)
Department of Mental Retardation (DMR)
Department of Education (SDE)
Department of Insurance (DOI)
Department of Children and Families (DCF)
Department of Mental Health and Addiction Services (DMHAS)
DSS SSA Disability Determination Unit
Office of the Child Advocate (OCA)
Office of Policy and Management (OPM)
Office of the Governor
Office of the Chief Medical Examiner (OCME)
Permanent Commission of the Status of Women
/2005/CT Fire Academy-Commission on Fire Prevention and Control
CT Poison Control Center
Department of Consumer Protection
Department of Corrections (DOC)
Department of Labor
Department of Transportation (DOT)
Medicaid Managed Care Council (MMCC)//2005//

Local and Federally Funded Agencies and Health Centers

Community Health Centers
Hospitals/Birthing facilities (30)
Local Health Departments
Planned Parenthood of Connecticut
School Based Health Centers
/2005/Capitol Region Education Council(CREC)
Local SAFE KIDS Coalitions//2005//

Associations and Organizations

Academy of Family Practice
American Academy of Pediatrics
American Association of State and Territorial Dental Directors (ASTDO)
American College of Gynecology (ACOG)
Association of SIDS and Infant Mortality Programs (ASIP)
Children's Health Council **/2005/Organization no longer exists./2005//**
Connecticut Association for Human Services
Connecticut Association of Dental Hygienists
Connecticut Association of Health Maintenance Organizations
Connecticut Association of School Based Health Centers
Connecticut Breastfeeding Coalition
Connecticut Coalition to Stop Underage Drinking/Drugs Don't Work
Connecticut Family Support Council
Connecticut Healthy Mothers/Healthy Babies (HM/HB) Coalition
Connecticut Hospital Association
Connecticut HUSKY Behavioral Health Steering Committee
Connecticut Infant Screening Task Force
Connecticut Perinatal Association
Connecticut PKU Planning Group
Connecticut Primary Care Association
Connecticut Sexual Assault Crisis Services

Connecticut State Dental Association
 Connecticut State Medical Society
 Family Resource Coalition of America
 Genetics Advisory Committee (GAC)
 Hearing Task Force
 Hispanic Health Council
 March of Dimes CT Chapter
 MCH I & R Advisory Committee - Infoline */2005/Committee is no longer active./2005//*
 National Assembly on School Based Health Care
 National Association of Social Worker (NASW)
 National Newborn Screening Advisory Committee
 National Newborn Screening Genetic Resource Center (NNSGRC)
 NERGG, Inc. (formerly known as New England Regional Genetics Group)
 New England Consortium of Metabolic Programs
 New England Consortium of Metabolic Programs Planning Group
 New England Resource Mothers Program
 New England SERVE */2005/Organization no longer active/ /2005//*
Office on Women's Health, Region One
Robert Wood Johnson Foundation
Sickle Cell Disease Association of America, CT Chapter
Southern Regional Sickle Cell Association, Inc.
State Adolescent Health Coordinator's Network
US Department of Labor -- CT Office
Youth Suicide Advisory Board
/2005/Child Health and Development Institute of Connecticut, Inc. (CHDI)
Children's Safety Network (HRSA funded)
Connecticut Lifespan Respite Coalition
CT Collaboration for Fall Prevention
CT SAFE KIDS Coalition
Early Childhood DataCONNECTIONS
Healthy Child Care CT
National Highway Traffic Safety Administration Region I
Northeast Injury Prevention Network
State and Territorial Injury Prevention Directors Association
A.J. Papanikou Center for Developmental Disabilities
US Consumer Product Safety Commission//2005//

Tertiary Care Facilities and Universities

Boston University School of Public Health
 Connecticut Children's Medical Center
 Griffin Hospital (Yale-Griffin Prevention Research Center)
 St. Francis Hospital and Medical Center
 University of Connecticut
 Yale University
 Yale-New Haven Hospital
/2005/Griffin Hospital --Community Center of Excellence on Women's Health (CCOE)
Harvard Injury Control Research Center (CDC funded)
University of Connecticut Health Center
Yale University Program on Aging//2005//

Because of the diverse programs funded by the Block Grant, the Department of Public Health works with other state agencies and within its own programs to insure coordination of services. The narrative below describes the most important of those collaborations.

Martha Okafor, the Director of the Family Health Division (FHD) within the Bureau of Community

Health of DPH, is the state Title V Director. Among her many duties, she is a member of the statewide, interagency task force on children with special health care needs, headed by the Office of Policy and Management (OPM). The task force main focus is identifying strategies to improve access to existing services for this target population.

The Children with Special Health Care Needs (CSHCN) program within the Child, Adolescent and School Health Unit of the FHD also collaborates with the Social Security Administration/Disability Determination Unit at DSS to identify and refer potential enrollees to the Program. CSHCN program staff also network with the Bureau of Rehabilitation Services (BRS) at DSS regarding the provision of occupational services to youth transitioning to adulthood.

The CSHCN program staff work with SASH, the Steering and Advisory Committee for Children with Special Health Care Needs (CSHCN) and Husky Plus Physical (HPP) which includes representation from the following entities: Department of Public Health (DPH), Department of Social Services (DSS), Department of Mental Retardation (DMR), State Department of Education (SDE), Department of Insurance (DOI), the Department of Children and Families (DCF) and the Office of the Child Advocate (OCA).

/2005/The SASH Advisory Committee no longer with exists./2005//

Staffs from DPH and the CSHCN Regional Centers participate on: the Department of Children and Families Advisory Committee for Medically Fragile Children in Foster Care, Birth to Three Public Awareness and Medical Advisory Committee, Birth-to-Three Interagency Coordinating Council (ICC), and the legislatively mandated Family Support Council. The DPH CSHCN staff is involved with other DPH initiatives that include the Urban Health and Women to Women Committees. Involvement with Departmental initiatives has afforded additional opportunities for program outreach activities, some of which are directed toward minority populations. This has enabled CSHCN staff to interface with exhibiting community-based agencies making important connections that may not occur otherwise. Examples of outreach activities provided through state venues include the Women's Health Summit and Asthma Summit, the Martin Luther King Birthday Celebration and a variety of health fairs in the Hartford and New Haven areas.

DPH SIDS program staff works collaboratively with the Office of the Chief Medical Examiner (OCME) in obtaining pertinent information regarding the infant/family to make a referral to DPH funded bereavement services and to update the Department's SIDS Surveillance System.

The CT birthing facilities, State Laboratory, DPH Newborn Screening Tracking Unit nurse consultants, and the Regional Treatment Centers collaborate to assure 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 Connecticut, and the CT Children's Medical Center. Technical assistance and current information is provided to the DPH Newborn Screening Program (NBSP) from the Genetic Advisory Committee (GAC). This committee meets quarterly and has representation from the Regional Treatment Specialists, multi-disciplinary healthcare professionals, DPH State Laboratory and Family Health Division management and Tracking Unit staff. NBSP Birthing Facility Guidelines, Physician Protocols, and educational materials are reviewed, revised, and approved by the GAC Specialists. NBSP Quality Assurance Reviews are analyzed and revised and emerging issues in genetics and NBS are identified, leading to the development of plans for expansion of newborn screening.

/2005/The GAC expanded membership to include consumer representation from the Citizens for Quality Sickle Cell Care, Inc./2005//

Health professionals of the DPH Newborn Screening Program and the Regional Treatment Centers participate on various state, regional, and national committees and resource groups such as: the CT PKU Planning Group, New England Mothers Resource Group, New England Consortium of Metabolic Programs Planning Group, New England Consortium of Metabolic Programs, NERGG, Inc., National Newborn Screening Genetic Resource Center, and the National Newborn Screening Advisory

Committee. Participation on these committees provides the opportunity to network with genetic and metabolic experts and consumers, to participate in educational conferences, and to keep abreast of advances in genetics and newborn screening as they impact public health.

/2005/Program staff participate in the UCONN MPH Program and provides NBS educational sessions to students as part of the Genetics course curriculum./2005//

Site Coordinators of School Based Health Centers (SBHCs) across the state meet bi-monthly with FHD 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.

Sixty-one School Based Health Centers in 18 communities are partially funded by DPH through legislative appropriations serving students in elementary, middle and high schools. SBHCs are licensed as outpatient facilities and staffed by both Advanced Nurse Practitioners and Licensed Social Workers. They offer an array 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. Students enrolled in the school based health centers are provided with early periodic screening, diagnosis and treatment (EPSDT). The practitioners coordinate the care they provide with a child's primary and specialist caregivers, while integrating the needs of the child with other school personnel.

/2005/There are now 62 School Based Health Centers in 18 communities./2005//

Child, Adolescent and School Health Unit staff are engaged in the interagency steering team of the Coordinated School Health Program. This team is comprised of members from DPH, SDE, and DCF. 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, and a member of the National Assembly on School Based Health Care.

/2005/Staff also participate in the Regional Stakeholders Group, with representation from the Departments of Public Health and Education. The group works to enhance collaboration on issues of HIV, STD, and Abstinence./2005//

Within the Women, Men, Aging and Community Health Unit of the FHD, MCH program staff continue to represent DPH on the CT Family Support Council, which assists state agencies in evaluating, coordinating and identifying emerging issues to address and promote statewide access to services. DPH 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.

/2005/Staff no longer participate on the CT Family Support council.

In an effort to build and strengthen community collaborations and to provide technical assistance to our community partners, DPH, in collaboration with the United Way of CT/Infoline 211, developed a manual on "Developing and Sustaining Coalitions." This manual will be available on CD Rom and will be accessible on the DPH website and will accompany and complement the MCH Training being conducted on developing coalitions./2005//

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 five 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. Patients served within the CHCs are provided with a wide variety of comprehensive services including early and periodic screening, diagnosis and treatment (EPSDT). The CHCs also work with Family Planning, WIC, SBHCs, Infoline and others to ensure that pregnant women are referred to receive appropriate care as provided under Title XIX.

/2005/Thirteen corporations now provide services in at 39 sites. This past year, approximately 173,927 people were served./2005//

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, inform policy, 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), 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. The FHD continues to work closely with the WIC program to promote and support breastfeeding in the state.

/2005/As of July 1, 2004, the SLRP will be transitioned from the CT PCA (CT Primary Care Association) back to the DPH.

In collaboration with CPCA, a Homeless Advisory Workgroup was established and a conference was held to strengthen links between healthcare providers and shelters. A needs assessment of homeless persons in CT and a strategic plan to improve the health status of CT's homeless men, women and children is currently being developed./2005//

The DPH continues to participate on the Connecticut Breastfeeding Coalition, which includes representatives from the state and local WIC program, La Leche League, American Academy of Pediatrics, Hospitals, Community Health Centers, Health Maintenance Organizations, independent Lactation Consultants, Medela Corporation and consumers. The Committee meets on a monthly basis and has five active committees, which include: Administrative, Policy and Advocacy, Data, Provider Education, and Public Awareness. The goal of the Committee is to increase public awareness and support for breastfeeding statewide. The Family Health Division continues to work closely with the WIC program to promote and support breastfeeding in the state.

/2005/An additional goal for the coalition is to promote breastfeeding as the social norm. In May 2004, in collaboration with the DPH, the CBC sponsored a health care provider symposium which focused on the integration of breastfeeding support in office practices. The symposium was attended by over 100 health care providers. Lisa Davis is currently serving her second year as CBC Board member./2005//

As part of the Women's Health Initiative, DPH staff actively participates 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.

/2005/The DPH convened a collaborative workgroup, "Going Home Healthy," at York Correctional Institute, the State's only female correctional facility, with the purpose of transitioning women back into the community healthy. The workgroup is comprised of representatives from various state and community-based agencies./2005//

Connecticut's Healthy Mothers/Healthy Babies Coalition is jointly chaired by a staff member within the FHD and the Connecticut Chapter of the March of Dimes. The mission of the Coalition is to promote the health and well being of women and children in Connecticut through leadership, collaboration, and resource sharing.

Within the Surveillance, Evaluation, and Quality Assurance Unit (SEQA) of FHD, staff have worked to establish the CSHCN Registry and work closely with birthing units within the hospitals of the state. The CSHCN Registry has developed working relationships for referrals of children with special health care needs to the Birth to Three program and the two regional CSHCN centers, the Connecticut Children's Medical Center (CCMC) located in Hartford, and the Yale University Medical School located in New Haven.

/2005/ SEQA staff have been assigned as the CT SSDI Project Coordinators. The activities are

described below:

SEQA staff represent DPH on the steering committee for Early Childhood DataCONNECTIONS, a public-private partnership of DSS and CHDI to bring together stakeholders to address the needs for better information on key early childhood indicators. The goal is to further build the capacity of state government to collect, analyze and report key information on the needs and services for young children (birth to age eight) and to develop and facilitate a research agenda for advancing early childhood public policy through partnerships.

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

SEQA staff act as the state identified data contact for the Office of Women's Health Region One database project. Staff have facilitated the collection of the health status information needed for this database and coordinated the subsequent in-state training for use of this database.//2005//

The DPH has worked 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 supported by the Maternal and Child Health Bureau. Its goal is to achieve optimal health and development for all children in childcare, by guiding and supporting service integration between the child care community and health care providers. DPH participates on the five member Leadership Team that guides the Healthy Child Care Connecticut, 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 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.

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 include prenatal and family planning clinics, child health clinics, nutrition services, immunizations, communicable disease surveillance and control, HIV counseling and testing and other services. DPH's 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.

/2005/The Early Childhood Partners Initiative is planning the implementation of a comprehensive, integrated early childhood system that affords children in all families optimal health and readiness to learn by age five. The steering team includes representation from the Commission on Children, CHDI, DCF, DMR, SDE, DSS, Connecticut Head Start State Collaboration, the MMCC and the State Prevention Council.

To address intentional and unintentional injuries, DPH staff collaborate with the CT DOT, CT and Local SAFE KIDS Coalitions (membership includes health care, EMS, Police, Fire and community service providers) to address motor vehicle injuries. Also, DPH facilitates the CT Young Worker Safety Team, a collaboration that includes the CT and US Departments of Labor and the CT SDE. The group promotes awareness and training to decrease adolescent work related injuries. DPH staff participate in the Northeast Injury Prevention Network, which includes State Health Injury Prevention Programs from Regions, I and II, University Injury

Research Centers and representatives from Federal Regional Offices. The Network collaborates on injury prevention initiatives, including data analysis and training, of relevance to both the region and the individual states.

The Family Health Division, in collaboration with The Consultation Center in New Haven, has developed a series of MCH trainings for community-based and DPH staff with the purpose of supporting community level infrastructure building and to assist the DPH and its Title V contractors to better collect, monitor and evaluate MCH programs. Programs offered include: Creating Culturally Relevant Programs, Program Evaluation I & II, How to Develop Evidence-Based Public Health Programs, Social Marketing, Program Monitoring and Quality Improvement, How to Engage Faith Based Organizations, Building and Sustaining Coalitions, Care Coordination Across Agencies and Systems, Normative Paternal Involvement and Effects of Domestic Violence on Children.

Staff have worked with the Commissioner's Office staff to utilize the DPH's "TRAINConnecticut" program. It is a free, centralized registry of training opportunities for the public health and health care workforce sponsored by the DPH in collaboration with the Public Health Foundation and is supported by CDC. Participants can register online for MCH trainings.//2005//

F. HEALTH SYSTEMS CAPACITY INDICATORS

1. The rate of children hospitalized for asthma (ICD-9 Codes: 493 -- 493.9) per 10,000 children less than five years of age.

The rate of hospitalizations with a primary diagnosis of asthma appears to have increased since reporting as part of the MCHBG began in 1998. The rate was 19.3 in 1998, 30.0 in 1999, and 36.2 in 2000. However, in 1998 the rate had dropped for that one year. In 1997, the hospitalization rate was 33.5 per 10,000. Over the period 1992 to 2000 the average annual hospitalization rate for children ages 0-4 years was 31.1 per 10,000, which is somewhat consistent with the most recently reported rate of 36.2 per 10,000. This rate is higher for black and Hispanic children than white children. In Connecticut, the average annual hospitalization rate for black children from 1992-2000 was 54.7 per 10,000, almost five times higher than the annual average for white children. Also the hospitalization rate is highest among residents of the larger cities in Connecticut.

The prevalence of asthma as reported through HUSKY A indicates some increase in prevalence among black and Hispanic children in comparison to white children, but the disparity is not as great as the hospitalization rate. This may indicate that asthma among black and Hispanic children tends to not be as well medically managed as the white children, thus leading to a greater occurrence of hospitalizations.

2. The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen.

Approximately 84.6 percent of Medicaid infants less than one received at least one initial periodic screen in 2003. This represents an increase from 80 percent reported in 2002.

3. The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one periodic screen.

Approximately 74.6 percent of HUSKY infants less than one received at least one initial periodic screen in 2003. This was a from 80.2 percent reported in 2002.

4. The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

Approximately 84.6 percent of women (15 through 44) with a live birth in 2002 had at least 80 percent of their expected prenatal visits as measured on the Kotelchuck Index. This was a slight decrease from 85.6 of the women in 2001.

5. Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State.

For the 2000 birth cohort year there was a match of Medicaid records and Vital Records completed by the Children's Health Council under agreement with the Department of Social Services (DSS) and the DPH. Therefore, limited analyses are available for that year. DPH has worked with DSS in establishing a Memorandum of Understanding to ensure this record match can continue every year.

For the year 2002, 9.1 percent of the deliveries paid for by Medicaid were low birth weight babies in comparison to the non-Medicaid population of 6.9 percent low birth weight. Also, Medicaid mothers were less likely to receive adequate prenatal care in the first trimester (80 versus 88.5 percent versus Non-Medicaid population).

6. The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1, children and pregnant women).

Infants, Children up to age 16, and pregnant women are eligible for Medicaid if the family income is up to 185 percent of the poverty level. Infants, Children up to age 19, and pregnant women are eligible for SCHIP or HUSKY if the family income is up to 300 percent of the poverty level.

7. The percent of EPSDT eligible children age 6 through 9 years who have received any dental services during the year.

The percent of EPSDT eligible children age 6 through 9 years who have received any dental services during 2002 was 45.4 percent, an increase from 43.6 percent in 2001. While this is a welcome increase, provision of dental services remains an important need. Connecticut's OPENWIDE program aims to increase the ability of non-dental health professionals to make appropriate referrals for dental care. The professionals targeted for this education during the coming year will include pediatricians, family practice physicians, and nurses

8. The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs Program.

In 2003, 7.3 percent of SSI beneficiaries received CSHCN services, which remains unchanged from 7.3 percent in 2002.

9a. The ability of States to assure that the Maternal and Child Health program and Title V agency have access to policy and program relevant information and data.

Some improvement, as well as areas of continued challenges has been seen in this indicator over past years. There was a link of Medicaid and birth records for the year 2000 birth cohort and a new MOU between the Department of Social Services (DSS) and DPH will make this an ongoing project. Also, the CSHCN Registry became operational in the fall of 2002.

9b. The ability of States to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the past month.

Connecticut uses data from the Youth Risk Behavioral Surveillance System (YRBSS) to respond to this indicator. Data from the YRBSS conducted in 2003 indicates that 22.5 percent of high school students surveyed have smoked a cigarette within the past 30 days.

9c. The ability of States to determine the percent of children who are obese or overweight.

Connecticut uses data from the Youth Risk Behavioral Surveillance System (YRBSS) to respond to this indicator. In 2003, data from the YRBSS indicated that 11.6 percent of high school students surveyed were obese or overweight. Also, local WIC Programs in Connecticut enter weight and height data on children 1 up to 5 years of age into the Statewide WIC Information System "SWIS." The data are provided to the local WIC office via the child's primary health care provider at six month intervals for the purpose of the WIC eligibility determination. The data are stored and tabulated at the state level.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

A. Background and Overview

The priorities presented in the next section were determined as part of the five year needs assessment completed for the FY 2001 application three years ago. To assist in the overview and direction of the FY 2001 Needs Assessment and identification of the priority needs, the MCH director established a Steering Committee within the 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.

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.

Another example was the development of the CSHCN Registry. Staff recognized the need for better data, tracking, and referral for children with special health care needs. Funding for the CSHCN Registry was obtained from CDC and the Registry became operational in the fall of 2002.

Mental health services were identified as a priority need. In the past few years a DPH workgroup has been established to evaluate mental health services within Title V programs. The workgroup has made progress in evaluating services and implementing methods for better collection of information on provision of services.

//2005/This current and coming year will mark an increasing emphasis placed on care coordination and the on implementation of the medical home model for children with special health care needs. The two CSHCN Centers will be replaced with five Regional Medical Home Support Centers. These Centers will enable DPH to reach more children with special health care needs with MCHBG funding.//2005//

B. STATE PRIORITIES

Through the needs assessment process initially completed for the 2001 application, DPH identified ten areas of priority needs. These ten areas with discussion of how they relate to the National and State Performance Measures are described below.

1. Enhance CSHCN services

The CSHCN Registry has been established by DPH in an effort to improve planning of CSHCN services and to get an accurate count of the number of these children in the state. The development of the CSHCN Registry became operational in the fall of 2002. State Performance Measure (SPM) # 9 monitors the development and initiation of the Registry.

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. National Performance Measure (NPM) #11 responds to efforts to address the insurance for the underinsured issue. A source of insurance for primary and specialty care is part of the intake assessment for children enrolling in the program.

Case management and care coordination continues to be an important need among the CSHCN population. The CSHCN program had made several efforts to address the issue of care coordination. SPM #1 recognizes the need for a written care service plan for children with a special health care needs.

A New England survey pointed to the need for increased attention to measuring the quality of mental health services. SPM #2 addresses the need to make appropriate referrals for mental health services.

SPM #1 measures the percentage of CSHCN enrolled in the State CSHCN program that have a written care service plan. SPM #9 measures the degree to which DPH has the infrastructure in place to collect and report information on all CSHCN in the State.

At the FY04 Public Hearing on June 18, 2003, families of children with special health care needs once again stressed the importance of a respite program, day care services and training for informal care providers (family and friends). The amount of funding, however, is insufficient compared to the degree of need.

A transition plan was developed for CSHCN, with a goal to develop a community-based system of care for CSHCN in Connecticut. In July 2003, a technical amendment redirected the two CSHCN Centers to focus on care coordination and medical home development. The CSHCN Centers will be replaced with five Regional Medical Home Support Centers (RMHSC). The RMHSCs will begin in January 2005, with start up beginning in October 2004.

The Department is seeking to develop and support an infrastructure for CSHCN with an emphasis on capacity building and care coordination activities. This infrastructure will recognize that CSHCN are also served by other state agencies, including the Departments of Social Services, the Department of Children and Families, the Department of Mental Health, and programs such as HUSKY (Medicaid managed care), Birth to Three, Help Me Grow, Preschool Special Education and Kid Care.

Two primary pediatric centers have completed the National Institute of Child Health Quality Medical Home Learning Collaborative and meet monthly with Title V staff to discuss implementation of improvement projects. A Connecticut Medical Home Academy is being developed to support the expansion of medical home for CSHCN.

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 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 and Hispanic populations. 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 SPM #4 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. SPM #4 measures the degree to which Title V programs target services to racial and/or ethnic groups with disparities in pregnancy outcomes.

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

CT's Title V programs need to continue to provide education and programmatic activities to promote healthy habits among children and adolescents such as is provided through the School Based Health Centers. The Youth Behavioral Risk Factor Survey was administered in the school setting in the spring of 2003 and data on reported adolescent behavior soon will be analyzed.

Unprotected sexual activity results in increases in unwanted teen pregnancies and increases the risk of sexually transmitted diseases. Young persons in the larger cities of the State continue to be most affected by gonorrhea and chlamydia.

Adequate exercise and nutrition are important for adolescents' overall health as well as their school performance. Obesity among youth and others is being recognized as a growing public health problem.

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.

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

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.

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.

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. 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.

State Performance Measure #3 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.

Title V programs work to improve access to health care for women, infants, and children.

BRFSS data indicate that many pregnancies may not be planned. The DPH sponsors services at 16 Family Planning Clinics. Services provided include health promotion/disease prevention, contraception, preconception counseling, pregnancy options counseling, STD screening and HIV/AIDS counseling and testing. Special outreach is targeted to teens, minority women and homeless women.

Prompt identification of infants at risk for metabolic or genetic diseases enables medical treatment to avert complications and prevents irreversible problems. Outreach programs are needed to assist young women of childbearing age with PKU back into genetic specialty services. An expanded panel of testing for genetic disease will be instituted in the fall of 2003.

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. 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.

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.

Two State Performance Measures were developed in relation to pregnant women, mothers and infants. SPM #5 refers to the development of an infrastructure within DPH to develop and implement a Statewide Genetics Plan. SPM #6 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, many sources of 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.

Progress is being made to share data within DPH and across agencies. We are working on a Memorandum of Understanding with the Department of Social Services to link Medicaid and Vital Records and WIC data sources. Also we are making progress in linking Universal Newborn Hearing Screening, Newborn Screening (laboratory screening), and the CSHCN Registry.

SPM #9 measures the degree to which DPH has the infrastructure in place to collect and report information on all CSHCN in the State.

8. Enhance Oral Health Services

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. This issue was once again highlighted at the FY04 MCHBG public hearing on June 18, 2003, families of children with special health care needs once again stressed the difficulty of finding a dental provider.

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
- ? residents working in public settings

State Performance Measure #8 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. 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.

SPM #2 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.

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.

State Performance Measure #7 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.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria*

and hemoglobinopathies) who receive appropriate follow up as defined by their State.

a. Last Year's Accomplishments

CT continued to meet its objective by assuring that 99.9% of all babies born in the state received newborn screening prior to discharge or within the first week of life. In 2003, there were 283 presumptive positive results, and of these, 41 were confirmed disorders. The number identified as having Hemoglobin Traits was 823. Infants with a positive screen were referred to state-designated Regional Treatment Centers for confirmation testing, treatment, education, counseling, and follow up services, as needed.

An amendment was made to the Connecticut General Statutes, Section 19a-55, that mandated additional screening of newborns to include amino acid disorders, organic acid disorders and fatty acid oxidation disorders, including, but not limited to, long-chain 3-hydroxyacyl CoA dehydrogenase deficiency (LCHADD) and medium-chain acyl CoA dehydrogenase deficiency (MCADD). This increased the number of disorders that CT newborns were screened for to eleven.

Currently 29 of 31 birthing facilities are utilizing the Newborn Screening System (NSS) of electronic reporting of biographical and laboratory testing information. The electronic reporting system is linked with the newborn hearing screening program data.

The newborn screening laboratory staff met monthly with the tracking staff to discuss Quality Improvement reviews, program concerns and emerging issues. Tracking staff met quarterly with the Genetics Advisory Committee (GAC) to discuss issues related to newborn screening.

Reviews determined an unsatisfactory specimen rate of .21%. All unsatisfactory 1st specimens were followed up to assure that all babies had 2nd specimens obtained and received laboratory screening. It was determined that .01% newborns were missed and 99.9% were screened, in effect meeting the goal of 100%. Of those screened at their 2 week visit to the PCP, 25% were not screened which is 0.01% of the 2003 CT births.

Technical assistance and education was provided by DPH staff to the birthing facility health professionals, and primary care providers (PCPs) during site visits, telephone, and written communications.

DPH contracted services to develop and implement educational and public awareness materials for health professional, families, and the general public. Grand rounds conferences were conducted by genetic specialists at the CT hospitals and medical teaching institutions regarding genetics and the expanded newborn screening disorders. Fact sheets were printed for MCADD, LCHADD, and Tyrosinemia.

DPH continued to maintain a Newborn Tracking System Database (NBTS) for all suspect positive screens through confirmation testing results and sent written correspondence to PCPs and parents, per protocols. Programming and development was initiated for the creation of a Child Health Profile that would serve as a data repository for newborn lab, hearing and birth defect registry data. The NBTS database was reviewed and plans were developed for a link with the Child Health Profile.

b. Current Activities

DPH continues to assure early identification of infants at increased risk for selected metabolic or genetic diseases. In collaboration with the Genetics Advisory Committee (GAC) specialists, DPH continues to revise guidelines, protocols, brochures, and fact sheets to reflect the expansion of the NBS testing panel. CT continues to collaborate with the New England Regional Genetics Group, Inc. and other states in various grant application opportunities to

obtain financial resources to address our genetic newborn screening program needs. The DPH Newborn Screening staff meets quarterly with the GAC to discuss issues relevant to newborn screening and genetics.

The State Laboratory completed appropriate staff training and the Tandem Mass Spectrometer (TMS) validation testing, interpretation of results and conducted a population study in preparation to implement the expanded three additions disorders (MCADD, LCHADD, and Tyrosinemia). The laboratory is presenting validating the second TMS.

A statewide courier system was implemented to pick up and deliver newborn laboratory screening specimens from the birth hospitals to the state lab. The goal is to provide rapid time frames from collection to completing and reporting abnormal laboratory results and prompt referrals to specialty centers for confirmation testing and treatment. The State lab monitors the timeliness of the courier services.

The laboratory and data processing support staff have reviewed the Laboratory's NBS database and have integrated the common reporting terminology for generating abnormal results for the expanded disorders.

A statewide genetic conference was held in December 2003 for birthing facility nurse managers and support staff to discuss the implementation of the expanded screening and other issues surrounding newborn screening.

The quality improvement reviews are ongoing to assure that all newborns are screened in a timely and accurate manner to enable prompt identification of disorders and referrals to State designated Regional Treatment Centers for confirmation testing, treatment, education, counseling, and follow up services. The laboratory designated a staff person to develop and perform various quality assurance activities assuring timely and accurate testing from receipt of the specimen to the completion of testing and reporting of results as well as other laboratory requirements. NBTS staff meets with the laboratory staff monthly to discuss quality assurance (QA) issues and to get updates on the plans for expanded screening

Statistical program reports are produced on a monthly and yearly basis and are used to respond to various state, regional, and national requests and required reports.

Physician's Guidelines for Laboratory Newborn Screening have been revised for distribution with other printed expanded Laboratory Newborn Screening educational materials through a mass mailing.

By October 2004, all birthing hospitals will be reporting electronically.

c. Plan for the Coming Year

CT will continue to assure that infants are screened for early identification of those at increased risk by adding other selected metabolic or genetic diseases to the screening panel so that medical treatment can be promptly initiated. All newborns with abnormal screening results will continue to be referred to State, Regional Treatment Centers for comprehensive testing, counseling, education, and treatment services

The NBTS database will continue to be modified to accommodate further expansion of potential additional disorders and to improve report output capability. A linkage will be developed between the NBS and the electronic vital records system database to assure that each child born receives a laboratory screen.

NBS will continue to work collaboratively with the GAC, the specialty treatment centers, and others in the development and implementation of educational programs.

Newborn screening staff will disseminate a satisfaction survey to a sample of families who have undergone the laboratory screening and/or referral to treatment processes with their newborns. The survey results will be analyzed to identify gaps in services, barriers to care and other improvement measures.

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

a. Last Year's Accomplishments

Data from the State and Local Area Integrated Telephone Survey (SLAITS) conducted between October, 2000 and April, 2002 indicated that in CT, 59.8 % of families of CSHCN partner in decision-making and are satisfied with the services received. This percentage is slightly higher, but statistically similar the national estimated of 57.5 %.

The two CSHCN centers located at the CT Children's Medical Center in Hartford and at Yale University in New Haven provided care coordination and ensured families involvement in decision making regarding their child's care.

Through Family Advocates (parents of CSHCN), Family Resource Specialists, and Outreach Workers located at the CSHCN Centers, families were linked with other families, found community based services, attended planning and placement team meetings, and facilitated support and self advocacy groups. The Centers employed bilingual staff for Latino support and self-advocacy groups.

Families were active members of groups including the following: the legislated Family Support Council, CT Lifespan Respite Coalition, New England SERVE, and Family Voices. Family surveys designed to identify needs were distributed to families enrolled in the CSHCN Program.

DPH invited 3 Medical Home Learning Collaborative teams comprised of pediatricians, nurse practitioners, and parents of CSHCN to participate in trainings to improve services and support to families. Families were compensated for their review and comments of Connecticut's Title V Maternal and Child Health Services Block Grant.

DPH implemented the statewide respite system which began with a 3-part needs assessment: a parent survey, three focus groups, and provider survey. A total of 306 families completed the survey for a 36% response rate. The provider survey was sent to 1,200 pediatric PCPs to obtain their perspective. Three focus groups were held to further examine the survey findings. Insurance coverage and advocacy was identified as a major stressor.

DPH funded the creation of an educational respite notebook entitled "Get Creative About Respite." DPH also funded a symposium on intergenerational respite program planning to design an intergenerational respite model, a test demonstration project, and report of best practice for Intergenerational respite programs.

Through the CSHCN Centers, DPH provided payment to families for self-directed respite relief and family-directed summer camp respite options. A survey of families who received respite summer camp funds identified families would have been unable to send their child for camp had the respite summer camp funds not been available.

The CSHCH Centers Family Advisory Committee (FAC) organized statewide family forums to

identify the strengths and weaknesses of the CSHCN program. Strengths included: CSHCN staff were helpful and knowledgeable, and respite funds were appreciated. Areas of improvement included; parents needed more assistance in getting insurance to fund needed items and services.

b. Current Activities

The two CSHCN centers located at the Connecticut Children's Medical Center in Hartford and at Yale University in New Haven continue to provide care coordination and ensure families are involved in decision making regarding their child's care. Family surveys were distributed to Children with Special Health Care Needs families.

A final Medical Home Learning Collaborative training was attended by Connecticut teams comprised of both professionals and parents of children with special health care needs covering the topics related to providing coordinated, comprehensive, family-centered services for children. The DPH staff continued to meet the Medical Home process evaluations. The Medical Home Learning Collaborative information sharing continue with a conference call hosted by Connecticut in February of 2004 in which CT reported a great change was realized through the family involvement component of the process. The introduction of family interviews and screens resulted in families' involvement with care plans and the creation of a pre-visit questionnaire.

A parent of children with special health care needs continued to be available to all Maternal and Child Health Programs within DPH and to the CSHCN Centers. Support staff continued to be employed at the CSHCN Centers.

Along with key stakeholders DPH continued to enhance the statewide respite system. DPH funded the production of 5,000 copies of the "Get Creative About Respite" notebook. DPH contracted to provide eight informational sessions to families across the state based upon the "Get Creative About Respite" notebook. The information sessions will ask attendees to identify where they have found success and barriers to accessing needed respite services.

DPH continued to offer direct respite funding and summer camp respite funding to families of children with special health care needs.

Families were offered the opportunity to be paid for their review of the Maternal and Child Health Services Block Grant. Families were invited annually to comment at the public hearing for the MCHBG.

c. Plan for the Coming Year

Infrastructure for programming is migrating to the Medical Home Collaborative Support Centers which will be located in 5 regional sites throughout Connecticut. The purpose of the Medical Home Collaborative Support Centers will be to provide care coordination, strengthen the Parent Network, and support family involvement in decision making. Orientation and training will be provided to families involved in the Parent Network by families currently employed by the Department. Since Request for Proposal application responses were received from only 4 regions, DPH is considering reposting an RFP for the eastern region of the state.

The DPH will continue to provide the support of a part-time Family Advocate at DPH available to all Maternal and Child Health Programs. Family support staff will continue to be employed at the CSHCN Centers and will continue to be active members of local, state, regional and national organizations.

DPH will continue to monitor, enhance, and make changes to the statewide respite system as

necessary.

Families will continue to be offered the opportunity to be paid for their review of the Maternal and Child Health Services Block Grant. Families will continue to be invited annually to comment at the public hearing for the MCHBG.

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

a. Last Year's Accomplishments

Data from the State and Local Area Integrated Telephone Survey (SLAITS) conducted between October 2000 and April 2002 indicated that in CT, 56.9 % of CSHCN age 0 to 18 receive coordinated, ongoing, comprehensive care within a medical home. This percentage is slightly higher, but statistically similar to the national estimate of 52.6 %.

In FY 2003, 464 of 505 children (92 %) enrolled in one of the 2 CSHCN Program Centers were identified to have a Primary Care Provider (PCP) as a medical home. The Centers coordinated activities to supplement care received from the PCP.

In the Newborn Screening program, 283 newborns were identified with suspect positive screens for at least of the 8 disorders and were referred to the infant's PCP and a genetic specialist. This valuable link between supports the definition of a medical home.

In December 2002, a task group convened to review the CSHCN Program. Six goals of the President's Freedom Initiative were discussed with staff from 2 centers, other state agencies, the Office of the Child Advocate and DPH staff. A transition plan for CSHCN was developed, with strategies including the redirection of Centers' operations to focus more on care-coordination and medical home; implementation of a community-based system of services targeting regionalized respite and care-coordination; and implementation in 2005.

Title V staff were selected to participate in the National Initiative for Children's Healthcare Quality's (NICHQ) Medical Home Learning Collaborative that began in April 2003. Three teams of pediatric PCPs attended the 3 learning sessions. Title V staff met with these teams between the national meetings to identify improvements in services for CSHCN at the PCP's practice and from a state level perspective.

The 2 CSHCN Centers, funded by DPH, through a contract amendment, supported the medical home spread in CT by working with the PCPs utilizing the Centers for care coordination activities, at a level of practice improvement. A second contract amendment charged the CSHCN Centers with providing quality improvement activities with 6 tertiary specialty clinics.

Through a study, the needs and gaps in services provided to families of CSHCN were identified in care coordination services. There was a consensus in both the family survey and the provider survey that providers did not always effectively address the impact on the family of CSHCN.

The Birth Defect Registry became operational in October 2002. The Birth Defect Registry improved case ascertainment. From October 2002 through March 2003, 20 of the 29 birthing facilities (that report electronically) reported 129 CSHCN cases. Through the birth defects registry, staff at the birth hospitals are able to link families in need of an early intervention referral to the Child Development Infoline (CDI). Staff at CDI triage the families to Birth to Three Services or to the Centers, who ensure that the infant and family are connected to a medical home.

b. Current Activities

From the survey conducted of families and primary care providers, infrastructure and capacity building strategies have been identified regarding respite, family support and a need for regionalized centers which will support medical home development, including care coordination activities and community-based resources. A transition plan was developed for CSHCN to develop a community-based system of care for CSHCN in CT. In July 2003, a technical amendment redirected the 2 CSHCN Centers to focus on care coordination and medical home development. The Centers will be replaced with 5 Regional Medical Home Support Centers (RMHSC), which will begin in January 2005, with start up beginning in October 2004.

Based on recommendations of the task group, DPH sought to develop and support an infrastructure for CSHCN with an emphasis on capacity building and care coordination activities. This infrastructure recognizes that CSHCN are also served by groups and state agencies, including the DSS, DCF, the DMHAS, HUSKY (Medicaid managed care), Birth to Three, Help Me Grow, Preschool Special Education and KidCare.

Two primary pediatric centers have completed the NICHQ Medical Home Learning Collaborative and meet monthly with Title V staff to discuss implementation of improvement projects. A CT Medical Home Academy is being developed to support the expansion of medical home for CSHCN.

A Request for Proposal (RFP) has been developed to select organizations that will serve as regional centers to enable CSHCN and their families to access quality health care services in their local communities. This new community-based system of care will: 1) reach more CSHCN and the families and assist them with coordination of multi-system of care they need to access; 2) provide training and support to the PCPs to improve quality of care by addressing family needs that will optimize the health of their CSHCN; 3) assist the PCPs with care coordination of CSHCN who have high severity of needs; 4) assist with the coordination between the PCPs and specialists; 5) promote the establishment of 'Medical Home' with PCPs that serve the pediatric population and care for CSHCN.

A process evaluation of pediatric practices participating in the Medical Home Learning Collaborative demonstrated that improvements in care coordination have occurred at different levels, including a significant change in response to parents, physician re-education, methods of linkage to specialists and community outreach, such as to schools.

State Title V staff is collaborating with the CT Chapter of AAP in the development of a CT-specific Medical Home Curriculum via creation of a Medical Home in-state Training Academy. There will be June 2004 seminar introducing new medical homes to the concept and practice principles. The CT Chapter of AAP is assisting with promotion of the medical home movement and will make special awards to the current homes at their April 2004 Annual Dinner.

c. Plan for the Coming Year

In July 2003, a technical amendment redirected the two CSHCN Centers to focus on care coordination and medical home development. The CSHCN Centers will be replaced with five Regional Medical Home Support Centers (RMHSC). The RMHSCs will begin in January 2005, with start up beginning in October 2004.

The future of the CSHCN Program includes early identification, complexity determination and triage of all children with special health care needs so that they receive the appropriate level of service and from the appropriate provider. The Regional Medical Home Support Centers at

designated statewide sites will be selected and staff trained to provide access to care that is comprehensive, collaborative, linguistically appropriate and culturally sensitive. It is expected that the full year will be devoted to the implementation of this Community-based system, as well as a pediatric training academy, with an emphasis on the improvement of medical homes for CSHCN.

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

a. Last Year's Accomplishments

Data from the State and Local Area Integrated Telephone Survey (SLAITS) conducted between October, 2000 and April, 2002 indicated that in Connecticut, 61.3 % (95 % CI 57.0, 65.6) of the families of children with special health care needs have adequate private and/or public insurance to pay for the services/equipment they need. This percentage is slightly higher, but statistically similar the national estimate of 59.6 % (95% CI 58.6, 60.6).

Ensuring adequate private/public insurance has been a key component of the Children with Special Health Care Needs Program. Upon initial assessment, families are asked about their insurance coverage and if they receive coverage for services through any other program. Benefit specialists located at each CSHCN Center identify other sources of payment for which families may qualify for as well as coordinate their existing benefits and services. The Center's target population has focused on the underinsured whose income is under 300% of the Federal Poverty Level. The percent of families with a source of private/public insurance at the Centers is 97%. The Center's provide extended funds to provide coverage for uninsured or underinsured families. Extended funds cover durable medical goods, pharmacy, and nutritional formulas/supplements.

The second Medical Home training was completed reviewing reimbursement options for the provision of care coordination for children with special health care needs.

b. Current Activities

The CSHCN Program was redesigned in an effort to provide services to more children with special health care needs and their families within available resources. Infrastructure building and medical home/care coordination were key features of the new program.

The Medical Home Learning Collaborative (MHC) identified the need to access reimbursement for care coordination activities as a value added service to children with special health care needs. The improvements to the medical homes included expanding the visit time period to accommodate the needs identified by the families, children and youth with special needs. The Legislative Managed Care Council Liaison and the Managed Care Ombudsman were invited to the MHC meetings to learn about the impact that utilizing the CSHCN Screener has had on improving the medical home for serving CSHCN. And, to discuss options in seeking reimbursement for the service time necessitated by the coordination of care activities.

The Managed Care Liaison was also invited to join the Title V Connecticut team in attending the Champions for Progress training as a key stakeholder. The training focused on tools to design statewide systems to address the level of coordinated, comprehensive, community-based care children with special health care needs require.

c. Plan for the Coming Year

Medical Home support staff will assist families of children with special health care needs in

assuring they have adequate insurance to pay for the services they need while providing coordinated, comprehensive, accessible, culturally-competent, community-based care. Medical Home support staff will work closely with the HUSKY Infoline staff to ensure all families eligible for state funded health insurance are able to access needed services.

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

a. Last Year's Accomplishments

Data from the State and Local Area Integrated Telephone Survey (SLAITS) conducted between October, 2000 and April, 2002 indicated that in Connecticut, 76.8 % (95 % CI 71.1, 82.4) community-based service systems are organized so families can use them easily. This percentage is slightly higher, but statistically similar to the national estimate of 74.3 % (95% CI 72.9, 75.7).

In FY 2003 the major goal of the CSHCN Program has continued to be to provide children access to coordinated, comprehensive, community based care. The two CSHCN Centers are located in tertiary care hospitals and provide access to needed sub-specialist and support services for families who have children with special health care needs. CSHCN Center staff work with families and other providers to coordinate community based services. Staff provides assistance with appointment scheduling for families who may need multiple subspecialty visits coordinated on a single day.

In FY 2003, the Medical Home Learning Collaborative, a joint effort between Title V agencies, Pediatric Primary care offices, the American Academy of Pediatrics, the National Initiative for Children's Health Quality and MCHB, was initiated. The purpose of this collaborative is to assure that all CSHCN will have access to community-based service systems and that all CSHCN children will receive comprehensive care in a medical home. Three pediatric practices, located in Stamford, Hamden, and Waterbury, will provide care coordination and increase the ease at which families can get their child's needs met through community based service systems. The expected outcome of this Medical Home Learning Collaborative will be to increase family satisfaction, decrease worry, provide a central contact for information and referrals and decrease hospitalizations and emergency room visits.

A three-part needs assessment study was begun. Part I was to identify and prioritize, from the perspective of the family as well as providers, a comprehensive view of the health, psychosocial, and educational needs of families with CSHCNs. This survey was distributed to approximately 850 families and 600 pediatric practice providers. This study identified that 40% of families were not aware of available services or lacked assistance in getting services that their child needs. Also that over 60% of families utilized private practices for medical care. Top services needed were identified as: 1) planned respite, 2) emergency respite, 3) after school program, 4) summer camps and 5) personal home care attendants. 68% of the providers identified serving 1-10% CSHCN, while 1% served between 51 and 75% CSHCN.

b. Current Activities

In FY 2004, the Medical Home Learning Collaborative continues to meet to support improvement activities with care coordination. The purpose of this state level medical home collaborative is to identify the issues and needs of the medical home community. The outcome of the collaborative is to increase family satisfaction, decrease family worry, provide a central contact for information and referrals and decrease hospitalizations and emergency room visits. The pediatric practice (medical home) in Stamford, and Waterbury, in consultation with the

Matrix Public Health Associates and the Title V DPH staff have presented their improvement strategies to seven other pediatric practices.

To develop community-based service systems, DPH is partnering with others who serve the same population. DPH staff has participated and will continue to work on legislated councils (i.e. Family Support Council, Interagency Coordinating Council), with the Birth to Three program, and the University of Connecticut's A.J. Pappanikou Center Developmental Disabilities in order to address issues regarding family access of community-based service systems.

Parts II and III of the Needs Assessment Study were conducted. Part II was a process evaluation of the pediatric practices participating in the medical home learning collaborative to document the developmental process. Results from this study is being utilized to develop the Medical Home Learning Academy and to support the spread of medical homes for CSHCN. Practice changes that occurred from the MHLC included a greater awareness of the complex needs of CSHCN and a more proactive approach towards parent involvement in decision making. Part III of the study was to investigate the role of the two Centers in delivering services to CSHCN, examine the interface between the Centers, Infoline and the pilot MHLC, in order to identify strengths, challenges and opportunities for improvement of the community-based system of services for CSHCN.

The Department is the lead agency on the Connecticut Early Childhood Comprehensive Systems (CECCS) Initiative and is drafting a strategic plan to address the five domains of the CECCS that impact young children's health and learning.

c. Plan for the Coming Year

In FY 2005 the DPH CSHCN program will continue to expand the Medical Home Initiative through the development and education of new primary pediatric practices in the Medical Home concept in order to improve their capacity to serve children with special health care needs. DPH will continue to develop the capacity for Infoline to service this population as a central depository information and referral resources.

The Department together with the University of Connecticut's A.J. Pappanikou Center for Developmental Disabilities, Birth to Three Program, the Department of Children and Families, and the Office of Child Advocacy, will plan an approach to create a state vision and training on care coordination. The Department will implement the Regional Medical Home Support Centers to support access of community based, culturally sensitive services

CECCS will field test and obtain stakeholder feedback about the strategic plan and develop a statewide CECCS Implementation Plan.

Performance Measure 06: The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)

a. Last Year's Accomplishments

Data from the State and Local Area Integrated Telephone Survey (SLAITS) conducted between October, 2000 and April, 2002 indicated that in Connecticut, 5.8 % (95 % CI 0.6, 6.4) of youth with special health care needs receive the services necessary to make transitions to adult life. This percentage is similar to the national estimate of 5.8 % (95% CI 4.6, 7.0). However, the number of families in Connecticut who responded positively to this question was too low (N=6) to consider this estimate a valid representation.

The Children with Special Health Care Needs Program at the two regional Centers have provided transition services to youth age 15-18 and their families. Families are informed of the Center's readiness to assist in the transition process. A letter is sent to inform families of the transition program and an individualized "transition Packet" is sent to families on request. Individualized family meetings are conducted and families are provided with information on all aspects of transition including educational, vocational and transition to adult medicine. In order to ensure a coordinated transition effort, Center staff collaborate with schools and community based organizations. Center staff have also been involved with task forces and committees that focus on transition including the Transition Task Force of the Department of Education Bureau of Special Education and Pupil Services.

Sickle Cell Centers offer transition services through a mentoring program where a young adult will meet with a youth to highlight what might be the same and what might be different as they transition to the adult community.

Connecticut Family Voices supports KASA, Kids as Self Advocates, which promotes and improves the lives of youth with special health care needs and disabilities through peer empowerment and advocacy and the development of leadership opportunities. KASA had three meetings and provided a presentation about the organization at the statewide Together We Will Conference

b. Current Activities

The CSHCN Center staff continued to address the transition needs of youth with special health care needs and their families.

DPH established the Medical Home Learning Academy which address six content areas, one of which focuses on transition.

An RFP for a Sickle Cell Initiative will focus on transition services by addressing education for healthcare providers and a health care needs assessment. An Adolescent Health Strategic Plan will also focus on transition services.

c. Plan for the Coming Year

The Medical Home Collaborative will continue to support children with special health care needs as they transition into the adult community. The Medical Home Collaborative will continue to receive transition educational benefits through updates on the Ticket to Work Program, Vocational Rehabilitation and KASA.

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

a. Last Year's Accomplishments

According to the Centers for Disease Control National Immunization Survey, for 2003, 91.1 +/- 3.6 percent of children age 2 have complete immunizations in Connecticut (<http://www.cdc.gov/nip/coverage/NIS/02-03/toc-0203.htm>). This percentage represents better immunization coverage than the national percentage of 77.9 +/- 1.0 percent. The percentage reported is based a telephone survey of reported vaccinations on records for the 5 reportable vaccines. In 2002, the percentage of children through age 2 with complete immunizations was 77.4 +/- 5.4. NIS data indicates a 13.7 % increase from State Fiscal Years 2002 to 2003 in estimated vaccination coverage for children aged 19-35 months in Connecticut. Based on the current NIS data, CT ranked the highest of all states in immunization levels for young children and continues to remain a leader in pediatric immunizations.

b. Current Activities

A number of Title V funded and non Title V programs direct activities to promote age appropriate immunizations:

Right From the Start (RFTS) provides case management services to pregnant and parenting teens, and assists with linking infants to primary care providers to promote compliance with an immunization schedule.

Comadrone, as part of its case management services, monitors, encourages and educates parents regarding the importance of keeping well child care visits. Comadrone does outreach and enrolls pregnant woman and infants, assesses infants for compliance with recommended schedules and links with primary care providers.

Healthy Start provides community-based case management services for pregnant women and children up to age three. The program assesses immunization status and links children with primary care providers to maintain up-to-date immunizations.

Healthy Choices for Women and Children monitors infants and children to age three for immunization status and refers children in need of immunizations to community resources achieving an 88.5% compliance rate. They also assist parents in obtaining immunization-related services.

Twelve Community Health Centers provide preventive and primary health care to children at thirty-five sites. Four of the centers received funding under the Pediatric Primary Care project and serve children not eligible for other insurance programs. All centers follow national guidelines for administration of childhood immunizations. Chart reviews are used to assure that infants and children are in compliance. Immunization coverage rates for CHCs based on CT Immunization Registry and Tracking System (CIRTS) data from 16 sites for children born in 1999 was 68% for 4DtaP, 3Polio, 1MMR, 3HIB and 3 Hepatitis B.

CSHCN assesses children for required immunizations and refers them to appropriate resources. Care coordination is used to support families in accessing services.

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

The Immunization Program provides funding to support the CIRTS and provides funding to 19 contractors to conduct immunization activities, procure and distribute publicly funded childhood vaccines. Contractor activities consist of performing clinic immunization assessments to monitor immunization coverage rates for preschool children, coordinate and provide outreach and referrals for children identified by CIRTS as being behind in their immunizations, conduct immunization education campaigns that are culturally appropriate to target pregnant women, new parents, new immigrants and provide training and support to providers who utilize the CIRTS.

c. Plan for the Coming Year

The Title V funded and non-funded programs including Children With Special Health Care Needs, WIC, Community Health Centers, Healthy Choices for Women and Children, Health Start, Comadrone and Right from the Start will continue their efforts described in the Current Activities Section. Provision of immunizations as part of well child care are a recognized

important component of protecting public health.

The immunization program plans to continue to assess and monitor immunization rates including HEDIS immunization rates for children enrolled Medicaid Managed Care, continue to convene local advisory/planning groups in all 19 IAP funded sites to improve immunization services for children in high risk areas, continue to partner with community organizations, coalitions, businesses and public and private professional and civic organizations to promote childhood immunizations and vaccine safety, continue to conduct outreach efforts in our 19 IAP sites and refer children especially targeting high-need groups such as immigrants to medical homes, state program will continue to support CIRTS and implement a web-based immunization registry application for providers targeted for roll out in 2004-05, continue to procure and distribute vaccines and provide appropriate immunization educational information and outreach materials as needed.

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

a. Last Year's Accomplishments

In Connecticut for 2001, there were 1,044 births among the estimated 64,362 females age 15 to 17 for a birth rate of 16.2 per 100,000. This is an improvement from the 2000 rate of 16.7 per 100,000 (1,077 births among the estimated 64,362 females age 15-17). Connecticut has exceeded its goal (16.6 projected) in lowering the birth rate to teens. Much of its success can be attributed to a renewed emphasis on prevention of teen pregnancy in general, concomitant with an intense focus on the prevention of repeat pregnancies. This has been achieved through the use of behavioral risk assessment for adolescents, comprehensive case management, referral and follow up for reproductive health care including comprehensive services. These core services are provided in all Title V programs serving teens.

A description of the ongoing programs aimed at adolescents to reduce unintended pregnancies among teens is presented in the Current Activities section of this performance measure. Some highlights of these program activities are presented here.

Right from the Start (RFTS) provided intensive case management services to 292 pregnant and/or parenting teens.

The Abstinence-Only Education program provided education and skills development on making healthy lifestyle choices, developing effective communication skills, setting future goals, attaining self-sufficiency before engaging in sexual activity, and rejecting unwanted sexual advances. A post participation survey demonstrated changes in view on sexual behavior and an increased understanding of abstinence as the only way to prevent pregnancy and sexually transmitted diseases (STDs). Program activities were sustained in five communities.

b. Current Activities

RFTS provides support, information and linkages to services for teen parents and places heavy emphasis preventing subsequent teen pregnancies by providing intensive case management services and linking clients with educational, health and social services, education in life skills, and family planning.

School Based Health Centers (SBHC) provide age-appropriate reproductive health education to students identified as being high risk for sexual activity. Students who tested negative for pregnancy were provided reproductive health education and referrals for contraceptive services.

Healthy Choices for Women and Children (HCWC) provides risk assessment and referral for adolescents age 15-17 to appropriate community service agencies for the prevention of subsequent unplanned pregnancies. The program continues to assist young women in responsible decision making about subsequent pregnancies.

The Family Planning Program (FPP) provides comprehensive reproductive health care services, education and counseling surrounding sexual decisions, pre-contraceptive counseling, contraceptive methods and pregnancy testing and referral to prenatal care providers.

Healthy Start provides support, information and linkages to teens to prevent subsequent, unintended pregnancies. The program provides community based case management services for pregnant women and children up to age 3.

Abstinence-Only Education provides skills development on making healthy lifestyle choices, developing effective communication skills, setting future goals, attaining self-sufficiency before engaging in sexual activity, and rejecting unwanted sexual advances. The program is conducting a media campaign to promote public awareness about teen pregnancy prevention, featuring the State's newest comprehensive teen-friendly website, www.ctnow.com/teens.

Community Health Centers provide behavioral risk assessments for sexual active adolescents age 12-19, to be used to develop treatment plans. CHCs continue to utilize EPSDT guidelines to provide reproductive health care including contraceptives, STD diagnosis and treatment.

The FHD is developing an MOA with AHEC, to develop a CT Youth Health Service Corp to promote teen pregnancy prevention by engaging youth in activities that promote healthy behaviors and lifestyles. It will also support workforce development by facilitating the transition of youth from school to employment in the health care field particularly with underserved populations (i.e. homeless persons). This project is also in partnership with CPCA.

An RFP was issued to develop a State Perinatal Health Plan with recommendations for addressing teen pregnancy prevention. Through another RFP, activities will commence in September to develop a research-based Adolescent Health Strategic Plan to serve as the blue print for a coordinated and comprehensive statewide initiative to address the unique health and developmental needs of adolescents in CT, including teen pregnancies.

c. Plan for the Coming Year

The Title V funded and non-Title V programs including Right from the Start, School Based health Centers, Healthy Choices for Women and Children, Family Planning, Healthy Start, Abstinence-Only Education and Community Health Centers will continue efforts described in the Current Activities section that direct their activities to adolescents to reduce unintended pregnancies among teens will continue their activities into FY05.

The FHD will be issuing an RFP for a consultant to develop a State Adolescent Health Plan. The recommendations from this plan, as well as the State Perinatal Plan, will be considered in reshaping the programs funded by the DPH that address teen pregnancy prevention.

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

a. Last Year's Accomplishments

A primary goal of the DPH Oral Health unit is to centralize, coordinate, enhance and integrate

oral health data, and information systems, in part, to monitor the prevalence of dental sealants. The Family Health Division reorganized to include a Surveillance, Evaluation and Quality Assurance unit, which will enable DPH to better monitor the prevalence of dental sealants.

During 2003, Title V funding was provided to School Based Health Centers (SBHCs) and 4 Community Health Centers (CHCs). However, it is up to the discretion of each site on how this money is used. Limited data is received from these SBHCs, CHCs and other dental safety net facilities and the dental data reporting is often incomplete, inconsistent, and not comparable. However, quarterly reports submitted by the 4 CHCs indicate approximately 67% of clients age six through and including fifteen years of age show they received protective sealants on the occlusal surfaces of their permanent molar teeth based on a sampling of 25 patient records each quarter.

b. Current Activities

A workgroup has been established to review and make recommendations regarding barriers and other issues affecting data collection and reporting, and billing for dental services by public health facilities. The Oral Health Unit is developing its data and information systems and data from recent surveys has been entered. These activities should help us to better monitor and report the number of dental sealants being done.

The statewide oral health-training program for non-dental health and human service providers on the importance of oral health in relation to general health and well-being has been on hold for several months due to overwhelming requests for OPENWIDE curriculum and depletion of current supply. OPENWIDE has been recognized nationally as a "best practice" model and because of this, HRSA funded reprinting of 500 additional OPENWIDE manuals. 200 of the manuals were delivered to Connecticut so that more training could occur in CT. The other 300 manuals will be distributed nationally to health professionals (administrators, providers, educators) working in public health agencies and institutions of higher learning. However, to date, over 800 non-dental professionals in CT have been trained with the OPENWIDE curriculum. Preventive measures promoted include dental sealants.

The DPH partnered with the CT Chapter of ACOG and disseminated a survey to all licensed Obstetricians in the state to ascertain their level of interest in participating in an OPENWIDE training. The data from this survey is currently being analyzed.

Also, the 2004 Behavioral Risk Factor Surveillance System (BRFSS) telephone survey, sponsored by the CDC, contains state-added questions on if the children in the household have ever had sealants. Data should be available next year.

Staff submitted a HRSA grant application to support a CT Sealants program. If awarded, this 3 year grant would provide the infrastructure to promote the placement of sealants in school aged children.

c. Plan for the Coming Year

The Oral Health unit will continue to collaborate with the DPH Surveillance, Evaluation and Quality Assurance unit to enhance data and information systems for oral health, enabling improved monitoring and reporting of the prevalence of dental sealants. Focus groups are planned with key stakeholders to try and resolve billing and data issues, which will ultimately enhance our ability to monitor and report the prevalence of dental sealants.

OPENWIDE training of non-dental professionals during the coming year will include more pediatricians, family practice physicians and nurses who also treat school age children. This will raise awareness about the importance of dental sealants. Therefore, we hope to see an

increase is the number of sealants placed as a result of pediatricians, nurses and family practice physicians making appropriate referrals for dental care.

Pending the analysis of the OB survey and ongoing collaboration with the CT Chapter of ACOG and the March of Dimes, the OPENWIDE curriculum will be adapted to include a section for OBs.

The DPH has issued an RFP for a consultant to evaluate the OPENWIDE curriculum. The evaluation will consist of interviews and surveys and assess the degree to which the information presented was effectively integrated in to various settings (Head Start, etc.).

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

a. Last Year's Accomplishments

In 2002 there were 5 deaths due to motor vehicle crashes among the age 1-14 population of 729,316 for a rate of 0.7 per 100,000. Since 1998, there has been a decrease in the number of deaths in CT due to motor vehicle crashes in this population (from 11 deaths in 1998). The annual performance measure objective of 1.0 per 100,000 was met. Motor vehicle crashes are still a major health risk for CT's children. Every year approximately 4,700 children aged 8 years and less are occupants of motor vehicles involved in crashes in Connecticut (CT DOT Crash File). CT continues to address this performance measure through a diverse array of Title V funded and non-Title V programs that provide activities designed to reduce the number of deaths and injuries among Connecticut's children due to motor vehicle crashes.

Many Title V programs have worked to reduce the rate of motor vehicle crashes among children age 1-14. The Injury Prevention Program (IPP), at the time a Non Title V Program, worked closely with state and local partners to address motor vehicle safety among children. The IPP provided support for efforts to enact Booster Seat legislation although this bill did not pass during the 2003 session. Preventive Health and Health Service Block Grant (PHHSBG) funds were provided to 3 local health departments to conduct motor vehicle injury prevention programs, including 17 car seat clinics, serving 170 adults and children. One local health department maintained a safe community coalition working towards environmental a policy changes with a specific focus on pedestrian safety.

Comadrona, Healthy Choices for Women and Children and Right from the Start provided referrals and linkages to child safety seat and booster seat resources so that infants and children served were properly secured when riding in a motor vehicle.

Community Health Centers, as EPSDT providers, provided children and/or their caregivers age appropriate risk assessments, anticipatory guidance and injury prevention information related to motor vehicle safety.

b. Current Activities

The Injury Prevention Program (IPP) collaborates with state and local partners to address motor vehicle injuries among children. There is a major national focus this year on reducing motor vehicle injuries among 4-8 years olds by increasing booster seat use, so the IPP is working with its partners to address this issue in CT. The IPP is again providing support for efforts to improve CT's child passenger safety law to cover booster seat age children. The Program is working with the CT Department of Transportation and CT SAFE KIDS Coalition to provide educational materials to all pediatricians, and childcare providers in the state as well as MCH providers and Title V programs.

DPH also provides PHHSBG funding to local health departments for injury prevention programs. Local health departments choosing to address motor vehicle injuries with this funding may conduct car safety seat clinics, child passenger safety programs, safety belt awareness activities, pedestrian safety programs and work towards environmental or policy changes that reduce the risk of injury. Two local health departments have chosen this option this year. The IPP continues to provide technical assistance to other units within DPH and community programs. Responsibility for the Crash Outcome Data Evaluation System (CODES) project has been transferred to the Family Health Division. The CODES project links police crash reports with death, hospital, and Emergency Department Data to provide a more comprehensive picture of motor vehicle crashes, injuries and deaths. This enhanced data set will be useful in planning and evaluating programs and policies aimed at reducing motor vehicle injuries in children and adolescents. The FHD is seeking additional funding from the National Highway Traffic Safety Administration (NHTSA) to continue CT's CODES project.

Comadrona, Healthy Choices for Women and Children and Right from the Start provide referrals and linkages so that infants and children served are properly secured when riding in a motor vehicle.

Community Health Centers, as EPSDT providers, provide children and/or their caregivers age appropriate risk assessments, anticipatory guidance and injury prevention information related to motor vehicle safety.

School Based Health Center (SBHC) professionals routinely offer motor vehicle safety information to students in the form of one-on-one meetings as well as group sessions.

Pediatric Primary Care Projects, as providers of a comprehensive package of primary and preventive health care services, and Community Health Centers, as EPSDT providers, provide children and/or their caregivers age appropriate risk assessments, anticipatory guidance and injury prevention information related to motor vehicle safety

The CT WIC program also displays and distributes available motor vehicle safety information to participants.

c. Plan for the Coming Year

As part of a DPH re-organization, the Injury Prevention Program (IPP) is now part of the Family Health Division (FHD). The IPP will work closely with the other FHD programs to integrate motor vehicle injury prevention into Title V and other children's programs. The IPP will also strengthen collaborations on child passenger safety with other DPH programs such as Day Care Licensing and Office of Emergency Medical Services.

Resources and technical assistance will be provided to MCH programs, contractors, and communities on motor vehicle occupant, bicycle and pedestrian injury prevention. Training will be offered to increase the capacity of providers to address injury prevention. The IPP is planning to offer two child passenger safety training courses recently developed by the National Highway Traffic Safety Administration. One course is designed to provide health care professionals with the basic knowledge they need to promote appropriate child occupant protection with parents, families and other caregivers. The second is targeted to childcare providers and addresses safe transportation of children in the daycare setting.

The IPP will continue its collaboration with MCH programs, CT SAFE KIDS Coalition, CT Department of Transportation and other traffic safety advocates throughout the state to promote the use of Booster seats. If booster seat legislation is passed during the 2004 Session, the IPP will work with its partners to increase awareness and compliance with the new law.

The FHD will use CODES data in the development and support of programs and policies that address the risk factors for motor vehicle injuries among children. An advisory committee of agencies and organizations concerned with motor vehicle injury prevention will be developed to help ensure the data are utilized at the state and local level.

Comadrona, HCWC and RFTS programs will work more closely with Injury Prevention Staff to enhance activities to reduce the death rate for children 14 and under caused by motor vehicle crashes.

SBHCs will continue to have motor vehicle safety as an integral focus of events and services. Pediatric Primary Care Projects, will continue as providers of a comprehensive package of primary and preventive health care services, and Community Health Centers, as EPSDT providers, will continue to provide children and/or their caregivers age appropriate risk assessments, anticipatory guidance and injury prevention information related to motor vehicle safety.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

a. Last Year's Accomplishments

The estimated rate of breastfeeding in Connecticut improved dramatically from 69.3 to 73.2 percent and exceeded the projected goal of 69.4. This is an estimated rate since the data are collected and reported by the Ross and Abbott Laboratories using their Mother' Survey.

Activities conducted included: collaborating with CT Children's Medical Center to promote Breastfeeding Awareness month in August, providing resources and promoting Breastfeeding Awareness month at statewide Babies ?R Us stores, displaying a promotional banner outside the State Office Building, developing and printing educational and promotional materials and providing information and resources for providers, specifically the Right from the Start Program and Healthy Mothers Healthy Babies Coalition members. The DPH purchased English/Spanish breastfeeding information sheets that were placed in all hospital discharge packets that are given to all new parents. .

Comadrona provided home visits, referrals to breastfeeding supports, and services of peer counselors to Hartford's low income Latino and African American breastfeeding mothers

Right From the Start programs provided information regarding breastfeeding to their teen population. The program provided support, information and linkages to necessary services for teen mothers to initiate and maintain breastfeeding. One of the RFTS contractors works directly with a lactation consultant to provide support for breastfeeding teens.

The WIC program continued to promote breastfeeding to all pregnant participants unless medically contraindicated. The breastfeeding initiation rate among infants whose mothers were enrolled in the WIC Program during their prenatal period remained constant at 53.6 percent. In September 2003 the WIC Program was awarded a \$44,000 WIC Infrastructure Grant from USDA to assist the program in improving the breastfeeding duration rate among WIC mothers. The WIC Program was represented on the Breastfeeding Committee of the Connecticut Chapter of the American Academy of Pediatrics (AAP) and the Connecticut Breastfeeding Coalition. The WIC Breastfeeding Committee continued to meet on a bimonthly basis and collaborated with the State WIC office in the development of draft breastfeeding promotion and support guidelines. Each local program has a designated Breastfeeding Coordinator who participates in the committee.

In 2003 The PRATS Survey was sent to 4700 mothers who gave birth in CT. One of the areas of focus was breastfeeding.

b. Current Activities

The CBC, in collaboration with the DPH, hosted a supper symposium on "Strategies for Health Care Providers to Support Breastfeeding." The DPH issued an RFP to assess and determine the rationale for disparities in initiation and duration rates of breastfeeding in Black/African American women, and to develop a plan to promote breastfeeding in this population. Breastfeeding packets for providers and consumers were developed for breastfeeding promotional. A focus group at one of the CHCs to review the consumer information and provide feedback. The final draft will be disseminated statewide and posted on the DPH's website.

Comadrona in addition to continuing activities mentioned above, is working to develop a data system to evaluate the effects of peer counseling in promoting and sustaining breastfeeding.

RFTS programs implemented in FY 2002 were required to provide information regarding breastfeeding to their teen population. The program provides support, information and linkages to necessary services for teen mothers to initiate and maintain breastfeeding.

The WIC program continues to promote breastfeeding to all pregnant participants unless medically contraindicated. It is represented on the Breastfeeding Committee of the CT Chapter of the AAP and the CBC. A designated Breastfeeding Coordinator who participates in the committee and is responsible for local agency breastfeeding activities during Breastfeeding Awareness Month and throughout the year. This includes the responsibility for issuing electric breast pumps to eligible women who are returning to work or school. Breastfeeding education is provided during regional sessions to all local WIC staff under Project ReNEW (Revitalizing Nutrition Education in the WIC Program), which is being funded through a \$500,000 USDA WIC Special Projects grant through 9/30/04. The CT WIC Program will send representatives to a meeting in June to discuss plans announced by USDA to implement breastfeeding peer counseling in WIC Programs nationwide.

DPH is in the process of enhancing the capacity to learn more about breastfeeding and other behaviors and risk factors of pregnant women and mothers through the analysis of PRATS Survey data in the coming year. Data entry for the 2002 and 2003 surveys are complete and are presently being analyzed. Information about breastfeeding will not appear on the birth certificate in January 2004 as originally planned due to software issues. However, the electronic newborn screening database began collecting information on breastfeeding from CT hospitals in January 2004 so it is anticipated that data will be available in FY 2005. DPH is also analyzing data from a survey sent to a total of 2,286 pediatricians, family practitioners, and obstetrician/gynecologists to obtain baseline data regarding the number of new mothers in the provider's practice who breastfeed and to determine provider training needs.

c. Plan for the Coming Year

Recommendations from the consultant in response to the RFP for addressing low rates in African American women, will be reviewed and implemented as appropriate. The majority of the work in addressing breastfeeding in African American women will be conducted in 2005.

DPH staff will continue to attend monthly meetings of the CBC and the Breastfeeding Committee of the CT Chapter of AAP to support and promote breastfeeding in CT.

Data from the Provider and PRATS surveys will continue to be analyzed and recommendations will be made in developing future activities regarding breastfeeding.

WIC will continue to promote breastfeeding to all pregnant participants unless medically contraindicated. It is anticipated that program activities will encourage the breastfeeding initiation rate to continue to increase. WIC Program staff will continue to participate on CBC, the Breastfeeding Committee of the CT Chapter of AAP, and the WIC Breastfeeding Committee to promote and support breastfeeding. Evaluation data from the breastfeeding activities conducted under Project ReNEW and the WIC Infrastructure grant will be used to identify specific activities to be carried out during FY 2005. Furthermore, pending the availability of adequate federal funds, the implementation of breastfeeding peer counseling programs will begin, and the breast pump program will be expanded.

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

a. Last Year's Accomplishments

In 2003, the Universal Newborn Hearing Screening (UNHS) program received data on 42,080 infants from the 31 birth hospitals. Of the data received, 99% of the infants were screened for hearing loss before discharge. This exceeded our objective of 97%.

CT standardized screening throughout the state by providing funding to six hospitals to purchase automatic brainstem response equipment (ABR). The initial hearing screening is conducted using either the otoacoustic emissions equipment or ABR. If the infant does not pass the initial screening, it is repeated before discharge using ABR equipment. Those infants that refer from the second hearing screen are referred to 1 of 17 Diagnostic Testing centers in CT. In an effort to standardize the diagnostic testing centers throughout the state Connecticut provided funding to the following: 6 centers to purchase tympanometry equipment with a frequency range up to at least 1000 HZ, and to 2 centers to purchase bone conduction automatic brainstem response equipment.

The average age of diagnosis of an infant with a hearing loss was 0.92 months. At the time of diagnosis, families of infants with hearing loss are referred to the CT Birth to Three System for an early intervention evaluation. Infants with a bilateral, 40 dB or greater hearing loss are automatically eligible for services. A follow up program (Ages and Stages) was implemented for infants with hearing loss or those with risk factors for hearing loss, who do not qualify for Birth to Three services.

DPH distributed a survey to parents. 97.90% of the respondents reported that their infant received a hearing screen and 72% reported that they received the UNHS brochure. Although only 84% reported that they were told the hearing results before discharge, 100% of those families who reported their infant did not pass the screening were told the results before discharge. 77.3% reported that they would have found it helpful to talk to another parent at that time. 88% reported that they were given the results in a private place and 90.6% were satisfied with screening staff. 50% of families of infants who referred were able to obtain a diagnostic testing appointment within 2 to 4 weeks and none were greater than 8 weeks. 75% of the families stated that the location of the diagnostic testing center was convenient. Only 31.9% of the families reported being told of the hearing screening during their pregnancy, indicating a need for education to OB/GYN practitioners.

Physicians from CT's 2 regional genetic resource centers conducted Grand Round presentations to physicians to educate them on Genetics in Newborn Screening.

DPH staff conducted a presentation to the University of CT Department of Genetics and had a one-day conference with birthing facility staff to review UNHS program guidelines, quality

improvement mechanisms and tracking and reporting requirements. DPH staff conducted site visits and provided technical assistance to the 31 birthing facilities, as needed.

b. Current Activities

Screening at birth, early diagnosis, and prompt referral to early intervention and treatment for hearing loss among newborns is continuing. Connecticut's Newborn Hearing Screening data system is an integral part of the Child's Health Profile. Data is linked between the Newborn Hearing Screening program, Newborn Laboratory Screening program (heel stick screen) and the Birth Defect Registry. Hearing screening results and other program data are reported to the DPH daily via an internet-based reporting system. The Child Health Profile is linked with the electronic vital records system, which provides program staff with available data on all births. Program staff provides technical assistance to hospital staff to support the internet-based reporting system.

Program staff sends bi-monthly reports to hospitals to track and obtain missing screening results. The primary care provider is contacted for infants who do not pass the initial screen and have not have follow up testing. Enrollment in early intervention is confirmed for each newborn diagnosed with a hearing loss.

Newborn Hearing Screening staff had a daylong conference with the 31 birth hospitals in December 2003. The topic was 'Newborn Screening in Public Health' and included information on infant hearing, genetics, laboratory and birth defects in newborns. It also provided an opportunity to train hospital staff on enhancements that were made to the internet-based reporting system. The enhancement was completed in January 2004 and includes provisions for birth hospitals to report data on infants with risk factors for hearing loss and any birth defects or special health care needs that may be present at birth. An electronic technical assistance manual was developed to guide hospitals through the reporting process.

UNHS program staff meets monthly with the Newborn Hearing Screening Advisory group to discuss issues relevant to infant hearing, early identification and habilitation. The DPH is represented on the Commission on Deaf & Hearing Impaired Advisory Board and meets quarterly. Additional collaboration includes membership in the Directors of Speech and Hearing in State and Welfare Agencies, the New England Regional Genetics Group and the New England Regional Hearing Directors group.

c. Plan for the Coming Year

In FY2004, audiologists, family practitioners, obstetricians and pediatricians will be educated on issues surrounding genetics in hearing loss through meetings, grand round presentations and written materials. Program staff will conduct a meeting with the diagnostic testing centers to review program guidelines, discuss health literacy, genetics in hearing loss and to discuss other advances in newborn screening. UNHS informational materials will be sent to obstetricians to increase their awareness about the program.

Screening, diagnosis, referral to early intervention and treatment for hearing loss will continue among newborns. Program staff will continue to provide technical assistance to the birth hospitals, health care providers and families regarding newborn hearing screening. Participations on committees related to infant hearing will continue.

The CSHCN Program continues to expand care coordination activities through implementation of a statewide system of care model. This will be an integrated community-based system of care for children and youth with special health care needs and their families. The changes are in response to the department's needs assessment of gaps and barriers to services for children and youth with special health care needs and their families and also evaluations of the three

medical homes and the two CSHCN Centers. The redesigned system will increase the number of regionally located CSHCN Centers and medical homes. This redesign will improve linkages between the medical homes, the Centers and referral specialists. UNHS staff will provide education and program information to the medical homes to assure that they are aware of various resources available for infants who are deaf or hard of hearing.

DPH plans to link the UNHS database with the Child Health Profile and improve the tracking system report capability. An ongoing plan is to decrease the number of infants who referred from the initial screening and are lost to follow up. Program staff will attempt to contact the family to ascertain whether there are language, insurance or other barriers that are hindering the infant's ability to receive follow up. Program staff will notify the infant's primary care provider by letter, on each infant who fails to have follow-up testing from the newborn hearing screening referral.

Once the link with the Child Health profile is completed, the UNHS tracking system will have a direct link with birth certificates and can identify and track infants on whom there are missing data. DPH staff will work with programming staff to enhance the data tracking system's report capability. Such enhancements will enable staff to compare infant hearing status data with birth weight, race, ethnicity, estimated gestational age and risk factors for hearing loss.

Program staff will conduct another family survey to assess the satisfaction level with the program and to identify areas in need of improvement.

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

a. Last Year's Accomplishments

In keeping with the data source reported in prior years, this year's measure reports on percent uninsured as a three year average among poor children. Using data from the Bureau of the Census, Current Population Survey table "Low Income Uninsured Children by State, 2000, 2001 and 2002" for children under age 19 at or below 200% Poverty, 4.5 % of children in CT are without health insurance (<http://www.census.gov/hhes/hlthins/liuc02.html>). This year's percentage meets the projected improvement over last year's value of 4.8% of children without health insurance. Connecticut compares favorably with data reported in this same table for the United States, namely 7.5%, and ranked CT in the top third among U.S. states reported in this table for the smallest percentage of children without health insurance.

The U.S. Census Bureau, Current Population Survey, 2003 Annual Social and Economic Supplement, "Table HI05. Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2002" (http://ferret.bls.census.gov/macro/032003/health/h05_000.htm) reports for 2002 that 91.9% of Connecticut's children under 18 were covered by some type of health insurance (private or government). Hence, for the remainder of the children under 18 of all income levels (not just below 200% poverty), 8.1% were uninsured. This compares favorably with data reported in this same table for the United States for 2001, namely 11.2% of all U.S. children under 18 were uninsured.

Lack of health insurance can be attributed in part to economic issues related to job loss in the private sector with a resulting loss of private health insurance and a decrease emphasis on outreach to populations eligible for publicly funded programs. It is projected that health insurance may be further compromised by ongoing state budget constraints and attempts to further limit enrollment in public programs as one means of dealing with projected state budget shortfalls.

HUSKY served as the primary source of publicly funded insurance for the state's uninsured

children. As a primary function it provided ongoing outreach, screening and assistance with the eligibility determination process.

Infoline provided five presentations and training to community based provider/agencies and groups to encourage enrollment in HUSKY. The program provided toll free telephone access and referral for maternal and child health issues, including access to insurance programs.

Right From The Start (RFTS), Comadrona, CCHI, Family Planning, SBHCs, CHCs, HCWC, WIC, CSHCN program, and Family Planning screened families for insurance, provided support, information and linkages to health care insurance coverage for children. These Title V and non-Title V programs maintain activities to increase health insurance coverage. These programs are described in more detail in the Current Activities Section.

b. Current Activities

HUSKY serves as the primary source of publicly funded insurance for the state's uninsured children. It provides outreach, screening and assistance with eligibility determination. As part of budget reductions, continuous eligibility has been discontinued and coverage for parents or guardians for families up to 150% of the poverty level have ended for new families. During the spring and early summer of 2003, eligibility for families has been confusing because of cuts, lawsuits, and injunctions.

RFTS uses a case management approach to screen families for insurance, provide support, advocacy, information and linkages to health care coverage for children. Comadrona continues to assist families in obtaining health care coverage while linking them to other Title V programs. Healthy Start continues to use a case management approach to provide outreach, screening and referral to the HUSKY Program.

Family Planning continues to screen and refer uninsured youth to appropriate sources for insurance coverage. The program, through its contract with Planned Parenthood, identifies uninsured adolescents at the time of registration. HCWC program staff, through an intensive case management model, continue to screen clients' insurance status. Infoline continues to maintain toll free telephone access and assist families in obtaining health insurance coverage while providing consumers and providers of care education on related issues. Training to community providers on HUSKY is by request only and none have occurred during the current period. WIC provides screening and referral for families in need of insurance coverage. As part of its enrollment process, all families receive income screening and assistance in linking with available funding sources.

CSHCN provides statewide outreach to the uninsured population to assist families in accessing needed health insurance programs. With a focus on case management and coordination of care, the program continues to screen and refer children to HUSKY, Birth-To-Three and WIC.

SBHCs screen, identify and refer youth to the HUSKY program. Present activities include follow up of incomplete insurance information on program enrollees, providing advocacy for and assisting students/families in obtaining needed coverage.

CHCs identify and refer children to appropriate resources of healthcare coverage including Medicaid. Present activities include follow up of applications and advocacy for families in obtaining coverage

Connecticut Early Childhood Comprehensive Systems Initiative (CECCS) is developing a strategic plan to address the 5 domains of the program which impacts young children's health and learning. One of the five domains addresses access to health insurance with the intent of implementing the plan the following year.

The 2004 BRFSS telephone survey, sponsored by the CDC, contains state-added questions on health insurance among children. These data will be available in 2005.

c. Plan for the Coming Year

In addition to the Title V and non-Title V programs continuing their efforts as described in the Current Activities Section:

Comadrona will use its increased funding for expanded outreach to increase the numbers of children identified as lacking insurance and link them to appropriate resources.

Right From the Start, as part of a proposed RFP process for refunding, will be required to increase its follow up with parents to assure that infants are linked to sources of insurance for which they are qualified.

WIC will increase its coordination with related programs to assure the clients have accessed health insurance services to which they have been referred.

Healthy Start will increase education to assure that families were updated regarding the rescinding of anticipated cuts that had intended to drop them from publicly funded programs.

Family Planning will continue to expand its focus on families' needs by screening and referral for health insurance access.

Infoline, in addition to continually provide toll free access and referral for maternal and child health issues, including access to insurance, will provide presentations and training to community based agencies and groups to update providers' knowledge of the rescinding of anticipated cuts in the HUSKY program.

CSHCN, through its newly organized Regional Medical Home Support Centers, will enhance the existing structure to assure that its specialized clients are screened for and referred for insurance programs for which they are eligible.

SBHC, as part of their new continuing funding applications, will be required to describe their plan for reducing the numbers of underinsured children.

Early Childhood Partners Initiative (formerly Connecticut Early Childhood Comprehensive Systems Initiative, CECCS) will develop a draft strategic plan, obtain feedback on the plan, field test the plan, and then develop a final statewide implementation plan that will include a focus on access to health insurance, including medical homes.

The Behavioral Risk Factor Surveillance System (BRFSS) telephone survey currently being conducted has included a state-added question on health insurance among children. Data from the survey will be available in 2005.

The Perinatal Advisory Committee will develop goals and objectives consistent with the federal "Healthy People 2010" Objectives and the MCHB's Title V Block Grant Performance Measures including the availability of insurance as it relates to perinatal health.

Performance Measure 14: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

a. Last Year's Accomplishments

The rate for potentially Medicaid eligible children who received a service paid by the program

increased from 43.1 to 44.2 percent in 2003. The objective goal of 43.2 was met. This increase is considered significant in light of decreased emphasis on outreach and enrollment by the Department of Social Services (DSS) secondary to the state budget crisis. As part of its ongoing mission, all Title V supported programs will continue efforts to address outreach, identification and advocacy for eligible children in accessing Medicaid.

A number of Title V and non-Title V programs direct their infrastructure building activities to children and adolescents to improve access and utilization of health care, including Healthy Choices for Women and Children (HCWC), Comadrona, Connecticut Community Health Care Initiative (CCHI) now known as Healthy Start, WIC, School Based Health Centers (SBHC), Family Planning services, CSHCN programs, and Community Health Centers. Their ongoing activities are described in the Current Activities section below.

b. Current Activities

Healthy Choices for Women and Children (HCWC) screens clients for health insurance coverage and provides information on how to access health coverage. Appropriate referral and assistance in accessing resources in the health care system are provided.

Comadrona screens children who are potentially eligible for Medicaid. With a focus on educating parents on the Medicaid managed care system, Comadrona provides advocacy for clients to assist in navigating the health care delivery system.

Connecticut Community Health Care Initiative (CCHI), now known as Healthy Start, provides outreach, screening, referral and advocacy for children potentially eligible for Medicaid. Utilizing a case management approach, it acts as a liaison with DSS while educating parents on the Medicaid managed care system and provides advocacy for clients.

SBHC provides physical exams, health screenings, immunizations, treatment of acute illness, prescriptions, laboratory diagnosis and treatment of STDs, nutrition counseling and weight management, individual, family and group counseling and oral health services to Medicaid eligible children. Program sites and state agencies are participating in a system wide effort to address the goal of improving documentation and reimbursement for publicly funded services as an approach to increase access to Medicaid services. With any eye on this goal, the program is working to standardize clinic encounter form and coding to improve access to publicly funded services.

Family Planning provides services to Medicaid eligible adolescents and refers those potentially eligible for publicly funded insurance coverage.

CSHCN provides screening and referral of all program contacts to other possible funding sources including HUSKY, Birth-To-Three and WIC. Using case management/care coordination it provides advocacy to assist families in accessing services. Through the use of family advocates, and family resources specialists, the program continues to assist families in accessing services.

Community Health Centers screens children who are potentially eligible for Medicaid services while providing primary and preventive health service including immunizations, lead and nutritional assessment, behavioral risk assessments for substance abuse and sexual activities to children/adolescents enrolled in the HUSKY plan.

WIC provides screening and identification of children in need of well child care and referral to the HUSKY Program.

HUSKY, the state's CHIP program, targeted uninsured children to increase enrollment in this

publicly funded program. The program continues its efforts to coordinate services between the DSS, the Children's Health Council and Title V programs to provide outreach and identification of potentially eligible children and adolescents. Through its community based contacts the program will continue to develop new outreach strategies to reach the uninsured population.

c. Plan for the Coming Year

The Title V and non-Title V programs will continue their efforts to direct their activities to help children receive Medicaid services are expected to continue into FY05. Specifically:

HCWC, WIC, Family Planning will continue their efforts to screen and refer children potentially eligible for Medicaid.

Comadrona will increase its education to the consumer community to provide updated information that planned cuts in Medicaid have been rescinded.

Healthy Start will increase its outreach and advocacy efforts to assist families in accessing and navigating the Medicaid system and increase education to overcome the loss of clients due to planned cuts in the program which have been rescinded.

SBHC will continue to provide a full range of Medicaid services to eligible populations and complete the standardization of clinical encounter forms, which will increase documentation and tabulation of Medicaid services provided.

CSHCN, through its newly organized Regional Medical Home Support Centers, will provide intensive case management, screening referral and linkage to HUSKY insurance while sustaining advocacy to assure that client access those sources of payment.

Community Health Centers will continue to screen and refer potentially eligible children to Medicaid will provide the extensive array of Medicaid reimbursable primary and preventative services funded under that program.

HUSKY will increase its community education and outreach to potentially eligible families to offset potential loss of enrolment in Medicaid resulting from the rescinded planned cuts to the program. These activities will promote continuation of currently eligible children will maintaining efforts to outreach to other potentially eligible families.

The Perinatal Health Advisory Committee will develop goals and objectives consistent with the federal "Health People 2010 Objectives" and MCHB's Title V Block Grant Performance Measures which will address the relationship of Medicaid supported services to perinatal health.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

a. Last Year's Accomplishments

Connecticut continues to demonstrate a positive trend in prevention of very low birth infants. However, in 2003 the rate slightly increased from year 2002 from 1.5 to 1.6 resulting in the achievement of the 2003 objective of 1.6. This is attributed to sustained emphasis on the identification of at risk pregnant teens and women through provision of intensive case management, referral and follow up to provide early and routine prenatal care to pregnant women. These services continued to be embedded in all programs serving Title V eligible pregnant women.

A number of Title V and non-Title V programs provide services to pregnant women with the goal of supporting healthy pregnancies and the delivery of a healthy full term infant. These program activities are presented in the Current Activities Section. Some highlights of FY02 activities are presented.

Right From The Start provided support, information and linkages to necessary services for pregnant teens to initiate and maintain behaviors compatible with the prevention of very low birth weight infants. Clients are encouraged to maintain regular prenatal care. The RFTS database was installed and tracked pregnancy outcomes. The program plans to continue these activities in the coming year.

Healthy Choices for Women and Children provided intensive case management services and linkage of clients with necessary community based services to promote early and consistent prenatal care. Out of 62 births, only one was very low birth weight. The program encourages and tracks compliance of pregnant clients prenatal care and provides support and advocacy to assist them in that process. The program will continue to provide intensive case management and support services to promote early entry into prenatal care.

Fetal and Infant Mortality Review provided the infrastructure under which community based teams of health and social service providers reviewed 72 perinatal related deaths.

The WIC Program outreaches and enrolls pregnancy women eligible for their services. Of those enrolled in the program for at least 6 months of their pregnancy, the rate for very low births was 1.0%.

b. Current Activities

Connecticut Community Healthcare Initiative (CCHI) now known as Healthy Start provides targeted outreach and case management services to link pregnant clients with early prenatal care. Its community based providers encourage early entry into care and link clients with services such as WIC to promote healthy pregnancies.

Community Health Centers provide risk assessment, care planning and support services to encourage early and routine prenatal care to pregnant women. The program uses extensive outreach, home visitation and onsite prenatal services (available at 10 of the 12 CHCs) to target women at significant risk for delivering low birthweight babies.

Comadrona provides culturally sensitive intensive case management services and linkage of clients with related prenatal services to promote healthy birth outcomes. The program provides comprehensive risk assessment to identify its population at risk for preterm delivery and uses home visits and advocacy to assist them in accessing appropriate services.

Fetal and Infant Mortality Review (FIMR) uses a confidential and de-identified case approach to provide a comprehensive, multidisciplinary team review of infant deaths, and in some cases, low birth weight. FIMR uses record abstraction and home visits to identify mortality related issues, such as lack of availability of prenatal care, which may contribute to perinatal deaths. FIMR promotes access to support services for those families who experience deaths.

Family Planning provides pregnancy testing, STD prevention, diagnosis and treatment services, reproductive health education and counseling and assistance in accessing prenatal care services. Clients who are identified as pregnant receive pregnancy options along with a referral for prenatal care and other support services such as WIC and Healthy Start. The program provides pregnancy and sexually transmitted disease testing to identified women at risk of premature delivery and complications due to age, income status or late entry into prenatal care.

Healthy Choices for Women and Children provides intensive case management services and linkage of clients with necessary community based services to promote early and consistent prenatal care.

Right From The Start provides support, information and linkages to necessary services for pregnant teens to initiate and maintain behaviors compatible with the prevention of very low birth weight infants.

WIC provides nutritious foods, nutrition education and related services to pregnant women. With an emphasis on enrolling clients in the first trimester, the program screens clients for enrollment in prenatal health care to promote healthy pregnancies.

SBHCs provides age appropriate reproductive health education, pregnancy testing, STD diagnosis and treatment, counseling and referrals to WIC, Healthy Start and Right From The Start. SBHCs screen and identify teens at risk for or pregnant to assure early diagnosis and referral.

c. Plan for the Coming Year

The Right From the Start, Healthy Choices for Women and Children, Community Health Centers, School based Health Centers, Family Planning, FIMR, Healthy Start, Comadrona and WIC will continue their efforts described under the Current Activities Section that direct their activities to help promote healthy pregnancies and prevent very low birth weight are expected continue.

With improved technology in addressing infertility, there has been an increased number of multiple gestation pregnancies which frequently results in preterm delivery of low birth weight infants. The developing Perinatal State Health Plan will provide information as to the extent of the problem and provide recommendations for to the DPH in addressing this health issue.

Recommendations from the perinatal health advisory committee that address low birthweight and very low birthweight will be reviewed and implemented as part of the state perinatal health plan.

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

a. Last Year's Accomplishments

Suicide rates among Connecticut youth aged 15 through 19 are unstable because of the relatively small number of deaths. In 2002 there were 13 deaths among the estimated 230,667 (rate 5.6/100,000) Connecticut youth ages 15-19. This represents a decrease from 21 deaths (rate 9.7/100,000) (CT Vital Statistics). In Connecticut , 16.2% of high school youth completing the Youth Risk Behavior Survey (YRBS) said that they seriously considered attempting suicide (YRBS 2003).

Title V and non-Title V programs provided services to adolescents with the goals of improving mental health, facilitating appropriate referral and reducing suicidal thoughts and actions among high school youth.

Infoline is Connecticut's information and referral service. Infoline staff provided 32 suicide prevention presentations and training to providers, agencies, community groups and students in the state.

Healthy Choices for Women and Children (HCWC) provided comprehensive assessment of clients (58 women), including the need for mental health services. This program continued to identify and refer clients who are at risk for suicide to appropriate resources.

School Based Health Centers provided mental health services at all sites. Topics included violence prevention, stress, self-esteem, healthy relationships and grief/bereavement. DPH requires that all programs have policies and procedures in place to address suicidal thoughts and attempts.

Community Health Centers (CHCs) provided mental health services through screening, assessment, direct care and/or referrals. They continue to assure these mental health services through direct provision via on-site clinicians such as social workers, psychiatrists and psychologists and through referrals to community agencies such as local hospitals, child guidance centers and mental health centers. They will continue to provide these services in the coming year.

Right From the Start (RFTS) provided a comprehensive assessment of clients (305 teens), including the need for mental health services. Referrals were made as necessary.

There were also a number of non-Title V funded activities. The Injury Prevention Program funded a contractor to provide suicide prevention training focused on adults and providers on college and university campuses and in the community. The Contractor provided ten sessions of training to a total of 261 adults. The Injury Prevention Program also funded violence prevention programs that focus on middle and high school aged youth. Most programs are community-based and integrate suicide prevention into ongoing violence prevention activities and training. The Injury Prevention Program also provides guidance for MCH programs related to this measure.

b. Current Activities

Infoline is CT's telephone information and referral service. Infoline staff continue to provide suicide prevention presentations and training to providers, agencies, community groups, and students in the state.

HCWC provides comprehensive assessment of clients, including the need for mental health services. Referrals are initiated as necessary. This program continues to identify and refer clients who are at risk for suicide to appropriate resources.

CHCs provide mental health services through assessment, direct care and/or referrals. They continue to assure these mental health services through direct provision via onsite clinicians such as social workers, psychiatrists and psychologists and through referrals to community agencies such as local hospitals, child guidance centers and mental health centers. They will continue to provide these services in the coming year.

RFTS provides a comprehensive assessment of clients, including the need for mental health services and referred as necessary. The same services will continue in the coming year.

School Based Health Centers continue to provide anticipatory guidance and risk assessments at all locations. They also provide services directed at high-risk populations. The School Based Health Center data collection system has been enhanced to monitor trends related to suicide related mental health issues. However, these trends continue to be difficult to document.

The Intentional Injury Prevention Program funds a Contractor to provide suicide prevention training for adults and providers and will continue to provide guidance related to suicide

prevention and other intentional injury issues to other DPH program staff.

c. Plan for the Coming Year

The program activities presented in the Current Activities section will be continued into FY05 with the continued goals of improving mental health, facilitating appropriate referral and reducing suicidal thoughts and actions among adolescents.

In addition, SBHC will continue to provide services directed at high-risk populations. DPH will continue to facilitate changes in the data collection system that lead to improvements in the design and implementation of programs to address needs in the communities the programs serve.

RFTS, HCWC and CHCs will work more closely with injury prevention staff to provide services described under current activities to reduce suicide deaths for youth 15-19 years.

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

a. Last Year's Accomplishments

In 2003, 87.5 percent of births of very low birth weight infants were delivered at facilities for high-risk deliveries and neonates. This percentage increased from 83.1 percent in 2002. Connecticut met its proposed objective of 83.1. Some of the success of improvement in this area can be attributed to Title V programs (such as Right From the Start which served 292 pregnant teens) continued emphasis in providing screening for early identification and referral for teens and women identified as high risk pregnancies. Continued emphasis will be applied to continue the trend toward better identification and referral.

A number of Title V programs support activities to pregnant women, to ensure that they receive appropriate prenatal care and identification of high risk pregnancies that may require a facility for high risk deliveries and neonates. These programs are described in the Current Activities Section.

b. Current Activities

DPH has organized a Perinatal Advisory Committee to conduct a statewide needs assessment, which will develop the first Perinatal State Health Plan. The plan will include recommendations for addressing perinatal systems, including facilities for high-risk deliveries and neonates in CT. CT currently does not have a system in place to identify facilities for high-risk deliveries and neonates.

Connecticut Community Healthcare Initiative, now known as Healthy Start, provides outreach, screening, and referral of high-risk pregnant women to specialist providers and tertiary care centers as indicated. Through its case management approach women identified as at risk are referred for appropriate evaluation.

Comadrone provides targeted outreach and case management to a disenfranchised population of pregnant women who, by virtue of cultural and linguist barriers, have difficulty in obtaining needed care. Clients are provided risk assessment, screening and referral for high-risk pregnancies to culturally appropriate health and related social services.

Healthy Choices for Women and Children provides intensive case management to its high-risk population who, by virtue of history of substance usage, places them at risk for premature

delivery and subsequent neonatal complications. The program, through its outreach efforts, targets clients who encounter barriers to care. Through its early intervention activities, clients in need of specialized health and social services are closely monitored and referred to appropriate facilities capable of providing specialized delivery and infant care.

Right From The Start provides targeted outreach and intensive case management services to pregnant and/or parenting teens who by virtue of their age, psychosocial development and pregnancy status are at high risk for premature delivery. Utilizing risk assessments clients are identified and referred for needed health related services to maximize the potential of a healthy pregnancy.

Community Health Centers provide early identification and screening for high risk pregnancies. Prenatal care is provided on site at 10 of the 12 centers. Clients identified as high risk are referred to community facilities and tertiary-based resources for pregnancy management.

Family Planning provides reproductive health services screens and refers clients for prenatal care. Clients identified as high risk are referred to appropriate community and tertiary resources for pregnancy management.

c. Plan for the Coming Year

The Title V programs including Comadrona, Right from the Start, Healthy Start, Family Planning, HCWC and Community Health Centers will continue their efforts described in the Current Activities section that support activities to pregnant women will continue in FY04. These programs will continue to ensure that pregnant women receive appropriate prenatal care and identification of high-risk pregnancies that may require a facility for high risk deliveries and neonates.

Recommendations from the perinatal health advisory committee that impact this measure will be reviewed and implemented as resources are available.

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

a. Last Year's Accomplishments

In CT in 2003, 88.5 % of infants were born to woman who began to receive prenatal care in the first trimester, which was a slight decrease from 88.8 % in 2002. The percent of women receiving prenatal care in the first trimester was slightly below the projected goal of 88.9%. Title V programs will continue to provide outreach and identification of pregnant women to promote early entry into prenatal care.

Comadrona provided outreach and intensive case management to enroll 100% of its pregnant women in the first trimester.

Healthy Choices for Women and Children provided outreach and intensive case management to a population of pregnant women who by virtue of a history of substance use often encounter barriers in obtaining early and appropriate prenatal care.

Right From The Start provided support, information, advocacy, and linkage to early prenatal care for pregnant teens. Utilizing an intensive case management approach, the program coordinated its activities with school and community providers to identify and enroll clients in the program and refer to appropriate prenatal care providers.

Family Planning provided pregnancy testing, reproductive health education, counseling, and prenatal linkage to promote first trimester care. Additionally, the program provided linkages to other programs such as WIC and Healthy Start to support compliance with prenatal care schedules.

Fetal and Infant Mortality Review Programs (FIMR) used a confidential and de-identified case approach, record abstraction, and home visits to identify mortality related issues including late entry into prenatal care.

School Based Health Centers provided outreach to identify pregnant women and age appropriate reproductive health education, counseling and referral of women to other related programs such as Healthy Start and WIC. Although the clinics are not considered primary sources of prenatal care for pregnant teens they prioritize the need to assist and support pregnant teens in accessing early prenatal care.

CT Pregnancy Risk Assessment and Tracking System Survey (PRATS) is a 88 question point-in-time survey that was mailed to 4500 postpartum women in CT in 2002 and 4700 women in 2003. The survey, designed to identify risk factors associated with pregnancy including date of entry into prenatal care, obtained a 50% response rate. Survey data has been entered. Analysis will provide a variety of information including the percent of respondents who entered prenatal care in the first trimester.

The WIC Program sought to enroll pregnant women in the program during their first trimester so that they can benefit from the supplemental foods and nutrition education as long as possible. The WIC Program currently does not tabulate rates of first trimester enrollment in prenatal care.

b. Current Activities

Comadrona uses its community-based networks, to identify and refer women to prenatal care providers. Comadrona provides a culturally sensitive approach to decreasing barriers to care while encouraging care providers to maximize their abilities to reach an increasing Hispanic population.

Healthy Choices for Women and Children provides outreach and intensive case management to a population of pregnant women who by virtue of a history of substance use often encounter barriers in obtaining early and appropriate prenatal care. The program provides a sensitive approach while educating clients on the benefits of early identification of pregnancy and early entrance into prenatal care.

Right From The Start provides support, information, advocacy, and linkage to early prenatal care for pregnant teens. Utilizing an intensive case management approach, the program coordinates its activities with school and community providers to identify and enroll clients in the program and refer to appropriate prenatal care providers.

Family Planning provides pregnancy testing, reproductive health education, counseling, and prenatal linkage to promote first trimester care. Additionally, the program provides linkages to other programs such as WIC and Healthy Start to support compliance with prenatal care schedules.

Fetal and Infant Mortality Review is comprised of community based teams of health and social service providers who reviewed perinatal deaths. Late entry into prenatal care has been a consistent finding through each community's case review process. FIMR uses a confidential and de-identified case approach, record abstraction, and home visits to identify mortality

related issues including late entry into prenatal care.

School Based Health Centers provide outreach to identify pregnant women and age appropriate reproductive health education, counseling and referral of women to other related programs such as Healthy Start and WIC. Although the clinics are not considered primary sources of prenatal care for pregnant teens they prioritize the need to assist and support pregnant teens in accessing early prenatal care.

WIC promotes early enrollment into WIC and provides referral to prenatal care providers. WIC focuses on first trimester enrollment to low income pregnant women to maximize the benefits of accessing supplemental foods and nutrition education.

Community Health Centers provide early identification of pregnant women and early and continuous prenatal care. Selected centers (10 of 12) provide obstetrical services on site, often utilizing nurse midwives. Smaller centers refer clients to other local prenatal care providers.

The WMACH Unit recently issued an RFP for a consultant to develop a State Perinatal Health Plan. The plan will provide information and recommendations regarding timeliness in accessing prenatal care.

c. Plan for the Coming Year

These Title V and non-Title V programs including Comadrona, Right from the Start, WIC, Healthy Start, FIMR, Family planning, SBHC, HCWC, Community Health Centers and the PRATS Survey will continue their efforts as described in the Current Activities section whose activities encourage early entrance into prenatal care will continue into FY 04. Recommendations that emerge from the State Perinatal Health Plan, that related to early entry into prenatal care will be implemented.

FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.				
1. Workplans developed and implemented to address the expansion of NBS to more than 30 diseases.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Participate in the quarterly Genetics Advisory Committee (GAC) meetings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Work with other groups to provide education on Genetics and NBS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Screen all infants for selected metabolic or genetic diseases.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

5. Refer newborns with abnormal screening results for appropriate services.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Update educational programs to reflect the expansion of the NBS testing panel.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7. Enhance the electronic reporting Newborn Screening System (NSS) for transfers of Newborns to NICU's.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Workgroup continues to meet to address the need for linkage of the NSS data with other databases.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. NBS staff continues to participate in various State, Regional, and National conferences.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. NBS staff continue to support families identified with genetic and metabolic diseases.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)				
1. Families participate in focus groups, meetings, and task force groups.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Family surveys are distributed to all CSHCN enrolled families.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Bilingual staff provides translation and linkage to Latino support groups.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Families assist in the development of policy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Orientation and training for families in the Parent Network System.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)				
1. Provide early identification of CSHCN and refer to PCP/medical home and provide care coordination.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Conduct tracking and follow-up with birth hospitals to assure that they report children with special health care needs on each new birth	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Develop a tracking system for all referrals made between the CDI, PCP and the RMHSC that assures appropriate care coordination of services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Coordinate with the Medical Home Collaborative.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Implement the medical home support centers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Integrate the Parent Network with the RMHSC	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Convene State-wide advisory group to support and enhance the RMHSC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)				
1. Provide education on benefits/services provided by insurance/other programs.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Coordinate interagency activities concerning insurance access.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Assess family?s insurance status.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Coordinate with HUSKY Infoline.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)				
1. Operationalize the Medical Home Support Centers to assist families with access to community based service systems.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Implement medical home concept statewide to access community based, culturally sensitive services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Create information sharing and linkage opportunities between Infoline and the medical homes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Maintain ongoing partnership with stakeholders.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects				

of adult life. (CSHCN Survey)				
1. Identify youth with special health care needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Identify and strengthen relationships with schools, community based organizations & State Agencies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Provide children and families individualized transition packets.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.				
1. Monitor infants and children for compliance with immunization schedules.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Outreach and identify infants and children for up to date immunizations.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Provide support, information and linkage to necessary services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Procure and provide publicly purchased vaccines.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Provide funding & technical support to health care providers to improve childhood immunization level	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Provide WIC check off to identify up to date immunization status.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. Provide risk assessment and referral for reproductive health services.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Support teen pregnancy prevention programs.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Collaborate with local and statewide initiatives.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Link teens with related life skills, education, and advocacy programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Plan and implement public awareness campaigns to promote positive youth development.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Enhance its data and information systems to improve, in part, the monitoring and reporting of dental sealants? prevalence.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. OPENWIDE training of non-dental providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Convene workgroup to address barriers/issues regarding billing of dental procedures in public health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. Provide technical assistance, resources, and funding to support to motor vehicle injury prevention activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Provide linkages to motor vehicle injury prevention resources.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Provide screening, risk assessment and anticipatory guidance in Title V funded programs.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Provide guidance for policy development regarding motor vehicle related mortality in children.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Participate in statewide coalitions and collaborations addressing motor vehicle injury prevention through public and professional education, policy change and system enhancements.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Utilize injury-related data to guide planning for state and community based programs and policy development.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. Convene monthly meetings with CT Breastfeeding Coalition on training, data collection, and awareness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Participate in monthly meetings AAP to collaborate on breastfeeding awareness and promotion.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Identify and track breastfeeding data sources to further build infrastructure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Promote provider and consumer education and awareness through training and education.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. Improve state data tracking system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Improve follow-up on missed or abnormal screens.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Improve follow-up on infants lost to diagnostic follow up.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Hire support staff to assist with tracking and follow up.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Improve tracking on follow up program for infants at risk for hearing loss.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Educate primary care providers on genetic factors associated with hearing loss.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Distribute culturally sensitive educational materials to parents.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Assure linkage to a medical home.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
13) Percent of children without health insurance.				
1. Provide outreach, screening and referral to sources of health insurance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide advocacy and liaison to assist families in obtaining health care coverage.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Provide education regarding resources to consumers and community based providers.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Support the state's information and referral services as a point of access for insurance coverage.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Provide follow-up and assistance with insurance application process.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Develop capacity with local organization as resources for outreach and enrollment.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. Provide eligible Medicaid services at appropriate client sites.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Provide screening, identification and referral to insurance programs.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Provide care coordination, information and advocacy for families accessing funding programs.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Assist providers in maximizing reimbursement for Medicaid eligible services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Assist in supporting data systems that capture service utilization activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live births.				
1. Provide outreach, identification and referral of pregnant women to prenatal services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Provide risk assessment and case management to high risk prenatal clients.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Provide support and advocacy to assist pregnant women in accessing appropriate services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Provide reproductive health and pregnancy options education.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Provide access to food and nutritional support services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Provide culturally competent services to decrease barriers to care.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Promote and support systems changes to reduce maternal mortality and morbidity.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. Provide suicide prevention training to students.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide suicide prevention training to providers and other adults.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Provide technical assistance and guidance for MCH programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provide anticipatory guidance and risk assessments in Title V funded programs, especially School Based Health Centers.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Provide mental health services through assessment, direct care and/or referrals in School Based Health Center, Community Health Centers and other MCH programs.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. Provide outreach, identification and referral of high risk pregnant teens.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Provide intensive case management and supports to promote positive pregnancy outcomes.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Provide culturally competent and linguistically appropriate care to high-risk populations.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Collaborate with tertiary care centers that provide specialized delivery and neonatal care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				
1. Provide outreach and case management to identify and enroll clients in	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

early prenatal care.				
2. Provide culturally & linguistically appropriate services to decrease barriers to prenatal care services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Provide outreach to targeted populations (i.e. pregnant substance users).	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Provide support, information and advocacy to pregnant teens.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Continue to analyze PRATS Survey data.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Provide pregnancy testing, reproductive health education, counseling & linkage to healthcare providers	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Support community based fetal and infant mortality review processes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Promote early enrollment into prenatal care as a linkage from programs such as WIC.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. Provide/promote comprehensive services to encourage women of reproductive age to enter prenatal care early	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *The percent of CSHCN clients enrolled in the state CSHCN program that have a written care service plan.*

a. Last Year's Accomplishments

Children with chronic and disabling conditions receive services from a multitude of sub specialty providers. A written health care plan helps maximize the delivery of health care services by coordinating and assuring the provision of necessary and quality health care services. One of the goals of the CSHCN Program is to assure that CSHCN clients receive coordinated and comprehensive primary and specialty health care which is documented and monitored.

In FY 03, the Children with Special Health Care Needs (CSHCN) Program continued to coordinate and collaborate care for children with special health care needs and to document coordinated care and services provided in a written care service plan. A written care service plan for children enrolled in the Title V CSHCN program remained a contractual requirement for the CSHCN Centers and was verified by DPH through the site visit process. In 2003, 95.7% of the children enrolled in the CSHCN Program had a written care service plan, which meets the objective of 95%. The quality assurance plan includes medical record audits including care plan reviews conducted during regular, quarterly site visits. The staff at the CSHCN Centers is contractually responsible for their own internal ongoing medical record audits to ensure that written care service plans are developed for each client, in concert with the family so that plans are comprehensive and collaborative.

b. Current Activities

In FY 2004, the CSHCN Program continues to expand care coordination activities through implementation of a statewide system of care model. This will be an integrated community-based system of care for children and youth with special health care needs and their families. The changes are in response to the department's needs assessment of gaps and barriers to services for children and youth with special health care needs and their families and also evaluations of the three medical homes and the two CSHCN Centers. The redesigned system will increase the number of regionally located CSHCN Centers and medical homes. This redesign will improve linkages between the medical homes, the Centers and referral

specialists.

State Title V staff is collaborating with the Connecticut Chapter of AAP in the development of a Connecticut specific Medical Home Curriculum. This curriculum will be delivered via creation of a Medical Home in-state Training Academy. Training will be provided for all medical homes based on their level of expertise. There will be a summer 2004 seminar introducing new medical homes to the concept and practice principles. The Connecticut Chapter of AAP is assisting with promotion of the medical home movement and will make special awards to the current homes at their April 2004 Annual Dinner.

As part of the Medical Home Learning Collaborative(MHLC), the three pilot Medical Home Pediatric Care Practices are meeting with the Title V team to develop and implement a portable plan of care for families. Each Medical Home has a parent-partner who has an active role at these meetings in the development and review of care plans. The portable plan of care that will be adopted will be a document that families can take with them as they navigate the health care system to assure that they receive appropriate care in an appropriate environment. This portable plan of care will be replicated throughout the State as new Medical Homes are developed. This plan is incorporated into the FY04 contract to assure that it is an important piece of the Quality Improvement Program at the CSHCN Centers and will continue to be monitored on a quarterly basis.

The MHLC and Title V staff are exploring the advantages/challenges of establishing a computerized information system that would be web-based, linked to the State's Child Health Profile system, and enable the Medical Homes to manage their data and care plan activities with the CYSHCN.

c. Plan for the Coming Year

In FY2005, the CSHCN Program will continue to expand care coordination activities through further implementation of the expanded statewide system of care model. This integrated community-based system of care will increase the number of children and youth with special health care needs who will have a written care service plan.

In FY05, the plan includes triaging of children based on complexity and referring them to the appropriate Medical Home for care/services. This includes completing an encounter form for every contact with the family and child. This encounter form provides the foundation for the development of the written care service plan.

Medical Home practice improvements will enhance care coordination at different levels: physician partners education & re-education; parents interviews through screener, care plan & pre-visit questionnaire; specialists referral information & follow-up; community outreach to schools & recreational activities; State Title V link through MHLC, Infoline, newsletters for professionals; and insurers working on successful reimbursement strategies within office, extend to state and HMOs.

State Performance Measure 2: *The degree to which Title V families have access to mental health screening, referral, assessment, and linkages.*

a. Last Year's Accomplishments

In FY2003 nine of the twelve objectives were met, meeting the goal for that year. The activities focused on trying to implement data collection and evaluation methods at Title V funded programs to assess provision of mental health services. See the attached document for progress towards achieving this performance measure.

Seven of the twelve Community Health Centers provided 51,849 mental health visits and 61,295 substance abuse treatment visits in 2003. The remaining five Community Health Centers Corporations refer to community based mental health and substance abuse treatment agencies. The twenty communities where Community Health Centers sites are located and serve include the following: Ansonia, Bridgeport, Clinton, Danielson, Groton, Hartford, Meriden, Middletown, New Britain, New Haven, New London, Norwalk, Norwich, Old Saybrook, Stamford, Stratford, Waterbury, West Haven, Willimantic, and Vernon.

Data collected from the annual family surveys administered by the CSHCN Centers identified a total enrollment of 912 children, 90 children received mental health services, and 266 children did not receive but needed mental health services. The data collection method changed from the previous year. The data were not complete but showed about 39.7% of the CSHCN families had identified the need for mental health services but for various reasons could not access needed services.

During Federal Fiscal Year (FFY) 2003, the School Based Health Center (SBHC) programs continued to improve their data collection for mental health-related services. In this period, 17 of 18 SBHC sites utilized a formal mental health assessment tool such as the Guidelines for Adolescent Prevention Services (GAPS). This represents an increase of 9 sites over last year. In 2002-2003 unduplicated mental health visits at SBHCs totaled 27,817 and unduplicated care coordination/collateral contacts totaled 23,669. Sixteen out of 18 sites now document a disposition code for all student visits to the SBHC utilizing the Clinical Fusion data tracking system.

On March 20, 2003 the DPH cosponsored the Adolescent Health: What You Need to Know conference with the Hartford School Based Health Centers. This was a statewide conference, which attracted participants primarily from Central Connecticut who are health, social services and education professionals working with adolescents. A focus included the preventive mental health approach to working with adolescents. Strategies, which are focus on strengths and assets, rather than deficits, were emphasized throughout the conference.

During the year FY03 all RFTS sites provided a comprehensive risk assessment and screening including mental health needs. Of the 305 screened, 34 were identified in need of future assessment were referred to appropriate providers and tracked to determine if they obtained those services. The total number of clients who received assessment services were 26.

b. Current Activities

The CSHCN Program and Medical Home Collaborative will enhance the statewide implementation of the system to serve families of children with special health care needs with comprehensive, accessible, coordinated care.

All RFTS sites continue to screen clients for mental health issues, refer and track those to determine if they received the needed assessments.

SBHC activities include comprehensive risk assessment and screening, education, counseling, referrals, and linkages. SBHCs are required to submit the type, number, and quality of such activities to DPH through numerous reporting tools. Improvement is being made in data tracking for collateral contacts and disposition. Review of SBHC reports allows DPH staff to monitor current levels of service and identify where significant gaps and barriers still remain. Data was provided at a planning meeting with SBHC Coordinators regarding the status of CT youth, inclusive of mental health-related issues. Funding was available from through the SBHC training funds for staff to access training through the Master's Therapist Series, attended by 43

SBHC.

DPH staff provided CHCs with information from Screening for Mental Health, Inc. (SMH), a nonprofit organization developed to coordinate nationwide mental health screening programs, and to ensure cooperation, professionalism and accountability in mental health screenings. SMH provides community outreach and education support for National Screening Days in Alcohol Use/Abuse, Anxiety Disorders, Depression, and Eating Disorders. The CHCs in CT have on-site Mental Health providers, and a range of referral relationships within their catchments area.

DPH staff informed the CHC Executive Directors of a competitive federal grant for health centers funded under the Consolidation Act of 1996 to increase services in Mental Health and Substance Abuse.

Staff at DPH provided mental health information to the CSHCN Centers including copies of the National Mental Health Information Center Publications Catalog from the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA). A variety of publications were ordered by DPH staff and shared with Center staff. DPH staff shared other mental health related information with Center staff including updates to Connecticut's KidCare System and articles on mental health consultation.

DPH cosponsored the Adolescent Health: What You Need to Know conference with the Norwalk School Based Health Centers, Norwalk Community Health Center, and Norwalk Health Department. This was also a statewide conference, which attracted participants primarily from southern and western Connecticut who are health, social services, education and outreach providers of services to adolescents.

The DPH sponsored Medical Home Academy will address six components of the medical home one component will focus on behavioral health.

c. Plan for the Coming Year

During FY2005, activities will focus on increasing screening for mental health services and supports.

Within Community Health Centers, the Title V funded Pediatric Primary Care Centers will continue to provide mental health screening, assessment, referral, linkage, and treatment within constraints of on going fiscal concerns.

The CSHCN Program and Medical Home Collaborative will enhance the statewide implementation of the system to serve families of children with special health care needs including.

The SBHC programs will continue to provide comprehensive mental health-related services to students. Technical assistance will be provided as needed to enhance data collection capacity of SBHCs. Program evaluation and planning will be included in technical assistance.

RFTS will continue to provide support, information and screening of pregnant and parenting teens for mental health issues and referral to assessment and treatment services as needed.

State Performance Measure 3: The death rate for children ages 1 - 19 by unintentional and intentional injury (pediatric mortality due to injury).

a. Last Year's Accomplishments

Injuries (intentional and unintentional) continue to be the leading cause of death in Connecticut for persons between the ages of 1 and 19 years, accounting for 58% of deaths for this age group. The child death rate from injuries had experienced a steady decline in the 1990s, but that decline has leveled off. In 2002 there were 109 deaths among an estimated 916,836 children for a rate of 11.9 per 100,000. This is similar to the 2001 rate of 11.9 per 100,000 (105 deaths among an estimated 882,629) and slightly above our performance objective of 11.5 per 100,000. The leading cause of mortality for children and youth aged 1 to 19 years is addressed in a number of ways.

A number of Title V funded and non Title V programs address prevention to infants, children and adolescents. More details on these programs are presented in the Current Activities Section, some highlights are presented here. A total of 4625 infants and 71,167 children and teens were provided with risk screening and anticipatory guidance.

The Injury Prevention Program (IPP) provided technical assistance and program monitoring to local health departments conducting unintentional injury and youth violence prevention programs with Preventive Health and Health Services Block Grant (PHHSBG) funding.

The IPP provided support during the 2003 Legislative Session for teen Graduated Drivers License legislation as well booster seat legislation (discussed under NPM #10). Technical assistance and resource materials on a range of injury prevention issues have been provided to other DPH programs, MCH providers and community groups. The IPP is a member of CT SAFE KIDS Coalition and have collaborated on activities geared to prevent childhood injuries. The IPP facilitated the CT Young Worker Safety Team, which is a collaborative effort with local, state and federal members to raise awareness and provide education and training on adolescent worker safety. Members of this group have sponsored or conducted over 75 workshops and presentations during the past 4 years.

b. Current Activities

Injury Prevention Program funded violence prevention programs focus on middle and high school aged youth. Most programs are located on community based settings and provide services after school, weekends and during school vacations. Two School Based Health Center Programs funded through their local health departments also conduct violence prevention programs. Programs employ a variety of strategies and methods to increase participant knowledge and behaviors related to non-violent resolution of conflict.

Unintentional injury prevention activities funded through the PHHSBG allocation to local health departments focus on motor vehicle injuries, childhood injuries in the home setting, and falls among older adults. The IPP continues to collaborate with CT SAFE KIDS and other partners.

Responsibility for the Crash Outcome Data Evaluation System (CODES) project has been transferred to the Family Health Division. The CODES project links police crash reports with death, hospital, and Emergency Department Data to provide a more comprehensive picture of motor vehicle crashes, injuries and deaths. This enhanced data set will be useful in planning and evaluating programs and policies aimed at reducing motor vehicle injuries in children and adolescents. The FHD is currently seeking additional funding from the National Highway Traffic Safety Administration (NHTSA) to continue CT's CODES project.

Comadrona, Healthy Choices for Women and Children and Right From The Start provide risk screening, identification, education and linkages to resources for pregnant/postpartum teens and women to prevent/reduce incidents of injury to their children. This same focus currently continues and will be a part of future services offered to this population.

Community Health Centers provide risk assessments, anticipatory guidance and health

education materials on an individual basis to children and their caregivers. These services remain current and will continue as services are provided to comply with EPSDT requirements. In addition information will be provided at health fairs, school education programs and other community/neighborhood events.

SBHC/ESHS provide classroom-based workshops on issues such as "stranger danger", bicycle safety and child safety education for teen mothers. Students received health education related to injury prevention. Anticipatory guidance, risk assessment and education are a key component of current group and individual services provided. SBHC's practitioners are encouraged to increase the use of GAPS to identify at-risk children and provide interventions directed at reducing deaths due to injuries and will improve their reporting system to track injuries. Injury prevention activities will continue to be part of SBHC's comprehensive services.

c. Plan for the Coming Year

The Right From the Start, Healthy Choices for Women and Children and Community Health Center programs will continue to enhance collaboration with Injury Prevention Staff to reduce the death rate of children ages 1 to 19 years.

As part of a DPH re-organization the Injury Prevention Program (IPP), is now part of the Family Health Division (FHD). The IPP will provide technical assistance and resources and work closely with the other FHD programs to integrate injury prevention into Title V and other programs serving children and youth. The Program will also strengthen collaborations with other DPH programs outside the Division and other agencies, organizations, and coalitions addressing injury prevention.

Specific activities addressing suicide among 15-19 year olds are listed under NPM #16 and addressing motor vehicle crash injuries among birth to 14 year olds are included under NPM #10.

The IPP will work with other organizations and agencies concerned with motor vehicle injury to utilize CODES data in program and policy development especially for the 15-19 year old population. Motor vehicle crashes are the leading cause of death for 15-19 year olds, but are not addressed under National Performance Measure 10.

State Performance Measure 4: *The degree to which Title V programs target services to racial and/or ethnic groups with disparities in pregnancy outcomes.*

a. Last Year's Accomplishments

In 2003, CT DPH was able to meet 6 of the 12 indicators for this performance measure. The goal for 2003 was to meet 7 of the indicators. Unfortunately, the DPH Office of Multicultural Health was disbanded with the budget cuts during the winter of 2003. However, department activities continued to focus their emphasis on programs serving individuals at high risk of adverse pregnancy outcomes. See the attached document for progress towards achieving this performance measure. These activities are discussed below:

Right from the Start (RFTS) served pregnant and parenting adolescents, provided support, information and linkages to needed services for a group already at risk of poor pregnancy outcomes by virtue of their age/immaturity. RFTS focused on reduction of racial/ethnic disparities in pregnancy outcomes. The program continues this emphasis on the degree to which they serve racial/ethnic subpopulations proportionate to their disparities in pregnancy outcomes.

Comadrona, served Hartford's low income Latina and African American pregnant women and their infants, provided culturally intensive case management services to their clients. Since the city of Hartford has higher rates in all perinatal indicators for women of Hispanic and African American heritage, this program is currently providing services appropriately to high risk women and their infants. In an effort to enhance outreach to this population and enhance services, the DPH increased MCHBG funding to this contractor.

Community Health Centers provided risk assessment care planning and support services to encourage early and routine prenatal care to pregnant women. The program used extensive outreach, home visitation and onsite clinical services to target women at significant risk for delivering low birthweight babies. The program provided an array of direct and support services to their high risk population with emphasis on the degree to which they serve racial/ethnic subpopulations proportionate to their disparities in pregnancy outcomes.

Healthy Choices for Women and Children (HCWC) provided intensive case management and referral services to pregnant Waterbury women at risk for, or abusing substances. The program encouraged and tracked compliance of pregnant clients with prenatal care and provided support and advocacy to assist them in that process. The program provided intensive case management and support services to promote early entry into prenatal care and emphasis on the degree to which they serve racial/ethnic subpopulations proportionate to their disparities in pregnancy outcomes.

The Hispanic Health council conducted a Rapid Assessment of Latina Teen Pregnancy Belief, Attitudes and Behaviors. The results were shared with the RFTS contractors so to better serve pregnant and parenting teens and to prevent subsequent teen pregnancies.

b. Current Activities

An RFP was developed and implemented to identify a consultant who will convene a Perinatal Advisory Committee which will develop a Perinatal State Health Plan, a component of which will address racial and ethnic disparities in perinatal health services

A cultural competency self-assessment tool developed by the FHD for contractors receiving Title V funding was mandated as part of the contractual requirements. The tool serve to provide those contractors a framework to assess the degree to which and manner in which they address the cultural and linguistic needs of the populations they serve. As part of the site visit process Title V community based contractors are provided with technical assistance to develop mechanisms for improving their performance in meeting client needs.

An RFP was issued to conduct a statewide needs assessment on the availability of culturally appropriate bereavement services and to develop and/or identify an existing media campaign to raise awareness regarding infant mortality. The campaign will be targeted towards those populations that experience a higher rate of infant mortality.

HCWC, CHCs, RFTS and Comadrona continue their emphasis on reduction of racial/ethnic disparities on the degree to which they serve racial/ethnic subpopulations proportionate to their disparities in pregnancy outcomes.

FIMR provides the infrastructure under which community-based multidisciplinary case review and community action teams review fetal and/or infant deaths and (in some cases) low birthweight births. Using a confidential and de-identified case approach, the programs use record abstraction and maternal interviews to identify related health care systems' issues such as a lack of availability of perinatal services and lack of client knowledge which may contribute to perinatal deaths.

c. Plan for the Coming Year

Outreach programs in specific Title V programs will be implemented to address racial/ethnic disparities in pregnancy outcomes and Perinatal Advisory Committee will develop a Perinatal State Health Plan.

The Right from the Start, Comadrona, Community Health Centers, Healthy Choices for Women and Children and Fetal and Infant Mortality Review Programs will continue their efforts as described in the Current Activities Section.

As part of the contract deliverables for the RFP to assess bereavement services, the consultant will develop or identify an existing evidence-based media campaign, that will address infant mortality in target populations that experience a high rate of infant mortality. Staff will continue to coordinate efforts with the Commissioner's Office and the newly established role, held by Nancy Berger, with a direct reporting relationship to the Commissioner, to assist in strengthening and integrating the Department's efforts in such public health priority areas as health disparities.

State Performance Measure 5: *The degree to which the State of Connecticut Department of Public Health has developed and implemented a Statewide Genetics Plan.*

a. Last Year's Accomplishments

The development of a statewide Genetics Plan and planning for the information technology infrastructure to support the plan is funded through a SPRANS grant from HRSA to the Connecticut DPH. This originally was a two-year planning grant, and the Department of Public Health has been granted approval of amended objectives and an extension to the grant period. The revised major deliverables were to 1). establish a Genetics Stakeholders Advisory Group of diverse stakeholders to help inform the process; 2). perform needs assessments of three key groups in state: consumers/families, genetics professionals, and general medical providers; 3). perform an assessment of internal data management infrastructure needs and write a data infrastructure development plan; 4). conduct a series of genetics workshops and a genetics symposium toward the goal of a more informed public health workforce, and 4). develop a statewide public health Genetics plan that would both incorporate advances in newborn screening and in medical genetics in general.

In the past year, of the 10 indicators related to developing and implementing a Statewide Genetics Plan, 6 were achieved, falling below the goal of achieving 8 for 2003. This past year, staff members were added to a project team to help complete the project. See the attached document for progress towards achieving this performance measure.

A statewide genetics needs assessment was conducted along with developmental work in this area. Key informant interviews with DPH staff involved with newborn screening and CSHSN were conducted to identify the genetic services they provide.

key stakeholders were recruited to work towards the development of a State Genetics Plan. The list of proposed individuals on the Genetics Stakeholders Advisory Group updated and modified to generate greater representation from family/consumers and genetics educators. A list of discussion questions to present at the stakeholders meeting was developed. A Prototype Resource Binder containing articles, data, surveys, genetics plans from other states, etc was initiated, to serve as a resource for the group.

A plan was established for integrating or linking Patient Profile Databases. Confidentiality mandates within the state were compiled and researched. No legislation was identified that

precludes development of a comprehensive, linked database within DPH. A survey of data managers who maintain the state-mandated child health-related databases within DPH was developed, distributed, and analyzed. The survey contained questions that probed the details of the databases and the data contained within them, the ways in which the data are used, and potential advantages and disadvantages to data sharing. The results of the survey were compiled into a draft report.

Develop a State Genetics Plan. A framework for the Plan was being researched using information gathered from national organizations, such as HRSA, CDC, CSTE, and ASTHO, and other states, such as Michigan

b. Current Activities

This period has been marked by many activities and accomplishments by the Genetics Planning Team, now under Meg Hooper, of the Office of Planning, Communication and Workforce Development. The main activities areas include: Genetic Stakeholders Advisory Group meetings, genetics educational activities, data integration survey and draft report, and genetics plan preparations.

The Genetics Stakeholders Advisory Group began meeting in the fall of 2003 and once each month for three months in a series of half-day working sessions. The group is comprised of genetics service providers, clinicians, academicians, consumer family representatives, ethicists, and genetic epidemiologists, with Department staffing. It was envisioned that these sessions would encompass: sharing background and informational resources; gathering input and feedback from the various stakeholders, and identifying key issues for the development for a Connecticut Genetics Plan. A draft of their input to the plan will be developed and sent to the membership for comment in the early summer, 2004.

To prepare DPH staff for the impact of genetics, a set of afternoon workshops in Public Health Genetics were planned and have been conducted. These workshops included topics in genetics relevant to public health, Medical Applications of Genetics, and Population Screening. These workshops, which were taped for future use by others within DPH who become interested in the topics, were offered by Drs. Sharon Krag and Neil Holtzman of Johns Hopkins School of Public Health. A set of 17 core internal representatives from units within DPH was recruited through meetings with Administration officials, and these same representatives attended the three workshops. The core DPH "gene team" will continue to meet periodically, and will meet later in the year to review the draft genetics plan. In addition to the workshop series, an all day, state-wide symposium in Public Health Genetics is being held on April 14, 2004. Confirmed keynote speakers include Dr. Muin Khoury, Dr. Brad Therrell, Dr. Wylie Burke and Dr. Robert Greenstein.

The series of genetics needs assessment will be conducted by using surveys to gather information from the Stakeholder group, consumer parents/families, and primary care physicians. These surveys will be used to help develop recommendations for the Connecticut Genetics Plan. Although delays have occurred in the development and distribution of these assessments, the additional time of the extension will allow for their completion. Currently, three separate draft surveys are in the final stages of development, and will be distributed in May, 2004. Once surveys are conducted, and reports on their feedback produced, the results will be used to generate recommendations for the Genetics Plan.

c. Plan for the Coming Year

Although the grant funding extension period will end on 9/30/04, the Genetics Planning Team anticipates that much genetics planning development work will need to take place. The draft state plan for public health genetics will require review and revision, and eventual

implementation. A commitment from the Genetics Stakeholders Advisory Group will be sought to continue to meet into the future to provide their input and advise relating to developments in genetics. The internal core DPH "gene team" will be brought together to begin being fostered as an important genetics resource for the Department. Further educational strategies and programs on genetics and public health are needed, and will be developed and proposed, including distance-learning possibilities. These educational programs will need to target public health professionals, genetics professionals and general medical providers workforce development in genetics. To further this goal, the Genetics Planning Team recently collaborated on a Regional Genetics Collaborative proposal, submitted to HRSA in January, 2004, and other opportunities will be sought.

State Performance Measure 6: The degree to which the State of Connecticut Department of Public Health has the infrastructure in place to collect and report accurate information on pregnancy-related mortality.

a. Last Year's Accomplishments

During FY2003 five of the seven objectives for this performance measure were achieved, meeting the projected objective of five. See the attached document for progress towards achieving this performance measure.

The Title V funded Pregnancy-Related Mortality Program (PRMS) directs its infrastructure building activities to pregnant women, mothers and infants. The PRMS, traditionally consisting of review of pregnancy-related deaths in collaboration with the Connecticut State Medical Society's Maternal Mortality Committee, has continued but was supplemented in FY 03 by a State Mortality & Morbidity Review Support grant from HRSA.

State Mortality & Morbidity Review Support grant allowed the pregnancy-related mortality process to become more comprehensive and added case reviews by a multidisciplinary review team with recommendations for program/policy changes to the Title V Director. The team met twice during the year.

b. Current Activities

A consistent finding by the review team has been the lack of data available in the medical records of the cases reviewed. In some instances, prenatal records from physicians' offices have not been made a part of the hospital record. In other cases, the prenatal records are not considered part of the permanent medical record by the hospital. There has been a consistent lack of information on psychosocial factors, especially about domestic violence and substance abuse. Access to medical examiner and police records may enhance these case reviews.

In an effort to increase provider awareness regarding maternal mortality, the OB/GYN Consultant conducted two hospital grand rounds presentations: Mortality Surveillance in the USA and Connecticut; and Enhancing Perinatal Outcomes Through Community Partnering.

Staff are in the process of convening a statewide workshop to provide an opportunity for state and local agencies that conduct mortality reviews to share resources and network. The objectives of the workshop include: a). To enhance awareness of factors in fetal, infant and maternal death. b). To provide an opportunity for understanding mortality review processes to strengthen inter-agency collaboration. This workshop has been planned in partnership with the Office of the Medical Examiner's, Department of Children and Families, Department of Child Advocate and FIMR community-based providers.

The data matching program, which matches deaths of women ages 10-54 with birth certificates/fetal death certificates, has been useful in increasing the number of pregnancy-related deaths reported. In addition, a check-off box has been incorporated into the death certificate that identifies pregnancy within one year of death.

c. Plan for the Coming Year

The consultant will develop a 10-year Pregnancy Related Mortality surveillance report for deaths that occurred from 1991-2000. The report will provide information for addressing maternal mortality and recommendation for future prevention activities.

The consultant has proposed developing an educational, multi-targeted prevention strategy to identify risk factors associated with "near misses". Information/resources will include epidemiological data and maternal interviews of survivors.

Staff are working with other DPH programs to gain access to hospital discharge data that could possibly provide the consultant with additional information for enhanced case ascertainment.

A consultant will be contracted to convene a perinatal advisory committee to develop a state perinatal health plan. Additional activities may be conducted based on the recommendations of a perinatal health advisory committee that is being convened.

State Performance Measure 7: *The degree to which the State of Connecticut Department of Public Health improves education, diagnosis, and case management for asthma.*

a. Last Year's Accomplishments

The state of CT has not achieved its projected number of activities related to SPM #7. (Projected value: 11 out of 14 indicators, value met 10 out of 14). See the attached document for progress towards achieving this performance measure.

The Family Health Division collaborated with the Asthma Program to enhance asthma-related services in the state through the Asthma Workgroup. This workgroup meets in order to link statewide initiatives with Title V service systems such as Community Health Centers (CHCs), Children with Special Health Care Needs (CSHCN), and School Based Health Centers (SBHCs).

Accomplishments with the Asthma Program included the Evaluation of the Managing Asthma in Connecticut Schools Manual and the implementation of the Breath Express mobile van. To enhance the state's ability to provide asthma prevalence estimates on school aged children, The Asthma Program added asthma questions on both the Connecticut Health Survey and the School Health Assessment Forms that are mandatory prior to school enrollment in sixth and seventh grades and tenth and eleventh grades. A childcare guide adopted from Asthma School Resource manual was also created.

In order to highlight State MCHBG State Performance Measures and collect information about activities related to those asthma-related measures, the actual measures were added to the mid year report format for SBHCs and contractors were asked to provide a summary of how they were striving toward SP#07.

The care coordinators/managers at each CSHCN Center continued to conduct a family-centered needs assessment, which includes evaluation of the family/child's asthma education needs. Referrals are also made with the PCP and others to ensure care coordination. In SFY 03 a total of 71/535 enrolled clients had a diagnosis of primary or secondary asthma. Both

Centers provided family education related to asthma and one performed an environmental assessment as part of their intake activities.

The Women, Men, Aging and Community Health Unit of the Family Health Division has worked with The Asthma Program on numerous collaborations involving the Community Health Centers (CHCs). The CHCs in Connecticut follow nationally recognized best practice standards; in fact, most of the CHC corporations are involved with National Best Practice Initiatives. In collaboration with the Asthma Workgroup, a need assessment survey related to asthma was conducted at four of the CHCs. All of the CHCs identified areas for further development. The particular challenges of providing asthma education, diagnosis, and case management during early childhood and adolescence were prioritized.

The Task Force on Asthma completed a statewide asthma plan. The Plan, to be implemented on a regional basis, was discussed at a statewide meeting in May 2003. The Asthma Plan focuses on areas such as clinical management, environment, professional education and public and patient education.

b. Current Activities

Community Health Center, Inc. is in year 3 of the HRSA Health Disparities Collaborative for Asthma. Hill Health Center and Staywell Health Center just completed the 3-year service research asthma grant with the Agency for Healthcare Research and Quality (AHRQ) and all child/adolescent participants showed a level of improvement of managing their asthma. Charter Oak Health Center continues to participate in the Easy Breathing program working in collaboration with Dr. Cloutier, CT Children's Medical Center.

In response to the needs assessment survey conducted on asthma, one of the recommendations was to provide information to early childhood care providers. The DPH Asthma Program produced an easy-to-read manual for early childhood care providers, CHC Medical Directors and some preschool programs, so that they would have access to the materials disseminated to childcare providers across CT.

The CSHCN Program is currently in transition. Plans are underway to establish 5 regional centers across the state with emphasis on medical home/care coordination to strengthen linkages with other specialty providers, schools, etc. to ensure that the needs assessment and care coordination efforts are as comprehensive as possible.

The Asthma Program is currently involved in The Asthma Action Plan Revision Project, the development of the Teen Toolbox, and the participation on the Tools for Schools Resource Team. The program is also supporting the regional implementation of the statewide asthma plan recommendations. Informational meetings are being conducted to assist regions in the implementation of the Asthma State Plan. Assigned staff will organize key players in each region, which will be inclusive of CHC's and SBHC's providers. Priorities identified in the needs assessment of CHCs will be incorporated into the regional plans.

Previously produced asthma television spots have been digitized and are on a dedicated website. All CHCs and schools received bookmarks to promote the availability of this site. In addition a total of 17 radio stations are airing a 60-second commercial titled "Asthma Doesn't Attack". The message is in both English and Spanish. Listeners are encouraged to call the Infoline to get more information about asthma. Demographic information on the callers will be collected to determine the effectiveness of the campaign in reaching the target population. Other public awareness activities consist of messages on billboards, and newspapers. The Asthma Program developed the Asthma Teen Toolbox which delivers health education through engaging media such as CDs and video to appeal to the preferred learning styles of adolescents. Clinicians also receive a range of tools including smoking cessation materials and

medication information. A tip sheet for parents is included. The CHCs Medical Directors received copies for each site across CT. Selected SBHCs also received the Tool Box. Plans are underway for evaluation of this tool.

c. Plan for the Coming Year

The Asthma Program will support the implementation of the statewide asthma plan recommendations on a regional basis.

The CHCs will appreciate the opportunity to participate in the community informational meetings across CT, which will be convened by the DPH Asthma Program. The Family Health Division strongly supports this funding application. The highly effective and collaborative Asthma Program enhances the ability of the CHCs to provide quality health care to the poor, underserved, and vulnerable populations from birth through old age.

SBHCs will continue to focus services on asthma-related issues such as education and preventive care. CSHCN sites will continue provide care coordination services to children and youth with asthma through December, 2004, when they will transition these services to the Regional Medical Home Support Centers (RMHSC). The RMHSC will serve as a regional center to provide care coordination services in collaboration with medical homes in the identified region.

State Performance Measure 8: *The percent of community-based health care facilities that provide comprehensive dental services for needy or vulnerable children and their families.*

a. Last Year's Accomplishments

DPH received a 1-year extension of the Community Integrated Service Systems (CISS) CT Community Oral Health Systems Development Project (CCOHP) to expend unused funds. A very successful 5th Annual Statewide Community Oral Health Conference was held on September 18, 2002. The conference provided an opportunity for representatives from the multiple oral health initiatives developed in Connecticut over the past few years to share their progress and lessons learned as well as gain a comprehensive understanding of the range of oral health programs currently operating in Connecticut.

The East Hartford Community Health Center expanded their dental services by:

- ? Completing a 4th operatory in their East Hartford site
- ? Hiring a part-time dentist 24 hours a week in East Hartford
- ? A dental resident from UCONN now rotates one day per week in East Hartford site
- ? New dentist was hired for the Manchester Dental site

As part of its ongoing efforts to improve access to quality dental care services for Connecticut's children, the Oral Health Unit at the Connecticut Department of Public Health (DPH) conducted a one-day forum on June 23, 2003, to develop strategies for improving the oral health of children enrolled in Head Start and Early Head Start. The Forum was co-sponsored by the Connecticut Head Start State Collaboration Office. Its planning and implementation involved multiple stakeholder groups, and it was supported by a grant from the Association of State and Territorial Dental Directors.

DPH dental contract spending plan for dental services in FY 2003 included 4 School Based Health Centers (SBHCs) and 4 Community Health Centers (CHCs). However, it is up to the discretion of each site on how this money is used. Limited data is received from these SBHCs, CHCs and other dental safety net facilities and the dental data reporting is often incomplete, inconsistent, and not comparable.

b. Current Activities

The IDEAS Project was completed in the fall of 2002. The findings and recommendations for data and information systems enhancement contained in the IDEAS Project final report are being reviewed for possible implementation.

A workgroup has been established to review and make recommendations regarding barriers and other issues affecting data collection and reporting, and billing for dental services by public health facilities. The Oral Health Unit is developing its data and information systems and entering data from recent surveys.

DPH has been rolling out OPENWIDE, a statewide oral health-training program for non-dental health and human service providers on the importance of oral health to general health and well-being. Priority was given to training non-dental providers who work with children age 0-5 years during the first year.

Staff collaborated with the Yale Research Prevention Center on a CDC grant application to promote oral health during the perinatal period. The proposed activities included developing a module in the OPENWIDE curriculum for Obstetricians

Staff submitted an application for HRSA'S State Oral Health Collaborative Systems grant. The proposed activities for this 3-year project would culminate in the development of a dental sealant program.

c. Plan for the Coming Year

The data and information systems for oral health will be enhanced, enabling improved monitoring and reporting of the prevalence of dental sealants. Focus groups are planned with key stakeholders to try and resolve billing and data issues, which will ultimately enhance our ability to monitor and report the prevalence of dental sealants. Lessons learned from the IDEAS project will be used in developing the oral health and information monitoring systems.

OPENWIDE training of non-dental professionals during the coming year will include more obstetricians, gynecologists, pediatricians, family practice physicians and nurses who also treat school age children. Preventive measures promoted for this group of children includes dental sealants. Therefore, we hope to see an increase in the number of sealants placed as a result of pediatricians, nurses and family practice physicians making appropriate referrals for dental care.

DPH is partnering with the American College of Obstetricians and Gynecologists, and the CT Chapter of The March of Dimes to add a module to the existing OPENWIDE curriculum for Obstetricians. The additional module would promote oral health screenings during the prenatal visits and the long term goal is that the curriculum is integrated as a standard part of prenatal care.

The first step of the project was to conduct a survey of all licensed OB/GYNs in CT to determine current practice with regards to oral health and level of interest in this project. An Advisory Committee will be convened consisting of key stakeholders such as the CT State Dental Association, ACOG, March of Dimes, University of Connecticut Dental School, Healthy Start representation and others to review the analysis and provide direction for adapting the OPENWIDE curriculum for OB/GYNs.

An RFP was issued to identify a consultant to conduct an evaluation of the OPENWIDE curriculum. This evaluation will gauge the degree to which providers were able to successfully

implement the curriculum into their practices, as well as identify modifications that might be required to enhance the curriculum.

State Performance Measure 9: *The degree to which the State of Connecticut 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.*

a. Last Year's Accomplishments

From October 1, 2002 to September 30, 2003 the CSHCN Registry achieved 13 of the 18 (72%) criteria for this performance measure. It was anticipated that 17/18 or 94% of the criteria would be met. In October 2002 the CSHCN Registry became operational, in which a data collection module was added onto the electronic Newborn Screening System for reporting cases to the Registry from birthing units and NICUs. A consultant was hired using funds from a CDC Cooperative Agreement for State Based Birth Defects Surveillance (U50/CCU119234-02) to develop the CSHCN Registry data management system. An epidemiologist was hired using CDC funds to work on the Registry project, including data management and statistical reports generation. The CSHCN Registry Advisory Committee was assembled and a meeting was held in February 2003. However, scheduled meetings were temporarily postponed in the later part of the year 2003 due to Registry staff turnover and will be resumed soon.

A single point of referral to CSHCN Centers for all children with special health care needs was discussed and it was decided to use "Infoline" as the single point of referral. Children who are reported to the CSHCN Registry from birthing and neonatal intensive care units are referred to the CSHCN Centers and Birth to Three System by the service provided by Infoline. A data collection tool for Infoline was developed and these data are to be submitted to the Registry to be analyzed and monitored for the pattern of referrals.

See the attached document for progress towards achieving this performance measure.

b. Current Activities

In December 2003, an education meeting was held by DPH to provide information on the modification of Newborn Screening System for all birth hospitals and NICU, along with a presentation to reinforce case reporting to the CSHCN Registry. Because of the lack of compliance on case reporting from birth hospitals in the past, January 2004 was set as the kick-off time for reinforcing the mandatory reporting of CSHCN cases to the Registry and for implementing the new system for Newborn Screening. A letter addressing the need to report CSHCN cases to the Registry was prepared by Registry staff and sent to all pediatricians in the state for better compliance of case reporting. Exception reports on Registry are generated and monitored by Registry staff to track the progress of case reporting and referrals from hospitals on a monthly basis. Records where information on CSHCN is not completed are flagged and corresponding hospitals are contacted for complete information.

Currently, both University of Connecticut Health Center (UCONN) and Yale New Haven Hospital are not reporting cases to the Registry through the electronic Newborn Screening System. Thus, a module was created for UCONN to incorporate their data submitted through floppy diskette and manual entry is needed for cases from Yale.

A module is being created to accommodate data submission from two treatment centers later this year, including Connecticut Children Medical Center (CCMC) and Yale-New Haven Hospital. With the implementation of the Medical Homes approach, CSHCN cases will be better served. Data submitted from Medical Homes to the two centers will be incorporated into

the Registry through this module. Data collected by "Infoline" are submitted to DPH for analysis and monitoring of referral patterns. Abstracts are submitted to CDC NCBDDD and MCH EPI conference call-for-paper this year for presentation on issues related to the Registry.

Current activities this FFY2004 have resulted in the accomplishment of two more component steps (#14 and #15) on the state performance measure checklist attached to the previous section. These indicators include the commencement of a one year post-implementation review and evaluation of the CSHCN Registry for cases ascertained via the electronic Newborn Screening System; and the creation of a paper reporting form for cases ascertained after discharge from the birth or a NICU hospitalization.

c. Plan for the Coming Year

Under the new Medical Home approach, efforts will be made to seek case reporting from PCPs and specialists to make the Registry data as complete as possible. A web-reporting system will be created to accommodate case reporting from PCPs and specialists statewide.

A post-implementation review and evaluation of the CSHCN Registry for cases ascertained from various sources will continue on a routine basis. As the data in the Registry are getting more complete, case ascertainment should be conducted for the CSHCN Registry through various methods. Issues on completeness, timeliness, and accuracy will be determined and assured before Registry data can be used for surveillance, planning, and research purposes.

FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of CSHCN clients enrolled in the state CSHCN program that have a written care service plan.				
1. Redesign the Statewide Care Coordination Program including standardization of the health care service plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Ongoing DPH Quality Assurance monitoring for the presence and quality of health care service plans.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Quarterly review of the CSHCN Center's quality assurance monitoring of the health care service plans.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Incorporate Family Centered Portable Health Service Plan in development of Medical Home Collaborative Project	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The degree to which Title V families have access to mental				

health screening, referral, assessment, and linkages.				
1. Provide screening, assessment, referral, and linkage for mental health needs.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Provide mental health treatment services.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Collect data related to mental health screening, referral, assessment and linkage.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Conduct trainings on mental health coding and billing to facilitate office practice enhancements.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Conduct presentations/workshops highlighting mental health best practice.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) The death rate for children ages 1 - 19 by unintentional and intentional injury (pediatric mortality due to injury).				
1. Provide risk screening identification, education and linkages and anticipatory guidance.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Collaborate with statewide advocates to address injury-related mortality.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Enhance data collection methods and utilize injury-related data to guide planning for state and community based programs and policy development.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provide funding and technical assistance to contractors providing injury prevention programs and activities for children.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Monitor & provide guidance for policy development that addresses injury-related mortality among children and youth.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Participate in statewide and regional coalitions and collaborations that provide and facilitate public and professional education, policy change and system enhancements that improve injury prevention services and programs for children and youth.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) The degree to which Title V programs target services to racial and/or ethnic groups with disparities in pregnancy outcomes.				
1. Establish a Perinatal Advisory Committee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. 1. Establish a Perinatal Advisory Committee Tracking of perinatal				

outcomes by race/ethnicity and community.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Monitor Title V programs for proportion of racial/ethnic clients served.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Implement the Cultural Competence Assessment Tool to Title V programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Develop a Perinatal State Health Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) The degree to which the State of Connecticut Department of Public Health has developed and implemented a Statewide Genetics Plan.				
1. Convene and maintain a stakeholders advisory group for genetics.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Conduct a statewide genetics needs assessments of families and primary care physicians.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Develop a data integration plan for DPH child health related data.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Develop and conduct education programs in genetics and its role in public health.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The degree to which the State of Connecticut Department of Public Health has the infrastructure in place to collect and report accurate information on pregnancy-related mortality.				
1. Continue meetings with Committee on Maternal Mortality to review cases of pregnancy-related mortality.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Develop additional data sources for enhancing case ascertainment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Implement recommendations from perinatal health consultant that relates to maternal mortality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) The degree to which the State of Connecticut Department of Public Health improves education, diagnosis, and case management for asthma.				
1. Maintain asthma workgroup to build capacity within TV programs to enhance asthma awareness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Assess asthma related activities within the SBHC, CHCs and the CSHCN Programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Participate in the CSHP to enhance asthma activities within schools in CT.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue and enhance asthma surveillance activities incorporating Title V data.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Implement data collection methods to determine whether children have an asthma management plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Implement activities related to asthma education, diagnosis, or management.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The percent of community-based health care facilities that provide comprehensive dental services for needy or vulnerable children and their families.				
1. Create, support & provide technical assistance to statewide public-private oral health collaboration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide technical assistance and state funding to CHC and SBHC dental programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Expand & implement OPENWIDE, an oral health integration & training program for non-dental health professionals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Explore means to expand progs. that increase number of dental students/residents working in public.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Enhance data/data systems to improve oral health assessment, surveillance and evaluation.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Pyramid Level of Service			
STATE PERFORMANCE MEASURE	DHC	ES	PBS	IB
9) The degree to which the State of Connecticut 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.				
1. Continue to enhance the CSHCN Registry data module.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Continue to develop the database management system for CSHCN Registry.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Provide referrals to CSHCN Centers and Birth-to-Three.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Conduct meetings with the Advisory Committee.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue to conduct info sessions on the CSHCN Registry to promote public/professional awareness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E. OTHER PROGRAM ACTIVITIES

Many other programs within DPH affect the MCH population but are not funded through MCHBG. Some of these are listed below:

Five a Day Head Start Project focuses on providing direct nutrition education to Food Stamp eligible families in CT with the "Captain 5 A Day" program for children and the "Supermarket Smarts" program for parents and families. These programs are delivered through workshops by state nutrition staff and provide education on food budgeting and developmentally appropriate feeding practices, and encourage dietary behavior modification including the purchase and consumption of fruits, vegetables and other low-fat foods.

Asthma program's mission is to reduce asthma-associated morbidity and mortality and improve the quality of life for people with asthma. The asthma program and FHD staff have collaborated to assess Title V program data and activities to develop interventions for children diagnosed with asthma.

Breast and Cervical Cancer Early Detection Program provides screening and diagnostic services through 18 primary health care facilities and over 100 subcontractors throughout the state. The program provides case management, and community-based public education and outreach initiatives targeting medically underserved women.

Childhood Lead Poisoning Prevention Program receives federal and state funding to operate a comprehensive lead surveillance system, provide professional and community education services and operate two regional lead treatment centers. Additionally, the DPH laboratory provides blood lead testing analysis and associated support services to medical providers and local health departments.

Chlamydia Infertility Prevention provide free chlamydia screening and treatment services to females and their partners who attend targeted Planned Parenthood clinics.

Comprehensive STD Prevention Systems Projects provides a variety of services to reduce the transmission and incidence of selected STDs. These include surveillance to monitor the trends in occurrence of syphilis, gonorrhea, chlamydia and HIV and to facilitate individual case intervention.

Enhanced Perinatal HIV Surveillance receives supplementary CDC funding to conduct Enhanced Perinatal Surveillance. All perinatal HIV exposures (approximately 75 infants per year) are followed-up with extensive medical record reviews to collect information about maternal HIV testing, prenatal care, risk factors, treatment compliance, etc.

Intimate Partner Violence: The Public Health and Health Services Block Grant (PHHSBG) funds a contractor that provides training to health, mental health and public health professionals, paraprofessionals and students about intimate partner violence issues, screening and appropriate referral.

/2005/ St. Francis Hospital is in contract negotiations to provide services./2005//

Healthy Child Care CT brings together on its Core Committee and various subcommittees more than 50 representatives of organizations that play a key role in the planning and delivery of child care and health care for children and families. Leadership is provided by a collaborative effort of DPH, DSS, and the Children's Health Council through the CT Head Start State Collaboration Office.

/2005/Healthy Choices for Women and Children provides support and advocacy services to pregnant women at risk for or abusing substances./2005//

Immunization Program activities are designed to prevent disease, disability and death from vaccine-preventable diseases in infants, children and adults. The Immunization Action Program funds 12 full time health departments, 4 health districts, and 3 additional community providers to conduct immunization activities and the Vaccines for Children ships vaccines on a monthly basis to over 500 health care providers.

Perinatal Hepatitis B Prevention: All hepatitis B positive pregnant women (approximately 120 women per year) and their providers are contacted by the case manager to provide education about the implications of hepatitis B infection in pregnancy, offer testing and vaccination to family members and ensure that the infant receives appropriate prophylactic immunization and testing.

Ryan White Care Act provides federal support for comprehensive health and social services for people living with AIDS and HIV disease, including women, infants and children. There are many AIDS activities aimed to serve women, infants, and adolescents.

Sexual Assault Prevention and Intervention Services ensures the provision of direct services for victims of rape and other sexual assaults throughout the state. DPH contracts with the CT Sexual Assault Crisis Services, Inc., an umbrella agency, to coordinate these efforts

Syphilis Elimination Funds: Funding has been provided to support efforts to maintain low levels of infectious syphilis in CT. Staff provide screening services to the high risk community and share information with providers on syphilis and the need for screening.

Injury Prevention Program (IPP) works to reduce the risk factors associated with unintentional injuries (motor vehicle crashes, falls, fires/burns, drowning, poisonings, etc. The Program works closely with a number of statewide and regional injury prevention collaboratives including CT SAFE KIDS and the CT Young Worker Safety Team.

/2005/IPP funds violence programs for youth to integrate suicide prevention into violence prevention activities and training. The PHHSBG provides funds to address motor vehicle crashes. IPP coordinates the Crash Outcome Data Evaluation System, a project in conjunction with the National Highway Traffic Safety Administration and has provided support for legislative initiatives to improve CT's child passenger safety law./2005//

WIC serves approximately 55,000 participants in CT. They include low income pregnant,

breastfeeding and postpartum, non-breastfeeding women, as well as infants and children up to five (5) years.

WISEWOMEN (The Well-Integrated Screening and Evaluation for Women Across the Nation Program) incorporates cardiovascular disease screening and intervention services into the healthcare delivery system at nine contracted health care provider sites.

Youth Violence Prevention: The PHHSBG funds contractors to provide violence prevention awareness, skill development and strategies to middle and high school aged youth and their providers.

//2005/With the Consultation Center, FHD developed trainings to support community level infrastructure building, and evaluation of MCH programs. "TRAINConnecticut" is an online registry of training opportunities sponsored by the DPH, Public Health Foundation and CDC.//2005//

F. TECHNICAL ASSISTANCE

The DPH has been an active participant in Title V's Technical Assistance Program for years, most often receiving aid; but, on occasion, providing reverse technical assistance to other areas as well.

This year's two specific requests for assistance fall into the Data-related Issues for Data Systems Development category. Technical assistance will result in the state's improved capacity to implement the Title V Needs Assessment, Planning and Monitoring Process to impact positively on CT's Title V target populations.

Form 15 Technical Assistance Requested

Each numbered heading is one of seven possible "Categories of Technical Assistance Requested."

The three bullets following these categories relate to the following column headings from Form 15:

? Description of Technical Assistance Requested

? Reason(s) Why Assistance is Needed

? What State, Organization or Individual Would You Suggest Provide the TA (if known).

1. Data--related Issues-Data Systems Development

- Develop Web-Based reporting system for Title V programs, with the first priority being for the CSHCN program.

-To improve provider access to comprehensive, electronic health care info in order to provide coordinated care planning in a timely manner. Web-based reporting eliminates the need for paper submission and is less burdensome on the Title V providers.

- Unknown

2. Data--related Issues-Data Systems Development

- Assistance with development of adequate data reporting systems that capture quality of services and properly evaluate outcomes of programs in addition to utilization. Need to assess current programs level of male involvement. Need to acknowledge male involvement in MCH programs.

- As a result of reorganization, and as identified through Division's strategic planning.

- Unknown or New Haven Family Alliance for men involvement

V. BUDGET NARRATIVE

A. EXPENDITURES

There were many overall factors that impacted the actual expenditures in comparison to the FFY2003 budget. More details specific to each of the Budget Forms are described below.

Form 3

For FFY2003, not all of the Federal Allocation was spent for several reasons. There was a delay in filling MCHBG funded vacancies. Payment for services for the Health Start Program was put on hold due to a contractual dispute (for a different contract) with the Department of Social Services (DSS). The money will be paid out in the near future.

The unobligated balance was not spent as budgeted in FFY03 for the same reasons as listed above, a delay in hiring and delay in payment. State funds expended differs from Budgeted due to almost \$1 million in budget cuts made to SBHCs as part of the Governor's budget reductions. There was a loss of personnel due to the state budget crisis. DPH issued lay-off notices effective January 2003 as well as offering an Early Retirement Incentive, effective April through May 2003. This loss of staff explains the difference in Administrative Expenditures. Effecting the amount expended from other federal funds was the finalization of NHSC Search Program, Birth Defects Surveillance Grant and the Oral Health Promotion and Training Grant.

Form 4

School Based Health Centers lost almost \$1 million in budget cuts as part of the Governor's budget reductions. A review of program activities resulted in a shift of the apportionment of funding among the population groups served with the MCHBG funding and the MOE funding. The State funded The reapportionment of staff time to different population groups as well as a shift in the selection of State programs used to comprise the State Match account for differences in amount expended on CSHCN.

The reapportionment of staff time in the Women, Men, Aging and Community Health unit to serving men and non-childbearing women accounts for the increase in amount expended for "other" population groups. A loss of staff due to the layoffs and early retirement explains the difference in Administrative Expenditures.

Form 5

Among the contracts and programs supported through the MOE and the MCHBG there was a shift in the way there was accounting for these services among the levels of the service pyramid. The state budget cuts to the School Based Health Centers that is used for the Match and the Maintenance of Effort accounts for the difference in expenditure for Direct Health Care Services.

The amount expended for Enabling Services differs because of the withholding of payment for the Healthy Start Program. A delay in hiring accounted for the difference in expended amount for Population Based Services, and a shift in personnel responsibility, layoffs and retirements impacted Infrastructure Building services.

B. BUDGET

State matching funds are met through funding of School-Based Health Centers, The Genetics Diseases Program, and the Children with Special Health Care Needs Clinics. These matching funds will total \$3,976,000 for FFY 2005. For FFY 2005, the maintenance of effort requirement is met from several sources: Community Health Centers, Family Planning Programs, and the School-Based Health Centers located throughout the state. The State of Connecticut dollars for these programs total \$7,101,000 for FFY 2005 (maintenance of effort total includes the matching).

Other state-funded programs that serve the maternal and child health population include: Community Health Centers, Lead Poisoning Prevention, Asthma, Genetic Sickle Cell Program, Healthy Choices for Women and Children, Expanded School Health Services, Rape Crisis and Prevention Services, Oral Health, Pregnancy Related Mortality Surveillance, Fetal and Infant Mortality Review, and Family Planning. In addition to these programs, there are several state-funded DPH personnel who provide support to the maternal and child health programs.

The requirement that there be three dollars of State matching funds for each four dollars in federal funding is met for FFY 2004. The federal allocation for FFY 2005 is \$5,081,795, which means that the State of Connecticut must match with at least \$3,811,347. Three dollars and thirteen cents (\$3,976,000) is funded for each four dollars in federal funds awarded. Maintenance of Effort for FFY 2005 is in the amount of \$7,101,000, which is \$323,809 more than the required FFY 89 base of \$6,777,191.

Other federal grants received by DPH that serve the maternal and child population include: Abstinence Education, Youth Violence and Suicide Prevention, Rape Crisis and Prevention, Genetics Planning, Universal Newborn Screening, State Systems Development Initiative (SSDI), and the Health Care Provider Loan Repayment program.

The allocation plan requires that 30% of the FFY allocation be budgeted for Prevention and Primary Care services, as well as 30% for Children with Special Health Care Needs. For FFY2005, \$1,664,693 (32.76%) is allocated for Primary Care Services; and \$1,804,295 (35.51%) for the CSHCN program. There is an allocation of administrative costs of \$168,202 (3.31%) of the projected federal allocation to all programs.

In FFY 2005, the federal allocation is \$5,081,795 plus using \$407,636 of the carry forward from FFY 2004 for a total of \$5,489,431 of federal funding. When combined with the state funds of \$7,101,000 there is a federal-state block grant partnership total of \$12,590,431.

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.