

# STATE OF CONNECTICUT AGENCY PREVENTION REPORT

November 2008



A REPORT TO THE CHILD POVERTY AND PREVENTION  
COUNCIL

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## **I. Background**

In June 2006, the Connecticut legislature enacted Public Act 06-179, An Act Concerning State Investments in Prevention and Child Poverty Reduction and the Merger of the State Prevention and Child Poverty Councils. The public act combined the two councils into one coordinated body the Child Poverty and Prevention Council. The Child Poverty and Prevention Council is comprised of membership from both councils.

In May 2007 Public Act 07-47 – An Act Concerning Reporting Requirements related to the Child Poverty and Prevention Council was implemented requiring each state agency with membership on the Council that provides prevention services to children and families to submit an agency prevention report to the Council by November 1<sup>st</sup> of each year through 2014. This report must also be included in the Council's annual progress report to the Governor and legislature. The State Agency Prevention Report was submitted to the Council in November of 2006 and 2007. This report represents the third annual State Agency Prevention Report.

Each agency represented in this report designated one staff person to serve as the single point of contact from their agency to work with the Office of Policy and Management (OPM) to complete the 2008 State Agency Prevention Report. The contact person distributed all requests for information from OPM to the appropriate division within their agency and forwarded the responses to OPM.

The following agencies are included in this report: the Office of Policy and Management, Departments of Children and Families, Developmental Services, Education, Mental Health and Addiction Services, Public Health, and Social Services, and the Children's Trust Fund.

For the purpose of this report, prevention is defined as:

*Policies and programs that promote healthy, safe and productive lives and reduce the likelihood of crime, violence, substance abuse, illness, academic failure and other socially destructive behaviors.*

In an effort to focus the scope of the agency's prevention report and refine this broad definition of prevention the agencies reported on primary prevention programs that serve children 0-18 and their families. Primary prevention refers to programs designed to prevent or eliminate at risk behavior before a problem occurs and promotes the health and well-being of children.

## **II. State Agency Reports**

In accordance with Public Act 07-47, this report informs the Council of action and activities taken by state agencies to address prevention. This section of the report highlights an array of primary prevention services that provide intensive, comprehensive and family-centered resources and support that reduces or eliminates high risk behavior and promotes the health and well-being of children and families.

Each report includes the following:

- a brief description of the purpose of the prevention program;
- the number of children and families served;
- long-term goals, strategies, performance-based standards and outcomes and performance-based vendor accountability;
- a statement on the overall effectiveness of prevention within the agency; and
- methods used to reduce disparities in child performance and outcomes by race, income level and gender

The departments of Corrections, Labor, Higher Education, Economic and Community Development, Office of Health Care Access, Office of Workforce Competitiveness, and the Judicial Branch, determined that their prevention programs did not meet the definition of primary prevention, and therefore, no reports from these agencies are included in this report.

The state agency prevention programs included in this report are as follows:

## **CHILDREN'S TRUST FUND**

Children's Legal Services  
Family Development Credential and Training  
Family Empowerment Initiatives  
Family School Connection  
Help Me Grow  
The Kinship and Grandparents Respite Fund  
Nurturing Families Network  
The Parent Trust Fund  
Shaken Baby Syndrome  
The Stranger You Know

**Program Name:** Children's Legal Services

**Program Description:** The mission of the Children's Law Center (CLC) is to protect the interest of poor children in family court and to advocate policies, which advance their well-being and best interest. Through its programs and services, CLC strives to create safe, stable environments for children whose parents are in chronic conflict. Services provided include legal representation of children by court appointment, a statewide legal help-line, and a parenting education and mediation program.

**Number of children and families served 2007-2008:** 371 children were represented, 56 families served thru Families in Transition and 1,790 children assisted thru the Children's Law Line.

**Program Cost 2007-2008:** \$154,773

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**Program Name:** Family Development Credential and Training Program (FDC)

**Program Description:** The FDC Program offers family serving agencies with training for their staff so that they have the skills needed to help the families they serve attain healthy self-reliance within their communities. A key component in this training is a curriculum developed by Cornell University, which is strength-based and family-focused, and covers home visiting, collaboration, communications, cultural competence, and community outreach.

**Number of children and families served 2007-2008:** A total of 371 children were represented.

**Program Cost 2007-2008:** \$ 155,745

**Program Name:** Family Empowerment Initiatives

**Program Description:** Family Empowerment Initiatives include 7 prevention programs that assist high-risk groups of parents with children of various ages. The programs are co-located in various settings including a school, a substance abuse center, a prison, a domestic violence shelter, a child guidance center and a public housing project where families may be addressing other issues.

These programs help families to address a whole range of issues including parenting and family relationships.

**Number of children and families served 2007-2008:** Nearly 700 children and families were served.

**Program Cost 2007-2008:** \$ 272,518

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**Program Name:** Family School Connection

**Program Description:** In 2001, the Children's Trust Fund piloted, in collaboration with Hands on Hartford, and the Junior League of Greater Hartford the first Family School Connection program in the state. The goals of the Family School Connection program are to improve parenting skills and help families become more involved with their children's educational experiences. The Family School Connection program provides home visitation and support services for families of children who have been identified as having truancy, academic, and/or behavior issues as these are indicators of educational neglect in the home. The program works to improve parenting skills, address basic needs and improve family's stabilization through individualized weekly scheduled home visits and participation in groups. In 2007, the Connecticut General Assembly authorized the expansion of the Family School Connection (FSC) program to Middletown, New Haven, Norwich, and Windham with a continued focus on helping parents and guardians of elementary school aged children (roughly 5 to 12 years old).

**Number of children and families served 2007-2008:** A total of 27 families served.

**Program Cost 2007-2008:** \$ 116,660

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**Program Name:** Help Me Grow

**Program Description:** The Help Me Grow Program is a prevention initiative that identifies and refers young children with behavioral health, development and psychosocial needs to community-based services. The program bridges the gap between children with early signs of developmental problems and the services designed to address them. The program also offers an *Ages and Stages* child development tracking system for interested parents of children ages 4 months to 5 years. The program serves children who

may not be eligible for the state's Birth to Three or preschool special education programs, yet are still at risk for developmental problems.

**Number of children and families served 2007-2008:** A total of 3,300 children and families received case coordination services and 6,000 enrolled in the Ages & Stages Program.

**Program Cost 2007-2008:** \$ 703,113

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**Program Name:** The Kinship and Grandparents Respite Fund

**Program Description:** The Kinship and Grandparents Respite Fund awards small grants to orphaned or abandoned children and the court-appointed relative guardians they live with. The Trust Fund provides funding to 10 probate courts to administer the program. The grants provide for a range of activities including tutoring, camp, fees for a variety of programs and extra-curricular experiences, clothing, eyeglasses and other basic necessities and respite for the caregivers.

**Number of children and families served 2007-2008:** Approximately 5,000 children and families served.

**Program Cost 2007-2008:** \$ 1,100,827

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**Program Name:** Nurturing Families Network (NFN)

**Program Description:** This program operates out of twenty-nine birthing hospitals in the state and in 10 community centers in the city of Hartford and 8 centers in New Haven. NFN provides education and support for all interested new parents and intensive home visiting services for parents identified as most at risk. The NFN reaches more than 4,000 first time families each year and has offered home visiting services to approximately 4,589 vulnerable families at risk of abusing, neglecting or abandoning their children. The program is expanding to eight neighborhood service areas in the City of New Haven and is expecting to reach an additional 250 vulnerable families through its home visiting services. The home visitors become involved during the mother's pregnancy and continue working with the family, on average, for nineteen months. The home visitors teach child development and help the family to bond with and take hold of their responsibility to their child. Seventy percent (70%) of the time fathers are involved. Home visitors support the parent to finish school, to secure a job, and to find and utilize the services of a pediatrician. They connect families to WIC, to counselors and others in the community who can help. The Network also offers intensive group support to parents and extended family members. The program teaches the family appropriate expectations for their children and fosters empathetic understanding and strategies for enhancing the well being of children. Approximately 600 families have participated in the Nurturing Program each year.

**Number of children and families served 2007-2008:** A total of 3,588 children and families were served.

**Program Cost 2007-2008:** \$ 11,639,390

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**Program Name:** The Parent Trust Fund

**Program Description:** The Parent Trust Fund provided 37 grants to offer classes to parents to help improve the health, safety and education of children by training parents in leadership skills and by supporting the involvement of parents in community affairs.

**Number of children and families served 2007-2008:** Nearly 600 parents were served.

**Program Cost 2007-2008:** \$ 422,395

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**Program Name:** Shaken Baby Syndrome

**Program Description:** Shaken Baby Syndrome can cause brain damage, fractures, and death from the violent shaking of infants and young children. The Shaken Baby Prevention project trains hospital staff, medical professionals and community service providers throughout Connecticut on methods to prevent shaken baby syndrome. Three regional trainers, Primary Prevention Services Coordinators of the Children's Trust Fund, provide outreach, education and support to the community on preventing shaken baby syndrome.

**Number of children and families served 2007-2008:** A total of 325 participants have attended presentations.

**Program Cost 2007-2008:** \$ 77,454

**Program Name:** The Stranger You Know

**Program Description:** The Stranger You Know is a child sexual abuse prevention program that offers insight into how the molester thinks, acts and operates to parents and community service providers. The program offers tips throughout the hour and a half presentation on how to have significant conversations about sexual safety with children. Presentations are being offered in communities across Connecticut.

**Number of children and families served 2007-2008:** A total of 1,100 professionals and parents participated.

**Program Cost 2007-2008:** \$ 31,886

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**Long-Term Agency Goals:** The goal of the Children's Trust Fund is to prevent child abuse and neglect and to ensure the positive development of children.



The funds appropriated to the Children's Trust Fund are used to support community efforts that assist families. The community programs are designed to engage families before a crisis occurs – to actually keep abuse and neglect from happening.

This strategy is working. The programs supported by the Children's Trust Fund are making a difference in the lives of children and their parents while reducing the number of families that enter the state child welfare system.

**Strategies:** To achieve its goal the Trust Fund:

- Conducts research to better understand and assess areas of risk for child abuse and neglect, finds the most effective ways to assist families, and develops strategies for improving the skills of service providers.
- Funds broad-based prevention efforts in communities that have been shown to address known risk factors for child abuse and neglect, including poverty, substance abuse, domestic violence, and social isolation.
- Funds programs that include a strong focus on matters that effect the well being of children including improving parent-child bonding and interaction, parenting skills and family relationships, healthy living and health care access, and developmental monitoring.
- Offers a range of program services to meet the needs of all families.
- Trains human services staff in prevention approaches and strategies to engage and assist culturally diverse and vulnerable families.
- Supports a network of agencies that work together to support families around their multiple needs.
- Increases public awareness and participation in efforts to prevent child abuse and neglect.

**Performance Based Standards:** Across all programs the Trust Fund is looking for statistically significant change that can be tied to program efforts. Contractor performance standards for the Nurturing Families Network are assessed annually by comparing each contractor's outcomes with the statewide aggregate outcomes on all evaluation and process measures. The statewide aggregate outcomes serve as the minimum performance standard for this purpose.

**Performance-Based Outcomes:**

- Reduced rate and severity of child abuse and neglect
- Improved parent –child interaction and parenting skills
- Connection to health care providers, high immunization rates
- Gains in household stability, education, employment
- Less financial hardship, access to more resources
- Enhanced family relationship and parent well-being
- Increases in developmental monitoring and access to services
- Enhanced child well being over time.

**Measure of Effectiveness:** Several studies conducted at the University of Hartford's Center for Social Research show that programs supported by the Trust Fund are successfully providing support and assistance to high-risk families. The studies show that these programs are reducing the incidence and severity of child abuse and neglect

and are helping parents to take hold of their responsibilities and to become better caregivers. Highlights of this research follows:

- The incidence and severity of child abuse and neglect in the high-risk families served by the Trust Fund is much less than expected.
- The evaluation of its Nurturing Families Network (NFN) shows the incidence of abuse and neglect to be well below that of high-risk families not participating in this type of program; 4% compared to 22%.
- The immunization rate for two-year old children whose families are involved in the program is 93% compared to 73% for two years olds with similar demographic background on Medicaid.
- A significant percentage of the parents are completing high school, becoming employed and moving out of financial hardship.
- The percentage of mothers establishing independent households increased from 53% to 93% in the second year of program involvement. This is a significant outcome, likely to ensure the future safety of children, given the high number of mothers who were living in abusive or violent or potentially violent households at the start of their program involvement.
- Families are also improving parent-child relationships as well as parenting capacity, attitudes and behavior.

Other research on home visiting shows that the early intervention reduces rates of tobacco and alcohol use, episodes of running away, behavioral problems, arrests, convictions, and sexual promiscuity among teenagers whose families had been reached in this way.

Research on other Trust Fund efforts have found that health care providers have increased their use of developmental surveillance and referrals of at risk youth following training.

**Performance -Based Accountability:** A continuous quality improvement team has been established to review practice guidelines, training needs and program protocols for the larger Trust Fund programs. The policies are written into a manual that guides program implementation efforts at each site. The Trust Fund staff monitors the sites compliance and effectiveness in implementing the program in accordance with these policies.

The Trust Fund staff works with each contractor to develop an Individualized Program Plan each year. The plan identifies areas in need of attention or improvement and strategies for achieving the identified goal. The sites are responsible for reporting on their progress implementing the plan and the results of their efforts.

**Methods:** The Trust Fund uses intensive home visiting, developmental surveillance and early identification of developmental delays and behavioral problems, and parent engagement to reduce racial and economic disparity.

**Intensive multi-focused home visiting:** Several studies have found that home visiting services reduce disparities in child performances and outcomes by race and income level.

One study, conducted by the Missouri Department of Elementary and Secondary Education, found that children enrolled in preschool - whose families participated in a home visiting program - scored significantly higher on all measures of intelligence, achievement, and language ability than children in the comparison group whose families did not receive home visiting services.

The parents who participated in the home visiting program were mostly young, poor, undereducated, single heads of household. Their children shattered the conventional wisdom that they would perform poorly in school. The children did as well as the national norm for children their age - with roughly 15% exceeding the national norm. The children out performed a comparison group of children from wealthier and more stable families not considered at risk for poor outcomes (study available upon request).

**How does Help Me Grow reduce disparities by race, income level and gender...?**

The National Research Council's report "Neurons to Neighborhoods" (Shonkoff and Phillips, 2000) and RAND's analysis of early childhood interventions, Investing in Children, (Karoly et al, 1998) indicate that high quality early intervention programs can have very positive results for those children receiving services. These included increases in short and long term academic achievement, reduction in grade retention rates, and reductions in special education referrals and reduction in teenage pregnancy.

The Help Me Grow program offers universal access to anyone in Connecticut who has concerns about their child's learning, behavior or development. Thousands of families have been connected to critical early intervention programs. Help Me Grow provides training to child health providers on developmental screening and connection to services. The Help Me Grow staff has visited over 50% of Connecticut's pediatric and family practices. Based on this research project, funded through the Commonwealth Fund, referrals for early intervention have doubled. In addition, Connecticut is the only state that provides universal access to an on-going child development monitoring system called *Ages & Stages*. Anyone in the state can access this free service.

**Other:** Child abuse and neglect is at the root of many of the problems children face. Children who are abused or neglected are at high risk for developmental and behavioral problems, health issues, learning disabilities and cognitive delays.

Abused or neglected children are more likely to become involved with the child protection and juvenile justice systems and to become involved with the departments of Social Services, Corrections and Mental Health as adults.

Children fare best when they are nurtured by parents who provide for their needs and help through difficult times growing up. And yet we find that most of the families who participate in Trust Fund programs are ripe for a crisis. More than half of the parents served were abused themselves as children, most are poor and have a limited education and more than half are teenagers – who are just growing up themselves.

As a result, many of the mothers are having difficulty bonding with their babies and meeting the needs of their infants. In Connecticut there are thousands more families who struggle with the demands of parenting and who are in the high range for abuse potential.

It is critical that families are reached before a crisis occurs. Child abuse and neglect must be prevented.

Research demonstrates that the strategies employed by the Children's Trust Fund can help more families and more children have a better life. By preventing child abuse and neglect we have a better chance of keeping children safe in their homes, able to perform well in school and have a productive future.

## **DEPARTMENT of CHILDREN and FAMILIES**

DCF/Head Start Collaboration  
Positive Youth and Family Strengthening Development Initiative  
Shaken Baby Prevention  
Youth Suicide Prevention

**Program Name:** DCF / Head Start Collaboration

**Program Description:** The original collaborative effort began in July 1999 in the Department of Children and Families (DCF) offices in Torrington, Waterbury and Danbury, and Head Start Programs in Litchfield County, Waterbury, Naugatuck and Danbury. The collaboration involved 150 staff from both agencies, developed new knowledge and understanding of the partner agency's program, improved communication, referral and collaboration; and had developed new services and resources. In February 2006, this collaborative partnership was revived and expanded to an additional five sites. The focus on this partnership is to develop strategies to promote family health and the stability of the child within the family. Eight DCF Area Offices have formed partnerships with the Head Start programs in their area affording more young children in DCF placement the opportunity to receive a high quality preschool experience and more support and resources for their parents.

**Number of Children and families served 2007-2008:** Potential number of children and families to be impacted 1,500. Approximately 60 staff members from both agencies participated.

**Program Cost 2007-2008:** N/A

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*The Division of Prevention at the Department of Children and Families is committed to applying the principles of performance-based standards and accountability into all contractual language and activities within our purview.*

**Long Term Agency Goals:**

- Children and Families experience coordinated services and continuity of care;
- Children's health, safety and development is monitored with increasing frequency and thoroughness;
- Families receive more frequent and comprehensive community based and in-home services;
- Children experience fewer placements;
- When placements out of home must occur children are placed with relatives and the agency works collaboratively to develop a plan of services and supports
- New strategies and resources are created for achieving child and family goals;
- Children and families increase strengths and resiliency; and
- Head Start and DCF have improved working relationship.

**Strategies:** The Collaboration promotes the strengthening of child and family relationships by developing a protocol for enhancing communication between each

agency. As a result of the protocol, DCF and Head Start staff know more about one another's programs and services, thus they can use each others resources more effectively, and each agency can make and receive appropriate referrals to/from their partner agency. Head Start and DCF staff work collaboratively to identify mutual families served and participate in all aspects of service provision to children and families including: DCF referral, investigation, and treatment planning; and referral, enrollment and case management in Head Start. DCF has developed a report that enables each DCF area office to identify children 0-5 years of age to support the enrollment of these children in Head Start and Early Head Start. Through partnering both agencies build capacity in communities in the area of cross training and resource development.

**Outcomes:** This collaboration will promote family strengthening by reducing the risk of child neglect and abuse, out-of-home placements and placement disruptions, while monitoring the development, health and safety of young children. Families will be strengthened as they participate in identifying their strengths, needs, goals and resources. Communities and participating agencies will be developing new resources and collaborative innovative strategies for working with families.

The possible outcomes under discussion include the following:

- Decrease in isolation by families
- Increase child and family strength and resiliency
- Increase visibility of children within community
- Decrease in abuse and neglect
- Increase in child developmental screening and monitoring
- Increased ability to maintain children within their biological home or when necessary in relative care
- Increase in Head Start knowledge of DCF mission, locations, services
- Increase in DCF knowledge of Head Start mission, location, services
- Increase contacts with Head Start during DCF investigations, treatment planning conference and Area Case Reviews
- Increase in DCF participation in Head Start trainings and committees

**Measures of Effectiveness:** Measurements of effectiveness include monitoring the use of the protocol which documents the understanding and implementation of practices with respect to Head Start Policies including: Developing Family Partnership, Developing Community Partnerships, and Child Health and Safety; and with respect to DCF Policies including: Conducting Investigations, Case Dispositions, Treatment Planning, Foster Care, Administrative Review, Treatment Plan Monitoring, and Case Closure. Both quantitative and qualitative data are collected quarterly on cross agency communication regarding referrals, investigations, on-going services and joint treatment planning; and collaborative staff training, program planning and resource development within communities.

**Methods:** The protocol is designed to be child-centered, family focused and strength based. Data are collected from participating DCF area offices and Head Start and Early Head Start programs on a quarterly basis and include collaborative communications on case and program related activities, joint meeting minutes, cross-trainings and products

developed and disseminated among Head Start/Early Head Start programs and within the DCF area offices.

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**Program Name:** Positive Youth and Family Strengthening Development Initiative

**Program Description:** The Department funds 7 agencies, all using evidence-based or best practice models, to provide positive youth development and family strengthening programs. The Bureau of Prevention and External Affairs staffs bimonthly technical assistance meetings. An independent evaluator is assisting the Department, in partnership with the providers, to develop common outcomes for this initiative, gather data and monitor effectiveness.

**Number of children and families served 2007-2008:** A total of 1,165 children and adults were served (124 adults and 1041 children).

**Program Cost 2007-2008:** \$ 909,967

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**Long-Term Agency Goals:**

- An increase in the social-emotional skills of children through a universal prevention program/strategy;
- An increase in support and opportunities for young people and their families through enrichment and/or recreation;
- An increase in bonding of children to their parents, school and peers;
- An increase in the engagement of/and communication with families; and
- An increase in youth and families ability to seek help when needed.

**Strategies:** The Positive Youth Development and Family Strengthening Initiative promotes approaches that help young people grow into competent, healthy adults by providing them with opportunities to build skills and form healthy relationships with others. The youth development approach defines goals or outcomes, based on the capacities, strengths, and developmental needs of youth. The Family Strengthening Approach promotes approaches that support parents in their role as parents.

**Performance Outcomes:** The results to date from the Positive Youth Development and Family Strengthening Initiative have been extremely encouraging and demonstrated a significant positive impact on youth and families. The strengths of the initiative have allowed for the successful engagement of many youth and families statewide. Moreover, focusing on continuous quality improvement and building internal capacity for evidence-based practice within regions of the state ‘raised the bar’ for prevention programming in the state of Connecticut. The vision of quality programming and accountability by DCF prevention will not only help children and families in need, but will also help advance the field through the sharing of information regarding the challenges in implementing evidence-based practices.

Parents reported significant changes in their own behavior as well as their family’s behavior including:

- Feeling the program helped their family/met their needs (96%)
- Feeling supported in their role as parents (93%) and returning to speak to program staff if they needed help (94%)
- Better parent-child communication (86% overall and 78% about risky behaviors)
- Learning key parenting skills (e.g., communication (29%), self-regulation (17%), boundary-setting (18%) and commitment to family time (14%))
- Doing things differently as a family (77%) with more time spent together (57%), more fun together (53%), and more relaxed together (53%)

Youth reported significant changes in their own behavior as well as their family's behavior including:

- Feeling the program helped their family/met their needs (96%)
- Increased knowledge about drug, alcohol and other risky behaviors (93%)
- Doing things differently as a family (77%), spending more time together (82%), having more fun together (83%), and being more relaxed together (76%)
- Learning conflict resolution skills (86%) and other key life skills such as self-regulation (58%), communication (57%), goals/life-planning (35%), and community (e.g., making friends, closer to family, work as team, help-seeking) (39%);
- Would return to speak to program staff if they needed help (78%)
- Better parent-child communication (79%)

**Measure of Effectiveness:** The purpose of the evaluation of PYDI is to understand and document the process and effect of replicable, evidence-based, prevention models (e.g., PATHS, FAST, Second Step, SFP, SFP 10-14, and All Stars) and two promising practices (Better Horizons and Farnam House) in CT communities. The outcome evaluation involves the analysis/synthesis of program-specific surveys and common outcome surveys. Program-specific tools are completed by a variety of informants including parents/caregivers, youth and teachers/staff. These tools measure parenting skills, children's skills within the family context, family strengths and relationships, and children's positive and negative behaviors. Common outcomes surveys for parents/caregivers and youth were created through a consensus process involving all PYDI programs and DCF which was facilitated by MATRIX. The common outcomes data are basic short-term/intermediate outcomes for parents and youth that are measured in greater detail in the program-specific surveys: satisfaction with program, learning /skills, parent support, parent-child communication including communication regarding risk behaviors, help-seeking behavior including awareness of resources, family interaction, and other program involvement.

**Methods:** Starting in 2004, the Connecticut Department of Children and Families (DCF) Prevention Unit reconfigured its positive youth development programming and introduced family strengthening programming to incorporate evidence-based and promising practices with continuous departmental oversight and evaluation. Programs were also required to support parents in their role as parents as well as provide enrichment activities for youth and families.



**Program Name:** Shaken Baby Prevention

**Program Description:** The Department, in collaboration with partners that include the Departments of Corrections; Public Health; Social Services; Department of Mental Health and Addiction Services; Corrections; Court Support Services Division and the Office of the Child Advocate is conducting a pilot of two programs to prevent shaken babies: The Happiest Baby on the Block and the Period of Purple Crying.

**Number of children and families served 2007-2008:** The pilot began in September of 2008. Parent Educators are currently being trained and approximately 300 parents are expected to be trained in one of the programs.

**Program Cost 2007-2008:** \$ 28,585

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**Long-Term Agency Goals:**

- Assess a range of approaches and their effectiveness with different populations
- Reduce the incidence of shaken baby syndrome
- Increase the bonding of parents and young children.

**Strategies:** Since crying is a known trigger for shaken baby, the Department is leading an interagency planning effort to create a Training of parent educators to disseminate baby calming strategies to the general population, and in particular, to parents who may be at greater risk for the perpetration of shaken baby syndrome across the State.

**Methods:** Training of Parent Educators

**Measures of Effectiveness:** An independent evaluation of this initiative is being conducted by Dr. Linda Frisman, Director of Research at the Department of Mental Health and Addiction Services.

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**Program Name:** Youth Suicide Prevention

**Program Description:** The CT Youth Suicide Advisory Board (YSAB) was legislatively established in 1989 within the Department of Children & Families. The membership is comprised of volunteers and community and state agency representatives with the goal of preventing suicide among children & youth. This goal is accomplished through statewide awareness campaigns and training.

**Number of children and families served 2007-2008:** A total of 912 people were trained.

**Program Cost 2007-2008:** \$48,995

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**Long-Term Agency Goals:**

- Increase public awareness of the existence of youth suicide and means of prevention;

- Make recommendations to the Commissioner of the Department of Children and Families for the development of state-wide training in the prevention of youth suicide;
- Develop a strategic youth suicide prevention plan;
- Recommend interagency policies and procedures for the coordination of services for youth and families in the area of suicide prevention;
- Make recommendations for the establishment and implementation of suicide prevention procedures in schools and communities;
- Establish a coordinated system for the utilization of data for the prevention of youth suicide;
- Make recommendations concerning the integration of suicide prevention and intervention strategies into other youth focused prevention and intervention programs

#### **Strategies:**

- Submit the recommendations to the DCF Commissioner.
- Combine funding with DMHAS and issue small community grants for youth suicide prevention in schools
- Continue training through United Way of CT and CT Clearinghouse
- Continue mailings to all schools, police, parents, mental health professionals, colleges, etc.
- Collaborate with State Departments of Education and Public Health to convene a statewide youth suicide prevention conference
- Update the YSAB brochures and other print materials
- Work with Bureau of Behavioral Health on improving access to existing services – in particular, the DCF Emergency Mobile Psychiatric Services (EMPS)
- Identify and link resources in communities
- Identify gaps in communities

#### **Outcomes:**

- Recommendations submitted to Commissioner
- Through blended funds from federal SAMSHA grant to DMHAS and DCF state prevention dollars, RFPs for mini-grants were issued in early fall of 2007 and spring 2008. These grants will fund 15-30 schools from \$1,000 - \$2,000 each. Another round is expected to occur in the spring of 2009.
- Training funded by DCF continues. These include training for college students, faculty and staff, DCF social workers and community providers. In addition, through combined dollars from federal SAMSHA grant to DMHAS with DCF state dollars, training in two evidence-based curricula, Assist (Applied Suicide Intervention Skills Training) and Assessing and Managing Suicide training. United Way continued with 5 ASIST trainings in 2007-2008. One Training for Trainer (TOT) session offered in the spring '09.
- Wheeler Clinic continues to conduct training on Assessing and Managing Suicide Risk (AMSR): Core Competencies for Mental Health Professionals clinical training for Masters and Ph.D. level clinicians. Two AMSR training sessions were held in 2007 and 2008.
- Mailing to all schools, chiefs of police, Youth Service Bureaus and DCF Area Offices sent in August of 2007 and 2008.

- Statewide Suicide Prevention Conference held on September 29, 2008 for school, Corrections, DCF and community personnel.
- EMPS contracts have been put out for competitive bid. Implementation will be done in phases through DCF's Bureau of Behavioral Health. 211 will serve as the EMPS call center for the State.

**Measure of Effectiveness:** The number of public awareness campaigns conducted and the number of individuals and groups trained on strategies to recognize risk factors for youth suicide and tools to manage and prevent youth suicide. Schools, police, mental health professionals, parents, foster parents and community colleges are to be targeted.

**Methods:** Cultural competency is incorporated into the designing and implementation of all training and awareness campaigns. Target populations include high risk groups such as Gay, Lesbian, Bisexual and Transgender youth and youth in the juvenile justice system.

## **DEPARTMENT of DEVELOPMENTAL SERVICES**

### **Birth to Three Systems Family Support Programs**

**Program Name:** Birth to Three System

**Program Description:** The Department of Developmental Services is the lead agency (17a-248 C.G.S.) for the Birth to Three program, which is also operated under the provisions of Part C of the Individuals with Disabilities Education Act. This is the same federal law that governs special education for children ages 3-21.

The mission of the program is to strengthen the capacity of families to meet the developmental and health-related needs of their infants and toddlers who have delays or disabilities. The program ensures that all families have equal access to a coordinated program of comprehensive services and supports that:

- foster collaborative partnerships
- are family centered
- occur in natural settings
- recognize current best practices in early intervention
- are built upon mutual respect and choice

Birth to Three seeks to assist families to ameliorate delays in their infants' or toddlers' development that are identified early or to prevent secondary delays or disabilities. We work with families to ensure that their children are ready for Kindergarten at age five.

The federal law requires that two groups of children receive services 1) those with developmental delays and 2) those with diagnosed conditions expected to lead to a developmental delay without the benefit of early intervention. The State is given quite a bit of latitude in defining both of those groups.

Early intervention services must be delivered in natural environments, and for children of this age, that is typically the home, (although services can be delivered in any setting that the child and family typically frequent, such as at child care.) Most services are delivered by occupational, physical, and speech therapists along with early childhood special education teachers, although there are many other professionals and paraprofessionals who can be service providers as well.

**Target Population:** Children under the age of three with significant developmental delays or with diagnosed medical conditions expected to lead to developmental delays.

**Number of children and families served 2007-2008:** A total of 9,108 children were newly referred for evaluation. A total of 9,112 eligible children and their families received services during some portion of the fiscal year, with 4,500-5,000 enrolled on any given day.

**Program Cost 2007-2008:** \$ 45,439,594

**Long-Term Agency Goals:** To ensure that children with developmental delays or who are at-risk for developmental delays are ready for Kindergarten.

**Strategies:** Family-centered early intervention services are delivered in natural environments as early as possible to all Connecticut infants and toddlers who have disabilities or significant developmental delays or who are at biological risk for significant developmental delays.

**Performance-Based Standards:** There is a single statewide point of access, which is easily marketed to referral sources. Once children are referred, they are evaluated and, if eligible, family service plans are developed within 45 days of referral. All new services are delivered no later than 45 days from the writing of the plan. Plans are reviewed at least every six months and rewritten at least annually. School Districts are notified of all children receiving early intervention services unless parents opt out of that notification.

**Performance –Based Outcomes:**

- All eligible children and their families are identified and offered services
- Children receive early intervention services as early as possible
- Children’s developmental trajectories are improved
- Families feel more confident and competent to foster their children’s development
- Fewer children need special education services by Kindergarten

**Performance-Based Accountability:** Birth to Three has an in-depth process for assuring the quality of services and the performance of its contractors. All contractors are part of a real-time data system that enables the state to view performance on a daily basis. That allows the department to monitor all data and produce monthly performance reports. The contractors have a “performance dashboard” as part of the data system, which allows them to monitor their own performance. In addition, every two years, each contractor submits a “Biennial Performance Report” looking at their own performance over a wide variety of indicators, many of which require them to review child records and interview families. That report is submitted electronically. The state verifies the data and the contractor is required to prepare an improvement plan for any items that are either not in compliance with the law or performance items that are extremely low. Twice a year, the state ranks contractors on three specific indicators. Low-performing contractors receive an on-site monitoring visit by a team composed of state staff, a program director from a different agency, and parents. The team focuses on the indicator that was low but then delves much deeper into issues of quality. They review child records, interview staff, and interview parents. The monitoring report is issued and any items found to need improvement are added to the contractor’s existing improvement plan. The last check on performance is procedural safeguards for parents. Each written complaint received is investigated and may result in one or more findings that must be corrected by the contractor. The same is true for any administrative hearings, although they are held infrequently. All of these accountability processes are detailed in the Birth to Three Quality Assurance Manual found on [www.birth23.org](http://www.birth23.org) under “Publications”

**Measure of Effectiveness: FY08 data:**

**Outcomes 1 and 2: All eligible children identified and offered services as early as possible**

- Percent of children under the age of three served - 3.35%. The national average for FY07 was 2.43%. Connecticut ranked 12<sup>th</sup> nationally.
- Percent of children under the age of 12 months served -.94%. The national average for FY07 was 1.05%. Connecticut ranked 18<sup>th</sup> nationally. 7/1/07 change in eligibility criteria for preemies should improve this by 2009.

**Outcome 3: Children's developmental trajectories are improved**

Percent of infants and toddlers served who demonstrate:

- Improved positive social-emotional skills - 55% achieved or maintained age level and an additional 38% improved to a level closer to their age peers
- Acquisition and use of knowledge and skills (including early language and communication) - 57% achieved or maintained age level and an additional 35% improved to a level closer to their age peers, and
- Use of appropriate behaviors to meet their needs - 58% achieved or maintained age level and an additional 34% improved to a level closer to their age peers

**Outcome 4: Families feel more confident and competent**

- Percent of families served who report that early intervention services have helped the family help their children develop and learn. This includes better understanding their children's special needs - 97.6% of families agree, with 78.7% strongly or very strongly agreeing)

**Outcome 5: Fewer children need special education by Kindergarten**

- Percent of children served who have exited the program and who are not receiving special education services in Kindergarten as of October, 2007 - 65%

**Methods:** All children that meet the eligibility criteria are eligible – irrespective of race, income level, gender, or town of residence. The program does not specifically target groups of children for services. However, by including all children with significant developmental delays, Birth to Three is working to teach families and other caregivers to facilitate the child's development so that they can "catch up" to their typical peers by Kindergarten. Therefore, we are actually concentrating on reducing disparities between children with developmental delays and their typically developing peers.

The focus of services is in teaching the family and caregiver(s) ways to intervene in the child's development during naturally occurring routines and activities. Research tells us that very young children do not generalize and do not learn through what are called "massed" trials (repeated practice of a skill within a short period.) Birth to Three uses a coaching process to help a caregiver feel more confident and competent in facilitating their child's development throughout the day, so that their child gets the opportunity to practice skills during their daily routines, which gives the child a maximum number of

opportunities for practice. Since each child's Individualized Family Service Plan is individualized for that child and that family, and since the focus of the plan is on the family's priorities for their child and themselves, the family's ethnicity and income level will be addressed because it affects that family's priorities and need for services.

As services begin, children are assessed using any one of three curriculum-based assessments. This allows the Birth to Three providers to summarize the child's development at entry, which is then compared to the child's development at exit to track developmental progress. Use of this type of assessment also helps the family track their child's progress and be aware of the general order of development across all areas.

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**Program Name:** Family Supports: Individual and Family Grants, DDS Respite Services and DDS Family Support Workers.

**Program Description:** The Department of Developmental Services (DDS) provides Family Supports that assist families to care for their children who have mental retardation in their homes. Most families who have children with mental retardation need extra support to help them keep their children at home. Family Supports are goods, services, resources, and other forms of assistance that help families successfully parent their children who have mental retardation. Family Supports include Individual and Family Grants, Respite Services provided by DDS and DDS Family Support Workers. Family Supports help children grow up in a nurturing family home where they are more likely to live healthy, safe and productive lives.

**Target Population:** Families who care for family members who have intellectual disabilities are eligible for the range of Family Supports including Individual and Family Grants, Respite Services and Family Support Workers. Approximately 5,000 families could potentially be eligible, including up to 2,400 families of children with intellectual disabilities under the age of 18. Up to 400 individuals served by DDS who live on their own are also eligible for Individual and Family Grants.

**Number of children and families served 2007-2008:** Individual and Family Grants were given to a total of 3,729 individuals and families across the state. This number includes 1,793 families with children under the age of 18. DDS Respite Centers served 1,109 persons who have mental retardation, including 400 children and their families. Family Support Workers served 656 individuals statewide including 299 children and their families.

**Program Cost 2007-2008:** \$4,898,493

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**Long-Term Agency Goals:** The Department of Developmental Services (DDS) serves 15,270 individuals including 2,896 children under the age of 18. This number does not include children who do not have mental retardation and are served in the Birth to Three System. While most children live with their families, about 241 or eight percent of children served by DDS live in other residential settings. The department's long-term prevention goal is to support families to care for their children in the family home and to

prevent out-of-home placement. The department also has the goal of adding two additional respite centers during FY 2009.

**Strategies:** Most families who have children with mental retardation need extra support to help them care for their children at home. DDS provides a range of Family Supports to assist these families to care for their children at home. Family Supports include goods, services, resources, and other forms of assistance that help families to successfully parent their children who have mental retardation. The Department of Developmental Services plans to continue to support families by providing Individual and Family Grants, Respite Services and assistance from Family Support Workers. Within available resources, the department will expand the number of families served with these Family Supports.

In addition to the Family Support services offered by the department, DDS continues to implement Home and Community Based Services (HCBS) Waivers that offer services in the community as an alternative to institutional care. The department continues to expand the range and number of services available under the waivers that assist families to care for their children within the family home. These services include personal services, individualized home supports, respite, home and vehicle modifications, family training and behavioral consultation services.

The department has a Children's Services Coordinator based at the Central Office who focuses on children's services, including expanding the availability and ensuring the quality of supports provided to children with intellectual disabilities and their families.

**Performance-Based Standards:** The goal of DDS Family Supports is to provide a range of supports for families of children with intellectual disabilities so they can stay together and keep their children in the family home. DDS prioritizes family supports based upon the level of need of the children and family; for instance, children who are high priority on the waiting list for residential services are also a high priority for services at respite centers. These standards are further described below in the "Other" section of the report, which includes the department's Vision and Guiding Principles for Family Support.

**Performance-Based Outcomes:** Specific outcomes in measuring the success and effectiveness of Family Supports provided by DDS include the number of children and families served and the number and percentage of children who live in family homes in comparison to those children in out-of-home placements.

**Performance-Based Accountability:** Family Supports are provided by DDS staff through the department's programs and are not contracted services. Family Support programs are operated based upon DDS policies and procedures specific to those services. The procedures describe the eligibility criteria, priority for services, and service operational guidelines. DDS regional offices maintain data on the numbers of children and adults served.

DDS has a centralized process to review requests for out-of-home placement for children. The department's Children's Services committee meets monthly to review any requests to place a child under age 18 out of the family home. The committee reviews alternative supports that have been put in place, makes recommendations for additional supports that



may be successful at keeping families together and makes recommendations to the Commissioner regarding appropriateness of placements.

**Measure of Effectiveness:** The percentage of children served by DDS who lived in their family home has remained consistent over the last six years. Since October of 2000, the percentage of children in out-of-home placements has remained constant at eight percent of the total number of children served by DDS.

**Methods:** DDS Family Support services are available to all children with intellectual disabilities and their families regardless of race, cultural background, income level or gender.

**Other:** The Department of Developmental Services' vision and guiding principles for children with mental retardation are as follows:

**Vision:** All children with mental retardation should grow up with the love and nurturing of their families. Families should be able to identify and receive the individually designed supports and services they need to raise their children in their local communities. Communities should embrace children with mental retardation and their families and include them in all aspects of community life.

**Guiding Principles:** The following guiding principles were identified by focus team members as critical ingredients in providing supports and services to children and their families:

- **Children Grow Best in Families**  
A “whatever it takes” approach should be adopted to keep children with their families. Families should receive the support they need to raise their children at home. When a family is not able to provide full time care for their child, arrangements should be made to share the care of their child with others who will provide a nurturing family home. When a child is unable to live with his or her family, even on a part-time basis, a permanent home should be provided for the child that balances the family’s wishes with the best interests of the child. It is essential that children maintain strong relationships with their families. Families’ bonds with their children should be maintained whenever possible.
- **Families Know Their Children Best**  
Families have primary responsibility for the well-being of their children. Families should have information about available options, services, and resources that will enhance their abilities to make informed choices. Support staff should listen to families and respect their decisions.
- **Supports Are Responsive to the Needs of the Entire Family**  
Families are the constant in their children’s lives. Children should be supported in the context of their families with services that are tailored to their unique family circumstance.
- **Supports Are Family-Directed**  
Families should drive the planning process and have a strong voice in designing, selecting, and evaluating the supports and services they and their children receive.

Families should have the tools and resources they need to be successful in directing their supports.

- **Supports Are Delivered in a Culturally Competent Manner**

The culture of the family influences the choices they make and will accept. Supports should be delivered in the family's language and in ways that are consistent with a family's cultural background. A culturally competent workforce that understands the diverse needs of families should provide supports.

- **Services and Supports Are Individualized, Flexible, Far-reaching, and Responsive to Changing Needs**

No two families are alike in their strengths, challenges, or aspirations. Families should have access to a full range of options including in-home and community supports that are uniquely tailored to their needs. Supports should be easily accessible and sufficiently available to make a difference. Supports should be available before a crisis arises, but in an emergency, families want a sense of security that help will be there when needed. Supports should be flexible to meet the changing needs of families in a timely way.

- **Families and Children Receive Supports and Services in Their Community of Choice**

Families want their children to be welcome participants in their communities. They want their children to be able to access the same formal and informal supports available to children who do not have disabilities. Assistance should be available to help families to use and strengthen their natural supports, connect with their communities, and develop new resources. Families should be assisted to reach out to other families for networking, and to work on community building and workforce development issues. Supports should promote the integration and inclusion of children with mental retardation in the daily life of the community.

- **Supports Are Designed to Maximize Families' Competencies**

Families should be supported to make decisions about needed supports and services and to direct the provision of those services. Professionals and others should promote the competencies of families and provide any tools necessary to assist families including leadership, networking, and advocacy skill development that will prepare families to advocate for new or enhanced supports.

## **DEPARTMENT of EDUCATION**

### Early Childhood Program (School Readiness) Even Start Family Literacy Program

**Program Name:** Early Childhood Program (School Readiness)

**Program Description:** Purpose of the program is:

- To significantly increase the number of accredited and/or approved spaces for young children in order to provide greater access to high-quality programs for all children;
- To significantly increase the number of spaces for young children to receive full-day, full-year child care services to meet family needs and to enable parents to become employed; and
- To establish a shared cost for such early care and education programs among the state and its various agencies, the communities and families.

All programs must receive NAEYC, Head Start, NEASC or Montessori accreditation within three years of initial funding and must maintain such accreditation for continued funding to ensure high-quality programs for all children. Communities must offer a range of options regarding the length of program day and year in order to meet the needs of families. Families are offered a sliding fee scale as a means of providing affordable high-quality early education programming.

#### **Performance Based Standards:**

- Quality preschool services are available for 100% of eligible children in priority school districts.
- By 2015 every School Readiness classroom will have a teacher with a bachelors degree or higher.
- All of the School Readiness Programs are accredited or approved under the recognized systems.

**Performance-Based Accountability:** School readiness programs are based on ten (10) quality components and provide supports and services for collaboration with community agencies, health, nutrition, parent education and services, transition to kindergarten, professional development that includes training in emerging literacy and diversity, family literacy, child and program evaluation, a sliding fee scale and a non-discriminatory admissions process. The plan to implement these supports and services is described by each school readiness program in their RFP application. The program's adherence to the quality components is reported through the Connecticut School Readiness Preschool Program Evaluation System (CSRPEPES), as well as state monitoring visits and quarterly Community Liaison site visits. These reports focus on the program's implementation of the services and emphasize collaboration with outside service providers in order to support the individual needs of families in the context of their community.

**Target Population:** Resident children in priority school districts and competitive grant municipalities who are ages 3 and 4 years of age and children age 5 years of age who are not eligible to enroll in school.

**Number of children and families served 2007-2008:** A total of 63 towns/school districts in Connecticut served 9,600 children in 19 priority school districts and 44 competitive districts.

**Program Cost 2007-2008:** \$66,281,219

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**Program Name:** Even Start Family Literacy Program

**Program Description:** The purpose of the program is to break the cycle of poverty and illiteracy for low-income families.

Even Start is a federally-funded program that provides intensive family literacy services that involve parents and children in a cooperative effort to help parents become full partners in the education of their children and assist children in reaching their full potential as learners. Even Start helps break the cycle of poverty and illiteracy by improving the education opportunities of families most in need in terms of poverty and illiteracy by integrating early childhood education, adult literacy or adult basic education, and parenting education into a unified family literacy program. Local programs are implemented through cooperative projects that build on high-quality existing community resources, creating a new range of services for low income children and parents. Even Start helps children and families achieve the academic standards set forth by the state and uses instructional programs that are based on scientifically-based reading research to:

- enrich language development, extend learning, and support high levels of educational success for children birth to age seven and their parents;
- provide literacy services of sufficient hours and duration to make sustainable changes in a family;
- provide integrated instructional services for families, where children and their parents learn together to develop habits of life-long learning; and
- support families committed to education and to economic independence.

**Performance Based Standards:**

- It is expected that 50% to 65% of the Even Start children birth through age five will meet the reading readiness standards for their age group.
- It is expected that 40% or more of the adults will meet adult literacy goals in ABE or ESL reading and 60% of the adults in a high school diploma or GED program will make progress toward attaining a diploma.
- It is expected that 40% to 60% of the parents will meet standards for skill development in family literacy such as reading to child, borrowing books from the library or other sources, encouraging children to read with them at home, etc.

**Performance-Based Accountability:** Even Start is required to contract for local program evaluation. All programs must report on quality, attendance and outcomes as well as meet state standards or performance indicators of success in early childhood, adult education and parenting education. Outcomes, attendance and quality assurance standards are reviewed on a monthly and an annual basis at the local and state level. Programs must also develop local objectives that are measurable and demonstrate the quality of their program and outcomes, monthly attendance of each child and adults. Local evaluation requires a visit 3-5 times per year to review early childhood records, lesson plans and observation of instruction, focus groups with staff and adults, etc.

**Target Population:** Parents and children up to age 8 from low-income families. Parents must be eligible to participate in an adult education program under the Adult Education Act.

**Number of children and families served 2007-2008:** Even Start in Connecticut operated with 6 programs serving high-need areas of Danbury, Middletown, Stamford, Windham, New London, Middletown and Shelton. Programs served 136 Even Start families (139 adults and 166 children) through early childhood education, adult education, and parenting classes. The number of programs supported has dropped significantly from a previous service level of 11 programs.

**Program Cost 2007-2008:** \$648,837

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*Agency goals as well as strategies, methods, outcomes and measures of effectiveness are referenced in the Connecticut State Board of Education's Five-year Comprehensive Plan for Education 2006-2011.*

### **Long-Term Agency Goal 1**

**Goal: High-quality preschool education for all students,** including preschool programs aligned with *Connecticut's Preschool Curriculum Framework and Preschool Assessment Framework* and linked to the *Connecticut Framework: K-12 Curricular Goals and Standards*. This will require alignment of research-based curriculum implemented by high-quality teachers in preschool through Grade 3, with a monitoring and assessment system aligned to the state standards.

**Strategies and Methods:** The State Board of Education will take the necessary steps to support the following state actions to address this priority:

- Provide funding for high-quality preschool education for all 3- and 4-year-old children living in high-need districts, as well as those children most in need throughout the state
- Provide incentives to districts to assume increased responsibility for high-quality preschool education
- Increase funds to existing state programs, such as School Readiness and Head Start, to support high-quality preschool education
- Revise current statute to increase funding for both school construction and the child-care facilities loan funds to expand capacity for preschool education

- Provide assistance to enable children of families most in need to receive a high-quality preschool education
- Collaborate with Connecticut higher education to establish a seamless system between two- and four-year programs to prepare high-quality early childhood educators
- Collaborate with Connecticut higher education institutions to provide incentives, such as scholarships, tuition waivers and forgivable loans, to candidates seeking an early childhood credential
- Expand early childhood educator preparation programs to allow alternate forms of obtaining a required credential, such as distance learning, off-campus and satellite learning centers, employment based and credit-granting courses, and supervised practicum; emphasis will be placed on increasing minority candidate participation
- Provide ongoing, systematic professional development in the use of *Connecticut's Preschool Curriculum Framework* and *Preschool Assessment Framework* to ensure that all early childhood educators have the knowledge and skills to prepare children for future school success
- Collaborate with the Department of Public Health to modify the role of the education consultant to support early childhood educators in effective instructional practices consistent with *Connecticut's Preschool Curriculum Framework* and *Preschool Assessment Framework*
- Establish a system of monitoring and technical assistance to support effective instructional practices consistent with *Connecticut's Preschool Curriculum Framework* and *Preschool Assessment Framework* and aligned with the *Connecticut Framework: K-12 Curricular Goals and Standards*
- Support the design and implementation of a developmentally appropriate measure of children's readiness for and progress in kindergarten

**Outcome and Measures of Effectiveness:** The expected outcome is a high-quality preschool education for all young children in Connecticut. The following indicators will serve as measures of success:

- More children will participate in high-quality, state-funded preschool programs, and there will be greater access to high-quality preschool programs statewide.
- More teachers will have specialized credentials in early childhood education and the skills and knowledge to provide a high-quality preschool education.
- All preschool programs will include a rigorous curriculum and an assessment system aligned to *Connecticut's Preschool Curriculum Framework* and *Preschool Assessment Framework*.
- Children who participate in all preschool programs will enter kindergarten fully prepared for further learning in literacy and numeracy.
- All children will have competencies in areas that support their learning and academic success, which include physical and motor development, creative and aesthetic expression, and personal, social and emotional skills.

## Long-Term Agency Goal 2

**Goal: High academic achievement of all students in reading, writing, mathematics and science**, with a focus on students in high-need schools and districts. High achievement will result only if all students are *expected* to achieve at high levels and have equal access to challenging curriculum and instruction, and adequate and equitable resources; and are taught by excellent educators who believe that all students, regardless of race, gender, ethnicity or socioeconomic status, can achieve at high levels.

**Strategies and Methods:** The State Board of Education will take the necessary steps to support the following state actions to address this priority:

- Develop model curriculums in reading, mathematics and science for prekindergarten through Grade 8
- Develop model curriculums for algebra and geometry
- Provide training and technical support for educators in the implementation of curriculums and monitor implementation in high-need districts
- Develop formative assessments, aligned to model curriculums, and provide training in the use of formative assessments
- Require low-performing districts to administer formative assessments in reading, writing, mathematics and science at all grade levels and use the information to improve instruction
- Establish incentives to attract, support and retain highly qualified and effective teachers in high-need districts, with priority given to attracting minority teachers
- Support “grow-your-own” programs in high-need districts by identifying (1) mentors for classroom-based support programs to increase teacher retention, (2) outstanding paraprofessionals to become certified teachers and (3) teachers who exhibit strong leadership skills to become school leaders/administrators
- Provide communication and outreach to middle and high school students from high-need districts on incentives available after high school graduation to those who attend educator preparation programs in Connecticut
- Collaborate with higher education in Connecticut to provide tuition assistance to students most in need to pursue teaching careers in mathematics and science
- Conduct a comprehensive evaluation of all components of the BEST Program and implement appropriate changes based on evaluation findings to ensure that all beginning teachers provide high-quality, effective instruction
- Develop and provide an induction program for all new administrators, beginning in high-need districts
- Establish pilot programs for extended learning opportunities beyond the regular school day and year, such as before- and after-school programs, weekend programs, tutoring, homework help and summer school, with expansion to additional schools based on results of the pilot
- Align pre-service training with the National Council for Accreditation of Teacher Education (NCATE) standards on partnering with families and communities

- Provide professional development to school and district staff members in developing effective school-family- community/business partnerships based on State Board of Education standards
- Continue to expand the Connecticut Accountability for Learning Initiative (CALI) and support schools and districts identified by the No Child Left Behind Act (NCLB) in Year 3 of “in need of improvement” by:
  - requiring school-wide instructional assessment by an external evaluator;
  - requiring the review of reading and mathematics curriculums in these districts and, if not standards-based, requiring implementation of State Department of Education model curriculums;
  - requiring on-site coaching of superintendents and principals in these districts, using as coaches administrators with records of high student achievement;
  - requiring leadership training for superintendents and principals in these districts in developing and implementing high-level instruction in reading and mathematics across all grade levels;
  - requiring the use of formative assessments in each of these districts to improve instruction; and
  - requiring the use of a longitudinal data system to track student indicators having direct impact on student achievement

**Outcome and Measures of Effectiveness:** The expected outcome for each of these actions is increased achievement of all students and a significant closing of the achievement gap in reading, writing, mathematics and science.

The following indicators, which are closely linked to student achievement, will serve as measures of success:

- Curriculums aligned to the *Connecticut Framework: K-12 Curricular Goals and Standards* implemented in every school
- District implementation of the full range of assessment options available, including common grade-level or subject-area assessments, benchmark assessments and formative classroom assessments
- Increased teacher retention rates and the number of minority teachers in high-need districts
- Increased retention of high-quality, new administrators in high-need districts
- Enhanced BEST Program so all beginning teachers are provided the necessary support for effective teaching of all students
- Fewer districts and schools identified as “in need of improvement” and “in need of corrective action”
- Implementation of a data system to measure student growth longitudinally
- Significant increases in reading, writing, mathematics and science achievement within one year at schools with pilot programs for extended learning opportunities
- Increased family participation in the planning and improvement of school programs



- Increased support to families for supporting children's learning at home
- Improved district policies on school-family-community/ business involvement and consistent implementation of these policies

### **Long-Term Agency Goal 3**

**Goal: High school reform,** so all students graduate and are prepared for lifelong learning and careers in a competitive, global economy. This will require all high schools to provide a rigorous, literacy-based curriculum linked to authentic, real-life experiences; performance-based assessments; a school climate in which personal and social responsibility is practiced; and school-business partnerships that offer students tangible knowledge and experience.

**Strategies and Methods:** The State Board of Education will take the necessary steps to support the following state actions to address this priority:

- Increase graduation requirements to reflect the skills needed to ensure success in a global society
- Establish competencies stating what students should know and be able to do upon graduation from Connecticut's high schools in order to be successful in postsecondary activities, and require districts to align local graduation requirements with the established competencies
- Ensure that all districts develop and implement rigorous, standards-based curriculums to meet the changing needs of the workplace, technology and a global economy
- Allow standards-based alternatives for demonstrating knowledge, skills and understanding as a way to earn high school and/or college credits
- Require access to meaningful out-of-school learning experiences for all students
- Develop strategies to reduce the number of students who are suspended from and/or drop out of high school, including alternate programs for students most in need
- Create and sustain a data warehouse to track students' performance from preschool through college
- Attract, support and retain highly effective secondary school administrators to meet the challenges and demands of redesigning Connecticut's high schools
- Require that all students have a personal education plan that includes career development, in- and out-of-school coursework and/or activities, and transition to postsecondary education and/or the workplace.

**Outcomes and Measures of Effectiveness:** All Connecticut high schools will be redefined using the research-based standards in the *Framework for Connecticut's High School: A Working Guide for High School Redesign*. The expected outcome from the preceding action is to have every student graduate from high school prepared for college and work.

Each high school will fully prepare students when the following are in place:

- a clear mission defining what it seeks to achieve;
- a rigorous, standards-based curriculum;

- a strong school community focused on the school's mission and high expectations for student learning;
- a small, safe, personalized and positive learning environment;
- embedded professional development with the single purpose of improving teaching and learning;
- a system using accurate data to inform and transform teaching, learning, leadership and management practices; and
- learning opportunities for all students that extend into the community.

## **Department of Mental Health & Addiction Services**

Best Practices Initiative  
Connecticut Youth Suicide Prevention Initiative  
Local Prevention Council Programs  
Regional Action Councils  
Statewide Service Delivery Agents  
Strategic Prevention Framework Incentive Grant  
Tobacco Regulation & Compliance

**Program Name:** Best Practices Initiative

**Program Description:** 14 statewide funded projects that apply science and research-based programs to populations across the life cycle. These science-based community prevention programs are designed to enhance the lives of adults and children and encourage family, peers, neighbors and others to become involved.

Utilizing multiple Substance Abuse and Mental Health Services Administration-Center for Substance Abuse Prevention (SAMHSA-CSAP) strategies, Best Practice programs focus on positive youth development; alcohol, tobacco and other drug education; healthy decision-making skills and recreation. Programming is varied and in many cases multi-pronged, but most target needy or otherwise at risk youth. Several programs incorporate academic support, peer leaders or mentors and many emphasize family development and parenting skills. Youth-led participatory research, training for professionals working in youth-serving organizations, and education, enrichment and respite services for grandparents and custodial relative caregivers are also represented.

The Best Practices engage youth, families, schools and communities in Danbury, Enfield, Hartford, Middletown, Milford, New Britain, New Haven, New London, Plainville, Torrington, Westport, Windham and surrounding municipalities in alternative activities, community-based processes, education, information dissemination, and problem identification and referral.

**Target Population:** Youth (0-18), Adults, Families, Grandparents

**Number of children and families served 2007-2008:** A total of 12,537 children and families were served. 365 from the age of 4 and under; 1,988 from the age of 5-11; 1,981 from the age of 12-14; 1,645 from the age of 15-17; 2,473 from the age of 18-20; 990 from the age 21-24; and 3,095 from the age of 25 and older.

**Program Cost 2007-2008:** \$1,716,968

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**Program Name:** CT Youth Suicide Prevention Initiative

**Program Description:** Develop and implement comprehensive, evidence-based youth suicide prevention and early intervention strategies that may be maintained over time and expanded throughout Connecticut. This initiative builds on the recommendations of the

Connecticut Interagency Suicide Prevention Network, the 2005 Connecticut Comprehensive Suicide Prevention Plan, the Connecticut Youth Suicide Advisory Board, and the CT Mental Health Transformation Initiative. It specifically addresses Goal 1.2 of the President's New Freedom Commission on Mental Health, the need to advance and implement a national strategy for suicide prevention.

Key components of the project are to: 1) Support the use of the science-based "Signs of Suicide" (SOS) Program, the Question, Persuade and Refer Gatekeeper Model, and the College Response Model in selected middle and high schools and CT State Universities (CSU); 2) Expand the existing DCF-sponsored training program for foster and adoptive parents, school nurses, parent/teacher organizations, youth service bureaus, and juvenile justice personnel in recognizing the signs and symptoms of suicidality and depression; 3) Design and pilot the implementation of a model program to increase the availability, accessibility, and linkages to mental health treatment by embedding services in school-based health and community-based hospital clinics; and 4) Develop a mini-grant program that serves communities statewide through the use of youth driven, positive community youth development approaches.

**Target Population:** Youth and families, young adults, adults and mental health professionals.

**Number of children and families served 2007-2008:** A total of 593 youth & families, 4,061 youth and young adults, 432 adults and professionals were served.

**Program Cost 2007-2008:** \$400,000

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**Program Name:** Local Prevention Council Programs

**Program Description:** The Local Alcohol, Tobacco and Other Drug Abuse Prevention Council Grant Program (LPCP) initiative supports the activities of local, municipal-based alcohol, tobacco, and other drug (ATOD) abuse prevention councils. The intent of this grant program is to facilitate the development of ATOD abuse prevention initiatives at the local level with the support of chief elected officials. The specific goal of this grant initiative is to increase public awareness focused on the prevention of ATOD abuse, and stimulate the development and implementation of local substance abuse prevention activities primarily focused on youth through 120 local municipal and town councils serving the 169 towns and cities in Connecticut.

Local Prevention Councils (LPCs) are advisory and coordinative in nature and reflective of each community's racial/ethnic, political, and economic diversity. Councils include representation from professionals working in the prevention field in general and ATOD abuse prevention in particular. Additionally, council membership includes a cross-section of the community which it serves including city/town agencies, organizations, communities and ethnic groups, parents, media, business, senior citizens, health care sector, etc., concerned with prevention issues. The LPCP initiative is designed to: 1) support the on-going prevention activities of established councils; 2) support specific prevention projects of local councils; and 3) support activities that increase public awareness of the problem of ATOD use and abuse.

**Target Population:** Youth, Adults, Families, Community Professionals

**Number of children and families served 2007-2008:** A total of 52,354 children, adults, family and community professionals were served. A total of 5,025 from the age 4 and under; 16,363 from the age of 5-11; 16,152 from the age of 12-14; 9,344 from the age of 15-17; 2,405 from the age of 18-20; 91 from the age of 21-24 and 2,974 from the age of 25 and older.

**Program Cost 2007-2008:** \$541,665

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**Program Name:** Regional Action Councils

**Program Description:** 14 sub-regional planning and action councils that have responsibility for the planning, development and coordination of behavioral health services in their respective region.

Regional Substance Abuse Action Councils are public-private agencies comprised of community leaders. Its purpose is to establish and implement an action plan to develop and coordinate needed services across the behavioral health continuum. These services are generally described as a continuum of care which includes community awareness and education, prevention, intervention, treatment and aftercare. The members of the Regional Action Council serve as volunteers assisted by professional staff. Members include representatives of major community leadership constituencies: chief elected officials, chiefs of police, superintendents of schools, major business and professional persons, legislators, major substance abuse service providers, funders, minority communities, religious organizations and the media.

**Target Population:** Youth, adults, family, and prevention professionals

**Number of children and families served 2007-2008:** A total of 82,710 children, family and community members, and prevention professionals were served. 8,923 from the age of 4 and under; 6,846 from the age of 5-11; 14,057 from the age of 12-14; 8,880 from the age of 15-17; 4,563 from the age of 18-20; 4,948 from the age of 21-24 and 34,493 from the age of 25 and older.

**Program Cost 2007-2008:** \$1,448,708

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**Program Name:** Statewide Service Delivery Agents

**Program Description:** The Statewide Services Delivery Agents (SSDA), also known as the DMHAS Resource Links, are five entities funded by DMHAS to support prevention efforts across the state by building the capacity of individuals and communities to deliver prevention services. Their target populations include local communities, individuals, and agencies providing prevention programming; regional and statewide service agencies; societal organizations and institutions, e.g. corporate, medical, religious and recreational entities. The Statewide Service Delivery Agents utilize multiple strategies like

information and public awareness, education, community development, capacity building and institutional change, and social policy to promote the health and well being of all Connecticut's residents across the life span. Within the last two years these SSDAs have provided distinct services to move Connecticut's prevention system to align with the blueprint of the Strategic Prevention Framework (SPF).

The Statewide Services Delivery Agents consists of the following entities:

1. Connecticut Assets Network - a network of individuals that promote the integration and successful use of strength-based strategies to build healthy communities and youth.
2. Connecticut Clearinghouse - is a comprehensive information resource center that makes available thousands of books, tapes and printed reports, and provides electronic access to the latest information on substance abuse, mental health and a variety of other issues.
3. Multicultural Leadership Institute, Inc. - is a coalition dedicated to promoting culturally and linguistically proficient services regarding the prevention of ATOD and other related problems among African origin and Latino populations.
4. Governor's Prevention Partnership - is a statewide organization comprising of public/private partnerships designed to change the attitudes and behaviors of Connecticut youths and adults toward substance through its School, Campus, Workplace and Media Partnerships.
5. Prevention Training Collaborative - is to provide prevention practitioners and others in the field of prevention the training needed to obtain and maintain certification status and provide support to individuals looking to increase their knowledge and skills in the prevention area.

**Target Population:** Local communities, individuals, and agencies providing prevention programming; regional and statewide service agencies; societal organizations and institutions, e.g. corporate, medical, religious and recreational entities.

**Number of children and families served 2007-2008:** A total of 9,949 children, family and community members, and prevention professionals were served. A total of 141 from the age of 4 and under; 396 from the age of 5-11; 511 from the age of 12-14; 672 from the age of 15-17; 424 from the age of 18-20; 736 from the age of 21-24; 7,069 from the age of 25 and older.

**Program Cost 2007-2008:** \$1,924,353

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**Program Name:** Strategic Prevention Framework State Incentive Grant (SPF SIG)

**Program Description:** The SPF SIG program is designed to help grantees build a solid foundation for delivering and sustaining effective substance abuse services in order to: prevent the onset and reduce the progression of underage drinking and related problems in communities, and build prevention capacity and infrastructure at the state and community levels.

The overall purpose of the CT SPF Initiative is to develop a comprehensive strategy for delivering and implementing effective substance abuse prevention services. The initiative serves as a blueprint for State and community partners to apply the federal Center for Substance Abuse Prevention's (CSAP) Strategic Prevention Framework towards creating healthy communities for everyone. Twenty eight communities throughout the state including campuses, municipalities and youth serving agencies utilize the SPF blueprint to address underage drinking in 54 towns by conducting needs assessments, developing community capacity, developing strategic plans, implementing programs, policies and practices identified in the plans, and evaluating their outcomes.

**Target Population:** Youth, Adults, Prevention Professionals, Community Members

**Number of children and families served 2007-2008:** A total of 114,723 children, family and community members, and prevention professionals were served. A total of 4,980 from the age of 4 and under; 6,946 from the age of 5-11; 9,061 from the age of 12-14; 13,161 from the age of 15-17; 6,936 from the age of 18-20; 6,331 from the age of 21-24; 67,308 from the age of 25 and older.

**Program Cost 2007-2008:** \$2,350,965

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**Program Name:** Tobacco Regulation & Compliance

**Program Description:** The federal government requires that states enforce and enact laws and implement strategies that reduce underage tobacco use. DMHAS employs a variety of strategies and activities to comply with the federal mandate.

These include:

1. Legislation & Law Enforcement: passing and enforcing youth tobacco access laws
2. Sampling Method & Survey Design: obtaining scientifically valid and reliable measure of tobacco retailer compliance with laws
3. Inspection Protocol & Implementation: following approved inspection protocols for conducting random, unannounced inspection of tobacco retailers
4. Merchant Education: producing and distributing educational and awareness materials for a merchant education program
5. Community Education & Media Advocacy: increasing public awareness on youth tobacco issues through youth forums and focus groups, community mini-grants and a statewide hotline for information and complaints.
6. Community Mobilization: forming coalitions to mobilize community support;

**Target Population:** Youth 0-17, tobacco retail merchants

**Number of children and families served 2007-2008:** During FY 2007 4,815 retail inspections were completed and 3,712 pieces of materials distributed to the general public. Approximately 3,084 children and adults were served through merchant and community education activities in FY 2008.

**Program Cost 2007-2008:** \$647,967

**Long-Term Agency Goals:**

- Provide cost-effective, research based, developmentally appropriate prevention services that promote the health & well-being of children and families
- Increase partnerships with state and local agencies to develop, implement, evaluate and diffuse effective prevention programs and strategies that focus on youth and families
- Increase the cultural ability of prevention program providers to work effectively with youth and parents from culturally, economically and geographically diverse populations

**Strategies:**

- Fund programs based on needs identified by communities
- Implement program standards to monitor the service system
- Develop partnerships with state and local agencies by participating committees and advisory boards
- Increase funding of evidence-based programs that focus on families, early childhood and youth development
- Assess the prevention needs for youth and families across the state
- Explore resources to implement the prevention data infrastructure, policy and program recommendations
- Ensure quality prevention services and assess program effectiveness by providing training and technical assistance and monitoring and evaluating provider activities.

**Performance-Based Standards:**

DMHAS requires that prevention contractors adhere to Prevention Program Operating Standards. These standards establish a minimum level of program operation intended to reflect quality and articulate a service philosophy that promotes health and builds strengths. The purpose of the standards is to provide assurances to the public that alcohol and drug abuse prevention and early intervention programs are regulated under a set of minimum standards established by DMHAS. These standards are divided into 8 categories:

1. Human Relationships – require programs to build relationships among staff, families and communities in order to create strong effective programs
2. Program Planning – requires the development of a logical and systematic process for designing, implementing and evaluating services that fulfill the programs mission
3. Program Activities – requires the provision of skills and knowledge to program participants so that they can make healthy lifestyle choices
4. Program Setting- requires that the physical environment is welcoming, comfortable, organized and well-equipped
5. Health & Safety – requires that the physical environment be healthy and safe
6. Program Implementation – requires organization, sufficient materials and effective communication to move planning into action
7. Program Administration – Requires sufficient resources and oversight to adequately manage the program



8. Evaluation – requires the systematic collection and analysis of data to make informed decisions.

**Performance-Based Outcomes:**

- Increased number of evidence-based programs for youth, families and professionals that focus on youth suicide prevention, tobacco and alcohol use prevention
- A more refined quality assurance process that assesses effectiveness and fidelity of implementation of prevention programs
- An integrated state plan that supports families and communities in youth and early childhood development
- Increased partnerships with state and local agencies
- Increased number of providers trained and receiving technical assistance on cultural competency
- Increased cost-effectiveness

Population Outcomes

- Reduction in the drug/alcohol use
- Reduction in suicidal behavior among high school students
- Increased employment or school retention
- Decreased criminal justice involvement
- Increased social connectedness

Program Outcomes

- Increased enforcement of alcohol laws
- Reduction in retailer violation rates for tobacco sales to minors

**Performance-Based Accountability:** Prevention program contractors complete program information and measures during the biannual contract renewal process. An action plan that identifies strategies to be used to meet objectives is also completed. Monthly process data are reviewed and monitored. Program changes are tracked via a fidelity tool. Quarterly telephone meetings are held to discuss progress and identify issues or technical assistance needs. Yearly site visits are made to validate activities and continued capacity and substantiate the need for continued funding. Agencies or programs not meeting objectives are placed on corrective action and closely monitored.

DMHAS will be receiving technical assistance to develop a process for collecting and reporting on program and community-level outcomes.

**Measure of Effectiveness:** In the last 3 years the DMHAS Prevention unit has increased by 50% the number of environmental and other evidence-based programs that focus on youth and their families. With the increase in staff, there were also increases in the number of Prevention partnerships between DMHAS and other state and local agencies. Several plans have emerged from these partnerships, most notably the Early Childhood Partners, Strategic Prevention Framework, Tobacco Use and Prevention and a policy recommendation to align substance abuse prevention and social and academic development through school community and family partnerships. The DMHAS

Prevention Training Collaborative has also increased the number of courses offered to providers.

**Methods:** DMHAS provides Prevention services aimed at increasing the health & wellness of children and their families through funding and assessing its pool of over 160 non-profit providers statewide. To address disparities, DMHAS contracts with the Multicultural Leadership Institute (MLI), a statewide resource in the provision of cultural competent mental health and substance abuse prevention services to assure that all products, activities and services are culturally competent.

**Other:** Where possible, the DMHAS Prevention Unit shares lessons learned and program outcomes and accomplishments with the field at national meetings and conferences.

## DEPARTMENT OF PUBLIC HEALTH

Asthma Program  
Child Day Care Licensing  
Community Health Centers  
Family Planning Program  
Immunization Program  
Injury Prevention Program  
Lead Poisoning and Control Program  
Newborn Screening Program  
Nutrition, Physical Activity and Obesity Prevention  
Oral Health-Home by One Program  
Rape Crisis and Prevention Services  
Tobacco Use Prevention and Control Program  
Women Infant and Children Program  
Youth Violence/Suicide Prevention

**Program Name:** Asthma Program: Pediatric Easy Breathing Program

**Program Description:** The Connecticut Children's Medical Center (CCMC) Asthma Center is conducting *Easy Breathing*, a clinical management program. The program has successfully expanded beyond the original five communities to provide statewide coverage. The *Easy Breathing* program is a professional education program that trains pediatric providers to administer a validated survey to determine whether a child has asthma, to conduct an assessment to determine asthma severity, to utilize treatment protocol guidelines for determining proper therapy, and to develop individual treatment plans. *Easy Breathing* is an asthma recognition and management program that is implemented by primary care providers that documents adherence to the National Asthma Education and Prevention Program Guidelines (NAEPP) standards for asthma care.

**Target Population:** The Connecticut Children's Medical Center (CCMC) Asthma Center completed five years of this *Easy Breathing* clinical management program in five Connecticut communities and their first year expanding the program statewide. For the first year of statewide coverage, 3,350 children have been surveyed, and 14 practices have been trained. Of the 3,350 children surveyed, 846 had asthma and 279 children with asthma were newly diagnosed.

**Number of children and families served 2007-2008:** A total of 3,350 children were served.

**Program Cost 2007-2008:** \$1,000,000

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### Long-Term Agency Goals:

- Health Goals: To ensure appropriate diagnosis and medical management of children with asthma
- Education Goals: To increase awareness that asthma is a controllable disease when properly managed

**Strategies:**

- Expand the current program beyond the original five communities for Easy Breathing Program implementation across the state
- Identify, recruit and train pediatric healthcare practices/clinic sites to conduct the Easy Breathing Program
- Conduct surveillance activities to evaluate effectiveness and adherence to National Asthma Guidelines

**Performance-Based Standards:** The contractor conducts quarterly site visits with the Regional Program Coordinators to review and rectify data issues, training needs and/or implementation problems. Submits quarterly narrative and surveillance data to DPH.

**Performance-Based Outcomes:** Improved asthma diagnosis and medical management by primary care providers for better patient control and self-management based on the National Asthma Education and Prevention Program (NAEPP) asthma diagnosis and treatment guidelines from the National Heart, Lung, and Blood Institute.

**Performance-Based Accountability:** Documentation of DPH oversight conducted under this contract with the contractor and subcontractors through audits, site visits, quarterly and annual aggregate reports as follows:

- Documentation of technical and professional assistance provided
- Description of the contractor-created, locally managed data quality control program and the actual assistance provided for the management of the Easy Breathing data system, generation of reports at each district
- Documentation of monitoring each participating district for adherence to required Program activities
- Documentation of review of all survey and treatment plan data from each district for consistency and appropriateness
- Documentation of the results of data analysis that include demographics of children surveyed in each community for asthma, by age, race/ethnicity, and number of newly diagnosed children by age, race/ethnicity
- Evaluation results of the effectiveness of the *Easy Breathing* Program in each participating community by analyzing the following process measures and outcome measures over time (quarterly)

**Measure of Effectiveness:**

- At least 95% of children surveyed to have a diagnosis of asthma have a written asthma treatment plan
- At least 95% of children surveyed to have a diagnosis of persistent asthma have an asthma treatment plan which includes anti-inflammatory therapy consistent with NAEPP guidelines.

**Methods:** Surveillance data of all participating children is reported for both Medicaid and non-Medicaid children including race and ethnicity. The program focuses on health care practices in urban areas where there is a higher proportion of asthma hospitalization and emergency department visits and Medicaid enrollment.

**Program Name:** Child Day Care Licensing

**Program Description:** This Program regulates all licensed child day care programs in accordance with required standards established by state statutes and regulations. This is accomplished by providing technical assistance, application processing, facility monitoring, complaint investigation, and enforcement activities. The Program licenses 1,588 Child Day Care Centers and Group Day Care Homes, and 2,642 Family Day Care Homes and is committed to promoting the health, safety, and welfare of Connecticut's children in these licensed facilities.

**Number of children and families served 2007-2008:** 118,458 Licensed Capacity

\*This number does not reflect actual enrollment, as some slots may be under utilized or shared between part-time children.

**Program Cost 2007-2008:** \$2,686,000

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**Long-Term Agency Goals:**

- Program goal: To establish the baseline of quality below which it is illegal for licensed family day care homes, group day care homes, and child day care centers to operate.
- Education goal: To provide technical assistance to license applicants and licensed child day care providers on regulatory issues to improve compliance.

**Strategies:**

- License and inspect child day care facilities.
- Provide resources and technical assistance to providers, upon request.
- Improve the quality of care children receive in licensed day care programs by revising Connecticut's licensing standards to be more in line with national standards and provide technical assistance to licensed programs.
- Collaborate with organizations such as the Departments of Social Services, Education, Children and Families, and the Early Childhood Education Cabinet, Child Day Care Council and the CT After School Network on issues that impact the Early Care and Education System and improve quality in child care settings.

**Performance-Based Standards:**

- Meet statutory requirements for inspections of licensed day care facilities: Inspect child day care centers and group day care homes every two years; inspect 1/3 of licensed family day care homes annually.
- Conduct complaint investigations.
- Take enforcement action against non-compliant facilities, as necessary.
- Meet statutory requirements for providing technical assistance on regulatory issues.

**Performance –Based Outcomes:**

- Continue the process to revise child day care regulations with improved health and safety standards.

- Fifty-five technical assistance activities conducted from 7/1/07 – 6/30/08 served 5,514 child care providers and applicants.
- The department consistently exceeds inspection goals for licensed child care facilities. From 7/1/07 – 6/30/08, 916 compliance monitoring inspections of family day care homes were required, 1415 inspections were completed; 802 compliance monitoring inspections of child day care centers and group day care homes were required, 881 inspections were completed.
- All complaints inspections include unannounced site visits. From 7/1/07 – 6/30/08 there were 1,242 complaint investigation inspections involving licensed and illegally operating child day care facilities.
- From 7/1/07 – 6/30/08, 123 enforcements against licensed or illegally operating child day care facilities were taken.

**Performance-Based Accountability:** The Department of Public Health is the state agency responsible for the regulation and monitoring of licensed child day care facilities in accordance with the following statutes and regulations:

- C.G.S., Sec. 19a-80; Sec. 19a-87b
- Public Health Code, Sec. 19a-79-1a through 19a-79-13
- Public Health Code, Sec. 19a-87b-1 through 19a-87b-18

**Measure of Effectiveness:** The Child Day Care Licensing Quality Enhancement Unit coordinates enforcement actions for child day care programs. Regulatory actions are posted quarterly on the Department's website.

**Methods:**

- Application and license renewal reviews
- Unannounced compliance monitoring inspections
- Complaint investigation inspections
- Technical assistance activities, including on-site assistance during inspections, office meetings, workshops, web page updates, and articles on regulatory issues in *All Children Considered*, a newsletter funded by the Department of Social Services and Published by the UCONN Cooperative Extension Service that is distributed to licensed and license exempt child care providers.

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**Program Name:** Community Health Centers

**Program Description:** The purpose of the Community Health Center program is to assure access to comprehensive primary and preventive health care services and improve the health status of the underserved and vulnerable populations in CT. Thirteen health care corporations receive partial funding through the Connecticut Department of Public Health to provide comprehensive preventive and primary health care services through Community Health Centers located in 30 towns throughout CT. As safety net providers, they deliver health care to individuals enrolled in Medicaid and Medicare as well as the underinsured and uninsured from birth through old age. Ten of the corporations are Federally Qualified Health Centers (FQHCs) that receive funding authorized by Section 330 of the Public Health Service Act. The other 3 meet FQHC program requirements but do not receive Section 330 funding. Community Health Centers (CHCs) serve as the

medical home and family physician for many of the poor, underserved, vulnerable, and at risk for poor health status people who live in communities throughout Connecticut. They offer comprehensive, community-based, primary and preventative health care including pediatric, adolescent, adult and geriatric health care, prenatal and postpartum care as well as supportive services such as translation, transportation, case management, health education, social services and culturally sensitive healthcare. Depending on the availability, many offer dental care, mental health and addiction services, school based health care and outreach programs.

**Target Population:** The residents of Connecticut not limited to those who are uninsured, underinsured or underserved. Services are provided across the lifespan.

**Number of children and families served 2007- 2008:** In 2007, Connecticut Community Health Centers served over 241,090 patients with over 1,098,032 visits. 64% of health center patients had family incomes under 100% of the Federal Poverty Level. (Note: United Community and Family Services, Inc. in Norwich, does not collect this information for all clients) and 33% were children <15 years and 22% were women between the ages of 15-44.

**Program Cost FY 2007-2008:** \$7,779,643

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**Long-Term Agency Goals:**

- Health Goals: To increase access to comprehensive, family-oriented community based health care to all who seek it, regardless of their ability to pay.
- Education Goals: To increase awareness of the mission of community health centers.

**Strategies:**

- Improve access to Primary and Preventive Care.
- Provide cost-effective and high-quality care.
- Assist in the reduction of health disparities.
- Provide effective management of chronic illness.
- Improve birth outcomes.

**Performance-Based Standards:** The contractor submits quarterly narrative and surveillance data to DPH.

**Performance-Based Outcomes:** Increase in unduplicated patient visits and medical management for low-income and uninsured clients.

**Performance-Based Accountability:** Documentation of DPH oversight conducted under this contract with the contractor through audits, site visits, quarterly and annual aggregate reports.

**Measure of Effectiveness:**

- Percentage of pregnant women beginning prenatal care in the first trimester.
- Percentage of children with 2nd birthday during the measurement year with appropriate immunizations.

- Percentage of women 21-64 years of age who received one or more Pap tests during the measurement year or during the two years prior to the measurement year.
- Percentage diabetic patients whose HbA1c levels are less than or equal to 9 percent.
- Percentage of adult patients 18 years and older with diagnosed hypertension whose most recent blood pressure was less than 140/90.
- Percentage of births less than 2,500 grams to health center patients.

**Methods:** Data of all unduplicated patients and patient visits is reported including age, sex, race/ethnicity, insurance status and federal poverty level.

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**Program Name:** Family Planning Program

**Program Description:** Twelve Family Planning Clinics (FPC) are funded by the Connecticut Department of Public Health through a contract with Planned Parenthood of Connecticut, Inc. Total DPH funding to FPCs equals \$1,099,438. The purpose of the Connecticut Department of Public Health Family Planning Program is to provide preventive and primary reproductive health care through health care services, information, and education to the uninsured or underserved individuals, both male and female, in CT.

**Target Population:** In 2007, the twelve DPH funded Family Planning Clinics served: 32,092 patients; 94% females, 6% males. Of the females served 27% were teens (ages 14-19).

- The race of the female patients served was identified as 56% White-non Hispanic, 15% Black- non-Hispanic, and 2% Asian/Pacific Islander. A total of 24% of the female patients served reported Hispanic ethnicity.
- Of the male patients served, the race was identified as 45% White-non Hispanic, 25% Black- non-Hispanic, and 0.7% Asian/Pacific Islander. A total of 23% of the male patients served reported Hispanic ethnicity.
- Of all clients served, 50% were Uninsured (Self-pay/No pay), 20% had private insurance, and 21% had public insurance and 9% had another funding source.
- Of all clients served, 7.5% were between the ages of 10-14, 25% were between ages 15-19, 15% between ages 20-21, and 55% were adults 22 years or older.

**Number of children and families served 2007-2008:** A total of 32,092 participants served.

**Program Cost 2007-2008:** \$1,099,438

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**Long-Term Agency Goals:** To increase access to comprehensive family planning and health care, to all who seek it, regardless of their ability to pay.

**Strategies:**

- Improve access to Primary and Preventive Care.
- Provide cost-effective and high-quality care.
- Expand community education and outreach services.
- Assist in the reduction of health disparities.



- Improve birth outcomes.

**Performance-Based Standards:** The contractor submits quarterly narrative and surveillance data to DPH.

**Performance –Based Outcomes:** Increase in unduplicated patient visits and family planning services for low-income and uninsured clients.

**Performance-Based Accountability:** Documentation of DPH oversight conducted under this contract with the contractor through audits, site visits, quarterly and annual aggregate reports.

**Measure of Effectiveness:** At least 60% of eligible clients received reproductive health care services regardless of their ability to pay.

- At least 90% of female patients with a preventive reproductive health exam received a Pap test.
- At least 90% of female patients with a preventive reproductive health exam received a clinical breast exam.
- At least 85% of female patients with a preventive reproductive health exam received a screening for Chlamydia trachomatis and gonorrhea.
- At least 80% of clients with a preventive reproductive health exam received AIDS Education, behavioral counseling, and information on HIV testing sites.

**Methods:** Data of all unduplicated patients and patient visits is reported including age, sex, race/ethnicity, insurance status and federal poverty level.

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**Program Name:** Immunization Program

**Program Description:** The State of Connecticut Immunization Program's mission is to stop the spread of diseases that are vaccine preventable. The following means are used to achieve this goal: providing vaccine to the residents of Connecticut, educating the medical personnel and the public on the importance of vaccinations, working with providers using the immunization registry to assure that all children in their practice are fully immunized, assuring that children who are in day care, Head Start, and school are adequately immunized against diseases that are harmful and sometimes deadly, and conducting surveillance for vaccine-preventable diseases to evaluate the impact of vaccination efforts and to identify groups that are still at risk of vaccine-preventable disease.

**Target population:** Program serves 0-18 year old population. Population estimate for 2008 is 854,221 children.

**Number of children and families served 2007-2008:** According to the 2007 National Immunization Survey (NIS), 86.8 % of the states' two year olds were up to date on their immunizations comprised of a series of 4 doses of DTaP, 3 doses of Polio, 1 dose of MMR, 3 doses of HiB, 3 doses of Hepatitis B, and 1 dose of varicella vaccines (4:3:1:3:3:1). Connecticut had the fourth highest immunization coverage rate among all states and continues to rank among the top five states nationally since the 1990's. CT has

also met the Healthy People 2010 goals for effective vaccination coverage levels for universally recommended vaccines for young children for the following vaccines:

- 3<sup>rd</sup> highest coverage for 4+ DTaP among all states at 91%
- highest coverage for 3+ Polio among all states at 97.9%
- the coverage rate for 1+ MMR decreased from 96.5% to 95.3%
- 5<sup>th</sup> highest coverage for 3+ Hib among all states at 96.8%
- 4<sup>th</sup> highest coverage for 3+ HepB among all states at 97.5%
- 4<sup>th</sup> highest coverage for 1+VAR among all states at 94.2%
- 2<sup>nd</sup> highest coverage for 4+PCV7 among all states at 88.8%

The 2007 NIS survey included children born January 2004 through July 2006.

**Program Cost 2007-2008:** \$45,460,155

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**Long Term Agency Goals:** The Department of Public Health (DPH) works proactively to protect the health and safety of the people of Connecticut and to prevent disease and promote wellness through education and programs such as prenatal care, newborn screenings, immunizations, nutrition and supplemental foods, AIDS and sexually transmitted disease awareness. Reducing health disparities in maternal and child health remains one of the agency's highest priorities. DPH selected its prevention programs for inclusion in this report based on a focus on children birth to age eighteen. These initiatives also impact the families of these children, either directly or indirectly. The selected programs are preventive in nature, provide education and information to families that promote healthy behaviors, attempt to reduce crime and violence, promote academic success, and discourage socially destructive behaviors. The Immunization Program seeks to:

- Prevent disease, disability and death from vaccine preventable diseases in infants, children and adolescents through surveillance, case investigation and outbreak control, vaccination, monitoring of immunization levels, provision of vaccine, and professional and public education
- Identify where our pockets of under immunized children continue to exist in our major urban centers by utilizing our state immunization registry data.

**Strategies:**

- Implement disease prevention and health promotion of women, infants and children including children and youth with special health care needs
- Identify and nurture community-based health and prevention initiatives through public and private partnerships
- Provide funding to community-based providers to implement prevention programs at the local level, including school-based and community health centers
- Through Community-Based Health Centers, assure the availability and accessibility of comprehensive primary and preventative health care and other essential public health services for low-income uninsured and vulnerable children and families in underserved areas

- Conduct surveillance activities to continuously monitor the effectiveness of the agency's prevention initiatives
- Collaborate with other state agencies to cut across agency boundaries and combine programmatic and funding efforts to improve outcomes
- Establish and coordinate the DPH's Virtual Children's Health Bureau to capture the overarching programs and initiatives throughout the agency
- Promote the use of asthma management plans by health care providers and parents of asthmatic children, address the early identification of children with asthma and work to develop a state asthma plan and enhance asthma surveillance activities
- Provide nutrition education to parents, pre-school children, and teachers in Head Start and School Readiness programs, and provide workshops to enable teachers to integrate nutrition education into their lesson plans and curriculum, and to educate parents on feeding healthy food to their children
- License and regulate child day care facilities and offer resources and technical assistance to providers
- Improve the quality of care children receive in licensed child day care programs by revising Connecticut's licensing standards to be more in line with national standards and provide technical assistance to licensed programs
- Work with organizations such as the Child Day Care Council and the CT After School Network to develop draft regulations, staff training, and assure inspection goals are met in accordance with state statutes
- Ensure that state-of-the-art emergency medical care is available for all ill or injured children or adolescents, and that pediatric services are well integrated into an emergency medical service system
- Prevent disease, disability and death from vaccine preventable diseases in infants, children and adolescents through surveillance, case investigation and outbreak control, vaccination, monitoring of immunization levels, provision of vaccine, and professional and public education
- Conduct comprehensive lead poisoning prevention programs to reduce the risk of lead exposure
- Screen all newborns for genetic and hearing disorders prior to hospital discharge or within seven days of birth to help prevent severe health and developmental consequences
- Through Oral Health initiatives, increase entry into long-term comprehensive dental services for Medicaid, SCHIP, and other underserved children and develop a best practice model for sealant programs
- Make available to sexual assault victims and their families free and confidential services such as crisis intervention, support and advocacy, survivor groups, 24-hour hotline, and emergency transportation
- Through collaborative effort between Injury Prevention Program and CT Safe Kids, provide child passenger safety workshops to health care and childcare professionals to increase provider capacity as effective educators on child passenger safety
- Provide a variety of services to adolescents to reduce the transmission and incidence of selected sexually transmitted diseases
- Address all risks associated with the use of tobacco products focusing on youth, pregnant women, disparate populations and environmental tobacco smoke
- Provide nutrition education and supplemental food to eligible women, infants, and

children through the WIC and Nutrition Programs

- Provide professional education, technical assistance and program development targeted toward youth violence prevention
- Identify where our pockets of under immunized children continue to exist in our major urban centers by utilizing our state immunization registry data.
- Improve the quality and comprehensiveness of care by promoting co-located care coordinators at community-based home for children and youth with special health care needs

The role of DPH is to address prioritized needs and gaps in services for the target populations. Services provided by community-based programs include case management, outreach, disease prevention, education, and the empowering of maternal and child health populations about health and health-related issues. The combination of ongoing assessments, quarterly reporting data, technical assistance meetings and site visits assist DPH in determining priorities.

**Outcomes:**

- 1.8 million newborns have been screened prior to hospital discharge and 941 identified with genetic disorders to allow treatment to be promptly initiated to avert complications and prevent irreversible problems
- Inception of newborn hearing screenings at birth in 2000 has identified 360 babies with hearing loss, with the average age of diagnosis dropping from 2 ½ years to 2 months, and in 2005, Connecticut conducted hearing screenings on 99% of newborns
- Coordinated prevention and intervention efforts with parents and health professionals as partners lead to improved health and school readiness
- Revision of child day care regulations with improved health and safety standards, staff training opportunities, number of technical assistance opportunities conducted, and the number of inspections and investigations completed
- Every child, their parents, and all pregnant women in Connecticut will have access to comprehensive, preventive, continuous health care
- All children will have access to affordable, healthy, safe, and developmentally-appropriate early care and education with comprehensive support services that facilitate effective transitions from birth to Kindergarten
- All families will have access to the information and resources they need to raise healthy children, and parents will be involved as partners in the planning of early childhood services
- Effective local or regional early childhood collaborative structures will ensure the provision of integrated services
- A state level infrastructure with community representation will guide, support, and monitor implementation of a comprehensive, integrated system of services for children and families
- Data integration among agency programs will allow for seamless retrieval of information

**Measure of Effectiveness:**

**Infant Mortality** - Programming within the Department of Public Health (DPH) to reduce infant mortality includes the fetal and infant mortality review programs in five communities.

- African American/Black babies consistently have had higher infant mortality rates than White and Hispanic populations in Connecticut and in the U.S. In 2006, the infant mortality rates for African Americans/Blacks was 14.6 per 1,000 live births, substantially higher than the rates for Hispanics (7.2 per 1,000) and for Whites (4.5 per 1,000).

**Births to Teens** – State programs serve pregnant women (including teens) provide intensive case management services with emphasis on promoting positive pregnancy outcomes and parenting.

- The 2006 teen birth rate was 23.4 per 1,000 teens age 15-19 yrs old, with the highest rates among Hispanic teens (78.1 per 1,000), followed by African American teens (46.6 per 1,000). The very slight increase from 2005 to 2006 is much less than that nationally.

**Prenatal Care** – DPH strives to improve access to prenatal care through several strategies, such as supporting sites for primary care and free pregnancy testing at family planning clinics.

- In 2006, 85.8% of infants were born to CT resident women who began receiving prenatal care in the first trimester. African American (25.3%) and Hispanic (24.9%) women were approximately 3 times more likely to receive late/no prenatal care compared to White (8.5%) women in 2006.
- In 2006, 19.9% of CT resident women received non-adequate prenatal care. African American and Hispanic women were 1.7 times more likely to receive non-adequate prenatal care than White women.

**Methods to Reduce Health Disparities:** Reducing disparities in maternal and child health indicators remains one of the major challenges facing the public health community, and DPH utilizes multi-level strategies that include:

- Addressing health disparities by targeting low-income families and encouraging them to participate in screenings, prevention activities such as immunizations and oral health, and HUSKY
- Improving the number and capacity of providers in underserved communities by functioning as liaison in the recruitment and retention of primary health care professionals through a collaboration with the DPH Primary Care Office and the Connecticut Primary Care Association
- Increasing the knowledge base on causes and intervention to reduce disparities by analyzing data on health care practices and use across racial and ethnic groups
- Utilizing the DPH Office of Multicultural Health to raise public and provider awareness of racial/ethnic disparities in health care
- Increase vaccination coverage rates in underserved populations for children living in poverty by utilizing immunization registry data to determine where our pockets of under immunized children continue to exist and develop intervention strategies targeting these children to improve vaccination coverage.

- Increase HPV vaccination coverage in underserved adolescent populations by measuring HPV vaccine uptake among high-risk underserved female adolescent population to reduce cervical cancer incidence among low-income women. This includes developing HPV educational messages for health care providers to address cultural barriers and increase sensitivity to specific ethnic groups that will impact vaccine acceptance.
  - As resources permit, consider addressing the recommendations of the Connecticut Health Foundation's Policy Panel on Racial and Ethnic Disparities which include:
    - Collect and integrate racial and ethnic data to its statewide planning efforts and publish a report on the key findings
    - The Office of Health Care Access and DPH should require health care organizations, including providers and payers, to collect data on each patient's primary language in health records and information systems, and post signage in the languages of the patients they serve
    - Establish a certification program for all medical interpreters to ensure cultural competence and quality service
    - Establish a system for monitoring and enforcing PA 00-119 regarding linguistic access in acute care hospitals
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**Program Name:** Injury Prevention Program

**Program Description:** The Program's goal is to reduce death and disability among children and adults from unintentional injury including motor vehicle crashes, falls, fire/burns, drowning and poisoning. The Program provides technical assistance and resources to providers and community agencies on injury prevention issues. The Program works closely with other agencies, and injury related coalitions to raise awareness, and develop and implement injury prevention programs and policies. Through the Maternal and Child Health Block Grant, the Program collaborates with Safe Kids Connecticut to provide child passenger safety training to health care, childcare and other service providers and provide education and booster seats to low-income families. The geographic service area is statewide

**Target Population:** There are 436,311 children aged birth to nine years of age in Connecticut (CT DPH 2005 population estimates). An estimated 25% of children (109,077) in Connecticut live in low-income households (below 200% Federal poverty level).

**Number of children and families served 2007-2008:** The program served 213 parents/caregivers, 238 children, and provided training for 92 service providers in 07-08.

**Program Cost 2007-2008:** \$40,000

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**Long-Term Agency Goals:** Reduce deaths and disabilities due to unintentional injuries among children in Connecticut.

**Strategies:**

- Contract with Safe Kids Connecticut for child passenger and transportation safety training and resources to health care, childcare and other service providers and provide education and booster seats to low income families.
- Collaborate with other State Agencies, including the Department of Transportation, Department of Consumer Protection, Department of Social Services, Department of Education, and coalitions such as Safe Kids Connecticut to raise awareness and develop injury prevention policies and programs.
- Develop and disseminate surveillance data on fatal and non fatal injuries in CT.

**Performance-Based Standards:** Training programs are based on national safety curricula developed by child passenger safety experts, and are regularly reviewed to ensure that they meet current “best practice” Standards. Nationally certified child passenger safety instructors or technicians deliver the training and educational programs and work with families to ensure that child safety seats and booster seats are correctly installed and used.

**Performance –Based Outcomes:** Health care, child care community service providers and parents report increased awareness of measures to prevent injuries to children in motor vehicle crashes.

**Performance-Based Accountability:** Contractor is required to submit periodic reports on program activities and outcome measures.

**Measures of Effectiveness:** Pre-Post evaluation surveys are used to measure increases in provider knowledge.

**Methods:** The Injury Prevention Program works closely with the contractor Safe Kids Connecticut and other partners to identify and insure that providers serving low-income families receive child passenger safety training.

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**Program Name:** Lead Poisoning Prevention and Control Program

**Program Description:** To protect the health and safety of the people of Connecticut and to prevent lead poisoning and promote wellness through education and a wide range of program activities that relate to lead poisoning prevention and in particular, childhood lead poisoning prevention.

**Number of children and families served 2007-2008:** A total of 270,187 children under the age of six years old.

**Program Cost FY 2007-2008:** \$2,931,834

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**Long-Term Agency Goals:**

**Health Goals:** The Connecticut Lead Poisoning Prevention Control Program (LPPCP) is

committed to reducing and eliminating lead poisoning in Connecticut children less than six years of age by 2010. The LPPCP will increase the monitoring of demographic and socioeconomic status of the high-risk populations being tested in Connecticut in order to evaluate the screening rates among these high-risk populations.

**Education Goals:** The LPPCP will increase the awareness of lead poisoning prevention by providing educational messages to the community (private and professional) about lead poisoning and lead poisoning prevention through monthly newsletters, two (2) educational conferences, and six (6) outreach and education opportunities.

**Case Management (Environmental and Child) Goals:** The LPPCP will maintain the number of audits and assistance visits conducted at contracted local health departments of 13 per year thereby maintaining oversight, surveillance, and LHD adherence to program protocol and statutory and regulatory mandates.

**Health Strategies:**

- **Annual Activity 1:** The LPPCP will develop a "findings" document that identifies screening rates of all children being tested, including the high-risk populations (Annual Surveillance Report).
- **Annual Activity 2:** The LPPCP will provide the Annual Surveillance Report, via e-mail, to approximately 45 Strategic Partners (including the Legislative Public Health Committee) and post the report on the LPPCP website.
- **Annual Activity 3:** The LPPCP will develop a document that identifies quality assessment/quality assurance measures, and any required correction of laboratory issues.
- **Annual Activity 4:** The LPPCP will review the specific issues of the "findings" document with the laboratory directors so they can revise their quality assurance measures on a large scale.
- **Annual Activity 5:** The LPPCP will review data submitted to DPH to evaluate whether the laboratories are complying with their specific laboratory issues in the "findings" document.

**Education Strategies:**

- **Annual Activity 1:** The LPPCP will publish monthly newsletters that will provide current prevention and regulatory information to the lead poisoning prevention community.
- **Annual Activity 2:** The LPPCP will conduct two educational conferences with targeted specialty sessions for local health department personnel, health care partners and regulatory authorities so that current information on childhood lead poisoning prevention may be disseminated on a widespread basis.
- **Annual Activity 3:** The LPPCP will develop six (6) outreach and education opportunities with elementary and preschools, Family Resource Centers, School Readiness programs, Head Start, Parent Teacher Organizations, School Nurse Organizations, and high schools with teen parents.

**Case Management Strategies:**

- **Annual Activity 1:** The LPPCP will conduct at least 3 audits and/or assistance visits to local health departments per quarter.



- **Annual Activity 2:** The LPPCP will submit written reports of findings to all agencies that received audits.
- **Annual Activity 3:** The LPPCP will review information submitted to DPH to evaluate whether the local health department is complying with the recommendations of the audit or assistance visit.

#### **Performance-Based Standards:**

- Elimination of lead poisoning - to decrease the rate of children under six years old residing in CT with blood lead levels of 10 µg/dL or above to less than 1%
- Screening of all children at ages 1 and 2 years
- Retesting of children (of any age) with blood lead levels greater than or equal to 10 µg/dL

#### **Performance-Based Outcomes:**

- The screening rates of children will increase.
- The prevalence of children with elevated blood lead levels greater than or equal to 10 µg/dL will decrease.
- The total number of elevated blood lead level cases greater than or equal to 10 µg/dL will decrease.

#### **Evidence based guidelines** for the LPPCP's intervention guidance includes:

- CDC documents
  - Screening Young Children for Lead Poisoning: Guidance for State and Local Public Health Officials, November 1997
  - Managing Elevated Blood Lead Levels Among Young Children: Recommendations from the Advisory Committee on Childhood Lead Poisoning Prevention, March 2002
- Connecticut Department of Public Health Lead Poisoning Prevention and Control Regulations
- Principal Connecticut General Statutes related to lead poisoning prevention
- Findings from audits of local health department lead poisoning prevention programs.
- Findings from oversight of the local health department case management activities (child and environmental) using the Lead Surveillance System.

#### **Measure of Effectiveness:**

- Increase in the screening rate of all one and two year olds due to newly passed Legislation
- Decrease of the incidence and prevalence of children with elevated blood lead levels greater than or equal to 10 µg/dL

#### **Methods:**

Education/outreach and intense screening efforts are targeted toward urban settings where low income, minority children between 1 and 2-years of age live. Children in this age group are at highest risk for lead poisoning for reasons including lower socioeconomic status, deteriorated lead-based paint in and around their homes, and common toddler behavior (e.g., crawling on floors and putting things in their mouths).

**Program Name:** Newborn Screening Program (Tracking)

**Program Description:** Connecticut State Law mandates that all newborns delivered in Connecticut be screened for selected genetic and metabolic disorders. The aim of this program is to screen all babies in CT prior to discharge from birthing facilities or within the first 4 days of life for early identification of disorders so that medical treatment can be promptly initiated to avert complications and prevent irreversible problems and death. Infants with abnormal screening results are referred to regional treatment centers for comprehensive testing, counseling, education, and treatment services.

**Target Population:** All newborns delivered in Connecticut.

**Number of Infants Served:** Over 1.8 million newborns have been tested since the program began. Blood specimens on infants born in Connecticut are received from 30 birthing facilities. Nurse mid-wife sites were identified that will increase the numbers of infant screening for genetic disease/disorders. In 2007 there were 42,261 births by occurrence resulting in 42,411 infants receiving at least one screen. There were 55 confirmed cases, all of which needed and received treatment.

**Program Cost FY 2007-2008:** \$969,563

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**Long Term Agency Goals:**

The Newborn Tracking System (NBTS) database will continue to be modified to accommodate further potential expansion of additional disorders and to improve data reporting and output capability. Database system enhancements will be developed between the Newborn Screening Program (NBS), the electronic vital records system and the Child Health Profile database to assure that each child born receives a laboratory screen. DPH will continue to enhance the website with additional information. NBS staff will continue to participate and collaborate on the implementation of the CT Genomic Action Plan and regional workgroups.

NBS Tracking program will be fully integrated in the DPH Laboratory Management and Database Infrastructure. Quality improvement reviews will continue 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.

Connecticut currently mandates testing for all of the 29 recommended disorders except Cystic Fibrosis (CF). The current screening panel consists of over 40 diseases. CF Testing is currently provided by the two medical centers Yale and UCONN on a voluntary basis. The CT Public Health Laboratory would perform initial screening, and both hospitals would provide follow-up confirmation laboratory and physical testing in addition to care plans and family counseling. The two CF treatment centers will handle all referrals from their catchment area. It is estimated that approximately 2,200 newborns a year will screen positive and will need further confirmation testing.

**Performance-Based Standards:** Successful newborn screening requires collaboration between the State Newborn Screening Program, health care facilities (hospitals, local

health departments, clinics), health care providers (pediatricians, family practice physicians, nurse practitioners, midwives), and families of newborns. The administrator or other person in charge of any facility of birth or a person assisting the birth of a child not attended by a physician is responsible for assuring that a satisfactory Newborn Screening blood sample is collected from all newborns born in the hospital, or admitted to the hospital within the first twenty-eight (28) days of life and submitted to the State Public Health Laboratory for testing pursuant to section 19a-55 of the Connecticut General Statutes.

The Newborn Screening Program consists of three components: Testing, Tracking, and Treatment. Specimens are collected at birthing facilities and sent to the CT State Public Health Laboratory for testing. The Program's Tracking Unit staff report all abnormal results to primary care providers and assure that referrals are made to the appropriate state-designated regional treatment centers or that repeat specimens are obtained. Yale and Connecticut Children's Medical Center's (CCMC) Sickle Cell Services, Yale and University of Connecticut's (UConn) Genetic Services, and Pediatric Endocrine Services at Yale and CCMC provide comprehensive care services that include confirmation testing, counseling, education and on-going treatment.

**Performance-Based Outcomes:**

- 1.8 million newborns have been screened prior to hospital discharge and ~ 996 identified with genetic disorders to allow treatment to be promptly initiated to avert complications and prevent irreversible problems.
- Newborn Screening Tracking Unit to the Lab results in: an integrated database enhancement system that will enable greater data exchange capability without collecting additional information; implementation of a quality assurance provision and practice; and a streamlined process to Testing, Tracking and Treatment.
- Collaborative partnership with the Maternal and Child Health, Children & Youth with Special Health Care Needs program (CYSHCN) to augment short & long-term follow-up services through the Medical Home model of care coordination.
- Disease condition is managed.

**Strategies:** The NBS program will reintroduce the legislation to include Public Health Cystic Fibrosis screening to the NBS screening panel for legislative consideration and to provide the funding to implement an efficient screening component.

- Revise the Laboratory Newborn Screening Guidelines for Connecticut's Birthing Facilities.
- Hire sufficient personnel to assure abnormal screening referral, and confirmatory testing/treatment/follow-up components of the program are adequately addressed. Hire an additional Nurse Consultant to assume the additional screening responsibilities.
- Develop a contractual agreement with established Cystic Fibrosis Treatment Centers to ensure confirmation testing and treatment for suspect positive and confirmed cases of CF.
- Maintain the Newborn Screening Program's Web-Based Training
- Procure and disseminate information for customers, parents, hospitals, primary care providers etc. (Brochures, website, fact sheets, special projects, etc).

- Prepare the Newborn Screening Program to be moved to the new laboratory facility in Rocky Hill ~2011.
- Work with State Laboratory Architects to assist in the development of an efficient workspace for the Testing and Tracking Units.
- Develop linkage between Laboratory NBS LIMS system and the electronic Vital Records birth certificate database to assure that each child born in CT has received the laboratory NB screening.
- Enable the Primary Care Provider (PCP) to access Laboratory Newborn Screening results for their patients. The NBTS database will continue to be modified to accommodate further expansion of potential additional disorders and to improve reporting & data output capability.
- Ensure confidentiality through the regulatory standards and provisions of CT State General Statutes Sec. 19a-55, clinical Laboratory Improvement Amendments of 1988, 42 U.S.C. 263a (CLIA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

#### **Outcomes:**

- Over 1.8 million newborns have been screened prior to hospital discharge and 996 confirmed diagnosis for a genetic disorder to allow treatment to be promptly initiated to avert complications and prevent irreversible problems.
- Coordinated prevention and intervention efforts with parents and health professionals as partners lead to improved health and school readiness.
- Revision of child day care regulations with improved health and safety standards, staff training opportunities, number of technical assistance opportunities conducted, and the number of inspections and investigations completed.
- Data Integration among agency programs will allow for seamless retrieval of information. Linkage developed between the NBS and the electronic vital records system database assures that each child born receives a laboratory screen.
- Treatment center referrals to the Children with Special Health Care Needs Program for establishing a medical home for the infants with a confirmed diagnosis.

#### **Performance-Based Accountability / Measures of Effectiveness:**

**Connecticut State Statute Sec. 19a-55:** Connecticut State Law mandates that all newborns delivered in Connecticut be screened for selected genetic and metabolic disorders. The aim of this program is to screen all babies born in CT prior to discharge from birthing facilities or within the first 4 days of life for early identification of newborns at risk for these diseases so that medical treatment can be promptly initiated to avert complications and prevent irreversible problems and death. Infants with abnormal screening results are referred to regional treatment centers for comprehensive testing, counseling, education and treatment services.

- Number of Newborns screened
- Number of Newborns with confirmed diagnosis
- Number of Newborns in Treatment

**Maternal and Child Health Bureau Federal Performance Measure for States:**  
***National Performance Measure #01:***

The percent of newborns that received timely follow-up to definitive diagnosis and clinical management for condition(s) mandated by their state-sponsored newborn screening programs.

- Numerator: the number of newborns screened and confirmed with condition(s) mandated by the State sponsored newborn screening program that received timely follow-up to definitive diagnosis and clinical management.
- Denominator: The number of newborns screened and confirmed with condition(s) mandated by the State sponsored newborn screening program.

Objectives were met by assuring that 100% of infants screened as positive with condition(s) received follow-up to definitive diagnosis and clinical management. In 2007, there were 42,261 births by occurrence resulting in 42,411 infants receiving at least one screen. There were 55 confirmed cases, of which needed and received treatment. To date, 908 of presumptive positive screens for Hemoglobin traits were identified (hemoglobin traits are not confirmed).

***Healthy People 2010 Objectives:***

- (Developmental) Ensure appropriate newborn bloodspot screening, follow-up testing, and referral to services.
- Ensure that all newborns are screened at birth for conditions mandated by their state sponsored newborn screening programs, for example, PKU and hemoglobinopathies.
- Ensure that follow-up diagnosis testing for screening positives is performed within an appropriate time period.
- Ensure that infants with diagnosed disorders are enrolled in appropriate service interventions within an appropriate time period.
- (Developmental) Reduce hospitalization for life-threatening sepsis among children aged 4 years and under with sickling hemoglobinopathies.
- (Developmental) Increase the proportion of children with special health care needs who have access to a medical home.

**Methods to Reduce Health Disparities:** NBS program contracts with providers who in part will deliver culturally competent services in the following manner:

- The program or institutional mission and goal statement of contractor shall explicitly incorporate a commitment to cultural diversity;
- Include policies and procedures for the provision of interpreter/translator services;
- Make readily available bilingual staff who can communicate directly with clients in their preferred language, and who are assessed for their ability to convey information accurately in both languages;
- Develop non-English client related materials that are appropriate for the population served by the program;
- Provide signage (in commonly encountered languages) that provide notices and directions to services within the facility;
- Develop policies and procedures to address the needs of the patient population, taking into account factors such as race and ethnicity, age, gender, hearing impairment, visual impairment, physically challenged, mental illness, developmental challenged, and sexual orientation;

- Implement strategies in place to actively recruit and retain a culturally diverse staff (e.g. if the patient population is mainly from minority populations, applicants who are of related minority groups with equivalent clinical expertise as the majority applicants could be assigned more value on the cultural competency scale);
  - Institutionalize policies and procedures to accommodate the ethnic and cultural practices of patients, families and staff;
  - Collect data on the ethnic and cultural characteristics of patients and families served by the program;
  - Provide survey methods of assessing the satisfaction of patients and their families related to cultural diversity.
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**Program Name:** Nutrition, Physical Activity and Obesity Prevention Program

**Program Description:** The Nutrition, Physical Activity and Obesity Prevention Program is partnering with School Readiness and Head Start programs in Connecticut to support young children's social, emotional, physical, cognitive, and language development. While nutrition efforts have typically focused on young children's physical development, the Nutrition, Physical Activity and Obesity Prevention Program provides training for and promotes an approach to classroom learning and mealtime environments at preschools and with families that support young children's social, emotional, cognitive, and language development. We achieve this expanded outcome by equipping School Readiness teachers and parents to use classroom learning experiences and mealtimes to better support young children's capability for self-regulation, experience emotionally connected relationships, and build healthy eating capabilities and life skills.

The Nutrition, Physical Activity and Obesity Prevention Program focuses on three areas:

- Developing and supporting School Readiness teachers' capability and motivation to provide nutrition and physical activity experiences in their classrooms that support young children's learning achievement in the areas of math, science, and language.
- Increasing young children's exposure to healthy foods, increasing the variety of healthy foods offered to them, and increasing young children's ability to eat and enjoy healthy foods and physical activity
- Building teachers and parents' capability to create and maintain healthy mealtime environments. This step was taken to equip and motivate teachers and parents to use mealtimes to build ten healthy eating capabilities and life skills in young children.

The Nutrition, Physical Activity and Obesity Prevention Program supports young children's enjoyment of and capability to learn.

The Nutrition, Physical Activity and Obesity Prevention Program uses a developmentally savvy approach to achieve a positive impact on young children's healthy eating and physical activity. The program achieves its results by focusing on teachers and parents who then use behaviors and strategies that have an impact on young children's eating and physical activity.

**Target Population:** The target population for this Program is age one children enrolled in the Women Infant's and Children Supplemental Food program (WIC)

**Number of children and families served 2007-2008:** In the 2005-2006 fiscal year the Nutrition, Physical Activity and Obesity Prevention Program:

- An average of 70 School Readiness teachers serving a total of 1,050 preschoolers indicated they were using The Adventures of Captain 5 A Day curriculum and were using mealtimes to promote preschoolers' healthy development. Since this data is only being collected from Bridgeport, Hartford, New Haven, and Waterbury School Readiness programs, it does not reflect the use of the curriculum by many other preschools and licensed child care providers in Connecticut.
- 2,424 teachers, parents, and providers and 1,890 children who attended training offered by the Food Stamp Nutrition Education Program.
- 2,570 adults and children who received nutrition education at community media events, health fairs and health expos.
- Additionally, over 200,000 people who were reached with targeted messages through the Community Health Network newsletters.

**Program Cost 2007-2008:** \$760,665

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**Long-Term Goals:**

**Education Goals:**

Increase the number of children who have a developmentally appropriate understanding of healthy lifestyle choices including better nutrition and food choices and engaging in physical activity; are able to make healthy lifestyle choices; are nutritionally and physically sound upon entering school and through their childhood; and are ready to enter school at an appropriate age, learn to read by third grade, succeed in school, and adopt healthy lifestyle behaviors for life.

**Strategies:**

DPH Preschool and Family Nutrition Education and Supplemental Nutrition Assistance Program (SNAP-formerly Food Stamps) Community Partnership Projects:

- Provide 20 minutes of classroom lessons and 30 minutes of structured physical activity 2 times/wk (960 minutes total) with this multi-component *Captain 5 A Day Program* that follows the Social Cognitive Theory.
- Increase the number of School Readiness and Head Start programs and the number of parent groups from School Readiness and Head Start programs receiving training about building healthy mealtime environments.
- Provide 4 direct and 4 indirect nutrition education opportunities with at least 120 Head Start teachers to assure quality delivery of the *Captain 5 A Day Program*.
- Assure integration of nutrition education and physical activity messages from school to home via frequent communications with parents, staff, and teachers.
- Ensure the provision of 30 minutes/day of nutrition education to School Readiness preschoolers in participating programs
- Reach 50% of School Readiness teachers from New Haven, Bridgeport, Waterbury and Hartford via at least one *Captain 5 A Day* workshop and 100% of teachers with 4 indirect nutrition education via newsletters and web-based materials.
- Provide frequent and varied communications with parents, staff, and teachers to assure integration of messages from school to home.

- Annually reach 4600 parents/caregivers via indirect English/Spanish nutrition education (newsletters, web-based materials, take-home activities with their children, healthy food recipes) and/or direct nutrition education (workshops, small group sessions with peer educators). This includes 1200 Head Start and 3400 School Readiness parents/caregivers with 6 indirect nutrition education contacts and 500 parents/caregivers with at least 1 workshop.

The Nutrition, Physical Activity and Obesity Prevention Program (NPAOP), with funding obtained through the Preventive Health Services Block Grant and state funds originated from the Tobacco and Health Trust Fund contracted the following activities:

- Funding was provided to the Norwalk Health Department to create a Community Garden with a purpose of preventing and reducing obesity. The community garden targeted South Norwalk families with children ages 8-18 by providing an opportunity for moderate physical activity and by increasing access to fruits and vegetables. The community garden is located at Fodor Farm, which is a city-owned property, located in South Norwalk, within the MUP area designation. The garden will be open to all Norwalk residents, but we will focus on encouraging the participation of South Norwalk families and organizations (Norwalk Community Health Center, Norwalk Neighbors Helping Teens, Family and Children's Agency, local Churches) serving these families. A sub-committee of the Norwalk Childhood Obesity Prevention Workgroup composed of various local agencies, community groups and residents will oversee the project.
- Funding was provided to CitySeed who are working with the New Haven Food Policy Council to review federal, state, and local policies that affect the ability of public school districts - like New Haven's - to serve fresh, healthy school meals. The Council identified school food and proper childhood nutrition as its current focus and will promote building consensus around the importance of fresh, healthy school meals. The goal is to increase student consumption of fresh cooked foods and fresh fruits and vegetables while decreasing consumption of processed foods served in New Haven schools.
- Funding was provided to Ledge Light Health District who are partnering with the Town of Groton Parks and Recreation to construct an "all inclusive" playground that will increase opportunities for low income children and their families to be physically active and is suitable for those with disabilities and or special needs.
- Manchester Health department established a LIVING WELL after school program which focuses on physical activity and healthy nutrition for students in grades 1-5. The goal of the program is to provide a curriculum of leisure activity and healthy nutrition to enhance the physical, emotional, social, and psychosocial wellbeing of school aged children. Students are exposed to non-traditional activities such as yoga, snow shoeing and water aerobics. Two days a week, dietetic students taught age appropriate lessons on nutrition.
- Northeast Distinct Health Department implemented a nutritional educational program targeting 4th, 5th and 6th graders in Putnam, Thompson and the Putnam Youth Group (approximately 500 students) utilizing the USDA My Pyramid and was integrated into the curriculum. To support classroom training, a field trip to the University of Connecticut Dairy Barns and Dairy Bar was done.
- The Canton health Department conducted a "Heart Health: Learn the facts, decrease the risk" program as part of the Canton School Wellness Policy Team.



- The program targeted families in the school system and employees of the town. Heart health education was provided to children, parents, municipal and school staff on nutrition education, physical activity and healthy lifestyles.
- Milford Health Department staff, community volunteers and local schools implemented and expanded a "Walking School Bus Program" to increase the awareness of physical activity among elementary school students.

### **Performance-Based Standards:**

DPH Preschool and Family Nutrition Education and SNAP Community Partnership Projects:

#### **Healthy Food**

After completion of SNAP Nutrition Education interventions, participants will increase intake of healthy foods by 5%

#### **Physical Activity**

After completion of SNAP Nutrition Education interventions, participants will increase (or decrease) physical activity to balance their individual needs with dietary intake.

#### **Fruit and Vegetable Consumption**

After completion of SNAP Nutrition Education interventions, participants will increase their average daily consumption of vegetables by one-half of cup per day.

After completion of SNAP Nutrition Education interventions, children's preference for vegetables will show measurable changes

After completion of SNAP Nutrition Education interventions, children's willingness to taste and consume targeted fruits and vegetables will show measurable changes.

#### **Resource Management**

After completion of SNAP Nutrition Education interventions, participants will increase their purchase power using SNAP benefits by 5%

#### **Food Safety**

After completion of SNAP Nutrition Education interventions, participants will increase their food safety practices by two per week

### **Measures of Effectiveness:**

DPH Preschool and Family Nutrition Education and SNAP Community Partnership Projects:

- Implementation of the DPH Nutrition Program Preschool Nutrition Education Curriculum has demonstrated increases from one in two children to three in four children willing to taste specific target vegetables. The control group had a decrease from one in two children to one in three children willing to taste target vegetables over the course of the evaluation.
- Implementation of the DPH Nutrition Program Preschool Nutrition Education Curriculum has demonstrated increases from one in four children to one in three children eating a full portion of target vegetables. The control group had a decrease from one in four children to one in five children eating a full portion of target vegetables over the course of the evaluation.
- School-based interventions that improve health behaviors early in life can have sustained effects for adolescents (1, 2) and adults (1).

- The DPH Nutrition Program Preschool Nutrition Education Curriculum follows the CDC Guidelines and social learning theory to the family/community involvement, nutrition and physical education, and nutrition services, and preschool performance standards. Proposed activities and community partnerships support delivery of high-quality programs that improve dietary quality, physical activity of preschool children and their families (3).
- Preschool teachers state the DPH Nutrition Program Preschool Nutrition Education Curriculum enables them to fulfill nutrition and physical activity education in the classroom; take-home assignments facilitate message delivery to the home (5).
- The teachers state the need for structured physical activities within the preschool day. Reaching parents via a menu of activities (take home activities with preschoolers, recipes, newsletters, workshops, and website) increases chances for behavior changes among low-income groups (4,6).
- Outcome assessment shows increases in preschoolers' vegetable intake and structured physical activity across a 5-week (5, 7) and 16-week (8) intervention as a result of implementation of the DPH Nutrition Program Preschool Nutrition Education Curriculum, the latter more sustainable for preschool education.
- Evidence also suggests that the DPH Nutrition Program Preschool Nutrition Education Curriculum, when implemented, has shown success in improving fruit and vegetable behaviors among parents and caregivers (9).
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### **Performance-Based Outcomes:**

DPH Preschool and Family Nutrition Education and SNAP Community Partnership Projects:

#### **Knowledge**

- For children, change in knowledge is measured directly through responses to tests, oral assessment, interactive game questions, observations by program staff and by teachers. These are often completed as pre and post-test designs.
- Change in knowledge of adults is measured by individual responses, responses to group activities, interactive activities and discussions.

#### **Skills**

- Response to tasks involving stated objectives in workshops, group, and interactive computer activities.
- Participants demonstrating increased skills to plan nutritious meals and snacks and improved ability to select healthful foods that increase their food buying power.
- Informal feedback documented by staff reports, proxies (e.g., parents), or teachers/peer educators, and observation toward achieving stated objectives
- Perceived change in skills to achieve stated goals from participants

#### **Behaviors**

- Perceived ability to change behaviors after participation in FSNE activities
- Reported change in behaviors by staff reports, proxies (e.g., parents), or teachers/peer educators, and observation. For example, reported change in children's intake of vegetables by teachers.
- Direct reporting of changes in diet and physical activities through food records, food frequency instruments and physical activity questions completed by the participant or a proxy (e.g., the parent).

### **Performance-Based Accountability:**

DPH Preschool and Family Nutrition Education and SNAP Community Partnership Projects (In partnership with the University of CT Department of Allied Health Sciences):

- Assess the number of SNAP eligible children and adults reached through direct education
- Assess the amount of time teachers in School Readiness and Head Start programs are providing nutrition education to children in their classrooms and during mealtimes
- Assess the nutrition education contacts made outside of preschool programs
- Assess the number of community partnerships/collaborations formed and enhanced to reach those eligible for SNAP
- Assess the minutes of technical assistance delivered to assure quality and consistent nutrition and physical activity education delivered
- Assess the percent of participants surveyed for needs assessment

- Assess the number of collaborations with agencies to prevent duplication of services, gain updated knowledge of new programs and tools, and facilitate effective management of the programs.
- Assess the number of presentations made, type of presentation, number of clients served per presentation, evaluations by participants or proxies
- Assess the number of “train-the-trainer” workshops delivered to teachers in Head Start and School Readiness
- Assess the number of materials prepared and delivered

**Methods:** DPH Preschool and Family Nutrition Education and SNAP Community Partnership Projects:

These projects provide nutrition education to Head Start and School Readiness families through direct education and through training to teachers on the effective delivery of nutrition education to children and creating classroom eating environments that are conducive to healthy eating.

- Head Start programs provide services to families  $\leq 130\%$  of the federal poverty guideline level, including preschool education for children ages 3-5, health assessments/services, and social services for families, including assistance with determining eligibility for federal assistance. Connecticut has over 7,300 Head Start children and their families.
  - School Readiness Programs are state funded education programs for preschoolers. Approximately 75% of School Readiness families are  $< 185\%$  of the federal poverty line. This project targets School Readiness programs in Hartford, Waterbury, New Haven and Bridgeport where all schools meet the 50% free and reduced price meals criteria. Connecticut has up to 4000 School Readiness children in these target areas.
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**Program Name:** Office of Oral Health: Home by One Program

**Program Description:** The purpose of the Home by One Program is to build integrated partnerships with the early childhood community at the state and local levels that focus on oral health as essential to the overall health and well-being of children in the state of Connecticut through the achievement of the following goals: increase the coordination and exchange of oral health information as it relates to overall health among state agencies and community organizations that address early childhood services; increase the number of parents trained as oral health advocates for children and families; increase the number of non-oral-health professionals who are competent in preventive oral health strategies to enhance access to oral health services for at-risk children; expand the number of dental practices and clinics providing dental homes for children, including those with special health care needs.

**Target Population:** The target population for this Program is children one year of age enrolled in the Women Infant’s and Children Supplemental Food program (WIC).

**Number of children and families served 2007-2008:** A total of 25,000 children

**Program Cost 2007-2008:** \$160,000

**Long-Term Agency Goals:**

General dentists routinely accept age one dental visits and provide quality preventive care; children with age one dental visits and a dental home remain caries free on entering school; early childhood providers incorporate oral health preventive strategies into their early childhood interventions; pediatricians and family practitioners routinely conduct oral disease risk assessment and promote age one dental visits during well-child visits; parents trained in oral health advocacy actively promote and support oral health initiatives in their communities and at the state level.

**Strategies:**

- Develop a Perinatal and Child Oral Health Advisory Group to aid in the success of the *Home by One Program* and promote the integration of oral health into early childhood initiatives.
- Attend the Governor's Early Childhood Education Cabinet meetings to promote integration of oral health into early childhood systems development
- Attend the Maternal Child Health (MCH) Advisory meetings and promote a integrated MCH strategies that includes oral health
- Develop an oral health advocacy curriculum and train WIC parents to become oral health community advocates
- Develop curriculum and train pediatricians and/or family practice physicians, in oral health concepts and fluoride varnish application
- Provide oral health training for WIC staff on the importance of age one dental visits and how to incorporate oral health preventive strategies into their nutritional assessments and counseling
- Develop and/or identify training tools for dental practices in the key concepts of dental home, dental risk assessment, age one dental visits and dental referrals from non-dental providers
- Promote dental homes and age one dental visits to dentists statewide and how to become dental homes for WIC children in their communities
- Develop a model medical-dental home collaboration to promote an integrated approach to health care for young children

**Performance-Based Standards:** The National Oral Health Objectives for the Year 2010 (Healthy People 2010 Objectives)

- For two to four year old children there are two primary oral health objectives:\*
- 1. Reduce the proportion of young children with untreated dental decay in their primary teeth to 9 percent.
- 2. Reduce the proportion of young children with dental caries experience in their primary teeth to 11 percent.
- For six- to eight-year-old children there are three primary oral health status objectives:\*
- 1. To decrease the proportion of children who have experienced dental caries in permanent or primary teeth to 42 percent.
- 2. To decrease the proportion of children with untreated dental caries in permanent or primary teeth to 21 percent.
- 3. To increase the proportion of eight-year-olds receiving protective sealing of the occlusal surfaces of permanent molar teeth to 50 percent.

\*Note: the 2007 oral health assessment of preschool (2-4 years old), kindergarten and third grade (6-8 years old) students in Connecticut determined the following:

- 31 percent of preschool children have experienced dental decay.
- Of those with decay experience, 20 percent have untreated decay.
- 41 percent of third grade children have experienced dental decay
- Of those with decay experience, 18 percent have untreated decay
- 38 percent of third graders have dental sealants

**Performance–Based Outcomes:**

- Advisory Group for the Home by One Program has been established and meets regularly
- Health Program Associate, the designee to the MCH Advisory, has attended all meetings since October 2007, has promoted Home by One concepts and activities and has presented an MCH workshop on Oral Health and perinatal issues
- The Project Director (PD) has attended monthly meetings of the Governor’s Early Childhood Cabinet since September 2007 and recommended oral health strategies for inclusion in the Infant Toddler Workgroup for the report to the Cabinet
- The curriculum for advocacy has been drafted, reviewed and will be pilot tested and finalized before the end of the year. The Project Coordinator and has met with the WIC coordinators, nutritionists and dietitians to request their guidance and assistance in identifying parents who may be interested in becoming oral health advocates.
- Several Local WIC staff have received an orientation to the Home by One Program and been provided with tools to facilitate the incorporation and integration of oral health in the WIC risk assessment and nutritional guidance
- Physician curriculum in oral health concepts and fluoride varnish application has been developed, tested and finalized. Four training sessions have been provided.
- A core medical-dental home group has been established and outlined the essential components of the medical-dental home model. A plan for implementation has been developed and medical-dental home sites have been identified. An evaluation consultant has been hired for the medical-dental home model development and measures have been drafted
- Pediatric dentists that are members of the Home by One Advisory have helped to identify general practice dentists to be trained in the key concepts of dental home, dental risk assessment, age one dental visits and dental referrals from non-dental providers. The CT State Dental Association is identifying dentists who are interested in becoming a dental home
- The training consultant has drafted the dental practices curriculum. It is currently pending approval

**Performance-Based Accountability:** Evaluation process for *Home by One* grant including:

- Assess number of early childhood organizations that expand their agenda to include oral health as a result of *Home By One* activities.
- Evaluate the number of families who report having engaged in oral health advocacy for themselves, their children or their families

- Determine the number of *Home By One* presentations completed in pediatric practices, family medicine practices
- Assess the impact of *Home by One* trainings by:
  - Interviewing a sample of staff in practices receiving *Home by One* training to determine impressions of changes in access to dental services
  - Assessing the impact of training by performing chart audit in a sample of *Home by One* trained practices to ascertain evidence of early preventive dental services delivered by pediatric or family medicine provider, fluoride varnish application and successful referral to dental provider
  - Determining the number of dental providers receiving training on treating young children, age one dental visits and serving as a dental home

**Measure of Effectiveness:**

- Number of WIC enrolled children in the Program with a dental visit by age one
- Number of dentists who are dental homes for age one WIC children
- Number of WIC children in the Program that remain caries free
- Number of physicians who routinely incorporate oral disease risk assessment for WIC children into well child visits
- Number of parents in the Program who are engaged in advocacy for oral health for themselves, their children or their community
- Integration of oral health in Maternal and Child Health statewide planning process
- Integration of oral health into statewide oral health planning process
- Integration of oral health into Early Childhood Partners Interventions

**Methods:**

*Home by One Program* was initiated to develop an oral health infrastructure in support of age one dental visits for at-risk children (WIC children) through training and education of physicians, dental professionals, WIC staff, early childhood providers and parents.

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**Program Name:** Rape Crisis and Prevention Services

**Program Description:** Make available to sexual assault victims and their families free and confidential services such as crisis intervention, support and advocacy, survivor groups, 24-hour hotline, and emergency transportation. Services also include community education, training, primary prevention activities, and coordination of services. The program goal is to end sexual violence and ensure high quality, comprehensive and culturally competent sexual assault victim services by offering primary prevention and victim crisis intervention services statewide through the following member service areas: Bridgeport, Danbury, Meriden/Middletown/New Haven, Milford, New Britain/Hartford, Stamford, Torrington, Waterbury, Willimantic/New London.

**Target Population:** Crisis intervention will be provided to women and men over the age of 12 that have ever been sexually assaulted. Primary prevention single and multi session programs will be provided to a broad sector of the state including pre-Kindergarten to college age students, general public, parents, medical professionals, law enforcement, social service providers, elderly, underserved, prison population, people with disabilities, and the lesbian, gay, bisexual, transgender, and intersex population.

**Number of children and families served:** Between the period of July 1, 2007 to June 30, 2008, a total of 18,495 children and youth in the school as well as non-school settings participated in rape prevention and educational sessions. Primary prevention curricula were presented as multi-sessions to 9,772 participants and as single sessions to 8,723 participants. 2,726 primary victims and 1,440 secondary victims were also served during that time period.

**Program Cost 2007-2008:** \$1,025,541

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**Long-Term Agency Goals:**

- Develop a State of Connecticut Sexual Violence Prevention Plan.
- Enhance decision-making and program planning by assessment and utilization of data, resources, tools, and evaluation methods.
- Utilize training and technical assistance to build state and local capacity for primary prevention.
- Enhance sexual violence prevention efforts in targeted populations.
- Increase the numbers of children and youth exposed to primary prevention curricula focused on building healthy relationships.
- Evaluate the cultural relevance and effectiveness of informational material and interventions reflecting primary prevention messages reaching targeted populations.

**Strategies:**

- DPH will collaborate with key partners to convene a Sexual Violence Prevention Planning Committee (SVPPC) with representation by key stakeholders and organizations.
- The SVPPC will assess current data capacity tools and resources, prevention programming, capacity for training, and level of evaluation activities for primary prevention at the state and local levels and make recommendations for implementation.
- The SVPPC will assess technical assistance needs and begin to identify and provide technical assistance and training to targeted populations and organizations.

**Performance-Based Standards:** The SVPPC will establish standards of accountability related to sexual violence prevention.

**Performance –Based Outcomes:** The SVPPC will establish outcomes related to sexual violence prevention. The CDC has provided tools to utilize to help in this process.

**Performance-Based Accountability:** The contractor submits quarterly and annual reports. The contractor performs pre and post-test surveys within primary prevention curricula.

**Measure of Effectiveness:** Over the past several years, the contractor has moved from a risk reduction approach to primary prevention activities. There has also been a shift from single-session to multi-session primary prevention educational sessions. The SVPPC will help evaluate measures of effectiveness of sexual violence prevention efforts.



**Methods:** The SVPPC will help perform a needs assessment of sexual violence prevention methods in the state and assess state and local capacity on prevention efforts and move towards establishing methods to reduce disparities across race, income level, and gender.

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**Program Name:** Tobacco Use Prevention and Control Program

**Program Description:** The Tobacco Use Prevention and Control Program follow the guidelines and recommendations put forward by the Centers for Disease Control and Prevention (CDC) via Best Practices documentation for state-based comprehensive tobacco control and prevention programs. Address all risks associated with the use of tobacco products and exposure to environmental tobacco smoke (ETS), focusing on youth, pregnant women, and disparate populations.

**Target population:** Youth, pregnant women, and disparate populations.

**Number of children and families served 2007-2008:** Local cessation and prevention programs served 8,878 individuals with most services targeted to low socio-economic status participants. Community cessation programs served at least 98 women who responded that they were pregnant at the time they entered the program.

**Program Cost 2007-2008:** \$2,875,637

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**Long-Term Agency Goals:**

To reduce exposure to secondhand smoke and prevent youth initiation of tobacco use.

**Strategies:** To educate parents and children about the hazards of tobacco use and exposure to secondhand smoke by providing examples and statistics on their health effects.

**Performance-Based Standards:** The goal of the prevention programs is to prevent or delay smoking initiation and to reduce participant's exposure to second-hand smoke. More specifically, the objective of the program is to prevent 50% of the non-smoking participants from starting to smoke through the implementation of a model curriculum taught by qualified instructors. The curriculum must adhere to CDC's best practices guidelines and incorporate education regarding the prevention of smoking initiation and the harmful effects of second hand smoke.

**Performance –Based Outcomes:**

- Average age participants smoked first whole cigarette.
- Proportion of participants that never tried a cigarette, not even 1 or 2 puffs.

**Performance-Based Accountability:** Contractors are required to submit periodic progress reports detailing their program activities, and submit deliverables as dictated by their contract. In addition, contractors must submit the results of their outcome measures.

**Measure of Effectiveness:** Contractors will be implementing pre- and post-surveys for determining program effectiveness.

**Methods:** Smoking and smoking-related diseases are higher in certain disparate populations. Through surveillance efforts, we can identify some of them and target services appropriately.

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**Program Name:** The Special Supplemental Nutrition Program for Women, Infants and Children (WIC Program)

**Program Description:** The Connecticut WIC Program serves pregnant, postpartum, and breastfeeding women; infants; and children up to five years of age. The program provides services in four major areas during critical times of growth and development, in an effort to improve birth outcomes and child health: 1) Nutrition Education and Counseling; 2) Breastfeeding Promotion and Support; 3) Referral to outside medical and social services; and 4) Vouchers for healthy foods prescribed by the WIC Nutritionists (WIC food packages). Eligibility is based on both income (up to 185% of the federal poverty level) and nutritional need based on an assessment of health and dietary information. Active enrollment in Medicaid (HUSKY A) qualifies applicants for categorical eligibility in the WIC Program. An analysis of linked birth, WIC and Medicaid records has revealed that participation in the CT WIC Program was responsible for preventing the occurrence of more than 300 low birth weights in the year 2000 among infants of women who participated in the program for at least 12 weeks of their pregnancy. The estimated savings in averted medical costs was \$11.8 million. The WIC Program's promotion and support of breastfeeding, and efforts to prevent childhood anemia also contribute to childhood health and school readiness.

**Number of children and families served 2007-2008:** A total of 45,020 children (as of 9/08) - number of families served is unavailable (12,911 women served in addition to children)

**Program Cost 2007-2008:** \$43,289,010

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**Long-Term Agency Goals:**

**Strategies:** Provide nutrition and breastfeeding education, supplemental food, and referrals for health and social services to eligible women, infants and children through the WIC Program.

**Performance-Based Standards:** Federal and state regulations include a number of prevention related standards that the local agencies must meet, including timeframes for enrolling program applicants; requirements regarding the early and continuous enrollment of pregnant women; policies to ensure that all pregnant women are encouraged to breastfeed, unless medically contraindicated, and provided breastfeeding information and support; requirements to provide information regarding the risks associated with drug, alcohol and tobacco use during pregnancy; and to ensure that children are screened for anemia and lead poisoning by their health care provider.

**Performance-Based Outcomes:**

- At least 70% of pregnant women participating in the WIC Program for a minimum of 6 months gain appropriate weight
- The incidence of low birth weight (LBW) among infants whose mothers were on the WIC Program for at least 6 months during pregnancy does not exceed 6%
- At least 55% of infants whose mothers were enrolled in the WIC Program during pregnancy breastfeed
- At least 25% of infants enrolled in the WIC Program breastfeed for at least 6 months
- The prevalence of anemia among children enrolled in the WIC Program for at least one year does not exceed 9%

**Performance-Based Accountability:**

- Local agencies that sponsor WIC Programs must submit annual program plans that identify measurable outcome and process objectives, and specify action plans and evaluation methods.
- The State WIC office tabulates and provides outcome data to the local agencies twice per year for their use in program evaluation.
- The State WIC office conducts on-site performance evaluations of each local agency at least once every two years.

**Measure of Effectiveness:**

- An analysis of linked birth, WIC and Medicaid records has revealed that participation in the CT WIC Program was responsible for preventing the occurrence of more than 300 low birth weights in the year 2000 among infants of women who participated in the program for at least 12 weeks of their pregnancy. The estimated savings in averted medical costs is \$11.8 Million.
- Between 2001 and 2005 the rates of low birth weight among women who participated in the WIC Program for at least 6 months during their pregnancies was lower than the rates among non-WIC mothers in Connecticut. Among Hispanic and Black (non-Hispanic) mothers, WIC versus non-WIC differences in LBW percents are significantly different for each year from 2001-2005.
- The WIC Program's promotion and support of breastfeeding, and efforts to prevent childhood anemia also contribute to childhood health and school readiness. The breastfeeding initiation rate among infants whose mothers were enrolled in the WIC Program is lower than the rate among all infants born in the state (57.7% and 79.5%, respectively for 2004 births), but it is increasing. The anemia rate among children enrolled in WIC Program for at least a year is lower than the national WIC anemia rate and decreasing (8.9% and 10.1%, respectively, in 2004)

**Methods:** WIC Program benefits and services are provided to all eligible applicants. Each applicant's nutritional needs are assessed and education is provided based on the individual's needs, and the WIC "food package" is tailored to the participant's preferences and needs, within regulatory limits. The birth outcomes reported above attest to the program's success in reducing disparities. The WIC Program is replicating a successful breastfeeding peer counseling program in New Haven, targeting African American women, whose breastfeeding rates are lower than White and Hispanic women enrolled in WIC. A statewide effort to further improve nutrition counseling techniques is underway and is anticipated to reduce disparities in the childhood anemia rates.

**Program Name:** Youth Violence/Suicide Prevention

**Program Description:** Youth violence prevention programs contracted by the Connecticut Department of Public Health (DPH) focus upon increasing knowledge and changing behaviors that are manageable within the limited scope and influence of the programs. Program goals include increasing awareness; recognizing and dealing appropriately with anger, conflicts, peer-to-peer relationships; increasing knowledge regarding the impact of, and risk factors, for violent behavior; decreasing arguments and fighting and providing knowledge of appropriate resources for help. Suicide prevention programs focus on increasing information and awareness of suicide, suicide risk and protective factors and places to go for help.

**Target Population:** The target population for youth violence/suicide prevention programs is middle and high-school aged youth. CT Population Estimate – 2005, for youth ages 10-19 = 494,102.

**Number of children and families served 2007-2008:** A total of 8,356 youth were served.

**Program Cost 2007-2008:** \$45,379

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**Long-Term Agency Goals:** Reduce youth violence.

**Strategies:** Youth violence prevention programs funded under the local health allocation are dependent upon local health departments and districts deciding to use Preventive Health and Health Services Block Grant (PHHSBG) funding for youth violence prevention. Programs are required to follow the program template, which recommends Federal sources and other resources for program development, and are required to report on the outcome measure. The Injury Prevention Program provides technical assistance and contract monitoring to contracted programs.

**Performance-Based Standards:** Programs are required to report on a specific youth violence prevention outcome measure.

**Performance –Based Outcomes:** Ninety-five percent of program participants are able to identify nonviolent alternatives to fighting.

**Performance-Based Accountability:** Contracted programs are required to report on program activities, process and outcome measures. Programs use questionnaires, surveys and/or observation to assess outcome measures including violence prevention related survey instruments from *Measuring Violence-Related Attitudes, Behaviors and Influences Among Youths*- Centers for Disease Control and Prevention publication.

**Measure of Effectiveness:** Contracted programs report that 95-100% of participants are able to identify nonviolent alternatives to fighting. Observation and program specific evaluation tools assess the outcome measure.

**Methods:** Local contractors decide who will participate in the program and report on participant demographic information. Programs are not required to report on income since there are no income requirements for program participation. Because individual program numbers are relatively small, group outcomes are reported. Demographic information documents that disparate populations are reached by violence prevention programs.

## **DEPARTMENT OF SOCIAL SERVICES**

Emergency Shelter for Victims of Domestic Violence  
John S. Martinez Fatherhood Initiative of Connecticut  
Promoting Responsible Fatherhood Project  
Teen Pregnancy Prevention

**Program Name:** Emergency Shelter for Victims of Domestic Violence

**Program Description:** Program participants who are victims of domestic or family violence are provided safe and supportive services in emergency shelters and/or host homes. Generally, the adult, usually the female parent, is the primary contact for the receipt of services. However, primary prevention occurs with the children, who are sheltered with the parent, through mandated shelter based children programs. These programs address emotional and social health issues that are found among child witnesses; many of whom may also have been victimized. Based on the best data available, children who witness domestic violence are more likely to repeat the behavior as adults as either a batterer (mainly males) or victim (mainly females). The shelter based programs for children helps them to address their anger, fear, and other issues in ways that reduce the likelihood of intergenerational transmission of family/domestic violence. The primary goal of the shelter's children program is to provide services to child witnesses/victims of family/domestic violence that address their health and safety needs. Poor people are disproportionately represented as victims/child witnesses of domestic/family violence. Most of the families who use State funded shelters do not have other alternatives. Case management and other shelter-based programs can lead to improved economic circumstances for these families and children.

**Target Population:** Women, young children 0-12 and teenagers

**Number of children and families served 2007-2008:** A total of 888 women, 884 children (0-12) and 84 teenagers for a total of 1,856 served

**Program Cost 2007-2008:** \$3,271,690

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**Long-Term Agency Goals:**

- Provide emergency shelter/host homes for victims of domestic/family violence;
- Provide 24 hour hotline access for victims of domestic/family violence;
- Provide shelter based programs that address the health and safety needs of adults/child witnesses/victims of family/domestic violence; and
- Provide programs and services for child witnesses that help to reduce the likelihood of intergenerational transmission of domestic violence.

**Strategies:** Case management; hotline services; educative counseling; client assessment; crisis intervention; support groups; housing referrals; and safety planning.

**Performance Standards:** Standards for the delivery of services and the circumstances and conditions under which those services are provided to clients are clearly delineated in

the contract. In addition to client/program participant based services, each contract specifies that providers must provide outreach and awareness education about family/domestic violence through collaborations, community education, and house meetings within shelters. Each of these activities must be documented by listing organizations with which the activity has occurred and, for house meetings, by recording attendance lists and meeting dates.

**Performance Based Outcomes:** Actual numbers for the following must be reported: bed occupancy; number of clients with a separate count for children; number of hotline calls, number of house meetings/dates; number and type of activities for children; and outcomes for clients.

**Performance Based Accountability:** Site visits, quarterly and annual reports of activities and accomplishments are submitted to the Department's staff.

**Measure of Effectiveness:** Measuring the effectiveness of intervention strategies used with child witnesses/victims of family violence requires a level of sophistication in research and resources that make this type of finding impossible. Parents' awareness and access to resources aid in their ability to become more self-sufficient. This acquisition of skill and knowledge ameliorate factors related to child poverty.

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**Program Name:** John S. Martinez Fatherhood Initiative of Connecticut

**Program Description:** The *John S. Martinez Fatherhood Initiative of Connecticut* (FI) is a broad-based, statewide effort led by this Department, and is focused on changing systems to improve fathers' ability to be fully and positively involved in all aspects of their children's lives. FI partners include seven state agencies (DOC, DCF, SDE, DOL, DMHAS, DPH, Children's Trust Fund); numerous community-based agencies/programs serving fathers and families; faith-based partners; experts in child development; women's and men's advocates; representatives from Judicial Branch divisions (SES, CCSD, FS); Greater Hartford Legal Aid; community technical colleges; Commission on Children; legislators and the Consultation Center at Yale University.

The Department and its numerous partners support and promote the positive interaction of fathers with their children, understanding that fathers are critical forces in their children's lives, and that they must be acknowledged and assisted with the important role they play -- fathers are a source of love, nurturance and guidance, as well as financial and emotional support. Because financial support is a reality for so many Connecticut fathers, part of the work of Initiative partners is to assist men in being better prepared to support their children financially through employment assistance, arrearage adjustment, and other methods to promote economic stability for fathers and their families.

The Department currently has contracts with six geographically dispersed agencies. Intervention strategies and tactics used by FI providers aim to prevent child poverty, child abuse and neglect, intergenerational poverty, and youth violence among children of program participants. The agencies provide a range of services including preparation for employment, job search assistance and referrals, life skills training, case management, and parenting skills education. Program participants are multi-ethnic, multicultural,

working income, no income, and marginal income men, many of whom have had some involvement with the criminal justice system, DCF, and DSS.

**Target Population:** Noncustodial, divorced, and fathers with shared custody.

**Number of Children and Families Served:** Approximately 400 fathers served annually

**Program Cost 2007-2008:** \$250,000

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**Specific long term goals for the Department are:**

- To provide structured ongoing programs/activities that support the development/retention of parenting skills among noncustodial, divorced, and fathers with shared custody;
- To reduce the level of poverty among children living in single-parent households;
- To support and facilitate healthy child development by providing programs and services for FI program participants that contribute to healthy father-child relationships;
- To promote and support co-parenting, regardless of marital status;
- To foster, through various community based programs and services, economic self-sufficiency for fatherhood program participants and their children;
- To provide programs/services that increase the participants' vocational skills/employability; and
- To provide community based programs and services that sustain co-parenting and successful father-child relationships.

**Specific intended outcomes of DSS' prevention efforts include but are not limited to:**

- Among Fatherhood program participants, a decrease in the number of unemployed and underemployed program participants;
- Increase in the number of children who have healthy relationships with their fathers;
- Increase in the number of gainfully employed non-custodial fathers who contribute to the financial support of their children;
- Decrease in the number of single female headed households who are totally dependent on entitlements;
- Among non-custodial fathers and single mothers, increased awareness of the pivotal role that men play in normal healthy child development and positive psycho-social/educational outcomes for children;
- Increase in voluntary child support payments; and
- Increase in the number and rate of voluntary paternity acknowledgement by unmarried fathers

**Strategies developed to achieve the goals and intended outcomes are:**

- Contract with six geographically dispersed agencies with expertise and knowledge about fatherhood, non-custodial parenting, co-parenting, cultural and ethnic factors in parenting, and proven ability to work with low/no income men;



- In collaboration and partnership with contracted agencies, identify best practices for developing, supporting, and/or improving father-child relationships and parent to parent relationships;
- Provide non-custodial fathers and other Fatherhood program participants with life skills training;
- Provide non-custodial fathers and other Fatherhood program participants with employment training and job placement;
- In partnership with contracted agencies, support and facilitate job development and job retention among Fatherhood program participants;
- Develop and provide knowledge and skill driven father-child activities that foster and support healthy father-child relationships;
- Educate fathers and mothers about the importance of male parent involvement in the lives of children; and
- Develop strategies and practices that, whenever possible, connect unmarried fathers to the gestation/birth process, parenting roles and responsibilities prior to the birth of the child.

**Specific outcomes that may be used to measure the success or strategic effectiveness of the Fatherhood Initiative may consist of:**

- Longitudinal comparison of changes in parent-child relationships, rate and extent of co-parenting (regardless of marital status), and rate of job retention among Fatherhood program participants from ethnic/cultural minority communities;
- Increase in the actual number of early pre-post birth paternity acknowledgements; and
- Positive changes in the rate of voluntary child support payments.

**Measure of Effectiveness:**

- Rate and extent of child support payments among program participants;
- Consistent ongoing employment;
- Reduction in the rate of unemployment and underemployment among program participants;
- Reported rate of co-parenting among program participants;
- Rate of voluntary paternity establishment and acknowledgement among unmarried fathers;
- Actual rate of pre-post birth involvement of unmarried fathers;
- Changes in pay rates/income among program participants; and
- Number of households evidencing an increase in income, resulting in a reduction in child poverty, as a result of the receipt of financial support from non-custodial, divorced, separated, and/or co-parenting fathers.
- Other measures of effectiveness will result from the completion of the grant related evaluation, currently under development.

**Methods:** In progress, however, greater emphasis is being placed on addressing the impact of ethnicity, income, and gender on performance outcomes.

**Program Name:** Promoting Responsible Fatherhood Project

**Program Description:** The Department was awarded a five year five (5) million dollar grant (one million dollars per year) from the Department of Health and Human Services (DHHS)/Administration for Children and Families (ACF) in October 2006. This grant funds the implementation of the Department's "Promoting Responsible Fatherhood" demonstration project. Grant strategies and activities include the three ACF authorized activity areas: healthy marriage, responsible parenting, and economic stability. Under this grant, in partnership with the six state-certified fatherhood programs, the Department has primarily targeted, low-income fathers, new fathers, fathers-to-be, and young fathers who may be single/unmarried, noncustodial, or cohabitating. In addition, couples interested in marriage and/or those who indicate that they are engaged are included in the target population.

The overall goal of the *Promoting Responsible Fatherhood Project* is to provide members of the target populations with a cohesive continuum of services that connects them to programs, resources, and services. Father involvement in the lives of children results in improved economic circumstances, better academic outcomes for children leading to better futures as self sufficient earners, and reduces the likelihood of childhood poverty. The same gains, for children, can also be seen in successful marriages.

**Number of Children and Families Served:** A total of 500 Fathers and 40 Couples

**Program Cost 2007-2008:** \$1,000,000

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**Long-Term Agency Goals:**

- Increase the earning capacity of program participants thereby increasing economic supports for children.
- Increase fathers' knowledge about responsible parenting.
- Increase the level of effectiveness of communication between parents.
- Increase commitment to healthy co-parenting.
- Optimize employability and employment of program participants through training and supportive services.

**Strategies:**

Project services include:

- Enhanced prevention and intervention strategies that promote healthy marriage; and
- Responsible parenting and economic stability.

Program providers/partners will offer standard curricula: "*Exploring Relationships and Marriage with Fragile Families*, *Inside Out Dad* (for incarcerated men), and *24/7 Dad*, for program participants, as an activity in the Healthy Marriage and Responsible Parenting program component.

Other strategic project activities include:

- Development of a curriculum to train DSS and community partners to enhance knowledge and skills in assessing domestic violence, cognitive limitations, and case management (connecting program participants to appropriate services).
- Collaboration with multi-disciplinary partners, statewide, to effectuate change in the conditions and situations that have a negative impact on low-income fathers and couples.
- Partnering with the Connecticut Coalition Against Domestic Violence, the Department's Bureau of Rehabilitation Services, and multiple community based stakeholders in order to ensure the development and provision of programs and services that are ecologically based.
- Contracting with the Consultation Center at Yale University to evaluate the Project.

**Performance-Based Standards:** For this program, the number of participants and the type of services to be provided are specified in each provider contract. In addition, program staff makes site visits, receive and review quarterly reports, and review client based outcome measures in determining providers' programmatic performance.

**Performance-Based Outcomes:** Clients complete before and after surveys related to knowledge about healthy marriage and responsible parenting. An objective assessment of each client's economic condition, educational level, and employment skills is also included. Changes in these factors, positive or negative, determines the extent to which program strategies and interventions are effective. Negative or lack of individual or situational change creates opportunities to review and modify strategies/interventions when indicated.

**Performance-Based Accountability:** This program relies on specific performance based language in the written contracts, reports, site visits, and evaluative outcomes to ensure compliance and accuracy of deliverables.

**Measure of Effectiveness:** The extent to which the effectiveness of *prevention* is evidenced in Promoting Responsible Fatherhood is directly related to participant outcomes including increased child support, improved co-parenting, increased employment among program participants, and increased involvement of fathers with their children.

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**Program Name:** Teen Pregnancy Prevention

**Program Description:** The primary purpose of the Teen Pregnancy Prevention Program is to provide information and enrichment activities to youth between ages 11 and 17 who are at risk for teen pregnancy. Contractors/service providers must use either the Children's Aid Society Carrera Adolescent Pregnancy Prevention Program the Reach for Health (RFH) or the Teen Outreach Program (TOP service learning model. There are two major components of RFH and TOP: volunteerism (teen program participants must volunteer in the community, performing tasks such as tutoring, public beautification, clean-up, etc.) and a structured curriculum that allows the teens to reflect on the volunteer

experience and to address adolescent life issues. Based on available research (Furstenberg and others), teen parents are more likely to depend on public welfare to meet their subsistence needs; children born to teen parents are more likely to become teen parents themselves; children of teen parents are more likely to be impoverished; and marriage rates among teen parents are very low. The poorest children in Connecticut tend to be members of single parent female headed households. This program (1) reduces dependency on public welfare and (2) reduces the incidence of single parent female-headed households. Both of these factors are positively correlated with child poverty.

**Target Population:** At risk youth

**Number of Children and Families Served:** A total of 350 youth were served.

**Program Cost 2007-2008:** \$2,223,368

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**Long Term Agency Goals:** The primary goal is to prevent teen pregnancy. Secondly, the Program provides experiences and activities that support the development of life skills, among Program participants, that lead to making responsible choices in their lives.

**Strategies:**

- Planned supervised community service projects;
- Individual and small group discussions;
- Assistance with access to health care;
- Assistance with personal development through guided interaction;
- Education about the legal, personal, and social responsibilities of responsible parenthood and bearing a child;
- Information and referral;
- Information about reduced risk sexual behavior including postponing sexual involvement, contraception, reproductive health education, life skills and social competency training; and
- Information about personal safety and dysfunctional family patterns.

**Performance-Based Standards:** Contractors/service providers are required to use any of the three standardized curriculums in addition to other services. They are also required to provide case management and individual youth assessments. Contracts clearly specify outcomes and how those outcomes are to be demonstrated or documented. Providers must also report on participation rates and outcome based data, on a quarterly and annual basis.

**Performance –Based Outcomes:**

- Percentage of participants who do not experience a pregnancy;
- Percentage of program participants who evidence understanding of risky sexual behavior based on three program measures of risky sexual behavior; and

- Percentage of program participants who attend school on a regular basis as documented by rate of absenteeism, dropout and academic performance.

**Performance-Based Accountability:** Field visits, provider reports, and participant feedback are used to ensure contract benchmarks and deliverables are aligned with the contractual agreement.

**Measure of Effectiveness:** Program participants who evidence consistent participation in Teen Pregnancy Prevention Programs have a much lower rate of teen pregnancy than their non-Program participant peers.

## OFFICE OF POLICY and MAGEMENT

### Title V Delinquency Prevention Program Governor's Urban Youth Violence Prevention Program

**Program Name:** Title V Delinquency Prevention Program

**Program Description:** The Title V Delinquency Prevention Program provides grants to cities and towns (units of local government) in Connecticut for delinquency prevention and early intervention projects based upon a risk and protective factor approach. This approach calls on communities to identify and reduce risk factors to which their children are exposed and to identify and increase/enhance protective factors which mitigate risk. Risk-focused delinquency prevention provides communities with a conceptual framework for prioritizing the risk and protective factors in their own community, assessing how their current resources are being used, identifying resources which are needed, and choosing specific programs and strategies that directly address those factors.

**Target Population:** Youth in the Meriden and Bloomfield areas that are between the ages of 10 and 18 and are at-risk to involvement with illegal behavior, criminal or status offenses (Families with Service Needs).

**Number of children and families served 2007-2008:** A total of 200 youth were served.

**Program Cost 2007-2008:** \$295,392

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**Long-Term Agency Goals:** The goal of this program is for communities to develop and implement a comprehensive delinquency prevention plan that coordinates and uses existing programs and resources for the purpose of specifically addressing those risk and protective factors which are known to be associated with delinquent behavior within the individual communities. The program seeks to address these factors at the earliest appropriate stage in each child's development. The target population is all, or any group of, at-risk children in a given program community.

**Strategies:** Program communities are to develop a comprehensive delinquency prevention plan that specifically addresses those risk and protective factors which are known to be associated with delinquent behavior within the communities. The strategies must inventory available federal, state, local and private resources and also develop vehicles for making these resources and programs readily accessible to children and families in need.

**Performance Strategies:** Program communities must develop and implement a local delinquency prevention plan that:

- Assesses the prevalence in the community of specific, identified risk and protective factors, including the establishment of baseline data for the factors and a list of priority factors to be addressed;
- Identifies all available resources in the community;

- Assesses gaps in the needed resources and how to address them;
- Establishes goals and objectives along with an implementation timeline; and
- Insures the collection of data for the measurement of performance and outcome of planned program activities.

**Performance Based Accountability:** Program grantees prepare quarterly progress reports and collect evaluation data for the measurement of performance and outcome of planned program activities.

**Performance Based Outcomes:** Program grantees are required to collect the following data elements:

Outputs:

- Number of full time equivalent employees funded with grant funds;
- Number of planning activities conducted; and
- Number of program youth served.

Outcomes:

- Number and percent of program youth exhibiting an increase in school attendance;
- Number and percent of program youth completing program requirements;
- Number and percent of program youth satisfied with the program; and
- Number and percent of program staff with increased knowledge of program area.

**Prevention Effectiveness:** The findings from the past outcome program evaluation suggest that involvement with the Title V Delinquency Prevention Program has a positive influence on youth's attitude towards school. It also appears that the staff and directors of the program derived information of value from their participation in the process evaluation. The collection and interpretation of youth perception data and the development of implementation plans with expert consultation resulted in tangible and positive changes in youth's experiences of the programs.

**Methods:** These programs are required to provide services that are appropriate to the populations they serve.

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**Program Name:** Governor's Urban Youth Violence Prevention Program

**Program Description:** The Governor's Urban Youth Violence Prevention Program is a competitive program for municipalities and nonprofit agencies that propose to serve youth ages 12 to 18 in urban neighborhoods. The purpose of the Governor's Urban Youth Violence Prevention Program is to reduce urban youth violence by providing grants for programs to serve youth ages 12 to 18 years in urban centers. It was created in 2007 by Section 9 of PA 07-4. Funding for this program (\$1,500,000) comes from the state line item in the Office of Policy and Management's budget entitled Urban Youth Violence Prevention and from the U. S. Department of Education to the Office of Policy and Management under the federal Safe and Drug-Free Schools and Communities Act, Governor's Portion.

**Target Population:** The target population for this program is Connecticut youth residing in urban communities who are between the ages of 12 and 18 and are at-risk to exposure or involvement with violent behaviors.

**Number of Children and Families Served 2007-2008:** A total of 2,000 youth were served.

**Program Costs 2007-2008:** \$1,500,000

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**Long-Term Agency Goals:** The goal of this program is to enhance safety in Connecticut urban communities by reducing street violence and promoting community order.

**Strategies:** Implement in the three largest Connecticut urban areas (Hartford, New Haven and Bridgeport) a comprehensive four-team strategy that involves multi-agency, multi-disciplined approach to:

- Directly and swiftly target offenders and associates who engage in community violence;
- Provide resources and services to those who are at high risk to engage in violence; and
- Promote community order through an integrated network of community-based organizations that reinforce non-violent and pro-social attitudes and behaviors.

**Performance-Based Standards:** On a regular basis, the selected agencies receiving funding under the Governor's Urban Youth Violence Prevention Program must collect data on program youth as well as the involvement of their parents. This data includes:

- Attendance and Participation (Youth Sign-In/Sign-Out);
- Youth Demographic Data;
- Youth Process Evaluation Questionnaire;
- Parent Permission Forms;
- Parent Involvement Data; and
- Staff Attendance at Technical Assistance Sessions.

**Performance Based Outcomes:** Program grantees are required to collect the following data elements:

**Outputs**

- Number of youth registered;
- Number of different youth who attend;
- Number of days the center is open;
- Average number of days youth attend monthly;
- Average number of youth served daily; and
- Number of parents participating.

**Outcomes**

- Number and percent of program youth exhibiting an increase in school attendance;
- Number and percent of program youth completing program requirements;



- Number and percent of program youth satisfied with the program; and
- Number and percent of program staff with increased knowledge of program area.

**Performance Based Accountability:** Program grantees prepare quarterly progress reports and collect evaluation data for the measurement of performance and outcome of planned program activities.

**Measure of Effectiveness:** A comprehensive evaluation of the Governor's Urban Youth Violence Prevention Program will be conducted through the analysis of the data elements that the projects are required to collect.

**Methods:** These programs are required to provide services that are appropriate to the populations they serve.



**House Bill No. 5108**

**Public Act No. 07-47**

**AN ACT CONCERNING REPORTING REQUIREMENTS RELATED TO THE CHILD POVERTY AND PREVENTION COUNCIL.**

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsections (f) and (g) of section 4-67x of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(f) (1) On or before **[January 1, 2006, and annually thereafter, until January 1, 2015]** January first of each year from 2006 to 2015, inclusive, the council shall report, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and human services and to the select committee of the General Assembly having cognizance of matters relating to children on the implementation of the plan, progress made toward meeting the child poverty reduction goal specified in subsection (a) of this section and the extent to which state actions are in conformity with the plan. The council shall meet at least two times annually for the purposes set forth in this section.

(2) On or before **[January 1, 2007]** January first of each year from 2007 to 2015, inclusive, the council shall, within available appropriations, report, in accordance with section 11-4a, to the Governor and the joint standing committees of the General Assembly having cognizance of matters relating to appropriations, education, human services and public health and to the select committee of the General Assembly having cognizance of matters relating to children, on the state's progress in prioritizing expenditures in budgeted state agencies with membership on the council in order to fund prevention services. The report shall include (A) a summary of measurable gains made toward the child poverty and prevention goals established in this section; (B) a copy of each such agency's report on prevention services submitted to the council pursuant to subsection (g) of this section; (C) examples of successful interagency collaborations to meet the

child poverty and prevention goals established in this section; and (D) recommendations for prevention investment and budget priorities. In developing such recommendations, the council shall consult with experts and providers of services to children and families.

(g) (1) On or before ~~[November 1, 2006, and on or before November 1, 2007]~~ November first of each year from 2006 to 2014, inclusive, each budgeted state agency with membership on the council that provides prevention services to children shall, within available appropriations, report to the council in accordance with this subsection.

(2) Each agency report shall include at least two prevention services ~~[for the report due on or before November 1, 2006, and the report due on or before November 1, 2007,]~~ not to exceed the actual number of prevention services provided by the agency. For each prevention service reported by the agency, the agency report shall include (A) a statement of the number of children and families served, (B) a description of the preventive purposes of the service, (C) for ~~[the report due on or before November 1, 2007]~~ reports due after November 1, 2006, a description of performance-based standards and outcomes included in relevant contracts pursuant to subsection (h) of this section, and (D) any performance-based vendor accountability protocols.

(3) Each agency report shall also include (A) long-term agency goals, strategies and outcomes to promote the health and well-being of children and families, (B) overall findings on the effectiveness of prevention within such agency, (C) a statement of whether there are methods used by such agency to reduce disparities in child performance and outcomes by race, income level and gender, and a description of such methods, if any, and (D) other information the agency head deems relevant to demonstrate the preventive value of services provided by the agency. Long-term agency goals, strategies and outcomes reported under this subdivision may include, but need not be limited to, the following:

(i) With respect to health goals, increasing (I) the number of healthy pregnant women and newborns, (II) the number of youths who adopt healthy behaviors, and (III) access to health care for children and families;

(ii) With respect to education goals, increasing the number of children who (I) are ready for school at an appropriate age, (II) learn to read by third grade, (III) succeed in school, (IV) graduate from high school, and (V) successfully obtain and maintain employment as adults;

(iii) With respect to safety goals, decreasing (I) the rate of child neglect and abuse, (II) the number of children who are unsupervised after school, (III) the incidence of child and youth suicide, and (IV) the incidence of juvenile crime; and

(iv) With respect to housing goals, increasing access to stable and adequate housing.

Sec. 2. Section 4-67v of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

For [the] each biennial budget for the fiscal years [commencing July 1, 2007, and July 1, 2008] ending June 30, 2008, to June 30, 2021, inclusive, the Governor's budget document shall, within available appropriations, include a prevention report that corresponds with the prevention goals established in section 4-67x, as amended by this act. The prevention report shall:

- (1) Present in detail for each fiscal year of the biennium the Governor's recommendation for appropriations for prevention services classified by those budgeted agencies that provide prevention services to children, youths and families;
- (2) Indicate the state's progress toward meeting the goal that, by the year 2020, at least ten per cent of total recommended appropriations for each such budgeted agency be allocated for prevention services; and
- (3) Include, for each applicable budgeted agency and any division, bureau or other unit of the agency, (A) a list of agency programs that provide prevention services, (B) the actual prevention services expenditures for the fiscal year preceding the biennium, by program, (C) the estimated prevention services expenditures for the first fiscal year of the biennium, (D) an identification of research-based prevention services programs, and (E) a summary of all prevention services by each applicable budgeted agency identifying the total for prevention services included in the budget.

Approved May 22, 2007