Connecticut State Action Plan Table 2026 Application/2024 Annual Report

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Women/Maternal Health					
Improve Access to Health, Dental, and Reproductive Health Care Services	1.1: By 2030, increase the percentage of women of reproductive age (15-44 years) in Connecticut with access to and utilization of comprehensive well-woman preventive care, including medical, behavioral, and reproductive health services by 5%. 1.2: By 2030, increase the percentage of women in Connecticut who received a check-up with a family doctor/primary care provider in the 12 months before pregnancy by 5%. 1.3: By 2030, increase the percentage of women in Connecticut who received a check-up with an OB/GYN in the 12 months before pregnancy by 5%. 1.4: By 2030, reduce the rate of severe maternal morbidity by 10%. 1.5: By 2030, increase the percentage of women receiving dental care during pregnancy by 5%.	1.1.1: Expand and strengthen partnerships with Connecticut healthcare providers, Federally Qualified Health Centers (FQHCs), and women's health clinics to integrate comprehensive preventive care services (medical, behavioral, and reproductive health), including increasing access to well-woman services via mobile care units. 1.1.2: Support the work of the Every Woman Connecticut Learning Collaborative (EWCTLC) and Connecticut Reproductive Justice Alliance (RJA) to ensure that its members have the infrastructure and resources needed to carry out its charge. 1.1.3: Support the work of partners and the CT Reproductive Justice Alliance in assessing quality maternity care, including the current state of mistreatment and access to care, and utilize findings to help create a Strategic Plan to improve quality maternity care. 1.1.4: Promote access to care before, during, and after pregnancy through multimedia campaigns and outreach. 1.1.5: Implement innovative care models that support well-being across the life course. 1.2.1: Collaborate with Access Health CT to promote enrollment in comprehensive insurance plans. 1.2.2: Support school and community-based education on pre-conception health services. 1.3.1: Collaborate with Access Health CT to promote enrollment in comprehensive insurance plans.	SPM ESM 1.1 - Percent of Black clients receiving an annual preventative reproductive health exam that receive a PAP test and/or will be current with receiving the recommended PAP screening schedule, as per ACOG and USPSTF Guidelines SPM ESM 1.2 - Percent of mothers enrolled in MIECHV-funded home visiting programs prenatally or within 30 days after delivery who received a postpartum visit with a healthcare provider within 8 weeks (56 days) of delivery?	SPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	

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	1.6: By 2030, increase the percentage of women of reproductive age (18-44 years) who report good mental health by 5%.	1.3.2: Support school and community-based education on reproductive health services. 1.4.1: Support the implementation of Alliance for Innovation on Maternal Health (AIM) safety bundles across Connecticut birthing hospitals. 1.4.2: Collaborate with the Connecticut Perinatal Quality Collaborative (CPQC) and other related programs to enhance quality of care for mothers. 1.4.3: Support the work of partners and the CT Reproductive Justice Alliance in assessing quality maternity care, including the current state of mistreatment, and utilize findings to help create a Strategic Plan to improve quality maternity care. 1.4.4: Collaborate and support partners and programs that support activities to improve management of conditions and responses to complications during pregnancy and postpartum (e.g., preeclampsia, postpartum hemorrhage). 1.4.5: Support the implementation of Connecticut Urgent Maternal Warning Signs Bracelet Initiative in birthing hospitals to enhance continuity and safety of care across the postpartum period. 1.4.5: Improve management of conditions and responses to complications during pregnancy and postpartum (e.g., preeclampsia, postpartum hemorrhage). 1.4.6: Support the use of the Hear Her Campaign to increase awareness of maternal warning signs. 1.4.7: Participate in Alliance for Innovation on Maternal Health (AIM) project initiatives undertaken by the Connecticut Perinatal Quality Collaborative (CPQC) to expand the adoption of evidence-based patient safety bundles. 1.4.8: Support partners in their activities to increase access to doula and community health worker services for people who are at higher risk of poor			

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		outcomes. 1.4.9: Apply public health surveillance and data analysis findings to improve services, programs and systems, including Maternal Mortality Review Committee (MMRC) findings. 1.4.10: Support the implementation of Alliance for Innovation on Maternal Health (AIM) safety bundles in birthing facilities. 1.5.1: Increase Medicaid dental provider participation by enhancing reimbursement rates. 1.5.2: Support mobile dental clinics and partnerships with Federally Qualified Health Centers (FQHCs) to offer prenatal dental screenings in underserved communities. 1.5.3: Leverage Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) to distribute oral health education and dental referrals. 1.5.4: Utilize social media, community influencers, and doulas to increase awareness of safe dental care during pregnancy. 1.6.1: Title V will leverage/work with current and new partners to determine limitations in trainings, outreach and provider tools for mental health. 1.6.2: Title V will leverage/work with partners to create recommendations to improve trainings, outreach and tools, including trainings around trauma informed care and stigma around mental health. 1.6.3: Incorporate data on mental health in materials for programs and trainings. 1.6.4: Title V will work with partners to determine current limitations in screening, referrals, and treatment in mental health. 1.6.5: Title V will work with programs to create recommendations to			

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		improve screenings, referrals and treatment for mental health. 1.6.6: Increase the capacity of a cross-disciplinary workforce to screen for and promote mental health to ensure timely and effective supports and interventions.			
Improve Comprehensive Reproductive, Prenatal, and Postpartum Care and Education	2.1: By 2030, decrease the percentage of unintended pregnancies among women who have delivered live births by 3%. 2.2: By 2030, increase the percentage of women who have had a discussion with a doctor, nurse, or other healthcare worker about how to improve their health before a pregnancy by 5%. 2.3: By 2030, increase the percentage of pregnant women in Connecticut who receive prenatal care in the first trimester by 5%. 2.4: By 2030, increase the percentage of postpartum women who receive a comprehensive postpartum visit within 12 weeks of delivery by 5%. 2.5: By 2030, increase the percentage of pregnant and postpartum women who receive documented prenatal and postpartum education on key health topics (e.g., mental health, breastfeeding, warning signs) by 10%.	2.1.1: Promote the sustained use of pregnancy intention screening tools across diverse health care and programmatic settings—such as Every Woman CT Learning Collaborative (EWCTLC), state agencies, and Healthy Start programs—to routinely engage patients in conversations about their reproductive goals. 2.1.2: Deliver evidence-based teen pregnancy prevention education to youth by strengthening collaborations with the Personal Responsibility Education Program (PREP), the Adolescent Services Program at the Hospital of Central Connecticut (HOCC), and the new Help for Kids reproductive and perinatal case management initiative. 2.1.3: Increase access to and utilization of Long-Acting Reversible Contraception (LARC) among women of reproductive age who wish to delay or prevent pregnancy through educational and clinical activities (e.g., Planned Parenthood partnerships). 2.2.1: Promote provider education on patient-centered contraceptive counseling, with an emphasis on supporting informed, patient-led decision-making and providing comprehensive education on Long-Acting Reversible Contraception (LARC). 2.2.2: Expand Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program participation in the Every Woman CT Learning Collaborative (EWCTLC). 2.2.3: Increase public awareness of the importance of preconception health by encouraging individuals to discuss ways to improve their health with their healthcare providers before becoming pregnant. 2.2.4: Increase provider awareness of the importance of integrating preconception health discussions into routine care across all health care settings.	ESM PPV.1 - Number of prenatal and postpartum visits delivered through the mobile health unit(s) in identified lower-maternal care resource communities.	NPM - Postpartum Visit	**Linked NOMs:** Maternal Mortality Neonatal Abstinence Syndrome Women's Health Status Postpartum Depression Postpartum Anxiety

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		2.2.5: Integrate into provider training mental health, social stressors, and trauma education relevant to infants and families. 2.2.6: Utilize Title V funds, when possible, to facilitate the expansion of Every Woman Connecticut (EWCTLC) and Healthy Start programs. 2.2.7: Promote and support the implementation of evidence-based comprehensive prenatal and postpartum care models that integrate physical, mental, and behavioral health services in Connecticut. 2.2.8: Collaborate with Title V partners to address barriers to access prenatal care and postpartum visits, especially among people who are uninsured. 2.3.1: Improve access to comprehensive health care for women before, during, and after pregnancy by supporting the Healthy Start programs, specifically serving women of childbearing age in Hartford's inner city. 2.3.2: Support the work of partners and the CT Reproductive Justice Alliance in assessing quality maternity care, including the current state of mistreatment, and utilize findings to help create a Strategic Plan to improve quality maternity care. 2.3.3: Promote and support the implementation of evidence-based comprehensive prenatal and postpartum care models that integrate physical, mental, and behavioral health services. 2.3.4: Collaborate with Title V partners to address barriers to access prenatal care and postpartum visits, especially among people who are uninsured. 2.3.5: Support and expand community-based perinatal support services, such as home visiting programs, doula services, and peer support networks. 2.4.1: Improve access to comprehensive health care for women before, during, and after pregnancy by supporting the Healthy Start programs, specifically serving women of childbearing age in Hartford's inner city.			

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		2.4.2: Support the work of partners and the CT Reproductive Justice Alliance in assessing quality maternity care, including the current state of mistreatment, and utilize findings to help create a Strategic Plan to improve quality maternity care. 2.4.3: Promote and support the implementation of evidence-based comprehensive prenatal and postpartum care models that integrate physical, mental, and behavioral health services. 2.4.4: Improve care coordination and continuity of care across the perinatal continuum, including seamless transitions between prenatal, labor and delivery, postpartum, and interconception care, including Healthy Start programs and their care coordination, education, and referral process to provide safety and trusted support. 2.4.5: Support and expand community-based perinatal support services, such as home visiting programs, doula services, and peer support networks. 2.4.1: Improve access to comprehensive health care for women before, during, and after pregnancy by supporting the Connecticut Healthy Start Program, specifically serving women of childbearing age in Hartford's inner city. 2.4.2: Support the work of partners and the CT Reproductive Justice Alliance in assessing quality maternity care, including the current state of mistreatment, and utilize findings to help create a Strategic Plan to improve quality maternity care. 2.4.3: Improve respectful interactions between patients, providers, and staff, including addressing implicit bias in healthcare, which supports improved patient-provider interactions, health communication, and health outcomes. 2.4.4: Increase the quality of health care systems, resources, and policies related to maternal health. 2.4.5: Promote and support the implementation of evidence-based			

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		comprehensive prenatal and postpartum care models that integrate physical, mental, and behavioral health services. 2.4.6: Improve care coordination and continuity of care across the perinatal continuum, including seamless transitions between prenatal, labor and delivery, postpartum, and interconception care, including Connecticut Healthy Start and their care coordination, education, and referral process to provide safety and trusted support. 2.4.7: Support and expand community-based perinatal support services, such as home visiting programs, doula services, and peer support networks. 2.5.1: Enhance the accessibility and quality of perinatal education programs, leveraging both in-person and virtual platforms, and addressing diverse linguistic and cultural needs. 2.5.2: Improve care coordination and continuity of care across the perinatal continuum, including seamless transitions between prenatal, labor and delivery, postpartum, and interconception care, including Healthy Start programs and their care coordination, education, and referral process to provide safety and trusted support. 2.5.3: Support and expand community-based perinatal support services, such as home visiting programs, doula services, and peer support networks. 2.6.1: Title V will leverage/work with current and new partners to determine limitations in training, outreach, and provider tools for mental health during prenatal and postpartum care. 2.6.2: Title V will leverage/work with partners to create recommendations to improve trainings, outreach, and tools, including trainings around trauma-informed care and stigma around mental health. 2.6.3: Incorporate data on mental health into programs and trainings. 2.6.4: Title V will work with partners to determine current limitations in			

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		screening, referrals, and treatment in mental health. 2.6.5: Title V will work with programs to create recommendations to improve screenings, referrals, and treatment for mental health. 2.6.6: Increase the capacity of a cross-disciplinary workforce to screen for and promote mental health to ensure timely and effective supports and interventions.			
Perinatal/Infant Health					
Increase Access to Comprehensive Medical Health	3.1: By 2030, increase the percentage of mothers who report practicing safe sleep habits by 3%. 3.2: By 2030, decrease the disparity ratio in singleton preterm birth rates between non-Hispanic Black and non-Hispanic White women by 3%. 3.3: By 2030, increase the percentage of infants (0–12 months) receiving all recommended well-child visits by 3%.	3.1.1: Collaborate with the Child Fatality Review Committee, Maternal and Child Health Coalition, Infant Mortality Review Committee (IMR), Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Connecticut Healthy Start, and others to expand safe sleep messaging, education, and training. 3.1.2: Increase social supports and education for mothers on safe sleep practices, as seen through Care Coordination and one-on-one demonstration via specialized infant models that visually impact. 3.1.3: Support fatherhood initiatives to increase social support within the family and home environment. 3.2.1: Address social determinants of health and systemic racism affecting women of color. 3.2.2: Implement provider education on implicit bias, culturally responsive care, and effective patient-provider communication. 3.2.3: Support fatherhood programs to enhance social support for birthing individuals and families. 3.2.4: Integrate mental health, trauma, and social stressor education into provider training, with a focus on infant-family mental health. 3.2.5: Support Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) in its implementation of the Revised Food Package changes by sharing information and updates with eligible families.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 2: Prevalence of unintended pregnancies among women delivering a live-born infant.	

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		3.3.1: Enhance care coordination and reminders through pediatric providers, community health workers, and home visiting programs. 3.3.2: Educate families on the importance of routine well-child visits during early infancy, including vaccine schedules and developmental milestones. 3.3.3: Partner with early childhood stakeholders (e.g., home visiting programs, Family Resource Centers) to promote early and continuous engagement in pediatric care.			
Improve Breastfeeding Education and Supports	Objective 4.1: By 2030, increase the percentage of infants who are breastfed or receive breast milk at 6 months by 3%. 4.2: By 2030, increase by 5% the proportion of women who are breastfeeding at 8 weeks postpartum.	4.1.1: Support employer compliance with the federal Providing Urgent Maternal Protections for Nursing Mothers Act (PUMP Act) by promoting lactation accommodations in the workplace. 4.1.2: Promote the CT Breastfeeding Coalition's Breast and Chest feeding Friendly Recognition programs for workplaces and childcare settings. 4.1.3: Increase engagement of prenatal and postpartum Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) participants with breastfeeding peer counselors. 4.1.4: Promote consistent prenatal breastfeeding education statewide using the Ready, Set, Baby online module. 4.2.1: Promote awareness and use of the Breast and Chest feeding: It's Worth It webpage and culturally appropriate resources in target communities. 4.2.2: Support the implementation of equitable workplace breastfeeding policies, including lactation room standards and education for employers. 4.2.3: Assist working mothers by disseminating information on Connecticut's paid family leave and other postpartum supports. 4.2.4: Engage Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) peer counselors to provide breastfeeding support to Hispanic and non-Hispanic Black mothers prenatally and postpartum.	ESM BF.1 - Number of pregnant and postpartum WIC clients served by breastfeeding peer counselors during the reporting year. ESM BF.2 - Percent of Women, Infants, and Children (WIC) participants in Connecticut receiving breastfeeding support and education	NPM - Breastfeeding	**Linked NOMs:** Infant Mortality Postneonatal Mortality SUID Mortality

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		4.2.5: Provide breastfeeding education, coaching, and resources to home visiting staff to promote best practices during in-home care.			
Child Health					
Medical Home	5.1: By 2030, increase by 5% the number of children aged 6 to 11 who receive services in a School Based Health Center (SBHC) and have a usual source of care. 5.2: By 2030 increase by 2% the number of children aged 6 to 11 in a SBHC who have received a dental service, including dental sealants.	5.1.1: Establish baseline via data obtained by School Based Health Center (SBHC), the percentage of children 6 to 11 years old who have a usual source of care. 5.1.2: Promote use of SBHCs through increasing the number of families who complete an enrollment form for annual well-child exams and other services. 5.1.3: Utilize the services of SBHC staff to provide children 6 to 11 years old with a usual source of care. 5.1.4: Promote services available in SBHC, such as immunizations through Open House events and social media. 5.1.5: Refer children ages 6 to 11 and families to a usual source of care. 5.2.1: Establish baseline via data obtained by SBHC, the percentage of children 6 to 11 years old who have received dental care, including dental sealant. 5.2.2: Educate families on the importance of dental services and where to access affordable, quality dental care. 5.2.3: Promote interagency and community-based partnerships to improve coordination between medical and dental services. 5.2.4: Promote the use of SBHCs through increasing the number of families who complete an enrollment form to access dental services.	***Inactive -*** *ESM MH.1 - Percent of CYSHCN who have a comprehensive care plan in place as evidence that they are receiving care in a well-functioning system* ESM MH.2 - Percent of children (ages 6-11) in a School-Based Health Center who have a usual source of care ESM MH.3 - Percent of parents and caregivers who report satisfaction with care coordination services for their child with special health care needs in the Connecticut Medical Home Initiative Program ESM MH.4 - Percent of Children and Youth with Special Health Care Needs (CYSHCN) in the Connecticut Medical Home Initiative	NPM - Medical Home; Medical Home_Usual Source of Sick Care	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

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			Program who received a referral to a mental health or behavioral health provider		
Mental Well-Being, Behavioral Treatment and Support	6.1: By 2030, increase by 5% the number of children who receive one developmental screening conducted using a validated screening tool.	6.1.1: Collaborate with stakeholders to promote the use of 2-1-1 Child Development, Ages and Stages Child Monitoring Program and mobile development screening applications such as Sparkler. 6.1.2: Provide explanations to parents and caregivers about the importance of developmental monitoring and screening and assist with the completion of developmental screening tools. 6.1.3: Coordinate and provide developmental screening training to medical professionals and childcare providers, infant mental health consultants and home visitors to improve screening and referrals. 6.1.4: Provide educational materials to students and parents about mental well-being, positive social-emotional and relationship skills such as Gizmo, Where is Bear? and Amazing Me: It's Busy Being 3!	ESM DS.1 - Percent of children birth to 36 months who received one developmental screening according to claims code 96110.	NPM - Developmental Screening	**Linked NOMs:** School Readiness Children's Health Status
Adolescent Health					
Adolescent Access to Comprehensive Health Care & Well-Visits	7.1: By 2030, increase by 5% the number of adolescent well-visits in School Based Health Centers (SBHC's).	7.1: Outreach and engagement strategies, including administering surveys, to increase awareness of SBHC services, including adolescents who visit annually. 7.2: Increase the number of enrolled students in SBHC services. 7.3: Educational materials, webinars, trainings, and administer surveys to get adolescents aware of the importance of a well visit, set the stage for a successful visit, and engage adolescents as health care consumers. School Based Health Alliance to provide trainings to SBHC staff on managing stress and healthy relationships. 7.4: Promote primary prevention programs in the SBHCs.	ESM AWV.1 - Percent of Adolescents (12–17) with at least one completed Body Mass Index (BMI) at time of medical visit at a School-Based Health Center ESM AWV.2 - Percent of adolescents 12 through 17 with a depression screening at the time of medical visit at a School-Based Health Center	NPM - Adolescent Well-Visit	**Linked NOMs:** Teen Births Adolescent Mortality Adolescent Motor Vehicle Death Adolescent Suicide Adolescent Firearm Death Adolescent Injury Hospitalization Children's Health Status Child Obesity Adolescent Depression/Anxiety CSHCN Systems of Care Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
Mental Health	8.1: By 2030, increase by 5% the	8.1.1: Encourage participation in mental and behavioral health education in	ESM MHT.1 -	NPM - Mental Health	**Linked NOMs:**

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and Behavioral Treatment and Supports	number of students at schools with School Based Health Centers who receive mental health and behavioral health education. 8.2: By 2030, increase by 5% the number School Based Health Center staff who have passed a training course in a suicide prevention strategy.	group settings. 8.1.2: Work with SBHC staff to provide educational materials, webinars, and training to make adolescents aware of the importance of mental health and behavioral health treatment, services, and supports. 8.1.3: Promote documentation of referrals for mental and behavioral health treatment services and supports, and to determine if services are provided within the SBHC, community setting, or both. 8.1.4: To promote SBHC staff to partner with state, local, and community organizations, including attending the Regional Care Coordination Community Collaborative meetings. 8.2.1: Establish a baseline for the number of SBHC staff who passed training in a suicide prevention strategy. 8.2.2: Expand training to SBHC to recognize the warning signs of suicide, intervene with confidence, and refer individuals at risk to appropriate resources. (Question Persuade Refer, 4 What's Next, 988).	Percent of students at schools with School-Based Health Centers who received mental health and behavioral health education	Treatment	Adolescent Mortality Adolescent Suicide Adolescent Firearm Death Adolescent Injury Hospitalization Children's Health Status Adolescent Depression/Anxiety CSHCN Systems of Care Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
Children with Special Health Care Needs					
Medical Home and Care Coordination	9.1: By 2030, increase by 1% the number of National Committee for Quality Assurance (NCQA) recognized or Joint Commission Accredited patient-centered medical homes. 9.2: By 2030, increase by 5% the number of children, including those with special health care needs, who have a National Committee for Quality Assurance (NCQA) recognized or Joint Commission Accredited Patient-Centered Medical Home (PCMH).	9.1.1: Partner with community organizations and stakeholders engaged through the CT Medical Home Advisory Council to promote the benefits of medical homes to providers. 9.1.2: Determine the percentage of Primary Care Providers whose practices are NCQA or equivalent, recognized as Patient-Centered Medical Homes. 9.1.3:Partner with the Department of Social Services, Patient-Centered Medical Home, Community Health Network, and others to support providers pursuing NCQA or Joint Commission-accredited patient-centered medical home recognition. 9.2.1: Conduct outreach to the families of children, including those with special health care needs, to educate consumers about the benefits and availability of patient-centered medical homes.	***Inactive -*** *ESM MH.1 - Percent of CYSHCN who have a comprehensive care plan in place as evidence that they are receiving care in a well-functioning system* ESM MH.2 - Percent of children (ages 6-11) in a School-Based Health Center who have a usual source of care ESM MH.3 - Percent	NPM - Medical Home; Medical Home_Care Coordination	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

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	9.3: By 2030, increase by 2% the number of parents and caregivers who report satisfaction with care coordination services for their child with special health care needs in the CT Medical Home Initiative Program. 9.4: By 20230, increase by 2% the number of children with special health care needs in the CT Medical Home Initiative Program who are insured.	9.2.2: Partner with community organizations and stakeholders engaged through the Connecticut Medical Home Advisory Council to promote the benefits of medical home to consumers. 9.3.1: Create a survey through Qualtrics or other methods to measure the satisfaction of parents and caregivers who receive a care coordination service in the CT Medical Home Initiative Program. 9.3.2: Pilot test satisfaction survey with families for survey characteristics such as length, understanding of questions, and accuracy of administration. Adjust survey questions as needed. 9.3.3: Evaluate methods of survey administration. Once the method is selected, ensure quality of survey distribution. 9.3.4: Administer satisfaction survey, assemble data, and provide analysis. 9.3.5: Create a baseline of parents and caregivers who report satisfaction with care coordination services in the CT Medical Home Initiative Program. 9.3.6: Review satisfaction survey results with CT Medical Home Initiate Program staff, addressing both successes and identified deficiencies. 9.4.1: Support training for providers working with children with special health care needs, to ensure knowledge of insurance coverage. 9.4.2: Offer insurance application assistance through community organizations. 9.4.3: Provide education or assistance to families in navigating health insurance financing options in their language. 9.4.4: Use social media for targeted information for families, including families of those with special health care needs. 9.4.5: Work with CT 2-1-1 Child Development to provide training to	of parents and caregivers who report satisfaction with care coordination services for their child with special health care needs in the Connecticut Medical Home Initiative Program ESM MH.4 - Percent of Children and Youth with Special Health Care Needs (CYSHCN) in the Connecticut Medical Home Initiative Program who received a referral to a mental health or behavioral health provider		

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		community partners on health care insurance resources for families of children, including those with special health care needs.			
Mental well-being, managing family stress, and self-care for caregivers.	10.1: By 2030, increase by 2% the number of children and youth with special health care needs in the CT Medical Home Initiative Program who receive a referral to a mental health or behavioral health provider.	10.1.1: Create a baseline of the number of children and youth with special health care needs in the CT Medical Home Initiative Program who receive a referral to a mental health or behavioral health provider. 10.1.2: Provide ongoing support groups, both virtually and in-person, for families of children and youth with special health care needs on the topics of mental well-being, managing family stress, and self-care for the caregiver. 10.1.3: Partner with community organizations to provide education to professionals who work with children and youth with special health care needs on the topics of mental well-being, managing family stress, and self-care for the caregiver through a variety of platforms, including the annual Care Coordination Conference. 10.1.4: Provide strategies and approaches that can improve mental well-being for students, including those with special health care needs, to School Based Health Center (SBHC) staff. 10.1.5: Develop a survey in Qualtrics for parents and caregivers about access to mental and behavioral health services.	***Inactive -*** *ESM MH.1 - Percent of CYSHCN who have a comprehensive care plan in place as evidence that they are receiving care in a well-functioning system* ESM MH.2 - Percent of children (ages 6-11) in a School-Based Health Center who have a usual source of care ESM MH.3 - Percent of parents and caregivers who report satisfaction with care coordination services for their child with special health care needs in the Connecticut Medical Home Initiative Program ESM MH.4 - Percent of Children and Youth with Special Health Care Needs (CYSHCN) in the Connecticut Medical Home Initiative Program who received a referral to a mental health or	NPM - Medical Home; Medical Home_Care Coordination	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

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			behavioral health provider		