# Connecticut State Action Plan Table 2025 Application/2023 Annual Report

| Priority Needs | Five-Year Objectives | Strategies | Evidence-Based or –Informed Strategy Measures | National and State Performance Measures | National and State Outcome Measures |
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| **Women/Maternal Health** | | | | | |
| Maternal Morbidity and Mortality | 1.1: By 2025, reduce the Maternal Mortality Ratio (MMRatio) by 10%.<br><br>1.2: By 2025, increase the number of birth hospitals who have a severe maternal morbidity review committee to 2.<br><br>1.3: By 2025, reduce the prevalence of cardiovascular disease in women of childbearing age by 5%. | 1.1.1: Explore innovative models of care that support health and wellbeing across the life cycle and foster healthy communities.<br><br>1.1.2: Address the Social Determinants of Health and racial and ethnic biases that impact women of color.<br><br>1.1.3: Address implicit bias in healthcare that would likely improve patient-provider interactions, health communication, and health outcomes.<br><br>1.1.4: Support the work of Every Woman Connecticut (EWCT) and Connecticut Reproductive Justice Alliance (RJA) to ensure that its members have the infrastructure and resources needed to carry out its charge.<br><br>1.1.5: Support fatherhood initiatives to increase social support within the family and home environment.<br><br>1.2.1: Participate in the 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.<br><br>1.2.2: Support the work of Every Woman Connecticut (EWCT) and Connecticut Reproductive Justice Alliance (RJA) to ensure that its members have the infrastructure and resources needed to carry out its charge.<br><br>1.2.3: Support advocacy through the Connecticut Perinatal Quality Collaborative (CPQC) and Title V Program collaborations.<br><br>1.2.4: Assess the burden of maternal morbidity in Connecticut. | ESM WWV.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<br><br>ESM WWV.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? | NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV | NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM<br><br>NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM<br><br>NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW<br><br>NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB<br><br>NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB<br><br>NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM<br><br>NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM |

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| | | 1.3.1: Work with the WISEWOMAN program to increase the percent of women who receive risk reduction counseling and healthy behavior support.<br><br>1.3.2: Promote education and awareness of cardiovascular risk factors.<br><br>1.3.3: Support WIC initiatives that address access to healthy food through nutrition assessments and food packages that meet health needs.<br><br>1.3.4: Support the work of the Community Health Network of Connecticut to increase availability of blood pressure cuffs and increase participation in the Intensive Perinatal Care program.<br><br>1.3.5: Identify and address barriers to access annual well visits especially in the uninsured population. | | | NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal<br><br>NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal<br><br>NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related<br><br>NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP<br><br>NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS<br><br>NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB<br><br>NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression, |

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| | | | | | Formerly NOM 24) - PPD |
| Preconception and Interconception Health | 2.1: By 2025, decrease the percent of unintended pregnancy by 3%.<br><br>2.2: By 2025, increase the percent 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%.<br><br>2.3: By 2025, increase the number of community-based organizations that are participating in the Every Woman CT initiative by 10%. | 2.1.1: Sustain and expand the use of the One Key Question (OKQ) screening tool by establishing formal relationships between EWCT and state agencies (DPH, DMHAS, OEC, etc.) that use OKQ in their programs as well as with regional entities that can serve as a hub for supporting the use of OKQ (such as Bridgeport Prospers and New Haven Healthy Start).<br><br>2.1.2: Provide evidence-based teen pregnancy prevention education to youth through collaborations with the PREP grant.<br><br>2.1.3: Increase the availability and use of Long Acting Reversible Contraception (LARC) in women of childbearing age who would like to postpone pregnancy.<br><br>2.1.4: Promote provider education focused on patient centered birth control including patient education on LARCs.<br><br>2.1.5: Expand Every Woman CT programming to include WIC staff throughout the state.<br><br>2.2.1: Sustain and expand the use of the One Key Question (OKQ) screening tool by establishing formal relationships between EWCT and state agencies that use OKQ in their programs (DPH, DMHAS, OEC, etc.) as well as with regional entities that can serve as a hub for supporting the use of OKQ (such as Bridgeport Prospers and New Haven Healthy Start).<br><br>2.2.2: Increase public awareness about the importance of discussing with your doctor how to improve your health prior to becoming pregnant.<br><br>2.2.3: Increase provider awareness about the importance of preconception health discussions in all health settings.<br><br>2.2.4: Improve access to healthcare for women before, during and after pregnancy.<br><br>2.2.5: Integrate into provider training mental health, social stressors, and | | SPM 1: The proportion of live births conceived within 18 months of a previous birth (percent, females 15–44 years). | |

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| | | trauma education relevant to infants and families.<br><br>2.3.1: Recruit community-based organizations to participate in EWCT's trainings.<br><br>2.3.2: Increase the awareness about EWCT/OKQ among providers in different health care settings statewide.<br><br>2.3.3: Utilize Title V funds, when possible, to facilitate the expansion of EWCT/OKQ. | | | |
| Maternal Morbidity and Mortality | 1.4: Increase to 95% from baseline (92%, PRAMS 2021) the percent of women who attended a postpartum checkup within 12 weeks after giving birth whose insurance is Medicaid. | 1.3.5: Identify and address barriers to access annual well visits especially in the uninsured population.<br><br>2.2.4: Improve access to healthcare for women before, during and after pregnancy.<br><br>1.1.3: Address implicit bias in healthcare that would likely improve patient provider interactions, health communication, and health outcomes. | No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report. | NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV | This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report. |
| **Perinatal/Infant Health** | | | | | |
| Infant Morbidity and Mortality | 3.1: By 2025, decrease the percent of unintended pregnancy for women who have delivered live births by 3%.<br><br>3.2: By 2025, increase the percent of mothers who report practicing safe sleep habits for their infants by 3%.<br><br>3.3: By 2025, decrease the disparity ratio between singleton preterm births among non-Hispanic Black- and non-Hispanic White women by 3%. | 3.1.1: Sustain and expand the use of the One Key Question (OKQ) screening tool by establishing formal relationships between EWCT and state agencies (DPH, DMHAS, OEC, etc.) that use OKQ in their programs as well as with regional entities that can serve as a hub for supporting the use of OKQ (such as Bridgeport Prospers and New Haven Healthy Start).<br><br>3.1.2: Provide evidence-based teen pregnancy prevention education to youth through collaborations with the PREP grant.<br><br>3.1.3: Increase the availability and use of Long Acting Reversible Contraception (LARC) in women of childbearing age who would like to postpone pregnancy.<br><br>3.1.4: Promote provider education focused on patient centered birth control | | SPM 2: The prevalence of unintended pregnancies among women delivering a live-born infant. | |

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| | | including patient education on LARCs.<br><br>3.1.5: Expand Every Woman CT programming to include WIC staff throughout the state.<br><br>3.2.1: Partner with the Child Fatality Review Committee, MCH Coalition, and other statewide partners to expand safe sleep education and messaging.<br><br>3.2.2: Increase social supports and education for mothers on safe sleep practices.<br><br>3.2.3: Support fatherhood initiatives to increase social support within the family and home environment.<br><br>3.3.1: Explore innovative models of care that support health and wellbeing across the life cycle and foster healthy communities.<br><br>3.3.2: Address the Social Determinants of Health and racial and ethnic biases that impact Women of Color.<br><br>3.3.3: Address implicit bias in healthcare that would likely improve patient-provider interactions, health communication, and health outcomes.<br><br>3.3.4: Improve access to healthcare for women before, during and after pregnancy.<br><br>3.3.5: Support fatherhood initiatives to increase social support within the family and home environment.<br><br>3.3.6: Integrate into provider training mental health, social stressors, and trauma education relevant to infants and families. | | | |
| Breastfeeding Initiation and Duration | 4.1: By 2025, increase the percent of infants who are breastfed or receive breast milk at 6 months to 3% (Data source: CDC National Immunization Survey). | 4.1.1: Support work environments to accommodate breastfeeding mothers through lactation rooms, etc.<br><br>4.1.2: Support policies on breastfeeding in the workplace (e.g., establishing minimum criteria for lactation rooms and how to have discussions with supervisors/managers). | ESM BF.1 - Number of pregnant and postpartum WIC clients served by breastfeeding peer counselors | NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively | NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM<br><br>NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal |

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| | 4.2: By 2025, increase by 5% the proportion of Hispanic women and non-Hispanic Black women breastfeeding at 8 weeks (Data source: PRAMS). | 4.1.3: Engage WIC peer counselors for pregnant and postpartum women.<br><br>4.1.4: Promote Ready. Set. Baby. (RSB) online module to increase prenatal education on breastfeeding that is consistent in the state.<br><br>4.1.5: Continue to provide Secrets of Baby Behavior (SBB) training to ensure parental competence around cues, crying and sleep.<br><br>4.2.1: Support work environments to accommodate breastfeeding mothers through lactation rooms, etc.<br><br>4.2.2: Support policies on breastfeeding in the workplace (e.g., establishing minimum criteria for lactation rooms and how to have discussions with supervisors/ managers).<br><br>4.2.3: Train women in the community as lactation peer support counselor.<br><br>4.2.4: Engage WIC peer counselors for pregnant and postpartum women. | | through 6 months (Breastfeeding, Formerly NPM 4B) - BF | Mortality, Formerly NOM 9.3) - IM-Postneonatal<br><br>NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID |
| **Child Health** | | | | | |
| Social-Emotional Development and Relationships for Children and Adolescents | 5.1: By 2025, increase by 5% the number of developmental screenings conducted using a validated screening tool.<br><br>5.2: By 2025, increase by 5% the number of social-emotional screenings conducted.<br><br>5.3: By 2025, increase referrals to appropriate services for positive screening results by 5%.<br><br>5.4: By 2025, disseminate educational information on positive social-emotional and relationship skills for children. | 5.1.1: Collaborate with stakeholders to promote the use of CT 2-1-1 Child Development Infoline's Ages and Stages Child Monitoring Program and mobile developmental screening applications such as Sparkler.<br><br>5.1.2: Initiate data collection for children including those with special health care needs to include what developmental screenings are being used and the results.<br><br>5.1.3: Assist parents in the completion of developmental screening tools.<br><br>5.1.4: Coordinate and provide developmental screening trainings to medical providers and childcare providers.<br><br>5.2.1: Determine baseline for social-emotional screenings completed by providers based on Department of Social Services claims codes.<br><br>5.2.2: Promote for increased social-emotional screenings by providers. | ESM DS.1 - Percent of children 1-2 years 364 days old who receive a developmental screening according to claims code 96110 | NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (Developmental Screening, Formerly NPM 6) - DS | NOM - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR<br><br>NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS |

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| | | 5.2.3: Explore the utilization of telehealth to conduct social-emotional screening tools.<br><br>5.2.4: Assist parents in the completion of social-emotional screening tools.<br><br>5.3.1: Determine the baseline of positive screenings leading to referrals.<br><br>5.3.2: Document follow up on referrals from positive screenings.<br><br>5.3.3: Engage pediatricians, child health providers, infant mental health consultants, and home visitors to improve screening and referrals.<br><br>5.4.1: Provide educational materials, webinars, and trainings to students, parents, and faculty about positive social-emotional and relationship skills.<br><br>5.4.2: Partner with the Office of Early Childhood and CT American Academy of Pediatrics to train pediatric providers on early positive social-emotional and relationship skills.<br><br>5.4.3: DPH Connecticut Medical Home Initiative to conduct family support group sessions both in person and virtually about positive social-emotional and relationship skills to share educational materials and provide a forum for discussion. | | | |
| Preventative Health Care | 6.1: By 2025, increase by 5% the number of children who receive a well-child exam annually.<br><br>6.2: By 2025, increase by 5% the number of children who receive a dental visit annually.<br><br>6.3: By 2025, reduce by 3% the number of children with BMI's that are in the categories of overweight or obese.<br><br>6.4: By 2025, decrease by 5% | 6.1.1: Document well-child exams for children in the Connecticut Medical Home Initiative.<br><br>6.1.2: Establish baseline via data obtained from Department of Social Services on the percentage of children 3 years old to 18 years old who receive yearly well-child exams.<br><br>6.1.3: Promote annual well-child exams including scheduled immunizations.<br><br>6.1.4: Promote the use of telehealth for components of the well-child exam when appropriate.<br><br>6.2.1: Promote the provision of dental services in School Based Health | | SPM 3: The proportion of children who drank soda or sugar sweetened beverages at least once daily. | |

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| | children who drink sugar sweetened beverages at least once daily. | Centers.<br><br>6.2.2: Promote the benefits of school-based sealant programs.<br><br>6.2.3: Support families in taking an active role in establishing and maintaining good oral health for their child.<br><br>6.3.1: Collect data to gather information about factors that contribute to an unhealthy weight.<br><br>6.3.2: Promote the use of healthy diet and activity (5-2-1-0 American Academy of Pediatrics) programs.<br><br>6.3.3: Work with early care and education providers to implement policies and best practices at their site that encourage the adoption of healthy eating and physical activity behaviors among young children.<br><br>6.3.4: Deliver evidence-based obesity-prevention education to low income SNAP-eligible preschool children and their families.<br><br>6.4.1: Determine the baseline of children including those with special health care needs who drink sugar sweetened beverages at least once daily.<br><br>6.4.2: Work with early care and education providers to implement policies and best practices at their site that encourage young children to decrease consumption of sugar sweetened beverages and increase consumption of plain drinking water.<br><br>6.4.3: Deliver evidence-based obesity-prevention education to low income, SNAP-eligible preschool children and their families.<br><br>6.4.4: Distribute nutrition education materials to School Based Health Centers on reducing sugar sweetened beverage consumption. | | | |
| Preventative Health Care | 6.1: By 2025, increase by 5% the number of children who receive a well-child exam annually. | 6.1.1: Document well-child exams for children in the Connecticut Medical Home Initiative.<br><br>6.1.2: Establish baseline via data obtained from Department of Social | ESM MH.1 - Percent of CYSHCN who have a comprehensive care plan in place as | NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a | NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning |

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| | | Services on the percentage of children 3 years old to 18 years old who receive yearly well-child exams.<br><br>6.1.3: Promote annual well-child exams including scheduled immunizations.<br><br>6.1.4: Promote the use of telehealth for components of the well-child exam when appropriate.<br><br>6.1.5: Analyze data from the National Survey of Children's Health for the % of children ages 0-17, who have a usual source for sick care, broken out by race and ethnicity.<br><br>6.1.6: Establish a baseline from DSS on the % of Children, 0-17 who have a usual source for sick care.<br><br>6.1.7: Promote the use of community-based access sites that provide for sick care for children ages, 0 to 17 (CHC, SBHC).<br><br>6.1.8: Promote the use of telehealth for components of the sick care for children ages, 0 to 17, when appropriate. | evidence that they are receiving care in a well-functioning system | medical home (Medical Home, Formerly NPM 11) - MH | system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC<br><br>NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX<br><br>NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS<br><br>NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC |
| **Adolescent Health** | | | | | |
| Supports for Health, Safety, and Enhanced Social-Emotional Development | 9.1: By 2025, increase by 15% the number of DPH funded School Based Health Center (SBHC) sites who are conducting Adverse Childhood Experiences (ACEs) screenings.<br><br>9.2: By 2025, increase the number referrals by DPH funded SBHCs to appropriate services in response to positive ACEs screening results by 5%.<br><br>9.3: By 2025, increase by 5% the number of adolescent well visits. | 9.1.1: Increase the number of School Based Health Center (SBHC) staff who are trained to conduct ACEs screenings.<br><br>9.1.2: Provide educational materials, webinars, and trainings with SBHC coordinators to increase the rate of ACES screenings completed.<br><br>9.1.3: Require SBHC to report on CPT billing codes for ACES and other social-emotional screening tools.<br><br>9.2.1: Encourage SBHC behavioral health staff to join and attend Regional Care Collaboratives.<br><br>9.2.2: Promote documenting referrals from positive screens and their outcomes. | ESM AWV.1 - Percent of adolescents 12 through 17 with at least one completed BMI at time of medical visit at all school-based health centers<br><br>ESM AWV.2 - Percent of adolescents 12 through 17 with a depression screening at the time of medical visit at all school-based health centers | NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV | NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM<br><br>NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle<br><br>NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide |

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| | 9.4: By 2025, reduce by 5% the number of adolescents who report using substances including vaping, prescription drugs, and illicit drugs.<br><br>9.5: By 2025, reduce by 0.5% the number of adolescents who report attempted suicide. | 9.2.3: Provide educational materials, webinars, and trainings about promoting strong connections to family and community supports to encourage resilience.<br><br>9.3.1: Employ outreach and engagement strategies to increase awareness of SBHC services including the adolescent well visits annually.<br><br>9.3.2: Encourage SBHCs to increase the number of signed consent forms for access to services including adolescent well visits.<br><br>9.3.3: Provide educational materials, webinars, and trainings to get adolescents in for a well visit, to set the stage for a successful well visit, and to engage the adolescent as a health care consumer.<br><br>9.3.4: Promote primary prevention programs to strengthen resiliency in high school students though school-based programs, such as 4 What's Next.<br><br>9.4.1: Provide educational materials, webinars, and trainings for school staff around vaping, prescription drugs, and illicit drugs.<br><br>9.4.2: Identify gaps in preventive messaging and materials on vaping, prescription drugs, and illicit drugs being used by youth-serving organizations and address through development of updated messages and materials for distribution.<br><br>9.4.3: Develop curriculum materials for vaping cessation that are age-appropriate, and make available to school districts and organizations that serve youth in CT.<br><br>9.5.1: Promote primary prevention programs to strengthen resilience in high school students through school-based programs, such as 4 What's Next.<br><br>9.5.2: Expand gatekeeper training for parents, schools and other youth serving organizations (Question Persuade Refer).<br><br>9.5.3: Provide educational materials and events, including promoting | | | NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC<br><br>NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX<br><br>NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS<br><br>NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS<br><br>NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu<br><br>NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, |

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| | | awareness of mobile crisis resources in CT and the National Suicide Prevention Crisis Lifeline phone and text numbers. | | | Formerly NOM 22.3) - VAX-HPV<br><br>NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP<br><br>NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN<br><br>NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB |
| **Children with Special Health Care Needs** | | | | | |
| Connections to Medical Home/Dental Home | 7.1: By 2025, increase by 1% the number of National Committee for Quality Assurance (NCQA) recognized or Joint Commission Accredited patient-centered medical homes.<br><br>7.2: By 2025, 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).<br><br>7.3: By 2025, increase by 5% the | 7.1.1: Partner with community organizations and stakeholders engaged through the CT Medical Home Advisory Council to promote the benefits of medical home to providers.<br><br>7.1.2: Determine the percentage of Primary Care Providers whose practices are NCQA or equivalent recognized as Patient-Centered Medical Homes.<br><br>7.1.3: Partner with the Department of Social Services Person-Centered Medical Home, Community Health Network, and others to support providers in pursuing NCQA or Joint Commission Accredited patient-centered medical home recognition.<br><br>7.2.1: Conduct outreach including 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. | 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 | NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH | NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC<br><br>NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX<br><br>NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health |

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| | number of children, including those with special health care needs, who have a dental home. | 7.2.2: Partner with community organizations and stakeholders engaged through the Connecticut Medical Home Advisory Council to promote the benefits of medical home to consumers.<br><br>7.2.3: Contact providers and health care facilities that are not recognized and share education materials on the benefits of becoming a Patient-Centered Medical Home.<br><br>7.3.1: Establish a mechanism of measuring the number of dental homes through Medicaid data.<br><br>7.3.2: Educate families on the importance of dental homes.<br><br>7.3.3: Promote interagency and community-based partnerships to improve coordination between medical and dental services. | | | Status, Formerly NOM 19) - CHS<br><br>NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC |
| Supports to Address the Special Health Care Needs of Children and Youth | 8.1: By 2025, increase by 3% the number of children including those with special health care needs who are insured.<br><br>8.2: By 2025, conduct an environmental scan of comprehensive health care services for children including those with special health care needs.<br><br>8.3: By 2025, increase the number of partner organizations who help families understand what services are available and covered by insurance for children including those with special health care needs 5%. | 8.1.1: Support trainings for providers working with children including those with special health care needs, to ensure knowledge of insurance coverage.<br><br>8.1.2: Offer insurance application assistance through community organizations.<br><br>8.1.3: Use social media for targeted information for families including families of those with special health care needs.<br><br>8.2.1: Use the CT 2-1-1 Child Development Infoline resource database for comprehensive health care services for all children including those with special health care needs.<br><br>8.2.2: Collaborate with partners and community organizations to identify gaps in services.<br><br>8.2.3: Collaborate with state agencies regarding insurance coverage.<br><br>8.3.1: Work with Care Coordination Collaboratives to increase the number of partner organizations.<br><br>8.3.2: Provide information on insurance access to partner organizations. | ESM AI.1 - The number of community organizations who help families understand what services are available and covered by insurance for all children including those with special health care needs | NPM - Percent of children, ages 0 through 17, who are continuously and adequately insured (Adequate Insurance, Formerly NPM 15) - AI | NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC<br><br>NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX<br><br>NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS<br><br>NOM - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months (Childhood |

| Priority Needs | Five-Year Objectives | Strategies | Evidence-Based or –Informed Strategy Measures | National and State Performance Measures | National and State Outcome Measures |
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| | | 8.3.3: Provide education or assistance to families in navigating health insurance financing options in their language.<br><br>8.3.4: Work with CT 2-1-1 Child Development Infoline to provide training to community partners on generating resource lists for families of children, including those with special health care needs. | | | Vaccination, Formerly NOM 22.1) - VAX-Child<br><br>NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu<br><br>NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV<br><br>NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP<br><br>NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN<br><br>NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC |
| Connections to Medical Home/Dental Home | 7.1: By 2025, increase by 1% the number of National Committee for Quality Assurance (NCQA) recognized or Joint Commission | 7.1.1: Partner with community organizations and stakeholders engaged through the CT Medical Home Advisory Council to promote the benefits of medical home to providers. | ESM MH.1 - Percent of CYSHCN who have a comprehensive care plan in place as | NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a | NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning |

| Priority Needs | Five-Year Objectives | Strategies | Evidence-Based or –Informed Strategy Measures | National and State Performance Measures | National and State Outcome Measures |
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| | Accredited patient-centered medical homes.<br><br>7.2: By 2025, 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). | 7.1.2: Determine the percentage of Primary Care Providers whose practices are NCQA or equivalent recognized as Patient-Centered Medical Homes.<br><br>7.1.3: Partner with the Department of Social Services Person-Centered Medical Home, Community Health Network, and others to support providers in pursuing NCQA or Joint Commission Accredited patient centered medical home recognition.<br><br>7.2.1: Conduct outreach including 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.<br><br>7.2.2: Partner with community organizations and stakeholders engaged through the Connecticut Medical Home Advisory Council to promote the benefits of medical home to consumers.<br><br>7.2.3: Contact providers and health care facilities that are not recognized and share education materials on the benefits of becoming a Patient Centered Medical Home. | evidence that they are receiving care in a well-functioning system | medical home (Medical Home, Formerly NPM 11) - MH | system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC<br><br>NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX<br><br>NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS<br><br>NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC |