HRSA
Health Resources & Services Administration

Title V MCH Block Grant Program

CONNECTICUT

State Snapshot

FY 2017 Application / FY 2015 Annual Report

November 2016

Title V Federal-State Partnership - Connecticut

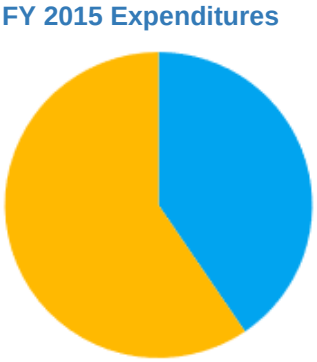
The Title V Maternal and Child Health Block Grant Program is a federal-state partnership with 59 states and jurisdictions to improve maternal and child health throughout the nation. This Title V Snapshot presents high-level data and the executive summary contained in the FY 2017 Application / FY 2015 Annual Report. For more information on MCH data, please visit the Title V Federal-State Partnership website (https://mchb.tvisdata.hrsa.gov)

State Contacts

MCH Director	CSHCN Director	State Family or Youth Leader
Mark Keenan Connecticut Title V Director mark.keenan@ct.gov (860) 509-8251	Ann Gionet CSHCN Director ann.gionet@ct.gov (860) 509-8251	Robin Tousey-Ayers Family Advocate robin.tousey-ayers@ct.gov (860) 509-8251

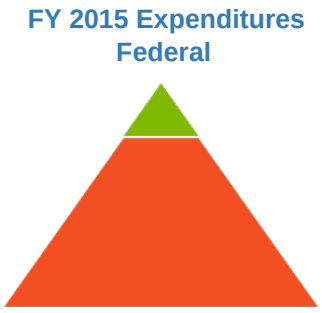
Funding by Source

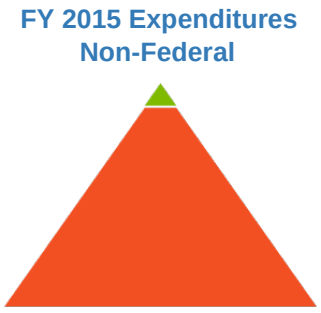
Source	FY 2015 Expenditures
Federal Allocation	$4,613,166
State MCH Funds	$6,780,181
Local MCH Funds	$0
Other Funds	$0
Program Income	$0



Funding by Service Level

Service Level	Federal	Non-Federal
Direct Services	$0	$0
Enabling Services	$1,093,744	$678,018
Public Health Services and Systems	$3,519,422	$6,102,163





Total Reach of Title V in Serving MCH Populations

Populations Served	Individuals Served	FY 2015 Expenditures	%
Pregnant Women	3,170	$1,363,923	12.2%
Infants < 1 Year	41,822	$2,688,065	24.0%
Children 1-22 Years	114,520	$4,939,767	44.1%
CSHCN	48,745	$2,137,732	19.1%
Others *	172,150	$68,709	0.6%
Total	380,407	$11,198,196	100%

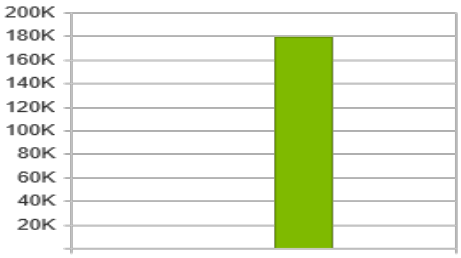
*Others– Women of childbearing age, over age 21, and any others defined by the State who are not otherwise included in any of the other listed classes of individuals.

FY 2015 Expenditures

FY 2015 Individuals Served

Communication Reach

Communication Method	Amount
State Title V Website Hits:	0
State Title V Social Media Hits:	0
State MCH Toll-Free Calls:	179,822
Other Toll-Free Calls:	0



Selected National Performance Measures

Measure #	Measure Short Name	Population Domain
NPM 1	Well-Woman Visit	Women/Maternal Health
NPM 3	Risk-Appropriate Perinatal Care	Perinatal/Infant Health
NPM 4	Breastfeeding	Perinatal/Infant Health
NPM 6	Developmental Screening	Child Health
NPM 10	Adolescent Well-Visit	Adolescent Health
NPM 11	Medical Home	Children with Special Health Care Needs
NPM 12	Transition	Children with Special Health Care Needs
NPM 13	Preventive Dental Visit	Cross-Cutting/Life Course

Evidence-Based or –Informed Strategy Measures

NPM #	NPM Short Name	ESM #	ESM Title
NPM 1	Well-Woman Visit	ESM 1.1	The percent of 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.
NPM 3	Risk-Appropriate Perinatal Care	ESM 3.1	The number of communities participating in Every Woman Connecticut.
NPM 4	Breastfeeding	ESM 4.1	The number of hospitals participating in the CT Breastfeeding Coalition's (CBC) Ten Steps Collaborative to implement evidenced-based maternity care and the 10 Steps for Successful Breastfeeding.
NPM 4	Breastfeeding	ESM 4.2	The number of Federally Qualified Health Centers (FQHCs) and/ or peer networks that were provided the Secrets of Baby Behavior (SBB) training.
NPM 6	Developmental Screening	ESM 6.1	Percent of children less than 3 years old (1-2 years 364 days old) who receive a developmental screening according to claims code 96110.
NPM 10	Adolescent Well-Visit	ESM 10.1	Percent of adolescents with at least one completed BMI at time of medical visit at all school-based health centers.
NPM 10	Adolescent Well-Visit	ESM 10.2	Behavioral Health Screening at time of medical visit at all school-based health centers.
NPM 11	Medical Home	ESM 11.1	Percent of CYSHCN who have a comprehensive care plan in place as evidence that they are receiving care in a well-functioning system.
NPM 11	Medical Home	ESM 11.2	Percent of CYSHCN who have a shared plan of care in use as evidence that they are receiving care in a well-functioning system.
NPM 12	Transition	ESM 12.1	Percentage of CYSHCN who have transition plans to adult health care in place by age 16.
NPM 13	Preventive Dental Visit	ESM 13.1	The percent of women who receive a dental cleaning during pregnancy.
NPM 13	Preventive Dental Visit	ESM 13.2	The percent of high risk children, ages 1 through 17, who have had a preventive dental visit in the past year.

State Performance Measures

SPM #	SPM Title	Population Domain(s)
SPM 1	The rate (per 100,000) of suicide deaths among youth aged 10 through 19.	Adolescent Health, Child Health
SPM 2	Percent of adolescents, ages 12 through 17, who are bullied.	Adolescent Health
SPM 3	The proportion of births occurring within 18 months of a previous birth (percent, females 15–44 years).	Women/Maternal Health, Perinatal/Infant Health

Executive Summary

INTRODUCTION

As part of the Title V Block Grant FFY 2017 Application/Annual Report, the Connecticut Department of Public Health (DPH) undertakes a statewide Needs Assessment every five years, examining the health status of Title V target populations of pregnant women, mothers, and infants; children and adolescents; and children and youth with special health care needs. This assessment is a systematic examination of the health behaviors, conditions, and risk factors of these populations, using indicators that can be tracked over time for each of the six identified population health domains (Women's/Maternal Health; Perinatal/Infant's Health; Child Health; Children with Special Health Care Needs (CSHCN); Adolescent Health; and Cross-cutting or Life Course). The Connecticut MCH Needs Assessment aims to serve as an important foundation for future data-driven planning efforts in the state. The Needs Assessment builds upon the Healthy CT 2020: State Health Improvement Plan (SHIP), a plan for improving the health of all Connecticut residents in the current decade. A dashboard is available on the CT DPH website to provide a transparent view of progress towards health indicators related to the SHIP.

Connecticut Department of Public Health (DPH) provides a leadership role in convening and facilitating a coalition of partners for Healthy CT 2020 implementation, as well as a robust Maternal and Child Health Coalition consisting of more than a hundred stakeholders committed to supporting SHIP Action Teams (which consist of focus areas including: Maternal Infant and Child Health, Environmental Health, Chronic Disease Prevention, Infectious Disease Prevention, Injury & Violence Prevention, Mental Health & Substance Abuse, and Health Systems) as well as the MCH Block Grant National and State Performance Measures. Connecticut DPH has been successful in partnering with other state agencies and with community partners; convening and facilitating other important forums for integration and coordination including the Medical Home Advisory Council, the Sickle Cell Disease Stakeholders Consortium, the School Based Health Center Advisory Council, the School Based Health Center Strategic Action Group, the Safe Schools/Healthy Students Data Innovation Committee, Healthy Start Community Action Network, and the Personal Responsibility Education Program Advisory. DPH MCH staff also partner through participation on statewide boards and advisories such as the Medical Administration Program Oversight Council, the CT Children's Behavioral Health Plan Implementation Committee, the CT Council on Developmental Disabilities, the CT Family Support Council, and the State Department of Education Transition Task Force. These numerous partnerships afford DPH the ability to perform the needs assessment with considerable input and contribution from stakeholders and to implement the strategies associated with both National and State Performance Measures in a coordinated and integrated manner.

Connecticut DPH has taken a leadership role in integration across the system of services through collaboration with the Department of Social Services and other partners with a focus on supporting and improving medical home care coordination, community care coordination collaboratives, and an emerging state level care coordination collaborative. This initiative serves to support efforts in agency integration, improvement in access to services and shared resources, and cross systems care coordination, with great success in promoting and connecting medical homes to the broader medical neighborhood and in working towards true shared care coordination. This systems integration has strengthened the MCH infrastructure in Connecticut and better positions Connecticut DPH and our partners to implement strategies associated with performance measures as well as in addressing emerging issues.

MCH FIVE-YEAR NEEDS ASSESSMENT

The MCH Needs Assessment and Planning process was continued in this second year of the grant cycle through data updates and review, stakeholder discussions, virtual and in-person planning sessions, and statewide agency, organization and workgroup input. Attention continued to include integration with the larger Connecticut State Health Assessment and Planning process (*Healthy Connecticut 2020*) and engaged stakeholders and Connecticut residents throughout the process to understand maternal and child health in its broadest context. Additionally, outreach to engage public input and comment were expanded.

The nine (9) State Selected Priorities identified in the Five-Year Needs Assessment: 1) Well woman care/health of women of reproductive age; 2) Preterm births and low birth weight births; 3) Breastfeeding; 4) Developmental screening, well-child visits and immunizations; 5) CSHCN Transition to Adult Health Care; 6) CSHCN Medical home; 7) Bullying; 8) Adolescent Wellness; and 9) Oral health remained in effect for this year. Our work this year expanded to include the identification of both State Performance Measures (SPMs) to support some of our State Selected Priorities, as well as Evidence-based Strategy Measures (ESMs) to support National Performance Measures (NPMs) identified in year one.

STATE PERFORMANCE MEASURES

The following is a description of the SPMs identified, as well as their relation to population domains identified in year one.

SPM 1 - The rate (per 100,000) of suicide deaths among youth aged 10 through 19.

This measure relates to the population domain of adolescent health. Our goal in this measure is to eliminate self-induced, preventable morbidity and mortality. Suicide is the second leading cause of death for ages 10 through 24, and the third leading cause of death for college age youths and ages 12 through18. In the U.S. each day, there are an average of more than 5,400 suicide attempts by young people grades 7-12. In Connecticut 15 youths ages 10 to 19 died by suicide in 2014 (DPH Health Statistics and Surveillance Section, 2014 Mortality Data).

SPM 2 - Percent of adolescents, ages 12 through 17, who are bullied.

This measure relates to the population domain of adolescent health. Our goal in this measure is to reduce the number of adolescent who are bullied. Bullying, particularly among school-age children, is a major public health problem. Current estimates suggest nearly 30% of American adolescents reported at least moderate bullying experiences as the bully, the victim, or both. Specifically, of a nationally representative sample of adolescents, 13% reported being a bully, 11% reported being a victim of bullying, and 6% reported being both a bully and a victim. Studies indicate bullying experiences are associated with a number of behavioral, emotional, and physical adjustment problems. Adolescents who bully others tend to exhibit other defiant and delinquent behaviors, have poor school performance, be more likely to drop-out of school, and are more likely to bring weapons to school. Victims of bullying tend to report feelings of depression, anxiety, low self-esteem, and isolation; poor school performance; suicidal ideation, and suicide attempts. Emotional and behavioral problems experienced by victims, bullies, and bully-victims may continue into adulthood and produce long-term negative outcomes, including low self-esteem and self-worth, depression, antisocial behavior, vandalism, drug use and abuse, criminal behavior, gang membership, and suicidal ideation. (2015 CDC Youth Risk Behavior Survey)

SPM 3 - The proportion of births occurring within 18 months of a previous birth (percent, females 15–44 years).

This measure relates to the population domain of Women/Maternal Health. Our goal in this measure is to increase the proportion of women with a live birth who report having had a preconception health care discussion with a health care provider. The timing between a live birth and the next pregnancy, termed the interpregnancy interval (IPI), may affect the risk of pregnancy complications, such as preterm birth, low birthweight, and small gestational age (birthweight that is small for a given gestational age). While there is no consensus on optimal IPI, research has shown that short intervals (less than 18months) and long intervals (60 months or more) were associated with higher risks of adverse health outcomes. Factors such as maternal age and socioeconomic status may affect IPI patterns. Health care providers have emphasized the importance of providing information about and access to family planning services during the postpartum period to reduce adverse outcomes associated with short IPI. Moreover, evidence suggests a relationship between long IPI and perinatal complications, but these mechanisms are less well understood.

Reference: http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_03.pdf

EVIDENCE-BASED STRATEGY MEASURES

As part of the performance measure framework, the ESMs provide accountability for improving quality and performance for the National Performance Measures (NPMs) through action. We worked to identify evidence-based activities and practices that could be measured and would support the NPMs identified in year one. The following is a summary of the NPMs identified in year one, and the ESMs to support that effort generated through this year's work.

NPM 1 – Percent of women with a past year preventive medical visit.
ESM 1.1: The percent of 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.

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU).
ESM 3.1: Increase the number of communities participating in Every Woman Connecticut.

NPM 4 – A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 Months.
ESM 4A.1: The number of hospitals participating in the CT Breastfeeding Coalition's (CBC) Ten Steps Collaborative to implement evidenced-based maternity care and the 10 Steps for Successful Breastfeeding.
ESM 4B.1: The number of Federally Qualified Health Centers (FQHCs) and/ or peer networks that were provided the Secrets of Baby Behavior (SBB) training.

NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool.
ESM 6.1: Percent of children less than 3 years old (1-2 years 364 days old) who receive a developmental screening according to claims code 96110.

NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
ESM 10.1: The percent of adolescents who have their Body Mass Index (BMI) measured at time of a medical visit at all school-based health centers.
ESM 10.2: Increase the percent of Behavioral Health Screenings completed at the time of a medical visit at all school-based health centers.

NPM 11 – Percent of children with and without special health care needs having a medical home.
ESM 11.1: Number of CYSHCN who have a comprehensive care plan in place as evidence that they are receiving care in a well-functioning system.
ESM 11.2: Number of CYSHCN who have a shared plan of care in use as evidence that they are receiving care in a well-functioning system.

NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care.
ESM 12.1: Number of CYSHCN who have transition plans to adult health care in place by age 16.

NPM 13 – A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year.
ESM 13A.1: Increase the percent of women who receive a dental cleaning during pregnancy.
ESM 13B.1: Increase the percent of high risk children, ages 1 through 17 who have had a preventive dental visit in the past year.

CONCLUSIONS

Connecticut has made significant progress in improving the health of residents across the life course. DPH has taken a prominent role in convening partners to address assessment, planning and implementation of activities directly contributing to this improvement. The identification of SPMs and ESMs this year has distinguished specific ways to advance positive health outcomes for our identified population domains, and add to our progress.

The distribution of these health improvements, and persistent and new issues affecting maternal and child health are not equally distributed among subpopulations. Indeed, lower-income residents, black non-Hispanics, and Hispanics generally have less favorable health and health behavior profiles than their counterparts. Additionally, some health patterns among maternal and child health populations vary by sex, town, sexual identity, and special health care need status. Initiatives and activities are planned to keep diverse populations in mind to begin to address these discrepancies.

These measures, developed through a participatory planning process, highlight areas of progress in maternal and child health in Connecticut, as well as health issues necessitating a public health approach to improve health outcomes.