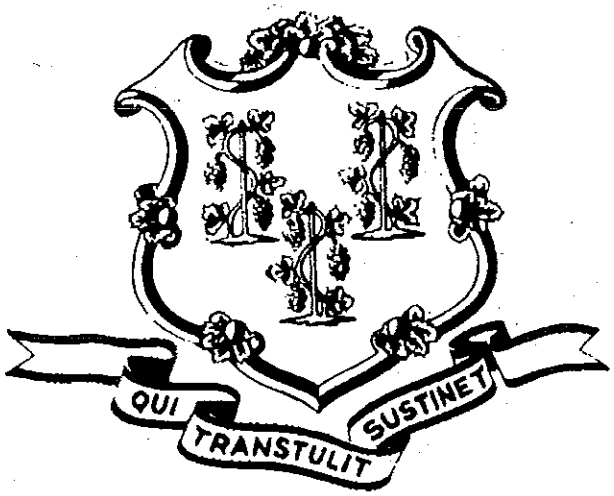
STATE OF CONNECTICUT

AGENCY PREVENTION REPORT



A REPORT TO THE

Child Poverty and Prevention Council
2014

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NOVEMBER 2014

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REPORT TO THE CHILD POVERTY AND PREVENTION COUNCIL

I. LEGISLATIVE AUTHORITY

Section 4-67x of the Connecticut General Statutes sets forth the requirement that each budgeted state agency with membership on the Child Poverty and Prevention Council that provides prevention services to children must submit an agency prevention report to the Council by November 1st of each year through 2014. The agencies must report on at least two prevention services. This report represents the eighth annual State Agency Prevention Report.

The prevention report includes the following:

- A description of the purpose of the prevention service including the number of children and families served through the service;
- A description of the agency's long-term goals, strategies, performance-based standards and outcomes and performance-based vendor accountability;
- A statement of the overall effectiveness of prevention within the agency;
- Methods used to reduce disparities in child performance outcomes by race, income and gender; and
- State and Federal funding amounts.

II. STATE AGENCY REPORT

The prevention programs in this report are administered by State agencies that serve on the Child Poverty and Prevention Council and provide primary prevention services to children and families. The section of the report provides detailed information on at least two of the agency's primary prevention programs. Although the agencies are required to report on, at a minimum, two programs, some reported on more than two programs. The following State agencies included in this report are:

Department of Children and Families

Department of Developmental Services

Department of Education

Department of Housing

Department of Labor

Department of Mental Health and Addiction Services

Department of Public Health

Department of Social Services

Judicial Branch

Office of Early Childhood

Office of Policy and Management

The Departments of Transportation, Higher Education, Economic and Community Development, Office of Health Care Access, Commission on Children, Agriculture, and the Commission on Human Rights and Opportunities 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.

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.*

Furthermore, the prevention programs and services highlighted in this report serve children aged 0-18 and their families. Primary prevention refers to programs designed to prevent or eliminate at- risk behavior before a problem occurs and promote the health and well-being of children.

State Agency Prevention Programs - SUMMARY

State Agency Prevention Programs

This section of the report provides a summary on state agency primary prevention services that provide intensive, comprehensive and family-centered resources and support which reduces or eliminates high-risk behavior and promotes the health and well-being of children and families.

In Fiscal Year (FY) 2014, these eleven agencies expended over $243 million to administer 34 comprehensive primary prevention programs and services that positively impact Connecticut's children and families. The chart below provides a snapshot of the state agency primary prevention programs included in this report.

Department of Children and Families			
Program	**FY14 Funding**	**Service Level**	**Description**
Early Childhood Consultation Partnership	$2,270,475	3,064 children and 1,068 teachers and assistant teachers	Prevent children birth to age 6 from being suspended or expelled from their early care and education setting due to challenging behaviors.
Triple P	$5,428,618	1,558 families served	Provides in-home parent education curriculum and support to create a safe and healthy home environment for children and the family.
Total	**$ 7,699,093**		

Department of Developmental Services			
Program	**FY 14 Funding**	**Service Level**	**Description**
Birth to Three	$50,709,007	9,686 children and families	Early intervention services to all infants and toddlers who have developmental delays or disabilities.
Family Support Services	$10,243,116	739 individuals including 178 children-Respite Centers; 869 individuals including 197 children – Family Support Services	Services, resources and other forms of assistance to help families raise their children who have intellectual disabilities.
Total	**$60,952,123**		

Department of Education			
Program	**FY14 Funding**	**Service Level**	**Description**
21st Century Community Learning Center Grant	$7,629,832	6,536 students	Funds community-learning centers that provide students with academic enrichment opportunities and other activities that complement their academic program.
Supports for Pregnant and Parenting Teens	$1,500,000	320 students	Focuses on improving the health, education and school outcomes for pregnant and parenting students and their children.
Total	**$9,129,832**		

Department of Housing			
Program	**FY 14 Funding**	**Service Level**	**Description**
Children in Shelters:	**$127,520**		Provides financial assistance for childcare to homeless families living in emergency shelters or enrolled in the Rapid Rehousing Program.
Total	**$127,520**		

Department of Labor			
Program	**FY 14 Funding**	**Service Level**	**Description**
Jobs First Employment Services	$18,747,981	15,678 annual caseload	Provides employment services to families in receipt of time- limited state cash assistance.
Connecticut Youth Employment Program	$4,500,000	3,100 youth served and 2,579 successful completions	Provides employment services for youth aged 14 through 21.
Total	**$23,247,981**		

Department of Mental Health and Addiction Services			
Program	**FY 14 Funding**	**Service Level**	**Description**
Best Practices Initiative	$2,005,087	2014 service level will be available after November 30, 2014	Fourteen statewide funded projects that employ a population-based public health approach to address demonstrated substance abuse prevention needs.

Local Prevention Council Programs	$552,470	2014 service level will be available after November 30, 2014	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.
Partnership for Success	$2,300,000	2014 service level will be available after November 30, 2014	The Partnership for Success (PFS) Initiative uses a public health approach in over 30 municipalities and statewide across college campuses to decrease alcohol consumption in youth ages 12 to 20.
Regional Action Council	$1,656,972	2014 service level will be available after November 30, 2014	Regional Substance Abuse Action Councils (RACs) 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.
Statewide Service Delivery Agents	$1,714,816	2014 service level will be available after November 30, 2014	Four entities funded by DMHAS to support prevention efforts across the state by building the capacity of individuals and communities to deliver prevention services.
Tobacco Prevention and Enforcement	$493,575	2014 service level will be available after November 30, 2014	Enforcement and strategies to reduce underage tobacco use.
FDA Tobacco Compliance Check Inspection Program	$651,868	2014 service level will be available after November 30, 2014	Enforce and implement the regulation of the federal Tobacco Control Act that restricts the sale and promotion of tobacco products to youth.
Total	**$9,374,788**		

Department of Public Health			
Program	**FY14 Funding**	**Service Level**	**Description**
Asthma Program: Pediatric Easy Breathing Program	$250,000	6,357 children surveyed and 6,182 treated	A professional education program that trains pediatric providers to administer a validated survey to determine whether a child has asthma.
Asthma Program: Adult Easy Breathing Program	$150,000	2,056 patients surveyed and 720 or 35% diagnosed and treated for asthma	Focuses on adults treated by medical resident physicians in Bridgeport Hospital.
Asthma Program: Putting on AIRS	$96,000	726 AIRS clients from September 2009 to February 2013	Reduce acute asthma episodes and improve asthma control the recognition and elimination/reduction of environmental and procedures/protocols
Immunization Program	$62,033,708	889,214 children served	Prevent disease, disability and death from vaccine preventable diseases in infants, children adolescents and adults.
Special Supplemental Nutrition Program for Women, Infant and Children	$44,940,512	52,308 monthly participation women, infant and children	Provides nutrition and breastfeeding education, supplemental food, and referrals for health and social services to eligible women, infants and children.
Tobacco Use Prevention and Control	$1,076,586	8,000 Connecticut residents through community based cessations programs and QuitLine	Provides local cessation and prevention programs.
Total	**$108,546,806**		

Department of Social Services			
Program	**FY 14 Funding**	**Service Level**	**Description**
Tobacco Cessation Program	$1,272,376	1,230 Individuals	Provides incentive to reduce smoking rates among the estimated 25%-30% of Connecticut Medicaid recipients.
Perinatal and Infant Oral Health Quality Improvement	$175,000	30,000 children	Focuses on oral health improvement and community integration strategies for improving preventive oral health care.
Fatherhood Initiative	$566,656	727 parents	Provides outreach, awareness and training for parents relating to parenting, healthy relationships, and healthy marriages.

Teen Pregnancy Prevention Program	$1,981,204	830 youth	Current programs use one of two science based models: 1) the comprehensive, long term, holistic youth development model based on the Carrera Program Model; or 2) The Teen Outreach Program, a service learning model where participants engage in, reflect on, and learn from community service projects.
Total	**$3,995,236**		

Judicial Branch Court Support Services			
Program	**FY 14 Funding**	**Service Level**	**Description**
Educational Support Services	$897,810	354 cases opened and 303 cases closed	Supports families to ensure that children's educational needs are identified and free and appropriate educational services are accessible.
Family Support Centers	$4,368,300	1,070 referred and 1,055 (98.6%) completed treatment	A multi-service "one-stop" service for children and families referred to juvenile court.
Total	**$5,266,110**		

Office of Early Childhood			
Program	**FY 14 Funding**	**Service Level**	**Description**
Nurturing Families Network	$10,588,370	Screened 6,300 parents; 875 families received Connection services; 2,200 families in intensive home visiting; over 200 families in parenting groups; and 65 father enrolled in the Father Home Visiting Program	Focuses on nurturing parenting, child development, and maternal and child health and community resources.
Help Me Grow	$331,462	1,275 families and children connected to community based services; and 1,200 families enrolled in the Ages and Stages Child Monitoring Program	Ensures that children and their families have access to a system of early identification, prevention and intervention services.

Family School Connection	$595,358	150 families received intensive home visiting services	Provides intensive home visiting services to families who children are frequently truant, tardy or otherwise at risk of school failure.
Family Empowerment Initiatives	$191,516	430 parents received home and group based services	Provides prevention programs to assist high-risk groups of parents and other involved in the lives of children
Total	**$11,706,706**		

Office of Policy and Management			
Program	**FY 14 Funding**	**Service Level**	**Description**
Title V Delinquency Prevention Program	$84,945	N/A	Provides grants to cities and towns for delinquency prevention and early intervention projects.
Youth Prevention Services	$3,500,000	Data not available until 2015	Provides grants to non-profit organizations to implement comprehensive programs and services to prevent and/ or reduce at-risk behavior among youth ages 6-18 and to maximize opportunities for them to become productive, responsible citizens.
Total	**$3,584,945**		

Department of Children and Families

- **Early Childhood Consultation**
- **Triple P Program**

Long-Term Agency Goals: The Department of Children & Families applies a generalized knowledge of prevention in the design and implementation of all its prevention programs and activities. The programs use existing data and national research as the foundation for designing and implementing appropriate evidence-based programs and practices. Similar to other state and federal agencies, risk and protective factors play an important role in the Department's planning process. For example, the federal Children's Bureau has outlined five protective factors that may diminish the likelihood of maltreatment: nurturing and attachment between family members; knowledge of parenting and child development; parental emotional resilience; social connections for parents; and concrete supports such as food, clothing, housing, transportation, and services. The theory is that parents and caregivers who better understand how to care for their children, have access to more and better resources and feel safe and connected to their community will thrive and be less likely to abuse or neglect their children. The programs described here have been shown through research and evaluation to be effective at addressing at least one of these important factors. Knowing that prevention resources are limited, the Department works diligently to collaborate with other state and community based agencies as well as internally to maximize existing prevention dollars. All of the programs listed are examples of collaborations and partnerships.

Goals:

- Prevention/Less Need for DCF Services
- Children to Remain Safely at Home
- Achieve More Timely Permanency
- Improved Child Well-Being
- Transitioning Youth Better Prepared for Adulthood

Strategies: Meeting the desired outcomes is best achieved through building agency and local capacity, public awareness, programs and services, and integrating prevention principles, strategies and resources throughout the department.

Performance-Based Outcomes: The Department is working diligently to meet the Exit Outcomes for its Consent Decree. Therefore, the following outcomes are aimed at meeting these court defined measures. A complete list of Outcome Measures can be found at http://www.ct.gov/dcf/LIB/dcf/positive_outcomes/pdf/Two_Page_Summary_Outcomes_1_22.pdf

1. **Prevention/Less Need for DCF Services**
   - Fewer investigations
   - Fewer open cases
   - Fewer delinquency petitions
   - Fewer Families with Service Needs (FWSN) petitions
   - Increase numbers of families receiving appropriate and effective services
   - Fewer re-entries into child welfare system

2. **Children to Remain Safely at Home**
   - Fewer removals from home
   - Fewer re-entries into care
   - Fewer delinquency commitments
   - Lower recidivism
   - Fewer disrupted adoptions
   - Fewer FWSN commitments

3. **Achieve More Timely Permanency**
   - Fewer youth aging out with APPLA goal
   - Reduce average Length of Stay (LOS) for reunification & Meet Outcome Measure (OM) 7 re: Reunification
   - Reduce average LOS for Transfer of Guardianship (T Of G) & Meet OM 9 re: T/G
   - Reduce average LOS for adoption & Meet OM 8 re: Adoption

4. **Improved Child Well-Being**
   - Fewer school changes
   - Improved school achievement
   - Fewer placement changes
   - Meet OM 14 re: Placements

within License Capacity
- Increase of placement with siblings
- Meet OM 6 re: Child maltreatment in Out of Home (OOH) care
- Increase percentage of children placed with relatives
- Timely medical/dental care
- Lower percentage of children in congregate care
- Reduction of children on discharge delay
- Improved performance on OM 15 re: Needs Met

5. **Transitioning Youth Better Prepared for Adulthood**
   - Increased percentage with family/adult connection
   - Increased percentage of high school graduates
   - Increased percentage engaged in treatment if needed
   - Increased percentage with financial literacy
   - Increase percentage with sustainable housing
   - Meet OM 20 re: Discharge
   - Meet OM 21 re: Discharge to DMHAS/DDS

Measure of Effectiveness: The findings thus far indicate that programs targeting and strengthening families have been the most effective. Research tell us that the earlier interventions are introduced into children's lives the greater the chance for positive results now and later. National research studies shows that very young children are especially vulnerable. The Adverse Childhood Experience Study (ACES) found that adverse childhood experiences are strongly related to the development and prevalence of risk factors for disease and health and social well-being throughout the lifespan. This emphasizes the need for prevention and early intervention programs for very young children and the need to target children in the context of their families and the communities in which they live.

Methods:, At the ground level, programs such as The Breakthrough Series (a program implemented in Waterbury to look at the issue of overrepresentation of minorities in the child welfare system) and Better Together (a program to engage families in our work to inform the Department's ongoing efforts) work to concretely address the issue of disparities in outcomes by race, income and gender. At the systems level, two new DCF initiatives, the Differential Response System and the Best Practice Model combine to support the mission of the Department to protect children, improve child and family well-being and support and preserve families. The goal is to provide a framework for how the agency as a whole will work internally and partner with families, service providers, and others to put our mission and guiding principles into action in daily practice and operations. The Department's workforce reflects the populations it serves. In addition, DCF requires all contractors to administer, manage and deliver a culturally responsive and competent program with specifics clearly articulated in every contract.

Other: Prevention is just one of the Department of Children and Families' many mandates but it is one of its most important. DCF defines prevention as the promotion of wellbeing for all children and families. This is accomplished by building local and agency capacity, public awareness and funding prevention and early intervention programs and services.

Building capacity is done primarily through training. Since 2005, thousands have been trained in a variety of workshops and conferences on early childhood specific topics, youth substance abuse, depression, suicide prevention, Strengthening Families 10 -14 (a nationally recognized evidence-based curriculum), working with parents with cognitive limitations and shaken baby prevention - to name just a few.

Knowledge is power. It is this belief that drives the Department's Public Awareness campaigns. Getting important and timely information to families, providers and DCF personnel requires constant contacts. Along with the dissemination of letters and brochures to schools, superintendents, police, youth service bureaus, and DCF Area Offices and the information regularly distributed electronically through the Prevention list serve, the new CT Parenting website http://www.ctparenting.com/ offers parents and other individuals a user friendly internet site for information on a multitude of topics for parents and caregivers.

The Department's prevention programs and services are designed to strengthen children and families.

Early Childhood Consultation Partnership (ECCP): The goal of ECCP is to prevent children birth to age 6 from being suspended or expelled from their early care and education setting due to challenging behaviors. ECCP promotes and facilitates the early identification of children in daycare education settings with mental health needs. The focus of this service is the provision of consultation and training to staff in Early Care and Education Settings in order to promote young children's social and emotional wellness in order to prevent behaviors that could result in the child being suspended or expelled from the early care and education setting. The program also provides service to DCF foster homes, safe homes, childcare homes, and parent child residential facilities.

Number Served: Since its inception in 2003 the program has served over 22,009 children and over 8,637 teachers and assistant teachers within an estimated 988 of Connecticut's licensed early care or education centers. In 2013-2014, 3,064 children and 1,068 teachers and assistant teachers were served.

Program Cost: FY 2014: $2,270,475

Performance-Based Standards: ECCP is a data driven program demonstrating its effectiveness through the internal quality assurance and program improvement measures it employs and through external research evaluations and national studies. ECCP is further backed by a 2007 rigorous randomized control evaluation conducted by Walter S. Gilliam, PhD, of Yale Child Study Center. A randomized study compared outcomes for children who were/ were not enrolled in classrooms that received ECCP services. Results indicated significant effectiveness in reducing classroom behavior problems in children, demonstrating changes such as decreased oppositional behaviors and hyperactivity. Program measures such as 6 month follow up data show that 99 percent of children in programs that received consultations were neither suspended nor expelled from their early care or education settings, and that 95 percent of classrooms served demonstrated improvement in the overall quality of classrooms environments.

Performance-Based Outcomes:

- Increased number of early childhood education centers and staff who have access to education and support services related to social and emotional wellness.
- Increased the number of caregivers and teachers that are implementing practices supportive of social and emotional health
- Improved ability of educators to observe and document children's behavior and identify behaviors that may be clinically significant
- Improved ability of educators to deliver classroom strategies and interventions targeted to specific children
- Improved ability of educators to initiate discussions with parents regarding children's behavioral difficulties, and to work in partnership with families, in helping to address children's individual needs
- Reduced incidence of suspension and expulsion in young children due to behavioral problem
- Increase coordination between parent /guardians, providers, DCF workers
- Increased capacity of parent /guardians, providers, DCF workers and early educators in the areas of healthy social/emotional development and attachment
- Increased support for children in foster care and for DCF staff

Performance-Based Vendor Accountability: ECCP is funded through Connecticut's State Department of Children and Families and is managed by Advanced Behavioral Health (ABH®), a non-profit behavioral health care management company. ABH has been responsible for the development and administration of the ECCP program. ABH subcontracts with 10 non profit behavioral health clinics for 20 Early Childhood Mental Health Consultants to provide statewide coverage. ECCP is backed by a rigorous research evaluation and features a fully manualized service approach, customized central Information System, and an integrated and competency based workforce development and training program. ECCP is now an evidence–based effective practice and nationally recognized as an evidence-based model for other states to follow.

Triple P: This service utilizes the evidenced-based model, Triple P (Positive Parenting Program®) of the University of Queensland, to provide an in-home parent education curriculum along with support and guidance so that parents will become resourceful problem solvers and will be able to create a positive and safe home learning environment for children to develop emotional, behavioral, and cognitive strengths. Within the multi-tiered Triple P system, this

service will use Triple P's Level 4 Standard and Level 4 Standard Teen courses. In addition to Triple P, this service will provide short term case management supports to help parents fully utilize the parenting services.

Number Served: A total of 1,558 families were served in FY 2014.

Program Cost: FY 2014 $5,428,618 (serves parents and primary caregivers of children and adolescents)

Performance-Based Standards: Level 4 Standard and Standard Teen Triple P is designed to decrease the key risk factors for child abuse and neglect. Risk factors include child's level of behavior problems, parent's level of hostility, parent's level of over-reacting, parent's level of laxness, and parent's level of stress, anxiety, and depression.

Performance-Based Outcomes:

- For the parents assessed at intake as having a dysfunctional level of child behavior problems, did we decrease the level of the child behavior problems?
- For the parents assessed at intake as having a dysfunctional disciplinary style, did we decrease the dysfunctional disciplinary style?
- For the parents assessed at intake as having a dysfunctional level of symptoms for anxiety, stress, or depression, did we decrease the parents' dysfunctional level of symptoms for anxiety, stress, or depression?

Performance-Based Vendor Accountability: Monthly, quarterly, and annual reports; statewide data system was implemented in August 2014.

Department of Developmental Services

- **Birth to Three**
- **Family Support Services**

Long-Term Agency Goals: The Department of Developmental Services (DDS) provides services and supports to 16, 274 individuals who have a diagnosis of intellectual disability in Connecticut including 2,698 children under the age of 18. This number does not include approximately 9,600 eligible children who are served each year in the Birth to Three System. While most of the children served by DDS live with their families, approximately 163 children live in other residential settings. The department's long term prevention goal is to 1) provide early intervention to families of very young children with delays or disabilities to ameliorate the delay or to prevent secondary disabilities; 2) support families to care for their children in the family home; and 3) to prevent out-of-home placement.

Strategies: For children enrolled in Birth to Three, family-centered early intervention services are delivered in natural environments as early as possible. Most families who have children with intellectual disability over the age of three need extra support to care for their children at home. DDS provides Family Supports to assist families caring for their children at home. Family Supports include goods, services, resources, and other forms of assistance that help families to successfully raise their children who have intellectual disability. The Department of Developmental Services plans to continue to provide Individual and Family Grants, Respite, and Family Support Workers to families. Within available resources, the department serves as many families as possible with these Family Supports. The Birth to Three System is funded through state and federal dollars as well as billing private insurance, Medicaid and parents. This year the Birth to Three state regulations were updated to reflect a single sliding fee scale for all parents with incomes over $45,000.

In addition to the Family Support services offered by the department, DDS continues to implement Home and Community Based Services Waivers which offer services in the community as an alternative to institutional care for children over the age of three. 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 supports, respite, home and vehicle modifications, family training and consultative services. All children who receive Medicaid fee for services are provided with a DDS case manager. A help line exists in each of the three DDS regions to assist families who do not have a case manager to access appropriate family support services. DDS also developed a waiver for three- and four-year-olds who have autism spectrum disorder but do not have intellectual disability. This Medicaid waiver received approval from the Centers for Medicare and Medicaid Services (CMS) in February 2104. This waiver is designed to bridge the gap between Birth to Three and Kindergarten services. It is anticipated that 30 children will be served through this waiver.

Performance-Based Outcomes: For children enrolled in Birth to Three, children are identified as early as possible, children's developmental trajectories are improved, parents feel more confident and competent to foster their child's development, and fewer children need special education services by Kindergarten. Children over the age of three are able to live at home longer with their families, receiving appropriate supports and avoiding more costly residential or out-of-home care.

Measures of Effectiveness: Because individuals eligible for DDS supports and services have a diagnosis of intellectual disability or autism spectrum disorder, they are likely to require lifetime services. While intellectual disability or autism spectrum disorder in and of itself is not "preventable", strategies are pursued to lessen or delay the need for more comprehensive services throughout an individual's lifetime and to provide supports and services that build skills and independence. The provision of in-home services often delays the need for more comprehensive and thus more expensive residential or out-of-home services. In Birth to Three, family survey outcome data supports that the stated outcomes are being achieved to a great degree.

Methods: Any child that meets the DDS eligibility criteria in section 1-1g of the Connecticut General Statutes is eligible for services, irrespective of race, income level, gender or town of residence. Funding for these services is allocated to a child and their family based upon the child's level of need and

available appropriations. Birth to Three is an entitlement program and all eligible children may receive services. Data about all children born during a given calendar year (birth cohort) indicate no racial, income level, or town of residence disparities. The prevalence of a wide range of developmental disabilities is greater for males than for females and Birth to Three follows this pattern with enrollment that is 64% boys. The focus of early intervention services is in teaching the family and other caregivers to facilitate the child's development during naturally occurring routines and activities.

BIRTH TO THREE: The Department of Developmental Services (DDS) 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 to 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 developmental 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. Birth to Three works 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. States are given quite a bit of latitude in defining both of these groups.

Early intervention services must be delivered in natural environments which, for children at this age, are 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.

Number Served: In FY 2014, there were 8,720 referrals for eligibility evaluations. During some portion of fiscal year 2014, 9,686 eligible children and their families received services with an average of 5,000 children enrolled on any given day. Data about children born between 2000 through 2010 show that 10% to 11% of the children born in each year (birth cohort) were eligible for Birth to Three at some point before turning three. Data on those children born in 2010 shows that one out of every seventy-nine children born in that year received autism services sometime before their third birthday.

Program Cost: FY 2014 $50,709,007
State: $40,275,377 Federal: $4,808,506 *Other: $5,625,123

*In addition to state and federal funding, the state netted $1,176,381 from parent fees and $49,448,742 from commercial insurance in FY14. (Medicaid billing resulted in $6,668,195 of federal reimbursement for the state's general fund in FY 14)

Performance-Based Standards: There is a single statewide point of access, which is easily marketed to health care providers and other 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. Individualized Family Service Plans (IFSPs) are reviewed at least every six months and rewritten at least annually. School Districts are notified of all children receiving early intervention services shortly before the child turns three, if the children have not already been referred to the districts. Parents are encouraged to refer their children no later than age two and a half.

Performance-Based Outcomes:

- All eligible children and their families are identified and offered services
- Children receive early intervention services as early as possible, with a renewed emphasis this year on enrolling children prior to age one
- 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 Vendor Accountability: Birth to Three has an in-depth, multi-layered process for assuring the quality of services and the performance of its contractors:

- *Data System.* All contractors are part of a real-time web-based data system that enables the state to view their performance on a daily basis. As part of that web-based data system, the contractors have a "performance dashboard" that allows them to monitor their own performance.
- *State Performance Plan/Annual Performance Report.* The department submits a five-year State Performance Plan to the U.S. Department of Education and then submits an Annual Performance Plan each year reporting on progress. Each indicator of performance in the annual plan is also reported for each contractor. Any contractor not in 100% compliance with the IDEA for any indicator receives a finding of non-compliance, which must be corrected as soon as possible but not later than 12 months from written identification. Connecticut's Annual Performance Report for IDEA Part C has resulted in a determination of "meets requirements" for the past seven consecutive years.
- *Self-Review.* In addition, every three years, each Birth to Three contractor submits a self-review looking at their performance over a wide variety of indicators. That review is submitted electronically to DDS central office staff, who verify the data. The contractor is required to prepare an improvement plan for any items that are either not in compliance with the law or any performance items that need improvement. Once a year, the state ranks contractors on one or more specific indicators chosen by a stakeholder group. 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. The team reviews child records, interviews staff, and interviews parents. The monitoring report is issued and any findings of non-compliance are made. Corrections of non-compliance findings or items needing improvement are added to the contractor's existing improvement plan. Any finding of non-compliance must be corrected as soon as possible, but not later than 12 months from written identification.
- *Dispute Resolution.* The last check on contractor 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 the last hearing held was in 2007. All of these accountability processes are detailed in the Birth to Three Quality Assurance Manual found on www.birth23.org under "How are we doing?"

FAMILY SUPPORT SERVICES: The Department of Developmental Services (DDS) provides Family Supports that assist families to care for their children who have intellectual disability in their homes. Most families who have children with intellectual disability need extra support to help them keep their children at home. Family Supports include goods, services, resources, and other forms of assistance that help families successfully raise their children who have an intellectual disability. Family Supports include 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. DDS Respite Centers provide 24-hour care for extended weekends in comfortable home-like environments.

Family Support Workers provide temporary in-home and community support to DDS consumers who live at home with their families. These supports are provided by DDS staff who have skills needed to work with children with intellectual disability and their families. The types of supports and services provided include in-home and community supports, respite, skill building, implementation of behavior programs, activities to promote health and wellness, transportation to medical appointments, and support with transitions to adult programs.

Number Served: The department has 11 Respite Centers which served a total of 739 individuals statewide in FY 14, including 178 children. During FY 14, DDS family support workers provided services to more than 869 individuals statewide, including 197 children.

Program Cost: FY – 2014 $10,243,116

Performance-Based Standards: The goal of DDS Family Supports is to provide a range of supports for children with intellectual disability and their families to keep these children in their family home. DDS prioritizes family supports based upon the level of need of the child; for instance, a child who is a high priority on the waiting list for residential services is also a high priority for services at respite centers.

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 compared to children in out-of-home placements.

Performance-Based Vendor 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. These procedures are described in 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 in keeping families together and makes recommendations to the Commissioner regarding the appropriateness of placements.

- **21st Century Community Learning Center Grant**
- **Supports for Pregnant and Parenting Teens**

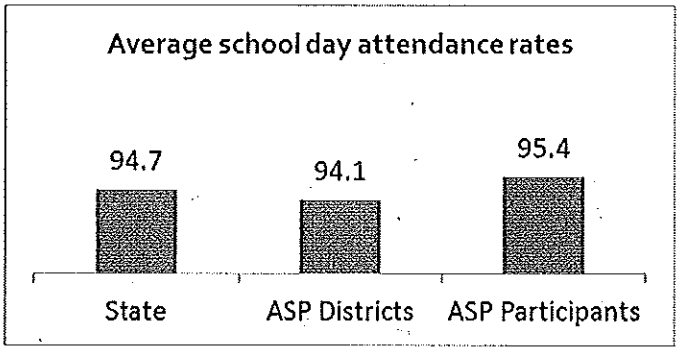
21st Century Community Learning Center Grant (CCLC): The purpose of the program is to fund *community-learning centers* that provide students with academic enrichment opportunities, as well as additional activities designed to complement their regular academic program. The 21st CCLC must offer students' families literacy and related educational development activities. Centers, which can be located in elementary or secondary schools or other similarly accessible facilities, provide a range of high-quality services to support student learning and development, including tutoring and mentoring, homework help, academic enrichment (such as hands-on science or technology programs), community service opportunities, as well as music, arts, sports, health and cultural activities. At the same time, centers help working parents by providing a safe environment for students when school is not in session.

Number Served: 6,536 students

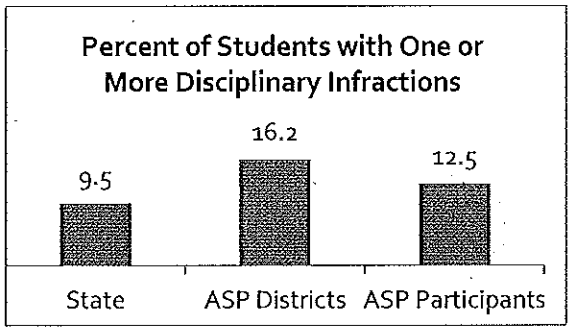
Program Cost FY 2014: $7,629,832

Performance-Based Standards: Overarching goals of the 21st CCLC Program aim to:
- Increase student performance
- Increase school attendance
- Reduce incidences of suspension or expulsion
- Reduce the rate of school dropout
- Increase school retention and completion
- Reduce risk of course failure

Performance-Based Outcomes:
Performance Indicator 1: School Attendance- Participants in the 21CCLC after school program (ASP) had higher school day attendance rates than students in ASP districts and students statewide. This represents a difference of one to two school days.



Performance Indicator 2: Disciplinary Infractions - Among 21CCLC after school program (ASP) participants with disciplinary infractions, the average number of infractions was 2.6, compared to 3.0 for students in ASP districts and 2.7 statewide.



Participants in the 21CCLC ASP received disciplinary infractions at a higher rate than the statewide general student population, but their rate was significantly lower than that of students in their ASP districts.

Supports for Pregnant and Parenting Teens (SPPT): The Supports for Pregnant and Parenting Teens (SPPT) program is a school-based grant program available in six Connecticut school districts with the highest teen pregnancy and school dropout rates. The programs are located in comprehensive high schools serving students in grades 9-12, with a focus on improving the health, education and social outcomes for pregnant and parenting students and their children. The program provides a coordinated approach to school health and student support services, which has been identified as an evidence-based approach for working with parenting students and their children. This coordinated model offers: flexible, quality schooling to help young parents complete high school; case management and family support; linkages and referrals to prenatal care and reproductive health services; quality child care for children with links to basic preventative health care; parenting and life skills education and support services; father involvement services and supports; links to higher education; and intergenerational supports.

NUMBER OF CLIENTS SERVED: 320 students

PROGRAM COST: FY 2014 $1,500,000

PERFORMANCE-BASED STANDARDS: Overarching goals of the SPPT Program aim to:
- Increase school retention and completion
- Reduce risk of course failure
- Reduce the rate of school dropout
- Reduce second pregnancies
- Increase access to prenatal care and reproductive health services
- Increase access to licensed child care centers
- Increase access to pediatric health services
- Increase access to case management and social services
- Increase access to services for teenage fathers

PERFORMANCE–BASED OUTCOMES:
99% of children were current with well-child visits and immunizations
74% of 12th grade students graduated or remained in school
1% repeat pregnancy rate

Department of Housing

- **Children in Shelter**

As the new lead state agency on all matters related to housing, the Department of Housing (DOH) is dedicated to meeting the housing needs of low- and moderate- income individuals and families, enabling them to live in communities where they have access to quality employment, schools, necessary services and transportation. One of the programs that was newly transferred to DOH, the Lead Action for Medicaid Primary Prevention (LAMPP) program provides early intervention and prevention funding to protect children and their families from lead and other health hazards in their homes. DOH contracted with the Connecticut Children's Medical Center in October to administer this program: conducting risk assessments and inspections of housing units, providing hazard control education to families and property owners, and providing homeowners with financial assistance to rehabilitate units with identified hazards. DOH is further supplementing this program with state funds to finance lead and environmental risk abatement in an additional 142 homes and rental units in 15 targeted communities across Connecticut.

In addition, DOH is responsible for administering the Children in Shelter program, which provides financial assistance for childcare to homeless families living in emergency shelters or enrolled in the Rapid Rehousing Program. While these are the DOH programs that are designed to directly promote the health and well-being of children, the majority of the department's programs provide vital prevention services by affording access to safe, quality housing for lower income families, which promotes the health and well-being of the whole family.

Children in Shelters: Children in Shelters: The Children in Shelters program provides financial assistance for childcare to homeless families living in emergency shelters or enrolled in the Rapid Rehousing Program.

Program Cost: FY: 2014 $127,520

Performance-Based Standards: Program communities must develop and implement a local delinquency prevention program plan that:

- Assess 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: Homeless children who do not have access to quality childcare and early childhood education have poorer outcomes than their peers who do have access to those services. Children in Shelters, by providing subsidies for childcare for children residing in homeless shelters, addresses this risk factor.
- Identify all available resources in the community: Care 4 Kids is available to pay for child care for this population, if the parent is working.
- Assess gaps in the needed resources and how to address them: Care 4 Kids is not available to families in which at least one parent is not working. Care 4 Kids also typically takes 2-4 weeks to take effect, creating an additional gap in childcare. Children in Shelters serves families living in homeless shelters, regardless of employment status of the parent(s). It also bridges the gap between application for Care 4 Kids and it going into effect.
- Establish goals and objectives along with an implementation timeline:
    - Objectives, to be met annually:
        - Provide 50 children with childcare assistance
        - At least 25 homeless service providers and 15 ECE services providers participate in training and technical assistance sessions as measured by program attendance.
        - At least five representatives of Connecticut's community plans to end homelessness participate in training and technical assistance sessions as measured by program attendance

    - At least 40 homeless services and/or ECE services providers participate in training sessions relating to the implementation of the federal HEARTH Act upon services for homeless children and their families as measured by program attendance.
    - At least two specialized sessions are provided at the CCEH Annual Training Institute relating to services for homeless children and their families as measured by event attendance and workshop descriptions.
- Insure the collection of data for the measurement of performance and outcome of planned program activities: Data on each outcome is collected and reported on annually.

Performance-Based Outcomes:
Outputs

- Number of full time equivalent funded with grant funds: 0.8 FTEs
- Number of planning activities conducted: No formal planning activities are conducted through CIS
- Number of program youth served: 50 youth are served annually.

Outcomes

- Number and percent of program youth exhibiting an increase in school attendance: N/A
- Number and percent of program youth completing program requirements: 100% (N=50) attend a licensed early childhood program as a result of program participation
- Number and percent of program youth satisfied with the program: N/A. Not collected due to age of the program participants.
- Number and percent of program staff with increased knowledge of program area: 100% of attendees at Children in Shelters related trainings have increased knowledge as a result of the trainings.

Performance-Based Vendor Accountability
Program grantees prepare quarterly progress reports and collect evaluation data for the measurement of performance and outcome of planned program activities: Reports are submitted to the Department of Housing on a quarterly basis on July 31, October 31, January 31 and April 30.

Department of Labor

- **Jobs First Employment Services**
- **Connecticut Youth Employment Program**

Long-Term Agency Goals: The Department of Labor (DOL) is committed to protecting and promoting the interests of Connecticut workers. In order to accomplish this in an ever-changing environment, the DOL assists workers and employers to become competitive in the global economy using a comprehensive approach to meeting the needs of workers and employers, and the other agencies that serve them.

Within the context of DOL's long term agency goals, the DOL has two programs that target families and children: Jobs First Employment Services (JFES) and CT Youth Employment Program. The goals of the JFES program are to enable all families who receive time-limited state cash assistance to become and remain independent of welfare through employment by the end of the 21-month durational limit on cash assistance. The goal of the CT Youth Employment Program (CYEP) is to provide low-income youth aged 14 through 21 years with meaningful paid work experiences.

Strategies: To meet the goals of the JFES program, parents on cash assistance are provided with employment-related assessments, job counseling, case management, vocational education, adult basic education, subsidized employment and support services to enable them to become employed before their cash assistance ends. TFA recipients often have multiple and/or severe barriers to participating in the program and obtaining and retaining employment. The program offers intensive, home-based case management which provides in depth assessments and assistance obtaining the services necessary to overcome the barriers to employment.

To meet the goals of the CYEP program, low-income youth are provided with job-readiness training, career exploration and guidance, exposure to the world of work and paid work experience.

Measure of Effectiveness: The DOL measures the effectiveness of these programs by collecting and reporting on obtained employment information on these two groups. The JFES program issues monthly figures on the number of JFES participants who are employed by vendor and statewide. The number of participants with earnings higher than the TFA payment standard and the Federal Poverty Level are also issued monthly. JFES contracts with vendors contain performance standards and contractors' performance are measured and issued once the wage file information is available.

CYEP measures effectiveness by collecting data on the number of youth to participate in a paid work experience and compare these numbers to the vendors' goals as stated in their contracts. DOL also collects data on the number of youth to participate in work-readiness training and to receive support services. Compliance monitoring is conducted at all five regional Workforce Investment Boards (WIBs). This includes a review of financial management, consisting of financial reporting, cost allocation methodology, cash management, allowable costs, payroll controls, audit requirements, procurement and property controls. Also, WIA eligibility verification for youth is reviewed by sampling client files throughout the state.

Jobs First Employment Services: Provides employment services to families in receipt of time-limited state cash assistance. These services assist Temporary Family Assistance recipients to prepare for, find and keep employment so that they can become independent from welfare.

Number Served: 15,678 annual caseload

Program Cost: FY 2014 $18,747,981

Performance-Based Standards:

- Number of participants to obtain employment during the State Fiscal Year
- Number of participants and percentage of JFES caseload to obtain employment with wages higher than the cash benefit that they receive during the State Fiscal Year
- Number of participants and percentage of JFES caseload to obtain employment with wages higher than the federal poverty level for their family size during the State Fiscal Year

Performance-Based Outcomes: SFY 14 complete employment data will not be available until January 2015. SFY 13 data is: total annual caseload 15,393, 6,033 or 39% of the caseload obtained employment; 5,689 or 37% of the caseload earned wages above temporary family assistance benefits; and 1,875 or 12% of the caseload earned wages above the federal poverty level.

Performance-Based Vendor Accountability: Indicators of performance toward achieving these standards at contractor and statewide levels are determined and issued monthly. Contracts with program vendors and subcontractors include these performance base standards. Standards are measured using the DOL wage data when it is available (normally six months after the end of a program period). Until the recent recession, all vendors consistently met these standards.

Connecticut Youth Employment Program: The state funded subsidized employment program serves low income youth aged 14-21 years. The State Youth Employment Program provides employment opportunities, work-readiness skills training and supportive services. In some instances, academic remediation is also provided.

Number Served: 3,100 youth were served between the summer component and the year round component.

Program Cost: FY 2014 $4,500,000

Performance-Based Standards: As established in the contract, the number enrolled and successfully completed the program and the wages paid.

Performance-Based Outcomes: FY 2014 – 3,100 youth served and 2,579 successful completions (83% success rate).

Performance-Based Vendor Accountability: Workforce Investment Boards (WIBs) ensure all vendors are knowledgeable about wage and workplace standards applicable to youth under the age of 18. Monitoring is conducted to ensure contractual obligations are being met, including the security of the payroll system. Worksites and working conditions are examined for compliance with health and safety laws and laws governing the employment of minors.

Department of Mental Health and Addiction Services

- **Best Practices Initiative**
- **Local Prevention Council**
- **Partnership for Success**
- **Regional Action Council**
- **Statewide Service Delivery Agent**
- **Tobacco Prevention and Enforcement**
- **FDA Tobacco Retail Inspection**

Long-Term Agency Goals: The goals of the Department of Mental Health and Addiction Services (DMHAS) include:

- Improve the behavioral health status of Connecticut's citizens and reduce health care and other costs to society of addiction and mental health problems
- Achieve quantifiable decreases in substance abuse, suicide and suicide attempt rates across the state
- Establish a quality care management system to achieve defined goals, service outcomes and the continued improvement of the integrated DMHAS health care system.
- Maintain a broad array of programs and practices that are data informed and will respond to changing needs as the prevention system grows.
- Increase workforce capacity to provide culturally competent and integrated services to persons whose needs are challenging or not well met.
- Create a resource base to improve the delivery and financing of DMHAS' prevention services

Strategies: The Departments' strategies include:

- Assess the prevention needs for youth, families and communities across the state
- Provide cost-effective, research based, developmentally appropriate prevention services that promote the health & well-being of children and families
- Develop, maintain and increase partnerships with state and local agencies to implement, evaluate and diffuse effective prevention programs and strategies that focus on youth and families
- Implement program standards to monitor the service system
- Increase funding of evidence-based programs that focus on families, early childhood and youth development
- Explore resources to implement the prevention data infrastructure, policy and program recommendations
- Provide training and technical assistance to increase the cultural ability of prevention program providers to: (1) work effectively with youth and parents from culturally, economically and geographically diverse populations; (2) identify and refer individuals at risk of suicide; and (3) utilize the data driven Strategic Prevention Framework planning model

Performance-Based Outcomes:

- Alignment of programs with federal and national initiatives
- Streamlined and on-line data collection
- Increased number of evidence-based programs for youth, families and professionals that focus on youth suicide prevention, tobacco and alcohol use prevention, and prescription drug abuse 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 and community readiness to implement prevention programs
- Improved population and program outcomes

<u>Population Results</u>

- A reduction in past month alcohol use drinking among 12-17 year-olds from 19.6% to 17.8% resulting in a $500K federal incentive to implement prescription drug abuse prevention strategies

- A reduction in cigarette and other tobacco use rates among 12-17 year-olds, as well as recent use of illicit drugs across all ages (2011 NSDUH report)
- Reduction in the illegal drug/alcohol use/ prescription drug abuse and misuse
- Reduction in suicidal behavior among youth and young adults
- Decreased criminal justice involvement
- Although alcohol and marijuana use remains above the national average, the state has seen an overall reduction in alcohol use rates over the past year among ages12-20 and 21 and over

Program Results

- The percentage of funded prevention programs that are evidence-based is at 68.4% in 2013. The percentage of expenditures on evidence-based programs and strategies has also increased.
- Increased enforcement of alcohol, tobacco and other drug laws
- The percent of merchants selling tobacco products to minors has decreased from 14.8% in 2013 to 13.3 in 2014
- Reduction in access to alcohol, tobacco and illegal drugs by minors
- Reduction in retailer violation rates for tobacco and alcohol sales to minors

Methods: DMHAS provides Prevention services aimed at increasing the health and wellness of children and their families through funding and assessing its pool of over 160 non-profit providers statewide. DMHAS contracts with several statewide and regional technical assistance resources to utilize data to identify vulnerable populations and Use the National CLAS Standards to ensure that all products, activities and services are culturally competent and developed and implemented with fidelity so as to advance health equity and eliminate disparities.

BEST PRACTICES INIATIVE: Fourteen (14) funded projects that employ the five-step Strategic Prevention Framework (SPF) address demonstrated substance abuse prevention needs for youth age12-20, college students, adults, families and grandparents. Approximately 50% of their overall funding for the initiative is used to reduce underage drinking and related consequences in youth ages 12-20 with the remaining funds used to reduce prescription drug misuse and other problem substance use.

Number Served: 2014 service level will be available after November 30, 2014.

Program Cost: FY -2014 $2,005,087

Performance-Based Standards: DMHAS requires programs under the Best Practices Initiative to 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.

Performance-Based Outcomes:

- 19 community-based prevention coalitions across the state
- 100% implementation of evidenced-based strategies measured by monthly reports on services activities
- 100% of target population participation in evidence-based strategies and activities to address problem substance use
- 7.7% reduction in past 30-day alcohol use among 12-17 year-olds

Performance-Based Contractor Accountability: Program contractors for this initiative complete a strategic plan of community needs and resources, evidence-based programs and strategies to address them and evaluation information and measures. An action plan that sets the stage for the collection of process measures necessary for federal reporting is also completed. It identifies and codes the action steps for implementing goals and objectives, the staff hours

required to implement activities and the numbers to be served by each activity. Contractors are required to use the federal guidance document for identifying and selecting evidence-based programs which assures program fidelity and fit. Progress reports are also required and consist of bi-monthly narrative and process data submitted electronically. The report generally allows contractors to share information with DMHAS regarding program participants and services that are delivered and helps staff to track compliance with contractual obligations as well as provides an opportunity to discuss any program changes and challenges. An annual site visit by DMHAS staff is conducted to validate program activities, assess continuing contractor capacity, determine technical assistance needs, and substantiate eligibility for continued funding.

Local Prevention Council Programs: 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.

Number Served: 2014 service level will be available after November 30, 2014

Program Cost: FY 2014: $552,470

PARTNERSHIP FOR SUCCESS: The Partnership for Success (PFS) Initiative uses a public health approach in over 30 municipalities and statewide across college campuses to decrease alcohol consumption and prescription drug misuse in youth ages 12 to 20. Programs under this initiative implement environmental strategies such as curtailing retail and social access, policy change, enforcement, media advocacy, and parental and merchant education. The target populations are: school aged children 12 to 17 years old, college students 18 to 20, and those adults who influence these youth including parents, family members, care-givers, schools, communities at large and the agencies, organizations and institutions within those communities

Number Served: 2014 service level will be available after November 30, 2014

Program Cost: FY –2014 $ 2,300,000

Performance-Based Standards: DMHAS requires programs under the PFS Initiative to 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.

Performance-Based Outcomes:

- 100% representation of twelve community sectors of effective coalition participated in coalition meetings and other activities to organize and plan the implementation of prevention services.

- 18% increase community awareness of prevention resources to implement SPF as evidenced by the 2014 Community Readiness Survey.
- 100% submission of a strategic plans that includes a logic model that reflects strategies and expected short and long term outcomes in underage drinking
- 100% implementation of evidenced-based programs, policy and practices
- 7.7 % reduction in past 30-day alcohol use among 12-17 year-olds
- 7.8% decrease in binge drinking among high-school students
- 27% decrease in underage liquor law violations

Performance-Based Vendor Accountability: Program contractors for this initiative complete a five-step planning process to guide their prevention activities. The steps include: 1) assessing population needs; 2) building capacity to address the needs; 3) developing a comprehensive strategic plan that articulates a vision for organizing programs, policies and practices to address the needs; 4) implementing evidence-based programs, practices and policies identified in step 3; and 5) monitoring implementation and evaluating effectiveness. Contractors also complete an action plan which identifies and codes the action steps for implementing their plan, the staff hours required to implement activities and the numbers to be served by each activity. Progress reports are also required and consist of bi-monthly narrative and process data submitted electronically. The report generally allows contractors to share information with DMHAS regarding program participants and services that are delivered and helps staff to track compliance with contractual obligations as well as provides an opportunity to discuss any program changes. An annual site visit by DMHAS staff is conducted to validate program activities, assess continuing contractor capacity, determine technical assistance needs, and substantiate eligibility for continued funding.

Regional Action Council: Thirteen (13) 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 (RACs) 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.

Number Served: 2014 service level will be available after November 30, 2014

Program Cost: FY 2014 $1,656,972

Performance- Based-Standards: DMHAS requires all contractors to 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.

Performance-Based Outcomes: Performance outcomes for the RACs are as follows:
- 100% of towns in sub regions are funded through Local Prevention Councils
- 25% of funding efforts are focused toward underage alcohol initiatives resulting in a reduction in use across sub regions
- 25% of funding efforts are directed towards the prevention of underage tobacco use resulting in a violation rate of less than 20% among tobacco retailers in the sub region
- The development of a Priority Needs Assessment on the substance abuse continuum of care from prevention through treatment and recovery in the sub region

- The development of SPF Sub-Regional Profiles to include alcohol, prescription drugs, heroin, cocaine, marijuana and other substances of note

Performance-Based Contractor Accountability: Program contractors for this initiative complete program information and measures during the biannual contract renewal process. An action plan that sets the stage for the collection of process measures necessary for federal reporting is also completed. It identifies and codes the action steps for implementing goals and objectives, the staff hours required to implement activities and the numbers to be served by each activity. Progress reports are also required and consist of bi-monthly narrative and process data submitted electronically. The report generally allows contractors to share information with DMHAS regarding program participants and services that are delivered and helps staff to track compliance with contractual obligations as well as provides an opportunity to discuss any program changes. An annual site visit by DMHAS staff is conducted to validate program activities, assess continuing contractor capacity, determine technical assistance needs, and substantiate eligibility for continued funding.

STATEWIDE SERVICE DELIVERTY AGENT: The Statewide Services Delivery Agents (SSDA), also known as the DMHAS Resource Links, are four 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 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.
2. Multicultural Leadership Institute, Inc. - is an agency dedicated to promoting culturally and linguistically proficient services regarding the prevention of ATOD and other related problems among African origin and Latino populations.
3. 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.
4. 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.

Number served: 2014 service level will be available after November 30, 2014

Program Cost: FY 2014 $1,714,816

Performance-Based Standards:
DMHAS requires contractors to 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.

Performance-Based Outcomes:
- Improvement in the health and wellness of gay, lesbian, bisexual, trans-gendered and questioning clients

- Increase in the number of DMHAS providers with approved cultural competency plans
- Increase in the number of Hispanic and African American staff in substance abuse agencies across the state
- Increase in the number of school and community based mentoring programs
- Reduction in the state rate for underage drinking
- Increase in the number of resources aimed at alcohol, tobacco and other drug prevention
- Increase in the capacity of prevention contractors to implement evidence-based programs, policies and practices

Performance-Based Vendor Accountability: Program contractors for this initiative complete program information and measures during the biannual contract renewal process. An action plan that sets the stage for the collection of process measures necessary for federal reporting is also completed. It identifies and codes the action steps for implementing goals and objectives, the staff hours required to implement activities and the numbers to be served by each activity. Progress reports are also required and consist of bi-monthly narrative and process data submitted electronically. The report generally allows contractors to share information with DMHAS regarding program participants and services that are delivered and helps staff to track compliance with contractual obligations as well as provides an opportunity to discuss any program changes. An annual site visit by DMHAS staff is conducted to validate program activities, assess continuing contractor capacity, determine technical assistance needs, and substantiate eligibility for continued funding.

TOBACCO PREVENTION and ENFORCEMENT:

Target Population: Youth 0-17, tobacco retail merchants across the state

Prevention 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;

Number Served: 2014 service level will be available after November 30, 2014

Program Cost: FY 2014: $ 493,575

Performance-Based Standards: DMHAS must comply with the federal requirements to enforce the state tobacco laws and maintain the tobacco retailer violation rate at or below 20%. Failure to do so will result in a 40% cut to the federal Substance Abuse Prevention and Treatment Block Grant allocation.

Performance –Based Outcomes:
- 3 statewide Tobacco Merchant Education Campaigns Provided
- 13,829 Tobacco Retail Merchants Served
- 652 tobacco retailers sampled and inspected
- 11.3% Tobacco Retailer Violation Rate
- 0 permits/licenses suspended row revoked

Performance-Based Vendor Accountability: Tobacco merchant inspections are completed in strict adherence with federal Substance Abuse Mental Health Services Administration (SAMHSA) guidelines. Annual reports on these inspections and their results, changes in the state's tobacco laws, coordination and collaboration activities are submitted and available for public review and comment on the DMHAS website

Department of Public Health

- **Asthma Program: Pediatric Easy Breathing**
- **Asthma Program: Adult Easy Breathing**
- **Asthma Program: Putting on AIRS**
- **Immunization Program**
- **Special Supplemental Nutrition Program for Women, Infant and Children**
- **Tobacco Use Prevention and Control Program**

ASTHMA PROGRAM: PEDIATRIC EASY BREATHING PROGRAM: The Connecticut Children's Medical Center (CCMC) Asthma Center is conducting Easy Breathing, an asthma 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.

Number Served: 6,357 patients surveyed for asthma of which, 6,182 were treated

Program Cost: FY 2014 $250,000

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. The contractor submits quarterly narrative and surveillance data to DPH. Indicators are guideline adherence for prescribing inhaled corticosteroids for those with persistent asthma and patient education and provision of patient written treatment plans to enable patients to effectively manage their asthma symptoms before they become acute. The contractor trained 108 new providers for a total of trained 472 providers.

Performance-Based Outcomes: Improved asthma diagnosis and medical management by primary care providers for better patient control and self-management based on the National Institute of Health's Asthma Guidelines was reported as follows: for patients with persistent asthma, between 63% to 81% of patients had a an Asthma Action Plan and 93% of patients with persistent asthma were prescribed inhaled corticosteroids. This is an excellent measure of adherence to NAEPP treatment guidelines.

Performance-Based Vendor 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).

ASTHMA PROGRAM: ADULT EASY BREATHING PROGRAM: Bridgeport Hospital continued Easy Breathing for Adults. This Program is based on pediatric Easy Breathing with the focus being on adults treated by medical resident physicians in Bridgeport Hospital's Primary Care Clinic. Easy Breathing for Adults is an asthma clinical management program. The program has successfully integrated training for medical residents to implement Easy Breathing. The Easy Breathing program is a professional education program that trains medical resident providers to administer a validated survey to determine whether a patient 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.

Program Cost: FY 2014 One contract for Adult Easy Breathing at Bridgeport Hospital was funded for the amount of $150,000.

Number Served:

- 2,056 patients surveyed for asthma with 720 (35%) identified and treated with asthma
- 14 providers were trained in Easy Breathing
- 82% of patients had an AAP
- 97% of patients with persistent asthma were prescribed inhaled corticosteroids

Performance-Based Standards: The contractor conducts weekly meetings with the Physician Champion and conducts monthly meetings with all Easy Breathing clinic staff to review and rectify data issues, training needs and/or implementation problems. The contractor submits quarterly narrative and surveillance data to DPH. Indicators are the number of providers trained in Easy Breathing. The contractor trained 14 medical resident physicians, in the Bridgeport Hospital Medical Clinic.

Performance-Based Outcomes: Improved asthma diagnosis and medical management by primary care providers for better patient control and self-management based on the National Institute of Health's Asthma Guidelines was reported as follows: for patients with persistent asthma, 97% were prescribed inhaled corticosteroids. This is an excellent measure of adherence to NAEPP treatment guidelines. In addition, 82% with persistent asthma received a written treatment plan per the NAEPP guidelines.

Indicators are guideline adherence for prescribing inhaled corticosteroids for those with persistent asthma and patient education and provision of patient written treatment plans to enable patients to effectively manage their asthma symptoms before they become acute.

Performance-Based Vendor 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, and 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).

ASTHMA PROGRAM: Putting on AIRS: The Putting on AIRS (AIRS) Program was developed by the Asthma Shoreline Action Partnership, a project of the Ledgelight Health District and the New London Department of Health & Social Services funded by the Connecticut Department of Public Health. The goal of the program is to reduce acute asthma episodes and improve asthma control through recognition and elimination/reduction of environmental and other asthma triggers. The Program grew out of a pilot project that illustrated the need for formalized documentation and procedures/protocols.

"Specific interventions can decrease environmental exposures in homes of children with asthma. Despite the growing body of evidence, many children and their families, particularly children who live in poverty and rely on emergency departments as their primary source of health care, may not be receiving adequate counseling about how to avoid environmental exposures. .... With proper management, many environmental exposures can be decreased." Pediatrics 2003;112:233-239.

The AIRS Program provides in home asthma education to the client/family/caregiver focusing on patient education and asthma management. An asthma education specialist conducts the education session with the client/family/caregiver by reviewing prescribed medications and its usage, and instruction on proper medication administration as well as education on asthma signs and symptoms. The environmental specialist conducts an environmental assessment of the home to identify asthma triggers and provide low cost remediation techniques. Follow-up phone calls are conducted with the client/family/caregiver at two-weeks, three and six month intervals.

Referrals to the program can be made by a variety of sources such as emergency department, health care providers, school health services, or self-referral. The AIRS Program follows the National Heart, Lung, and Blood Institute (NHLBI) Guidelines for the Diagnosis and Management of Asthma for asthma education and management.

The AIRS Implementation Guide was developed to provide clear and easily applied guidance to help local health departments/agencies implement an asthma home assessment program. The guide was designed to be user-friendly and adaptable to fit the needs of most communities. Components of the guide include: implementation protocols/steps, patient knowledge and environment assessment tools, client/family/caregiver education materials, data collection and evaluation template.

Number Served: Six local Health Departments in CT provide "Putting on AIRS". From September 2009 to February 2013, 726 AIRS clients were served.

Program Cost: FY 2014 $96,000

Performance-Based Standards: Each contractor from 6 Local Health Districts provides

- an Asthma Education Specialist to conduct home visits and conduct asthma
- management education activities, provide demonstration and education materials
- An Environmental Specialist to conduct home environmental assessments to identify asthma triggers and develop remediation strategies for each home
- Follow-up phone calls to program participants at 2 weeks, 3 months and 6 months
- Attends and participates in AIRS protocol trainings
- Submits to AIRS database to the Department tri-annually
- Submits periodic summary reports regarding the number of visits conducted, follow-up phone calls completed, referral sources
- Submits year-end reports to the Department on the number of visits and referrals, success stories, challenges and lessons learned

Performance-Based Outcomes: The Contractor reports to the Department on Program Outcomes:

- Document all individuals who have received home visits
- Document all follow-up calls completed at 2 weeks, 3 months and 6 months
- Document all individuals who have received appropriate information related to identified and assessment needs
- Document all participants surveyed on knowledge of asthma management

- Market AIRS Program targets 75% of children

Results: All follow-up calls at two-weeks, three- and six- months were completed for 306 clients (42%) of the 726 AIRS clients who received the home visit.

Performance-Based Vendor Accountability:

- The Department obtains quantitative and qualitative data from Contractor several times a year
- In recent years (< 2014), contract management activities by the Connecticut Asthma Program focused on administration (awards and budget and contract amendments) and less on monitoring and evaluation (ongoing assessment of deliverables).
- Consequently, as of 09/01/14, contract deliverables were modified to facilitate reach, follow-ups and staff availability

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IMMUNIZATION PROGRAM: The prevention of disease, disability and death from vaccine-preventable diseases in infants, children, adolescents and adults through surveillance, case investigation and control, vaccination and monitoring of immunization levels, provision of vaccine and professional and public education.

Number Served: Children from birth through 18 years of age. Total CT population 0-18 years of age served for Calendar year 2014 is 889,214.

Program Cost: FY 2014 $62,033,708

Performance-Based Standards: Immunization coverage is one of our principal performance-based standards. The program uses data from the National Immunization Survey (NIS) conducted annually by CDC estimates vaccination coverage among children aged 19-35 months old nationally and for each state and our statewide immunization registry called CIRTS to measure immunization coverage rates for children in CT.

Performance –Based Outcomes: According to the 2013 National Immunization Survey (NIS), Connecticut's 2013 NIS coverage for 4 doses of DTaP, 3 doses polio, 1 dose MMR, a full series of Hib vaccine (3 or 4 doses depending on product type), 3 doses Hepatitis B, 1 dose Varicella and 4 doses PCV (4:3:1:3*:3:1:4) was 78.2% well above the national average of 70.4%. Based on this information, CT was ranked 5th among all 50 states with highest immunization coverage rates. The 2013 NIS included children born January 2010 through May 2012.

According to our Connecticut Immunization Registry and Tracking System (CIRTS) immunization registry data which looked at the records of 31,697 two-year-olds born in 2010 for 4:3:1:2:3:1.4* is 79%. The 31,697 represents 86% of the 36,805 births recorded in CIRTS for 2010.

Performance-Based Vendor Accountability: Funding provided to 11 health departments representing the largest municipalities in Connecticut to increase immunization levels among children residing in their communities by conducting the following activities to improve vaccine/immunization delivery, tracking, outreach, referral, education and assessment.

Specific Program Outcomes and Measures

Outcomes	Measures
1. Children 0-24 months of age who reside in the contractor's service area who are enrolled in CIRTS have been age-appropriately immunized against vaccine- preventable diseases	1. At least 85% of children 24 months of age who reside in the contractor's service area, and who are enrolled in CIRTS have been age-appropriately immunized against vaccine preventable diseases
2. Children 0-24 months of age referred to the IAP Coordinator for outreach are successfully identified and referred for appropriate care, and/or their records are updated in CIRTS.	2. At least 90% of children 0-24 months of age who are referred to the IAP Coordinator for outreach are successfully identified and referred for appropriate care, and/or their records are updated in CIRTS.

SPECIAL SUPPLEMENTAL NUTRITION PROGRAMS FOR WOMEN INFANT and CHILDREN (WIC):

The Connecticut *Special Supplemental Nutrition Program for Women, Infants & Children* (CT WIC Program) serves pregnant, postpartum and breastfeeding women, infants, and children up to five years of age. The program provides services in five (5) major areas during critical times of growth and development in an effort to improve birth outcomes and child health: 1. Nutrition Education & Counseling; 2. Breastfeeding Promotion & Support; 3. Referral to appropriate health & social services; 4. Referral from Health Care Providers to ensure clients have a medical home; and, 5. Vouchers for healthy foods (WIC "Food Packages") prescribed by WIC Nutritionists. Eligibility is determined based on income [up to 185% of the Federal Poverty Level (FPL)] and nutritional need, following a complete assessment of health and dietary information. Alternatively, active enrollment in Medicaid / HUSKY A, SNAP or TANF qualifies applicants for adjunctive eligibility in WIC.

The WIC Program's promotion and support of breastfeeding and efforts to prevent childhood anemia also contribute to childhood health and school readiness. Clients are seen in WIC offices or satellite clinic sites at least every three (3) months, but can be seen monthly if identified as high risk. Currently, WIC services are provided to an average of 52,308 participants each month through a service provider network of 12 local agency sponsors at 57 service sites statewide. Local agency sponsors include hospitals, community health centers, city and town health departments, and community action agencies throughout the State. The Department of Public Health (DPH) also has agreements with a 471 food stores, 163 pharmacies, and 17 farmers authorized to accept and redeem WIC checks (food "vouchers") in exchange for WIC-approved supplemental foods.

Number served 2014: Average monthly participation: 52,308 (11,179 women, 13,160 infants and 27,968 children up until their 5th birthday).

Program Cost: Fiscal Year 2014 $44,940,512

Performance-Based Standards:
Federal and state regulations include a number of prevention-related standards that Local WIC 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 contra-indicated, 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 (12 WIC Regions):

- First Trimester Enrollment in WIC: Increase to 50% the rate of first trimester enrollment of pregnant women.
  - Statewide average [Federal Fiscal Year (FFY) 2014 to date (YTD)]: 51.3%; Range: 41.5% – 65.1%.
- Maternal Weight Gain (MWG): At least 70% of pregnant women who participate in the WIC Program for a minimum of 6 months gain appropriate weight:
  - Statewide average (FFY 2014 YTD): 72.4%; Range: 53.8% - 82.8%.
- Low Birth Weight (LBW): The incidence of low birth weight among infants whose mothers were on the WIC Program for at least 6 months during pregnancy does not exceed 6%.
  - Statewide average (FFY 2014 YTD): 5.8%; Range: 1.4% - 8.3%.
- Breastfeeding Initiation (BFI): At least 65% of infants whose mothers were enrolled in the WIC Program for any length of time during pregnancy breastfeed.
  - Statewide average (FFY 2014 YTD): 75.8%; Range: 59.3% - 92.3%.
- Childhood Anemia: The prevalence of anemia among children 2-4 years of age enrolled in the WIC Program for at least one year does not exceed 7.5%.
  - Statewide average (FFY 2014 YTD): 10.2%; Range: 4.6% - 14.5%.
- Overweight in Children: The prevalence of overweight (BMI $\geq$ 85th percentile to $<$ 95th percentile) among children 2-4 years of age enrolled in the WIC Program for at least one year does not exceed 10%.
  - Statewide average (FFY 2014 YTD): 11.8%; Range: 7.3% - 16.6%.
- Obesity in Children: The prevalence of obesity (BMI $\geq$ 95th percentile) among children 2-4 years of age enrolled in the WIC Program for at least one year does not exceed 15%.

- Statewide average (FFY 2014 YTD): 12.1%; Range: 6.7% - 17.4%.

Performance-Based Accountability:

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

TOBACCO USE PREVENTION AND CONTROL PROGRAM: The Tobacco Use Prevention and Control Program follows guidelines and recommendations published by the Department of Health and Human Services, Centers for Disease Control and Prevention and all programs are evidence-based.

The program works towards addressing all areas in tobacco control that includes educating the public about the risks associated with the use of tobacco products and the hazards of exposure to secondhand smoke. Current areas of focus include preventing initiation among youth and young adults, promoting quitting among all tobacco users, eliminating exposure to both second- and third-hand smoke for all state residents, and identifying and eliminating tobacco-related disparities among population groups with known higher usage of tobacco products such as those of low socioeconomic status, individuals with mental illness, and pregnant women.

Number of Clients Served: For the period from 2013-2014, the community-based tobacco use cessation programs and the tobacco use cessation telephone QuitLine have served at least 8,000 Connecticut residents.

Program Cost: 2014 $1,076,586

Performance-Based Standards:
Our standards include the reduction and elimination of use of all forms of tobacco products, to prevent tobacco use initiation, and to reduce all residents' exposure to second and third-hand smoke. Our funded programs must adhere to CDC's best practice guidelines and must use evidenced-based curricula. All programs offered include education regarding the harmful effects of second- and third-hand smoke.

Performance-Based Outcomes

- At least 75% of program participants will reduce their tobacco use;

- At least 75% of program participants will make changes to protect the health of non-smokers.

Performance-Based Accountability:
Contractors are required to collect data at intervals during the period in which services are provided, in order to assess program effectiveness. Contractors must submit periodic progress reports (at least quarterly, some are monthly) detailing their program activities including their self-evaluation and the results of their outcome measures, as well as financial and expenditure reports and documentation.

In addition, an independent evaluator is on contract to evaluate funded programs

Department of Social Services

- **Tobacco Cessation Prevention**
- **Perinatal and Infant Oral Health Quality Improvement**
- **Fatherhood Initiative**
- **Teen Pregnancy Prevention Program**

Long Term Agency Goals: The Department of Social Services collects and uses internal program and service data as well as data collected from other local and national agencies, organizations and institutions to inform the development of programs, services, policies, and procedures that address factors that contribute to as well as prevent poverty. The Department's mandate it unique; its stakeholder (client) population includes all demographics. Therefore, its goals include:

- Through the implementation of ConneCT, increase efficiency, effectiveness, and access to staff and services for initial applicants for agency services as well as ongoing program participants.
- Increase awareness and educate communities and clients about the availability and access to food/good nutrition for income eligible children, families, and individuals.
- Increase efficiency in the application process for SNAP Program participants.
- Increase awareness about and access to preventive and curative health care for income eligible children, families, and individuals.
- Increase efficiencies in the program eligibility process/system for children, families, and individuals by implementing technological improvements.
- Implement function based staff development and training to increase accuracy and improve staff performance in order to better serve children, families, and individuals.

Strategies:

- Program and contract staff will have the most up to date local, regional, and national data related to clients' needs, poverty and its concomitants. Staff will also be knowledgeable about strategies needed to objectively determine the effectiveness of program/service outcomes for targeted low income/income eligible children and families. This data/information will be used to inform/plan, develop, and contract for services for clients with external agencies/organizations. Ongoing training will be provided to individual staff members as well as cohorts to ensure that this strategy is realized.
- In addition to actually enumerating level of program participation, within the next 12 months contractees will be required to provide objective outcome measures that demonstrate effectiveness of programs/services based on documented client progress and client feedback. Documentation will also include progress outcomes based on income, ethnicity, culture, language, proficiency, etc. to support and inform the Department's efforts to address disparities in outcome and impact.
- Quarterly reviews/evaluations of client outcome data will be provided by contractees.
- Make information about the Department's programs and services for low income children and families available through many access points public libraries, doctors' offices, health care centers, neighborhood markets and stores, malls, schools, hospitals, other agencies/organizations, child care/day care, etc., in order to increase awareness and program participation.
- Engage in ongoing recruitment of health care providers/physicians in order to increase access to health care for income eligible children, individuals and families. Special efforts will also focus on identifying and addressing individual and social determinants of health disparities within health care settings among health care providers.
- Enhance contractual relationships with community action agencies to ensure awareness and supportive access for clients to programs/services provided by DSS, via various community based locations.

- Whenever possible, dispatch staff to provide information about the Department's programs/services such as speaking at community events, participating in community fairs, and convening focus groups for purposes of providing, collecting program/service related information.

- Introduce a formal mechanism to collect program participant/service recipients' feedback related to the receipt and use/usefulness of services provided.

- Train and support staff in modifying contracts based on objectively determined clients/program participants' outcome data.

- Continue to refine ConneCT in order to ensure optimal access to accounts/setting up of accounts for clients twenty-four hours per day seven days per week.

Measure of Effectiveness: The effectiveness of prevention is best measured longitudinally; the Department is in the process of formalizing a data collection and analysis approach that addresses this issue.

Methods: Current data collection processes do not lend themselves to performance measures and outcomes based on race, income level, language proficiency, and gender. The Department is in the process of addressing this challenge.

Methods to Reduce Disparities: As the Medicaid, TANF agency, lead agency for persons with disabilities and the administrator/manager of the Supplemental Nutritional Assistance Program, the Department provides programs and services that by their very nature address the health and safety needs of children, individuals, and families. There is no doubt that it succeeds in doing so; however, in the coming months and years, DSS will collect data that will guide the development and implementation of its Health Disparities Plan as well as the resulting Action Plan. Because disparities are intricately interwoven with ongoing poverty, the implementation of the Plan will assist in clearly demonstrating the extent to which current programs are succeeding in preventing intergenerational poverty, the concomitants of poverty, and poor health conditions. The information will also allow the Department to make adjustments in its allocation of funds, and in programs and services, based on sound data.

Other Relevant Information: DSS' staff represent the agency on various local, regional, and state-wide task forces, commissions, committee and councils. This level of involvement supports and enhances ongoing program and service reviews. It also allows members of various service communities to secure information about DSS and to share information with DSS.

Tobacco Cessation Program: "The Rewards To Quit" tobacco cessation initiative is being funded by a five-year federal grant from The Centers for Medicaid Services (CMS) of up to $10 million. Connecticut is one of 10 selected grantees, nationwide, of a larger Medicaid Incentives for Prevention of Chronic Disease (MIPCD) grant that seeks to determine the impact of financial incentives on preventing chronic disease. The goal of Rewards To Quit is to significantly reduce smoking rates among the estimated 25-30 percent of Connecticut Medicaid recipients who currently smoke. Through the program, providers (local mental health authorities, federally-qualified health centers and primary care practices and clinics) will offer individual and group smoking cessation counseling sessions, peer coaching in selected sites, nicotine replacement therapies and medication and smoking cessation education and encouragement. Participating Medicaid beneficiaries 18 years of age and over will receive financial incentives for both engaging in an intervention strategy (i.e. attending an individual or group counseling session) and outcomes (having a negative CO breathalyzer test) aimed toward quitting smoking. In doing so, the Department intends to increase the quit rate among Medicaid recipients in Connecticut. Pregnant women and parents of young children as well as those with severe mental illness are specially targeted for program participation. The efficacy of providing financial and non-financial incentives will be studied using control and intervention groups.

Number Served: 1,230 for 2014. Estimated 6,000 over the life of the project

Program Cost 2014 $1,272,376

Performance- Based Standards:

- Strong evaluation design and internationally recognized evaluation team
- Comparison of incentive types (process vs. outcome) through randomization
- Deploying and testing these innovations in the context of a medical home
- Flexibility in recipient choice of service type and incentive

Performance-Based Outcomes: Evidence and documentation of:

- Reached 66% of target projection for participant enrollment
- Recruited and contracted with 31 identified provider sites
- There were 216 Nicotine replacement or medication visits, 1,818 individual counseling visits, and 236 group counseling visits.
- A total of 1,538 CO breathalyzer tests were administered, of which, 861 were negative.
- Reduction in smoking amongst participants from self-reported survey results are not yet available

Performance- Based Vendor Accountability: The Rewards to Quit Program has contracts with 3 organizations. 1- Community Health Network of CT (CHNCT) that operates the program 2- Yale University that is responsible for the evaluation of the project and 3- Hispanic Health Council to employ the peer coaching aspect of the program. The contractors are accountable to DSS by the following evidence and documentation of:

- Quarterly progress and expenditure reports to DSS
- Weekly monitoring of operations and provision of technical assistance by DSS
- Weekly monitoring of subcontractor performance by DSS and CHNCT
- Bi-weekly CT and CMS status update meetings
- Monthly MIPCD grantee meetings with CMS
- Semi-annual meeting amongst all MIPCD grantees to update CMS on progress

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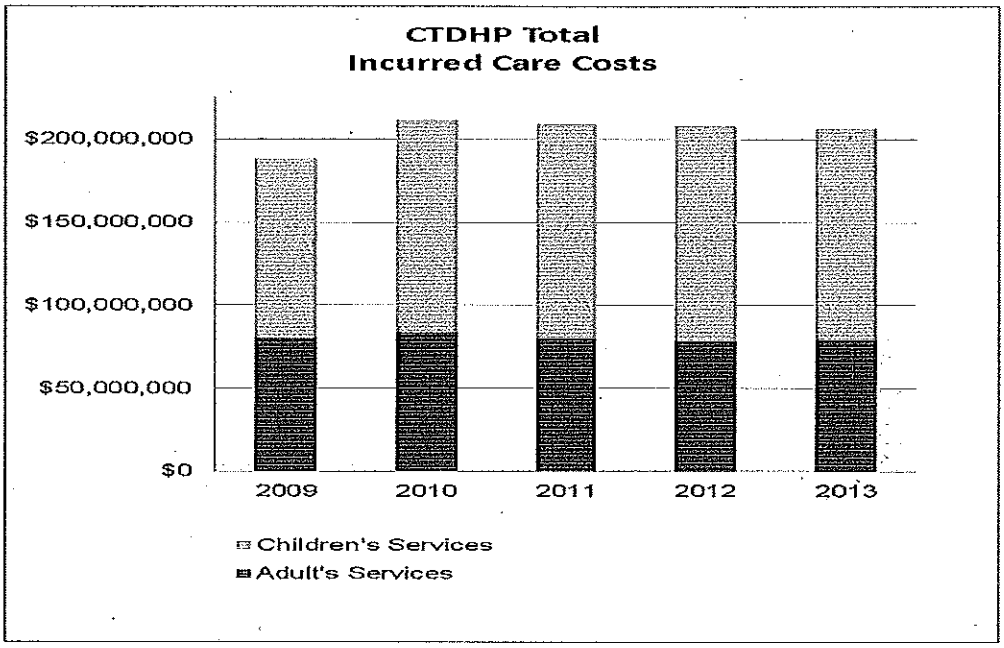
Perinatal and Infant Oral Health Quality Improvement: Connecticut is one of only four states awarded a U.S. Department of Health and Human Services Health Resource and Services Administration (HRSA) Grant for Perinatal & Infant Oral Health Quality Improvement (PIOHQI in 2013. The grant is focused upon oral health improvement and community integration strategies for improving preventive oral healthcare.

Preventable oral disease, particularly caries, among low-income/at-risk children is a serious persistent concern in Connecticut. Early childhood decay is five times more prevalent than asthma. Thirty-one percent of Head Start children, 27% of kindergarten children and 41% of third graders have experienced dental disease according to the "*Every Smile Counts Survey*l;" a surveillance system utilized by the Department of Public Health. These statistics demonstrate the need for Connecticut to continue to focus on early childhood oral disease prevention in order to reduce the prevalence of decay present in children. Oral health initiatives have not yet been fully integrated into early childhood whole – health systems on the national level.

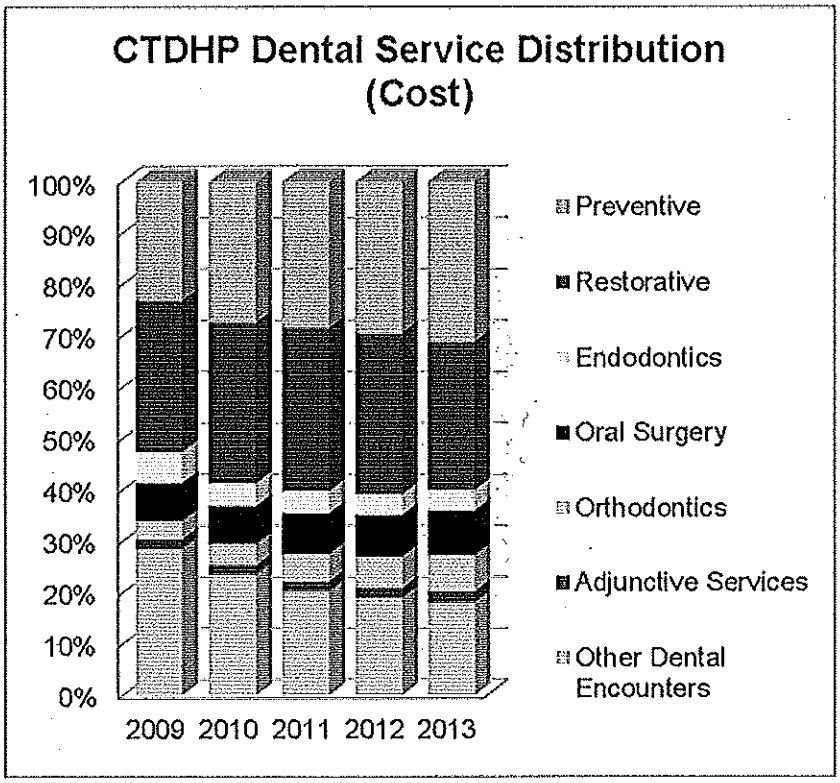
The PIOHQI/ICO project's is funded over five years for an amount of up to$750,000.00. The grant will enhance the current Connecticut Dental Health Partnership's outreach activities to the peri-natal mothers and infant populations to Instill the concept of good oral health practices. Early intervention strategies are predicted to continue throughout a child's life to increase the utilization of prevention based dental services over the restorative based approach to controlling dental disease.

The Connecticut Dental Health Partnership is using a long term approach which will attempt to change the perception and practices related to oral health status in the population served. The new approach integrates medical and dental intra- office referrals and educates the medical staff on the importance of oral health, how to educate their patients of the importance of good oral health practices and provided kits which consist of toothbrushes, floss, education materials and baby bibs. In the two pilot cities where this initiative was tested, progress in dental utilization was seen to increase by 30%.

The expenditures for the dental program have remained relatively stable despite an increase in the HUSKYHealth population; this demonstrates that improvements in member's oral health are occurring; see graphs below. This attributed to children who enrolled in the program early on and have had ongoing dental care.



DSS



Number Served: 30,000

Program Cost: FY 2014 $175,000

Performance Based Standards: The PIOHQI/ICO project's purpose is to provide a coordinated approach across Connecticut that addresses the comprehensive oral health needs of pregnant women and infants most at risk, supporting an environment that seeks to eliminate oral health barriers and disparities. Lack of oral care during pregnancy and in infancy, poverty and low economic status, lack of education, and racial background are some of the determinants associated with high rates of dental diseases such as early childhood caries. Through PIOHQI Connecticut will expand its current pilot project, into 15 communities in the state, develop statewide policy, procedures and clinical standards of practice that support the reduction of oral health disparities and reduce dental disease while improving and maintaining better oral healthcare delivery systems in the targeted communities.

Performance Based Outcomes: The long-term goal of the grant is to achieve sustainable improvement in the oral health status of the Maternal Child Health (MCH) population. Documentation of successful outcomes and lessons learned will be applied to the development of a national strategic framework for the purpose of replicating effective and efficient approaches to serving the oral health care needs of this targeted MCH population. This grant dovetails into the current premise of the Connecticut Dental Health Partnership's mission and strategy to get children into early preventive care reducing the need for the more costly restorative care producing better oral health outcomes.

Performance Based Vendor Accountability: Identification and referral of children into a dental home for consistent dental care. This will produce the following outcome measures:

- Increase in utilization through screening strategies and a consistent oral health message integrated into the community.
- Improvement in outcomes, including reduction of caries in young children.
- Objective reports that include client demographics correlated with outcomes.
- Reduction in secondary more costly dental services for children.

Fatherhood Initiative: This Fatherhood Initiative provides outreach /awareness education and training for parents related to parenting, healthy relationships, and healthy marriages. The program also provides support services that connect parents/program participants to programs and services that address their emotional and socio-economic needs.

Number Served: 727 participants

Program Cost: FY 2014: $566,656

Performance- Based Standards:

- Increase in effective communication skills (between partners/parents)
- Increase in knowledge about responsible parenting
- Increase in the ability to secure and retain employment
- Decrease in the potential for child abuse and neglect
- Increase in responsible parenting
- Identify and assess potential for spouse/partner/child abuse
- Targeted intervention strategies for parents with cognitive limitations

Performance-Based Outcomes:

- Results of pre and post-test of training offered for each program participant
- Decrease in child/partner/spousal abuse
- Improved communication between parents/partners
- Improved parent-child relationships
- Increase in marriage between partners (couples)

Primary Prevention Outcomes:

- Decrease in child poverty
- Prevention of child abuse and/or neglect
- Collaboration with DCF to prevent the occurrence/reoccurrence of child abuse/neglect among parents referred to DCF for services.

Performance –Based Vendor Accountability: Grant access to Yale researchers who are evaluating the program; evidence of dissemination and collection of pre-post-test of curricula; observable use of the 24/7 Curriculum developed by the National Fatherhood Initiative and approved/required by the federal government; report number of program participants; evidence of recruiting and retaining program participants; attend and participate in mastering curricula related to assessing domestic violence and working with parents with cognitive limitations; and evidence of a program plan for each participant in which all services and rationale for the service/referral is included.

Teen Pregnancy Prevention Program: The Department of Social Services operates a statewide teen pregnancy prevention initiative. The initiative is comprised of individual programs run by not-for-profit organizations and municipalities in thirteen (13) Connecticut town and cities. Communities served are Bridgeport, East Hartford,

Hartford Killingly, Meriden, New Britain, New Haven, New London, Norwich, Torrington, Waterbury, West Haven, and Willimantic.

The initiative was restructured and went out to bid in 2007 and 2008 in order to procure teen pregnancy prevention services from non-profit organizations and municipalities with the ability to use proven science-based program models. Current programs use one of two science based models: 1) the comprehensive, long term, holistic youth development model based on the Carrera Program Model; or 2) The Teen Outreach Program, a service learning model where participants engage in, reflect on, and learn from community service projects. Both of these program models have been evaluated and have shown evidence that they are among the most effective approaches to preventing teen pregnancies. Currently, New Britain, Torrington and Waterbury have implemented the Carrera Model. Bridgeport, East Hartford, Hartford, Killingly, Meriden, New Haven, New London, Norwich, West Haven, and Willimantic have implemented the Service Learning Model.

Number Served: 830 youth

Program Cost FY 2014: $1,981,204

Judicial Branch Court Support

- **Educational Support Services**
- **Family Support Centers**

Long Term Goals: The prevention goal of the Judicial Branch, Court Support Services Division (CSSD) is to divert children from juvenile court involvement and penetration into the criminal justice system.

Strategies:

- Divert children from the judicial process through non-judicial supervision services and referrals to appropriate community-based agencies and diversion programs.
- Identify needs and risk factors of children and families through the use of valid risk/need screening and assessment instruments, and refer children and families to programs and services that address their needs in order to prevent further juvenile court involvement or penetration into the criminal justice system.
- Collaborate with schools, community partners, provider agencies, and other state agencies to support local and state efforts designed to prevent or eliminate at-risk behaviors and to promote the health, well-being, and success of children.

Performance-Based Outcomes:

- Reduction in juvenile court intake (Families with Service Needs-FWSN, and Delinquency referrals)
- Reduction in 24-month re-arrest rates for juveniles on probation or supervision
- Fewer delinquency commitments

Measures of Effectiveness: CSSD has adopted a results-based accountability framework to measure the effectiveness of its strategies. Data is collected on outcome measures and reported quarterly to management, line staff, judges, attorneys, and contracted service providers as part of a continuous quality improvement effort. In addition, CSSD conducts, through both internal and contracted resources, evaluations of targeted strategies and/or programs. Performance measures include:

- Performance Measure 1 – Juvenile Court Intake: Intake fell 32.4% from 15,857 in FY 2007 to 10,717 in FY 2014, despite the inclusion of 16 and 17 year olds in the juvenile court system, beginning January 1, 2010 and July 1, 2012, respectively.
- Performance Measure 2 – Reduction in 24-month Re-arrest Rates: The rate of re-arrest (recidivism) at 24-months after the start of a period of probation or supervision has remained consistent over the last four years and is beginning to show progress in the right direction. For example, 66 percent of the juveniles placed on probation or supervision in 2005 were re-arrested by the time their 24-month follow up period ended in 2007. The trend remains on the decline showing a 59% re-arrest rate for FY 2014.
- Performance Measure 3 – Juveniles Committed to the Department of Children and Families: Juveniles committed to either long-term residential placement or for incarceration at the Connecticut Juvenile Training School have decreased by nearly 63 percent in the past 14 years, from 687 juveniles committed in 1999 to 256 in 2013, despite the inclusion of 16 and 17 year olds in the juvenile system.

Methods: A core goal of the CSSD strategic plan is to in engage in activities that provide a diverse, gender responsive and culturally competent environment for staff and clients that are sensitive to values and responsive to needs. CSSD supports a Cultural Competency Advisory Committee which guides the implementation of this strategic goal. CSSD employees a diverse staff that is representative of the population served, including in key management positions within the agency. The Training Academy has embarked on an organization-wide cultural competency training initiative, as well as hired staff to focus solely on increasing the cultural competence of the agency. CSSD provides culturally competent, research- and evidence-based programming, interventions and supervision services through the use of race- and gender-neutral screening and risk/need assessment tools and a network of contracted providers. CSSD requires all contractors to meet cultural competence expectations in hiring and service delivery. CSSD routinely reviews operation and program performance measures for any disparities based on gender or race/ethnicity. In addition no race/ethnicity disparity was found in case handling,

adjudication rates, court outcomes and placement rates in an independent report, *A Reassessment of Disproportionate Minority Contact (DMC) in the Connecticut Juvenile Justice System* (May 2009), funded by the OPM Juvenile Justice Advisory study. Beginning in 2011, CSSD began work with the Hartford and Bridgeport communities on specific disproportionate minority contact (DMC) reduction initiatives that have increased diversion rates and resulted in a revision to the Probate Graduated Sanctions Policy to include incentives to encourage compliance with court orders and decrease the use of detention for probation violations. In 2013, DMC reduction initiatives began in the New Haven and Waterbury communities.

Other: CSSD has implemented several strategies to support the prevention or diversion of children and youth from court referral, including a focus on increasing family engagement, decreasing school arrests, and building local partnerships. Detention clinicians are meeting with families of newly detained juveniles to engage the family in the child's care while in detention and to help prepare the family for working with the Court and treatment providers to support the child's success and limit further court involvement. Probation staff is being trained in parent engagement to assist officers in working with families to support them in managing at home behaviors and providing parents with alternatives to calling police during domestic disagreements. Also, the use of a contracted family engagement specialist is being piloted in one court location to work with the families that Probation and Detention Staff struggles most to engage. Juvenile Probation also engages in outreach efforts to better coordinate with schools to manage the in-school behaviors and divert students from arrest. In addition, CSSD revised the Probation Intake policy to allow probation supervisors to return any referral that does not warrant court intervention, which resulted in the return of over 800 referrals in the first two years. These efforts, in addition to the expansion of the School-based Diversion Initiative highlighted below, should reduce the number of court referrals for in-school arrests, which may be better managed by local schools and service providers. CSSD, in conjunction with DCF and through its partnership with other stakeholders of the Executive Implementation Team of the Joint Juvenile Justice Strategic Plan, has established a local interagency services team (LIST) for each juvenile court district to increase local awareness and support for the needs of children at risk for juvenile justice involvement. The LIST initiative is increasing community attention and local-state partnerships in addressing the contributing factors to juvenile delinquency.

A model intervention that holds great promise in diverting school-based arrests is the School-based Diversion Initiative (SBDI), jointly developed and piloted by CSSD, DCF and CHDI, and funded by the MacArthur Foundation. As of FY 12-13, CSSD, DCF and SDE fully fund the program. SBDI seeks to bridge existing behavioral health services and supports to children and youth with mental health needs to prevent juvenile justice involvement. The creation of SBDI was based on three areas of concern in Connecticut, and nationally. First, although juvenile arrest rates have trended downward in the last 5 to 10 years, there remain high rates of *in-school* arrests, as well as expulsions and out of school suspensions, particularly among students with mental health needs. Exclusionary discipline results in more arrests, leading to academic failure and eventually to school drop-out. Youth with unmet behavioral health needs are disproportionality represented among students arrested in schools and approximately 65-70% of youth in detention have a diagnosable behavioral health condition. Second, students who are arrested, suspended or expelled are disproportionately students of color, particularly African-American and Hispanic males. Even when the behaviors are the same, too often school responses to behaviors are more severe for students of color. Third, to meet the needs of students at-risk of arrest or expulsion, schools report a need for better linkage to community-based mental health resources, particularly crisis response. The SBDI model was designed to address these concerns and attends to the underlying needs of school professionals, which in turn allows schools to more effectively meet the needs of at-risk students. SBDI incorporates a Graduated Response model for disciplinary intervention, which seeks to ensure that school policies and procedures are fair and equitable, do not rely excessively on juvenile justice system interventions, and effectively meet students' needs.

The primary goals and objectives of SBDI include:

Goal 1: Enhance knowledge and capacity of school professionals for early identification of mental health needs, diversion from arrest and expulsion, and referral to community-based services

Objective 1: Coordinate delivery of expert training to school professionals in key content areas

Objective 2: Facilitate staff skill development and attitude change regarding key competencies

Goal 2: Reduce number of in-school arrests and expulsions and associated racial/ethnic disparities
Objective 3: Develop individualized school policies and procedures to build capacity for reducing arrests and expulsions
Objective 4: Enhance awareness of racial/ethnic disparities in arrests and expulsions
Goal 3: Increase utilization of community-based resources as alternatives to arrest or expulsion for youth with mental health needs
Objective 5: Enhance collaboration between participating schools, local law enforcement, and service providers to improve service referrals
Objective 6: Improve early identification and referral of youth with mental health needs to effective diversionary services such as Emergency Mobile Psychiatric Services (EMPS)

Students in SBDI-participating schools are diverted from arrest whenever possible, and instead linked to appropriate community-based resources. SBDI emphasizes use of each community's local EMPS team. EMPS is a statewide mobile crisis response program that deploys teams of specially trained mental health professionals to respond immediately to requests for crisis stabilization, provide brief treatment, and ensure appropriate linkage to ongoing care. EMPS providers respond directly to homes, schools, and emergency departments and services are intended to reduce inappropriate service referrals to correctional and inpatient settings. EMPS is available to every school in the state; however, existing data suggests that schools have historically underutilized this resource due to a lack of awareness and in some cases, a history of poor collaboration with the broader mental health provider community. SBDI seeks to strengthen relationships between schools and EMPS as a key community resource.

Outcomes: SBDI was piloted in four school districts (2 in SY 09-10, 2 in SY 10-11), expanded to three districts in SY 11-12, two school districts in SY 12-13, and one additional school district in SY 13-14. Recent data from all 17 former and current participating schools from the 2012-13 school year indicate:

- 19% decrease in school-based court referrals across SBDI schools, with one inner-city school decreasing by 92%, and
- 44% increase in utilization of EMPS Crisis Intervention Services by schools.

An external evaluation by Yale University compared EMPS utilization rates and court referral data for communities with SBDI compared to similar communities without SBDI with the following results:

- Communities participating in SBDI during the 2010-11 school year had a significantly higher rate of referral to EMPS compared to non-SBDI comparison communities.
- Youth served by EMPS had fewer subsequent court referrals the following year (11%) compared to those referred directly to court (42%) for an in-school behavior incident, regardless of prior court involvement.

Educational Support Services: Approximately 50% of the children referred to the juvenile justice system have academic performance concerns and/or learning difficulties. High school graduation is closely linked to future success as related to income earning levels, court involvement and recidivism. The goal of *Education Support Services (ESS)* is to support families in ensuring that their children's educational needs are properly identified and that children have access to a free and appropriate education as required by law. *Education Support Services* include legal case consultation, advocacy, and training by contracted special education attorneys serving families and probation officers of children referred to juvenile court due to status offending or delinquent behaviors, and who exhibit school difficulties and/or performance challenges. Services are available at all twelve (12) juvenile courts.

Number of Clients Served: 354 cases opened and 303 cases closed

Program Cost: FY 2014 $897,810

Performance-Based Standards:

- Percentage of clients that obtained/modified/preserved special education services
- Percentage of clients that overcame proposed suspension or expulsion
- Percentage of clients that obtained education-related benefits
- Percentage of clients that obtained procedural protections

Performance –Based Outcomes:

- 75.2% (vs. 68% in FY 13) of clients obtained/modified/preserved special education services
- 17.2% (vs. 20% in FY 13) of clients overcame proposed suspension/expulsion
- 73.9% (vs. 49% in FY 13) of clients obtained education-related benefits
- 33.7% (vs. 24% in FY 13) of clients obtained procedural protections

Performance-Based Vendor Accountability: CSSD has established a continuous quality improvement team for each contracted service. Each team includes best practices staff, who develop program models based on the best practice literature and oversee program implementation; contract compliance specialists, who ensure that providers are adhering to the program model and the contract requirements; data collection support staff, who ensure that providers are inputting data into the CSSD "contractor data collection system" (CDCS) and the data meets quality standards; and program analysis staff, who analyze the data to ensure that programs are meeting benchmarks. Provider performance is reviewed by CSSD management staff on a quarterly basis, and the CQI team works with the provider to ensure quality service.

Family Support Centers: Since 2005, legislative change impacting the treatment and handling of status offenders (Families with Service Needs, FWSN) resulted in the development of distinct services for FWSN children and their families. Beginning with the prohibition on a court's placing an adjudicated child in detention for a violation of a court order, changes in the law also called for statewide process modification for the handling of FWSN referrals. Public Act 05-250 established that "no child that is found to be in violation of any such FWSN order may be punished for such violation by commitment to any juvenile detention center". In 2006, the legislature authorized an amendment to this legislation, Public Act 06-188, which established the Families with Service Needs Advisory Board to oversee the implementation of services in response to 05-250. The most recent legislative change came in an amendment of 46b-149 which changed the FWSN statute substantially, resulting in the development and funding of Family Support Centers.

A Family Support Center (FSC) is a multi-service "one-stop" service center for children and a family referred to juvenile court due to status offenses (e.g., truancy, beyond control, runaway) and serves as a diversion to formal court processing. There were four (4) FSCs servicing the Bridgeport, Hartford, New Haven, and Waterbury juvenile courts. FSCs services were made available to the eight (8) remaining juvenile courts in FY 10-11. The purpose of the FSC is to quickly assess service and/or treatment needs for the children and families and then provide and/or access the needed services in a timely fashion. Services offered include assessment, crisis intervention, family mediation, educational advocacy, case planning and management, psycho-educational groups, and flexible funds for prosocial supports.

Number of Clients Served: 1,070 referred and 1,055 (98.6% completed treatment)

Program Cost: FY 2014 $4,368,300

Performance-Based Standards:

- Program completion rate: completion of the FSC program means that the client satisfied 80 percent of the goals identified on the collaborative plan. The goal through December 2013 is for 85% of clients under age 16, and 78% of 16 and 17 year olds to successfully complete the program.
- Arrest rate for completers: percentage of program completers arrested within 12 months of program discharge. The goal is improved program performance by at least one percentage point each year.
- Re-referral rate for completers: percentage of program completers who have a new status offending court referral within 12 months of program discharge. The goal is improved program performance by at least one percentage point each year.

Performance –Based Outcomes:

- Program completion rate: 92% for clients under age 16, and 87% for clients ages 16 and 17. (In CY 13, the rate was 87% and 82%, respectively.)
- Arrest rate for completers: 31% for clients under age 16, and 22% for clients ages 16 and 17. (In CY 13, the rate was 32% and 21%, respectively.)
- FWSN referral rate for completers: 24% for clients under age 16, and 5% for clients ages 16 and 17. (In CY 13, the rate was 20% and 13%, respectively.)

Performance-Based Vendor Accountability: CSSD has established a continuous quality improvement team for each contracted service. Each team includes best practices staff, who develop program models based on the best practice literature and oversee program implementation; contract compliance specialists, who ensure that providers are adhering to the program model and the contract requirements; data collection support staff, who ensure that providers are inputting data into the CSSD "contractor data collection system" (CDCS) and the data meets quality standards; and program analysis staff, who analyze the data to ensure that programs are meeting benchmarks. Provider performance is reviewed by CSSD management staff on a quarterly basis, and the CQI team works with the provider to ensure quality service.

Office of Early Childhood

- **Nurturing Families Network**
- **Help Me Grow**
- **Family School Connection**
- **Family Empowerment**

Long-Term Agency Goals: The Office of Early Childhood delivers and supports early childhood services that are rooted in a prevention framework. Our long-term child prevention goal is described in our vision: All young children in Connecticut are safe, healthy, learning and thriving. Each child is surrounded by a strong network of nurturing adults who deeply value the importance of the first years of a child's life and have the skills, knowledge, support and passion to meet the unique needs of every child.

Our long-term agency program prevention goal is to ensure that early childhood services and supports (1) are safe, healthy, and nurturing, (2) support children's physical, social and emotional, and cognitive development, (3) are accessible to all children, particularly those at greater risk (including those from families in poverty, families with a single parent, families with limited English proficiency, and parents with less than a high school diploma); (4) build parent's capacity to be effective caregivers and develop nurturing relationships with their children; and (5) support communities to be more responsive to the needs of children and support their positive growth and development.

Strategies: To achieve these goals, the Office of Early Childhood will:

- Build agency capacity, and integrate prevention principles, strategies and resources within the agency;
- Support and build capacity of early childhood providers;
- Research and implement promising evidence-based programs support children and families;
- Deliver high-quality professional development to early childhood providers in every setting, including the home, center, or public school;
- Monitor state-funded early childhood programs to ensure program quality, integrity and accountability;
- Integrate and streamline early care and education services;
- Coordinate home visiting services;
- Make information available about programs and services through many access points, including public libraries, doctor's office, health care centers, neighborhood stores, schools, etc.
- Deliver services that are culturally and linguistically responsive;
- Reach out to parents and ask about their desires and needs for their children and family;
- Continually evaluate the effectiveness of our programs and services.

Performance-Based Outcomes: The Office of Early Childhood will work toward the following performance-based outcomes for our family prevention services:

- Decrease in rigid parenting attitudes
- Reduce the rate and severity of child abuse and neglect
- Increase in parent knowledge and use of social and community-based supports
- Decrease in parental stress
- Increase in parent education and employment rates
- Increase family connection to health care providers
- Decrease in children born with serious medical problems
- Improve parent-child interaction and parenting skills
- Enhance family relationship and parent well-being
- Increased parent involvement with their child's early learning experience
- Decrease in maternal depression

Measures of Effectiveness: This is not applicable since this is the first year the Office of Early Childhood has completed this report.

Methods: Our early care and education programs promote mixed-age and mix-income classrooms. Research shows that lower-income children perform better when enrolled in preschool classrooms with higher-income children.

The Office of Early Childhood strongly supports diversity and inclusion in its early childhood programs. Children with special needs are integrated into our early care and education settings. Our Early Learning and Development Standards include a supplementary Dual Language Learning Framework to support professionals working specifically with children acquiring multiple languages. The Office of Early Childhood is with the University of Connecticut Center for Excellence in Developmental Disabilities, Education, Training and Research (UCEDD) to focus on the use of the CT ELDS with children with disabilities and children who are dual language learners. UCEDD is conducting focus groups and a survey with home-based and center-based preschool programs to gain feedback about what would be most helpful to providers and parents to aid them in using the CT ELDS with children with disabilities and children who are dual language learners.

Family Support Services uses intensive home visiting, developmental surveillance and early identification of developmental delays and behavioral problems, parenting groups and parent engagement to reduce racial and economic disparity. Our home visiting programs promote families to participate in social connection activities, such as family activities, parent groups, and personal celebrations.

Nurturing Families Network (NFN): NFN has three primary components which focus on nurturing parenting, child development, and maternal and child health and community resources The program components are; Intensive home visiting for new parents who are at high risk for child abuse and neglect, Nurturing parenting groups assist parents in developing appropriate expectations of their children and enhance their parenting skills, and Nurturing Connections that brings new parents together with volunteers and others in the community who can help them adjust to the demands of having a baby. In recent years NFN has developed home visiting tailored to the needs of fathers and men. Additionally NFN offers in-home cognitive behavioral therapy to treat maternal depression.

Number Served: In fiscal year 2014 the program screened approximately 6,300 parents and provided Connections services to 875 families. Additionally, NFN served approximately 2,200 families in intensive home visiting and more than 200 families in Nurturing Parenting groups. In fiscal year 2014, approximately 65 fathers enrolled in NFN father home visiting program.

Program Cost: FY 14 $10,588,370

Performance-Based Standards:

- Maternal Health/Behavioral Outcomes:
- Infant and Child Health and Mortality
- Child Development
- Parenting Skills and Stress
- School Readiness
- Crime and Domestic Violence
- Child Abuse and Neglect
- Economic and family well being

Performance-Based Outcomes: The annual rate of abuse and neglect is 2%. This rate is very low when compared with rates of 20-25% reported in studies with similarly high-risk mothers who did not receive home visitation services.

- NFN mothers made statistically significant gains in life course outcomes during their participation in the program.
- Mothers were more likely to have graduated from high school and be employed
- Fathers in the program for six months made gains in employment

- Data on Community Life Skills scale indicate families improve in connecting to others in the community and accessing both financial and social resources.
- Percentage of children born with serious medical problems has decreased from 13% to 11%
- Parents participating in the program for one or two years significantly reduced their rigid parenting attitudes.
- Parents participating in groups are significantly less stressed and have more realistic attitudes of their children.

Performance-Based Vendor Accountability: A continuous quality improvement team has been established to review practice guidelines, training needs and program protocols for the larger network. Providers must agree to participate in an evaluation. Providers submit monthly data, review results and develop a written plan to address areas needing improvements in the form of a program improvement plan. OEC staff monitors the sites compliance and effectiveness in implementing the program accordance with policy.

Help Me Grow (HMG): Help Me Grow ensures that children and their families have access to a system of early identification, prevention and intervention services. HMG links child health providers, parents and service providers with existing community resources through a toll free telephone number. Through HMG families are connected to monitor their child's development using the Ages & Stages Questionnaire.

Number Served: In fiscal year 2014 HMG connected approximately 1,275 families and children to community based services. And, over 1200 families were newly enrolled to the Ages & Stages Child Monitoring program

Program Cost: FY 14 $331,462

Performance-Based Standards:
- Successfully connecting children and families to services
- Monitoring child development and informing parents

Performance–Based Outcomes:
- 2,180 calls were made to Help Me Grow, 75% of which were parents or guardians
- 80% of families were successfully connected to services
- Sent approximately 3,100 developmental screens for children and provided feedback, activities and referrals for families with need

Performance-Based Vendor Accountability: Maintains extensive database including assessment, attempts and connections to service and takes part in a program evaluation process. A continuous quality improvement team has been established to review processes and develop ways to maximize services to families.

Family School Connections (FSC): Family School Connections provides intensive home visiting services to families whose children are frequently truant or tardy or otherwise at risk of school failure. These children are often not getting their needs met at home and are at greater risk for child abuse and neglect, developmental, behavioral and health issues. The program is offered in grades K – 8 at three elementary schools in Connecticut.

Number Served: Approximately 150 families received intensive home visiting services

Program Cost: FY 14 $595,358

Performance-Based Standards:
- Improvement in parenting skills and as indicated on the CAPI-R a reduction in rigid parenting attitudes

- Based on CLS scale, parents increased their knowledge and access to community and social resources
- Increased involvement with their child's education experience

Performance –Based Outcomes: The participants showed a significant increase in their involvement with their with their child's school. Additionally, they found that parents were spending more time listening to their child read and helping them with their homework. Participants showed an increase in life skills, specifically in the areas of budgeting and getting support from others.

Performance-Based Vendor Accountability: A continuous quality improvement team has been established to review practice guidelines, training needs and program protocols for the larger network. Providers must agree to participate in an evaluation. Providers submit monthly data, review results and develop a written plan to address areas needing improvements in the form of a program improvement plan. OEC staff monitors the sites compliance and effectiveness in implementing the program accordance with policy.

Family Empowerment Initiatives: : Family Empowerment Initiatives include seven nationally recognized prevention programs that assist high-risk groups of parents and others involved in the lives of children.

Number Served: 430 parent received home and group based services

Program Cost: FY 14 $191,516

Performance-Based Standards: Follow model replication standards. Use the AAPI 2 or other tool to assess changes in parenting attitudes and behaviors.

Performance –Based Outcomes: Program sites have developed within recognized standards of best practice. Parent participate consistently and report gains in knowledge and less stress caring for their children, as well as valuable community resources to keep them and their children safe.

Performance-Based Vendor Accountability: Providers submit quarterly reports and receive feedback on implementation from OEC staff. Providers submit an individualized program plan annually which identifies and provides ways to improve services to families.

- **Title V Delinquency Prevention Program**
- **Youth Services Prevention Program**

TITLE V DELINQUENCY PREVENTION PROGRAM: The Title V Delinquency Prevention Program goal is to reduce delinquency and youth violence by supporting communities in providing their children, families, neighborhoods and institutions with the knowledge, skills and opportunities necessary to foster a healthy and nurturing environment. The 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 provides communities with a conceptual framework for prioritizing the risk and protective factors in their 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. A youth advisory committee that reflects the racial, ethnic, and cultural composition of the community's youth population and includes youth at various levels of academic and social competencies must provide input into the design and implementation of program strategies.

Program Cost: FY: 2014 $84,945

Performance-Based Standards: Program communities must develop and implement a local delinquency prevention plan that:

- Assess 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;
- Identify all available resources in the community;
- Assess gaps in the needed resources and how to address them;
- Establish goals and objectives along with an implementation timeline; and
- Insure the collection of 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.

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

YOUTH SERVICES PREVENTION PROGRAM: Youth Services Prevention Program: In 2013, the legislature enacted Public Act 13-247. This public act specifies that OPM's Youth Services Prevention appropriations of $3.5

million be distributed to certain governmental and non-governmental entities in both fiscal years 2014 and 2015. In 2014, OPM awarded grants to 42 nonprofit organizations throughout the State. Grant amounts ranged from $20,000 to $396,400. The major focus of the grants is to implement comprehensive programs and services to prevent and/ or reduce at-risk behavior among youth ages 6-18 and to maximize opportunities for them to become productive, responsible citizens. Programs range from structured after-school activities to mental health services that assist youth in bettering their lives and the lives of their families.

Program Cost: FY 2014 $3.5 million

Performance –Based Standards: All programs must complete and submit semi-annual reports on the status of their programs including: program accomplishments, barriers or challenges that may change the scope of the project, identification of new approaches or strategies implemented or planned, and budget information.

House Bill No. 5323

Public Act No. 14-132

AN ACT CONCERNING THE CHILD POVERTY AND PREVENTION COUNCIL.

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

Section 1. Subsection (a) of section 4-67x of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) There shall be a Child Poverty and Prevention Council consisting of the following members or their designees: The Secretary of the Office of Policy and Management, the president pro tempore of the Senate, the speaker of the House of Representatives, the minority leader of the Senate and the minority leader of the House of Representatives, the Commissioners of Children and Families, Social Services, Correction, Developmental Services, Mental Health and Addiction Services, Transportation, Public Health, Education, Housing, Agriculture and Economic and Community Development, the Labor Commissioner, the Chief Court Administrator, the chairperson of the Board of Regents for Higher Education, the Child Advocate and the executive directors of the Commission on Children, the Office of Early Childhood and the Commission on Human Rights and Opportunities. The Secretary of the Office of Policy and Management, or the secretary's designee, shall be the chairperson of the council. The council shall (1) develop and promote the implementation of a ten-year plan, to begin June 8, 2004, to reduce the number of children living in poverty in the state by fifty per cent, and (2) within available appropriations, establish prevention goals and recommendations and measure prevention service outcomes in accordance with this section in order to promote the health and well-being of children and families.

Sec. 2. Subsection (g) of section 4-67x of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(g) (1) On or before 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. On or before November first of each year from 2015 to 2020, inclusive, each budgeted state agency that provides prevention services to children shall, within available appropriations, report to the joint standing committees of the General Assembly having cognizance of matters related to appropriations, human services and children in accordance with this subsection.

(2) Each agency report shall include at least two prevention services 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 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.

(4) Each agency report shall also include (A) a list of agency programs that provide prevention services, (B) the actual prevention services expenditures for the most recently

completed fiscal year, and (C) the percentage of total actual agency expenditures in the most recently completed fiscal year that were actual prevention services expenditures.

Sec. 3. Section 4-67v of the general statutes is repealed. (*Effective from passage*)

Approved June 6, 2014