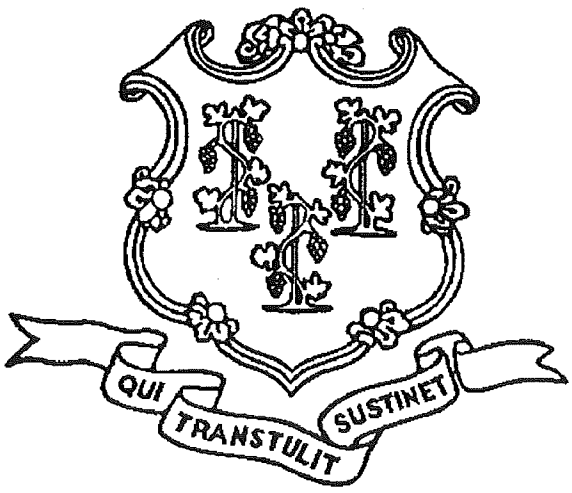
HEALTHY CONNECTICUT

2000

Baseline Assessment Report

Replacements and Additions

July 1997



Connecticut Department of Public Health

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

July 1997

TO: Healthy Connecticut 2000 Contacts

SUBJECT: HEALTHY CONNECTICUT 2000 SERVICES AND PROTECTION OBJECTIVES

As a result of a Department-wide effort, enclosed are the **Services and Protection Objectives** and insertion pages for your copy of the ***Healthy Connecticut 2000 Baseline Assessment*** report. We have also added two new chapters to the report. These are Chapter 8 - Educational and Community Based Programs and Chapter 13 - Oral Health.

These objectives were selected to address the Health Status and Risk Reduction objectives already identified in the baseline assessment report. I hope this work will be useful to you and your programs. As we enter into our review and revision period in monitoring the status of all the objectives contained in the report, the Baseline Assessment report will be updated periodically. This may occur as a result of targets being met and/or the addition of new objectives. These updates will be shared with you as necessary.

We welcome any comments you may have on this work, and any suggestions for future improvements and refinements.

Marie V. Roberto

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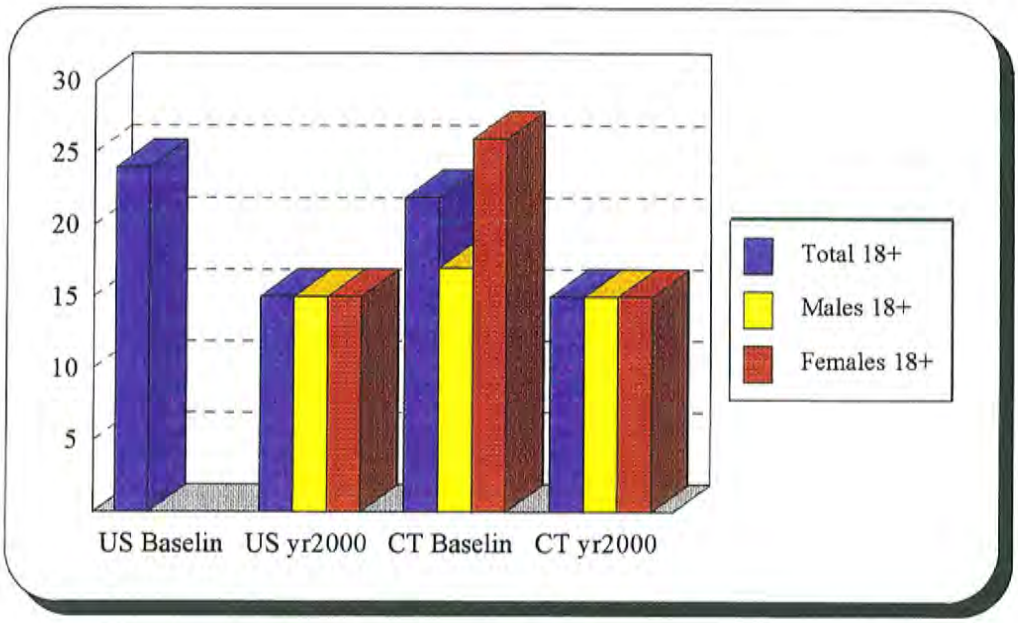
HEALTHY CONNECTICUT 2000 BASELINE ASSESSMENT REPORT
July 1997

Chapter 1 - PHYSICAL ACTIVITY AND FITNESS

Selected Objectives

OBJ.#	OBJECTIVE DESCRIPTION
	Health Status Objective
1.1	Reduce coronary heart disease deaths to no more than 84.4 per 100,000 people
1.2	Reduce overweight to a prevalence of not more than 20 percent among people aged 20 and older and no more than 15 percent among adolescents aged 12 through 19
	Risk Reduction Objectives
1.3	Increase to at least 30 percent the proportion of people aged six and older who engage regularly, (preferably daily) in light to moderate physical activity for at least 30 minutes per day
1.4	Increase to at least 20 percent the proportion of people aged 18 and older and to at least 75 percent the proportion of children and adolescents aged 6-17 who engage in vigorous physical activity that promotes the development and maintenance of cardiorespiratory fitness three or more days per week for 20 or more minutes per occasion
1.5	Reduce to no more than 15 percent the proportion of people aged eighteen and older who engage in no leisure time physical activity
1.6	Increase to at least 40 percent the proportion of people aged six and older who regularly perform physical activities that enhance and maintain muscular strength, muscular endurance, and flexibility
1.7	Increase to at least 35 percent the proportion of overweight people aged 12 and older who have adopted sound dietary practice combined with regular physical activity to attain an appropriate body weight
	Services and Protection Objectives
11a	Increase the proportion of block grant funded local health departments/agencies offering fitness activities for their service area

Objective 1.5: **Reduce to no more than 15 percent the proportion of people aged eighteen and older who engage in no leisure-time physical activity**



Age/Sex	US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
Total age 18 & Older	24% (1991)	15%	21.9% (1994)	15%
Males - Age 18 & Older	N/A	15%	17% (1994)	15%
Females - Age 18 & Older	N/A	15%	26% (1994	15%

Source: Bureau of Community Health, Connecticut Department of Public Health, Behavioral Risk Factor Survey, 1994.

Data Limitations: Data are limited due to self-reporting of a sampling of residents surveyed by telephone.

Rationale: Regular exercise of even mild to moderate levels of activity has been shown to decrease the risk of coronary heart disease and overall mortality.

Objective 1.11: *US* - Increase community availability and accessibility of physical activity and fitness programs

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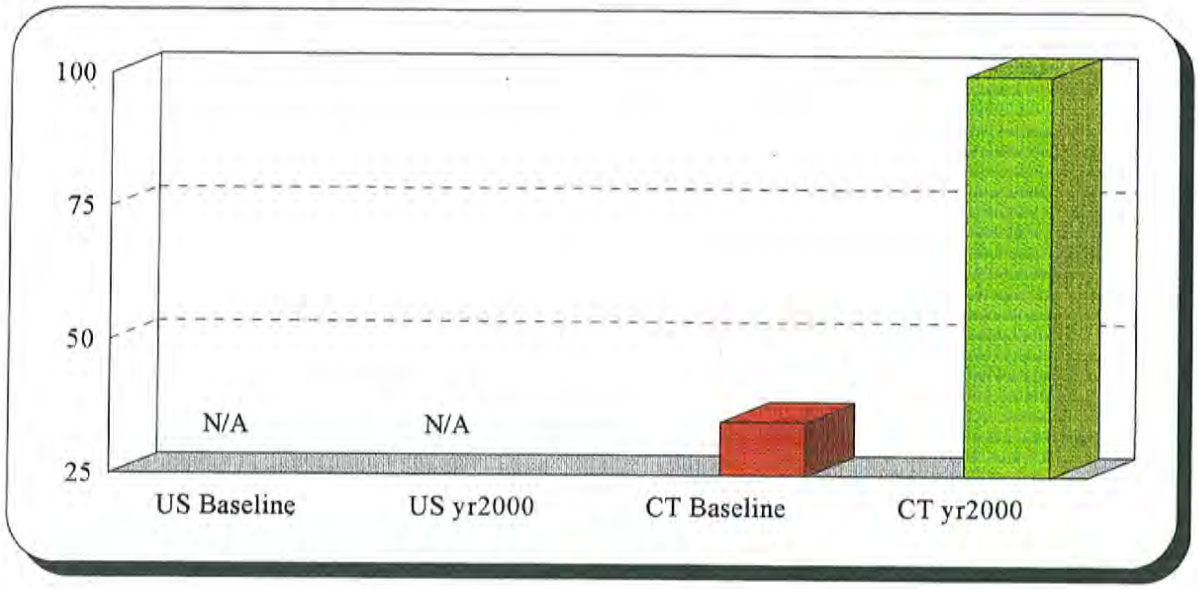
1.11(a) *CT* - Increase the proportion of block grant funded local health departments/agencies offering fitness activities for their service area



The Connecticut objective is directed to block grant funded local health departments.

US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
N/A	N/A	6 out of 18 (1995)	18 out of 18

Source: Bureau of Community Health, Connecticut Department of Public Health.

Data Limitations:

Rationale: Persons of all ages should include physical activity in a comprehensive health program, and should increase their daily physical activity to a level appropriate to their capabilities, needs, and interest.

Chapter 2 - Nutrition

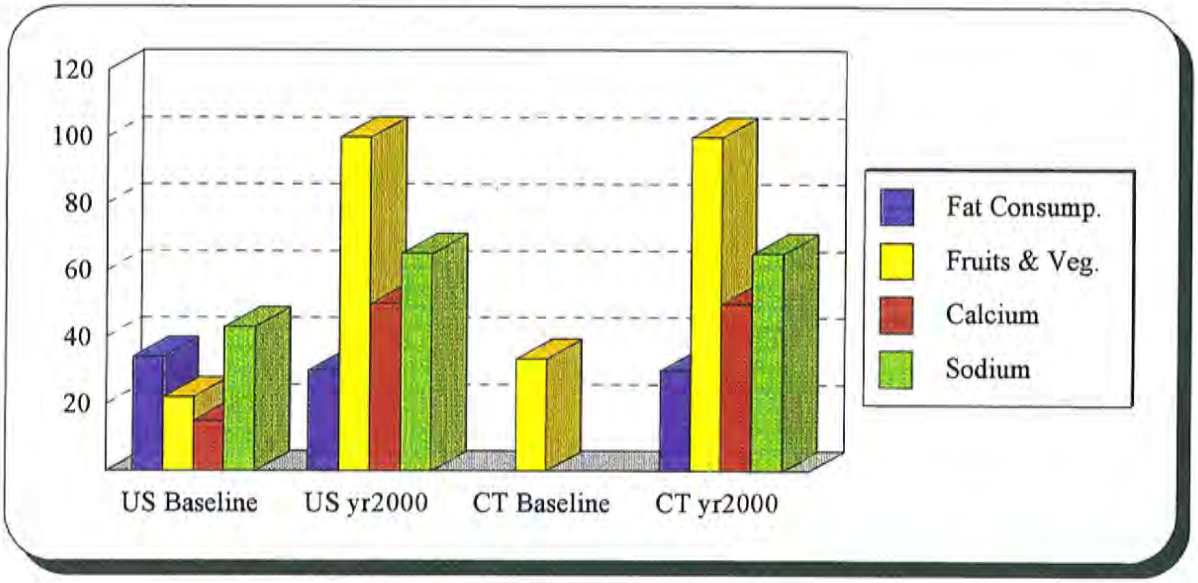
Selected Objectives

OBJ. #	OBJECTIVE DESCRIPTION
	Health Status Objective
2.3	Reduce overweight to a prevalence of no more than 20 percent among people aged 20 and older and no more than 15 percent among adolescents aged 12 through 19
2.4	Reduce growth retardation among low income children under five years of age to less than seven percent
	Risk Reduction Objectives
2.5	Reduce dietary fat intake to an average of 30 percent of calories or less and average saturated fat to less than ten percent among people aged two and older
2.6	Increase complex carbohydrate and fiber-containing foods in diets of adults to five or more servings for vegetables (including legumes) and fruit and six or more daily servings for grain products
2.10	Reduce iron deficiency to less than ten percent among children aged one through four and less than three percent for women of childbearing age
2.11	Increase to at least 75 percent the proportion of mothers who breastfeed their babies in the early postpartum period and to at least 50 percent the proportion who continue to breastfeed until their babies are five to six months old
	Services and Protection Objectives
2.16a	Promote acceptance and practice of the 1995 U.S. Dietary Guidelines
2.17a	Establish nutrition as part of a comprehensive school program for grades K-12 for 90 percent of the schools in Connecticut
2.21	Increase to at least 75 percent the proportion of primary care providers who provide nutrition assessment and counseling and/or referral to qualified nutritionists or dietitians
2.21a	Include medical nutrition therapy as a funded/integral service in managed care programs
2.21b	Identify funding to continue and expand professional education on breastfeeding management and prenatal and post partum support for breastfeeding mothers

Note: Cholesterol Reduction Objective appears in Heart Disease Section 15.6.

Objective 2.16: *US* - Increase to at least 90 percent the proportion of restaurants and institutional food service operations that offer identifiable low-fat, low-calorie food choices, consistent with the *Dietary Guidelines for Americans*

2.16(a) *CT* - Promote acceptance and practice of the 1995 U.S. Dietary Guidelines in food service at state facilities and community health providers



Diet	US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
Fat Consumption (% Calories from total fat)	34%	30%	Not Available	30%
Fruits and Vegetables (5 Servings per day)	22%	100%	33.5%	100%
Calcium (3 or more servings per day)	15%	50%	Not Available	50%
Sodium (Prepare foods without salt)	43%	65%	Not Available	65%

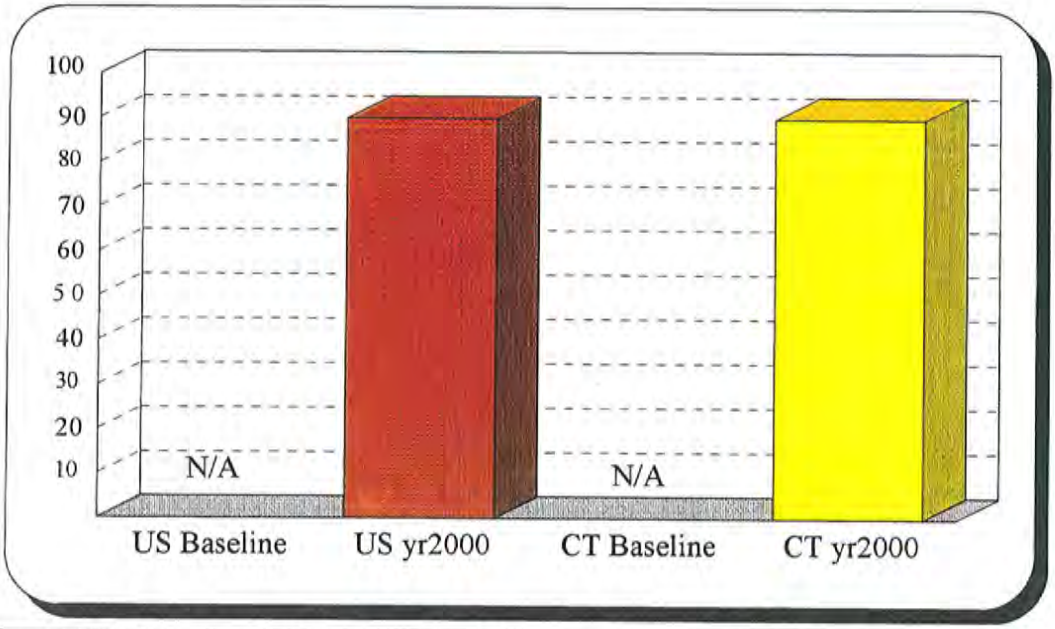
Source: Bureau of Community Health, Connecticut Department of Public Health, Behavioral Risk Factor Survey, 1994.

Data Limitations: Baseline data for Connecticut are very limited since DPH has data only on fruits and vegetable consumption. Funding is limited, therefore, it will be difficult to collect data on calcium and sodium consumption.

Rationale: The Department of Public Health (DPH) should take leadership in developing and promoting use of 1995 U.S. Dietary Guidelines for the public and in facilitating their use in food service at state facilitie DPH nutritionists will work with colleagues to implement use of 1995 U.S. Dietary Guidelines. Guidelines will be disseminated to community providers and the public. Implementation of Dietary Guidelines will reduce dietary fat and sodium intakes and increase consumption of complex carbohydrates, fiber-containing foods, folic acid, and calcium. These changes will improve the nutriti and health of affected populations thereby reducing health care costs and improving quality of life.

Objective 2.17: ***US*** **- Increase to at least 90 percent the proportion of school lunch and breakfast services and child care food services with menus that are consistent with the nutrition principles in the *Dietary Guidelines for Americans***

2.17(a) *CT* - Establish nutrition as part of a comprehensive school program for grades K-12 for 90 percent of the schools in Connecticut



US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
N/A	90%	N/A	90%

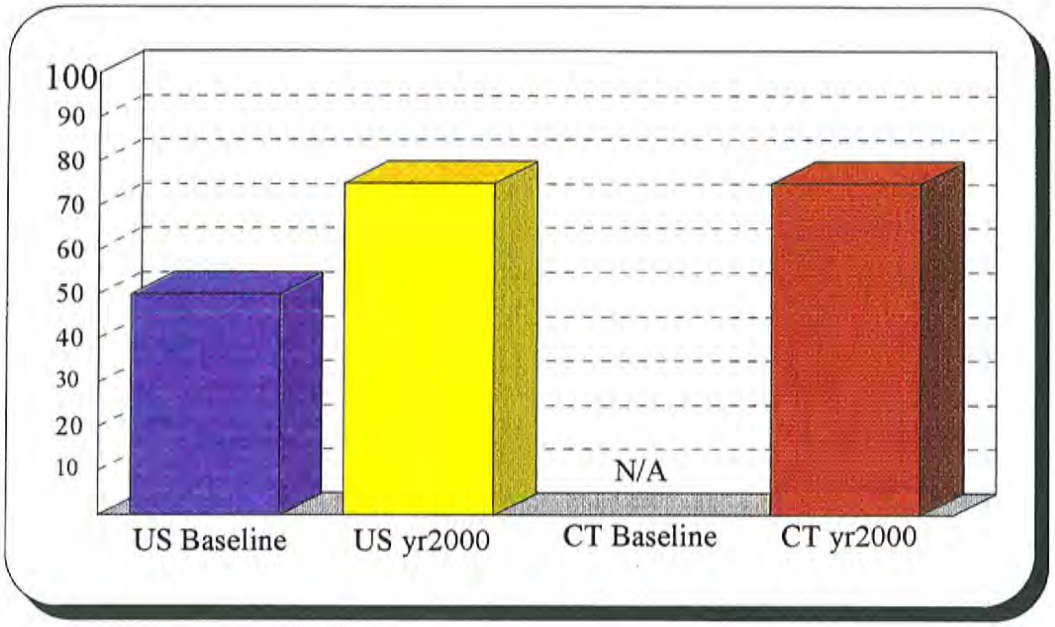
Source: Bureau of Community Health, Connecticut Department of Public Health.

Data Limitations: Both State and Federal data for baseline are unavailable at this time. Currently, every school meal has to meet set criteria which is monitored by the Department of Education.

Rationale: In order for healthy food habits to be sustained throughout life, an early introduction to good nutrition that is reinforced and supported throughout a child's school experience can positively impact the nutrition knowledge, attitudes and behaviors of school-children.

The CT Department of Public Health nutrition staff will develop a model for coordinated comprehensive school health and nutrition following national guidelines modules on: a) health education, b) physical education, c) health services, d) school food service and nutrition, e) counseling, guidance and mental health, f) staff health promotion, g) school environment, and h) community. This model will be distributed throughout the state. While each component may be implemented as a free-standing module, together a synergistic effect should ensue resulting in better learning and implementation of sound nutrition practices. Better nutrition of school-aged children should improve their health and that of their offspring for years to come.

Objective 2.21: **Increase to at least 75 percent the proportion of primary care providers who provide nutrition assessment and counseling and/or referral to qualified nutritionists or dietitians**



	US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
Percent of Primary Care Providers	40-50% (1988)	75%	N/A	75%

Source: Bureau of Community Health, Connecticut Department of Public Health.

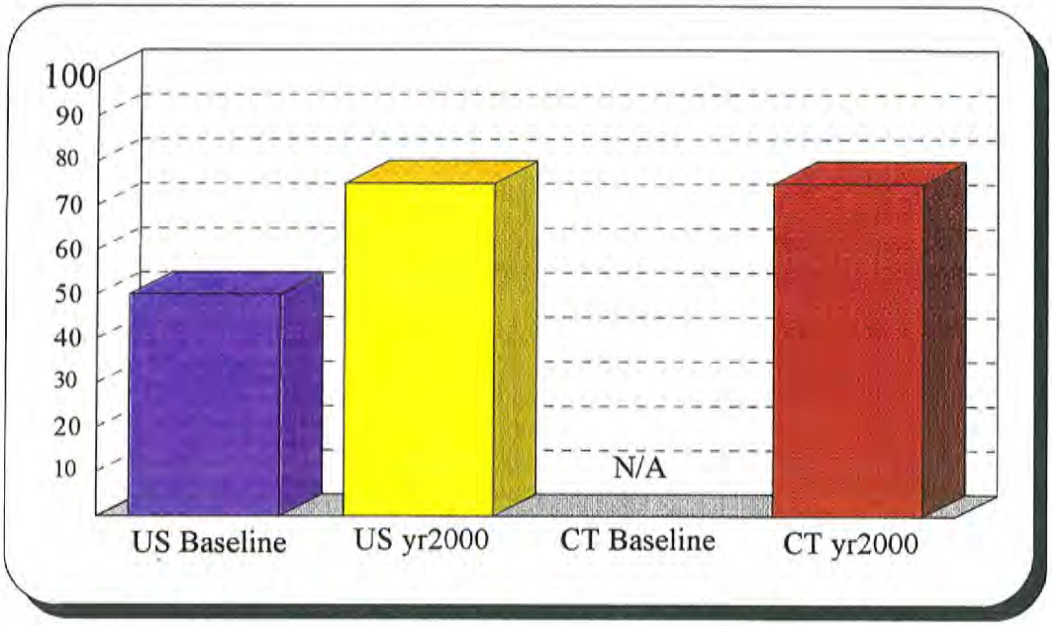
Data Limitations: There is no data for Connecticut at this time.

Rationale: Nutrition assessment and treatment (medical nutrition therapy) by certified dietitian/nutritionists is critical and cost effective in the treatment of a variety of conditions including hypercholesterolemia, obesity, metabolic defects, failure to thrive, etc.

Department of Public Health nutritionists will provide training and technical assistance to providers to enhance the availability of medical nutrition therapy in Connecticut.

Objective 2.21: ***US*** **- Increase to at least 75 percent the proportion of primary care providers who provide nutrition assessment and counseling and/or referral to qualified nutritionists or dietitians**

2.21(a) ***CT*** **- Include medical nutrition therapy as a funded/integral service in 75 percent of Medicaid managed care programs**



The Connecticut objective is directed only to Medicaid managed care programs.

	US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
Percentage of Medicaid Managed care programs with nutrition therapy	40-50% (1988)	75% of Primary Care Providers	Not Available	75%

Source: Bureau of Community Health, Department of Public Health.

Data Limitations: Federal survey data is the sole source of data at this time.

Rationale: Medical nutrition therapy is a vital part of both preventive and therapeutic primary care. Maintaining awareness of the role of medical nutrition therapy as well as funding this service will greatly enhance public health.
State nutritionists will educate managed care providers about the importance of medical nutrition therapy. Department of Public Health (DPH) nutritionists will also provide input to D.S.S. decision-makers on nutrition services for the Medicaid population. DPH nutritionists will make recommendations about the integration of medical nutrition therapy into managed care programs.

Objective 2.21: ***US*** **- Increase to at least 75 percent the proportion of primary care providers who provide nutrition assessment and counseling and/or referral to qualified nutritionists or dietitians**

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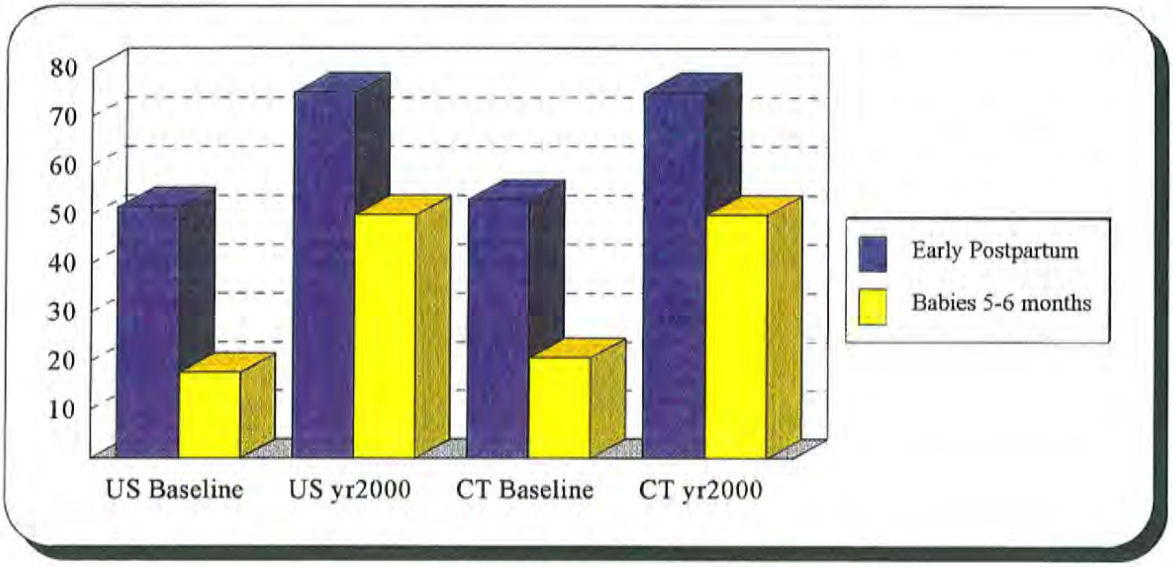
2 .21(b) ***CT-*** **Identify funding to continue and expand professional education on breastfeeding management and prenatal and postpartum support for breastfeeding mothers to increase the rates of breastfeeding initiation and duration**



Population	US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
Early Postpartum (mothers breastfeeding)	51.5% (1990)	75%	53.1% (1990)	75%
Mothers breastfeeding Babies 5-6 months	17.6% (1990)	50%	20.7% (1990)	50%

Source: Bureau of Community Health, Connecticut Department of Public Health.

Data Limitations:

Rationale: Breastfeeding reduces infant morbidity and provides long term health benefits to both mother and child. The state has played a vital role in the training of health professionals to provide accurate and consistent information to new mothers through the Breast is Best (BIB) Initiative. This effort must be expanded in an effort to achieve Healthy Connecticut objective 2.11. State staff will explore the availability of foundation funding and provide technical assistance to outside groups supporting this effort. Legislation will be drafted for submission through the Connecticut Department of Public Health to establish a mechanism to coordinate the necessary training, support services and obtain funding on a statewide basis.

HEALTHY CONNECTICUT 2000 BASELINE ASSESSMENT REPORT

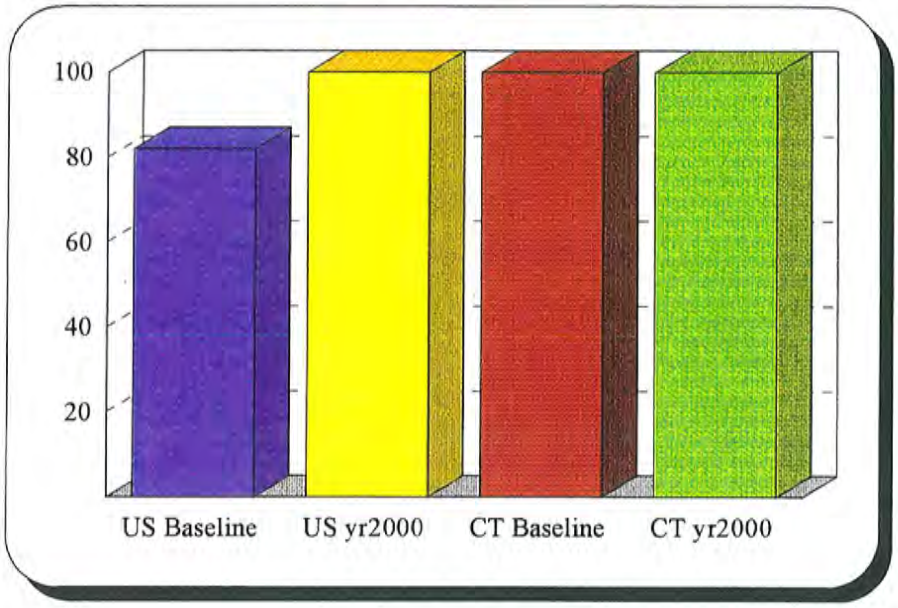
July 1997

Chapter 3 - TOBACCO

Selected Objectives

OBJ. #	OBJECTIVE DESCRIPTION
	Health Status Objectives
3.1	Reduce coronary heart disease deaths to no more than 84 per 100,000 people
3.2	Slow the rise in lung cancer deaths to achieve a rate of no more than 42 per 100,000 people
3.3	Slow the rise in deaths from chronic obstructive pulmonary disease to achieve a rate of no more than 20 per 100,000 people
	Risk Reduction Objectives
3.4	Reduce cigarette smoking to a prevalence of no more than 15 percent among people aged 20 and older
3.5	Reduce the initiation of cigarette smoking by children and youth so that no more than 15 percent have become regular cigarette smokers by age 20
3.6	Increase to at least 60 percent the proportion of cigarette smokers aged 18 or older who stopped smoking cigarettes for at least one day during the preceding year
3.7	Increase smoking cessation during pregnancy so that at least 60 percent of women who are cigarette smokers at the time they become pregnant quit smoking early in pregnancy and maintain abstinence for the remainder of their pregnancy
3.8	Reduce to no more than 20 percent the proportion of children aged six and younger who are regularly exposed to tobacco smoke at home
	Services and Protection Objectives
3.14	Develop and Maintain a Tobacco Use Prevention Plan

Objective 3.14: Develop and Maintain a Tobacco Use Prevention Plan



US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
82% (41 States with Plan - 1994)	100% (50 States with Plan)	Plan completed in 1996	Plan maintained

Source: Bureau of Community Health, Connecticut Department of Public Health.

Data Limitations: Data limitations exist because most of the data used comes from CDC and other State Departments which are not under the control of DPH.

Rationale: Since tobacco use effects the community, developing a tobacco use prevention plan using community organizations as advisers, advocates and partners is an effective way to generate visible tobacco use prevention activities that will continue over time.
The development and maintenance of a tobacco use prevention plan with backing by a multidisciplinary coalition will fulfill this objective.

Target Population Group:
Youth
Women of child bearing age

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Chapter 5 - FAMILY PLANNING

Selected Objectives

OBJ. #	OBJECTIVE DESCRIPTION
	Health Status Objectives
5.1	Reduce pregnancies among girls aged 17 and younger to no more than 50 per 1,000
5.3	Reduce the prevalence of infertility to no more than 6.5 percent
	Risk Reduction Objectives
5.4	Reduce the proportion of adolescents who have engaged in sexual intercourse to no more than 15% by age 15 and no more than 40 percent by age 17
5.6	Increase to at least 90 percent of clients seen in DPH funded clinics the proportion of sexually active, people with multiple sex partners, aged 19 and younger who use contraception, especially combined contraception methods that both effectively prevent pregnancy and provide barrier protection against disease
	Services and Protection Objectives
5.9a	Increase to 100 percent the number of prenatal care referrals made for women seeking such care after receiving positive pregnancy test results and options counseling at Department of Public Health funded Family Planning clinics
5.10a	Increase the number of Department of Public Health funded Family Planning clinics that provide Level 1 infertility screening, testing and counseling to the target population
5.10b	Increase to 100 percent the number of Department of Public Health funded Primary Health Care settings that provide or refer to provide Family Planning services
5.11a	Increase to 100 percent the proportion of Department of Public Health funded Family Planning contractors that provide education and outreach activities to males, minorities of any age, and to all persons aged 10-18 years old
5.11b	Increase to 100 percent the proportion of women in the Department of Public Health funded Family Planning clinics who are counseled and when counseled elect to receive sexually transmitted diseases screening where appropriate, as part of a reproductive health care visit

Objective 5.9: *US* - Increase to at least 90 percent the proportion of pregnancy counselors who offer positive, accurate information about adoption to their unmarried patients with unintended pregnancies

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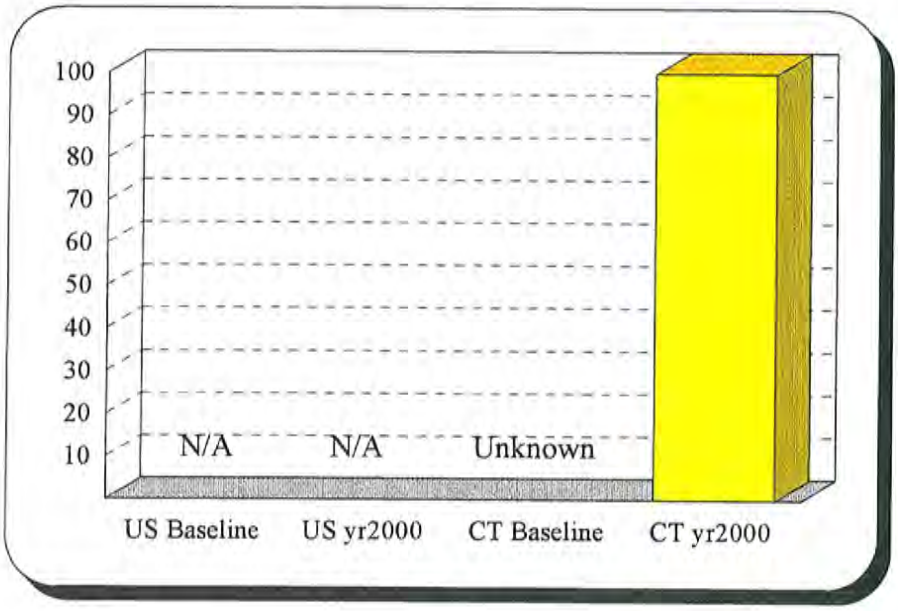
5.9(a) *CT* - Increase to 100 percent the number of prenatal care referrals made for women seeking such care after receiving positive pregnancy test results and options counseling at Department of Public Health funded Family Planning clinics



US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
Not Applicable	Not Applicable	Unknown. Family Planning clinics refer but do not make appointments for prenatal care.	100% of clients with a positive pregnancy test who choose to retain the pregnancy and want prenatal care will receive referrals at the time of the family planning visit

Source: Bureau of Community Health, Connecticut Department of Public Health.

Data Limitations: No baseline data are available at this time.

Rationale: Early entry into prenatal care promotes positive birth outcomes. Community linkages to comprehensive services can facilitate early entry into prenatal care.

The Department of Public Health (DPH) will fund and develop contract terms that reflect required service provision for entities it funds and will monitor contract compliance. Through contract compliance, Family Planning clinics funded by DPH will increase to 100% the number of prenatal care referrals made for women seeking such care after receiving positive pregnancy test results and options counseling, thereby facilitating early entry into prenatal care and promoting positive birth outcomes.

Objective 5.10: *US* - Increase to at least 60 percent the proportion of primary care providers who provide age-appropriate preconception care and counseling

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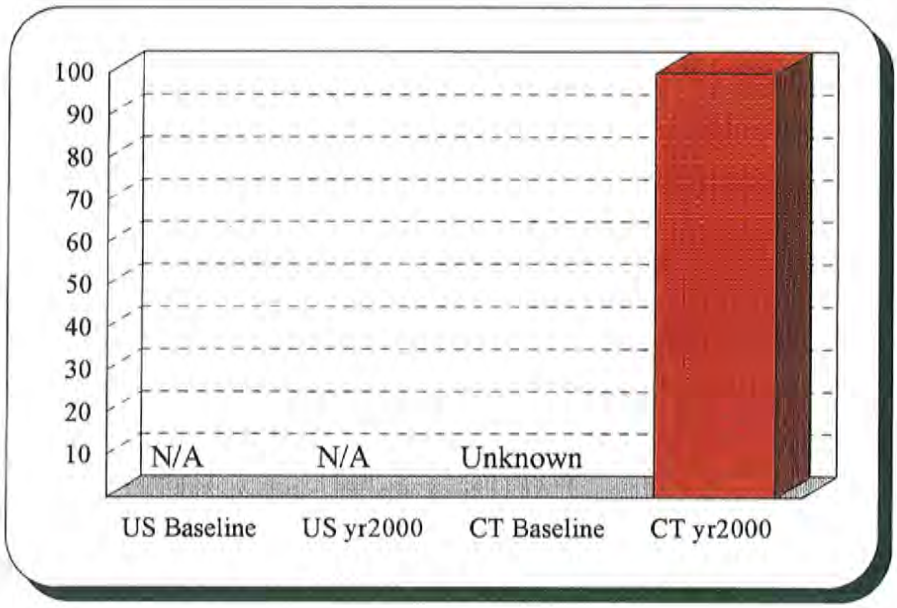
5.10(a) *CT* - Increase the number of Department of Public Health funded Family Planning clinics that provide Level 1 infertility screening, testing and counseling to the target population



US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
Not Applicable	Not Applicable	Unknown	100% of DPH funded family planning clinics will provide Level 1 infertility screening, testing, and counseling and referrals

Source: Bureau of Community Health, Connecticut Department of Public Health.

Data Limitations: No baseline data are available at this time.

Rationale: Reductions in infertility are possible through improved preconception counseling (especially related to prevention of STDs), increased fertility awareness and fertility monitoring. More complex treatment interventions such as medical induction of ovulation, surgical procedures to correct blocked fallopian tubes, artificial insemination and *in vitro* fertilization require appropriate referral.

The Department of Public Health (DPH) will fund and develop contract terms that reflect required service provision and provide technical assistance and consultation, and will monitor contract compliance for entities it funds. Compliance with contract terms will assure that Level 1 infertility screening, testing and counseling as appropriate is provided through DPH funded Family Planning clinics to the target population, in order to enhance the client's awareness and monitoring, and identify the need for more complex interventions.

Objective 5.10: *US* - Increase to at least 60 percent the proportion of primary care providers who provide age-appropriate preconception care and counseling

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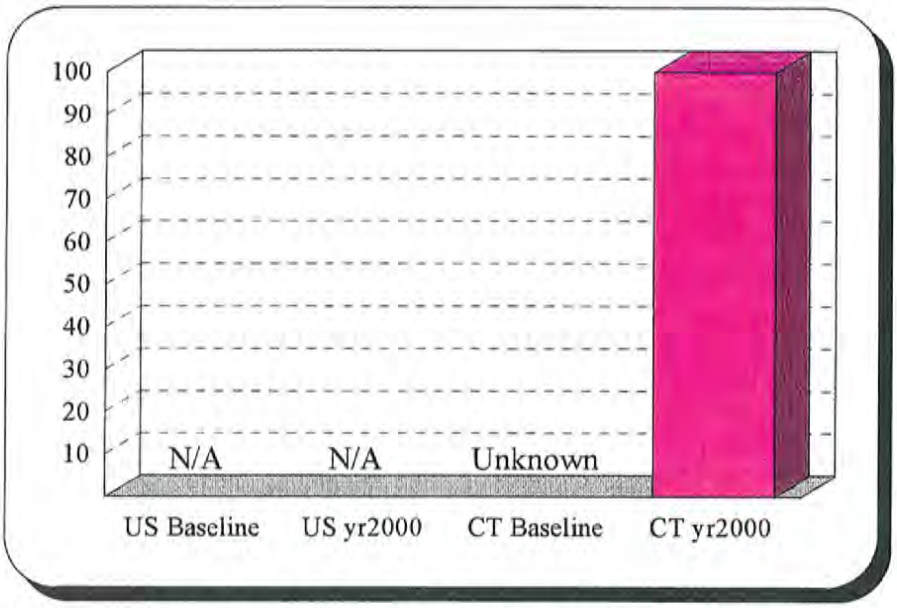
5.10(b) *CT* - Increase to 100 percent the number of Department of Public Health funded Primary Health Care settings that provide or refer to provide Family Planning services



The Connecticut objective is directed to DPH funded primary care settings.

US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
Not Applicable	Not Applicable	Unknown	100% of Primary Health Care settings funded by DPH will provide Family Planning services

Source: Bureau of Community Health, Connecticut Department of Public Health.

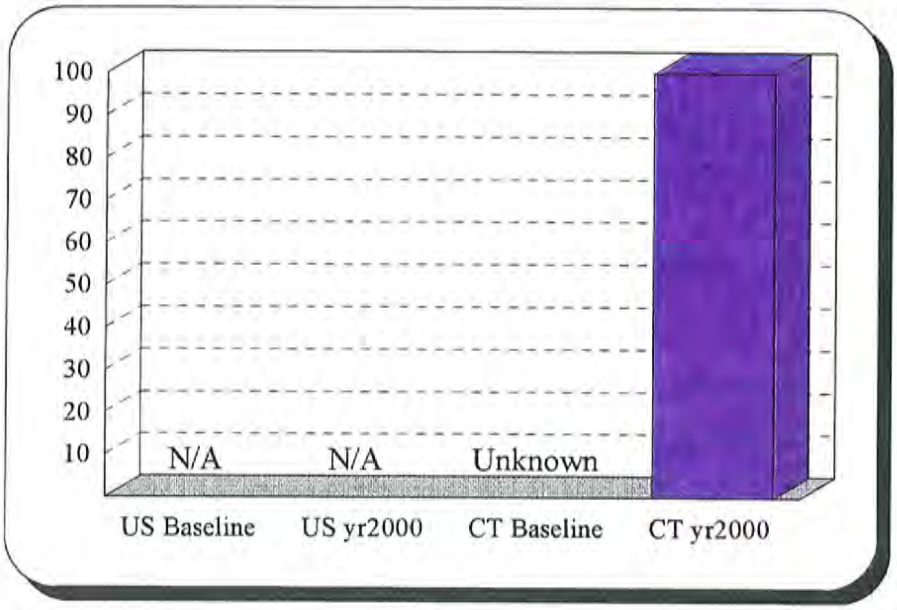
Data Limitations: No baseline data are available at this time.

Rationale: "One stop shopping" with a complete array of core services should ideally be available and accessible to all Connecticut residents. Co-located service sites are encouraged.

The Department of Public Health (DPH) will fund and develop contract terms that reflect required service provision and provide technical assistance and consultation, and will perform site visits, review the contractor's quarterly reports and Quality Assurance Program. Compliance with contract terms will assure that DPH funded Primary Health Care settings will provide Family Planning Services, increasing the availability and accessibility of preventive health services.

Objective 5.11: ***US*** **- Increase to at least 50 percent the proportion of family planning clinics, maternal and child health clinics, sexually transmitted disease clinics, tuberculosis clinics, drug treatment centers, and primary care clinics that screen, diagnose, treat, counsel, and provide (or refer for) partner notification services for HIV infection and bacterial sexually transmitted diseases (gonorrhea, syphilis, and chlamydia)**

5.11(a) ***CT*** **- Increase to 100 percent the proportion of Department of Health funded Family Planning contractors that provide education and outreach activities to males, minorities of any age, and to all persons aged 10-18 years old**



The Connecticut objective is directed only toward family planning contractors funded by DPH.

US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
Not Applicable	Not Applicable	Unknown	100% of DPH funded clinics will have an executed outreach/education program for this population

Source: Bureau of Community Health, Connecticut Department of Public Health.

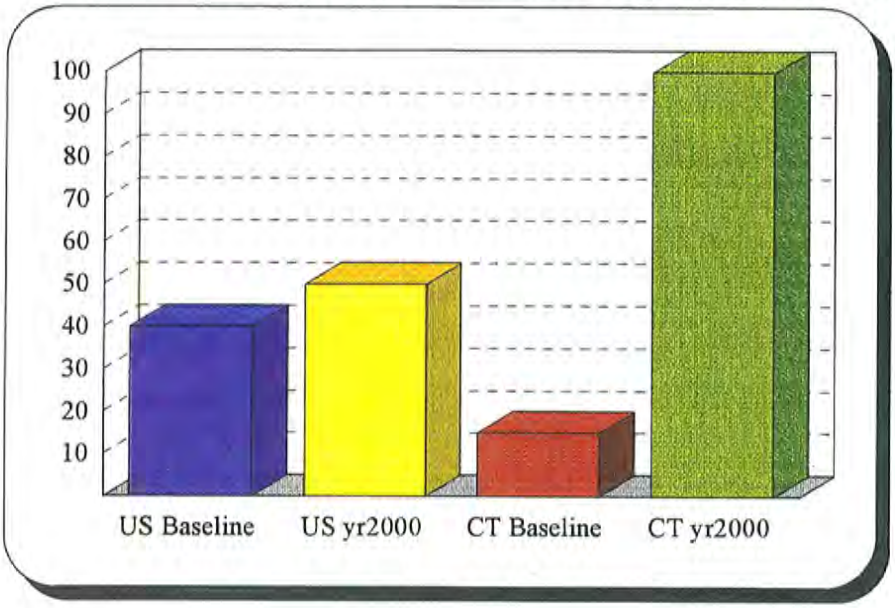
Data Limitations: Inconsistent reporting across Department of Public Health funded Family planning clinics.

Rationale: Minorities and teens are at high risk for unintended pregnancy and disease. Fostering male responsibility will improve effective use of Family Planning methods, thereby reducing the rates of unintended pregnancies and infectious diseases.

The Department of Public Health will fund and develop contract terms that reflect required service provision for entities it funds and will monitor contract compliance. Through contract compliance, the Family Planning clinics funded by DPH will increase education and outreach activities to males, minorities of any age, and to all persons aged 10-18 years, fostering male responsibility and prevention of behaviors that lead to unintended pregnancy among these "at risk" populations.

Objective 5.11: ***US*** **- Increase to at least 50 percent the proportion of family planning clinics, maternal and child health clinics, sexually transmitted disease clinics, tuberculosis clinics, drug treatment centers, and primary care clinics that screen, diagnose, treat, counsel, and provide (or refer for) partner notification services for HIV infection and bacterial sexually transmitted diseases (gonorrhea, syphilis, and chlamydia)**

5.11(b) ***CT*** **- Increase to 100 percent the proportion of women in the Department of Public Health funded Family Planning clinics who are counseled and when counseled elect to receive sexually transmitted diseases including HIV screening where appropriate as part of a reproductive health care visit**



US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
40% in 1989	50%	2 of 13 of DPH funded Family Planning Clinics (15%)	100% of DPH funded Family Planning Clinics

Source: Bureau of Community Health, Connecticut Department of Public Health.

Data Limitations:

Rationale: For many women, the Family Planning clinic is the first contact with the health care system. "One stop shopping" increases access and facilitates acceptance of counseling and testing.

The Department of Public Health (DPH) will fund and develop contract terms that reflect required service provision and provide technical assistance and consultation, and will perform site visits, review the contractor's quarterly reports and Quality Assurance program. Through contract compliance the Family Planning clinics funded by DPH will provide AIDS counseling and testing, enhancing identification and treatment of HIV positive clients and maximizing the potential for healthy birth outcomes for pregnant clients.

Chapter 7 - VIOLENT AND ABUSIVE BEHAVIORS

Selected Objectives

OBJ. #	OBJECTIVE DESCRIPTION
	Health Status Objectives
7.1	Reduce homicides to no more than 5.0 per 100,000 people
7.2	Reduce suicides to no more than 6.7 per 100,000 people
7.4	Reverse to less than 25.2 per 1,000 children the rising incidence of maltreatment of children younger than age 18
7.5	Reduce physical abuse directed at women by male partners to no more than 27 per 1,000 couples
7.6	Reduce assault injuries among people aged 12 and older to no more than eight per 1,000
7.7	Reduce rape and attempted rape of women aged 12 and older to no more than 108 per 100,000 women
7.8	Reduce the incidence of injurious suicide attempts among adolescents aged 14 through 17 to no more than 3 per 100,000
	Risk Reduction Objectives
7.9	Reduce by 20 percent the incidence of physical fighting among adolescents aged 14 through 17
7.10	Reduce by 20 percent the incidence of weapon-carrying by adolescents aged 14 through 17
	Services and Protection Objectives
7.12a	Extend protocols for routinely identifying, treating and properly referring victims of spouse abuse to at least 90 percent of the hospital emergency room departments in Connecticut and at least 10% of hospital based primary care centers
7.17a	Extend coordinated health department facilitated violence prevention programs to 75 percent of communities in the State with populations over 40,000

Objective 7.12: *US* - Extend protocols for routinely identifying, treating and properly referring suicide attempters, victims of sexual assault, and victims of spouse, elder, and child abuse to at least 90 percent of the hospital emergency departments

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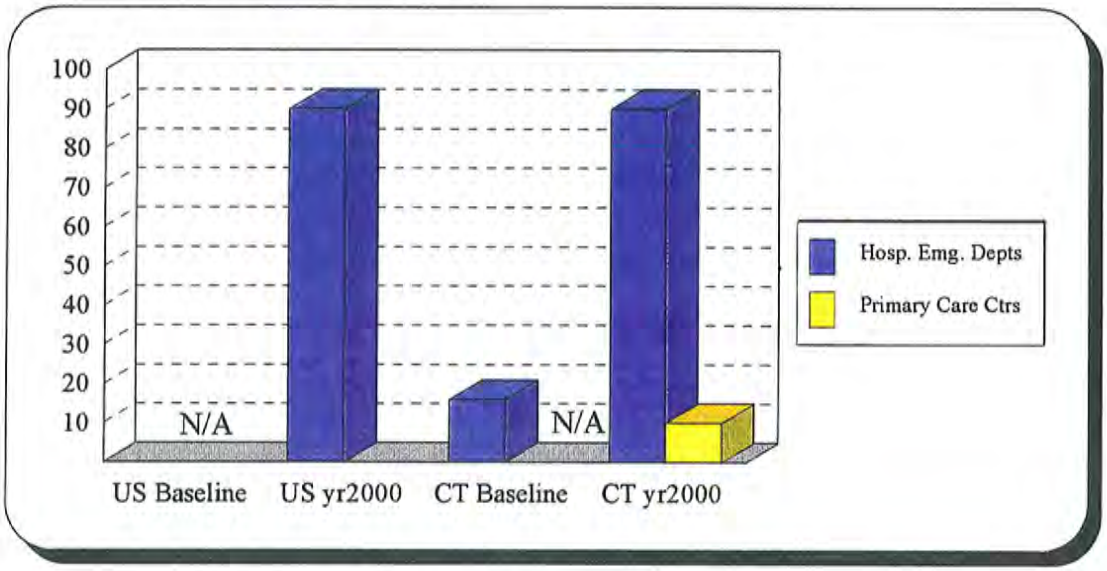
7.12(a) *CT* - Extend protocols for routinely identifying, treating and properly referring victims of spouse abuse to at least 90 percent of the hospital emergency departments in Connecticut and at least 10 percent of hospital-based primary care centers



The Connecticut objective is directed only toward spouse abuse.

	US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
Percent of Hospital Emergency Departments	N/A	90%	16%	90%
Primary Care Centers	-	-	N/A	10%

Source: Bureau of Community Health, Connecticut Department of Public Health.

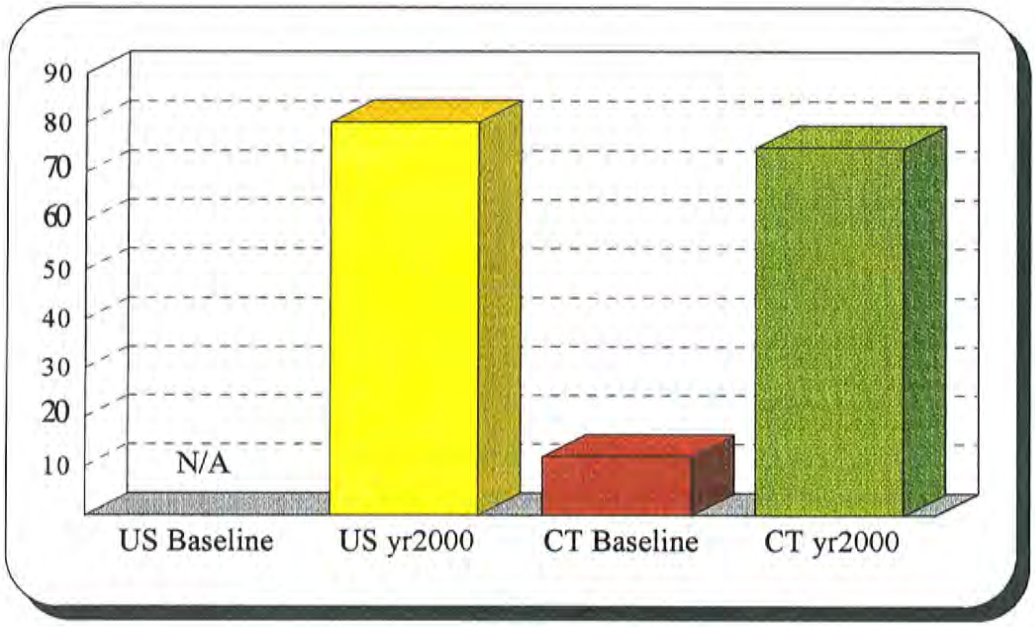
Data Limitations: We may be able to determine numbers of hospitals with protocols through surveys.

Rationale: Over 6 million women are beaten by male partners in the U.S. every year. In 1991 there were 21,520 incidents of violent crime committed against women by male partners in Connecticut.

Department of Public Health funds the Domestic Violence Training project (DVT) through the Preventive Health Services Block Grant. This objective will be addressed through the provision of professional training, multidiciplinary conferences, site-specific education and development of educational materials and domestic violence resource centers. Technical assistance will be provided to hospitals to encourage development of standard protocols. Note: Connecticut's objective applies to spousal abuse and does not include the U.S. objectives that relate to sexual assault, elder and child abuse.

Objective 7.17: *US* - Extend coordinated, comprehensive violence prevention programs to at least 80 percent of local jurisdictions with populations over 100,000

7.17(a) *CT* - Extend coordinated health department facilitated violence prevention programs to 75 percent of communities in the state with populations over 40,000



US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
Not Available	80%	12% (1995)	75%

Source: Bureau of Community Health, Connecticut Department of Public Health.

Data Limitations: Connecticut baseline percent reflects the experience of prior grant funded projects i.e. the percent of funded communities who are funded via RFP for violence prevention projects and who chose to use Preventive Health & Health Services Block Grant or National and Maternal and Child Health Block Grant funds to address violence prevention.

Rationale: Violence related injuries are the second leading cause of death for all of Connecticut between the ages of 1 and 24 years. Professional education, technical assistance and program development activities targeted toward youth violence prevention will be offered to local communities.

Note: U.S. objective targets communities over 100,000 population. The Connecticut objective includes smaller communities.

Chapter 8 - EDUCATIONAL AND COMMUNITY BASED PROGRAMS

The success of the Healthy Connecticut 2000 project depends largely on a public health infrastructure capable of providing the core functions of public health. A local public health system which effectively carries out the core functions of public health will assure that local public health needs in communities are identified, strategies developed and scarce public health resources are directed to address health problems of a high priority.

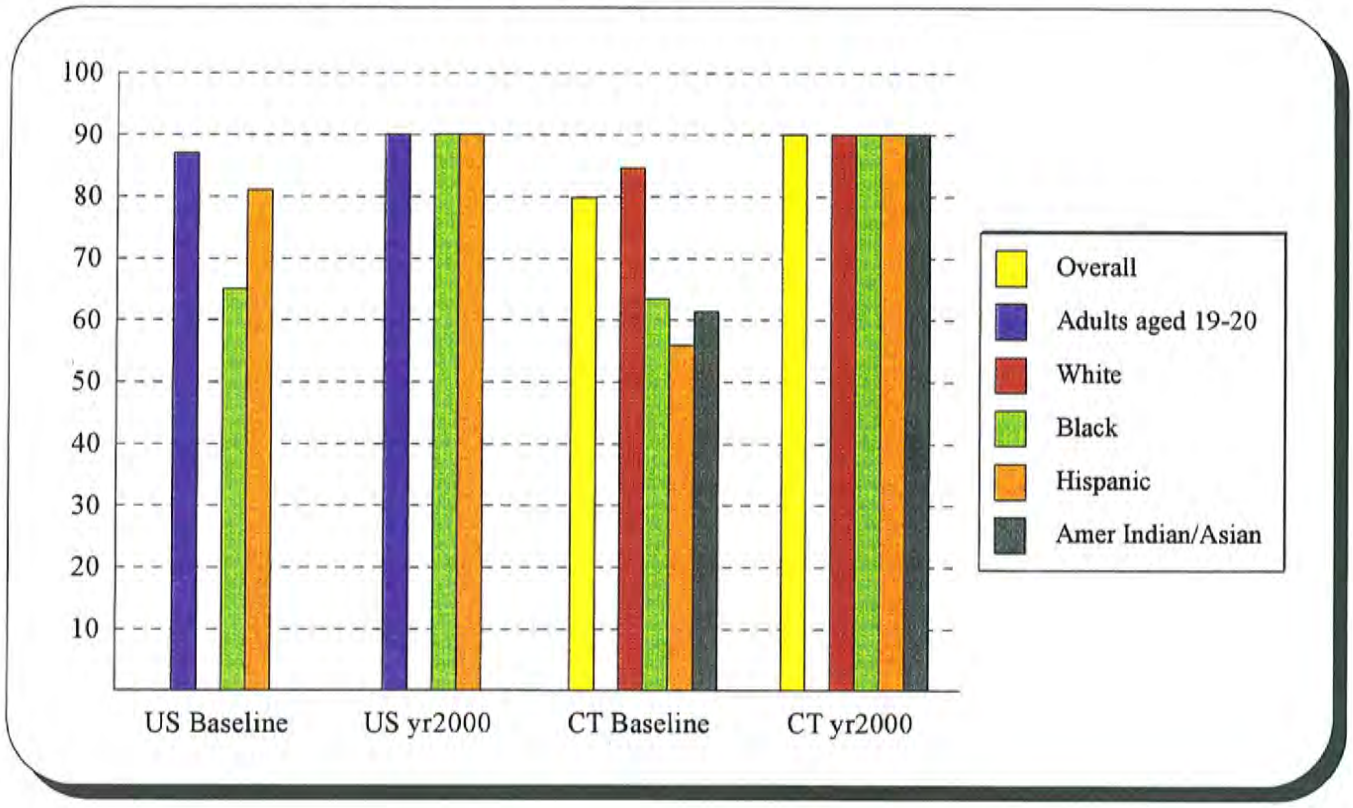
An essential component of this public health infrastructure in Connecticut is the local health department. In 1995, there were 29 full ime municipal health departments and 17 health districts serving a population of 2,580,814 in 104 cities, towns and boroughs throughout the state with full time public health services. The remainder of the municipalities were served by part time local public health services. The Connecticut State Department of Public Health supports the continued development of full time public health services throughout the state.

Chapter 8 - EDUCATIONAL AND COMMUNITY BASED PROGRAMS

Selected Objectives

OBJ. #	OBJECTIVE DESCRIPTION
	Risk Reduction Objectives
8.2	Increase the high school graduation rate to at least 90 percent, thereby reducing risks for multiple problem behaviors and poor mental and physical health
	Services and Protection Objectives
8.14a	Increase to 100 percent the proportion of people who are served by a local health department that is effectively carrying out the assessment component core functions of public health
8.14b	Increase to 100 percent the proportion of people who are served by a local health department that is effectively carrying out the policy development component of core functions of public health
8.14c	Increase to 100 percent the proportion of people who are served by a local health department that is effectively carrying out the assurance component of the core functions of public health

Objective 8.2: **Increase the high school graduation rate to at least 90 percent, thereby reducing risks for multiple problem behaviors and poor mental and physical health**



Completion of High School Race/Ethnicity	US Baseline (1992)	US Year 2000 Target	CT Baseline (1992)	CT Year 2000 Target
Overall	Not Applicable	Not Applicable	79.8%	90%
Adults aged 19-20	87%	90%	Not Applicable	Not Applicable
White	Not Applicable	Not Applicable	84.5%	90%
Black	65%	90%	63.4%	90%
Hispanic	81%	90%	55.9%	90%
American Indian/Asian American	Not Applicable	Not Applicable	61.3%	90%

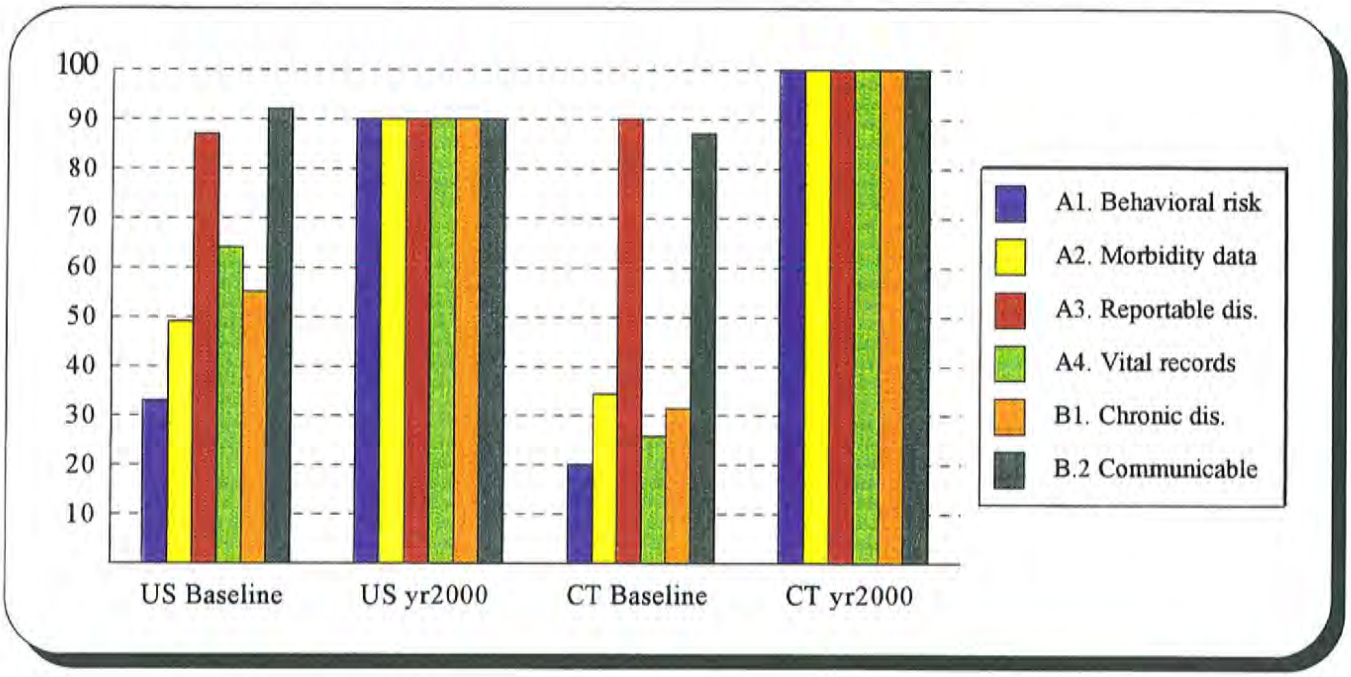
Source: Bureau of Community Health, Connecticut Department of Public Health; Connecticut Department of Education.

Data Limitations: Data is controlled by the Department of Education.

Rationale: Schools offer a natural setting for the provision of crosscutting educational interventions in health, and studies have shown that school health education is an effective means of helping children improve their health knowledge and develop attitudes that facilitate healthier behaviors. This objective and its target is consistent with the National Education goal to increase high school graduation rates.

Objective 8.14: *US* - Increase to at least 90 percent the proportion of people who are served by a local health department that is effectively carrying out the core functions of public health

a: CT - Increase to 100 percent the proportion of people who are served by a local health department that is effectively carrying out the assessment component core functions of public health



Assessment activities conducted by Local Health Departments	US Baseline (1990)	US Year 2000 Target	CT Baseline (1990)	CT Year 2000 Target
A. Data collection/analysis				
1. Behavioral risk assessment	33%	90%	20.0%	100%
2. Morbidity data	49%	90%	34.3%	100%
3. Reportable diseases	87%	90%	90.0%	100%
4. Vital records and statistics	64%	90%	25.7%	100%
B. Epidemiology/surveillance				
1. Chronic diseases	55%	90%	31.4%	100%
2. Communicable diseases	92%	90%	87.1%	100%

Source: Bureau of Community Health, Connecticut Department of Public Health;
Document: U.S. Department of Health and Human Services, Public Health Service; Centers for Disease Control and Prevention, Atlanta, GA. Profile of State and Territorial Public Health Systems: United States, 1990. Public Health Practice Program Office Publication, Dec., 1991.

Data Limitations: Data reported in this document are self reported by a sample of local health departments who may not be representative of non-respondents. Not every respondent answered every question.

Rationale: The Institute of Medicine Report *The Future of Public Health* outlined the need to strengthen the local public health system in the USA. The desired outcome is a public health system effectively performing the core functions which are identified as assessment, policy development and assurance.

Objective 8.14: *US* - Increase to at least 90 percent the proportion of people who are served by a local health department that is effectively carrying out the core functions of public health

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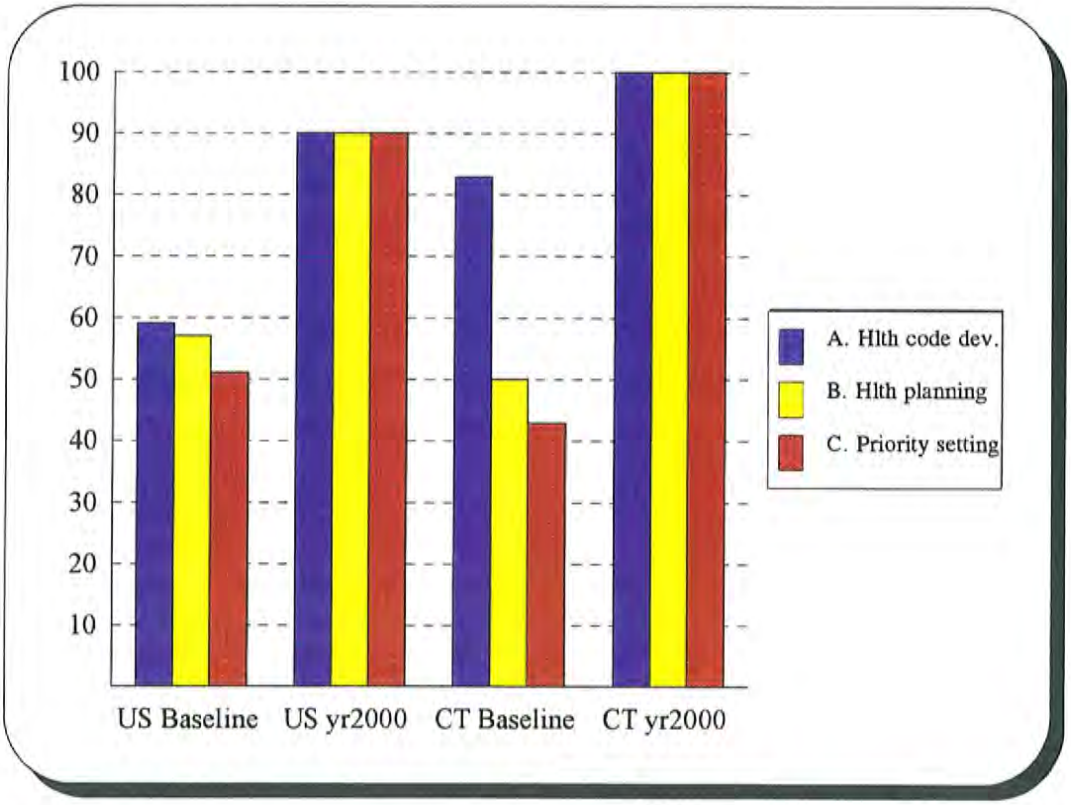
.4b: *CT* - Increase to 100 percent the proportion of people who are served by a local health department that is effectively carrying out the policy development component of core functions of public health



Policy development activities by Local Health Departments	US Baseline (1990)	US Year 2000 Target	CT Baseline (1990)	CT Year 2000 Target
A. Health code development and enforcement	59%	90%	82.9%	100%
B. Health planning	57%	90%	50.0%	100%
C. Priority setting	51%	90%	42.9%	100%

Source: Bureau of Community Health, Connecticut Department of Public Health;
Document: U.S. Department of Health and Human Services, Public Health Service; Centers for Disease Control and Prevention, Atlanta, GA. Profile of State and Territorial Public Health Systems: United States, 1990. Public Health Practice Program Office Publication, Dec., 1991.

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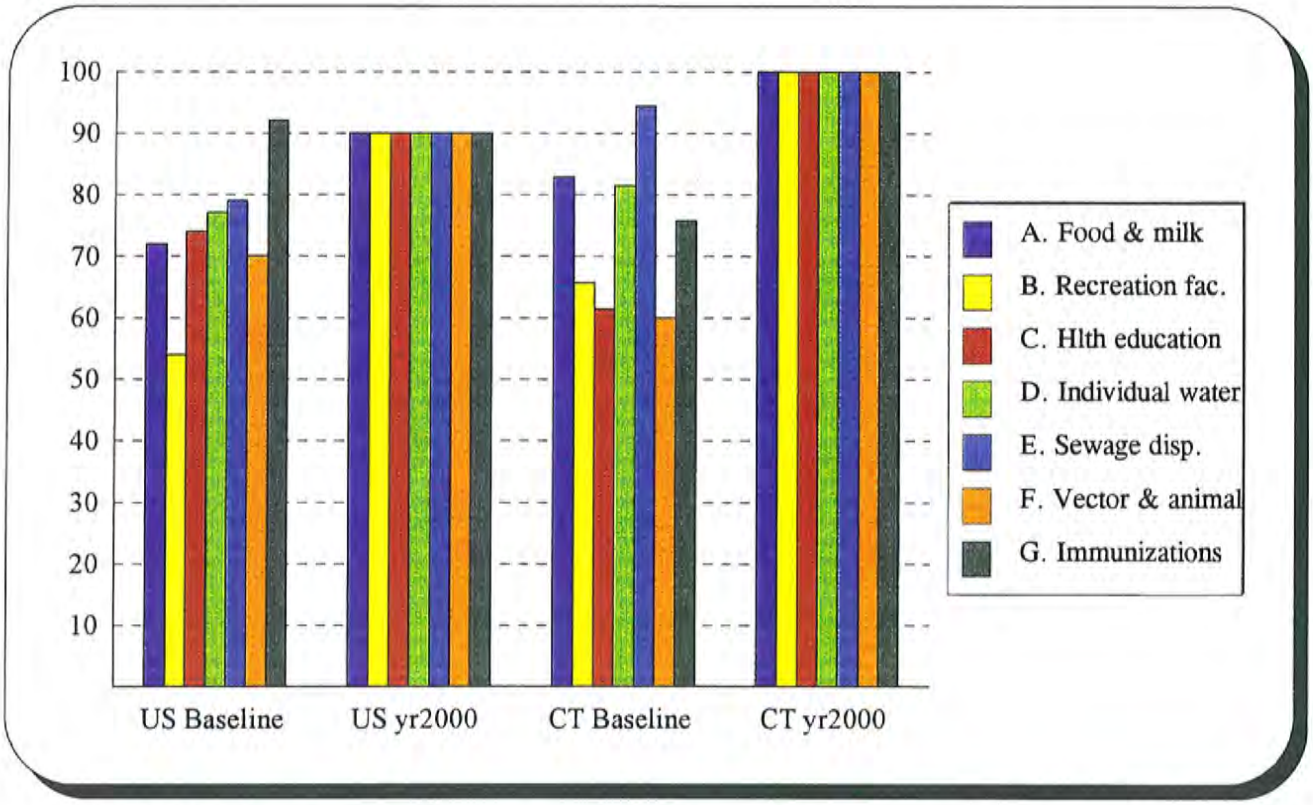
Objective 8.14: ***US*** **- Increase to at least 90 percent the proportion of people who are served by a local health department that is effectively carrying out the core functions of public health**

c: ***CT*** **- Increase to 100 percent the proportion of people who are served by a local health department that is effectively carrying out the assurance component of the core functions of public health**



Assurance activities by Local Health Departments	US Baseline (1990)	US Year 2000 Target	CT Baseline (1990)	CT Year 2000 Target
A. Food and milk control	72%	90%	82.9%	100%
B. Recreation facility safety/quality	54%	90%	65.7%	100%
C. Health education	74%	90%	61.4%	100%
D. Individual water supply/safety	77%	90%	81.4%	100%
E. Sewage disposal systems	79%	90%	94.3%	100%
F. Vector and animal control	70%	90%	60.0%	100%
G. Immunizations	92%	90%	75.7%	100%

Source: Bureau of Community Health, Connecticut Department of Public Health;
Document: U.S. Department of Health and Human Services, Public Health Service; Centers for Disease Control and Prevention, Atlanta, GA. Profile of State and Territorial Public Health Systems: United States, 1990. Public Health Practice Program Office Publication, Dec., 1991.

Data Limitations: Data reported in this document are self reported by a sample of local health departments who may not be representative of non-respondents. Not every respondent answered every question.

Rationale: The Institute of Medicine Report *The Future of Public Health* outlined the need to strengthen the local public health system in the USA. The desired outcome is a public health system effectively performing the core functions which are identified as assessment, policy development and assurance.

Chapter 9 - UNINTENTIONAL INJURIES

Selected Objectives

OBJ. #	OBJECTIVE DESCRIPTION
	Health Status Objectives
9.3	Reduce deaths caused by motor vehicle crashes to no more than 10.8 per 100,000 people
9.4	Reduce deaths from falls and fall-related injuries to no more than 2.3 per 100,000 persons
9.5	Reduce drowning deaths to no more than 1.0 per 100,000 persons
9.6	Reduce residential fire deaths to no more than 0.5 per 100,000 people
)	Reduce non-fatal head injuries so that hospitalizations from these injuries are no more than 106 per 100,000 persons
	Risk Reduction Objectives
9.12	Increase the use of occupant protection systems, such as seatbelts, inflatable safety restraints, and child safety seats, to at least 85 percent of motor vehicle occupants
9.13	Increase use of helmets to at least 80 percent of motorcyclists and 50 percent of bicyclists
	Services and Protection Objectives
9.14a	Increase the age requirement for Connecticut's Bicycle Helmet law through age 16 years (or all ages of bicyclists)
9.21a	Increase the number of local health departments who routinely provide age appropriate counseling on injury prevention or have incorporated injury prevention into their programs

Objective 9.14: *US* - Extend to 50 States laws requiring safety belt and motorcycle helmet use for all ages

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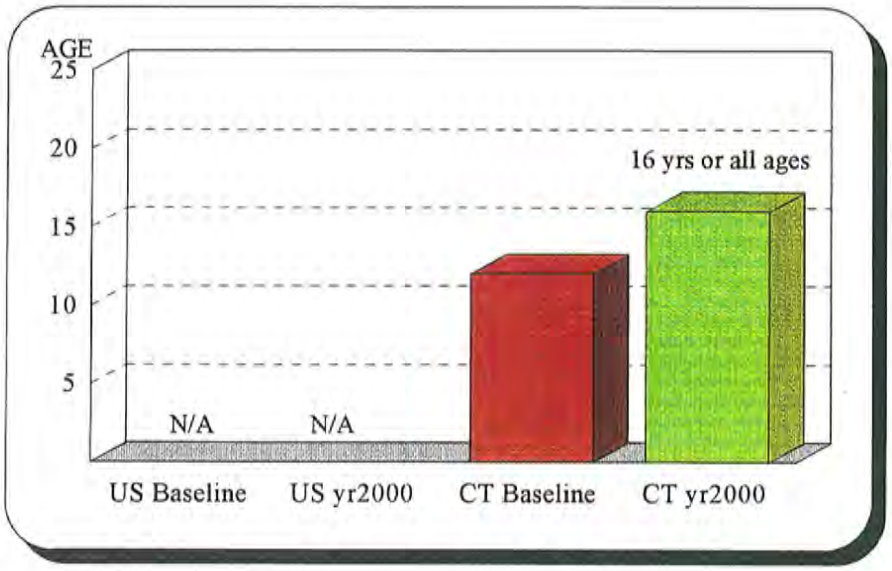
9.14(a) *CT* - Increase the age requirement for Connecticut's Bicycle Helmet law through age 16 years (or all ages of bicyclists)



US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
Not Applicable	Not Applicable	Law currently covers helmet use among youths less than 12 years old (1995)	Law covers children through age 16 years or all ages

Source: Bureau of Community Health, Connecticut Department of Public Health.

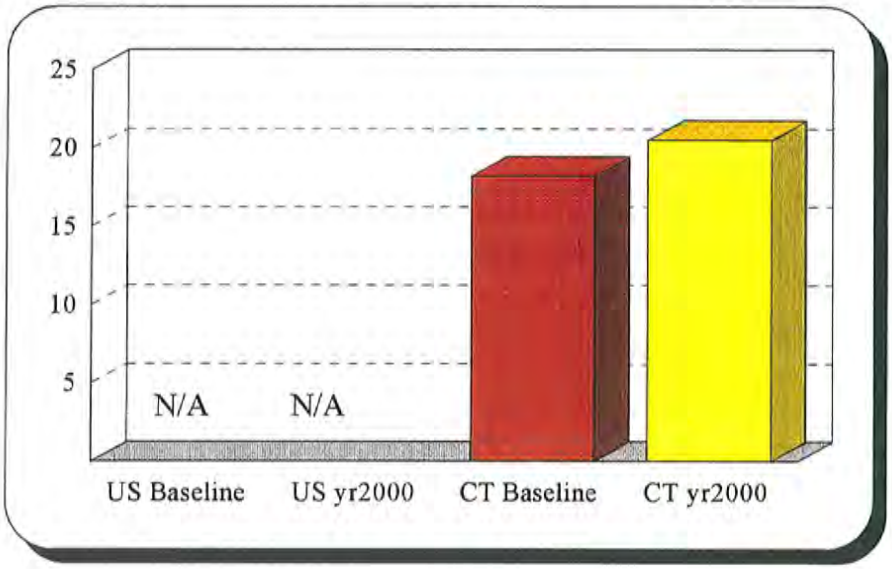
Data Limitations:

Rationale: Connecticut's Bicycle Helmet law currently requires children under the age of 12 to wear a bicycle helmet. Connecticut hospitalization data indicates that adolescents are also at high risk for bicycle related injuries.

The Connecticut Department of Public Health will provide technical assistance and data to advocacy groups to change the age requirements in the Bicycle Helmet Law.

Objective 9.21: *US* **Increase to at least 50 percent the proportion of primary care providers who routinely provide age-appropriate counseling on safety precautions to prevent unintentional injury**

9.21(a) *CT* - **Increase the number of local health departments who routinely provide age appropriate counseling on injury prevention or have incorporated injury prevention into their programs**



US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
Not Applicable	Not Applicable	18.2%	20.5%

Source: Bureau of Community Health, Connecticut Department of Public Health.

Data Limitations: Connecticut baseline represents the number of local health departments choosing to conduct injury prevention programs with their Preventive Health and Health Services funding.

Rationale: Unintentional injury is the leading cause of death for persons under the age of 50 in Connecticut. Children, young adults, and older adults are especially at risk. Motor vehicle crash related injuries are the leading cause of injury related death. Older adults have the highest death rate from falls.

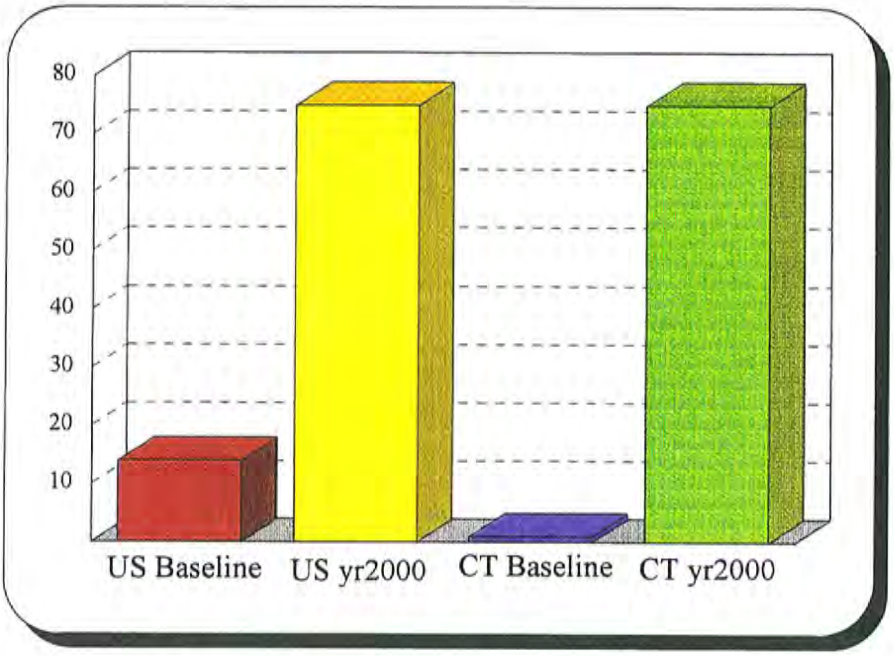
The Connecticut Department of Public Health will provide professional education and technical assistance to local health agencies on program design, implementation and education.

Chapter 10 - OCCUPATIONAL SAFETY AND HEALTH

Selected Objectives

OBJ. #	OBJECTIVE DESCRIPTION
	Health Status Objectives
10.4	Reduce incidence of occupational skin disorders or diseases to an incidence of no more than 55 per 100,000 full-time workers
	Risk Reduction Objectives
10.8	Eliminate exposures which result in workers having blood lead concentrations greater than 25 µg/dl of whole blood
	Services and Protection Objectives
10.15	Increase to at least 75 percent the proportion of primary care providers who routinely elicit occupational health exposures as a part of patient history and provide relevant counseling

Objective 10.15: **Increase to at least 75 percent the proportion of primary care providers who routinely elicit occupational health exposures as a part of patient history and provide relevant counseling**



	US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
Primary care providers	6-14% (1992)	75%	<1% (1992-95)	75%

Source: Bureau of Community Health, Connecticut Department of Public Health.

Data Limitations: Based on number of physicians who report occupational diseases compared to number of physician licenses.

Rationale: Increased physician awareness of occupational history will lead to improved recognition and appropriate treatment of patients. Improved reporting of such diseases will enable interventions to prevent these disease conditions in the future.

The intervention strategy that will affect this objective is: 1) Presentation of Grand Rounds at hospitals for physician awareness; 2) Sending of mailings to physician specialties on occupational disease reporting; and 3) Publication of special occupational health articles in physician-read publications.

Chapter 11 - ENVIRONMENTAL HEALTH

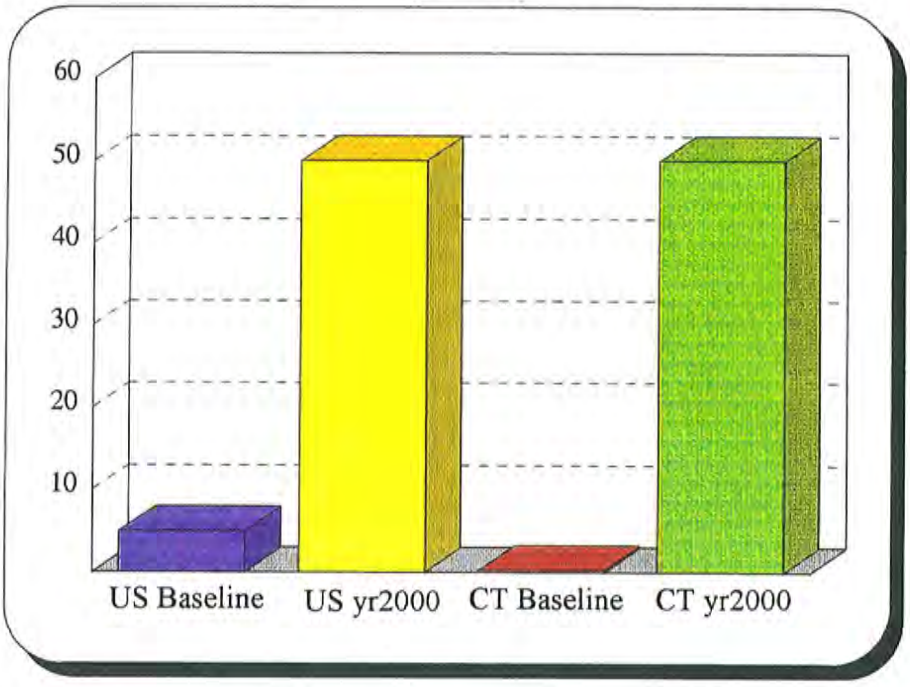
Selected Objectives

OBJ. #	OBJECTIVE DESCRIPTION
	Health Status Objectives
11.1	Reduce asthma morbidity, as measured by a reduction in asthma hospitalizations, to no more than 160 per 100,000 people
11.3	Eliminate outbreaks of waterborne disease from infectious agents and chemical poisoning
11.4	Reduce prevalence of blood lead levels exceeding 10µg/dl among children aged six months through five years to no more than 13,000
	Risk Reduction Objectives
11.5	Reduce the human exposure to criteria air pollutants, as measured by an increase to at least 85 percent in the proportion of people who live in counties that have not exceeded any Environmental Protection Agency standard for air quality in the previous 12 months
11.6	Increase to at least 50 percent the proportion of homes in which homeowners and to at least 75 percent the proportion of homes in which occupants have tested for radon concentrations and that have either been found to pose minimal risk or have been modified to reduce the risk to health
11.9	Increase to 100 percent the proportion of people who receive a supply of public drinking water that meets the safe drinking water standards established by the Environmental Protection Agency
13.9*	Increase to 100 percent the proportion of people served by community water systems providing optimal levels of fluoride

* This is an environmental health objective from chapter 13 in the Healthy People 2000 report.

	Services and Protection Objectives
11.11	Perform testing for lead-based paint in at least 50 percent of homes and public buildings built before the year 1950
11.12a	Expand and promote the use of radon resistant building techniques in new construction for high radon potential areas

Objective 11.11: *US* - Perform testing for lead-based paint in at least 50 percent of homes and public buildings built before the year 1950



	US Baseline	US Year 2000 Target	CT Baseline (1995)	CT Year 2000 Target
Percentage of Buildings inspected	5%	50%	0.27% (residential dwelling units)	50% (residential dwelling units)

Source: Bureau of Regulatory Services, Connecticut Department of Public Health.

Data Limitations:

- The data are derived from quarterly reporting furnished by local health departments that provide summary data including the number of lead inspections conducted at residential dwelling units. These dwelling units were built before 1978.
- Lead inspections of public buildings are not reported and there is little regulatory impetus to conduct such inspections in Connecticut other than in day care facilities.
- Less than 100% of local health departments forward quarterly reports. For example 65% of the quarterly reports were received for SFY (state fiscal year) 1996.
- Lead inspections are also conducted by private sector lead inspectors and such inspections are not reflected in these data.

Rationale: Lead poisoning is a major environmental disease that particularly effects children less than six years of age. Adverse impacts may include effects upon cognitive and developmental skills, IQ, hearing, and kidney function among others. Lead inspections identify lead-based paint and in particular potentially hazardous conditions involving that paint, which is a primary source of lead exposure to children.

Objective 11.12: *US* - Expand to at least 35 the number of States in which at least 75 percent of local jurisdictions have adopted construction standards and techniques that minimize elevated indoor radon levels in those new building areas locally determined to have elevated radon levels

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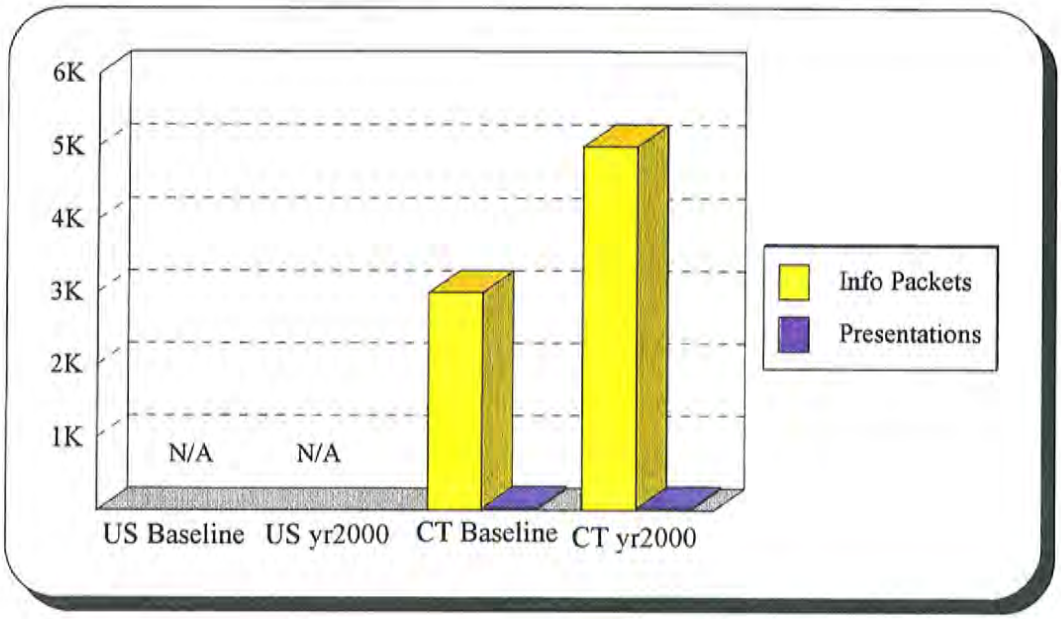
11.12(a) *CT* - Expand and promote the use of radon resistant building techniques in new construction for high radon potential areas through mailings and presentations



Method of Promotion	US Baseline	US Year 2000 Target	CT Baseline (1995)	CT Year 2000 Target
Information Packets	Not Applicable	Not Applicable	3,000	5,000
Presentations	Not Applicable	Not Applicable	25	25

Source: Bureau of Regulatory Services, Connecticut Department of Public Health

Data Limitations: Data only includes Department of Public Health efforts.

Rationale: Radon is a known lung carcinogen. Reducing radon exposure through testing and construction standards can prevent radon caused lung cancers. The Indoor Air Protection Program, Radon Component will promote the adoption of radon resistant new construction building standards for high radon potential areas. The program will continue to seek the support of building code changes through various avenues such as mailings to local chapters of building officials, home builders associations and realtors.

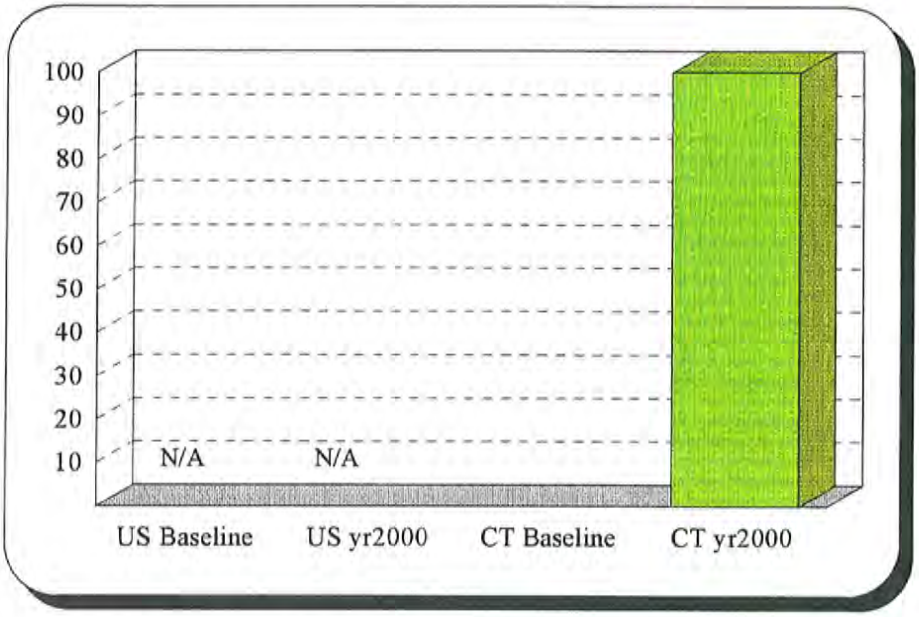
Chapter 12 - FOOD AND DRUG SAFETY

Selected Objectives

OBJ. #	OBJECTIVE DESCRIPTION
	Health Status Objectives
12.1	Reduce infections caused by key foodborne pathogens to incidences of no more than: *Salmonella species* 16 per 100,000 *Campylobacter jejune* 25 per 100,000 *Escherichia coli* 0157:H7 4 per 100,000 *Listeria monocytogenes* 0.5 per 100,000
12.2	Reduce outbreaks of infections due to *Salmonella enteritis* to fewer than two outbreaks yearly
	Risk Reduction Objectives
12.3	Increase to at least 75 percent the proportion of households in which principal food preparers routinely refrain from leaving perishable food out of the refrigerator for over two hours and wash cutting boards and utensils with soap after contact with raw meat and poultry
	Services and Protection Objectives
12.4a	By the year 2000 the Department of Public Health will review the Public Health Code regulations pertaining to food establishments and promulgate regulations

Objective 12.4: *US* - **Extend to at least 75 percent the proportion of States and territories that have implemented model food codes for institutional food operations and to at least 70 percent the proportion that have adopted the new uniform food protection code ("Unicode") that sets recommended standards for regulation of all food operations**

12.4(a) *CT* - **By the year 2000 the Department of Public Health will review the Public Health Code regulations pertaining to food establishments and promulgate regulations**



	US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
Percent of Review and Regulations Completed	Not Applicable	Not Applicable	0%	100%

Source: Bureau of Regulatory Services, Connecticut Department of Public Health.

Limitations: The review process will be restricted because of staffing limitations.

Rationale: Foodborne disease is preventable. The disease causes disability and in some cases death, all of which are unnecessary. Additionally, it has an adverse economic impact due to lost days from work, restaurant closures, etc. Sound regulations provide the basic framework for the prevention of foodborne disease associated with food establishments. Inspections that focus on the key risk factors for foodborne disease provide the best assurance of identifying and correcting problems linked to the causation of foodborne- disease. The existing regulations are based on a previous version of an FDA model food code. While the regulations provide essential elements to assure public health protection they need to be updated to reflect current science and technological advances.

The review process will be initiated in 1997 and involve local health officials and representatives of the affected industries. The most recent version of the model Food Code issued by the Food and Drug Administration (FDA) will be considered in the review process. The target is to have new regulations promulgated by 2000.

Chapter 13 - ORAL HEALTH

Oral Health is a significant public health concern. Dental diseases and conditions remain among the most prevalent and preventable chronic health problems in the United States. Dental caries remains the single most common disease of childhood that is not self-limiting or amenable to a course of antibiotics. Nationally, over 84 percent of children have experienced dental disease in the form of caries by age 17 years.

Minority and low income children experience disproportionately extensive caries. Seventy percent of socioeconomically disadvantaged children, age 6-8 years, have untreated dental disease. The 20 percent of the population who are poor and minority children experience between 60 and 75 percent of the dental disease. This disadvantaged population is growing relatively more rapidly than the majority population, nationally as well as in Connecticut; the prevalence of dental disease in minority and poor children is projected to rise, worsening an already serious and costly public health problem.

Oral health is an integral part of total health, and oral health care is an integral part of comprehensive health care, including primary care. Dental disease is an infectious disease process which can profoundly reduce the individual's overall health and productivity. Untreated dental disease is not self-limiting, progressively becoming more serious, difficult and expensive to treat; more painful, debilitating, and may become life-threatening. Untreated dental disease can lead to severe pain, primary infections in the jaw and face, secondary infections in the upper and lower intestinal tracts, anemia, nutritional

and other problems. Untreated dental disease can severely complicate co-existing medical conditions, such as pneumonia, urinary tract infections, diabetes, and heart disease; and the presence of dental disease complicates orthopedic and cardiac surgery, organ and bone marrow transplants, dialysis, chemotherapy and radiation therapy. Psychological problems, such as lack of self-esteem, may result from dental deformities caused by carious necrosis of the teeth. Nationally, over 20 million days were missed from work and over 51 million hours were lost from school in 1989 as the result of dental conditions.

The public health impact of oral disease and conditions extends far beyond care of and concerns about the teeth. Health professionals must concern themselves with the interrelationships of oral health with such health issues as cranio-facial birth anomalies, tobacco use, oral-facial injuries, nutrition, and even child abuse. It is important to realize, for example, that greater than 65 percent of all child abuse injuries are clinically evident around the head, neck, or mouth, areas readily apparent to dental professionals during routine oral-facial examination.

The Healthy Connecticut 2000 objectives addressed herein will implement preventive and early intervention strategies aimed at high prevalence areas where significant savings can be achieved in the areas of cost, decreased morbidity, long-term sequelae and, of significant concern, patient pain and suffering.

HEALTHY CONNECTICUT 2000 BASELINE ASSESSMENT REPORT

July 1997

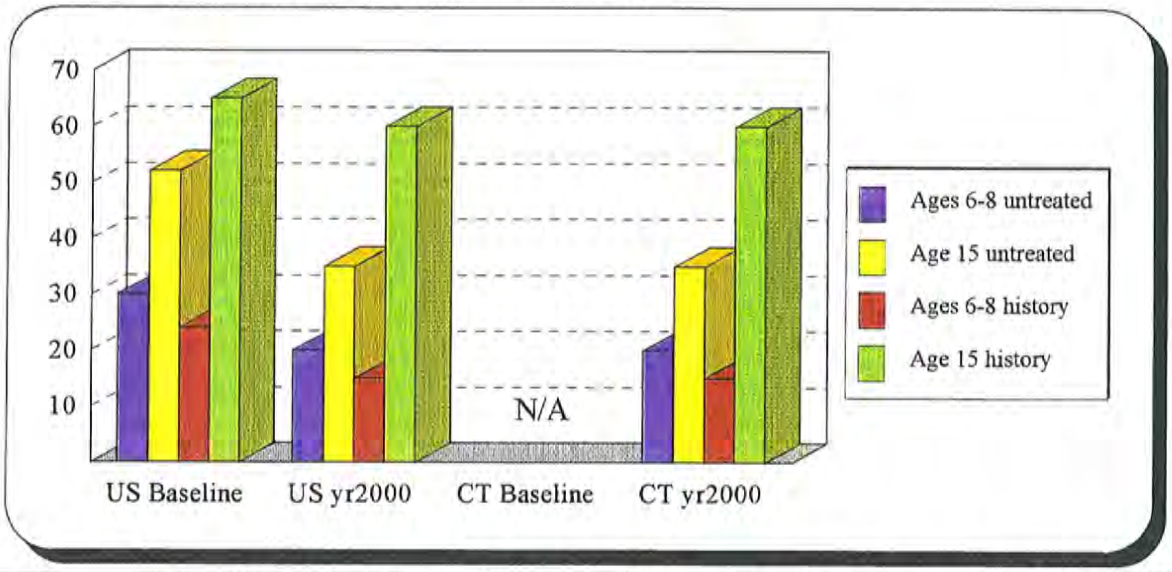
Chapter 13 - ORAL HEALTH

Selected Objectives

OBJ. #	OBJECTIVE DESCRIPTION
	Health Status Objectives
13.1a	Reduce dental caries (cavities) so that the proportion of children 6 to 8 years old with untreated dental diseases is no greater than 20 percent; and such children shall have a history of dental caries, decayed missing filled surfaces (DMFS), of no greater than 15 percent (percentages for adolescents 15 years old are 45 percent for both untreated and history)
	Risk Reduction Objectives
13.11	Increase to at least 75 percent the proportion of parents and caregivers who use feeding practices that prevent baby bottle tooth decay (BBTD)
	Services and Protection Objectives
13.15a	Establish an effective system in Connecticut for recording and referring infants with cleft lips and/or palates to craniofacial anomaly teams
13.16	Extend the requirement of the use of effective head, face, eye, and mouth protection to institutions sponsoring sporting and recreation events that pose risk of injury

Objective 13.1: *US* - Reduce dental caries (cavities) so that the proportion of children with one or more caries (in permanent or primary teeth) is no more than 35 percent among children aged 6 through 8 and no more than 60 percent among adolescents aged 15

13.1a: *CT* - Reduce dental caries (cavities) so that the proportion of children 6 to 8 years old with untreated dental diseases is no greater than 20 percent; and such children shall have a history of dental caries, decayed missing filled surfaces (DMFS), of no greater than 15 percent (percentages for adolescents 15 years old are 45 percent for both untreated and history)



Ages	US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
8 Years Old - Untreated*	30% (1992)	20%	Not Available	20%
15 Years Old - Untreated*	52% (1992)	35%	Not Available	45%
*dental disease				
6-8 Years Old - History*	24% (1992)	15%	Not Available	15%
15 Years Old - History*	65% (1992)	60 %	Not Available	45%
*dental caries				

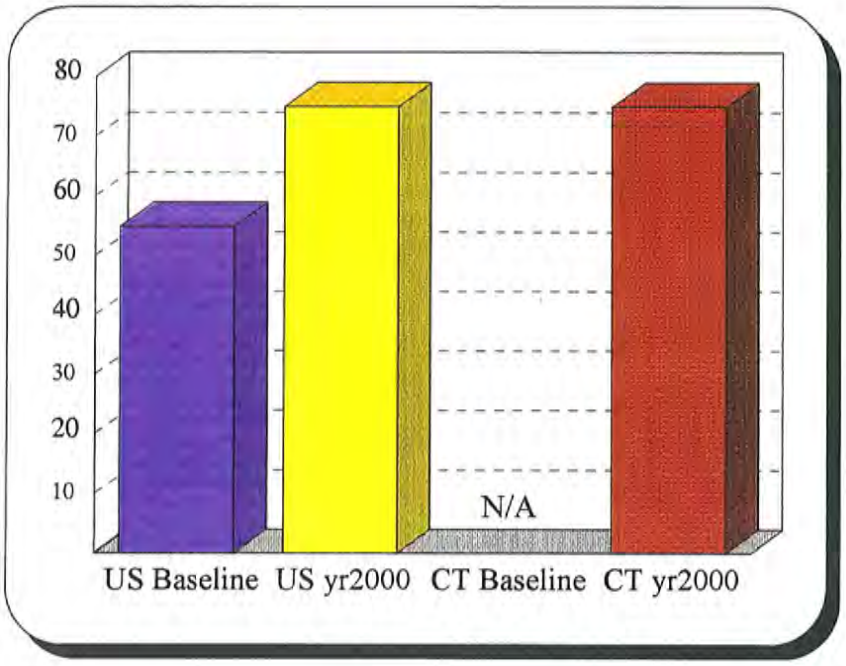
Source: Bureau of Community Health, Connecticut Department of Public Health, Oral Health of U.S. Children; The National Survey of Dental Caries in U.S. Schoolchildren: 1986-1987, NIDR, PHS, DHHS.

Data Limitations: At the present time Connecticut data is being developed through the ongoing Connecticut Department of Public Health Oral Health Survey and Needs Assessment. The Connecticut objective incorporates elements from two U.S. objectives: 13.1 and 13.2.

Rationale: Dental caries and other oral diseases are among the most prevalent as well as preventable health problems in the United States. Despite a decline in caries nationally, 70% of socioeconomically disadvantaged children, age 6-8, reveal dental disease. This serious health problem often adversely affects the child's overall nutrition, health, social functioning, and educability and attendance at school. The Department of Public Health intends:

1. To incorporate findings of existing and ongoing oral health survey and needs assessment and planning initiatives into policy and program development.
2. To institute a statewide process to screen for the prevalence of dental sealants in children ages 6-8 and 15, when first and second adult molars, respectively, are erupted.
3. To support, through all possible sources of funding, the four existing School Based Health Clinics (SBHCs) with dental components, as well as to expand the number of SBHCs with dental components from 4 clinics to 10 clinics.

Objective 13.11: *US* - Increase to at least 75 percent the proportion of parents and caregivers who use feeding practices that prevent baby bottle tooth decay (BBTD)



US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
55% (1991)	75%	N/A	75%

Source: Bureau of Community Health, Connecticut Department of Public Health, National Health Interview Survey, CDC, NCHS, 1991 and 1990 Baby Bottle Tooth Decay 5-Year Evaluation Report, IHS, Dental Service Branch.

Data Limitations: At the present time Connecticut data is being collected through the Connecticut's Department of Public Health ongoing Oral Health Survey and Needs Assessment.

Rationale: BBTD or "nursing caries" is present in approximately 15 to 65% of infants in national surveys of populations at risk. BBTD is a severe dental disease in which the upper anterior baby teeth become grossly decayed. BBTD may cause destruction of these teeth, resulting in severe caries in the succeeding adult teeth, as well as problems with speech articulation, mastication, poor nutrition, and lowered self-esteem.

The Department of Public Health intends:

1. To collaborate with WIC, Nutrition, Primary Care, and other related agencies, as well as with the Department of Pediatric Dentistry, University of Connecticut, to promote breastfeeding and other feeding practices that reduce the risk of BBTD.
2. To develop, achieve funding, and institute a culturally sensitive comprehensive community-based pilot program to reduce the incidence of BBTD.

Objective 13.15: *US* - Increase to at least 40 the number of States that have an effective system for recording and referring infants with cleft lips and/or palates to craniofacial anomaly teams

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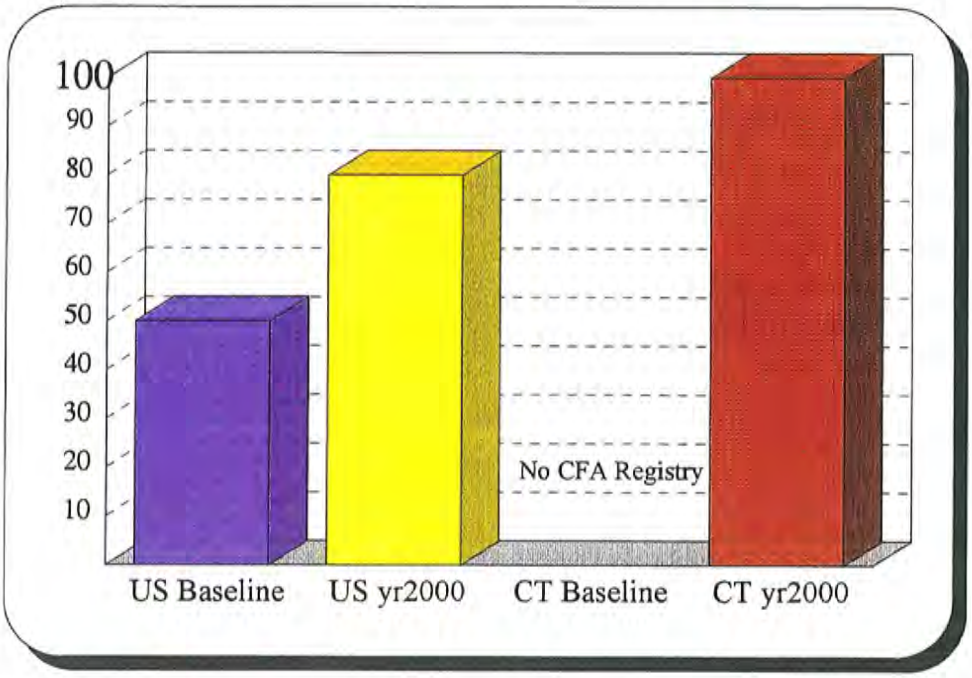
13.15a: *CT* - Establish an effective system in Connecticut for recording and referring infants with cleft lips and/or palates to craniofacial anomaly teams



US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
23 State CFA Registries Nationwide in 1993	40 CFA Registries Nationwide	Connecticut CFA Registry Discontinued in 1990	Reinstate Connecticut CFA Registry

Source: Bureau of Community Health, Connecticut Department of Public Health.

Data Limitations: At the present time Connecticut data are not available.

Rationale: The incidence of cleft lip/cleft palate in infants in Connecticut is relatively stable and consistent with the national data at one to two births per thousand. Cleft lip/Cleft palate is often associated with other birth abnormalities. Early recognition and referral to a craniofacial anomaly team for surgical, prosthetic and other interventions has proven successful in reducing the social and health problems secondary to CFAs.

The Connecticut Department of Public Health, Bureau of Community Health has secured Federal seed money to reinstate a Birth Defects Surveillance System in Connecticut in 1996. Systems, staffing and ongoing funding will be part of the challenge in this important endeavor.

Chapter 14 - MATERNAL AND INFANT HEALTH

Selected Objectives

OBJ. #	OBJECTIVE DESCRIPTION
	Health Status Objectives
14.1	Reduce the overall infant mortality rate to no more than 5.5 per 1,000 live births
14.3	Reduce the maternal mortality rate to no more than 5.3 per 100,000 live births
14.4	Reduce fetal alcohol syndrome to no more than 0.12 per 1,000 live births
	Risk Reduction Objectives
14.5	Reduce low birth weight to an incidence of no more than 5 percent of live births and very low birth weight to no more than 1 percent of live births
14.6	Increase to at least 85 percent the proportion of mothers who achieve the minimum recommended weight gain during their pregnancies
14.7	Reduce severe complications of pregnancy to no more than 15 per 100 deliveries
14.10	Increase abstinence from tobacco use by pregnant women to 90 percent and increase abstinence from alcohol, cocaine, and marijuana use by pregnant women to 20 percent
	Services and Protection Objectives
14.11a	Increase to 90 percent the proportion of all pregnant women who receive prenatal care in the first trimester in Connectict DPH funded programs
14.12a	Increase to 100 percent the proportion of primary care providers in Department of Public Health funded programs who provide age-appropriate preconception care and counseling
14.13a	Increase to 90 percent, in DPH funded programs, the proportion of women in prenatal care who are offered screening and counseling on the prenatal detection of fetal abnormalities
14.15	Increase to 100 percent the proportion of newborns screened for genetic disorders and maintain at 100 percent the proportion of newborns testing positive for disease who receive appropriate treatment
14.16a	Increase to 95 percent the proportion of infants aged 18 months and younger who receive recommended primary care services at the appropriate intervals at Department of Public Health funded facilities

Objective 14.11: *US* Increase to 90 percent the proportion of all pregnant women who receive prenatal care in the first trimester

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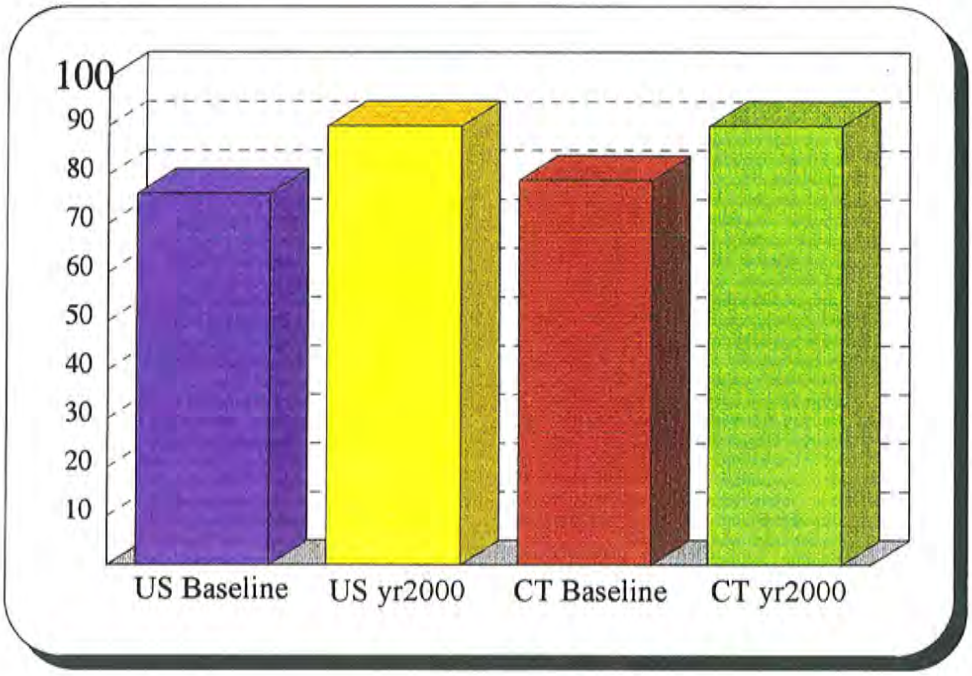
14.11(a) *CT* Increase to 90 percent the proportion of all pregnant women who receive prenatal care in the first trimester in Connecticut DPH funded Programs



US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
76.2% of live births, All races (1991)	90% of live births, All Races	78.8 percent of live births, All Races (1991)	90% of live births, All Races

Source: Bureau of Community Health, Office of Policy, Planning and Evaluation, Connecticut Department of Public Health.

Data Limitations: Data is accessed from birth certificates and reflects the accuracy and completeness of the individuals completing these documents.

Rationale: Early entry into prenatal care, especially for high risk women, results in improved pregnancy outcomes. Conversely, late or no care is associated with increased risk of poor outcomes, which increases the cost of neonatal care. (Per U.S. government studies, for each dollar spent on prenatal care, three dollars are saved on medical care during an infant's first year.)

The Department of Public Health (DPH) will fund and develop contract terms that reflect required service provision for entities it funds and will monitor compliance with contract terms. The effect on the entire population will be monitored from vital statistics data.

Objective 14.12: *US* - Increase to at least 60 percent the proportion of primary care providers who provide age-appropriate preconception care and counseling

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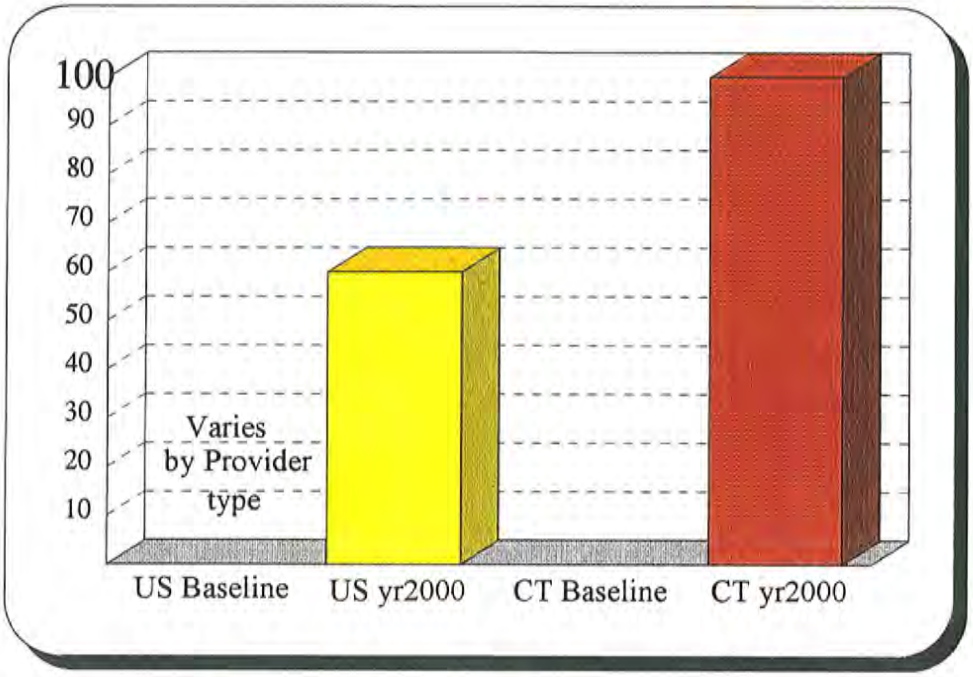
14.12(a) *CT* - Increase to 100 percent the proportion of primary care providers in Department of Public Health funded programs who provide age-appropriate preconception care and counseling



US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
1992 data varies by provider type	60% of primary care providers	Unknown	100% of DPH funded primary care providers

Source: Bureau of Community Health, Connecticut Department of Public Health.

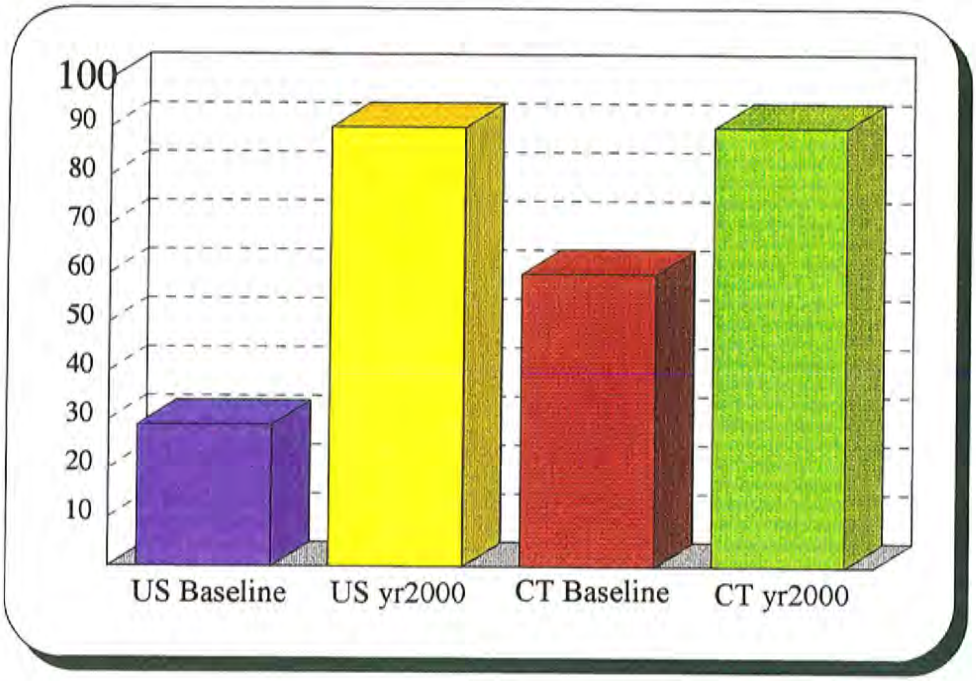
Data Limitations: Data not available at this time.

Rationale: Many medical conditions, personal behaviors, and environmental conditions associated with poor pregnancy outcomes can be identified and modified or treated prior to conception. Preconception care and counseling will help to assure that women are healthy prior to beginning pregnancy. Counseling should not be limited to maternal behavior, as the behavior of other household members can influence pregnancy outcomes (e.g., exposure to environmental tobacco smoke may be associated with low birthweight).

The Department of Public Health (DPH) will fund and develop contract terms that reflect required service provision and provide technical assistance and consultation and will perform site visits review the contractor's quarterly reports and Quality Assurance program. Through contract compliance, the primary care providers in DPH funded programs will provide age appropriate pre-conception counseling and care, enhancing the identification of medical conditions, personal behaviors, and environmental conditions that are associated with poor birth outcomes and can be modified or treated prior to conception.

Objective 14.13: US - Increase to at least 90 percent the proportion of women enrolled in prenatal care who are offered screening and counseling on prenatal detection of fetal abnormalities

13(a) CT - Increase to 90 percent, in DPH funded programs, the proportion of women in prenatal care who are offered screening and counseling on the prenatal detection of fetal abnormalities



US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
29% (1988)	90% of women in prenatal care	60% of women in prenatal care offered Maternal Serum Fetal Protein (MSAFP) or Triple Screen Test (1991)	90% women in prenatal care (DPH funded programs)

Source: Bureau of Community Health, Connecticut Department of Public Health, University of Connecticut SPRANS Grant Needs Assessment "Serving the Underserved Population of Hartford, CT".

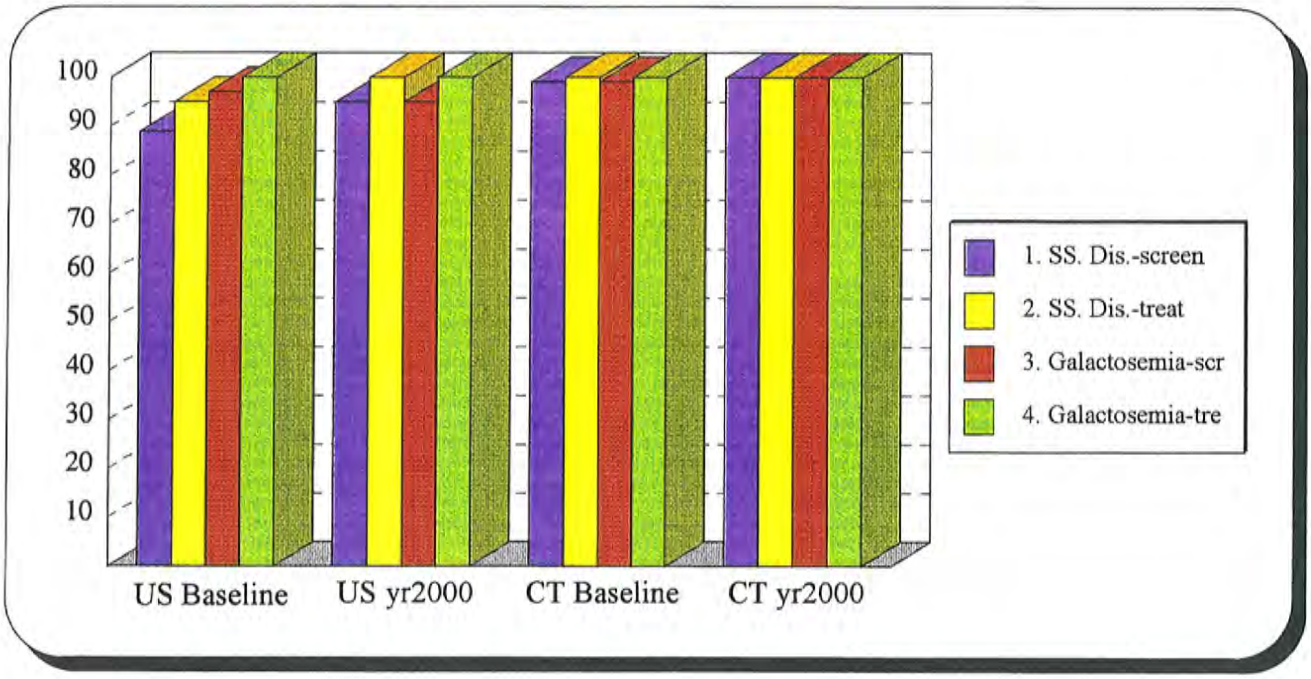
Data Limitations: Sampled data from Hartford public clinics only, 1991.

Rationale: Prenatal screening is used to identify serious disorders which have long-term consequences for infants and their families. Identification allows for initiation of counseling and specialized obstetric and neonatal care to deal with these disorders.

The Department of Public Health through the Clinical Genetics program, will provide educational activities targeting obstetricians, regarding the significance of offering screening and counseling on the prenatal detection of fetal abnormalities.

The increased awareness of the need to provide screening and counseling on the prenatal detection of fetal abnormalities will promote an increase in the proportion of women in prenatal care who are offered these services, resulting in the identification of disorders and the initiation of counseling and specialized obstetric and neonatal care.

Objective 14.15: Increase to 100 percent the proportion of newborns screened for genetic disorders and maintain at 100 percent the proportion of newborns testing positive for disease who receive appropriate treatment



reatment	US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
1. Sickle cell disease: screening	89% (1992)	95%	99.1% (1995)	100%
2. Sickle cell disease: treatment	95% (1990)	100%	100%	100%
3. Galactosemia: screening	97% (1990)	95%	99.1%	100%
4. Galactosemia: treatment	100% (1990)	100%	100%	100%

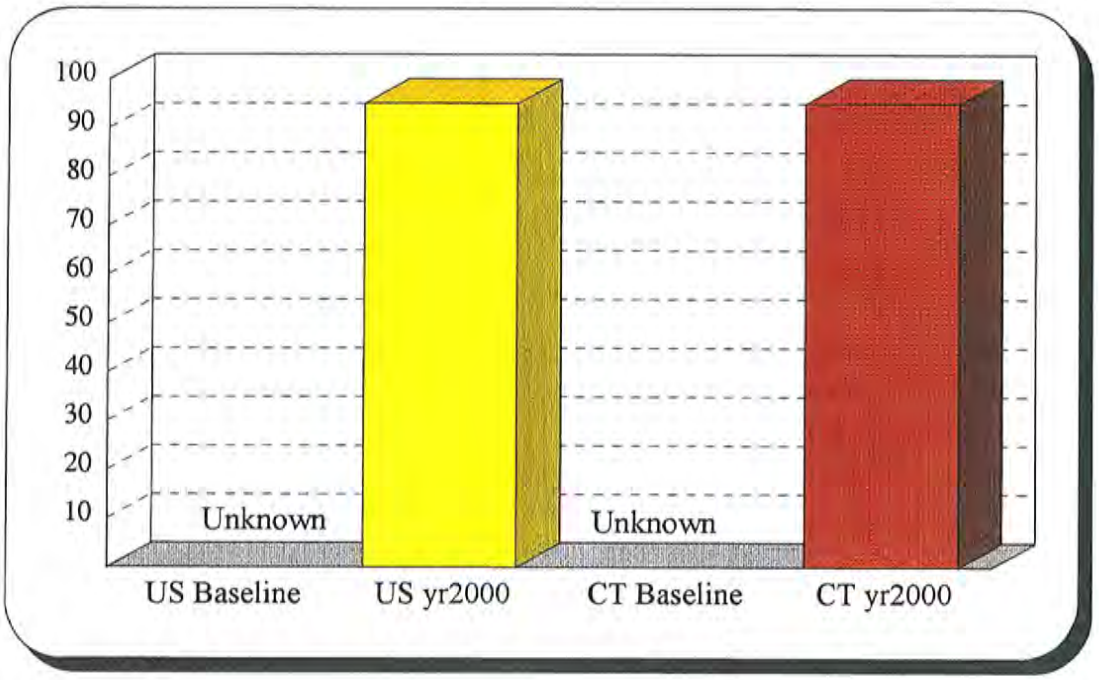
Source: Bureau of Community Health, Office of Policy, Planning and Evaluation Connecticut Department of Public Health, Linkage Study of Vital Records, 1995.

Data Limitations: Data are from a study of June through August, 1995 lab and birth records which may/may not be representative of other time periods.

Rationale: It is crucial that the state's commitment to newborn screening is accompanied by a commitment to treatment and tracking of affected newborns. Early identification and entry into programs of comprehensive care will reduce both mortality and morbidity. The results of comparison between the state birth records and the newborn screening database demonstrated that the screening database, which registered 99.1% of the 11,526 babies born 4/1/95-6/30/95, had at least one sample submitted to the laboratory for newborn screening. The Department of Public Health (DPH) plans to repeat this matching project in 1997.

Objective 14.16: ***US*** **- Increase to at least 90 percent the proportion of babies aged 18 months and younger who receive recommended primary care services at the appropriate intervals**

16(a) ***CT*** **- Increase to 95 percent the proportion of infants aged 18 months and younger who receive recommended primary care services at the appropriate intervals at Department of Public Health funded facilities**



US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
Unknown	90%	Unknown	95% of the proportion of infants aged 18 months and younger at DPH funded facilities

Source: Bureau of Community Health, Connecticut Department of Public Health.

Data Limitations: No baseline data are available at this time.

Rationale: Assuring that infants receive appropriate primary care will help to reduce infant mortality and childhood disease through prevention and early identification of health problems, including developmental and emotional problems. In addition, if primary care is to reduce infant mortality and childhood morbidity, primary care providers must be linked to providers of specialty care. To establish these crucial links, primary care providers must identify children who need specialized resources, make appropriate and timely referrals, and work collaboratively with those providing care.

The Department of Public Health will fund and develop contract terms that reflect required service provision and provide technical assistance and consultation and will perform site visits, review the contractor's quarterly reports and Quality Assurance program. Through contract compliance which involves outreach activities, case finding, case management and Maternal & Child Health information and referral services, as well as the development linkages among providers, the proportion of infants receiving recommended primary care services at the appropriate intervals will be enhanced, promoting the reduction of infant mortality and early identification and intervention of health, developmental and emotional problems.

Chapter 15 - HEART DISEASE AND STROKE

Selected Objectives

OBJ. # OBJECTIVE DESCRIPTION

Health Status Objectives

15.1 Reduce coronary heart disease deaths to no more than 84.4 per 100,000 people

15.2 Reduce stroke deaths to no more than 16.8 per 100,000 people

Risk Reduction Objectives

15.4 Increase to at least 50 percent the proportion of people with high blood pressure whose blood pressure is under control

15.5 Increase to at least 90 percent the proportion of people with blood pressure who are taking action to help control their blood pressure

15.6 Maintain the mean serum cholesterol level among adults at 200 mg/dl or less

15.8 Increase to at least 55 percent the proportion of adults with high blood cholesterol who are aware of their condition and are taking action to reduce their cholesterol to recommended levels

15.9 Reduce dietary fat intake to an average of 30 percent of calories or less and average saturated fat to less than 10 percent among people aged two and older

15.11 Increase to at least 30 percent the proportion of people aged six and older who engage regularly, preferably daily, in light to moderate physical activity for at least 30 minutes per day

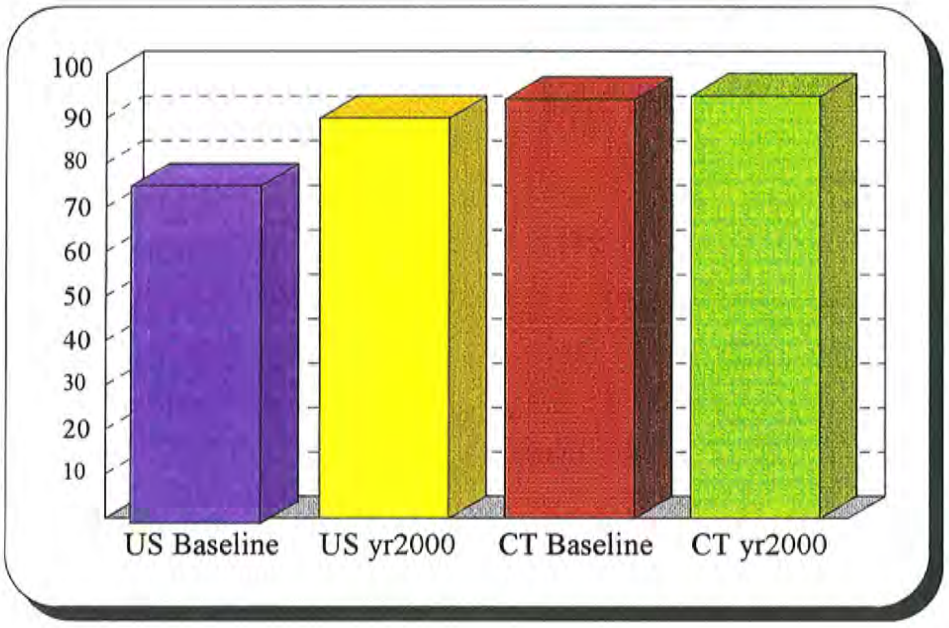
15.12 Reduce cigarette smoking to a prevalence of no more than 15 percent among people aged 20 and older

Services and Protection Objectives

15.13 Increase to at least 95 percent the proportion of adults who have had their blood pressure measured within the last 2 years and can state whether their blood pressure was normal or high

15.14 Increase to at least 75 percent the proportion of adults who have had their blood cholesterol checked within the preceding 5 years

Objective 15.13: Increase to at least 95 percent the proportion of adults who have had their blood pressure measured within the last 2 years and can state whether their blood pressure was normal or high



US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
76% 18 years and older had measurement in last 2 years (1990)	90%	94.2% (1993)	95%

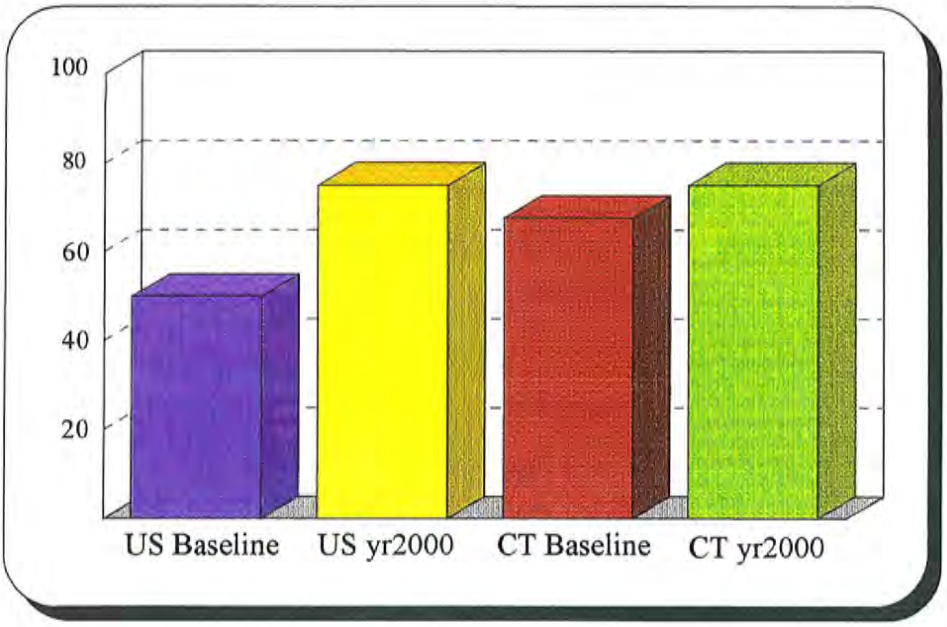
Source: Bureau of Community Health, Connecticut Department of Public Health, Behavioral Risk Factor Survey, 1994.

Data Limitations: Data are self-reports of having blood pressure measured; no data on whether they can state status.

Rationale: To reduce the risk of cardiovascular disease among the total population, all adults should be aware of their blood pressure level, whether it is high or normal. Almost all adults have had their blood pressure checked at least once, but blood pressure needs to be checked on a regular basis. It is equally important that people be able to interpret the meaning of their blood pressure readings. This knowledge can help encourage appropriate blood pressure management.

The Department of Public Health (DPH) will provide funding, and technical assistance to local health departments and community agencies to conduct hypertension screening, referral, education and counseling programs to identify clients with elevated blood pressure. Programs are monitored for contract compliance and quality assurance.

Objective 15.14: Increase to at least 75 percent the proportion of adults who have had their blood cholesterol checked within the preceding 5 years



US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
50% 18 years and older had measurement in last 2 years (1991)	75%	67.6% (1994)	75%

Source: Bureau of Community Health, Connecticut Department of Public Health, Behavioral Risk Factor Survey, 1994.

Data Limitations: Data are limited due to self-reporting of a sampling of residents surveyed by telephone.

Rationale: Blood cholesterol measurement identifies individuals in need of treatment for high blood cholesterol and provides an opportunity to educate and recommend lifestyle changes to reduce the risk of coronary heart disease. Knowledge of one's cholesterol level is of primary importance because knowledge can motivate one toward appropriate action, whether it be periodic monitoring, changes in diet or, if necessary, following prescribed treatment.

The Department of Public Health (DPH) will provide funding and technical assistance to local health departments and community agencies to conduct screening, counseling, education and referral programs to identify clients with elevated blood cholesterol. DPH will also provide funding and technical assistance to community nutrition education programs to provide information and practical skills necessary to establish healthy eating patterns. Programs are monitored for contract compliance and quality assurance.

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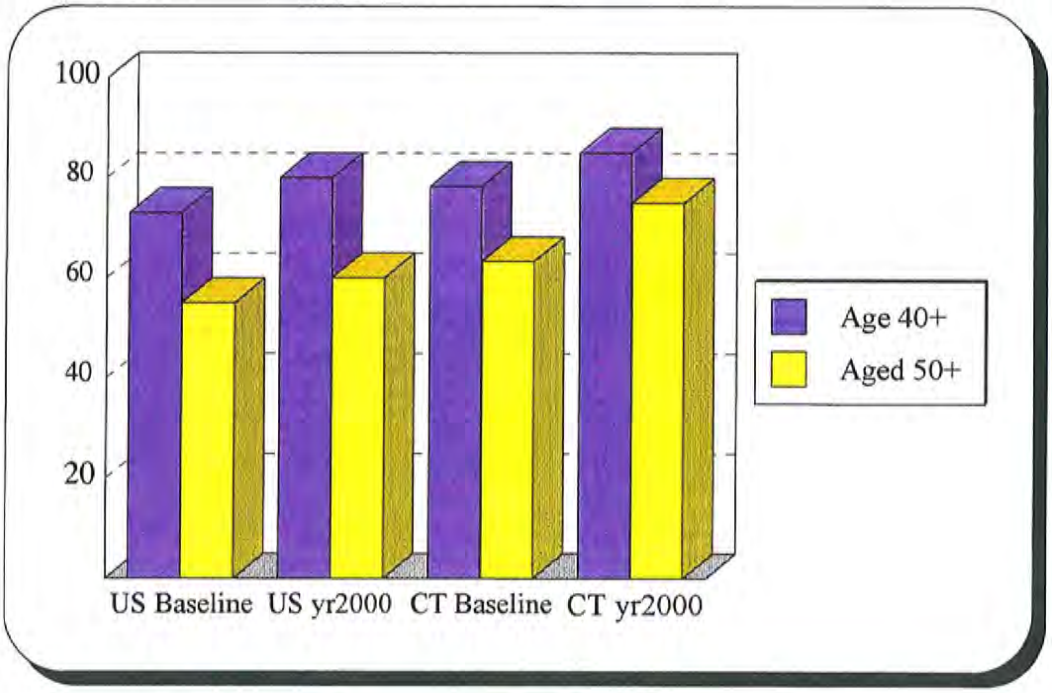
Chapter 16 - CANCER

Selected Objectives

OBJ. #	OBJECTIVE DESCRIPTION
	Health Status Objectives
16.1	Reverse the rise in cancer deaths to achieve a rate of no more than 120 per 100,000 people
16.2	Slow the rise in lung cancer deaths to achieve a rate of no more than 42 per 100,000 people
16.3	Reduce breast cancer mortality rate to no more than 20.0 per 100,000 women
16.4	Reduce deaths from cancer of the uterine cervix to no more than 1.1 per 100,000 women
	Risk Reduction Objectives
16.6	Reduce cigarette smoking to a prevalence of no more than 15 percent among people aged 20 and older
16.7	Reduce dietary fat intake to an average of 30 percent of calories or less and average saturated fat intake to less than 10 percent of calories among people aged two or older
16.8	Increase complex carbohydrate and fiber-containing foods in the diets of adults to five or more daily servings for vegetables (including legumes) and fruits, and to six or more daily servings of grain products
	Services and Protection Objectives
16.11	Increase to at least 85 percent the proportion of women aged 40 years and older who have ever received a clinical breast examination and a mammogram and to at least 75 percent those aged 50 years and older who have received a clinical breast examination within the preceding 1 to 2 years

Objective 16.11: Increase to at least 85 percent the proportion of women aged 40 years and older who have ever received a clinical breast examination and a mammogram and to at least 75 percent those aged 50 years and older who have received a clinical breast examination within the preceding 1 to 2 years



Women who had Clinical Breast Exam	US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
Age 40+ Ever tested	73% (1993)	80%	78.3% (1994)	85%
Age 50+ within the preceding 2 years	55% (1993)	60%	63.3% (1994)	75%

Source: Bureau of Community Health, Connecticut Department of Public Health, U.S.D.H.S., CDC, National Health Interview Survey, 1993, CT. Risk Factor Survey, 1994.

Data Limitations: Data based on self-reports.

Rationale: In Connecticut, for the periods 1990-1992, 16.5 percent of all breast cancers were diagnosed in women ages 40-49 years. Eighty percent of all breast cancers occur in women age 50 years and older.

The Department of Public Health will implement a statewide breast cancer screening program targeting the high risk population involving strong outreach, public education and professional education components.

HEALTHY CONNECTICUT 2000 BASELINE ASSESSMENT REPORT

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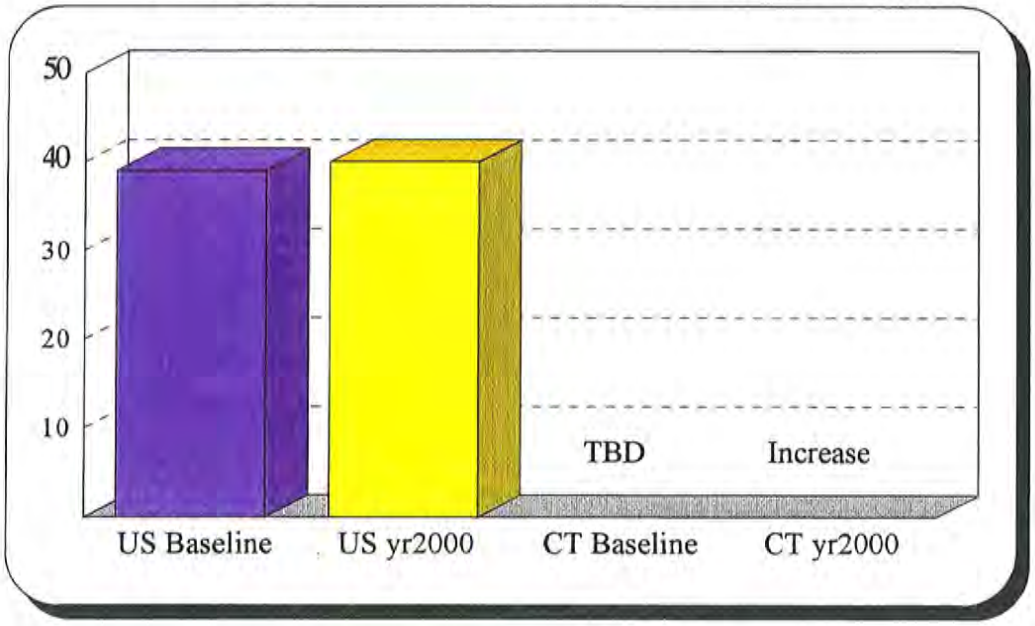
Chapter 17 - DIABETES AND CHRONIC DISABLING CONDITIONS

Selected Objectives

OBJ. #	OBJECTIVE DESCRIPTION
	Health Status Objectives
17.10	Reduce the most severe complications of diabetes as follows: Lower extremity amputation to 4.9 per 1,000 Lower blindness to 1.4 per 1,000
	Special Target Populations: Hispanics Blacks Elderly
	Services and Protection Objectives
17.14a	Increase to 75 percent the number of Connecticut residents with diabetes who receive formal patient education about community and self-help resources to reduce diabetes related complications

Objective 17.14: *US* - **Increase to at least 40 percent the proportion of people with chronic disabling conditions who receive formal patient education including information about community and self-help resources as an integral part of the management of their condition**

17.14(a) *CT* - **Increase the number of Connecticut residents with diabetes who receive formal patient education about community and self-help resources to reduce diabetes related complications**



US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
39% (Persons with diabetes) (1991)	40% (Persons with diabetes)	To be determinded	Increase

Source: Bureau of Community Health, Connecticut Department of Public Health.
U.S.D.H.H.S., N.C.H.S., C.D.C., National Health Interview Survey, 1992.

Data Limitations: A surveillance system is being put in place by program staff.

Rationale: More than 185,000 Connecticut residents have diabetes and approximately 50 percent are undiagnosed. Diabetics face shortened life spans as well as risk of amputation, renal disease, blindness and reduced activity.

The Department of Public Health is using the federal Preventive Health and Health Services block grant portion set aside for heart disease prevention programs to fund diabetes self care programs in local communities through contracts with the local health departments. The local departments use a program designed by the department and Connecticut Diabetes Educators. The local health departments contract with certified diabetes educators and registered dietitians so that clients are made aware of self care practices and to improve self-care behaviors to reduce complications related to diabetes.

Chapter 18 - HIV INFECTION

Selected Objectives

OBJ. #	OBJECTIVE DESCRIPTION
	Health Status Objectives
18.2	Confine the prevalence of HIV infection to no more than 1,100 per 100,000 people
	Risk Reduction Objectives
18.3	Reduce the proportion of adolescents who have engaged in sexual intercourse to no more than 15 percent by age 15 and no more than 40 percent by age 17
.4	Increase to at least 50 percent the proportion of sexually active, people with multiple sex partners who used a condom at last sexual intercourse
18.6	Increase to at least 50 percent the estimated proportion of intravenous drug abusers not in treatment who use only uncontaminated drug paraphernalia (works)
	Services and Protection Objectives
18.10a	Maintain at 100 percent the proportion of schools that have age-appropriate HIV education curricula for students in the 4th through 12th grade, preferably as part of quality school health education
18.12a	Maintain at 100 percent the proportion of cities with populations over 100,000 that have outreach programs to contact drug abusers (particularly intravenous drug abusers) to deliver HIV risk reduction messages

Objective 18.10: *US* - Increase to at least 95 percent the proportion of schools that have age-appropriate HIV education curricula for students in 4th through 12th grade, preferably as part of quality school health education

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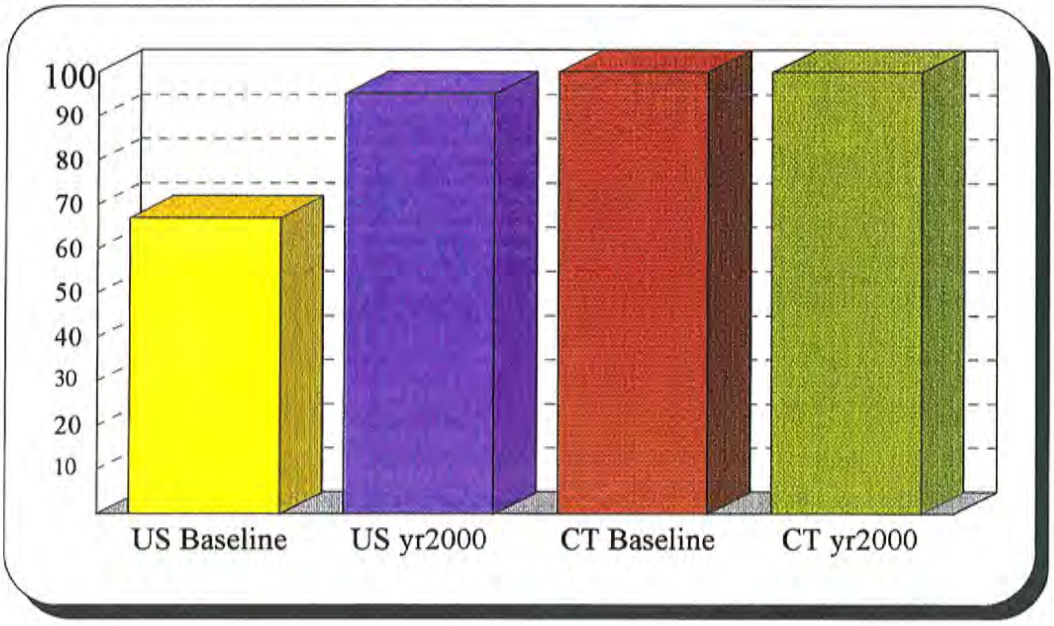
18.10(a) *CT* - Maintain at 100 percent the proportion of schools that have age-appropriate HIV education curricula for students in the 4th through 12th grade, preferably as part of quality school health education



The Connecticut objective has been established as "Maintain" since the State has already achieved 100%.

US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
67% (1987)	95%	100% (1995)	100%

Source: Bureau of Community Health, Connecticut Department of Public Health, Connecticut Department of Education.

Data Limitations:

Rationale: Connecticut General Statutes require HIV education for all students in grades K-12. A survey conducted by the Department of Education indicates that the HIV education curriculum has been implemented in all school districts.

Staff at the Department of Public Health will provide regional training for teachers on revising the curriculum. Implementation of quality assurance activity will maintain statewide compliance.

Objective 18.12: *US* - Increase to at least 90 percent the proportion of cities with populations over 100,000 that have outreach programs to contact drug abusers (particularly intravenous drug abusers) to deliver HIV risk reduction messages

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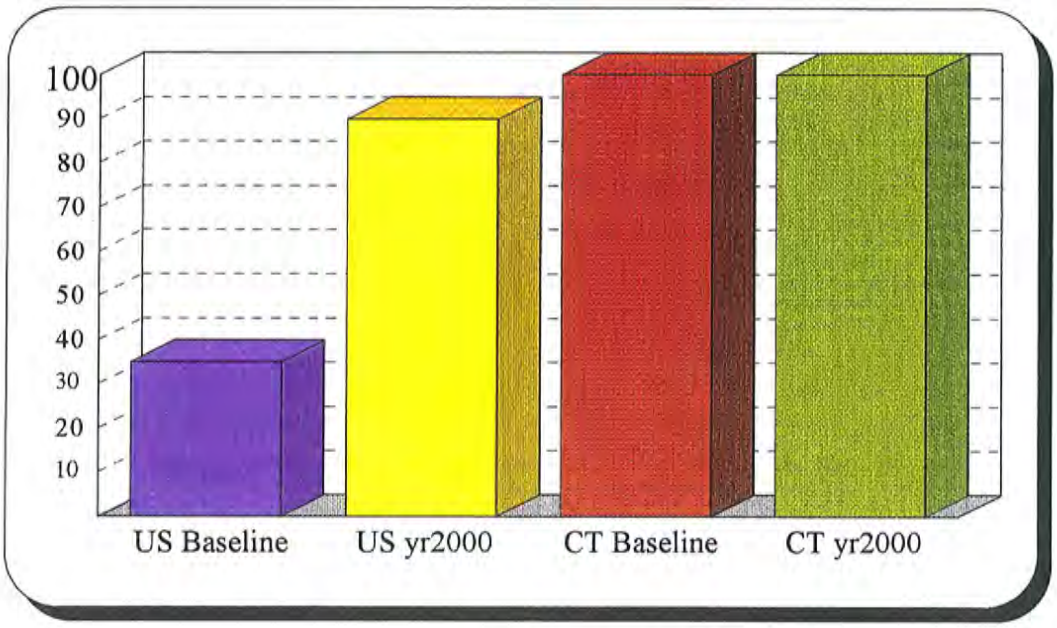
18.12(a) *CT* - Maintain at 100 percent the proportion of cities with populations over 100,000 that have outreach programs to contact drug abusers (particularly intravenous drug abusers) to deliver HIV risk reduction messages



The Connecticut objective has been established as "Maintain" since the State has already achieved 100%.

US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
35% (1991)	90%	100% (1995)	100%

Source: Bureau of Community Health, Connecticut Department of Public Health.

Data Limitations:

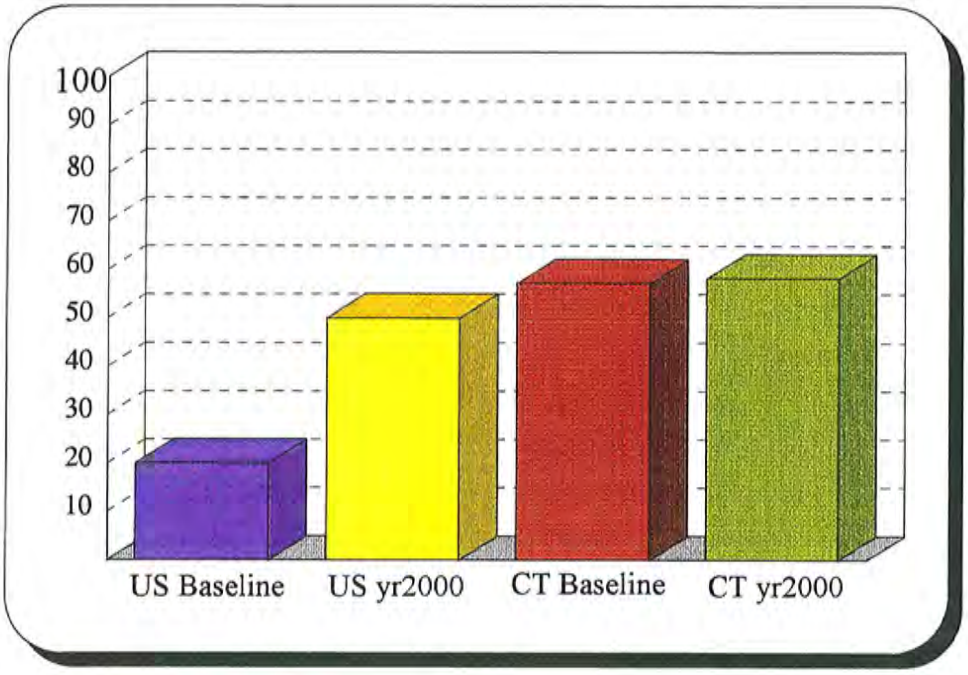
Rationale: Outreach to drug abusers will provide risk reduction messages to influence behavior change. The Department of Public Health will maintain outreach workers in the proportion of cities in Connecticut with populations over 100,000, thereby maintaining 100 percent for this objective.

Chapter 19 - SEXUALLY TRANSMITTED DISEASES

Selected Objectives

OBJ. #	OBJECTIVE DESCRIPTION
	Health Status Objectives
19.1	Reduce gonorrhea incidence to no more than 120 cases per 100,000 people overall, in blacks to no more than 1,150 per 100,000, in adolescents to no more than 450 per 100,000 and to no more than 206 per 100,000 in women
19.2	Reduce Chlamydia trachomatis infection, as measured by a decrease in the incidence of nongonococcal urethritis, to no more than 170 cases per 100,000 people
19.3	Reduce primary and secondary syphilis to an incidence of no more than four cases per 100,000 people, and to no more than 30 cases per 100,000 blacks
19.4	Reduce congenital syphilis to an incidence of no more than 20 cases per 100,000 live births
	Services and Protection Objectives
19.15	Maintain at greater than 50 percent the proportion of all patients with gonorrhea, syphilis and chlamydia who are offered provider referral services

Objective 19.15: **Maintain at greater than 50 percent the proportion of all patients with gonorrhea, syphilis and chlamydia who are offered provider referral services**



US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
20% (1988)	50%	>50% (1994)	>50%

Source: Bureau of Community Health, Connecticut Department of Public Health.

Data Limitations:

Rationale: Maintenance of this objective will impact directly on the effects of syphilis, gonorrhea and chlamydia rates. Provider referral services act to interrupt chains of transmission by assuring that persons recently exposed to an infectious case of the above diseases get empirically treated before they become ill and infectious themselves.

Chapter 20 - IMMUNIZATION AND INFECTIOUS DISEASES

Selected Objectives

OBJ. #	OBJECTIVE DESCRIPTION
	Health Status Objectives
20.1	Reduce indigenous cases of vaccine-preventable diseases as follows:

diphtheria in people aged less than 25 years to zero cases
tetanus in people aged less than 25 years to zero cases
polio (wild type virus) to zero cases
measles, rubella and congenital rubella to zero cases
mumps and pertussis to less than five and ten cases respectively

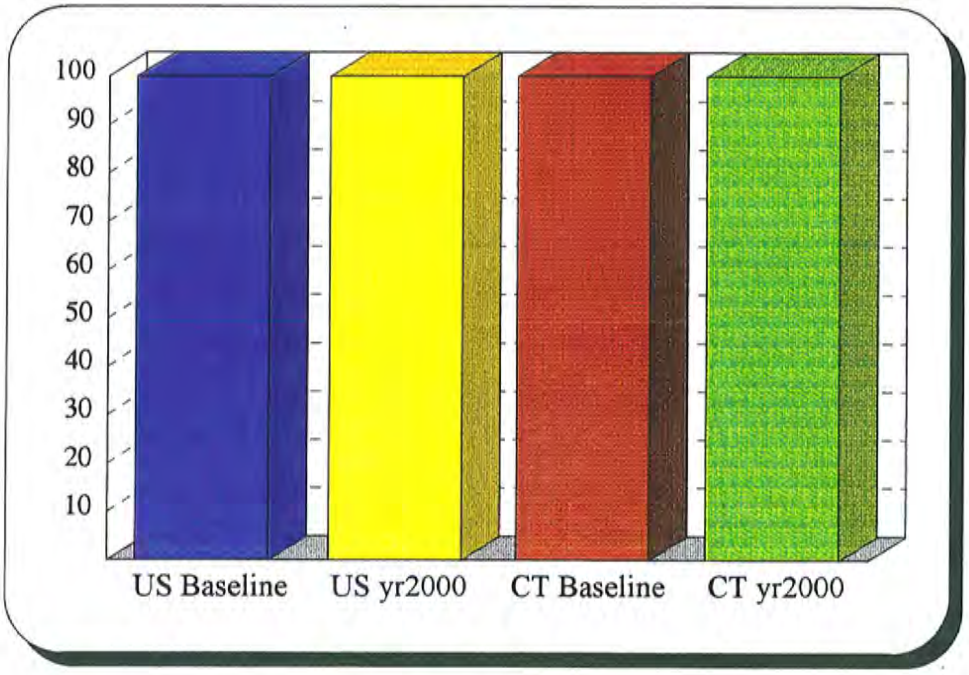
20.2	Reduce epidemic-related pneumonia and influenza deaths among people aged 65 and older to no more than 7.3 per 100,000
20.3	Reduce Hepatitis B to an overall incidence of 40 cases per 100,000 and to no more than five cases per 100,000 in infants
20.4	Reduce tuberculosis to an overall incidence of no more than 2.8 cases per 100,000 people; in Asian Pacific Islander to no more than 12.0 cases per 100,000; in Blacks to no more than 9.0 cases per 100,000; and in Hispanics to no more than 5.0 cases per 100,000
20.7	Reduce bacterial meningitis to no more than 0.8 cases per 100,000 people
	Risk Reduction Objectives
20.11	Increase immunization levels as follows: . Basic immunization series among children under age two to at least 90 percent . Basic immunization series among children in licensed child care facilities and kindergarten through post-secondary education institutions to 98 percent . Pneumococcal pneumonia and influenza immunizations among institutionalized chronically ill or older people to at least 80 percent . Hepatitis B immunization among high risk populations, including infants of surface antigen-positive mothers, to at least 90 percent
20.12	Reduce post-exposure rabies treatment by at least 50 percent per year

Chapter 20 - IMMUNIZATION AND INFECTIOUS DISEASES

Selected Objectives

OBJ. #	OBJECTIVE DESCRIPTION
	Services and Protection Objectives
20.13	Maintain immunization laws for schools, pre-schools, and all day care settings in Connecticut for all antigens
20.15	Maintain financing and delivery of immunizations for children and adults so that virtually no Connecticut resident has a financial barrier to receiving recommended immunizations
20.18	Increase to at least 85 percent the proportion of people found to have Tuberculosis infection who have completed courses of preventive therapy

Objective 20.13: **Maintain immunization laws for schools, pre-schools, and all day care settings in Connecticut for all antigens**



US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
67-100% (1989)	100%	100% (1994)	100%

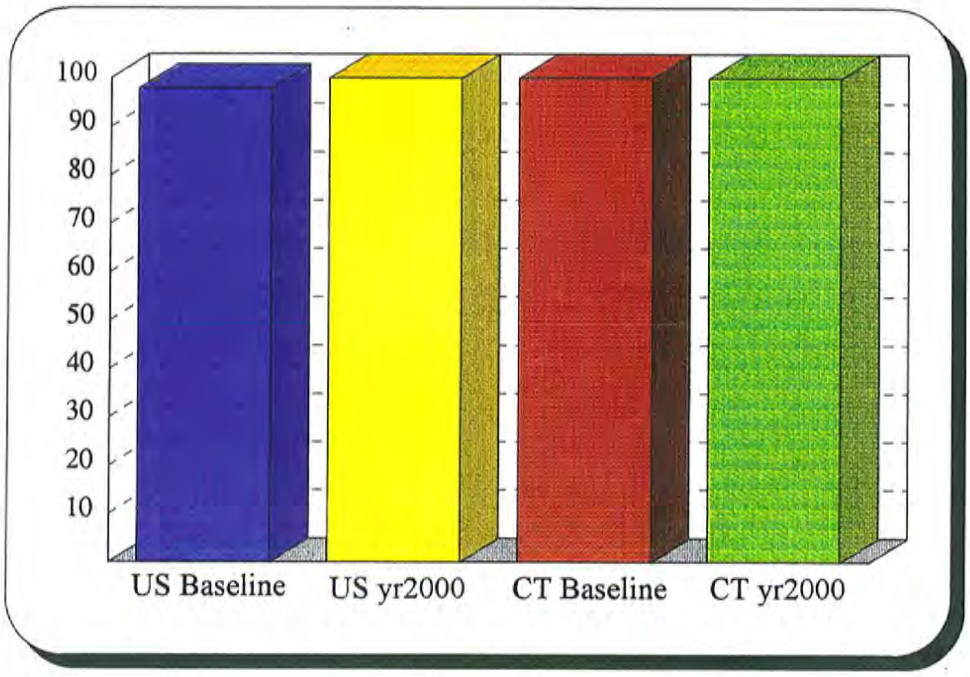
Source: Bureau of Community Health, Connecticut Department of Public Health.

Data Limitations:

Rationale: Having and enforcing day care and school entry immunization requirements is essential to reducing the occurrence of vaccine-preventable diseases in children in congregate settings where there is a high risk of exposure. Such laws have also made it possible for the U.S. to have one of the highest rates of immunizations by school entry of any country in the world.

Since 1991, Connecticut has had a statutory requirement that day care and school entry requirements be tied to current national standards for immunization. To make this statute effective, regulations must be updated and communication made to day care operators and school systems whenever there is a new vaccine added to the nationally recommended immunization schedule. Thus, regulations will be updated and communications made as necessary to continue to fully achieve this objective.

Objective 20.15: **Maintain financing and delivery of immunizations for children and adults so that virtually no Connecticut resident has a financial barrier to receiving recommended immunizations**



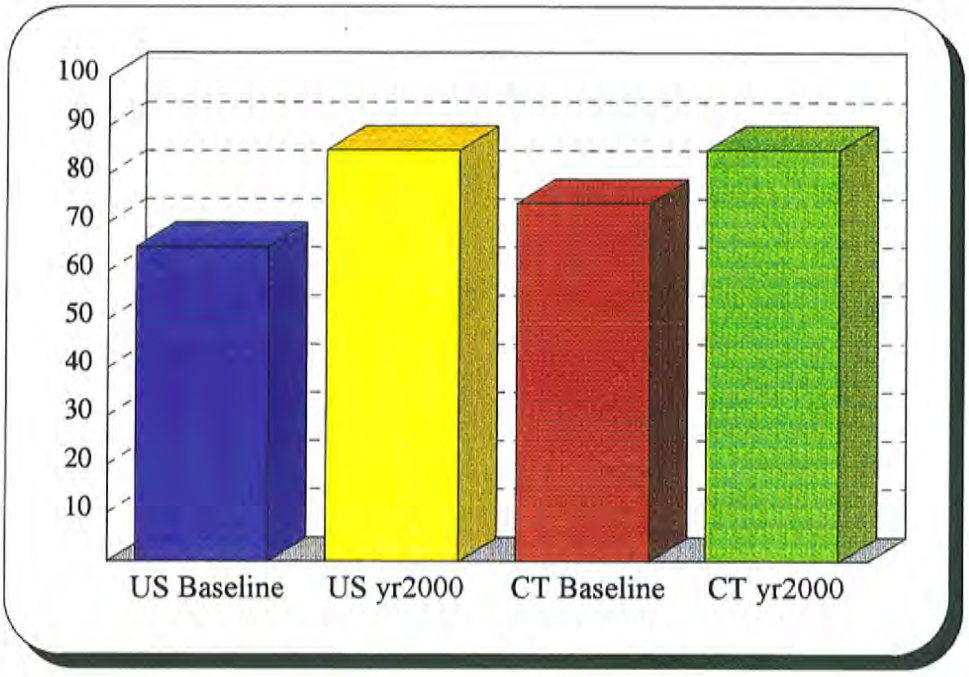
US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
45-98% (1989)	100%	100% (1994)	100%

Source: Bureau of Community Health, Connecticut Department of Public Health.

Data Limitations:

Rationale: Removing cost barriers to timely immunization results in higher immunization levels and a reduction in the occurrence of vaccine-preventable diseases. Connecticut has been able to purchase most required vaccines to distribute to any provider for use with any child for several decades. This has removed vaccine financing as a barrier to immunization. To maintain this capacity, it will be essential to support efforts to maintain the current federal and state levels of financing and to be able to expand both to meet the needs raised by price changes, new vaccine formulations and new vaccines. Intervention strategies to do this will include efforts to get legislation to establish a special immunization purchase account to be contributed to by health insurers, or to require that all insurers cover all costs of all nationally recommended vaccines. Alternatively, budget options to seek additional state funding as needed will be pursued.

Objective 20.18: **Increase to at least 85 percent the proportion of people found to have Tuberculosis infection who have completed courses of preventive therapy**



US Baseline	US Year 2000 Target	CT Baseline	CT Year 2000 Target
65% (1991)	85%	74% (1994)	85%

Source: Bureau of Community Health, Connecticut Department of Public Health.

Data Limitations: Data may reflect medicine given to patient rather than actually ingested.

Rationale: Treatment of persons latently infected with Tuberculosis (TB) prevents them from developing TB disease and spreading TB to others. Given that it takes at least 6 months of therapy to effectively reduce the risk of subsequent TB, it is important to have measures of the extent to which full treatment is occurring.

The TB Control Program distributes TB medicines free of charge to providers around the state. As part of this, a tracking system is maintained which enables the program to know how much TB medication has been given to each patient. When patients are identified who have not completed a full course of treatment, notification of the provider and local health department occurs and outreach services are offered, particularly for those patients who are not taking their medication consistently is brought to the attention of the provider. The availability of outreach should make it possible to raise preventive therapy completion rates.

Chapter 22 - SURVEILLANCE AND DATA SYSTEMS

Selected Objectives

OBJ. #	OBJECTIVE DESCRIPTION
22.1	Develop a set of health status indicators appropriate for Federal, State and local health agencies, and to establish use of the set in at least 40 States
22.1(a)	Reduce the infant mortality rate to no more than 5.5 per 1,000 live births: Black infants rate to no more than 11 per 1,000 live births and Hispanic infants rate to no more than eight per 1,000 live births
22.1(b)	Reduce deaths caused by motor vehicle crashes to no more than 10.8 per 100,000 people
22.1(c)	Reduce deaths from work-related injuries to no more than 4.0 per 100,000 full-time workers
22.1(d)	Reduce suicides to no more than 6.7 per 100,000
22.1(e)	Slow the rise in lung cancer deaths to a rate of no more than 42.0 per 100,000 people; rate in females to no more than 34.0 per 100,000; and rate in males to no more than 54.8 per 100,000
22.1(f)	Reduce breast cancer mortality rate to no more than 20.0 per 100,000 women
22.1(g)	Reduce cardiovascular disease deaths to no more than 84.4 per 100,000 people
22.1(h)	Reduce homicides to no more than 5.0 per 100,000 people
22.1(i)	Reduce deaths from all causes to no more than 328.4 per 100,000 people
22.1(j)	Confine the incidence of diagnosed AIDS to no more than 32.9 per 100,000 cases
22.1(k)	Reduce measles incidence to zero
22.1(l)	Reduce tuberculosis to an incidence of no more than 2.8 cases per 100,000 people: Asian Pacific Islander incidence to no more than 12.0 per 100,000, Blacks incidence to no more than 9.0 per 100,000 and Hispanic incidence to no more than 5.0 per 100,000

Chpt. 22 - Surveillance and Data Systems - Selected Objectives

22.1(m)	Reduce primary and secondary syphilis to an incidence of no more than 4.0 cases per 100,000 people
22.1(n)	Reduce low birth weight to an incidence of no more than five percent of live births and very low birth weight to no more than one percent of live births
22.1(o)	Reduce births to adolescents (ages 10-17) as a percentage of total live births to 2.3 percent
22.1(p)	Reduce the percentage of mothers delivering babies with late or no prenatal care to no more than ten percent
22.1(q)	Reduce human exposure to criteria air pollutants, as measured by an increase to at least 85 percent in the proportion of people who live in counties that have not exceeded any Environmental Protection Agency standard for air quality in the previous 12 months
22.5	Periodic analysis and publication of State progress toward the national objectives for each racial or ethnic group that makes up at least ten percent of the State population
22.6	Expand all state systems for the transfer of health information related to the national health objectives among Federal, State and local agencies