Child Poverty and Prevention Council Meeting

Friday, December 19, 2014
10:00 a.m. – 12:00 p.m.
Room 1C
Legislative Office Building
Hartford, Connecticut

I. Welcome 10:00 a.m.

Introduction of New Members

Myra Jones-Taylor, Commissioner
Office of Early Childhood

Kathleen Durand, Director of Strategic Initiatives
Department of Housing

Stephen Anderson, Supervising Environmental Analyst
Department of Agriculture

II. Presentations 10:15 a.m.

a. TFA/TANF Redesign Workgroups
   Peter Palermino – Department of Social Services
   Lisa Arends – Department of Labor

b. United Way-ALICE Report
   Richard Porth – United Way

c. Two Generational School Readiness Plan
d. Elizabeth Zimmerman – Commission on Children

III. Child Poverty and Prevention Report 11:25 a.m.

IV. Next Steps 11:45 a.m.

Child Poverty and Prevention Council Meeting Summary

Friday, December 19, 2014
10:00 a.m. – 12:00 p.m.
Room 1C
Legislative Office Building
Hartford, Connecticut

Members Present: Chair Anne Foley, Stephen Anderson, Lezlye Zupkus, Kim Somaroo-Rodriguez, Peter Palermino, Patricia Kupec for Monica Rinaldi, Rod O'Connor, Paulette Barrett for Kathleen Durand, Carol Meredith, Lisa Rivers, John Frassinelli, Lindy Gold, Lisa Arends for Ram Aberasturia, Bernadette Conway, Faith VosWinkel, Karen Foley-Schain for Myra Jones-Taylor, and Elaine Zimmerman.

Members Absent: MaryAnn Handley, Gregg Cogswell, Renee Coleman-Mitchell, Gregory Gray, Mary Mushinsky, and Tanya Hughes.

Welcome	The Chair, Anne Foley, convened the meeting at 10:01 a.m. The Chair stated that the Office of Early Childhood (OEC) and the departments of Housing (DOH) and Agriculture (DAg) were added to the Council. She introduced Stephen Anderson as the designee from the DAg and Karen Foley–Schain representing the OEC. She also noted that Kathleen Durand, designee for DOH was unable to attend today's meeting, but another staff member would join us later. Other members introduced themselves.
Presentations TFA/TANF Redesign Workgroup	The Chair reminded the members that the Council agreed to focus its efforts on the TFA/TANF Redesign efforts. She asked Peter Palermino (DSS) and Lisa Arends (DOL) to give an update on the TFA/TANF Redesign Workgroup. Peter Palermino provided a brief overview of the workgroup and discussed the work of the

	TFA Policies subcommittee. Highlights include: • TFA/TANF Redesign Workgroup was established to review current policies and procedures of the Temporary Family Assistance (TFA) and Connecticut's Jobs First Employment Services (JFES) programs. • Two workgroups were established, the TFA Policies and JFES workgroups. • The TFA Policies workgroup began its work by educating workgroup participants on current policies related to the TFA program. • Based on a document prepared by Jane McNichol (Legal Assistance Resource Center) identifying issues and concerns with current TFA policies, review of national research, information gathered from a focus group with TFA clients and results from the TFA/TANF Best Practices forum, the workgroup developed a TFA Policies Consensus Document. • The TFA Policies Consensus Document identifies policy areas and options to consider for recommended redesign strategies. • Several policy areas may require significant financial investments. • The next step is to analyze the fiscal impact and programmatic feasibility of the identified policy areas. Through this analysis, policy changes with little to no fiscal impact will be recommended. Lisa Arends updated the members on the work of the JFES Workgroup. Highlights include:

	• Workgroup members reviewed recommendations of the 2011 JFES Enhancement Workgroup to assess whether the recommendations were still valid and would enhance the service delivery of the current JFES program. • The workgroup agreed to implement three pilots recommended by the 2011 JFES Enhancement Workgroup. • The Integrated Basic Education and Skills Training (I-BEST) pilot program is in the second year of operations. I-BEST provides vocational skills training with adult basic education for Jobs First participants. Testing to determine skill levels of potential participants showed that a significant number of participants were at a 7th grade level. • As part of the I-BEST pilot, the Workforce Investment Boards offer adult basic education and training programs to Jobs First participants. • DOL is piloting a JFES Intake Enhancement program. DOL has worked with a national motivational trainer to develop and implement a new approach to the current JFES intake and orientation process. The new approach is more motivational than punitive and has had a positive effect on both the participants and staff. • DOL is piloting the Career Occupational Preference System (COPSystem) which is a career guidance program that outlines individual's occupational interest, abilities and work values.

	The TFA Policies Consensus and the TANF Employment & Training Workgroup Summary will be added to the Child Poverty and Prevention Report.
United Way – ALICE Report	Richard Porth presented information on the recently released Asset Limited, Income Constrained, Employed (ALICE) report by United Way. Highlights include: • Connecticut's United Ways partnered with Rutgers University to provide an in-depth research study that measures financial hardships across Connecticut and the impact it has on struggling families. • According to the study, in Connecticut, 1 in 4 households have earnings above the Federal Poverty Level but below a basic cost-of-living threshold. United Way calls this population ALICE, an acronym for Asset Limited, Income Constrained, Employed. • Household Survival Budget is a new tool to assess the financial hardship for ALICE households. Based on the Household Survival Budget, the two most prominent factors contributing to financial hardship for ALICE households are housing and child care. • Household Survival Budget also indicates that it costs $64,689 for a family of four to afford the essentials in Connecticut. A single adult would need a full-time job earning $10.97 per hour and a family of four would need full-time work with an hourly wage of $32.34 to afford the basics. In Connecticut 51% of the jobs pay less than $20 per hour.

	• Next Steps is to identify the policy recommendations and implications that United Way would like to put forward. DSS and members of the Council is interested in working with United Way on this effort.
Two-Generational School-Readiness Plan	Elaine Zimmerman updated the Council on the Two-Generational School Readiness Plan. Highlights include: • The Commission on Children has been charged through legislation to establish a two-generational school readiness plan to promote the long-term learning and economic success for low-income families by addressing intergenerational barriers to school readiness and workforce readiness. • A two-generational approach focuses on the needs of both the parent and the child together (not a separately). • Head Start is an example of a two-generational approach, which integrates services for the child (early childhood education) and services for the parent. The committee is looking at how to better coordinate services for children and parents and report on results to determine the efficacy of such coordinated efforts. • In an effort to promote the two-generational approach, Connecticut's legislative committee on children will ask each group or individual testifying before the committee two-generational questions. • Elaine will share the progress report on the Two-Generational School Readiness Plan in January 2015.

Child Poverty and Prevention Council Report	The Chair provided members with a brief overview of the draft 2014 Child Poverty and Prevention Council Progress Report. The Council reviewed the draft report. After a discussion of the report members suggested that the TFA Policies Consensus and JFES Workgroup Summary documents are added to the report. The Chair asked members to send Examples of Successful Interagency Collaborations to Pam Trotman by next Friday, December 26th to be included in the report. Members discussed the statutory sunset of the Council in June 2015. Council members noted that the legislative intent and agreement with the executive branch was for the Council to meet for ten years only, recent significant state policy and budget initiatives enacted under the Malloy administration implement many of the Council's recommendations and there are many other state collaborative entities such as the Commission on Children, the Early Childhood Cabinet, the TANF Redesign Workgroup, the ISHF Project Advisory Board, etc. that are and have been established doing similar work. Following discussion, Lindy Gold moved that the Council support the sunset provided for the Council in statute as of June 2015. The motion was seconded by Rod O'Connor and approved 14-3.
Next Steps	The Council will meet in late spring. The meeting adjourned at 12:05 p.m.

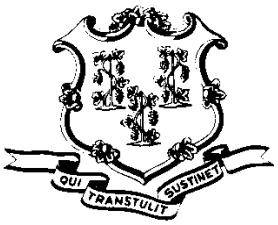
STATE OF CONNECTICUT

Child Poverty and Prevention Council

2014 Progress Report

For submission to the
Honorable Dannel P. Malloy
Governor

and members of the
Joint Standing Committees of the General Assembly on
Appropriations, Children, Education,
Human Services and Public Health



Anne Foley, Chair

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APPENDICES

I. Executive Summary

The Child Poverty and Prevention Council consists of the heads of state agencies, or their designees, that share responsibility for preventing and addressing child poverty and the myriad problems resulting from and associated with children living in poverty in this state.[1]

The purpose of the Council is two-fold: First, to develop and promote the implementation of a ten-year plan to reduce the number of children living in poverty in the state; and second, to establish prevention goals and recommendations and measure prevention service outcomes in order to promote the health and well-being of children and families.

This annual report focuses on three major items: trends in child poverty in Connecticut, state actions that have been taken over the past year to implement Council recommendations and address child poverty. Also, as required by Connecticut General Statutes (C.G.S.) Section 4-67x[2] the report contains examples of successful interagency collaborations and a report on prevention services administered by state agencies.

A. Trends in Child Poverty in Connecticut

To measure the child poverty rate in Connecticut, the Council uses findings from two U.S. Census Bureau surveys: the American Community Survey (ACS) for data on households with income below 100% of the federal poverty level and the Current Population Survey (CPS) for those with income below 200% of the federal poverty level. The Child Poverty and Prevention Council continues to focus its efforts on reducing child poverty both among "very poor" households with income below 100% of the federal poverty level ($19,530 for a family of three and $23,550 for a family of four)[3] and "poor" households with income below 200% of the federal poverty level ($39,060 for a family of three and $47,100 for a family of four).[4]

In 2013, Connecticut's child poverty rate for "very poor" households with income below 100% of the federal poverty level was 14.5%, a slight decrease from the 2012 child poverty rate of 14.8%. Connecticut's child poverty rate of 14.5% is substantially below

[1] See Appendix A for council membership
[2] See Appendix B
[3] See http://aspe.hhs.gov/poverty/13poverty.cfm
[4] U.S. Department of Health and Human Services Poverty Guidelines 2013. Annual income amounts calculated by the Office of Policy and Management

the national child poverty rate of 22.2%. Connecticut had the 8th lowest child poverty rate in the nation where child poverty rates range from 10.2% in New Hampshire to 34% in Mississippi.

For "poor" households with income below 200% of the federal poverty level, Connecticut's child poverty rate in 2013 was 29.9%, an increase from the 2012 child poverty rate of 25.4%. Using this measure, the national child poverty rate is 42.6% and Connecticut had the 2nd lowest child poverty rate of all the states and D.C. where the child poverty rates range from 29.4% in New Hampshire to 57.5% in Arizona.

Child Poverty in Connecticut 2003-2013

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Percent of children under 18 in households with income < 100% of FPL	11.0%	10.5%	11.6%	11.0%	11.1%	12.5%	12.1%	12.8%	14.9%	14.8%	14.5%
State Rank for percentage of children 18 in households with income < 100% of FPL	48	50	46	49	47	42	49	50	45	47	43
Percent of children under 18 in households with income < 200% of FPL	23%	23.9%	25.8%	25.8%	27.5%	26.2%	23..1%	26.8%	30.9%	25.4%	29.9%
State Rank for percentage of children 18 in households with income < 200% of FPL	48	47	48	49	48	50	50	50	47	50	49

In 2013, rates of child poverty in Connecticut continue to vary significantly based on location. The percentage of children living in households with income below 100% of the federal poverty level in Connecticut's cities with a population over 65,000 was: Bridgeport

(32.7%), Danbury (14.4%), Hartford (47.6%), New Britain (32.0%), New Haven (33.1%), Norwalk (6.9%), Stamford (18.6%) and Waterbury (40.0%)[5]. Racial and ethnic disparities persist. Black and Hispanic children are more likely to live in poverty than white children. According to the Children's Defense Fund, 28.2% of black children and 32.9% of Hispanic children live in poverty as compared to 5.6% of white children[6]. Child poverty rates also vary by family structure as single parent families with related children are more likely to live in poverty than married couples with children. In 2013 the poverty rate for married couple families with related children was 3.7% and the poverty rate for single parent families with related children was 32.2%[7].

B. State Actions Taken to Address Child Poverty in 2014

The following state actions taken or becoming effective in 2014 to address child poverty are directly related to the Child Poverty and Prevention Council's top three recommendations. The top three recommendations were based on an economic modeling conducted in 2009. These recommendations focus on subsidized housing and nutrition assistance, higher education, particularly Associates Degrees, and child care. The state actions include:

- **State Earned Income Tax Credit (EITC).** In 2011, Connecticut joined 24 other states and the District of Columbia with a state earned income tax credit. For the 2012 tax year (claimed in the 2013 filing season), Connecticut's refundable EITC assisted 186,734 families with a total of $112,245,946 in benefits. During the 2013 legislative session, the state EITC was reduced from 30% to 25% of the federal credit for the 2013 tax year; however, for the 2014 tax year it will increase to 27.5% and then be restored to 30% for subsequent tax years.

- **Minimum Wage Increase.** During the 2013 legislative session, the minimum wage was increased to $9.00 through two phased-in increases. Effective January 1, 2014, the hourly minimum wage will increase from $8.25 to $8.70. It will then increase to $9.00 effective January 1, 2015[8].

- **Affordable Housing.** Developing and rehabilitating our state's affordable housing stock is crucial to increasing the affordable housing options for workers, young professionals, and low-income families. The FY 2013 state budget authorized $50 million in FY 2012 and an additional $70 million in FY 2013 for a total of $120 million in capital funds to revitalize and develop new units of affordable housing across the state. The FY 2015 state budget authorized an additional $136 million in capital funding over the biennium (approximately $70 million in each fiscal year).

[5] U.S. Census Bureau, 2013 American Community Survey Chart S1701
[6] Children's Defense Fund; Child Poverty in America 2013: State Analysis, September 29, 2014
[7] U.S. Census Bureau, 2013 American Community Survey Chart S1702
[8] PA 13-117 An Act Increasing the Minimum Fair Wage

- **Supportive Housing.** Supportive housing is a successful and cost-effective approach to addressing homelessness by creating permanent affordable housing with services. The FY 2013 state budget authorized $30 million in capital funding for 150 new units of supportive housing, coupled with an annualized $2.6 million for operating and support services. An annualized $1.5 million ($375,000 beginning in April 2013) was also included to support an additional 150 Rental Assistance Program (RAP) certificates for scattered site supportive housing. The FY 2015 state budget built on these investments by authorizing an additional $20 million to develop 100 new units of supportive housing targeting families involved in the child welfare system with an annualized $1 million for rental assistance subsidies and $1 million for services. Additionally, legislation[9] in 2013 authorized the Department of Social Services (DSS), Department of Mental Health and Addition Services (DMHAS), Department of Correction (DOC), Office of Policy and Management (OPM), and Court Support Service Division (CSSD) to develop a plan to provide supportive housing services, including housing rental subsidies, during FY 2014 and FY 2015 for an additional 160 individuals and families who frequently use expensive state services.

- **Early Childhood System**. Public Act 14-39[10] established the Office of Early Childhood (OEC) to provide a comprehensive, collaborative system for delivering improved program and services to children age zero to five and their parents. Previously, this office existed under PA 13-184[11] and Executive Order No. 35 (June 24, 2013).

- **School Readiness Expansion.** The 2014-2015 state budget authorized $11.5 million to OEC for 1,020 additional pre-kindergarten (Pre-K) spaces for low income children in Priority, Alliance and Competitive School Districts.[12] This expansion is part of a five year plan to incrementally increase the capacity of the school readiness program to serve a total of 4,010 additional children by the end of 2019. Access to additional Pre-K spaces will be phased-in and low-income children ages 3 and 4 will be given first priority to fill the additional spaces. An additional $1.275 million [13] is included in OEC's budget for startup costs for additional Pre-K seats in school readiness programs.

[9] §60, PA 13-247, An Act Implementing Provisions of the State Budget for the Biennium Ending June 30, 2013 Concerning General Government
[10] §4, PA 14-39, An Act Establishing the Office of Early Childhood, Expanding Opportunities for Early Childhood Education and Concerning Dyslexia and Special Education
[11] PA 13-184 An Act Concerning Expenditures and Revenue for the Biennium Ending June 30, 2015
[12] PA 14-39, An Act Establishing the Office of Early Childhood, Expanding Opportunities for Early Childhood Education and Concerning Dyslexia and Special Education and PA §17,14-47, An Act Making Adjustments to State Expenditures and Revenues for the Fiscal Year Ending June 30, 2015
[13] IBID.

- **Universal Pre-Kindergarten Grants**. OEC allocated $600,000 for School Readiness Quality Enhancement funding for pre-kindergarten planning grants at the district and regional level for fiscal year 2015. The purpose of the grants is to provide funding for programs that focus on education and early care that address quality standards and/or expand comprehensive services for children and families. OEC is in the planning phase of this project.

- **Baby CHET Scholars Program.** Public Act 14-217[14] established this program, which builds on the success of the state's 529 college savings plan, the Connecticut Higher Education Trust (CHET). The CHET Baby Scholars program is capitalized with $4.4 million from a portion of the assets of the defunct Connecticut Student Loan Foundation and potential contributions from taxpayers through an income tax check-off. The program provides a one-time incentive of $100 to families of Connecticut children who open a CHET 529 savings account by the child's first birthday, or within a year after adoption. Families who make an additional contribution of $150 within four years of the child's first birthday or adoption will receive a one-time match of $150. If this investment is done in the child's first year of life, a $400 total contribution in an interest-bearing CHET account could grow to $1,350 by the time the child reaches age 18 and is ready to pursue higher education.

- **Next Generation Connecticut.** This initiative expands the educational opportunities, research, and innovation in the science, technology, engineering, and math (STEM) disciplines over the next decade, by authorizing $1.5 billion in bond funds, and operating support of $15 million beginning in FY 2015 to:
    - Hire 259 new faculty (of which 200 will be in STEM);
    - Enroll an additional 6,580 talented undergraduate students;
    - Build STEM facilities to house materials science, physics, biology, engineering, cognitive science, genomics, and related disciplines;
    - Construct new STEM teaching laboratories;
    - Create a premier STEM honors program;
    - Upgrade aging infrastructure to accommodate new faculty and students;
    - Expand digital media and risk management degree programs and provide student housing in Stamford; and
    - Relocate UConn's Greater Hartford Campus to downtown Hartford.

[14] §§ 27-34, PA 14-217, An Act Implementing Provisions of the State Budget for the Fiscal Year Ending June 30, 2015

- **Governor's Scholarship Program.** Administered through the Office of Higher Education, this program provides $43.6 million in FY 2015 for need and merit based student financial aid for college students attending both public and private institutions of higher education in the state, by consolidating four financial aid programs. For FY 2014, the Governor's Scholarship Program provided funding to 19,789 Connecticut students attending state colleges and universities.

II. Background

The purpose of the Child Poverty and Prevention Council[15] is to:

1. Develop and promote the implementation of a ten-year plan to reduce the number of children living in poverty in the state by fifty percent; and

2. Establish prevention goals and recommendations and measure prevention service outcomes to promote the health and well-being of children and families.

This annual report focuses on three major items: trends in child poverty in Connecticut, state actions that have been taken over the past year to address child poverty, and future actions of the Child Poverty and Prevention Council. Also, as required by statute, the report also contains examples of successful interagency collaborations and a report on prevention services.

A. Child Poverty and Prevention Council

In 2004, the Connecticut legislature enacted Public Act 04-238, An Act Concerning Child Poverty and the Use of Psychotropic Medications with Children and Youth in State Care which established a Child Poverty Council. The Council was charged with recommending strategies to reduce child poverty in the State of Connecticut by fifty percent (50%) within ten years.

The legislation required that the Council consist of the following members or their designees: the Secretary of the Office of Policy and Management; the President Pro Tempore of the Senate; the Speaker of the House of Representatives; the Minority Leader of the Senate and the Minority Leader of the House of Representatives; Commissioners of the Department of Children and Families, Education, Higher Education, Labor, Mental Health and Addiction Services, Developmental Services, Public Health, Social Services, Corrections, Transportation, Economic and Community Development, Health Care Access; the Child Advocate, the chair of the State Prevention Council, the Executive Director of the Children's Trust Fund, the Executive Director of Human Rights and Opportunities and the Executive Director of the Commission on Children. In 2006, the Chief Court Administrator was added to the Council.

In its first year, the Council engaged in numerous strategies to gather the appropriate data to assist in the formation of its recommendations and presented its first report to

[15] See Appendix B for statutory authority

the Governor and legislature in January 2005. The report contained 67 recommendations to reduce child poverty in Connecticut by fifty percent over a ten year period. The recommendations were organized under six major objectives:

- Enhance families' income and income-earning potential;
- Help low income families build assets;
- Enhance affordable health care, housing, child care and early childhood education;
- Support safety net programs for families with multiple barriers;
- Enhance family structure stability; and
- Further study child poverty issues and solutions.

In July 2005, the legislature enacted Public Act 05-244, An Act Concerning the Implementation of the Recommendations of the Child Poverty Council. This public act made the executive director of the Commission on Human Rights and Opportunities a member of the Child Poverty Council and required the Council to meet at least twice a year to review and coordinate state agency efforts to meet the goal of reducing child poverty. The Council's annual implementation reports to the legislative committees included progress made toward meeting this goal. The Council continued its work to develop strategies to implement, monitor and report on the implementation of the recommendations.

In June 2006, the Connecticut legislature enacted Public Act 06-179, An Act Concerning State Investments in Prevention and Child Poverty Reduction and the Merger of the State Prevention and Child Poverty Councils.

This public act merged the Prevention Council with the Child Poverty Council and required the newly formed Child Poverty and Prevention Council to adhere to provisions of the previous councils and imposed additional responsibilities relating to prevention services. The Child Poverty and Prevention Council is comprised of members of both the Child Poverty Council and the State Prevention Councils. In 2006, the Chief Court Administrator was added to the Council.

The public act directs the Child Poverty and Prevention Council to:

- Establish prevention goals and recommendations and measure prevention service outcomes to promote the health and well-being of children and their families.
- Report to the Governor and various legislative committees on the state's progress in prioritizing expenditures for prevention services in budgeted state agencies with membership on the council including:
    - Summarizing measurable gains made toward the child poverty and prevention goals established by the Council.

- Providing examples of successful interagency collaborations to meet the child poverty and prevention goals established by the Council.
- Recommending prevention investment and budget priorities.

The public act also requires each state agency with membership on the council that provides prevention services to children and families to submit an agency prevention report to the Council which must be included in the Council's report to the Governor and legislature. Each agency report must include at least two prevention programs.

In 2007, the Child Poverty and Prevention Council began a process to re-examine and prioritize its 67 child poverty and 27 prevention recommendations. At the September 2007 meeting, the Council selected three target populations in order to narrow its focus and make a greater impact on the following priority populations: birth to age five; late teen to young adult (16-24); and working poor families.

To help focus the Council's efforts, a panel of six nationally-recognized experts was engaged to discuss proven strategies to reduce child poverty. The panel consisted of J. Lawrence Aber, Ph.D. (Professor of Applied Psychology and Public Policy at New York University), Rebecca M. Blank (Professor of Public Policy and Economics at the University of Michigan), Mark H. Greenberg, J.D. (executive Director of the Task Force on Poverty for the Center for American Progress), Ron Haskins, Ph.D. (Co-Director of the Center on Children and Families at the Brookings Institution), Clifford Johnson (Executive Director of the Institute for Youth, Education and Families at the National League of Cities), and Rucker C. Johnson, Ph.D. (Assistant Professor in the Goldman School of Public Policy at the University of California, Berkeley).

The expert panel met and deliberated twice by phone and once in person in late 2007. They scrutinized the council's recommendations based on three main criteria: evidence of impact, cost-effectiveness, and timeframe.

In December 2007, the panel offered recommendations to the council about which among the 67 recommendations had sufficiently strong evidence to support their potential effectiveness in reducing child poverty. They identified four major areas of policy and thirteen specific policies for which there was evidence to support their likely effectiveness in short-term child poverty reduction. In addition, they made one process recommendation.

At the January 2008 meeting, the Council considered the expert advice and adopted 12 priority recommendations for action and two process recommendations. The Council's priority recommendations were grouped into five major categories: Family Income and Earnings Potential; Education; Income Safety Net; Family Structure and Support; and Process Recommendations.

In 2009, with funding from the Early Childhood Education Cabinet, the Office of Policy and Management contracted with the Urban Institute to provide an economic analysis regarding which of the Council's recommended strategies would reduce child poverty in Connecticut most significantly. The results of that analysis identified three recommendations that hold the most promise to reduce child poverty in Connecticut – depending on the definition of poverty used: (1) increased enrollment in subsidized housing, energy assistance and nutrition assistance; (2) increased attainment of Associates Degrees; and (3) guaranteed child care subsidies. In 2010, the Council agreed to target its efforts on further development of these three recommendations.

In 2010, the legislature enacted Public Act 10-133, An Act Concerning Children in the Recession. This act requires the Child Poverty and Prevention Council to serve in a leadership role to make recommendations for the state's emergency response to children affected by the recession. The public act directs the Council to:

- Develop and promote policies, practices and procedures that (1) mitigate the long-term impact of economic recessions on children; (2) provide appropriate assistance and resources to families to minimize the number of children who enter poverty as a result of the recession; and (3) reduce human and fiscal costs of recessions, including foreclosures, child hunger, family violence, school failure, youth runaways, homelessness, child abuse and neglect.

In December 2011, the council agreed that a subcommittee be created to address the additional council functions required in Section 1(c) of Public Act 10-133 and make recommendations to the full committee. Elaine Zimmerman, Executive Director of the Commission on Children was named to lead the subcommittee and representatives from DSS, DSS and OCA agreed to serve on the subcommittee. The Children in the Recession subcommittee's recommendations include:

- Council meetings should include a presentation by one agency and its actions and policies related to a specific topic in Public Act 10-133.
- Community partners and other stakeholders should periodically participate in discussions to provide input on the implementation of the public act

Statutorily, the subcommittee is required to meet quarterly if the unemployment rate of the state, as reported by the Department of Labor, is eight percent (8%) or greater for the preceding three months. Connecticut's unemployment rate for the period of January 2014 – October 2014 (latest data available) was below 8%. For the last three months, August 2014 – October 2014, the unemployment rate was slightly over 6%. As a result the subcommittee did not meet in 2014.

In 2014, the legislature enacted Public Act 14-132, An Act Concerning the Child Poverty and Prevention Council. This act made the commissioners of Housing, Agriculture and

the Office of Early Childhood, or their designee members of the Child Poverty and Prevention Council. The public act also requires each state agency that provides prevention services to children submit a prevention report to the Joint Standing Committee of the General Assembly on Appropriations, Children, and Human Services by November first of each year from 2015 to 2020.

III. Council Recommendations

The Child Poverty and Prevention Council webpage, which contains the 2005 Initial Child Poverty Plan and the subsequent Progress Reports (2006-2014), along with meeting agendas and minutes, is on the Office of Policy and Management home page. The website address is:
http://www.ct.gov/opm/cwp/view.asp?a=2997&Q=383356&opmNav_GID=1809

In 2009, the Office of Policy and Management contracted, on behalf of the Child Poverty and Prevention Council, with the Urban Institute to develop an economic model to determine how the implementation of various policy options would change the number of children living in poverty in Connecticut.

The report utilized two measures of child poverty. The first measure includes only cash income and represents the official poverty measure reported by the U.S. Census Bureau. The second measure, which is based on recommendations from the National Academy of Science (NAS) adds capital gains and non-cash income and subtracts taxes and "nondiscretionary" expenses (child care and work-related).

Findings

According to the report, child poverty rates are substantially lower in Connecticut than in the United States as a whole. In 2006, using the federal poverty level (FPL), 10.7% of Connecticut's children were poor compared with 16.9% nationwide. The percent of "near-poor" (200% FPL) was 25.2% in Connecticut compared with 38.8% nationwide. Using the NAS definition, the Connecticut child poverty rate was 10.9% while the national child poverty rate was 13.4%.

The "poverty gap" or the amount of money by which incomes of poor families would have to increase in order for all families to be at the poverty level was $351 million using the standard definition and $372 million using the NAS threshold.

Using the Council's priority recommendations, the Urban Institute was able to model the impact on the state child poverty rate if some of the recommendations were implemented. In general, no recommendation by itself would result in a dramatic decrease in child poverty. The most effective single recommendation depends on the definition of poverty used: for the federal poverty level it is guaranteed child care subsidies, for 200% FPL it is increased attainment of AA degrees, and using the NAS definition it is increased enrollment in nutrition, housing, and energy assistance

programs. Across the board, the least effective recommendation among those modeled is case management for people who have left the TANF program.

When combined together, the recommendations result in a significant decrease in child poverty – especially using the NAS definition, but implementation would require significant fiscal expenditures.

Bolded percentages represent the single recommendation with the most significant impact on reducing the child poverty rate in Connecticut.

Recommendation	**Standard Poverty Rate (10.7%)**	**200% Poverty Rate (25.2%)**	**NAS Poverty Rate (10.9%)**
1. Guaranteed Child Care Subsidies, No Additional Employment	10.7%	25.2%	10.4%
2. Guaranteed Child Care Subsidies, including additional employment *(Model assumes 10,000 new subsidies.)*	**9.2%**	24.7%	9.5%
3. Increased Attainment of AA Degrees, hypothesizing lower employment and wage impacts	10.6%	24.5%	10.7%
4. Increased Attainment of AA degrees, hypothesizing higher employment and wage impacts. (*Model assumes 300,000 new AA degrees.)*	9.5%	**22.6%**	9.8%
5. Increased Attainment of GED degrees, hypothesizing lower employment and wage impacts	10.3%	25.1%	10.6%
6. Increased Attainment of GED Degrees, hypothesizing higher employment and wage impacts *(Model assumes 135,000 receive GEDs).*	9.8%	24.4%	10.1%
7. Increased Post-Secondary Job Training, hypothesizing lower employment and wage impacts	10.6%	24.8%	10.8%
8. Increased Post-Secondary Job Training, hypothesizing higher employment and wage impacts. *(Model assumes 300,000 adults receive additional job training.)*	10.5%	24.0%	10.5%

9. 85% Participation in SNAP			10.7%
10. 85% Enrollment Rate for Subsidized Housing, LIHEAP and WIC			**7.7%**
11. 85% Enrollment Rate for Medicaid/HUSKY			10.9%
12. Post-TANF Wage Supplement	10.5%	25.2%	10.8%
13. Case Management for TANF Leavers	10.7%	25.2%	10.8%
14. Full Payment of All Child Support Awards	10.4%	24.8%	10.6%
15. Combined impact of child care (#2), AA degrees (#4), GED degrees (#6), job training (#8), 85% enrollment in selected programs (#9, #10 and #11), post-TANF wage supplement (#12), case management for TANF leavers (#13), and full payment of all child support awards(#14).	7.4%	21.6%	4.9%

The economic modeling performed by the Urban Institute identified the Council's top three recommendations that were most likely to reduce child poverty in Connecticut. The recommendations are:

- Increase enrollment in subsidized housing, energy assistance and nutrition assistance
- Increase attainment of Associates Degrees
- Guarantee child care subsidies

COUNCIL RECOMMENDATIONS

The Council worked with Connecticut Voices for Children, Connecticut Association for Human Services, and Legal Assistance Resource Center of Connecticut to develop and recommend short-term low cost strategies to implement the Council's recommendations. The result was several realistic short-term strategies that the Council endorsed as priority recommendations for action:

1. EARNED INCOME TAX CREDIT: Maximize the benefits of the federal and the state Earned Income Tax Credit (EITC). *(COUNCIL PRIORITY RECOMMENDATION)*

a) Continue to raise public awareness of the *state* EITC with working poor families. Encourage the development and implementation of a statewide public awareness campaign led by Governor Malloy and various Connecticut entities to increase marketing efforts of the United Way and nonprofit free tax preparation providers.

2. PROMOTE POST-SECONDARY EDUCATION: Increase Attainment of Associates Degrees. *(COUNCIL PRIORITY RECOMMENDATION)*

a) Support additional investment in funds for certified and degree programs that meet the needs of employers in occupations with growth potential such as advanced manufacturing, health care and energy/utilities industry.

b) A major impediment to attainment of associate's degrees is the failure of many of the 70-80% of community college students who need remedial education to progress beyond remedial classes. Western Connecticut State University's Bridges program has agreements with the Danbury and Bethel school districts. WestConn professors work with middle school students and with high school students, administrators and teachers to reduce the need for remedial education. This effort includes offering placement tests for remedial education (AccuPlacer and a written test) in junior year of high school. *The program has reduced the need for remedial education by graduates of these high schools attending WestConn by half over the past seven years.* Each CSU college has some funding to replicate this program. WestConn's program also receives private support. Manchester Community College has a program with the Manchester and East Hartford school districts. There may also be interest by private higher education institutions in operating and private funders in supporting such programs. WestConn estimates it would cost about $50,000 per district to replicate. A state investment in future years could expand the program to all community colleges, covering all or most of the state's Priority School Districts.

c) Invest in additional funds in certificate and degree programs that meet the needs of employers in the fields that are growing and with substantial numbers of current workers retiring.

d) Ensure that every parent in Connecticut has a high school diploma.

e) The Board of Regents conducted a massive data project to analyze and inform all public school districts of their remedial education needs for graduates and the six-year college graduation rate of their high school graduates. http://www.ctregents.org/files/pdfs/p20/Supplemental%20Data%20Review%20for%20Superintendents%20-%20web.pdf . This data should inform decisions by the state Department of Education, in collaboration with superintendents,

teacher unions, parent groups, and advocates on how to reduce remedial education needs for high school graduates. This data should be collected and distributed every two years.

f) Replicate the "Achieving the Dream" model at community colleges to close student achievement gaps. There is not additional Bill & Melinda Gates Foundation funding available to expand the programs, but it may be possible to replicate using state funds or funds from other foundations.

g) Expand financial aid strategies to cover cost of living expenses: Charter Oak State College has a successful program to provide living expenses, including all tuition, books, internet costs and a computer, as well as continuous advisement, to a cohort of students. State and private funds supplement federal dollars. The program was not expanded to community colleges, as originally contemplated, due to cost.

3. INCREASE CONNECTICUT'S MINIMUM WAGE: *(COUNCIL PRIORITY RECOMMENDATION)*

a) Support raising the minimum wage in Connecticut from $8.25 per hour to $9.75 per hour as the most direct way to decrease children living in Connecticut.

4. EXPAND RENTAL ASSISTANCE PROGRAM (RAP): Increase Rental Assistance Program for Low Income Families *(COUNCIL PRIORITY RECOMMENDATION)*

a) Target Rental Assistance Program (RAP) certificates to families with children below the federal poverty level or the National Academy of Science (NAS) definition of poverty.

5. PROMOTE YOUTH EMPLOYMENT WITH A COMPREHENSIVE YOUTH EMPLOYMENT SYSTEM *(COUNCIL PRIORITY RECOMMENDATION)*

a) Provide tax credits for job creators that hire eligible teenagers and young adults for part-time and full-time employment.

b) Develop a School to Career Youth Employment Program that collaborates with the regional Workforce Development Boards to provide youth and young adults with job-training and skill development necessary for successful employment.

c) Develop critical job training and support programs for young parents, including basic education programs, job search and placement initiatives, and child care services

6. HOMELESSNESS:

Keep children out of homeless shelters.

a) Increase Rental Assistance Program certificates (RAPs) available to families with children, within available appropriations. The Council supports rental assistance programs prioritizing services to populations such as families involved in the child welfare system who are separated or at risk of permanent separation, young adults ages 18-24 who have aged out of the child welfare system and are homeless or at risk of being homeless, families with children with physical and mental health needs, and families with children living below the official poverty level or the alternative poverty level.

b) Re-open the Security Deposit Guarantee Program.

c) Continue to implement supportive housing for families with children (funded with $30 million in bonding during 2011 session and $1.5 million in 2012).

d) Align investments of state agencies in family housing between the Departments of Housing, Mental Health and Addiction Services, Social Services, and Children and Families to create pools of funds for housing vouchers, needed support services and creative use of federal funds.

e) Support the Northeast Hartford Initiative, a newly established national not-for-profit organization based in New York City whose mission is to strengthen communities to end homelessness.

EDUCATION:

7. EARLY CHILDHOOD EDUCATION:

a) Guarantee Child Care Subsidies: Within available appropriations, allow low-income parents up to 75% of the state median income (instead of the current 50%) to enroll in Care4Kids to reduce poverty, since it would improve the ability of parents to participate in the labor force, while providing safe, developmentally appropriate care for their children. This would need to be phased in over several years due to the cost.

b) In the short-term, and within available appropriations, increase eligibility to 75% of state median income for minor parents, including the parents of a minor parent in the income calculation. (This would address the small group of teen parents living with their parents, making it more likely that they would attend high school and graduate, and succeed economically.)

c) Create a "bridge" program, within available appropriations, to cover Care4Kids costs for providers between the time an application is submitted and approved (usually 60 days), to ensure that parents do not lose a job during the wait period.

8. YOUTH DROPOUT PREVENTION

Although youth dropout prevention is not one of the Council's priority recommendations, the Council believes the enforcement and implementation of existing truancy laws is of highest priority and supports efforts to address this issue.

a) Enforce existing law which requires districts to annually collect and report in the strategic school profiles truancy statistics and actions taken to reduce truancy.

b) Enforce existing law which requires school districts to: hold meetings with parents of truant students and appropriate school personnel within 10 school days of the child obtaining truant status; refer truant children to community agencies for services; and within 15 calendar days file a Families With Service Needs (FWSN) petition for truant children whose parents do not respond to school outreach efforts. Create new accountability mechanisms and penalties that allow the Department of Education to monitor local board follow-through and enforce compliance.

c) Ensure compliance with state and federal Child Find laws to identify students with special needs.

d) Expand from the current ten day window the time frame in which districts must immediately re-enroll students who have dropped out (formally through signing disenrollment forms).

e) Establish clear guidelines for alternative schools and programs, including a specific definition of what constitutes each type of program, entry and exit processes for students voluntarily or involuntarily placed into an alternative setting, and minimum requirements for curricular offerings and teacher training and credentialing.

f) Establish new accountability procedures for alternative schools and programs, including a list of all program locations, students served in each program, and annual educational data (including truancy, graduation rates, and test scores), publicly accessible online through a Strategic School profile or similar means.

g) Adopt the *National School Climate Standards* at the state level; expand and support local evidence-based school climate improvement initiatives.

h) Encourage districts to implement new or better utilize existing programs that reduce and appropriately address behaviors leading to involvement in the juvenile justice system, including graduated response models in school discipline codes, training of school personnel (including police) in conflict de-escalation and behavior management, school based diversion programs, and emergency mobile psychiatric services.

i) Require schools to track and report number of children arrested in school.

j) Require schools with high arrest rates to implement strategies to reduce those rates and address disproportionate minority contact issues.

k) Increase provision of wrap-around services in schools, particularly for mental health, by maintaining current funding levels for School Based Health Centers and encouraging partnership with local community providers to supplement district staff capacity by bringing community services into schools or referring students for services into the community.

7. WORKFORCE DEVELOPMENT FOR TEMPORARY FAMILY ASSISTANCE PROGRAM. Enhance GED and literacy programs for Temporary Family Assistance (TFA) participants.

    a) Endorse and support the proposals put forward by the JFES Enhancement Workgroup convened by the Department of Labor which address these issues.

    b) Modify C.G.S. § 17b-112(c) to apply the same federal poverty level income test that is used to determine TFA eligibility in the first 21 months to the first two six-month TFA extensions.

    c) Revise JFES operating principles to make the attainment of a secondary education credential a goal in addressing barriers to employment. The state should apply for federal and/or private grant opportunities for pilots to test various ways of expediting the attainment of a high school diploma/GED.

d) Establish pilot projects that would test service models that provide adult base education/GED and vocational education (I-Best model) and intensive, short-term GED programs. The state should apply for federal and/or private funding to help fund the pilots.

e) Adopt program to supplement income from work for parents who move from welfare to work and lose cash assistance because of earnings. Estimated cost of the program in past years was $1-2 million.

f) Eliminate the cliff in benefits by gradually lowering the cash benefit in TFA when a parent is working rather than terminating it entirely when family income exceeds the cash benefit amount. Cost depends on the design of the program.

g) Lower caseloads for case managers in the Jobs First Employment Services Program from the current level of between 110 and 150 cases per case manager to at most 80 – 100 cases per case manager, within available appropriations.

h) Support TANF waiver to allow states to test new ways of achieving better employment outcomes for needy families.

INCOME SAFETY NET:

9. SUPPORT FOR YOUNG MOTHERS ON TFA:

a) Coordinate with the state Dept. of Education on its $1.99M grant from the U.S. Dept. of Health and Human Services to develop programs in the "top five districts" for support of pregnant and parenting teens.

b) Coordinate with the DSS' HUSKY administrative services organization which will have some responsibility for care coordination during pregnancy.

10. ENHANCE ACCESS TO SUPPLEMENTAL NUTRITION PROGRAM:

The DSS should, within available appropriations, increase enrollment for federal energy and nutrition assistance programs administratively. The DSS should solicit specific recommendations from advocates (End Hunger CT, Hispanic Health Council, CAP agencies, CAHS, etc.) and discuss with Commissioner Bremby.

a) Streamline applications (simplifying application forms), improve access to DSS offices (including simpler, more easily understood communications from DSS),

increase efficiency of application processing, enhance outreach for SNAP and child nutrition programs, etc. DSS wants to increase efficiency in processing SNAP applications and services, and is under pressure from USDA to do so, but will need to hire additional staff to accomplish this. While this will cost the state in funding, continued slow processing will result in additional USDA fines; funding the positions and improve processing is therefore recommended for reasons of both service improvement and fiscal prudence.

b) Improve access, including on-line applications, a voice response phone system, and worker retraining through the first phase of DSS's "modernization" effort. Full implementation is at least 18 months away, but steps will be implemented in the interim. The second phase (involving replacement of DSS's computer system) is four to five years away, and 90 percent of the cost will be funded by the federal Affordable Care Act. A planning committee involving end-users, advocates, and DSS staff should determine how to speed implementation.

c) Change DSS internal procedures and external contract to create "integrated service delivery," "one-stop shopping" where clients who come to the agency or any contractor are provided with an array of services and informed of all programs for which they are eligible to enroll.

d) Improve communication between the Central DSS Office administrators and regional line staff to ensure that policies and procedures are implemented uniformly throughout the state.

- Examine best practices at DSS regional offices and work to apply these across regions to simplify the application process and optimize use of existing resources.

- Improve signage in DSS offices so people don't wait in wrong line – and/or adopt the "bank" method: one line from which you are sent to the correct workstation based on your issue (would probably need a worker to talk to people in line and identify what workstation they need to go to).

- Assign specific front-desk staff to deal with clients as they enter DSS offices so that practices are consistent.

- Implement and enforce consistent rules about how documents can be delivered. Implement consistent policies about logging in documents so that documents are not lost.

e) Grant expedited SNAP (food stamp) benefits pending an interview. Presently, some applications for expedited food assistance are not processed because the

applicant cannot be reached for an interview within the seven day time frame. This policy change would require a waiver from the federal FNS. The policy change would be most useful with mail-in applications or applications taken by community outposts.

FAMILY STRUCTURE AND SUPPORT

11. REDUCE TEEN PREGNANCY
As noted in #7 above, the CDC awarded the City of Hartford $4.5 M for reducing teen pregnancy by 10%.

12. CASE MANAGEMENT FOR EMPLOYMENT-RELATED SERVICES
Case management for all mothers of high risk newborns for the first twelve months after birth.

Although, support for young mothers on TFA is not one of the Council's priority recommendations, the Council fully supports program models such as Child First and other home visitation programs designed to assistance young mothers on TFA.

PROCESS RECOMMENDATIONS:

13. IMPROVE POVERTY MEASURE: Conduct a review of alternative measures of poverty using an Economic Modeling consultant and monitor the federal government and other states addressing this issue.

Census information on the new supplemental poverty measure (SPM) for 2012 shows a three year average of poverty rates for the two measures for U.S. totals and for each state. Child poverty rate using this measure is not available for each state.

The new measure includes both a more comprehensive list of "costs" as well as "income" sources. There is also an adjustment for cost of living. Using the three year estimate (2009-2010) the SPM poverty rate for Connecticut (12%) was higher than the official poverty rate (9.2%). The report indicates that geographic adjustments for housing costs, a different mix of housing tenure or metropolitan are status, or higher nondiscretionary expenses such as, taxes or medical expenses may attribute to the higher SPM.

14. COORDINATION AND SYSTEMS

a) State agencies' employees (and their contractors) should be made aware of various services across agency lines administratively, and little cost. For example, eligibility is the same for SNAP and school meal programs operated by local districts through

SDE. These agencies could collaborate initially to publicize to enrollees for one program their eligibility for the other, and could eventually have common applications.

b) Technology used by various state contractors, including screening tools and navigators operated by 2-1-1, CAPs, CAHS, End Hunger CT, and others can facilitate benefit eligibility determinations and enrollment. Integrate these tools to improve the quality of applications and recertifications for SNAP and other benefits submitted to DSS, which proved successful in the recent Disaster SNAP program implementation.

c) Create a master contract or coordinated leadership team across agencies and branches of government:

- Coordinate between DCF and DMHAS to ensure services to clients aging out of DCF services.

- Implement recommendations of the Achieving Administrative Efficiencies Workgroup of the Commission on Nonprofit Health and Human Services, March, 2011.

IV. Progress Report

This section of the report describes implementation of the Council's plan to reduce child poverty, including the extent to which state actions are in conformance with the plan and progress made toward reducing child poverty.

A. Trends in Child Poverty in Connecticut

The Council's child poverty goal is to reduce poverty among children in Connecticut by 50% over ten years. When the Council's ten-year plan was released in 2005, the most up-to-date figures on child poverty were based on 2003 census figures. Currently, the most recent figures are based on 2013 census data. The Council continues to focus on reducing child poverty both among "very poor" households with income below 100% of the federal poverty level ($19,530 for a family of three and $23,550 for a family of four in 2013)[16] and "poor" households with income below 200% of the federal poverty level ($39,060 for a family of three and $ 47,100 for a family of four in 2013)[17]. Because Connecticut has a high cost of living, both measures are used in order to give a more complete picture of poverty in Connecticut. The 200% FPL measure roughly corresponds to Connecticut's Self-Sufficiency Standard, a measure of the income necessary for a family to meet basic needs.

To measure the child poverty rate in Connecticut, the Council uses findings from two U.S. Census Bureau surveys: the American Community Survey (ACS) for data on households with income below 100% of the federal poverty level and the Current Population Survey (CPS) for those with income below 200% of the federal poverty level. The Council uses ACS for the "very poor" household data because it is a more statistically valid and reliable data. CPS surveys approximately 100,000 households nationally each year, while ACS surveys approximately 3 million households each year. The relatively large sampling errors of state-level estimates using CPS limit its usefulness. Because of its large sample size, the ACS provides the best survey-based state-level income and poverty estimates available. The sample size of the ACS makes it exceptionally useful for state-level analysis. ACS now has the capability to produce data on families with income below 200% of the federal poverty level. However, for consistency the Council will continue to use the CPS data to measure the number of children living in families with income below 200% of the federal poverty level.

[16] See http://aspe.hhs.gov/poverty/13poverty.cfm;

[17] Source: U.S. Department of Health and Human Services Poverty Guideline 2013. Annual amount calculated by the Office of Policy and Management

In 2013, Connecticut's child poverty rate for "very poor" households with income below 100% of the federal poverty level was 14.5%, a slight decrease from the 2012 child poverty rate of 14.8%. Connecticut's child poverty rate of 14.5% remains substantially below the national child poverty rate of 22.2%. Connecticut had the 8th lowest child poverty rate in the nation where child poverty rates range from 10.2% in New Hampshire to 34.0% in Mississippi.

For "poor" households with income below 200% of the federal poverty level, Connecticut's child poverty rate in 2013 was 29.9% which represents an increase over the previous year's rate of 25.4%. Using this measure the national child poverty rate is 42.6% and Connecticut had the 2nd lowest child poverty rate of all the states and D.C. where child poverty rates range from 29.4 in New Hampshire to 57.5% in Arizona.

Using these sources, the child poverty rate in Connecticut has been:

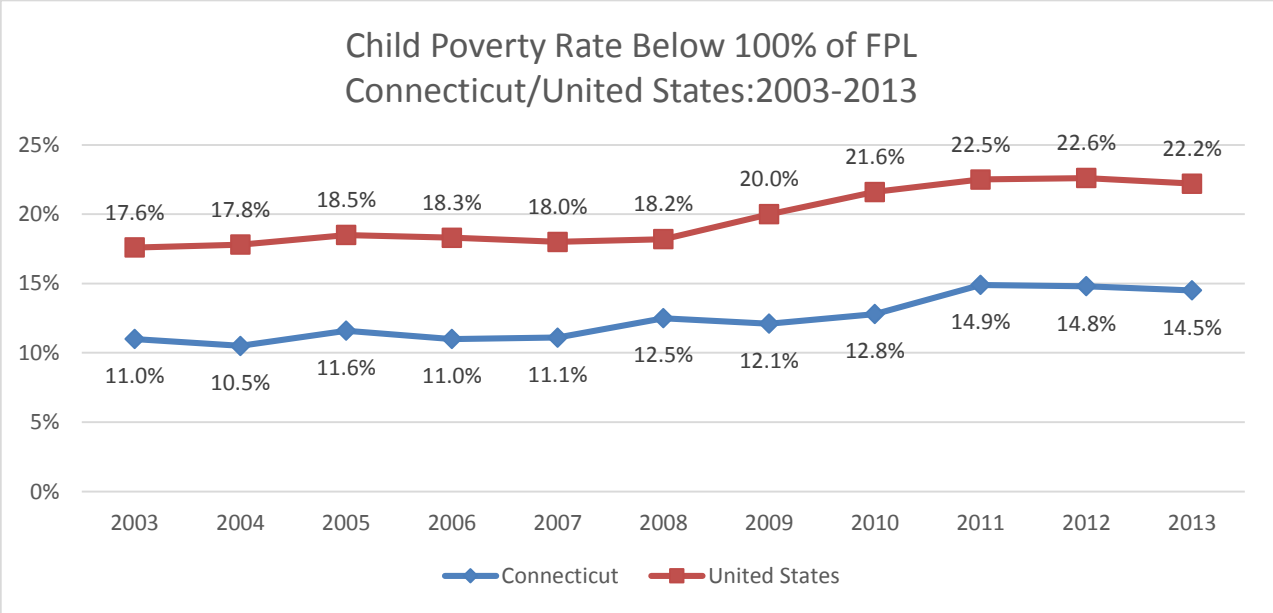
Children Poverty in Connecticut and United States
2003-2013

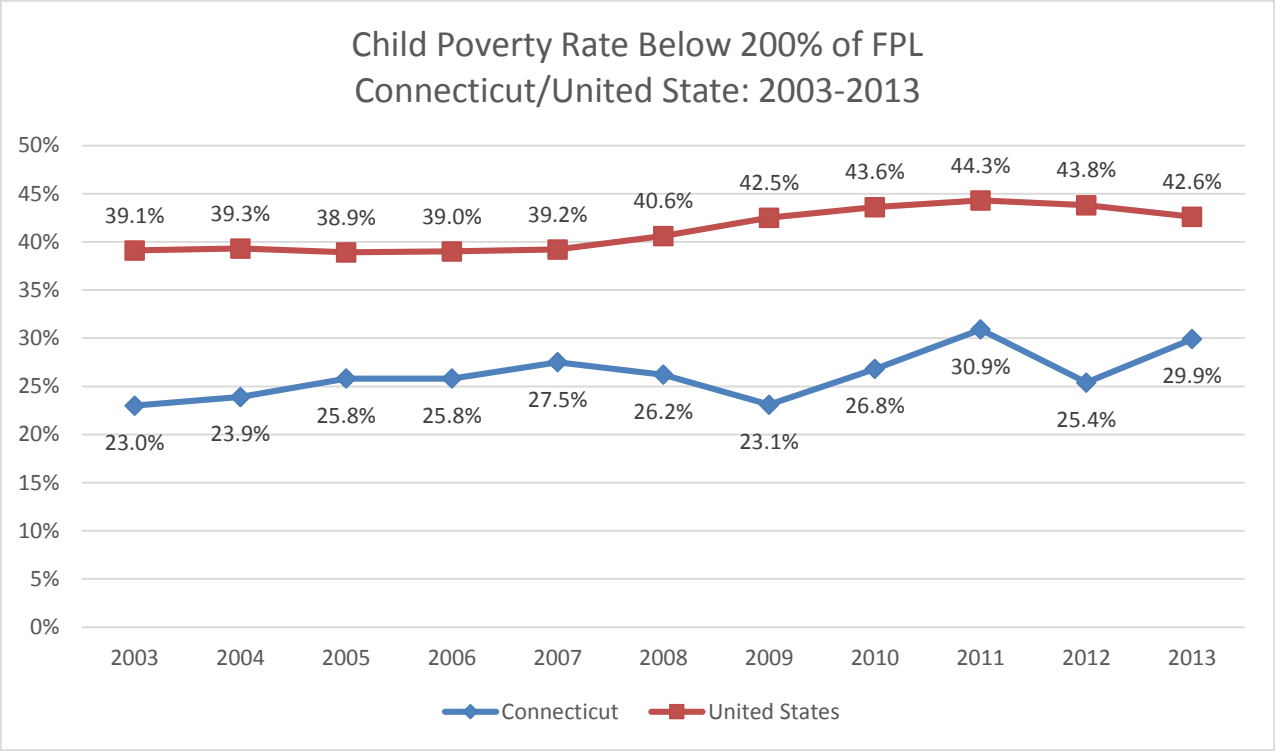
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Percent of children under 18	11.0%	10.5%	11.6%	11.0%	11.1%	12.5%	12.1%	12.8%	14.9%	14.8%	14.5%
Percentage of children under 18 United States	17.6%	17.8%	18.5%	18.3%	18.0%	18.2%	20.0%	21.6%	22.5%	22.6%	22.2%
Connecticut rank among states	48	50	46	49	47	42	49	50	45	47	43

All "Low Income" Children in Connecticut and United States
Households with Income Under 200% of the Federal Poverty Level
2003-2013

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Percentage of children under 18	23.0%	23.9%	25.8%	25.8%	27.5%	26.2%	23.1%	26.8%	30.9%	25.4%	29.9%
Percentage of children under 18 United States	39.1%	39.3%	38.9%	39.0%	39.2%	40.6%	42.5%	43.6%	44.3%	43.8%	42.6%
Connecticut rank among states	48	47	48	49	48	50	50	50	47	50	49

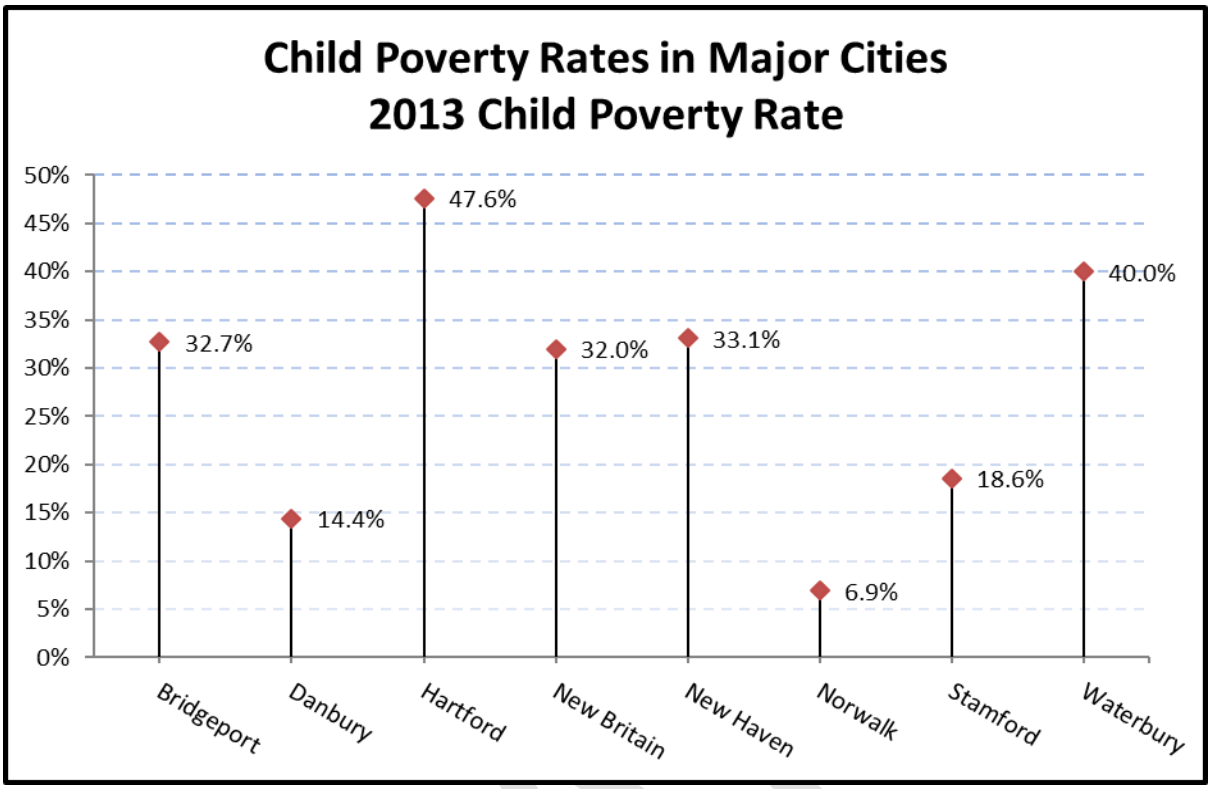
The charts below depict child poverty rates of children living below 100% and 200% of the federal poverty levels in Connecticut and the United States from 2003-2013.





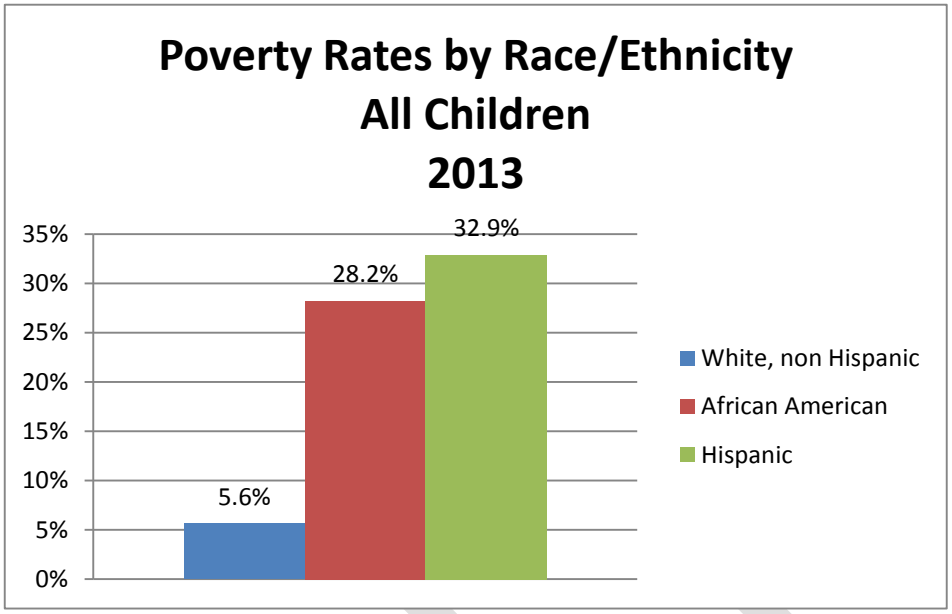
In 2013, rates of child poverty in Connecticut continue to vary significantly based on location. The percentage of children living in poverty in Connecticut's cities with a population over 65,000 was: Bridgeport (32.7%), Danbury (14.4%), Hartford (47.6%), New Britain (32.0%), New Haven (33.1%), Norwalk (6.9%), Stamford (18.6%) and Waterbury (40.0%)[18]. Child poverty rates also vary by family structure as single parent families with related children are more likely to live in poverty than married couples with children. In 2013 the poverty rate for married couple families with related children was 3.7% and the poverty rate for single parent families with related children was 32.2%[19]. The chart on the following page illustrates the disproportionate impact of poverty on children based on location.

[18] U.S. Census Bureau, 2013 American Community Survey Chart S1701
[19] U.S. Census Bureau, 2013 American Community Survey Chart S1702



Racial and ethnic disparities persist Black and Hispanic children are more likely to live in poverty than white children. According the Children's Defense Fund, 28.2% of black children and 32.9% of Hispanic children live in poverty as compared to 5.6% of white children[20]. The chart on the following page illustrates the disproportionate impact of poverty on some of the state's children.

[20] Children's Defense Fund; Child Poverty in America 2013: State Analysis, September 29, 2014



B. Implementation of the Plan and State Actions in Conformity

Included below are the Council's priority recommendations and a synopsis of state actions taken or becoming effective in 2014 to address child poverty. Since taking office in January 2011, Governor Malloy has undertaken a comprehensive array of reforms that will likely result in a reduction in child poverty over the coming years.

FAMILY INCOME AND EARNINGS POTENTIAL:

- **State Earned Income Tax Credit (EITC).** The ETIC was implemented for the first time for the 2011 tax year. For the 2012 tax year (claimed in the 2013 filing season), Connecticut's refundable EITC assisted 186,734 families with a total of $112,245,946 in benefits. During the 2013 legislative session, the state EITC was reduced from 30% to 25% of the federal credit for the 2013 tax year; however, for the 2014 tax year it will increase to 27.5% and then be restored to 30% for subsequent tax years.

- **Minimum Wage Increase.** During the 2013 legislative session, the minimum wage was increased to $9.00 through two phased-in increases. Effective January 1, 2014, the hourly minimum wage will increase from $8.25 to $8.70. It will then increase to $9.00 effective January 1, 2015[21].

- **Asset Building.** The Individual Development Account (IDA) program is a special matching savings account designed to help low-income individuals and families save money to purchase assets. The state contributes a maximum of $2 for every $1

[21] PA 13-117, An Act Increasing the Minimum Fair Wage

a participant contributes with a maximum of $3,000 per participant. Legislation passed in 2013[22] allows money saved in IDAs to be used for a variety of specified purposes, instead of limiting it to only one, as under prior law. Since the program began in 2000, a total of $5,419,363 has been allocated to provide 962 IDAs statewide, resulting in more than 407 asset purchases to date.

HOUSING AND HOMELESSNESS PREVENTION:

When Governor Malloy took office in 2011, he recognized that safe, affordable housing is essential to our future as a state and that when the state invests in housing, the state invests in people, communities and our economic future. Stable housing affects the quality of the state's neighborhoods, education of our kids, health of our citizens and opportunity for individuals and families to live in thriving communities. Governor Malloy has made an historic investment in affordable housing over the past few years.

- **Affordable Housing.** Developing and rehabilitating our state's affordable housing stock is crucial to increasing the affordable housing options for workers, young professionals, and low-income families. The FY 2013 state budget authorized $50 million in FY 2012 and an additional $70 million in FY 2013 for a total of $120 million in capital funds to revitalize and develop new units of affordable housing across the state. The FY 2015 state budget authorized an additional $136 million in capital funding over the biennium (approximately $70 million in each fiscal year).

- **Public Housing Revitalization**. The state budget authorized $90 million in bonding ($30 million in each year FY13-15) as the first three years of a ten year commitment of $300 million to preserve and upgrade this housing, bringing deteriorated and vacant units back on line. Funding is supported with an additional $1.5 million each year for 150 new RAPs to ensure an adequate ongoing revenue stream to prevent future deterioration. Several properties have already been redeveloped under this initiative and many more are in different stages of construction following the State-Sponsored Housing Portfolio Capital Plan, which outlines the plan to revitalize more than 340 properties over 10 years.

- **Incentive Housing Zones.** $1 million in the current biennium budget was added to the $2 million from the last biennium budget for financial incentive payments to help municipalities plan for and create mixed-income housing that is critical to attracting and retaining young professionals, working families, retirees, and people in public service jobs. Legislative changes to the program facilitated the ability to manage limited funds and ensure that funding is targeted to those municipalities that are taking steps to develop affordable housing for their residents. Since 2008, 69

[22]§§ 1 & 2, PA 13-140, An Act Concerning Technical and Other Changes to the Labor Department Statutes

municipalities have received grants for planning for or creating these zones. 9 municipalities have adopted incentive housing zones and several more are in the process of adoption. Municipalities receive $20,000 for zone adoptions and Old Saybrook received a building permit payment of $15,000 for construction in their zone.

- **Rapid Re-Housing.** Rapid Re-Housing is short-term financial assistance and services such as case management, outreach, and housing search assistance for individuals and families who are in emergency shelters or on the streets and need temporary assistance in order to obtain and retain housing. The General Assembly included funding in the FY 2015 state budget, but repurposed it exclusively for rapid re-housing activities and homeless prevention in Southeastern Connecticut, through the Norwich/New London Continuum of Care. The FY2015 adjusted budget included another $650,000 for rapid re-housing through carry forward funding from FY 2014.

- **Establishment of the Department of Housing.** Governor Malloy created the new Department of Housing (DOH) to consolidate and streamline widely dispersed state housing functions in a single agency. DOH provides leadership for the state's housing policy issues and develop strategies to encourage the provision of housing in the state, including housing for very low, low, and moderate income families.

- **Supportive Housing.** Supportive housing is a successful and cost-effective approach to addressing homelessness by creating permanent affordable housing with services. The FY 2013 state budget authorized $30 million in capital funding for 150 new units of supportive housing, coupled with an annualized $2.6 million for operating and support services. An annualized $1.5 million ($375,000 beginning in April 2013) was also included to support an additional 150 Rental Assistance Program (RAP) certificates for scattered site supportive housing. The FY 2015 state budget built on these investments by authorizing an additional $20 million to develop 100 new units of supportive housing – targeting families involved in the child welfare system -- with an annualized $1 million for rental assistance subsidies and $1 million for services. Additionally, legislation[23] in 2013 authorized Department of Social Services (DSS), Department of Mental Health and Addition Services (DMHAS), Department of Correction (DOC), Office of Policy and Management (OPM), and Court Support Service Division (CSSD) to develop a plan to provide supportive housing services, including housing rental subsidies, during FY 2014 and FY 2015 for an additional 160 individuals and families who frequently use expensive state services.

[23] §60, PA 13-247, An Act Implementing Provisions of the State Budget for the Biennium Ending June 30, 2013 Concerning General Government

- **Greater New Haven Behavioral Health Collaborative.** The 2014-2015 state budget allocated $2 million to replace the loss of federal Substance Abuse and Mental Health Services Administration (SAMHSA) funding to DMHAS for housing and support services for individuals housed in Permanent Supportive Housing programs. Participants receive individualized services based on need and support services such as employment, expedited referral to Social Security benefits, case management, independent living skills training, peer support, increased access and referral to medical and dental services, smoking cessation, budgeting, tenancy issues, in-home clinical supports and referral to out-patient clinical supports.

- **Department of Children and Families (DCF) Family Reunification RAPS.** The 2014-2015 state budget transferred $1 million ($500,000 in each fiscal year) from DCF to the new DOH to support 50 new RAPs for DCF families seeking to be reunified with their children in the care and custody of DCF.

- **Scattered Site Supportive Housing.** The 2015 state budget authorized $1.1 million to support 110 new RAP certificates to be administered through the DOH. RAP is the major state-supported program for assisting very low income families to afford decent, safe, and sanitary housing in the private market. Participants find their own housing, including apartments, townhouses, and single-family homes. An additional $1.1 million is allocated to DMHAS to support wrap around services for individual living in the scatter housing units. Services are individualized based on the level of need of the client and include support services such as case management, independent living skills training, peer support, and budgeting, tenancy issues and referrals to clinical supports.

- **DCF Homeless Youth Program.** Public Act 10-179[24] established a program within DCF for youth who are at risk of becoming homeless. The FY 2015 state budget includes an additional $1 million to expand DCF's Homeless Youth Program, which is designed to provide transitional living services to youth who are homeless or at risk of becoming homeless. The program provides: respite housing; host homes; family mediation; street outreach; crisis housing services; and survival aides to youth. Additional funding allows DCF to serve youth not associated with the department; increase the age for eligible youth from 18-24 to 16-24 and doubles the capacity from 35 youth to 75 youth. DCF will provide $50,000 to the Connecticut Coalition to End Homelessness to conduct a Homeless Youth Count in 2015. Connecticut will be the first state to engage in a statewide effort to count the number of homeless youth.

- **Housing Assistance Fund**. The FY 2015 state budget authorized $1 million in funding for the Housing Assistance Fund (HAF). The HAF provides rental

[24] § 28-30, PA 10-179, An Act Making Adjustments to State Expenditures for the Fiscal Year Ending Jun 30,2011

assistance and security deposit loans to persons with psychiatric disorders until permanent affordable housing becomes available. DMHAS currently funds 16 private non-profit agencies throughout Connecticut to provide rental subsidies and security deposit loans. In FY 2014, approximately 400 individuals and families received a HAF subsidy.

EARLY CHILDHOOD EDUCATION:

- **Early Childhood System.** Public Act 14-39[25] established the Office of Early Childhood (OEC) to provide a comprehensive, collaborative system for delivering improved program and services to children age zero to five and their parents. Previously, this office existed under PA 13-184[26] and Executive Order No. 35 (June 24, 2013).

- **School Readiness.** The 2014-2015 state budget authorized $11.5 million to OEC for 1,020 additional pre-kindergarten (Pre-K) spaces for low income children in Priority, Alliance and Competitive School Districts.[27] This expansion is part of a five year plan to incrementally increase the capacity of the school readiness program to serve a total of 4,010 additional children by the end of 2019. Access to additional Pre-K spaces will be phased-in and low-income children ages 3 and 4 will be given first priority to fill the additional spaces. An additional $1.275 million [28] is included in OEC's budget for startup costs for additional pre-K seats in school readiness programs.

- **Universal Pre-Kindergarten**. OEC allocated $600,000 for School Readiness Quality Enhancement funding for pre-kindergarten planning grants at the district and regional level for fiscal year 2015. The purpose of the grants is to provide funding for programs that focus on education and early care that address quality standards and/or expand comprehensive services for children and families. OEC is in the planning phase of this project.

- **Safe School Climates.** Public Act 14-172[29], allows OEC to offer a competitive grant, in collaboration with the Department of Education, for up to three Alliance School Districts to develop and implement a strategy to promote the social and emotional

[25] §4, PA 14-39, An Act Establishing the Office of Early Childhood, Expanding Opportunities for Early Childhood Education and Concerning Dyslexia and Special Education
[26] PA 13-184 An Act Concerning Expenditures and Revenue for the Biennium Ending June 30, 2015
[27] PA 14-39, An Act Establishing the Office of Early Childhood, Expanding Opportunities for Early Childhood Education and Concerning Dyslexia and Special Education and PA §17,14-47, An Act Making Adjustments to State Expenditures and Revenues for the Fiscal Year Ending June 30, 2015
[28] IBID.
[29] PA 14-172, An Act Concerning Improving Employment Opportunities Through Education and Ensuring Safe School Climates

well-being and health of children age three to third grade. The program will focus on instructional tools and family engagement. Funds may come from public, private, federal or philanthropic sources.

- **Access to Pre-School Programs for DCF Children.** Public Act 14-1-22[30], requires DCF, in consultation with the OEC, to adopt policies and procedures that maximize enrollment of children, who are placed in out-of home care by DCF, in eligible preschool programs. A workgroup has been established to address the requirements of this legislation.

- **Smart Start Program.** Public Act 14-41[31], requires OEC, in consultation with the DOE, to design and administer the Connecticut Smart Start competitive grant program for local and regional boards of education to establish or expand preschool programs. The program must provide grants for capital and operating expenses. The act requires OEC to give preference to programs serving children from low-income families who live in towns with unmet preschool needs. This is a ten year initiative totaling $205 million. For each year, $10 million is for capital improvement bonds to renovate existing public school classrooms and $10 million in operating expenses.

- **Two-Generational School Readiness Plan.** Public Act 14-217[32], requires the Commission on Children to develop a two-generational school readiness plan to promote long-term learning and economic success for low-income families by addressing intergenerational barriers to school readiness and workforce readiness with high-quality preschool, intensified workforce training and targeted education, coupled with related support services. The plan must include recommendations for: (1) promoting and prioritizing access to high-quality early childhood programs for children ages birth to five years who are living at or below one hundred eighty-five per cent of the federal poverty level; (2) providing the parents of such children with (A) the opportunity to acquire their high school diplomas, (B) adult education, and (C) technical skills to increase their employability and sustainable employment; and (3) funding for implementation of the plan, including, but not limited to, use of the temporary assistance for needy families program and other federal, state and private funding. A report on the plan must be submitted to the legislative committees on children, education, workforce development and appropriations by December 1, 2014.

[30] PA 14-22, An Act Concerning Access to Preschool Programs in the Care of the Department of Children and Families
[31] PA 14-41, An Act Establishing the Smart Start Program
[32] §198, PA 14-217, An Act Implementing the Provisions of the State Budget for Fiscal Year Ending June 30, 2015.

- **Achievement Gap Task Force.** Public Act 11-85[33] established an Achievement Gap Task Force to address the academic achievement gaps in Connecticut by considering effective approaches to closing the achievement gaps in elementary, middle and high schools. An Interagency Council on Ending the Achievement Gap was created and in 2014, a draft master plan to eliminate the achievement gap was developed to: (1) identify the achievement gaps that exist among and between cohorts; (2) focus efforts on closing the achievement gaps; and (3) establish annual benchmarks for implementation of the master plan. Each member state agency has identified critical first steps in implementing portions of the plan.

- **After-School Programming.** The 2014-2015 state budget authorized $4.5 million to support 26 after-school programs, serving 4,421 children throughout the State.

HIGHER EDUCATION/WORKFORCE DEVELOPMENT:

- **Transform CSCU 2020.** This is a long-term, multi-phase initiative to improve the student experience by uniting 17 colleges and universities within the Board of Regents. The 2014-2015 state budget authorized $42 million for:

    - **Developmental Education**. $10.8 million to continue support of development programs and implementation of best practices to ensure that all students enrolled in the Board of Regents' colleges and universities have the support needed to succeed.
    - **Go Back to Get Ahead Program** $6 million to support Connecticut residents previously enrolled in college, but have not completed a degree. Eligible students may receive up to three free courses in pursuit of a college degree at state universities and colleges.
    - **Early College Experience**. $1million to provide planning funds to allow high school students to earn college credits and experience high-tech disciplines in preparation for the 21st century.
    - **Operations and Tuition Support**.-$24.2 million allows the Board of Regents to maintain tuition costs at a reasonable level for the 2014-2015 academic year.

- **Baby CHET Scholars Program.** Public Act 14-217[34] established this program, which builds on the success of the state's 529 college savings plan, the Connecticut Higher Education Trust (CHET). The CHET Baby Scholars program is capitalized with $4.4 million from a portion of the assets of the defunct Connecticut Student Loan Foundation and potential contributions from taxpayers through an income tax check-off. The program provides a one-time incentive of $100 to families of

[33] PA 11-85, An Act Closing the Academic Gap
[34] §§ 27-34, PA 14-217, An Act Implementing Provisions of the State Budget for the Fiscal Year Ending June 30, 2015

Connecticut children who open a CHET 529 savings account by the child's first birthday, or within a year after adoption. Families who make an additional contribution of $150 within four years of the child's first birthday or adoption will receive a one-time match of $150. If this investment is done in the child's first year of life, a $400 total contribution in an interest-bearing CHET account could grow to $1,350 by the time the child reaches age 18 and is ready to pursue higher education.

- **Next Generation Connecticut.** This initiative expands the educational opportunities, research, and innovation in the science, technology, engineering, and math (STEM) disciplines over the next decade, by authorizing $1.5 billion in bond funds, and operating support of $15 million beginning in FY 2015 to:
    - Hire 259 new faculty (of which 200 will be in STEM);
    - Enroll an additional 6,580 talented undergraduate students;
    - Build STEM facilities to house materials science, physics, biology, engineering, cognitive science, genomics, and related disciplines;
    - Construct new STEM teaching laboratories;
    - Create a premier STEM honors program;
    - Upgrade aging infrastructure to accommodate new faculty and students;
    - Expand digital media and risk management degree programs and provide student housing in Stamford; and
    - Relocate UConn's Greater Hartford Campus to downtown Hartford.

- **Subsidized Training and Employment Program (STEP-UP).** Public Act 14-98[35] authorized $10 million in additional funding for the STEP-UP program. STEP-Up provides wage and training subsidies to employers that hire an unemployed jobseeker. The program, administered by the CT Department of Labor and the state's five Workforce Investment Boards, helps small businesses hire employees and expand their workforce. Step-Up features two types of hiring incentives: (1) a wage subsidy, which helps pay a new employee's salary (up to $12,000) for the first six months of employment and (2) a training grant that provides employers up to $12,500 over 180-day period to train a new employee.

- **Developmental/ Remedial Education**. In 2012, legislation passed directing public community colleges and state universities to reconfigure how remedial/ developmental education is delivered. It also required public high schools to align

[35] §9 (c), PA 14-98, An Act Authorizing and Adjusting Bonds of the State For Capital Improvements, Transportation and Other Purposes, and Concerning Miscellaneous Program, Including The Smart Program, The Water Improvement System Program, School Security Grants, The Regenerative Medicine Research Fund, The Connecticut Manufacturing Innovation Fund and the Board of Regents For Higher Education Infrastructure Act.

their curriculum as described by the Common Core State Standards to ensure that graduates are ready for college level work. The 2014-2015 state budget authorized $10 million for colleges to partner with adult education providers to deliver the lowest level of developmental education and related student support services. The program is currently in the first semester of implementation across the Connecticut State Colleges and Universities system.

- **Governor's Scholarship Program.** Administered through the Office of Higher Education, this program $43.6 million in FY 2015 for need and merit based student financial aid for college students attending both public and private institutions of higher education in the state, by consolidating four financial aid programs. For FY 2014, the Governor's Scholarship Program provided funding to 19,789 Connecticut students attending state colleges and universities.

- **Incumbent Worker Training Program.** Public Act 13-140[36] combined the Twenty-First Century Program previously administered by DOL, with the Incumbent Worker Training Program, administered by the Workforce Investment Boards, into one program. In FY 2014, DOL expended about $700,000 in Incumbent Worker training funds for 2,061 employees and contracted with 88 Connecticut employers. While the legislation governing the Incumbent Worker Training required that a minimum of 50% of the funds go to new employers, DOL surpassed the requirement with 81%.

- **Small Business Express Program.** C.G.S. Section 32-7g requires DECD to provide small businesses with various forms of financial assistance, using a streamlined application process to expedite assistance. Priority for available funding is given to those eligible applicants who (1) are creating new jobs and (2) are within Connecticut's economic base industries, including, but not limited to: precision manufacturing, business services, green and sustainable technology, bioscience, and information technology sectors. As of December 2014, 1,220 businesses received financial assistance; $60 million private investments were leveraged; over $173 million state investments; 4,542 jobs created and 12,791 jobs retained.

INCOME SAFETY NET

Case Management for Employment Related Services. Jobs First Employment Services (JFES) serves families receiving state cash assistance, Temporary Family Assistance (TFA), through a partnership with DSS, DOL and the Workforce Investment Boards. In 2014, over 15,000 participants received employment services such as job search assistance; vocational education; adult basic education; subsidized employment; case

[36] PA 13-140, An Act Concerning Technical and Other Changes To The Labor Department Statutes

management; and transportation benefits. Childcare subsidies are also provided to participants by the OEC.

ENHANCE ACCESS TO SUPPLEMENTAL NUTRITION PROGRAM

Supplemental Nutrition Assistance Program (SNAP). SNAP, formerly Food Stamps, provides monthly benefits to help eligible families and individuals afford food purchases. Benefits are provided electronically, enabling clients to use a debit-type swipe card at food markets for federally approved purchases. The general income limit is 185% of the federal poverty level.

As a result of a technical change included in the federal Farm bill signed into law on February 7, 2014, nearly 50,000 Connecticut households were at risk of losing vital food benefits through the SNAP program. The change included a provision that required households to receive a Low Income Home Energy Assistance Program (LIHEAP) benefit greater than $20 in order to automatically qualify for the Standard Utility Allowance under SNAP. In response to this federal change, Governor Malloy took decisive action to protect these families. By directing the expenditure of $1.4 million in available federal energy assistance funding, the Governor was able to preserve approximately $66.6 million annually in SNAP benefits for these needy households.

FAMILY STRUCTURE AND SUPPORT

Teenage Pregnancy Prevention Initiative, designed to prevent first-time pregnancies in at-risk teenagers, targets the urban areas of Bridgeport, East Hartford, Hartford, Killingly, Meriden, New Britain, New Haven, New London, Norwich, Torrington, Waterbury, West Haven, and Willimantic. In 2014, the programs served 830 individuals. In addition to the above services, Social Work Services staff provided more than 100 educational and training sessions to community members, professional associations, agency and staff of DSS social work programs and services. Staff continues to develop practice standards for the agency's social work programs, program databases to track client services and outcomes and revised regulations to comply with recent statutory changes.

V. Council Activities

The Child Poverty and Prevention Council is working with the Departments of Labor and Social Services to develop recommendations to reform the state's implementation of the federal Temporary Assistance for Needy Families (TANF) program. Top officials at the DOL and DSS agreed to take the lead on this initiative.

In January 2014, the DOL and DSS established a TFA/TANF Redesign Workgroup to review the federal and related state program components that have evolved since the TANF Block Grant was instituted in Connecticut and determine if Connecticut is meeting the goals of the TANF Block Grant and, more specifically, the goals of Connecticut's Jobs First Employment Services (JFES) and Temporary Family Assistance (TFA) programs.

Early in the process, DOL and DSS determined the need to create two separate working groups; the TFA Policy Workgroup and the JFES Employment and Training Workgroup to complete its work. The workgroups consist of key staff from DOL, DSS, DCF, SDE, Commission on Children, Office of Child Advocacy, Judicial Branch, Workforce Investment Boards (WIB), Connecticut Women's Education and Legal Fund (CWEALF), University of Connecticut, Mothers for Justice, and members of the Child Poverty and Prevention Council.

The TFA/TANF Redesign Workgroup agreed to address concerns identified with the current TANF/JFES/TFA service delivery model:

- Current focus is on work activities and not job or employment outcomes in occupations that are in demand;
- Current focus is on referrals for eligible adults rather than comprehensive services for the family;
- Current assessment tools are antiquated and not uniform;
- Connecticut's 21-month time limit presents a significant challenge for barrier reduction, basic skills attainment and vocational skill development; and
- Multiple state and community agencies working with mutual clients and are not properly communicating and providing appropriate and relevant services. Data metrics are not sufficient to measure employment or self-sufficiency outcomes.

The TFA/TANF Workgroup also agreed in order to proceed in a new direction the recommendations should:

- Implement efficient and/or effective ways to help participants with employment entry, retention, advancement and access to employment with earnings and advancement to avoid dependence on government benefits
- Build on existing evidence-based models for improving employment outcomes such as Vocational Education combined with Contextualized Adult Basic Education or Intensive, Accelerated Adult Basic Education
- Develop and pilot alternative and innovative strategies, policies, and procedures designed to improve skill assessments and employment outcomes

Over the past several months, the TFA/TANF Redesign Workgroup engaged in many discussions on TFA and JFES policies and procedures to explore viable alternatives to the current TFA/TANF programs. The workgroups identified innovative practices through literature review and discussions with other states on innovative practices of TFA/TANF/JFES programs to determine the appropriate service delivery model for assisting families in establishing self-sufficiency and maintaining employment in Connecticut.

To further identify appropriate innovative practices the TFA/TANF Redesign Workgroup held a forum in September 2014, titled "Improving Pathways to Employment: Best Practices Forum." Local and national experts were invited to present and discuss information specific to TFA policies and employment & training opportunities that Connecticut may consider adopting. The presenters included: Connecticut State Representative Toni Walker, House Chair - Appropriations Committee; LA Donna Pavetti, Vice President for Family Income Support Policy - Center on Budget and Policy Priorities; Brian Campbell, Special Assistant to the Administrator - District of Columbia; William Durden, Policy Associate - Washington State Board for Community & Technical Colleges; Rochelle Finzel, Group Director - National Council of State Legislatures; and Charisse Hutton, Director - Support Enforcement Services, Connecticut Judicial Branch - Court Operations.

The TFA Workgroup was tasked with the responsibility of identifying and determining the effectiveness of current TFA policies. To assist the TFA Policy Workgroups in developing its recommendations, DSS designed and administered a survey to obtain pertinent information related to current TFA policies. DSS distributed the survey to its Eligibility Supervisors, State Legislators and TFA Policy Workgroup members. Based on the results of the survey, the workgroup identified and agreed that the recommendations will focus on the following policy areas:

- Need Assessment - an evaluation to determine unmet needs, eligibility for programs and services, barriers to employment and employment potential
- Time-Limits - limits benefits for eligible households to 21 months
- Income Cliff - occurs when a family's income rises above the payment standard resulting in a sudden loss of benefits

- Benefit Level – pre-determined financial support to low-income families meeting standard eligibility criteria
- Family Cap – restrict increase in benefits for additional children conceived while the mother is on assistance
- Assets Limit – the amount of allowable assets used to determine TFA eligibility
- Exemptions – exemptions to time limit or work requirements based on individual circumstances
- Sanctions – penalties for noncompliance with rules of the TFA program
- Safety Net – assistance to TFA families with barriers to employment who are no longer eligible for or at risk of losing TFA benefits
- Diversion Assistance –alternative assistance to TFA assistance for families who have short term needs

The JFES Employment and Training Workgroup was tasked with the responsibility of determining if the current service delivery model improves outcomes for participants to secure/obtain and retain/maintain employment, access training, achieve career advancement /progression, and economic well-being.

The JFES Workgroup reviewed recommendations of the 2011 JFES Enhancement Workgroup and determined that the recommendations made by the previous workgroup were still valid. Below is a list of the recommendations and actions adopted by the current JFES Workgroup:

- Provide a more in-depth assessment for every JFES participant including Comprehensive Adult Student Assessment Systems (CASAS- reading/math appraisal) and career inventory testing. To meet this recommendation DOL is currently piloting the Career Occupational Preference System (COPSystems) Assessments statewide. The COPSystem assessment consists of: Career Occupational Preference System Interest Inventory (COPS), Career Ability Placement Survey (CAPS), and Career Orientation Placement and Evaluation Survey (COPES). The intent of this assessment is to relate participants' interests, abilities and values to occupations and occupational information. Assessment results are organized into major career clusters.

- Implement JFES Integrated Basic Education and Skills Training (I-BEST) pilot programs for JFES participants. Three Workforce Investment Boards (WIBs) are in the process of completing I-BEST pilot programs which began in FY 2014. In FY 2015, an allocation of $1.7 million allowed the DOL to issue an RFP to grant I-BEST awards for the second year of the pilot and to cover the costs for an evaluation.

- Enhance JFES Intake Procedures. DOL held a training session with Dr. Beverly Ford, a national expert in Workforce Development to provide JFES staff with "Motivating the TANF Customer" training. Currently, DOL is working directly with Dr. Ford to enhance the JFES Intake session. The new approach will focus on helping participants make the transition from welfare to work by moving toward a more participant-centered approach that engages participants in examining where their lives are now and next steps to take to reach independence of assistance.

- Individualized Development Accounts (IDAs). As a result of the interest in IDAs at the TFA Policy Workgroup, DOL will promote IDAs to JFES participants as part of its Employment and Training Workgroup's efforts.

The TFA Policy and JFES workgroups continue their work to develop and refine recommendations on alternative approaches of the state's implementation of the federal TANF Block grant and the JFES and TFA programs. Recommendations will be presented to DOL and DSS Commissioners, as well as the Child Poverty and Prevention Council for approval.

VI. Prevention Report

This section of the report summarizes the State Agency Prevention Report to the Child Poverty and Prevention Council which is available on the Council's website.[37] Each state agency represented on the Council which provides primary prevention services to children reported on at least two prevention services provided by their agency. Prevention services are defined as "policies and programs that promote healthy, safe and productive lives and reduce the likelihood of crime, violence, substance abuse, illness, academic failure and other socially destructive behaviors". State agencies use an evidence-based approach to design and implement their prevention programs.

In Fiscal Year (FY) 2014, eleven state agencies expended over $243 million to administer 34 comprehensive primary prevention programs and services that positively impact Connecticut's children and families. The summary of the state agency prevention report and examples of evidence-based prevention programs are on the following pages.

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

[37] http://www.ct.gov/opm/cwp/view.asp?a=2997&Q=383356&opmNav_GID=1809

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

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

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

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

Department of Mental Health and Addiction Services			
Program	**FY 14 Funding**	**Service Level**	**Description**
Best Practices Initiative	$2,005,087	2014 service level will be available after November 30, 2014	Fourteen statewide funded projects that employ a population-based public health approach to address demonstrated substance abuse prevention needs.
Local Prevention Council Programs	$552,470	2014 service level will be available after November 30, 2014	The Local Alcohol, Tobacco and Other Drug Abuse Prevention Council Grant Program (LPCP) initiative supports the activities of local, municipal-based alcohol, tobacco, and other drug (ATOD) abuse prevention councils.
Partnership for Success	$2,300,000	2014 service level will be available after November 30, 2014	The Partnership for Success (PFS) Initiative uses a public health approach in over 30 municipalities and statewide across college campuses to decrease alcohol consumption in youth ages 12 to 20.
Regional Action Council	$1,656,972	2014 service level will be available after November 30, 2014	Regional Substance Abuse Action Councils (RACs) are public-private agencies comprised of community leaders. Its purpose is to establish and implement an action plan to develop and coordinate needed services across the behavioral health continuum.
Statewide Service Delivery Agents	$1,714,816	2014 service level will be available after November 30, 2014	Four entities funded by DMHAS to support prevention efforts across the state by building the capacity of individuals and communities to deliver prevention services.
Tobacco Prevention and Enforcement	$493,575	2014 service level will be available after November 30, 2014	Enforcement and strategies to reduce underage tobacco use.
FDA Tobacco Compliance Check Inspection Program	$651,868	2014 service level will be available after November 30, 2014	Enforce and implement the regulation of the federal Tobacco Control Act that restricts the sale and promotion of tobacco products to youth.
Total	**$9,374,788**		

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

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

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

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

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

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

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

Evidence-Based Prevention Program.

The following programs illustrate the efforts of state agencies regarding the development and implementation of evidence-based prevention programs.

Department of Public Health

The Connecticut Special Supplemental Nutrition Program for Women, Infants &Children (CT WIC Program) serves pregnant, postpartum and breastfeeding women, infants, and children up to five years of age. The program provides services in five (5) major areas during critical times of growth and development in an effort to improve birth outcomes and child health: (1) Nutrition Education & Counseling; (2) Breastfeeding Promotion & Support; (3) Referral to appropriate health & social services; (4) Referral from Health Care Providers to ensure clients have a medical home; and, (5) Vouchers for healthy foods (WIC "Food Packages") prescribed by WIC Nutritionists.

Performance-Based Standards Federal and state regulations include a number of prevention-related standards that Local WIC Agencies must meet, including timeframes for enrolling program applicants; requirements regarding the early and continuous enrollment of pregnant women; policies to ensure that all pregnant women are encouraged to breastfeed unless medically contraindicated, and provided breastfeeding

information and support; requirements to provide information regarding the risks associated with drug, alcohol and tobacco use during pregnancy; and, to ensure that children are screened for anemia and lead poisoning by their health care provider.

Performance-Based Outcomes (12 WIC Regions)

- First Trimester Enrollment in WIC: Increase to 50% the rate of first trimester enrollment of pregnant women.
  - Statewide average [Federal Fiscal Year (FFY) 2014 to date (YTD)]: 51.3%; Range: 41.5% – 65.1%.

- Maternal Weight Gain (MWG): At least 70% of pregnant women who participate in the WIC Program for a minimum of 6 months gain appropriate weight:
  - Statewide average (FFY 2014 YTD): 72.4%; Range: 53.8% - 82.8%.

- Low Birth Weight (LBW): The incidence of low birth weight among infants whose mothers were on the WIC Program for at least 6 months during pregnancy does not exceed 6%.
  - Statewide average (FFY 2014 YTD): 5.8%; Range: 1.4% - 8.3%.

- Breastfeeding Initiation (BFI): At least 65% of infants whose mothers were enrolled in the WIC Program for any length of time during pregnancy breastfeed.
  - Statewide average (FFY 2014 YTD): 75.8%; Range: 59.3% - 92.3%.

- Childhood Anemia: The prevalence of anemia among children 2-4 years of age enrolled in the WIC Program for at least one year does not exceed 7.5%.
  - Statewide average (FFY 2014 YTD): 10.2%; Range: 4.6% - 14.5%.

- Overweight in Children: The prevalence of overweight (BMI ≥ 85th percentile to < 95th percentile) among children 2-4 years of age enrolled in the WIC Program for at least one year does not exceed 10%.
  - Statewide average (FFY 2014 YTD): 11.8%; Range: 7.3% - 16.6%.

- Obesity in Children: The prevalence of obesity (BMI ≥ 95th percentile) among children 2-4 years of age enrolled in the WIC Program for at least one year does not exceed 15%.
  - Statewide average (FFY 2014 YTD): 12.1%; Range: 6.7% - 17.4%.

Judicial Branch Court Support Service Division

The Educational Support Services Program supports families in ensuring that their children's educational needs are properly identified and that children have access to a free and appropriate education as required by law. Education Support Services include legal case consultation, advocacy, and training by contracted special education attorneys serving families and probation officers of children referred to juvenile court due to status offending or delinquent behaviors, and who exhibit school difficulties and/or performance challenges. Services are available at all twelve (12) juvenile courts.

Performance-Based Standards

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

Performance –Based Outcomes

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

VII. Examples of Successful Interagency Collaborations

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Below are examples from previous reports.

2013

- The Three-Branch Institute on Child Social and Emotional Well-Being
- Connecticut State Prevention Enhancement Initiative Consortium

2012

- State Prevention Enhancement Initiative Consortium
- DCF Head Start Partnership
- Child Day Care Licensing Program
- State Healthy Start Program
- Children and Youth with Special Health Care Needs
- The Tobacco Program
- Environmental Health Program

2010

- Jobs First Employment Services
- Transportation to Work Program
- Supplemental Nutrition Assistance Program Employment and Training (SNAP E&T) 50% Reimbursement Program
- Parents with Cognitive Limitations Workgroup
- Families with Service Needs
- Shaken Baby Prevention Initiative: Empowering Parents
- In-Depth Technical Assistance (IDTA) Substance Abuse and Child Welfare Project
- Raise the Age
- Recovery Specialist Volunteer Program
- Zero to Three Court Team
- Connecticut Alcohol and Drug Policy Council
- Connecticut Partnerships for Success Initiative
- Joint Juvenile Justice Strategic Plan
- Juvenile Review Boards

2008

- Connecticut Strategic Prevention Framework Initiative
- Connecticut Youth Suicide Prevention Initiative

2007

- Connecticut Supportive Housing Initiative
- Mental Health Transformation Grant
- Governor's Early Childhood Research and Policy Council
- Connecticut Birth to Three System

Appendix A
COUNCIL MEMBERS
2014

Anne Foley, Chair
Under Secretary
Office of Policy and Management

Ram Aberasturia
Director of Labor Operations - Employment Services
Department of Labor

Stephen Anderson
Supervising Environmental Analyst
Department of Agriculture

Gregg Cogswell
Senate Republican Office
Connecticut General Assembly

Renee Mitchell-Coleman
Section Chief
Department of Public Health

Bernadette Conway
Judge
Superior Court

Kathleen Durand
Director of Strategic Initiatives
Department of Housing

John Frassinelli
Chief of the Bureau of Health/Nutrition, Family Services and Adult Education
Department of Education

Lindy Lee Gold
Community Development Specialist
Department of Economic and Community Development

Gregory Gray
President
Board of Regents for Higher Education

Mary Ann Handley
Former State Senator

Tanya Hughes
Executive Director
Commission on Human Right and Opportunities

Myra Jones-Taylor
Commissioner
Office of Early Childhood

Dennis King
Manager of Community Advocacy
Department of Transportation

Carol Meredith
Director
Department of Mental Health and Addiction Services

Mary Mushinsky
State Representative
Connecticut General Assembly

Rod O'Connor
Legislative and Regulations Analyst
Department of Developmental Services

Peter Palermino
Division of Integrated Services, Economic Security Unit
Department of Social Services

Monica Rinaldi
Warden
Department of Correction

Kim Somaroo-Rodriguez
Central Office Administrator
Department of Children and Families

Faith VosWinkel
Assistant Child Advocate
Office of Child Advocacy

Elaine Zimmerman
Executive Director
Commission on Children

Lezlye Zupkus
State Representative

Child Poverty and Prevention Council Staff
Pamela Trotman, Planning Specialist,
Office of Policy and Management

Appendix B
STATUTORY AUTHORITY
Connecticut General Statutes Sections 4-67x and 4-67y

Sec. 4-67x. Child Poverty and Prevention Council established. Duties. Ten-year plan. Prevention goals, recommendations and outcome measures. Protocol for state contracts. Agency reports. Council report to General Assembly. Termination of council. (a) There shall be a Child Poverty and Prevention Council consisting of the following members or their designees: The Secretary of the Office of Policy and Management, the president pro tempore of the Senate, the speaker of the House of Representatives, the minority leader of the Senate and the minority leader of the House of Representatives, the Commissioners of Children and Families, Social Services, Correction, Developmental Services, Mental Health and Addiction Services, Transportation, Public Health, Education and Economic and Community Development, the Labor Commissioner, the Chief Court Administrator, the chairperson of the Board of Regents for Higher Education, the Child Advocate and the executive directors of the Commission on Children and the Commission on Human Rights and Opportunities. The Secretary of the Office of Policy and Management, or the secretary's designee, shall be the chairperson of the council. The council shall (1) develop and promote the implementation of a ten-year plan, to begin June 8, 2004, to reduce the number of children living in poverty in the state by fifty per cent, and (2) within available appropriations, establish prevention goals and recommendations and measure prevention service outcomes in accordance with this section in order to promote the health and well-being of children and families.

(b) The ten-year plan shall contain: (1) An identification and analysis of the occurrence of child poverty in the state, (2) an analysis of the long-term effects of child poverty on children, their families and their communities, (3) an analysis of costs of child poverty to municipalities and the state, (4) an inventory of state-wide public and private programs that address child poverty, (5) the percentage of the target population served by such programs and the current state funding levels, if any, for such programs, (6) an identification and analysis of any deficiencies or inefficiencies of such programs, and (7) procedures and priorities for implementing strategies to achieve a fifty per cent reduction in child poverty in the state by June 30, 2014. Such procedures and priorities shall include, but not be limited to, (A) vocational training and placement to promote career progression for parents of children living in poverty, (B) educational opportunities, including higher education opportunities, and advancement for such parents and children, including, but not limited to, preliteracy, literacy and family literacy programs, (C) housing for such parents and children, (D) day care and after-school programs and mentoring programs for such children and for single parents, (E) health care access for such parents and children, including access to mental health services and family planning, (F) treatment programs and services, including substance

abuse programs and services, for such parents and children, and (G) accessible childhood nutrition programs.

(c) In developing the ten-year plan, the council shall consult with experts and providers of services to children living in poverty and parents of such children. The council shall hold at least one public hearing on the plan. After the public hearing, the council may make any modifications that the members deem necessary based on testimony given at the public hearing.

(d) Funds from private and public sources may be accepted and utilized by the council to develop and implement the plan and the provisions of this section.

(e) Not later than January 1, 2005, the council shall submit the plan, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and human services and to the select committee of the General Assembly having cognizance of matters relating to children, along with any recommendations for legislation and funding necessary to implement the plan.

(f) (1) On or before January first of each year from 2006 to 2015, inclusive, the council shall report, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and human services and to the select committee of the General Assembly having cognizance of matters relating to children on the implementation of the plan, progress made toward meeting the child poverty reduction goal specified in subsection (a) of this section and the extent to which state actions are in conformity with the plan. The council shall meet at least two times annually for the purposes set forth in this section.

(2) On or before January first of each year from 2007 to 2015, inclusive, the council shall, within available appropriations, report, in accordance with section 11-4a, to the Governor and the joint standing committees of the General Assembly having cognizance of matters relating to appropriations, education, human services and public health and to the select committee of the General Assembly having cognizance of matters relating to children, on the state's progress in prioritizing expenditures in budgeted state agencies with membership on the council in order to fund prevention services. The report shall include (A) a summary of measurable gains made toward the child poverty and prevention goals established in this section; (B) a copy of each such agency's report on prevention services submitted to the council pursuant to subsection (g) of this section; (C) examples of successful interagency collaborations to meet the child poverty and prevention goals established in this section; and (D) recommendations for prevention investment and budget priorities. In developing such recommendations, the council shall consult with experts and providers of services to children and families.

(g) (1) On or before November first of each year from 2006 to 2014, inclusive, each budgeted state agency with membership on the council that provides prevention services to children shall, within available appropriations, report to the council in accordance with this subsection.

(2) Each agency report shall include at least two prevention services not to exceed the actual number of prevention services provided by the agency. For each prevention service reported by the agency, the agency report shall include (A) a statement of the number of children and families served, (B) a description of the preventive purposes of the service, (C) for reports due after November 1, 2006, a description of performance-based standards and outcomes included in relevant contracts pursuant to subsection (h) of this section, and (D) any performance-based vendor accountability protocols.

(3) Each agency report shall also include (A) long-term agency goals, strategies and outcomes to promote the health and well-being of children and families, (B) overall findings on the effectiveness of prevention within such agency, (C) a statement of whether there are methods used by such agency to reduce disparities in child performance and outcomes by race, income level and gender, and a description of such methods, if any, and (D) other information the agency head deems relevant to demonstrate the preventive value of services provided by the agency. Long-term agency goals, strategies and outcomes reported under this subdivision may include, but need not be limited to, the following:

(i) With respect to health goals, increasing (I) the number of healthy pregnant women and newborns, (II) the number of youths who adopt healthy behaviors, and (III) access to health care for children and families;

(ii) With respect to education goals, increasing the number of children who (I) are ready for school at an appropriate age, (II) learn to read by third grade, (III) succeed in school, (IV) graduate from high school, and (V) successfully obtain and maintain employment as adults;

(iii) With respect to safety goals, decreasing (I) the rate of child neglect and abuse, (II) the number of children who are unsupervised after school, (III) the incidence of child and youth suicide, and (IV) the incidence of juvenile crime; and

(iv) With respect to housing goals, increasing access to stable and adequate housing.

(h) Not later than July 1, 2006, the Office of Policy and Management shall, within available appropriations, develop a protocol requiring state contracts for programs aimed at reducing poverty for children and families to include performance-based standards and outcome measures related to the child poverty reduction goal specified

in subsection (a) of this section. Not later than July 1, 2007, the Office of Policy and Management shall, within available appropriations, require such state contracts to include such performance-based standards and outcome measures. The Secretary of the Office of Policy and Management may consult with the Commission on Children to identify academic, private and other available funding sources and may accept and utilize funds from private and public sources to implement the provisions of this section.

(i) For purposes of this section, the Secretary of the Office of Policy and Management, or the secretary's designee, shall be responsible for coordinating all necessary activities, including, but not limited to, scheduling and presiding over meetings and public hearings.

(j) The council shall terminate on June 30, 2015.

Section 4-67y. Child Poverty and Prevention Council to constitute the children in the recession leadership team. Duties. Report. (a) The Child Poverty and Prevention Council, established pursuant to section 4-67x, shall constitute the children in the recession leadership team to make recommendations for the state's emergency response to children affected by the recession. The council may establish a subcommittee to act for it under this section. For purposes of this section, the council or a subcommittee established under this subsection shall meet quarterly if the unemployment rate of the state, as reported by the Labor Commissioner, is eight per cent or greater for the preceding three months.

(b) The council shall work in consultation with other government agencies to develop and promote policies, practices and procedures, within available appropriations, that (1) mitigate the long-term impact of economic recessions on children; (2) provide appropriate assistance and resources to families to minimize the number of children who enter poverty as a result of the recession; and (3) reduce human and fiscal costs of recessions, including foreclosures, child hunger, family violence, school failure, youth runaways, homelessness, child abuse and neglect.

(c) For purposes of this section, the council, within available appropriations, shall utilize strategies to mitigate the impact of the recession on children that include, but are not limited to, the following: (1) Resource information sharing and strategic planning to address emergency response to children in the recession; (2) training of pertinent personnel on the availability of services, access points and interventions across agencies, including child trauma treatment; (3) development of linkages between job training and education programs and services; (4) development and implementation of efforts to coordinate outreach and improve access to services, including the

establishment of multiple enrollment sites where feasible; (5) reduction of current response times to clients for safety net programs, including, but not limited to, the federal Supplemental Nutrition Assistance Program, the federal Special Supplemental Food Program for Women, Infants and Children, the National School Lunch Program and other federal child nutrition programs, the temporary family assistance program, the child care subsidy program, heating and rental assistance, eviction prevention services and free and reduced preschool meal programs; (6) identification of appropriate revisions to regulations and procedures to be streamlined to increase program access; (7) maximization of availability of targeted case management and intervention services; (8) assessment of the unique needs of children of soldiers serving or returning from war or other military service; and (9) maximization of all federal funding opportunities.

(d) Not later than January 1, 2011, the council shall prepare a report on (1) the progress in implementing the provisions of this section; and (2) other government actions taken to reduce the impact of the recession on children and families. Such report shall be submitted to the select committee of the General Assembly having cognizance of matters relating to children and to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies and human services.

House Bill No. 5323

Public Act No. 14-132

AN ACT CONCERNING THE CHILD POVERTY AND PREVENTION COUNCIL.

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

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

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

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

(g) (1) On or before November first of each year from 2006 to 2014, inclusive, each budgeted state agency with membership on the council that provides prevention services to children shall, within available appropriations, report to the council in accordance with this subsection. On or before November first of each year from 2015 to 2020, inclusive, each budgeted state agency that provides prevention services to children shall, within available appropriations, report to the joint standing committees of the General Assembly having cognizance of matters related to appropriations, human services and children in accordance with this subsection.

(2) Each agency report shall include at least two prevention services not to exceed the actual number of prevention services provided by the agency. For each prevention service reported by the agency, the agency report shall include (A) a statement of the number of children and families served, (B) a description of the preventive purposes of the service, (C) for reports due after November 1, 2006, a description of performance-based standards and outcomes included in relevant contracts pursuant to subsection (h) of this section, and (D) any performance-based vendor accountability protocols.

(3) Each agency report shall also include (A) long-term agency goals, strategies and outcomes to promote the health and well-being of children and families, (B) overall findings on the effectiveness of prevention within such agency, (C) a statement of whether there are methods used by such agency to reduce disparities in child performance and outcomes by race, income level and gender, and a description of such methods, if any, and (D) other information the agency head deems relevant to demonstrate the preventive value of services provided by the agency. Long-term agency goals, strategies and outcomes reported under this subdivision may include, but need not be limited to, the following:

(i) With respect to health goals, increasing (I) the number of healthy pregnant women and newborns, (II) the number of youths who adopt healthy behaviors, and (III) access to health care for children and families;

(ii) With respect to education goals, increasing the number of children who (I) are ready for school at an appropriate age, (II) learn to read by third grade, (III) succeed in school, (IV) graduate from high school, and (V) successfully obtain and maintain employment as adults;

(iii) With respect to safety goals, decreasing (I) the rate of child neglect and abuse, (II) the number of children who are unsupervised after school, (III) the incidence of child and youth suicide, and (IV) the incidence of juvenile crime; and

(iv) With respect to housing goals, increasing access to stable and adequate housing.

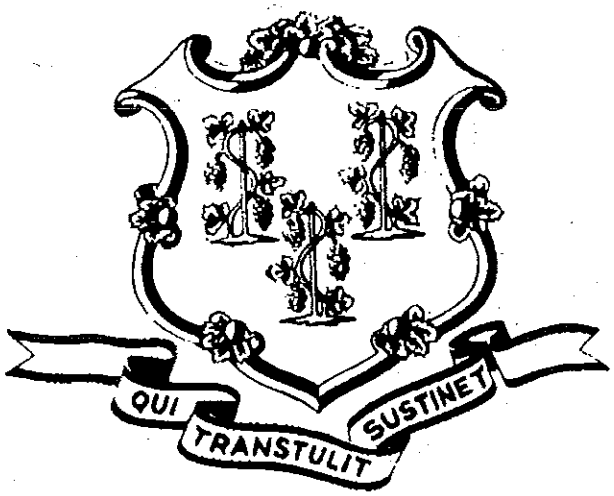
(4) Each agency report shall also include (A) a list of agency programs that provide prevention services, (B) the actual prevention services expenditures for the most recently completed fiscal year, and (C) the percentage of total actual agency expenditures in the most recently completed fiscal year that were actual prevention services expenditures.

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

Approved June 6, 2014

STATE OF CONNECTICUT

AGENCY PREVENTION REPORT



A REPORT TO THE

Child Poverty and Prevention Council
2014

STATE OF CONNECTICUT AGENCY PREVENTION REPORT

A REPORT TO THE

CHILD POVERTY AND PREVENTION COUNCIL

NOVEMBER 2014

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REPORT TO THE CHILD POVERTY AND PREVENTION COUNCIL

I. LEGISLATIVE AUTHORITY

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

The prevention report includes the following:

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

II. STATE AGENCY REPORT

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

Department of Children and Families

Department of Developmental Services

Department of Education

Department of Housing

Department of Labor

Department of Mental Health and Addiction Services

Department of Public Health

Department of Social Services

Judicial Branch

Office of Early Childhood

Office of Policy and Management

The Departments of Transportation, Higher Education, Economic and Community Development, Office of Health Care Access, Commission on Children, Agriculture, and the Commission on Human Rights and Opportunities determined that their prevention programs did not meet the definition of primary prevention, and therefore, no reports from these agencies are included in this report.

Prevention is defined as: *Policies and programs that promote healthy, safe and productive lives and reduce the likelihood of crime, violence, substance abuse, illness, academic failure and other socially destructive behaviors.*

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

State Agency Prevention Programs - SUMMARY

State Agency Prevention Programs

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

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

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

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

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

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

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

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

Local Prevention Council Programs	$552,470	2014 service level will be available after November 30, 2014	The Local Alcohol, Tobacco and Other Drug Abuse Prevention Council Grant Program (LPCP) initiative supports the activities of local, municipal-based alcohol, tobacco, and other drug (ATOD) abuse prevention councils.
Partnership for Success	$2,300,000	2014 service level will be available after November 30, 2014	The Partnership for Success (PFS) Initiative uses a public health approach in over 30 municipalities and statewide across college campuses to decrease alcohol consumption in youth ages 12 to 20.
Regional Action Council	$1,656,972	2014 service level will be available after November 30, 2014	Regional Substance Abuse Action Councils (RACs) are public-private agencies comprised of community leaders. Its purpose is to establish and implement an action plan to develop and coordinate needed services across the behavioral health continuum.
Statewide Service Delivery Agents	$1,714,816	2014 service level will be available after November 30, 2014	Four entities funded by DMHAS to support prevention efforts across the state by building the capacity of individuals and communities to deliver prevention services.
Tobacco Prevention and Enforcement	$493,575	2014 service level will be available after November 30, 2014	Enforcement and strategies to reduce underage tobacco use.
FDA Tobacco Compliance Check Inspection Program	$651,868	2014 service level will be available after November 30, 2014	Enforce and implement the regulation of the federal Tobacco Control Act that restricts the sale and promotion of tobacco products to youth.
Total	**$9,374,788**		

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

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

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

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

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

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

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

Department of Children and Families

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

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

Goals:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Performance-Based Outcomes:

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

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

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

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

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

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

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

Performance-Based Outcomes:

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

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

Department of Developmental Services

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

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

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

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

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

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

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

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

BIRTH TO THREE: The Department of Developmental Services (DDS) is the lead agency (17a-248 C.G.S.) for the Birth to Three Program, which is also operated under the provisions of Part C of the Individuals with Disabilities Education Act. This is the same federal law that governs special education for children ages 3 to 21.

The mission of the program is to strengthen the capacity of families to meet the developmental and health-related needs of their infants and toddlers who have developmental delays or disabilities. The program ensures that all families have equal access to a coordinated program of comprehensive services and supports that:

- foster collaborative partnerships
- are family centered
- occur in natural settings
- recognize current best practices in early intervention
- are built upon mutual respect and choice

Birth to Three seeks to assist families to ameliorate delays in their infants' or toddlers' development that are identified early or to prevent secondary delays or disabilities. Birth to Three works with families to ensure that their children are ready for Kindergarten at age five.

The federal law requires that two groups of children receive services 1) those with developmental delays and 2) those with diagnosed conditions expected to lead to a developmental delay without the benefit of early intervention. States are given quite a bit of latitude in defining both of these groups.

Early intervention services must be delivered in natural environments which, for children at this age, are typically the home, (although services can be delivered in any setting that the child and family typically frequent, such as at child care.) Most services are delivered by occupational, physical, and speech therapists along with early childhood special education teachers, although there are many other professionals and paraprofessionals who can be service providers as well.

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

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

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

Performance-Based Standards: There is a single statewide point of access, which is easily marketed to health care providers and other referral sources. Once children are referred, they are evaluated and, if eligible, family service plans are developed within 45 days of referral. All new services are delivered no later than 45 days from the writing

of the plan. Individualized Family Service Plans (IFSPs) are reviewed at least every six months and rewritten at least annually. School Districts are notified of all children receiving early intervention services shortly before the child turns three, if the children have not already been referred to the districts. Parents are encouraged to refer their children no later than age two and a half.

Performance-Based Outcomes:

- All eligible children and their families are identified and offered services
- Children receive early intervention services as early as possible, with a renewed emphasis this year on enrolling children prior to age one
- Children's developmental trajectories are improved
- Families feel more confident and competent to foster their children's development
- Fewer children need special education services by Kindergarten

Performance-Based Vendor Accountability: Birth to Three has an in-depth, multi-layered process for assuring the quality of services and the performance of its contractors:

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

FAMILY SUPPORT SERVICES: The Department of Developmental Services (DDS) provides Family Supports that assist families to care for their children who have intellectual disability in their homes. Most families who have children with intellectual disability need extra support to help them keep their children at home. Family Supports include goods, services, resources, and other forms of assistance that help families successfully raise their children who have an intellectual disability. Family Supports include Respite Services provided by DDS and DDS Family Support Workers. Family Supports help children grow up in a nurturing family home where they are more likely to live healthy, safe and productive lives. DDS Respite Centers provide 24-hour care for extended weekends in comfortable home-like environments.

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

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

Program Cost: FY – 2014 $10,243,116

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

Performance-Based Outcomes: Specific outcomes in measuring the success and effectiveness of Family Supports provided by DDS include the number of children and families served and the number and percentage of children who live in family homes compared to children in out-of-home placements.

Performance-Based Vendor Accountability: Family Supports are provided by DDS staff through the department's programs and are not contracted services. Family Support programs are operated based upon DDS policies and procedures specific to those services. These procedures are described in the eligibility criteria, priority for services, and service operational guidelines. DDS regional offices maintain data on the numbers of children and adults served. DDS has a centralized process to review requests for out-of-home placement for children. The department's Children's Services committee meets monthly to review any requests to place a child under age 18 out of the family home. The committee reviews alternative supports that have been put in place, makes recommendations for additional supports that may be successful in keeping families together and makes recommendations to the Commissioner regarding the appropriateness of placements.

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

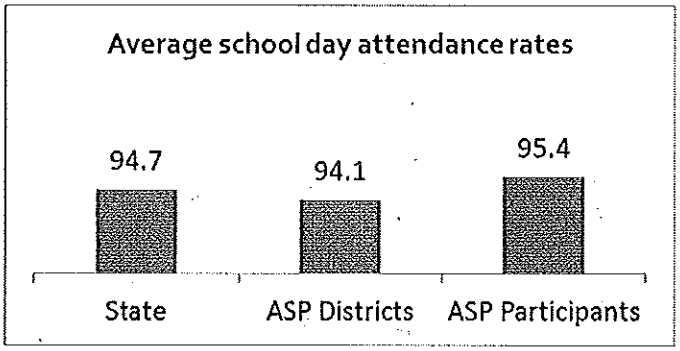
21st Century Community Learning Center Grant (CCLC): The purpose of the program is to fund *community-learning centers* that provide students with academic enrichment opportunities, as well as additional activities designed to complement their regular academic program. The 21st CCLC must offer students'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

Number Served: 6,536 students

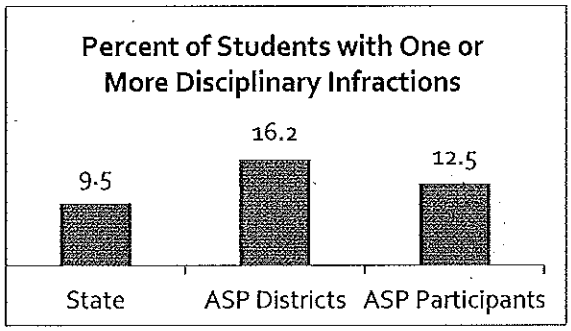
Program Cost FY 2014: $7,629,832

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

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



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



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

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

NUMBER OF CLIENTS SERVED: 320 students

PROGRAM COST: FY 2014 $1,500,000

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

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

Department of Housing

- **Children in Shelter**

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

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

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

Program Cost: FY: 2014 $127,520

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

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

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

Performance-Based Outcomes:
Outputs

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

Outcomes

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

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

Department of Labor

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

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

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

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

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

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

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

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

Number Served: 15,678 annual caseload

Program Cost: FY 2014 $18,747,981

Performance-Based Standards:

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

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

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

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

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

Program Cost: FY 2014 $4,500,000

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

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

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

Department of Mental Health and Addiction Services

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

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

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

Strategies: The Departments' strategies include:

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

Performance-Based Outcomes:

- Alignment of programs with federal and national initiatives
- Streamlined and on-line data collection
- Increased number of evidence-based programs for youth, families and professionals that focus on youth suicide prevention, tobacco and alcohol use prevention, and prescription drug abuse prevention
- A more refined quality assurance process that assesses effectiveness and fidelity of implementation of prevention programs
- An integrated state plan that supports families and communities in youth and early childhood development
- Increased partnerships with state and local agencies
- Increased number of providers trained and receiving technical assistance on cultural competency
- Increased cost-effectiveness and community readiness to implement prevention programs
- Improved population and program outcomes

<u>Population Results</u>

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

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

Program Results

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

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

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

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

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

Performance-Based Standards: DMHAS requires programs under the Best Practices Initiative to adhere to Prevention Program Operating Standards. These standards establish a minimum level of program operation intended to reflect quality and articulate a service philosophy that promotes health and builds strengths. The purpose of the standards is to provide assurances to the public that alcohol and drug abuse prevention and early intervention programs are regulated under a set of minimum standards established by DMHAS.

Performance-Based Outcomes:

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

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

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

Local Prevention Council Programs: The Local Alcohol, Tobacco and Other Drug Abuse Prevention Council Grant Program (LPCP) initiative supports the activities of local, municipal-based alcohol, tobacco, and other drug (ATOD) abuse prevention councils. The intent of this grant program is to facilitate the development of ATOD abuse prevention initiatives at the local level with the support of chief elected officials. The specific goal of this grant initiative is to increase public awareness focused on the prevention of ATOD abuse, and stimulate the development and implementation of local substance abuse prevention activities primarily focused on youth through 120 local municipal and town councils serving the 169 towns and cities in Connecticut.

Local Prevention Councils (LPCs) are advisory and coordinative in nature and reflective of each community's racial/ethnic, political, and economic diversity. Councils include representation from professionals working in the prevention field in general and ATOD abuse prevention in particular. Additionally, council membership includes a cross-section of the community which it serves including city/town agencies, organizations, communities and ethnic groups, parents, media, business, senior citizens, health care sector, etc., concerned with prevention issues. The LPCP initiative is designed to: 1) support the on-going prevention activities of established councils; 2) support specific prevention projects of local councils; and 3) support activities that increase public awareness of the problem of ATOD use and abuse.

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

Program Cost: FY 2014: $552,470

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

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

Program Cost: FY –2014 $ 2,300,000

Performance-Based Standards: DMHAS requires programs under the PFS Initiative to adhere to Prevention Program Operating Standards. These standards establish a minimum level of program operation intended to reflect quality and articulate a service philosophy that promotes health and builds strengths. The purpose of the standards is to provide assurances to the public that alcohol and drug abuse prevention and early intervention programs are regulated under a set of minimum standards established by DMHAS.

Performance-Based Outcomes:

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

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

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

Regional Action Council: Thirteen (13) sub-regional planning and action councils that have responsibility for the planning, development and coordination of behavioral health services in their respective region.

Regional Substance Abuse Action Councils (RACs) are public-private agencies comprised of community leaders. Its purpose is to establish and implement an action plan to develop and coordinate needed services across the behavioral health continuum. These services are generally described as a continuum of care which includes community awareness and education, prevention, intervention, treatment and aftercare. The members of the Regional Action Council serve as volunteers assisted by professional staff. Members include representatives of major community leadership constituencies: chief elected officials, chiefs of police, superintendents of schools, major business and professional persons, legislators, major substance abuse service providers, funders, minority communities, religious organizations and the media.

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

Program Cost: FY 2014 $1,656,972

Performance- Based-Standards: DMHAS requires all contractors to adhere to Prevention Program Operating Standards. These standards establish a minimum level of program operation intended to reflect quality and articulate a service philosophy that promotes health and builds strengths. The purpose of the standards is to provide assurances to the public that alcohol and drug abuse prevention and early intervention programs are regulated under a set of minimum standards established by DMHAS.

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

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

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

STATEWIDE SERVICE DELIVERTY AGENT: The Statewide Services Delivery Agents (SSDA), also known as the DMHAS Resource Links, are four entities funded by DMHAS to support prevention efforts across the state by building the capacity of individuals and communities to deliver prevention services. Their target populations include local communities, individuals, and agencies providing prevention programming; regional and statewide service agencies; societal organizations and institutions, e.g. corporate, medical, religious and recreational entities. The Statewide Service Delivery Agents utilize multiple strategies like information and public awareness, education, community development, capacity building and institutional change, and social policy to promote the health and well being of all Connecticut's residents across the life span. Within the last two years these SSDAs have provided distinct services to move Connecticut's prevention system to align with the blueprint of the Strategic Prevention Framework (SPF).

The Statewide Services Delivery Agents consists of the following entities:

1. Connecticut Clearinghouse - is a comprehensive information resource center that makes available thousands of books, tapes and printed reports, and provides electronic access to the latest information on substance abuse, mental health and a variety of other issues.
2. Multicultural Leadership Institute, Inc. - is an agency dedicated to promoting culturally and linguistically proficient services regarding the prevention of ATOD and other related problems among African origin and Latino populations.
3. Governor's Prevention Partnership - is a statewide organization comprising of public/private partnerships designed to change the attitudes and behaviors of Connecticut youths and adults toward substance through its School, Campus, Workplace and Media Partnerships.
4. Prevention Training Collaborative - is to provide prevention practitioners and others in the field of prevention the training needed to obtain and maintain certification status and provide support to individuals looking to increase their knowledge and skills in the prevention area.

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

Program Cost: FY 2014 $1,714,816

Performance-Based Standards:
DMHAS requires contractors to adhere to Prevention Program Operating Standards. These standards establish a minimum level of program operation intended to reflect quality and articulate a service philosophy that promotes health and builds strengths. The purpose of the standards is to provide assurances to the public that alcohol and drug abuse prevention and early intervention programs are regulated under a set of minimum standards established by DMHAS.

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

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

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

TOBACCO PREVENTION and ENFORCEMENT:

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

Prevention Program Description: The federal government requires that states enforce and enact laws and implement strategies that reduce underage tobacco use. DMHAS employs a variety of strategies and activities to comply with the federal mandate. These include:

1. Legislation & Law Enforcement: passing and enforcing youth tobacco access laws
2. Sampling Method & Survey Design: obtaining scientifically valid and reliable measure of tobacco retailer compliance with laws
3. Inspection Protocol & Implementation: following approved inspection protocols for conducting random, unannounced inspection of tobacco retailers
4. Merchant Education: producing and distributing educational and awareness materials for a merchant education program
5. Community Education & Media Advocacy: increasing public awareness on youth tobacco issues through youth forums and focus groups, community mini-grants and a statewide hotline for information and complaints.
6. Community Mobilization: forming coalitions to mobilize community support;

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

Program Cost: FY 2014: $ 493,575

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

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

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

Department of Public Health

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

ASTHMA PROGRAM: PEDIATRIC EASY BREATHING PROGRAM: The Connecticut Children's Medical Center (CCMC) Asthma Center is conducting Easy Breathing, an asthma clinical management program. The program has successfully expanded beyond the original five communities to provide statewide coverage. The Easy Breathing program is a professional education program that trains pediatric providers to administer a validated survey to determine whether a child has asthma, to conduct an assessment to determine asthma severity, to utilize treatment protocol guidelines for determining proper therapy, and to develop individual treatment plans. Easy Breathing is an asthma recognition and management program that is implemented by primary care providers that documents adherence to the National Asthma Education and Prevention Program Guidelines (NAEPP) standards for asthma care.

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

Program Cost: FY 2014 $250,000

Performance-Based Standards: The contractor conducts quarterly site visits with the Regional Program Coordinators to review and rectify data issues, training needs and/or implementation problems. The contractor submits quarterly narrative and surveillance data to DPH. Indicators are guideline adherence for prescribing inhaled corticosteroids for those with persistent asthma and patient education and provision of patient written treatment plans to enable patients to effectively manage their asthma symptoms before they become acute. The contractor trained 108 new providers for a total of trained 472 providers.

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

Performance-Based Vendor Accountability:
Documentation of DPH oversight conducted under this contract with the contractor and subcontractors through audits, site visits, quarterly and annual aggregate reports as follows:

- Documentation of technical and professional assistance provided
- Description of the contractor-created, locally managed data quality control program and the actual assistance provided for the management of the Easy Breathing data system, generation of reports at each district
- Documentation of monitoring each participating district for adherence to required program activities
- Documentation of review of all survey and treatment plan data from each district for consistency and appropriateness
- Documentation of the results of data analysis that include demographics of children surveyed in each community for asthma, by age, race/ethnicity, and number of newly diagnosed children by age, race/ethnicity
- Evaluation results of the effectiveness of the Easy Breathing Program in each participating community by analyzing the following process measures and outcome measures over time (quarterly).

ASTHMA PROGRAM: ADULT EASY BREATHING PROGRAM: Bridgeport Hospital continued Easy Breathing for Adults. This Program is based on pediatric Easy Breathing with the focus being on adults treated by medical resident physicians in Bridgeport Hospital's Primary Care Clinic. Easy Breathing for Adults is an asthma clinical management program. The program has successfully integrated training for medical residents to implement Easy Breathing. The Easy Breathing program is a professional education program that trains medical resident providers to administer a validated survey to determine whether a patient has asthma, to conduct an assessment to determine asthma severity, to utilize treatment protocol guidelines for determining proper therapy, and to develop individual treatment plans. Easy Breathing is an asthma recognition and management program that is implemented by primary care providers that documents adherence to the National Asthma Education and Prevention Program Guidelines (NAEPP) standards for asthma care.

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

Number Served:

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

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

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

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

Performance-Based Vendor Accountability:
Documentation of DPH oversight conducted under this contract with the contractor and subcontractors through audits, site visits, quarterly and annual aggregate reports as follows:

- Documentation of technical and professional assistance provided
- Description of the contractor-created, locally managed data quality control program and the actual assistance provided for the management of the Easy Breathing data system, generation of reports at each district
- Documentation of monitoring each participating district for adherence to required Program activities
- Documentation of review of all survey and treatment plan data from each district for consistency and appropriateness
- Documentation of the results of data analysis that include demographics of children surveyed in each community for asthma, by age, race/ethnicity, and number of newly diagnosed children by age, and race/ethnicity
- Evaluation results of the effectiveness of the Easy Breathing Program in each participating community by analyzing the following process measures and outcome measures over time (quarterly).

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

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

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

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

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

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

Program Cost: FY 2014 $96,000

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

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

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

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

- Market AIRS Program targets 75% of children

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

Performance-Based Vendor Accountability:

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

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

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

Program Cost: FY 2014 $62,033,708

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

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

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

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

Specific Program Outcomes and Measures

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

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

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

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

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

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

Performance-Based Standards:
Federal and state regulations include a number of prevention-related standards that Local WIC Agencies must meet, including timeframes for enrolling program applicants; requirements regarding the early and continuous enrollment of pregnant women; policies to ensure that all pregnant women are encouraged to breastfeed unless medically contra-indicated, and provided breastfeeding information and support; requirements to provide information regarding the risks associated with drug, alcohol and tobacco use during pregnancy; and, to ensure that children are screened for anemia and lead poisoning by their health care provider.

Performance-Based Outcomes (12 WIC Regions):

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

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

Performance-Based Accountability:

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

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

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

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

Program Cost: 2014 $1,076,586

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

Performance-Based Outcomes

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

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

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

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

Department of Social Services

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

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

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

Strategies:

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

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

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

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

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

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

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

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

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

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

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

Program Cost 2014 $1,272,376

Performance- Based Standards:

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

Performance-Based Outcomes: Evidence and documentation of:

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

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

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

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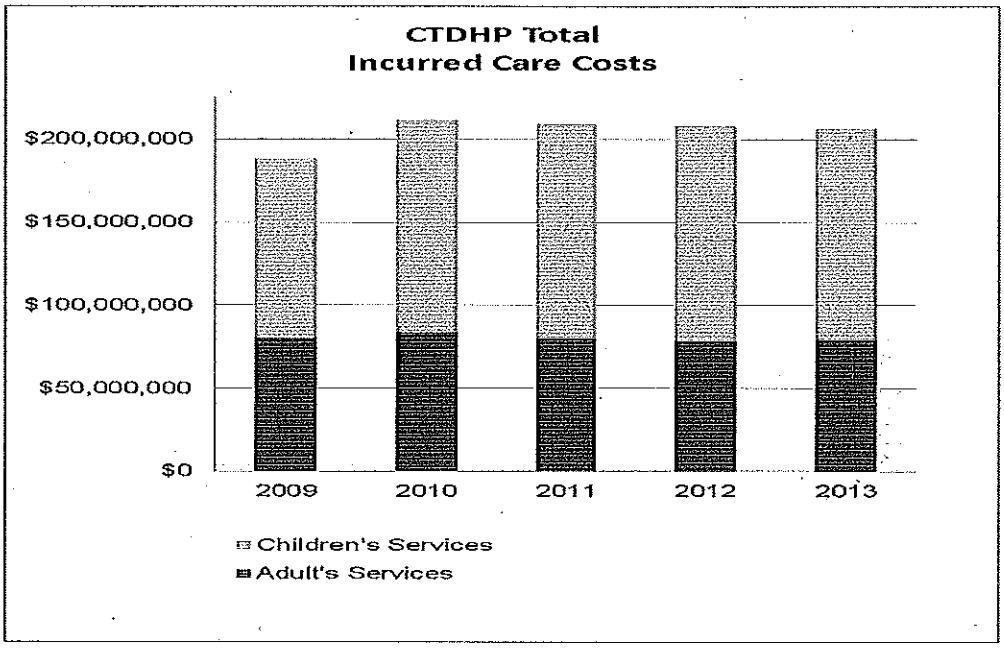
Perinatal and Infant Oral Health Quality Improvement: Connecticut is one of only four states awarded a U.S. Department of Health and Human Services Health Resource and Services Administration (HRSA) Grant for Perinatal & Infant Oral Health Quality Improvement (PIOHQI in 2013. The grant is focused upon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

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

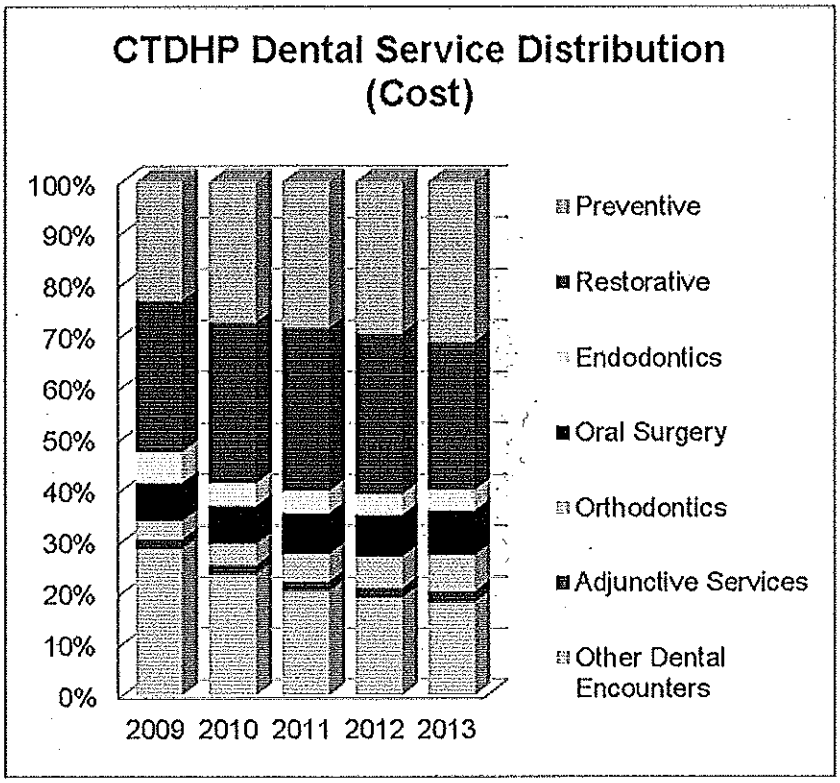
The PIOHQI/ICO project's is funded over five years for an amount of up to$750,000.00. The grant will enhance the current Connecticut Dental Health Partnership's outreach activities to the peri-natal mothers and infant populations to Instill the concept of good oral health practices. Early intervention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

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

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



DSS



Number Served: 30,000

Program Cost: FY 2014 $175,000

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

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

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

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

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

Number Served: 727 participants

Program Cost: FY 2014: $566,656

Performance- Based Standards:

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

Performance-Based Outcomes:

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

Primary Prevention Outcomes:

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

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

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

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

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

Number Served: 830 youth

Program Cost FY 2014: $1,981,204

Judicial Branch Court Support

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

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

Strategies:

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

Performance-Based Outcomes:

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

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

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

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

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

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

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

The primary goals and objectives of SBDI include:

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

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

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

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

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

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

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

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

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

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

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

Program Cost: FY 2014 $897,810

Performance-Based Standards:

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

Performance –Based Outcomes:

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

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

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

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

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

Program Cost: FY 2014 $4,368,300

Performance-Based Standards:

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

Performance –Based Outcomes:

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

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

Office of Early Childhood

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

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

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

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

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

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

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

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

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

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

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

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

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

Program Cost: FY 14 $10,588,370

Performance-Based Standards:

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

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

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

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

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

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

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

Program Cost: FY 14 $331,462

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

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

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

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

Number Served: Approximately 150 families received intensive home visiting services

Program Cost: FY 14 $595,358

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

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

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

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

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

Number Served: 430 parent received home and group based services

Program Cost: FY 14 $191,516

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

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

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

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

TITLE V DELINQUENCY PREVENTION PROGRAM: The Title V Delinquency Prevention Program goal is to reduce delinquency and youth violence by supporting communities in providing their children, families, neighborhoods and institutions with the knowledge, skills and opportunities necessary to foster a healthy and nurturing environment. The program provides grants to cities and towns (units of local government) in Connecticut for delinquency prevention and early intervention projects based upon a risk and protective factor approach. This approach provides communities with a conceptual framework for prioritizing the risk and protective factors in their community, assessing how their current resources are being used, identifying resources which are needed, and choosing specific programs and strategies that directly address those factors. A youth advisory committee that reflects the racial, ethnic, and cultural composition of the community's youth population and includes youth at various levels of academic and social competencies must provide input into the design and implementation of program strategies.

Program Cost: FY: 2014 $84,945

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

- Assess the prevalence in the community of specific, identified risk and protective factors, including the establishment of baseline data for the factors and a list of priority factors to be addressed;
- Identify all available resources in the community;
- Assess gaps in the needed resources and how to address them;
- Establish goals and objectives along with an implementation timeline; and
- Insure the collection of data for the measurement of performance and outcome of planned program activities.

Performance-Based Outcomes: Program grantees are required to collect the following data elements:

Outputs

- Number of full time equivalent employees funded with grant funds;
- Number of planning activities conducted; and
- Number of program youth served.

Outcomes

- Number and percent of program youth exhibiting an increase in school attendance;
- Number and percent of program youth completing program requirements;
- Number and percent of program youth satisfied with the program; and
- Number and percent of program staff with increased knowledge of program area.

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

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

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

Program Cost: FY 2014 $3.5 million

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

House Bill No. 5323

Public Act No. 14-132

AN ACT CONCERNING THE CHILD POVERTY AND PREVENTION COUNCIL.

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

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

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

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

(g) (1) On or before November first of each year from 2006 to 2014, inclusive, each budgeted state agency with membership on the council that provides prevention services

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

(2) Each agency report shall include at least two prevention services not to exceed the actual number of prevention services provided by the agency. For each prevention service reported by the agency, the agency report shall include (A) a statement of the number of children and families served, (B) a description of the preventive purposes of the service, (C) for reports due after November 1, 2006, a description of performance-based standards and outcomes included in relevant contracts pursuant to subsection (h) of this section, and (D) any performance-based vendor accountability protocols.

(3) Each agency report shall also include (A) long-term agency goals, strategies and outcomes to promote the health and well-being of children and families, (B) overall findings on the effectiveness of prevention within such agency, (C) a statement of whether there are methods used by such agency to reduce disparities in child performance and outcomes by race, income level and gender, and a description of such methods, if any, and (D) other information the agency head deems relevant to demonstrate the preventive value of services provided by the agency. Long-term agency goals, strategies and outcomes reported under this subdivision may include, but need not be limited to, the following:

(i) With respect to health goals, increasing (I) the number of healthy pregnant women and newborns, (II) the number of youths who adopt healthy behaviors, and (III) access to health care for children and families;

(ii) With respect to education goals, increasing the number of children who (I) are ready for school at an appropriate age, (II) learn to read by third grade, (III) succeed in school, (IV) graduate from high school, and (V) successfully obtain and maintain employment as adults;

(iii) With respect to safety goals, decreasing (I) the rate of child neglect and abuse, (II) the number of children who are unsupervised after school, (III) the incidence of child and youth suicide, and (IV) the incidence of juvenile crime; and

(iv) With respect to housing goals, increasing access to stable and adequate housing.

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

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

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

Approved June 6, 2014