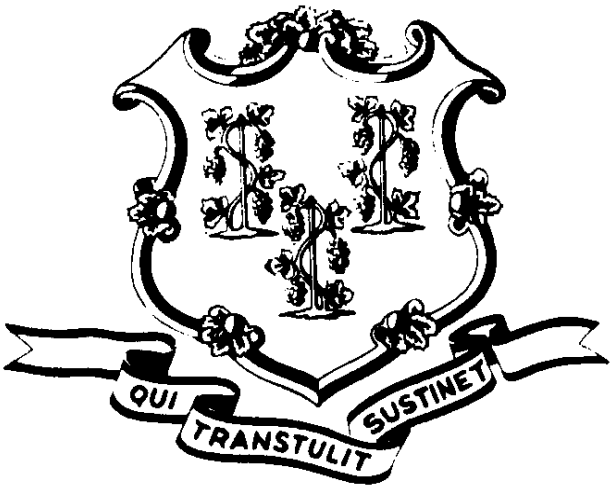
STATE OF CONNECTICUT

AGENCY PREVENTION REPORT



A REPORT TO THE

CHILD POVERTY AND PREVENTION COUNCIL

November 2009

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REPORT TO THE CHILD POVERTY AND PREVENTION COUNCIL

I. State Agency Report

This report implements to key provisions enacted into law in Public Act 07-47, *An Act Concerning Reporting Requirements related to the Child Poverty and Prevention Council.* Accordingly, the Act 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 by November 1st of each year through 2014. This report must also be included in the Council's annual progress report to the Governor and legislature. This report represents the fourth annual State Agency Prevention Report.

For the purpose of 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.

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.

Each report includes the following:

- long-term agency goals, strategies, performance-based standards and outcomes and performance–based vendor accountability;
- a statement on the overall effectiveness of prevention within the agency;
- methods used to reduce disparities in child performance and outcomes by race, income level and gender
- a brief description of the purpose of the prevention program;
- the number of children and families served; and
- state and federal funding for fiscal year 2009.

This Prevention Report is comprised of reports from:

- Children's Trust Fund
- Department of Children and Families
- Department of Developmental Services
- Department of Education
- Department of Mental Health and Addiction Services
- Department of Public Health
- Department of Social Services
- Office of Policy and Management

The Departments of Correction, Labor, Higher Education, Economic and Community Development, Office of Health Care Access, Office of Workforce Competitiveness, and the Judicial Branch, 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.

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) 2009, these agencies expended over $276 million to administer 28 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.

Children's Trust Fund			
Program	**FY09 Funding**	**Service Level**	**Description**
Nurturing Families Network	$10,148,252	3,500 children and families	Provides education and support for all interested new parents and intensive home visiting services for parent identified as most at risk of abusing, neglecting or abandoning their children.
Help Me Grow	$355,982	2,500 case management services and 3,129 enrolled in the Ages & Stages Program	Identifies and refers young children with behavioral health, development and psychosocial needs to community – based services.
Total	**$10,504,234**		

Department of Children and Families			
Program	**FY09 Funding**	**Service Level**	**Description**
DCF/Head Start Collaboration	N/A	8,728 children (0-5 yrs old); 44 pregnant women; 14 DCF area offices; 75 DCF staff and 100 Head Start staff	A collaborative partnership focused on the development of strategies to promote family health and the stability of the child within the family.
Positive Youth Development	$754,035	633 children and 95 adults	Funds seven agencies to provide positive youth development and family strengthening programs.
Shaken Baby Prevention	$55,000	43 parent educators and 78 parents trained	Training for Parent Educators to disseminate baby calming strategies to parents at risk of perpetrating shaken baby syndrome.
Youth Suicide Prevention	$ 69,995	1,163 individuals trained	Statewide awareness campaigns and training.
Total	**$879,030**		

Department of Developmental Services			
Program	**FY09 Funding**	**Service Level**	**Description**
Birth to Three	$47,645,943	9,671 children and families	Early intervention services to all infants and toddlers who have developmental delays or disabilities.
Family Support Services	$3,368,157	1,203 individuals and children-Respite Care and 1,189 individuals statewide-Family Support Services	Services, resources and other forms of assistance to help families raise their children who have intellectual disabilities.
Total	**$51,014,100**		

Department of Education			
Program	**FY09 Funding**	**Service Level**	**Description**
Even Start Family Literacy Program	$472,241	131 Even Start families	Intensive family literacy services to low-income parents and children.
Early Childhood Program (School Readiness)	$79,400,000	10,583 children	Expands and enhance access to and availability of school readiness and child-day care programs.
Total	**$79,872,241**		

Department of Mental Health and Addiction Services			
Program	**FY09 Funding**	**Service Level**	**Description**
Best Practices Initiative	$2,034,178	N/A	Positive youth development programs including academic support, peer leaders, mentors, family development and parenting skills.
Local Prevention Council Programs	$543,120	59,372 children, adults, family and professionals	Alcohol, tobacco, and other drug abuse prevention initiatives at the local level.
Strategic Prevention Framework State Incentive Grant	$2,350,965	172,651 children, family, community members and professional**s**	Developing a comprehensive strategy for delivering and implementing effective substance abuse prevention services.
Youth Suicide Prevention Initiative	$400,000	5,093 students, adults and professionals	Youth suicide prevention and early intervention strategies.
Regional Action Councils	$1,532,698	242,574 children, family, community members and professionals	Community awareness, education, prevention, intervention, treatment and aftercare for substance abuse.
Statewide Service Delivery Agents	$1,976,849	18,146 children, family, community members and professionals	Supports prevention efforts locally and statewide by building the capacity of individuals and communities to deliver prevention services.
Tobacco Regulation & Compliance	$647,967	2,368 retail inspections and 772 children and adults	Enforcement and strategies to reduce underage tobacco use.
Total	**$9,485,777**		

Department of Public Health			
Program	**FY09 Funding**	**Service Level**	**Description**
Asthma Program: Easy Breathing	$1,000,000	10,304 children	Statewide training of pediatric providers on determining whether a child has asthma, asthma severity, proper therapy, and developing treatment plans.
Child Day Care Licensing	$1,934,957	114,151 Licensed Capacity	Regulates child day care programs through technical assistance, application processing, facility monitoring, complaint investigation, and enforcement activities.
Community Health Centers	$7,552,912	219,912 clients	Provides comprehensive, community-based, primary and preventive health care.
Family Planning	$1,063,048	39,473 participants	Provides preventive and primary reproductive health care through health care services, information, and education to the uninsured or underserved.
Immunization Program	$44,830,209	69.8% of the state's children aged 2	Prevent disease, disability and death from vaccine preventable diseases in infants, children adolescents and adults.
Injury Prevention - Unintentional Childhood	$40,00	266 parents/caregivers and 301 children	Technical assistance and resources to providers and community agencies on injury prevention issues.
Injury Prevention Intentional Youth Violence	$45,188	11,887 youth	Raises awareness, increase knowledge and changes manageable behaviors.
Lead Poisoning Prevention and Control	-	270,187 children	Education, outreach, and screening e targeted toward urban settings.
Newborn Laboratory Screening and Tracking	$1,113,407	42,411 infants screened	Screening for inborn genetic disorders which have the potential for severe health consequences.
Nutrition, Physical, Activity and Obesity	$2,032,657	112,000 children and families	Develops school readiness teachers' capability and motivation to provide nutrition and physical activity experiences, increases young children's exposure to healthy foods and physical activity; and builds teachers' and parents' capability to create and maintain healthy mealtime environments.
Oral Health-Home by One	$247,448	25,000 children	Provides training and education of physicians, dental professionals, WIC staff, early childhood providers and parents to support age one dental visits for at-risk children.
Rape Crisis and Prevention Services	$1,014,729	30,416 children, youth, adolescents, patients, clients, primary and secondary victims	Makes available to sexual assault victims and their families free and confidential services such as crisis intervention, support and advocacy, survivor groups, 24-hour hotline, and emergency transportation.
Tobacco Use Prevention and Control	$1,702,260	2,285 individuals	Provides local cessation and prevention programs.
Women, Infant and Children	$51,280,930	46,641 children and 13,209 women	Provides nutrition and breastfeeding education, supplemental food, and referrals for health and social services to eligible women, infants and children.
Total	**$113,857,745**		

Department of Social Services			
Program	**FY09 Funding**	**Service Level**	**Description**
Family Planning	$1,090,074	15,000 residents	Comprehensive reproductive health care to low-income –income eligible residents.
Employment and Training Reimbursement Program for SNAP Recipients	$229,153	400 participants	Development of local collaboratives to provide comprehensive employment and training programs for SNAP recipients.
Emergency Shelter for Victims of Domestic Violence	$3,569,771	875 Women; 773 children (0-12) and 94 teenagers	Provides emergency shelter and host homes, 24-hour hotline, shelter-based programs that address the health and safety needs of victims, and programs and services for child witnesses that help to reduce the likelihood of intergenerational transmission of domestic violence.
Fatherhood Initiative	$250,000	204 fathers	Improves fathers' ability to be fully and positively involved in all aspects of their children's lives by providing preparation for employment, job search assistance and referrals, life skills training, case management, and parent skills education.
Promoting Responsible Fatherhood	$1,000,000	1,502 fathers and mothers and 59 couples	Services include enhanced prevention and intervention strategies that promote healthy marriage, responsible parenting, and economic stability.
Teen Pregnancy Prevention	$2,427,547	799 youth	Provides information and enrichment activities to youth between ages 11 and 17 who are at risk for teen pregnancy.
Total	**$8,566,545**		

Office of Policy and Management			
Program	**FY09 Funding**	**Service Level**	**Description**
Title V Delinquency Prevention	$78,252	93 youth (10-18 years old)	Provides grants to cities and towns for delinquency prevention and early intervention projects.
Governor's Urban Youth Violence Prevention	$1,500,000	1,235 youth (12-18 years old)	Provides grants to municipalities and nonprofits that serve youth in urban neighborhoods who are at-risk of exposure to or involvement with violent behaviors.
Total	**$1,578,252**		

- **Nurturing Families Network**
- **Help Me Grow**

Long-Term Agency Goals: The goal of the Children's Trust Fund is to prevent child abuse and neglect and to ensure the positive development of children. The funds appropriated to the Children's Trust Fund are used to support community efforts that assist families. The community programs are designed to engage families before a crisis occurs to actually keep abuse and neglect from happening. This strategy is working. The programs supported by the Children's Trust Fund are making a difference in the lives of children and their parents while reducing the number of families that enter the state child welfare system.

Strategies: To achieve its goal the Trust Fund:

- Conducts research to better understand and assess areas of risk for child abuse and neglect, finds the most effective ways to assist families, and develops strategies for improving the skills of service providers.
- Funds broad-based prevention efforts in communities that have been shown to address known risk factors for child abuse and neglect, including poverty, substance abuse, domestic violence, and social isolation.
- Funds programs that include a strong focus on matters that effect the well being of children including improving parent-child bonding and interaction, parenting skills and family relationships, healthy living and health care access, and developmental monitoring.
- Offers a range of program services to meet the needs of all families.
- Trains human services staff in prevention approaches and strategies to engage and assist culturally diverse and vulnerable families.
- Supports a network of agencies that work together to support families around their multiple needs.
- Increases public awareness and participation in efforts to prevent child abuse and neglect.

Performance-Based Outcomes:

- Reduced rate and severity of child abuse and neglect.
- Improved parent –child interaction and parenting skills.
- Connection to health care providers, high immunization rates.
- Gains in household stability, education, employment.
- Less financial hardship and access to more resources.
- Enhanced family relationship and parent well-being.
- Increases in developmental monitoring and access to services.
- Enhanced child well being over time.

Measure of Effectiveness: Several studies conducted at the University of Hartford's Center for Social Research show that programs supported by the Trust Fund are successfully providing support and assistance to high-risk families. The studies show that these programs are reducing the incidence and severity of child abuse and neglect and are helping parents to take hold of their responsibilities and to become better caregivers. Highlights of this research follows:

- The incidence and severity of child abuse and neglect in the high-risk families served by the Trust Fund is much less than expected.
- The evaluation on its Nurturing Families Network (NFN) shows the incidence of abuse and neglect to be well below that of high-risk families not participating in this type of program; 4% compared to 22%.
- The immunization rate for two-year old children whose families are involved in the program is 93% compared to 73% for two years olds with similar demographic background on Medicaid.
- A significant percentage of the parents are completing high school, becoming employed and moving out of financial hardship.
- The percentage of mothers establishing independent households increased from 53% to 93% in the second year of

program involvement. This is a significant outcome, likely to ensure the future safety of children, given the high number of mothers who were living in abusive or violent or potentially violent households at the start of their program involvement.

- Families are also improving parent-child relationships as well as parenting capacity, attitudes and behavior.

Other research on home visiting shows that the early intervention reduces rates of tobacco and alcohol use, episodes of running away, behavioral problems, arrests, convictions, and sexual promiscuity among teenagers whose families had been reached in this way.

Research on other Trust Fund efforts have found that health care providers have increased their use of developmental surveillance and referrals of at risk youth following training.

Performance-Based Accountability: A continuous quality improvement team has been established to review practice guidelines, training needs and program protocols for the larger Trust Fund programs. The policies are written into a manual that guides program implementation efforts at each site. The Trust Fund staff monitors the sites compliance and effectiveness in implementing the program in accordance with these policies.

The Trust Fund staff works with each contractor to develop an Individualized Program Plan each year. The plan identifies areas in need of attention or improvement and strategies for achieving the identified goal. The sites are responsible for reporting on their progress implementing the plan and the results of their efforts.

Methods: The Trust Fund uses intensive home visiting, developmental surveillance and early identification of developmental delays and behavioral problems, and parent engagement to reduce racial and economic disparity. Methods include:

Intensive multi-focused home visiting:
Several studies have found that home visiting services reduce disparities in child performances and outcomes by race and income level.

One study, conducted by the Missouri Department of Elementary and Secondary Education, found that children enrolled in preschool whose families participated in a home visiting program scored significantly higher on all measures of intelligence, achievement, and language ability than children in the comparison group whose families did not receive home visiting services.
The parents who participated in the home visiting program were mostly young, poor, undereducated, single heads of household. Their children shattered the conventional wisdom that they would perform poorly in school. The children did as well as the national norm for children their age with roughly 15% exceeding the national norm. The children out performed a comparison group of children from wealthier and more stable families not considered at risk for poor outcomes (study available upon request).

How does Help Me Grow reduce disparities by race, income level and gender…?
The National Research Council's report Neurons to Neighborhoods (Shonkoff and Phillips, 2000) and RAND's analysis of early childhood interventions, Investing in Children, (Karoly et al, 1998) indicate that high quality early intervention programs can have very positive results for those children receiving services. These included increases in short and long term academic achievement, reduction in grade retention rates, and reductions in special education referrals and reduction in teenage pregnancy.

The Help Me Grow program offers universal access to anyone in Connecticut who has concerns about their child's learning, behavior or development. Thousands of families have been connected to critical early intervention programs. Help Me Grow provides training to child health providers on developmental screening and connection to services. The Help Me Grow staff has visited over 50% of Connecticut's pediatric and family practices. Based on this research project funded through the Commonwealth Fund, referrals for early intervention have doubled. In addition, Connecticut is the only state that provides universal access to an on-going child development monitoring system called *Ages & Stages.* Anyone in the state can access this free service.

Other: Child abuse and neglect is at the root of many of the problems children face. Children who are abused or neglected are at high risk for developmental and behavioral problems, health issues, learning disabilities and cognitive delays.

Abused or neglected children are more likely to become involved with the child protection and juvenile justice systems and to become involved with the departments of Social Services, Corrections and Mental Health as adults.

Children fare best when they are nurtured by parents who provide for their needs and help through difficult times growing up. And yet we find that most of the families who participate in Trust Fund programs are ripe for a crisis. More than half of the parents served were abused themselves as children, most are poor and have a limited education and more than half are teenagers – who are just growing up themselves.

As a result, many of the mothers are having difficulty bonding with their babies and meeting the needs of their infants. In Connecticut there are thousands more families who struggle with the demands of parenting and who are in the high range for abuse potential.
It is critical that families are reached before a crisis occurs. Child abuse and neglect must be prevented.

Research demonstrates that the strategies employed by the Children's Trust Fund can help more families and more children have a better life. By preventing child abuse and neglect we have a better chance of keeping children safe in their homes, able to perform well in school and have a productive future.

NURTURING FAMILIES NETWORK (NFN): This program operates out of twenty-nine birthing hospitals in the state and in 10 community centers in the city of Hartford and 8 centers in New Haven. NFN provides education and support for all interested new parents and intensive home visiting services for parents identified as most at risk. The NFN reaches more than 4,000 first time families each year and has offered home visiting services to approximately 4,589 vulnerable families at risk of abusing, neglecting or abandoning their children. The program is expanding to eight neighborhood service areas in the City of New Haven and is expecting to reach an additional 250 vulnerable families through its home visiting services. The home visitors become involved during the mother's pregnancy and continue working with the family, on average, for nineteen months. The home visitors teach child development and help the family to bond with and take hold of their responsibility to their child. Seventy percent (70%) of the time fathers are involved. Home visitors support the parent to finish school, to secure a job, and to find and utilize the services of a pediatrician. They connect families to WIC, and to counselors and others in the community who can help. The Network also offers intensive group support to parents and extended family members. The program teaches the family appropriate expectations for their children and fosters empathetic understanding and strategies for enhancing the well being of children. Approximately 600 families have participated in the Nurturing Program each year.

Number of served: 3,500 children and families were served during 2008 – 2009.

Program Cost: FY 2008 – 2009 -$10,148,252

Program Performance-Based Standards: Rate of abuse or neglect; risk of child abuse and neglect; improvements in education and employment; positive change in parenting stress; and positive change in parenting attitudes and expectations of children.

Program Performance-Based Outcomes: 1.3% of families substantiated for abuse or neglect; statistically significant gains on CAPI score (instrument to measure improvement); statistically significant gains in education and employment; statistically significant positive change on the Parenting Stress Index and the AAPI - 2 - standardized instruments to measure these changes.

Performance-Based Vendor Accountability: A continuous quality improvement team has been established to review practice guidelines, training needs and program protocols for the larger Trust Fund programs. The policies are written into a manual that guides program implementation efforts at each site. The Trust Fund staff monitors the sites compliance and effectiveness in implementing the program in accordance with these policies.

The Trust Fund staff works with each contractor to develop an Individualized Program Plan each year. The plan identifies areas in need of attention or improvement and strategies for achieving the identified goal. The sites are responsible for reporting on their progress implementing the plan and the results of their efforts.

The Nurturing Families Network Program is required to participate in extensive evaluation of services including process and outcome measures; and required to participate in extensive evaluation of services including process and outcome measures required to participate in extensive evaluation of services including process and outcome measures.

HELP ME GROW: The Help Me Grow Program is a prevention initiative that identifies and refers young children with behavioral health, development and psychosocial needs to community-based services. The program bridges the gap between children with early signs of developmental problems and the services designed to address them. The program also offers an *Ages and Stages* child development tracking system for interested parents of children ages 4 months to 5 years. The program serves children who may not be eligible for the state's Birth to Three or preschool special education programs, yet are still at risk for developmental problems.

Number served: 2,500 case management services and 3,129 enrolled in the Ages & Stages Program.

Program Cost: FY 2008 - 2009 **$**355,982

Program Performance Standards: Increases in identification of emerging problems; successful placement for services; and ongoing monitoring.

Program Performance-Based Outcomes: Fourteen percent (14%) increase in 2008 for pediatric referrals; 82% of families were placed into appropriate services; 16% were pending at the time the report was published and a 224% increase in the number of families tracking their child developments.

Performance-Based Vendor Accountability: A continuous quality improvement team has been established to review practice guidelines, training needs and program protocols for the larger Trust Fund programs. The policies are written into a manual that guides program implementation efforts at each site. The Trust Fund staff monitors the sites compliance and effectiveness in implementing the program in accordance with these policies.

The Trust Fund staff works with each contractor to develop an Individualized Program Plan each year. The plan identifies areas in need of attention or improvement and strategies for achieving the identified goal. The sites are responsible for reporting on their progress implementing the plan and the results of their efforts.

The Help Me Grow Program is required to participate in extensive evaluation of services including process and outcome measures.

Department of Children and Families

- **DCF/Head Start Collaboration**
- **Positive Youth and Family Strengthening Development Initiative**
- **Shaken Baby Prevention**
- **Youth Suicide Prevention**

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 four 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. In addition, national research tells us that the earlier interventions are introduced in children's lives the greater the chance for positive results now and later in life.

Methods: The Department's workforce reflects the populations it serves. Through outside funding DCF implemented a program called, The Breakthrough Series, in Waterbury which looked at the issue of over representation of minorities in the child welfare system. The lessons learned from this effort as well as through programs such as Better Together which engage families in our work inform the Department's ongoing efforts to address this issue. In addition, DCF requires that all contractors administer, manage and deliver a culturally responsive and competent program with specifics clearly articulated in every contract.

Other: Building local and agency capacity is done primarily through training. Since 2005, thousands have been trained in a variety of workshops and conferences on 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.

Public awareness is basically the belief that knowledge is power. Getting important and timely information to families, providers and DCF personnel requires constant contacts. To this end, thousands of letters and brochures are mailed annually to schools, superintendents, police, youth service bureaus, and DCF Area Offices and information is regularly distributed electronically through the Prevention list serve. The new CT Parenting website http://www.ctparenting.com/ offers parents and other individuals a place on the internet for a wealth of information on a multitude of topics for parents and caregivers. Launched in 2008, this website now sees over a thousand unique individual website visits every week.

Programs and services are designed to strengthen children and families and the communities in which they live. The Positive Youth Development / Family Strengthening Initiative has served over two thousand youth and adults since 2005, resulting in improved communications between youth and parents and improved life skills in the youth. Another unique collaborative is the Shaken Baby Prevention Pilot which targets DCF, DMHAS, DPH and DOC populations with training in awareness and baby soothing techniques.

We know from national research studies that very young children are especially vulnerable. The Adverse Childhood Experiences 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. In other words, what happens to young children stays with them for life. This emphasizes the need for prevention and early intervention programs for this particular population.

It is precisely for this reason that the Prevention Division focuses 80% of its budget on children, birth to age 8, and their families. Two new Parents in Partnership programs have recently received DCF contracts. Each of these contracts serves 45 – 65 families in Bridgeport and Norwich with preschool intervention services for children and their parents. The Early Childhood Consultation Partnership

(ECCP) provides early childhood mental health consultation services to early care and education centers statewide and for children at risk of disruption and their foster parents. Over 8,000 children have been served through ECCP within core class rooms since 2003, resulting in far fewer at risk youth being suspended from preschools.

Another early childhood project, the DCF Head Start Partnership, saw 108 children referred to Head Start and 67 enrolled just from July through October 2008. Through this Partnership, the Department has been better able to engage and serve families of young children. Since 2006, every DCF Area Offices has linked with their local Head Start offices resulting in more DCF young children receiving a high quality preschool experience, more offices engaging in joint treatment planning and more potential foster parents identified.

As important as programs, services and information are to meeting our goals, it is equally important to know that what we are doing is actually working. So the Prevention Division contracts with outside evaluators to report on program effectiveness, provide technical assistance and make recommendations.

Families need comprehensive and connected services. It is crucial that we connect all the points of the continuum. Prevention must be integrated into the very fabric of the Department. This occurs through training, information sharing and collaboration. In addition, every Area Office has an identified Prevention Liaison who helps integrate prevention into the work at the local level.

DCF / HEAD START COLLABORATION: The original collaborative effort began in July 1999 in the Department of Children and Families (DCF) offices in Torrington, Waterbury and Danbury, and Head Start Programs in Litchfield County, Waterbury, Naugatuck and Danbury. The collaboration involved 150 staff from both agencies, developed new knowledge and understanding of the partner agency's program, improved communication, referral and collaboration; and had developed new services and resources. In February 2006, this collaborative partnership was revived and expanded to an additional five sites. The focus on this partnership is to develop strategies to promote family health and the stability of the child within the family. Fourteen DCF Area Offices have formed partnerships with the Head Start programs in their area affording more young children in DCF placement the opportunity to receive a high quality preschool experience and more support and resources for their parents

Number Served: 8,728 children (0-5 yr); 44 pregnant women; 14 DCF area offices; 75 DCF staff; 100 Head Start staff

Program Cost: FY 2008 - 2009 This is a statewide collaboration between DCF Central Office and area offices, the CT Head Start State Collaboration Office, and local Head Start and Early Head Start programs. Funding is not allocated to this collaboration.

Performance-Based Standards: This is a statewide collaboration and does not have any contracts.

Performance-Based Outcomes: This is a new initiative. Performance based outcomes are being developed. Possible outcomes include the number of children involved with DCF who are enrolled in Head Start, the number of Head Start programs with a DCF social worker on their policy council, , the number of area offices conducting joint treatment planning, the number of DCF area offices that have a collaboration with the Head Start programs in their area, the number of Head Start programs utilizing the early Childhood Consultation Partnership consultant, the number of Head Start programs with an early Childhood Behavioral Consultation program the number of Head Start programs conducting joint home visits with their DCF area office. The enrollment rate for each Head Start program, the number of Head Start programs working with their DCF area office to recruit foster parents, the number of DCF area offices with an organized system for referring children to Head Start for enrollment.

Performance-Based Vendor Accountability: This is a statewide collaboration and does not have any contracts.

POSITIVE YOUTH AND FAMILY STRENGTHENING DEVELOPMENT INITIATIVE: The Department funds seven (7) agencies, all using evidence-based or best practice models, to provide positive youth development (ages 6-13) and family strengthening programs. The Bureau of Prevention staffs bimonthly technical assistance meetings. Long-Term Goals include: (1) an increase in the social-emotional skills of children through a universal prevention program/strategy, (2) an increase in support and opportunities for young people and their families through enrichment and/or recreation, (3) an increase in bonding of children to their parents, school and peers, (4) an increase in the engagement of/and communication with families, and (5) an increase in youth and families' ability to seek help when needed. The programs are located in Enfield, Torrington, Hartford, New Haven, West Haven, Willimantic and Bridgeport.

Number Served: 633 children and 95 adults

Program Cost: FY 2008 - 2009 $754,035

Performance-Based Standards: Designed to teach social skills, promote positive mental health and support the role of parents of children ages 6 through 12. They teach children effective communication, understanding feelings, coping with anger and criticism, stress management, social skills, problem solving, resisting peer pressure, consequences of substance use, and compliance with parental rules. Families taught skills to strengthen communication and bonds within their family by providing feedback to families, modeling desired outcomes and providing opportunities for families to practice their new skills.

Performance-Based Outcomes: For parents: Better parent child communication, learning key parenting skills such as self-regulation, boundary setting, and commitment to family time. For youth: Increased knowledge about drug, alcohol and other risky behavior. Learning conflict resolution skills and other key life skills such as self-regulation, communication, and goals/life planning.

Performance-Based Vendor Accountability: An independent evaluator is assisting the Department, in partnership with the providers, to develop common outcomes for this initiative, gather data and monitor effectiveness. The purpose of the evaluation of PYDI is to understand and document the process and effect of replicable, evidence-based prevention models (e.g. PATHS, FAST, Second Step, Strengthening Families, SPF 10-14, and All Stars) and two promising practices (Better Horizons and Farnam House) in CT communities. The outcome evaluation involves the analysis/synthesis of program specific surveys and common outcome surveys.

SHAKEN BABY PREVENTION: Persistent crying is known to be a trigger for shaken baby and a number of State Agencies formed a Collaborative to work on preventing shaken baby by addressing the issue of parents' response to their baby's' crying. The Department of Children and Families led this Collaborative consisting of Department of Mental Health and Addiction Services (DMHAS), Department of Correction (DOC), Department of Public Health (DPH), and Office of the Child Advocate (OCA). All partners supported this initiative with dollars and staff. Parent educators were recruited from contracted providers of those agencies and included substance abuse residential programs, York Correctional Institution, Women, Infant and Children's (WIC), Community Health Centers, Maternity Homes and Independent Living Centers for Youth. The Happiest Baby on the Block (a behavioral intervention) teaches parents strategies for soothing crying babies. The period of Purple Crying (a cognitive intervention) normalizes crying by putting it in the context of normal infant development and parent educators teach their parents to never shake a baby.

Number Served: A total of 43 Parent Educators have been trained in either The Period of Purple Crying or the Happiest Baby on the Block. A total of 78 parents have been trained.

Program Cost: FY 2008 - 2009 $55,000

Performance-Based Standards: There were no contracts. Agencies participated voluntarily and received no compensation for participating in the pilot.

Performance-Based Outcomes: Parents will feel more confident about parenting and parent educators will feel more effective in working with parents.

Performance-Based Vendor Accountability: An independent evaluator, DMHAS' Director of Research is in the process of conducting an evaluation.

YOUTH SUICIDE: PREVENTION: The Connecticut Youth Suicide Advisory Board (YSAB) was legislatively established in 1989 within the Department of Children & Families. The membership is comprised of volunteers and community and state agency representatives with the goal of preventing suicide among children and youth. This goal is accomplished through statewide awareness campaigns and training.

Number Served: 1,163 individuals trained. Information emailed and posted statewide.

Program Cost: FY 2008 - 2009 $69,995

Performance-Based Standards: Numbers and types of populations trained (e.g. police, parents, school social workers, and youth). Number and types of information and public awareness efforts.

Performance-Based Outcomes: Parents, foster parents, caregivers, youth workers, police, first responders and schools will be better able to identify and appropriately respond to suicidal youth. Public awareness will be raised.

Performance-Based Vendor Accountability: All contractors are monitored and held accountable to their contracts. Satisfaction type surveys are conducted at the end of each training session.

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

Long-Term Agency Goals: The Department of Developmental Services (DDS) serves over 15,000 individuals who have mental retardation in Connecticut including 2,825 children under the age of 18. This number does not include children who are served in the Birth to Three System. While most children live with their families, approximately 215 children served by DDS 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 disabilities or delays to ameliorate the delay or to at least prevent secondary disabilities; 2) support families to care f

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 disabilities 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 mental retardation. 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.

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 referral service or help line is being put in place in all regions this fall to assist families who do not have a case manager to access appropriate family support services.

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 children's development, and fewer children need special education services by Kindergarten. For children over the age of three, children 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: Other than in the Birth to Three Program, DDS is unique among state agencies that provide services, in that individuals eligible for DDS supports and services have a diagnosis of mental retardation and will likely require lifetime services. While mental retardation in and of itself is not "preventable", strategies are pursued to lessen or delay the need for more comprehensive services throughout a consumer's lifetime and to provide support 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, the data supports that the stated outcomes are being achieved to a great degree.

Methods: All children that meet the DDS eligibility criteria for all programs are eligible, irrespective of race, income level, gender or town of residence. Birth to Three is an entitlement program and all eligible children receive services. The focus of services is in teaching the family and other caregivers to intervene in the child's development during naturally occurring routines and activities. Resources for other programs are allocated to consumers and families based upon an individual's level of need and available appropriations.

BIRTH TO THREE: The Department of Developmental Services 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. We work 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 those groups.

Early intervention services must be delivered in natural environments, and for children at this age, that is 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 2009, 9,228 referrals were accepted for evaluation. 9,671 eligible children and their families received services during some portion of the fiscal year, with an average of 5,000 enrolled on any given day.

Program Cost: FY 2008 - 2009 $47,645,943

Performance-Based Standards: There is a single statewide point of access, which is easily marketed to 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 unless parents opt out of that notification.

Performance-Based Outcomes:

- All eligible children and their families are identified and offered services
- Children receive early intervention services as early as possible
- 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 data system that enables the state to view their performance on a daily basis. As part of that data system, the contractors have a "performance dashboard" that allows them to monitor their own performance.

State Performance Plan/Annual Performance Report - The department submitted 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 Individual with Disability Education Act (IDEA) for any indicator receives a finding of non-compliance which must be corrected as soon as possible but no later than twelve (12) months from written identification.

Self Review- **In** addition, every two years, each Birth to Three contractor submits self-review looking at their performance over a wide variety of indicators. That review is submitted electronically to DDS central office staff who verifies the data and the contractor is required to prepare an improvement plan for any items that are either not in compliance with the law or performance items that need improvement. Twice a year, the state ranks contractors on one or more specific indicators chosen by a stakeholders 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 no later than twelve (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 they have been held infrequently. All of these accountability processes are detailed in the Birth to Three Quality Assurance Manual found on www.birth23.org under "Publications".

FAMILY SUPPORT SERVICES which includes Department of Developmental Services (DDS) Respite Centers and DDS Family Support Workers. The DDS provides Family Supports that assist families to care for their children who have intellectual disabilities in their homes. Most families who have children with intellectual disabilities 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 intellectual disabilities. 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 who have mental retardation 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 1,203 individuals statewide in FY 09, including 384 children. During FY 09, DDS family support workers provided services to more than 1,189 individuals statewide, including 448 children.

Program Cost: FY 2008 - 2009 $ 3,368,157

Performance-Based Standards: The goal of DDS Family Supports is to provide a range of supports for families of children with intellectual disabilities so they can stay together and keep their children in the family home. DDS prioritizes family supports based upon the level of need of the child and the family; 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. The procedures describe 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.

- **Even Start Family Literacy Program**
- **Early Childhood Program (School Readiness)**

Long-Term Agency Goal #1:

High-quality preschool education for all students, including preschool programs aligned with *Connecticut's Preschool Curriculum Framework and Preschool Assessment Framework* and linked to the *Connecticut Framework: K-12 Curricular Goals and Standards.* This will require alignment of research-based curriculum implemented by high-quality teachers in preschool through Grade 3, with a monitoring and assessment system aligned to the state standards.

Strategies and Methods:
The State Board of Education will take the necessary steps to support the following state actions to address this priority:

- Provide funding for high-quality preschool education for all 3- and 4-year-old children living in high-need districts, as well as those children most in need throughout the state
- Provide incentives to districts to assume increased responsibility for high-quality preschool education
- Increase funds to existing state programs, such as School Readiness and Head Start, to support high-quality preschool education
- Revise current statute to increase funding for both school construction and the child-care facilities loan funds to expand capacity for preschool education
- Provide assistance to enable children of families most in need to receive a high-quality preschool education
- Collaborate with Connecticut higher education to establish a seamless system between two- and four-year programs to prepare high-quality early childhood educators
- Collaborate with Connecticut higher education institutions to provide incentives, such as scholarships, tuition waivers and forgivable loans, to candidates seeking an early childhood credential
- Expand early childhood educator preparation programs to allow alternate forms of obtaining a required credential, such as distance learning, off-campus and satellite learning centers, employment based and credit-granting courses, and supervised practicum; emphasis will be placed on increasing minority candidate participation
- Provide ongoing, systematic professional development in the use of *Connecticut's Preschool Curriculum Framework* and *Preschool Assessment Framework* to ensure that all early childhood educators have the knowledge and skills to prepare children for future school success
- Collaborate with the Department of Public Health to modify the role of the education consultant to support early childhood educators in effective instructional practices consistent with *Connecticut's Preschool Curriculum Framework* and *Preschool Assessment Framework*
- Establish a system of monitoring and technical assistance to support effective instructional practices consistent with *Connecticut's Preschool Curriculum Framework* and *Preschool Assessment Framework* and aligned with the *Connecticut Framework: K-12 Curricular Goals and Standards*

- Support the design and implementation of a developmentally appropriate measure of children's readiness for and progress in kindergarten

Outcome and Measures of Effectiveness:
The expected outcome is a high-quality preschool education for all young children in Connecticut. The following indicators will serve as measures of success:

- More children will participate in high-quality, state-funded preschool programs, and there will be greater access to high-quality preschool programs statewide.

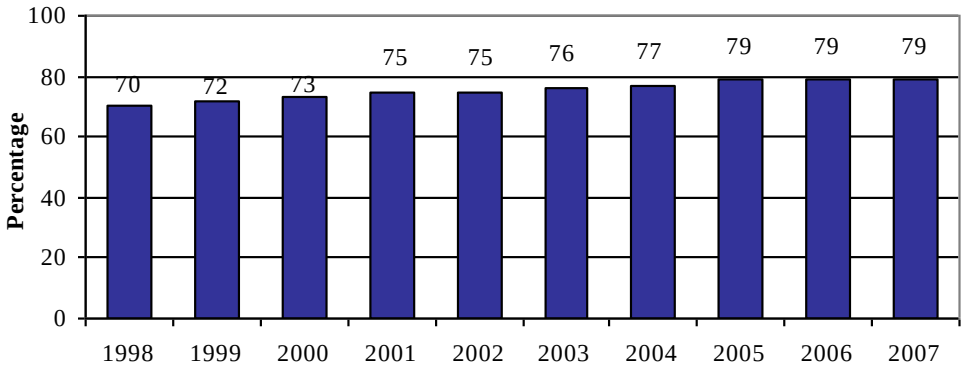
- More teachers will have specialized credentials in early childhood education and the skills and knowledge to provide a high-quality preschool education.

- All preschool programs will include a rigorous curriculum and an assessment system aligned to *Connecticut's Preschool Curriculum Framework* and *Preschool Assessment Framework.*

- Children who participate in all preschool programs will enter kindergarten fully prepared for further learning in literacy and numeracy.
- All children will have competencies in areas that support their learning and academic success, which include physical and motor development, creative and aesthetic expression, and personal, social and emotional skills.

Overall Findings on Effectiveness:
After increasing by 9 percentage points from 1998 to 2005, the percentage of kindergarteners with prekindergarten experience has remained stable at 79 percent for the last three years. The high rate of kindergarteners with a prekindergarten experience means that the vast majority of kindergarteners enter kindergarten having some preparation for school. There is room for improvement, however. In 2007-08, more than 8,000 students entered kindergarten without prekindergarten educational experience. (Source: *The Condition of Education in Connecticut*, Connecticut State Department of Education, 2009).

Percentage of Kindergartners Who Attended Preschool, Nursery School or Head Start



Long-Term Agency Goal #2:

High academic achievement of all students in reading, writing, mathematics and science, with a focus on students in high-need schools and districts. High achievement will result only if all students are *expected* to achieve at high levels and have equal access to challenging curriculum and instruction, and adequate and equitable resources; and are taught by excellent educators who believe that all students, regardless of race, gender, ethnicity or socioeconomic status, can achieve at high levels.

Strategies and Methods:
The State Board of Education will take the necessary steps to support the following state actions to address this priority:

- Develop model curriculums in reading, mathematics and science for prekindergarten through Grade 8
- Develop model curriculums for algebra and geometry
- Provide training and technical support for educators in the implementation of curriculums and monitor implementation in high-need districts
- Develop formative assessments, aligned to model curriculums, and provide training in the use of formative assessments
- Require low-performing districts to administer formative assessments in reading, writing, mathematics and science at all grade levels and use the information to improve instruction
- Establish incentives to attract, support and retain highly qualified and effective teachers in high-need districts, with priority given to attracting minority teachers
- Support "grow-your-own" programs in high-need districts by identifying (1) mentors for classroom-based support programs to increase teacher retention, (2) outstanding paraprofessionals to become certified teachers and (3) teachers who exhibit strong leadership skills to become school leaders/administrators
- Provide communication and outreach to middle and high school students from high-need districts on incentives available after high school graduation to those who attend educator preparation programs in Connecticut
- Collaborate with higher education in Connecticut to provide tuition assistance to students most in need to pursue teaching careers in mathematics and science
- Conduct a comprehensive evaluation of all components of the BEST Program and implement appropriate changes based on evaluation findings to ensure that all beginning teachers provide high-quality, effective instruction
- Develop and provide an induction program for all new administrators, beginning in high-need districts
- Establish pilot programs for extended learning opportunities beyond the regular school day and year, such as before- and after-school programs, weekend programs, tutoring, homework help and summer school, with expansion to additional schools based on results of the pilot
- Align pre-service training with the National Council for Accreditation of Teacher Education (NCATE) standards on partnering with families and communities
- Provide professional development to school and district staff members in developing effective school-family- community/business partnerships based on State Board of Education standards
- Continue to expand the Connecticut Accountability for Learning Initiative (CALI) and support schools and districts identified by the No Child Left Behind Act (NCLB) in Year 3 of "in need of improvement" by:
    - requiring school-wide instructional assessment by an external evaluator;

- requiring the review of reading and mathematics curriculums in these districts and, if not standards-based, requiring implementation of State Department of Education model curriculums;

- requiring on-site coaching of superintendents and principals in these districts, using as coaches administrators with records of high student achievement;

- requiring leadership training for superintendents and principals in these districts in developing and implementing high-level instruction in reading and mathematics across all grade levels;

- requiring the use of formative assessments in each of these districts to improve instruction; and

- requiring the use of a longitudinal data system to track student indicators having direct impact on student achievement

Outcome and Measures of Effectiveness:
The expected outcome for each of these actions is increased achievement of all students and a significant closing of the achievement gap in reading, writing, mathematics and science.

The following indicators, which are closely linked to student achievement, will serve as measures of success:

- Curriculums aligned to the *Connecticut Framework: K-12 Curricular Goals and Standards* implemented in every school

- District implementation of the full range of assessment options available, including common grade-level or subject-area assessments, benchmark assessments and formative classroom assessments

- Increased teacher retention rates and the number of minority teachers in high-need districts

- Increased retention of high-quality, new administrators in high-need districts

- Enhanced BEST Program so all beginning teachers are provided the necessary support for effective teaching of all students

- Fewer districts and schools identified as "in need of improvement" and "in need of corrective action"

- Implementation of a data system to measure student growth longitudinally

- Significant increases in reading, writing, mathematics and science achievement within one year at schools with pilot programs for extended learning opportunities

- Increased family participation in the planning and improvement of school programs

- Increased support to families for supporting children's learning at home

- Improved district policies on school-family-community/ business involvement and consistent implementation of these policies

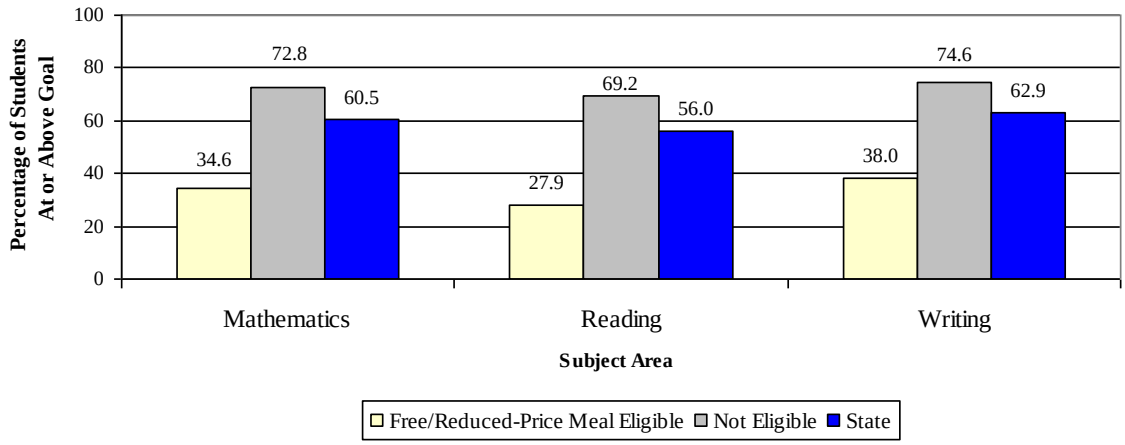
Overall Findings on Effectiveness:
Findings on effectiveness are summarized below for elementary and middle school students based on the Connecticut Mastery Test (CMT) and for high school students based on the Connecticut Academic Performance Test (CAPT). More detailed information can be found in *The Condition of Education in Connecticut* (Connecticut State Department of Education, 2009) and online at www.ctreports.com.

Connecticut Mastery Test (Grades 3 through 8)
Overall, Connecticut's elementary and middle grade students generally improved their performance in mathematics and reading, while posting mixed results in writing on the 2008 CMT. The annual, state-administered CMT assesses approximately 250,000 students in Grades 3 through 8 on their application of skills and knowledge in mathematics, reading and writing. For the first time in 2008, public school students in Grades 5 and 8 were also given an assessment in science. For all grades assessed, CMT test scores are reported at five achievement levels: Below Basic, Basic, Proficient, Goal and Advanced. While the percentage of students scoring at or above Proficiency is used to meet the NCLB standards, Connecticut continues to use the higher standard of Goal or above as its standard for achievement.

The 2008 results indicate student performance gaps based on families' economic status. The Connecticut State Department of Education (CSDE) uses eligibility for free and reduced-price meals (FRM) under the National School Lunch Program as its poverty indicator. Federal nutrition program eligibility is based on household size and income. More than one in four (or 28.7 percent) of Connecticut students came from families poor enough to qualify for free and reduced-price meals. In all subjects tested and in all grades, a higher percentage of noneligible students scored at or above goal and at or above proficient than their FRM-eligible peers.

For example, Grade 4 data indicate that students who were not eligible for free and reduced-price meals outperformed their peers in the three areas assessed (i.e., mathematics, reading and writing). The gap between those students eligible for free and reduced-price meals and those not eligible was very large with no difference smaller than 35 percentage points and the gap in reading exceeded 41 percentage points.

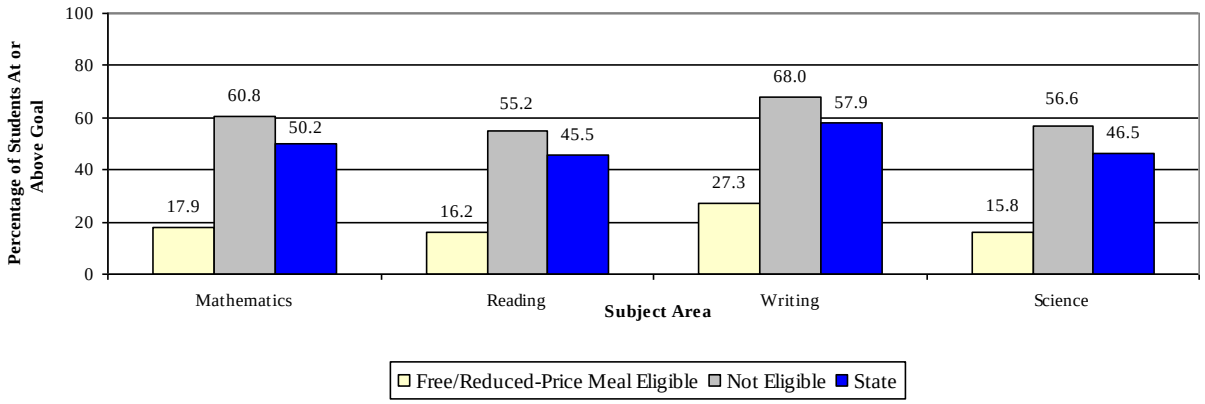
Connecticut Mastery Test - Grade 4
Percentage of Students At or Above Goal



Connecticut Academic Performance Test (Grade 10)
Grade 10 students take the CAPT in the spring of each year. This test assesses student performance in mathematics, science, reading and writing. The CAPT is aligned with Connecticut's curriculum frameworks and provides information on how well students are performing with respect to the critical skills required in the four content areas. As on the CMT, CAPT scores are reported at five achievement levels (Below Basic, Basic, Proficient, Goal and Advanced). While Connecticut uses the Proficient level for NCLB purposes, the state continues to use the higher standard of Goal or above as its benchmark for achievement.

As on the CMT, students eligible for free and reduced-price meals lagged behind their noneligible peers on all four assessments of the CAPT. Overall, Grade 10 students scored the highest on the writing assessment with 57.9 percent of students scoring at or above Goal. This strength in writing was seen in students eligible for free and reduced-price meals as well as those noneligible students. The weakest subject overall was reading with only 45.5 percent of Grade 10 students achieving the Goal level. The reading assessment also saw the smallest achievement gap of the four CAPT assessments with a gap of 39 percentage points.

Connecticut Academic Performance Test
Percentage of Students At or Above Goal



Long-Term Agency Goal #3:

High school reform, so all students graduate and are prepared for lifelong learning and careers in a competitive, global economy. This will require all high schools to provide a rigorous, literacy-based curriculum linked to authentic, real-life experiences;
performance-based assessments; a school climate in which personal and social responsibility is practiced; and school-business partnerships that offers students tangible knowledge and experience.

Strategies and Methods:
The State Board of Education will take the necessary steps to support the following state actions to address this priority:

- Increase graduation requirements to reflect the skills needed to ensure success in a global society
- Establish competencies stating what students should know and be able to do upon graduation from Connecticut's high schools in order to be successful in postsecondary activities, and require districts to align local graduation requirements with the established competencies
- Ensure that all districts develop and implement rigorous, standards-based curriculums to meet the changing needs of the workplace, technology and a global economy
- Allow standards-based alternatives for demonstrating knowledge, skills and understanding as a way to earn high school and/or college credits
- Require access to meaningful out-of-school learning experiences for all students
- Develop strategies to reduce the number of students who are suspended from and/or drop out of high school, including alternate programs for students most in need
- Create and sustain a data warehouse to track students' performance from preschool through college
- Attract, support and retain highly effective secondary school administrators to meet the challenges and demands of redesigning Connecticut's high schools
- Require that all students have a personal education plan that includes career development, in- and out-of-school coursework and/or activities, and transition to postsecondary education and/or the workplace.

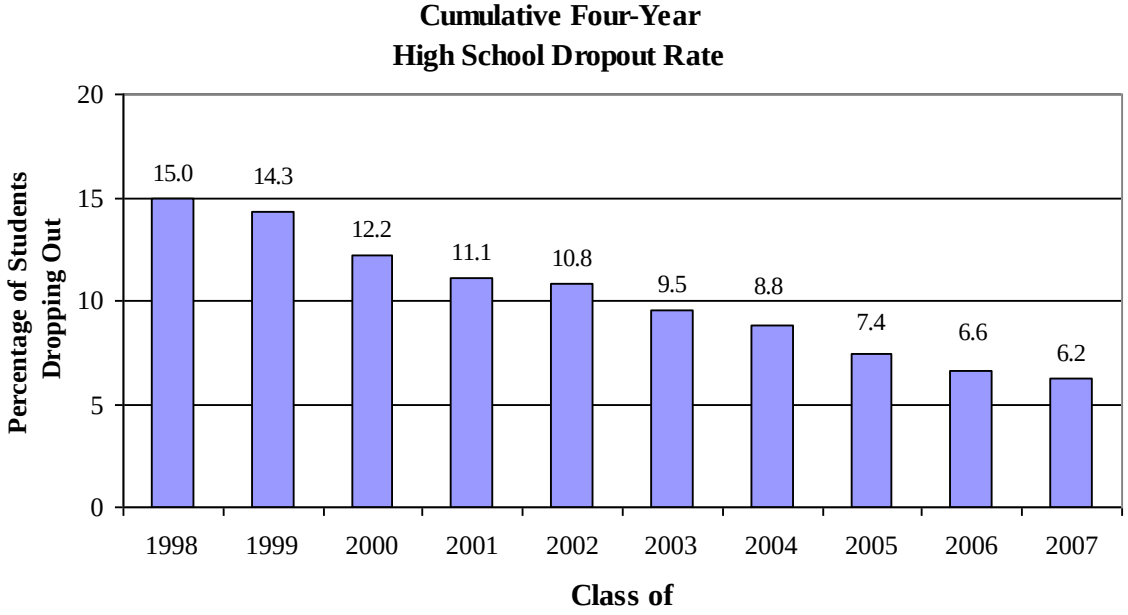
Outcomes and Measures of Effectiveness:
All Connecticut high schools will be redefined using the research-based standards in the *Framework for Connecticut's High School: A Working Guide for High School Redesign.* The expected outcome from the preceding action is to have every student graduate from high school prepared for college and work.

Each high school will fully prepare students when the following are in place:

- a clear mission defining what it seeks to achieve;
- a rigorous, standards-based curriculum;
- a strong school community focused on the school's mission and high expectations for student learning;
- a small, safe, personalized and positive learning environment;
- embedded professional development with the single purpose of improving teaching and learning;
- a system using accurate data to inform and transform teaching, learning, leadership and management practices; and
- learning opportunities for all students that extend into the community.

Overall Findings on Effectiveness:
In the spring of 2008, 38,097 students graduated with diplomas from Connecticut public high schools and moved into a number of post-high school activities. The CSDE's long-term agency goal for high school effectiveness can be examined through data on dropout rates and the subsequent activities of high school graduates.

Since the class of 1998, Connecticut's cumulative four-year percentage of high school dropouts (the percentage of students of a class of students that drop out between Grade 9 and graduation) has been consistently declining. During this period, the cumulative dropout rate decreased from 15 percent for the class of 1998 to 6.2 percent for the class of 2007. More than half of the 2008 graduates attended a four-year college or university. An additional 27 percent of the graduates continued their education at two-year colleges or other educational institutions. Of the graduates who did not further their education, three out of four were engaged in civilian employment. In all, more than 93 percent of the 2008 graduates were either furthering their education or engaged in military or civilian employment. (Source: *The Condition of Education in Connecticut*, Connecticut State Department of Education, 2009).



EVEN START FAMILY LITERACY PROGRAM

Purpose: To break the cycle of poverty and illiteracy for low-income families.

Even Start is a federally-funded program that provides intensive family literacy services that involve parents and children in a cooperative effort to help parents become full partners in the education of their children and assist children in reaching their full potential as learners. Even Start helps break the cycle of poverty and illiteracy by improving the education opportunities of families most in need in terms of poverty and illiteracy by integrating early childhood education, adult literacy or adult basic education, and parenting education into a unified family literacy program. Local programs are implemented through cooperative projects that build on high-quality existing community resources, creating a new range of services for low income children and parents.

Even Start helps children and families achieve the academic standards set forth by the state and uses instructional programs that are based on scientifically-based reading research to:

- enrich language development, extend learning and support high levels of educational success for children birth to age seven and their parents;
- provide literacy services of sufficient hours and duration to make sustainable changes in a family;
- provide integrated instructional services for families, where children and their parents learn together to develop habits of life-long learning; and
- support families committed to education and to economic independence.

Number Served: During the 2008-09 period, Even Start in Connecticut operated with five programs serving high-need areas of Danbury, Middletown, New London, Shelton, and Windham. Programs served 131 Even Start families (134 adults and 156 children) through early childhood education, adult education, and parenting classes. The number of programs supported has dropped significantly from a previous service level of 11 programs.

Program Cost FY 2008-2009: $472,241.

Performance-Based Standards:

1. It is expected that 50 to 65 percent of the Even Start children birth through age 5 will meet the reading readiness standards for their age group.

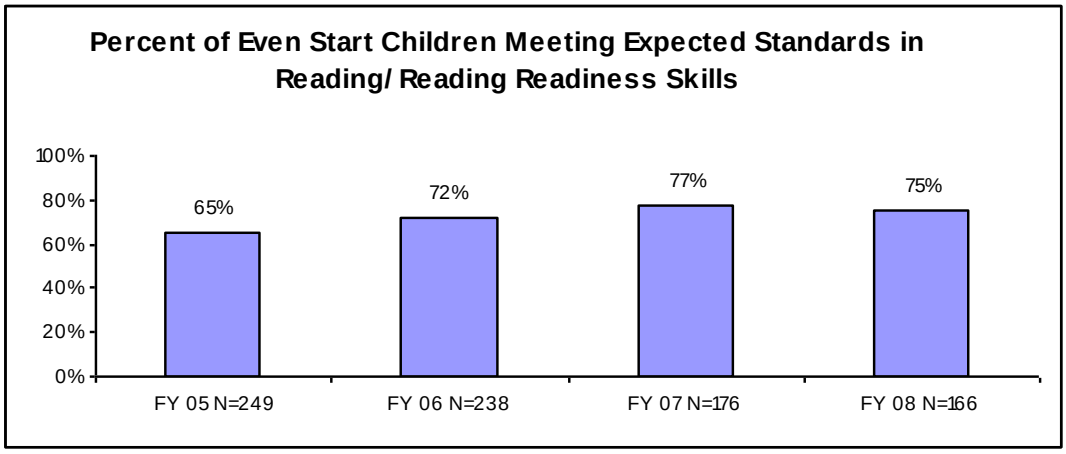
2. It is expected that 40 percent or more of the adults will meet adult literacy goals in Adult Basic Education or English as a Second Language reading and 60 percent of the adults in a high school diploma or General Educational Development program will make progress toward attaining a diploma.

3. It is expected that 40 to 60 percent of the parents will meet standards for skill development in family literacy such as reading to child, borrowing books from the library or other sources, encouraging children to read with them at home, etc.

Performance-Based Outcomes:

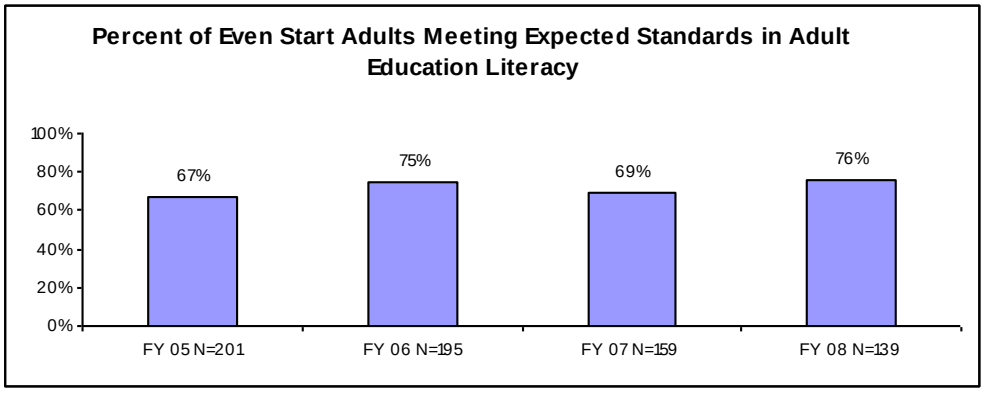
Although we see solid gains in Even Start, the number of participants continues to decrease due to federal budget cuts. Connecticut's federal allocation has decreased 70 percent from $1,615,000 in 2005-06 to $472,241 in 2008-09. Level federal funding is anticipated for 2009-10. In order to accommodate rising program costs and maintain fidelity to the federal program requirements, the number of participants will continue to decline in 2009-2010.

Performance Measure 1: Percent of Even Start children meeting standards in reading/reading readiness skills.



Even Start program performance data show that between 65 percent to 77 percent of the children met or exceeded standards in reading readiness for their age group (ages birth to 7). The trend in program performance is relatively stable. Reading/reading readiness skills are assessed with the following measures, depending on the child's age: the Ages and Stages Questionnaire, the CT Preschool Assessment Framework, the Phonological Awareness Literacy Screening (PALS), the Peabody Picture Vocabulary Test (PPVT), grade promotion, Concepts About Print and the Developmental Reading Assessment. Although research data are not available for Connecticut, research from other states indicates that children who receive Even Start services outperform children who do not participate in Even Start. These studies suggest that Even Start children score significantly higher on measures of reading readiness, and are twice as likely as non Even Start children to be reading at or above grade level.[1]

Performance Measure 2: Percent of Even Start parents showing significant learning gains or earning a high school diploma.

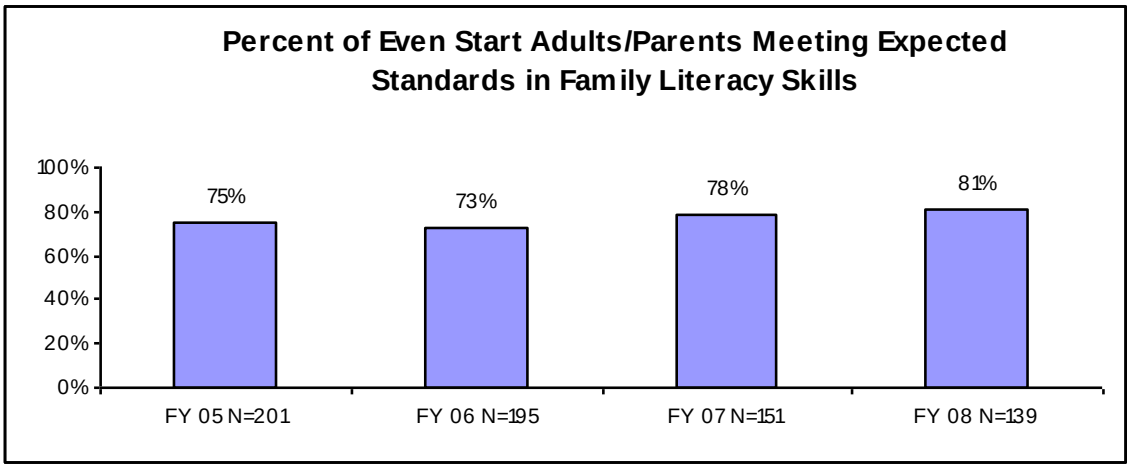


Over the past four years, adults in Even Start have consistently made significant gains. Compared to the entire population of adult education students, Even Start participants make impressive gains on measures of high school completion and English language acquisition. The percent of Even Start parents attaining a measurable educational outcome has been significantly greater than that of all adult education participants statewide by about 25 percentage points annually.[2]

[1] Link, D.E. & Weirauch, D.M. (2005). Questioning the validity of the evidence against family literacy programming: A critical analysis of the National Even Start Evaluations. Literacy Harvest/Family Literacy Forum, 12, 33-38. New York: Literacy Assistance Center.

[2] Source: Connecticut Adult Reporting System (CARS)

Performance Measure 3: Percent of Even Start parents demonstrating gains in family literacy skills.



Results show that in the past four years, three-quarters or more of the parents were observed to learn and apply parenting skills related to family literacy in all areas. The trend is improving in that 75 percent met the standard in FY 2005 and 81 percent met the standard in 2008. Programs have focused their parenting classes more purposefully on literacy development.

Performance-Based Vendor Accountability:

Even Start is required to contract for local program evaluation. All programs must report on quality, attendance and outcomes as well as meet state standards or performance indicators of success in early childhood, adult education and parenting education. Outcomes, attendance and quality assurance standards are reviewed on a monthly and an annual basis at the local and state level. Programs must also develop local objectives that are measurable and demonstrate the quality of their program and outcomes, monthly attendance of each child and adults. Local evaluation requires a visit 3-5 times per year to review early childhood records and lesson plans, observe instruction and conduct focus groups with staff and adults.

EARLY CHILDHOOD PROGRAM (SCHOOL READINESS)

Program Description:
Purpose: To significantly increase the number of accredited and/or approved spaces for young children in order to provide greater access to high-quality programs for all children; To significantly increase the number of spaces for young children to receive full-day, full-year child care services to meet family needs and to enable parents to become employed; and To establish a shared cost for such early care and education programs among the state and its various agencies, the communities and families. All programs must receive NAEYC or Head Start accreditation within three years of initial funding and must maintain such accreditation for continued funding to ensure high-quality programs for all children. Communities must offer a range of options regarding the length of program day and year in order to meet the needs of families. Families are offered a sliding fee scale as a means of providing affordable high-quality early education programming.

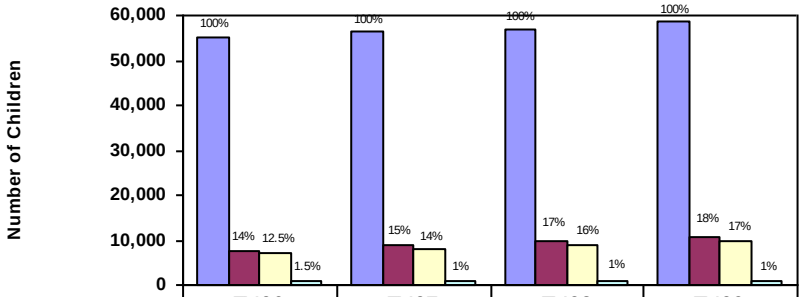
Number Served: During 2008/2009, a total of 64 towns/school districts in Connecticut served 10,583 children in 19 priority school districts and 45 competitive districts.

Program Cost FY 2008-2009: $79,400,000

Performance-Based Standards:
Quality preschool services are available for 100 percent of eligible children in priority school districts. By 2015 every School Readiness classroom will have a teacher with a bachelors degree or higher. All of the School Readiness Programs are accredited or approved under the recognized systems.

Performance-Based Outcomes:
Quality early childhood programs ameliorate the risk factors that lead to achievement gaps. Two components that contribute to program quality are: teachers with early childhood specific training; and systematic monitoring across multiple program components.

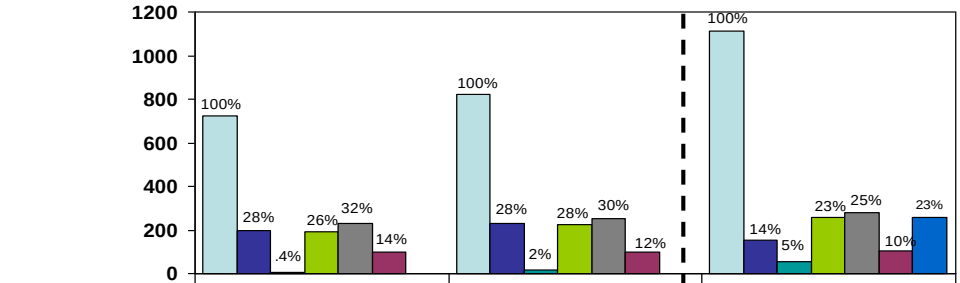
Performance Measure 1: Access to quality early childhood programs in eligible municipalities.



	FY06	FY07	FY08	FY09
Birth Cohort	55,158	56,263	56,734	58,655
All SR	7,718	8,734	9,769	10,583
PSR	6,900	7,925	8,933	9,719
CSR	818	809	836	864

This graph shows a comparison of the School Readiness-funded space capacity over the past four years in relation to the birth cohorts, for eligible 3 and 4 year olds, in the 64 School Readiness Municipalities. The Priority School Readiness (PSR) Districts have increased access by 4.5 percent, whereas, Competitive School Readiness (CSR) Municipalities have remained stagnant at one percent. Level funding for the CSR Municipalities hinders the capability for further expansion to provide access to School Readiness programming.

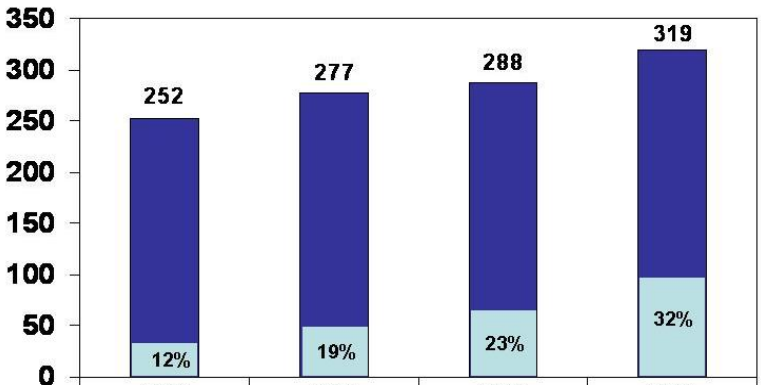
Performance Measure 2: Progress toward teacher qualifications.



	FY06 (Priority only)	FY07 (Priority only)	FY08 (Priority & Competitive) All FY 08 Data are Preliminary
Total	723	823	1,111
CDA	200	229	155
ECE Certificate	3	19	56
Associate's Degree	190	227	255
Bachelor's Degree	231	250	279
Master's Degree	99	98	106
Undetermined			260

The CSDE now relies on the new Early Childhood Professional Development Registry for this measure. All data for FY 08 are preliminary, and data for FY 06 and FY 07 are not comparable to FY 08 because the collection method changed. Factoring out the "undetermined" category in FY 08, there does not seem to be significant progress toward attaining higher level teacher qualifications. The additional category labeled "undetermined" represents the number of remaining teacher files currently being disaggregated. It is expected that most of those files will represent qualified teachers; however some will represent teachers who do not meet the minimum qualifications.

Performance Measure 3: Monitoring progress toward quality standards.



	FY06	FY07	FY 08	FY 09
Total # of sites (PSR & CSR)	252	277	288	319
In process	30	54	66	102

There are 319 School Readiness programs in Connecticut, 300 of these programs are participating in the National Association for the Education of Young Children (NAEYC) accreditation system; 62 percent of which hold accreditation and 32 percent are in process of achieving such status. There are 12 programs that hold Head Start status and seven that hold New England Association of Schools and Colleges (NEASC) approval. The NAEYC and Head Start systems align with the School Readiness quality components and are therefore adopted as the School Readiness quality monitoring system. These systems address multiple program quality components such as health, curriculum, family, assessment, physical environment, teaching, leadership, and community partnerships.

Performance-Based Vendor Accountability:
School readiness programs are based on ten quality components and provide supports and services for collaboration with community agencies, health, nutrition, parent education and services, transition to kindergarten, professional development that includes training in emerging literacy and diversity, family literacy, child and program evaluation, a sliding fee scale and a non-discriminatory admissions process. The plan to implement these supports and services is described by each school readiness program in their application. The program's adherence to the quality components is reported through the Connecticut School Readiness Preschool Program Evaluation System (CSRRPES), as well as state monitoring visits and quarterly community liaison site visits. These reports focus on the program's implementation of the services and emphasize collaboration with outside service providers in order to support the individual needs of families in the context of their community.

Department of Mental Health and Addiction Services

- **Best Practices Initiative**
- **Local Prevention Council Programs**
- **Strategic Prevention Framework State Incentive Grant**
- **Connecticut Youth Suicide Prevention Initiative**
- **Regional Action Councils**
- **Statewide Service Delivery Agents**
- **Tobacco Regulation & Compliance**

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

- 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 support DMHAS' prevention services goals, expansions, and fiscally sound system investments

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 work effectively with youth and parents from culturally, economically and geographically diverse populations

Performance-Based Outcomes:

- Increased number of evidence-based programs for youth, families and professionals that focus on youth suicide prevention, tobacco and alcohol use 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
- 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

Population Outcomes

- Reduction in the drug/alcohol use
- Reduction in suicidal behavior among high school students
- Increased employment or school retention
- Decreased criminal justice involvement
- Increased social connectedness

Program Outcomes

- Increased enforcement of alcohol laws
- Reduction in retailer violation rates for tobacco sales to minors

Measure of Effectiveness: Connecticut has improved in many key federal health outcome measures over the past four years as indicated in the 2007 National Survey on Drug Use and Health (NSDUH). Among 12-17 year-olds and those 18years and older, measures reflecting improvement include: age of first use for alcohol and marijuana; percent of those perceiving harm in using marijuana once or twice a week and having five or more drinks once or twice a week; and percent of those reporting who heard, read, or watched advertisement about substance use prevention in the past 12 months. The contribution of DMHAS prevention and health promotion programs to these

results speaks to their ability to assist Connecticut residents in need. The percentage of funded prevention programs that are evidence-based is at 65.5%. With the increase in staff, there were also increases in the number of Prevention partnerships between DMHAS and other state and local agencies. The DMHAS Prevention Training Collaborative has also increased the number of courses offered to providers**.**

Methods: DMHAS provides Prevention services aimed at increasing the health & wellness of children and their families through funding and assessing its pool of over 160 non-profit providers statewide. To address disparities, DMHAS contracts with the Multicultural Leadership Institute (MLI), a statewide resource in the provision of cultural competent mental health and substance abuse prevention services to assure that all products, activities and services are culturally competent.

Other: Since the establishment of a State Epidemiological and Outcomes Workgroup (SEOW) in 2005, DMHAS has convened the group quarterly to review substance abuse consumption and related consequence indicators, ranked problem substances based on their magnitude and impact, and set performance targets for various programs and initiatives. The SEOW will continue to be used by DMHAS to review process and outcome data relevant to meeting these performance targets.

BEST PRACTICES INITIATIVE: 14 statewide funded projects that apply science and research-based programs to populations across the life cycle. These science-based community prevention programs are designed to enhance the lives of adults and children and encourage family, peers, neighbors and others to become involved.

Utilizing multiple Substance Abuse and Mental Health Services Administration-Center for Substance Abuse Prevention (SAMHSA-CSAP) strategies, Best Practice programs focus on positive youth development; alcohol, tobacco and other drug education; healthy decision-making skills and recreation. Programming is varied and in many cases multi-pronged, but most target needy or otherwise at risk youth. Several programs incorporate academic support, peer leaders or mentors and many emphasize family development and parenting skills. Youth-led participatory research, training for professionals working in youth-serving organizations, and education, enrichment and respite services for grandparents and custodial relative caregivers are also represented.

The Best Practices engage youth, families, schools and communities in Danbury, Enfield, Hartford, Middletown, Milford, New Britain, New Haven, New London, Plainville, Torrington, Westport, Windham and surrounding municipalities in alternative activities, community-based processes, education, information dissemination, and problem identification and referral.

Program Cost FY 2008 - 2009: $ 2,034,178

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. These standards are divided into 8 categories:

1. *Human Relationships* – require programs to build relationships among staff, families and communities in order to create strong effective programs
2. *Program Planning* – requires the development of a logical and systematic process for designing, implementing and evaluating services that fulfill the programs mission
3. *Program Activities* – requires the provision of skills and knowledge to program participants so that they can make healthy lifestyle choices
4. *Program Setting*- requires that the physical environment is welcoming, comfortable, organized and well-equipped
5. *Health & Safety* – requires that the physical environment be healthy and safe
6. *Program Implementation* – requires organization, sufficient materials and effective communication to move planning into action
7. *Program Administration* – requires sufficient resources and oversight to adequately manage the program
8. *Evaluation* – requires the systematic collection and analysis of data to make informed decisions.

Performance-Based Outcomes: In the past year, all providers have updated their work plans to facilitate improved data collection, evaluation of direct and indirect costs associated with provision of services, comparison and communication of activities and programming across agencies, and compliance with reporting of National Outcome Measures. Current efforts and next steps include exploration and development of a limited set of common outcome indicators or proxy measures that are both meaningful and appropriate.

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. With the adoption of the Strategic Prevention Framework (SPF – a five-step outcome-based planning process), contractors are required to use the federal guidance document for identifying and selecting evidence-based programs. This also 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. 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: To date, a total of 59,372 children, adults, family and community professionals were served in SFY 09. 172 from the age of 4 and under; 25,244 from the age of 5-11; 22,631 from the age of 12-14; 6,038 from the age of 15-17; 4,302 from the age of 18-20; 190 from the age of 21-24 and 795 from the age of 25 and older.

Program Cost: FY 2008 - 2009 $543,120

STRATEGIC PREVENTION FRAMEWORK STATE INCENTIVE GRANT: The SPF SIG program is designed to help grantees build a solid foundation for delivering and sustaining effective substance abuse services in order to: prevent the onset and reduce the progression of underage drinking and related problems in communities, and build prevention capacity and infrastructure at the state and community levels.

The overall purpose of the CT SPF Initiative is to develop a comprehensive strategy for delivering and implementing effective substance abuse prevention services. The initiative brings together State and community partners to apply the federal Center for Substance Abuse Prevention's (CSAP) Strategic Prevention Framework towards creating healthy communities for everyone. Twenty eight communities throughout the state including campuses, municipalities and youth serving agencies utilize the SPF blueprint to address underage drinking in 54 towns by conducting needs

assessments, developing community capacity, developing strategic plans, implementing programs, policies and practices identified in the plans, and evaluating their outcomes.

Number Served: A total of 172,651 children, family and community members, and prevention professionals were served in SFY 09. 6,983 from the age of 4 and under; 16,715 from the age of 5-11; 15,422 from the age of 12-14; 20,456 from the age of 15-17; 11,951 from the age of 18-20; 11,287 from the age of 21-24; 89,837 from the age of 25 and older.

Program Cost: FY 2008 - 2009 **$**2,350,965

Performance-Based Standards: DMHAS requires programs under the SPF 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. These standards are divided into 8 categories:

1. *Human Relationships* – require programs to build relationships among staff, families and communities in order to create strong effective programs
2. *Program Planning* – requires the development of a logical and systematic process for designing, implementing and evaluating services that fulfill the programs mission
3. *Program Activities* – requires the provision of skills and knowledge to program participants so that they can make healthy lifestyle choices
4. *Program Setting*- requires that the physical environment is welcoming, comfortable, organized and well-equipped
5. *Health & Safety* – requires that the physical environment be healthy and safe
6. *Program Implementation* – requires organization, sufficient materials and effective communication to move planning into action
7. *Program Administration* – Requires sufficient resources and oversight to adequately manage the program
8. *Evaluation* – requires the systematic collection and analysis of data to make informed decisions

Performance-Based Outcomes:

Abstinence from Drug Use/Alcohol Abuse

- 30-day substance use (non-use/reduction in use)
- Availability of alcohol, tobacco and other drugs
- Perception of drug use as harmful
- Attitude toward use (Perception of drug use as wrong)

Increased/Retained Employment or Return to/Stay in School

- School attendance
- ATOD-related suspensions/expulsions
- Drug-related workplace injuries

Decreased Criminal Justice Involvement

- Drug-related crime

Increased Stability in Family and Living Conditions

- Parent participation in prevention activities

Increased Access to Services (Service Capacity)

- Number of persons served by age, gender, race, and ethnicity

Increased Social Supports/Social Connectedness

- Under development

OMB Required Outcome/Domain

Cost Effectiveness

- Increase services provided within cost bands

Use of Evidence-Based Practices

- Total number of evidence-based programs and strategies funded by SPF SIG

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.

CT YOUTH SUICIDE PREVENTION INITIATIVE: Develop and implement comprehensive, evidence-based youth suicide prevention and early intervention strategies that may be maintained over time and expanded throughout Connecticut. This initiative builds on the recommendations of the Connecticut Interagency Suicide Prevention Network, the 2005 Connecticut Comprehensive Suicide Prevention Plan, the Connecticut Youth Suicide Advisory Board, and the CT Mental Health Transformation Initiative. It specifically addresses Goal 1.2 of the President's New Freedom Commission on Mental Health, the need to advance and implement a national strategy for suicide prevention.

Key components of the project are to: 1) Support the use of the science-based "Signs of Suicide" (SOS) Program, the Question, Persuade and Refer Gatekeeper Model, and the College Response Model in selected middle and high schools and CT State Universities (CSU); 2) Expand the existing DCF-sponsored training program for foster and adoptive parents, school nurses, parent/teacher organizations, youth service bureaus, and juvenile justice personnel in recognizing the signs and symptoms of suicidality and depression; 3) Design and pilot the implementation of a model program to increase the availability, accessibility, and linkages to mental health treatment by embedding services in school-based health and community-based hospital clinics; and 4) Develop a mini-grant program that serves communities statewide through the use of a youth driven, positive community youth development approaches .

Number Served: In 2009, 694 high school students participated in training; 3,574 students sought counseling through the CT State University system; 144 adults and professionals were trained in various model programs; and, 681middle school students were assessed for depression and suicide risk and where appropriate referred for therapeutic counseling.

Program Cost: FY 2008 - 2009 $ 400,000

Performance-Based Outcomes:

- Reduction in suicidal behavior among high school students
- Improvement in treatment outcomes for students who screen positive for depression symptoms at school health clinics
- Improve suicide knowledge of parents and community health care personnel
- Increase in the number of students accessing college counseling services

REGIONAL ACTION COUNCILS: 14 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: A total of 242,574 children, family and community members, and prevention professionals were served in SFY 09. 12,055 from the age of 4 and under; 27,995 from the age of 5-11; 39,980 from the age of 12-14; 43,912 from the age of 15-17; 18,106 from the age of 18-20; 13,953 from the age of 21-24 and 86,573 from the age of 25 and older.

Program Cost: FY 2008 - 2009 $1,532,698

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. These standards are divided into 8 categories:

1. *Human Relationships* – require programs to build relationships among staff, families and communities in order to create strong effective programs
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5. *Health & Safety* – requires that the physical environment be healthy and safe
6. *Program Implementation* – requires organization, sufficient materials and effective communication to move planning into action
7. *Program Administration* – Requires sufficient resources and oversight to adequately manage th*e program*
8. Evaluation – requires the systematic collection and analysis of data to make informed decisions.

Performance-Based Outcomes:

- 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 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.

STATEWIDE SERVICE DELIVERY AGENTS: The Statewide Services Delivery Agents (SSDA), also known as the DMHAS Resource Links, are five 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 Assets Network - a network of individuals that promote the integration and successful use of strength-based strategies to build healthy communities and youth.
2. 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.
3. Multicultural Leadership Institute, Inc. - is a coalition dedicated to promoting culturally and linguistically proficient services regarding the prevention of ATOD and other related problems among African origin and Latino populations.
4. 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.
5. 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: A total of 18,146 children, family and community members, and prevention professionals were served in SFY 09. 6 from the age of 4 and under; 75 from the age of 5-11; 793 from the age of 12-14; 1,655 from the age of 15-17; 894 from the age of 18-20; 978 from the age of 21-24; 13,745 from the age of 25 and older.

Program Cost: FY 2008-2009: $1,976,849

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. These standards are divided into 8 categories:

1. *Human Relationships* – require programs to build relationships among staff, families and communities in order to create strong effective programs
2. *Program Planning* – requires the development of a logical and systematic process for designing, implementing and evaluating services that fulfill the programs mission
3. *Program Activities* – requires the provision of skills and knowledge to program participants so that they can make healthy lifestyle choices
4. *Program Setting*- requires that the physical environment is welcoming, comfortable, organized and well-equipped
5. *Health & Safety* – requires that the physical environment be healthy and safe
6. *Program Implementation* – requires organization, sufficient materials and effective communication to move planning into action

7. *Program Administration* – Requires sufficient resources and oversight to adequately manage the program
8. *Evaluation* – requires the systematic collection and analysis of data to make informed decisions.

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 programs that bridge prevention and recovery efforts
- 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 REGULATION & COMPLIANCE: 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: During FY 2009, 2,368 retail inspections were completed and 16,045 pieces of materials distributed to the general public. Approximately 772 children and adults were served through merchant and community education activities in FY 2009.

Program Cost: FY 2008 – 2009: $647,967

Performance-Based Outcomes:

- Increase in age of first use for tobacco products
- Decrease in tobacco use rates among youths ages 12-17
- A rate of no more than 10% of merchants across the state who sell tobacco products to minors

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.

- **Asthma Program: Easy Breathing**
- **Child Day Care Licensing**
- **Community Health Centers**
- **Family Planning**
- **Immunization Program**
- **Injury Prevention – Unintentional Childhood**
- **Injury Prevention- Intentional Youth Violence**
- **Lead Poisoning Prevention and Control**
- **Newborn Laboratory Screening and Tracking**
- **Nutrition, Physical Activity and Obesity**
- **Oral Health-Home by One**
- **Rape Crisis and Prevention Services**
- **Tobacco Use Prevention and Control**
- **Women, Infant and Children**

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: A total of 10,304 children were surveyed to identify symptoms that needed to be assessed to determine if the child had asthma.

Program Cost: FY 2008-2009: $1,000,000

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. 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.

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

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)

CHILD DAY CARE LICENSING: This Program regulates all licensed child day care programs throughout the state of Connecticut in accordance with required standards established by state statutes and regulations. This is accomplished by providing technical assistance, application processing, facility monitoring, complaint investigation, and enforcement activities. The Program licenses 1598 Child Day Care Centers and Group Day Care Homes, and 2738 Family Day Care Homes, and is committed to promoting the health, safety, and welfare of Connecticut's children in these licensed facilities.

Number Served: 114,151 Licensed Capacity.*
* This number does not reflect actual enrollment, as some slots may be under utilized or shared between part-time children.

Program Cost FY 2008-2009 $1,934,957

Performance-Based Standards:
- Meet statutory requirements for inspections of licensed day care facilities: Inspect child day care centers and group day care homes every two years; inspect 1/3 of licensed family day care homes annually.
- Conduct complaint investigations.
- Take enforcement action against non-compliant facilities, as necessary.
- Meet statutory requirements for providing technical assistance on regulatory issues.

Performance-Based Outcomes:
- Continue the process to revise child day care regulations with improved health and safety standards.
- 123 technical assistance activities conducted from 7/1/08 – 6/30/09 served 2,766 child care providers and applicants.
- The department consistently exceeds inspection goals for licensed child care facilities. From 7/1/08 – 6/30/09, 902 compliance monitoring inspections of family day care homes were required, 1091 inspections were completed; 798 compliance monitoring inspections of child day care centers and group day care homes were required, 890 inspections were completed.
- All complaints inspections include unannounced site visits. From 7/1/08 – 6/30/09 there were 1255 complaint investigation inspections involving licensed and illegally operating child day care facilities.
- From 7/1/08 – 6/30/09, 136 enforcements against licensed or illegally operating child day care facilities were taken.

Performance-Based Vendor Accountability:
The Department of Public Health is the state agency responsible for the regulation and monitoring of licensed child day care facilities in accordance with the following statutes and regulations:
- C.G.S, Sec. 19a-80; Sec. 19a-87b
- Public Health Code, Sec. 19a-79-1a through 19a-79-13
- Public Health Code, Sec. 19a-87b-1 through 19a-87b-18

COMMUNITY HEALTH CENTERS: The purpose of the Community Health Center program is to assure access to comprehensive primary and preventive health care services and improve the health status of the underserved and vulnerable populations in CT. Thirteen health care corporations receive partial funding through the Connecticut Department of Public Health to provide comprehensive preventive and primary health care services through Community Health Centers located in 30 towns throughout CT. As safety net providers, they deliver health care to

individuals enrolled in Medicaid and Medicare as well as the underinsured and uninsured from birth through old age. Twelve of the 13 corporations are Federally Qualified Health Centers (FQHCs) that receive funding authorized by Section 330 of the Public Health Service Act and one does

Community Health Centers (CHCs) serve as the medical home and family physician for many of the poor, underserved, vulnerable, and at risk for poor health status people who live in communities throughout the Connecticut. They offer comprehensive, community-based, primary and preventative health care including pediatric, adolescent, adult and geriatric health care, prenatal and postpartum care as well as supportive services such as translation, transportation, case management, health education, social services and culturally sensitive healthcare. Depending on the availability, many offer dental care, mental health and addiction services, school based health care and outreach programs.

Number Served: 219,912 from quarterly reporting. This number includes those clients seen for primary and preventive care, oral health care, and health care access. The Uniform Data System (UDS) data from the federal government is not yet available for the calendar year 2008. This UDS data is what is utilized for most reporting.

Program Cost FY 2008-2009: $7,552,912

Performance-Based Standards: All 13 CHCs submitted quarterly reports to DPH. Annual reports are also submitted but are not yet compiled for 08-09. These data are not unduplicated and not as accurate as the documentation (Uniform Data System or UDS) submitted to the federal government annually by section 330 funded health centers that includes 10 of 13 CHCs in calendar year 2008. In calendar year 2009, this UDS data will be submitted by 12 of 13.

Performance-Based Outcomes:

- Number of pregnant women beginning prenatal care in the first trimester.
- Number of children with second birthday during the measurement year with appropriate immunizations.
- Number of women 21-64 years of age who received one or more Pap tests during the measurement year or during the two years prior to the measurement year.
- Number of diabetic patients whose HbA1c levels are less than or equal to 9 percent.
- Number of adult patients 18 years and older with diagnosed hypertension whose most recent blood pressure was less than 140/90.
- Number of births less than 2,500 grams to health center patients.

Performance-Based Vendor Accountability: Review of reports including reports 10 of 13 CHCs submit to the federal government; periodic site visits to the contractor; medical record audits on site visits; communication and collaboration with CHC contractors and CHC Association of CT.

FAMILY PLANNING: Twelve Family Planning Clinics (FPC) are funded by the Connecticut Department of Public Health (DPH) through a contract with Planned Parenthood of Connecticut, Inc. Total DPH funding to the Family Planning Program equals $1,063,048. The purpose of the DPH Family Planning Program is to provide preventive and primary reproductive health care through health care services, information, and education to the uninsured or underserved individuals, both male and female, in CT.

Number served: A total of 29,473 participants served.

Program Cost FY 2008-2009 $1,063,048

Performance-Bases Standards: Planned Parenthood of CT's Family Planning program met or exceeded all outcome measure goals and improved over the previous year. Seventy nine percent of the program's clients received services regardless of ability to pay (this includes patients paying according to their sliding fee scale and those covered by Medicaid). Based on sample chart reviews, 98% of female patients receiving a preventive reproductive health exam

received a Pap test; 99% of female patients with a reproductive health exam received a clinical breast exam; 89% of female patients with a reproductive health exam received screening for Chlamydia trachomatis; and 91% of clients with a reproductive health exam received AIDS education, non-specific behavioral counseling and, upon request, information on testing sites.

Performance-Based Outcomes:

- Number of clients receiving services this period regardless of ability to pay (were unable to pay all or part of cost). Goal: 60%-Actual: 79%

- Number of patients receiving a comprehensive annual preventive reproductive health exam during this reporting period.
- Number of female patients with a preventive reproductive health exam who received a Pap test. Goal: 90% Actual: 98%
- Number of clients with a preventive reproductive health exam who received a clinical breast exam. Goal: 90%-Actual: 99%
- Number of clients receiving a comprehensive initial preventive reproductive health exam during this reporting period.
- Number of female patients receiving a preventive reproductive health exam during this reporting period who received a screening for Chlamydia trachomatis and gonorrhea. Goal: 85% -Actual: 89%
- Number of clients with a preventive reproductive health exam who received AIDS education, non-specific behavioral counseling and, upon request, information on testing sites. Goal: 80%-Actual: 91%

Performance-Based Vendor Accountability: Performance based vendor accountability is monitored through site visits with random medical record reviews, observations and staff interviews, review of quarterly and annual report data, and contractor participation and updates on various Maternal and Child Health Committees and Advisory Boards.

IMMUNIZATION: The State of Connecticut Immunization Program's mission is to prevent disease, disability and death from vaccine-preventable diseases. The following means are used to accomplish this goal: provide vaccine for Connecticut children; educate medical personnel and the general public on the importance of vaccination; work with providers using the immunization registry to assure that all children in their practice are fully immunized; assure that children who are in day care, school and college are adequately immunized; and conduct surveillance and outbreak control activities for vaccine-preventable diseases.

Number served 2008-2009: According to the 2008 National Immunization Survey (NIS), 69.8 % of the states' two year olds were up to date on their immunizations comprised of a series of 4 doses of DTaP, 3 doses of Polio, 1 dose of MMR, 3 doses of HiB, 3 doses of Hepatitis B, and 1 dose of varicella vaccines (4:3:1:3:3:1). (This is a decrease from last year's rate of 86.8% due to a shortage of Hib vaccine and deferment of the Hib booster dose.) Coverage for individual antigens is as follows: 4+ DTaP at 88.2%; 3+ Polio at 99.5%; 1+ MMR at 95.3%; 3+ Hep B at 98.1%; 1+Varivella at 93.2%. The coverage rates for the individual antigens are all above the national rates. The 2007 NIS survey included children born January 2005 through June 2007.

Program Cost FY 2008-2009: $44,830,209

Performance-Based Standards: Immunization coverage is one of our principal performance-based standards. The National Immunization Survey (NIS) conducted annually by CDC estimates vaccination coverage among children aged 19-35 months old nationally and for each state.

Performance-Based Outcomes: Connecticut's 2008 NIS coverage for 4 doses of DTaP, 3 polio, 1 MMR, 3 Hib, 3 hepatitis B, 1 varicella (4:3:1:3:3:1) was 69.8%. This is a decrease from last year's rate of 86.8% due to a shortage of

Hib vaccine and deferment of the Hib booster dose. For individual antigens, coverage was all above the national average and includes: 4+ DTaP 88.2%; 3+ Polio 99.5%; 1+ MMR 95.3%; 3+ Hep B 98.1%; 1+Varicella 93.2%.

According to our immunization registry which looked at the records of 35,000 two-year-olds born in 2006, 4:3:1:3:3:1 coverage is 68% and 4:3:1:2:3:1 coverage is 83%. Eighty seven % of our 2006 birth cohort (35,000 out of 40,260) is enrolled in our registry.

Performance-Based Accountability: The Immunization Program has contracts with 14 Immunization Action Plan Coordinators (IAPs) working at local health departments in areas of greatest need. IAPs are required to submit quarterly reports and they are evaluated on their outreach efforts (number and percentage of children behind on their immunizations who are brought back into medical care) and the immunization coverage rates of the providers with whom they work.

INJURY PREVENTION – UNINTENTIONAL CHILDHOOD: The Program's overall goal is to reduce death and disability among children and adults from unintentional injury including motor vehicle crashes, falls, fire/burns, drowning and poisoning. The Program provides technical assistance and resources to providers and community agencies on injury prevention issues. The Program works closely with other agencies, organizations and coalitions to raise awareness, and develop and implement injury prevention programs and policies. Through Maternal and Child Health Block Grant funding the Program contracts with Safe Kids Connecticut to provide child transportation safety training to health care, childcare and other service providers and to provide education, child safety seats and booster seats to low-income families. The geographic service area is statewide.

Number served: Through Maternal and Child Health Block Grant funding the program served 266 parents/caregivers and 301 children. Seven (7) Child Passenger Safety Technicians were also trained and certified.

Program Cost FY 2008-2009: $40,000

Performance-Based Standards: Training programs are based on national safety curricula developed by child passenger safety experts, and are regularly reviewed to insure that they meet current "best practice" Standards. Nationally certified child passenger safety instructors or technicians deliver the training and educational programs and work with families to ensure that child safety seats and booster seats are correctly installed and used.

Performance-Based Outcomes: Percentage of parents/family members and service providers reporting increased awareness of effective measures to prevention injuries to children in motor vehicle crashes including selection and use appropriate occupant protection systems.

Performance-Based Vender Accountability: Contractor is required to submit periodic reports on program activities and outcome measures. The Injury Prevention Program monitors selected training programs and closely with the Contractor and other partners to identify providers organizations and to insure that low-income families receive program services.

INJURY PREVENTION – INTENTIONAL YOUTH VIOLENCE: Youth violence prevention programs contracted by the Connecticut Department of Public Health (DPH) focus upon increasing knowledge and changing behaviors that are manageable within the limited scope and influence of the programs. Program goals include increasing awareness; recognizing and dealing appropriately with anger, conflicts, peer-to-peer relationships; increasing knowledge regarding the impact of, and risk factors, for violent behavior; decreasing arguments and fighting and providing knowledge of appropriate resources for help.

Number Served: Through Youth violence prevention programs funded under the local health allocation are dependent upon local health departments and districts deciding to use Preventive Health and Health Services Block Grant (PHHSBG) funding for youth violence prevention. A total number of 11,887 youths were served.

Program Cost FY 2008-2009: $45,188

Performance-Based Standards: Programs are required to report on a specific youth violence prevention outcome measure.

Performance-Based Outcomes: Ninety-five percent of program participants are able to identify nonviolent alternatives to fighting.

Performance-Based Vender Accountability: Contracted programs are required to report on program activities, process and outcome measures. Programs use questionnaires, surveys and/or observation to assess outcome measures including violence prevention related survey instruments from *Measuring Violence-Related Attitudes, Behaviors and Influences Among Youths*- Centers for Disease Control and Prevention publication.

LEAD POISONING PREVENTION AND CONTROL: To protect the health and safety of the people of Connecticut and to prevent lead poisoning and promote wellness through education and a wide range of program activities that relate to lead poisoning prevention and in particular, childhood lead poisoning prevention.

Number Served: 270,187 children under the age of six years old.

Performance-Based Standards:

- Elimination of lead poisoning - to decrease the rate of children under six years old residing in CT with blood lead levels of 10 µg/dL or above to less than 1%
- Screening of all children at ages 1 and 2 years
- Retesting of children (of any age) with blood lead levels greater than or equal to 10 µg/dL

Performance-Based Outcomes:

- The screening rates of children will increase.
- The prevalence of children with elevated blood lead levels greater than or equal to 10 µg/dL will decrease.
- The total number of elevated blood lead level cases greater than or equal to 10 µg/dL will decrease.

Performance-Based Vendor Accountability: Development of specific contract deliverables focusing on items listed in the scope of work along with submission of quarterly statistical and narrative reports, quarterly site visits and audits by program staff.

NEWBORN LABORATORY SCREENING TRACKING: The Connecticut Public Health Code 19a-55-1, mandates that, "the administrator or other person in charge of any institution providing medical care of newborn infants twenty-eight days of age or younger shall cause to be taken from every newborn infant in its care a blood specimen for tests pursuant to section 19a-55 of the Connecticut General Statutes."

The aim of this program is to screen all babies in CT prior to discharge from birthing facilities or within the first 4 days of life for early identification of disorders so that medical treatment can be promptly initiated to avert complications and prevent irreversible problems and death. Infants with abnormal screening results are referred to regional treatment centers for comprehensive testing, counseling, education, and treatment services.

Number Served: Over 1.8 million newborns have been tested since the program began. Blood specimens on infants born in Connecticut are received from 30 birthing facilities. Nurse mid-wife sites were identified that will increase the numbers of infant screening for genetic disease/disorders. In 2008, there were 41,244 births by occurrence resulting in 42,411infants receiving at least one screen. There were 77 confirmed cases, all of which needed and received treatment. 921 (2.2%) trait cases were identified.

Program Cost FY 2008-2009: $1,113,407

Performance-Based Standards:

- The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

- Successful newborn screening requires collaboration between the State Newborn Screening Program, health care facilities (birthing facilities, local health departments, & specialty clinics), health care providers (pediatricians, family practice physicians, nurse practitioners, and midwives), and families of newborns. The Administrator of other person in charge of any facility of birth or a person assisting the birth of a child not attended by a physician is responsible for assuring that a satisfactory Newborn Screening blood sample is collected from all newborns born in the hospital, or admitted to the hospital within the first twenty eight days of life and submitted to the State Public Health Laboratory for testing pursuant to section 19a-55 of the Connecticut General Statutes.

Performance-Based Outcomes:

- TESTING: Blood Specimens successfully screened & received at the state Laboratory. Reduction in the unsatisfactory specimen rate from birthing facilities.
- TRACKING: Assure that 100% of infants screened as positive with metabolic & genetic condition(s) received follow-up to definitive diagnosis and clinical management.
  - Of the 41,244 (Occurrent births) in CT for 2008,
  - 99% received newborn screening (NBS) prior to discharge or within first 4 days of life.
- All 878 (2.1%) suspect positive results were reported to Regional Treatment Centers and/or primary care physicians for further testing and follow-up.
- TREATMENT: Of these, 77 were confirmed as disease cases 921(2.2%) trait cases were identified.
  - Of 652 cases of unsatisfactory NBS specimens, all but 1 was resolved with receipt of a 2nd specimen.
  - There were 10 CT State Waivers submitted to the lab for refusal of screening due to conflicts with religious tenets. Five families or 50% who refused screening, later had screens collected at their primary care physicians' office.
  - The tracking staff followed 245 infants with transfusions. Those babies who were transfused prior to the NBS blood test were tracked until a 90-day post-transfusion specimen was collected and tested for Hemoglobinopathies and Galactosemia
  - Disease Condition is Managed

Performance Vendor Accountability:

- Laboratory Newborn Screening Guidelines for Birthing Facilities (effective 12.01.08).
- Connecticut Public Health Statutes and Public Health Code – 19a-55, 19a-55-1 & 19a-55-3; Maternal and Child Health Bureau Federal Performance Measure, Healthy People 2010 Objectives, and CT's methods to Reduce Health Disparities;
  - Number of Newborns Screened
  - Number of Newborns with confirmed diagnosis
  - Number of Newborns in Treatment with confirmed diagnosis
  - Number of Newborns in Treatment
  - CT Dept. of Public Health Statistical Report of Contract Activities (Quarterly Reporting form used by designated regional contractors providing treatment services)
  - CT Electronic Reporting-Newborn Screening Data System (NSS), HIPAA and DPH Business Associate Agreement

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NUTRITION, PHYSICAL ACTIVITY AND OBESITY: The NPAO program receives federal funds to provide nutrition education to low-income individuals in Connecticut, and many projects focus specifically on children and parents. The successful, evidence-based "Adventures of Captain 5 A Day" curriculum is utilized in over 93 Head Start and School Readiness programs across the state. The curriculum supports social, emotional, cognitive, and language development in young children while encouraging healthy eating and physical activity. The program trains and motivates teachers, provides materials, and serves as an ongoing resource to promote the implementation of nutrition education and physical activity in the preschool classroom.

In addition, the program uses "Supermarket Smarts" parent workshops to inform parents on how to make healthy food choices within a limited budget and to promote a positive mealtime environment. This developmentally savvy approach achieves results by focusing on teachers and parents who then display behaviors and strategies that impact young children. Further, the program participates in statewide health fairs and community events, and supports a website and seasonal newsletters; these activities extend and reinforce the healthy eating and physical activity messages.

The NPAO program also awarded federal funds to 21 Local Health Departments/Districts (LHD) who carry out various activities to reduce the consumption of excess dietary fats through multi-session educational programs. These sessions are intended to provide needed information on dietary fats and offer practical skills to establish healthy eating patterns. Other initiatives are for the promotion of physical activity and prevention of obesity through multi-session programs to assist individuals to establish a minimum level of wellness into their lifestyles. Each LHD hire qualified personnel and submit a "Service and Evaluation Plan" that details: activities, indicators for evaluation, staff responsible for oversight, and target date for completion for all services in the fiscal year funded.

The program also provided state funds to 5 Local Health Departments/Districts and 2 community based organizations to develop, coordinate, implement, and evaluate population-based obesity prevention and control environmental change and related policy interventions designed to positively impact physical activity and nutrition behaviors targeting children between 8-18 and their families in their respective communities.

Using state funds appropriated through the Connecticut Cancer Partnership, the NPAO program contracted the implementation of a pilot program to test healthy eating and physical activity curricula among elementary age children. This pilot was intended to assess the impact and feasibility of the curricula implementation. Six school districts and ten elementary schools participated in the program. Two healthy eating and two physical activity curricula were tested in grades K through 3rd in both urban and sub-urban/rural settings.
Number Served: 112,000 children and families

Program Cost FY 2008-2009 $2,032,657

Performance-Based Standards:
Nutrition Education:
- Healthy Food – After completion of SNAP-Ed interventions, participants will increase their intake of healthy foods by 5%.
- Physical Activity – After completion of SNAP-Ed interventions, participants will increase physical activity to balance their individual dietary intake needs.
- Fruit & Vegetable Consumption – After completion of SNAP-Ed interventions, participants will increase their average daily consumption of vegetables by ½ cup per day.
- Resource Management – After completion of SNAP-Ed interventions, participants will increase their purchasing power by 5%.

Reduce Excess Dietary Fats:
- Program participants can accurately identify t least three dietary practices to reduce fat intake and promote heart health.
- Program participants report at program end, taking action to reduce dietary fat intake.

Block Grant Physical Activity:
- Program participants are able to correctly identify the recommended levels of physical activity to promote heart health.
- Program participants report at program end that they plan to engage in at least light to moderate physical activity three to five days a week

Policy and/or environmental changes:
- Participants are aware of risk factors that contribute to obesity.
- Participants will participate in activities to reduce obesity.
- Participants will participate in activities to reduce obesity.

Testing of Curricula:
- Needs Assessment
- Process and Outcomes Evaluation
- System for Observing Fitness Instruction (SOFIT)
- Healthy Living Questionnaire
- Sustainability Assessment

Performance-Based Outcomes:
- Eight (8) LHDs conducted ninety-one (91) nutrition education programs.
- Seven (7) LHDs conducted a total of twenty (20) physical activity programs.
- Six (6) LHDs implemented (12) policy and/or environmental changes increasing physical activity, and improved nutritional practices at the community level.
- Seven contractors implemented 28 policy and/or environmental changes increasing physical activity, and improved nutritional practices at the community level.
- Pre- and post-tests; oral assessments; interactive game questions; program staff and teacher observations
- Individual teachers and parents responses; group activity responses; interactive activities; discussions
- Children task response to stated objectives, skill demonstration and informal feedback
- Teachers and parents task response to stated objectives, skill demonstration (e.g. meal planning and food purchasing), informal feedback and perceived change in skills
- Children's perceived ability to change; reported change (e.g. reported change in children's intake of vegetables by teachers); food records; food frequency instruments; physical activity questions
- Teachers and parents' perceived ability to change; reported change

Performance-Based Vendor Accountability:
- Number of SNAP-eligible children and parents reached through direct nutrition education.
- Number of Head Start and School Readiness programs participating in the program.
- Number of "train-the-trainer" workshops delivered to Head Start and School Readiness teachers.
- Time Head Start and School Readiness teachers provide nutrition education in the classroom and at mealtime.
- Time of technical assistance delivered to ensure fidelity of the nutrition education program.
- Number of materials and resources prepared and delivered.
- Number of Supermarket Smarts workshops delivered to Head Start and School Readiness parents.
- Number of community partnerships/collaborations formed and enhanced to reach SNAP-eligible children and parents.
- Number of collaborations with agencies to prevent duplication of services, gain updated knowledge of new programs and tools, and facilitate effective management of the programs.
- Service and Evaluation Plans submitted.
- Quality Assurance Plans submitted.
- Quarterly narrative and expenditure reports.
- Participate in site visits as appropriate.
- Staffing plans, including responsibilities of funded or in-kind staff to meet proposal objectives.
- Number of community wellness coalitions that demonstrate community support, mobilization, and buy-in.
- Number of agencies, organizations and municipalities that serve in a leadership capacity.
- Documentation of community inventory/assessment, and report or recommendations completed.
- Submission of comprehensive evaluation plans to include defined outcome and process measures.
- Demonstration of plans implementation and project sustainability.

ORAL HEALTH-HOME BY ONE: The purpose of the Home by One Program is to build integrated partnerships with the early childhood community at the state and local levels that focus on oral health as essential to the overall health and well-being of children in the state of Connecticut through the achievement of the following goals: increase the coordination and exchange of oral health information as it relates to overall health among state agencies and community organizations that address early childhood services; increase the number of parents trained as oral health

advocates for children and families; increase the number of non-oral-health professionals who are competent in preventive oral health strategies to enhance access to oral health services for at-risk children; expand the number of dental practices and clinics providing dental homes for children, including those with special health care needs.

Number Served: 25,000 children

Program Cost FY 2008-2009: $247,448

Performance-Based Standards: he National Oral Health Objectives for the Year 2010 (Healthy People 2010 Objectives)

For two to four year old children there are two primary oral health objectives:*
1. Reduce the proportion of young children with untreated dental decay in their primary teeth to 9 percent.
2. Reduce the proportion of young children with dental caries experience in their primary teeth to 11 percent.

For six- to eight-year-old children there are three primary oral health status objectives:*
1. To decrease the proportion of children who have experienced dental caries in permanent or primary teeth to 42 percent.
2. To decrease the proportion of children with untreated dental caries in permanent or primary teeth to 21 percent.
3. To increase the proportion of eight-year-olds receiving protective sealing of the occlusal surfaces of permanent molar teeth to 50 percent.

*Note: the 2007 oral health assessment of preschool (2-4 years old), kindergarten and third grade (6-8 years old) students in Connecticut determined the following:

- 31 percent of preschool children have experienced dental decay.
- Of those with decay experience, 20 percent have untreated decay.
- 41 percent of third grade children have experienced dental decay.
- Of those with decay experience, 18 percent have untreated decay.
- 38 percent of third graders have dental sealants.

Performance-Based Outcomes:
- Advisory Group for the Home by One Program has been established and meets regularly.
- Health Program Associate, the designee to the MCH Advisory, has attended all meetings since October 2007, has promoted *Home by One* concepts and activities and has presented an MCH workshop on Oral Health and perinatal issues.
- The Project Director (PD) has attended monthly meetings of the Governor's Early Childhood Cabinet since September 2007 and recommended oral health strategies for inclusion in the Infant Toddler Workgroup for the report to the Cabinet and *A Framework for Child Health Services* report published by the Child Health and Development Institute March 2009.
- The completed curriculum for advocacy was incorporated into 9 advocacy and oral health workshops that were given in the following WIC sites, Torrington, Willimantic, East Hartford, Meriden, Norwich, Bridgeport, Stamford (Separate English and Spanish workshops) and Norwalk. The Putnam and Bridgeport workshops were cancelled by the WIC staff and have been rescheduled. The Project Coordinator and has met with the WIC coordinators, nutritionists and dietitians to request their guidance and assistance in identifying parents who may be interested in becoming oral health advocates.
- 85 parents received advocacy oral health training.
- 19 of the 24 Local WIC sites with full time staff have received an orientation to the *Home by One* Program and provided with tools to facilitate the incorporation and integration of oral health in the WIC risk assessment and nutritional guidance. WIC sites include, Waterbury (3), Hartford (2), East Hartford (2), New Haven(2), Norwich, New London, Torrington, Danbury, Stamford, Norwalk, Bridgeport, Meriden, Willimantic and Putnam.
- 130 WIC professionals have received oral health training through Home by One program.
- Physician curriculum in oral health concepts and fluoride varnish application has been developed, tested and finalized. Thirteen training sessions have been provided and 114 physicians have completed the credentialing

process allowing them to bill DSS for oral risk assessment and fluoride varnish application. Over 300 child health providers have been provided the training between September 2008 and August 2009.

- A core medical-dental home group has been established and outlined the essential components of the medical-dental home model. A plan for implementation has been developed and medical-dental home sites have been identified. An evaluation consultant has been hired for the medical-dental home model development and measures have been drafted.
- Pediatric dentists that are members of the *Home by One* Advisory have helped to identify general practice dentists to be trained in the key concepts of dental home, dental risk assessment, age one dental visits and dental referrals from non-dental providers. The CT State Dental Association identified dentists interested in becoming a dental home.
- Between December 2008 and March 2009, 13 dental homes received an orientation to the Home by One Program and 12 partnered with the program to offer age one dental visits and accept referrals from the WIC program. The training consultant and dental director provided trainings along with the Program Coordinator. Resources for coordination of WIC referrals were provided by the Program Coordinator and individual referral programs were developed for each dental home.
- The Home by One Coordinator presented to Registered Dental Hygienists at New Haven and Alternative Practice component meetings of the Connecticut Dental Hygienists Association. The Faculty of University of Bridgeport participated in a Home by One presentation, as did the faculty and community public health dental hygiene class at the Briarwood dental hygiene program.
- A special needs and infant oral health presentation was given in coordination with the birth to three advisory member Anna Gorski, and the Department of Developmental Services advisory member, Izabella Pulvermacher to the Danbury area.
- A general dentist in Hamden partnered with the Home by One Program in April 2009 after his dental hygienist attended the New Haven dental hygienists presentation on the program and persuaded her office to participate. The total of dental homes increased to 14 after his orientation.
- 89 dental professionals have received the orientation to Home by One Program in dental practices.
- The contract between Home by One Program and University of Connecticut Health Center was expanded with carry over dollars from year one of grant funding, to provide additional training sessions to both dentists and physicians between September 2008 and August 2009.
- The contract between Home by One Program and Connecticut Oral Health Initiative was expanded with carry over dollars from year one of grant funding, to provide 4 additional advocacy workshops to parents in the WIC program between September 2008 and August 2009.
- A Contract between Home by One Program and Child Health and development Institute for purposes of evaluating the Home by One Program was executed
- A media campaign promoting the well baby dental message of first visit by age one ran on busses in New Haven, Bridgeport and Hartford during the month of August. There were radio messages and all media ads ran in both Spanish and English.
- A parent fact sheet was developed to coincide with the media campaign and presented at breast-feeding events through local WIC sites during the month of August. 60 Parents participated in oral health education around a breast feeding event in Waterbury, Bridgeport and Torrington.
- Home by One coordinator presented at 2 Oral health education classes at Access WIC in October 2008. 9 parents and 4 children participated in oral health training.
- A webpage for the Home by One Program has been launched and linked with the Early Childhood Partners webpage.
- The training consultant and program associate produced an online course, which is available on CT Train for dental providers. Course # 1018656 *The Dental Providers Perspective on the Age One Dental Visit.*
- Over 200 completed age one dental visits; referred from the WIC program has been reported by dental homes in the Home by One Program to date.

Performance-Based Accountability:

Evaluation process for *Home by One* grant including:

- Assessing number of early childhood organizations that expand their agenda to include oral health as a result of Home By One activities.
- Evaluate the number of families who report having engaged in oral health advocacy for themselves, their children or their families.

- Determine the number of *Home By One* presentations completed in pediatric practices, family medicine practices.
- Assess the impact of *Home by One* trainings by:
    - Interview a sample of staff in practices receiving *Home by One* training to determine impressions of changes in access to dental services.
    - Assess the impact of training by perform chart audit in a sample of *Home by One* trained practices to ascertain evidence of early preventive dental services delivered by pediatric or family medicine provider, fluoride varnish application and successful referral to dental provider.
- Determining the number of dental providers receiving training on treating young children, age one dental visits and serving as a dental home.

RAPE CRISIS AND PREVENTION SERVICES: Make available to sexual assault victims and their families free and confidential services such as crisis intervention, support and advocacy, survivor groups, 24-hour hotline, and emergency transportation. Services also include community education, training, primary prevention activities, and coordination of services. The program goal is to end sexual violence and ensure high quality, comprehensive and culturally competent sexual assault victim services by offering primary prevention and victim crisis intervention services statewide through the following member service areas: Bridgeport, Danbury, Meriden/Middletown/New Haven, Milford, New Britain/Hartford, Stamford, Torrington, Waterbury, Willimantic/New London.

Number Served: Between the period of July 1, 2008 and June 30, 2009, a total of 20,904 children, youth, adolescents and young adults in the school settings participated in rape prevention and educational sessions. A total of 3,825 patients and clients were served based on their town of residence, and 90 professional trainings were offered to 1862 professionals. 2,504 primary victims and 1,321 secondary victims were also served during that time period.

Program Cost FY 2008-2009: $1,014,729

Performance-Based Standards: Standards of accountability are measured based on the following outcomes: clients are able to access the needed and appropriate services from a choice of service options, clients are provided acute care and safety at time of contact, clients are able to access long-term support services. The Rape Crisis Prevention Services met or exceeded all outcome measure goals and improved over the previous year.

Performance-Based Outcomes:

- Clients are able to access the needed and appropriate services from a choice of service options. 90% or more of clients requesting referrals will receive them within 3 days (72 hours). Goal: 90%-Actual:100%
- Clients are provided acute care and safety at time of contact. 90% or more of clients requesting immediate emotional assistance will receive such assistance by phone or in person. Goal: 90% -Actual: 99.85%; 90% or more clients who request that an advocate meet them at the hospital will be met by an advocate. Goal: 90%-Actual: 99.12%
- Clients are able to access long term support services. 90% or more of clients requesting individual counseling will receive an appointment within three days (72 hours). Goal: 90% -Actual: 100%; 70% of clients requesting group counseling will receive an appointment within thirty days. Goal: 70%

  Actual: 99.93%

Performance-Based Vendor Accountability: Performance-based vendor accountability is monitored through review of quarterly and annual report data. The contractor also performs pre and post-test surveys within primary prevention curricula.

TOBACCO USE PREVENTION AND CONTROL: The Tobacco Use Prevention and Control Program follows the guidelines and recommendations put forward by the Centers for Disease Control and Prevention (CDC) in their document "Best Practices for Comprehensive Tobacco Control Programs". The Tobacco Program works toward addressing all areas in tobacco control including educating the public about the risks associated with the use of

tobacco products and exposure to environmental tobacco smoke (ETS). Areas of focus include youth prevention, pregnant women, those of low-socioeconomic status, individuals with mental illness and other disparate populations who are affected by tobacco use.

Number served 2008-2009: Community cessation programs funded during the period along with the telephone-based tobacco quitline served at least 2,285 individuals with most services targeted to low socio-economic status participants. Community cessation programs served at least 158 women who responded that they were pregnant at the time they entered the program.

Program Cost 2008-2009: **$**1,702,260

Performance-Based Standards: Our standards include the reduction and elimination of use of all forms of tobacco, to prevent or delay smoking initiation, and to reduce participant's exposure to second-hand smoke. All funded programs must adhere to CDC's best practices guidelines and use evidenced-based curriculums. All programs include education regarding the prevention of smoking initiation and the harmful effects of second hand smoke.

Performance-Based Outcomes:

- At least 70% 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 Vendor Accountability: Contractors are required to collect data at several intervals during the program to assess program effectiveness, including pre-and post-program surveys. Contracts must submit periodic progress reports detailing their program activities including their self-evaluation and the results of their outcome measures.

WOMEN INFANTS AND CHILDREN (WIC): The Connecticut WIC Program serves pregnant, postpartum, and breastfeeding women; infants; and children up to five years of age. The program provides services in four major areas during critical times of growth and development, in an effort to improve birth outcomes and child health: 1) Nutrition Education and Counseling; 2) Breastfeeding Promotion and Support; 3) Referral to outside medical and social services; and 4) Vouchers for healthy foods prescribed by the WIC Nutritionists (WIC food packages). Eligibility is based on both income (up to 185% of the federal poverty level) and nutritional need based on an assessment of health and dietary information. Active enrollment in Medicaid (HUSKY A) qualifies applicants for categorical eligibility in the WIC Program. An analysis of linked birth, WIC and Medicaid records has revealed that participation in the CT WIC Program was responsible for preventing the occurrence of more than 300 low birth weights in the year 2000 among infants of women who participated in the program for at least 12 weeks of their pregnancy. The estimated savings in averted medical costs was $11.8 million. The WIC Program's promotion and support of breastfeeding, and efforts to prevent childhood anemia also contribute to childhood health and school readiness.

Number served 2008-2009: A total of 46,641 children and 13,209 women

Program Cost 2007-2008: $51,280,930

Performance-Based Standards: Federal and state regulations include a number of prevention related standards that the local 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:

- At least 70% of pregnant women participating in the WIC Program for a minimum of 6 months gain appropriate weight .

- The incidence of low birth weight (LBW) among infants whose mothers were on the WIC Program for at least 6 months during pregnancy does not exceed 6%
- At least 55% of infants whose mothers were enrolled in the WIC Program during pregnancy breastfeed.
- At least 25% of infants enrolled in the WIC Program breastfeed for at least 6 months.
- The prevalence of anemia among children enrolled in the WIC Program for at least one year does not exceed 9% .

Performance-Based Accountability:

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

Department of Social Services

•Family Planning
•New Employment and Training
•Reimbursement Program for SNAP Recipients
•Emergency Shelter for Victims of Domestic Violence
•Fatherhood Initiative
•Promoting Responsible Fatherhood
•Teen Pregnancy Prevention

Long Term Agency Goals: The Department of Social Service (DSS) is informed by relevant data, partner and/or contract with other agencies and organizations to create and implement programs and services that address the *root causes of poverty and the concomitants of poverty*, in order to effectively promote/facilitate the health and well being of children and families. Goals include:

- Increase access to affordable sound housing stock for income eligible children and families.
- Increase awareness about availability and access to food/good nutrition for income eligible children and families.
- Increase awareness about and access to preventive and curative health care for income eligible children and families.
- Increase the number of children, from infancy to three, who are "ready to learn" by providing child care/parenting education that help infants and toddlers develop characteristics and skills confidence, risk taking, how to socialize and get along with others, trust that are essential in school success.

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 as well as knowledge and awareness of objectively determined effective program/service outcomes for targeted low income/income eligible children and families that will be used to inform/plan, develop, and contract for services for clients, with external agencies/organizations.
- In addition to actually enumerating level of program participation, contractees will be required to provide objective outcome measures that demonstrate effectiveness of programs/services based on documented client progress and client feedback.
- 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 and families.
- Continue the contractual relationships with community action agencies to ensure awareness and supportive access to programs/services provided by DSS.
- 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.
- In DSS funded child care settings, place greater emphasis on helping parents understand the relationship between child rearing practices and "readiness/ability" to learn as well as the value of good nutrition for optimal growth, development, and learning.
- Train and support staff in modifying contracts based on objectively determined clients/program participants' outcome data.
- Take advantage of funding opportunities that can be used to increase the number of sound adequate housing for income eligible children and families.

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, and gender. The Department plans to rectify this as soon as possible.

Other: As the Medicaid, housing, TANF agency, lead agency for persons with disabilities, subsidizer of child care, 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 and families. There is no doubt that it succeeds in doing so; however, in the coming months and years, DSS will collect data in ways that clearly demonstrate the extent to which current programs are succeeding in prevention.

FAMILY PLANNING: The purpose of the Family Planning Program is to provide comprehensive reproductive health care to low income/income eligible residents of Connecticut. Payment for services is based on a sliding fee scale that takes income into account; the grant for the Department is used as supplemental funding. A central office, Planned Parenthood of Connecticut (PPCT), allocates the funds to 11 sites scattered throughout Connecticut. The focus is mainly on women; however, men are also provided services such as testing for sexually transmitted diseases.

Number Served: In excess of 15,000

Program Cost: FY 2008 – 2009: $1,090,074

Performance-Based Standards: Standards are medically determined through discussions between the service recipient and health care providers located in the 11 sites. Providers are required to create and maintain records related to procedures performed and medications dispensed for each service recipient; they must also keep track of and report the names of individuals infected with any of the 5 reportable sexually transmitted diseases, when appropriate, to the Department of Public Health. They must also provide information and counseling to the infected individual.

Children of teen parents tend to become dependent on public assistance. Moreover, children of teen parents tend to become teen parents (Furstenberg's longitudinal study of children of teen parents). Providing comprehensive reproductive health care services that are accessible and affordable has been shown to be a contributing factor in the reduction of teen pregnancy; it is primary prevention that contributes to the overall health and wellness of children and families.

Performance-Based Outcomes: Number of men and women, especially low income single parents, who seek and secure information and processes/methods related to reproductive health and pregnancy prevention. Also, because the services are primarily medical, service quality is determined by continued renewal of required licenses, certification, evident record of advocacy for women's health, and continued expansion of and use of services offered by residents of Connecticut by facilities and individual practitioners.

Performance-Based Vendor Accountability: Monitoring visits that include review of relevant documents and reviews of the degree or extent to which deliverables meet or exceed contract specifications.

EMPLOYMENT AND TRAINING REIMBURSEMENT PROGRAM FOR SNAP RECIPIENTS: This program is an option of the Supplemental Nutrition Assistance Program (SNAP); the program receives oversight from the USDA's Food and Nutrition Services. Based on both legislation and an earlier Departmental contract with Capital Community College (pilot) the program supports/funds the creation of local collaboratives whose role is to develop and provide education, training, and a range of support services for SNAP recipients. During the pilot, Capital Community College implemented a program for the greater Hartford area. Program participants received employability and career interest assessments; they were also provided a range of services that included case management, job readiness training, basic skills/ESL training (literacy, math, GED preparation, etc.), individual needs assessments, vocational training in a variety of short term certificate programs, job search assistance, job placement

assistance, and family focused services such as child care, and transportation assistance. Outcomes of the Capital's pilot program will be shared; however, each collaborative will be unique in that the partners that make up the collaborative may differ based on location, services offered, and needs of program participants. Most are expected to employ an ecological approach in response to the needs of program participants.

In general, program participants are expected to complete the program within six to nine months; additional jobs for which they may receive training and or education are various trades such as culinary arts, hazardous material handlers, customer service positions, word processing, electronic, and work as mechanics. Participants will be educated and trained for jobs that are available; this will be ensured through coordination of training and education with the Workforce Investment Boards.

The relationship with Capital will be expanded to include other community college, non-profit organizations, community based agencies, municipalities, etc. Currently, the Department is in the process of reviewing proposals it has received from Bridgeport, New Haven, New London, and Greenwich.

Number Served: Approximately 400 since December, 2008

Program Cost FY 2008 – 2009: Federal reimbursement of the State's initial outlay. Expenditures to date: $229,153

Performance-Based Standards: Performance standards are and will be included in all contracts; they will include, but not be limited to, the collection, analysis, and maintenance of statistical data related to program participation, documentation of the range of services provided, documentation of program expenditures, and providers' meeting or exceeding program deliverables.

Performance-Based Outcomes: Quarterly reviews and reports that will include: enumeration of the following:

- Overall number of persons served- broken down into gender, education, race, prior income;
- Number of participants completing a particular segment of the program;
- Number of program participants who become employed and remain so for at least 60 days;
- Pre-post comparison of earned income;
- Number of participants employed in a single job for 20 hours or more per week;
- Number of job searches/placements;
- Number of units of case management provided;
- Number of certificates earned by program participants – EMT, CNA;
- The extent or degree to which employment related services are provided and used effectively by program participants, such as housing assistance, case management, and child care.

Performance-Based Vendor Accountability: This is based on the ongoing review of the extent to which the vendor is complying with the contract as ascertained by site visits, quarterly reports, and outcome data.

EMERGENCY SHELTER FOR VICTIMS OF DOMESTIC VIOLENCE: Program participants who are victims of domestic or family violence are provided safe and supportive services in emergency shelters and/or host homes. Generally, the adult, usually the female parent, is the primary contact for the receipt of services. However, primary prevention occurs with the children, who are sheltered with the parent, through mandated shelter based children's programs. These programs address emotional and social health issues that are found among child witnesses; many of whom may also have been victimized. Based on the best data available, children who witness domestic violence are more likely to repeat the behavior as adults as either a batterer (mainly males) or victim (mainly females). The shelter based programs for children helps them to address their anger, fear, and other issues in ways that reduce the likelihood of intergenerational transmission of family/domestic violence. The primary goal of the shelter's children's program is to provide services to child witnesses/victims of family/domestic violence that address their health and safety needs. Poor people are disproportionately represented as victims/child witnesses of domestic/family violence. Most of the

families who use State funded shelters do not have other alternatives. Case management and other shelter-based programs can lead to improved economic circumstances for these families and children

Number Served: 875-Women; 773 Young Children (birth-12 years of age); and 94 Teenagers

Program Cost FY 2008 – 2009: $3,569,771

Performance-Based Standards: Standards for the delivery of services and the circumstances and conditions under which those services are provided to clients are clearly delineated in the contract. In addition to client/program participant based services, each contract specifies that providers must provide outreach and awareness education about family/domestic violence through collaborations, community education, and house meetings within shelters. Each of these activities must be documented by listing organizations with which the activity has occurred and, for house meetings, by recording attendance lists and meeting dates.

Performance-Based Outcomes: Actual numbers for the following must be reported: bed occupancy; number of clients with a separate count for children; number of hotline calls, number of house meetings/dates; number and type of activities for children; and outcomes for clients.

Performance-Based Vendor Accountability: Site visits, quarterly and annual reports of activities and accomplishments are submitted to the Department's staff.

FATHERHOOD INITIATIVE: The purpose of the Fatherhood Initiative Program is to promote and facilitate positive interaction between fathers and their children thereby increasing the parent child bond that contributes to optimal growth and development for children. The Initiative also facilitates and supports social and emotional connections between fathers and their children, which has been shown to increase financial support for children of non-custodial, separated, and divorced fathers.

This Initiative is operationalized through contracts with five geographically dispersed agencies. Intervention strategies and tactics used by Fatherhood Initiative providers aim to prevent child poverty, child abuse and neglect, absentee fathers, intergenerational poverty, and youth violence among children of program participants. The agencies provide a range of services including preparation for employment, job search, life skills training, case management, parenting skills and education for parenting. Program participants are multi-ethnic, multicultural, working income, no income, and marginal income men, many of whom have had some involvement with the criminal justice system, DCF, and DSS.

Number Served: 204 fathers

Program Cost FY 2008 – 2009: 250,000

Performance-Based Standards:

- Among Fatherhood program participants, a decrease in the number of unemployed and underemployed program participants;
- Increase in the number of children who have healthy relationships with their fathers;
- Increase in the number of gainfully employed non-custodial fathers who contribute to the financial support of their children;
- Decrease in the number of single female headed households who are totally dependent on entitlements;
- Among non-custodial fathers and single mothers, increased awareness of the pivotal role that men play in normal healthy child development and positive psycho-social/educational outcomes for children;
- Increase in voluntary child support payments; and
- Increase in the number and rate of voluntary paternity acknowledgement by unmarried fathers.

Performance-Based Outcomes: Specific outcomes that may be used to measure the success or strategic effectiveness of the Fatherhood Initiative may consist of:

- Longitudinal comparison of changes in parent-child relationships, rate and extent of co-parenting (regardless of marital status), and rate of job retention among Fatherhood program participants from ethnic/cultural minority communities;
- Increase in the actual number of early pre-post birth paternity acknowledgements; and
- Positive changes in the rate of voluntary child support payments.

Performance-Based Vendor Accountability: This program relies on reports, monitoring visits and review of contract deliverables to ensure compliance.

PROMOTING RESPONSIBLE FATHERHOOD IS UNDER THE AUSPICES OF THE FATHERHOOD INITIATIVE: The Department was awarded a five year five (5) million dollar grant (one million dollars per year) from the Department of Health and Human Services (DHHS)/Administration for Children and Families (ACF) in October, 2006. This grant funds the implementation of the Department's "Promoting Responsible Fatherhood" demonstration project. Grant strategies and activities include the three ACF authorized activity areas: healthy marriage, responsible parenting, and economic stability. In partnership with the five state-certified fatherhood programs, the Department has targeted, primarily, low-income fathers, new fathers, fathers-to-be, and young fathers who may be single/unmarried, non-custodial, or co-habiting. In addition, couples interested in marriage and/or those who indicate that they are engaged are included in the target population.

The overall goal of the Responsible Fatherhood Project is to provide members of the target populations with a cohesive continuum of services that connects them to programs, resources, and services. Father involvement in the lives of children results in improved economic circumstances, better academic outcomes for children leading to better futures as self sufficient earners, and reduces the likelihood of childhood poverty. The same gains, for children, can also be seen in successful marriages.

Number Served: 1,502 fathers and mothers and 59 Couples (Healthy Marriages) were served; services were also provided to 627 fathers and mothers via economic stability education/training.

Program Cost FY 2008 – 2009: $1,000,000

Performance-Based Standards: For this program, the number of participants and the type of services to be provided are specified in each provider contract. In addition, program staff makes site visits, receive and review quarterly reports, and review client based outcome measures in determining providers' programmatic performance.

Performance–Based Outcomes: Clients complete before and after surveys related to knowledge about healthy marriage and responsible parenting. An objective assessment of each client's economic condition, educational level, and employment skills is also included. Changes in these factors, positive or negative, determines the extent to which program strategies and interventions are effective. Negative or lack of individual or situational change creates opportunities to review and modify strategies/interventions when indicated.

Performance-Based Vendor Accountability: This program relies on specific performance based language in the written contracts, reports, site visits, and evaluative outcomes to ensure compliance and accuracy of deliverables**.**

TEEN PREGNANCY PREVENTION: The primary purpose of the Teen Pregnancy Prevention Program is to provide information and enrichment activities to youths between ages 11 and 17 who are at risk for teen pregnancy. Contractors/service providers must use either the Children's Aid Society Carrera Adolescent Pregnancy Prevention Program the Reach for Health (RFH) or the Teen Outreach Program (TOP) service learning model. There are two major components of RFH and TOP: volunteerism (teen program participants must volunteer in the community, performing tasks such as tutoring, public beautification, clean-up, etc.) and a structured curriculum that allows the

teens to reflect on the volunteer experience and to address adolescent life issues. Based on available research (Furstenberg and others), teen parents are more likely to depend on public welfare to meet their subsistence needs; children born to teen parents are more likely to become teen parents themselves; children of teen parents are more likely to be impoverished; and marriage rates among teen parents are very low. The poorest children in Connecticut tend to be members of single parent female headed households. This program (1) reduces dependency on public welfare and (2) reduces the incidence of single parent female-headed households. Both of these factors are positively correlated with child poverty.

Number Served: 799 youth

Program Cost FY 2008 – 2009: $2,427,547

Performance-Based Standards: Contractors/service providers are required to use any of the three standardized curriculums in addition to other services. They are also required to provide case management and individual youth assessments. Contracts clearly specify outcomes and how those outcomes are to be demonstrated or documented. Providers must also report on participation rates and outcome based data, on a quarterly and annual basis.

Performance-Based Outcomes:

- Percentage of participants who do not experience a pregnancy;
- Percentage of program participants who evidence understanding of risky sexual behavior based on three program measures of risky sexual behavior; and
- Percentage of program participants who attend school on a regular basis as documented by rate of absenteeism, dropout and academic performance.

Performance-Based Vendor Accountability: Field visits, provider reports, and participant feedback are used to ensure contract benchmarks and deliverables are aligned with the contractual agreement.

Office of Policy and Management

- **Title V Delinquency Prevention Program**
- **Governor's Urban Youth Violence Prevention Program**

TITLE V DELINQUENCY PREVENTION PROGRAM: The Title V Delinquency Prevention 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 calls on communities to identify and reduce risk factors to which their children are exposed and to identify and increase/enhance protective factors which mitigate risk. Risk-focused delinquency prevention provides communities with a conceptual framework for prioritizing the risk and protective factors in their own 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.

Number Served: 93 at-risk youth who are between the ages of 10 and 18.

Program Cost: FY 2008-2009 $78,252

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.

GOVERNOR'S URBAN YOUTH VIOLENCE PREVENTION PROGRAM: The Governor's Urban Youth Violence Prevention Program is a competitive program for municipalities and nonprofit agencies that propose to serve youth ages 12 to 18 in urban neighborhoods. The purpose of the Governor's Urban Youth Violence Prevention Program is to reduce urban youth violence by providing grants for programs to serve youth ages 12 to 18 years in urban centers. It was created in 2007 by Section 9 of PA 07-4. Funding for this program ($1,500,000) comes from the state line item in the Office of Policy and Management's budget entitled Urban Youth Violence Prevention and from the U. S. Department of Education to the Office of Policy and Management under the federal Safe and Drug-Free Schools and Communities Act, Governor's Portion

Number of Served: 1,235 youth residing in urban communities who are between the ages of 12 and 18

Program Cost: FY 2008-09 $1,500,000

Performance-Based Standards: On a regular basis, the selected agencies receiving funding under the Governor's Urban Youth Violence Prevention Program must collect data on program youth as well as the involvement of their parents. This data includes:

1. Attendance and Participation (Youth Sign-In/Sign-Out);
2. Youth Demographic Data;
3. Youth Process Evaluation Questionnaire;
4. Parent Permission Forms;
5. Parent Involvement Data; and
6. Staff Attendance at Technical Assistance Sessions.

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

Outputs

- Number of youth registered;
- Number of different youth who attend;
- Number of days the center is open;
- Average number of days youth attend monthly;
- Average number of youth served daily; and
- Number of parents participating.

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.

House Bill No. 5108

Public Act No. 07-47

AN ACT CONCERNING REPORTING REQUIREMENTS RELATED TO THE CHILD POVERTY AND PREVENTION COUNCIL.

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

Section 1. Subsections (f) and (g) of section 4-67x of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(f) (1) On or before **[**January 1, 2006, and annually thereafter, until January 1, 2015**]** 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 1, 2007**]** 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 1, 2006, and on or before November 1, 2007**]** 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 **[**for the report due on or before November 1, 2006, and the report due on or before November 1, 2007,**]** 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 **[**the report due on or before November 1, 2007**]** 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.

Sec. 2. Section 4-67v of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

For **[**the**]** each biennial budget for the fiscal years **[**commencing July 1, 2007, and July 1, 2008**]** ending June 30, 2008, to June 30, 2021, inclusive, the Governor's budget document shall, within available appropriations, include a prevention report that corresponds with the prevention goals established in section 4-67x, as amended by this act. The prevention report shall:

(1) Present in detail for each fiscal year of the biennium the Governor's recommendation for appropriations for prevention services classified by those budgeted agencies that provide prevention services to children, youths and families;

(2) Indicate the state's progress toward meeting the goal that, by the year 2020, at least ten per cent of total recommended appropriations for each such budgeted agency be allocated for prevention services; and

(3) Include, for each applicable budgeted agency and any division, bureau or other unit of the agency, (A) a list of agency programs that provide prevention services, (B) the actual prevention services expenditures for the fiscal year preceding the biennium, by program, (C) the estimated prevention services expenditures for the first fiscal year of the biennium, (D) an identification of research-based prevention services programs, and (E) a summary of all prevention services by each applicable budgeted agency identifying the total for prevention services included in the budget.

Approved May 22, 2007