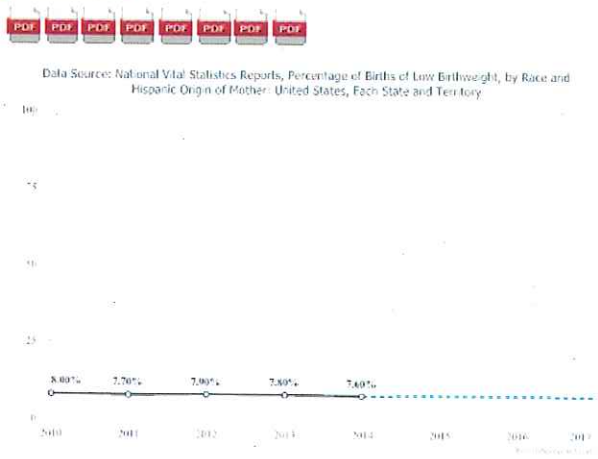
Healthy Scorecard

Healthy Scorecard

R HEALTHY All Connecticut Children Grow Up Healthy.

I Headline Low Birth Weight



Time Period	Actual Value	Forecast Value	Current Trend	Baseline %Change
2014	7.60%	7.70%	↘ 2	-6% ↓
2013	7.80%	7.80%	↘ 1	-4% ↓
2012	7.90%	—	↗ 1	-2% ↓
2011	7.70%	—	↘ 1	-5% ↓
2010	8.00%	0.00%	→ 2	-1% ↓
2009	8.00%	0.00%	→ 1	-1% ↓
2008	8.00%	0.00%	↘ 1	-1% ↓
2007	8.10%	0.00%	→ 0	0% →

Story Behind the Curve

Any baby born weighing less than 2,500 grams (or 5 pounds, 8 ounces) is defined being low birth-weight. This data is tracked by the CDC as a percentage of all births. DPH notes the causes of low birth weight include poor maternal health, risky behaviors, inadequate prenatal care, twins/multiples, and intrauterine growth restriction (a condition in which an unborn baby is not growing at a normal rate inside the womb). In Connecticut, children born with a low birthweight has remained just below the national rate.

Despite Connecticut's history of battling low birth weight, further disaggregation reveals a continued need for improvement. Black mothers have consistently been almost twice as likely to give birth to low birth-weight babies as white mothers. Also the Permanent Commission on the Status of Women (PCSW) indicates that preliminary data from DPH shows 10-15% of low birth-weight babies have been born using assisted reproductive technology (ART). These treatments include fertility medication, artificial insemination, in vitro fertilization, and surrogacy, which are used twice as often in Connecticut compared to the national average.

The negative effects for a child that is born with a low birthweight include: substantial health impacts (ex: cerebral palsy, developmental delays, respiratory disorders, etc.), lower achievement during primary school, a decreased likelihood of attending college and subsequent long-term economic difficulties. It should be noted that a number of studies exist that found most low birthweight children were able to become productive adults (though men experience more detrimental effects).

In recent years, legislation has been passed to put more resources into studying and reducing low birth-weight. Public Act 10-133, develops action items to reduce the rate of low birth weight babies. PCSW has cited evidence that Connecticut's infertility insurance mandate may be having a negative effect by increasing the occurrence of ART treatments. However, Medicaid coverage limits for women up to 258% of the Federal poverty level has positively assisted women in poverty to deliver healthy weight children by increasing access to pregnancy-related resources and services.

Partners

- Connecticut Department of Public Health
- CT Voices for Children
- Commission on Children
- Latino and Puerto Rican Affairs Commission
- Permanent Commission on the Status of Women
- Planned Parenthood of Connecticut

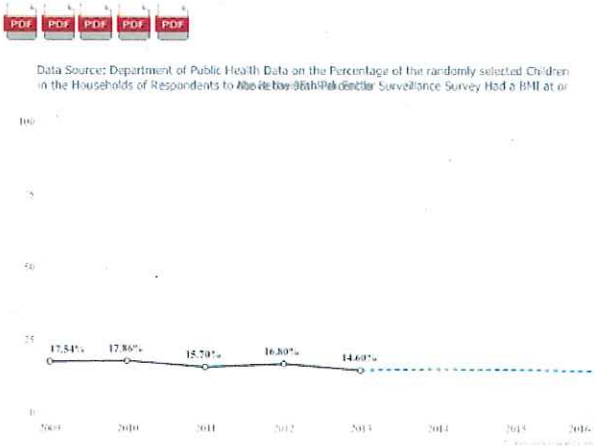
Strategy

- Promote, and continue to increase, 1st trimester enrollment of pregnant women in WIC.
- Strengthen referral networks with healthcare providers and ancillary services.
- Provide training, technical assistance and/or reference materials to low performing local agencies.
- Identify and track risk factors contributing to poor birth outcomes.
- Map and evaluate associations between high birth weight rates and selected health, demographic and socioeconomic variables at the local level.
- Ensure adequate and timely prenatal care.
- Implement DPH-WIC/DSS-HUSKY-A data-sharing & exchange agreement, to increase referrals and co-enrollment, improve coverage, enhance program outcomes and realize cost savings.
- Survey current WIC participants who are not co-enrolled in HUSKY-A to identify reason(s); implement new/revised inter-agency coordination strategies, as appropriate, based on survey results.
- Continue to implement and enhance health promotion efforts, and assess the effectiveness of education efforts on such topics as proper nutrition and weight gain during pregnancy, and abstaining from alcohol, drugs and tobacco use.
    - Provide sample lesson plans for group and/or individual education sessions on healthy behaviors
    - Provide on-site technical assistance to low performing local agencies as needed.
- Promote conditions to improve health equity.
    - Ensure that local staff are as linguistically and culturally representative as possible of the population served by the program.

- Monitor disparities in birth outcomes.

Strategies contributed by staff from the Connecticut Department of Public Health (**DPH**).

Headline Childhood Obesity



2013	14.60%	14.60%	↘ 1	-8% ↓
2012	16.80%	–	↗ 1	6% ↑
2011	15.70%	–	↘ 1	-1% ↓
2010	17.86%	–	↗ 2	13% ↑
2009	17.54%	0.00%	↗ 1	11% ↑
2008	15.80%	0.00%	→ 0	0% →

Story Behind the Curve

The Body Mass Index (BMI) is the primary measurement to determine how children's weight and height reflect their overall health- in other words, whether they're underweight, at a healthy weight, overweight, or obese. Children are classified as overweight when their BMIs land between the 85th and 95th percentiles; obesity describes anything in the 95th percentile or higher. The data for this measure is collected from parent responses to a telephone survey known as the Behavior Risk Factor Surveillance System (BRFSS), which is used by the federal government and many of the states. Connecticut data, provided by the state Department of Public Health (DPH), shows the rates of obesity among children in Connecticut tend to be at or above the national averages. Based upon reports from the Department of Public Health, the primary factors that impact the current rates are ethnicity, sex, and income.

The National Heart, Lung, and Blood Institute call inactive lifestyles a significant contributor to increasing rates of overweight and obese children. Watching more than two hours of television a day and increased use of modern technology (smartphones, computers, etc.) contribute to inactivity in children. Additionally, the CT YMCA Alliance estimates that preschoolers and an children aged 6-11 respectively saw 39% and 25% more PepsiCo television advertisements for sugary drinks in 2013 than they did in 2010. A lack of availability of healthy foods, heavy advertising of unhealthy food, and a lack of safe recreational areas are frequently listed among the environmental factors that contribute to obesity. Nine percent of the total U.S. population lives in communities that do not provide adequate access to healthy food retailers within a reasonable distance from their homes. Cities like Hartford, New Haven, and Bridgeport often lack grocery stores with healthy food.

Recreation areas like trails, parks, & affordable gyms can also be difficult for the average city resident to find. Also, as noted by the Central Connecticut Coast YMCA, the perception of danger through various media outlets enforces the notion that cities lack safe play spaces.

These factors and others related to childhood obesity have a distinct impact on the outcomes for children. The physical health issues associated with childhood obesity range from basic vitamin deficiencies and metabolic complications to developing diabetes and heart disease. Also, the likelihood for low self-esteem, incidences of bullying, depression, and outright discrimination increase in children who are obese. The development of those psychological issues has the potential to negatively impacting their school experience through absenteeism and the effects of peer pressure or bullying.

Both policy initiatives and organizational efforts have been undertaken in order to curb unhealthy eating practices and increase physical activity over the past 10 years. Since 2006, foods and beverages deemed unhealthy have been banned from sale in schools. The State Department of Education has also established a Health Food Certification program for schools that follow the Connecticut Nutrition Standards. Efforts by the Connecticut General Assembly have included revised school recess laws to improve regular physical activity or students. Outside of state government, Connecticut's YMCAs have adopted the Healthy Eating and Physical Activity (HEPA) standards for their after school programs to encourage active lifestyles and restrict unhealthy foods/activities. Their organization has also noted that, in seven communities across the state, a Pioneering Healthier Communities (PHC) initiative has been undertaken to strengthen public policies at the local level.

Partners

- Department of Public Health
- Department of Education
- End Hunger CT!
- Latino and Puerto Rican Affairs Commission
- American Heart Association of Connecticut
- Connecticut YMCAs
- UConn Rudd Center for Food Policy and Obesity

Strategy

- Review and revise local/school wellness policy annually as part of the Healthy Food Certification process. (**DPH**)
- Increase healthy food options in vending machines by reducing the price of healthy choices and increasing the proportion of healthy choices. Increase availability of water and promote its consumption. (**DPH**)
- Implement age-appropriate policies that support increased physical activity.

(DPH)

- Advocate for universal screening for overweight and obesity in schools, and for appropriate reimbursement for nutritional counseling, medical follow-up, and weight loss programs. (DPH)
- Provide training and technical assistance to teachers on the implementation of early childhood programs' nutrition standards. (DPH)
- Provide age-appropriate health education with pre- and post-testing on topics such as heart disease and healthy living. (DPH)
- Educate providers concerning proven strategies to promote healthy behavioral change. (DPH)
- Identify or develop surveillance system with age-appropriate data collection methodology on diet and physical activity. (DPH)
- Develop a population level data base to track BMI. (CHDI)

Strategies contributed by staff from the Connecticut Department of Public Health (DPH) and the Child Health and Development Institute of Connecticut. (CHDI)

Headline Health Insurance Access

2013	94.80%	94.80%	↘ 2	3% ↑
2012	94.90%	—	↘ 1	3% ↑
2011	95.20%	—	↗ 3	4% ↑
2010	94.40%	—	↗ 2	3% ↑
2009	93.80%	0.00%	↗ 1	2% ↑
2008	91.70%	0.00%	→ 0	0% →

Story Behind the Curve

The CT Kid's Report Card has collected data on annual health insurance rates for children up to 18 years old from 2008 to 2013. This includes private sector insurance generally provided through work, as well as insurance provided through the public sector, such as Medicare and Medicaid. Children receiving health insurance from the State Health Insurance Program (SCHIP) are counted as having health insurance. Since 2008, there's been a 3.38% increase in children with health insurance. Every major race saw an increase since 2008, starting with Black children (4.6%), White children (4.43%), and Hispanic children (3.4%). All other races saw a 1.8% increase in the total number of insured children during the six-year period.

Giving children access to high-quality, affordable health care is crucial to their development and wellbeing. Health insurance promotes immunizations that protect them and their communities from serious diseases, identifies and treats recurring

illnesses, provides access for urgent care services, and improves overall school attendance and performance. While some perceive the cost of health insurance as onerous and the process of obtaining it difficult insurance costs between 2014-2015 have declined three to seven percent for individuals and families, and programs like Medicaid and HUSKY are often low-cost or free for lower-income families. The most substantial factor in the cost to health insurance is caring for the uninsured. According to the CASBHC, uninsured parents often delay seeking healthcare for their children. This delay results in families relying on critical emergency department services that are inherently reactive, rather than proven preventative screenings. Screenings allow for early detection of significant illnesses, immediate treatments, and lower rates of missed diagnoses.

The expansion of health insurance under the Affordable Care Act was a primary national catalyst for increasing the rates of people with health insurance. At the state level, school based health centers have been providing additional quality health care services for children. This led the General Assembly and the governor to adopt Public Act No. 15-59, An Act Concerning School Based Health Centers. This law, which took effect in October 2015 defines "school-based health center" and allows the commissioner of DPH to adopt minimum-quality standards for school-based health centers.

Partners

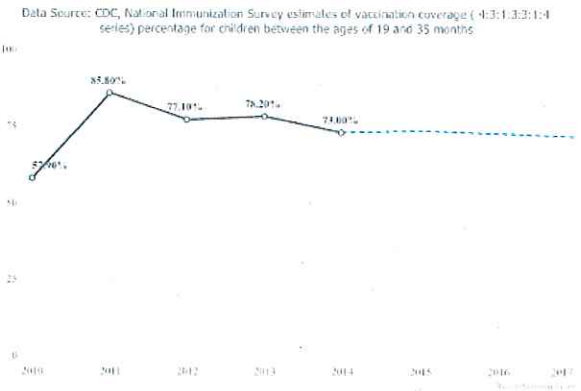
- Department of Public Health
- Connecticut Association for School Based Health Centers
- Office of the Healthcare Advocate

Strategy

- Partner with Access Health CT to encourage youths under 21 years of age to obtain primary care.
- Develop and implement an education campaign for parents around patient-centered medical homes.
- Identify cultural barriers to using primary care physicians.
- Support school-based health centers, community health centers, and other community-based organizations.

Strategies provided by the Connecticut Association of School Based Health Centers (**CTASBHC**)

1	Secondary	Appropriate Immunizations By Age Two	2014	73.00%	73.00%	↘	1	-10% ↓
			2013	78.20%	–	↗	1	-4% ↓
			2012	77.10%	–	↘	1	-5% ↓



2011	85.80%	—	↗	1	5% ↑
2010	57.90%	—	↘	1	-29% ↓
2009	78.90%	0.00%	↗	1	-3% ↓
2008	66.00%	0.00%	↘	2	-19% ↓
2007	81.20%	0.00%	↘	1	0% →
2006	81.80%	0.00%	↗	1	0% →
2005	81.50%	0.00%	→	0	0% →

Story Behind the Curve

Administered by the CDC, the National Immunization Survey collects state-by-state and overall national estimates the percentage of children 19-35 months old receiving age-appropriate immunizations, which is measured with the following vaccination pattern 4:3:1:3:3:1:4. The percentage of children receiving immunizations has varied widely since 2005 and is currently declining after a 2011 high of 85%. Percentages for the last three years have failed to hit the Healthy People 2020 goal.

From the 2010 National Vaccine Plan, proposed federal initiatives to improve appropriate vaccination/immunization rates include: improving upon current vaccines and the national supply, enhancing the vaccine safety system, and expanding communications to enhance informed decision-making regarding vaccines. Based upon the research of Healthy People 2020, appropriate immunization from birth can save up to 33,000 lives, prevent 14 million cases of disease, and reduce direct health care costs by nearly $10 billion. Additional benefits of vaccination include: reduced risk of spreading serious illnesses to our most vulnerable populations; and reduced chances of contracting a serious illness from international travelers/traveling, which could lead to the eradication of certain diseases worldwide.

The **Connecticut Vaccine Program (CVP)** is Connecticut's expanded pediatric vaccination program. The program is state and federally funded and provides vaccines at no cost to children under the age of 19 years. The CVP was developed in response to the enactment of Public Act 12–1, which requires healthcare providers who administer pediatric vaccines to obtain the vaccines through the Department of Public Health in most cases. On February 26, 2014, the newly constituted **Childhood Vaccine Advisory Council (CVAC)** held its first meeting. The council's objective is to improve health outcomes for children in Connecticut by reducing vaccine preventable diseases through the effective, efficient, and evidence based use of CVP supplied vaccines.

The Connecticut Commission on Children has actively discussed the importance of child vaccinations, promoting such programs like the Connecticut Immunization Registry and Tracking System (CIRTS). In 2012, a report produced by the Childhood Immunization Task Force recommended allowing providers to choose brands other

than those recommended by the Vaccine Purchase Advisory Council (VPAC), increasing appropriations for the purchase, storage, and distribution of vaccines under VPAC, and continued monitoring of several issues surrounding vaccine programs, their impact, and implications of certain policies/programs. In 2015, the state of Connecticut passed legislation that exempts children who present a statement that the immunization would be contrary to the parents' or guardians' religious beliefs. It requires any such statement to be officially acknowledged by a notary public, Connecticut-licensed attorney, judge, family support magistrate, court clerk or deputy clerk, town clerk, or justice of the peace. Legislation passed in 2010 requires that childrenhave age-appropriate immunizations prior to being permitted to attend a day care center or group day care home.

Partners

- Department of Public Health
- Connecticut Academy of Pediatrics
- Connecticut Early Childhood Alliance
- Connecticut Nurses Association

Strategy

- Assure costs of vaccines/administration for all ages are covered by all insurers.
- Expand access to Advisory Committee on Immunization Practices (ACIP) recommended vaccines for children.
- Enhance Connecticut immunization registry.
- Implement comprehensive reminder/recall systems.

Strategies contributed by staff from the Connecticut Department of Public Health.

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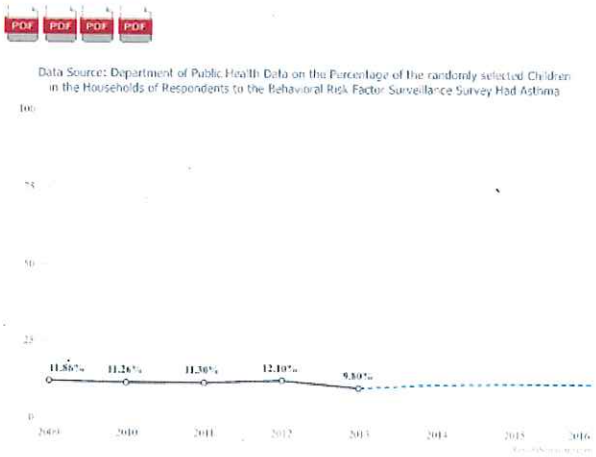
1 Secondary Children with Asthma



2013	9.80%	9.80%	↘ 1	-7% ↓
2012	12.10%	—	↗ 2	15% ↑
2011	11.30%	—	↗ 1	8% ↑
2010	11.26%	—	↘ 1	7% ↑
2009	11.86%	0.00%	↗ 2	13% ↑
2008	11.10%	0.00%	↗ 1	6% ↑
2007	9.70%	0.00%	↘ 1	-8% ↓
2006	10.60%	0.00%	↗ 1	1% ↑
2005	10.50%	0.00%	→ 0	0% →

Story Behind the Curve

National asthma data is collected on an annual basis by the CDC via the Behavioral Risk Factor Surveillance System phone survey, which was founded in 1984.Households are selected through a random-digit-dial sample, and one child is randomly selected in each household. Information on each child is based on responses of the parent or guardian in the household most knowledgeable about the sampled child's health. Children affected by asthma are defined as those who have ever been diagnosed by a doctor or health professional as having asthma and who still have asthma, and for whom one or more of the following occurred in the past year: used medication for asthma, had moderate or severe difficulties due to asthma, had an asthma attack, and/or had been hospitalized for asthma.

Since 2005 Connecticut has ranked above the nationwide prevalence for childhood asthma, and is often one of the highest. Research has shown urban/city youth are at a higher risk of asthma than those children living in suburban or rural areas. For Connecticut, two other factors in play that have an effect on the risk for asthma are low-birth weights, and children born during winter, which can be an especially long season in the Northeast.

Incidences of asthma have been noted as causing behavioral and emotional problems for children. Some of these problems include reduced self-esteem due to an inability to be involved in sports or recreational physical activities, worries about taking medication or suffering an asthma attack in school, an inability to spend time with friends who have pets, and missing school days. In Connecticut, school-aged children from 2007-2009 on average missed 59,814 days from school or day care each year due to asthma. Asthma has also been known to stunt a child's growth and, depending on the severity, disrupt their sleep patterns and even require overnight hospitalization. If a child's asthma is not properly controlled, the resulting increase in medication and hospitalization, as well as lost wages from parental leave, places a financial burden on those families with afflicted children. Based upon a study of 628 children from age 6-12 with asthma, the overall cost of treating asthma is twice as much when it is poorly controlled.

One of Connecticut's primary asthma related programs is The Easy Breathing Program, run through the Connecticut Children's Medical Center Asthma Center since 1997. This program has screened more than 125,000 individuals and ensured 35,000 have received appropriate asthma care, which has reduced costs to families and hospitals. The Department of Public Health (DPH) provides guidance and preventative measures regarding asthma. The CT Association for School Based Health Centers (CASBHC) highlighted the Putting on AIRS (Asthma Indoor Risk Strategies) program, which helps reduce household triggers which by offering free in-home environmental assessments and additional educational materials through local/regional health departments. In addition, the Asthma Advisory Council (AAC) actively collaborates across the public/private sector to revise Connecticut's statewide asthma plan.On a legislative level, local and regional boards of education have been required since 2003 to provide a chronic disease assessment, which

includes asthma, to children enrolling in public schools at certain grade levels and report on an annual basis to the Public Health and Education Committees. The CABHC has also noted the prohibition of municipal school buses from idling while waiting for school dismissal as an important policy change.

Partners

- Department of Public Health
- African American Affairs Commission
- Connecticut Association of School Based Health Centers
- Connecticut Academy of Pediatrics

Strategy

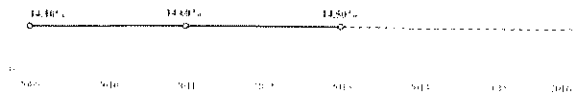
- Target children and adults with poorly controlled asthma for home-based asthma education.
- Reduce exposure to asthma risk factors such as obesity, exposure to smoke, and poor housing conditions.
- Promote the use of evidence-based asthma guidelines.
- Provide comprehensive asthma services through a collaboration between hospitals and community centers.
- Identify schools with a high prevalence of asthma or asthma-related emergency department visits and provide education to students affected by asthma.
- Advocate for written asthma treatment plans for all children with asthma in schools and licensed day care centers.
- Conduct health communication messages to the general public regarding the effects of poor air quality on asthma and health.
- Promote comprehensive smoking prevention and cessation programs
- Promote housing policies for improved air quality.
- Promote use of green cleaning in daycare centers and schools.
- Train health care providers to assess, manage, collect data and develop an asthma treatment plan for their patients.

Strategies provided by staff at the Department of Public Health (DPH)

Secondary Students Who Have Seriously Considered Suicide

2013	14.50%	14.50%	↘ 1	-4% ↓
2011	14.60%	0.00%	↗ 2	-3% ↓
2009	14.10%	0.00%	↗ 1	-7% ↓
2007	13.10%	0.00%	↘ 1	-13% ↓
2005	15.10%	0.00%	→ 0	0% →

Data Source: Results from the Connecticut High School, Youth Risk Behavior Survey, Percentage of High School Students Who Seriously Considered Attempting Suicide During the Past 12 months



Story Behind the Curve

The Connecticut School Health Survey (CSHS) Youth Behavior Component (YBC) is conducted biennially and subsequently published by the Connecticut Department of Public Health (DPH). The YBC surveys students from grades 9-12 in randomly chosen classrooms within selected schools. The question that relates to this indicator is: **"During the past 12 months, did you ever seriously consider attempting suicide."**

According to the National Governor's Association suicide is attempted by well over 300,000 Americans annually. The National Alliance for Mental Illness Connecticut chapter (NAMI-CT) has also indicated suicide as the second leading cause of death for youths in the U.S. between 15-24 years old, 90 percent of whom have a diagnosable mental illness. Students who seriously considered suicide in the past twelve months closely correlates with those who have actually attempted suicide in the same period of time. Connecticut has seen some decline in the percentage seriously considering suicide since 2005, but not a significant amount.

Responses from Hispanic students in Connecticut have demonstrated a higher frequency of suicidal ideation than among their non-Hispanic peers. Also, female students were more likely to seriously consider suicide than males. Some components to consider when looking at this data are the home lives of the students surveyed and the liklihood of exposure to high-risk behaviors.

Regular family meal occurrence (three or more times in the last seven days) has been noted as a protective factor against suicidal ideation. CASBHC identified the "1Word, 1 Voice, 1 Life" campaign of the CT Suicide Advisory Board as a vital tool towards ensuring family, friends, and educators can recognize the warning signs and risk factors for suicidal youth. Negative factors that have been noted as significantly attributing to high school students considering suicide include: sexual assault, being bullied or teased, whether they felt sad/ hopeless two or more weeks in a row, frequent absence from school, and the use of drugs or alcohol. CASBHC notes the use of suspensions/expulsions as punishment in lieu of providing culturally aware behavioral health services as another possible facet. NAMI-CT asserts that the negative factors that impact suicidal tendencies stem not only from a lack of support services, but also growing social isolation in teens. The use of internet-

capable technologies has created a venue for students to carry a negative school climate into their home lives. Not only do these factors play into increasing thoughts of suicide, they also affect student outcomes in the classroom.

Program and policy initiatives undertaken in response to the prevalence of youth suicide in Connecticut include DCF's Connecticut Youth Suicide Advisory Board and DMHAS's Suicide Prevention and Mental Health Promotion Initiative. The Connecticut General Assembly has also sought to address cyberbullying, school safety plans and standards, and develop a comprehensive children's mental health, emotional and behavior health plan.

Partners

- Department of Public Health
- Connecticut Community Providers Association
- Keep the Promise Coalition
- Connecticut Association for School Based Health Centers
- Department of Education

Strategy

- Work with DPH contractors to integrate the practice of conducting a mental health assessment during a physical.
- Reduce access to lethal means of suicide among individuals with identified risks.
- Provide training to community and clinical service providers on prevention of suicide and related behaviors.
- Address integration of prevention efforts across sectors and settings.
- Develop, implement and monitor effective programs that promote wellness and prevent suicide and related behaviors for adolescents; lesbian, gay, bisexual, and transgender youth.
- Increase timeliness and usefulness of surveillance systems and improve ability to collect, analyze and use information.

Strategies contributed by staff from the Connecticut Department of Public Health (**DPH**).

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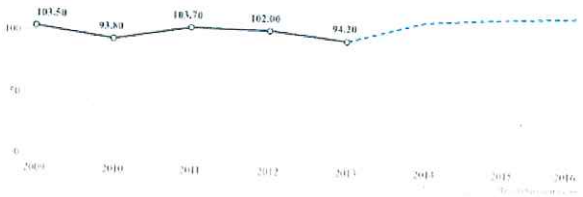
1 Secondary Emergency Department Visits for Asthma

2013	94.20	105.23	↘	2	17% ↑
2012	102.00	102.00	↘	1	26% ↑
2011	103.70	–	↗	1	29% ↑
2010	93.80	–	↘	1	16% ↑
2009	103.50	0.00	↗	2	28% ↑
2008	89.50	0.00	↗	1	11% ↑

Data Source: Department of Public Health Data on the Rate of per 10,000 of Children Who Were Discharged from an Emergency Department due to a Primary Diagnosis of Asthma



2007	84.20	0.00	↘ 1	4% ↑
2006	85.90	0.00	↗ 1	6% ↑
2005	80.70	0.00	→ 0	0% →

Story Behind the Curve

The data for this indicator has been collected from the Connecticut Department of Public Health's (DPH) Office of Health Care Statistics, Quality, Analysis, and Reporting annually since 2005. DPH indicates that asthma visits to the emergency room is a key indicator that the child's asthma is not well controlled. Connecticut's baseline trend has increased 26% as of 2012, the latest reporting year.

The effects of ER visits can impact a child and their family in a variety of ways. Behavioral and emotional problems include reduced self-esteem due to an inability to participate in sporting activities, reduced time with friends and missing full or partial school days. In Connecticut, between 2007-2009, school-aged children collectively missed approximately 59,814 days from school or day care each year due to asthma. The cost of emergency department visits place a substantial burden on children and their families. The American College of Allergy, Asthma & Immunology reported, "...patients with very poorly controlled asthma incurred an average of $7,846 in costs compared with $3,766 for well-controlled asthma. Direct costs of care (labor, supplies and equipment) were also 50% higher for families with children with poorly controlled asthma compared to children with whose asthma was controlled.

One of Connecticut's primary asthma related programs is The Easy Breathing Program, run through the Connecticut Children's Medical Center Asthma Center since 1997. This program has screened more than 125,000 individuals and ensured 35,000 have received appropriate asthma care, which has reduced costs to families and hospitals. The Department of Public Health (DPH) provides guidance and preventative measures regarding asthma. The CT Association for School Based Health Centers (CASBHC) highlighted Putting on AIRS (Asthma Indoor Risk Strategies), a program that helps reduce household triggers which by offering free in-home environmental assessments and additional educational materials through local/regional health departments. In addition, the Asthma Advisory Council (AAC) actively collaborates across the public/private sector to revise Connecticut's statewide asthma plan.On a legislative level, local and regional boards of education have been required since 2003 to provide a chronic disease assessment, which includes asthma, to children enrolling in public schools at certain grade levels and report on an annual basis to the Public Health and Education Committees.

Partners

- Department of Public Health
- African American Affairs Commission
- Connecticut Association for School Based Health Centers
- Connecticut Academy of Pediatrics

Strategy

- Advocate for mandatory written asthma treatment plans for all children with asthma in schools and in licensed day care centers.
- Promote the use of evidence-based asthma guidelines by primary care clinicians, dentists, and other dental and medical professionals.
- Conduct a public education campaign, in partnership with local news stations, on the effects of poor air quality days on health.
- Implements evidence-based, comprehensive asthma programs and smoking prevention/cessation programs.
- Encourage pediatricians to discuss smoking cessation/prevention with parents.

Strategies contributed by staff from the Connecticut Department of Public Health (**DPH**).