State of Connecticut
Department of Public Health

MATERNAL AND CHILD HEALTH SERVICES (TITLE V) BLOCK GRANT ALLOCATION PLAN
FFY 2027

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I. Narrative Overview of Maternal and Child Health Services Block Grant

A. Purpose

The Maternal and Child Health Services Block Grant (MCHBG) is administered by the Maternal and Child Health Bureau (MCHB) within the Health Resources and Services Administration (HRSA), United States Department of Health and Human Services. The Department of Public Health (DPH) is designated as the principal state agency for allocating and administering the MCHBG within Connecticut.

The MCHBG, under Section 505 of the Social Security Act as amended by the Omnibus Budget Reconciliation Act of 1989 (OBRA-89, PL 101-239), is designed to provide a mechanism for program planning, management, measurement of progress, and accounting for the costs of state efforts. Connecticut uses the Application and Annual Report in applying for the MCHBG under Title V of the Social Security Act and in preparing the required Annual Report. Connecticut reports annually on national and state outcome and performance measures, which document the State's progress towards the achievement of established performance targets, ensure accountability for the ongoing monitoring of health status in women and children, and lend support to the delivery of an effective public health system for the maternal and child health population.

B. Major Use of Funds

- The MCHBG is intended to provide quality maternal and child health services for mothers, children, and adolescents, especially those from low-income families. Its goals include reducing infant mortality and the incidence of preventable diseases and disabilities among children, as well as offering treatment and care for children and youth with special health care needs. The MCHBG is a federal/state program aimed at building system capacity to improve the health status of mothers and children.
- MCHBG funds may not be used for cash payments to the intended recipients of health services or for the purchase of land, buildings, or major medical equipment.
- The MCHBG promotes the development of service systems in states to meet critical challenges in:
    - Reducing infant mortality
    - Providing and ensuring access to comprehensive care for women
    - Promoting the health of children by providing preventive and primary care services
    - Increasing the number of children who receive health assessments and treatment services
    - Providing family-centered, community-based, coordinated services for children and youth with special health care needs (CYSHCN)

Connecticut primarily uses MCHBG funds to support departmental resources and grants to local agencies, organizations, and other state agencies in each of the following areas:

- Maternal and Child Health (including adolescents and all women)
- Children and Youth with Special Health Care Needs

C. Federal Allotment Process

The following is from Section 502, *Allotments to States and Federal Set-Aside*, of Title V, *the Maternal and Child Health Services Block Grant,* of the Social Security Act. The Secretary shall allot to each State, which has transmitted an Application for a fiscal year, an amount determined as follows:

(1) The Secretary shall determine for each State-

(A) (i) The amount provided or allotted by the Secretary to the State and to entities in the State under the provision of the consolidated health programs, as defined in section 501 (b)(1), other than for any of the projects or programs described in subsection (a), from appropriations for fiscal year 1981, and (ii) the proportion that such amount for that State bears to the total of such amounts for all States and,

(B) (i) The number of low-income children in the State and (ii) the proportion that such number of children for that State bears to the total of such numbers of children in all the States.

(2) Each such State shall be allotted for each fiscal year an amount equal to the sum of-

(A) The amount of the allotment to the State under this subsection in fiscal year 1983, and,

(B) The State's proportion, determined under paragraph (1)(B)(ii) of the amount by which the allotment available under this subsection for all the States for that fiscal year exceeds the amount that was available under this subsection for allotment for all the States for fiscal year 1983.

D. Estimated Federal Funding

FFY 2027 funding amounts have not yet been announced. The FFY 2027 award has a two-year period of availability, from October 1, 2026 through September 30, 2028. The Maternal and Child Health Services Block Grant allocation plan is based on estimated federal funding of $5,005,306 and may be revised when the final federal appropriation is authorized.

E. Total Available and Estimated Expenditure

The FFY 2027 federal award is estimated to be $5,005,306. Since the FFY 2026 and FFY 2027 federal award allocations have not been announced formally, the FFY 2025 award amount was used to prepare the FFY 2027 application. There are no carryover funds in the MCHBG program, however, states have 24 months (not 12 months) to obligate and spend each year's awarded funds.

F. Proposed Allocation Changes from Last Year

Level funding, as compared to the FFY 2026 estimated expenditure amount, is proposed for Reproductive Health Services, Perinatal Case Management, Information and Referral, Genetics, School Based Health Centers, and Medical Home Community Based Care Coordination Services.

The proposed FFY 2027 plan will decrease overall staff support from 22.0 FTE positions to 20.0 FTE

positions. The increase in MCH Personal Services and Fringe Benefits costs in FFY 2027 reflects negotiated wage and benefit increases.

"Other Expenditures" in FFY 26 totals $386,887 and is split between MCH and CYSHCN for the following expenses:

- $314,933 for a consultant from the CDC Foundation to provide management and oversight support of MCH and CYSHCN initiatives, programs and staff;;
- $20,000 to support a one-time expense for Connecticut Children's to distribute the state Respite and Extend Service Funds; $12,500 for database services;
- $10,290 in required dues;
- $10,000 for the Behavioral Risk Factor Surveillance Survey;
- $6,000 to the Department of Social Services for the Fatherhood Initiative;
- $10,000 in travel expenses for conferences;
- $1,500 for staff training; $1,000 for legal notices for RFPs; and
- $664 to be split between supplies and postage.

"Other Expenditures" in FFY 27 total $120,308 and are split between MCH and CYSHCN for the following expenses:

- $83,982 for a consultant from the CDC Foundation to provide management and oversight support on MCH and CYSHCN initiatives, programs and staff;
- $10,290 in required dues;
- $10,000 for the Behavioral Risk Factor Surveillance Survey;
- $6,000 for the Department of Social Services for the Fatherhood Initiative; and
- $10,036 to be split among required travel, supplies, and legal notice.

FFY2026 "Other" contractual expenditures include funding of $85,000 to support the Maternal Health Task Force, Every Woman Connecticut, and the Reproductive Justice Alliance. This amount is part of a larger contract to implement evidence-informed interventions to address critical gaps in the state's provision of maternity care services, train patient navigators to implement a prenatal care curriculum with clients that are a part of the mobile health navigation project, work the State Maternal Health Taskforce to develop a baseline assessment of CT maternal care and coverage and identify gaps, and convene and lead meetings of the Reproductive Justice Alliance and its subcommittees. The Family Wellness Healthy Start contract was not extended, and the Department is working to identify other funding sources or other existing evidence-based interventions that can support this work.

FFY 2027 "Other" contractual expenditures include $85,000 to support the Maternal Health Task Force, Every Woman Connecticut, and the Reproductive Justice Alliance.

G. Contingency Plan

In the event that the actual FFY 2027 federal award amount is less than $5,005,306, the Department will review the various programs, and each allocation will be assessed to prioritize program activities deemed most critical to the public. If actual funding exceeds $5,005,306, the

Department will review its five-year MCH Needs Assessment and will prioritize the increased funding to best align with objectives identified therein.

In accordance with section 4-28b of the Connecticut General Statutes, after recommended allocations have been approved or modified, any proposed transfer to or from any specific allocation of a sum or sums of over fifty thousand dollars or ten per cent of any such specific allocation, whichever is less, shall be submitted by the Governor to the speaker of the house and the president pro tempore of the senate and approved, modified, or rejected by the joint standing committee of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies and to the joint standing committee or committees of the General Assembly having cognizance of the subject matter relating to such recommended allocations, as determined by the speaker and the president pro tempore. Notification of all transfers made shall be sent to the joint standing committee of the General Assembly, having cognizance of matters relating to appropriations and the budgets of state agencies, and to the committee or committees of cognizance, through the Office of Fiscal Analysis. For planning purposes, the relevant committees are expected to include the Appropriations Committee and the Public Health Committee, subject to the final determination of the Speaker of the House and the President Pro Tempore of the Senate under the statute.

H. State Allocation Planning Process

Federal legislation mandates that an application for funds be submitted annually and that an MCH Statewide Needs Assessment be conducted every five years. DPH submitted its federal application for FFY 2026 in July 2025. The data presented in the annual application are based on 5 National Performance Measures (NPM), 3 State Performance Measures (SPM), and 12 Evidence-Based or Informed Strategy Measures (ESM). The Department completed its 2025-2030 MCH Needs Assessment in September 2025. Funds are allocated to address crucial challenges in reducing adverse perinatal outcomes, including infant mortality and low birth weight; providing and ensuring access to care across MCH population groups; reducing health disparities and health inequities; and the priority needs identified in the Needs Assessment.

I. Grant Provisions

A state application for federal grant funds under the MCHBG is required under Section 505 of the Social Security Act (the Act), as amended by the Omnibus Budget Reconciliation Act of 1989 (OBRA-89, PL 101-239). The application offers a framework for states to describe how they plan for, request, and administer MCH Services Block Grant funds. The Act requires that the state health agency administer the program. CT's electronic application is available at https://mchb.tvisdata.hrsa.gov/Home/StateApplicationOrAnnualReport

Paragraphs (1) through (5) of Section 505(a) require states to prepare and transmit an application that:

- Reflects that three dollars of state matching funds are provided for each four dollars in federal funding (for FFY 2027, CT's state match is $4,054,451);
- Is developed by, or in consultation with, the state MCH agency and made public for comment during its development and after its transmittal; contains a statewide needs assessment (to be conducted every five years) with updates submitted in the interim years in the annual application. The application will contain information (consistent with the health status goals and

national health objectives) regarding the need for: (A) preventive and primary care services for pregnant women, mothers, and infants up to age one; (B) preventive and primary care services for children; and (C) services for children with special health careneeds.

- Includes a plan to meet the needs identified by the statewide needs assessment, a description of how the state intends to use its block grant funds to provide and coordinate services to carry out that plan (including a statement of how its goal and objectives are tied to applicable Year 2025 national goals and objectives), and an identification of the types of service areas within the state where services will be provided;
- Specifies the information that states will collect to prepare annual reports required by Section 506(a); unless a waiver is requested under Section 505(b), provides that the state will use at least 30 percent of its block grant funds for preventive and primary care services for children and at least 30 percent of its block grant funds for children with special health careneeds;
- Provides that the state will maintain at least the level of funds for the program, which is provided solely for maternal and child health programs in FFY 1989 (Connecticut FFY 1989 baseline: $6,777,191; the FFY 2027 state maintenance of effort is $7,047,965;
- Provides that the state will establish a fair method for allocating funds for maternal and child health services and will apply guidelines for frequency and content of assessments, as well as quality of services;
- Provides that funds be used consistent with nondiscrimination provisions and only for mandated Title V activities or to continue activities previously conducted under the health programs consolidated into the1981 block grant; provides that the state will give special consideration (where appropriate) to continuing "programs or projects" funded in the state under Title V prior to enactment of the 1981 block grant;
- Provides that no charge will be made to low-income mothers or children for services. According to the MCHBG guidance, low income is defined as "an individual or family with an income determined to be below the official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981." Charges for services provided to others will be defined according to a public schedule of charges, adjusted for income, resources, and family size;
- Provides for a toll-free telephone number (and other appropriate methods) for use by parents to obtain information about health care providers and practitioners participating under either Title V or Medicaid programs as well as information on other relevant health and health-related providers and practitioners; provides that the state MCH agency will participate in establishing the state's periodicity and content standards for Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program;
- Provides that the state MCH agency will participate in the coordination of activities among Medicaid, the MCH block grant, and other related federal grant programs, including the Supplemental Nutrition Program for Women, Infants, and Children (WIC), education, developmental disabilities, and reproductive health programs; and
- Requires that the state MCH agency provide (both directly and through their providers and contractors) for services to identify pregnant women and infants eligible for services under the state's Medicaid program and to assist them in applying for Medicaid assistance.

II. Tables

Table A

Maternal and Child Health Services Block Grant
Recommended Allocations

PROGRAM CATEGORY	FFY 25 Expenditures	FFY 26 Estimated Expenditures	FFY 27 Proposed Expenditure	Percentage Change - FFY 26 to FFY 27
Number of Positions (FTE)	22.0	22.0	20.0	-9.1%
Maternal and Child Health	$2,973,534	$3,005,728	$3,065,094	2.0%
Children and Youth with Special Health Care Needs	$2,031,772	$1,999,577	$1,940,212	-3.0%
TOTAL[1]	**$5,005,306**	**$5,005,306**	**$5,005,306**	**0.0%**
SOURCE OF FUNDS				
Federal Block Grant Funds Available[2]	$5,005,306	$5,005,306	$5,005,306	0.0%
TOTAL FUNDS AVAILABLE	**$5,005,306**	**$5,005,306**	**$5,005,306**	0.0%

[1] Numbers may not add to totals due to rounding.
[2] The FFY 2026 and FFY 2027 federal award allocations have not been finalized and may be subject to change. The FFY 2025 award amount was used to prepare the FFY 2027 application.

Note: According to the Health Resources and Services Administration, the MCHBG award for each fiscal year has a 2-year period of availability. As such, the funds for each fiscal year are available for expenditure over a 2-year period and do not require carry-forward approval. There are no carryover funds in the MCH Block Grant program. Funds must be obligated within the 2-year project period.

Table B1

Maternal and Child Health Services Block Grant

PROGRAM EXPENDITURES:

Maternal and Child Health

Program Category	FFY 25 Expenditure	FFY 26 Estimated Expenditure	FFY 27 Proposed Expenditure	Percentage Change - FFY 26 to FFY 27
Number of Positions (FTE)	12.75	12.75	11.5	-9.8%
Personal Services	$1,156,592	$1,005,023	$1,157,661	15.2%
Fringe Benefits	$866,097	$885,780	$992,442	12.0%
Other Expenses[1]	$244,055	$290,165	$90,231	-68.9%
Contracts/Grants to:				
Other State Agencies	$36,000	$36,000	$36,000	0.0%
Private Agencies	$670,790	$788,760	$788,760	0.0%
TOTAL EXPENDITURES[2]	**$2,973,534**	**$3,005,728**	**$3,065,094**	2.0%
SOURCE OF FUNDS	**Sources of FFY 25 Allocations**	**Sources of FFY 26 Allocations**	**Sources of FFY 27 Allocations**	**Percentage Change – FFY 26 to FFY 27**
Federal Block Grant Funds[3]	$2,973,534	$3,005,728	$3,065,094	2.0%
TOTAL FUNDS AVAILABLE	**$2,973,534**	**$3,005,728**	**$3,065,094**	**2.0%**

1 FFY 2025 Other Expenditures include a consultant to complete work that the CDC Assignee had been working on including the five year needs assessment and the severe maternal morbidity (SMM) surveillance; Office of Support Services at DPH to have necessary updates made to the CORE-CT system; AMCHP dues; prenatal and breastfeeding website and education services; BRFSS; DSS Fatherhood Initiative; travel to conferences; Newborn Screening Laboratory materials; database services; needs assessment consultant; staff training;; legal notice; CYSHCN materials; licenses and supplies. FFY 2026 Other Expenditures include CDC Foundation consultant; Respite and Extend Service Funds distribution; database services; dues; BRFSS; DSS Fatherhood Initiative; travel; staff training; legal notices; and supplies and postage. FFY 2027 Other Expenditures include CDC Foundation consultant; dues; BRFSS; DSS Fatherhood Initiative; travel; supplies; and legal notices.

2 Numbers may not add to totals due to rounding.

3 The FFY 2026 and FFY 2027 federal award allocations have not been finalized and may be subject to change. The FFY 2025 award amount was used to prepare the FFY 2027 application.

Table B2
Maternal and Child Health Services Block Grant

PROGRAM EXPENDITURES:

Children and Youth with Special Health Care Needs

Program Category	FFY 25 Expenditure	FFY 26 Estimated Expenditure	FFY 27 Proposed Expenditure	Percentage Change - FFY 26 to FFY27
Number of Positions (FTE)	9.25	9.25	8.5	-8.1%
Personal Services	$574,833	$519,693	$530,347	2.1%
Fringe Benefits	$430,456	$458,033	$454,657	-0.7%
Other Expenses[1]	$81,352	$96,722	$30,077	-68.9%
Contracts/Grants to:				
Other State Agencies	$4,000	$4,000	$4,000	0.0%
Private agencies	$941,131	$921,130	$921,131	0.0%
TOTAL EXPENDITURES[2]	**$2,031,772**	**$1,999,577**	**$1,940,212**	-3.0%
SOURCE OF FUNDS	**Sources of FFY 25 Allocations**	**Sources of FFY 26 Allocations**	**Sources of FFY 27 Allocations**	**Percentage Change – FFY 26 to FFY 27**
Federal Block Grant Funds[3]	$2,031,772	$1,999,577	$1,940,212	-3.0%
TOTAL FUNDS AVAILABLE	**$2,031,772**	**$1,999,577**	**$1,940,212**	**-3.0%**

[1] FFY 2025 Other Expenditures include a consultant to complete work that the CDC Assignee had been working on including the five year needs assessment and the severe maternal morbidity (SMM) surveillance; Office of Support Services at DPH to have necessary updates made to the CORE-CT system; AMCHP dues; prenatal and breastfeeding website and education services; BRFSS; DSS Fatherhood Initiative; travel to conferences; Newborn Screening Laboratory materials; database services; needs assessment consultant; staff training;; legal notice; CYSHCN materials; licenses and supplies. FFY 2026 Other Expenditures include CDC Foundation consultant; Respite and Extend Service Funds distribution; database services; dues; BRFSS; DSS Fatherhood Initiative; travel; staff training; legal notices; and supplies and postage. FFY 2027 Other Expenditures include CDC Foundation consultant; dues; BRFSS; DSS Fatherhood Initiative; travel; supplies; and legal notices.

2 Numbers may not add to totals due to rounding.

3 The FFY 2026 and FFY 2027 federal award allocations have not been finalized and may be subject to change. The FFY 2025 award amount was used to prepare the FFY 2027 application.

Table B3

Allocations by Program Category*
Maternal and Child Health Services Block Grant

List of Block Grant Funded Programs

Major Program Category	Expenditures		
Maternal and Child Health	**FFY 25 Actual**	**FFY 26 Estimated**	**FFY 27 Proposed**
Perinatal Case Management	$147,037	$212,287	$212,287
Reproductive Health Services [1]	$16,092	$16,092	$16,092
Information and Referral [1]	$201,690	$201,690	$201,690
School Based Health Services [1]	$273,691	$273,691	$273,691
Genetics [1]	$36,000	$36,000	$36,000
Other [2]	$32,280	$85,000	$85,000
MCH Total[3]	**$706,790**	**$824,760**	**$824,760**
Children and Youth with Special Health Care Needs	**FFY 25 Actual**	**FFY 26 Estimated**	**FFY 27 Proposed**
Medical Home Community Based Care Coordination Services	$883,011	$863,011	$863,011
Reproductive Health Services [1]	$2,405	$2,405	$2,405
Genetics [1]	$4,000	$4,000	$4,000
Information and Referral [1]	$41,310	$41,310	$41,310
School Based Health Services [1]	$14,405	$14,405	$14,405
Other [2]	$0	$0	$0
CYSHCN Total[3]	**$945,131**	**$925,131**	**$925,131**
Grand Total	**$1,651,921**	**$1,749,891**	**$1,749,891**

[1] These contracts are allocated to both program categories to reflect a dual focus of programming in the areas of Maternal and Child Health (MCH) and Children and Youth with Special Health Care Needs (CYSHCN).

[2] FFY 2025 "Other" contractual expenditures includes funding in the amount of: $32,280 to support consumers served through the Family Wellness Healthy Start Program; FFY2026 "Other" contractual expenditures: Funding in the amount of $85,000 to support the Maternal Health Task Force, Every Woman Connecticut, and the Reproductive Justice Alliance; FFY2027 "Other" contractual expenditures: Funding in the amount of $85,000 to support the Maternal Health Task Force, Every Woman Connecticut, and the Reproductive Justice Alliance;

[3] Numbers may not add to totals due to rounding.

*This table presents program expenditures for contractual services only. Salaries and fringe are not represented here.

Table C1

Maternal and Child Health Services Block Grant
Summary of Service Objectives and Activities
Maternal and Child Health

Service Category	Objective	Grantor/Agency Activity	Program-wide Number Served*	National Performance Measures
Perinatal Case Management	To provide case management services for pregnant and parenting young women to promote healthy birth outcomes.	DPH provides funding for Comprehensive Reproductive and Perinatal Health services for pregnant and parenting young women, through the Exchange Club Center for the Prevention of Child Abuse of Southern CT, Inc. who have transitioned from the child welfare system to the adult mental health system, as well as to other women with significant trauma histories. The Hospital of Central Connecticut offers Specialized Services for Adolescents, a program that provides perinatal support services to teenagers and young adolescents in a community setting.	Program-wide total: 377 pregnant or parenting women and teens were served.	**National Outcome Measure #1:** Percent of pregnant women who receive prenatal care beginning in the first trimester. Data: In 2023, 83.2% of pregnant women in Connecticut reported having received prenatal care beginning in the first trimester, which is lower than in 2020. Source: National Vital Statistics System (NVSS).
Reproductive Health Services	To prevent unintended pregnancies and risky health behaviors.	DPH funds Planned Parenthood of Southern New England, Inc. to deliver reproductive health care services. This includes screenings for breast and cervical cancer, HIV, and STIs (sexually transmitted infections), as well as contraception, preventive education, counseling, and clinical services for men and women of reproductive age at 14 health centers located in Bridgeport, Danbury, Enfield, Hartford North, Manchester,	Program-wide total: PPSNE's DPH Family Planning Program provided family planning/reproductive health services to 40,792 individuals.	**National Performance Measure #1:** Percent of women, ages 13 through 44, with a preventive medical visit in the past year. Data: In 2024, 75.2% of women in Connecticut, ages 18 through 44 reported having a preventive medical

Service Category	Objective	Grantor/Agency Activity	Program-wide Number Served*	National Performance Measures
		Meriden, New London, New Haven, Norwich, Stamford, Torrington, Waterbury, West Hartford and Willimantic. Services are also offered via Telehealth.		visit in the past year, compared to 76.3% in 2020. Source: Behavioral Risk Factor Surveillance System
Information and Referral	To provide statewide, toll free MCH information.	DPH provides funding to the United Way of CT/2-1-1 Infoline to provide toll free 24-hour, 7 days/week information and referral services regarding MCH services in the state.	279,422 Callers	N/A
School-Based Primary and Behavioral Health Services	To promote the health of children and youth through preventive and primary interventions.	Licensed as outpatient facilities or hospital satellites, School-Based Health Centers (SBHCs) provide services that address the medical, mental, and oral health needs of children and youth. The DPH supported 91 school health service sites across 27 communities statewide.	24,017 un-duplicated users 147,753 visits (2024-2025)	N/A

Genetics	To provide information to consumers and providers on pregnancy exposure services.	DPH provides funding to UConn Health to provide information on exposures to occupational and environmental hazards, medications, and other risk factors during pregnancy through a toll-free telephone line, "MotherToBaby CT."	584 unique contacts. Of those, 255 were callers, 325 were email contacts, and 4 were in-person sessions. MotherToBaby CT counseled on 2,399 exposures among those 584 contacts.	N/A

** For Tables C1 and C2, service counts are program-wide totals from the most recent available reporting period, generally SFY 2026, and may include services supported by state and federal funding sources. Because MCHBG funds are frequently braided with other resources and also support personnel, infrastructure, coordination, and system-level activities, the counts generally cannot be attributed solely to MCHBG funding.*

Table C2

Maternal and Child Health Services Block Grant

Summary of Service Objectives and Activities
Children and Youth with Special Health Care Needs

Service Category	Objective	Grantor/Agency Activity	Program-wide Number Served*	National Performance Measures
Medical Home Community-Based Care Coordination Services	To identify children and youth with special health care needs in medical homes and provide care coordination with the support of regional networks.	DPH supports the community-based system of care coordination. 186 community-based medical homes are part of the CYSHCN medical home program. The Medical Home Advisory Council (MHAC) continues to provide input into the medical home system of care for CYSHCN. There are 6 consumers/families on the MHAC.	9,300 CYSHCN Individuals	**National Performance Measure #11:** Percent of children with and without special health care needs, ages 0 through 17, who have a medical home. In 2023-24, 36.5% of parents/ guardians of children with special health care needs in Connecticut, ages 0 through 17, reported having a medical home. In 2023-24, 63.5% of parents/ guardians of children without special health care needs in Connecticut, ages 0 through 17, reported having a medical home. Source: National Survey of Children's Health (NSCH).

Service Category	Objective	Grantor/Agency Activity	Program-wide Number Served*	National Performance Measures
Newborn Hearing Screening	To provide early hearing detection and intervention to infants and minimize speech and language delays.	All CT newborns are screened prior to hospital discharge. DPH participates on the Early Hearing Detection task force, quarterly, and the Intervention Task Force to discuss and identify issues relevant to the early identification of hearing loss.	35,394 (99.02%) screened1 Ongoing	95% Screened Before 1 Month of Age: 35,048 (97.46%) were screened before 1 month of age.

Service Category	Objective	Grantor/Agency Activity	Program-wide Number Served*	National Performance Measures
Newborn Bloodspot Screening	To provide early identification of infants at increased risk for selected metabolic or genetic diseases so that medical treatment can be promptly initiated to avert complications and prevent irreversible problems and death.	Connecticut's Newborn Screening Program screens newborns using bloodspot specimens processed primarily by the State Public Health Laboratory. Cystic fibrosis screening is conducted by Yale and UConn laboratories, which report data to DPH pursuant to CGS § 19a-55. The program coordinates timely follow-up for out-of-range results and conducts quality-improvement activities focused on specimen collection, transport, completeness, testing, and reporting.	35,458 (99.7%) of eligible newborns[2] screened	**National Outcome Measure #12** (DEVELOPMENTAL): Percent of eligible newborns screened for heritable disorders with on time physician notification for out-of-range screens who are followed up with in a timely manner. Baseline data: Number of referrals in Connecticut made/reported to primary care physician (PCP) within 24 hours of receipt of presumptive positive results (2018): 99.3%. CT NBS Program 2024 data: Number of referrals in Connecticut made/reported to primary care physician (PCP) within 24 hours of receipt of presumptive positive results (2024): 100% CF Screening Program 2024 data: data is not available at this time

	To Improve Timeliness in Sample Collection and Receipt	In mid-2022, the first NBS Timeliness Quality Indicator (QI) report cards were distributed to every birth hospital in the state. Quarterly distribution of the report cards continues. The QIs measured include: • (QI) 1: Date of Birth to Collection Time • (QI) 2: Time from Collection to Receipt at the SPHL • (QI) 3: Specimens Satisfactory for Testing • (QI) 4: Essential Data Fields Complete Since release of the initial QI report card, CT NBS Program staff have worked with the CT Hospital Association and teams from each birth hospital to discuss strategies for improvement. NBS FU Database User Training classes were held in January 2024, February 2024, May 2024, June 2024 and October 2024 and were well attended by representatives of birth hospitals across the state. Improvements have been noted in the areas of QI 2 and QI 4 at the individual hospital levels since inception of the report card. The implementation of a new Newborn Screening Laboratory Information Management System LIMS) and is expected to go live in July 2025. The new LIMS will greatly enhance NBS testing, follow up and tracking abilities with a focus on improved accuracy and timeliness.		State Outcome Measures: Goal is $\geq$ 99% for all QI Timeliness Indicators Baseline Data 2022 (statewide): QI 1: 97.7% QI 2: 78.0% QI 3: 100.0% QI 4: 96.9 % CT NBS Program 2023 data (statewide): QI 1: 98.8% QI 2: 94.6% QI 3: 100.0% QI 4: 96.3 % CT NBS Program 2024 data (statewide): QI 1: 99.2% QI 2: 97.5% QI 3: 99.9% QI 4: 97.6 %

Service Category	Objective	Grantor/Agency Activity	Program-wide Number Served*	National Performance Measures
		The CT Newborn Screening Program Genetics Advisory Committee (GAC) is comprised of State NBS staff, State Laboratory administrators, treatment center clinicians and staff, hospital birthing center and NICU clinicians and staff, as well as representatives from community-based advocacy groups. Meetings are conducted to identify and address current and emerging issues.		

[1] The number screened is derived from the number of births that occurred in CT, as obtained from the DPH Vital Records program. The Early Hearing Detection and Intervention (EHDI) Program identifies the number of these infants who received at least one hearing screening.
[2] The number screened is derived from the number of births that occurred in CT, as obtained from the DPH Vital Records program, indicating the number of infants who receive at least one newborn bloodspot screening through the CT NBS Program.

Note: Newborn hearing screening is overseen by DPH's EHDI Program, and Newborn Bloodspot Screening is overseen by DPH's NBS Program, except for Cystic Fibrosis (CF) screening, which is administered by the Yale and UConn Health CF Laboratories. The hearing number differs from the genetic and metabolic number, as the physical screening procedures and the timing of the screenings are different.

Table D
SELECTED PERINATAL HEALTH INDICATORS
Connecticut, 2020-2024

Infant Mortality Rate	YEAR	Race/Ethnicity			
		All Races	non-Hispanic White	non-Hispanic Black/Afr Am	Hispanic
Rate of mortality among infants less than one year of age, per 1,000 live births	2020	4.3	2.3	9.7	5.5
	2021	4.7	3.3	9.9	5.8
	2022	4.5	2.3	8.7	6.8
	2023	4.8	3.1	8.2	6.3
	2024	4.7	3	7.9	5.5

Teen Birth Rate	YEAR	Race/Ethnicity			
		All Races	non-Hispanic White	non-Hispanic Black/Afr Am	Hispanic
Live births per 1,000 females aged 15-19	2020	7.4	2.4	10.8	20.0
	2021	7.1	1.7	10.7	20.4
	2022	6.4	1.6	8.5	18.5
	2023	6.8	1.7	9.1	18.3
	2024	6.5	1.7	8	17.3

Singleton Low Birth Weight Rate	YEAR	Race/Ethnicity			
		All Races	non-Hispanic White	non-Hispanic Black/Afr Am	Hispanic
Rate of singleton low birth weight; less than 2,500 g or 5.5 lbs	2020	6.1	4.5	10.4	6.7
	2021	6.3	4.5	10.5	7.2
	2022	6.3	4.7	11.5	7
	2023	6.2	4.3	11.2	7.4
	2024	6.5	5	11.5	6.7

Singleton Very Low Birth Weight Rate	YEAR	Race/Ethnicity			
		All Races	non-Hispanic White	non-Hispanic Black/Afr Am	Hispanic
Rate of singleton very low birth weight; less than 1,500g or 3.5 lbs	2020	1.0	0.6	2.3	1.3
	2021	1.0	0.5	2.5	1.2
	2022	1.0	0.6	2.1	1.3
	2023	0.9	0.5	2.3	1.0
	2024	0.9	0.6	2.1	1.0

Late/No Prenatal Care	YEAR	Race/Ethnicity			
		All Races	non-Hispanic White	non-Hispanic Black/Afr Am	Hispanic
Percent of live births to mothers who received initial prenatal care after the first trimester, or who did not receive prenatal care	2020	15.3	11.2	20.8	20.5
	2021	15.3	11.2	20.8	21.3
	2022	16.4	11.5	22.7	22.7
	2023	16.8	11.5	23.7	23.6
	2024	16.3	11.2	24.6	22.0

Early Prenatal Care	YEAR	Race/Ethnicity			
		All Races	non-Hispanic White	non-Hispanic Black/Afr Am	Hispanic
Percent of live births to mothers who received initial prenatal care during the first trimester	2020	84.7	88.8	79.2	79.5
	2021	84.7	88.8	79.2	78.7
	2022	83.6	88.5	77.3	77.3
	2023	83.2	88.5	76.3	76.4
	2024	83.7	88.8	75.4	78.0

Singleton Preterm Birth	YEAR	Race/Ethnicity			
		All Races	non-Hispanic White	non-Hispanic Black/Afr Am	Hispanic
Rate of Singleton Births prior to 37 weeks gestation	2020	7.6	6.4	10.6	8.6
	2021	7.8	6.3	10.9	9.1
	2022	7.6	6.4	11.2	8.5
	2023	7.6	6.1	12.0	8.5
	2024	8.1	6.8	11.7	9.0

Selected Perinatal Health Indicators

Although residents of Connecticut report good overall health status relative to the U.S., large health disparities exist based on various social and demographic factors. These differences, particularly by race and ethnicity, reflect the cumulative impact of structural inequities including differential access to high-quality care, socioeconomic conditions, chronic stress, and systemic barriers within healthcare and public health systems. Addressing these inequities is a central priority for Connecticut's Title V Maternal and Child Health (MCH) program. **Table D** provides statewide data for selected perinatal health indicators for 2020-2024.

The data described below demonstrate continued progress in several areas, including declining infant mortality and historically low teen birth rates. However, much remains to be done to achieve optimal outcomes for all Connecticut mothers and infants. The lifetime effects of racism, social class, poverty, stress, environmental influences, health policy, and other social determinants of health are reflected in the elevated rates of adverse outcomes and persistent differences. These indicators highlight the need for the continuation of evidence-based programs, coupled with efforts to improve birth outcomes for all by addressing social determinants of health. While we continue to strive to reduce health inequities, these challenges are also apparent at the national level and are not unique to Connecticut.

Infant Mortality

Connecticut continues to perform well on overall infant mortality, with rates that are both low and stable over time, however, Black/African American and Hispanic infants continue to experience significantly higher mortality than White infants, highlighting persistent disparities. From 2020-2024, Connecticut's infant mortality rate (4.6 deaths per 1,000 live births, range: 4.3-4.8) remained consistently below the national average for the same period (5.5). While low mortality among non-Hispanic White infants is the driving factor for the state's overall low rate, Black/African American infants (8.9) and Hispanic infants (6.0) experienced 3.2- and 2.1-times greater mortality, respectively, than White infants (2.8). Within the Hispanic population, the Puerto Rican subpopulation drives the high mortality rate. This subpopulation represents nearly half of Hispanic births and a mortality rate of 7.3, compared to the remainder of the Hispanic population with a mortality rate of 5.0. Infant mortality rates for both Black/African American and Puerto Rican infants exceed the national average, underscoring that these populations do not share in the state's overall success. This pattern highlights a disproportionate burden concentrated among specific groups and reinforces that Connecticut's favorable statewide outcomes are not equitably distributed.

Teen Birth Rate

Connecticut continues to see long-term declines in teen births, yet teens of color remain disproportionately affected, indicating the disparities are not being narrowed. Overall teen birth rates averaged 6.8 births per 1,000 females aged 15-19 during 2020-2024 (range: 6.4-7.4), stabilizing after years of steady decline. The 2022 rate (6.4) was the lowest recorded this century. Despite overall declines across all racial and ethnic groups, inequities remain pronounced. Black/African American teens (9.4) and Hispanic teens (18.9) had birth rates 5.2 and 10.5 times higher, respectively, than White teens (1.8). These disparities reflect differences in access to comprehensive sexual health education, reproductive healthcare services, and broader

socioeconomic conditions.

Singleton Low Birth Weight and Very Low Birth Weight

Low birth weight and very low birth weight remain stable overall, but Black/African American infants face markedly higher risk, indicating persistent influences of chronic stress and unequal access to optimal prenatal care. Women on Medicaid and those without a Bachelor's degree also face increased rates of low and very low birth weight.

Singleton low birth weight (LBW) averaged 6.3% from 2020-2024 (range: 6.1-6.5%), with stable rates among White and Hispanic infants and a rising trend among Black/African American infants (2.1% annual increase since 2016). During 2020-2024, LBW rates for Black/African American singletons (11.0%) and Puerto Rican singletons (8.4%) were 2.4 and 1.8 times higher, respectively, than those of White singletons (4.6%). During this same period, LBW rates for women on Medicaid were 1.6 times higher than those with private insurance (8.1% vs 5.1%), and LBW rates among women without a Bachelors degree were 1.6 times higher than those with a Bachelors degree or more (7.7% vs 4.7%).

Very low birth weight (VLBW) remained low overall (1.0%, range: 0.9%-1.0%) and continued a long-term downward trend, but disparities were even more pronounced: Black/African American infants (2.3%) had nearly four times the VLBW rate of White infants (0.6%) and Puerto Rican infants (1.5%) had more than double the rate. Similarly, women on Medicaid had nearly twice the VLBW rate than those on private insurance (1.3% vs 0.7%), and women without a Bachelors degree had twice the rate of those with a college degree (1.3% vs 0.6%). Inequities in LBW/VLBW are strongly associated with structural factors, including chronic stress, inequitable access to high-quality prenatal care, access to education, and differences in underlying health conditions shaped by social and environmental determinants.

Singleton Preterm Birth

Preterm birth rates remain largely unchanged in recent years, but Black/African American women continue to experience nearly twice the rate of singleton preterm birth compared to White women, driving inequitable infant health outcomes. From 2020-2024, Connecticut's singleton preterm birth rate averaged 7.7%, with little variation across years (range: 7.6-8.1%). Yet rates were consistently higher among Black/African American women (11.3%) and Puerto Rican women (10.0%) compared with White women (6.4%). Rates were also higher for women on Medicaid (9.3%) compared to those with private insurance (6.7%), as well as those without a college degree (9.1%) compared to those with a college degree (6.2%). These disparities suggest ongoing differences in maternal health conditions and reflect the cumulative effects of structural inequities, including differences in access to high-quality maternal care, chronic stress exposure, and social determinants such as housing and economic stability.

Late or No Prenatal Care

Access to timely prenatal care remains a critical challenge, particularly for Black/African American and Hispanic women. Most women in Connecticut begin prenatal care in the first

trimester, but meaningful gaps persist, with Black/African American and Hispanic women twice as likely as White women to begin care later or not at all, reinforcing access and equity challenges. Between 2020-2024, 16.0% of births (range: 15.3%-16.8%) involved late or no prenatal care. Rates were significantly higher among Black/African American (22.5%) and Hispanic women (22.0%), approximately double the rate observed among White women (11.3%). Although other health indicators for Hispanic women are driven by the Puerto Rican subpopulation, late PNC is driven by non-Puerto Rican Hispanic women. Puerto Rican women are less likely to start PNC after the first trimester (16.3%) than other Hispanic subgroups (26.1%). Women on Medicaid were more likely to delay prenatal care than those on private insurance (22.9% vs 10.1%). Women without a college degree were also more likely to delay prenatal care than those with a college degree (20.6% vs 11.1%). These disparities suggest differences in health system access. These differences highlight ongoing inequities in access to timely care and reinforce the importance of Title V investments in community-based supports, outreach, and system-level improvements to ensure equitable access to early and continuous prenatal services. Title V efforts are focused on early entry into care, care coordination, and community-based supports remain essential to improving maternal and infant outcomes.

Program Highlights

Within DPH, several initiatives are underway to reduce adverse birth outcomes, address risk factors associated with poor outcomes, and reduce disparities in maternal and child health indicators. These initiatives are supported through a mix of MCHBG funds, other federal awards, state funds, and partner resources. The descriptions below identify whether FFY 2027 MCHBG support is provided through a direct contractual allocation or indirectly through MCHBG-funded personnel, data infrastructure, coordination, and other Title V system-building activities.

Crosscutting Domain

- The **Connecticut Maternal and Child Health (MCH) Coalition** has served for nearly 20 years as a statewide collaborative body comprised of state agencies, healthcare providers, academic partners, community-based organizations, funders, and advocates dedicated to improving maternal and child health outcomes. The Coalition includes more than 180 members representing approximately 100 organizations and functions as a key forum for cross-sector communication, coordination, and information sharing. The Coalition aligns its priorities with the State Health Improvement Plan (SHIP), with a focus on advancing access to care, economic stability, food and housing security, and community strength and resilience. The Coalition also prioritizes health equity and the elimination of racial and ethnic disparities in maternal and child health outcomes, consistent with statewide and national Title V priorities. Through quarterly convenings, targeted workgroup activities, and dissemination of regular communications (e.g., "Notes of Interest"), the MCH Coalition supports stakeholder engagement, elevates emerging issues, and facilitates coordinated responses to maternal and child health needs across Connecticut. **MCHBG support: MCHBG-funded staff coordinate the Coalition, convenings, and communications; no separate contractual allocation is identified in Table B3.**

- The **Reproductive Health Program, administered by Planned Parenthood of Southern New England, Inc. (PPSNE)**, is financially supported by state and a very small proportion of Title V funds under a five-year contract. This program extends its services to regions in Connecticut characterized by a high concentration of low-income under or uninsured women of reproductive age and elevated rates of teenage pregnancy. The Reproductive Health program provided family planning/reproductive health services to 40,792 individuals, of these patients served, 30,127—74%—had an income at or below 150% of the Federal Poverty Level (goal of 14,000); almost half (47%) were covered by Medicaid, 30% were covered in part or in full by private insurance, and 23% were uninsured patients receiving discounted or free services based on PPSNE's income-based sliding fee scale. The ethnic and racial breakdown is 34% Hispanic/Latinx, 28% White/Anglo, 21% Black/African American, 1% Asian, and 15% were mixed race or other race. Eighty seven percent of patients identify as female, 13% identify as male, and less than 1% (81 patients) identify as nonbinary or other gender. Fifty-seven percent (20,367) of females were people of color (including Black/African American, Hispanic/Latinx, Asian and Native American but not including White or Other/Unknown/Mixed Race). Teen patients numbered 4,751—12%—of patients who received clinical services. Nine percent (3,755) of patients were ages 20-21, and 53% (21,716) were between the ages of 22 and 34. **FFY 2027 MCHBG support: $18,497 in contractual funding ($16,092 under MCH and $2,405 under CYSHCN) supports a limited portion of these reproductive health services; state and other funding sources support the broader program.**

Women's/Maternal Health & Infant Health Domain

- **United Way of Connecticut's 2-1-1 Infoline** is an integral part of the CT Medical Home team, along with the State WIC Program staff, and continues to partner with the CT Initiative, providing a statewide point of entry as well as information and referral. United Way has also provided outreach and training to family and community-based organizations regarding how to effectively use the 2-1-1 website. The 2-1-1 Infoline website recorded 611,089 visits with 2,643,726 page views in the 2025 fiscal year. This is a decrease from the previous year, when there were 914,378 visits with 2,795,729 page views. The decrease is a result of people no longer searching for information about the COVID-19 pandemic and fewer people needing to find information about services on a wide range of topics, including maternal and child health. **FFY 2027 MCHBG support: $243,000 in contractual funding ($201,690 under MCH and $41,310 under CYSHCN) supports statewide maternal, child, and CYSHCN information and referral services.**

- DPH was awarded funding for the **Maternal Health Innovation (MHI)** Grant from the Health Resources and Services Administration (HRSA) to serve as a statewide advisory body to DPH, providing guidance and coordination across maternal health initiatives to align efforts in a unified framework. The Task Force is organized into four subcommittees, including: Data, Evaluation, & Quality; Perinatal Mental Health; Doula-Friendly Hospitals: Workforce and Access; and Community and Lived Experience. Each subcommittee leads key deliverables, ranging from the development of a State Maternal Health Equity Report Card and Dashboard to executing a study focusing on recommendations for the expansion of doula-friendly hospitals and access to maternal mental health services. This work informs the Maternal Health Strategic Plan (MHSP) designed to reduce maternal mortality and morbidity by improving health outcomes

and addressing inequities to high-quality maternal health care for all birthing individuals. The MHSP guides the state-level policy decisions, directs resources to areas of greatest need, and establishes measurable goals to monitor progress and ensure accountability. In addition, the MHI Grant supports direct service delivery and quality improvement initiatives across the state. Through a partnership with Community Health Center, Inc. (CHC), prenatal and postpartum care is delivered via mobile health units in underserved areas with limited OB/GYN access, addressing barriers such as transportation, geographic isolation, and provider shortages. DPH also partners with the Connecticut Hospital Association (CHA) to implement Alliance for Innovation on Maternal Health (AIM) bundles across birthing hospitals to monitor performance and identify areas of strength and opportunities for improvement, focusing on the leading contributors to severe maternal morbidity (SMM) in Connecticut: hypertension, mental health conditions, and substance use disorders. Other initiatives include the Hear Her Campaign, raising awareness of urgent maternal warning signs during and after pregnancy, and the Statewide Orange Bracelet Initiative, to support timely identification and appropriate triage of postpartum complications. **Funding clarification: MHI activities are financed through a separate HRSA award. MCHBG supports DPH staff time for coordination, alignment, and oversight; this plan does not include a separate MHI contractual allocation.**

- The **Pregnancy Risk Assessment Monitoring System (PRAMS)** is a surveillance project of the federal Centers for Disease Control and Prevention (CDC) and state and jurisdictional health departments that collects information on maternal health, experiences, and behaviors before, during, and shortly after pregnancy from recent postpartum individuals. PRAMS provides statewide data on a variety of topics that are **not available from any other data source**, including but not limited to maternal mental health, preconception health and education, pregnancy intention, contraception methods, discrimination, respectful care, management of high blood pressure during pregnancy, education on maternal warning signs, social determinants of health (e.g., food insecurity; transportation to medical appointments, work, errands), substance use (e.g., cannabis, prescription pain relievers, alcohol, tobacco), safe sleep, oral health, social support, postpartum maternal and infant care, and father involvement. **Funding clarification: PRAMS is principally supported through the CDC cooperative agreement. MCHBG supports staff time and the integration of PRAMS data into Title V needs assessment, performance measurement, planning, and evaluation; no separate PRAMS contractual allocation is listed in Table B3.**

  PRAMS is a key data source for the MCHBG and MCHBG needs assessment, and data have been integrated into efforts to address state MCH priorities, as well as statewide plans and initiatives to reduce low birth weight, infant mortality, maternal morbidity & mortality, and health disparities. Some examples of how PRAMS data has been translated into public health practice include:

  - Establishing a new Reproductive Justice Alliance that evolved out of a 2020 PRAMS Data to Action project around discrimination before and during pregnancy;
  - Increasing efforts to promote and protect perinatal mental health in CT through an outreach and education project with obstetrical and midwifery providers;

- Helping to evaluate the CT Department of Children and Family's (DCF) Child Abuse Prevention and Treatment Act (CAPTA) notification system; and
- Improving the Connecticut Coalition Against Domestic Violence's (CCADV) trainings for professionals by integrating state-specific data.

We are pleased to report that the Pregnancy Risk Assessment Monitoring System Integrated Data System (PIDS) is now functional, marking a positive development in the system's operational capacity. We will continue to monitor updates from the CDC and provide additional information as it becomes available.

- In 2021, the **Reproductive Justice Alliance** was formed by DPH, the MCH Coalition, and the March of Dimes to expand and unify reproductive justice efforts within the state, with a vision of ensuring that individuals receive respectful, quality care, which ultimately serves to reduce maternal morbidity and severe maternal morbidity while promoting positive birth outcomes. The Alliance evolved from a 2020 PRAMS Data to Action project addressing discrimination prior to and during pregnancy. The Alliance consists of over 30 individuals who represent those with lived experiences, doulas, community-based organizations (CBOs), statewide organizations, and state agencies. **FFY 2027 MCHBG support: The Alliance is supported within the combined $85,000 contractual allocation for the Maternal Health Task Force, Every Woman Connecticut, and the Reproductive Justice Alliance; the amount is not separately apportioned among the three activities in this plan.**

- In 2023, legislation was enacted in CT to establish an **Infant Mortality Review committee (IMRC)** and an associated program within the Department of Public Health (DPH). The IMRC comprises both clinical and non-clinical subject matter experts who conduct a comprehensive, multidisciplinary review of infant deaths for the purpose of reducing health care disparities, identifying factors associated with infant deaths, and making recommendations to reduce infant deaths. The infant mortality review committee shall include available infant death reports and recommendations produced by the child fatality review panel, established pursuant to section 46a-13l, in its review of infant deaths for the purposes of making recommendations to reduce health care disparities and identify gaps in or problems with the delivery of care or services to reduce infant deaths. The purpose of the Infant Mortality Review Program shall be to review medical records and other relevant data related to infant deaths, including, but not limited to, information collected from death and birth records, and medical records from health care providers and health care facilities for the purposes of making recommendations to reduce health care disparities and identify gaps in or problems with the delivery of care or services to reduce infant deaths. The CT DPH IMR Program receives support from funding provided by the Centers of Disease Control and Prevention (CDC) for the Sudden Unexplained Infant Death (SUID) to assist the infant death reviews and collate recommendations for the prevention of infant deaths and address disparities and inequities amongst birthing parents in CT. **Funding clarification: CDC SUID funding supports infant death review activities. MCHBG-funded staff contribute coordination and integration with Title V priorities; no separate IMRC contractual allocation is identified in Table B3.**

- In 2018, legislation was enacted in Connecticut to establish a **Maternal Mortality Review Committee (MMRC)** and an associated program within the Department of Public Health (DPH). The MMRC comprises both clinical and non-clinical subject matter experts who conduct a comprehensive, multidisciplinary review of each pregnancy-associated death that occurs within one year following the conclusion of a pregnancy. This thorough review encompasses medical records, medical examiner reports, death certificates, vital statistics related to an infant's birth, along with fetal and maternal death files, police reports, informant interviews, obituaries, social media, and various other information sources. The objective of the MMRC's review is to identify factors that may have contributed to these deaths and to formulate recommendations aimed at reducing pregnancy-related morbidity, mortality, and disparities. The Department's Maternal Mortality Review Program receives support from funding provided by the Centers for Disease Control and Prevention (CDC), which facilitates program administration, data collection, analysis of maternal mortality data, and the publication of an annual Maternal Mortality Report. The MMRC is dedicated to a multifaceted approach that seeks to prevent all avoidable maternal deaths while enhancing maternal health and health equity. Through equitable partnerships with communities, the MMRC aims to comprehend the severity and complexity of maternal health disparities, advocate for policy solutions, and support innovative strategies and interventions designed to eliminate inequities that jeopardize the health and well-being of all birthing individuals. **Funding clarification: CDC funding supports MMRC program administration, data collection, analysis, and reporting. MCHBG-funded staff contribute coordination and use of findings in Title V planning; no separate MMRC contractual allocation is identified in Table B3.**

- The Department continues to support the **Connecticut Breastfeeding Coalition's (CBC)** efforts to promote evidence-based maternity care and the 10 Steps for Successful Breastfeeding in Connecticut hospitals. The Department launched another paid media campaign (Summer-Fall 2025) to align with an updated It's Worth It (IWI) website and revised materials. Maintenance of the Ready, Set, Baby (RSB) online website is funded by the **Women, Infants, and Children (WIC)** program for prenatal breastfeeding education available in English, Spanish, and Arabic, as resources permit. Funding for Paving the Way (PTW) concluded in 2024. In Spring 2025, three (3) individuals (all from WIC) are scheduled to take the IBCLC exam. The remaining 10 active participants are either finalizing mentorship and expect to sit for the IBCLC exam in September 2025 or are completing their coursework. **MCHBG support: MCHBG-funded staff provide Title V coordination and program support; specific activities described above may also be financed by WIC or other funding sources, and no separate breastfeeding contractual allocation is identified in Table B3.**

Children and Youth with Special Healthcare Needs

- **The Children and Youth with Special Health Care Needs Program's CT Medical Home Initiative** provides community-based medical home care coordination networks and collaboratives to support children with special health care needs. Services include: a statewide point of intake, information and referral; provider and family outreach; and parent-to-parent support. Care coordination services include linkage to specialists and to community resources, coordination with school-based services, and assistance with

transition to adult health care and other services. Community Care Coordination Collaboratives support local medical home providers and care coordinators in accessing state and local resources and work to resolve case-specific and systemic problems, including the reduction in duplication of efforts. **FFY 2027 MCHBG support: $863,011 in direct contractual funding supports medical home community-based care coordination services. The separate $41,310 CYSHCN information-and-referral allocation also supports statewide access to resources.**

- **The Children and Youth with Special Health Care Needs** program collaborates with the A.J. Pappanikou Center on Developmental Disabilities to improve access to comprehensive, coordinated health and related services, including training on the importance of developmental screening and distribution of the CDC's "Learn the Signs. Act Early" materials. DPH staff coordinate with the Help Me Grow Advisory Committee to increase developmental screening by conducting an education and awareness campaign that targets families and communities on the importance of developmental screening, training community and healthcare providers to improve screening rates and coordination of referrals and linkage to services, and engaging in cross-systems planning and coordination of activities around developmental screening. **MCHBG support: This work is supported through CYSHCN program administration and the broader Medical Home system allocation; no separate A.J. Pappanikou Center line item is identified in Table B3.**

Adolescent Health

- **Preventive interventions aimed at addressing adolescent pregnancy through Connecticut's Title V programs** encompass initiatives designed to postpone the initiation of sexual activity, advocate for abstinence as a social norm, decrease the prevalence of early sexual engagement among adolescents, and enhance the effective use of contraceptives among sexually active adolescents. The Perinatal Case Management Program provides intensive case management services for severely traumatized and abused adolescents statewide, and is contracted to the Exchange Club Center for the Prevention of Child Abuse of Southern CT, Inc., alongside the Comprehensive Pre-Teen and Adolescent Health Services (Comprehensive Health Services) offered by the Hospital of Central Connecticut (HOCC), which focuses on the needs of pregnant and parenting teens and pre-teens, incorporating interconception services. Both programs provide preventative education and interventional support for pregnant, postpartum, and parenting adolescents that include social workers, doulas, and case managers. This program endeavors to eliminate disparities in infant mortality and adverse perinatal outcomes, particularly among the target demographic of African American and Hispanic women in New Britain. **FFY 2027 MCHBG support: $212,287 in direct contractual funding supports Perinatal Case Management services, including intensive case management and perinatal support for adolescents and young women.**

- The **Personal Responsibility Education Program (PREP)** specifically targets teenagers aged 13-19, delivering evidence-based activities focused on HIV, STD, and pregnancy prevention. Research and evaluation have substantiated the efficacy of these interventions in reducing sexual activity, increasing contraceptive usage among sexually active youth, and delaying unplanned pregnancies through the promotion of both

abstinence and contraception. The Department will release an RFP to implement PREP, which is expected to be administered statewide. In addressing the needs of adolescents, the Connecticut Title V program strategies underscore the importance of fostering adolescent wellness, including comprehensive well-child visits, and facilitating process improvements for the transition to adulthood. **School-Based Health Centers** have been employed to promote thorough adolescent well visits, which include developmental assessments, risk assessments, behavioral health screenings, anticipatory guidance, and the screening and intervention of body mass index (BMI). **Funding clarification: PREP is financed through a separate federal ACF award. MCHBG-funded staff may support coordination and alignment with Title V adolescent health priorities; there is no direct PREP allocation in Table B3.**

- Although separate funding is available to support SBHCs, the MCHBG funds support staff who administer contracts, collect data from SBHCs, and evaluate the data associated with this work. **DPH staff support School Based Health Service Sites** in 27 communities, including Ansonia, Bloomfield, Branford, Bridgeport, Chaplin, Danbury, East Hartford, East Haven, East Windsor, Groton, Hamden, Hartford, Madison, Meriden, Middletown, Mystic, New Britain, New Haven, New London, Newtown, Norwalk, Putman, Stamford, Stratford, Waterbury, Waterford, and Windham. Of these, 79 were School Based Health Centers (SBHC) and 12 were Expanded School Health (ESH) sites. SBHCs serve students, Pre-K- 12, and are in elementary, middle, and high schools. SBHCs provide access to physical, mental health, and dental (in some locations) services to students enrolled in the school, regardless of their ability to pay. Services provided to students include but are not limited to: diagnosis and treatment of acute injuries and illnesses, managing and monitoring chronic disease, physical exams, administering immunizations, prescribing and dispensing medications, laboratory testing, health education, promotion and risk reduction activities, crisis intervention, individual, group and family counseling, outreach, oral health (in some locations), referral and follow-up for specialty care, and linkages to community based providers. Being able to treat students while at school reduces absenteeism, saves money by keeping children out of emergency rooms, and supports families by allowing parents to stay at work. Care is delivered in accordance with nationally recognized medical/mental health, cultural, and linguistically appropriate standards. **FFY 2027 MCHBG support: The contractual allocation for School-Based Health Services is $288,096; MCHBG support is limited to staff time for contract administration, data collection, evaluation, and Title V coordination.**