State of Connecticut
Department of Public Health

# MATERNAL AND CHILD HEALTH SERVICES (TITLE V) BLOCK GRANT ALLOCATION PLAN FFY 2026

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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 2026 funding amounts are not yet finalized. Because the current fiscal year's award (FFY 2025) has also not been finalized, the FFY 2024 federal award amount was used to prepare the FFY 2026 federal application for funding. The FFY 2026 (October 1, 2025 - September 30, 2026) Maternal and Child Health Services Block Grant allocation plan is based on estimated federal funding of $4,821,680. In FFY2024, $160,664 is directly allocated from the Health Resources and Services Administration to the Centers for Disease Control and Prevention to fund the CDC Assignee designated for Connecticut. The allocation plan may be subject to change when the final federal appropriation is authorized.

## E. Total Available and Estimated Expenditure

The FFY 2026 federal award is estimated to be $4,821,680. Since the FFY 2025 and FFY 2026 federal award allocations have not been finalized, the FFY 2024 award amount was used to prepare the FFY 2026 application. There are no carryover funds in the MCHBG program. Funds must be obligated within the 2-year project period.

## F. Proposed Allocation Changes from Last Year

Level funding as compared to the FFY 2025 estimated expenditure amount is proposed for Reproductive Health Services, Perinatal Case Management, Information and Referral, Genetics, School-Based Health Services, and Medical Home Community Based Care Coordination Services.

The proposed FFY 2026 plan will maintain overall staff support at 22.0 FTE positions.

## G. Contingency Plan

In the event that the actual FFY 2026 federal award amount is less than $4,821,680, the Department will review the criticality and performance of the various programs. Each allocation will be assessed to prioritize program activities deemed most critical to the public. In the event that actual funding exceeds $4,821,680, 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 and the president pro tempore and approved, modified, or rejected by the committees. 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.

## 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 July 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 2026, 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 care needs.
- Includes a plan for meeting the needs identified by the statewide needs assessment and a description of how the state intends to use its block grant funds for the provision and coordination of services to carry out such a plan (to include a statement of how its goals

and objectives are tied to applicable Year 2025 national goals and objectives); and an identification of types of service areas of 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 2026 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 24 Expenditures | FFY 25 Estimated Expenditures | FFY 26 Proposed Expenditure | Percentage Change - FFY 25 to FFY 26 |
|---|---|---|---|---|
| Number of Positions (FTE) | 22.0 | 22.0 | 22.0 | 0.0% |
| Maternal and Child Health | $2,840,738 | $2,837,513 | $2,901,028 | 2.2% |
| Children and Youth with Special Health Care Needs | $1,980,942 | $1,984,167 | $1,920,652 | -3.2% |
| **TOTAL**[1] | **$4,821,680** | **$4,821,680** | **$4,821,680** | **0.0%** |
| | | | | |
| **SOURCE OF FUNDS** | | | | |
| Federal Block Grant Funds Available[2] | $4,821,680 | $4,821,680 | $4,821,680 | 0.0% |
| Direct Assistance Funds for CDC Assignee | $160,664 | $0 | $0 | 0.0% |
| **TOTAL FUNDS AVAILABLE** | **$4,982,344** | **$4,821,680** | **$4,821,680** | 0.0% |

[1] Numbers may not add to totals due to rounding.
[2] The FFY 2025 and FFY 2026 federal award allocations have not been finalized and may be subject to change. The FFY 2024 award amount was used to prepare the FFY 2026 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 24 Expenditure | FFY 25 Estimated Expenditure | FFY 26 Proposed Expenditure | Percentage Change - FFY 25 to FFY 26 |
|---|---|---|---|---|
| **Number of Positions (FTE)** | 12.75 | 12.75 | 12.75 | 0.0% |
| **Personal Services** | $941,334 | $1,086,894 | $1,124,474 | 3.5% |
| **Fringe Benefits** | $794,868 | $932,056 | $936,399 | 0.5% |
| **Other Expenses**[1] | $39,676 | $23,454 | $15,395 | -34.4% |
| | | | | |
| **Contracts/Grants to:** | | | | |
| Local Government | $0 | $0 | $0 | 0.0% |
| Other State Agencies | $36,000 | $36,000 | $36,000 | 0.0% |
| Private Agencies | $1,028,859 | $759,110 | $788,761 | 3.9% |
| **TOTAL EXPENDITURES**[2] | **$2,840,738** | **$2,837,513** | **$2,901,028** | **2.2%** |
| | | | | |
| **SOURCE OF FUNDS** | **Sources of FFY 24 Allocations** | **Sources of FFY 25 Allocations** | **Sources of FFY 26 Allocations** | **Percentage Change – FFY 25 to FFY 26** |
| Federal Block Grant Funds[3] | $2,840,738 | $2,837,513 | $2,901,028 | 2.2% |
| Direct Assistance Funds for CDC Assignee | $160,664 | $0 | $0 | 0.0% |
| **TOTAL FUNDS AVAILABLE** | **$3,001,402** | **$2,837,513** | **$2,901,028** | 2.2% |

1 FFY 2024 Other Expenditures include AMCHP membership fees, travel to mandatory conferences for staff, professional license reimbursements for staff, software licenses (SAS and Qualtrics), and contributions to the Fatherhood Initiative Conference.

2 Numbers may not add to totals due to rounding.

3 The FFY 2025 and FFY 2026 federal award allocations have not been finalized and may be subject to change. The FFY 2024 award amount was used to prepare the FFY 2026 application.

## Table B2

## Maternal and Child Health Services Block Grant

## PROGRAM EXPENDITURES:

## Children and Youth with Special Health Care Needs

| Program Category | FFY 24 Expenditure | FFY 25 Estimated Expenditure | FFY 26 Proposed Expenditure | Percentage Change - FFY 25 to FFY26 |
|---|---|---|---|---|
| **Number of Positions (FTE)** | 9.25 | 9.25 | 9.25 | 0.0% |
| **Personal Services** | $491,603 | $555,153 | $540,386 | -2.7% |
| **Fringe Benefits** | $415,112 | $476,066 | $450,004 | -5.5% |
| **Other Expenses**[1] | $13,225 | $7,818 | $5,132 | -34.4% |
| | | | | |
| **Contracts/Grants to:** | | | | |
| Local Government | $0 | $0 | $0 | 0.0% |
| Other State Agencies | $4,000 | $4,000 | $4,000 | 0.0% |
| Private agencies | $1,057,002 | $941,130 | $921,130 | -2.1% |
| **TOTAL EXPENDITURES**[2] | **$1,980,942** | **$1,984,167** | **$1,920,652** | -3.2% |
| | | | | |
| **SOURCE OF FUNDS** | **Sources of FFY 24 Allocations** | **Sources of FFY 25 Allocations** | **Sources of FFY 26 Allocations** | **Percentage Change – FFY 25 to FFY 26** |
| Federal Block Grant Funds[3] | $1,980,942 | $1,984,167 | $1,920,652 | -3.2% |
| **TOTAL FUNDS AVAILABLE** | **$1,980,942** | **$1,984,167** | **$1,920,652** | -3.2% |

1 FFY 2024 Other Expenditures include AMCHP membership fees, travel to mandatory conferences for staff, professional license reimbursements for staff, software licenses (SAS and Qualtrics), and contributions to the Fatherhood Initiative Conference.

2 Numbers may not add to totals due to rounding.

3 The FFY 2025 and FFY 2026 federal award allocations have not been finalized and may be subject to change. The FFY 2024 award amount was used to prepare the FFY 2026 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 24 Actual** | **FFY 25 Estimated** | **FFY 26 Proposed** |
| Perinatal Case Management | $164,735 | $212,287 | $212,287 |
| Reproductive Health Services [1, 2] | $66,585 | $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 [3] | $322,157 | $55,349 | $85,000 |
| **MCH Total[4]** | **$1,064,859** | **$795,110** | **$824,761** |
| **Children and Youth with Special Health Care Needs** | **FFY 24 Actual** | **FFY 25 Estimated** | **FFY 26 Proposed** |
| Medical Home Community Based Care Coordination Services | $863,011 | $863,011 | $863,011 |
| Reproductive Health Services [1, 2] | $9,950 | $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 [3] | $128,327 | $20,000 | $0 |
| **CYSHCN Total[4]** | **$1,061,002** | **$945,130** | **$925,130** |
| | | | |
| **Grand Total** | **$2,125,861** | **$1,740,240** | **$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] Includes $58,038 as a one-time fiscal adjustment in FFY 24 to align cost-of-living increases with established contract reporting funding periods. This amount is state-funded moving forward.

[3] FFY 2024 "Other" contractual expenditures includes funding in the amount of: $55,369 to support consumers served through the Family Wellness Healthy Start Program; $74,318 for MCH data analysis support; $99,000 for a 5-year needs assessment consultant split between MCH and CYSHCN; $221,817 for the School Based Health Alliance to fund SBHCs for health education and health promotion activities in communities with high needs split between MCH and CYSHCN. FFY 2025 "Other" contractual expenditures includes funding in the amount of: $55,369 to support consumers served through the Family Wellness Healthy Start Program; $20,000 to support a one-time increase for the Sickle-Cell 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.

[4] 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 | Number Served SFY 2025 | National Performance Measures |
|---|---|---|---|---|
| **Perinatal Case Management** | To provide case management services for pregnant and parenting women to promote healthy birth outcomes. | DPH provides funding for Comprehensive Reproductive and Perinatal Health services for pregnant and parenting women, through Birth Support Education and Beyond, 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 Teens, a program that provides perinatal support services to teenagers and young adolescents in a community setting. | 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.<br>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.<br>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 health centers located in Bridgeport, Danbury, Enfield, Hartford North, Manchester, Meriden, New London, New Haven, Norwich, Stamford, Telehealth and Torrington. | PPSNE's DPH Family Planning program provided family planning/re productive health services to 43,102 individuals. | **National Performance Measure #1:** Percent of women, ages 13 through 44, with a preventive medical visit in the past year.<br>Data: In 2023, 80.6% of women in Connecticut, ages 18 through 44 reported having a preventive medical visit in the past year, compared to 76.3% in 2020.<br>Source: Behavioral Risk Factor Surveillance System |

| Service Category | Objective | Grantor/Agency Activity | Number Served SFY 2025 | National Performance Measures |
|---|---|---|---|---|
| | | West Hartford and Willimantic. In-person services continued through COVID-19 and telehealth visits were offered and provided as appropriate. | | |
| **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. | 293,315 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. This includes 91 SBHCs (79 full SBHCs and 12 Expanded School Health (ESH) sites). There were 23,849 unduplicated users and 134,172 visits. | 23,849 un-duplicated users<br><br>134,172 visits | 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 |

**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 | Number Served SFY 2025 | 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. 188 community-based medical homes are part of the CYSHCN medical home program.<br><br>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. | 9,400 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.<br><br>In 2022-23, 36.1% of parents/ guardians of children with special health care needs in Connecticut, ages 0 through 17, reported having a medical home.<br><br>In 2022-23, 52.1% of parents/ guardians of children without special health care needs in Connecticut, ages 0 through 17, reported having a medical home.<br><br>Source: National Survey of Children's Health (NSCH). |
| **Newborn Hearing Screening** | To provide early hearing detection and intervention to infants and minimize speech | All CT newborns are screened prior to hospital discharge.<br><br>DPH participates on the Early Hearing Detection | 35,325 (99.3%) screened[1]<br><br>Ongoing | N/A |

| Service Category | Objective | Grantor/Agency Activity | Number Served FFY 2025 | National Performance Measures |
|---|---|---|---|---|
| | and language delays. | and Intervention Task Force to discuss and identify issues relevant to the early identification of hearing loss. | | |
| **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. | As of January 1, 2023, newborns in CT undergo screening for all Core RUSP disorders and all secondary RUSP conditions except for Krabbe Disease. The CT NBS Program at the Laboratory (SPHL) is currently validating a method to screen for Krabbe Disease, and universal screening will be implemented by the end of 2025. All bloodspot screening takes place at the SPHL with the exception of Cystic Fibrosis (CF) screening. CF is conducted by the Yale and the University of Connecticut (UConn) CF Laboratories. CGS 19a-55 (Newborn Infant Health Screening) of the general statutes that were effective October 1, 2021, requires laboratories conducting blood-spot screening for CF to begin reporting data to DPH for epidemiologic purposes. The CT NBS Program is working in conjunction with the CF screening laboratories at Yale and UConn to put electronic systems in this place for reporting of CF data to the CT NBS Program (DPH). | 35,458 (99.7%) of eligible newborns[2] screened | **National Outcome Measure #12** (DEVELOPMENTAL):<br><br>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.<br><br>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%.<br><br>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%<br><br>CF Screening Program 2024 data: data is not available at this time |

| Service Category | Objective | Grantor/Agency Activity | Number Served SFY 2025 | National Performance Measures |
|---|---|---|---|---|
| | 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:<br>• (QI) 1: Date of Birth to Collection Time<br>• (QI) 2: Time from Collection to Receipt at the SPHL<br>• (QI) 3: Specimens Satisfactory for Testing<br>• (QI) 4: Essential Data Fields Complete<br><br>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.<br><br>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:<br><br>Goal is $\geq$ 99% for all QI Timeliness Indicators<br><br>Baseline Data 2022 (statewide):<br>QI 1: 97.7%<br>QI 2: 78.0%<br>QI 3: 100.0%<br>QI 4: 96.9 %<br><br>CT NBS Program 2023 data (statewide):<br><br>QI 1: 98.8%<br>QI 2: 94.6%<br>QI 3: 100.0%<br>QI 4: 96.3 %<br><br>CT NBS Program 2024 data (statewide):<br>QI 1: 99.2%<br>QI 2: 97.5%<br>QI 3: 99.9%<br>QI 4: 97.6 % |

| Service Category | Objective | Grantor/Agency Activity | Number Served SFY 2025 | 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, 2019-2023

| 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 | 2019 | 4.5 | 3.4 | 9.5 | 5.2 |
| | 2020 | 4.3 | 2.3 | 9.7 | 5.5 |
| | 2021 | 4.7 | 3.3 | 9.9 | 5.8 |
| | 2022 | 4.3 | 2.2 | 8.0 | 6.5 |
| | 2023 | 4.7 | 3.1 | 7.7 | 6.2 |

| 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 | 2019 | 7.7 | 2.3 | 11.0 | 22.4 |
| | 2020 | 7.4 | 2.4 | 10.8 | 20.0 |
| | 2021 | 7.1 | 1.7 | 10.7 | 20.3 |
| | 2022 | 6.4 | 1.6 | 8.5 | 18.5 |
| | 2023 | 6.8 | 1.7 | 9.1 | 18.3 |

| 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 | 2019 | 6.1 | 4.5 | 10.2 | 7.0 |
| | 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 | 7.0 |
| | 2023 | 6.2 | 4.3 | 11.2 | 7.4 |

| 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 | 2019 | 1.0 | 0.6 | 2.4 | 1.3 |
| | 2020 | 1.0 | 0.6 | 2.3 | 1.3 |
| | 2021 | 1.0 | 0.5 | 2.5 | 1.1 |
| | 2022 | 1.0 | 0.6 | 2.1 | 1.3 |
| | 2023 | 0.9 | 0.5 | 2.3 | 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 | 2019 | 15.3 | 11.3 | 23.0 | 19.9 |
| | 2020 | 15.3 | 11.2 | 20.8 | 20.5 |
| | 2021 | 15.3 | 11.2 | 20.8 | 21.3 |
| | 2022 | 16.4 | 11.4 | 22.7 | 22.7 |
| | 2023 | 16.8 | 11.5 | 23.7 | 23.6 |

| 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 | 2019 | 84.7 | 88.7 | 77.0 | 80.1 |
| | 2020 | 84.7 | 88.8 | 79.2 | 79.5 |
| | 2021 | 84.7 | 88.8 | 79.2 | 78.7 |
| | 2022 | 83.6 | 88.6 | 77.3 | 77.3 |
| | 2023 | 83.2 | 88.5 | 76.3 | 76.4 |

| 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 | 2019 | 7.6 | 6.6 | 10.4 | 8.5 |
| | 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 |

## Selected Perinatal Health Indicators

While Connecticut residents report a favorable overall health status compared to the U.S. average, significant health disparities persist between non-Hispanic White individuals and the non-Hispanic Black/African American and Hispanic populations. Notably, perinatal indicators show marked and ongoing disparities. Addressing these racial and ethnic inequalities in the state is a priority. The public health community faces the substantial challenge of reducing disparities in maternal and child health indicators, necessitating well-coordinated, multi-ecological strategies implemented simultaneously. Table D presents statewide data for selected perinatal health indicators from 2019 to 2023.

The subsequent data reveal that Connecticut has made significant progress in maternal and infant health, evidenced by declining infant mortality and teen birth rates. However, substantial work remains to achieve the best possible outcomes for all mothers and infants in the state. The long-term impacts of race, racism, social class, poverty, stress, environmental factors, health policy, and other social determinants of health contribute to higher rates of negative outcomes and ongoing disparities. Continuing evidence-based programs and efforts to promote health equity and address social determinants of health are crucial for enhancing birth outcomes and reducing or eliminating disparities. Although we are dedicated to minimizing health inequities, these challenges are also evident at the national level and are not exclusive to Connecticut.

## Infant Mortality

The Connecticut annual infant mortality rate (IMR, reported as deaths per 1,000 live births) averaged 4.5 (range: 4.3 - 4.7) during the period 2019-2023. Annual IMRs in Connecticut's non-Hispanic White population averaged 2.9 deaths per 1,000 live births from 2019-2023 and were significantly lower than those observed for the non-Hispanic Black/African American and Hispanic populations. Annual IMRs for non-Hispanic Black/African American populations averaged 9.0 deaths per 1,000 live births, and those for Hispanic populations averaged 5.8 deaths per 1,000 live births. The averages were 3.1 and 2.0 times higher, respectively, than that of Connecticut's non-Hispanic White population.

## Teen Birth Rate

The 2019-2023 annual overall teen birth rates in Connecticut averaged 7.1 (range = 6.4 – 7.7, reported as live births per 1,000 women aged 15-19) and continued declines since at least 2016 with a 4.8% annual decline. The teen birth rate in 2022 (6.4 births per 1,000 women aged 15-19) represents the lowest teen birth rate observed this century in Connecticut. Declines across all three major race-ethnicity groups are also evident for the period 2019-2023, with annual rates of declines in teen birth rates in the non-

Hispanic White, non-Hispanic Black/African American, and Hispanic populations during this period averaging 10.0%, 6.6%, and 5.3% per year, respectively. In the presence of these significant declines across all three major race-ethnicity groups in Connecticut, however, disparities by race and ethnicity nonetheless exist. For the period 2019-2023, the average annual teen birth rates of non-Hispanic Black/African American and Hispanic women were 10.0 and 19.9 births per 1,000 women aged 15-19, respectively, which were 5.3 and 10.5 times higher than the average rate for non-Hispanic White women (1.9 births per 1,000 women aged 15-19).

**Singleton Low Birth Weight and Very Low Birth Weight**

Connecticut's average rate of singleton low birth weight (LBW) from 2019-2023 was 6.2% (range = 6.1 – 6.3%). Racial and ethnic disparities in the singleton LBW rates were evident. Non-Hispanic Black/African American singletons (10.8%) and Hispanic singletons (7.1%) were 2.4 and 1.6 times, respectively, more likely to be LBW than non-Hispanic White singletons (4.5%). Since 2016, the annual rate for non-Hispanic White singletons has been stable, while the annual rates among non-Hispanic Black/African American and Hispanic singletons have shown average annual increases of 2.1% and 1.1%, respectively.

Between 2019 and 2023, the rate of singleton very low birth weight (VLBW) averaged 1.0% for the total population (range=0.9 – 1.0%), while decreasing as part of a long-term declining trend (since 2016) of 1.6% annually. Recent declines in rates of VLBW from 2019-2023 were not statistically significant for any major race-ethnicity group. Disparities in rates of VLBW by race-ethnicity in Connecticut were more marked than those for LBW for the period 2019-2023. Average rates of VLBW for the non-Hispanic Black/African American population (2.3%) and Hispanic population (1.2%) were 3.8 and 2.0 times that of the non-Hispanic White population rate of 0.6%, respectively.

**Singleton Preterm Birth**

There was little change in the singleton preterm birth rate, defined as births before 37 weeks gestation, for the 2019-2023 period, which averaged 7.6% (range 7.6 – 7.8%). Non-Hispanic White women experienced a lower rate of singleton preterm birth (average 6.4%; range 6.1 – 6.6%) compared to non-Hispanic Black/African American women (average 11.0%; range 10.4 – 12.0%) and Hispanic women (average 8.6%; range 8.5 – 9.1%).

**Late or No Prenatal Care**

The rate of late/no prenatal care (PNC), defined as not having a PNC visit during the first trimester, among live births in Connecticut averaged 15.8% for 2019-2023. Rates of late/no PNC were not different between non-Hispanic Black/African American and Hispanic populations for the period 2019-2023, averaging 22.2% and 21.6%,

respectively. These rates were approximately twice the rate of 11.3% observed for non-Hispanic White women during that same five-year period.

**Prenatal Visits**

An average of 84.2% of pregnant women in Connecticut initiated PNC in their first trimester for the period 2019-2023. An additional 12.2% initiated PNC in their second trimester during this period, with the remaining 3.6% starting PNC in the third trimester or not at all. Like other health indicators, disparities among race-ethnicity groups exist. Non-Hispanic White women during this five-year period averaged 88.7% first-trimester care, 8.8% second-trimester PNC initiation, and 2.5% third-trimester or no PNC. Non-Hispanic Black/African American women averaged 77.8% first-trimester care, 16.8% second-trimester PNC initiation, and 5.4% third-trimester or no PNC. Hispanic women averaged 78.4% first-trimester care, 16.5% second-trimester PNC initiation, and 5.1% third-trimester or no PNC.

**Program Highlights**

Within DPH, several initiatives are underway to reduce adverse birth outcomes and risk factors associated with poor birth outcomes, and to address disparities in these health indicators. The initiatives listed below may not be directly funded by the MCHBG but are in alignment with the mission of improving the health of the MCH population through a health equity lens. These initiatives will continue and include the following:

- DPH successfully submitted its reaccreditation application to the **Public Health Accreditation Board (PHAB)** in September 2023. This comprehensive process commenced in 2022, following DPH's approval from PHAB to apply under their updated standards and measures. On November 22, 2024, PHAB officially decided to continue the accreditation. This decision initiates the next five-year accreditation cycle with PHAB. PHAB accreditation is a rigorous process that evaluates and acknowledges health departments' performance against established national standards. This reaccreditation confirms that the health department possesses the essential Foundational Capabilities to effectively serve its community.

- The **Connecticut Maternal and Child Health (MCH) Coalition** has served as a collaborative body of state agencies, providers, funders, and advocates dedicated to improving maternal and child health for over 15 years. Comprising over 180 individuals representing 97 organizations, the Coalition acts as a vital communication and networking hub. It represents the state's MCH priorities within the State Health Improvement Plan (SHIP), focusing on: access to health care, economic stability, healthy food and housing, and community strength and resilience. The Coalition also champions health equity and the elimination of racial and ethnic health disparities. Through quarterly meetings and regular

"Notes of Interest," the MCH Coalition raises awareness and mobilizes responses to relevant MCH issues.

- 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.

  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.

  Currently, the future of PRAMS remains uncertain. The entire CDC PRAMS Team was dissolved as a result of the federal reduction in force (RIF), and we are currently in Year 5 of a 5-year Cooperative Agreement, with funding secured only through April 30, 2026. Without additional resources to support PRAMS staff and activities, data collection beyond this date may be compromised or discontinued.

However, 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 goals of the Alliance are to enhance access to respectful, quality maternity care; foster respectful interactions between patients and providers; improve health care systems, resources, and policies related to maternal health; and ensure accountability within health care systems by centering the voices of patients.

  The Alliance consists of over 30 individuals who represent those with lived experiences, doulas, community-based organizations (CBOs), statewide organizations, and state agencies. Meaningful engagement and collaboration with people with lived experiences of racism and discrimination during pregnancy, childbirth, and the postpartum period, through a collective approach, can inform efforts to improve the quality of care and ultimately reduce disparities in MH.

  The founding partners of the Alliance drew inspiration from ongoing initiatives in New York City and from Columbia University's Averting Maternal Death and Disability (AMDD) project, aimed at tackling inequities in maternal outcomes. The Alliance builds upon Columbia's primary research to get an understanding of the thoughts and experiences of respectful maternity care in CT and access to care; generate ideas of how to improve respectful care in CT from those who experienced disrespectful care, including racism and discrimination; and promote community engagement in strategizing ways to improve respectful care.

- DPH was awarded funding for the **Maternal Health Innovation (MHI)** Grant from the Health Resources and Services Administration (HRSA). This federal funding is specifically designed to help states reduce maternal mortality and severe maternal morbidity by improving access to comprehensive, high-quality care throughout preconception, prenatal, labor and delivery, and postpartum periods. As part of this funding, DPH recently established a Maternal Health Task Force (MHTF), which serves as a central coordinating body for developing and implementing strategies to improve maternal health outcomes across the

state, with a strong focus on data-driven decision-making, community engagement, and addressing health disparities. The MHTF is capable of integrating the functions of other proposed maternal health task forces (such as those related to perinatal mental health or birthing hospital report cards) to minimize duplication of effort and leverage existing subject matter expertise. In addition, two innovative initiatives under the MHI are underway. First, the AIM Patient Safety Bundles will be adopted across birthing hospitals throughout Connecticut to enhance clinical practices and improve outcomes. Second, a Mobile Health Unit will be deployed to provide prenatal and postpartum care in Windham County, a region with limited access to maternal health services.

- 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 Evaluation 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.

- DPH's **State Physical Activity and Nutrition (SPAN) Program** breastfeeding activities have concluded. In August 2023, the Centers for Disease Control and Prevention (CDC) informed CT-DPH that it had not been selected to receive funding for the 2023-2028 SPAN Cooperative Agreement. To the extent possible, SPAN projects were integrated into existing CT-DPH programming.

  For instance, DPH staff endeavored to promote Breastfeeding Basics training via Educating Practices (EP), which is offered by Connecticut Children's Medical Center (CCMC) through various channels. During the past two years, a total of four (4) medical offices participated in and completed the Educating Practices

Breastfeeding Basics module, self-reporting an estimated total reach of 1,362 newborns or pregnant individuals seen in their practices each year.

- 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 is currently awaiting final approval for three toolkits: Breast and Chest Feeding Friendly: Child Care - Center-Based, Home-Based, and Medical Offices; four updated newsletters (make it yours/planning, skin-to-skin contact, rooming-in, and breastfeeding laws); and two updated checklists (make it yours and it's your journey) which incorporate updates to the It's Worth It (IWI) breast and chest feeding messaging, along with branded campaign materials. A paid media campaign was conducted from August 5, 2024, through October 31, 2024, utilizing existing social media posts developed in 2023, employing the following tactics: Facebook/Instagram Ads, limited Broadcast TV, Broadcast Radio, Streaming Over-the-Top (OTT), and Streaming Audio.

  High-level results indicated the following:
  TOTAL CAMPAIGN IMPRESSIONS: 9,952,321
  - Total Social Impressions: 2,610,884
  - Total Digital Impressions: 3,254,167
  - Total Traditional Impressions: 1,724,000

- The Department is in the process of launching 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. Over the past year, three (3) individuals completed the International Board-Certified Lactation Consultant (IBCLC) exam. In total, PTW had 24 participants. In previous years, three (3) individuals also completed and passed the IBCLC exam. 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.

- The Department promotes nutrition and breastfeeding in early childhood settings through the **Go Nutrition and Physical Activity Assessment for Child Care (Go NAPSACC) Program** and advocates for the **CT Breastfeeding Coalition's (CBC) Breastfeeding Friendly recognition programs.** Go NAPSACC is an evidence-based tool designed to enhance childcare policies and practices. Initially funded by SPAN, this initiative is now sustained through SNAP-Ed, the Maternal and Child Health (MCH) Block Grant, and the Preventive Health and Health Services Block Grant. Funding facilitates nutrition education, provider

training, technical assistance, program implementation materials, and stipends for quality improvement projects within the following modules: Breastfeeding & Infant Feeding, Farm to Early Childhood Education (ECE), Child Nutrition, Physical Activity, Oral Health, and Screen Time Reduction. The CBC administers recognition programs for worksites, childcare programs, and campuses that comply with lactation accommodation laws and provide environments supportive of breastfeeding. The Breast and Chest Feeding Friendly Child Care Recognition program utilizes the tools and coaching available through Go NAPSACC to assist providers in meeting recognition requirements. CT-DPH has supported 19 providers in achieving this recognition over the past two years. CT-DPH intends to collaborate with at least four (4) worksites in 2025 to achieve CBC's Worksite Recognition and aims to expand to additional worksites in the future.

- **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 reduction in duplicity of efforts.

- **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. DPH Way resource database and website, thus enhancing access to information for providers and consumers. The improvements include the ability to access information in numerous languages. 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 914,378 visits with 2,795,729 page views in the 2024 fiscal year. This is a decrease from the previous year when there were 1,231,925 visits with 2,466,505 pageviews. 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.

- **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.

- **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 case management services statewide, alongside the Comprehensive Pre-Teen and Adolescent Health Services (Comprehensive Health Services) offered by the Hospital of Central Connecticut (HOCC), which caters to the needs of pregnant and parenting teens and pre-teens, incorporating interconception services. 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.

- 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 in late Summer to implement PREP, which is expected to be administered statewide.

- The **Reproductive Health Program, administered by Planned Parenthood of Southern New England, Inc. (PPSNE)**, is financially supported by state and 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 women of reproductive age and elevated rates of teenage pregnancy.

- 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).

- **DPH supported 91 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.

- The **DPH Immunization Program** provides all recommended childhood vaccines to approximately 650 providers statewide, including private physician offices, community health centers, School Based Health Centers, urgent care centers, STD clinics, CVS Minute Clinics, and local health departments. In State FY 2024, approximately 1,082,278 doses of vaccine were distributed by the Immunization Program, and the program continues to universally offer all Advisory Committee on Immunization Practices (ACIP) vaccines for all children up through 18 years of age in Connecticut, regardless of insurance status. Adult vaccines, including HPV, Shingles, and Pneumococcal Conjugate (PCV 20), are provided free of charge to local health departments, community health centers, STD clinics, and drug treatment facilities. On October 1, 2024, the RSV vaccine was added to the adult program for all uninsured adult patients 60 years of age and older. All children 9-18 years of age are eligible and strongly encouraged to receive the HPV vaccine, which protects against 9 different strains of cervical cancer.

- The **Connecticut Vaccine Program (CVP)** is funded through a combination of state and federal monies. The state monies are from an assessment tax on all health insurers doing business in the state of Connecticut. This assessment allows us to provide all nationally recommended vaccines for privately insured children up through 18 years of age free of charge.

- DPH's **Childhood Lead Poisoning Prevention Program (CLPPP)** evaluates the effectiveness of universal screening laws (i.e., mandated blood lead testing) for children under the age of three by assessing the screening rate. All healthcare providers in Connecticut are required to conduct annual blood lead testing for children between 9 to 35 months of age. Compliance with the law is assessed by measuring the proportion of children born in Connecticut during a given year who have had one blood lead test by age one, at age one or age two, and two annual tests by age three. DPH has maintained a blood lead surveillance system since 1994. In 2010, the CLPPP upgraded its surveillance system to a more comprehensive web-based system. This has enhanced the ability to merge birth records and comprehensive environmental data with childhood blood lead data. The surveillance system has had a significant positive impact on the program's capability to utilize surveillance data to enhance child case management efforts. Under Connecticut Public Act 22-49, the Lead Hazard Reduction and Control (LHRC) Section lowered the blood lead reference value from 5 µg/dL to 3.5 µg/dL on January 1, 2023. Connecticut local health departments are required to initiate case management actions for children with a blood level of ≥ 3.5 µg/dL. A venous level of 3.5 µg/dL and greater is now defined as an elevated blood lead level. In 2023, 65,681 children under the age of 6 were tested. There was a decrease of 229 children with elevated blood lead levels at ≥ 5 µg/dL and greater identified from 2022 (1,005 children) to 2023 (776 children), reflecting a 23% decrease in the number of children who are considered lead-poisoned. With the adoption of the new blood lead reference value of 3.5 µg/dL, the number of children lead poisoned increased to 1,562.