STATE OF CONNECTICUT

GOVERNOR NED LAMONT

August 30, 2021

The Honorable Martin Looney
President Pro Tempore
Connecticut State Senate
Legislative Office Building, Room 3300
Hartford, CT 06106

Dear Senator Looney,

Pursuant to Section 4-28b of the Connecticut General Statutes, I am pleased to transmit for legislative review the recommended allocations for the following six block grant programs for Federal Fiscal Year 2022: Community Mental Health Services, Community Services, Maternal and Child Health Services, Preventive Health and Health Services, Social Services, and Substance Abuse Prevention and Treatment. Table A in each respective plan contains the recommended allocations. Please note that these plans are based on anticipated federal funding and may be subject to change when the State of Connecticut receives the final federal grant award notices.

Thank you for your attention to this matter. Please contact Danielle Palladino at the Office of Policy and Management at Danielle.Palladino@ct.gov or 860-402-7576 if you have any questions about the recommended allocations or any other aspects of the plan.

Sincerely,

Ned Lamont
Governor

cc: Honorable Kevin Kelly, Senate Minority Leader
Josh Geballe, Chief Operating Officer, Office of Governor Ned Lamont
Melissa McCaw, Secretary, Office of Policy and Management
Vannessa Dorantes, Commissioner, Department of Children and Families
Nancy Navarretta, Acting Commissioner, Department of Mental Health and Addiction Services
Deidre S. Gifford, Commissioner, Department of Social Services & Acting Commissioner, Department of Public Health
Claudio Gualtieri, Under Secretary, Office of Policy and Management

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STATE OF CONNECTICUT

GOVERNOR NED LAMONT

August 30, 2021

The Honorable Matthew Ritter
Speaker of the House
Connecticut House of Representatives
Legislative Office Building, Room 4100
Hartford, CT 06106

Dear Representative Ritter:

Pursuant to Section 4-28b of the Connecticut General Statutes, I am pleased to transmit for legislative review the recommended allocations for the following six block grant programs for Federal Fiscal Year 2022: Community Mental Health Services, Community Services, Maternal and Child Health Services, Preventive Health and Health Services, Social Services, and Substance Abuse Prevention and Treatment. Table A in each respective plan contains the recommended allocations. Please note that these plans are based on anticipated federal funding and may be subject to change when the State of Connecticut receives the final federal grant award notices.

Thank you for your attention to this matter. Please contact Danielle Palladino at the Office of Policy and Management at Danielle.Palladino@ct.gov or 860-402-7576 if you have any questions about the recommended allocations or any other aspects of the plan.

Sincerely,

Ned Lamont
Governor

cc: Honorable Vincent Candelora, House Minority Leader
Josh Geballe, Chief Operating Officer, Office of Governor Ned Lamont
Melissa McCaw, Secretary, Office of Policy and Management
Vannessa Dorantes, Commissioner, Department of Children and Families
Nancy Navarretta, Acting Commissioner, Dept. of Mental Health and Addiction Services
Deidre S. Gifford, Commissioner, Department of Social Services & Acting Commissioner, Department of Public Health
Claudio Gualtieri, Under Secretary, Office of Policy and Management

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State of Connecticut
GENERAL ASSEMBLY
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

To: Senator Cathy Osten
Representative Toni E. Walker
Co-Chairpersons, Appropriations Committee

Senator Mary Daugherty
Representative Jonathan Steinberg
Co-Chairpersons, Public Health Committee

From: Martin M. Looney, Senate President Pro Tempore
Matthew D. Ritter, Speaker of the House

Re: Maternal and Child Health Services (Title V) Block Grant

Date: August 31, 2021

Pursuant to Connecticut General Statutes Section 4-28b, we are submitting the Governor's allocation plan for the Federal fiscal year 2022 Maternal and Child Health Services (Title V) Block Grant program to you for your approval or modifications.

Thank you for your consideration of these recommendations.

Sincerely,

Martin M. Looney
Senate President Pro Tempore

Matthew D. Ritter
Speaker of the House

Cc: Susan Keane, Senior Committee Administrator, Appropriations Committee
Beverly Henry, Senior Committee Administrator, Public Health Committee
Danielle Palladino, Policy Development Coordinator, Office of Policy & Management

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

FFY 2022

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 the allocation and administration of 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. The Application/Annual Report is used by Connecticut in applying for the MCH Block Grant under Title V of the Social Security Act and in preparing the required Annual Report. Connecticut reports annually on national and state outcome/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 designed to provide quality maternal and child health services for mothers, children and adolescents (particularly of low income families); to reduce infant mortality and the incidence of preventable diseases and disabling conditions among children; and to treat and care for children and youth with special health care needs. The MCHBG is a federal/state program intended to build system capacity to enhance the health status of mothers and children.

- MCHBG funds may not be used for cash payments to 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 program 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 2022 funding amounts are not yet finalized. Because the current fiscal year's award (FFY 2021) has also not been finalized, the FFY 2020 federal award amount was used to prepare the FFY 2022 federal application for funding. The FFY 2022 (October 1, 2021 - September 30, 2022) Maternal and Child Health Services Block Grant allocation plan is based on estimated federal funding of $4,663,927. The allocation plan may be subject to change when the final federal appropriation is authorized.

E. Total Available and Estimated Expenditure

The FFY 2022 federal award is estimated to be $4,663,927. Because the FFY 2021 and FFY 2022 federal award allocations have not been finalized, the FFY 2020 award amount was used to prepare the FFY 2022 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 2021 estimated expenditure amount is proposed for the Perinatal Case Management, Reproductive Health Services, Information and Referral, Genetics, School Based Health Services, and Medical Home Community Based Care Coordination Services program categories.

The proposed FFY 2022 plan will maintain overall staff support at 22.0 FTE positions.

It is proposed that $60,000 dedicated to "Other" Maternal and Child Health activities in FFY 2022 be utilized to support implementation of Alliance for Innovation on Maternal Health (AIM) "Patient Safety Bundles" in birthing hospitals in collaboration with the Connecticut Hospital Association.

G. Contingency Plan

In the event that the actual FFY 2022 federal award amount is less than $4,663,927, 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 $4,663,927, 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 will be submitting its federal application for FFY 2022 in September 2021. 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 2021-2026 MCH Needs Assessment, which will be submitted to HRSA with its federal FFY 2022 application for funds in September 2021. 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 MCH Services Block Grant 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 2021, CT's state match is $3,500,906);

- 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 2021 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 in order 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 care needs;

- provides that the state will maintain at least the level of funds for the program which it provided solely for maternal and child health programs in FFY 1989 (Connecticut FFY 1989 baseline: $6,777,191; the FFY 2022 state maintenance of effort is $6,780,000);

- 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 the 1981 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 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, other health 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 20 Expenditures	FFY 21 Estimated Expenditures	FFY 22 Proposed Expenditure	Percentage Change - FFY 21 to FFY 22
Number of Positions (FTE)	22.0	22.0	22.0	0.0%
Maternal and Child Health	$2,659,883	$2,741,329	$2,717,048	-0.9%
Children and Youth with Special Health Care Needs	$2,004,044	$1,922,598	$1,946,879	1.3%
TOTAL	**$4,663,927**	**$4,663,927**	**$4,663,927**	**0.0%**
SOURCE OF FUNDS				
Federal Block Grant Funds[1]	$4,663,927	$4,663,927	$4,663,927	0.0%
TOTAL FUNDS AVAILABLE	**$4,663,927**	**$4,663,927**	**$4,663,927**	**0.0%**

[1] The FFY 2021 and FFY 2022 federal award allocations have not been finalized and may be subject to change. The FFY 2020 award amount was used to prepare the FFY 2022 application.

Note: According to the Health Resources and Services Administration, the MCH Block Grant 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 20 Expenditure	FFY 21 Estimated Expenditure	FFY 22 Proposed Expenditure	Percentage Change – FFY 21 to FFY 22
Number of Positions (FTE)	12.75	12.75	12.75	0.0%
Personal Services	$735,887	$872,400	$886,339	1.6%
Fringe Benefits	$708,755	$856,173	$869,787	1.6%
Other Expenses	$29,008	$23,162	$23,162	0.0%
Contracts/Grants to:				
Local Government	$224,936	$225,000	$225,000	0.0%
Other State Agencies	$35,908	$0	$0	0.0%
Private Agencies	$925,390	$764,594	$712,760	-6.8%
TOTAL EXPENDITURES[1]	**$2,659,883**	**$2,741,329**	**$2,717,048**	**-0.9%**
SOURCE OF FUNDS	**Sources of FFY 20 Allocations**	**Sources of FFY 21 Allocations**	**Sources of FFY 22 Allocations**	**Percentage Change – FFY 21 to FFY 22**
Federal Block Grant Funds[2]	$2,659,883	$2,741,329	$2,717,048	-0.9%
TOTAL FUNDS AVAILABLE	**$2,659,883**	**$2,741,329**	**$2,717,048**	**-0.9%**

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

[2] The FFY 2021 and FFY 2022 federal award allocations have not been finalized and may be subject to change. The FFY 2020 award amount was used to prepare the FFY 2022 application.

Table B2

Maternal and Child Health Services Block Grant

PROGRAM EXPENDITURES:

Children and Youth with Special Health Care Needs

Program Category	FFY 20 Expenditure	FFY 21 Estimated Expenditure	FFY 22 Proposed Expenditure	Percentage Change - FFY 21 to FFY22
Number of Positions (FTE)	9.25	9.25	9.25	0.0%
Personal Services	$514,844	$525,485	$537,760	2.3%
Fringe Benefits	$495,862	$515,711	$527,717	2.3%
Other Expenses	$9,669	$7,721	$7,721	0.0%
Contracts/Grants to:				
Local Government	$0	$0	$0	0.0%
Other State Agencies	$0	$0	$0	0.0%
Private agencies	$983,669	$873,681	$873,681	0.0%
TOTAL EXPENDITURES	**$2,004,044**	**$1,922,598**	**$1,946,879**	**1.3%**
SOURCE OF FUNDS	**Sources of FFY 20 Allocations**	**Sources of FFY 21 Allocations**	**Sources of FFY 22 Allocations**	**Percentage Change – FFY 21 to FFY 22**
Federal Block Grant Funds[1]	$2,004,044	$1,922,598	$1,946,879	1.3%
TOTAL FUNDS AVAILABLE	**$2,004,044**	**$1,922,598**	**$1,946,879**	**1.3%**

[1] The FFY 2021 and FFY 2022 federal award allocations have not been finalized and may be subject to change. The FFY 2020 award amount was used to prepare the FFY 2022 application.

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 FFY 2020	National Performance Measures
Perinatal Case Management	To provide case management services for pregnant and parenting women to promote healthy birth outcomes.	DPH provides funding to Birth Support, Education & Beyond, DMHAS, and the Hospital of Central Connecticut to provide perinatal support services to pregnant and parenting women who have aged out of the child welfare system into the adult mental health system and other women with significant trauma histories.	98 pregnant or parenting women and teens	**National Outcome Measure #1:** Percent of pregnant women who receive prenatal care beginning in the first trimester. Data: In 2019, 84.7% of pregnant women reported having received prenatal care beginning in the first trimester, compared to 84.0% in 2018. Source: National Vital Statistics System (NVSS).
Reproductive Health Services	To prevent unintended pregnancies and risky health behaviors.	DPH provides funding to Planned Parenthood of Southern New England, Inc., to provide reproductive health care including breast and cervical cancer screenings, HIV and STI (sexually transmitted infections) screenings, contraception, prevention education, counseling, and clinical services to men and women of reproductive age in health centers in Bridgeport, Danbury, Hartford, Meriden, New London, New Haven,	35,151 women and men of reproductive age	**National Performance Measure #1:** Percent of women, ages 18 through 44, with a preventive medical visit in the past year. Data: In 2019, 77.9% of women, ages 18 through 44 reported having a preventive medical visit in the past year, compared to 76.7% in 2018. Source: Behavioral Risk Factor

Service Category	Objective	Grantor/Agency Activity	Number Served FFY 2020	National Performance Measures
		Norwich, Torrington, West Hartford and Willimantic. In-person services continued through COVID and telehealth visits were offered and provided as appropriate.		Surveillance System (BRFSS).
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 day/week information and referral services regarding MCH services in the state.	336,109 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) offer services addressing the medical, mental and oral health needs of children and youth. DPH supported 92 school health service sites in 27 communities statewide. Included are 80 SBHCs and 12 Expanded School Health (ESH) sites.	20,148 un-duplicated users 100,166 visits	N/A
Genetics	To provide information to consumers and providers on pregnancy exposure services.	DPH provides funding to the Univ. of Connecticut Health Center 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."	784 callers	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 FFY 2020	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 support of regional networks.	DPH supports the community-based system of care coordination. There are 86 community based medical homes that 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 5 consumers/families on the MHAC.	9,500 approximate CYSHCN	**National Performance Measure #11:** Percent of children with and without special health care needs, ages 0 through 17, who have a medical home. In 2018-19, 40.4% of parents/ guardians of children with special health care needs, ages 0 through 17, reported having a medical home. In 2018-19, 56.8% of parents/ guardians of children without special health care needs, ages 0 through 17, reported having a medical home. Source: National Survey of Children's Health (NSCH).
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 and Intervention Task	35,608 (99.28%) screened[1] Ongoing	N/A

Service Category	Objective	Grantor/Agency Activity	Number Served FFY 2020	National Performance Measures
		Force to discuss and identify issues relevant to 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, 2021, all CT newborns are screened through the CT Newborn Screening (NBS) Program for 33 core Recommended Uniform Screening Panel (RUSP) disorders, 25 secondary RUSP disorders, 7 non- RUSP disorders and hemoglobin traits within the first 48 hours of life. Screening for Spinal Muscular Atrophy was implemented by the CT NBS Program statewide on January 1, 2020. The CT NBS Program added screening for Adenosine deaminase deficiency SCID (ADA SCID) to its panel on July 1, 2021, enhancing the program's ability to identify children with ADA SCID. Validation of Pompe Disease and Mucopolysaccharidosis Type-I (MPS-I) took place in 2020, with the implementation of statewide screening	34,911 (99.91%) 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 made/reported to primary care physician (PCP) within 24 hours of receipt of presumptive positive results (2018): 99.3%. N/A

Service Category	Objective	Grantor/Agency Activity	Number Served FFY 2020	National Performance Measures
		beginning January 1, 2021. Bloodspot screening for Cystic Fibrosis (CF), a core RUSP disorder, is not conducted by the CT NBS Program, but is conducted by Yale and UConn Health Center laboratories. Guidelines for CF screening differ from those established by the CT NBS Program and the CT NBS Program currently does not have the capacity to report data related to CF screening. 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. The GAC did not meet during 2020 because of COVID-19 related issues. However, smaller virtual	The GAC met every 4 months prior to the COVID-19 pandemic but did not meet during 2020.	

Service Category	Objective	Grantor/Agency Activity	Number Served FFY 2020	National Performance Measures
		gatherings of treatment center specialists, CT Newborn Diagnosis and Treatment Network staff and CT NBS Program staff took place, as needed, to discuss specific topics (for example implementation of Pompe/MPS-1 screening). The program is hopeful that GAC meetings can reconvene in late 2021 and is currently re-examining committee makeup, meeting structure (virtual vs. hybrid, process and schedule).		

[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 that 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 that 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, 2015-2019*

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	8.6	5.2
	2018	4.4	2.8	7.0	6.1
	2017	4.6	3.1	9.8	4.9
	2016	4.9	2.9	11.2	3.7
	2015	5.6	3.7	12.3	8.0

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	2.2	11.3	22.4
	2018	8.3	2.5	13.9	23.7
	2017	8.8	2.7	15.8	24.9
	2016	9.4	3.2	15.5	26.7
	2015	10.1	3.6	15.8	29.1

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	9.9	7.0
	2018	5.9	4.2	10.1	6.8
	2017	6.1	4.8	9.8	6.8
	2016	5.8	4.4	9.4	6.7
	2015	5.9	4.4	10.5	6.6

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	2.5	1.2
	2018	1.1	0.8	2.1	1.3
	2017	1.0	0.5	2.4	1.3
	2016	1.1	0.6	2.2	1.3
	2015	1.0	0.6	2.5	1.2

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	11.2	22.4	19.9
	2018	16.1	12.0	22.9	20.0
	2017	15.7	11.6	22.0	21.2
	2016	15.9	11.4	22.9	21.4
	2015	11.7	8.0	18.2	16.9

* Reporting of race/ethnicity changed in 2016 due to an update of the birth certificate to reflect the National Vital Statistics System 2003 revisions. During 2016-19, mothers could self-report multiple races and were then assigned to a single race by the National Center for Health Statistics, whereas mothers could only report single races in earlier years.

† Following CDC's recommendation, rates of Late/No Prenatal Care for 2016 and subsequent years are not directly comparable to rates of Late/No Prenatal Care for 2015. With adoption of the latest revision of the birth certificate by Connecticut in 2016, as described in the previous footnote,* mothers are now asked the date of the first prenatal care visit rather than the month of pregnancy during which prenatal care was initiated. It is felt that the reporting method used prior to 2016 may have underestimated the percentage of mothers who received Late/No Prenatal Care.

Selected Perinatal Health Indicators

Although residents of Connecticut report good health status overall relative to the U.S. as a whole, large health disparities exist between non-Hispanic Whites and the non-Hispanic Black/African American and Hispanic populations. Disparities among perinatal indicators are significant and persistent. Addressing racial and ethnic disparities in the state is a priority. Reducing disparities in maternal and child health indicators remains one of the major challenges facing the public health community, requiring coordinated and simultaneously executed multi-ecological strategies. Table D provides statewide data for selected perinatal health indicators for 2015-2019. (Note: 2019 data are provisional figures and, therefore, are not final).

The data described below indicate that major improvements in the health of mothers and infants in Connecticut have been made; infant mortality and teen birth rates continue to decline. However, much remains to be done to achieve optimal outcomes for all Connecticut mothers and infants. The lifetime effects of race, 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 disparities. The continuation of evidenced-based programs, coupled with efforts to increase health equity and address social determinants of health, is essential to achieving improved birth outcomes and reducing/eliminating disparities. While we continue to strive to reduce health inequities, these challenges also are apparent at the national level and are not unique to Connecticut.

Infant Mortality

The Connecticut annual infant mortality rate (IMR, reported as deaths per 1,000 live births) averaged 4.8 (range: 4.4 - 5.6) during the period 2015-2019. With the exception of the 2015 rate of 5.6 deaths per 1,000 live births, all annual overall (i.e., across all race-ethnicities) IMRs for this five-year period were lower than any reported for Connecticut since 2005 and are consistent with a trend of declining IMRs for the state of 2.5% annually since that year. Annual IMRs in both non-Hispanic Black/African American and Hispanic populations also declined for the period 2015-2019, at rates of 2.9% and 2.3% per year, respectively, as they had since 2005. By contrast, there was no evidence of decline in mortality rates among Non-Hispanic White infants between 2015 and 2019. Most recently, and specifically for the period 2015-2019, annual IMRs in Connecticut's non-Hispanic White population averaged 3.2 deaths per 1,000 live births 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 9.8 deaths per 1,000 live births, and those for Hispanic populations averaged 5.6 deaths per 1,000 live births. The averages were 3.1 and 1.7 times higher, respectively, than that for Connecticut's non-Hispanic White population.

Births to Teens

The 2015-2019 annual overall teen birth rates in Connecticut averaged 8.9 (range = 7.7 - 10.1, reported as live births per 1,000 women aged 15-19) and continued an 11-year decline observed to have begun in 2008. The lower limit for the range of teen birth rates during this five-year period of 7.7 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 2015-2019, 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 12.9%, 11.2%, and 6.6% 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 2015-2019, the average annual teen birth rate of Hispanic women of 25.4 births per 1,000 women aged 15-19 was 8.9 times higher than the average rate for non-Hispanic White women of 2.8. The average annual teen birth rate among non-Hispanic Black/African American women of 14.5 births per 1,000 women aged 15-19 for 2015-2019 was 5.1 times that of non-Hispanic White women.

Singleton Low Birth Weight and Very Low Birth Weight

There was no change in the overall rate of singleton low birth weight (LBW) around an average value of 5.9% (range = 5.8 - 6.1%) for Connecticut, nor for non-Hispanic White and Hispanic populations, for the period 2015-2019. This result is consistent with an observed stable rate of singleton LBW, both overall and in these two race-ethnicities, since the mid-2000s, when rates stopped increasing. Singleton LBW rates for the non-Hispanic Black/African American population, on the other hand, declined during the 2015-2019 period, at a modest rate of 0.08 percentage points per year, as they had since 2003. Disparities among minority race-ethnicity groups have persisted. From 2015 to 2019, the average rate of singleton LBW infants among non-Hispanic Black/African American populations (9.9%) was 2.2 times higher than that among non-Hispanic White women (4.5%). The average rate of singleton LBW among Hispanic women (6.8%) was 1.5 times that of non-Hispanic White women.

Between 2015 and 2019, there was also no change for Connecticut overall in the rate of singleton very low birth weight (VLBW). There were some minor fluctuations across all three major race-ethnicity groups, but the rates remained largely unchanged and averaged 1.1% for the total population (range=1.0-1.1%). Disparities in rates of VLBW by race-ethnicity in Connecticut were more marked than those for LBW for the period 2015-2019. Average rates of VLBW for the non-Hispanic Black/African American population (2.4%) and Hispanic population (1.3%) were 3.8 and 2.1 times that of the non-Hispanic White population rate of 0.6%, respectively.

Late or No Prenatal Care

The rate of late/no prenatal care (PNC) for the entire population of pregnant women in Connecticut was 11.7% in 2015. This rate is lower than the average rate of 15.7% for the more recent period of 2016-2019. Following CDC's recommendation, rates of Late/No Prenatal Care for 2016 and subsequent years are not directly comparable to rates of Late/No Prenatal Care for earlier time periods. With adoption of the latest revision of the birth certificate by Connecticut in 2016, mothers are now asked the date of the first prenatal care visit rather than the month of pregnancy during which prenatal care was initiated. It is felt that the reporting method used prior to 2016 may have underestimated the percentage of mothers who received Late/No Prenatal Care. Prior to 2016, rates of late/no PNC were neither increasing nor decreasing for Connecticut's entire population. Rates of late /no PNC were not different between non-Hispanic black/African American and Hispanic populations for the period 2016-2019, averaging 22.6% and 20.6%, respectively. These rates were approximately twice the rate of 11.6% observed for non-Hispanic White women during that same four-year period.

Program Highlights

Within DPH, a number of 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. These initiatives will continue and include the following:

- DPH completed the 2020 update of the State Health Needs Assessment. The report was released as the State Health Improvement Plan (SHIP) Coalition launched a series of planning workshops to update the health improvement plan. The DPH Public Health Systems and Equity (PHSE) team worked with partners across the state to design the Healthy CT 2025 SHIP framework. Although the COVID-19 pandemic disrupted the planning process by requiring working remotely, the PHSE team completed the plan through multiple virtual meetings and webinars to discuss priority areas and cross-cutting themes.

  The plan's strategies focus on policy, systems, and environmental changes to address upstream causes of poor health. The priorities under consideration include: a) access to health services and primary healthcare, b) economic stability, particularly around issues of poverty and employment, c) access to healthy eating and issues of food security, d) housing quality and stability, and e) community resilience as it relates to crime/violence and emergency preparedness. Cross-cutting priorities include education, transportation, and racial discrimination.

In addition to launching Healthy Connecticut 2025, DPH is undergoing preparations for its re-accreditation application due by the first quarter of 2022. DPH received its first national public health accreditation in March 2017 and has submitted annual reports to the Public Health Accreditation Board (PHAB). The agency is now preparing documentation that demonstrates a culture of quality improvement and performance management. Additionally, DPH worked to maintain the capacity needed to provide the ten essential services of public health. The agency also worked on developing systems and programmatic functions to narrow gaps identified during an assessment of DPH's current work based on the re-accreditation standards. MCH grant funding makes possible continued progress and allows DPH to conduct the accreditation work across the agency.

- The CT Maternal and Child Health Coalition is a representative group of state agencies, providers, funders, and advocates working in concert with the state's maternal and child health population. The Coalition has over 120 individuals representing 97 organizations. It serves as a communication and networking vehicle for those working in the field of maternal and child health by holding quarterly meetings and sending out notes of interest to Coalition members. The Coalition represents the state's maternal and child health priorities/interests in the State Health Improvement Plan, and also advocates for health equity and the elimination of racial and ethnic health disparities.

  A Coalition advocacy initiative, being done in collaboration with the Every Woman Connecticut Learning Collaborative and the March of Dimes, is the establishment of a Reproductive Workgroup. Modeled on work being done in New York, this workgroup will be looking at the degree and types of disrespect and abuse experienced by women seeking pre/interconception as well as prenatal and postpartum health care. Based on the fact-finding results, the workgroup will propose recommendations to address identified areas of concern.

- DPH participates in the Every Woman Connecticut Learning Collaborative, which seeks to increase expertise and self-efficacy in implementing routine pregnancy intention screening and appropriate care, education, and services to ultimately improve birth spacing, increase pregnancy intentionality, and the proportion of Connecticut women who deliver a live birth who report discussing pre/interconception health with a healthcare worker.

- CT legislation was passed in 2018 to establish a Maternal Mortality Review Committee (MMRC) and program within DPH. The Maternal Mortality Review Committee is comprised of both clinical and non-clinical subject matter experts that conduct a comprehensive, multidisciplinary review of each pregnancy-associated death that occurred within one year of the end of a pregnancy. The comprehensive review

includes medical records; medical examiner reports; death certificates; vital statistics infant birth, and fetal and maternal death files; police reports; informant interviews; obituaries; social media and other sources of information. The purpose of the MMRC review is to identify factors that may have contributed to the death, and to make recommendations to reduce pregnancy-related morbidity, mortality and disparities. The department's Maternal Mortality Review Program is supported by CDC funding that provides for program administration, data collection and analysis of maternal mortality data, and an annual Maternal Mortality Evaluation Report.

- The Department's State Physical Activity and Nutrition (SPAN) Program breastfeeding team, along with the State WIC Program staff, continues to partner with the CT Breastfeeding Coalition's (CBC) Ten Step Collaborative to encourage implementation of evidenced-based maternity care and the 10 Steps for Successful Breastfeeding in CT hospitals. In 2020, the "It's Worth It" media campaign (launched in late 2019), was again run in targeted areas of the State aimed at increasing the awareness of the campaign's community support message and also documenting stories of diverse populations.

  Additionally, DPH successfully launched the English version of the Ready, Set, Baby (RSB) online website, in partnership with the Carolina Global Breastfeeding Institute, in March 2020. Translation of the RSB site into Spanish was completed in May 2021, with a soft launch planned for July 2021. The Arabic translation will be available in Fall 2021.

  In partnership with CBC, DPH launched a scholarship program for underrepresented populations in order to improve equity in community lactation support. In September 2020, CBC awarded six individuals (all women of color) funds to pursue becoming an International Board Certified Lactation Consultant (IBCLC). To date, one candidate has taken the exam and the other five are working towards meeting the exam credentials. It is anticipated that two additional awardees will sit for the exam in early 2022. DPH and CBC, with SPAN funds, plan to support these women through the process and have provided additional financial and moral support through 2021. Four technical assistance sessions were held and an email group was created to facilitate communication among the awardees. In addition, SPAN funded twelve individuals to attend the online Healthy Children Certified Lactation Counselor course and exam in 2020/2021, based on the scholarship applications.

- 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 Initiative, providing a statewide point of entry as well as information and referral. DPH has dedicated MCHBG as well as other federal funding towards improving the United 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 2,171,275 visits in the 2020 calendar year. This is a 56% increase from 1,393,352 website visits in the 2019 calendar year. The large increase is a result of the COVID-19 pandemic.

- 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 trainings on the importance of developmental screening and distribution of the CDC's "Learn the Signs. Act Early" materials.

  The CT State Heath Improvement Plan Developmental Screening Workgroup coordinates their activities with the CT Act Early team to increase developmental screening through the strategies of 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 to address teen pregnancy through CT's Title V programs include those to delay the onset of sexual activity, promote abstinence as the social norm, reduce the number of adolescents who have sex at young ages, and increase the number of sexually active adolescents who use contraceptives effectively. Healthy Choices for Women and Children, a case management program serving Waterbury, and the Family Wellness Healthy Start (FWHS) program serve pregnant and parenting teens and include interconception services. The FWHS program works to eliminate disparities in infant mortality and adverse perinatal outcomes especially among the target population of African American and Hispanic women in Hartford and New Britain. The FWHS Program maintains and expands Healthy Start services by focusing on the following goals: (a) improve women's health; (b) improve family health and wellness; (c) promote systems change through community/population health; and (d) assure impact and effectiveness through quality improvement, performance monitoring, and evaluation.

DPH also works with the Department of Mental Health and Addiction Services to support clients in the Young Adult Services (YAS) program who may be pregnant or parenting and transitioning from the Department of Children and Families to the adult mental health system to achieve the necessary skills for adulthood.

The Personal Responsibility Education Program targets teens ages 13-19 in Bridgeport, Hartford, Meriden, Waterbury, and New Britain and provides evidence-based HIV, STD, and pregnancy prevention activities that have been found through rigorous research and evaluation to be effective in reducing sexual activity, increasing contraceptive use in already sexually active youth and delaying unplanned pregnancy through both abstinence and contraception.

- The Reproductive Health Program is administered by Planned Parenthood of Southern New England, Inc. (PPSNE) and is funded with State and Title V funds through a five-year contract. The program provides services in those areas of Connecticut with a high concentration of low-income women of reproductive age, and with high rates of teen pregnancy.

- The Connecticut Asthma Program continues to support six contractors in delivering asthma home visits to families disproportionately affected by asthma. The multi-component, evidence-based asthma home visiting program called Putting on AIRS (POA) is available statewide to children whose asthma is poorly controlled. Several components are integrated in the three-visit home intervention: asthma education, environmental assessment, and remediation of asthma triggers; assessment of social determinants of health; and linkages to reduce barriers to asthma management. Each contractor's POA team consists of an Asthma Education Specialist, an Environmental Education Specialist and a Community Health Worker. Progress reports are shared with participants' primary care providers for optimal coordination and continuity of care. Due to the COVID-19 pandemic, all in-person asthma home visits were interrupted by March 2020. The POA is based in five local health departments, and it became increasingly challenging for these agencies to allocate resources to asthma-related activities. A decrease in asthma services, combined with a significantly low number of children referred to the program, accounts for the unexpected results. Between September 1, 2019 and August 31, 2020, 115 participants were referred and consented to participate in the POA program. Of these, 56 (48.7%) did not have a well-controlled score for asthma at the time of visit.

- In addressing the needs of adolescents, the CT Title V program strategies emphasize supporting adolescent wellness (including comprehensive well child visits) and process improvement for the transition to adult life. School Based Health Centers were utilized in promoting comprehensive adolescent well visits, inclusive of

developmental assessment, risk assessment and behavioral health screening, anticipatory guidance, and body mass index (BMI) screening and intervention.

- DPH supported 92 school 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, 80 were School Based Health Centers (SBHC) and 12 were Expanded School Health (ESH) sites.

  SBHCs serve students, Pre K-12, and are located 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 and cultural and linguistically appropriate standards.

- The Connecticut Breast and Cervical Cancer Early Detection Program (CBCCEDP) continues to partner with six health systems (consisting of 21 hospitals) throughout Connecticut to promote and provide breast, cervical and cardiovascular screening services. In FY 2021 the program screened 3,818 women. The program continued sustained partnerships with the Consultation Center at Yale, the University of Connecticut, the University of St. Joseph, Walmart Corporation, Connecticut Physicians for Women, Northern CT Black Nurses Association, United Way of CT, Hartford Health Care and Yale New Haven Health Systems' mobile mammography vans. Community Health Navigators partnered with staffs of both mobile mammography vans and enrolled women in program services at Wellness Day events in communities where women reside and work. CBCCEDP also partnered with the Connecticut Cancer Partnership to increase awareness and education about Human Papillomavirus Vaccine (HPV); as well as with KNOX Inc., the Connecticut Snap-Ed program, Sardili's Produce, Joan Dauber Food Bank, and the Women's Empowerment Center to promote healthy nutrition and physical activities, thereby reducing cancer and heart disease risks. Additionally, CT was awarded a CDC grant for colorectal cancer screening for low income men and women 45 years and over.

- The DPH Immunization Program oversees the provision of all recommended childhood vaccines to over 680 providers statewide including private physician offices, community health centers, School Based Health Centers, and local health departments. In 2020, nearly 1,000,000 doses of vaccine were distributed and the program universally expanded provision of influenza vaccine for all children up through 18 years of age regardless of insurance status. Adult vaccines, including HPV for uninsured patients 19-45 years of age are provided to local health departments, community health centers, and drug treatment facilities. Uninsured and Medicaid patients 9-18 years of age, as well as privately insured 11 and 12 year olds, are also provided HPV vaccine. All nationally recommended childhood vaccines are provided to School Based Health Centers for children up through 18 years of age free of charge.

  The Immunization Program also partners with the WIC program to promote timely immunizations and well child care at WIC locations statewide. Nine local Immunization Action Plan (IAP) contractors (Hispanic Health Council, Ledge Light Health District, Naugatuck Valley Health District, New Britain Heath Department, New Haven Health Department, Norwalk Health Department, Southwestern AHEC (Area Health Education Center), Torrington Area Health District, Waterbury Health Department) worked with providers, maternal and child health partners, and local WIC agencies to ensure that all children have a medical home and access to age appropriate vaccinations.

- DPH's Lead and Healthy Homes Program (LHHP) 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 LHHP upgraded its surveillance system to a new, 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. The prevalence of lead poisoning (defined as venous tests ≥ 5 µg/dL) decreased from 1.8% to 1.7% from 2019 to 2020 (1,188 cases versus 1,025 cases), a 13.7% decrease, while the prevalence of lead poisoning decreased by 38.4% from 2017 to 2020 (1,665 cases versus 1,025 cases).

Table E

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 20 Actual**	**FFY 21 Estimated**	**FFY 22 Proposed**
Perinatal Case Management	$335,695	$350,287	$350,287
Reproductive Health Services [1]	$16,092	$16,092	$16,092
Information and Referral [1]	$183,955	$201,690	$201,690
School Based Health Services [1]	$273,691	$273,691	$273,691
Genetics [1]	$35,908	$36,000	$36,000
Other [2,3,4]	$340,893	$111,833	$60,000
MCH Total	**$1,186,234**	**$989,593**	**$937,760**
Children and Youth with Special Health Care Needs	**FFY 20 Actual**	**FFY 21 Estimated**	**FFY 22 Proposed**
Medical Home Community Based Care Coordination Services	$811,561	$811,561	$811,561
Reproductive Health Services [1]	$2,405	$2,405	$2,405
Genetics [1]	$3,990	$4,000	$4,000
Information and Referral [1]	$37,677	$41,310	$41,310
School Based Health Services [1]	$14,405	$14,405	$14,405
Other [2,3,4]	$113,631	$0	$0
CYSHCN Total	**$983,669**	**$873,681**	**$873,681**
Grand Total	**$2,169,903**	**$1,863,274**	**$1,811,441**

Footnotes:

[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 2020 "Other" contractual expenditures supported: upgrading laboratory newborn screening equipment for X-linked Adrenoleukodystrophy and other disorders ($297,788): WIC program "Ready, Set, Baby" materials in English and Spanish ($21,770); upgrades and hosting fees for the MAVEN online data reporting platform that supports the Newborn Screening, Early Hearing Detection and Intervention, CYHCN, and Healthy Start Programs ($27,712); printing of CYSHCN parent materials in Spanish ($23,000); placement of additional child health questions on the Behavioral Risk Factor Surveillance System (BRFSS) telephone survey questionnaire ($20,000); the CT Women's Consortium One Key Question Initiative ($10,000); supplementing the CT Pregnancy

Risk Assessment Monitoring System survey to obtain answers to questions about experiences with prenatal care, delivery, postpartum care, and infant care during the COVID-19 pandemic ($5,895); Association of Maternal & Child Health Programs (AMCHP) dues ($9,800); enhanced family supports through the Early Hearing Detection and Intervention program ($7,500); funding to Health Resources in Action (HRiA) to coordinate the MCH needs assessment ($30,000); and Request for Proposals advertisement for CYSHCN contracts ($1,059).

[3] FFY 2021 "Other" contractual expenditures will support: upgrading laboratory newborn screening equipment for X-linked Adrenoleukodystrophy and other disorders ($51,833); placement of additional child health questions on the BRFSS ($20,000); website enhancement and social media outreach intended to increase knowledge of and expand access to community resources under the CYSHCN and SBHC programs ($40,000).

[4] FFY 2022 "Other" contractual expenditures will support: Connecticut Hospital Association to implement Alliance for Innovation on Maternal Health (AIM) Patient Safety Bundles ($60,000).