

DEPARTMENT OF PUBLIC HEALTH

February 24, 2022 Appropriations Hearing Questions –

Healthy and Lead-Safe Homes

1. *What is the plan for this ARPA funding, including the details for lead abatement?*

The \$70 million investment of ARPA funding is part of a three-pronged approach to addressing the issue of lead poisoning in Connecticut's children.

A. This approach includes:

- a. Updating the State's lead poisoning prevention statute to align with CDC guidance; and requiring more frequent testing of children living in the communities most at risk;
- b. A \$70 million investment through ARPA in lead abatement and remediation in vulnerable homes; and
- c. Investment of IJA funds to replace lead service lines in Connecticut's most vulnerable communities

B. ARPA Investment

- a. A \$70 million ARPA investment in lead remediation and abatement will support the work that is being done at the municipal level by:
 - a. Providing the fiscal support needed to manage the increased number of cases, inspections, and abatement/remediation activities anticipated from the amendment of Connecticut statute. This work involves
 - i. Conducting epidemiological investigation of a child's dwelling when a child has an elevated blood lead level (BLL)
 - ii. ensuring remediation of lead in paint and dust in dwellings that have poisoned a child
 - iii. relocating children and families while dwellings are abated
 - iv. providing a focus on children who reside in high Social Vulnerability Index (SVI) neighborhoods with housing stock built in or before 1978
 - v. provide continuous educational information
 - b. Creating a proactive pathway allowing landlords to address lead issues in their properties, improving the housing stock of high SVI communities.
 - c. The ARPA investment complements Governor's bill 5045, which reduces the blood lead levels that triggers parental notifications and epidemiological investigations to more closely align with CDC and American Academy of Pediatrics recommendations. Additionally, the bill requires annual testing of children 3 to 6 who live in certain towns where exposure to lead is most common, as determined by DPH.

Specifically, the bill proposes that the following interventions shall occur at the specified thresholds, which tighten over time to give local public health

departments necessary time to adjust. However, municipalities are encouraged to adopt the 2025+ thresholds at earlier dates.

Level of intervention	What steps are taken?	Current	2023	2024	2025+
Level 1: Parental Notification	Parents given educational materials	10 µg/dL	3.5 µg/dL	3.5 µg/dL	3.5 µg/dL
Level 2: Onsite Inspection	Local public health inspects home/apartment.	15 µg/dL	10 µg/dL	5 µg/dL	-
Level 3: Epidemiological Investigation	Local public health undertakes thorough investigation to determine the cause of elevated blood lead levels.	20 µg/dL	15 µg/dL	10 µg/dL	5 µg/dL

As an example of the potential impact of HB 5045, in 2019, 1188 children had a blood lead level over 5 micrograms per deciliter, a level at which the CDC would have recommended an investigation of their homes. Our current statutes required only 78 investigations. This means that over a thousand children had elevated levels of lead and may not have received the treatment and interventions they needed. Under HB 5045, the homes of all 1188 children would have received an inspection, representing an increase of 1532%. While this is a substantial increase, it is important to note that New Haven, which has the highest percentage of children in Connecticut with elevated blood lead levels, already operates successfully under the same home inspection standards set in HB 5045.

2. *Where are the areas most in need of lead abatement in Connecticut? (Please provide a map.)*

**Top Eleven Towns
Reported Information to DPH
Connecticut 2020 – Distribution by BLLs by category by Town**

#	Town	% < 3.5 mcg/dL (n=58,323)	% ≥ 3.5 mcg/dL (n=2,994)
1	New Haven	4.8%	12.6%
2	Bridgeport	6.3%	10%
3	Waterbury	5.4%	8.4%
4	Hartford	4.4%	5.7%
5	Meriden	1.9%	2.9%
6	Stamford	4.8%	2.3%
7	Danbury	3.3%	2.5%
8	Norwalk	3.2%	2.3%

9	West Haven	1.8%	2.2%
10	Norwich	0.9%	2.2%
11	New Britain	3.0%	2.2%

Note: Denominator reported does not necessarily reflect all children that may require testing

These are the towns where children have been most affected by lead poisoning. Many of these towns are also classified as high SVI areas and the children affected are mostly living in the high SVI parts of the towns. Focusing the funding on the high SVI areas promotes equity in how we are spending this money and will have the greatest impact on children suffering from lead poisoning.

Workforce Development/Student Loan Repayment Program (SLRP)

3. How is DPH addressing healthcare workforce shortages?

Through a cooperative agreement with the Health Resources and Services Administration (HRSA), the DPH Primary Care Office (PCO) works with health care providers and communities to improve access to care for the underserved, by recruiting and retaining providers to practice in federally designated shortage areas. The mission of the PCO is to improve the health of Connecticut residents who live in underserved areas, through timely and accurate assessment, planning, and assistance, to increase access to primary care providers of medical, dental, and mental health services. The PCO conducts in-depth research and analysis of the healthcare delivery system and the population it serves to identify trends in access and develop strategies to address deficiencies. To accomplish this, the PCO maintains strong working relationships with other agencies and programs, both public and private. The PCO also works with communities to identify areas that may meet federal guidelines for Health Professional Shortage Area (HPSA) designations.

The PCO ensures that Connecticut is able to recruit and retain high quality health care professionals to serve as primary care providers in our urban and rural areas. Working with HRSA, the PCO serves as the point of contact for many federal and state workforce assistance programs, designed to help attract new and experienced health professionals of various disciplines to join our healthcare provider community.

The PCO works with health care providers and communities to improve access to care for the underserved, by assisting them with the application process in order to recruit and retain providers to practice in federally designated shortage areas and expand new and existing Federally Qualified Health Centers (FQHC's).

4. How is CT attracting people from out-of-state to work here in healthcare?

The National Health Service Corps (NHSC) Loan Repayment Program (LRP) offers medical and dental clinicians the opportunity to have their student loans repaid, while earning a competitive salary, in exchange for providing health care in urban, rural, or tribal communities with limited access to care. Under the NHSC, there is also a Students to Service Loan Repayment Program (S2S LRP) designed for medical students (MD or DO), dental students (DMD or DDS) and nursing students (NP or CNM) in their final year of school from which they can receive loan repayment assistance in return for providing health care in urban, rural, or frontier communities with limited access to care. In addition, the NHSC has a scholarship program and offers loan

repayment for nurses.

The PCO works very closely with several health professions universities in the state to promote the awareness of the NHSC loan repayment and scholarship programs. Many students who are enrolled in these institutions of higher education are from out of state, and it is hoped that these efforts will assist in recruiting these future clinicians into a Connecticut HPSA.

5. *Are there incentives for individuals to work in nursing homes/hospitals/group homes?*

There are not specific programs offered by the state for particular nursing homes, hospitals or group homes, but many of their employees would be eligible for the state Student Loan Repayment Program (see below) if they hold one of the eligible license types. In addition, some nursing homes, on their own, are offering in-house certified nurse aide (CNA) training. Such training is provided free of charge to the trainees, and the training can also be applied to their certification process.

6. *What are the details of the SLRP?*

The administrative details of the SLRP are under development. DPH proposes mirroring the eligibility criteria after the Health Resources and Services Administration (HRSA) State Loan Repayment Program criteria and other federal loan repayment programs. We propose having an application period for interested participants and relying on a lottery system to select loan recipients. The amount of the loans will likely be \$25,000 per year per individual for 2 years, with the option of extending it for a third and fourth year to encourage workforce retention in Health Professional Shortage Areas (HPSAs).

7. *How much funding, by profession, will be provided each fiscal year to repay student loans?*

The exact distribution of funding is contingent upon an assessment of available workforce data, including the CT Primary Care Needs Assessment, and current Health Professional Shortage Area designations. Funding will be distributed to those eligible under CT state statute. Under the proposed ARPA budget, the SLRP could distribute \$4 million in FY 23, \$7 million in FY 24, and \$7 million in FY 25.

8. *Will the SLRP include Social Workers? Behavioral health professionals? If so, which ones?*

DPH supports eligibility for the following behavioral health clinicians: psychiatrists, psychologists, licensed clinical social workers, licensed marriage and family therapists and licensed professional counselors. Adding these professions to the list of eligible providers is before the legislature this session in HB 5040, AAC the Governor's Budget Recommendations for Human Services.

Tobacco Prevention Account

9. *What requirements will be applied to local and district health departments in order for them to receive tobacco prevention funding?*

The Preventive Health and Health Services Block Grant allocation to Local Health Departments (LHD) provides a menu of evidence-based activities for LHDs that focus on implementing

tobacco prevention-related policies and environmental changes (i.e, sales or flavor restrictions, tobacco free spaces and places) and health systems changes to encourage providers to screen, treat and refer for tobacco cessation. This could be used as a model for tobacco prevention funding requirements.

10. Which specific, evidence-based tobacco prevention activities will be funded?

We would anticipate initiatives would follow the CDC's Best Practice for Comprehensive Tobacco Control Programs (<https://www.cdc.gov/tobacco/stateandcommunity/guides/index.htm>), such as:

- a. State and Community interventions (prevent initiation among youth/young adults – Tobacco Free Campuses; promote quitting, including initiatives to improve community-clinical linkages; eliminate exposure to secondhand smoke; address disparities)
- b. Mass-reach health communications
- c. Cessation services (contracts with Quitline and youth cessation options)
- d. Program evaluation services
- e. Infrastructure, Administration, and Management

Community Violence Prevention Programs

11. Where, within DPH, is the community violence prevention funding to be allocated? Within the Office of Injury Prevention?

It's best suited within the Office of Injury and Violence Prevention in the Community, Family Health, and Prevention Section. The Office oversees programs related to sexual violence prevention, suicide prevention; tracks surveillance data on homicides, firearm injuries and deaths; and collaborates with a growing network of violence prevention and intervention partners.

12. Please provide a summary, and the corresponding plan, for community violence prevention programs using ARPA funding.

DPH is proposing to spend \$3.6M over a 3.5 year period for community gun violence intervention and prevention programming across the state.

DPH proposes to:

- Establish a Gun Violence Prevention and Intervention Program in the Office of Injury and Violence Prevention to effectively address and respond to the sharp rise in gun-involved homicides, stabbing/sharp force homicides, and homicides in general, in CT's communities since the start of the COVID-19 pandemic
- Fund and support the growth of the existing evidence-based or evidence-informed community violence and gun violence prevention and intervention programs throughout the state. This will be done through a mini-grant program that will award qualified applicants funding to build capacity and resources within their programs.
- Fund and support a CT Hospital Violence Intervention Program (HVIP) Collaborative Program Coordinator who will strengthen partnerships within the community, state, and federal agencies involved in community violence prevention and intervention. This position will build new partnerships and strengthen partnerships between community violence prevention services organizations and hospitals across Connecticut. The mission of the CT

HVIP Collaborative is to strengthen and expand the HVIP safety net across the state through training, research, sharing of best practices and collaboration.

- Contract with a statewide hospital-based injury prevention center with a history of community outreach and connections to trauma centers to
 - o coordinate the project;
 - o assist with coordinating a mini-grant program that will award funds to qualified applicants from the community-based violence and gun violence prevention and intervention programs, including trauma-informed health and behavioral health care, and violence prevention professional training programs;
 - o conduct health education and trainings; and
 - o assess performance of initiated strategies.
- Contract with a public health evaluator who will conduct a performance assessment of the project and measure the effectiveness of the strategies implemented over the three year funding period. The Evaluator's role will include working with CT DPH and the Injury Prevention Contractor to: identify output and process measures, conduct an asset map of community violence prevention and intervention services, and design the project Evaluation and Performance Measurement Plan to demonstrate how the proposed project will meet short, intermediate, and long-term outcomes
- Continue timely surveillance of firearm and stabbing-involved homicides and assaults at DPH and build a data dissemination plan to share that data with state partners for focused public health prevention strategies and interventions.
- Educate and build awareness of law enforcement leadership to designate the incident commander at a scene of a homicide or assault-related serious injury to call the United Way of CT/2-1-1's ACTION line or advise the victim's family members and friends who are in emotional distress to call the ACTION line. This service offers an array of supports and options to individuals in distress, including telephonic support; referrals and information about community resources and services; and/or warm-transfer to the Mobile Crisis Team (MCT) of their area. This training can be extended to other first responders and emergency department personnel who are on the frontlines of community violence-related injuries and deaths.

Other

13. Provide information about the Storage and Maintenance Costs of COVID-19 Preparedness Supplies that is intended to be supported by ARPA funding.

DPH maintains additional medical surge assets at the Meyers Warehouse in Windsor Locks, much of which was acquired during the COVID-19 response:

- Personal Protective Equipment (PPE)
 - o DPH stockpiled a cache of PPE (N95s, surgical masks, single use isolation gowns, and gloves) to augment the state's overall supply to support health and medical organizations.
- Ventilators/Aspirators
 - o DPH's Office of Public Health Preparedness and Response currently manages several hundred ventilators and aspirators. The aspirators and some of the ventilators are owned by DPH, purchased several years ago with federal grant funds. Many of the DPH-owned ventilators are staged at hospitals and require annual maintenance.

- During the COVID-19 response, the state purchased 100 ventilators from BioMed, a Connecticut durable medical equipment manufacturer. These ventilators are stored in climate-controlled units and will require preventive maintenance next year. Connecticut also received over three hundred ventilators from the federal Strategic National Stockpile (SNS). Most have been returned to the SNS, though some remain at hospitals or in DPH's storage facility.
- Powered Air Purifying Respirators (PAPRs)
 - o Through FEMA, DPH received a supply of nearly 1000 Powered Air Purifying Respirators (PAPRs). Most of these PAPRs were distributed to hospitals and EMS agencies. DPH reserved a supply for nursing homes which are stored at the Meyers Warehouse.
- Federal Medical Station (FMS)
 - o During the COVID-19 surge in the Spring of 2020, Connecticut requested and received a 250-bed federal medical station. Federal medical stations (FMS) are rapidly deployable caches managed by the Strategic National Stockpile that contain beds, supplies, and medicines that can quickly turn a pre-identified building into a temporary medical shelter during a national emergency. The FMS was set-up in an athletic facility at Southern Connecticut State University for several months. The FMS was eventually demobilized, inventoried, and stored at the Meyers warehouse.

PPE/VENTILATOR/ETC. STORAGE & MAINTENANCE				
Item	Category	Cost Per	Quantity	FY 2023 Cost
Personal Protective Equipment	Storage	\$1.25 per sq foot/mo	3800 sq. ft.	\$57,000
Ventilator	Storage	\$1.50 per sq foot /mo	600 sq. ft.	\$10,800
Connex boxes	Storage	\$140 per month	12	\$1,680
Federal Medical Station Storage	Storage	\$1.25 per sq foot/mo	3000 sq. ft.	\$45,000
Moving/delivering items from	Service		\$500/month	\$6,000
Lite Transport Ventilators	Ventilator Service	\$2,700/month		\$32,400
Impact Ventilators	Ventilator Service	\$410/ventilator	79	\$32,390
Ventilators	Ventilator Service	\$1,400/every 2 years	100	\$140,000
TOTAL			TOTAL	\$325,270
			<i>Rounded to</i>	\$ 325,000

14. What is the status of wastewater monitoring for opioids?

Yale University is working with the Connecticut Agricultural Experiment Station on wastewater analysis. In 2020 and 2021 they have utilized such analyses for COVID-19 infection prevalence and have also detected the presence of opioids. This is an emerging methodology for Connecticut.

15. What is the number of small water systems in Connecticut that are estimated to be contaminated?

There are an estimated 320 small community water systems that each serve under 1000 people in Connecticut. Of those, we estimate that 20-30% are experiencing contamination challenges. DPH will follow up with a list of water systems that are experiencing contamination issues, identified by the contaminant.

16. Are we promoting immunizations – not just against COVID-19 – using Immunization Services account funding? Please detail Immunization Services outreach efforts.

DPH administers the Connecticut Vaccine Program (CVP), which provides an array of routine childhood vaccines free of charge to healthcare providers. The program consists of a federally funded Vaccines for Children (VFC) program that serves low-income children on an entitlement basis, and a state-funded program that serves privately insured children. Over 99% of the funding appropriated to the Immunization Services account, under the Insurance Fund, is dedicated to the costs of operating the state-funded component of the CVP, which immunizes children against sixteen diseases. Inclusion within the state program allows the vaccines to be purchased at Centers for Disease Control and Prevention (CDC) established prices, which are often about 25% less than private sector prices. The remaining funding under the Immunization Services account is utilized to purchase adult serums and medicines for the purposes of preventing and controlling tuberculosis and sexually transmitted diseases; 3.0 FTE state employees who administer the CVP are also compensated from this account.

DPH applies for federal grant dollars on an ongoing basis for a variety of public health outreach activities, in accordance with the objectives and grant deliverables established by the Centers for Disease Control and Prevention.

17. How is DPH supporting Health Equity?

DPH has allocated approximately \$59 million to develop and execute broad health equity strategies that will enable high penetration of the Socially Vulnerable Index (SVI) communities through strategic outreach, canvassing, out-bound calling, and mobile, community and homebound vaccination clinics; human resources for vaccine equity and long-term pandemic recovery work, including but not limited to, community health workers, door-to-door canvassers, call center staff, data analysts, and technical support; and development of platforms and networks for public health education and awareness, including but not limited to, paid advertising, media, language bank services, and trusted messenger forums.

In April 2021, the department implemented the Vaccine Equity Partnership Fund (VEPF) totaling approximately \$13.2 million. This grant funding was issued to implement equity partnerships with local health departments/districts, community organizations, and providers in high CDC Social Vulnerability Index communities. The local health departments and districts held vaccination clinics, conducted outreach to the local community, and provided vaccinations to the homebound and other hard to reach populations.

The department allocated approximately \$4.9 million to contract with Community Health Workers (CHW) and other Community Based Organizations (CBOs) to support the outreach work of LHDs in reaching local communities of color. CHW hiring will aim to employ residents of the communities/reflective of community demographics.

Furthermore, the department allocated funds to support other strategies in penetrating the high SVI communities. Some of the strategies included a collaboration with Access Health, conducting a door-to-door canvassing outreach campaign to increase access to vaccination for people of color and other vulnerable communities in Connecticut for approximately \$2.8 million. The department will be implementing a request for proposal (RFP) for an additional \$2.5 million to extend this effort.

Additionally, the department recently partnered with the Connecticut Office of Rural Health, part of Northwestern Connecticut Community College, through a memorandum of agreement totaling approximately \$1 million. Through collaboration with the Northwestern CT Health District, COVID-19 outreach and educational services are to be provided specifically in rural communities as part of the department's strategy to enhance and extend equity in high SVI communities to fill gaps equitably by deploying COVID-19 vaccines and providing long-term supports during the pandemic recovery period in communities with health and economic inequities. Also, the department will be collaborating with Northeastern, Northwestern and Torrington Health Districts to provide similar COVID-19 outreach and educational services. Each of the 3 LHDs will be allocated approximately \$290,000 for a total of \$870,000.

The department allocated \$1.1 million to engage Community Outreach Specialists (COS) and Regional Coordinators specifically recruited from high SVI communities in Connecticut. Funds are also allocated to recruit and deploy Community Health Workers (CHWs) to canvass the high SVI and high uninsured census tract neighborhoods, connecting with hard-to-reach residents around testing, contact tracing, mitigation, quarantine support, vaccination, and health insurance.

The department, in collaboration with the Department of Social Services (DSS), allocated \$1 million to support 7 regional outbound calling centers that will directly call eligible residents of the 50 priority zip codes (based on highest Social Vulnerability Index). These outbound callers will be able to schedule appointments and arrange for transportation. The aim of outreach will be to increase vaccination uptake in these zip codes and communities by directly reaching populations of color and vulnerable populations and helping overcome access issues to receiving the vaccine (i.e., scheduling and transportation). The seven regional call centers will have 10 callers each and one supervisor and will employ residents of the community with the appropriate local knowledge (e.g., bilingual). The outbound call centers will run for 20 weeks.

The department also engaged with Care Partners (CPs) to provide standard and community engagement mobile vaccination clinics including homebound vaccination services to the top SVI cities/towns. The Health Equity team eliminated barriers such as insurance, identification but most importantly added trusted providers in the community. The funding is as follows:

- Griffin Health: \$20.9 million to provide standard and mobile community engagement clinics including homebound services.
- Community Health Center Inc. (CHC): \$1.9 million to provide standard and mobile community engagement clinics including homebound.
- Harriott Home Health Services: \$517,000 to provide homebound services.
- Pillar Health: \$540,000 to provide homebound services.
- CT Institute for Communities (CIFIC): \$280,000 for community vaccination services.

These CP activities are structured to cover all the counties in the state.

Moreover, approximately \$4.5 million was allocated to engage in media strategies to communicate about the importance of COVID-19 vaccination. Funds were utilized to purchase airtime, billboards, bus advertisements, posters, facility fees to hold a meeting/town hall session, or the printing of materials especially designed to reach socially vulnerable populations. The department developed and used educational messages with "We Can Do This" messaging that reflect the overall vaccine confidence strategy, targeting specific audiences (e.g., by age, gender, race, and ethnicity). This messaging was deployed across digital, print, TV, and radio channels that reach the targeted populations. Messages will be reviewed with the communities to be reached and updated as necessary to educate and encourage COVID19 vaccinations.

The department also allocated approximately \$2 million to support other administrative functions necessary in implementing these initiatives including in the areas of equity planning, vaccination administration and community resource support. The team is comprised of COVID-19 Regional Coordinators, Outreach Specialists, Data Analyst, Project Managers, etc.

Through the department's efforts, our health equity work continues to grow and now includes distributing self-test kits and masks to community partners who help distribute these resources to the most vulnerable populations throughout our state. Over 300k have been distributed to date. With this initiative we have gained nearly 1,000 partners in the communities of color to host future vaccination sites. As of February 17, 2022, the Health Equity Team has worked to ensure the administration of a total of 161,924 COVID-19 vaccinations which includes pediatric clinics. 64.6% of total doses have been administered in high SVI cities/towns, while 35.4% have been administered in other communities.

18. Are there state, or federal funds available in FY 23 for health equity?

The various federal funds supporting these health equity initiatives are available on or before June 30, 2024. These resources may not be available after June 30, 2024.

Office of Injury Prevention:

1. Please present on the Office of Injury Prevention.

The Office of Injury and Violence Prevention (OIVP) was written into Connecticut statute in 1993. The mission of the OIVP is to promote a safe and healthy Connecticut by reducing factors associated with intentional (e.g. homicide and suicide) and unintentional (e.g. falls and motor vehicle) accidents. The current programs of the OIVP are sexual violence prevention, suicide prevention, and opioid and prescription drug overdose prevention. Other primary programs are violence and homicide prevention, falls prevention, traffic and motor vehicle crash injury prevention, concussion and traumatic brain injury prevention, and elderly abuse and maltreatment awareness and education. The OIVP and the Injury and Violence Surveillance Unit (IVSU), the epidemiology and surveillance arm of the OIVP, employ 13 full time DPH staff, two of whom are funded through state funds. The rest are supported by federal grant funds.

The IVSU manage the Connecticut Violent Death Reporting System, which tracks homicides and suicides monthly and collects information related to these violent deaths. DPH partners with

local police departments across the state, the State Police, and the Office of the Chief Medical Examiner to collect and disseminate valuable information to stakeholders.

2. *What is its governing statute?*

Sec. 19a-4i. Office of Injury Prevention. There shall be, within the Department of Public Health, an Office of Injury Prevention, whose purpose shall be to coordinate and expand prevention and control activities related to intentional and unintentional injuries. The duties of said office shall include, but are not limited to, the following: (1) To serve as a data coordinator and analysis source of mortality and injury statistics for other state agencies; (2) to integrate an injury and violence prevention focus within the Department of Public Health; (3) to develop collaborative relationships with other state agencies and private and community organizations to establish programs promoting injury prevention, awareness and education to reduce automobile, motorcycle and bicycle injuries and interpersonal violence, including homicide, child abuse, youth violence, domestic violence, sexual assault and elderly abuse; (4) to support the development of comprehensive community-based injury and violence prevention initiatives within cities and towns of the state; and (5) to develop sources of funding to establish and continue programs to promote prevention of intentional and unintentional injuries.

3. *What is its General Fund supporting FY 23?*

DPH will follow up with this information

4. *Is there Federal funding for OIP?*

Yes, the OIP is primarily federally funded by the Centers for Disease Control and Prevention, which provides discretionary grants to address opioid and drug overdose prevention and surveillance, comprehensive suicide prevention, sexual violence prevention, and the CT Violent Death Reporting System. Federal grant requirements limit broad application of funding and thus program staff are restricted to working on activities identified within the grant.

5. *Is there federal funding to prevent violence against women?*

The DPH Sexual Violence Prevention Program receives federal CDC Rape Prevention and Education funding and Preventive Health and Health Services Block Grant dollars to support crisis services through the CT Alliance to End Sexual Violence, in addition to state rape crisis funding. Funding for domestic violence services is part of the CT Department of Social Services budget.