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

FFY 2017

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 Annual Reporting Guidance specified under Section 506 indicates that states must select 8 national performance measures based on the 7-10 identified state priorities. This serves as the process through which the health status of Connecticut's mothers and children can be measured.

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 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 2017 funding amounts are not yet finalized, but the President's proposed budget includes level funding with FFY 2016 for the MCHBG. Because the current fiscal year's award (FFY 2016) has not been finalized, the FFY 2015 federal award amount was used to prepare the FFY 2017 federal application for funding. The FFY 2017 (October 1, 2016 - September 30, 2017) Maternal and Child Health Block Grant allocation plan is based on estimated federal funding of $4,613,166 and may be subject to change when the final federal appropriation is authorized.

E. Total Available and Estimated Expenditure

The FFY 2017 federal award is estimated to be $4,613,166. Because the FFY 16 and FFY 17 federal award allocations have not been finalized, the FFY 15 award amount was used to prepare the FFY 17 application.

F. Proposed Changes From Last Year

Level funding as compared to FFY 2016 is proposed for the Perinatal Case Management, Family Planning, Information and Referral, School Based Health Services, Genetics, and Medical Home Community Based Care Coordination Services programs. However, funding has been adjusted to reflect: a small shift in staff allocation from CYSHCN to MCH as a growing need for epidemiological support for all MCH programs was addressed; additional staff training necessary to implement changes associated with MCH Block Grant transformation; and activities to assist the state in meeting the new National Performance Measures.

G. Contingency Plan

In the event that the actual FFY 2017 federal award amount is less than $4,613,166, the Department will review the criticality and performance of the various programs. Each allocation will be assessed so as to prioritize those programs deemed most critical to the public. In the event that actual funding exceeds $4,613,166, the Department will review its five-year MCH Needs Assessment and State Plan to Improve Birth Outcomes, and will prioritize the increased funding to best align with objectives identified therein.

H. State Allocation Planning Process

Federal legislation mandates that an application for funds be submitted annually, and that an MCH Statewide Needs Assessment be conducted every five years. DPH submitted its federal application for FFY 2017 in July 2016. The data presented in the annual application are based on 8 mandated National Performance Measures (NPM) and 3 State Performance Measures (SPM). The Department completed its 2016-2020 MCH Needs Assessment, which was submitted to HRSA with its federal FFY 2016 application for funds in July 2015. 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 Block Grant funds. The Act requires that the State health agency administer the program. CT's electronic application is available at:
https://perfdata.hrsa.gov/mchb/mchreports/Search/Search.asp

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 2017, CT's state match is $3,459, 875);

- 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 2020 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 FY 1989 (Connecticut FFY 1989 baseline: $6,777,191; the FFY 2017 state maintenance of effort is $6,777,191);

- 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 (Federal Poverty Level);

- 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 WIC, education, other health developmental disabilities, and family planning 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 15 Expenditures	FFY 16 Estimated Expenditures	FFY 17 Proposed Expenditure	Percentage Change from FFY 16 to FFY 17
Number of Positions (FTE)	21	21.5	21.5	0.0%
Maternal and Child Health	$2,708,901	$2,466,343	$2,707,160	9.8%
Children and Youth with Special Health Care Needs	$1,904,265	$1,962,308	$1,906,006	-2.9%
TOTAL	**$4,613,166**	**$4,428,651**	**$4,613,166**	**4.2%**
SOURCE OF FUNDS				
Federal Block Grant Funds[1]	$4,613,166	$4,613,166	$4,613,166	0.0%
TOTAL FUNDS AVAILABLE	**$4,613,166**	**$4,613,166**	**$4,613,166**	0.0%

[1] Because the FFY 16 and FFY 17 federal award allocations have not been finalized, the FFY 15 award amount was used to prepare the FFY 17 application. Estimated FFY 16 expenditures shown above are lower than the anticipated available funds as a precautionary measure in the event that the actual federal award is decreased.

Each fiscal year's MCH Block Grant award 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 no carry forward approval is required from year 1 to year 2. Any unexpended funds cannot be carried forward into the following fiscal year.

TABLE B1

Maternal and Child Health Services Block Grant

PROGRAM EXPENDITURES:
Maternal & Child Health

Maternal & Child Health	FFY 15 Expenditure	FFY 16 Estimated Expenditure	FFY 17 Proposed Expenditure	Percentage change from FFY 16 to FFY17
Number of Positions (FTE)[1]	12.30	12.50	13.50	8.0%
Personal Services	$831,527	$843,991	$982,145	16.4%
Fringe Benefits	$668,101	$708,688	$804,278	13.5%
Other Expenses	$27,204	$57,549	$64,622	12.3%
Equipment	$0	$0	$0	0.0%
Contracts/Grants to:				
Local Government	$175,287	$175,287	$175,287	0.0%
Other State Agencies	$200,487	$200,487	$200,487	0.0%
Private agencies	$806,295	$480,341	$480,341	0.0%
TOTAL EXPENDITURES	**$2,708,901**	**$2,466,343**	**$2,707,160**	9.8%
SOURCE OF FUNDS				
Federal Block Grant Funds[2]	$2,708,901	$2,564,863	$2,707,160	5.5%
TOTAL FUNDS AVAILABLE	**$2,708,901**	**$2,564,863**	**$2,707,160**	5.5%

[1] The change in the number of FTE's across fiscal years is related to vacant/vacated positions and positions that are split-funded with other grants.

[2] Because the FFY 16 and FFY 17 federal award allocations have not been finalized, the FFY 15 award amount was used to prepare the FFY 17 application. Estimated FFY 16 expenditures shown above are lower than the anticipated available funds as a precautionary measure in the event that the actual federal award is decreased.

Each fiscal year's MCH Block Grant award 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 no carry forward approval is required from year 1 to year 2. Any unexpended funds cannot be carried forward into the following fiscal year.

TABLE B2

Maternal and Child Health Services Block Grant

PROGRAM EXPENDITURES:
Children & Youth with Special Health Care Needs

Children & Youth with Special Health Care Needs	FFY 15 Expenditure	FFY 16 Estimated Expenditure	FFY 17 Proposed Expenditure	Percentage change from FFY 16 to FFY17
Number of Positions (FTE)[1]	8.70	9.00	8.00	-11.1%
Personal Services	$579,697	$607,671	$576,815	-5.1%
Fringe Benefits	$465,765	$510,252	$472,345	-7.4%
Other Expenses	$9,068	$19,183	$31,644	65.0%
Equipment	$0	$0	$0	0.0%
Contracts/Grants to:				
Local Government	$0	$0	$0	0.0%
Other State Agencies	$2,800	$2,800	$2,800	0.0%
Private agencies	$846,935	$822,402	$822,402	0.0%
TOTAL EXPENDITURES	**$1,904,265**	**$1,962,308**	**$1,906,006**	-2.9%
SOURCE OF FUNDS				
Federal Block Grant Funds[2]	$1,904,265	$2,048,303	$1,906,006	-6.9%
TOTAL FUNDS AVAILABLE	**$1,904,265**	**$2,048,303**	**$1,906,006**	-6.9%

[1] The change in the number of FTEs across fiscal years is related to vacant/vacated positions and positions that are split-funded with other grants.

[2] Because the FFY16 and FFY 17 federal award allocations have not been finalized, the FFY 15 award amount was used to prepare the FFY 17 application. Estimated FFY 16 expenditures shown above are lower than the anticipated available funds as a precautionary measure in the event that the actual federal award is decreased.

Each fiscal year's MCH Block Grant award 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 no carry forward approval is required from year 1 to year 2. Any unexpended funds cannot be carried forward into the following fiscal year.

Table C1

Maternal and Child Health Services Block Grant
Summary of Service Objectives and Activities[1]

Maternal and Child Health

Service Category	Objective	Grantor/Agency Activity	Number Served FFY 2015	Performance Measures[1]
Perinatal Case Management[2]	To provide case management services for pregnant and parenting women to promote healthy birth outcomes.	DPH provides funding to several agencies to provide case management services to pregnant women and teens.	**Case Management for Pregnant Women:** 83 pregnant or parenting women and teens	**National Outcome Measure #1:** Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester. Updated data: In 2014, 87.0% of infants were born to pregnant women receiving prenatal care beginning in the first trimester. This is unchanged from the previous year's baseline data.
Information and Referral	To provide statewide, toll free MCH information. To provide information to consumers and providers on pregnancy exposure services.	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. DPH's Newborn Screening Tracking Program provides funding to the Univ. of CT Health Center (UCHC) to provide information on occupational and environmental	179,822 callers 615 callers	**N/A**

Service Category	Objective	Grantor/Agency Activity	Number Served FFY 2015	Performance Measures[1]
		exposures, medications, etc. during pregnancy through a toll-free telephone line, "MotherToBaby CT" (formerly called Connecticut Pregnancy Exposure Information Service).		
Family Planning Services	To prevent unintended pregnancies and risky health behaviors.	DPH provides funding to Planned Parenthood of Southern New England to provide reproductive health prevention services and education to men and women (Bridgeport, Danbury, Hartford, Meriden, New Britain, New London, New Haven, Norwich, Torrington, West Hartford and Willimantic).	49,445 teens, women and men	**National Performance Measure 10:** Percent of women with a past year preventive medical visit.
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, SBHCs offer services addressing the medical, mental and oral health needs of youth. DPH provides funding to 24 contractors in 28 communities to implement 96 SBHC sites; 11 Expanded Health Services Programs in 3 communities; and 1 school-linked site.	29,217 (unduplicated users) 120,676 (served)	**N/A**

[1] As part of the annual MCHBG application, Connecticut must report on numerous performance measures and indicators. The MCHBG guidance has undergone a transformation and includes new federal reporting measures beginning with the application for FFY 2017. One MCHBG measure that best relates to each of the service categories has been selected and is presented above. Because these are new measures, we reported baseline data last year. This year we have provided updated data for these measures, if available.

[2] The programs include case management programs in Waterbury and the Young Adult Services Program.

Table C2
Maternal and Child Health Services Block Grant
Summary of Service Objectives and Activities[1]

Children & Youth with Special Health Care Needs

Service Category	Objective	Grantor/Agency Activity	Number Served FFY 2015	Performance Measures[1]
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 continues the community-based system of care coordination. To date, 57 pediatric practices are accessing care coordination through 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 8 consumers/families on the MHAC.	7,800 CYSHCN	**National Performance Measure 11:** Percent of children with and without Special Health Care Needs having a medical home. Baseline data: 49.6% in 2011-2012 according to the National Survey of Children's Health (NSCH). The NSCH has no updated data for this measure.
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 Force to discuss and identify issues relevant to early identification of hearing loss.	36,943 newborns[1] Ongoing	**N/A**

[1] As part of the annual MCHBG application, Connecticut must report on numerous performance measures and indicators. The MCHBG guidance has undergone a transformation and includes new federal reporting measures beginning with the application for FFY 2017. One MCHBG measure that best relates to each of the service categories has been selected and is presented above. Because these are new measures, we reported baseline data last year. This year we have provided updated data for these measures, if available.

Service Category	Objective	Grantor/Agency Activity	Number Served FFY 2015	Performance Measures[1]
Newborn Genetic 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.	All CT newborns are screened for over 65 disorders and traits prior to hospital discharge or within the first 4 days of life. DPH refers newborns identified with abnormal results to primary care physicians and state designated Regional Treatment Centers for confirmation testing, treatment and follow-up services. The Newborn Screening Program Advisory Committee (formerly entitled the Genetics Advisory Committee) is comprised of State Laboratory staff, as well as CT's endocrine and genetic treatment center clinicians and Sickle Cell community-based organizations that work on behalf of their consumers (newborns who have been diagnosed with a metabolic or genetic disease and their families). Meetings are conducted to identify and address current and emerging issues.	36,940 newborns tested Meets quarterly	**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: Currently unavailable since this is a developmental measure.

[2] The "number served" is derived from the occurrent births, as obtained from the Connecticut Department of Public Health State Vital Records program, subtracted by the number of children that did not receive early hearing screening due to the following reasons: Death; parent refused/declined services; infant transferred to other facilities and , no record of screening exists; the infant was missed or otherwise not tested by hospital; and "unknown" reasons why infant was not screened or screening documentation was not submitted.

TABLE D
SELECTED PERINATAL HEALTH INDICATORS[1]
Connecticut, 2010-2014*

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	2014	4.9	3.3	8.7	7.5
	2013	4.6	3.4	8.7	6.0
	2012	5.2	3.6	11.8	7.1
	2011	5.2	3.7	9.8	5.9
	2010	5.2	3.7	10.6	7.5

Teen Births	YEAR	Race/Ethnicity			
		All Races	non-Hispanic White	non-Hispanic Black/Afr Am	Hispanic
Percent of live births to mothers less than 20 years of age (%)	2014	4.0	2.0	6.2	8.4
	2013	4.5	2.0	7.2	10.3
	2012	5.3	2.5	8.1	12.1
	2011	5.5	2.3	9.7	12.3
	2010	6.8	2.8	10.8	13.6

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	2014	4.3	3.6	7.0	5.1
	2013	4.8	3.8	8.1	5.0
	2012	6.0	4.3	9.9	7.5
	2011	5.6	4.1	9.6	6.4
	2010	5.8	4.3	10.1	6.9

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	2014	1.0	0.7	2.3	1.3
	2013	1.0	0.7	2.4	1.3
	2012	1.1	0.7	2.5	1.3
	2011	1.1	0.7	2.6	1.1
	2010	1.1	0.8	2.5	1.3

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	2014	12.1	8.6	19.0	17.0
	2013	12.1	8.3	17.8	18.7
	2012	12.6	8.5	20.3	19.3
	2011	13.0	8.8	21.0	19.4
	2010	12.8	8.9	19.5	19.5

*** NOTE: 2014 data are <u>PROVISIONAL</u> figures only, provided by the DPH Health Statistics and Surveillance Section**

[1] Data for calendar years 2010-2013 were obtained from DPH Vital Records Registration Reports Tables. Provisional data for calendar year 2014 were provided by the DPH Health Statistics and Surveillance Section.

Selected Perinatal Health Indicators

While Connecticut residents report good health status, overall, compared to national statistics, large health disparities exist between non-Hispanic Whites and that of 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 2010-2014 (**NOTE:** 2014 data are provisional figures and, therefore, are not final).

The data described below indicate that, although perinatal programs in Connecticut appear to be having a positive effect on the maternal and child health population, much remains to be done to achieve optimal outcomes for all Connecticut mothers and babies. 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.

Infant Mortality

The Connecticut infant mortality rate (IMR) in 2014 was 2.6 times higher among the non-Hispanic Black/African American population than among the non-Hispanic White population (8.7 deaths per 1,000 live births *versus* 3.3 deaths per 1,000 live births, respectively). The IMR within the Hispanic population (7.5 deaths per 1,000 live births) was 2.3 times higher than the rate among non-Hispanic White women. Between 2013 and 2014, the IMR increased within the Hispanic populations. The rate decreased among non-Hispanic White women, but this change was not statistically significant. Between 2010 and 2014, there was a small increase in the IMR for Connecticut overall, but the rates have mostly remained level for the past several years. The rates among non-Hispanic Black/African American and Hispanic women fluctuated between 2010 and 2014, with no apparent consistent trend in either direction. These fluctuations are largely a statistical artifact related to the relatively small number of infant deaths annually.

Singleton Low Birth Weight and Very Low Birth Weight

Between 2010 and 2014, the rate of singleton low birth weight (LBW) experienced a decrease for Connecticut overall and among the non-Hispanic Whites, non-Hispanic Black/African American, and Hispanic populations. Disparities among minority racial/ethnic groups have persisted. In 2014, the rate of singleton LBW infants among non-Hispanic Black/African American women (7.0%) was 1.9 times higher than that

among non-Hispanic White women (3.6%). The rate of singleton LBW babies among Hispanic women (5.1%) was 1.4 times that of non-Hispanic White women. Between 2010 and 2014, there was no change in the rate of singleton very low birth weight (VLBW) for Connecticut overall. There were some minor fluctuations across the racial/ethnic groups, but the rates remained largely unchanged.

Late or No Prenatal Care

The receipt of late or no prenatal care among non-Hispanic Black/African American women (19.0%) was 2.2 times greater than among non-Hispanic White women (8.6%) in 2014. Receipt of late or no prenatal care among Hispanic women (17.0%) was 2.0 times greater than among non-Hispanic White women. The overall percent of Connecticut women who received late or no prenatal care during their pregnancies remained the same between 2013 and 2014. Between 2010 and 2014, there were some minor fluctuations in the percent of women receiving late or no prenatal care (Connecticut overall and across racial/ethnic groups).

Births to Teens

The percent of teen births exhibited an apparent decline among all three race/ethnic groups from 2010 to 2014, but significant racial and ethnic disparities persist. In 2014, the percent of teen births to Hispanic women (8.4%) was 4.2 times higher than non-Hispanic White women (2.0%). The percent of teen births among non-Hispanic Black/African American women (6.2%) in 2014 was 3.1 times higher than non-Hispanic White women.

Interventions

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. These initiatives will continue and include the following:

- Working closely with the City of Hartford on the federally funded Hartford Healthy Start Program to eliminate disparities in infant mortality and adverse perinatal outcomes especially among the target population of African American women.

- Exploring, participating in, and supporting unfunded opportunities to reduce low birth weight and infant mortality, and racial and ethnic disparities in adverse birth and infant outcomes.

- Preventive interventions to address teen pregnancy through CT's Title V programs include programs 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. The Case Management Program for Pregnant Women and Parenting Teens, Healthy Choices for Women and Children, and the federal Hartford Healthy Start serve pregnant and

parenting teens and include inter-conception services. The Case Management Program for Pregnant Women and Parenting Teens provides services in the City of Waterbury; the federal Healthy Start program provides services In addition, the Personal Responsibility Education Program conducts HIB, STD, and pregnancy prevention activities for clients in the Young Adult Services program (at risk young adults in the DMHAS, who may be pregnant or parenting and have transitioned out of the child welfare system into the adult mental health system.

During State fiscal year 2016, a number of DPH projects were initiated and/or implemented to reduce adverse perinatal health and child health outcomes and to address racial and ethnic disparities in these outcomes. These activities will continue and include the following:

- In March of 2014 the Connecticut Department of Public Health released the Healthy Connecticut 2020 State Health Improvement Plan (SHIP). The plan is based on the findings of the Healthy Connecticut 2020: State Health Assessment and provides a blueprint for collective action among a wide array of partners to address some of Connecticut's most challenging health issues.
- In the summer of 2015, the Connecticut Maternal and Child Health Coalition assumed the role of the SHIP Maternal Infant and Child Health Action Team co-lead and was charged with setting priorities and developing a 2016 action agenda. Through that process the coalition prioritized and developed an action agenda for the following objectives:

    - Reducing unplanned pregnancies
    - Reducing low birth weight and very low birth weight
    - Reducing singleton births delivered at less than 37 weeks
    - Reducing infant mortality and disparity between non-Hispanic blacks and non-Hispanic whites
    - Increasing the proportion of women delivering live births who discuss preconception care prior to pregnancy
    - Increasing the percent of children under 3 years of age at greatest risk for oral disease who receive any dental care
    - Increasing the percent of parents who complete standardized developmental screen tools consistent with the American Academy of Pediatrics

    The coalition and its partners are actively utilizing best and promising practices to address these objectives. Work of the coalition and data updates for these objectives are tracked through the Healthy CT Performance Dashboard at www.ct.govdph/dashboard.

- CT completed activities identified in the HRSA State Implementation Grant for Improving Services for Children and Youth with Autism Spectrum Disorders and other Developmental Disabilities (SIG/ASD) to improve access to comprehensive, coordinated health and related services. The grant was a collaborative project between DPH – the state's Title V agency and A.J. Pappanikou Center – the state's University Center for Excellence on Developmental Disabilities (UCEDD). Proposed outcomes of the project

included: (1) implementation of the CT State Autism Plan, with activities that strengthen stakeholders' awareness of early signs of ASD; knowledge about and access to evidenced-based, individualized and timely screening; diagnostic assessment and interventions implemented by a competent workforce; (2) engage ASD specific family support and training organizations to provide information and education on ASD; (3) work with the AAP, pediatric primary and family care providers, and the CT Medical Home Initiative for CYSHCN (CMHI) providers to expand practices proving family-centered, comprehensive coordinated health care and related services including screening, linkage to diagnosis, and transition to evidence-based interventions.

- The WIC Electronic Benefits Transfer (EBT) System, replacing the paper food vouchers used at grocery stores with a swipe card similar to a credit card was rolled out June 2016. The new system called eWIC improves the WIC Client's shopping experience by removing the stigma associated with use of the food vouchers. WIC clients will have more flexibility in the items they purchase and reduce errors in choosing non-WIC approved foods. WIC families will continue to receive the same WIC benefits as before.

- The CT WIC program with CDC 1305 grant funds support DPH's partnership with the CT Breastfeeding Coalition's (CBC) Ten Steps Collaborative to encourage hospitals to implement evidenced-based maternity care and the 10 Steps for Successful Breastfeeding. Two CT hospitals were Designated as Baby-Friendly in 2016 (Day Kimball Hospital and Yale New Haven Hospital). The "Breastfeeding- It's Worth It" is supported and in 2016, a multifaceted logo was developed in addition to a website www.itsworthitct.org to serve as a repository for CT moms "It's Worth It" stories. Funding supported staff training at two Federally Qualified Health Centers, as well as training for Connecticut Breastfeeding Counselors from the CT Chapter of Breastfeeding USA and Early Childhood and Education Providers (ECE) in Hartford. DPH supported worksite voluntary applications to the CBC's *Breastfeeding Friendly Worksite Program* via an open letter to businesses, signed by the DPH Commissioner to call attention to the needs of breastfeeding mothers who return to work.

  Connecticut has received a State Innovation Model Test (SIM) grant through Centers for Medicaid and Medicare Innovation (CMMI) to address issues of quality of care, reduction of cost and improvement of population health outcomes. The effort is led by the Office of the Lieutenant Governor and executed in collaboration by multiple agencies and organizations: Department of Social Services, Department of Public Health, Office of the State Comptroller, Access Health Connecticut and UConn Health. Funds will support development of a Population Health Plan that specifically seeks to build community health capabilities through enabling structures (i.e., Prevention Service Centers (PSCs) and Health Enhancement Communities (HECs) to address improvements in tobacco use, obesity and diabetes and other selected population health indicators to be determined. HECs in particular, foster coordination among community organizations (e.g., housing, food security), healthcare providers, schools, and other local entities. PSC's are community placed organizations that would meet criteria for the provision of evidence-informed, culturally and linguistically appropriate community prevention services that will initially focus on environmental quality issues in homes and promoting positive behaviors (asthma home assessments, diabetes prevention programs, and fall

prevention). The plan will utilize and build upon the State Health Improvement Plan (Healthy Connecticut 2020) and the State Chronic Disease Prevention Plan (Live Healthy Connecticut) issued by the Department of Public Health in March and May of 2014 respectively. Additional information on Connecticut's State Innovation Model Initiative can be found at http://www.healthreform.ct.gov/ohri/site/default.asp.

- Title V staff worked with Dr. Thyde Dumont-Mathieu from the University of Connecticut on the Early Detection Study (EDS), a screening study for detecting Autism in pediatric practices at age 18-24 months using the Modified Checklist for Autism in Toddlers –Revised with Follow-up (M-CHAT- R/F), a 2-stage parent-report screening tool to assess risk for Autism Spectrum Disorder (ASD). The study was completed and published showing the reliability and validity of the M-CHAT-R/F.

- Title V continued to partner with Child Health and Development Institute (CHDI) and CT Children's Medical Center (CCMC) to conduct ASD training including two new Educating Practices In the Community (EPIC) training modules that build upon the American Academy of Pediatrics (AAP) recommendation of formal screening at 9, 18 and 24 (30) months of age. Eighty-four ASD EPIC presentations have been provided to date.

- A comprehensive service resource guide was placed on line as part of the CT legislature's study of individuals with ASD. The guide is a user-friendly clearinghouse to facilitate access to services, catalog resources currently available (federal, state, private), catalog qualified professionals/facilities based on Qualified Credentialing Application; and catalog existing training opportunities for parents and professionals. SIG/ASD staff will serve as the liaison for the comprehensive resource guide initiative and the training initiative. SIG/ASD staff and grant partners will work to have Child Development Infoline (CDI) identified as the host site for the resource guide.

- 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 – inclusive of the identification of primary care providers for Youth with Special Health Care Needs. The School Based Health Centers were used as an infrastructure in promoting comprehensive adolescent well child visits, inclusive of developmental assessment, risk assessment and behavioral health screening, anticipatory guidance, and BMI screening and intervention.

- DPH supported 96 school health service sites in 28 communities statewide. Included are 85 School Based Health Centers (SBHC) and 11 Expanded School Health (ESH) sites. SBHCs serve students, Pre K-12, and are located in elementary, middle and high schools as well as in combination schools where two schools are located in one facility (elementary and middle school or middle and high school). Eligible students are those that attend the schools in which the SBHC is located. All DPH funded SBHCs provide primary care, mental/ behavioral health services and health education/promotion activities designed to meet the physical and psycho-social needs of children and youth within the context of family, culture and environment. In some instances, dental care is also offered. ESH sites offer some level of behavioral/mental health services and/or risk reduction education. Care is delivered in accordance with nationally recognized medical/mental health and cultural and linguistically appropriate standards.

- The Family Planning Program is administered by Planned Parenthood of Southern New England (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 high a concentration of low-income women of "reproductive age," and with high rates of teen pregnancy. In 2017, the plan is to expand services in the city with the highest repeat teen birth rate to a full time center.

- The Breast and Cervical Cancer program has partnered with a number of organizations to promote breast, cervical and cardiovascular screening services. Some of the partners are Community Solutions, a community based organization that focuses on the social determinants of health, e-Health CT. an organization that evaluates an efficient process of identifying patients eligible for age appropriate or past due for program screening services. The program has also partnered with the United Way of Connecticut to advertise program services on Connecticut billboards, bus stop shelters, Connecticut magazine and advertisement in the retail shopping malls advertisement boards. The program has also partnered with a media agency where promotional advertisements will scroll on Pandora radios for SMART devices.

III. Proposed Expenditures 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 15 Actual**	**FFY 16 Estimated**	**FFY 17 Proposed**
Perinatal Case Management	$350,487	$350,574	$350,574
Family Planning [1]	$20,083	$20,083	$20,083
Information and Referral [1]	$183,867	$183,867	$183,867
School Based Health Services [1]	$273,691	$273,691	$273,691
Genetics [1]	$27,900	$27,900	$27,900
Other [2]	$326,041	$0	$0
MCH Total	**$1,182,069**	**$856,115**	**$856,115**
Children and Youth with Special Health Care Needs	**FFY 15 Actual**	**FFY 16 Estimated**	**FFY 17 Proposed**
Medical Home Community Based Care Coordination Services	$796,963	$796,963	$796,963
Family Planning [1]	$1,057	$1,057	$1,057
Genetics [1]	$3,100	$3,100	$3,100
Information and Referral [1]	$9,677	$9,677	$9,677
School Based Health Services [1]	$14,405	$14,405	$14,405
Other [2]	$24,533	$0	$0
CYSHCN Total	**$849,735**	**$825,202**	**$825,202**
Grand Total	**$2,031,804**	**$1,681,317**	**$1,681,317**

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 15 "Other" expenditures included: A) $20,000 to support Suicide Crisis Intervention and Referral Line through the United Way's 211 CT Infoline. B) $20,000 for Connecticut Children's Medical Center (CCMC) training on Child Protective Factors. C) $15,000 to support the Medical Home Training Academy Curriculum through the UConn Health Center. D) $30,000 for the United Way of CT to support and facilitate the MCH Coalition and CYSHCN Integration Collaborative project. E) $20,000 contribution for CCMC to host statewide Medical Home Conference. F) $40,000 for Health Resources in Action for statewide needs assessment report. G) $34,500 for printing of brochures for Zika, Transitioning into Adult Health Care, and Faces of Sickle Cell. H) $50,574 for Maven contract to provide enhancements and additional reports. I) $7,500 for gift cards for

participants in the Pregnancy Risk Assessment Monitoring System (PRAMS) survey and MCHBG public input focus groups. J) $3,000 for Maternal Mortality Review to identify confirmed cases of perinatal maternal deaths, and develop a written report including case findings and policy recommendations to avert future maternal deaths. K) $25,000 for Child Health and Development Institute (CHDI) Educating Practices in the Community (EPIC) presentations for suicide prevention training for primary care providers. L) $45,000 for Family Advocacy Organization (FAVOR) for Respite Services for Children and Youth with Special Health Care Needs. M) $20,000 for CT Parent Advocacy Center to provide family training regarding bullying prevention. N) $20,000 for family training by Parents Available to Help/Family Voices CT regarding access to Medicaid and other health financial resources.