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

FFY 2020

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 2020 funding amounts are not yet finalized, however the President's proposed budget includes additional funding for the MCHBG. Because the current fiscal year's award (FFY 2019) has also not been finalized, the FFY 2018 federal award amount was used to prepare the FFY 2020 federal application for funding. The FFY 2020 (October 1, 2019 - September 30, 2020) Maternal and Child Health Services Block Grant allocation plan is based on estimated federal funding of $4,671,480. The allocation plan may be subject to change when the final federal appropriation is authorized.

E. Total Available and Estimated Expenditure

The FFY 2020 federal award is estimated to be $4,671,480. Because the FFY 2019 and FFY 2020 federal award allocations have not been finalized, the FFY 2018 award amount was used to prepare the FFY 2020 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 2019 estimated expenditure amount is proposed for the Perinatal Case Management, Reproductive Health Services, Information and Referral, Genetics and School Based Health Services program categories.

A proposed reduction of $14,999 in funding for Medical Home Community Based Care Coordination Services, as compared to the FFY 2019 estimated level, reflects the completion of an initiative to develop and implement protocols associated with referring clients between agencies. Use of these protocols has become standard practice. Additionally, the frequency of Care Coordination Collaborative meetings has also decreased as interagency relationships have grown. This funding adjustment will not impact services to families.

The proposed FFY 2020 plan will increase support for the CYSHCN Program by expanding access to epidemiological, nurse consultant and health program associate staff. An equivalent of 1.0 FTE additional position will be dedicated to CYSHCN activities, one 0.5 FTE of which will be redeployed from the MCH program. This additional staff support will facilitate the procurement of three components of the CT Medical Home Initiative: 1) Regional Care Coordination sites, 2) Respite and Extended Service funds, and 3) Family and Professional Partnership services.

It is proposed that $30,000 be dedicated to supporting Other MCH and CYSHCN activities in FFY 2020. This funding will support efforts to coordinate and facilitate the development of an MCH needs assessment. This five year needs assessment is a requirement of the Maternal and Child Health Block Grant and involves convening groups of stakeholders

including consumers, providers, and other agency partners as well as a review of existing data sources.

G. Contingency Plan

In the event that the actual FFY 2020 federal award amount is less than $4,671,480, 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 $4,671,480, 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.

In accordance with section 4-28b of the Connecticut General Statutes, after recommended allocations have been approved or modified, any proposed transfer to or from any specific allocation of a sum or sums of over fifty thousand dollars or ten per cent of any such specific allocation, whichever is less, shall be submitted by the Governor to the speaker and the president pro tempore and approved, modified or rejected by the committees. Notification of all transfers made shall be sent to the joint standing committee of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies and to the committee or committees of cognizance, through the Office of Fiscal Analysis.

H. State Allocation Planning Process

Federal legislation mandates that an application for funds be submitted annually, and that an MCH Statewide Needs Assessment be conducted every five years. DPH submitted its federal application for FFY 2020 in July 2019. 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 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 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 2020, CT's state match is $3,503,610);

- 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 FFY 1989 (Connecticut FFY 1989 baseline: $6,777,191; the FFY 2020 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 18 Expenditures	FFY 19 Estimated Expenditures	FFY 20 Proposed Expenditure	Percentage Change - FFY 19 to FFY 20
Number of Positions (FTE)	22.0	21.5	22.0	2.3%
Maternal and Child Health	$2,694,771	$2,783,104	$2,672,688	-4.0%
Children and Youth with Special Health Care Needs	$1,976,709	$1,888,376	$1,998,792	5.8%
TOTAL	**$4,671,480**	**$4,671,480**	**$4,671,480**	**0.0%**
SOURCE OF FUNDS				
Federal Block Grant Funds[1]	$4,671,480	$4,671,480	$4,671,480	0.0%
TOTAL FUNDS AVAILABLE	**$4,671,480**	**$4,671,480**	**$4,671,480**	**0.0%**

[1] The FFY 2019 and FFY 2020 federal award allocations have not been finalized and may be subject to change. The FFY 2018 award amount was used to prepare the FFY 2020 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 18 Expenditure	FFY 19 Estimated Expenditure	FFY 20 Proposed Expenditure	Percentage Change - FFY 19 to FFY 20
Number of Positions (FTE) [1]	12.82	13.6	13.1	-3.7%
Personal Services	$936,461	$911,055	$889,298	-2.4%
Fringe Benefits	$831,784	$884,343	$836,830	-5.4%
Other Expenses	$37,616	$28,251	$26,299	-6.9%
Contracts/Grants to:				
Local Government	$94,617	$125,287	$125,287	0.0%
Other State Agencies	$225,000	$225,000	$225,000	0.0%
Private Agencies	$569,293	$609,167	$569,974	-6.4%
TOTAL EXPENDITURES[3]	**$2,694,771**	**$2,783,104**	**$2,672,688**	**-4.0%**
SOURCE OF FUNDS	**Sources of FFY 18 Allocations**	**Sources of FFY 19 Allocations**	**Sources of FFY 20 Allocations**	**Percentage Change – FFY 19 to FFY 20**
Federal Block Grant Funds[2]	$2,694,771	$2,783,104	$2,672,688	-4.0%
TOTAL FUNDS AVAILABLE	**$2,694,771**	**$2,783,104**	**$2,672,688**	**-4.0%**

[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] The FFY 2019 and FFY 2020 federal award allocations have not been finalized and may be subject to change. The FFY 2018 award amount was used to prepare the FFY 2020 application.

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

Table B2

Maternal and Child Health Services Block Grant

PROGRAM EXPENDITURES:

Children and Youth with Special Health Care Needs

Program Category	FFY 18 Expenditure	FFY 19 Estimated Expenditure	FFY 20 Proposed Expenditure	Percentage Change - FFY 19 to FFY 20
Number of Positions (FTE)[1]	9.18	7.90	8.90	12.7%
Personal Services	$561,307	$483,666	$571,275	18.1%
Fringe Benefits	$488,508	$469,485	$537,570	14.5%
Other Expenses	$12,539	$9,417	$8,766	-6.9%
Contracts/Grants to:				
Local Government	$0	$0	$0	0.0%
Other State Agencies	$0	$0	$0	0.0%
Private agencies	$914,355	$925,809	$881,180	-4.8%
TOTAL EXPENDITURES[3]	**$1,976,709**	**$1,888,376**	**$1,998,792**	**5.8%**
SOURCE OF FUNDS	**Sources of FFY 18 Allocations**	**Sources of FFY 19 Allocations**	**Sources of FFY 20 Allocations**	**Percentage Change – FFY 19 to FFY 20**
Federal Block Grant Funds[2]	$1,976,709	$1,888,376	$1,998,792	5.8%
TOTAL FUNDS AVAILABLE	**$1,976,709**	**$1,888,376**	**$1,998,792**	**5.8%**

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

[2] The FFY 2019 and FFY 2020 federal award allocations have not been finalized and may be subject to change. The FFY 2018 award amount was used to prepare the FFY 2020 application.

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

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 2018	National Performance Measures
Perinatal Case Management[1]	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.	111 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 2017, 84.4% of pregnant women reported having received prenatal care beginning in the first trimester, up from 84.1% in 2016. Source: National Survey of Children's Health (NSCH).
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 prevention services and education to men and women (Bridgeport, Danbury, Hartford, Meriden, New London, New Haven, Norwich, Torrington, West Hartford and Willimantic).	38,173 teens, women and men	**National Performance Measure #1:** Percent of women, ages 18 through 44, with a preventive medical visit in the past year. Data: In 2017, 69.4% of women, ages 18 through 44 reported having a preventive medical visit in the past year, down from 71.2% in 2016. Source: Behavioral Risk Factor Surveillance System (BRFSS).

Service Category	Objective	Grantor/Agency Activity	Number Served FFY 2018	National Performance Measures
		DPH provides funding to the New Britain School District to support a project that focuses on the prevention of teen pregnancy, placing emphasis on the siblings of young parents and building upon protective factors. Services began in April 2019.	25 students from grades 6-8	**N/A**
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.	251,323 callers	**N/A -** This is no longer an MCH performance measure; however the service provided remains a requirement of the grant. Enhancements to the 2-1-1 website have resulted in a 51% increase in website visits.
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 91 school health service sites in 27 communities statewide. Included are 80 SBHCs and 11 Expanded School Health (ESH) sites.	26,669 un-duplicated users 120,488 visits	**N/A**

Service Category	Objective	Grantor/Agency Activity	Number Served FFY 2018	National Performance Measures
Genetics	To provide information to consumers and providers on pregnancy exposure services.	DPH's Newborn Screening Tracking Program provides funding to the Univ. of CT 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".	1,098 callers	**N/A**

[1] Programs under this service category include a case management program in Waterbury, and the Young Adult Services Program.

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 2018	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 65 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 7 consumers/families on the MHAC.	8,000 CYSHCN	**National Performance Measure #11:** Percent of children with and without special health care needs, ages 0 through 17, who have a medical home. Updated Data: In 2016-17, 49.8% of parents/ guardians of children with and 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 Force to discuss and identify issues relevant to early identification of hearing loss.	35,906 newborns screened[1] Ongoing	**N/A**

Service Category	Objective	Grantor/Agency Activity	Number Served FFY 2018	National Performance Measures
Newborn Genetic and Metabolic 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 64 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. An additional three metabolic screens are scheduled to be added in 2020. [3] The Newborn Screening (NBS) Program Advisory Committee (formerly entitled the Genetics Advisory Committee) 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.	36,070 newborns[2] screened Meets every 4 months	**National Outcome Measure #12 (DEVELOP-MENTAL):** 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%.

[1] The number screened is derived from the number of births that occurred in Connecticut, as obtained from the Connecticut DPH Vital Records program. The Early Hearing Detection and Intervention 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 Connecticut, as obtained from the Connecticut DPH Vital Records program, indicating the number of infants that receive at least one genetic and metabolic screening.

[3] The CT NBS Program is preparing to add three screens to the metabolic panel: two Lysosomal Storage Disorders (LSDs), Pompe and Mucopolysaccharidosis type I (MPS I), and a neurodegenerative disease, Spinal Muscular Atrophy (SMA). The Program is in the process of method development and validation to prepare for testing of these disorders.

Note: Newborn hearing screening is overseen by DPH's Early Hearing Detection and Intervention Program, and Newborn Genetic and Metabolic Screening is overseen by DPH's Newborn Screening Program. The hearing screening number differs from the genetic and metabolic screening number as the physical screening procedures and the timing of the screenings are different.

Table D
SELECTED PERINATAL HEALTH INDICATORS
Connecticut, 2013-2017*

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	2017	4.6	3.1	9.8	4.9
	2016	4.9	3.0	11.4	3.7
	2015	5.6	3.7	12.3	8.0
	2014	5.0	3.5	8.7	7.4
	2013	4.8	3.5	9.4	5.5

Teen Birth Rate	YEAR	Race/Ethnicity* All Races	non-Hispanic White	non-Hispanic Black/Afr Am	Hispanic
Live births per 1,000 females aged 15-19	2017	8.8	2.7	15.8	24.8
	2016	9.4	3.2	15.5	26.7
	2015	10.1	3.6	15.8	29.1
	2014	11.5	4.7	18.5	31.4
	2013	12.9	4.9	20.8	37.3

Singleton Low Birth Weight Rate	YEAR	Race/Ethnicity* All Races	non-Hispanic White	non-Hispanic Black/Afr Am	Hispanic
Rate of singleton low birth weight; less than 2,500 g or 5.5 lbs	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
	2014	5.6	4.4	9.4	6.4
	2013	5.8	4.4	10.1	6.3

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	2017	1.1	0.8	2.1	1.3
	2016	1.0	0.6	2.5	1.2
	2015	1.1	0.6	2.6	1.5
	2014	1.0	0.7	2.4	1.3
	2013	1.0	0.7	2.0	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	2017	15.7	11.5	21.9	21.1
	2016	15.9	11.4	23.0	21.4
	2015	11.7	7.9	18.2	16.9
	2014	12.2	8.6	19.1	17.2
	2013	12.8	9.0	18.4	19.2

* 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 2016-17, 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 2013-2015 as described in the previous footnote*. 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.

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 2013-2017. (**Note:** 2017 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; most notably, declines in infant mortality and teen birth rates. 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 5.0 (range: 4.6 - 5.6) during the period 2013-2017. 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 annual IMRs for the state since that year. Annual IMRs in both non-Hispanic white and non-Hispanic Black/African American populations declined for the period 2013-2017 at rates of 3.3% and 2.8% per year, respectively, as they had since 2005. By contrast, there was no evidence of decline in mortality rates among Hispanic infants between 2013 and 2017. Most recently, and specifically for the period 2013-2017, annual IMRs in Connecticut's non-Hispanic white population averaged 3.3 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 10.3 deaths per 1,000 live births, and those for Hispanic populations averaged 5.9 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 2013-2017 annual overall teen birth rates in Connecticut averaged 10.5 (range=8.8 and 12.9, reported as live births per 1,000 women aged 15-19) and continued a recent 10-year decline observed to have begun in 2008. The lower limit for the range of teen birth rates during this five-year period of 8.8 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 2013-2017, 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 11.2%, 12.3%, and 10.4% 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 2013-2017, the average annual teen birth rate of Hispanic women of 29.9 births per 1,000 women aged 15-19 was 7.8 times higher than the average rate for non-Hispanic White women of 3.8. The average annual teen birth rate among non-Hispanic Black/African American women of 17.3 births per 1,000 women aged 15-19 for 2013-2017 was 4.6 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 5.8% (range = 5.6-6.1%) for Connecticut, nor for non-Hispanic White and Hispanic populations, for the period 2013-2017. 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 2013-2017 period, at a modest rate of .01% per year, as they had since 2000. Disparities among minority race-ethnicity groups have persisted. From 2013 to 2017, the average rate of singleton LBW infants among non-Hispanic Black/African American populations (9.8%) was 2.2 times higher than that among non-Hispanic White women (4.5%). The average rate of singleton LBW among Hispanic women (6.6%) was 1.4 times that of non-Hispanic White women.

Between 2013 and 2017, 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 2013-2017. Average rates of VLBW for the non-Hispanic Black/African American population (2.3%) and Hispanic population (1.3%) were 3.4 and 2.0 times that of the non-Hispanic white population rate of 0.7%, respectively.

Late or No Prenatal Care

Rates of late/no prenatal care (PNC) for the entire population of pregnant women in Connecticut ranged from 11.7% to 12.8% for the period of 2013-2015, and were higher for 2016-2017, averaging 15.8%. 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 2013-2015. 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 populations. Rates of late /no PNC were not different between non-Hispanic black/African American and Hispanic populations for the period 2016, averaging 20.1% and 19.2%, respectively. These rates were approximately twice the rate of 9.7% observed for non-Hispanic white women during that same two-year period.

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. 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 is in the midst of preparing the upcoming State Health Needs Assessment. The last State Health Needs Assessment was released in March 2014. The assessment will provide an updated blueprint for collective action among a wide array of partners to address some of Connecticut's most challenging health issues. In September 2019, DPH will be hosting a Healthy Connecticut 2025 Health Improvement Coalition Summit: Navigating Towards Health Equity. The purpose of the Summit is to share the preliminary findings of the updated State Health Assessment and begin developing the framework of the next State Health Improvement Plan (SHIP). There is a strong emphasis to build on existing initiatives, further leverage our resources and extend the reach of collective impact moving forward.

- The CT MCH Coalition is made up of over 120 stakeholders that meet quarterly and are dedicated to improving the health of mothers, infants and children statewide. The Maternal, Infant and Child Health focus area of the State Health Improvement Plan directly impacts and supports the MCHBG activities in several areas including perinatal/infant health, child health, children with special health care needs, and oral health. The MCH Coalition members support efforts such as:

creating a developmental screening media campaign and distributing materials; promoting awareness of developmental screening tools for use in their communities; enhancing school-based dental sealant programs; and increasing the use of fluoride varnish in primary care practice, school-based programs and community access points, to name a few.

- DPH participates in the Every Woman Connecticut (EWCT) 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 preconception/interconception health with a healthcare worker.

- The maternal mortality review program is responsible for identifying maternal death cases in Connecticut and reviewing medical records and other relevant data related to each maternal death case, including, but not limited to, information collected from death and birth records, files from the Office of the Chief Medical Examiner, and physician office and hospital records. Legislation passed in 2018 established a maternal mortality review committee within the DPH to conduct a comprehensive, multidisciplinary review of maternal deaths for purposes of identifying factors associated with maternal death and making recommendations to reduce maternal deaths. Members of the committee represent a wide range of licensed health care professionals. Through the work of the Committee, CT identifies and characterizes these maternal deaths as pregnancy-related or pregnancy-associated maternal deaths. The Committee is charged with excluding deaths that, though tragic, were not classified in either of these two categories.

- The approved state budget for FYs 2020 and 2021 provided support to expand the state's newborn screening panel to include three new nationally recommended disorders: Pompe Disease, Mucopolysaccharidosis type 1 (MPS 1) and Spinal Muscular Atrophy (SMA). The State Public Health Laboratory (SPHL) staff is in the process of method development and validation to prepare for the testing of these disorders. Testing is projected to go live for SMA in January 2020 and mid-calendar year 2020 for the other two disorders.

- The Department's State Physical Activity and Nutrition (SPAN) Program Breastfeeding team, along with the State WIC Program staff, will continue 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. The focus of this year's work to highlight the "It's Worth It" campaign in targeted areas in the State is aimed at increasing the awareness of the Community Support message and also documenting stories of diverse populations. Additionally, DPH is partnering with the Carolina Global

Breastfeeding Institute to transfer the Ready. Set. Baby. prenatal breastfeeding curriculum from face-to-face education modules to an interactive on-line webpage. There are plans to pilot the webpage in early August for a scheduled launch in September 2019. DPH is partnering with CBC to launch a scholarship program for underrepresented populations in order to improve equity in community lactation support.

- 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). The program partners with Child Health and Development Institute of Connecticut, Inc. (CHDI) to conduct Educating Practices In the Community (EPIC) training modules on topics including Care Coordination in the Medical Home, Developmental Surveillance Screening and Help Me Grow, and Family Professional Partnership in the Medical Home.

- 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 an information and referral. United Way coordinates Medical Home Collaborative meetings, important to identifying and addressing duplication of services for consumers. Over the past three years, DPH has dedicated MCH Services Block Grant 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 2,023,447 website visits in the 2018 calendar year, a 51% increase from calendar year 2017 (1,335,715 visits), and a 113% increase from calendar year 2016 (950,381 visits).

- 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 "Learn the Signs. Act Early" materials. DPH staff work with Dr. Thyde Dumont-Mathieu, MD, MPH on a Connecticut study which describes efforts to identify and disseminate

systems of care factors and culture of care factors that promote a higher level of screening and referral within patient centered medical homes and assesses the impact of cultural and linguistic competency/effectiveness as a barrier or facilitator across the continuum of care. Dr. Dumont-Mathieu convenes a workgroup of stakeholders, including DPH staff, to review and recommend tools, office practices, and levels of family involvement that may reduce the cultural and linguistic barriers to higher screening and referral. Trainings will be matched to providers' needs and will address barriers such as; Insufficient office time, better screening policies and practices, prolonged wait time for evaluation, language and reading level barriers.

- 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 Department received a federal grant to expand services which previously included African American women in Hartford to now include African American and Hispanic women in Hartford and New Britain. Services include 1) improving women's health, 2) promoting quality services, 3) strengthening family resilience, 4) achieving collective impact, and 5) increasing accountability 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.

- Through funding from the CDC's National Asthma Control Program, the Connecticut Asthma Program supports interventions that target population subgroups who are disproportionately affected by asthma, resulting in greater health disparities and health care utilization. Asthma quality initiatives have improved the quality of asthma management in 4 FQHCs and 14 SBHCs, resulting in upgraded therapeutic approaches, better asthma control, decreased emergency-department (ED) use, and reduced school absenteeism. A multi-component, evidence-based asthma home visiting program called Putting on AIRS (POA) is available statewide to children and adults whose asthma is poorly controlled. The POA program integrates asthma education, environmental assessment, remediation of asthma triggers, and reduces barriers to asthma management. A POA team consists of an Asthma Education Specialist (Certified Asthma Educator or Registered Nurse or Respiratory Therapist), an Environmental Specialist (e.g. Sanitarian or Certified Healthy Home staff or House Inspector) and a Community Health Worker who conduct three home visits over a six month period and report to primary providers for optimal coordination and continuity of care. The POA has demonstrated improvement in asthma control, better quality of life, reduced ED visits and health care costs.

- 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. School Based Health Centers were utilized in promoting comprehensive adolescent well child visits, inclusive of developmental assessment, risk assessment and behavioral health screening, anticipatory guidance, and body mass index (BMI) screening and intervention.

- DPH supported 91 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, New Britain, New Haven, New London, Newtown, Norwalk, Putman, Stamford, Stonington, Stratford, Waterbury, Waterford, and Windham. Of these, 80 were School Based Health Centers (SBHC) and 11 were 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 a 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 Connecticut Breast and Cervical Cancer Early Detection Program (CBCCEDP) continues to partner with six health systems (consisting of 20 hospitals) throughout Connecticut to promote and provide breast, cervical and cardiovascular screening services. In FY 2019 the program screened 4,000 women; of these, 1,733 women were screened for the first time. The program created and sustained partnerships with the Connecticut Consultation Center, e-Health CT, 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 (CHN) partnered with staffs of both mobile mammography vans and enrolled women in program services 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) and the HPV vaccine among parents, adolescents and young adults at Southern Connecticut State University and local school districts.

- The Immunization Program provides all recommended childhood vaccines to over 710 providers statewide including private physician offices, community health centers, school based health centers, and local health departments. Adult vaccines are also provided for uninsured adults seen at drug treatment facilities, community health centers, and local health departments. In 2018 over 1,100,000 doses of vaccine were distributed by the Immunization Program. The Program partners with several Planned Parenthood of Southern New England, Inc. (PPSNE) facilities throughout the state as well as local health departments, and community health centers to provide HPV vaccine for uninsured 19-26 year old males and females. Uninsured and Medicaid patients 9-18 years of age as well as privately insured 11 and 12 year olds are also provided HPV vaccine. Nationally recommended childhood vaccines are provided to School Based Health Centers (SBHC) for children up through 18 years of age. The Immunization Program also partners with the WIC program to promote timely immunizations and well child care at WIC locations statewide. Ten local Immunization Action Plan (IAP) coordinators (Hartford, Bridgeport, Naugatuck Valley, New Britain, New Haven, Norwalk, Stamford, Torrington Area Health District, Waterbury, West Haven) work with their local WIC agency to ensure that all children have a medical home and have access to age appropriate vaccinations.

- DPH's Lead and Healthy Homes Program 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 Lead and Healthy Homes Program upgraded its blood lead surveillance system to a new, more comprehensive web based system. The system 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 Lead and Healthy Homes 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 2.3% to 1.9% from 2017 to 2018, a 17.4% decrease, while the prevalence of lead poisoning decreased by 30% from 2016 to 2018.

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 18 Actual**	**FFY 19 Estimated**	**FFY 20 Proposed**
Perinatal Case Management	$319,617	$350,287	$350,287
Family Planning [1]	$15,930	$36,092	$36,092
Information and Referral [1]	$176,841	$201,690	$201,690
School Based Health Services [1]	$275,020	$273,691	$273,691
Genetics [1]	$10,800	$36,000	$36,000
Other [2]	$90,702	$61,694	$22,501
MCH Total	**$888,910**	**$959,454**	**$920,261**
Children and Youth with Special Health Care Needs	**FFY 18 Actual**	**FFY 19 Estimated**	**FFY 20 Proposed**
Medical Home Community Based Care Coordination Services	$810,653	$826,560	$811,561
Family Planning [1]	$2,380	$2,405	$2,405
Genetics [1]	$1,200	$4,000	$4,000
Information and Referral [1]	$36,220	$41,310	$41,310
School Based Health Services [1]	$14,475	$14,405	$14,405
Other [2]	$49,427	$37,129	$7,499
CYSHCN Total	**$914,355**	**$925,809**	**$881,180**
Grand Total	**$1,803,264**	**$1,885,263**	**$1,801,441**

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 2018 "Other" contractual expenditures supported: the placement of additional child health questions on the Behavioral Risk Factor Surveillance System (BRFSS) telephone survey questionnaire ($12,500); enhanced Sickle Cell disease management ($33,129); a grant to Health Resources in Action (HRiA) to coordinate the MCH needs assessment ($41,500); newborn laboratory instrumentation for required screening protocols ($25,000); printing of developmental screening materials ($20,000); and printing of adolescent health materials ($8,000).

[3] FFY 2019 "Other" estimated contractual expenditures will support: Sickle Cell disease management ($26,346); newborn laboratory instrumentation for required screening protocols ($25,000); a grant to HRiA to coordinate

the MCH needs assessment ($30,000); printing of adolescent health materials ($7,000); and the placement of additional child health questions on the BRFSS ($10,478).

[4] FFY 2020 "Other" estimated contractual expenditures will support a grant to HRiA to coordinate the MCH needs assessment ($30,000).