THE MATERNAL AND CHILD HEALTH SERVICES (TITLE V) BLOCK GRANT ALLOCATION PLAN FFY 2025

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 and Annual Report are used by Connecticut in applying for the MCHBG under Title V of the Social Security Act and in preparing the required Annual Report. Connecticut reports annually on national and state outcome and performance measures, which document the State's progress towards the achievement of established performance targets, ensure accountability for the ongoing monitoring of health status in women and children and lend support to the delivery of an effective public health system for the maternal and child health population.

B. Major Use of Funds

- The MCHBG is designed to provide quality maternal and child health services for mothers, children, and adolescents, particularly those 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 the intended recipients of health services or for the purchase of land, buildings, or major medical equipment.

- The MCHBG promotes the development of service systems in states to meet critical challenges in:
    - Reducing infant mortality

- Providing and ensuring access to comprehensive care for women
- Promoting the health of children by providing preventive and primary care services
- Increasing the number of children who receive health assessments and treatment services
- Providing family centered, community based, coordinated services for children and youth with special health care needs (CYSHCN)

Connecticut primarily uses MCHBG funds to support departmental resources and grants to local agencies, organizations, and other state agencies in each of the following 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 2025 funding amounts are not yet finalized. Because the current fiscal year's award (FFY 2024) has also not been finalized, the FFY 2023 federal award amount was used to prepare the FFY 2025 federal application for funding. The FFY 2025 (October 1, 2024 - September 30, 2025) Maternal and Child Health Services Block Grant allocation plan is based on estimated federal funding of $4,969,761. Of this amount, $144,058 is directly allocated from the Health Resources and Services Administration to the Centers for Disease Control and Prevention to fund the CDC Assignee designated for Connecticut. The remaining amount that is awarded to Connecticut is $4,825,703. The allocation plan may be subject to change when the final federal appropriation is authorized.

E. Total Available and Estimated Expenditure

The FFY 2025 federal award is estimated to be $4,969,761 with $4,825,703 available after accounting for the CDC Assignee. Because the FFY 2024 and FFY 2025 federal award allocations have not been finalized, the FFY 2023 award amount was used to prepare the FFY 2025 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 2024 estimated expenditure amount is proposed for Reproductive Health Services, Information and Referral, Genetics, School Based Health Services, and Medical Home Community Based Care Coordination Services. Perinatal Case Management will see an increase in funding of $55,349 only in FFY24 to support consumers transitioning out of the Family Wellness Healthy Start program.

The proposed FFY 2025 plan will maintain overall staff support at 22.0 FTE positions.

G. Contingency Plan

In the event that the actual FFY 2025 federal award amount is less than $4,969,761, the Department will review the criticality and performance of the various programs. Each allocation will be assessed to prioritize program activities deemed most critical to the public. In the event that actual funding exceeds $4,969,761 the Department will review its five-year MCH Needs Assessment and will prioritize the increased funding to best align with objectives identified therein.

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

having cognizance of matters relating to appropriations and the budgets of state agencies and to the committee or committees of cognizance, through the Office of Fiscal Analysis.

H. State Allocation Planning Process

Federal legislation mandates that an application for funds be submitted annually, and that an MCH Statewide Needs Assessment be conducted every five years. DPH will be submitting its federal application for FFY 2025 in July 2024. The data presented in the annual application are based on 5 National Performance Measures (NPM), 3 State Performance Measures (SPM), and 12 Evidence-Based or Informed Strategy Measures (ESM). The Department completed its 2021-2026 MCH Needs Assessment in September 2020. Funds are allocated to address crucial challenges in reducing adverse perinatal outcomes, including infant mortality and low birth weight; providing and ensuring access to care across MCH population groups; reducing health disparities and health inequities; and the priority needs identified in the Needs Assessment.

I. Grant Provisions

A state application for federal grant funds under the MCHBG is required under Section 505 of the Social Security Act (the Act), as amended by the Omnibus Budget Reconciliation Act of 1989 (OBRA-89, PL 101-239). The application offers a framework for states to describe how they plan for, request, and administer MCH Services Block Grant funds. The Act requires that the state health agency administer the program. CT's electronic application is available at https://mchb.tvisdata.hrsa.gov/Home/StateApplicationOrAnnualReport

Paragraphs (1) through (5) of Section 505(a) require states to prepare and transmit an application that:

- Reflects that three dollars of state matching funds are provided for each four dollars in federal funding (for FFY 2025, CT's state match is $4,054,451);
- Is developed by, or in consultation with, the state MCH agency and made public for comment during its development and after its transmittal; contains a statewide needs assessment (to be conducted every five years) with updates submitted in the interim years in the annual application. The application will contain information (consistent with the health status goals and national health objectives) regarding the need for: (A) preventive and primary care services for pregnant women, mothers, and infants up to age one; (B) preventive and primary care services for children; and (C) services for children with special health care needs;
- Includes a plan for meeting the needs identified by the statewide needs assessment and a description of how the state intends to use its block grant funds for the provision and coordination of services to carry out such a plan (to include a statement of how its goals

and objectives are tied to applicable Year 2021 national goals and objectives); and an identification of types of service areas of the state where services will be provided;

- Specifies the information that states will collect in order to prepare annual reports required by Section 506(a); unless a waiver is requested under Section 505(b), provides that the state will use at least 30 percent of its block grant funds for preventive and primary care services for children and at least 30 percent of its block grant funds for children with special health care needs;

- Provides that the state will maintain at least the level of funds for the program which it provided solely for maternal and child health programs in FFY 1989 (Connecticut FFY 1989 baseline: $6,777,191; the FFY 2025 state maintenance of effort is $7,047,965;

- Provides that the state will establish a fair method for allocating funds for maternal and child health services and will apply guidelines for frequency and content of assessments as well as quality of services;

- Provides that funds be used consistent with nondiscrimination provisions and only for mandated Title V activities or to continue activities previously conducted under the health programs consolidated into the1981 block grant; provides that the state will give special consideration (where appropriate) to continuing "programs or projects" funded in the state under Title V prior to enactment of the 1981 block grant;

- Provides that no charge will be made to low-income mothers or children for services. According to the MCHBG guidance, low income is defined as "an individual or family with an income determined to be below the official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981." Charges for services provided to others will be defined according to a public schedule of charges, adjusted for income, resources, and family size;

- Provides for a toll-free telephone number (and other appropriate methods) for use by parents to obtain information about health care providers and practitioners participating under either Title V or Medicaid programs as well as information on other relevant health and health-related providers and practitioners; provides that the state MCH agency will participate in establishing the state's periodicity and content standards for Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program;

- Provides that the state MCH agency will participate in 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 23 Expenditures	FFY 24 Estimated Expenditures	FFY 25 Proposed Expenditure	Percentage Change - FFY 24 to FFY 25
Number of Positions (FTE)	22.0	22.0	22.0	0.0%
Maternal and Child Health	$2,814,655	$2,826,072	$2,789,551	-1.3%
Children and Youth with Special Health Care Needs	$2,011,047	$1,999,631	$2,036,152	1.8%
TOTAL[1]	**$4,825,703**	**$4,825,703**	**$4,825,703**	**0.0%**
SOURCE OF FUNDS				
Federal Block Grant Funds Available[2]	$4,825,703	$4,825,703	$4,825,703	0.0%
Direct Assistance Funds for CDC Assignee	$144,058	$144,058	$144,058	0.0%
TOTAL FUNDS AVAILABLE	**$4,969,761**	**$4,969,761**	**$4,969,761**	**0.0%**

[1] Numbers may not add to totals due to rounding.
[2] The FFY 2024 and FFY 2025 federal award allocations have not been finalized and may be subject to change. The FFY 2023 award amount was used to prepare the FFY 2025 application.

Note: According to the Health Resources and Services Administration, the MCHBG award for each fiscal year has a 2-year period of availability. As such, the funds for each fiscal year are available for expenditure over a 2-year period and do not require carry forward approval. There are no carryover funds in the MCH Block Grant program. Funds must be obligated within the 2-year project period.

Table B1

Maternal and Child Health Services Block Grant

PROGRAM EXPENDITURES:

Maternal and Child Health

Program Category	FFY 23 Expenditure	FFY 24 Estimated Expenditure	FFY 25 Proposed Expenditure	Percentage Change - FFY 24 to FFY 25
Number of Positions (FTE)	12.75	12.75	12.75	0.0%
Personal Services	$1,012,887	$1,020,884	$1,037,508	1.6%
Fringe Benefits	$1,007,084	$981,253	$997,549	1.7%
Other Expenses	$17,520	$28,826	$14,733	-48.9%
Contracts/Grants to:				
Local Government	$0	$0	$0	0.0%
Other State Agencies	$36,000	$36,000	$36,000	0.0%
Private Agencies	$741,164	$759,109	$703,761	-7.3%
TOTAL EXPENDITURES[1]	**$2,814,655**	**$2,826,072**	**$2,789,551**	**-1.3%**
SOURCE OF FUNDS	**Sources of FFY 23 Allocations**	**Sources of FFY 24 Allocations**	**Sources of FFY 25 Allocations**	**Percentage Change – FFY 24 to FFY 25**
Federal Block Grant Funds[2]	$2,814,655	$2,826,072	$2,789,551	-1.3%
TOTAL FUNDS AVAILABLE	**$2,814,655**	**$2,826,072**	**$2,789,551**	**-1.3%**

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

[2] The FFY 2024 and FFY 2025 federal award allocations have not been finalized and may be subject to change. The FFY 2023 award amount was used to prepare the FFY 2025 application.

Table B2

Maternal and Child Health Services Block Grant

PROGRAM EXPENDITURES:

Children and Youth with Special Health Care Needs

Program Category	FFY 23 Expenditure	FFY 24 Estimated Expenditure	FFY 25 Proposed Expenditure	Percentage Change - FFY 24 to FFY25
Number of Positions (FTE)	9.25	9.25	9.25	0.0%
Personal Services	$533,552	$542,985	$563,915	3.9%
Fringe Benefits	$530,495	$521,907	$542,196	3.9%
Other Expenses	$5,840	$9,609	$4,911	-48.9%
Contracts/Grants to:				
Local Government	$0	$0	$0	0.0%
Other State Agencies	$4,000	$4,000	$4,000	0.0%
Private agencies	$937,160	$921,130	$921,130	0.0%
TOTAL EXPENDITURES[1]	**$2,011,047**	**$1,999,631**	**$2,036,152**	**1.8%**
SOURCE OF FUNDS	**Sources of FFY 23 Allocations**	**Sources of FFY 24 Allocations**	**Sources of FFY 25 Allocations**	**Percentage Change – FFY 24 to FFY 25**
Federal Block Grant Funds[2]	$2,011,047	$1,999,631	$2,036,152	1.8%
TOTAL FUNDS AVAILABLE	**$2,011,047**	**$1,999,631**	**$2,036,152**	**1.8%**

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

[2] The FFY 2024 and FFY 2025 federal award allocations have not been finalized and may be subject to change. The FFY 2023 award amount was used to prepare the FFY 2025 application.

Table B3

Allocations by Program Category*
Maternal and Child Health Services Block Grant

List of Block Grant Funded Programs

Major Program Category	Expenditures		
Maternal and Child Health	**FFY 23 Actual**	**FFY 24 Estimated**	**FFY 25 Proposed**
Perinatal Case Management	$212,287	$267,636	$212,287
Reproductive Health Services [1]	$16,092	$16,092	$16,092
Information and Referral [1]	$201,690	$201,690	$201,690
School Based Health Services [1]	$273,691	$273,691	$273,691
Genetics [1]	$36,000	$36,000	$36,000
Other [2]	$37,403	$0	$0
MCH Total[3]	**$777,164**	**$795,109**	**$739,761**
Children and Youth with Special Health Care Needs	**FFY 23 Actual**	**FFY 24 Estimated**	**FFY 25 Proposed**
Medical Home Community Based Care Coordination Services	$863,011	$863,011	$863,011
Reproductive Health Services [1]	$2,404	$2,404	$2,403
Genetics [1]	$4,000	$4,000	$4,000
Information and Referral [1]	$41,310	$41,310	$41,310
School Based Health Services [1]	$14,405	$14,405	$14,405
Other [2]	$16,030	$0	$0
CYSHCN Total[3]	**$941,160**	**$925,130**	**$925,129**
Grand Total	**$1,718,324**	**$1,720,239**	**$1,664,891**

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 2023 "Other" contractual expenditures: funds will be used to support consumers served through the Family Wellness Healthy Start Program to transition to services with other providers.

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

*This table presents program expenditures for contractual services only. Salaries and fringe are not represented here.

Table C1

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

Maternal and Child Health

Service Category	Objective	Grantor/Agency Activity	Number Served FFY 2024	National Performance Measures
Perinatal Case Management	To provide case management services for pregnant and parenting women to promote healthy birth outcomes.	DPH provides funding to Birth Support, Education & Beyond and Reproductive Education and Comprehensive Health (REACH). BSEB provides perinatal support services to pregnant and parenting women who have aged out of the child welfare system into the adult mental health system and other women with significant trauma histories. REACH provides perinatal support services to teenagers and young adolescents in the community setting.	298 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 2022, 83.6% of pregnant women in Connecticut reported having received prenatal care beginning in the first trimester, this was the same in 2020. Source: National Vital Statistics System (NVSS).
Reproductive Health Services	To prevent unintended pregnancies and risky health behaviors.	DPH provides funding to Planned Parenthood of Southern New England, Inc., to provide reproductive health care including breast and cervical cancer screenings, HIV and STI (sexually transmitted infections) screenings, contraception, prevention education, counseling, and clinical services to men and women of reproductive age in health centers in Bridgeport, Danbury, Hartford, Meriden, New London, New Haven, Norwich, Torrington,	29,295 women and men of reproductive age	**National Performance Measure #1:** Percent of women, ages 13 through 44, with a preventive medical visit in the past year. Data: In 2022, 76.9% of women in Connecticut, ages 18 through 44 reported having a preventive medical visit in the past year, compared to 76.3% in 2020. Source: Behavioral Risk Factor

Service Category	Objective	Grantor/Agency Activity	Number Served FFY 2024	National Performance Measures
		West Hartford, and Willimantic. In-person services continued through COVID-19 and telehealth visits were offered and provided as appropriate.		Surveillance System (BRFSS).
Information and Referral	To provide statewide, toll free MCH information.	DPH provides funding to the United Way of CT/2-1-1 Infoline to provide toll free 24-hour, 7 day/week information and referral services regarding MCH services in the state.	299,014 callers	N/A
School-Based Primary and Behavioral Health Services	To promote the health of children and youth through preventive and primary interventions.	Licensed as outpatient facilities or hospital satellites, School Based Health Centers (SBHCs) offer services addressing the medical, mental, and oral health needs of children and youth. DPH supported 91 school health service sites in 27 communities statewide. Included are 91 SBHCs (79 full SBHCs and 12 Expanded School Health (ESH) sites).	22,280 un-duplicated users 130,059 visits	N/A
Genetics	To provide information to consumers and providers on pregnancy exposure services.	DPH provides funding to the Univ. of Connecticut Health Center to provide information on exposures to occupational and environmental hazards, medications, and other risk factors during pregnancy through a toll-free telephone line, "MotherToBaby CT."	1657 callers	N/A

Table C2

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

Children and Youth with Special Health Care Needs

Service Category	Objective	Grantor/Agency Activity	Number Served FFY 2024	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 145 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 6 consumers/families on the MHAC.	9,200 CYSHCN individuals	**National Performance Measure #11:** Percent of children with and without special health care needs, ages 0 through 17, who have a medical home. In 2021-22, 37.4% of parents/ guardians of children with special health care needs in Connecticut, ages 0 through 17, reported having a medical home. In 2021-22, 49.3% of parents/ guardians of children without special health care needs in Connecticut, 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	All CT newborns are screened prior to hospital discharge. DPH participates on the Early Hearing Detection	35,250 (99.2%) screened[1] Ongoing	N/A

Service Category	Objective	Grantor/Agency Activity	Number Served FFY 2024	National Performance Measures
	and language delays.	and Intervention Task Force to discuss and identify issues relevant to early identification of hearing loss.		
Newborn Bloodspot Screening	To provide early identification of infants at increased risk for selected metabolic or genetic diseases so that medical treatment can be promptly initiated to avert complications and prevent irreversible problems and death.	As of January 1, 2023, newborns in CT undergo screening for all Core RUSP disorders and all secondary RUSP conditions except for Krabbe Disease. The CT NBS Program at the Laboratory (SPHL) is currently validating a method to screen for Krabbe Disease and universal screening will be implemented around October 2024. All bloodspot screening takes place at the SPHL with the exception of Cystic Fibrosis (CF) screening. CF is conducted by the Yale and The University of Connecticut (UConn) CF Laboratories. CGS 19a-55 (Newborn Infant Health Screening) of the general statutes that were effective October 1, 2021, requires laboratories conducting blood-spot screening for CF to begin reporting data to DPH for epidemiologic purposes. The CT NBS Program is working in conjunction with the CF screening laboratories at Yale and UConn to put electronic systems in this place for reporting of CF data to the CT NBS Program (DPH).	35,388 (99.7%) of eligible newborns[2] screened	**National Outcome Measure #12** (DEVELOPMENTAL): Percent of eligible newborns screened for heritable disorders with on time physician notification for out-of-range screens who are followed up with in a timely manner. Baseline data: Number of referrals in Connecticut made/reported to primary care physician (PCP) within 24 hours of receipt of presumptive positive results (2018): 99.3%. CT NBS Program 2023 data: Number of referrals in Connecticut made/reported to primary care physician (PCP) within 24 hours of receipt of presumptive positive results (2023): 99.8 % CF Screening Program 2023 data: data is not available at this time

Service Category	Objective	Grantor/Agency Activity	Number Served FFY 2024	National Performance Measures
	To Improve Timeliness in Sample Collection and Receipt	In mid-2022, the first NBS Timeliness Quality Indictor (QI) report cards were distributed to every birth hospital in the state. Quarterly distribution of the report cards continues. The QIs measured include: • (QI) 1: Date of Birth to Collection Time • (QI) 2: Time from Collection to Receipt at the SPHL • (QI) 3: Specimens Satisfactory for Testing • (QI) 4: Essential Data Fields Complete Since release of the initial QI report card, CT NBS Program staff have worked with the CT Hospital Association and teams from each birth hospital to discuss strategies for improvement. NBS FU Database User Training classes were held in January 2023, March 2023, May 2023 and December 2023 and were well attended by representatives of birth hospitals across the state. Improvements have been noted in the areas of QI 2 and QI 4 at the individual hospital levels since inception of the report card. The implementation of a new Newborn Screening Laboratory Information Management System LIMS) and is expected to go live in July 2025. The new LIMS will greatly enhance NBS testing, follow up and tracking abilities with a focus on improved accuracy and timeliness.		State Outcome Measures: Goal is $\geq$ 99% for all QI Timeliness Indicators Baseline Data 2022 (statewide): QI 1: 97.7% QI 2: 78.0% QI 3: 100.0% QI 4: 96.9 % CT NBS Program 2023 data (statewide): QI 1: 98.8% QI 2: 94.6% QI 3: 100.0% QI 4: 96.3 %

Service Category	Objective	Grantor/Agency Activity	Number Served FFY 2024	National Performance Measures
		The CT Newborn Screening Program Genetics Advisory Committee (GAC) is comprised of State NBS staff, State Laboratory administrators, treatment center clinicians and staff, hospital birthing center and NICU clinicians and staff, as well as representatives from community-based advocacy groups. Meetings are conducted to identify and address current and emerging issues.		

[1] The number screened is derived from the number of births that occurred in CT, as obtained from the DPH Vital Records program. The Early Hearing Detection and Intervention (EHDI) Program identifies the number of these infants that received at least one hearing screening.

[2] The number screened is derived from the number of births that occurred in CT, as obtained from the DPH Vital Records program, indicating the number of infants that receive at least one newborn bloodspot screening through the CT NBS Program.

Note: Newborn hearing screening is overseen by DPH's EHDI Program, and Newborn Bloodspot Screening is overseen by DPH's NBS Program, except for Cystic Fibrosis (CF) screening which is administered by the Yale and UConn Health CF Laboratories. The hearing number differs from the genetic and metabolic number as the physical screening procedures and the timing of the screenings are different.

Table D
SELECTED PERINATAL HEALTH INDICATORS
Connecticut, 2018-2022

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	2022	4.3	2.2	8.8	6.4
	2021	4.7	3.0	10.1	5.8
	2020	4.3	2.6	9.7	5.6
	2019	4.5	3.3	9.1	5.4
	2018	4.4	3.3	7.8	5.4

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	2022	6.4	1.6	8.5	18.4
	2021	7.1	1.7	10.6	20.3
	2020	7.4	2.3	10.8	20.0
	2019	7.7	2.3	11	22.4
	2018	8.3	2.6	12.9	23.8

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	2022	6.3	4.7	11.5	6.9
	2021	6.3	4.5	10.5	7.2
	2020	6.1	4.5	10.4	6.7
	2019	6.1	4.5	10.1	7
	2018	5.9	4.2	10.4	6.8

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	2022	1.0	0.6	2.2	1.3
	2021	1.0	0.5	2.5	1.1
	2020	1.0	0.6	2.3	1.3
	2019	1.0	0.6	2.4	1.3
	2018	1.0	0.5	2.4	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	2022	16.4	11.4	22.7	22.7
	2021	15.3	11.1	20.7	21.3
	2020	15.3	11.1	20.6	20.5
	2019	15.3	11.2	23.0	19.9
	2018	16.1	12.1	23.2	20.0

The new tabulations use race6_eth for stratification instead of raceeth.

Early Prenatal Care	YEAR	Race/Ethnicity			
		All Races	non-Hispanic White	non-Hispanic Black/Afr Am	Hispanic
Percent of live births to mothers who received initial prenatal care during the first trimester	2022	83.6	88.6	77.3	77.3
	2021	84.7	88.9	79.3	78.7
	2020	84.7	88.9	79.4	79.5
	2019	84.7	88.8	77.0	80.1
	2018	83.9	87.9	76.8	80.0

Singleton Preterm Birth	YEAR	Race/Ethnicity			
		All Races	non-Hispanic White	non-Hispanic Black/Afr Am	Hispanic
Rate of Singleton Births prior to 37 weeks gestation	2022	7.6	6.4	11.2	8.4
	2021	7.7	6.3	10.9	9.1
	2020	7.6	6.4	10.4	8.6
	2019	7.6	6.6	10.4	8.5
	2018	7.6	6.2	11.0	8.8

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 2018-2022.

The data described below indicate that improvements in the health of mothers and infants in Connecticut have been made; infant mortality and teen birth rates continue to decline, overall. However, much remains to be done to achieve optimal outcomes for all Connecticut mothers and infants. Infant mortality for the Hispanic population has risen every year since 2019, and for non-Hispanic Black/African Americans every year since 2018 except 2022. The lifetime effects of race, racism, social class, poverty, stress, environmental influences, health policy, and other social determinants of health are reflected in the elevated rates of adverse outcomes and persistent disparities. The continuation of evidenced-based programs, coupled with efforts to increase health equity and address social determinants of health, is essential to achieving improved birth outcomes and reducing/eliminating disparities. While we continue to strive to reduce health inequities, these challenges also are apparent at the national level and are not unique to Connecticut.

Infant Mortality

The Connecticut annual infant mortality rate (IMR, reported as deaths per 1,000 live births) averaged 4.4 (range: 4.3 - 4.7) during the period 2018-2022. Annual IMRs in Connecticut's non-Hispanic White population averaged 2.9 deaths per 1,000 live births 2018-2022 and were significantly lower than those observed for the non-Hispanic Black/African American and Hispanic populations. Annual IMRs for non-Hispanic Black/African American populations averaged 9.1 deaths per 1,000 live births, and those for Hispanic populations averaged 5.7 deaths per 1,000 live births. The averages were 3.1 and 2.0 times higher, respectively, than that for Connecticut's non-Hispanic White population.

Births to Teens

The 2018-2022 annual overall teen birth rates in Connecticut averaged 7.4 (range = 6.4 – 8.3, reported as live births per 1,000 women aged 15-19) and continued declines since at least 2016 of 5.8% annual decline. The lower limit for the range of teen birth rates during this five-year period of 6.4 births per 1,000 women aged 15-19 represents the lowest teen birth rate observed this century in Connecticut. Declines across all three major race-ethnicity groups are also evident for the period 2018-2022, with annual rates of declines in teen birth rates in the non-Hispanic White, non-Hispanic Black/African American, and Hispanic populations during this period averaging 10.8%, 8.5%, and 5.8% 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 2018-2022, the average annual teen birth rate of Hispanic women of 21.0 births per 1,000 women aged 15-19 was 10.0 times higher than the average rate for non-Hispanic White women of 2.1. The average annual teen birth rate among non-Hispanic Black/African American women of 10.8 births per 1,000 women aged 15- 19 for 2018-2022 was 5.1 times that of non-Hispanic White women.

Singleton Low Birth Weight and Very Low Birth Weight

There was little change in the overall rate of singleton low birth weight (LBW) around an average value of 6.1% (range = 5.9 - 6.3%) for Connecticut, primarily driven by increases in singleton LBW for the non-Hispanic Black/African American population, for the period 2018-2022. Singleton LBW rates for the non-Hispanic Black/African American has been increasing since 2016 at an average annual increase of 2.3%. In contrast, non-Hispanic White and Hispanic populations have had an observed stable rate of singleton LBW since 2016. Disparities among minority race-ethnicity groups have persisted. From 2018 to 2022, the average rate of singleton LBW infants among non-Hispanic Black/African American populations (10.6%) was 2.4 times higher than that among non-Hispanic White women (4.5%). The average rate of singleton LBW among Hispanic women (6.9%) was 1.5 times that of non-Hispanic White women.

Between 2018 and 2022, the rate of singleton very low birth weight (VLBW) averaged 1.0% for the total population (range=1.0-1.0%), while decreasing as part of a long-term declining trend (since 2016) of 1.1% annually. Recent declines in rates of VLBW 2018-2022 were not statistically significant for non-Hispanic Black and non-Hispanic White populations. VLBW rates 2018-2022 remain largely unchanged for the Hispanic population of the state. Disparities in rates of VLBW by race-ethnicity in Connecticut were more marked than those for LBW for the period 2018-2022. Average rates of VLBW for the non-Hispanic Black/African American population (2.4%) and Hispanic population (1.3%) were 4.1 and 2.2 times that of the non-Hispanic White population rate of 0.6%, respectively.

Late or No Prenatal Care

The rate of late/no prenatal care (PNC) for the entire population of pregnant women in Connecticut was 11.7% in 2015. This rate is lower than the average rate of 15.7% for the more recent period of 2018-2022. Following CDC's recommendation, rates of Late/No Prenatal Care for 2016 and subsequent years are not directly comparable to rates of Late/No Prenatal Care for earlier time periods. With adoption of the latest revision of the birth certificate by Connecticut in 2016, mothers are now asked the date of the first prenatal care visit rather than the month of pregnancy during which prenatal care was initiated. It is felt that the reporting method used prior to 2016 may have underestimated the percentage of mothers who received Late/No Prenatal Care. Prior to 2016, rates of late/no PNC were neither increasing nor decreasing for Connecticut's entire population. Rates of late/no PNC were not different between non-Hispanic black/African American and Hispanic populations for the period 2018-2022, averaging 22.0% and 20.9%, respectively. These rates were approximately twice the rate of 11.4% observed for non-Hispanic White women during that same five-year period.

Program Highlights

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

- DPH has submitted its reaccreditation application to the Public Health Accreditation Board (PHAB) in September 2023. The preparation for the application began in 2022, as soon as DPH obtained an extension approval from the Public Health Accreditation Board (PHAB) to apply for reaccreditation under their revised standards and measures version 2022. In August 2024, a site visit with PHAB is scheduled and the final determination of accreditation will be provided.

- The Connecticut Maternal and Child Health (MCH) Coalition, which has been in existence for over 15 years, is a representative group of state agencies, providers, funders, and advocates working in concert with the state's maternal and child health population. The Coalition has over 180 individuals representing ninety-seven organizations and serves as a communication and networking vehicle for those working in the field of maternal and child health. The Coalition represents the state's maternal and child health priorities/interests in the State Health Improvement Plan (SHIP), which has established the following priority areas: access to health care; economic stability; healthy food and housing; and community strength and resilience. The Coalition also advocates for health equity and the elimination of racial and ethnic health disparities. Through quarterly meetings and Notes of Interest shared on a regular basis, the MCH Coalition is a catalyst

for increasing awareness on relevant MCH issues and mobilizing responses. Through the establishment of Initiatives, operating under the auspices of the MCH Coalition, Connecticut is currently supporting efforts to improve pre and interconception health care/pregnancy intentionally through the establishment of Every Woman Connecticut and, in 2021, the MCH Coalition convened the Reproductive Justice Alliance designed to improve the state's maternal mortality and morbidity statistics, especially for Black and Brown birthing people. These Initiatives welcome MCH Coalition members as well as those who are limiting their involvement to a working group and their scope of focus and work.

- Every Woman Connecticut was established in 2016 as a joint effort of the Connecticut MCH Coalition and the March of Dimes. It is a product of the Connecticut Plan to Improve Birth Outcomes, an ambitious undertaking by the MCH Coalition. This Plan is the result of a highly participatory and systematic process that allowed over 80 Coalition members to come together and identify the recommendations and strategies believed to have the greatest potential for impact and feasibility. One of the Plan's recommendations is to provide better pre and interconception care. With that task in mind, Every Woman Connecticut, supports the use of One Key Question (OKQ), a simple pregnancy intention screening tool. Over the years, Every Woman Connecticut has trained over 300 individuals representing 101 agencies in selected clinical and community-based settings in implementing OKQ and offers trainings requested by OKQ implementers. Training topics include pregnancy intention screening, sexual health, optimal birth spacing and effective contraceptive counseling for people of reproductive ages; chronic conditions that can affect a future pregnancy; pre/inter-conception health care; trauma informed pregnancy intention screening; implicit bias and micro-aggressions; and human trafficking. The goal of Every Woman Connecticut's promotion of OKQ, in partnership with providers, is to ensure that birthing people and their partners achieve optimal health and positive birth outcomes. Every Woman Connecticut is guided and supported by an Advisory Committee of maternal health leaders, stakeholders and champions representing key organizations that include, in addition to DPH and the March of Dimes, Planned Parenthood of Southern New England, Connecticut Hospital Association, Connecticut Coalition Against Domestic Violence, The Connecticut Department of Mental Health and Addiction Services, The Connecticut Office of Early Childhood, Community Health Network of Connecticut (the Administrative Service Organization or ASO for Medicaid's provision of health care), Connecticut Dental Health Partnership (the ASO for Medicaid provision of oral health), and the Connecticut Community for Addiction Recovery. In 2021, DPH, the MCH Coalition and the March of Dimes established a Reproductive Justice Alliance that evolved from a 2020 Pregnancy Risk Assessment Monitoring Data to Action project around discrimination before and during pregnancy. The Alliance's founding partners were also inspired by the work being done in New York City and by Columbia University's Averting Maternal Death and Disability (AMDD) project to address inequity in maternal outcomes. The Alliance is expanding upon Columbia's central research questions: (A) how do women describe their experiences of mistreatment or disrespect during facility-based childbirth, and (B) what

are the individual, institutional, structural, and policy drivers of the treatment that women experience as disrespectful? Connecticut's focus will include prenatal care experiences as well as childbirth and immediate postpartum care.

The Alliance has more than 30 members and continues to grow on both the state and community- based level. Members, in addition to DPH and the March of Dimes, includes representatives from the Connecticut Department of Social Services; the Connecticut Office of Early Childhood; the Community Health Network of CT (the ASO for Medicaid's provision of health care); the Connecticut Hospital Association; Health Equity Solutions; Connecticut Coalition Against Domestic Violence; Women's Health USA; Family Centered Services of Connecticut; the Northwest Community Foundation; Greater Waterbury Health Partnership; UConn Health Center; Nurse Family Partnership; Yale University/VA Connecticut Health Care System; Southern Connecticut State University; and the City of New Haven Health Department.

The Alliance was established, by consensus of its members, to expand and unify reproductive justice efforts in the state with a vision to better ensure individuals receive respectful quality care, which ultimately serves to reduce maternal morbidity, severe maternal morbidity, and promote positive birth outcomes. The goals of the Alliance are to improve access to respectful, quality maternity care; respectful interactions between patients and providers; health care systems, resources, and policies related to maternal health; and accountability of health care systems by centering patients' voices.

- CT legislation was passed in 2018 to establish a Maternal Mortality Review Committee (MMRC) and program within DPH. The MMRC is comprised of both clinical and non-clinical subject matter experts that conduct a comprehensive, multidisciplinary review of each pregnancy-associated death that occurred within one year of the end of a pregnancy. The comprehensive review includes medical records; medical examiner reports; death certificates; vital statistics regarding an infant's birth, and fetal and maternal death files; police reports; informant interviews; obituaries; social media and other sources of information. The purpose of the MMRC review is to identify factors that may have contributed to the death and to make recommendations to reduce pregnancy-related morbidity, mortality, and disparities. The Department's Maternal Mortality Review Program is supported by CDC funding that provides for program administration, data collection and analysis of maternal mortality data, and an annual Maternal Mortality Evaluation Report. The MMRC is committed to a multipronged approach to avoid all preventable maternal deaths and improve maternal health and health equity. Through equitable partnerships with communities, the MMRC will work to understand the severity and complexity of maternal health disparities, advocate for policy solutions, and support innovative approaches and interventions to eliminate inequities that threaten the health and well-being of all birthing persons.

- The Department's State Physical Activity and Nutrition (SPAN) Program breastfeeding team, along with the State WIC Program staff, continues to partner with the CT

Breastfeeding Coalition's (CBC) Ten Step Collaborative to encourage implementation of evidenced-based maternity care and the 10 Steps for Successful Breastfeeding in CT hospitals. An evaluation of the It's Worth It Campaign was conducted by our contractors at UConn and REACH collaborators at CARE to determine whether any updates were needed to the campaign or its materials. Based on the findings, the SPAN breastfeeding team selected a vendor (May 2023) to update campaign materials, update a radio PSA and develop a 52-week social media campaign based on the It's Worth It (IWI) themes. A photoshoot to capture new images with local breast/chest feeding families was implemented to create images with a diverse range of families and health care professionals, in a variety of settings. The project is on track to place creatives digitally at the end of the year.

Deliverables were completed in Fall 2023. The Ready, Set, Baby (RSB) online website, in partnership with the Carolina Global Breastfeeding Institute (CGBI), remains available for prenatal breastfeeding education in English, Spanish and Arabic. DPH consulted with a local organization (NH Pride) to review the English webpage, and DPH and CGBI's plan for adding inclusive language. NH Pride provided a report and recommendations in November 2022. Updates to the language, photos and resources on the English webpage was completed in Fall 2023.

In partnership with Connecticut Breastfeeding Coalition (CBC), DPH launched a scholarship program in 2020 for underrepresented populations to improve equity in community lactation support. Six individuals received an award. In 2021, a scholarship recipient that took the IBCLC exam, passed, and is now an International Board-Certified Lactation Consultant (IBCLC). The IBCLC from the 2020 awardee group continues to work with the other five scholarship recipients and an additional nine individuals that are interested in obtaining their IBCLC exam credentials. The CBC has applied for and received a CHEFA grant in 2023 to expand the Diversity in Lactation: Paving the Way project.

- The Children and Youth with Special Health Care Needs Program's CT Medical Home Initiative provides community-based medical home care coordination networks and collaboratives to support children with special health care needs. Services include: a statewide point of intake, information and referral; provider and family outreach; and parent-to-parent support. Care coordination services include linkage to specialists and to community resources, coordination with school-based services, and assistance with transition to adult health care and other services. Community Care Coordination Collaboratives support local medical home providers and care coordinators in accessing state and local resources, and work to resolve case specific and systemic problems, including reduction in duplicity of efforts.

- United Way of Connecticut's 2-1-1 Infoline is an integral part of the CT Medical Home Initiative, providing a statewide point of entry as well as information and referral. DPH has dedicated MCHBG as well as other federal funding towards improving the United

Way resource database and website, thus enhancing access to information for providers and consumers. The improvements include the ability to access information in numerous languages. United Way has also provided outreach and training to family and community- based organizations regarding how to effectively use the 2-1-1 website. The 2-1-1 Infoline website recorded 2,017,699 visits with 3,429,271 pageviews in the 2022 fiscal year. This is a decrease from the previous year when there were 3,146,882 visits with 14,575,636 pageviews. This is still an increase over pre-pandemic numbers when there were 1,393,352 visits to the website. The decrease is a result of people no longer searching for information about the COVID-19 pandemic and fewer people needing to find information about services on a wide range of topics, including maternal and child health.

- The Children and Youth with Special Health Care Needs program collaborates with the A.J. Pappanikou Center on Developmental Disabilities to improve access to comprehensive, coordinated health and related services, including trainings on the importance of developmental screening and distribution of the CDC's "Learn the Signs. Act Early" materials. DPH staff coordinate with the Help Me Grow Advisory Committee to increase developmental screening by conducting an education and awareness campaign that targets families and communities on the importance of developmental screening, training community and healthcare providers to improve screening rates and coordination of referrals and linkage to services, and engaging in cross systems planning and coordination of activities around developmental screening.

- Preventive interventions to address teen pregnancy through CT's Title V programs include those to delay the onset of sexual activity, promote abstinence as the social norm, reduce the number of adolescents who have sex at young ages, and increase the number of sexually active adolescents who use contraceptives effectively. Healthy Choices for Women and Children, a case management program serving Waterbury, and the Family Wellness Healthy Start (FWHS) program serve pregnant and parenting teens and include interconception services. The FWHS program works to eliminate disparities in infant mortality and adverse perinatal outcomes especially among the target population of African American and Hispanic women in Hartford and New Britain. The FWHS Program maintains and expands Healthy Start services by focusing on the following goals: (A) improve women's health; (B) improve family health and wellness; (C) promote systems change through community/population health; and (D) ensure impact and effectiveness through quality improvement, performance monitoring, and evaluation.

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

- In addressing the needs of adolescents, the CT Title V program strategies emphasize supporting adolescent wellness (including comprehensive well child visits) and process improvement for the transition to adult life. School Based Health Centers were utilized in promoting comprehensive adolescent well visits, inclusive of developmental assessment, risk assessment and behavioral health screening, anticipatory guidance, and body mass index (BMI) screening and intervention.

- DPH supported 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, Mystic, New Britain, New Haven, New London, Newtown, Norwalk, Putman, Stamford, Stratford, Waterbury, Waterford, and Windham. Of these, 79 were School Based Health Centers (SBHC) and 12 were Expanded School Health (ESH) sites. SBHCs serve students, Pre-K-12, and are in elementary, middle, and high schools. SBHCs provide access to physical, mental health and dental (in some locations) services to students enrolled in the school regardless of their ability to pay. Services provided to students include but are not limited to: diagnosis and treatment of acute injuries and illnesses, managing and monitoring chronic disease, physical exams, administering immunizations, prescribing and dispensing medications, laboratory testing, health education, promotion and risk reduction activities, crisis intervention, individual, group and family counseling, outreach, oral health (in some locations), referral and follow-up for specialty care, and linkages to community based providers. Being able to treat students while at school reduces absenteeism, saves money by keeping children out of emergency rooms, and supports families by allowing parents to stay at work. Care is delivered in accordance with nationally recognized medical/mental health, cultural, and linguistically appropriate standards.

- The Connecticut Breast and Cervical Cancer Early Detection Program (CBCCEDP) continues to partner with five health systems (consisting of 21 hospitals) throughout Connecticut to promote and provide breast, cervical, and cardiovascular screening services. In SFY 2023 the program screened 4,961 women. The program continued partnerships with the Consultation Center at Yale, the University of Connecticut, the University of St. Joseph, Walmart Corporation, Connecticut Physicians for Women, Northern CT Black Nurses Association, United Way of CT, Hartford Health Care, and Yale New Haven Health Systems' mobile mammography vans. Community Health Navigators partnered with staffs of both mobile mammography vans and enrolled women in program services at Wellness Day events in communities where women reside and work. CBCCEDP also partnered with the Connecticut Cancer Partnership to increase awareness and education about Human Papillomavirus Vaccine (HPV), as well as with

KNOX Inc., the Connecticut Snap-Ed program, Sardilli's Produce, Joan Dauber Food Bank, and the Women's Empowerment Center to promote healthy nutrition and physical activities, thereby reducing cancer and heart disease risks. CBCCEDP continues to partner with CRCP and CCCP to provide colorectal cancer screening for low-income men and women 45 years and older.

- The Connecticut Department of Public Health (CT DPH) Immunization Program provides all recommended childhood vaccines to approximately 660 providers statewide including private physician offices, community health centers, School Based Health Centers, urgent care centers and local health departments. In 2023, approximately 1,100,000 doses of vaccine were distributed by the Immunization Program and the program continues to universally offer all Advisory Committee on Immunization Practices (ACIP) vaccines for all children up through 18 years of age in Connecticut regardless of insurance status. Adult vaccines including HPV, Shingles, and Pneumococcal Conjugate (PCV 20) for uninsured patients are provided free of charge to local health departments, community health centers, STD clinics, and drug treatment facilities. Uninsured and Medicaid patients 9-18 years of age as well as privately insured 11- and 12-year-olds are also provided HPV vaccine. In Fiscal Year 2024, HPV vaccine was expanded to include 4 additional age ranges for privately insured patients (13, 14, 17 & 18 year olds). By July 1, 2024, all 9-18 year old privately insured patients will be eligible to receive state supplied HPV vaccine.

  The Connecticut Vaccine Program (CVP) is funded through a combination of state and federal monies. The state monies are from an assessment tax on all health insurers doing business in the state of Connecticut. This assessment allows us to provide all nationally recommended vaccines for privately insured children up through 18 years of age free of charge. All nationally recommended childhood vaccines are provided to School Based Health Centers (SBHCs) for children up through 18 years of age free of charge. The Immunization Program also partners with the WIC program to promote timely immunizations and well-child exams.

- DPH's Childhood Lead Poisoning Prevention Program (CLPPP) evaluates the effectiveness of universal screening laws (i.e., mandated blood lead testing) for children under the age of three by assessing the screening rate. All healthcare providers in Connecticut are required to conduct annual blood lead testing for children between 9 to 35 months of age. Compliance with the law is assessed by measuring the proportion of children born in Connecticut during a given year who have had one blood lead test by age one, at age one or age two, and two annual tests by age three.

  DPH has maintained a blood lead surveillance system since 1994. In 2010, the CLPPP upgraded its surveillance system to a more comprehensive web-based system. This has enhanced the ability to merge birth records and comprehensive environmental data with childhood blood lead data. The surveillance system has had a significant positive impact on the program's capability to utilize surveillance data to enhance child case

management efforts. The prevalence proportion of lead poisoning, defined as the proportion of children under 6 years of age with a confirmed venous lead test whose result was ≥5 µg/dL in a specific calendar year, decreased slightly from 1.7% to 1.6% from 2021 to 2022. There was a 4% decrease in the number of cases (1,047 versus 1,005 cases). Over the past five years, the number of prevalent cases of lead poisoning has decreased by 25% from 2018 to 2022 (1,333 cases versus 1,005 cases).