Connecticut Health
FOUNDATION
Changing Systems, Improving Lives.

REPORT | FALL 2025

Maternal Health Equity: A Blueprint for Connecticut

Acknowledgements and Disclosures

With gratitude: This blueprint would not have been possible without the commitment of a wide range of collaborators across the state, including advisory members who were generous with their time, experience, and spirit; subject matter experts and reviewers who contributed their deep expertise; and participants in CT Insights forums who shared their critical and constructive feedback. We are most grateful to the many people who work tirelessly to identify and address structural racism and other drivers of inequities in maternal health.

Disclosure of funding: The Connecticut Health Foundation contracted with Yale University to lead the development of the blueprint. The Connecticut Health Foundation offered honoraria to advisory committee members, expert reviewers, and any participants in CT Insight convenings for whom participation was outside the scope of their paid employment.

Acknowledgements: This blueprint was prepared by members of the Maternal Health Advisory Committee (Appendix A), the Yale Equity Research and Innovation Center, the Yale Global Health Leadership Initiative, and the Connecticut Health Foundation. Project team members were:

Arielle Levin Becker
Ashley Demory, MD
Ellen Carter, MPA
Erika Linnander, DrPH, MBA
Ishita Arora, PhD
Jessica Lewis, PhD, LMFT
Marcella Nunez-Smith, MD, MHS
Mikaili Charlemagne, MPH
Sabrina Selk, ScD, ScM
Sakinah Carter Suttiratana, PhD, MPH, MBA
Samantha Lew Fretz, LMSW
Sarah Christie, PhD, MPH
Shelley Duodu
Tara Rizzo, MPH
Tiffany Donelson, MPH

Suggested Citation: Connecticut Health Foundation. Maternal health equity: A blueprint for Connecticut. Hartford, CT; Nov. 6, 2025.

This publication can be downloaded from:
https://www.cthealth.org/publication/maternal-health-equity-blueprint-ct

Note on terminology: This document uses gender-neutral language (such as “pregnant people”) alongside terms traditionally associated with maternal health.

Photography: Gale Zucker Photography
Design: Ritz Henton Design

Contents

Introduction

By many measures, Connecticut ranks among the best places in the United States to give birth. But not everyone has the same opportunity for or likelihood of having a safe and healthy pregnancy, birth, and start to parenthood. **Black women in Connecticut are twice as likely as their white counterparts to experience life-threatening complications related to pregnancy – a condition known as severe maternal morbidity.** Connecticut ranks in the bottom half of the nation in this measure. This blueprint aims to close the gap, and outlines evidence-backed strategic actions that can be taken in the coming years.

Our vision is a 50 percent reduction in the burden of severe maternal morbidity among Black women over three years (2026-2029), closing the racial gap for Connecticut and improving outcomes for all. While this blueprint focuses on the population with the greatest risk of poor outcomes, many of the strategic recommendations have the potential to reduce severe complications for all people experiencing childbirth in our state.

The recommendations in this blueprint build on current resources and initiatives and are designed for collaborative action across sectors and organizations to reduce severe maternal morbidity among Black people. Each of these recommendations is supported by a set of actions that can be taken in the first year to move toward this goal.

Following the publication of this blueprint, the Connecticut Health Foundation plans to bring together those interested in implementing the recommendations and work toward the first-year actions. We also anticipate mapping the landscape of maternal health efforts in Connecticut to ensure there is strong coordination and recognition of the tremendous work occurring in the state. We hope that people from every sector will see a role for themselves in this work and join this effort. Together, we can create a healthier future for all the people of Connecticut.

Rationale and Approach

Across the U.S., Black women face more barriers to having a healthy pregnancy, birth, and start to parenthood than their peers. These inequities exist at every step along the path to motherhood before, during, and after pregnancy, resulting in far higher rates of severe complications and death. Specifically, Black women are at three times greater risk of death from pregnancy-related causes compared to non-Hispanic white women.

These inequities are the direct result of both interpersonal discrimination and structural racism. Black women are less likely to have their concerns, including reported pain, taken seriously by their medical teams. They are less likely to receive the quality, evidenced-based care they need in a timely way.[1] While socioeconomic status contributes to many differences in health outcomes, it does not explain the vast gaps in maternal health. For example, a Black woman with a college degree is 1.6 times more likely to die from pregnancy-related causes than a white woman who did not graduate from high school.[2]

The persistent inequities in maternal health outcomes are signs that the systems we rely on are broken. Working together to fix them will benefit everyone who gives birth in our state and will provide lessons that we can use to make our health care system more equitable for everyone.

While these inequities have been well-documented, the evidence on how to correct them is much less well-developed. Some states and national organizations have created playbooks or blueprints for advancing maternal health equity that can serve as a useful starting point. Nevertheless, these playbooks are not tailored for the unique context, challenges, and opportunities in Connecticut. Advancing maternal health equity for people of color in Connecticut will require practical approaches that integrate lived experiences, scientific evidence, and insights from policymakers and practitioners within and beyond our state.

The Connecticut Health Foundation commissioned Yale University to facilitate the development of this blueprint, informed by evidence and the expertise and experience of collaborators across the state. This blueprint is not an academic exercise or a framework for thinking about maternal health equity. Instead, it is a set of strategic recommendations to shape action by a wide range of actors, including policymakers, advocacy and philanthropic groups, health care and social service providers, and community organizations statewide

The focus of this blueprint is on Black birthing people because they face the highest rates of severe maternal morbidity in Connecticut. We recognize that other populations also face barriers to healthy pregnancies and births as a result of racism and other factors. We expect that the strategies outlined in this blueprint will benefit all populations, but we acknowledge that the needs of other groups also warrant focused solutions.

How we developed this blueprint

This blueprint has been designed by and for Connecticut residents. We have listened to stories and included a variety of people in the writing of this document. Key partners in making this work a reality include pregnant people and their care partners, including fathers and grandparents; health care providers and professionals; health care systems and administrators; community organizations and social services agencies; health professional educators; state and local government agencies; and funding organizations.

The blueprint was shaped by a 14-member advisory committee that provided strategic guidance, expertise, and oversight. The committee included people with lived experience of racism in maternal health, and those representing health systems, community-based organizations, foundations, and state agencies. The committee deliberations integrated evidence provided through written briefs by the Yale team, as well as testimony from subject matter experts. We engaged over 215 individuals, using existing organizations and networks (referred to as "CT Insights") to ensure that feedback was integrated into the development of the blueprint. The process also involved a robust desk review to identify the most pressing issues and effective interventions in maternal health equity, including reviewing existing state and national data on maternal morbidity and examining successful models from other states. We received critical review of the blueprint from six national experts, with the goal of ensuring alignment with national thought leadership. We hope this broad engagement fostered collaboration, investment and ownership from diverse perspectives across the state. For details on who participated, see appendices A-D.

The resulting strategic recommendations reflect the following principles and assumptions:

Time horizon: The blueprint makes recommendations for three years and beyond, balancing the urgency of the problem with the reality that the inequities we are addressing are deeply rooted and will require long-term change.

Principles: The recommendations are designed to:

- Reflect the perspectives of those with lived experience of the issues at hand
- Foster shared accountability for inequities in maternal health outcomes
- Name and address the impact of structural racism

We acknowledge the impact of national politics on this work and affirm that pursuit of equity is local and must continue.

Prioritization: Additional factors used to prioritize recommendations were:

- Anticipated impact on the problem
- Feasibility (including organizational capacity and political will)
- A commitment to elevate actions that build on positive momentum already in the system
- Relevance to a wide range of actors across the state, rather than a specific sector, profession, or organization

Limitations and tradeoffs: Although we worked to gain committee consensus on the recommendations, there are limitations and tradeoffs inherent in the work. These recommendations do not include all possible actions, and do not reflect consultations with all possible collaborators. Further, the blueprint is not intended to serve as a comprehensive map of all current policies and programs supporting maternal health equity in Connecticut. We recognize that there are more policies and programs in this field than are named in this blueprint.

In the following pages, we define the scope of the current problem, set a vision for the future, and identify five strategic priorities for moving toward that vision.

Health equity means the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.[3]

Social drivers of health (SDOH): The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH refers to community-level factors. They are sometimes called "social determinants of health."[4]

Health-related social needs (HRSN): Social and economic needs that affect individuals' ability to maintain health and well-being. They put individuals at risk for worse health outcomes and increased health care use. HRSN refers to individual-level factors such as financial instability, lack of access to healthy food, lack of access to affordable and stable housing and utilities, lack of access to health care, and lack of access to transportation.[5]

Quotation from CT Insights

> **“This work exists because of the long-standing impact of bias, medical neglect, and the failure to truly listen to Black and Brown birthing people. Prevention isn’t just about what individuals can do to protect themselves; it’s about transforming the systems that were never built to serve us equitably. Providers must be willing to confront uncomfortable truths – including the fact that Black and Brown birthers often have different lived experiences, systemic exposures, and stressors that directly impact maternal outcomes. Prevention means acknowledging that, and actively responding to it in care plans, listening practices, and institutional policies. True prevention is not passive – it’s intentional, equity-centered, and provider-led.”**
>
> – Community member

Problem, Vision, and Five Strategic Priorities For Action

This blueprint is based on the following problem statement and vision, developed by the advisory committee:

> Black people in Connecticut face an **inequitable burden of severe health complications** from pregnancy, labor, and delivery. These severe complications are called severe maternal morbidity.
>
> **Our vision** is a 50 percent reduction in the burden of severe maternal morbidity among Black women over three years (2026-2029), closing the racial gap for Connecticut. Many of the strategic recommendations described in this blueprint have the potential to reduce severe complications for all people experiencing childbirth in our state.

To address this problem, we identify five strategic priorities for action:

1. Treat inequities in severe maternal morbidity as a critical public health issue.
2. Ensure patients can access a wide range of maternal health care providers.
3. Strengthen connections between maternal health and behavioral health services.
4. Address discrimination in health care and diversify the workforce.
5. Increase economic security and economic mobility among families.

These strategic priorities are aligned with the recommendations of federal blueprints and other state strategies for maternal health equity while reflecting the unique strengths and opportunities in Connecticut.

We use data and stories from Connecticut to show why each strategic priority matters, describe evidence-informed recommendations for systems change, and identify concrete actions to begin the work.

Many of the recommendations focus on policy, implementation, and monitoring. Policy is critical, but achieving equity also requires implementation and monitoring to ensure that policies are reaching the people they are meant to benefit and having the intended outcomes.

Why focus on severe maternal morbidity in Connecticut?

While maternal mortality is the most devastating outcome, severe maternal morbidity and near-miss events occur substantially more frequently and can have enduring health consequences for families.

- Severe maternal morbidity refers to the unexpected, life-threatening complications that arise during pregnancy, childbirth, or the postpartum period, often leaving long-term physical and emotional scars and potentially affecting future pregnancies and relationships.
- Examples of severe maternal morbidity include kidney failure, disseminated intravascular coagulation, respiratory distress syndrome, shock, and heart failure.
- These complications often result in prolonged hospital stays, intensive care needs, and long-term health consequences, but are *often preventable*.[6]

Connecticut has the third lowest maternal mortality rate in the nation,[7] but is ranked 35th in severe maternal morbidity. Severe maternal morbidity affects 350 families in Connecticut each year, and Black women are twice as likely as their white peers to experience it. Deliveries with severe maternal morbidity are five times more likely to result in infant deaths. Rates of severe maternal morbidity are highest in Fairfield, New Haven, and Windham counties, the latter of which has limited access to labor and delivery services.[10] Yet despite the dire consequences of severe maternal morbidity, Connecticut does not routinely track and prioritize severe maternal morbidity as an important public health issue.

Connecticut ranked

35th

in nation for severe maternal morbidity rates[8] in 2021 (103.9 births with complications/10,000 births).

Black women have

2x

the rate of severe maternal morbidity of their white peers.

Deliveries with severe maternal morbidity are

5x

more likely to result in infant death,[9] compounding the trauma of these near-miss experiences.

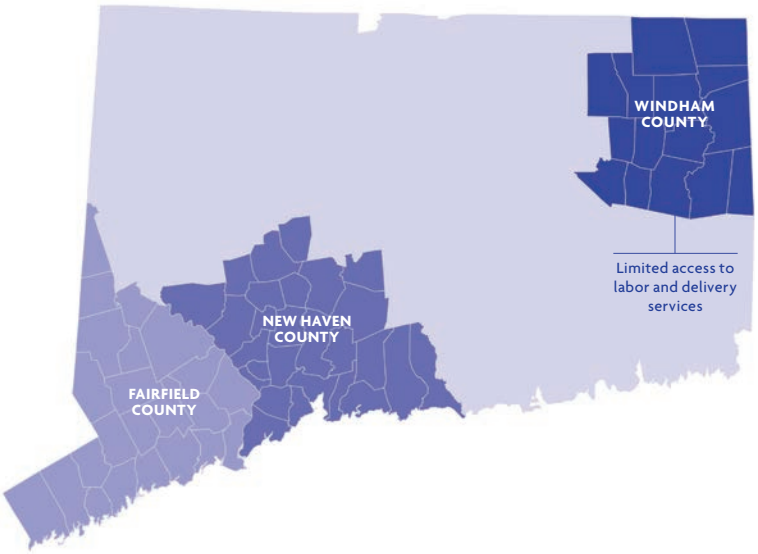
Severe maternal morbidity rates by race/ethnicity in Connecticut per 10,000 births, 2018-2020:[9]

The cost of severe maternal morbidity

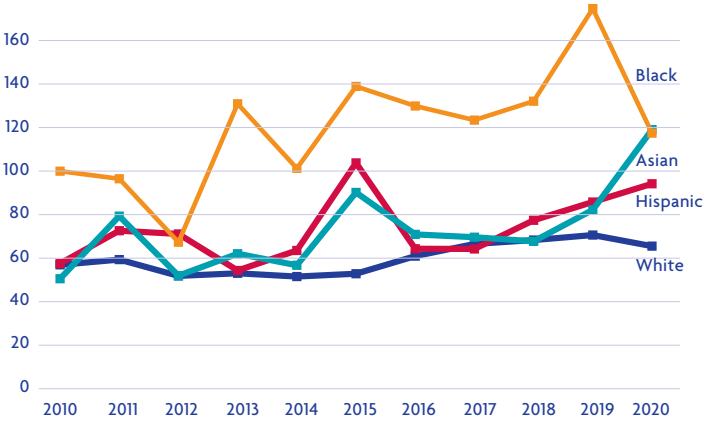
The economic burden of severe maternal morbidity is significant. Nationally, the costs related to complications of pregnancy and childbirth amount to $32.3 billion annually.[11] This figure captures both the direct health care costs (such as hospitalizations and treatment) and broader economic consequences (including lost productivity and increased reliance on social services). In addition, in Connecticut, hospital readmissions for those who experience severe maternal morbidity are ten times higher than those who do not experience severe maternal morbidity, adding further cost to both families and society.

Connecticut counties with the highest severe maternal morbidity rates

Severe maternal morbidity rates are highest in New Haven, Fairfield, and Windham counties, the latter of which has limited access to labor and delivery services.[10]



Severe maternal morbidity rates per 10,000 deliveries in Connecticut, 2010-2020



Black mothers experience twice the rate of severe complications as their white counterparts.[12]

Note by source: Rates for Asian mothers should be interpreted with caution due to small numbers causing low statistical reliability.

Treat Inequities In Severe Maternal Morbidity As A Critical Public Health Issue.

RECOMMENDATIONS

To treat inequities in severe maternal morbidity as a critical public health issue, we recommend:

1. **Establishing a statewide severe maternal morbidity review process.**
2. **Prioritizing data collection by establishing standards and a reporting mechanism.**
3. **Identifying a coordinating structure to support work to address equity in reducing severe maternal morbidity.**
4. **Creating a mechanism to track and evaluate policies supporting equity in reducing severe maternal morbidity.**
5. **Promoting awareness of severe maternal morbidity as a critical public health issue.**

1. Establish a statewide severe maternal morbidity review process.

Connecticut has adopted a standardized maternal mortality review[13] process and is well-positioned to implement a similar process for severe maternal morbidity. This is already done across the country and Connecticut can learn from the experiences of other states.

Regular severe maternal morbidity reviews can be highly effective for identifying trends and patterns that can be lost at the individual patient level, including identifying opportunities for intervention in regional hotspots and underperforming facilities (hospitals or practices). Generally, severe maternal morbidity reviews occur at the facility and state level.

As of 2023, more than a dozen states and New York City had evaluated maternal morbidity under their jurisdictions.[14] Illinois was the first state to mandate that all health facilities in the state participate in severe maternal morbidity review.[15]

There are opportunities to tailor the review process to advance equity. Specifically, a focus on the social drivers of health, inclusion of people with lived experience on the review committee, and monitoring and evaluation of uptake of committee recommendations would ensure that the review process reflects a commitment to equity and can make a meaningful difference.

2. Prioritize data collection by establishing standards and a reporting mechanism.

Data is critical to understanding the situation but gathering and sharing data can be challenging. Six states and New York City routinely track maternal morbidity data.[14] Among the challenges these states have worked to overcome:

- Getting access to timely, quality data
- Sharing or linking data across systems, platforms, and organizations (particularly data on social drivers of health)
- Getting supplemental information that could shed light on cases, such as witness accounts or records from law enforcement
- Securing resources to enhance data analysis

Many states have also passed laws related to hospital data-sharing with mandated maternal mortality review committees and reports. Connecticut could join the six states and New York City in tracking maternal morbidity data by:

- Updating data definitions and sources of information included in case abstractions.
- Ensuring that the review process incorporates efforts to understand and address challenges in the data from missing information, underreporting or misclassification.
- Collecting data from maternal health entities other than hospitals (including for home births).

3. Identify a coordinating structure to support work to address severe maternal morbidity.

It's one thing to agree that something is a health problem worth addressing; it's another to ensure that work to address it happens in a coordinated, sustained way. To make progress in addressing severe maternal morbidity, it's critical that one or more organizations take ownership, coordinate with those in other sectors, explore ways to fund the work, and ensure that review findings lead to better and more equitable maternal health outcomes.

The Connecticut Department of Public Health already plays a major role in maternal health; the department leads the Maternal Mortality Review Committee (MMRC),[13] compiled the 10-year Report on Severe Maternal Morbidity for the state, and convenes a Maternal Health Task Force. The coordinating structure we recommend could align with these existing structures.

Having a coordinating structure is a sustainable way to ensure change. Models used in other places include a joint task force,[16] guiding coalition,[17] or health equity hub[18] that supports the severe maternal morbidity work as part of a broader mission. Detailed landscape analysis and community participation are key to ensuring that this work sits within the right organizational home.

Recognizing that states have many obligations and finite resources, this coordinating entity should foster partnerships to advance equity in reducing severe maternal morbidity. This could include identifying and testing collaborative financing models to ensure there is adequate funding for efforts to address severe maternal morbidity. Partnerships in other places (including New York City[19]) included hospital quality initiatives and social service programs. Funding partnerships can build on existing federal and state funding and policy mandates but can also explore funding agreements with other partners, such as payers, health system quality initiatives, philanthropy, and community organizations with aligned missions. While challenging at times to coordinate, funding partnerships help share costs and distribute accountability so that findings related to severe maternal morbidity reviews are actionable by parties with different arenas of authority and influence. This coordinating entity could also encourage participation in relevant federal programs such as the Perinatal Quality Collaborative and the Alliance for Innovation on Maternal Health, and would have visibility to optimize resources for maternal health services and improvements.

4. Create a mechanism to track and evaluate policies for reducing severe maternal morbidity.

Adopting equity-focused policies is a key step. Ensuring they are fully implemented and studying them to ensure they have the intended outcomes is equally critical.

For example, Connecticut has led the way in legislating health-friendly policies, including Medicaid expansion, Medicaid coverage for one year postpartum, and "baby bonds." However, some strong legislation or policy initiatives have stalled because of delays in implementation, funding, awareness, or uptake.

Ongoing monitoring and evaluation to assess development, approval, and use of these policies with a health equity lens would provide much-needed evidence for efforts to promote equity in reducing severe maternal morbidity in the state. This monitoring should include the use of data that is segmented by key population characteristics, because aggregate data can mask issues affecting smaller or more marginalized populations. This mechanism for tracking and evaluating could be included as a function of the coordinating structure described above or commissioned as a discrete body of work. More broadly, this mechanism could also support the development and coordination of a research and learning agenda on equity in reducing severe maternal morbidity.

Existing quality improvement efforts should continue to evaluate the outcomes of maternal health policies. For example, Connecticut tracks prenatal and postpartum care as quality measures used to assess provider performance.

NEXT STEPS

Actions for success in year 1

- The state should authorize a severe maternal morbidity review committee, with plans for initial and longer-term funding.
- Philanthropy should work with existing maternal health coalitions and working groups to plan for implementation of the blueprint recommendations. This work should include creating or identifying a coordinating structure to support work on severe maternal morbidity.

5. Promote awareness of severe maternal morbidity as a critical public health issue.

As noted, Connecticut is ranked in the bottom half of the nation for severe maternal morbidity.[7] The reality is even more dire for Black Connecticut residents, who are twice as likely to experience severe maternal morbidity as their non-Hispanic white counterparts.[9]

Despite this gap, there is little public discussion of the relatively high rates of severe maternal morbidity in our state, or the regional differences (rates of severe maternal morbidity are elevated in Fairfield, New Haven, and Windham counties). Promoting awareness of this critical gap – with tailored approaches to engage communities, health systems, legislators, payers and state agencies – would be an achievable early step to building shared ownership and accountability for addressing inequities in severe maternal morbidity.

There are many efforts underway that Connecticut could build on. Many states, including Connecticut,[20] have adopted the Centers for Disease Control and Prevention's Hear Her campaign,[21] which targets pregnant people to raise awareness of warning signs of severe maternal morbidity and empower patient-provider dialogue. At the national level, the U.S. Department of Health and Human Services launched the M.O.M.S. Tour (Maternal Outcomes Matter Showers[22]) in 11 cities, serving over 5,000 prenatal and postpartum families. Faith-based and culturally engaged models (for example, Waterbury Bridge to Success's #Day 43 program[23] that elevates Black mothers as community advocates for better health outcomes) will be especially important for raising awareness and fostering accountability for action. By including advocates and those with lived experience in work to raise awareness, such efforts could foster trust with communities and partners across the state. Similar efforts in other states have been supported by Merck for Mothers and March of Dimes in addition to state agencies.

Ensure Patients Can Access A Wide Range Of Maternal Health Care Providers.

Carla is an experienced community-based doula. She supports clients throughout their pregnancies and postpartum period and advocates for them with the health system.*

One client, Sara, began working with Carla at the start of her third trimester. By then she had switched prenatal care providers three times because she felt they did not listen to her or care about her. Sara said they treated her "like just a number."

Sara was experiencing severe headaches, sometimes causing her to vomit, and had rib pain and kidney problems. She hadn't checked her blood pressure recently and didn't remember if her doctor had tested her urine.

"Sara was not well connected to care, and I started to worry that Sara might have preeclampsia," Carla said. "I let Sara know how important it was for her to contact her provider immediately and insist on testing to rule out preeclampsia. I told Sara how important it was for her to advocate for her health with her care team to make sure this was fully investigated."

When pregnant clients do not feel heard or seen during their visits, they may not report the symptoms they experience. Having people on their team that they trust is critical – as happened when Carla connected Sara back to care in an urgent circumstance. That connection turned out to be lifesaving.

**This story is a composite account, based on stories shared during CT Insights conversations.*

Patients benefit from having access to a wide range of care providers to support their pregnancies, deliveries, and beginning stages of parenthood, but access to these providers varies widely – often because of limitations in how our health care system pays for services. This priority area focuses on how financing can enable patients to access a wide range of care providers during and after pregnancy.

While every person's experiences and needs vary, an ideal maternal health care team includes a diverse group of clinical and non-clinical professionals. For any given patient, this could include some or all the following team members:

- Obstetricians and gynecologists (ob-gyns), midwives (nurse and certified practice)
- Fetal medicine specialists
- Other nurses and nurse navigators
- Doulas
- Social workers
- Lactation consultants
- Community health workers
- Behavioral health specialists
- Nutritionists
- Patient navigators (nurse and lay)
- Social service managers

Team-based care models, also called extended care models, are designed to have multiple professionals collaborate to provide comprehensive, patient-centered care for pregnant individuals. Team-based care models emphasize integration of various specialties and coordination to deliver holistic, seamless, and appropriate care throughout pregnancy, childbirth, and the postpartum period.[24] The federal Transforming Maternal Health (TMaH) Model calls this "whole-person care delivery."[24,25] Team-based maternal health care models have improved maternal health, birth outcomes and access to comprehensive care in diverse geographic and political settings in the U.S. and internationally.[25-28]

While descriptions of team-based care models sometimes focus on **who** is providing care, the payment model for maternal health care is one of the most important levers for ensuring that patients have access to team-based care. If it takes more than one type of professional and more than one type of organization to provide care needed by a pregnant person, it's critical to ensure that the payments for services can also be shared by them.[29]

In addition to coordination within the maternal care team, coordination is critical between the maternal care team and other providers treating a patient. This includes the primary care

provider who will resume most care in the weeks following birth, and other providers such as chronic condition specialists and dentists, who should be providing care throughout pregnancy.

Nationally, the most common innovations in insurance coverage for team-based/extended maternal health care are:

- Coverage for care through a 12-month postpartum period.
- Payment for doula and midwife services and care teams.
- Bundled episode of care payments.
- Payment for community health workers to support pregnant people and address health-related social needs.

Favorably, Connecticut has initiated health financing reforms consistent with each of these innovations, with varying degrees of implementation. In particular:

- Postpartum people are now eligible for Medicaid for 12 months after delivery.
- Connecticut has launched registration and certification for doulas.
- Medicaid launched a bundled payment for maternity care services in 2025. Doula payments are included in this model, though doula participation is low.
- State law calls for Medicaid to pay for community health worker services, though these payments have not yet been implemented.

RECOMMENDATIONS

To ensure that all pregnant patients have access to a wide range of care providers, we recommend:

1. **Building on financing reforms such as bundled payment models for maternity care services.**
2. **Addressing implementation barriers to reforms that have already been secured.**
3. **Studying Medicaid's 12-month postpartum coverage to advance knowledge of how best to support patients after delivery.**
4. **Supporting innovation in team-based care.**
5. **Building on existing state efforts to improve health for individuals incarcerated while pregnant.**

1. Build on financing reforms such as bundled payment models for maternity care services.

Bundled payments are a form of alternative payment model designed to move away from fee-for-service reimbursement toward value-based care. In a bundled payment model, providers receive a set, comprehensive payment rate for professional services delivered as part of an episode of care. The bundled payment model is designed to encourage greater efficiency and coordination in the management of patients, improving quality and outcomes and reducing costs. Bundled payments allow providers to share in savings when costs are kept below the bundle's target price; providers may also assume risk for costs that go above the target price. In maternal health, a bundle would cover the cost of treatments, tests, and procedures during pregnancy and a certain period after delivery.[30]

Connecticut Medicaid (HUSKY)[31] began offering bundled payments for each maternity episode on Jan. 1, 2025. Coverage spans 280 days before delivery to 90 days after delivery. Doulas are included[32] in the Medicaid maternity bundle program through direct payments from Medicaid to doulas who chose to become certified and registered with the state. This innovation in financing will be assessed and refined, and is expected to be a major driver of improved outcomes for patients covered by Medicaid. However, patients with commercial insurance will not benefit. To reach full potential, we recommend that Connecticut:

a. Identify and test innovative financing models for birthing care.

An essential step is to create a multi-sector working group to develop and propose creative financing models for birth care tailored to Connecticut. There are many examples of creative financing that Connecticut can draw on:

- The New Jersey Birth Equity Funders Alliance[33] was established to improve birth outcomes and promote maternal and infant health equity and to reduce maternal mortality by 50 percent within five years, using public and private funding to support demonstration projects.[34, 35]
- Community of Hope,[36] a community health center in Washington D.C., used blended funding[37] to establish a comprehensive care model that includes birthing center care and intentional collaboration between clinical and nonclinical providers.

Additional financing options may stem from creative extensions of Medicaid waivers and advocacy for changes in Medicaid payment.

b. Create a commercial payer strategy for alignment on financing models.

Patients with commercial insurance represent about 62 percent of births in Connecticut.[38] As the HUSKY bundle and other innovative financing approaches are assessed and refined, we recommend advocacy to engage commercial payers and policy action to promote alignment between commercial payers and Medicaid. This alignment would be expected to encourage consistent care pathways, accelerate provider shifts toward value-based care processes and systems, facilitate data-sharing and quality improvement, and create a more balanced pool of higher- and lower-complexity patients.

2. Address implementation barriers to reforms that have already been secured.

Connecticut policymakers have taken steps to make community health worker and doula services more accessible to patients, but these efforts have not been fully implemented; as a result, patients are not receiving the full potential benefits from these policies.

a. Begin Medicaid payment for community health workers.

A 2023 Connecticut law requires Medicaid to pay for community health worker services for: coordination of medical, oral, and behavioral health care services and social supports; connection to and navigation of health systems and services, prenatal, birth, lactation, and postpartum supports; and health promotion, coaching and self-management education.

While the state Department of Social Services moved forward with plans to begin coverage of these services, payment has not started,[39] and state lawmakers have not appropriated funding to cover these services. Implementing Medicaid payment for community health workers would expand patients' access to a key workforce that can build trust and improve outcomes.

b. Address barriers to doula care.

Connecticut has established a certification and registration process for doulas. Certified and registered doulas can be reimbursed by HUSKY (Medicaid) through the maternity bundle beginning in 2025. Most privately insured people pay out of pocket for doula services.

Doula registration for participation in the HUSKY maternity bundle program remains very low. Barriers include low payment rates[40] for doulas and lack of clarity about doulas' scope of independent practice, and lack of infrastructure for doula certification, registration, and billing. Increasing doula participation will require efforts to identify and address all barriers.

Another way to address barriers to doula care is to partner with trusted messengers to promote awareness among Black birthing people of available pregnancy-support options in Connecticut. Raising awareness among community members coupled with advocacy could help build demand for team-based care options and help ensure that policy gains are implemented.

c. Promote adequate payment rates and expanded coverage for all members of the maternal health care team, across payers.

While various plans for advancing maternal health recommend integrating certified nurse-midwives, freestanding birth centers, lactation consultants, doulas, and other perinatal support services, payment rates and adequate development of coverage procedures for such workers can be challenging.

Similarly, payment rates for physicians, midwives, nurses and other care workers vary by payer, causing some providers to turn away certain patient groups based on their insurance coverage.

3. Study Medicaid's 12-month postpartum coverage to advance knowledge of how to best support patients after delivery.

In 2022, Connecticut increased Medicaid and Children's Health Insurance Program coverage from 60 days to 12 months postpartum. This is funded by both the state and federal governments. We recommend evaluating outcomes of 12-month postpartum Medicaid coverage by critical population characteristics (such as race, ethnicity, and disability status). Post-implementation evaluation could demonstrate if expected outcomes and benefits of this coverage have been realized equitably and how to improve on any gaps that are found. This research could also help address current knowledge gaps related to what types of support at what points during the postpartum period are most important.

4. Support innovation in team-based care.

a. Advocate for state funding to expand universal home visiting beyond two pilot locations.

State agencies piloted Family Bridge, a universal home visiting program, in Bridgeport using federal American Rescue Plan Act funds beginning in 2023. A New London/Thames Valley area program began in January 2025. Continuation or expansion of this program will require state funding.

b. Support adaptation and testing of group prenatal care models to identify essential design components and inform anticipated updates to the Medicaid maternity bundle.

Group prenatal care models have been implemented in multiple locations, but not yet at scale. Proactively identifying and addressing implementation challenges can help the maternal health community roll out high quality group prenatal care programs that people are enthusiastic about attending.

c. Promote equitable access to technological innovations in extended care, including remote patient monitoring, telehealth visits, and AI-supported risk identification algorithms that are derived from and relevant to patients from historically marginalized groups.

Artificial intelligence can improve care and reduce the burden of certain tasks. Examples include use in imaging and risk prediction for gestational diabetes. However, it's critical to ensure that AI is being appropriately applied and is not reinforcing existing inequities.

5. Build on existing state efforts to improve health for individuals incarcerated while pregnant.

Nationally, 3.8 percent of women entering incarceration are pregnant, with numbers increasing.[41] This means that approximately 35 to 50 women in Connecticut enter corrections while pregnant each year, and others are incarcerated shortly after giving birth.[42] The Connecticut Department of Correction, with assistance from the Office of Early Childhood, has taken many steps to improve pregnancy and postpartum health for people who are incarcerated. These include having living arrangements near medical facilities where incarcerated pregnant and postpartum individuals can live together, as well as offering prenatal care, perinatal education, labor support through doulas; mental health services; and breastmilk pumping, storage, and transport capabilities.

To further reduce severe maternal morbidity for women who are incarcerated, we recommend the following measures:

a. **Support community services for those released from incarceration while pregnant to ensure continuity of care.** This is especially important for those dismissed from court without prior opportunities for Department of Correction transfer of care planning (such as medication access, insurance coverage, prenatal care and community doulas, and mother-child supportive housing placements).

b. **Expand pilot programs and commission studies of alternatives to child separation for pregnant incarcerated people,** including alternative-to-incarceration and prison nursery programs, to reduce anticipatory grief during pregnancy, psychological trauma after delivery, and long-term attachment issues for pregnant people and their children.

c. **Strengthen connections between prison and external health systems** through shared electronic health record systems, patient access to subspecialty (e.g., maternal fetal medicine) care and consultation during pregnancy to optimize care of high-risk obstetric populations.

NEXT STEPS

Actions for success in year 1

- Researchers should engage multiple sectors to identify creative opportunities for financing team-based maternal health care, to inform future statewide efforts.
- State lawmakers should appropriate funding to implement previously approved legislation supporting Medicaid coverage of community health worker services for pregnant and postpartum people.
- State agencies should work with doulas and health care providers to identify and address barriers to participation in the Medicaid maternity bundle.
- State policymakers should work to shield pregnant and postpartum people from any Medicaid cuts.

Examples from CT

Family Bridge

The Connecticut Office of Early Childhood offers Family Bridge, an evidence-based, universal nurse and community health worker home visiting program based on the Family Connects model. All families with newborns, as well as bereaved parents, can receive a free home visit from a nurse and community health worker to screen mother and baby and connect them to local services to meet their needs. Nurses carefully assess newborns and mothers and discuss next steps to address opportunities and concerns, including seeking immediate medical care when necessary. Nurses attend to the whole family, recommending appropriate community-based resources and follow-up as needed. Family Bridge is currently available to families of all babies delivered at Bridgeport Hospital or St. Vincent's Medical Center who live in Bridgeport, Easton, Fairfield, Milford, Monroe, Shelton, Stratford, and Trumbull. It is also available to families who deliver at Backus Hospital and reside in Norwich, Windham, Griswold, Lisbon, Montville, the Mashantucket Pequot Tribal Nation and the Mohegan Tribal nation. For more details visit https://www.ctoec.org/family-connects-bridgeport/.

Family Wellness Center

The Hispanic Health Council's Family Wellness Center, in the heart of Hartford's Latino community, integrates 15 agencies to provide culturally relevant and competent clinical services in English and Spanish for families seeking holistic care, support, and opportunities. With a health equity focus, and through trauma-informed care, the center addresses eight principal areas of health: physical, intellectual, occupational, spiritual, social, emotional, financial, and environmental. The Hispanic Health Council's Maternal and Child Health services include its Comadrona Program, Family Wellness Healthy Start, Breastfeeding Heritage and Pride, Stronger Families, Stronger Futures, and Community Doula programs. For more details visit https://hispanichealthcouncil.org/programs-services/family-wellness-center/

Strengthen Connections Between Maternal Health and Behavioral Health Services.

Londyn is a 25-year-old second-time mom. Londyn always considered herself a happy and outgoing person. She felt joyful and excited during her first pregnancy. But this pregnancy feels different to her. Londyn feels exhausted from caring for a toddler while pregnant. And she just cannot seem to shake off the sadness and fear that crashes over her sometimes. "It feels hard to concentrate and to go through the motions of my day," she said. "I just cannot seem to enjoy anything during this pregnancy."*

Londyn knows she needs help, but she feels afraid. Growing up, she heard that people who go to therapists are "mentally disturbed" or "crazy." She is afraid people might think she is a "bad mother." Her neighbor Keisha struggled with mental health issues after giving birth and when Keisha sought help, someone called child protective services and Keisha's baby was taken away from her. Londyn is afraid that could happen to her too.

At Londyn's last check-up, she received a screening questionnaire that told her provider she likely had perinatal depression. Her provider suggested that she talk to a mental health professional and gave her some phone numbers. Londyn called them all. She was hoping to find a provider of color who would understand her better. But Londyn found that every therapist she called had a wait list or did not take insurance. Londyn doesn't know what to do next.

**This story is a composite account, based on stories shared during CT Insights conversations.*

Mental health and substance use disorders – which can occur separately or together – are significant challenges for pregnant and postpartum individuals. Yet many women face significant barriers to getting the care they need. Among the reasons:

A lack of screening: Connecticut's Maternal Mortality Review Committee[43] has noted multiple missed opportunities in acute care (emergency department), labor and delivery, and ongoing postpartum care for screening for mental health issues and referring for care, despite patients' pre-existing mental health concerns. Unlike many other states, Connecticut does not require that providers offer mental health screening and that insurance provide reimbursement for screening postpartum individuals.[44]

Workforce shortages: Even those who are screened might not find a provider to treat them. Connecticut has a behavioral health workforce shortage,[45] with over half of residents living in a designated mental health professional shortage area.[46, 47]

Inappropriate referrals to child welfare authorities: Infants of Black women are referred for testing for substance exposure under the Child Abuse Prevention and Treatment Act (CAPTA) in Connecticut at higher rates,[48] despite Black women's having similar self-reports of alcohol and substance use as their white and Hispanic counterparts.

In Connecticut between 2015 and 2020, mental health issues likely or definitely contributed[49] to almost half (42 percent) of maternal deaths, all of which were deemed preventable. During that timeframe, five out of six maternal suicides in Connecticut were women of color.[49] Among maternal deaths from mental health conditions, more than two-thirds occurred in the late postpartum period, highlighting the need for extended postpartum support. According to one national assessment,[50] 10.4 percent of women in Connecticut reported postpartum depressive symptoms after a live birth in 2020, yet fewer than half sought help for their symptoms.

Connecticut offers several mental and behavioral health resources for women during the perinatal and postpartum periods, but gaps remain between mental health screenings and access to maternal mental health care. Across national focus groups, Black women have described specific challenges[51] in reaching mental health services.

A focus on behavioral health for Black birthing people must recognize the interplay of racism, structural drivers of health, and a legacy of mistrust that may characterize interactions with the health system.[52] Such experiences put Black women at greater risk of perinatal mental health issues[53] and can also deter pregnant

and postpartum people from seeking behavioral health services and support. Trauma-informed care and building trust[54] with behavioral service providers and state agencies is paramount to providing culturally responsive services, and there is an unmet demand from Black birthing people for mental health care that considers their lived experience with racism and systemic discrimination in the health system. Trust needs to be built[55] to address the mental health care needs among Black moms, and women need to be heard[56] to access appropriate services and support.

RECOMMENDATIONS

To strengthen connections between maternal health and behavioral health services, we recommend:

1. **Ensuring there is appropriate infrastructure (policy, funding, and training) to support maternal mental health needs from pregnancy to one year postpartum.**
2. **Developing policies to integrate mental health screening and linkages to care at multiple entry points.**
3. **Prioritizing pregnant and postpartum people for substance use disorder resources and mental health care.**
4. **Supporting a community-led task force to monitor maternal mental health services for Black birthing people and develop a hub to streamline access to services.**

1. Ensure there is appropriate infrastructure (policy, funding, and training) to support maternal mental health needs from pregnancy to one year postpartum.

a. Fund, train, and deploy diverse behavioral health workers who are well-equipped to identify and address the mental health needs of Black birthing people both within and outside hospital settings.

Medicaid covers licensed marriage and family therapists, licensed professional counselors, and other mental health professionals who can provide perinatal mental health services as part of maternal health teams. Their services can complement the work of doulas, midwives, patient navigators, social workers, community health workers and other practitioners. This recommendation would help address the shortage of behavioral health providers and ensure choice for birthing people to access mental health services and support.

b. Continue to support, staff and promote the ACCESS Mental Health for Moms hotline to ensure that behavioral health services are available 24/7 to pregnant and postpartum people.

The ACCESS Mental Health for Moms hotline provides psychiatric expertise and consultation to health care providers who treat pregnant and postpartum patients with mental health or substance use concerns. The hotline is available 24/7 at (833) 978-MOMS (6667).

The National Maternal Mental Health Hotline at (833) 852-6262 (1-833-TLC-MAMA) is available for individuals to call or text and has counselors who speak English and Spanish.

c. Implement and monitor the Alliance for Innovation on Maternal Health (AIM) patient safety bundle for perinatal mental health to ensure standardized, evidence-based care and support for maternal mental health across the care continuum.

Hospitals should ensure that patients have access to a multidisciplinary care team to provide coordinated clinical pathways for pregnant and postpartum people experiencing perinatal mental health conditions, including inpatient services when needed. The Core AIM Patient Safety Bundle for Perinatal Mental Health Conditions includes implementable changes for organizations to prepare and address maternal mental health, as well as trainings and drills focused on perinatal stress, trauma, anxiety, and depression.[57] The Connecticut Perinatal Quality Collaborative could monitor implementation.[58]

2. Develop policies to integrate mental health screening and linkages to care at multiple entry points.

Any health care site that perinatal patients access should be equipped to identify, screen, and refer patients for mental health services. These include emergency departments, pediatrician offices, birthing centers, community health care clinics, and home visits,[59] and is consistent with recommendations from the Connecticut Maternal Mortality Review Committee.[60] Those who have suffered a pregnancy loss should be included in screening.

a. Embed evidence-based, easy to use tools for screening and connection to follow-up for common behavioral health conditions, including perinatal mood disorders and postpartum depression, that can be administered at any care site for patients within one year of delivery.

This is particularly important in emergency departments. While behavioral risk assessments are part of the HUSKY maternity bundle for prenatal care,[61] ongoing screening through the postpartum period is essential, including during lactation support and pediatric visits. Any screening tools should be available in multiple languages.

b. Ensure that postpartum women can access culturally safe perinatal mental health screening and support to identify underlying mental health concerns without stigma, bias or fear of losing their children.

While leaders of the state Department of Child and Families and Department of Mental Health and Addiction Services have tried to make their systems accessible, many women who participated in CT Insights said that they still view the departments as punitive, and this distrust makes them less likely to seek services. System reform is needed. Doulas, community health workers, and patient navigators can serve as trusted allies to help connect women to services and support, particularly for those in postpartum crisis.

c. Prioritize and deploy patient navigators within clinical care settings to link pregnant and postpartum people in need of mental health services with warm hand-offs, as well as community health workers to support social needs through HUSKY.

3. Prioritize pregnant and postpartum people for substance use disorder resources and mental health care.

a. Ensure that pregnant and postpartum people can access substance use disorder and mental health services (including crisis resources), without fear of legal consequences.

Pregnancy is a sensitive time when people struggling with substance use disorders or mental health challenges should be encouraged and supported in seeking treatment. Yet many pregnant and postpartum people are afraid to disclose or seek help for their substance use or mental health challenges because they fear repercussions, including having their children taken away.

Connecticut has a system for collecting data on substance use among pregnant people that allows for reporting de-identified information – that is, data that does not identify the patient. However, research suggests this system is not being used evenly. Although Black pregnant people report substance use at similar rates of their white peers, more Black women are reported to the system,[48] suggesting that there is bias and discrimination in the surveillance.

In Connecticut, substance use and mental health screening is routine and does not immediately equate to a child welfare concern. Pregnant people need to be made aware of their rights, and medical and behavioral health providers and community organizations need to be clearer in communicating the information. It's also important that all frontline workers who could encounter a pregnant person receive this information.

b. Fast-track referrals and deploy patient navigators to link pregnant and postpartum people in need of behavioral health services, including substance use disorder treatment.

While substance use disorder (SUD) services are limited throughout Connecticut, pregnant and postpartum people should be fast-tracked for access and wraparound support (such as respite housing and social services). Patient navigators in clinical care settings and community health workers could link those in need to such services.

c. Promote use of the AIM Core Patient Safety Bundle for Care for Pregnant and Postpartum People with Substance Use Disorder (AIM CPPSUD), a set of evidence-based practices aimed at health systems, including clinical and non-clinical staff, designed to improve the quality of care and outcomes for pregnant and postpartum individuals struggling with substance use disorders. These practices address the specific needs of this population, including screening, brief intervention, referral to treatment, and respectful, equitable care while supporting close coordination with community partners for referrals and warm handoffs.

4. Support a community-led task force to monitor maternal mental health services for Black birthing people and develop a hub to streamline access to services.

Often, the traditional health system is the last point of contact for Black moms to access behavioral health services. Community-based organizations can provide behavioral health support and extend care for those in need, particularly in the postpartum period.

a. Establish a community-led maternal mental health task force[62] to ensure that the complex and unique mental health needs of Black birthing people are being met.

Such a task force, designed to promote accountability of the system to the community, would review performance data through an equity lens, and recommend and monitor activities that promote and sustain equity in maternal mental health and well-being. A similar task force was proposed in recent legislation but was not included in the final bill.[63]

This task force could play a role in promoting existing community-based mental health resources that support mothers in places they feel most comfortable, as well as identifying where resources are lacking or do not exist at the level needed. When they have partnerships with health care providers, community mental health programs can refer to higher levels of care and encourage people in care or to share information with clinicians when they might be reluctant or afraid to do so.

b. Develop and fund a resource hub for maternal mental health and behavioral health services.

The goal of the hub would be to streamline access to resources and promote uptake of services and could be accessed by providers and staff of community-based organizations, as well as patients and families. Such a hub, envisioned as a managed, public online platform/portal, would feature community-driven resources, including group-based and dyadic care models (with babies and fathers) that are feasible and culturally acceptable in community-based settings to bolster mental health before, during and after pregnancy.

NEXT STEPS

Actions for success in year 1

- Community-based organizations and state agencies should work together to establish a community-led maternal mental health task force.

Examples from CT

PROUD and Women's REACH

PROUD (Parents Recovering from Opioid Use Disorder) is a Connecticut Department of Mental Health and Addiction Services (DMHAS) program[64] that is designed to support pregnant and postpartum women and their families who are struggling with substance use disorders. PROUD uses a network of recovery navigators who have lived experience in recovery to provide case management and recovery coaching, helping women navigate the system and access resources. DMHAS navigators also play a role in the Women's REACH program (Recovery, Engagement, Access, Coaching & Healing), which focuses on recovery, engagement, access, coaching, and healing for women and their families.

Finding Safe Spaces to discuss Perinatal Mental Health

Understanding Black women's lived experiences and the toll racism takes on their mental and physical health is key to addressing maternal health disparities[65] and supporting women beyond birth. Every pregnancy journey is different. While Connecticut lacks sufficient behavioral health providers, there are examples of Black-led counseling services and programs that could serve as models for compassionate, culturally aligned care. New Chapter Counseling Services, LLC[66] led by Samantha Smalls, DSW, who also serves on the Board for the Connecticut Chapter of Postpartum Support International,[67] provides perinatal mental health services, mental wellness counseling, and breastfeeding support groups. Her practice recognizes that perinatal mood and anxiety disorders, infant loss, infertility, abortion, and birth trauma are often unheard because people are afraid to talk about their experiences and struggles. New Chapter creates a safe space to discuss these issues, with a highly qualified, diverse team. In addition, various programs[68] are available through the HUSKY bundle across Connecticut to provide perinatal care management[69] services and support, as well as a United Way-staffed hotline (211)[70] for perinatal and postpartum depression.

SEPI-CT

The Substance Exposed Pregnancy Initiative of Connecticut (SEPI-CT) works with providers and families to bring awareness to substance exposure during pregnancy and ensure families have access to the needed treatment, recovery, and support resources. SEPI-CT meets families where they are, works toward equity, strives to eliminate stigma, empowers individuals to seek support, and helps health systems build capacity to deliver compassionate, quality care. This initiative is funded by the Connecticut Department of Mental Health and Addiction Services and the Connecticut Department of Children and Families and is contracted through Wheeler Clinic. For more details visit https://www.sepict.org/about/

Quotations from CT Insights

> **Having peer navigators, having individuals that look like people we're serving and have had similar experiences is important. Everyone's experience is different, but we need to be able to say to someone who is still struggling, 'I've been there. I got through it. It's not all bad. Not all social workers are bad. These are the things they can offer you. This is what's on the other side of accepting help.' With our federal landscape, we're afraid that people are going to go underground again with substance use and mental health concerns.**
>
> – State agency representative

> **I have a person in particular who was very much so reprimanded [for seeking mental health crisis services]. She did not have backup support so she was separated from her child, and hospitalized for less than a week. When she came out of the hospital till this day, she does not have custody of her child. DCF has custody of her child. She's now charged with neglect because it was neglectful for her to have a mental crisis, and how dare she not have somebody to watch her child.**
>
> – Provider

Address Discrimination In Health Care and Diversify The Workforce.

Jasmine is a 26-year-old patient care assistant who has worked on the labor and delivery floor of the hospital for five years. Now that she is pregnant, Jasmine notices things that happen at work in a different light. She hears some providers dismiss patients' concerns, as if they do not know anything about their own bodies. She hears nurses joke and loudly whisper about patients who are in pain, who ask for "too many things," or who are culturally different from themselves.*

Jasmine used to think they were just blowing off steam from a busy shift or finding a way to cope with the constant demands of their hard jobs. But now she realizes how vulnerable patients feel during pregnancy, the worries they have about birth, and the pain of not feeling heard, cared about, or respected within the health care system. Jasmine has felt it when she is rushed through prenatal visits and her provider seems annoyed by her and her husband's questions.

Jasmine now tries to speak up for the patients when the nurses are gossiping or complaining loudly enough for other patients to hear. She tries to listen to the patients and help, but it is hard when she has no power to make anyone change their behavior. "I wish some of my co-workers could find their compassion again," Jasmine said. Jasmine also wishes she knew how to deal with the more serious racist comments and behaviors from one of her co-workers without losing her temper or her job.

Jasmine's husband Ben wants to support his wife as best he can, but sometimes he feels like there is no room for him in the health care process.

"I get worried hearing Jasmine's stories of what she sees at her job every day. How fathers are treated on the labor and delivery floor sometimes. How people make assumptions that they are not the husband or a good support for the mom. How husbands trying to speak up for their wives have had security called on them."

Ben worries about taking care of his wife during the delivery when dads don't seem to be respected. "When your wife is in pain, you have to step up and advocate for her any way you can, but what happens if no one listens?"

**This story is a composite account, based on stories shared during CT Insights conversations.*

We can't have an honest discussion about Black maternal health without addressing the discrimination that too many women encounter. This reality is borne out in research and in personal accounts. According to the Connecticut Maternal Mortality Review Committee, discrimination plays a significant role in maternal mortality; it was implicated in 70 percent of deaths studied in 2018-2020.[71] The committee said discrimination needs to be addressed urgently to safeguard the health and well-being of Black families. In a national survey conducted in 2023,[49] 30 percent of Black respondents reported experiencing mistreatment while getting maternity care during their most recent pregnancy, and 40 percent reported experiencing discrimination.

Mistreatment and discrimination can take many forms. There are overt racism, implicit bias, and structural factors – including algorithms that use race as a factor to recommend different care – that can lead even well-intentioned individuals and systems to cause harm to Black patients.

Combatting bias and discrimination will require ongoing, evidence-based training in trauma-informed care and a willingness to learn with humility on the part of everyone in the health care system. Equipping the existing maternal health workforce with evidence-based training on culturally safe care is necessary to advance maternal health equity[72] and such training has been successfully rolled out in other states.

Accountability is also critical. Current accountability mechanisms are insufficient to address racial discrimination in the health system. Implementing mechanisms for individuals to report and respond to incidents of bias can help ensure that people who experience discrimination or witness biased care can report these incidents for continuous quality improvement and accountability at the provider and system levels.

Increasing the diversity of the health care workforce, and families' access to non-physician care providers, can also help provide choice and potentially improve care experiences for Black families. Many Black moms seek community-based, midwifery-led care,[26] which has the potential to support better outcomes, fewer medical intervention, and lower costs.[73] Broadening the maternal health workforce is considered a key national strategy to advance maternal health equity and has been prioritized in many states to improve outcomes.

By the numbers, Connecticut has an ample supply of maternity care physicians for the population. But choice is more limited for families who want to receive care from midwives or doulas, or within a birthing center. Connecticut has the lowest percentage of midwifery-attended births in New England, accounting for just 12 percent of births.[74] Connecticut has 4.9 certified nurse-midwives (CNM) per 100,000 residents, compared to 18.91 ob-gyns. The certified nurse-midwife workforce in Connecticut is predominantly white,[75] and there is only one midwifery-led freestanding birthing center in Connecticut. It is estimated that there are 100-150 doulas in Connecticut,[76] which is considered likely inadequate to meet the demand for their services. Additionally, while the physician workforce meets the demand overall, its diversity does not match the population. Black patients who wish to be treated by a physician or have complex needs that require one should have access to providers who represent the diversity of the state.[77]

RECOMMENDATIONS

To address discrimination in health care and diversify the workforce, we recommend:

1. **Increasing the number and diversity of doulas, nurse-midwives, behavioral health workers, and ob-gyns–the parts of the perinatal workforce with the largest gaps.**
2. **Mandating that frontline care providers receive training designed to advance equity and reduce bias in the health setting, using content and format with strong evidence of effectiveness.**
3. **Setting up multiple measurement systems to safeguard maternal health equity and foster accountability and mitigation at the provider- and health system-level.**

1. Increase the number and diversity of doulas, nurse-midwives, behavioral health workers, and ob-gyn – the parts of the perinatal workforce with the largest gaps.

a. **Enlist additional doulas and certified nurse-midwives** by making training and support available to complete certification and expand practice.

b. **Expand community-based training for certified nurse-midwives, and recruit diverse candidates** by targeting local nursing programs and community-based health centers to enhance accessibility, diversity, and rapid scale-up.

c. **The state should appropriate funds for training and hiring new perinatal behavioral health workers**, including community health workers, to address the behavioral health workforce shortage.

d. **Promote retention of the midwifery and perinatal workforce** by supporting programs that provide "care for the carers," recognizing the burnout burden among maternal health providers of color,[78] behavioral health providers, and perinatal mental health professionals.

2. Mandate that frontline care providers receive training designed to advance equity and reduce bias in the health setting, using content and format that have strong evidence of effectiveness.

Many trainings exist, but studies have found that not all are effective in reducing bias and promoting equity. It is critical to select training that has been found to have both content and formats that are effective.

a. **Train frontline providers and support staff, including in primary care, ob-gyn, and emergency settings, in an evidence-based maternal health equity curriculum**, which emphasizes interprofessional collaboration, cultural humility, and trauma-informed, risk-appropriate care.

b. **Provide Continuing Education Units/Medical Education (CEU/CME) credits to share findings and recommendations from the Connecticut Maternal Mortality Review Committee and severe maternal morbidity report**, including case studies/grand rounds/debriefings, using Connecticut state-level data and opportunities for ongoing learning to disseminate best practices in equitable care.

c. **Design and implement a mandatory maternal health equity curriculum for pre-service health professionals** that includes bystander and upstander[79] intervention training.

3. Set up multiple systems of measurement to safeguard maternal health equity and foster accountability and mitigation at the provider- and health system-level.

In addition to the recommendations in Priority #1 that will foster accountability at the system/state level for severe maternal morbidity, we recommend:

a. **Ensuring that existing metrics used for value-based purchasing and public reporting are reported by race and ethnicity.**

b. **Piloting and adapting an anonymous reporting system** such as Lift Every Voice[80] (currently operational in Philadelphia ER/ob-gyns) with Connecticut health systems and federally qualified health centers.

c. **Evaluating the acceptability and feasibility of a validated, patient-reported measure** to track experiences of discrimination at hospital- and provider-level (i.e., PREDICT, PREM-OB).

d. **Supporting and training community-based organizations and doulas to act as community ombudsmen** to sustain accountability to communities and establish ongoing listening sessions to integrate the lived experiences of Black birthing people in recommendations proposed by the severe maternal morbidity review committee.

e. **Introducing a pragmatic tool to assess maternal health equity by health system and service area** (as will be studied under Special Act No. 25-7)[63] to ensure accountability and improvement. Other states, including New Jersey, have implemented similar measures.[81]

NEXT STEPS

Actions for success in year 1

- Providers and state agencies should work together to identify evidence-based, trauma-informed curricula on maternal health equity for frontline health care providers, with input from people with lived experience. Providers and state agencies should work together to incorporate these trainings into existing mandated trainings.
- Researchers and providers should work together with input from people with lived experience to identify an evidence-based measure of discrimination that would provide just-in-time data for clinical providers and be feasible and acceptable to use.

Examples from CT

Connecticut has several policies and programs that support professional development and accountability in the maternal health workforce, including:

- The Midwifery Working Group,[82] which convenes monthly to discuss birthing care, safety, and coordination of care.
- The CT Maternal and Child Health Block Grant,[83] which supports states in addressing the unique needs and priorities of their maternal and child health populations, including addressing implicit bias and social determinants of health that affect women of color.
- The Connecticut Hospital Association strategy[84] for collective work and advocacy on maternal health.
- The Perinatal Quality Collective,[58] which presents an opportunity for accountability.
- The Trauma Informed Care Racial Equity Lens Initiative,[85] a Department of Social Services racial equity training program intended to establish a consistent approach to trauma-informed care as part of the Value-Based Payments Initiative.

Quotations from CT Insights

> **To be real, when I've had a bad experience with a doctor or nurse, I usually just keep it to myself. Not because it didn't bother me but because I don't always feel safe speaking up. As a Black woman, there's this worry that if I say something, they'll see me as angry or difficult, and I'll be treated worse the next time.**
>
> – Community member

> **I thought about telling someone, but I didn't know who to talk to. And even if I did, would they actually do anything about it? I've filled out those little surveys after visits, but I never hear anything back. It feels like no one is really listening.**
>
> – Community member

> **I'm traumatized. I'm not even going to lie. It makes me so emotional sometimes. If you're speaking to a doctor, they look at you like you're crazy. It's a lack of understanding. It's a lack of communication.**
>
> – Community member

> **You're not going to go to your diversity workshop and then you're good for three months. It is an ongoing process of understanding. You know who you are, what you bring into the room, and how that impacts on what you see and don't see.**
>
> – Workforce educator

Increase Economic Security and Economic Mobility Among Families.

Sofia is a 33-year-old mom who just delivered her third baby. She and her husband always dreamed of having three children, and it feels like their family is now complete.*

The joy they feel for their family is accompanied by stress. Because Sofia has had to miss so much work during a difficult pregnancy, they are struggling to put food on the table, and paying for diapers and other baby essentials adds even more strain to their budget. Their landlord raised the rent again this year and they can barely keep up, but staying there and paying more still seems like a better plan than trying to move. It seems like the cost of rent is up everywhere.

Sofia's doctors encouraged her to breastfeed, and she does. But she worries she will not be able to pump enough milk when she goes back to her job at a warehouse, and it would be hard to find another job because she does not have a car. Sofia wishes she did not have to go back to work so quickly, but she is worried about affording diapers, childcare, and all their other bills.

As tired as she is with a newborn, Sofia often stays awake worrying about her family's future. It feels impossible to even think about building a secure, middle-class life with the mounting debt they are facing just for buying the essentials. She wants more for her children, but most of the time, she's focused on keeping them from losing ground.

**This story is a composite account, based on stories shared during CT Insights conversations.*

The first four priorities of this blueprint focus on ways to address severe maternal morbidity in the health care system itself. We recognize that these strategies alone cannot succeed without concurrent efforts to address the economic barriers that shape the health of families.

Addressing basic economic needs is essential. Attending prenatal visits is challenging for pregnant women who do not have access to reliable transportation. Being unable to afford rent or pay for diapers are both material challenges and risk factors for stress and depression.

At the same time, addressing all the economic issues that affect pregnant people and families is an enormous undertaking. Many efforts are underway to address the challenges facing Connecticut families – including housing, food and nutrition security, transportation, economic stability, education, and others – and we recognize the role they play in pregnancy and postpartum health and well-being.

We also recognize the importance of making long-term changes that will close wealth gaps and allow future generations to live with more opportunities and fewer barriers. Families like Sofia's have needs today that require attention, but it's also critical to take steps so their children have more opportunities.

While ensuring equitable economic opportunity is long-term work, there are actions we can promote that can improve maternal health and well-being. Significant work is already underway in the state to promote economic mobility for women of reproductive age, especially Black women and women from other groups who have been marginalized based on their location, socioeconomic status, or other characteristics.

What do we mean by economic security and economic mobility?

Economic security can be defined as having enough income and other resources to meet basic monthly expenses – such as housing, food, transportation, and childcare – and save for emergencies and retirement.[86]

Economic mobility is the ability of individuals or households to improve their economic status over their lifetimes. Economic mobility is central to the idea of the American dream and is shaped by economic security, as well as gaps and opportunities for people to benefit from the resources around them.[87,88]

Targeted policies have improved insurance coverage and reduced cost-related barriers to reproductive and pregnancy care for women overall, and especially people living on low incomes.[89]

Similarly, there are targeted policies and practices that are effective in moving families out of poverty and improving overall socioeconomic status.[90-92] There is evidence that measurable improvement in economic mobility can happen when states support employment and asset development practices, parental leave, access to affordable childcare, and child tax credits.

Connecticut already has many promising policies and programs that address economic mobility as a key driver of maternal and family health and well-being. Connecticut is leading the way with policies for paid leave; paid sick leave; family and medical leave; and baby bonds, a first-in-the-nation investment program for children born with Medicaid coverage in the state. Regional programs[93] delivering guaranteed basic income, universal childcare, maternal health and newborn supply boxes, paid prenatal leave, and expanded access to infertility care offer additional ways to support birthing people.

RECOMMENDATIONS

To improve economic security and economic mobility among families, we recommend:

1. **Championing efforts to address economic mobility before, during, and after pregnancy.**
2. **Strengthening partnerships, coordination, and communication to serve families better during and after pregnancy.**
3. **Making pregnancy and birth affordable.**

1. Champion efforts to address economic mobility before, during, and after pregnancy.

a. Elevate economic mobility as foundational for thriving individuals and families.

b. Consistently collect, analyze, and report data needed to drive action on social and structural drivers of health most relevant for Connecticut, such as adequate wages, housing, nutritional security, reliable transportation, childcare costs and availability, insurance coverage, and internet access.

c. Promote development of basic income initiatives for birthing people most at risk of experiencing poor outcomes.

d. Develop and sustain programs that address financial and opportunity costs associated with diapers (such as not being able to use daycare without providing diapers).

Nationally, roughly half of all families with young children cannot afford an adequate supply of diapers. In Connecticut, about 30 percent of families have difficulty affording diapers.[94]

e. Allocate more temporary assistance to needy families (TANF) funds to basic assistance, emergency medical home improvement for people experiencing homelessness, or non-recurrent, short-term benefits.

TANF is not a health care program and cannot fund health care. However, it can be used to fund services that support the goal of having a consistent source of care (a medical home), including transportation assistance to health care appointments, for people experiencing homelessness.

f. Advocate for the sustainability of CT Baby Bonds beyond the initial 12 years of allocated program funds.

g. Advocate for and support efforts to expand access to free or affordable, quality childcare for all.

Childcare facilitates health, well-being, and appointment attendance for people giving birth and their newborns.

2. Strengthen partnerships, coordination, and communication to serve families better during and after pregnancy.

Many community-based organizations are already working hard to address economic mobility at the community and individual level.

a. Invest in strategic partnerships to address economic and social needs before, during, and after pregnancy for those in most need of help.

Opportunities to have the biggest influence on economic needs involve organizations outside the health care system. Health systems and providers should partner with organizations that are best positioned to address economic needs of pregnant people. These partnerships, when coupled with strong communication and coordination, can help to ensure that patients' needs are addressed and that health care encounters can be focused on physical and mental health.

I. Health systems should prioritize partnerships with organizations and agencies with a track record of providing supportive care to Black birthing people to bridge service gaps.

II. Health systems and community-based organizations should co-develop and test contractual agreements so that organizations with expertise in economic and social support receive recognition and payment for contributing to health outcomes and health status and reductions in overall health care expenditures.

III. State agencies should streamline enrollment in programs for housing, childcare, financial assistance, and food by building better connections between these programs and the health system, so that pregnant and postpartum women can more easily obtain services.

b. Develop strategies to encourage use of wraparound care, benefits, and services to fill gaps in support such as safe childcare, intimate partner violence intervention, food access, and transportation assistance.

I. Ensure that pregnant and postpartum patients have access to medical-legal partnerships in which poverty-focused legal services are embedded in health care settings, so that lawyers can meet clients where they are, in places they trust, and aim to address their civil legal needs across a spectrum of issues.

II. Use outreach campaigns for workers and employers to increase awareness of workplace protections for pregnant and postpartum women, including access to a private lactation room and break time to pump.[95]

III. Raise awareness about and monitor implementation of Connecticut's paid leave and guaranteed leave programs among diverse groups. Connecticut's program is fairly new but national studies have found that Hispanics and non-Hispanic Black workers have not used family medical leave as often white workers.[96, 97]

3. Make pregnancy and birth affordable.

State policymakers should align policies and resources to ensure that costs associated with pregnancy and birth are not catastrophic for families. Connecticut has implemented policies within the past few years to reduce out-of-pocket costs for pregnancy and birth. Examples include the HUSKY B prenatal-postpartum coverage for uninsured noncitizens, mandated state coverage for maternity care, extended postpartum coverage, transparency in coverage laws, CT paid family leave which includes two additional weeks for prenatal leave, financial assistance programs such as The Bridge Project, and expanded access to doulas and birthing centers. Let us keep going; there is more to be done.

Too many people, both with insurance coverage and without, cannot pay the medical bills they receive after birth. High medical costs and out-of-pocket payments lead to medical debt and medical bankruptcy just as families are growing. New mothers are twice as likely to have medical debt as women who did not recently give birth and the estimated additional out-of-pocket costs for privately insured individuals is about $3,000.[98-100] For households struggling to keep up with living costs, such costs can be damaging to their budgets and stability for months or even years.

NEXT STEPS

Actions for success in year 1

- Philanthropy should convene partners to develop a plan to coordinate piloting and expanding guaranteed basic income programs in the state.
- Advocates should work with state lawmakers to expand the state child tax credit and ensure sustainability of the Baby Bonds program.
- Hospitals and community-based organizations should work together to identify and publicize the financial and opportunity costs associated with childbirth (for example, the cost of diapers and not being able to use daycare without providing diapers).

DIRECT CASH AND BASIC INCOME PROGRAMS

One type of policy that can improve health is the use of direct cash transfer programs to increase people's wealth and assets. Basic income, child development accounts, unrestricted cash aid, and other programs have been found to boost financial stability at the individual and household levels.

Basic Income Programs

A guaranteed basic income program uses government or philanthropic funds to give cash or electronic deposits to people the program wants to help. Connecticut has at least three pilot basic income programs that are supported by the Connecticut Urban Opportunity Collaborative and 4-CT. These pilots are assisting more than 700 households and include: UpTogether, The Bridge Project, and the Bridgeport New Haven Health Equity Pilot.

Direct Cash and Cash Transfer Programs

Direct cash programs support household financial stability by increasing families' buying power and assets. The "baby bonds" program and tax deductions for participation in 529 college savings plans are other forms of direct cash or cash transfer programs. Some programs give set dollar amounts; some give funds on a sliding scale of need. Some programs are time limited (such as the first 1,000 days of child's life) or start and end at times based on a specific event such as a birth.

"Baby bonds" gives children who meet certain criteria accounts at birth, and the funds in those accounts are invested until they are independent adults. CT Baby Bonds accounts allow Connecticut youth to accumulate assets by the time they are adults.

Earned Income Tax Credit

Tax credits reduce families' overall tax bill, allowing them to keep more of their money. The Connecticut earned income tax credit (EITC) is a refundable state income tax credit for low- to moderate-income working individuals and families. The state's credit is similar to the federal EITC. When the federal and state tax credits exceed the amount of taxes owed by a household, the household that claims the credit can receive a refund. The EITC is only available to tax filers that have earned income.

The size of the tax credit varies based on family size. For a family with one child, the maximum federal EITC is $4,213, and the maximum state EITC is $1,685. For a family with three or more children, the maximum federal credit is $7,830, and the maximum state credit is $3,132. The state EITC is set at 40 percent of the federal EITC.[101] Research shows that most families use their tax credit to pay for necessities, like food and housing, and for education and training that can boost their job prospects and earning potential.[102]

Child Tax Credit

Policymakers have considered the use of child tax credits as a way to provide economic support to families. In 2021, the federal American Rescue Plan Act temporarily expanded the child tax credit, made it fully refundable, and paid half of it in monthly installments for six months. Researchers found that this temporary expansion lifted 2.9 million children out of poverty.[103] In 2022, Connecticut provided a one-time child tax rebate of $250 per child, up to a maximum of $750 per family.[104] There have been efforts since then to create a state child tax credit. The state budget adopted in 2025 included an additional $250 tax credit for families who qualify for the earned income tax credit. The United Way of Connecticut has said that there are 355,000 working families with children that struggle to make ends meet but would not benefit from this credit because their incomes are above the limit to qualify for the earned income tax credit.[105]

ADDRESSING DIAPER NEED[106]

Families who cannot afford diapers delay diaper changes (which may result in infections), reduce spending on food, utilities or other expenses, and may delay or skip work, medical appointments and daycare. There is increasing evidence that providing diapers to people with financial need can improve parent/caregiver mental health and ability to work or study and support child health and development.

Diaper Connections, a collaboration between the Connecticut Hospital Association, the Diaper Bank of Connecticut, and community-based organizations, is an example of how hospitals and health systems could help address diaper need and health-related social needs by connecting eligible families directly with diapers and service providers during their health care visits. Diaper Connections distributed more than one million diapers to 2,200 children from November 2022 to April 2023. This partnership helped extend entry points for the work of the Diaper Bank of Connecticut.

The Diaper Bank of Connecticut, one of the largest diaper banks in the national diaper bank network, has 61 partners, yet fills only 7 percent of the estimated diaper need in the state with the 300,000 diapers it helps distribute each month (more than 3.6 million diapers each year).

Treating diapers as a basic need and supplying diapers helps families reduce stress and use their money for other needs–including investments in education and health.

For more details visit https://thediaperbank.org/diaper-connections/

Year 1 Implementation Actions

This blueprint is one step. The next is an implementation planning stage that engages collaborators across the state in pursuit of each recommendation. The table below summarizes ambitious, yet achievable actions to build momentum in one year, laying the foundation for sustained improvements in maternal health equity. Although each item lists one or more sectors as taking a lead, we anticipate that people from many sectors will have a role in most or all of these activities.

Priority		Actions for Success in Year 1
1	**Treat inequities in severe maternal morbidity as a critical public health issue.**	• The state should authorize a severe maternal morbidity review committee, with plans for initial and longer-term funding. • Philanthropy should work with existing maternal health coalitions and working groups to plan for implementation of the blueprint recommendations. This work should include creating or identifying a coordinating structure to support work on severe maternal morbidity.
2	**Ensure patients can access a wide range of maternal health care providers.**	• Researchers should engage multiple sectors to identify creative opportunities for financing team-based maternal health care, to inform future statewide efforts. • State lawmakers should appropriate funding to implement previously approved legislation supporting Medicaid coverage of community health worker services for pregnant and postpartum people. • State agencies should work with doulas and health care providers to identify and address barriers to participation in the Medicaid maternity bundle. • State policymakers should work to shield pregnant and postpartum people from any Medicaid cuts.
3	**Strengthen connections between maternal health and behavioral health services.**	• Community-based organizations and state agencies should work together to establish a community-led maternal mental health task force.
4	**Address discrimination in health care and diversify the workforce.**	• Providers and state agencies should work together to identify evidence-based, trauma-informed curricula on maternal health equity for frontline health care providers, with input from people with lived experience. Providers and state agencies should work together to incorporate these trainings into existing mandated trainings. • Researchers and providers should work together with input from people with lived experience to identify an evidence-based measure of discrimination that would provide just-in-time data for clinical providers and be feasible and acceptable to use.
5	**Increase economic security and mobility among families.**	• Philanthropy should convene partners to develop a plan to coordinate piloting and expanding guaranteed basic income programs in the state. • Advocates should work with state lawmakers to expand the state child tax credit and ensure sustainability of the CT Baby Bonds program. • Hospitals and community-based organizations should work together to identify and publicize the financial and opportunity costs associated with childbirth (for example, the cost of diapers and not being able to use daycare without providing diapers).

The Connecticut Health Foundation plans to work with advisory committee members and others focused on maternal health issues in the state to begin planning for implementation.

Conclusion

The birth of a child is a pivotal time in a family's life. For many people, pregnancy, birth, and early parenthood are a time of joy. But for too many people, particularly Black women, pregnancy, birth, and the months following are traumatic experiences that can lead to death or life-threatening complications known as severe maternal morbidity.

Severe maternal morbidity can produce long-term health consequences, yet it is often preventable. Although Connecticut ranks high in many health indicators, the state ranks 35th in severe maternal morbidity. The burden is particularly severe for Black women who experience severe maternal morbidity at more than twice the rate of their white peers.

We can change this situation. This blueprint aims to reduce the burden of severe maternal morbidity among Black women by 50 percent over three years, closing the racial gap in Connecticut. The strategies to do so have the potential to reduce severe complications for all people giving birth in the state.

This blueprint focuses on five strategic priorities:

1. Treating inequities in severe maternal morbidity as a critical public health issue.
2. Ensuring patients can access a wide range of maternal health care providers.
3. Strengthening connections between maternal health and behavioral health services.
4. Addressing discrimination in health care and diversifying the workforce.
5. Increasing economic security and economic mobility among families.

An underlying theme in our recommendations is that while policy is critical, achieving equity requires implementation and monitoring to ensure that policies are reaching the intended people and having the desired outcomes.

The development of this blueprint included intensive desk research, the guidance of an advisory committee representing many sectors and people with lived experience, insights from more than 200 people across the state, and input and feedback from subject matter experts in Connecticut and across the country.

This blueprint is a first step. Next, we plan to bring together a wider group to build on the recommendations and work toward the year-one actions. We see a role for virtually every sector in this work, including policymakers, health care providers, insurers, community-based organizations, philanthropy, academia, and people with lived experience. Many efforts are already underway to address maternal health equity in Connecticut, and we hope the work that grows out of this blueprint will bolster and complement these efforts. We share a common goal: making Connecticut a state in which everyone has an equal opportunity for a healthy pregnancy, birth, and start to parenthood.

Appendix A: Advisory Committee Members

Althea Marshall Brooks, M.S., M.Div.
Executive director, Waterbury Bridge to Success (BTS) Community Partnership

Althea Marshall Brooks leads BTS's strategic direction with a focus on shifting power to BIPOC (Black, Indigenous, and people of color), youth, and caregivers. She brings extensive experience in community engagement, education, and municipal leadership. She served as director of coordinated school health for New Haven Public Schools and community services administrator for the City of New Haven.

Tamika Julien, DNP, CNM, WHNP-BC, CLC
Senior lecturer in nursing and women's health; nurse practitioner (WHNP) specialty director, Yale School of Nursing

Dr. Tamika Julien brings over a decade of clinical experience in community health, specializing in maternal health, breastfeeding, and family planning. She leads the education and training of future women's health practitioners and conducts research on postpartum care and reducing maternal mortality.

SciHonor Devotion, CPM, eCID, CLC
Midwife and founding director, Earth's Natural Touch: Birth Care & and Beyond, Inc.

SciHonor Devotion has 25 years of experience in reproductive health, including birth and postpartum care, lactation counseling, and doula training. She leads one of the largest Black-owned doula training organizations in the Northeast and actively contributes to state-level maternal health initiatives focused on racial equity.

Tiffany Donelson, MPH
President and CEO, Connecticut Health Foundation

Tiffany Donelson leads the state's largest independent health philanthropy focused on health equity for people of color. She previously held strategic leadership roles at Aetna and in health care consulting. She brings deep expertise in health systems and a strong commitment to equity.

Tabassum Firoz, MD
Attending physician, Bridgeport Hospital; assistant clinical professor, Yale School of Medicine

Dr. Tabassum Firoz founded the Collaborative Obstetric Medicine Clinic and Postpartum Heart Care Program at Bridgeport Hospital. Her work focuses on postpartum cardiovascular risk, pre-eclampsia, and global maternal health policy. She serves on the Connecticut Maternal Mortality Review Committee and consults for the World Health Organization.

Deidre Gifford, MD, MPH
Commissioner, Office of Health Strategy; senior advisor to the governor for health and human services (retired June 2025)

Dr. Deidre Gifford previously served as commissioner of the Connecticut Department of Social Services and as acting commissioner of the Department of Public Health during the COVID-19 response. She is a nationally recognized leader in health care quality, Medicaid policy, and public health strategy. Her background includes leadership roles at the Center for Medicare and Medicaid Services and in Rhode Island state government.

Djana Harp, MD, MBA, MS
Chief medical officer, obstetrics and gynecology, Norwalk Community Health Center

Dr. Djana Harp leads ob-gyn services for a diverse patient population, advancing access and equity in women's health. She brings extensive experience in clinical leadership and care innovation in community health settings.

Manisha Juthani, MD
Commissioner, Connecticut Department of Public Health

Dr. Manisha Juthani leads the state's public health agency with a focus on equity, mental health, infectious diseases, and opioid response. She has a strong academic medicine and research background, with more than 50 peer-reviewed publications, and formerly served as fellowship director and faculty at Yale School of Medicine.

Iyanna Liles, MD
Fellow of the American College of Obstetricians and Gynecologists (FACOG) Board certified obstetrics and gynecology physician, co-chair Connecticut Maternal Mortality Review Committee

Dr. Iyanna Liles provides comprehensive reproductive health care, emphasizing family planning, adolescent health, and minimally invasive surgery. She is actively involved in clinical leadership and advocacy through ACOG and the Connecticut Maternal Mortality Review Committee.

Lisa Morrissey, MPH
Deputy commissioner, Connecticut Department of Public Health

Lisa Morrissey served as a local health director in Danbury, Bridgeport, and the Housatonic Valley Health District. She teaches public health at the University of Bridgeport and Western Connecticut State University and oversees environmental health, drinking water, local health, public health preparedness, and the Office of Health Equity.

Marcella Nunez-Smith, MD, MHS
Associate dean, health equity research, and director of the Equity Research and Innovation Center

Dr. Marcella Nunez-Smith leads research and strategy to advance health equity, with expertise in discrimination measurement and system-level drivers of disparities. She holds multiple leadership roles in equity-focused academic and clinical initiatives at Yale and beyond.

Natasha Ray, MS
Director, New Haven Healthy Start, The Community Foundation for Greater New Haven

Natasha Ray leads a long-standing community-based maternal health initiative focused on reducing infant mortality and improving service access. She brings 25 years of experience in community health and participatory research and chairs statewide engagement and equity efforts.

Andrea Barton Reeves, JD
Commissioner, Connecticut Department of Social Services

Andrea Barton Reeves oversees programs supporting children, families, and older adults statewide. She brings experience in public administration, legal advocacy, and nonprofit leadership, and formerly served as CEO of the Connecticut Paid Leave Authority.

Lutonya Russell-Humes
Vice president, grants and programs, Fairfield County's Community Foundation

Lutonya Russell-Humes leads strategy and implementation of community investments focused on equity and well-being. She oversees major initiatives addressing systemic challenges in Fairfield County.

Mark Schaefer, PhD
Vice president, system innovation and financing, Connecticut Hospital Association

Dr. Mark Schaefer leads policy and financing reforms to strengthen Connecticut's health care delivery system. He previously served as state Medicaid director and director of healthcare innovation, bringing expertise in behavioral health, quality improvement, and system transformation.

Milagrosa Seguinot, AS, CCHW, TMI
Executive director, Community Health Workers Association of Connecticut

Milagrosa Seguinot leads statewide community health worker workforce development, education, and advocacy. She brings decades of experience in maternal health, chronic disease prevention, and service navigation, serving as an educator, mentor, and statewide representative for CHWs.

Appendix B. Expert Reviewers

Abbe R. Gluck, JD
Faculty director, Solomon Center for Health Law and Policy, Yale Law School

Abbe Gluck is the Alfred M. Rankin Professor of Law and founding faculty director of the Soloman Center for Health Law and Policy at Yale Law School. She directs the Yale Law School Medical Legal Partnership Program, has a secondary appointment on the faculty of Yale School of Medicine, and serves in leadership roles on the Uniform Law Commission and the American Law Institute (ALI). Abbe's extensive knowledge of health law and policy enhances the review process.

Eugene DeClercq, PhD
Professor, community health sciences, Boston University School of Public Health

Dr. Eugene DeClercq is a professor of community health sciences at Boston University School of Public Health and holds a join appointment in obstetrics and gynecology at Boston University School of Medicine. His research on maternal mortality and morbidity includes the Listening to Mothers series. He is a member of the Massachusetts Maternal Mortality Review Committee and founder of Birth by the Numbers.

Jacquelyn Caglia, MPH
Head, Merck for Mothers

Jacque Caglia has over 20 years of experience in public health and currently serves as head of Merck for Mothers within the company's social impact and sustainability team. She leads a dedicated team focused on improving maternal health outcomes and fostering transformative public-private partnerships with collaborators and grantees in the U.S. and around the world. Previously, she worked at the Harvard T.H. Chan School of Public Health, co-authoring the Lancet Commission on Women and Health report.

Laurie Zephyrin, MD, MBA, MPH
Senior vice president, advancing health equity, The Commonwealth Fund

Dr. Laurie Zephyrin is the senior vice president of Advancing Health Equity at The Commonwealth Fund. She is driven by a passion to transform health care and advance equity. She brings her experience as a clinician, health policymaker, and intrapreneur to her role at The CMWF to drive delivery system change.

Reverend Que English, PhD
President and CEO, Elev8 Health Inc.

Rev. Dr. Que English is the president and CEO of Elev8 Health Inc. and former director of the U.S. Department of Health & Human Services' Center for Faith-Based and Neighborhood Partnerships. She has collaborated with the White House on national initiatives addressing COVID-19, maternal health, youth mental health, suicide prevention, and substance use disorders. Dr. English is a visionary leader and passionate advocate, excelling in driving public-private partnerships, public health advocacy, and faith-based community engagement to advance equity, policy change, and large-scale social impact.

Zahirah McNatt, DrPH, MHSA
Deputy commissioner, Center for Health Equity and Community Wellness, and chief equity officer, NYC Health Department

Dr. Zahirah McNatt is the chief equity officer and deputy commissioner for the Center for Health Equity and Community Wellness (CHECW) at the New York City Health Department. In this role, she oversees the agency's equity portfolio and provides direct oversight and management of programs and initiatives that work to increase visibility of the harm perpetuated by centuries of racist, socially unjust policy while pushing towards redress for the most impacted NYC communities. Dr. McNatt's expertise lies at the intersection of global public health, humanitarian systems, and human rights. Her work has spanned academic, non-profit, and government sectors.

Appendix C. Subject Matter Experts

Lucinda Canty, PhD, RN, CNM, FACNM, FAAN
Certified nurse-midwife, associate professor of nursing, and director of the Seedworks Health Equity in Nursing Program at the University of Massachusetts Amherst

Dr. Lucinda Canty is a certified nurse-midwife, associate professor of nursing, and director of the Seedworks Health Equity in Nursing Program at UMass Amherst, with over 30 years of experience in reproductive health care. Her research focuses on preventing maternal mortality, addressing racial disparities in reproductive health, and promoting anti-racism and diversity in nursing and midwifery. She is the founder of Lucinda's House, a nonprofit that addresses maternal health equity in the community, and a nationally recognized scholar, artist, and poet, honored with multiple prestigious awards, including the 2024 Trailblazer Award from the National Black Nurses Association.

Deborah Garneau, MA
Deputy director, Division of Community Health and Equity; director for Maternal and Child Health, Rhode Island Department of Health

Deborah Garneau serves as the deputy director of the Division of Community Health and Equity and director for Maternal and Child Health at the Rhode Island Department of Health. She is an expert in aligning systems, addressing structural health drivers, and leading authentic community engagement. Deborah's background includes mental health and child welfare administration, making her a key leader in strategic public health planning. She shared insights on the design and implementation of the Rhode Island strategic plan during the February advisory committee meeting.

Sangini S. Sheth, MD, MPH, FACOG
Associate professor, obstetrics, gynecology and reproductive sciences, Yale School of Medicine

Dr. Sangini S. Sheth is an associate professor at Yale School of Medicine, specializing in obstetrics, gynecology, and reproductive sciences. She is dedicated to providing comprehensive gynecologic services, including cervical cancer prevention, prenatal care, and advanced treatments and surgeries. Dr. Sheth earned her MD and MPH from Johns Hopkins and has collaborated on international projects to improve cervical cancer prevention. She provided a pre-recorded video briefing on inequities in severe maternal morbidity for the November advisory committee meeting.

Leseliey Welch, MPH, MBA
Co-founder, Birth Detroit and Birth Center Equity

Leseliey Welch is a public health strategist, social entrepreneur, and writer. She co-founded Birth Detroit, which opened the city's first freestanding community birth center in 2024, and Birth Center Equity, a national initiative investing in Black, Indigenous, and people of color-led birth centers. With nearly two decades of leadership in public health, she is also the vision behind National Birth Center Week and Beloved Birth 50 by 50 and an Aspen Institute Ascend fellow. She shared expertise on the role of community birth centers in advancing maternal health equity during the May advisory committee meeting.

Appendix D. Connecticut Insights Participants

We gratefully **acknowledge the 216 individuals** who contributed their time, expertise, and experiences as part of the "CT Insights" conversations. We also thank the many community organizations and leaders who hosted these conversations.

Participants came from communities across Connecticut, and included clinical directors, doulas, community health workers, social workers, therapists, physicians, midwives, nurse-midwives, lactation consultants, nurses, community members/perinatal families (including pregnant people and supportive partners), health care executives, advocates, educators, faith leaders, philanthropic funders, private payors, and public health professionals.

This engagement occurred in a variety of formats including town halls, one-on-one conversations, and conversations with existing groups. Forums and participating organizations included:

Town Halls	Participating Organizations
Mental Health Providers Conversation on the mental health needs of pregnant and postpartum people and the barriers and facilitators to mental health and mental health care that affect maternal health equity.	• Clifford Beers Community Care Center • Hartford Health Initiative • Hartford HealthCare • New Chapter Counseling Services, LLC • Waterbury Hospital • Connecticut Department of Public Health • Mind Blossom • Ledge Light Health District
Philanthropic Funders Conversation on the philanthropic priorities and investments in maternal health equity and the role of philanthropy in advancing maternal health equity.	• Waterbury Bridge to Success (BTS) Community Partnership • Mind Blossom • The Connecticut Project • Connecticut Council for Philanthropy • Connecticut Community Foundation • Yale New Haven Health System • Bridgeport Prospers
Clinical Providers Conversation about clinical programs and practices to address maternal health equity and health system and clinical facilitators and barriers to equity. Discussed how to achieve interdisciplinary collaboration to improve maternal health equity.	• Hispanic Health Council • Yale-Griffin Prevention Research Center • Middlesex Health • Hartford HealthCare • Bridgeport Hospital - Yale New Haven Health • Nurse-Family Partnership at RVNAhealth • Women's Health Connecticut • American College of Nurse-Midwives (ACNM) & Yale • Earth's Natural Touch: Birth Care and Beyond, Inc.
Workforce Educators Conversation with educators about plans and challenges to preparing the next generation of professionals to advance maternal health equity, including addressing bias, promoting trauma-informed care, and strengthening workforce training.	• Golden Radiance Village and Danbury Hospital • Eastern Connecticut State University • Southern Connecticut State University • Saint Mary's Hospital • Earth's Natural Touch: Birth Care and Beyond, Inc. • New Haven (CT) Chapter of The Links, Incorporated

Town Halls	Participating Organizations
Community-Based Organizations Conversation with community organizations on their work to address the needs of pregnant and postpartum people and families, and community assets, needs, and opportunities to advance maternal health equity locally.	• Waterbury Bridge to Success (BTS) Community Partnership and Day 43 Black Maternal Health Initiative • Black Women United • Trinity Health of New England • Health Equity Solutions • Nurse-Family Partnership at RVNAhealth • CT Health Community Advisory Committee • American Heart Association • She Leads Justice • New Haven Healthy Start • Ministerial Health Fellowship • Colored Hemisphere • Black Health Collective • BSEB - Birth Support, Education & Beyond, Inc • PT Partners • Triumph Through Transitions, LLC.

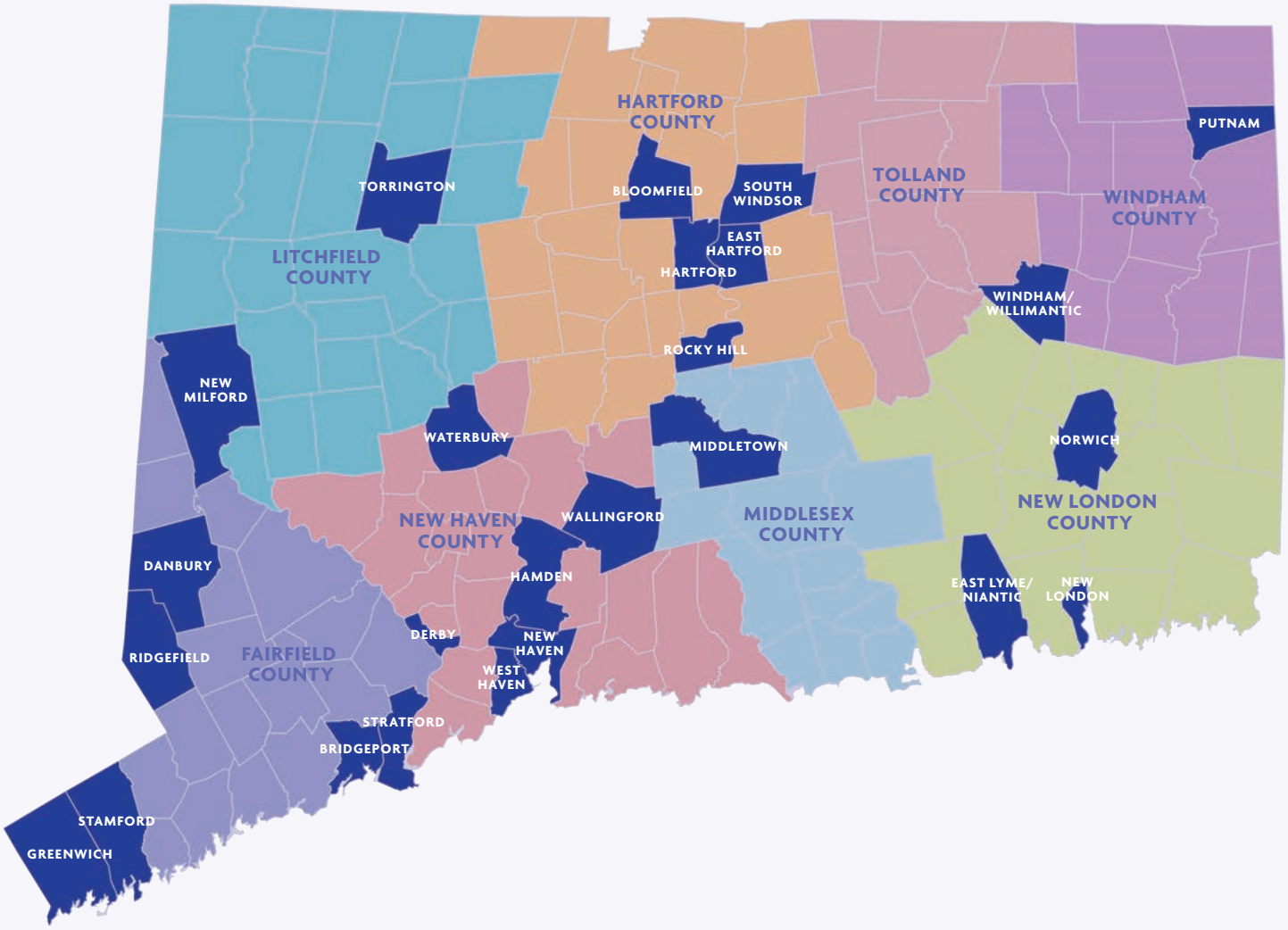
We collaborated with Waterbury Bridge to Success and New Haven Healthy Start to hold small group conversations with birthing people and partners to learn from those about to give birth or with recent birth experiences.

In addition, we met with existing groups and individual organizations engaged in maternal health work. Through this process, we consulted with the following organizations and groups:

- New Haven Healthy Start
- Hispanic Health Council Inc.
- Earth's Natural Touch: Birth Care and Beyond, Inc.
- Molina Health/ConnectiCare
- Lawrence & Memorial Hospital
- **Community Health Improvement Plan Health System Leaders**
  - Middlesex Health
  - Yale New Haven Health
  - Charlotte Hungerford Hospital/Hartford HealthCare
  - Nuvance Health
  - Hartford Hospital
  - St. Vincent's Medical Center/Hartford HealthCare Fairfield Region
  - Day Kimball Health
  - Greenwich Hospital
  - Connecticut Hospital Association
  - Hartford HealthCare Backus and Windham Hospitals
  - Trinity Health
  - Community Health Center, Inc.
  - Stamford Health
  - Saint Mary's Hospital
- **Yale Center for Clinical Investigation Cultural Ambassadors**
  - Junta for Progressive Action
  - St. Stephens AME Zion Church
  - Walters Memorial AME Zion Church
  - Varick Memorial AME Zion Church
  - Northeastern Episcopal District and New England Conference of the African Methodist Episcopal Zion Church
  - Cross Street AME Zion Church
  - Mount Olive AME Zion Church
- **Substance Exposed Infant Initiative**
  - Department of Children and Families
  - Department of Mental Health and Addiction Services
  - Wheeler Clinic
- **Connecticut State Agencies**
  - Department of Children and Families
  - Department of Correction
  - Office Of Early Childhood
  - Department of Mental Health and Addiction Services

As a result of this work, we had input from organizations and individuals from all Connecticut counties. This was important because each region has unique challenges and assets for pregnant people.

Towns Represented



References

1. "What Drives Black Maternal Health Inequities in the U.S.," American Medical Association, accessed August 8, 2025, https://www.ama-assn.org/delivering-care/population-care/what-drives-black-maternal-health-inequities-us.
2. Petersen EE et al., "Racial/Ethnic Disparities in Pregnancy-Related Deaths—United States, 2007–2016," *MMWR Morb Mortal Wkly Rep* 68, no. 35 (2019): 762–765, doi.org/10.15585/mmwr.mm6835a3.
3. "CMS Framework for Healthy Communities," Centers for Medicare & Medicaid Services, updated February 28, 2025, accessed August 8, 2025, retrieved from https://www.cms.gov/priorities/health-equity/minority-health/equity-programs/framework.
4. "Healthy People 2030: Social Determinants of Health," adapted from U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, accessed October 23, 2024, retrieved from https://health.gov/healthypeople/objectives-and-data/social-determinants-health.
5. "HHS Call to Action: Addressing Health-Related Social Needs in Communities Across the Nation," adapted from U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, accessed October 23, 2024, retrieved from https://aspe.hhs.gov/sites/default/files/documents/3e2f6140d0087435cc6832bf8cf32618/hhs-call-to-action-health-related-social-needs.pdf.
6. Howell EA, "Reducing Disparities in Severe Maternal Morbidity and Mortality," *Clin Obstet Gynecol* 61, no. 2 (2018): 387–399, doi.org/10.1097/GRF.0000000000000349.
7. "2024 State Scorecard on Women's Health and Reproductive Care," The Commonwealth Fund, July 2024, doi.org/10.26099/6gr0-t974.
8. Analysis of U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, Federally Available Data, America's Health Rankings, United Health Foundation, accessed October 17, 2024, retrieved from https://www.americashealthrankings.org/.
9. "Connecticut's Severe Maternal Morbidity Report: 2010–2020,"Connecticut Department of Public Health, Community, Family Health and Prevention Branch, accessed September 7, 2025, retrieved from https://portal.ct.gov/-/media/dph/maternal-mortality/ct-dph-severe-maternal-morbidity-report-2010_2020-v2.pdf?rev=7ffc823526fb47fa803a592f8996658b&hash=2B1DF414ABB02B930DE8A5B5CE1337AD.
10. "2024 March of Dimes Report Card for Connecticut," March of Dimes PeriStats, updated November 2024, accessed August 18, 2025, retrieved from https://www.marchofdimes.org/peristats/reports/connecticut/report-card.
11. "The High Costs of Maternal Morbidity Show Why We Need Greater Investment in Maternal Health," The Commonwealth Fund, November 2021, doi.org/10.26099/nz8s-4708.
12. "Rates for Severe Complications from Labor and Delivery Have Been Higher for Black Mothers for Most Years," Datawrapper, accessed September 3, 2025, available from https://www.datawrapper.de/_/qEUxM/.
13. "Maternal Mortality Review Program," Connecticut Department of Public Health, Maternal Child Health and Access to Care Section, accessed September 7, 2025, retrieved from https://portal.ct.gov/dph/maternal-mortality/maternal-mortality-review.
14. "Maternal Mortality Review Committees," Guttmacher Institute, Sept. 1, 2023.
15. Koch AR et al., "Implementing Statewide Severe Maternal Morbidity Review: The Illinois Experience," *J Public Health Manag Pract* 24, no. 5 (2018): 458–464, doi.org/10.1097/PHH.0000000000000752.
16. "Joint Biennial Report," Maternal Mortality and Morbidity Task Force and Department of State Health Services, Texas Health and Human Services, accessed September 7, 2025, retrieved from https://www.dshs.texas.gov/sites/default/files/legislative/2018-Reports/MMMTFJointReport2018.pdf.
17. Johnson I et al., "Building Collective Power to Advance Maternal and Child Health Equity: Lessons from the New Orleans Maternal and Child Health Coalition," *Matern Child Health J* 28, no. 12 (2024), accessed June 27, 2025, doi.org/10.1007/s10995-024-04000-7.
18. "Task Force Launches the Maternal Health Hub to Advance Value-Based Maternity Care," Health Care Transformation Task Force, June 25, 2020, accessed June 27, 2025, retrieved from https://hcttf.org/maternal-health-hub/.
19. "Introducing: The Severe Maternal Morbidity Toolkit." New York City Department of Health and Mental Hygiene, December 2020, accessed August 18, 2025, retrieved from https://www.nyc.gov/assets/doh/downloads/pdf/csi/introducing-severe-maternal-morbidity-toolkit.pdf.
20. "Hear Her," Connecticut Department of Public Health, accessed September 7, 2025, retrieved from https://portal.ct.gov/dph/family-health/hear-her/hear-her.
21. "Hear Her Campaign," Centers for Disease Control and Prevention, accessed September 7, 2025, retrieved from https://www.cdc.gov/hearher/index.html.
22. "The White House Blueprint for Addressing the Maternal Health Crisis: Two Years of Progress," The White House, July 10, 2024, accessed July 11, 2025, retrieved from https://bidenwhitehouse.archives.gov/briefing-room/statements-releases/2024/07/10/the-white-house-blueprint-for-addressing-the-maternal-health-crisis-two-years-of-progress/.
23. "Black Maternal Health Awareness," Waterbury Bridge to Success, 2022, accessed August 18, 2025, retrieved from https://www.waterburybridgetosuccess.org/blackmh2022/.
24. "Transforming Maternal Health (TMAH) Model Maternal Health Care Team Factsheet," Centers for Medicare & Medicaid Services, 2023, accessed September 7, 2025, retrieved from https://www.cms.gov/priorities/innovation/innovation-models/transforming-maternal-health-tmah-model.
25. "Improving Maternal and Infant Health Through Multisector, Community-Driven Partnerships," The Commonwealth Fund, December 3, 2024, retrieved from https://www.commonwealthfund.org/publications/fund-reports/2024/dec/improving-maternal-infant-health-community-partnerships.
26. "Community-Based Models to Improve Maternal Health Outcomes and Promote Health Equity," The Commonwealth Fund, March 2021, doi.org/10.26099/6s6k-5330.

27. Mianda S, Todowede O, Schneider H, "Service Delivery Interventions to Improve Maternal and Newborn Health in Low- and Middle-Income Countries: Scoping Review of Quality Improvement, Implementation Research and Health System Strengthening Approaches," *BMC Health Serv Res* 23, no. 1 (2023): 1223, doi.org/10.1186/s12913-023-10202-6.

28. Smith V, "Midwife-Led Continuity Models Versus Other Models of Care for Childbearing Women," *The Practising Midwife* 16, no. 10 (2013): 39–40.

29. Byrd DP et al., "Community-Based Doulas—Can Clinicians Share Power to Improve Maternal and Infant Health Outcomes?" *N Engl J Med* 389, no. 26 (2023): 2405–2407, doi.org/10.1056/NEJMp2308601.

30. "Bundled Payments," Centers for Medicare & Medicaid Services, accessed September 7, 2025, retrieved from https://www.cms.gov/priorities/innovation/key-concepts/bundled-payments.

31. "HUSKY Maternity Bundle: Details of Connecticut's Maternity Bundle," Connecticut Department of Social Services, accessed September 7, 2025, retrieved from https://portal.ct.gov/dss/health-and-home-care/husky-maternity-bundle/details-of-connecticut-maternity-bundle?language=en_US.

32. "HUSKY Maternity Bundle: Doula Integration," Connecticut Department of Social Services, accessed September 7, 2025, retrieved from https://portal.ct.gov/dss/health-and-home-care/husky-maternity-bundle/doula-integration?language=en_US.

33. "Birth Equity Alliance," New Jersey Birth Equity Funders Alliance, accessed September 7, 2025, retrieved from https://www.birthequityalliance.com.

34. "Grants Will Support Advocacy for Community Health Workers," Connecticut Health Foundation, accessed September 7, 2025, retrieved from https://www.cthealth.org/latest-news/news-releases/grants-will-support-advocacy-for-community-health-workers/.

35. "Public/Private Partnerships to Create Optimal Birth Outcomes," Association of Maternal & Child Health Programs, Community Health Acceleration Partnership (CHAP), 2025, accessed September 7, 2025, retrieved from https://www.amchp.org/wp-content/uploads/2023/12/CHAP_Public-Private-Partnerships.pdf.

36. "Family Health and Birth Center," Community of Hope, accessed September 7, 2025, retrieved from https://www.communityofhopedc.org/locations/family-health-and-birth-center/.

37. "Maternal and Child Health Program Impact Report," Community of Hope, accessed September 7, 2025, retrieved from https://www.communityofhopedc.org/wp-content/uploads/2024/12/MaternalChildHealth_COH_121824_FINAL-1.pdf.

38. Public Act No. 23-147, An Act Protecting Maternal Health, Substitute Senate Bill No. 986, 2023, accessed September 7, 2025, retrieved from https://www.cga.ct.gov/2023/ACT/PA/PDF/2023PA-00147-R00SB-00986-PA.PDF.

39. "Consultation on a Program to Provide Medicaid Reimbursement to Certified Community Health Workers: Report to the Connecticut Department of Social Services," Connecticut Department of Social Services, September 2024, accessed September 19, 2025, retrieved from: https://portal.ct.gov/dss/-/media/departments-and-agencies/dss/health-and-home-care/community-health-worker/chw-stakeholder-working-group-final-report.pdf?rev=9962d0df06bb4f9a82861f99c55202b8&hash=EABF110C2E6E6E8F217E98C9205F5DF4

40. "Doula Fee Schedule," Connecticut Department of Social Services, retrieved from https://portal.ct.gov/-/media/departments-and-agencies/dss/health-and-home-care/husky-maternity-bundle/111662---doula-fee-schedule_083123_v1.

41. Sufrin C et al., "Pregnancy Outcomes in US Prisons, 2016–2017," *Am J Public Health* 109, no. 5 (2019): 799–805, doi.org/10.2105/AJPH.2019.305006

42. "Incarceration Trends in Connecticut," Vera Institute of Justice, retrieved from https://vera-institute.files.svdcdn.com/production/downloads/pdfdownloads/state-incarceration-trends-connecticut.pdf.

43. "Mental Health Conditions and Pregnancy-Associated Deaths in Connecticut," Connecticut Department of Public Health, 2015–2020, retrieved from https://portal.ct.gov/-/media/dph/maternal-mortality/mhc_brief2.pdf.

44. "A Comprehensive Look at State Maternal Mental Health Screening and Reimbursement Legislation," Policy Center for Maternal Mental Health, retrieved from https://policycentermmh.org/a-comprehensive-look-at-state-maternal-mental-health-screening-and-reimbursement-legislation/.

45. "Connecticut's Behavioral Health Workforce Shortage," Behavioral Health and Economics Network, retrieved from https://www.bhecon.org/wp-content/uploads/2018/09/CT-Behavioral-Health-Workforce-Fact-Sheet.Final_.pdf.

46. "Mental Health Care Health Professional Shortage Areas (HPSAs)," KFF (Kaiser Family Foundation), retrieved from https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/.

47. "HPSA Find," HRSA (Health Resources & Services Administration) Data Warehouse, retrieved from https://data.hrsa.gov/tools/shortage-area/hpsa-find.

48. Sieger ML et al., "A Comparison of Two Statewide Datasets to Understand Population Prevalence of Substance Use In Pregnancy: Findings and Considerations for Policy & Research," *Matern Child Health J* 28, no. 6 (2024): 1121–1131, doi.org/10.1007/s10995-024-03914-6.

49. "Pregnancy-Related Deaths in Connecticut: Data from Connecticut Maternal Mortality Review Committee, 2015–2020," Connecticut Department of Public Health, accessed September 7, 2025, retrieved from https://portal.ct.gov/-/media/dph/maternal-mortality/2015-2020-maternal-mortality-in-connecticut-report_final.pdf.

50. "Needs Assessment Update," Connecticut Department of Public Health, accessed September 7, 2025, retrieved from https://mchb.tvisdata.hrsa.gov/Narratives/III.C.%20Needs%20Assessment%20Update/403b9776-0fb7-432c-8b16-8e10a15cfbcc.

51. Norcott C et al., for the ECHO Cohort Consortium. "Listening to the Perspectives of Black Women on Perinatal Health Disparities: Reversing the Tide and Improving Outcomes," *J Racial Ethn Health Disparities* 11, no. 5 (2024): 1234–1242, doi.org/10.1007/s40615-024-02181-z.

52. Glickman CP et al., "Black Women's Preferences for Embedding Mental Health Services in Obstetrical Settings," *J Matern Child Health* 5, no. 2 (2020): 353–363, doi.org/10.26911/thejmch.2020.05.02.06.

53. Bauman BL et al., "Vital Signs: Postpartum Depressive Symptoms and Provider Discussions About Perinatal Depression—United States, 2018," *MMWR Morb Mortal Wkly Rep* 69, no. 19 (2020): 575–581, doi.org/10.15585/mmwr.mm6919a2

54. Howard H et al., "If I Knew What Was Going On With Me, Then I Probably Wouldn't Feel So Sad or Scared": A CBPR Study Addressing Health Disparities For Black Pregnant Women," *J Fam Strengths* 23, no. 2 (2024): Article 5, retrieved from https://digitalcommons.library.tmc.edu/jfs/vol23/iss2/5.

55. Ogunwole SM et al., "Health Experiences of African American Mothers, Wellness in the Postpartum Period and Beyond (HEAL): A Qualitative Study Applying a Critical Race Feminist Theoretical Framework," *Int J Environ Res Public Health* 20, no. 13 (2023): 6283, doi.org/10.3390/ijerph20136283.

56. Barnett KS et al., "I Just Want Us to Be Heard": A Qualitative Study of Perinatal Experiences Among Women of Color," *Women's Health* 43, no. 12 (2022): 1234–1250, doi.org/10.1177/17455057221123439.

57. "Perinatal Mental Health Conditions Patient Safety Bundle," Alliance for Innovation on Maternal Health, accessed September 7, 2025, retrieved from https://saferbirth.org/psbs/perinatal-mental-health-conditions/.

58. "Connecticut Perinatal Quality Collaborative," Connecticut Hospital Association, accessed September 7, 2025, retrieved from https://cthosp.org/connecticut-perinatal-quality-collaborative/.

59. "Home Visiting," Connecticut Office of Early Childhood, accessed September 7, 2025, retrieved from https://www.ctoec.org/home-visiting/#nurse-family-partnership.

60. "Connecticut's Maternal Mortality Review Committee Recommendations Report for 2020–2021 Deaths," Connecticut Department of Public Health. accessed September 7, 2025, retrieved from https://portal.ct.gov/-/media/dph/maternal-mortality/2020-2021-mmrc-recommendations-report-feb2024.pdf.

61. "HUSKY Maternity Bundle Payment Program: Quality Measures Guide," Connecticut Department of Social Services. October 2024, accessed September 7, 2025, retrieved from https://portal.ct.gov/-/media/departments-and-agencies/dss/health-and-home-care/husky-maternity-bundle/maternity-bundle-quality-measures-guide---october-2024.pdf.

62. "States with MMH Task Forces/State Strategic Plans," March 2024, [Unpublished document], accessed September 7, 2025, retrieved from https://docs.google.com/document/d/11JWpDbDIaKa-svP8djqpr3isvMljKaK8RdcHCtNvauQ/edit?usp=sharing.

63. Special Act No. 25-7: An Act Concerning Maternal Health, Substitute for Raised House Bill No. 7214, 2025, accessed September 11, 2025, retrieved from https://www.cga.ct.gov/asp/CGABillStatus/cgabillstatus.asp?selBillType=Bill&bill_num=HB7214.

64. "PROUD: Parents Recovering from Opioid and Other Use Disorders," Department of Mental Health and Addiction Services, accessed September 7, 2025, retrieved from https://portal.ct.gov/proud.

65. "Evidence-Informed and Community-Based Recommendations for Improving Black Maternal Health," Metropolitan Housing and Communities Policy Center, Urban Institute, April 2021, accessed August 22, 2025, retrieved from https://cdn.givingcompass.org/wp-content/uploads/2021/04/16113247/Evidence-Informed-and-Community-Based-Recommendations-for-Improving-Black-Maternal-Health.pdf.

66. Our Services. New Chapter Counseling Services, accessed August 22, 2025, retrieved from https://www.newchapterservices.com/services.

67. Postpartum Support International, Connecticut Chapter. Connecticut Chapter of Postpartum Support International, accessed August 22, 2025, retrieved from https://psichapters.com/ct/#toggle-id-1.

68. "Maternal Depression," accessed August 22, 2025, available at: https://portal.ct.gov/-/media/dmhas/publications/fasd-sei-may-2021-campaign-final.pdf.

69. "Perinatal Care Management (PCM)," HUSKY Health Connecticut, accessed August 22, 2025, retrieved from https://www.huskyhealthct.org/members/members_healthybeginnings.html

70. "Perinatal Depression / Postpartum Depression," 211 Connecticut (United Way of Connecticut), content last reviewed November 2024, accessed August 22, 2025, retrieved from https://uwc.211ct.org/perinatal-depression-postpartum-depression/.

71. Cubbin C et al., "Longitudinal Measures of Neighborhood Poverty and Income Inequality Are Associated with Adverse Birth Outcomes In Texas," *Soc Sci Med* 2020, 245: 112665, doi.org/10.1016/j.socscimed.2019.112665.

72. Green TL et al., "Rethinking Bias to Achieve Maternal Health Equity: Changing Organizations, Not Just Individuals," *Obstet Gynecol* 137, no. 5 (2021): 935–940, doi.org/10.1097/AOG.0000000000004363.

73. Johnson R, Berry S, and Moore, J, "Maternal Health Equity in Medicaid: Midwifery Led Model of Care," Institute for Medicaid Innovation, 2023, accessed August 22, 2025, retrieved from https://medicaidinnovation.org/wp-content/uploads/2024/01/Midwifery-Led-Models-of-Care-FINAL.pdf.

74. "Midwives: Information on Births, Workforce, and Midwifery Education," United States Government Accountability Office. (GAO-23-105861), April 26, 2023, accessed August 22, 2025, retrieved from https://www.gao.gov/assets/gao-23-105861.pdf.

75. "Area Health Resources Files," Health Resources and Services Administration, U.S. Department of Health and Human Services, accessed July 13, 2025, retrieved from https://data.hrsa.gov/topics/health-workforce/ahrf.

76. "Doula Landscape Analysis–Connecticut," Connecticut General Assembly, Women & Children's Health Committee, accessed July 13, 2025, retrieved from https://www.cga.ct.gov/ph/med/related/20190101_Women%20&%20Childrens%20Health%20Committee/20230313/CT%20Doula%20Landscape%20Analysis.pdf.

77. "Study Finds Black Birthing People Prefer Black Obstetric Providers Due to Discrimination and Fear," Society for Maternal-Fetal Medicine, accessed July 13, 2025, retrieved from https://www.smfm.org/news/study-finds-black-birthing-people-prefer-black-obstetric-providers-due-to-discrimination-and-fear.

78. Nelson HO et al., "Structural Inequities and Provider Burnout in Maternal Health in the United States," *Soc Sci Med* 372 (2025), 118010, doi.org/10.1016/j.socscimed.2025.118010.

79. "Bystander Intervention Tip Sheet," American Psychological Association, accessed August 25, 2025, retrieved from https://www.apa.org/pi/health-equity/bystander-intervention.

80. "Lift Every Voice: Capturing and Intervening on Experiences of Racism in Health Care," Penn Medicine Center for Health Care Transformation and Innovation, accessed July 13, 2025, retrieved from https://chti.upenn.edu/lift-every-voice.

81. “Maternal Health Hospital Report Card,” New Jersey Department of Health, New Jersey Maternal Data Center. Last reviewed January 17, 2025, accessed July 13, 2025, retrieved from https://www.nj.gov/health/maternal/maternal-health-hospital-report-card/.

82. “Midwifery Working Group,” Connecticut Department of Public Health, 2023–2025, retrieved from https://portal.ct.gov/dph/working-groups/midwifery-working-group.

83. “Connecticut State Action Plan Table: FY 2025 Application / FY 2023 Annual Report,” Maternal and Child Health Bureau, U.S. Department of Health and Human Services, Health Resources & Services Administration, published October 7, 2024, accessed July 13, 2025, retrieved from https://mchb.tvisdata.hrsa.gov/Admin/FileUpload/DownloadStateUploadedPdf?fileType=stateActionplan&state=CT.

84. “Connecticut Hospital Association Statewide Strategy to Improve Maternal Health,” accessed July 13, 2025, retrieved from https://cthosp.org/webfoo/wp-content/uploads/ImproveMaternalHealthFINAL.pdf.

85. “Home and Community-Based Services: Racial Equity Training,” Connecticut Social Services, updated March 2024, accessed July 13, 2025, retrieved from https://portal.ct.gov/dss/common-elements/home-and-community-based-services/racial-equity-training.

86. “IWPR Priority Areas,” (n.d.), Institute for Women’s Policy Research, accessed April 28, 2025, retrieved from https://iwpr.org/.

87. Acs G et al., “Measuring Mobility from Poverty: A Toolkit,” SPARQtools (Stanford), June 2018, accessed July 13, 2025, retrieved from https://sparqtools.org/wp-content/uploads/2018/06/measuring_mobility_paper.pdf.

88. “Economic Mobility Project,” The Pew Charitable Trusts, accessed July 13, 2025, retrieved from https://www.pew.org/en/projects/archived-projects/economic-mobility-project/.

89. Daw JR, Sommers BD, “The Affordable Care Act and Access to Care For Reproductive-Aged and Pregnant Women in the United States, 2010–2016,” *Am J Public Health* 109, no. 4 (2019): 565–571, doi.org/10.2105/AJPH.2018.304928.

90. Himmelstein G, Desmond M, “Association of Eviction with Adverse Birth Outcomes Among Women in Georgia, 2000 to 2016,” *JAMA Pediatr* 175, no. 5 (2021): 494–500, doi.org/10.1001/jamapediatrics.2020.6550.

91. Khadka A et al., “In Utero Exposure to Threat of Evictions and Preterm Birth: Evidence from the United States,” *Health Serv Res* 55 suppl 2 (2020): 823–832, doi.org/10.1111/1475-6773.13551.

92. Sullivan K et al., “Food Insecurity in an Urban Pregnancy Cohort,” *Am J Perinatol*, published online May 2, 2021, doi.org/10.1055/s-0041-1729159.

93. Snyder JE et al., “Regional Variations in Maternal Mortality and Health Workforce Availability in the United States,” *Ann Intern Med* 172, no. 5 (2020): 315–323, doi.org/10.7326/M19-3254.

94. “Diaper Connections,” The Diaper Bank of Connecticut, accessed August 18, 2025. https://thediaperbank.org/diaper-connections/.

95. Connecticut Breastfeeding Coalition, accessed August 18, 2025, retrieved from https://www.breastfeedingct.org/.

96. Bartel AP et al., “Racial and Ethnic Disparities in Access to and Use of Paid Family and Medical Leave: Evidence From Four Nationally Representative Datasets,” Monthly Labor Review, U.S. Bureau of Labor Statistics. January 2019, doi.org/10.21916/mlr.2019.2, retrieved from https://www.bls.gov/opub/mlr/2019/article/racial-and-ethnic-disparities-in-access-to-and-use-of-paid-family-and-medical-leave.htm.

97. “Paid Family and Medical Leave: A Racial Justice Issue–and Opportunity,” National Partnership for Women & Families, August 2018, accessed June 2025, retrieved from https://nationalpartnership.org/wp-content/uploads/2023/02/Paid-Family-and-Medical-Leave-A-Racial-Justice-Issue-and-Opportunity.pdf.

98. “Medical Debt Among New Mothers,” Peterson-KFF Health System Tracker, published 2024, retrieved from https://www.healthsystemtracker.org/brief/medical-debt-among-new-mothers/.

99. “Many Households Do Not Have Enough Money to Pay Cost-Sharing Typical in Private Health Plans,” Kaiser Family Foundation, 2022, retrieved from https://www.kff.org/health-costs/issue-brief/many-households-do-not-have-enough-money-to-pay-cost-sharing-typical-in-private-health-plans/.

100. “Who Had Medical Debt in the United States?” U.S. Census Bureau America Counts. 2021, accessed June 2025, retrieved from https://www.census.gov/library/stories/2021/04/who-had-medical-debt-in-united-states.html.

101. “CT Earned Income Tax Credit,” Connecticut Department of Revenue Services, accessed August 2025. Available from: https://portal.ct.gov/drs/ct---eitc/ct-eitc-information/ct-earned-income-tax-credit.

102. “Do EITC Recipients Use Their Tax Refunds to Get Ahead? Evidence from the Refund to Savings Initiative,” St. Louis, MO: Washington University in St. Louis, Center for Social Development; 2015. (CSD Research Brief No. 15–38).

103. Burns K, Fox LE, “The Impact of the 2021 Expanded Child Tax Credit on Child Poverty,” Working Paper No. SEHSD WP-2022-24. U.S. Census Bureau; 2022, accessed August 18, 2025, retrieved from https://www.census.gov/content/dam/Census/library/working-papers/2022/demo/sehsd-wp2022-24.pdf.

104. “2022 Child Tax Rebate,” Connecticut Department of Revenue Services, accessed August 18, 2025, retrieved from https://portal.ct.gov/drs/credit-programs/child-tax-rebate/overview.

105. “Unlocking Solutions: 2025 Policy Agenda,” United Way of Connecticut, accessed August 18, 2025, retrieved from https://www.ctunitedway.org/advocacy/policy-2/.

106. “Diaper Connections,” The Diaper Bank of Connecticut, published June 15, 2023, accessed August 18, 2025, retrieved from https://thediaperbank.org/diaper-connections/.

Connecticut Health
FOUNDATION

Changing Systems, Improving Lives.

100 Pearl Street
Hartford, CT 06103

cthealth.org
860-724-1580