Governor's Council on Women and Girls - Health and Safety Subcommittee

MEETING MINUTES

Microsoft Teams Virtual Meeting

Monday December 1, 2025 at 10:00am

I. Welcome & Opening Remarks

The Interim Commissioner at the Connecticut Office of Early Childhood, Elena Trueworthy, called the meeting to order at 10:05am, welcomed new members, and introduced Deputy Commissioner Lisa Morrissey of the Connecticut Department of Public Health, who issued welcoming remarks and provided an overview of the central topic of the meeting: maternal health.

II. Presentation: 'Delivering Whole-Person Care Through Nursing and Community Partnership', Family Bridge Program - Rachel Guthrie, Ashley McAuliffe, and Rachel Ruznak

Family Bridge is a universal nurse home visiting program led by the Office of Early Childhood. The program offers families access to a registered nurse, along with a certified community health worker. It is a multi-agency collaboration between the Office of Early Childhood, the Office of Health Strategy, the Department of Social Services, the Department of Public Health, and the Department of Children & Families. This collaboration exists to ensure that families in Connecticut are given comprehensive support from birth through the early months of their child's life. The program works to identify and address the social determinants of health impacting maternal and child health. The Statewide Advisory Board, made up of the aforementioned five state agencies, is at the center of Family Bridge working to shape and guide the program. Family Bridge utilizes the Universal Nurse Model Family Connects International, but is unique in integrating services with community health workers.

Each family is offered up to three nurse home visits, which are focused on the mother as well as the baby. If a family needs additional support or resources after they have used all of their visits, the community health worker coordinates finding them the care they need.

Family Bridge is in the pilot stage, but their goal is to be able to serve every mom and baby across the state. The two qualifications to receive services consist of giving birth in one of the three hospitals that the program currently works with (Bridgeport Hospital, St. Vincent Hospital, and Backus Hospital) and within the specific pilot towns in the location.

The Family Connects International Model has shown to improve maternal mental and physical health and child health outcomes. Family Bridge is working on their own evaluation covering three primary components: performance measures, outcomes, and cost savings/avoidance. They plan to compare their evaluation results to the Family Connects baseline and use this to guide their sustainability plan and possible expansion.

Family Bridge has worked with the Health Consulting Group at the University of Massachusetts Medical School to engage in sustainability work. The original landscape analysis they completed found that programs like Family Bridge are clinically effective and cost-effective. The analysis also found that multiple funding sources are necessary for their sustainability plan, along with addressing commercial coverage and identifying champions to support their cause. Family Bridge is currently working on their roadmap, which is their project plan for how the previously mentioned findings can be addressed to help the program move past the pilot stage.

Lauren Junge-Maughan, Director of the Bridgeport Family Bridge Program, covered performance data from 2023 to 2025. At this time, over 2,400 births occurred in Bridgeport Hospital, ~2,050 were eligible for the program, over 1,600 families were successfully contacted, over 1,000 families enrolled/scheduled, over 1,800 home visits were completed, and the visit completion rate has been 70-85%. They complete screenings for mental health, substance abuse, and intimate partner violence. Since they opened. They have improved cancellation rates as well as client satisfaction. Majeda Basillio, Nursing Supervisor for the Bridgeport team at Family Bridge, discussed how their program meets clinical needs and social needs. Most of their nurses have become lactation certified so they can provide breastfeeding guidance to families. The nurses can also provide education on postpartum recovery and support, along with maternal and infant education. They also offer virtual visits. For the social needs of families, the community health workers assist in everything from housing applications, food benefit information, childcare assistance, making appointments, finding transportation options, navigating resource benefits, meeting basic needs, and providing cultural and emotional support. Their team has gone through extensive professional development to ensure each family feels valued, respected, and safe.

Regina Brady, Director of the Family Bridge Program in Eastern Connecticut, provided an overview of their program and services. From January 2025-November 2025, they have scheduled 134 visits with families. They have been successful in timely scheduling visits as 80% of their visits have occurred when the infant was between 14 and 34 days old. Brady then shared two success stories from the program, highlighting their strengths and ability to achieve their goals. Their registered nurse and community health workers are currently going through the lactation training the nurses in Bridgeport completed.

III. Presentation: 'Maternal Health Equity: A Blueprint for Connecticut', Connecticut Health Foundation– Ellen Carter and Tiffany Donelson

The Connecticut Health Foundation is the largest health philanthropy in the state, supporting innovative grant-making, public policy research, strategic communications, and leadership development to improve the health of people in Connecticut. Since they do not fundraise, they are considered a neutral source of information. Since their founding in 1999, they have focused on health equity for people of color and investing in systems change. Maternal health equity is a new area of focus for the foundation. Connecticut ranks in the bottom half of the nation when it comes to severe maternal morbidity, which in many cases, is preventable.

Overview of the Blueprint:

- The blueprint aims to close the gap in severe maternal morbidity and outlines evidence-based actions
- It was facilitated by the Yale Global Health leadership Initiative and the Yale Equity Research and Innovation Center
- Was developed utilizing input from an advisory committee, community members, and national experts in the fields of focus
- Includes the best practices from across the nation on how to improve severe maternal morbidity, especially among Black women
- Highlights efforts in Connecticut to improve maternal health

5 Priority Areas for Improving Severe Maternal Morbidity:

1. Treat inequalities in severe maternal morbidity as a critical public health issue
    - Goals include: establishing the groundwork to recognize and understand the problem through creating a statewide severe maternal morbidity review process, prioritizing data collection, tracking and evaluating policies related to equity and mental health, and raising awareness of severe maternal morbidity as a critical public health issue
2. Ensure patients can access a wide range of maternal health care providers
    - Goals include: building financing reforms for maternity care services, addressing barriers to reforms that have already been passed, building on state efforts to improve health for individuals who are incarcerated while they are pregnant
3. Strengthen connections between maternal health and behavioral health services
    - Goals include: ensuring there is appropriate infrastructure to support maternal mental health needs from pregnancy to one year postpartum, prioritizing pregnant and postpartum people for substance use disorder resources and mental health care, supporting a community-led task force to monitor maternal health services for Black birthing people and develop a hub to streamline access to services

4. Address discrimination in health care and diversify the workforce
    - Goals include: increasing the number and diversity of health personnel centered around birth and postpartum health along with mandating that frontline care providers receive training designed to advance equity and reduce bias in the health setting
5. Increase economic security and economic mobility among families
    - Goals include: championing efforts to address economic mobility before, during and after pregnancy, strengthening partnerships, coordination, and communication to better serve families during and after pregnancy, and making pregnancy and birth affordable

IV. Adjournment

The meeting concluded at 11:01am.