3RD ANNUAL

MOVING BEYOND IMPLICATIONS: RESEARCH INTO POLICY

HOSTED BY:

STATE REPRESENTATIVE
JAIME FOSTER, PHD, RD
Proudly serving
East Windsor,
Ellington, Vernon

STATE REPRESENTATIVE
DOMINIQUE JOHNSON
Proudly Serving
Norwalk & Westport

STATE REPRESENTATIVE
LAURIE SWEET
Proudly serving
Hamden

STATE REPRESENTATIVE
BILL PIZZUTO
Proudly Serving
Middlebury & Waterbury

DR. KERRI RAISSIAN
CT SSN Co-leader

STATE SENATOR
JEFF GORDON
Proudly Serving
The 35th District

STATE SENATOR
SAUD ANWAR
Proudly Serving
The 3rd District

STATE SENATOR
SUJATA GADKAR-WILCOX
Proudly serving
The 22nd District

THURSDAY, JANUARY 15TH | HARTFORD, CT

LEGISLATIVE OFFICE BUILDING – 2ND FLOOR ATRIUM & 2ND FLOOR HEARING ROOM

Most policy makers aim to implement evidence-based policy. They want to create and pass bills that have the exact desired impact and incorporate the very best available evidence. Unfortunately, most academic research is behind a paywall and inaccessible to policy makers.

Most scientists and scholars have written a sentence in a peer reviewed publication that starts something along the lines of, “implications for policy include….” Unfortunately, the only people who often read those implications are other scholars. This conference is designed to build a bridge between these two ivory towers.

Thank you for being here today!

IN PARTNERSHIP WITH

SCHOLARS STRATEGY NETWORK
CONNECTICUT

CHIP

CHDI®
Child Health and
Development Institute

CONNECTICUT ACADEMY OF SCIENCE AND ENGINEERING
QUI TRANSTULIT SUSTINET
1976

A HUGE THANK YOU TO ALL OUR PARTNERS FOR MAKING THIS HAPPEN!

Thank you to all State Leaders, Legislators, Academics, and Scholars for participating today!

AGENDA

Lunch.....11:30am - 12:30pm (2nd Floor Atrium)

Please gather your lunch in the 2nd floor atrium and proceed to the hearing room

Welcome.....12:30 - 1:30pm (Hearing room 2C)

Rep. Foster, Dr. Kerri Raissian, and other invited dignitaries

- Lieutenant Governor Susan Bysiewicz
- House Majority Leader Jason Rojas
- House Minority Leader Vincent Candelora
- State Representative Laurie Sweet
- State Representative Bill Pizzuto
- State Senator Stephen Harding
- Presentations by OPM Scott Gaul, Alfredo Herrera, and Rachel Leventhal-Weiner

Presentation Tracks-Session 1.....1:30 - 2:45pm

Track A- Energy and Technology (Room 2A)
Track B- General Topics (Room 2E)
Track C- Childrens and Education (Room 2C)

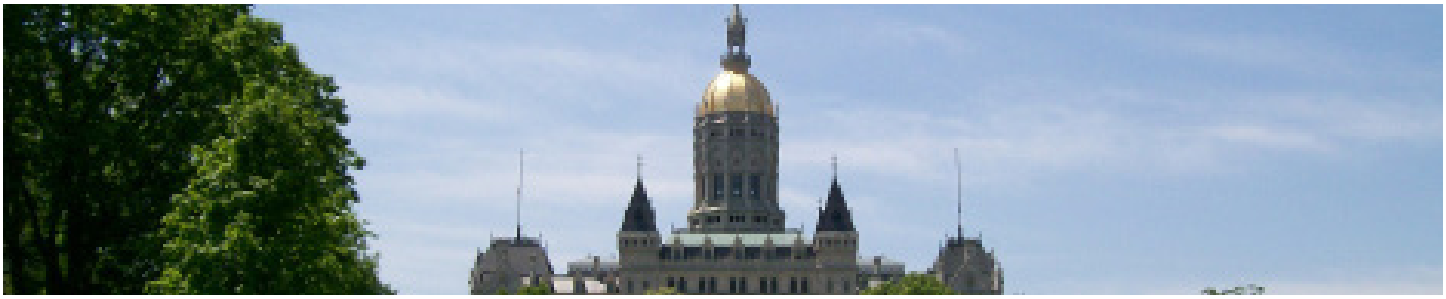
Break for Coffee and Networking.....2:45 – 3:15pm (2nd Floor Atrium)

Presentation Tracks-Session 2.....3:15 - 4:30pm (Hearing Rooms)

Track D- Human Services (Room 2C)
Track E- Environment (Room 2E)
Track F- Public Health (Room 2A)

Happy Hour, Snacks, and Networking.....4:30 – 6:00pm (1st floor Atrium)

Light refreshments and open bar!



COMMITTEE CHAIRS & VICE CHAIRS

Energy & Technology

Chairs – State Senator Norman Needleman & State Representative Jonathan Steinberg
Vice Chairs – State Senator James Maroney & State Representative James Sanchez

Transportation

Chairs – State Senator Christine Cohen & State Representative Aimee Berger-Girvalo
Vice Chairs – State Senator Rick Lopes & State Representative Marcus Brown

Housing

Chairs – State Senator Martha Marx & State Representative Antonio Felipe
Vice Chairs – State Senator Herron Gaston & State Representative Kadeem Roberts

Public Health

Chairs – State Senator Saud Anwar & State Representative Cristin McCarthy Vahey
Vice Chairs – State Senators Martha Marx & Douglas McCrory, State Representative Kai Belton

Veterans

Chairs – State Senator Paul Honig & State Representative Jaime Foster
Vice Chairs – State Senator Matthew Lesser & State Representative Hubert Delany

Childrens

Chairs – State Senator Ceci Maher & State Representative Corey Paris
Vice Chairs – State Senator Christine Cohen & State Representative Mary Welander

Education

Chairs – State Senator Douglas McCrory & State Representative Jennifer Leeper
Vice Chairs – State Senator Gary Winfield & State Representative Kevin Brown

Human Services

Chairs – State Senator Matthew Lesser & State Representative Jillian Gilchrest
Vice Chairs – State Senator Ceci Maher & State Representative Robin Comey

Banking

Chairs – State Senator Pat Billie Miller & State Representative Jason Doucette
Vice Chairs – State Senator Paul Honig & State Representative Farley Santos

Environment

Chairs – State Senator Rick Lopes & State Representative John-Michael Parker
Vice Chairs – State Senator Jan Hochadel & State Representative Aundre Bumgardner

SCHOLAR PRESENTATIONS (TRACK A & B)

Session 1

Track A - Energy & Technology (Room 2A)

Connecticut Grid Resilience Assessment: A Strategic Guide for Key Stakeholders
Emmanouil Anagnostou (UConn)
Eleanor Shoreman-Ouimet (UConn)
Francesco Rouhana (UConn)
Andreas Prevezianos (UConn)

Electric Vehicle (EV) Charging
Emmanouil Anagnostou (UConn)
Francesco Rouhana (CASE)

Siting Hydrogen Refueling Stations with On-Site Production on Connecticut Highways
Adrian R. Irhamna (UConn)
George M. Bollas (UConn)

Small Modular Reactors (SMRs): The Future of Nuclear Power
Regis Matzie (CASE) and Sten Caspersson (CASE)

Track B - General Topics (Room 2E)

Street & Urban Development: Opportunities to Inform Safety Initiatives
Brady Bushover (Yale School of Public Health)
Christopher Morrison (Yale School of Public Health)

Dysphagia Policy
Michael Werner (CWESCO)
Xiayu “Katniss” Ni (Yale School of Public Health)
Mesk Alhammadi (Yale School of Public Health)

Invisible Veterans: Policy Reforms to Address the Mental Health Needs of American IDF Lone Soldier Veterans Living in Connecticut
Faigy Mandelbaum (Yale School of Medicine/CHDI)

SCHOLAR PRESENTATIONS (TRACK C & D)

Track C - Childrens & Education (Room 2C)

Medicaid Reimbursement for Peer Support Services
Aleece Kelly (CHDI)
Jason Lang (CHDI)

Who Benefits: Making Teacher Pension Financing More Fair in CT
Anthony Randazzo (Equable Institute)

Feel Your Best Self: A Connecticut Exemplar for Moving Beyond Emotion Knowledge to Regulation Across Ages and Contexts
Sandra M. Chafouleas (UConn)
Jessica Koslouski (UConn)

Roberta Willis Scholarship Program – Leveraging State Data to Examine Program Benefits
Monnica Chan (University of Massachusetts – Boston)

Session 2

Track D - Human Services (Room 2C)

Assessing Healthcare Access for Immigrant Families via Qualitative Analyses of Legislative Testimony
Isha Yardi (Yale School of Medicine)
Shaan Mehta (Yale School of Medicine)
Noah Brazer (Yale School of Medicine)
Julia Rosenberg (Yale School of Medicine)

The Promise of Pharmacists Improving Access to Birth Control Services
Marie Smith (UConn Pharmacy)

Understanding the Real-World Availability of Pharmacy Access to Contraceptives in Connecticut
Andrea Contreras (UConn Health)
Simone Buck (UConn Health)
Marina DiPiazza (UConn Health)
Shayna Cunningham (UConn Health)
Emil Coman (UConn Health)
Neena Qasba (UConn Health)

Banking Services for Marginalized Populations
Annie Harper (Yale School of Medicine)

SCHOLAR PRESENTATIONS (TRACK E & F)

Track E - Environment (Room 2E)

Engineering Data Systems for Waste-to-Energy Policy in Connecticut
Ioulia (Julia) Valla (UConn Engineering)

On the Brink: Examining Preemptive Indicators of Disaster Vulnerability in Connecticut
Eleanor Shoreman-Ouimet (UConn)
Kenneth Lachlan (UConn)
Abigail Beckham (UConn)
Alexandra Harden (UConn)
James DiCairano (UConn)
Christopher Burton (UConn)

Continuing Progress Towards a More Climate Resilient Connecticutte Production on Connecticut Highways
James O'Donnell (UConn)
John Truscinski (UConn)

Track F - Public Health (Room 2A)

Return on Disinvestment (RoD) of Terminating the Federal Healthcare Insurance Subsidies: Potential Public Health and Health Disparities Effects in CT
Emil Coman (UConn Health)
Thomas Agresta (UConn Health)

Overdose Prevention Centers: Evidence, Evaluation, and Urgency for Connecticut
Carson F. Ferrara (CLEAR)
Brandon Marshall (Brown University)

Advancing Access to Genomic Newborn Screening in Connecticut
Mark Adams (The Jackson Laboratory for Genomic Medicine)
Rachel O'Neill (UConn)
Jeffrey Shenberger (Connecticut Children's)

Expanding Access to Produce Prescriptions for Pregnant Women in CT
Katina Gionteris (Wholesome Wave)
Ashauna Lee (Wholesome Wave)
Amber Hromi-Fiedler (Wholesome Wave)
Rafael Pérez-Escamilla (Yale School of Public Health)

CONTACT US

State Representative Jaime Foster
jaime.foster@cga.ct.gov | (860) 240-8760
Constituent Engagement Coordinator: Arbenita Zeka | Arbenita.Zeka@cga.ct.gov

State Representative Dominique Johnson
Dominique.Johnson@cga.ct.gov | (860) 240-8399
Constituent Engagement Coordinator: Arbenita Zeka | Arbenita.Zeka@cga.ct.gov

State Representative Laurie Sweet
Laurie.Sweet@cga.ct.gov | (860) 240-8585
Constituent Engagement Coordinator: Noah Gulla | Noah.Gulla@cga.ct.gov

State Representative Bill Pizzuto
William.Pizzuto@housegop.ct.gov | (860) 240-8700
Constituent Engagement Coordinator: Maureen Urso | Maureen.Urso@cga.ct.gov

UConn InCHIP
Greidy Miralles - Research Development Assistant | greidy.miralles@uconn.edu

Connecticut Scholars Strategy Network
CT SSN – ctscholarsnetwork@gmail.com
Kerri Raissian – Senior Research Scientist, Yale School of Public Health | kerri.raissian@yale.edu

Connecticut Academy of Science and Engineering
Jeffrey Orszak – Executive Director | jorszak@ctcase.org | 860 – 282 - 4229

Child Health and Development Institute (CHDI)
www.chdi.org | 860 – 404 - 6616

Jeffrey Vanderploeg, Ph.D. – President and CEO | jvanderploeg@chdi.org

Committee Contacts
Energy & Technology - LOB Room 3900 | 860 - 240 - 0430 | et@cga.ct.gov
Transportation - LOB Room 2300 | 860 - 240 - 0590 | tra@cga.ct.gov
Housing - LOB Room 2700 | 860 - 240 - 0340 | hsg@cga.ct.gov
Human Services - LOB Room 2000 | 860 - 240 - 0492 | hs@cga.ct.gov
Banking - LOB Room 2400 | 860 - 240 - 0410 | ba@cga.ct.gov
Veterans - LOB Room 2300 | 860 - 240 - 8467 | va@cga.ct.gov
Children - State Capitol Room 011 | 860 - 240 - 0370 | kid@cga.ct.gov
Education - LOB Room 3100 | 860 - 240 - 0420 | ed@cga.ct.gov
Environment - LOB Room 3200 | 860 - 240 - 0440 | env@cga.ct.gov
Public Health - LOB Room 3000 | 860 - 240 - 0560 | ph@cga.ct.gov

Catering Restaurant
Epicurean Feast Cafés
580 Main St., Suite 1, Bolton, MA 01740
978 - 897 - 0660 | info@epicureanfeast.com

Policy Briefs

The first set of briefs accompany the presentations and are in order of the presentations listed on the program.

The second set of briefs do not accompany a presentation and are not included in any particular order.

Connecticut Grid Resilience Assessment: A Strategic Guide for Key Stakeholders

Emmanouil Anagnostou[1], Eleanor Shoreman-Ouimet[2], Francesco Rouhana*[3], Andreas Prevezianos[4]

1 Professor, School of Civil and Environmental Engineering; Executive Director, Institute of the Environment and Energy; Executive Director, UConn Tech Park, University of Connecticut, Storrs, CT 06269. Email: emmanouil.anagnostou@uconn.edu

2 Assistant Professor, Department of Anthropology; Associate Director, Institute of the Environment and Energy, University of Connecticut, Storrs, CT 06269. Email: eleanor.ouimet@uconn.edu

3 Postdoctoral Research Associate, School of Civil and Environmental Engineering, University of Connecticut, Storrs, CT 06269. Email: francesco.rouhana@uconn.edu ; *Corresponding presenter

4 Ph.D. Candidate, School of Civil and Environmental Engineering, University of Connecticut, Storrs, CT 06269. Email: andreas.prevezianos@uconn.edu

Recent climate scenarios indicate that damaging wind gusts, especially in winter, are projected to intensify across northern and central Connecticut, increasing the likelihood that cold snaps and power loss coincide. Predictive modeling suggests these hazards overlap geographically with places that already experience long outages and slow recovery, producing compounding risk. In several coastal municipalities, historically rare events (e.g., ~1-in-50-year) associated with intense extratropical storms appear to recur more frequently in forward-looking scenarios, implying a higher cadence of disruptive storms. At the same time, increasing heat wave incidence in urban areas raises concerns about potential system instabilities caused by elevated cooling demand. When combined with the construction of AI-class facilities, these trends underscore the importance of implementing carefully designed safeguards and scalable infrastructure planning. State leaders have new regulatory and funding tools that can steer resources to support the communities most vulnerable to outage impacts and at the highest exposure.

Communities Impacted by Climate Disaster and Power Loss

With funding from the U.S. Department of Energy Grid Deployment Office, researchers at the Eversource Energy Center, University of Connecticut, collaborating with the Atmospheric Research Center at the State University of New York at Albany, have created a comprehensive Grid Resilience Analysis and Climate Change Impacts guide. GRACI integrates downscaled climate projections, historical outage records, infrastructure impact and restoration modeling, analysis of distributed energy resources, customer surveys, and social vulnerability mapping, to identify where and for whom climate-driven hazards are most likely to cause prolonged outages and turn evidence into practical investment guidance.

Spatial analysis of historical performance identifies persistent outage “hotspots,” many of which also register high values on a Connecticut Social Vulnerability Index (SoVI). This spatial alignment implies that socioeconomically vulnerable households, including low-income, minoritized, and otherwise underserved residents disproportionately endure the longest and most frequent interruptions. Customer-survey evidence reinforces the equity signal: lower-income households (e.g., <$50,000) exhibit the highest annual willingness to pay (WTP) for reductions in outage frequency and duration, consistent with heightened exposure and limited coping capacity. High-income households (>$200,000) also show relatively high WTP, likely reflecting productivity and service expectations, whereas middle-income groups often exhibit lower or statistically insignificant WTP, plausibly due to prior private preparedness (e.g., generators, batteries). Collectively, these findings support a shift from uniform, system-wide resilience improvements toward place- and population-specific solutions (Fig. 1).

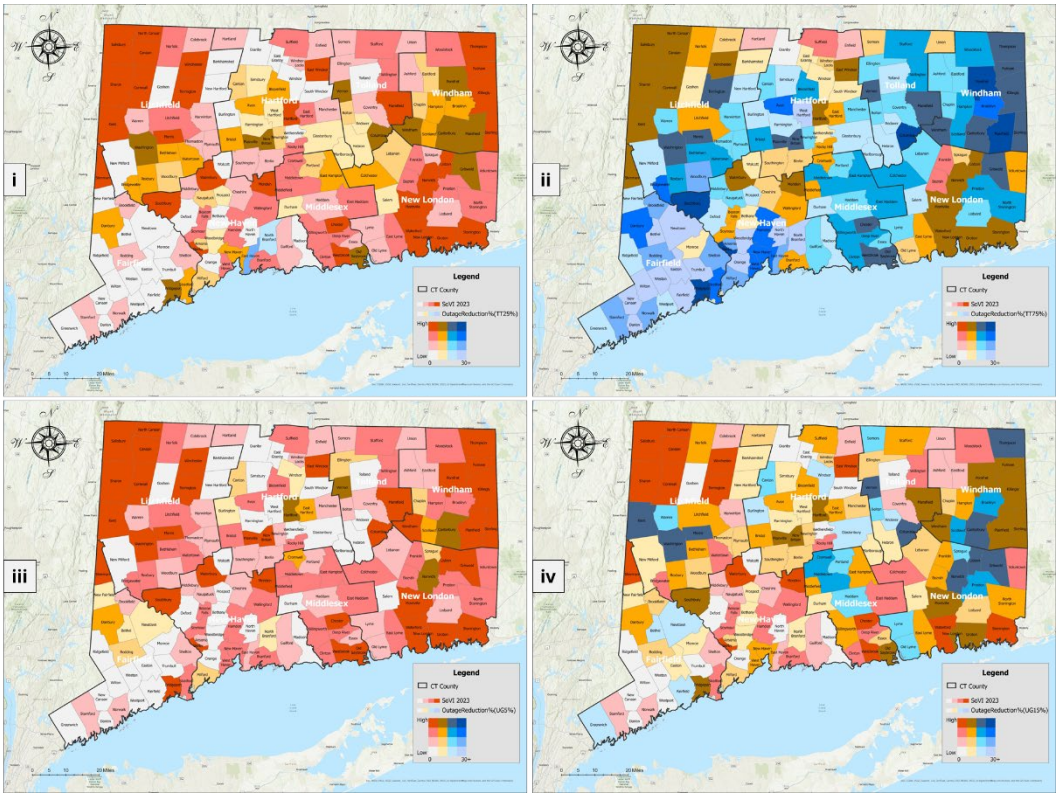


Fig. 1: *SoVI overlayed on Resilience Enhancement Strategies: Tree-Trimming (i) 25%, (ii) 75% & Undergrounding (iii) 5%, (iv) 15%.*

Power outage risk is very uneven across the system, so it is important to focus upgrades where they will have the biggest impact. Our analysis suggests that combining practical measures such as better tree trimming, putting the most vulnerable lines underground, adding smart switches, and building microgrids in key locations can cut major outages by two to three times and make the average event about 30% smaller.

Preparing Connecticut's Climate and Energy Safety

Connecticut's investment in its future as it faces critical climate challenges, must include:

- Further developing statewide outage forecasting
- Targeting investments to circuits under highest risk
- Deploying adaptive microgrids in high-priority areas
- Strategically reallocating restoration crews during outage events
- Integrating outage models into utility and public grant filings
- Aligning planning, funding, and equity metrics
- Measuring progress and ensuring public accountability

There is a clear, analytics-driven roadmap to reduce outage harms and advance energy equity by combining climate risk, infrastructure performance, household preferences, and social vulnerability. The proposed actions support current state policy directions, including PURA's shift to performance-based regulation and DEEP's expansion of the 2025 Climate Resilience Fund. All communities in Connecticut deserve a resilient and well-prepared state as we continue to navigate a climate crisis.

Electric Vehicle Investment and Regulation Will Help Connecticut Meet Its Climate Resiliency Goals

Summative Research Presentation by Emmanouil Anagnostou[1], Ph.D.

Co-Developed with Dr. Francesco Rouhana[2], UConn

1 Professor, School of Civil and Environmental Engineering; Executive Director, Institute of the Environment and Energy; Executive Director, UConn Tech Park, University of Connecticut, Storrs, CT 06269.
Email: emmanouil.anagnostou@uconn.edu *Corresponding presenter

2 Postdoctoral Research Associate, School of Civil and Environmental Engineering, University of Connecticut, Storrs, CT 06269. Email: francesco.rouhana@uconn.edu

Primary: Energy and Technology Committee
Secondary: Commerce Committee

Connecticut's target of greenhouse gas reductions of 45% below 2001 levels by 2030 and 80% by 2050 are mandated under the Global Warming Solutions Act (PA 08-98), as amended by PA 18-82. Transportation is the largest source of greenhouse-gas emissions in Connecticut (~38– 40%). Renters, multi-unit housing residents, and rural communities lack electric vehicle (EV) charging options. Unmanaged charging can increase peak demand without legislative direction on planning. Recent federal laws provide funding; Connecticut needs enabling statutes to compete effectively as Massachusetts and New York are advancing faster.

Connecticut can treat electrification of public and utility fleets not only as cleaner modes of transportation but as a grid-modernization strategy that strengthens reliability during heat waves and storms. Buses, university and government vehicles, and utility line-trucks sleep at depots and run on predictable schedules, which makes them ideal for managed charging that shifts load to low-cost, off-peak hours. They are also ideal for bidirectional charging, or vehicle-to-grid (V2G): when plugged in with the right charger and controls, the vehicle's battery can send electricity back to the grid to support local peaks, heat waves, or storm-related outages. Peer-reviewed research work consistently finds that bidirectional fleets can shave up to about 20% of peak demand while lowering system costs, which takes pressure off substations and feeders and smooths the ramp for new electrification. If a modest share of the fleet transitions to EVs with V2G capability, conservative assumptions suggest depots could provide approximately 125 MWh of dispatchable energy during high-impact events.

EV Investment Yields Significant Benefits, Including Disaster Resiliency

More federal investment and funding has been approved to expand high-speed EV charging and accelerate fleet electrification across Connecticut. For example, the Windham Regional Transit District–UConn bus infrastructure has much to celebrate after being awarded a $35.7 million Infrastructure Law grant. With roughly 155 school bus depots and 8,600 school buses statewide, these investments position the state to strategically expand charging and electrify public and school fleets (*Figure 1*). Connecticut can prioritize island-capable, V2G-ready depots in overburdened communities so buses keep moving, shelters and schools have backup, and utilities can call targeted relief using outage forecasts and grid visibility. Combining these capabilities with storm outage forecasting could transform preparedness and response to high-impact weather events, enabling utility and communities to manage risks proactively and collaboratively.

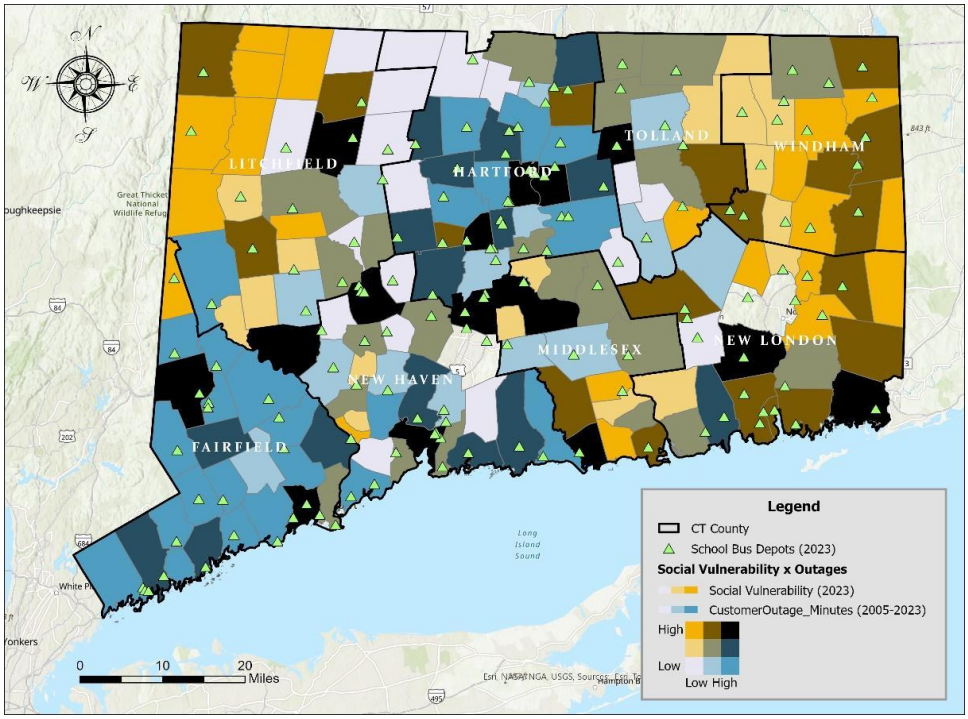


Figure 1: School Bus Depots, Social Vulnerability, and Historical Power Outages in Connecticut

Investing in a public fast-charging network that serves heavy-duty and public fleets doubles as resilience policy: on ordinary days it cuts fuel and maintenance costs for agencies and shifts load to low-cost hours; during heat waves or high-impact weather, island-capable depots with bidirectional chargers can keep buses moving, support shelters and schools, and in collaboration with utilities, provide targeted relief to local circuits, especially when sited to benefit overburdened communities that host depots and corridors. With EV adoption rising, charging already halfway to long-term needs, and utility visibility along with advanced predictive modeling in place, Connecticut can use fleet electrification to deliver cleaner air, lower system costs, and stronger grid resilience in the very neighborhoods where people live, learn, and work.

Legislative Efforts Will Enable Greater Efficiency and Capabilities

With these interventions, the Connecticut Academy of Science and Engineering (CASE) would be able to provide technical expertise regarding costs, air emissions, and system reliability. Investments would enable CASE to:

- Present impartial science-based analysis to support reforms to utility interconnection processes, including management and enforceable timelines.
- Offer insights on alternative rate structures that reduce demand-charge barriers for fast-charging sites.
- Advise on statewide EV-ready building code updates and siting considerations to minimize retrofit costs and expand access for residents in multi-unit housing, helping the state deploy charging infrastructure more efficiently and equitably.

These advancements will better inform and support the Connecticut General Assembly in future implementation of managed charging and time-of-use rates that mitigate peak demand impacts, and to guide trial vehicle-to-grid programs for school and transit buses.

Planning of Hydrogen Refueling Stations with On-Site Production on Connecticut Highways

Authors: Adrian R. Irhamna and George M. Bollas
Affiliation: Department of Chemical & Biomolecular Engineering, University of Connecticut
Corresponding Author: George M. Bollas (george.bollas@uconn.edu)

Author Brief Bio
Dr. George M. Bollas is the Pratt & Whitney Endowed Chair Professor in Advanced Systems Engineering, Director of the Pratt & Whitney Institute for Advanced Systems Engineering, and Associate Dean of Research for the UConn College of Engineering. His research focuses on energy systems, optimization, and AI-enabled infrastructure planning with applications across transportation, manufacturing, and defense sectors.

Primary Legislative Committee: Energy and Technology
Secondary Legislative Committee: Transportation

Research Type
Focused research project

Executive Policy Summary
Decarbonizing freight transportation is a critical and unresolved challenge for Connecticut. Heavy-duty trucks account for a disproportionate share of transportation-sector emissions, yet electrification pathways for long-haul freight remain limited. Hydrogen fuel-cell trucks are entering commercial deployment, but the absence of refueling infrastructure is the primary barrier to adoption.
This policy brief presents data-driven guidance for where Connecticut should prioritize early hydrogen refueling stations (HRS) with on-site hydrogen production. Using an integrated geospatial and techno-economic optimization framework, this research identifies a small number of strategically located hubs along Interstate-95 and Interstate-84 that can support early hydrogen truck deployment at modest adoption levels. The results demonstrate that targeted state action, focused on corridor planning, site readiness, and coordinated incentives, can reduce infrastructure costs, unlock federal funding, and position Connecticut as a regional hydrogen-refueling gateway for New England.

Research Question and Approach
This research asks: **Where should Connecticut locate early hydrogen refueling stations to maximize freight coverage, minimize cost, and support near-term deployment of hydrogen fuel-cell trucks?**
To address this question, we developed an integrated geospatial and techno-economic optimization framework that combines freight traffic density, proximity to existing natural gas infrastructure, land-use constraints, and energy system considerations. A mixed-integer linear programming (MILP) formulation evaluates multiple adoption and emissions-reduction scenarios, explicitly considering the benefits of co-locating modular hydrogen production directly at refueling sites. This approach moves beyond conceptual planning and provides actionable, site-specific insights that can directly inform state infrastructure investment and permitting decisions.

Why This Matters for Connecticut
Connecticut is uniquely positioned to lead hydrogen freight deployment in the Northeast. The state sits at the gateway of New England's primary freight corridor (I-95), has the highest truck traffic volume in the region, and already maintains extensive natural gas and electric infrastructure suitable for early hydrogen production.
At the same time, Connecticut has enacted policies that explicitly support clean transportation and alternative fuels, including recent clean transportation funding mechanisms and hydrogen-focused

initiatives administered by the Department of Energy and Environmental Protection (DEEP). However, these programs require clear, evidence-based guidance to ensure that early investments are efficient, scalable, and aligned with freight demand.
Absent coordinated planning, hydrogen infrastructure risks being underutilized, poorly sited, or misaligned with fleet needs. Strategic, data-driven siting can avoid these outcomes while accelerating emissions reductions in one of the state's hardest-to-decarbonize sectors.

Key Findings

- With approximately 5% adoption of hydrogen fuel-cell trucks, statewide freight coverage can be achieved with seven strategically located hydrogen refueling hubs.
- On-site, modular hydrogen production at refueling stations significantly reduces distribution costs and improves system reliability compared to centralized production and trucking of hydrogen.
- Optimal sites cluster along I-95 and I-84, reflecting freight density, accessibility, and proximity to existing energy infrastructure.
- Connecticut's compact geography allows a relatively small number of hubs to serve both in-state and through-traffic, reinforcing its role as a regional freight and energy node.
- These findings indicate that Connecticut can support early hydrogen freight adoption without large-scale overbuilding, provided investments are strategically targeted.

Policy Recommendations for Connecticut

1. **Designate Hydrogen Freight Corridors along I-95 and I-84**
   The General Assembly should direct DEEP and CTDOT to formally designate priority hydrogen freight corridors along I-95 and I-84. Corridor designation provides planning certainty, aligns infrastructure investments with freight demand, and signals long-term commitment to fleet operators and investors.
2. **Prioritize State-Owned and Industrial Sites for Hydrogen Hub Pilots**
   Connecticut should prioritize state-owned parcels, transportation facilities, and existing industrial sites identified by optimization analysis for early hydrogen refueling pilots. Pre-screening and pre-permitting these locations can significantly reduce deployment timelines and project risk.
3. **Align Clean Transportation Incentives with Co-Located Production and Refueling**
   Existing clean transportation funding mechanisms should explicitly support hydrogen stations that integrate on-site production. This approach lowers delivered hydrogen cost, improves resilience, and reduces reliance on hydrogen trucking in early deployment phases.
4. **Leverage Connecticut's Position to Secure Federal Cost-Share Funding**
   By advancing ready-to-deploy, corridor-based projects, Connecticut can strengthen applications for federal hydrogen infrastructure funding and regional hub initiatives. State leadership in site readiness and coordination is critical to capturing these resources.
5. **Launch a Data-Driven Pilot before Large-Scale Deployment**
   A phased pilot supporting modest fleet adoption allows Connecticut to validate assumptions, collect operational data, and refine policy design before committing to large capital investments. This approach balances innovation with fiscal responsibility.

Policy Takeaway

Connecticut can accelerate freight decarbonization and capture regional economic benefits by strategically co-locating hydrogen production and refueling along its major freight corridors. Data-driven siting enables cost-effective early deployment, strengthens the state's competitiveness for federal funding, and positions Connecticut as a hydrogen gateway for New England, without overextending public resources.

Small Modular Reactors (SMRs) and Advanced Reactors

Summative Research Presentation by Dr. Regis Matzie;
President, RAMatzie Nuclear Technology Consulting, LLC
regismatzie@gmail.com
Presented by Sten Caspersson
Nuclear Power Consultant
scaspersson6@comcast.net
Connecticut Academy of Science and Engineering (CASE)

Primary: Energy and Technology Committee;
Secondary: Commerce Committee

Power demand across the United States is projected to grow substantially over the next decade. Projections show that electricity consumption in New England is projected to rise by more than 11%. Connecticut's mandate of 100% zero-carbon electricity by 2040 also requires more than intermittent renewable resources to keep up with demand, especially during seasonal peaks. The Connecticut Department of Energy and Environmental Protection (DEEP)'s informational process that explores new nuclear energy capacity is a good step towards educating municipalities on the possibilities of nuclear energy, including small modular reactors (SMRs).

What Drives Energy Demand

Increasing use of electric cars, the electrification of industries, the expanded use of the internet, and the widespread deployment of artificial intelligence (AI) are all major driving forces behind the increased demand in energy capacity. These data centers are proliferating energy use with their high usage of electricity to power computer servers and the necessary cooling for the processors.

Tech companies, including Google, Microsoft, Meta, and Amazon, are all demanding reliable, safe, and carbon-free electricity to power their future needs. They are turning to nuclear power to reliably supply this 24/7, year-round. These companies have signed power purchase agreements with several new small modular reactor (SMR) technologies and, in some cases, are investing directly in these technologies to provide a boost in the development and deployment of them. Power purchase agreements are also being signed with owners of shutdown reactors, investing in SMRs for the long term and providing the financial support to warrant restart of these reactors, including Palisades (Michigan), Three Mile Island Unit 1 (Pennsylvania), and Clinton (Illinois). Over 5 billion dollars has been raised by the private sector with the Federal government nearly matching this amount to develop and demonstrate these technologies, making SMRs a potential worthwhile investment for Connecticut's nuclear future.

The Use of Small Modular Reactors (SMRs)

SMRs can be characterized by their lower power rating (300 MWe and less) versus 1000+ MWe for traditional light water reactors (LWRs), by their small physical sizes, and by their cooling media: light water, helium, molten salt, or liquid metal. Each of the resulting reactor designs has positives and negatives in its path to commercialization. Light water-cooled SMRs have substantial operating experience and licensing precedent based on nearly 100 of their "big brothers" currently operating in the United States and over 415 around the world. Other SMR technologies have been demonstrated in the past but lack significant

operating experience and licensing history. Nevertheless, these more advanced technologies have highly desirable characteristics, including significantly higher operating temperatures and lower operating pressures that offer lower capital costs along with more benign responses to potential accidents. Some of these advanced technologies use TRISO fuel that can operate at very high temperatures in the event of loss of cooling without any fuel failure, making them extremely well suited to "close-in" siting near load demand areas such as data centers.

The deployment of new nuclear reactors in the United States has bi-partisan support. Low-cost preparatory actions today, including clarifying regulations, community engagement, and market design will allow Connecticut to make an informed decision when SMR technology reaches commercial maturity, which for some of these technologies will be achieved in the early 2030s.

Policymakers should act now to preserve strategic optionality, mitigate future costs, and maintain competitiveness in the regional energy transition. To meet this challenge, policymakers must instill a statewide nuclear readiness framework aimed at realizing SMR technology to be developed. Experts and the state should consider an assessment of the various SMR technologies, the identification of potential siting targets including protocol for internal power use and grid interconnection, impact of potential loads and resources that would be associated with operation of SMRs, safety including transport of fuel and removal of waste from SMR facilities, costs including impact to the rate base, and potential collaboration with utilities for grid interconnection and collaboration with large energy users (such as data centers) for internal power use.

Connecticut's goal of lowering its carbon footprint as well as the individual and industry demand of energy can be met with the help of SMRs. The early investment in education, implementation and assessments will be effective as well as supported by growing federal incentives, private-sector investment, and bipartisan momentum for advanced nuclear technologies.

Policy Brief

January 2026

Street and Urban Development

Opportunities to inform safety initiatives

Christopher Morrison and Brady Bushover, Yale School of Public Health

Interpersonal violence is a major cause of injury and death in the US,[1,2] with consequences that are both nationally significant and locally concentrated. In 2023, Connecticut hospitals billed over $179 million for the admission and treatment of injuries related to assault, highlighting the burden on the state's health system and communities.[3] Place-based interventions, which involve changing the physical environment at locations where violence concentrates, represent a proven tool in reducing violence, with prior studies demonstrating impacts from strategies such as greening vacant lots or remediating vacant buildings.[4]

This Study

- Previous place-based prevention work has primarily focused on private places, such as buildings and vacant lots.
- This project extended that work to public roadways that underwent street and urban development projects in New York City.
- This study examined whether streets that received infrastructure upgrades experienced fewer violent crime incidents compared with similar streets that did not.

Project Types

- We investigated several types of street and urban development projects completed by the New York City Department of Transportation (NYC DOT).[5]
- Projects varied in scope, from sidewalk repairs that address uneven slabs or cracks to street reconstruction that involves the replacement of underground roadway structures.

Key Findings

- Street and urban development projects were associated with reductions in multiple types of violent crime, compared to streets that had not yet been improved.
- Streets that received projects experienced 3.4% fewer robberies, 1.6% fewer weapons offenses, and 1.3% fewer reckless endangerment incidents.
- These reductions were observed using a rigorous ten-year analysis of more than 155,000 street-quarters across New York City, strengthening confidence that the changes are not due to chance.
- Findings indicate that routine infrastructure investments, like resurfacing streets and repairing sidewalks, can also function as effective violence prevention tools, in addition to their established traffic safety and mobility benefits.

Crime Type	% Change
Reckless endangerment	-1.3%
Robbery	-3.4%
Weapons offenses	-1.6%

Recommendations

1. Leverage infrastructure investments as violence prevention tools. Routine maintenance helps reduce crime. Action: Prioritize these improvements in high-crime areas to mitigate violence.
2. Identify and targe high-crime areas. Use crime data to locate where improvements are most needed. Action: Focus infrastructure and safety enhancements in these neighborhoods for the greatest impact.
3. Integrate public safety goals into transportation and urban planning programs: align development projects with crime reduction strategies. Action: Include public safety experts in the planning and design phases of development projects.

Questions? Contact Us:
Christopher Morrison, Associate Professor
Yale School of Public Health
christopher.morrison@yale.edu

Brady Bushover, Research Associate
Yale School of Public Health
brady.bushover@yale.edu

REFERENCES

1. Centers for Disease Control and Prevention, *2022 NHAMCS Emergency Department Web Tables* (Hyattsville, MD: National Center for Health Statistics, 2024), https://www.cdc.gov/nchs/data/nhamcs/web_tables/2022-nhamcs-ed-web-tables.pdf.
2. Centers for Disease Control and Prevention, *National Vital Statistics System – Mortality Data*, CDC WONDER, https://wonder.cdc.gov.
3. Connecticut Department of Public Health, *Assault-Related Injury in Connecticut: A Fact Sheet – 2023 Update* (Injury and Violence Surveillance Unit, 2024), https://portal.ct.gov/dph/-/media/dph/injury-and-violence-prevention/injuryfactsheets/2023-assault-fact-sheet-final-11124.pdf?rev=1b7bed41565e46b4b75895983c5ad1db&hash=3636804DA9F45D2A110265CA43DD7192.
4. Gobaud AN, Jacobowitz AL, Mehranbod CA, et al. "Place-Based Interventions and the Epidemiology of Violence Prevention." *Current Epidemiology Reports* 9, no. 4 (August 2022): 316-25. https://doi.org/10.1007/s40471-022-00301-z.
5. New York City Department of Transportation, *Street Design Manual: Capital Projects*, https://www.nycstreetdesign.info/process/capital-projects.

Implementing IDDSI to Improve Dysphagia Safety and Culturally Responsive Diets to Address Malnutrition in Connecticut Long Term Care Facilities

Mesk Alhammadi, Xiayu "Katniss" Ni, Michael Werner

Issue/problem: Connecticut long term care facilities lack a unified, statewide standard for managing diets of residents with dysphagia. This absence contributes to inconsistent care, higher rates of aspiration pneumonia, and increased healthcare costs. Should Connecticut mandate the adoption of a standardized framework such as the International Dysphagia Diet Standardization Initiative (IDDSI) to ensure safe, evidence-based nutrition management for residents with swallowing disorders.

Background: **Dysphagia** is the medical term for difficulty swallowing and occurs when the oral, pharyngeal, or esophageal phases of swallowing are disrupted. While natural protective mechanisms generally prevent aspiration, illness or frailty can impair these safeguards. Dysphagia is commonly classified as oropharyngeal or esophageal and affects an estimated **15 million U.S. adults** (ASHA). It is especially prevalent among older adults and residents of long-term care facilities, where it is a significant cause of mortality.

Aspiration pneumonia, a critical complication of dysphagia is among the leading causes of death in older adults which prolongs hospital stays, worsens prognosis, and increases healthcare utilization. Dysphagia adds an estimated **$4–7 billion annually** to U.S. healthcare costs, excluding indirect economic impacts such as lost productivity. On the other hand, malnutrition is a significant complication of dysphagia and a major public health concern. More than half of residents in long-term care facilities are malnourished or at risk of malnutrition.

Connecticut context: The CT Department of Developmental Services reports that respiratory diseases, including pneumonia, are the second leading cause of death, and aspiration pneumonia ranks sixth **(4.2% of all deaths)** which are strongly linked to swallowing dysfunction.

Current Practice: Existing practices follows the federal Centers for Medicare & Medicaid Services (CMS) regulations using F-tags, shown in Table 1. However, Connecticut lacks dysphagia-specific training and annual competency verification for all direct care staff. Facilities vary widely in screening, diet texture, and staff training

Table 1: F-Tags

F805	**Food in Form to Meet Individual Needs**
F684	**Quality Of Care**
F689	**Accidents & Supervision**
F580	**Notification Of Change**
F757	**Unnecessary Drugs**

Evidence-Based Standards: The **International Dysphagia Diet Standardization Initiative (IDDSI)** provides a globally recognized framework describing texture and thickness levels for foods and liquids, from thin to extremely thick. Major professional organizations, including the Academy of Nutrition & Dietetics and the American, speech-Language-Hearing Association, supports IDDSI.

References

1. McCarty, E., Berryhill, M. E., et al. (2021). *Dysphagia and swallowing disorders*. **Medical Clinics of North America, 105**(5), 939–954.https://www.medical.theclinics.com/article/S0025-7125(21)00081-X/fulltext
2. Hong, I., Bae, S., Lee, H. K., & Bonilha, H. S. (2024). Prevalence of dysphonia and dysphagia among adults in the United States in 2012 and 2022. *American Journal of Speech-Language Pathology*, *33*(4), 1868–1879. https://doi.org/10.1044/2024_ajslp-23-00407
3. Connecticut State Department of Developmental Services. (2022). *Mortality ANNUAL REPORT - 2022*. https://portal.ct.gov/dds/-/media/dds/health/reports/mortality_report_fy_22.pdf?rev=5ead779cb38346828ac75b36ab69c530&hash=71045E53F0836D18DD58370364F1384B
4. Centers for Medicare & Medicaid Services. (n.d.). State Operations Manual Appendix PP - Guidance to surveyors for long term care facilities. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

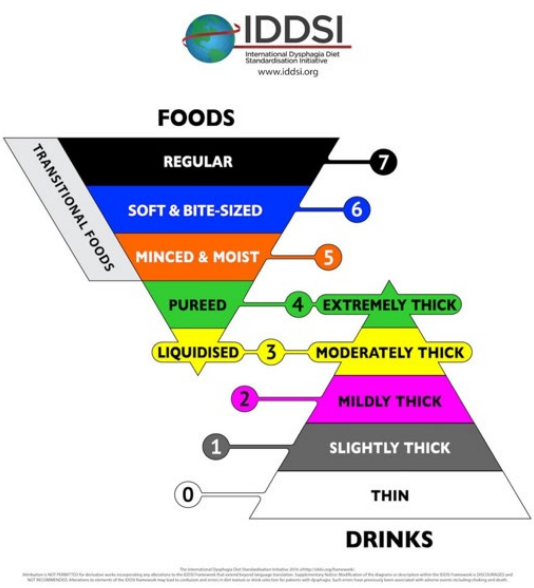
While many voluntarily support IDDSI, there is **no** federal standardized practice resulting in uneven practices except for Indiana has a specific dysphagia competency evaluation & documentation that the staff follow. Even facilities that use IDDSI can be cited when staff apply it inconsistently, such as Westview in Rhode Island (F805) where incorrect thickened-liquid levels led to complications.

Other Jurisdictions:

Canada is currently underway for IDDSI nationwide implementation[1]. Regionally, Rhode Island introduced legislation (2024-H 7733) to establish nursing-home quality standards, highlighting growing legislative interest in standardized care.

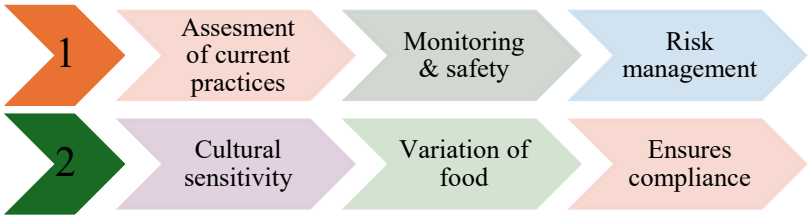
Importance of Palatable, Easy-to-Eat Food:

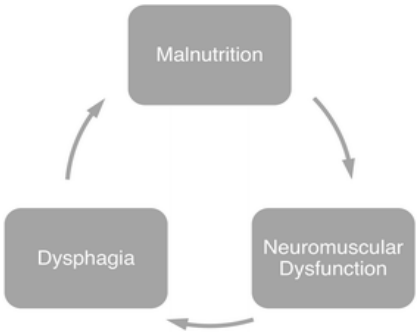
Not all residents need texture-modified diets, and unnecessary restriction can worsen intake and muscle loss. Attractive, culturally appropriate foods, offered at the safest appropriate level, are essential for overall health, independence, and dignity.



Implementation Considerations:

Training + patient centered = safer meals and better nutrition





Policy Recommendations

1. Food safety & regulations

- Encourage IDDSI adoption as the statewide standard for modified diets and thickened liquids in long term care facilities, through providing food texture training to kitchen staff and feeding assistants.
- Require facilities to use IDDSI terminology at admission and across care transitions, integrate IDDSI compliance into routine state inspections and quality monitoring.

2. Prevent malnutrition through dysphagia-informed nutrition and culturally responsive meal options

- Provide options of culturally-responsive meals in long term care facilities. Ensure meals offered at long term care facilities support adequate intake, dignity, and cultural preferences
- Compliance standards should evaluate not only safety, but also palatability, and resident choice to prevent malnutrition and weight loss among residents.

Conclusion: Following the recommendations will improve resident safety, decrease aspiration-related hospitalizations, and reduce healthcare expenditures while ensuring culturally sensitive, patient-centered care.

Moving Beyond Implications Conference
January 2026
Abstract Submission

Invisible Veterans: Policy Reforms to Address the Mental Health Needs of American IDF Lone Soldier Veterans Living in Connecticut

Faigy Mandelbaum, Ph.D.
Psychology Fellow, Yale Child Study Center, Trauma Track
Yale School of Medicine
Israel Fulbright Scholar (2022-2023)
CHDI Policy Fellowship (2025)
Faigy.Mandelbaum@yale.edu

Committee Audience
Primary Committee: Committee on Veterans' and Military Affairs
Alternate: Public Health Committee

Research Type: Summative Research Presentation

Relevance to Connecticut Policymakers

Unlike traditional U.S. veterans, American Lone Soldier veterans who served in Israel and then returned to the United States are not eligible for federal or state VA benefits, despite their exposure to combat and trauma while serving a close American ally. As a result, those who are on Medicaid have no choice but to seek care in community mental health settings, where providers often lack specialized training in military trauma. This gap in care places an additional burden on Connecticut's mental health system, as clinicians without military trauma expertise are tasked with treating conditions that would typically fall under VA-trained providers. This leaves soldiers trapped in a cycle of government-funded, inadequate mental health care without the healing they need for recovery. By considering policy reforms that would allow Medicaid-eligible American Lone Soldiers and their families to access veteran mental health services, Connecticut can address this urgent and growing need, ensuring that those who served an American ally can receive appropriate specialized treatment and fully contribute to the state's communities and economy.

Abstract

Lone Soldiers Experience High Prevalence of PTSD and Mental Health Needs. Connecticut policymakers are often unaware of the struggles of American Lone Soldier veterans. Lone Soldiers are from the U.S. and other countries who are serving without family support. There are an estimated 7,000 active-duty Israeli Defense Force (IDF) Lone Soldiers, plus reservists. About 50% of these soldiers are Americans who return as veterans to the U.S., predominantly to the East Coast. Lone Soldiers serving in the Israel-Hamas war have faced intense combat exposure, including guerrilla warfare, navigating tunnels and terrorism, and loss of comrades. A study on U.S. military personnel who just completed service found PTSD rates to be between 1.39% and 2.98%. Among U.S. veterans, PTSD rates are even higher, ranging from 2%-29%. However, **a recent study finds even higher rates of PTSD and other mental health needs among Lone Soldiers, serving as a call to action for Connecticut policymakers.** During the Israel-Hamas war, 576 active-duty IDF soldiers were recruited in-person and online and asked to complete a survey via paper surveys and Qualtrics. Soldiers responded to items on childhood trauma histories, traumatic war-related experiences, loneliness, social-related experiences, and PTSD

symptomatology. Results found that while on duty, **78% of the Lone Soldiers met diagnostic criteria for PTSD**.

Lone Soldiers Lack Access to Appropriate Care. **Unlike traditional U.S. veterans, American Lone Soldier veterans remain ineligible for federal or state VA benefits,** despite their military service for an American ally and their severe PTSD. As a result, Medicaid-eligible veterans seek care in community mental health settings, without access to military trauma specialists. The lack of access to the appropriate treatments not only impacts veterans, but also their spouses, children, and families. With untreated trauma, veterans struggle to reintegrate into civilian life, maintain relationships, and contribute economically. As Lone Soldiers return to CT from serving in the Israel-Hamas war, they urgently require access to clinicians trained in military trauma who are equipped to help them heal and reintegrate.

The Call to Action for CT Policymakers. The severity of Lone Soldiers' trauma symptoms far exceeds the PTSD rates among U.S. veterans. As trauma symptoms typically increase after the trauma has passed, it is projected that the trauma rates of Lone Soldier veterans may increase to nearly 100%. These soldiers who are Medicaid-eligible should be provided with access to military psychologists/psychiatrists who can help ease their suffering. They are small in number and supporting them will not cause significant financial strain for state budgets. Furthermore, if they are provided with the right support, they will spend less on Medicaid mental health care, rehabilitate faster, be more present for their families, and continue their contributions to Connecticut's communities and economy.

Policy Recommendations

1. **Expand state eligibility for veteran mental health services**
    - Propose state-level legislation allowing American citizens who served as Lone Soldiers in the IDF, and their children and spouses, to access veteran mental health services if they are Medicaid-eligible.

2. **Advocate for federal recognition and benefits**
    - Urge Connecticut's congressional delegation to introduce or support legislation that would recognize service in the IDF for the purpose of accessing federal VA services for Medicaid-eligible lone soldiers, their children, and spouses.

3. **While awaiting state and federal eligibility and benefits, ensure Connecticut's community-based providers receive specialized training to address the mental health needs of Lone Soldiers**
    - Allocate funding for training select Connecticut community mental health providers in military trauma treatment, specifically tailored to the needs of Lone Soldiers to improve the quality of their mental health care.

References

Bliese, P. D. , Wright, K. M. , Adler, A. B. , Thomas, J. L. & Hoge, C. W. (2007). Timing of postcombat mental health assessments. *Psychological Services*, *4*(3), 141-148. doi: 10.1037/1541-1559.4.3.141.

Hoge, C. W., Grossman, S. H., Auchterlonie, J. L., Riviere, L. A., Milliken, C. S., & Wilk, J. E. (2014). PTSD treatment for soldiers after combat deployment: Low utilization of mental health care and reasons for dropout. *Psychiatric Services*, *65*(8), 997–1004. https://doi.org/10.1176/appi.ps.201300307

US Department of Veteran Affairs (December, 2024), National Center for PTSD. How common is PTSD in veterans? https://www.ptsd.va.gov/understand/common/common_veterans.asp

Van der Kolk, B. A. (2014). The body keeps the score: Brain, mind, and body in the healing of trauma. New York: Viking.

Vest, B. M., Hoopsick, R. A., Homish, D. L., Daws, R. C., & Homish, G. G. (2019). Childhood trauma, combat trauma, and substance use in national guard and reserve soldiers. *Substance Abuse*, *39*(4), 452-460. www.ncbi.nlm.nih.gov/pmc/articles/PMC6294699/

Walter, Kristen H., et al. (2018). Prevalence of posttraumatic stress disorder and psychological comorbidities among U.S. active-duty service members, 2006–2013. *Journal of Traumatic Stress*, *31*(6), 837–844, doi/abs/10.1002/jts.22337, https://doi.org/10.1002/jts.22337

Medicaid Coverage of Family and Youth Peer Support

Strengthen Children's Behavioral Health Care by Expanding Staff with Lived Experience

Family Peer Support Specialists are caregivers with lived experience navigating behavioral health and related systems who are trained to support other families.

Youth Peer Support Specialists are young adults (18-29) with personal lived experience as children or youth receiving behavioral health or related services who are trained to support other youth.

Outcomes of Family and Youth Peer Support

Peer support work is anchored in shared lived experience, strategic sharing of personal story, and emotional support that offers a unique approach and benefit when integrated within prevention services or as a component of behavioral health interventions. **Research has demonstrated benefits to youth, families, and systems:**

Family benefits[1]:

- Increased engagement in treatment and adherence to interventions
- Improved family functioning
- Reduced caregiver stress and isolation
- Greater confidence to navigate systems and meet children's needs
- More shared decision-making with providers

> "You are a mom...and someone says, 'You know what, **I've been there. Let me help you**.'"
>
> *-Connecticut parent regarding family peer support*

Youth benefits[2]:

- Increased engagement in treatment
- Greater trust of providers
- Improved social-emotional functioning
- Decreased conflict with parents and caregivers

System benefits[3]:

- Shorter hospital stays
- Reduced re-hospitalization and emergency room treatment rates
- Lowered costs
- Long-term opportunity to improve equity in service delivery, increase access, and decrease wait times

Connecticut Family and Youth Peer Support Research Project

Goal: Develop recommendations for Connecticut to expand family and youth peer support roles within the children's behavioral health workforce.

Builds Upon recommendation within Connecticut's strategic plan for the children's behavioral health workforce.

Research Questions:

- Literature on effectiveness?
- Best practices in implementation?
- Connecticut landscape?
- Funding and sustainability?

Methods:

- Literature review
- Landscape analysis of CT programs
- Key informant interviews
- Focus groups with families and providers
- Survey of peers and other staff

This project is funded by the CT Department of Children and Families and completed in partnership with the Children's Behavioral Health Plan Implementation Advisory Board.

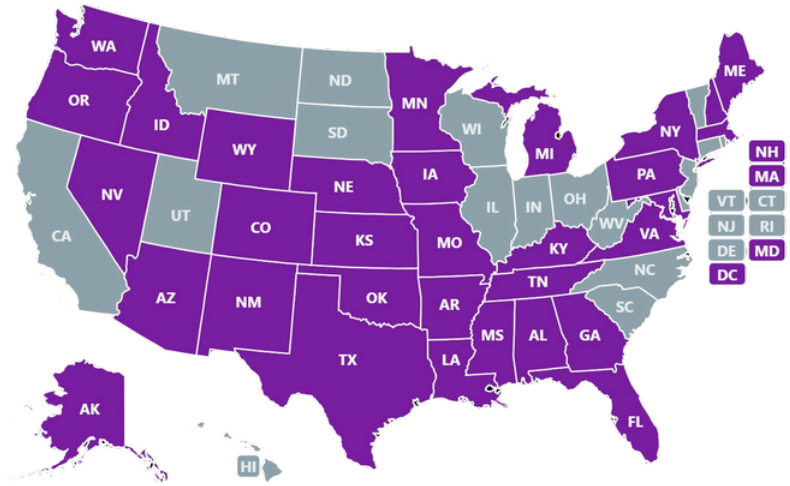
CHDI® Child Health and Development Institute

Medicaid Funding for Family and Youth Peer Support: A National Perspective

Medicaid is a primary source of funding for most states' implementation of family and youth peer support. While many states braid funding across multiple sources, Medicaid serves as the most stable, sustainable source of funds for peer support. **The Center for Medicare and Medicaid Services identifies family and youth peer support as evidence-based services** and an important component of a state's delivery of effective behavioral health services. Medicaid coverage can include **fee-for-service reimbursement**, **value-based payment methods**, and **waivers**.

33

states have Medicaid coverage for family and/or youth peer support services[4*]



Connecticut Landscape

Connecticut currently has multiple programs implementing family peer support services (and very few youth peer support programs). These programs have very limited capacity in relation to the potential need among children and families receiving behavioral health services. **Connecticut family and youth peer support services are currently funded by a patchwork of funding mechanisms and have limited sustainability**.

There is **currently no Medicaid fee-for-service funding for family or youth peer support in Connecticut**. Innovative approaches to Medicaid funding, such as the 1115 substance use waiver and the Certified Community Behavioral Health Clinic planning grant, offer opportunities to explore alternative payment models for peer support, but are very limited in scope.

The Connecticut General Assembly, in recent years, has expanded Medicaid coverage for other non-clinical health care staff. **Public Act No. 23-247 expanded coverage to doulas and Public Act No. 23-186 expanded coverage to community health workers** (although funding for reimbursement has yet to be allocated for the latter).

Policy Recommendation

Change Connecticut Medicaid policy through a state plan amendment to allow reimbursement for services offered by family and youth peer support specialists.

- Include prevention, early intervention, and treatment services
- Cover the full continuum of care
- Peers should be self-identified as youth or caregivers/family members of youth who have experience with behavioral health needs
- Support family-run organizations, in addition to providers, to build capacity to bill Medicaid

[1]Hoagwood, K.E., et al. (2010). [2]Simmons, M.B., et al. (2023). Ojeda, V.D., et al. (2021). Vojtila, L, et al. (2021). Hawke, L.D., et al. (2019). [3]Mental Health America (2019). Ojeda, V.D., et al. (2021). [4]Schober, M. and Baxter, K. SAMHSA (2020). **Data current as of Apr. 2020.*

Child Health and Development Institute

For more information, contact Aleece Kelly, MPP at akelly@chdi.org or visit www.chdi.org.

Child Health and Development Institute

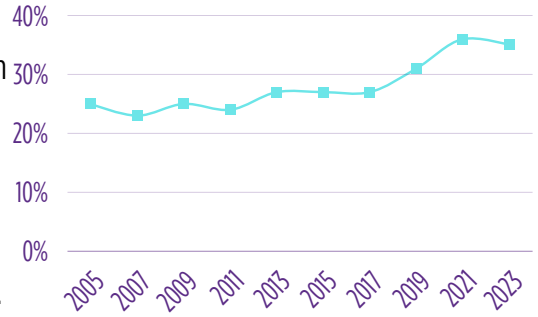
Raising Medicaid Rates will Expand Access to Children's Behavioral Health Services

Behavioral health needs among youth in Connecticut are rising. Families seeking care regularly encounter long wait lists and delays in accessing services due to staffing shortages.

Connecticut's behavioral health system has been nationally recognized for its continuum of care and highly trained staff. However, high burnout, low salaries, and the resulting workforce challenges are eroding the system's infrastructure and reducing service access, especially for the most vulnerable.

The state's own analyses conducted per legislative mandate have found that Connecticut's Medicaid reimbursement rates for behavioral health are dramatically lower than both comparable states and rates of commercial insurers within Connecticut.

Connecticut High School Students Reporting Feeling Sad or Hopeless



Increasing Medicaid rates will help address workforce shortages and increase access to care.

Research on the Children's Behavioral Health Workforce in Connecticut

In 2024 the Child Health and Development Institute (CHDI) conducted a study of licensed behavioral health professionals in Connecticut (psychologists, professional counselors, social workers, marriage and family therapists, addiction counselors, and psychiatrists). Over 2,800 currently licensed professionals responded (of the 23,639 invited). The survey was designed to increase the state's understanding of providers' experiences working in Connecticut. Relevant to Medicaid reimbursement, the following questions were addressed in the analysis:

(1) Does acceptance of public insurance vary by setting?
(2) How do children's needs differ as reported by providers accepting Medicaid compared to those only serving children with commercial insurance or paying out-of-pocket?
(3) Are there differences in salaries or job satisfaction among the workforce serving children with Medicaid compared to the workforce serving children with commercial insurance or paying out-of-pocket?

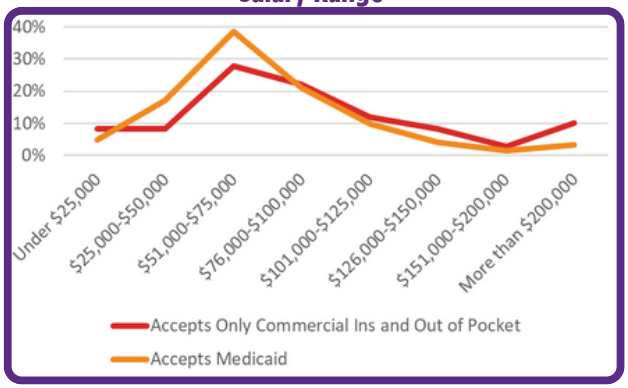
The analysis compared experiences of the workforce accepting Medicaid with the workforce accepting only commercial insurance or out-of-pocket payment. The findings highlighted the strong role that providers who accept Medicaid insurance offer in serving children and those with highest needs (professionals accepting Medicaid were more likely to serve children, more likely to work in a nonprofit clinic or hospital setting, and more likely to serve children who had more significant needs related to social and economic conditions and exposure to trauma. The findings also raised concerns regarding the impact of reimbursement rates on salaries, and in turn, recruitment and retention of providers in settings that accept Medicaid. Professionals accepting Medicaid were more likely to make less than $75,000 than their those who did not, and scored higher on average on a measure of staff intention to leave their employer (Turnover Intention Scale).

Findings

Providers who accept Medicaid payments are more likely than those who don't to..

- ✓ Serve children
- ✓ Work in nonprofit clinics or hospital settings
- ✓ Serve populations with higher needs, including social and economic challenges and trauma exposure.
- ⚠ Work for lower salaries
- ⚠ Dream of a new job

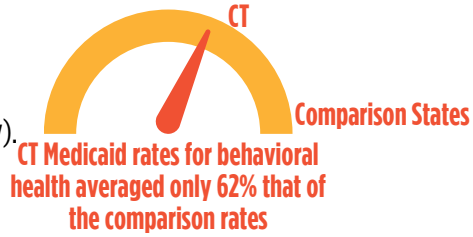
Salary Range



Child Health and Development Institute

The Role of Reimbursement Rates in Access to Care

The state legislature previously mandated review of Medicaid rates and their parity with commercial insurance as well as parity between rates for behavioral and medical services. **The results were clear that Connecticut's Medicaid reimbursement rates are lower than comparable states' rates, and behavioral health rates are the lowest.**



- Department of Social Services' Phase 1 Medicaid rate study found that nearly all of Connecticut's behavioral health billing codes had rates lower than those of the other states, and an estimated annual shortfall of $42 million to meet the 5 state comparison rates (considerably more than the $7 million allocated following the release of the study).
- The Office of Health Strategy's report on parity found that Medicaid payments for behavioral health services were significantly lower than commercial insurance and Medicare, with some services covered at only half the rate of commercial insurers.
- The report further indicated challenges with access to care for Medicaid enrollees, with up to four times as many providers available for those with commercial insurance.
- The State Comptroller Healthcare Cabinet Children's Subcommittee recommended increasing reimbursement rates to both meet parity with rates for medical services, and as a strategy to address unmet behavioral health needs among children.

The findings from CHDI's survey of Connecticut's behavioral health professionals indicate that these low reimbursement rates are placing downward pressure on salaries and in turn increasing burnout and turnover in the settings serving the most vulnerable populations with highest needs.

Nonprofits relying on insufficient reimbursement rates are not able cover costs and raise salaries to be competitive with other settings which offer more flexibility, smaller caseloads, and less acuity. Prior reports from providers demonstrated significant challenges with recruitment and retention of behavioral health staff among nonprofits in Connecticut (e.g., an average of one third of staff positions were vacant in intermediate level of care settings and nonprofits overall reported an 18% vacancy rate in a recent report by The Alliance). **These staffing challenges in turn result in reduced access to care. The Alliance report found 59% of nonprofits reporting waitlists overall, with waits varying from a few weeks to a few months depending on the level of care**.

This connection between reimbursement rates and access to care mirror the findings from the broader literature and experiences in other states. In an evaluation of factors impacting the behavioral health workforce in Oregon, low reimbursement rates were identified as having increased turnover in the behavioral health field broadly, and in particularly within publicly funded services. Research indicates that higher reimbursement rates have the potential to lead to greater access to services by improving recruitment and retention for settings serving those with Medicaid and by incentivizing additional providers (e.g., those in private practice, etc.) to accept Medicaid insurance.

Recommendation

Connecticut's Medicaid rates for behavioral health services are documented as consistently significantly lower than all available benchmarks (other states, Medicare rates, and commercial insurers). Research has demonstrated that professionals working in settings that are more reliant on Medicaid reimbursement are receiving lower salaries for what is often more challenging work, and are getting burnt out and leaving for less stressful and higher paying opportunities. Children covered by Medicaid are among the states most vulnerable populations with the highest needs.

Connecticut has the opportunity to stabilize the workforce, increase access to critical services, and address the rising behavioral health needs among children in Connecticut. In the upcoming session, the state legislature should increase Medicaid reimbursement rates for children's behavioral health services.

Contact Us:
Jason Lang, PhD (jlang@chdi.org)
Chief Program Officer, Child Health and Development Institute

Aleece Kelly, MPP (akelly@chdi.org)
Senior Associate, Child Health and Development Institute

About CHDI:
The Child Health and Development Institute is a non-profit organization providing a bridge to better and more equitable behavioral health and well-being for children, youth, and families. We collaborate with policymakers, providers, and partners to transform child-serving systems, disseminate evidence-based and best practices, and advance policy solutions that result in better outcomes for children in Connecticut and beyond.

Read the full Strategic Plan for the Children's Behavioral Health Workforce in Connecticut here.

EQUABLE

BRIEF

Who Benefits?

Making Teacher Pension Financing More Fair in CT

DECEMBER 2025

CONTACT: Anthony Randazzo| Executive Director, Equable Institute| anthony@equable.org

BACKGROUND & SUMMARY

Salary is an important factor as districts compete for a high-quality educator workforce, especially during a period of shortage. Teacher salary is also tied to teacher retirement benefits, through the funding formula that the state uses to determine the amount of each teacher's retirement:

[Years of Service]	x	2% (Benefit Multiplier)	x	[Final Average Salary]	=	A Teacher's Annual Benefit

Based upon this formula, teachers' pension benefits are more valuable when teachers work longer and get paid higher salaries. Both salary schedules and retention policies are ultimately set at the local level. However, the employer contribution towards teacher retirement is paid annually by the State of Connecticut exclusively, on behalf of local school districts.

Annually, teacher retirement benefits cost the state approximately $1.5 billion, an allocation that should, in principle, be allocated equitably. Nonetheless, our research has shown that Connecticut's system of financing teacher pensions rewards the very districts that are already able to pay teachers the most and retain them for the longest.

Connecticut is among only about a dozen states to cover local districts' teacher compensation packages, without requiring districts or municipalities to pay any portion of the pension contributions.[1] Beyond being unequal across district lines, our research shows that Connecticut's system of financing teacher pensions is also deeply inequitable.[2]

A policy solution would incorporate municipal contributions from some districts—in order to allocate state education funds fairly, protect and sustain teacher retirement benefits, and maintain a fully funded Teacher Retirement System long term.

OVERVIEW OF FINDINGS

Our research sought to evaluate the equity implications of these unequal state subsidies covering teacher pension costs. We used a "Per Pupil Pension Subsidy"metric—derived by taking each district's total pension debt and dividing it by its number of students enrolled. This metric allows for resource comparisons between districts[3] because it measures the state's contributions to teacher retirement for each district on a per pupil basis.

[District Pension Obligation]	÷	[District Student Enrollment]	=	Per Pupil Pension Subsidy

Scan to access the full report

[1]See, Center for Retirement Research (2024). "What Role Does State Government Play in Funding Teacher Pensions?"
[2]Complicating the problem is that a significant share of the costs for Connecticut's Teachers' Retirement System (TRS) are to pay down unfunded liabilities. (See, Equable Institute (2023). "America's Hidden Education Funding Cuts;" Equable Institute (2021). "Sources of Unfunded Liabilities, in $Billions Connecticut TRS; Aubry, J. and Munnell A. (Center for Retirement Research at Boston College, 2015). "Final Report on Connecticut's State Employees Retirement System and Teachers' Retirement System."
[3]Our research was limited to districts with at least 1,000 students enrolled, to eliminate the impact of outlier data.

FINDINGS, Cont'd

By comparing the state's pension allocations across districts, we identified that the Per Pupil Pension Subsidy compounds various forms of resource inequity. Specifically:

1. **Districts with smaller pension obligations are likely to have a high percentage of their workforce getting paid lower salaries, at or below $60,000.**
2. **Connecticut pays Per Pupil Pension Subsidies at less that 50% the rate for students from low-income families as compared to their peers.**
3. **Connecticut pays Per Pupil Pension Subsidies at less than 50% the rate for students of color as compared to white students.**
4. **Connecticut pays a 28% larger Per Pupil Pension Subsidy on behalf of teachers in high-performing districts than in districts with lower performance.**

A subsequent 2025 brief also showed a moderate correlation between the Per Pupil Pension Subsidy and a district's performance on the 2025 Smarter Balanced Assessment (SBAC) in English Language Arts (ELA) and Math. Examples of how this unfair state pension subsidy disadvantages lower resourced, lower performing districts, include pairings like the following:

Hartford, which receives a $2,793 pension subsidy, and has only 19.9% of its students meeting/exceeding expectations on the 2025 ELA SBAC. Right next door, 38.8% of **East Hartford** students meet that benchmark, and the district received a subsidy of $3,122—$329 more per pupil.

Bridgeport (where 15.7% of students met/exceeded expectations on the 2025 Math SBAC) gets a PPPS subsidy of $2,325, compared to a higher PPPS subsidy of $3,506 in neighboring **Fairfield** (72.4% on Math SBAC).

New Britain (17% on the ELA SBAC and a subsidy of $2,945), which competes with **West Hartford** (66.2% on ELA SBAC and a pension subsidy of $3,275 per pupil).

Stamford (32.8% on the Math SBAC and a subsidy of $3,319) versus neighboring **Greenwich** (77.6% on Math SBAC and a Per Pupil Pension Subsidy of $4,375).

New Haven (23.8% on the ELA SBAC and a $2,648 subsidy) compared to **North Haven** (69.9% on ELA SBAC and a $3,045 in Per Pupil Pension Subsidy).

Waterbury (19.2% on the Math SBAC and a subsidy of $2,208), seeking teachers right next to **Wolcott** (60.6% on Math SBAC and a subsidy of $3,034 for each enrolled student).

POLICY SOLUTIONS

The legislature must act to create a more fair and sustainable model for teacher pension financing, based upon the following four principles:

- **Retirement benefits should be treated as a form of compensation.** These are related to the discretionary salary levels established by local leaders, so local dollars—and not just state funds—should cover them.
- **The highest-need districts should be protected from budget increases.** Having municipalities pay a portion of the normal cost will increase local school budgets, so high-need districts should be protected across the state.
- **The state should cover all/most of unfunded liability costs** since these have been accumulated and managed at the state-level, without local school district authority.
- **A new policy solution must be phased-in.** Shifting obligations to municipalities should not lead to supplanting local spending in a way that harms students and educators.

FEEL YOUR BEST SELF: A CONNECTICUT EXEMPLAR FOR MOVING BEYOND EMOTION KNOWLEDGE TO REGULATION ACROSS AGES AND CONTEXTS

A CSCH Brief by Sandra M. Chafouleas and Jessica B. Koslouski for the Connecticut *Moving Beyond Implications: Research into Policy Briefing Conference* on January 15, 2026

The Challenge

Connecticut's educators, families, and youth mentors are committed to supporting children's emotional development, yet many caregivers lack a shared vocabulary and access to evidence-based tools to do so effectively. Without flexible, credible solutions, critical opportunities are missed to help young people develop the essential life skills they need in emotional navigation—skills that are foundational to academic success, healthy relationships, and long-term well-being.

> Educators, families and youth mentors need common language & credible solutions to make emotional navigation simpler so kids gain these important life skills.

Research consistently demonstrates that emotion regulation skills—developed starting in early childhood—have cascading effects resulting in improved social skills, friendships, peer acceptance, and greater emotion regulation through middle childhood. Throughout childhood and adolescence, students with strong emotion regulation skills demonstrate increased academic achievement. **Despite the evidence, disconnect with practice can be found, highlighting space for state guidance to strengthen implementation in emotional development**.

A *first challenge* is the need for common language and credible solutions that can be embedded across caregiving settings. Confusion exists about defining features as well as roles and responsibilities for different caregiving settings (school, home, community). Controversy about social and emotional learning (SEL) has focused on the roles and responsibilities for different caregiving settings (school, home, community). Some feel that SEL should not be taught in schools, as it can infringe upon time for academic instruction and family authority. Others feel that SEL does not go far enough in teaching critical concepts. Across the perspectives, however, there are more similarities than differences; caregivers across the political spectrum acknowledging critical life skills include emotion regulation. **A solution can be found through shared responsibility to teach emotion-coping strategies and language that work everywhere children are: schools, homes, libraries, and pediatrician offices**.

A *second challenge* is the flexibility and accessibility with which simple tools can be put in place by caregivers across diverse settings. School-based programs that teach SEL skills to all students may be evidence-based but are often expensive and require extensive training. In addition, many overwhelmingly emphasize social skills while underrepresenting critical skills in emotion regulation, empathy, and perspective taking. Emotion regulation skills are critical for children to respond to everyday stressors (e.g., feeling overwhelmed in a situation) wherever they live and learn.

Despite the challenges, **Connecticut has opportunity to be a national leader through scalable solutions to enable caregivers across settings with the tools that they need to make emotional navigation simpler**. And that opportunity already exists in Connecticut.

Developed through partnership at the University of Connecticut, Feel Your Best Self (FYBS) has been highlighted as a breakthrough innovation fueled by collaborative persistence and creativity.

FYBS is an award-winning toolkit that brings credibility, accessibility, creativity, and joy to learning about emotions and emotion-coping strategies.

Since its release in 2022, FYBS has achieved wide use by over 4,000 adults and 32,000 children, with adoption from Connecticut to around the world along with national media recognition and kids' entertainment awards. Engaging multi-media – songs, strategy videos, visuals, puppet-making materials – are flexibly chosen and easily accessed to match the setting. FYBS teaches how to recognize when you aren't feeling your best self (think stormy, heavy feelings like stomach butterflies, head spinning, or short temper), reflect on the positive coping direction that might help, and then respond by using a FYBS strategy that fits best for the moment. Recent implementation studies in Connecticut schools demonstrate increases in student engagement and positive affect, with high teacher-reported usability. Most importantly, FYBS was designed for expanded use across settings, with resources that have wide appeal across educators, families, and youth mentors as they explore together right alongside kids. Originally created for elementary ages, FYBS has been well-received by all ages – with users across cultures and contexts finding FYBS to bring joyful learning in simple ways. The variety of materials – grounded by a freely-available web-based toolkit – means FYBS is accessible across price points and is a scalable solution.

FYBS is a Connecticut innovation that demonstrates what is possible when evidence-based research and practical accessibility converge. By ensuring quality standards, leveraging state-developed exemplars, removing implementation barriers, supporting cross-sector professional learning, and extending common language across the contexts where children live and learn, we can transform how young people develop the emotional navigation skills that will serve them throughout their lives. These are foundational life skills that support academic achievement, reduce behavioral challenges, strengthen mental health, and prepare young people to thrive as adults. The return on investment extends across generations.

Paths Forward for Legislators

Connecticut has the research expertise, proven resources, and commitment to innovation needed to be a national leader by demonstrating how evidence-based research and innovation can converge to create scalable solutions that support children's emotional health and well-being. Legislators can engage in shared responsibility through the following actions:

1. **Prioritize Accessibility Through Low-Barrier, Evidence-Informed Resources.** Direct policy toward emotion-coping resources that are low-cost, user-friendly, and require minimal training. This reduces barriers for under-resourced settings while ensuring all Connecticut children have access to quality emotional wellness support wherever they learn and live.
2. **Align Funding with Comprehensive Professional Learning.** Allocate resources for ongoing professional development that equips caregivers with knowledge and confidence to deliver comprehensive SEL programming that includes emotion-coping. Ensure training reaches teachers, support staff, administrators, families, and community partners to create common language across all settings.
3. **Create Cross-Sector Coordination to Extend Common Language Across Settings**. Establish coordination mechanisms between schools, families, healthcare providers, and youth-serving organizations to reinforce shared emotional wellness language and strategies. When core concepts are consistent across settings, children gain mastery through meaningful practice.
4. **Leverage Connecticut-Developed Exemplars to Maximize Impact.** Support adoption of Connecticut-created resources like Feel Your Best Self that demonstrate research credibility and practical usability. Investing in proven, homegrown solutions maximizes taxpayer return, showcases state innovation, and ensures resources are designed for Connecticut's context.

To Learn More

Chafouleas, S. M., Wicks, E.& Koslouski, J. B. (2026, January). *Feel Your Best Self: Coping with Emotions at Any Age*. Available at https://www.feelyourbestself.org/s/FYBS-Coping-with-Emotions-at-Any-Age.pdf.

Chafouleas, S. M., Koslouski, J.B., Marcy, H.M., Stein, R., & Bracey, J. (2025, November). *A Simple Refresh: Simple Strategies Anyone Can Use to Foster an Emotionally Safe School Environment*. Storrs, Connecticut: University of Connecticut. Available at https://csch.media.uconn.edu/wp-content/uploads/sites/2206/2025/11/CSCH-Brief-Simple-Strategies-Refresh-Final-Fall-2025.pdf.

UConn Collaboratory on School and Child Health (n.d.). *Emotional Well-being: The Science and Practice of Feeling Well Learning Series.* https://csch.uconn.edu/2025/09/02/emotional-well-being-learning-series/.

Note. Full reference list available upon request.

To cite this brief: Chafouleas, S. M. & Koslouski, J. B. (2026, January). *Feel Your Best Self: A Connecticut Exemplar for Moving Beyond Emotion Knowledge to Regulation Across Ages and Contexts.* Storrs, CT: UConn Collaboratory on School and Child Health. Available from: http://csch.uconn.edu/.

Disclosures: Dr. Sandra Chafouleas and Emily Wicks are co-inventors of the Feel Your Best Self (FYBS) intellectual property owned by the University of Connecticut, and are co-Chief Executive Officers with FYBS & Co. Dr. Sandra Chafouleas and Emily Wicks also have an equity interest (stock) in FYBS & Co.

Roberta Willis Scholarship Program – Leveraging state data to examine program benefits

Monnica Chan, monnica.chan@umb.edu
Dan He, dan.he@ct.gov

Project Overview

The Roberta B. Willis Scholarship Program (RWSP) annually distributes over $30 million to Connecticut residents that attend Connecticut postsecondary institutions. With support from the U.S. Department of Education, the Office of Higher Education (OHE) and researchers at the University of Massachusetts Boston are analyzing the historical impact of the program using state administrative data via DataLinkCT.

Project Goals

Our research project investigates the following research questions:

1. Who receives RWSP and how does this vary across high schools and colleges?
2. What is the impact of RWSP on student enrollment, persistence, and completion, accounting for student and institutional characteristics?

Why RWSP Matters: Financial aid supports college access and completion.

- Grant aid increases college enrollment, persistence, and degree completion (Dynarski, Page, & Scott-Clayton, 2022; Nguyen, Kramer, & Evans, 2019).
- The impacts of grant aid are context specific, mediated by program design elements and interactions between aid programs such as state aid programs and the federal Pell grant (Dynarski, Page, & Scott-Clayton, 2022; Eng & Matsudaira, 2021).
- In Connecticut, RWSP has unique and nuanced program characteristics. The program provides both need-merit and need-based awards to cover eligible costs for residents enrolled in Connecticut institutions of higher education.

RWSP Program Requirements*

Need-Merit RWSP	Need-Based RWSP
Hold CT residency	Hold CT residency
SAI below a pre-determined threshold with financial need (requires FAFSA)	SAI below a pre-determined threshold with financial need (requires FAFSA)
Attend a participating institution at least part-time in an undergraduate program	Attend a participating institution at least part-time in an undergraduate program
Recipients are selected by the state	Recipients are selected by colleges
Junior year class rank of at least 20% and/or meet an SAT/ACT threshold	

*Students eligible for both awards may only receive one RWSP award per year

Leveraging state data to examine program benefits

Project Data Sources

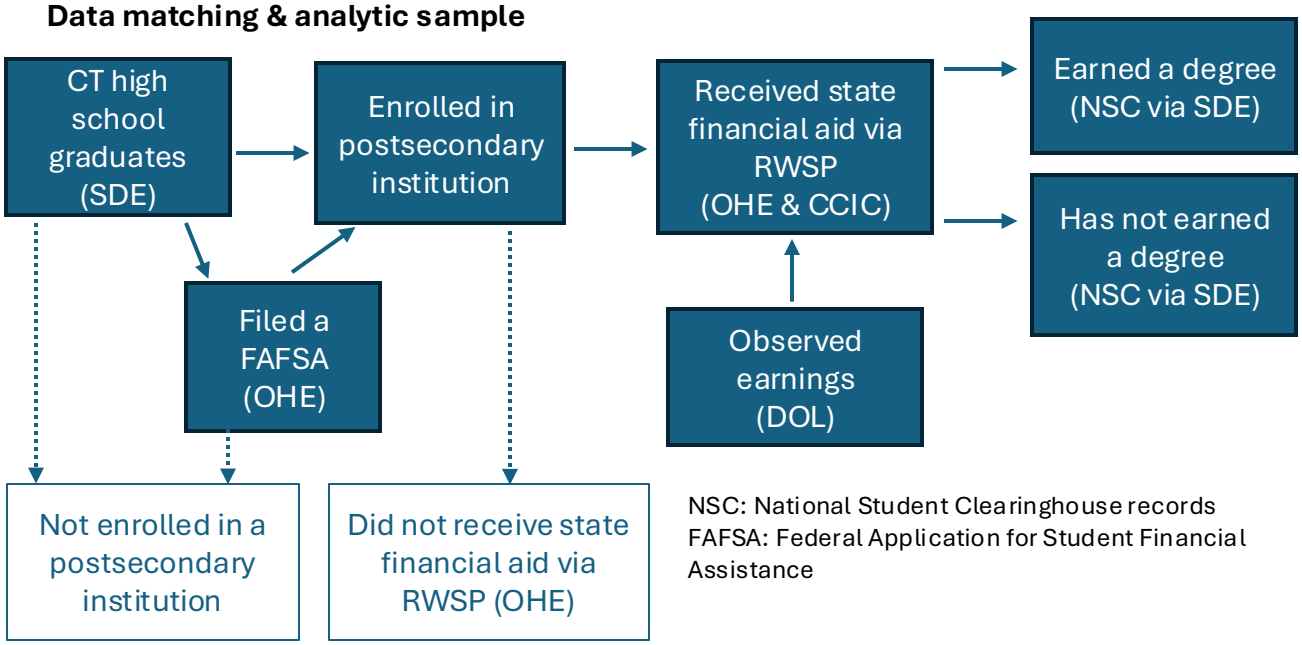
The analysis uses student-level data from the Office of Higher Education (OHE), State Department of Education (SDE), Department of Labor (DOL), and the Connecticut Conference of Independent Colleges (CCIC) collected and matched via DataLinkCT. This process required careful coordination across state agencies to ensure data confidentiality and the use of a secure computing environment.

Steps for utilizing DataLinkCT* to answer policy-relevant questions

- Identify your research question, and the data elements required to answer the question.
- Confirm:
  - Does your research question require individual, de-identified data?
  - Does it support the DataLinkCT research agenda?
- Work with OPM to submit a data sharing request and enter into a data sharing agreement with all participating agencies.
- Work with OPM on data security, privacy, storage and disclosure.

*DataLinkCT is Connecticut's state longitudinal data system. DataLinkCT helps facilitate using data across state agencies to address critical policy questions. All data linked and shared via DataLinkCT are de-identified and cannot be used to identify individuals.

Data matching & analytic sample



NSC: National Student Clearinghouse records
FAFSA: Federal Application for Student Financial Assistance

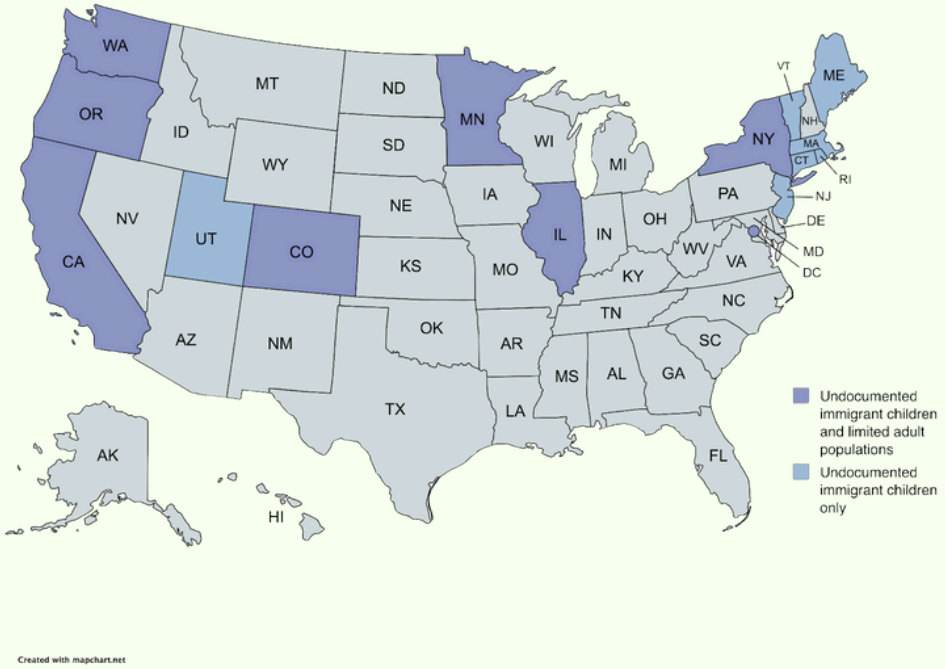
Extending HUSKY Medicaid Access for Undocumented Immigrants in CT

Isha Yardi, B.S., Shaan Mehta, Noah Brazer, B.S., Julia Rosenberg, M.D., M.H.S., F.A.A.P.

SCHOLARS STRATEGY NETWORK

Background

- **14 states and Washington, D.C.** have extended their state Medicaid programs to cover undocumented immigrant children.[1]
- **7 of these states and Washington, D.C.** have extended their state Medicaid programs to also cover limited, income-eligible adult undocumented immigrant populations.[1]
- Connecticut has extended HUSKY to cover **undocumented immigrant children ⩽ 15 years old**.[2.] Still, undocumented immigrant adults lack any HUSKY access in the state.



"Connecticut has the resources, moral obligation, and political will to be a leader in what it means to treat health care like a human right."

-Student, 2021 Testimony

Why is this Important?

- Undocumented immigrant communities face several unique barriers to healthcare access, including **fears around deportation, cost burdens, and wait times for free and subsidized clinic appointments**, among others.*
- New **federal policy** has further limited access to care.
- Statewide uncompensated care costs in CT increased by 2% to **almost $250 million in FY2023**.[3]
- In 2022, undocumented immigrants contributed **~$100 billion in federal, state, and local income taxes**.[4]
- In public testimony, community members have expressed **support for public insurance coverage expansion** to undocumented immigrants.*

Impacts of Medicaid Expansion to Undocumented Immigrants

- Medicaid improves access to care and health outcomes among beneficiaries, including **reduced mortality, improved self-reported health, and increased use of critical health services** such as prenatal care for pregnant women.[5]
- Expanding Medicaid to undocumented immigrants can reduce uncompensated care costs and Emergency Medicaid utilization: a 2022 research report from RAND estimated that providing Medicaid to undocumented immigrants in Connecticut could generate **$63-$72 million in savings for hospitals from uncompensated care and savings from reduced Emergency Medicaid spending**.[6]
- The demand for HUSKY enrollment among newly-eligible children in CT is high: **11,000 children enrolled in HUSKY after the legislature expanded coverage to include children aged 12 and under in 2022.**[7]

Policy Recommendations

Propose legislation that would extend HUSKY to all income-eligible adults and children regardless of immigration status.

Continue to fund and support legislation that has extended public health insurance eligibility to include undocumented immigrant children up to the age of 15.

Continue to support and expand data protections for undocumented immigrants in Connecticut.

Fund research to explore ongoing health and economic outcomes of current expansion legislation in CT.

"When my children were sick, I did not take them to the doctor because I feared the bills."

-Community Member, 2021 Testimony

"Providing adequate, affordable healthcare will allow for increased productive participation for the betterment of all of us."

-Lawyer, 2023 Testimony

"My sister is 16 years old and had she not been born in the United States she would have aged out of eligibility. This age limit restriction leaves many undocumented children and people without access to health insurance."

-Community Member, 2024 Testimony

"Connecticut is a small state but we have a population of over 3,600,000 individuals and we are a state of immigrants, as is much of the country. We benefit from the diversity of our population in terms of race, ethnicity, language and cultural diversity."

-Community Organization, 2022 Testimony

"I have heard from friends that have been afraid to go to the doctor's to receive medical care due to concerns they will be turned away due to their immigration status."

-Student, 2021 Testimony

"I remember one time my best friend got seriously ill and his family had to choose between paying the rent or taking him to the hospital. It was a heartbreaking decision."

-Student, 2025 Testimony

"Since I arrived in this country, it has been difficult for me to navigate the health system or understand how it work and apply to help because I do not speak or read in English."

-Community Member, 2024 Testimony

References

*All quotes were taken directly from written testimonies submitted for public hearings of legislation that would extend HUSKY Medicaid for undocumented immigrant children in Connecticut (2021-2025).

Map was created using mapchart.net.

1. State Coverage for Immigrants and Implications for Health Coverage and Care. KFF. tinyurl.com/KFFStates
2. CT HUSKY for Immigrants Expands. CT Mirror. tinyurl.com/CTMirrorExpand
3. Annual Report Financial Status CT Hospitals. CT Office of Health Strategy. tinyurl.com/HospitalsCT
4. Study Undocumented Immigrants Paid Almost $100 Billion in Taxes. Alabama Reflector & ITEP. tinyurl.com/1billiontaxes
5. Medicaid: Health & Economic Benefits of Expanding Eligbility. HHS. tinyurl.com/HHSMedicaid
6. Expanding Insurance Coverage to Undocumented Immigrants in CT. Rand. tinyurl.com/RandHusky
7. A Year After Launch, HUSKY for Immigrants sees Strong Demand. CTMirror. tinyurl.com/CTMirrorDemand

Contact Information

For questions about this policy brief, please contact Isha Yardi at isha.yardi@yale.edu or Dr. Julia Rosenberg at julia.rosenberg@yale.edu. Thank you!

UCONN
SCHOOL OF PHARMACY

The Promise of Pharmacists Improving Access to Hormonal Contraception In CT

Marie Smith, PharmD - Assistant Dean and Professor, UConn School of Pharmacy
Email: marie.smith@uconn.edu

In June 2023, a law was enacted in Connecticut to allow pharmacists to prescribe self-administered hormonal birth control (e.g., oral contraceptive pills and patches) directly to consumers. These pharmacist clinical services involve screening for patient eligibility or referral to another health care professional, assessing patient histories and prior contraception use, and prescribing safe and effective hormonal contraceptives based on patient-specific needs and therapeutic guidelines.

While Connecticut pharmacists can prescribe hormonal contraceptives, there is no health plan coverage and payment mechanism in Connecticut for pharmacist clinical services — including hormonal contraception prescribing services. Therefore, **there has been no uptake with pharmacist prescribing of hormonal contraceptives** to prevent unwanted pregnancies.

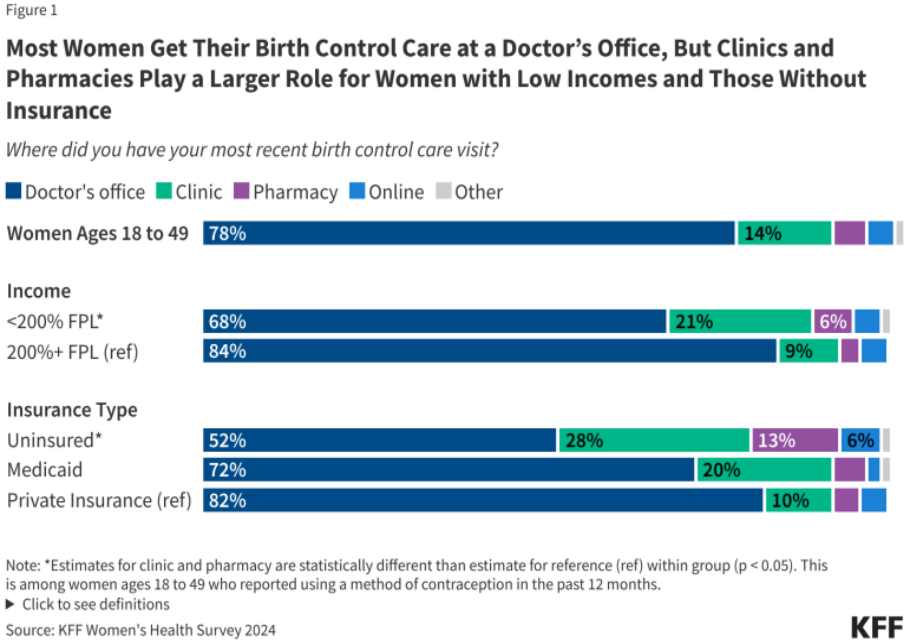
The Role of Pharmacists in People's Contraceptive Access

Pharmacist-prescribing of hormonal contraceptives has the promise of reducing common barriers associated with obtaining a prescription for contraception, such as taking time off from work, locating a nearby doctor or nurse practitioner who is in-network and has available appointments, paying for the cost of an office or clinic visit, and finding childcare or affordable transportation.

More than 90% of Americans live within five miles of a pharmacy, making pharmacists the most accessible healthcare professionals and perfectly positioned to improve hormonal contraceptive access.

While most women get their birth control care at a physician's office**, women with lower incomes and no insurance coverage visit pharmacies for birth control care.**

Figure 1



If a Connecticut physician or nurse practitioner prescribes hormonal contraception, the health care provider receives payment for each patient care visit by the patient's insurance – for example, Medicaid or commercial health plans. Yet, neither CT Medicaid nor commercial health plans will pay a pharmacist to provide the same clinical assessment and prescribe the same hormonal contraceptives.

Addressing the Barriers to Pharmacists' Contraceptive Prescriptions
In April 2024, we surveyed Connecticut pharmacists to determine their barriers to offering hormonal contraceptive prescribing services consistent with the new law. The **major barrier** identified by both pharmacy managers and staff pharmacists was the **lack of payment for pharmacists** to provide the necessary pharmacist staffing for the implementation of pharmacist-prescribing of hormonal contraception.

Previous experience in states that allowed hormonal contraceptive prescriptive authority, yet did not provide pharmacist payment, had low uptake of pharmacist participation. The lack of reimbursement policies creates a disincentive for pharmacists and pharmacies to offer these services even if the state allows pharmacist prescribing. An unintended consequence may be that patients will be left with out-of-pocket costs for obtaining contraceptive care at pharmacies.

The promise of improved access to and consistent use of birth control with pharmacist prescribing services will not be fully realized and is not sustainable without a corresponding payment mechanism.

As of February 2025, **35 US states and the District of Columbia have laws for pharmacist prescribing of self-administered hormonal contraception**, and 26 states provide payment for these pharmacists' services.

In Connecticut, Public Act 23-52 was signed by Governor Lamont in June 2023 to improve access to self-administered birth control, especially in rural and underserved areas where access to reproductive healthcare is limited. However, **CT pharmacists are NOT offering prescribing services of hormonal and emergency contraceptives since there is *no pharmacist payment for this patient care service.***

- **Relevant to Public Act 25-167 (Section 7)** – a working group will make recommendations for legislation needed to compensate pharmacists for health care services; proposed legislation is expected to be introduced in the 2026 CT General Assembly session.

KEY POLICY TAKEAWAYS
The promise of improved access to and consistent use of birth control with pharmacist prescribing services will not be fully realized and is not sustainable without a corresponding payment mechanism.

As of February 2025, 35 US states and the District of Columbia have laws for pharmacist prescribing of self-administered hormonal contraception, and 26 states provide payment for these pharmacists' services.

ACTION NEEDED
This year, the CT Insurance Committee is expected to propose legislation for health plans to reimburse pharmacists when clinical services (including self-administered hormonal contraception) is: (1) within the legal scope of the pharmacist's license under chapter 400j, and (2) otherwise eligible for reimbursement when provided by a physician, physician assistant, or advanced practice registered nurse.

If such legislation is passed, patients will have improved access to self-administered oral contraception services since it will accelerate the uptake of hormonal contraceptive services offered by community pharmacists.

Towards Equitable Contraceptive Access

Understanding the Real-World Availability of Pharmacy-based Contraceptives in Connecticut

Andrea Contreras, Simone Buck, Marina DiPiazza, Shayna Cunningham, Emil Coman, Neena Qasba

Background & Study Objectives

Background — Connecticut legislation allows minors and adults to purchase the over-the-counter (**OTC**) oral contraceptive pill (**OCP**; i.e., O-pill) and emergency contraception pill (**ECP**; i.e., Plan B) without a prescription, and additionally the Ulipristal acetate (**UPA**; i.e., ella) ECP with a prescription. While OTC ECP is safe for all ages, prescription-only ECP is more effective. The real-world availability of these products and services, however, remains unclear, particularly in socially vulnerable communities like those that primarily speak Spanish. As Spanish-speaking individuals comprise ~13% of Connecticut's population, it is crucial to evaluate whether these services are equitably available across the state.

Objectives — In this study, we sought to assess the real-world availability of pharmacy-based contraception (OTC OCP, OTC ECP, prescription-only ECP) in Connecticut by product availability, geography (by county), and by Spanish-language services (**SLS**) access. We conducted a mystery caller study of all 647 pharmacies in Connecticut in which a team member called as an adult caller or called as a minor caller, indicating they were 16 years of age. We asked each pharmacy about the availability of ECPs, availability of the OTC OCP, and SLS availability.

Contraceptive Availability

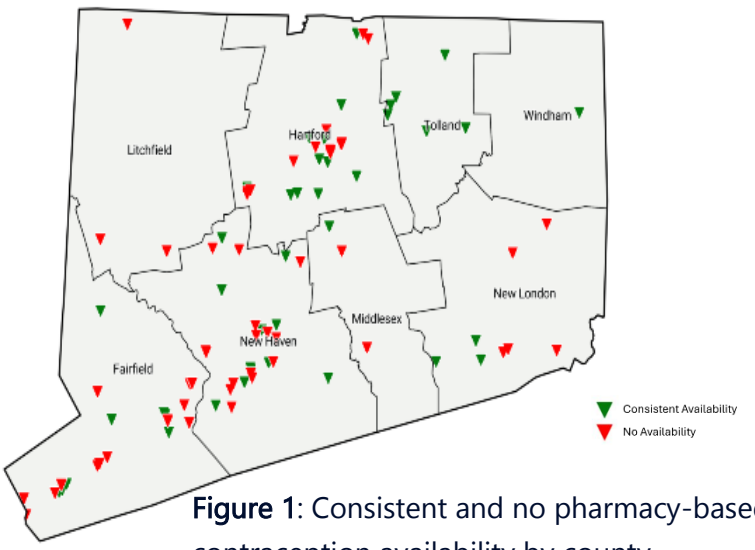


Figure 1: Consistent and no pharmacy-based contraception availability by county

Only 7.7% of pharmacies statewide reported consistent contraceptive availability of all options.

There is variation in availability between regions and counties in Connecticut.

For example, 0% of pharmacies in the Northwest reported consistent availability to all contraceptive methods.

By contrast, 11.7% of pharmacies in Hartford County reported having consistent availability.

UCONN HEALTH

Spanish Language Services Availability

Language barriers are often cited when discussing access to contraception.

Approximately 1/5th of pharmacies do not provide SLS at all levels of percentage of Spanish speaking population: low (<1/9%), moderate (2-15.9%), and high (>16%). The availability of SLS is not driven by the population being served.

Of pharmacies that provide consistent access to contraception, 83% provide SLS.

While most pharmacies provide SLS, there is still a gap in SLS availability that may exacerbate disparities in access to pharmacy-based contraception services.

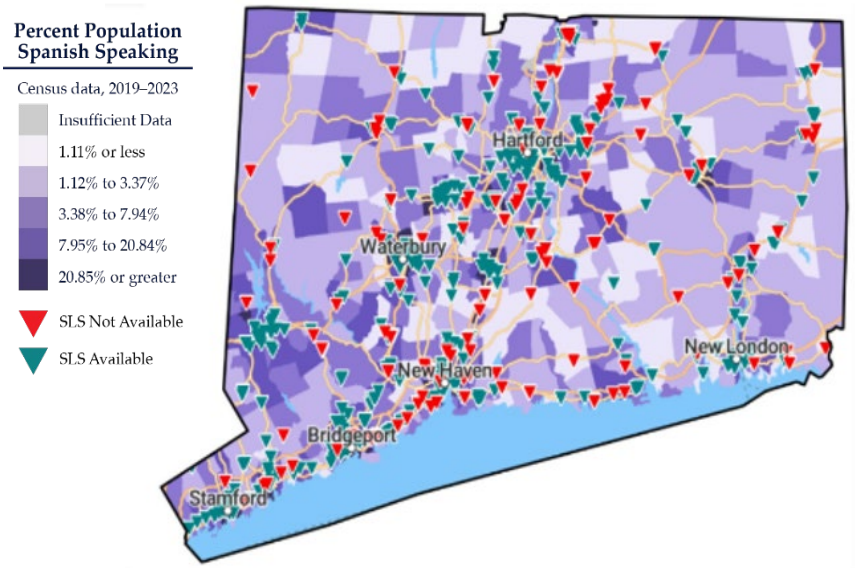


Figure 2: SLS availability by pharmacy overlaid onto census tracts showing percent of the tract population that speaks Spanish.

Key Policy Takeaways & Recommendations

This study demonstrates that the real-world availability of ECPs and OTC contraception in Connecticut is limited. Furthermore, at the time of the study, direct pharmacist-prescribed contraception was not available yet despite passage of Public Act 23-52 two years ago. Below are our recommendations for The Office of Health Strategy to bridge the gap between legislation and access.

1. **Establish a dedicated oversight entity.**
    a. A statewide taskforce, for example, could monitor & ensure consistent availability and equitable access, considering regional and linguistic disparities.
2. **Increase investment in oversight of pharmacist-prescribed contraception.**
    a. Enabling pharmacists to prescribe contraceptives would ensure more equitable access to contraceptives statewide.
3. **Require continuing education for pharmacists.**
    a. We recommend the Board of Pharmacists require training on ECPS and OTC OCP to ensure up-to-date information and stocking in pharmacies.

UCONN HEALTH

Banking for All

By Annie Harper, PhD. Program for Recovery and Community Health, Yale School of Medicine

Background

We all need high quality, safe and affordable financial services to manage our money well and flourish. The less money you have, and the more susceptible you are to exploitation or over-spending, the more critical are financial services that minimize costs, avoid exploitation and help to control spending. People with mental illness, who are homeless, and/or have addiction problems badly need good financial services but currently are not well-served. **Policy change to improve financial services for these groups would support their well-being and recovery and improve the system for us all**.

Banking and exclusion of marginalized populations

- **People with mental illness** often have no bank account and have problem debt. This is partly due to very low incomes, but also sometimes due to mental health symptoms.
- Some people with mental illness need **help managing their money** but have few options for support; people must either give up financial control completely or manage alone.
- Most **people who are homeless** do not use banks. Instead, many use non-bank phone apps such as Cash App and PayPal to manage their money. Many **people who have addiction problems** also do not use banks and prefer to use these phone apps.
- These non-bank phone apps are convenient, have fewer fees than banks, and easier proof-of-address and ID requirements. But lack of in-person customer service is a problem, and some people report being scammed. Not having a bank account makes it difficult for people to build long-term financial stability.

Risks of Cash Advance loans

Some non-bank phone apps offer loans, often known as **cash advance or earned wage access.** These loans are not subject to Connecticut's usury laws and interest rate caps. People who are susceptible to over-spending can quickly get in trouble with these loans – they are easy to get and can quickly **spiral a person into financial disaster.**

"I relapsed and then started using daily pay…every day I come home from work, and I take all the money I just earned and spend it, so by the time I get my paycheck, I got none…I didn't have enough rent money… I got to the point where I couldn't catch it up no more. I wish [daily pay] wasn't available…You get caught in the cycle of borrowing and you're borrowing from them to pay them back …."

What needs to change

- Non-bank phone apps holds promise for improving financial services for marginalized populations, but **costly loan products are dangerous.**
- Banks and credit unions must offer banking products that allow people with cognitive or addiction challenges to get **help with managing their finances without having to entirely give up control.**
- We need **financial services that enable everyone** to manage their money well and not be taken advantage of. Financial problems faced by people with mental illness, who are homeless, and/or have addiction problems are **not so different from others**. Many of us have incomes that barely cover expenses, we are all susceptible to over-spending and tempting loan offers, and many of us will experience cognitive decline as we get older.

Financial services that work well for people who struggle most with their finances will be better financial services for everyone.

Policy Recommendations

Require banks and credit unions to offer basic bank accounts with no minimum balance, overdraft or monthly fees

Require banks to offer 3rd party view-only options and transaction holds, for people who need help managing their money.

Regulate non-bank app loans, particularly Earned Wage Access.

Expand housing-first and rent subsidies to stabilize recovery environments

Require businesses to accept cash if customers prefer

Learn from other states and consider creating a Public Bank

FURTHER READING

- Farr, B., Cash, B., & Harper, A. (2019). Banking for All: Why Financial Institutions Need to Offer Supportive Banking Features. Yale Law School Community and Economic Development Clinic. https://law.yale.edu/sites/default/files/area/clinic/document/banking_for_all_cedc.report.final.pdf
- Harper, A. (2018). Financial management support for SSA beneficiaries: Looking beyond the payee. Center for Retirement Research at Boston College. http://crr.bc.edu/wp-content/uploads/2018/05/wp_2018-5.pdf
- Harper, A., & Rowe, M. (2017). Environment-Level Strategies to Support Independent Control of Finances: A Response to the SSA Review of Financial Capability Determination Review. Psychiatric Services, 68(1), 6–8. https://psychiatryonline.org/doi/10.1176/appi.ps.201600428

UCONN | COLLEGE OF AGRICULTURE, HEALTH AND NATURAL RESOURCES | COLLEGE OF ENGINEERING

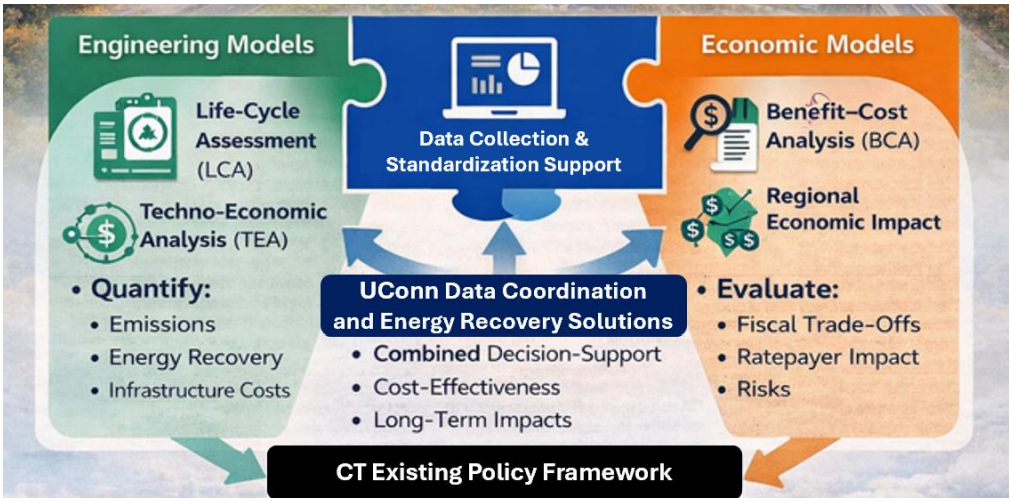
Solving Connecticut's Waste Crisis: Data-Driven Coordination and Energy Recovery Solutions

Objective

Connecticut (CT) decision-makers face challenges in their efforts to make cost-effective, environmentally responsible waste management decisions across municipal and statewide levels. The University of Connecticut (UConn) can deliver **Waste Management Technical Assistance** through data-driven coordination of statewide waste data with engineering and economic models to evaluate short- and long-term costs and benefits, **enabling informed decisions on Connecticut's waste management** policies and infrastructure investments.

Waste Management Technical Assistance Overview

CT currently has fragmented waste data, leaving gaps in cost and performance tracking. UConn, as the state's land-grant university, has established relationships with all 169 municipalities through its **Extension network** and can help close these gaps, working with state entities to support data collection and standardization. Our **expert economists and engineers** identify the most valuable data for modeling, while growing industry partnerships provide **private-sector insights** for more complete, actionable analyses.



Integrated Engineering and Economic modeling supported by Data to enhance the existing CT waste policy framework with informed-decisions for long term effectiveness.

With standardized waste data, UConn can integrate **engineering models** like Life-Cycle Assessment (LCA) and Techno-Economic Analysis (TEA) with **economic models** such as Benefit-Cost Analysis (BCA) and Computable General Equilibrium (CGE) to evaluate emissions, energy recovery potential, infrastructure costs, and fiscal trade-offs. These outputs are combined with policy data from CT Department of Energy and Environmental Protection (DEEP) Comprehensive Materials Management Strategy (CMMS), legislative reforms, and emissions targets to help ensure municipal decisions are cost-effective and

consistent with state goals. By bridging technical, economic, and policy data, UConn can help CT **overcome fragmented decision-making** and enable **robust, long-term waste planning**.

Why it Matters and Why Act Now

CT faces a growing waste crisis as in-state disposal capacity declines, costs rise, and municipal coordination remains limited. The Hartford Waste Plant closure eliminated 860,000 tons of annual capacity, forcing costly and volatile **out-of-state disposal is projected to quintuple by 2050** (CT DEEP, NVCOG). Despite the state's 60% waste diversion goal, rates hover near 42%, and organics (41% of MSW) remain largely **untapped for diversion, energy recovery, and emissions reduction.**

Data-driven waste management coordination would reduce dependence on out-of-state landfills, **stabilizing disposal costs** and allowing municipalities to **reinvest millions in local priorities**. Expanding in-state diversion and processing could **cut greenhouse gas emissions** from long-haul transport and landfilling. Investments in waste recovery technologies, like anaerobic digestion would **add renewable power to the grid** and strengthen **energy resilience**. With transparent data, municipalities can collectively evaluate infrastructure trade-offs and make informed decisions, ensuring public dollars deliver measurable economic and environmental returns.

Call To Action

To achieve the diversion and infrastructure goals outlined in the CMMS, CT needs standardized data, integrated modeling, and energy recovery expertise – **with state support, UConn is uniquely positioned to deliver Waste Management Technical Assistance.**

1. Direct budget appropriation for the "UConn Waste Management Technical Assistance Center" (CGS §22a-228, Solid Waste Plan/CMMS).
2. DEEP/Regional Waste Authorities release new or use existing Request For Proposals to secure UConn Technical Assistance (PA 23-170, Service Contracts).
3. Clarify eligibility in program guidance or budget language with UConn Technical Assistance projects allowable as Sustainable Materials Management (SMM) grant recipient/fund matching (CGS §16-244bb: MSW, Technical Assistance).

Authors:
Ioulia (Julia) Valla, Ph.D., Associate Professor, Chemical & Biomolecular Engineering, UConn
Kimberly Rollins, Ph.D., Professor, Agricultural & Resource Economics, UConn
Contact: *ioulia.valla@uconn.edu; kimberly.rollins@uconn.edu*
Legislative Committees: *Energy & Technology; Environment*
References:
• *CT DEEP. Solid Waste Management. 2015 Waste Characterization Study. 2023 CMMS. 2025.*
• *NVCOG. Regional Waste Authority Report. 2025.*
• *Xu, D.; Rollins, K. Data-Driven Decision Support for Municipal Waste Management. UConn, 2025.*
• *U.S. EPA. Facts and Figures on Materials, Waste and Recycling. 2025.*

A Brief on CT Hazard and Disaster Response and Preparedness: Emergency Management Directors and Resident Survey December 2025

A report on feedback from CT EMDs, PWDs, community stakeholders and residents across CT counties on perceptions and concerns regarding CT disaster preparedness.

Eleanor Shoreman-Ouimet
Assistant Professor of Environment and Human Interactions
Dept of Anthropology, UCONN
Eleanor.ouimet@uconn.edu

Committee Audience: 1. Environment; 2. Public Health

Eleanor Shoreman-Ouimet, PhD
Ken Lachlan, PhD
Christopher Burton, PhD
Abigail Beckham, ABD
Alexandra Harden, ABD
James DiCairano, PhD

Executive Summary

This summative research reflects upon an interdisciplinary effort to assess disaster preparedness and identify the roots and repercussions of preparedness disparity across socioeconomic groups in Connecticut. This report juxtaposes the results of ethnographic interviews with Emergency Managers across Connecticut with survey data collected among CT residents examining issues of trust, preparedness, and information sufficiency regarding local emergency services. The results highlight the ways in which state-level systems of disaster management may be exacerbating preparedness disparity, often leaving Connecticut towns, certain socioeconomic groups, and rural communities ill-equipped to manage the growing threats of climate change induced natural hazards and disasters facing southern New England. This applied research seeks to provide guidance on the types and form of hazard-related information most desired and sought after by residents, particularly minoritized and impoverished residents, for policy-makers and state, regional, and municipal disaster management personnel; as well as underline the needs of increasingly overburdened, predominantly volunteer, emergency management directors across the state. We end with recommendations as to the resources local level disaster management may need to inform and assist residents as well as suggestions as to how best to engage local residents in the disaster management planning and decision-making processes.

Our research to date indicates that longstanding state and regional preparedness practices have yet to be updated to reflect current climate forecasts, effectively equip local emergency volunteers, or improve communication services to the extent necessary to properly equip first responders or community members in times of threat or crisis. Further, our research demonstrates that the Planning Assumptions of the State Response Framework are imprecise based on the reality of the on-ground situation and local towns and populations are vulnerable to being disproportionately and unnecessarily impacted by disasters due to a lack of available resources and knowledge.

Key Takeaways

Interviews with Emergency Management Directors reveal a number of significant themes:

- CT's State Response Framework depends upon a declining number of aging EMDs who are overburdened in light of increasingly frequent and severe weather-related hazard events.
- There are widespread issues with inadequate communication systems between EMDs and community members.
- There is an overall sense that residents lack risk awareness and preparedness knowledge.
- The state is not providing adequate financial resources to support EMD responsibilities, the development of emergency plans, or attract much needed additional employees/volunteers.
- The general lack of diversity among EMDs in Connecticut lies in sharp contrast to increasing numbers of low-income residents who may be linguistically isolated, ethnically diverse, or otherwise marginalized

Resident survey data furthermore indicates that racially minoritized and impoverished residents, and those that score higher on social vulnerability scales, in general, are:

- Seeking more preparedness information that less vulnerable residents.
- Prefer person-to-person sources of emergency and disaster-related information, ideally from friends, family, church, libraries, schools, etc.
- Are less likely to be aware of their community's emergency management plan.
- Are more likely to feel as though their needs are not being served by their town's emergency services.

Recommendations

- Risk communication and preparedness education should initiate at the community level and be dispersed through trusted community institutions (libraries, schools, community centers, senior centers, churches.)
- Crisis responders would be wise to build relationships with community leaders at trusted community institutions (churches, youth programs) to more effectively inform those who may be in harm's way.
- Risk education on preparedness strategies and municipal policies (parking restrictions, alert notification schedules, etc.) should be provided in multimedia forms (radio, mailings, emails, bulletins) and available for ESL and non-English speaking residents.
- Increase diversity of EMD and emergency response personnel through inclusion of women and racially minoritized groups, by increasing the scope of position advertising to schools, community colleges, public health facilities, churches, and other institutions where residents have reason to trust and seek information pertinent to their lives.
- Increase state-distributed funding for part-time town positions, updated emergency communications systems, emergency plan development, and resident risk and preparedness education programming.

UCONN
UNIVERSITY OF CONNECTICUT

"Continuing Progress Towards a More Climate Resilient Connecticut"

James O'Donnell, Professor of Marine Science and Executive Director, CIRCA, james.odonnell@uconn.edu;
John Truscinski, Director of Resilience Planning, CIRCA, john.truscinski@uconn.edu

Recent analyses of data and global climate models (IPCC, 2022; USGCRP, 2023) have concluded that the modification of the Earth's heat budget by the emissions of greenhouse gases over the past century is likely to lead to an increase in the global mean surface air temperature of between 1.5 and 2.5 C by 2050. It is also now virtually certain that this warming will increase global mean sea level (Hicke et al., 2022). Following the Connecticut Institute for Resilience and Climate Adaptation's (CIRCA) recommendation (O'Donnell, 2019), PA 18-82 requires coastal towns plan for *up to* 20" of sea-level rise in Long Island Sound, above the National Tidal Datum Epoch, by 2050. There's high confidence that average temperatures and the frequency of extreme heat events will increase across the state. There's also very high confidence that annual precipitation will increase across the northern half of the North American continent (Gutiérrez et al., 2021), and it is very likely that the intensity of heavy precipitation will increase (Emmanouil et al., 2023; Easterling et al., 2017; Prein et al., 2017). These changes are creating a wide array of challenges to societies around the world, and governments at all levels are seeking strategies to reduce the negative consequences to humans, infrastructure, and the natural environment.

Connecticut's Resilience Project Pipeline Addresses Rising Concerns

CIRCA was established in 2014 as a multi-disciplinary center of excellence that brings together experts in the natural sciences, planning, engagement, engineering, economics, political science, finance, and law to provide practical solutions to problems arising from a changing climate. CIRCA's approach to research and outreach is to apply interdisciplinary science in partnership with state agencies, municipal government, the private sector, and local communities to address critical flooding and heat related challenges. In 2018, the Resilient Connecticut program was established through the HUD sponsored National Disaster Resilience Competition (NDRC). Its goal is to establish a "resilience project pipeline" across the state through interagency collaboration between CIRCA, state agencies, municipalities. Since establishment, CIRCA's outreach has expanded, by meeting with towns, conducting vulnerability assessments, and mapping Zones of Shared Risk across the Western, Naugatuck Valley, Metropolitan, South Central, River, Southeastern, and Capitol Regional Councils of Governments areas. As a result, 177 Resilience Opportunity Areas (ROARs) have been identified, and 17 site scale projects have been advanced through stages of planning towards implementation. Identifying these areas is critical in deciding where to best use resources to mitigate disaster hazards in the future. Engagement with the Northwest and Northeastern regions will occur in 2026-27, to map ZSR and identify ROARs. CIRCA will seek additional funding for site planning projects in this region as well as continuing stages of design and implementation for ROARs from the previous regions.

In recent years Connecticut has made significant progress towards both setting greenhouse gas emissions reduction goals and increasing the state's resilience to the impacts of climate change. Executive Order 3 renewed the Governor's Council on Climate Change (GC3) which led to the 2021 report Taking Action on

Avery Point Campus
Connecticut Institute For Resilience
And Climate Adaptation
1080 SHENNECOSSETT ROAD
MARINE SCIENCES BUILDING
GROTON, CT 06340
PHONE 860.405.9228
FAX 860.405.9287
circa@uconn.edu
circa.uconn.edu
An Equal Opportunity Employer

CIRCA
Connecticut Institute for Resilience and Climate Adaptation

Climate Change and Building a More Resilient Connecticut for All. Many state agencies (DEEP, DEMHS, DOH, DOT, DPH, OPM, DAS) have established programs or assigned staff roles to climate resilience.

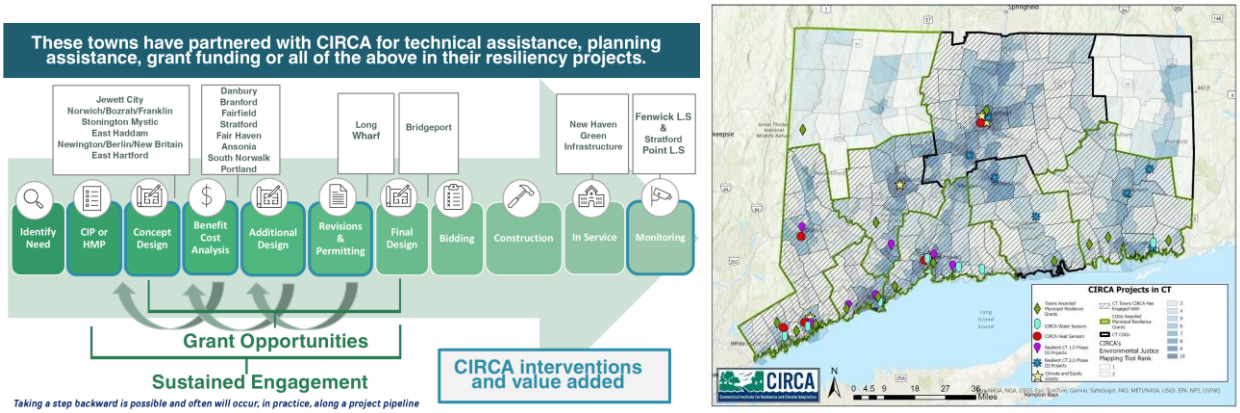


Fig. 1: Left is the CIRCA resilience project pipeline concept. On the right is a map showing areas of Connecticut where identification of Zones of Shared Risk, Resilience Opportunity Areas (ROARs), and site planning projects have been undertaken through the Resilient Connecticut Program.

In 2022 The CT Department of Energy and Environmental Protection created the DEEP Climate Resilience Fund which recently opened its 2nd round of funding for towns to conduct planning and project advancement. Recent legislative successes have included PA 21-115, which enabled new tools for municipalities (e.g. Stormwater Authorities) and the recent PA 25-33, which requires climate vulnerability assessments to be included in municipal Plans of Conservation and Development as well as enabling "resilience improvement districts", which function as tax increment financing districts and enable local investments to improve resilience. In 2024 CIRCA created a Resilience Road Map for Connecticut, which documented the lessons learned as well as policy and programmatic recommendations from a decade of developing and implementing the Resilient Connecticut program. Many of the 45 recommendations from the Road Map were incorporated into PA 25-33. 2025 saw dramatic changes across Federal agencies and programs that provide funding and support to Connecticut towns for projects. This includes EPA, NOAA, FEMA, the National Weather Service, and others, which have seen dramatic reductions in staff and programs eliminated altogether.

How Can We Maintain and Improve Connecticut's Progress on Climate Resilience?

1) It's critical that Connecticut maintain and build upon the capacity that's been developed within the agencies and CIRCA. If FEMA and other agencies are eliminated or scaled back, Connecticut will take on more responsibility to manage and recover from increasing extreme weather disruption. Services such as localized flood alerts, resilience hubs, and hazard mitigation assistance could be provided by expanding the Resilient Connecticut program and by strengthening and formalizing interagency participation.

2) We'll need to get more out of the capacity we have. Interagency coordination is critical to make efficient use of resources. This should be formalized by having Commissioners assign a resilience lead at each agency that sits on an interagency resilience council. The council should be led by a Chief Resilience

Avery Point Campus
Connecticut Institute For Resilience And Climate Adaptation
1080 SHENNECOSSETT ROAD
MARINE SCIENCES BUILDING
GROTON, CT 06340
PHONE 860.405.9228
FAX 860.405.9287
circa@uconn.edu
circa.uconn.edu
An Equal Opportunity Employer

Officer that reports to the Governor. The goal of this council should be to coordinate and integrate the various initiatives and projects across the agencies.

3) Connecticut's climate resilience strategy should be updated. A vulnerability assessment of the state's assets and operations will be conducted in 2026. However, a comprehensive and coordinated strategy across agencies has not been undertaken in recent years and should be developed upon completion of that assessment.

References:

Easterling, D.R., K.E. Kunkel, J.R. Arnold, T. Knutson, A.N. LeGrande, L.R. Leung, R.S. Vose, D.E. Waliser, and M.F. Wehner, (2017) Precipitation change in the United States. In Climate Science Special Report: Fourth National Climate Assessment, Volume I. D.J. Wuebbles, D.W. Fahey, K.A. Hibbard, D.J. Dokken, B.C. Stewart, and T.K. Maycock, Eds., U.S. Global Change Research Program, pp. 207-230, https://doi:10.7930/J0H993CC

Emmanouil, S., A. Langousis, E. I. Nikolopoulos, and E. N. Anagnostou, 2023: Exploring the future of rainfall extremes over CONUS: The effects of high emission climate change trajectories on the intensity and frequency of rare precipitation events. Earth's Future, https://doi.org/10.1029/2022EF003039

Gutiérrez, J.M., R.G. Jones, G.T. Narisma, L.M. Alves, M. Amjad, I. V. Gorodetskaya, M. Grose, N.A.B. Klutse, S. Krakovska, J. Li, D. Martínez-Castro, L.O. Mearns, S.H. Mernild, T. Ngo-Duc, B. van den Hurk, and J.-H. Yoon (2021) 2021 Atlas. In *Climate Change 2021: The Physical Science Basis. Contribution of Working Group I to the Sixth Assessment Report of the Intergovernmental Panel on Climate Change*[Masson-Delmotte, V., P. Zhai, A. Pirani, S.L. Connors, C. Péan, S. Berger, N. Caud, Y. Chen, L. Goldfarb, M.I. Gomis, M. Huang, K. Leitzell, E. Lonnoy, J.B.R. Matthews, T.K. Maycock, T. Waterfield, O. Yelekçi, R. Yu, and B. Zhou (eds.)]. Available from http://interactive-atlas.ipcc.ch/.

Hicke, J.A., S. Lucatello, L.D., Mortsch, J. Dawson, M. Domínguez Aguilar, C.A.F. Enquist, E.A. Gilmore, D.S. Gutzler, S. Harper, K. Holsman, E.B. Jewett, T.A. Kohler, and K. Miller, 2022: North America. In: *Climate Change 2022: Impacts, Adaptation, and Vulnerability.* Contribution of Working Group II to the Sixth Assessment Report of the Intergovernmental Panel on Climate Change [H.-O. Pörtner, D.C. Roberts, M. Tignor, E.S. Poloczanska, K. Mintenbeck, A. Alegría, M. Craig, S. Langsdorf, S. Löschke, V. Möller, A. Okem, B. Rama (eds.)]. Cambridge University Press, Cambridge, UK and New York, NY, USA, pp. 1929-2042, doi:10.1017/9781009325844.016.

IPCC (2022) Summary for Policymakers [H.-O. Pörtner, D.C. Roberts, E.S. Poloczanska, K. Mintenbeck, M. Tignor, A. Alegría, M. Craig, S. Langsdorf, S. Löschke, V. Möller, A. Okem (eds.)]. In: *Climate Change 2022: Impacts, Adaptation, and Vulnerability.* Contribution of Working Group II to the Sixth Assessment Report of the Intergovernmental Panel on Climate Change [H.-O. Pörtner, D.C. Roberts, M. Tignor, E.S. Poloczanska, K. Mintenbeck, A. Alegría, M. Craig, S. Langsdorf, S. Löschke, V. Möller, A. Okem, B. Rama (eds.)]. Cambridge University Press, Cambridge, UK and New York, NY, USA, pp. 3-33, https://doi:10.1017/9781009325844.001

O'Donnell, J. (2019) Sea Level Rise in Connecticut. https://s.uconn.edu/ctsealeelrisereport

Prein, A.F., C. Liu, K. Ikeda, S.B. Trier, R.M. Rasmussen, G.J. Holland and M.P. Clark (2017) Increased rainfall volume from future convective storms in the US. *Nat. Clim. Chang.* , **7** (12), 880, https://doi:10.1038/s41558-017-0007-7

USGCRP (2023) Fifth National Climate Assessment. Crimmins, A.R., C.W. Avery, D.R. Easterling, K.E. Kunkel, B.C. Stewart, and T.K. Maycock, Eds. U.S. Global Change Research Program, Washington, DC, USA. https://doi.org/10.7930/NCA5.2023

Avery Point Campus
Connecticut Institute For Resilience
And Climate Adaptation
1080 SHENNECOSSETT ROAD
MARINE SCIENCES BUILDING
GROTON, CT 06340
PHONE 860.405.9228
FAX 860.405.9287
circa@uconn.edu
circa.uconn.edu
An Equal Opportunity Employer

Tinyurl.Com/ RODBRIEF

Return on Disinvestment (RoD) – Health and Health Disparities Effects
January 2024

Emil Coman [1] coman@uchc.edu, Thomas Agresta [2] agresta@uchc.edu
[1]Health Disparities Institute & Department of Public Health Sciences UConn;
[2]School of Medicine & Family Medicine, UConn

We formalize a novel approach to evaluate policy impacts on population health, the **return on disinvestment (RoD)** and suggest a case scenario for CT residents.
RoDs sizes are typically **1.5–3x larger** than RoIs (Return on Investment) due to asymmetries:
a) Investment effects compound gradually while disinvestments have more accelerated effects, especially in sectors like health, where withdrawing funding cascades into uncompensated care burdens;
b) The effects of investment vs. disinvestment involve different processes, such that after disinvestment, reallocating the same investment does not revert to the 'initial' state – but ends up in a worse state.

This Research Focused on Four Key Areas:

1) The contrast of investing in preventing diseases, and in individual and public health, vs. disinvesting and the spending needed to treat diseases.

2) The health disparities (HD) area of health gaps attributable to resource availability differences (health insurance, e.g.) between racial/ethnic/disability/other disadvantaged populations/groups and the more fortunate ones.

3) The interconnections between policy decision ability and applicability at federal, state, and lower levels. Additionally, their impact in mitigating or exacerbating the effects of the federal axing of prior investments, particularly in healthcare.

4) The need to add social components of a RoD analyses, such as existing social RoI approaches.

Disinvestment Consequences

1) The recent termination of healthcare insurance subsidies is a form of plain disinvestment - a direct federal government withdrawal of funds, and not the diversion of investment, which re-purposes the subsidies to potentially improve other healthcare areas. The processes of maintaining good health and of curing diseases follow different individual biological

mechanisms, but more importantly different public health pathways; some decay processes are not reversible at all, others only partially. Once atrophied, an individual or community financial standing and population health require more resources for recovering.

2) The "minorities' diminishing returns" research found that racial/ethnic/disable/other minorities gain less health uplift from socio-economic boosts like income, such that health disparities gaps cannot be fully reversed (or eliminated), if conditions driving them were reversed themselves. Healthcare disinvestments imply "entrenchment effects" too, by boosting healthcare avoidance behaviors e.g., which multiplies HDs.

3) Democratic-leaning states (e.g., CA, NY) that counteract federal disinvestments may reduce RoD by 30–50%, while Republican-leaning states (e.g., TX, FL) may amplifying RoD by 20–40% (*AI informed*). Local authorities intervening powers may be less consequential than state level policies, and cannot make up for complete slashing of investments (e.g. in federal SNAP subsidies).

4) The social consequences of disinvestment derive from what they signal: abandonment, which erodes trust and amplifies also spatial spillovers (neighboring communities affecting each other), in contrast to diversion of funds, which could instead foster adaptation. The public health consequences are broad, and sharper when emergencies like epidemics or pandemics occur: the conflict between individual protecting behaviors and public health fostering ones becomes stronger, and axing health insurance enrollment incentives likely leads to a drop in civic engagement and can fuel anti-public health narratives.

Recommendations

1. Policymakers are faced with difficult *remedial actions* required by the recent disinvestments dictated at the federal level. Achieving the least damage to CT residents, caused specifically by the axing of healthcare subsidies, requires careful return on disinvestment analyses (RoD).

* Funding & de-funding decisions both should be accompanied by prior RoI and RoD analyses, and comparing the 'going up' vs 'going down' processes and effects.

2. The social and economic processes initiated by the federal cuts in healthcare have clear predictable effects on individual and public health, and on health disparities. Reigning these processes requires additional input from communities most affected by them outside of researchers.

* Decision-makers' perspectives of community impacts are incomplete until community voices are heard: community outreach and listening sessions should accompany plain financial analyses.

Overdose Prevention Centers: Evidence, Evaluation, and Urgency for Connecticut

Carson F. Ferrara, MPH, Brandon D.L. Marshall, PhD

January 2026

In 2024, Connecticut recorded 990 deaths due to drug overdose, representing a 26% decrease from 2023.[1] While these recent declines represent important progress**, overdose deaths remain unacceptably high in our state**. Despite the scale of this public health emergency, Connecticut remains without a sanctioned overdose prevention center (OPC), even after the introduction of SB1285 in the 2025 legislative session and HB06301 in 2023. OPCs are evidence-based facilities that prevent fatal overdoses and connect people to care. **This session will provide policymakers with a 'state of the science' overview on the research examining the impacts of overdose prevention centers in the United States and will discuss key insights from other countries.**

What are Overdose Prevention Centers?

Overdose prevention centers (OPCs), sometimes called safe consumption sites, supervised injection sites, or drug consumption rooms, are safe, monitored spaces where trained staff can intervene in the event of an overdose. In OPCs, trained staff can use naloxone (an overdose reversal medication) and oxygen to reverse an overdose and save a life, without needing to call 911. These sites also provide new, sterile supplies (pipes, cookers, etc.) to reduce the risk of infection and disease, by preventing the need to share or reuse equipment. People can also get connected to services like healthcare, drug treatment, recovery programs, and housing at these sites. Importantly, OPCs provide people with a supportive and safe environment, free from stigma and judgment. OPCs recognize people's dignity, reduce public drug use, and create a reliable connection to treatment, recovery services, housing, and healthcare.[2] They fill a current gap that exists in our state, where people who use drugs often die alone from an increasingly contaminated drug supply due to stigma and barriers to accessing resources. OPCs have been operating in other countries around the world—including in Canada—for decades, with robust evaluations supporting their effectiveness.[3,4,5]

Evidence Supports Overdose Prevention Centers

In this session, we will provide an update on research evaluating the overdose prevention centers that are currently operating in the United States, including two in New York City and one in Providence, Rhode Island. We will discuss their impacts on neighborhood-level outcomes, including crime, drug-related arrests, commercial activity, and other economic measures (e.g., real estate prices). In addition, we will summarize key evidence from other countries, including the impact of OPCs on the health of people who use such facilities, including reductions in overdose risk, increased uptake of addiction treatment, and connection to other services. Finally, we will highlight key finding from our team's qualitative research, which involved speaking directly to people who use OPCs in New York City and Providence (see quotes below).

Insights from Overdose Prevention Center Participants

"Once I started going to the OPC, I had this central wheel hub to be able to sort of think about and focus on services and possible assistance. It's [the OPC] *the hole in the middle that makes everything happen."*

34-year-old white man

"It's the safe spot. [...] I would say pretty much everyone is very respectful of that [keeping to the rules]. I think the same thing. Like they all appreciate being able to go there. They appreciate that spot so they don't want to wreck it, you know?"

47-year-old white man

Policy Recommendations

Authorize a multi-site overdose prevention center pilot program

Why This Matters:

Connecticut continues to experience high rates of overdose deaths—990 in 2024, with 76% involving fentanyl. Evidence from New York City and Rhode Island shows OPCs prevent fatal overdoses, reduce public drug use, and connect people to treatment without increasing crime. A pilot would allow Connecticut to implement a proven harm-reduction strategy while collecting local data to inform future policy.

How This Benefits Connecticut:

OPCs have been shown to reduce strain on emergency services, lower healthcare costs by preventing hospitalizations, and improve public safety by moving drug use indoors. Evaluation through partnerships with public health agencies and academic researchers ensures transparency and accountability. This approach positions Connecticut as a leader in harm reduction and public health innovation.

Fund wraparound services and transparent data reporting

Why This Matters:

OPCs are most effective when integrated with services such as treatment navigation, housing referrals, and drug-checking—services that already exist in Connecticut. Without these supports, opportunities to engage people in care are missed. Public trust also depends on transparent reporting of outcomes—such as overdoses reversed, EMS calls avoided, and referrals to treatment.

How This Benefits Connecticut:

Funding wraparound services ensures OPCs serve as gateways to essential health services for PWUD. Transparent dashboards build public confidence and demonstrate impact, helping policymakers make informed decisions. These measures reduce overdose deaths, improve health equity, and generate cost savings for healthcare and criminal justice systems—benefits that ripple across communities statewide.

References:

1. CT Opioid and Drug Overdose Statistics
2. Overdose Prevention Centers | National Harm Reduction Coalition
3. Evaluation of an Unsanctioned Safe Consumption Site in the United States
4. Supervised injection services: what has been demonstrated? A systematic literature review
5. Perspectives on drugs: preventing overdose deaths in Europe

Promoting Genomic Newborn Screening in Connecticut

Each year, 100-150 babies born in Connecticut with severe childhood conditions are identified through the state's newborn screening program. Thanks to advances in genomic sequencing technologies, we now have the opportunity to detect many more babies with treatable genetic disorders by augmenting the current program with genomic newborn screening. (PMID: 39446378; PMID: 41238356; CT.GOV).

Background

Since its inception in 1964, the Connecticut Newborn Screening Program has played a central role in one of the most successful public health initiatives in history, leading to substantial reductions in infant morbidity and mortality (PMID: 36582269). Today, states across the country are taking the next step by integrating genomic sequencing into their newborn screening to further expand this impact. Connecticut is not yet among them, but it possesses all the essential elements needed to advance into this space, including a successful partnership between the Connecticut Newborn Screening Network and the Connecticut Department of Public Health.

Genomic sequencing is a comprehensive tool that allows for the detection of rare and severe genetic conditions that are currently missed by traditional newborn screening methods. Now more accurate and cost effective than ever, genome sequencing is being increasingly integrated globally into newborn screening programs to enhance conventional methods, with a focus on identifying genetic disorders that are treatable in childhood, removing barriers to timely identification of genetic diseases, and leading to lifesaving treatments. However, innovation has outpaced the adoption of genomic sequencing into newborn screening in the US.

That tide is beginning to change. Genomic newborn screening initiatives being developed in at least six US states, and recently the National Institutes of Health's (NIH) Building Evidence and Collaboration for GenOmics in Nationwide Newborn Screening (BEACONS) initiative was launched to develop a framework for expanding genomic newborn screening. These efforts are demonstrating a range of paths forward for incorporating the local infrastructure, stakeholders, and resources necessary to implement these technologies.

Six states are already redefining newborn care through genomic newborn screening.

Florida became the first state to pass legislation to include genomic sequencing within newborn screening (Sunshine Genetics Act).

Connecticut has an opportunity to advance public health today.

Drawing on the progress being demonstrated by efforts nationwide, we strongly advocate for the legislature to take steps to advance broad access to genomic newborn screening in Connecticut as a natural next step in advancing children's health in our state.

Connecticut Children's · The Jackson Laboratory · UCONN HEALTH · University of Connecticut

Seeking to ensure Connecticut does not lose pace with advancements in newborn screening, Connecticut Children's, The Jackson Laboratory, UConn Health, and The University of Connecticut have proactively collaborated on a pilot study to investigate the feasibility of implementing genomic newborn screening in our state.

Targeting early detection of treatable childhood diseases, whole genome sequencing focused on over 460 expert-curated, medically actionable genes associated with severe childhood disease was performed on samples collected from newborns at the Connecticut Children's NICU at John Dempsey Hospital. An additional study surveyed Connecticut parents and prospective parents to evaluate community interest and perspectives on genomic newborn screening.

PILOT STUDY OUTCOMES

- Established a successful workflow for patient consent, sample collection, specimen transport, processing, analysis and reporting of genomic newborn screening.
- Demonstrated that dried blood spots are sufficient specimens for genomic sequencing. Collection of dried blood spots through an infant heel prick is the longstanding, minimally invasive method utilized by the state newborn screening program. This specimen type was purposefully chosen to demonstrate that we can pivot off procedures that are already in place. Genomic sequencing is a scalable approach and adaptable as new evidence emerges.
- Identified strong parental interest in learning about the types of health conditions that genomic newborn screening can identify in a newborn, and revealed factors that may influence test decision making and trust.

The pilot study demonstrates the feasibility of integrating genomic newborn screening, as well as the strong interest among Connecticut parents and leading medical and research institutions in advancing this effort.

Policy Recommendations

Connecticut's robust newborn screening program, strong public health infrastructure, and exceptional healthcare institutions, coupled with the recent legislative momentum expanding access to genomic technologies, position the state to move forward with the next step toward implementing a genomic newborn screening program. To support this progress, we recommend the following:

- **Convene a legislative workgroup** composed of existing state newborn screening infrastructure and experts; healthcare delivery institutions, providers and workforce; experts to ensure scientific validity, ethics, operational design, equity, and population health; individuals and families directly impacted; payors and purchasers; and policymakers and advisory bodies to develop a stakeholder-informed framework for the responsible, equitable, and sustainable implementation of genomic newborn screening in Connecticut. As this stakeholder group explores how best to integrate genomic technologies into Connecticut's highly regarded newborn screening program, explicit attention will go towards protecting the integrity of the existing biochemical blood spot screening system. Any advancements must reinforce, rather than compromise, its effectiveness.
- **Engage actively with states developing genomic newborn screening programs and with NIH partners** to leverage national findings and lessons learned—particularly those related to feasibility, implementation, and ethics—as Connecticut begins informed discussions about the future of genomic newborn screening in the state.

Contacts

Jeffrey S. Shenberger, MD | jshenberger@connecticutchildrens.org
Professor and Division Head Neonatology, Connecticut Children's, University of Connecticut School of Medicine
Adam Matson, MD, MS | amatson@connecticutchildrens.org
Associate Professor, Connecticut Children's, University of Connecticut School of Medicine
Bruce Liang, MD, FACC | bliang@uchc.edu
Dean, University of Connecticut School of Medicine; Ray Neag Distinguished Professor of Cardiovascular Biology and Medicine
Mark Adams, PhD | mark.adams@jax.org
Scientific Director, The Jackson Laboratory for Genomic Medicine

Connecticut Children's · The Jackson Laboratory · UCONN HEALTH · University of Connecticut

Expanding Access to Produce Prescriptions for Pregnant Women in CT

At Wholesome Wave, we believe every child deserves a healthy start, beginning during pregnancy. A Connecticut based non-profit, Wholesome Wave has made a positive systemic impact on nutrition security across the country since 2007, by working to make fresh fruits and vegetables affordable and accessible to all. Our Food4Moms Produce Prescription (PRx) Program[1] is generating critical evidence to demonstrate why this high-impact, low-cost intervention should be covered under Medicaid for eligible beneficiaries, including pregnant/postpartum women.

Food Insecurity & Maternal and Child Health in Connecticut

- More than 516,000 Connecticut residents, including 122,000 children, lack access to enough food to meet their basic needs, and these numbers have risen in recent years.[2]
- Pregnant women are especially vulnerable to food insecurity. Experiencing food insecurity during pregnancy can increase the risk of gestational diabetes, preeclampsia, preterm birth, and NICU admissions, threatening the health of the mother and child.[3]
- In Connecticut, the financial burden associated with preterm birth is an estimated $72,000 annually.[4]

Food4Moms: A Produce Prescription Program for Low-Income Pregnant Women[1]

Produce prescription (PRx) programs allow healthcare professionals to prescribe fresh fruits and vegetables to patients who meet specific criteria, such as having a diet-related disease or limited access to healthy food. Food4Moms is a PRx program designed to assess and bolster maternal health outcomes among low-income pregnant women experiencing food and nutrition insecurity. The program has been implemented in Hartford, CT with community-based partner Hispanic Health Council and in Bridgeport, CT with partner Southwest Community Health Center, a federally qualified health center, and evaluation partners Yale-Griffin Prevention Research Center and Tufts Food Is Medicine Institute.

Food4Moms integrates produce prescriptions into prenatal care at partnering health and community based organizations, enrolling patients in their 1st or 2nd trimester of pregnancy. Participants receive:

PRx Benefit

$60-$100 per month to buy fresh fruits and vegetables with the Fresh Connect card until 4-6 weeks postpartum

Nutrition Education

Nutritional guidance to improve pregnancy outcomes and support fresh produce consumption

Check-Ins

Check-ins during prenatal visits or over the phone with program staff about their experiences in the program

Funding Acknowledgement: This work was supported by the Gus Schumacher Nutrition Incentive Program (USDA #2022-70423-38075 and USDA #2021-70030-35871), Anthem Blue Cross and Blue Shield Foundation, Point32Health Foundation and M&T Bank.

Contact Us! For more information on the Food4Moms Program and Wholesome Wave, please visit **www.wholesomewave.org/food4moms** or contact us at **tom@wholesomewave.org** or **katina@wholesomewave.org**.

Expanding Access to Produce Prescriptions for Pregnant Women in CT

Produce Prescriptions (PRx): A Promising Solution

Produce prescription programs hold promise at improving maternal and child health outcomes, including addressing pregnancy-related adverse outcomes. PRx programs have been shown to:

- Improve diet quality, by increasing fruit and vegetable intake[5]
- Improve cardio-metabolic health, including reducing blood sugar, blood pressure, and weight[5]
- Increase healthy food access and purchasing, including improved food and nutrition security[6]
- Optimize healthcare utilization and spending, by reducing emergency room and hospital visits[7]

Preliminary Findings from Food4Moms in Hartford

Preliminary data from Food4Moms in Hartford show that the program had a meaningful, positive impact for participating mothers.

INCREASED FRUIT & VEGETABLE CONSUMPTION

Participants reported a 16% increase in the cups of vegetables and 14% increase in the cups of fruits they eat each day.

HIGH SATISFACTION

92.8% were completely/mostly satisfied with the program, and 91.8% of participants would strongly recommend the program to other women in their community.

IMPROVED FOOD SECURITY

40.8% of participants who were food insecure at baseline reported improved food security after the program.

HIGH PRx REDEMPTION

The average redemption rate for participants was 82.5%, which is higher than the national average of less than 60%.

Policy Implications

- Proposing and supporting legislation to **apply for and implement a Section 1115 demonstration waiver to provide Medicaid coverage for "Food as Medicine,"** including Produce Prescriptions (PRx) for Medicaid beneficiaries who are pregnant/postpartum
- **All states surrounding Connecticut have approved Section 1115 demonstration waivers providing coverage for nutrition interventions**, including Rhode Island, Massachusetts, and New York, targeted towards vulnerable populations such as pregnant/postpartum women.
- A recent study found that in Massachusetts, participation in Medicaid-funded Food Is Medicine programs was associated with a 23% reduction in hospitalizations, 13% reduction in emergency department visits, and lower healthcare costs among participants compared to eligible nonparticipants.[8]

Citations

1. https://pubmed.ncbi.nlm.nih.gov/40145018/
2. https://www.ctfoodshare.org/hunger-in-ct
3. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2829483
4. https://www.marchofdimes.org/peristats/reports/connecticut/prematurity-profile
5. https://www.ahajournals.org/doi/10.1161/CIRCOUTCOMES.122.009520
6. https://pmc.ncbi.nlm.nih.gov/articles/PMC8369461/
7. https://www.annualreviews.org/content/journals/10.1146/annurev-nutr-111124-092627
8. https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.01409

Food As Medicine
as a CT Policy Priority

PREVENTION RESEARCH CENTERS

At a Glance

Produce prescription programs are an effective and cost-saving method to improve health and food security for Connecticut residents. Local studies show feasibility, patient satisfaction, and impact. Policy changes such as a Medicaid 1115 waiver would significantly support scale-up, positively impact population health, allow long-term sustainability, and save taxpayer dollars.

Currently, Connecticut does not have a Medicaid waiver for nutritional programs, while 19 other states, including all surrounding states, provide nutritional services within Section 1115 demonstration waivers.

Chronic Disease & Food Insecurity

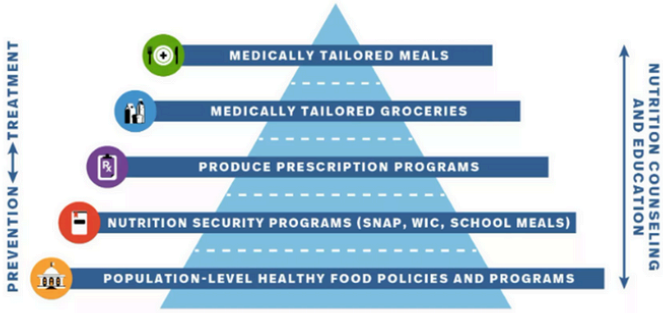
Nutrition-related chronic diseases are leading causes of death and disability in Connecticut. Nearly 11% of adults have been diagnosed with diabetes, with 17,000 new cases reported annually. In 2021, heart disease accounted for 20% of deaths and stroke accounted for an additional 4%.

At the same time, food insecurity has continued to worsen in the past five years, especially due to the elimination of federal relief programs. Currently, 18% of CT residents are food insecure, reporting they could not afford enough food to feed themselves or their families.

Food As Medicine

> “Food As Medicine can be defined as food-based nutritional interventions integrated within health systems to treat or prevent disease and advance health equity.”

Dariush Mozaffarian, MD, DrPH



Tufts Food Is Medicine Institute (2024)

Produce prescription (PRx) programs allow healthcare providers to prescribe produce to patients who meet specific criteria like food insecurity and nutrition-related diseases.

Produce prescription programs have been shown to

- Increase access to healthy foods, health care, and nutrition knowledge
- Improve diet quality, especially fruit and vegetable consumption
- Improve health outcomes like diabetes control and cardiovascular disease
- Save on healthcare costs (like Medicaid spending)
  - In Massachusetts, patients who received nutritional services funded by a Medicaid Section 1115 Demonstration Waiver had 23% fewer hospitalizations, 13% fewer visits to the emergency department, and paid $1,721 less in health care costs from 2022-2023 compared to patients who did not receive nutritional services

American Diabetes Association (2024), Connecticut Department of Public Health (2023), Data Haven (2024), Hager et al. (2023), Muleta et al. (2023), Wang et al. (2023), Hager et al. (2025), Hanson et al. (2024)

Produce Prescriptions (PRx) in Connecticut

The Yale-Griffin Prevention Research Center partners with community and healthcare organizations on produce prescription program studies in CT.

Study Name	Population	PRx type	Partners
Food4Moms Greater Hartford Region	Low income, pregnant Latina women	Fresh Connect card or delivery, nutrition education - $100/mo for 10 months	Wholesome Wave, Hispanic Health Council, About Fresh
Griffin Hospital PRx Lower Naugatuck Valley	Medicaid eligible, pre-diabetes or diabetes	Fresh Connect card, nutrition education - $40/mo for 1 person and $5 per additional household member for 6 months	Griffin Faculty Practices, Griffin Hospital, About Fresh
Fair Haven Community Health Care PRx New Haven	At risk for diabetes	Fresh Connect card and farmers market vouchers - $80/mo for 6 months	Fair Haven Community Health Care, Community Alliance for Research and Engagement, Southern Connecticut State University, About Fresh
Produce4Life Greater Hartford Region	Medicaid-eligible, type 2 diabetes, Hispanic/Latino	Fresh Connect card, nutrition education, community health worker (CHW) - $40/mo for 6 months	Hispanic Health Council, Hartford Hospital, Wholesome Wave, Emory University

Preliminary Results

- Food4Moms: high Fresh Connect card redemption (82.5%), increased consumption of fresh fruits and vegetables during pregnancy, improved food security and self-reported health
- Griffin Hospital PRx: increased fruit and vegetable intake, nutrition knowledge, and self-reported health
- Fair Haven Community Health Care PRx: high Fresh Connect card redemption (80-90%) and voucher redemption (~60%), high participant satisfaction
- Produce4Life: high interim redemption from 69.4% (without CHW) to 81.4% (with CHW)

Policy Implication: Support a budget reallocation to fund a Medicaid 1115 waiver and pilot a produce prescription program for Medicaid beneficiaries with nutrition-related chronic disease.

Funding Acknowledgement. This work was supported in part by the American Heart Association Grant # 24FIM1264456/Yale School of Public Health/2024 and the Gus Schumacher Nutrition Incentive Program USDA # 2022, 7042438552

Contact us!
For more information about our program, contact
Rafael Pérez-Escamilla, PhD, PRC Principal Investigator
rafael.perez-escamilla@yale.edu

To learn more, visit:
www.yalegriffinprc.griffinhealth.org

Yale SCHOOL OF PUBLIC HEALTH | GRIFFIN HEALTH | PRC PREVENTION RESEARCH CENTERS

A Brief on CT Hazard and Disaster Response and Preparedness: Emergency Management Directors and Resident Survey December 2025

A report on feedback from CT EMDs, PWDs, community stakeholders and residents across CT counties on perceptions and concerns regarding CT disaster preparedness.

Eleanor Shoreman-Ouimet
Assistant Professor of Environment and Human Interactions
Dept of Anthropology, UCONN
Eleanor.ouimet@uconn.edu

Committee Audience: 1. Environment; 2. Public Health

Eleanor Shoreman-Ouimet, PhD
Ken Lachlan, PhD
Christopher Burton, PhD
Abigail Beckham, ABD
Alexandra Harden, ABD
James DiCairano, PhD

Executive Summary

This summative research reflects upon an interdisciplinary effort to assess disaster preparedness and identify the roots and repercussions of preparedness disparity across socioeconomic groups in Connecticut. This report juxtaposes the results of ethnographic interviews with Emergency Managers across Connecticut with survey data collected among CT residents examining issues of trust, preparedness, and information sufficiency regarding local emergency services. The results highlight the ways in which state-level systems of disaster management may be exacerbating preparedness disparity, often leaving Connecticut towns, certain socioeconomic groups, and rural communities ill-equipped to manage the growing threats of climate change induced natural hazards and disasters facing southern New England. This applied research seeks to provide guidance on the types and form of hazard-related information most desired and sought after by residents, particularly minoritized and impoverished residents, for policy-makers and state, regional, and municipal disaster management personnel; as well as underline the needs of increasingly overburdened, predominantly volunteer, emergency management directors across the state. We end with recommendations as to the resources local level disaster management may need to inform and assist residents as well as suggestions as to how best to engage local residents in the disaster management planning and decision-making processes.

Our research to date indicates that longstanding state and regional preparedness practices have yet to be updated to reflect current climate forecasts, effectively equip local emergency volunteers, or improve communication services to the extent necessary to properly equip first responders or community members in times of threat or crisis. Further, our research demonstrates that the Planning Assumptions of the State Response Framework are imprecise based on the reality of the on-ground situation and local towns and populations are vulnerable to being disproportionately and unnecessarily impacted by disasters due to a lack of available resources and knowledge.

Key Takeaways

Interviews with EMDs reveal a number of significant themes:

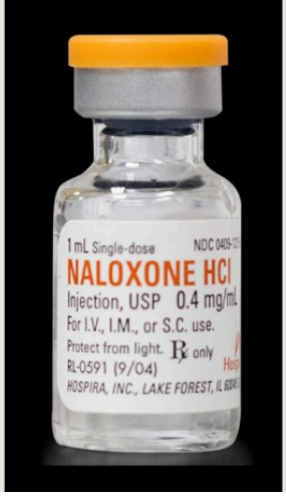
- CT's State Response Framework depends upon a declining number of aging EMDs who are overburdened in light of increasingly frequent and severe weather-related hazard events.
- There are widespread issues with inadequate communication systems between EMDs and community members.
- There is an overall sense that residents lack risk awareness and preparedness knowledge.
- The state is not providing adequate financial resources to support EMD responsibilities, the development of emergency plans, or attract much needed additional employees/volunteers.
- The general lack of diversity among EMDs in Connecticut lies in sharp contrast to increasing numbers of low-income residents who may be linguistically isolated, ethnically diverse, or otherwise marginalized

Resident survey data furthermore indicates that racially minoritized and impoverished residents, those that score higher on social vulnerability indices are:

- Seeking more preparedness information that less vulnerable residents.
- Prefer person-to-person sources of emergency and disaster-related information, ideally from friends, family, church, libraries, schools, etc.
- Are less likely to be aware of their community's emergency management plan.
- Are more likely to feel as though their needs are not being served by their town's emergency services.

Recommendations

- Risk communication and preparedness education should initiate at the community level and be dispersed through trusted community institutions (libraries, schools, community centers, senior centers, churches)
- Crisis responders would be wise to build relationships with community leaders at trusted community institutions (churches, youth programs) to more effectively inform those who may be in harm's way.
- Risk education on preparedness strategies and municipal policies (parking restrictions, alert notification schedules, etc.) should be provided in multimedia forms (radio, mailings, emails, bulletins) and available for ESL and non-English speaking residents.
- Increase diversity of EMD and emergency response personnel through inclusion of women and racially minoritized groups, by increasing the scope of position advertising to schools, community colleges, public health facilities, churches.
- Increased state-distributed funding for part-time town positions, updated emergency communications systems, emergency plan development, and resident risk and preparedness education programming.



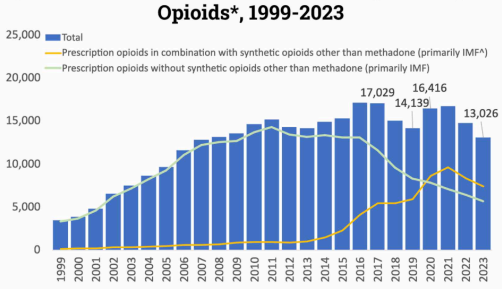
IMPLEMENTING NALOXONE CO-PRESCRIPTION LAWS TO REDUCE PRESCRIPTION OVERDOSE DEATHS

BY: ALEXANDRA TORRES MUÑOZ, B.S., B.A.; NATHANIEL RICKLES, PHARMD

Executive Summary

Each year, thousands of Americans die from preventable, prescription opioid–related causes. Most often such deaths are due to overdose, dangerous drug interactions, or accidental ingestion by children—underscoring the significant risks these medications carry. While the issue of overdose deaths involving prescription opioids is severe, these risks can be mitigated with the presence of Naloxone. Commonly known by its brand name Narcan, Naloxone is a medication that works by blocking the effects of opioids, effectively reversing overdoses and saving lives. Its effectiveness, however, is highly time-dependent and requires rapid administration to counteract an overdose.

Figure 4. U.S. Overdose Deaths Involving Prescription Opioids*, 1999-2023



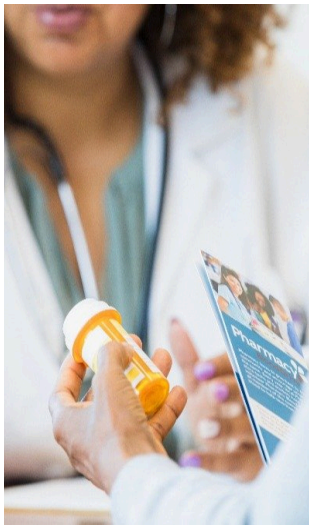
*Among deaths with drug overdose as the underlying cause, the prescription opioid subcategory was determined by the following ICD-10 multiple cause-of-death codes: natural and semi-synthetic opioids (T40.2) or methadone (T40.3). ^Illicitly manufactured fentanyl. Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2023 on CDC WONDER Online Database, released 1/2025.

By co-prescribing Naloxone alongside opioids, prescribers can ensure that this life-saving medication is readily available in the household, providing an immediate response to potential overdoses. Naloxone co-prescription mandates have been successfully implemented in several states, demonstrating its considerable potential to reduce opioid-related fatalities and save lives. Naloxone co-prescription mandates have been implemented in 18 states, including close neighbors like Vermont, Rhode Island and New Jersey, as well as states across the U.S. like Florida, New Mexico, and Washington. The mandate set higher standards for harm reduction efforts, and they saw reduced opioid overdose deaths.[1]

Current and Proposed Policies

Connecticut Public Act 15-198 established the authority for pharmacists to complete training and receive certification in prescribing Naloxone at the patient's request. While this represents a step in the right direction, this still leaves advocacy up to the patient, who may not understand or internalize the risks associated with their medications. Certain states require pharmacists to offer Naloxone to patients who meet certain criteria while other states mandate co-prescription immediately if the patient fits into the criteria, some of which are listed in the Policy Recommendations Section. Further discussions with community healthcare providers and the Public Health Committee may determine the right regulations for Connecticut legislation.

Established Effectiveness in Participating States

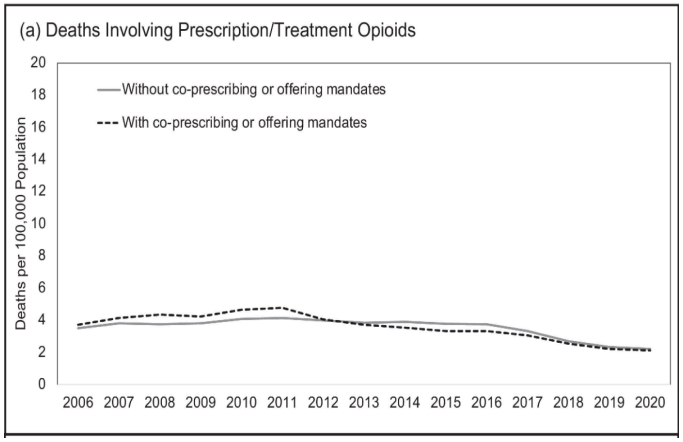


- The National Institute on Drug Abuse recognized research indicating that co-prescription lowers the number of prescription opioid overdose deaths, and that the CDC already recommends that Naloxone be prescribed to some individuals. [2]
- Rhode Island, a state that has notoriously struggled with overdoses, was able to achieve a faster reduction in the percent of overdose deaths than Connecticut. Their 2018 legal mandate to offer or prescribe naloxone to high-risk patients was followed by a **2.2 per 100,000 annual reduction in opioid deaths from 2020** to 2023, compared to Connecticut's slower 1.9 per 100,000 decline over the same time period. [3]
- This is further confirmed by studies which have shown that prescribing/offering laws significantly reduced the number of prescription drug overdose deaths by **8.61 deaths per state per quarter.** [4]
- Naloxone prescription has been well received, with one survey showing **79% of recipients with positive or neutral reactions**.[5]

Policy Recommendations

I. Providing funding for Naloxone access

Without making naloxone an affordable option, this medicine likely won't reach the communities it needs. The over the counter price of $50 for Naloxone is often a barrier between the medication and the families who need it most. Securing funding, possibly from existing and future opioid settlements, and including Naloxone under Medicaid will expand the reach and effectiveness of the law.



II. Require the prescriptions of Naloxone alongside especially high risk opioid prescriptions.

Examples of regulations included in other state policies include:

- New prescriptions for particularly strong opioids– characterized as a schedule II opioid for over 90 morphine milligram equivalents (MME) per day.
- Opioids prescribed alongside other medications like benzodiazepines.
- Opioid prescriptions to patients with a history of overdose or abuse.
- Establish precedent for frequency of prescription if continued opioid prescription– 2 years to ensure remaining within expiration dates.

Sources

1. Green, Traci C et al. "Laws Mandating Coprescription of Naloxone and Their Impact on Naloxone Prescription in Five US States, 2014-2018." American journal of public health vol. 110,6 (2020): 881-887. doi:10.2105/AJPH.2020.305620
2. National Institute on Drug Abuse. Drug Overdose Deaths: Facts and Figures | National Institute on Drug Abuse (NIDA). 21 Aug. 2024, https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates.
3. Sohn, Minji, et al. "The Impact of Naloxone Coprescribing Mandates on Opioid-Involved Overdose Deaths." American Journal of Preventive Medicine, vol. 64, no. 4, Apr. 2023, pp. 483–91. ScienceDirect, https://doi.org/10.1016/j.amepre.2022.10.009.
4. CDC. "SUDORS Dashboard: Fatal Drug Overdose Data." Overdose Prevention, 3 Dec. 2025, https://www.cdc.gov/overdose-prevention/data-research/facts-stats/sudors-dashboard-fatal-overdose-data.html.
5. Behar, Emily, et al. "Primary Care Patient Experience with Naloxone Prescription." The Annals of Family Medicine, vol. 14, no. 5, Sept. 2016, pp. 431–36. www.annfammed.org, https://doi.org/10.1370/afm.1972.
6. "CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016." MMWR. Recommendations and Reports, vol. 65, 2016. www.cdc.gov, https://doi.org/10.15585/mmwr.rr6501e1er.

Contact: Alexandra Torres Muñoz; alex.torresmunoz3@gmail.com

Connecticut needs to establish a multistakeholder cybersecurity task force to assess its critical infrastructure sectors' readiness and resiliency from ever-sophisticated cyber attacks – revival of SB 1319.

Tirthankar Ghosh
Professor, Elder Family Chair
Director, Connecticut Institute of Technology
University of New Haven
tghosh@newhaven.edu

Ron Harichandran
Dean, Tagliatela College of Engineering
University of New Haven
rharichandran@newhaven.edu

Connecticut's critical infrastructure needs protection from ever-growing and sophisticated cyber attacks. Adversaries, powered by advanced AI-augmented automation and backed by nation states, are increasingly posing threats on our electric grids, water treatment facilities, smart manufacturing infrastructure, financial institutions, and healthcare systems. In January 2024, the then FBI Director Christopher Wray testified before Congress explaining how Chinese government hackers were trying "to find and prepare to destroy or degrade the civilian critical infrastructure that keeps us safe and prosperous." In April of the same year, the then White House National Security Council (NSC) published the National Security Memorandum (NSM) on Critical Infrastructure Security and Resilience to bolster the work that CISA is already doing. Last year, CISA announced "Vulnrichment" with a goal to enrich public CVE records with Common Platform Enumeration (CPE), Common Vulnerability Scoring System (CVSS), Common Weakness Enumeration (CWE) and Known Exploit Vulnerabilities (KEV) data.

Recent attacks on the Cities of Hartford (2020) and West Haven (2024), Ascension Healthcare (2024), New Haven Public Schools (2023), and on America's electric power grids have exposed the vulnerabilities in our critical infrastructure. According to North American Electric Reliability Corporation (NERC), the electric power grids' virtual and physical attack surfaces grew to a range of 23,000 to 24,000 by the end of 2023. To counter increasingly sophisticated adversaries using AI-augmented automation targeting our critical infrastructure, the defense mechanisms also need to use at-par sophistication at the least. Traditional systems based on reactive measures and relying on existing off-the-shelf solutions have shown to be ineffective. This underscores the need for integrating sophisticated AI-powered technology into our defensive mechanisms. The challenge, however, is multifaceted: 1) Various stakeholders are working in silos to design and deploy AI-powered tools in their Security Operations Centers (SOCs); 2) There are no systematic studies, including creating baselines, to evaluate feasibility, readiness and effectiveness of AI-powered cyber defense tools and technologies that need to be deployed by organizations; 3) Lack of real-world experimental data for designing and evaluating the AI/ML models developed to secure our critical infrastructure is creating a hurdle for advancing the field; 4) Lack of testing infrastructure and sharable metrics to study adversarial tactics, techniques, and procedures (TTPs) is hindering researchers and practitioners from studying the effectiveness and feasibility of using AI-powered technologies; and 5) Lack of simulation/emulation platforms or digital twins for AI-enabled and/or AI-augmented attacks on critical infrastructure leaves us vulnerable to the next wave of cyberattacks that may have actual physical manifestations.

In view of these shortcomings, we urge Connecticut's legislators to revive SB 1319 to build a multistakeholder coalition in Connecticut on 'Exploring and Implementing AI-Powered Intelligent Systems to Secure Connecticut's Critical Infrastructure'. The coalition will comprise of academia, state

and local government, private sector, and non-profits to work toward the following goals in addition to the objectives that were proposed earlier:

1. Evaluate the feasibility, readiness and effectiveness of using AI/ML-powered tools and technologies in defending five critical infrastructure areas: the energy sector including nuclear reactors, water treatment facilities, financial institutions, transportation, and healthcare organizations.
2. Create baselines and metrics to evaluate feasibility, readiness and effectiveness as mentioned above.
3. Generate and curate cyber attack datasets that will be used for training and research.
4. Offer a series of summer workshops to the current and future workforce to help them navigate through the feasibility and effectiveness of using AI to secure their data and infrastructure.
5. Collect input to build insights into creating digital twins of critical infrastructure control systems that may be vulnerable to cyber-takeover via malicious AI agents.

UCONN
UNIVERSITY OF CONNECTICUT

Enhancing Emergency Preparedness for Vulnerable Populations in Connecticut

Research team: Juliana Barrett, Nancy Balcom, Eleanor Ouimet, Faye Griffiths-Smith, Mary Ellen Welch, Heather Peracchio, Kenneth Lachlan, Abigail Beckham, James DiCairano

Executive Summary
Connecticut faces an increase in recurring hazard events such as hurricanes, floods, ice storms, and high winds. Older adults, low-income families, immigrants, and people with disabilities are disproportionately affected due to barriers in communication, transportation, medical access, and trust in institutions. This brief outlines key challenges and provides a policy recommendation to strengthen resilience, equity, and safety during emergencies.

Background
With funding from the National Oceanic and Atmospheric Administration, University of Connecticut faculty from the Departments of Anthropology, Communication and Extension are collaborating on a project to assess the status, challenges and needs of disadvantaged or aging residents in coastal communities to extreme weather events, developing emergency preparedness programing, training and a partnership platform piloted in the cities of Stamford, West Haven and New London, Connecticut. The team will work to establish a system of long-term preparedness support for aging community members that can be expanded to other coastal communities facing comparable socioeconomic and environmental challenges.

Over the past six months, we conducted roundtables, listening sessions, and surveys. We held roundtable discussions with community groups engaged in emergency preparedness and those agencies that support older adults and underserved residents. We held listening sessions at senior living communities, libraries, and senior centers. We surveyed coastal residents age 50+ about extreme weather preparedness, risk awareness, individual needs and challenges.

Findings and Key Challenges

- **Hazard Vulnerability**: Older adults and medically fragile populations are at high risk during storms and power outages.
- **Communication Barriers**: Non-English speakers and those without access to or trust in technology struggle to receive timely information.
- **Transportation Limitations**: Many cannot evacuate or access food, medicine, and medical care; caregivers face transportation challenges.

- **Energy & Utility Dependence**: Power outages disrupt heating, cooling, oxygen machines, and medication storage.
- **Information Trust**: Mistrust of news sources and government agencies reduces compliance with emergency guidance.
- **Shelter Concerns**: Fear of theft, violence, or unsafe conditions discourage evacuation.
- **Disability & Isolation**: Individuals living alone face heightened safety risks and limited support.
- **Resource Gaps**: Many households lack basic emergency supplies; low-income families face food and energy insecurity, particularly during power outages.
- **Funding Shortfalls**: Public health and emergency programs lack adequate resources.
- **Training Needs**: Communities require education on preparedness and mutual aid.

Policy Recommendation:
Expand and better coordinate state and local preparedness and inclusive outreach: fund multilingual public education, community liaisons, and volunteer training to reach seniors and limited English speakers. Additionally, recognize that Connecticut has designated disaster coordinators in all 169 towns, but many residents are unaware of who these individuals are. Part of the strategy should include increasing public awareness of these coordinators and equipping them equitably with resources and training to support vulnerable populations during weather emergencies.

Improving Food Insecurity among Connecticut's diverse student populations

Authors:

Kritee Niroula, PhD; Summaya Abdul Razak, MS; Kristen Cooksey Stowers, MPP, PhD

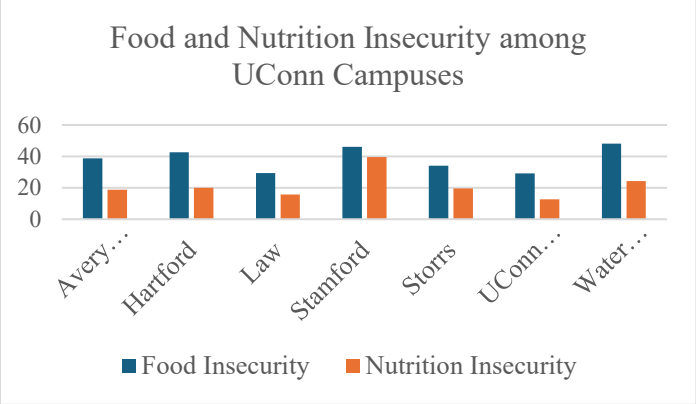
Affiliation: Department of Allied Health Sciences, University of Connecticut, Storrs, Connecticut, USA

Email: ubl24004@uconn.edu

Committee audience: Higher Education, Public Health

Background:

Food and nutrition security have emerged as a significant problem in the United States, particularly among college and university students, severely affecting their physical, mental health and academic performance. College students struggle with anxiety and stress when dealing with finances and food, which affects their academic performance and mental health.



Over time, the rising cost of higher education has increased students' financial burden. The increase in tuition, combined with stagnant wages and high living costs, heightens the risk of food insecurity, forcing students to skip meals or remain hungry for extended periods. Although federal financial aid provides some support, it fails to cover the full cost of attendance. Moreover, the changes to federal student aid affect Pell Grant eligibility and loan borrowing limits, further widening the existing financial gap.

Connecticut has actively addressed college food insecurity through state legislation like HB 5301, which mandates surveys at public colleges to assess needs and expand SNAP access, and federal bills championed by CT's Jahana Hayes, such as the Student Food Security Act, to simplify SNAP enrollment for students by leveraging FAFSA data and expanding eligibility. These efforts aim to tackle high student hunger rates by connecting students with federal aid, promoting on-campus food pantries, and increasing overall awareness, recognizing that hunger severely impacts academic success. Despite the efforts, a 2023 report on the UConn college survey reported that food and nutrition insecurity prevalence on UConn campuses was 35.9% and 19.8%, with over 20% experiencing very low food security. There is a need for more rigorous evaluation and evidence-informed initiatives to address the gap and to ensure the programs are both effective and equitable across diverse student populations.

Policy Recommendations: Food insecurity significantly affects college students' physical and mental health, academic performance, and overall well-being. To ensure long term food and nutrition security for college students:

- Expand SNAP access: Policymakers should strengthen policies that remove requirements aiming to make SNAP enrollment simpler and more accessible with demonstrated financial need.
- Strengthening campus food security initiatives: The SNAP accessibility strategies could be complemented by offering campus reduced cost meal plans, meal sharing programs and operating campus food pantries.
- Evidence based strategies: Conducting research to study the patterns of food and nutrition insecurity to inform targeted strategies, as well as routine surveys to monitor and evaluate the need.

Social Vulnerability and Food Swamps in Hartford: A Call for Place-Based Policy Action

Summaya Abdul Razak MSc, Kritee Niroula PhD, Kristen Cooksey Stowers PhD

Key Finding: Hartford neighborhoods with high social vulnerability have the highest concentrations of fast-food outlets and convenience stores. Social vulnerability explains 30% of the variation in food swamp exposure, yet Connecticut policy addresses food deserts (a lack of healthy food) but not food swamps (oversaturation with unhealthy food).

The Problem

Social vulnerability and food swamps are two interconnected structural factors that are prevalent in disadvantaged communities, exacerbating the risk of food insecurity and diet-related health disparities. Social vulnerability refers to the socioeconomic and demographic factors that affect a community's ability to prepare for, respond to, and recover from stressors. These factors limit residents' access to and ability to afford healthy food. Food swamps are areas saturated with fast-food restaurants and convenience stores relative to healthier food options, further diminishing dietary quality by making unhealthy choices the easiest to obtain and most affordable. When social vulnerability and food swamps overlap, communities face a dual challenge: they have limited access to healthy food and are situated in environments that encourage unhealthy eating. National research indicates that Black and Hispanic communities, as well as low-income neighborhoods, are disproportionately located in food swamps. This contributes to ongoing diet-related health disparities, including obesity, diabetes, and cardiovascular disease.

How This Affects Connecticut

In 2024, food insecurity in Connecticut rose by 23%, with over 400,000 residents currently receiving SNAP benefits. The recent enactment of federal SNAP cuts totaling $185 billion will increase demand on emergency food systems. Communities that are highly vulnerable socially and experience food swamp conditions are the least equipped to handle these challenges. They face both limited resources and environments that make healthy eating difficult, even when food is accessible.

A gap in current Connecticut policy: Connecticut has taken steps to address food deserts through HB 6854 (2023), which established tax incentives for grocery stores in underserved areas. However, this legislation focuses solely on the absence of healthy food, not the oversaturation of unhealthy options. Research increasingly shows that food swamps may be equally or more predictive of diet-related health outcomes than food deserts alone. Addressing food insecurity requires tackling both problems simultaneously.

What Research Shows

Research consistently shows that food swamps are more impactful than food deserts on health outcomes. A nationwide study of 3,141 U.S. counties found that the severity of food swamps better explains adult obesity rates than the presence of food deserts, and adults with diabetes living in severe food swamps experience higher hospitalization rates. These patterns are not exclusive to the U.S.; studies in Brazilian and Canadian cities also confirm that food swamps tend to cluster in socially vulnerable areas with lower incomes and higher minority populations. Hartford exhibits

this same trend. Previous research has documented "supermarket redlining" in the city, where grocery stores have historically avoided socially vulnerable neighborhoods while fast-food chains tend to concentrate there. The CDC created the Social Vulnerability Index to help allocate resources for disaster preparedness; combining food environment data with SVI mapping would produce a more comprehensive tool for identifying communities at increased risk of food insecurity.

Hartford Findings

Our spatial analysis of six Hartford neighborhoods revealed that social vulnerability (measured by the CDC's Social Vulnerability Index) and food swamp exposure tend to cluster geographically. Using Global Moran's I statistics, we observed significant positive spatial autocorrelation for both social vulnerability ($I = 0.55$, $p < 0.001$) and food swamp exposure ($I = 0.51$, $p < 0.001$). Hartford's North End neighborhoods had the highest SVI scores (0.95–0.99) and the highest food swamp scores, while peripheral neighborhoods showed lower values for both. A strong positive correlation ($r = 0.55$, $p < 0.001$) exists between social vulnerability and food swamp exposure. Each one-unit increase in SVI was associated with a 15.7-point rise in food swamp exposure, even after adjusting for food insecurity and income, accounting for about 30% of the variation in food swamp exposure across Hartford neighborhoods.

Policy Recommendations

Single-focus interventions that target either poverty or food access alone are not enough to solve food insecurity. As Connecticut considers HB 6089 (2025) to reduce barriers to food security, legislators should think about multi-pronged, place-based strategies that tackle both food swamps and food deserts:

1. Broaden food environment policies beyond food deserts: Revise existing tax incentive programs to address food swamp issues by setting limits on the density of fast-food and convenience stores in oversaturated areas.

2. Incorporate food environment data into resource planning: Use SVI mapping along with food swamp indices to find communities at higher risk of food insecurity and focus efforts there.

3. Promote zoning reforms: Allow municipalities to restrict fast-food density while making it easier for healthy food retailers, mobile markets, and community food projects to operate.

4. Invest in supportive infrastructure: Improve transportation, housing stability, and language access in high-SVI neighborhoods to increase the success of food environment strategies.

5. Fund community-led solutions: Support gardens, food co-ops, and local initiatives, building on models like the Healthy Hartford Hub.Hub.

Policy Brief: Regulating Automated License Plate Readers

Charlotte Resing, J.D., Government Affairs Manager | Jiadi Chang, Government Affairs Associate

What are Automated License Plate Readers?

States across the country, including Connecticut, have seen a meteoric rise in the use of Automated License Plate Reader (ALPR) systems. These systems consist of high-speed cameras, commonly mounted onto street poles and vehicles, that collect data on every vehicle that passes into their view. Historically, these cameras have captured only license plate numbers, but modern, AI-powered cameras are capable of recording other vehicle characteristics, such as color, type, damage, and alterations.

The Problem

Map of known ALPRs in Connecticut published by deflock.me

ALPRs collect intimate data indiscriminately. ALPRs have been deployed by municipalities and law enforcement agencies for decades and can be useful in locating missing persons or stolen vehicles. However, these systems collect large swaths of data on the general public, and when that data is retained and accumulated, it can be used to track a vehicle's every move and form an intimate picture of any individual's activities and associations.

- One's health care choices, relationships, places of worship, immigration status, and more can be uncovered by tracking their vehicle's movements.
- The surveillance capabilities of ALPR systems are so intense that some argue that they violate the Fourth Amendment. Ongoing lawsuits in Norfolk, Virginia and here in West Hartford, Connecticut contend that those jurisdictions' 30-day retention periods of ALPR data amount to a warrantless search.

The troves of data collected by ALPR systems are vulnerable to misuse, whether inadvertently or by bad actors.

- There is evidence that Connecticut ALPR data is being shared with out-of-state law enforcement agencies. This could have serious consequences. Earlier this year, law enforcement in Texas queried Illinois ALPR data in an attempt to locate a woman who self-administered an abortion. Illinois explicitly prohibits the sharing of ALPR data to investigate a law that denies reproductive health services, but the query slipped through the cracks.

The abuse and misuse of ALPR data from the nationwide network of ALPR systems should be especially alarming, given the Trump administration's persecution of immigrants.

- Flock Safety, one of the nation's largest ALPR system vendors and operators, operated a pilot program in which they provided federal immigration authorities with access to ALPR data from across the country.
- It's still unclear whether Connecticut ALPRs were included in that access, but we know immigration authorities were able to access ALPR data even in states that prohibit law enforcement from sharing ALPR data for immigration enforcement, such as Illinois and California.

Policy Solutions

As ALPR data is used to target vulnerable communities, state lawmakers must take action to protect the privacy and safety of their constituents, and many already have. Last session, legislators in at least 16 states introduced bills to establish or update regulations on ALPR systems. Broadly speaking, lawmakers should take the following steps to regulate ALPRs:

- **Limit data retention periods.** Reducing the amount of time that ALPR data can be retained addresses many of the privacy and misuse concerns related to the technology. Several states, such as New Hampshire (3 minutes) and Virginia (21 days), have already shortened retention periods and/or placed restrictions on accessing historical data.
- **Restrict data sharing with out-of-state and federal agencies.** To prevent the use of Connecticut's ALPR data to enforce laws incongruent with the state's laws and values, legislators should ensure that data sharing with outside agencies is limited and consistent with the spirit of Connecticut's Trust Act, Shield Law, and other data privacy laws.
- **Define authorized and unauthorized uses of ALPR data.** Employing surveillance technologies like ALPRs to investigate low-level, non-violent offenses erodes trust in law enforcement. Lawmakers should limit their use to purposes such as investigating serious felonies, locating missing persons or stolen vehicles, and running ALPR data against hotlists.
- **Establish transparency measures.** In order to track compliance by agencies and vendors, law enforcement agencies should be transparent about how they use ALPRs and ALPR data. Legislative measures should include publicly available privacy and usage policies, analyses of ALPR detections and resulting police activity, and routine audits of how the data is queried and shared.
- **Create mechanisms for accountability.** Connecticut should deter violations of any data privacy laws by creating private rights of action, making evidence inadmissible, and establishing that violators are subject to administrative penalties and criminal prosecution.

CONTACT US

For questions, contact **Charlotte Resing**, Government Affairs Manager, cresing@policingequity.org

POLICY BRIEF: From Blight to Wellbeing: A Pilot to Leverage Federal Funds for Brownfield Remediation and Family Health in CT

Authors: Suzi Ruhl, JD, MPH; Child Study Center, Yale School of Medicine; Yale School of Public Health;
Tania de Jesús Espinosa, RN, MSN; Yale Graduate School of Arts and Sciences; Yale School of Nursing;
Emily Goines, RN, BSN; Yale School of Public Health;
YSPH EHS 544 Students
Corresponding Authors: Tania de Jesús Espinosa, RN, MSN tania.dejesusespinosa@yale.edu
Committee Audience: Primary Legislative Committee- Environment
Re: Follow-up legislation to CTGA Bills HB 5297 and HB 5101 filed in 2025.

Executive Summary

Connecticut has a unique opportunity to maximize the return on investment for environmental cleanups, linking them directly to family health outcomes. **We urge the Environment Committee to support follow-up legislation to CTGA 2025 bills, HB 5297 and HB 5101.**

The initiative leverages $7 million in 2025 federal brownfields funding by pairing remediation with a health monitoring pilot. Specifically, we request the legislature:

1. **Authorizes a "Brownfields to Healthfields" Pilot:** Completes and scales the "Mount Growmore" Triple Bottom Line Justice (TBLJ) model to revitalize contaminated sites into health assets.
2. **Mandates ROI Tracking:** Directs the Department of Public Health (DPH) and the Departments of Energy and Environmental Protection (DEEP) to co-develop a TBLJ ICD-10 Z Code Prototype using existing medical billing codes (ICD-10 Z Codes) to track pollution-related health trends and unlock federal health reimbursements.

(1) Research and Methodology

The legislative proposal is grounded in two primary research areas: the **Brownfields to Healthfields (B2H)** framework and the **ICD-10 Z Code** classification system.

A. The Framework: Brownfields to Healthfields (B2H)

B2H approach achieves "Triple Bottom Line Justice" (TBLJ): Environment, Health, and Economy.

- **The Problem:** Vulnerable populations often live near "brownfields" (contaminated sites), bearing a disproportionate burden of pollution, poverty, disease, and violence.
- **The Synergistic Solution:** B2H connects siloed government programs. Instead of just cleaning contaminated soil (environment), the B2H model engages the healthcare sector to improve resident resilience (health) and creates sustainable land use (economy).

B. The Data Tool: ICD-10 Z Codes

To measure and amplify the success of B2H, this initiative utilizes the International Classification of Diseases, 10th Revision (ICD-10) Z Codes. These are medical billing codes that document social and environmental determinants of health. Identifying a core data set of Z Codes allows the state to:

- **Track Exposures:** Public health officials can track separate environmental drivers of disease in real-time.
- **Foster Health and Environmental Communication:** Patients can engage health providers about environmental exposures and health care, advancing prevention and resilience
- **Specific Examples:** Research identifies at least 46 unique codes for environmental conditions, including:
    - **Z58.6:** Inadequate Drinking-Water Supply
    - **Z77.110:** Contact with and (suspected) exposure to air pollution

    - **Z77.112:** Contact with and (suspected) exposure to soil pollution
- **Reimbursement & Workforce:** These codes are essential for billing and allow non-physician providers (like community health workers) to document environmental risks during patient encounters.

(2) The Economic Opportunity

Connecticut currently has an untapped opportunity to increase healthcare capacity by leveraging federal brownfields funding.

- **The Multiplier Effect:** By using Z Codes to link health delivery with environmental cleanup, the state creates a "funding multiplier." Remediation funds prepare the land, while health reimbursement funds (via Z Codes) sustain the community wellness programs.
- **Rural Application:** This data-driven approach is critical for rural towns that lack the resources to monitor environmental stressors. Z Codes provide the "geocodable data" necessary for rural leaders to apply for grants and policy support.

(3) Case Study: The "Mount Growmore" Model

The research concept has been validated by the **Mount Growmore Hydroponic Farm, Wellness Campus, and Learning Center** in Bridgeport, CT.

- **Background:** For 30 years, the community suffered from "Mount Trashmore," an abandoned waste dump that degraded local health and safety.
- **Intervention:** A coalition involving East End NRZ Market and Café, East End NRZ, Yale Child Study Center, DEEP, City of Bridgeport, and US EPA remediated the site.
- **Outcome:** The site is transitioning into a wellness campus that addresses critical community needs, including food insecurity, healthcare accessibility, and violence prevention.
- **Community Engagement:** The project successfully piloted the use of Z Codes as an engagement tool, producing a "doorhanger" guide to help residents communicate housing conditions to doctors.

Mount Growmore serves as the **Proof of Concept** for this legislation. It demonstrates that transforming blighted land into health-focused spaces yields measurable, cross-sector benefits.

(4) Policy Recommendations

To institutionalize these research findings, we recommend:

- **Foster Cross-Department Collaboration:** Allocate funding for a pilot project involving the East End NRZ Market and Café and Yale Child Study Center that replicates the Mount Growmore B2H model, transforming sites of neglect into dynamic spaces of resilience.
- **Institutionalize Tracking:** Activate DPH and DEEP to develop a prototype ICD-10 monitoring system. This will provide the data needed to track the relationship between environmental cleanup and family health and wellbeing.

References

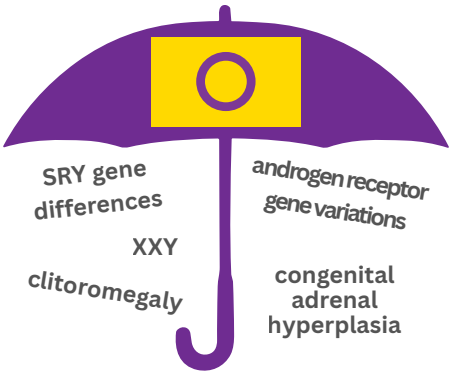
1. Brownfields to Healthfields for Family Mental Health, Yale Child Study Center, Elevate Policy Lab, https://law.yale.edu/sites/default/files/area/clinic/document/1._factsheet.pdf
2. Environmental Law Institute. (2023, August 30). *Mount Trashmore to Mount Growmore: Transforming a Brownfield into a Healthfield. Vibrant Environment Blog.* https://www.eli.org/vibrant-environment-blog/mount-trashmore-mount-growmore
3. U.S. Environmental Protection Agency. (2023). *Brownfields and Land Revitalization Program: Healthfields Success Stories.* Washington, DC: EPA.
4. Stefan Wheat *et al*, Coding for climate: sourcing better climate-health data from medical billing 2023 *Environ. Res.: Health* **1** 021008 (2023) https://iopscience.iop.org/article/10.1088/2752-5309/acc887

Policy Brief

Ending Nonconsensual Surgeries on People with Intersex Conditions

By: Beth Clifton, MD and Meredithe McNamara, MD MSc

Defining Intersex



Intersex is an identity that describes people with a variety of natural differences in sex traits or reproductive anatomy that may be congenital or may develop during childhood. These variations can involve genitalia, hormones, internal organs, or chromosomal differences. **Intersex traits do not conform to standard definitions of male or female bodies, and they represent a normal part of human biological diversity.**[1]

About 1.7% of people are born with intersex conditions.[2] Comparatively, about 2% of people in the world have green eyes,[3] and 1-2% have red hair.[4]

Disfiguring the Intersex Body

In the 1960s, doctors began performing surgeries to "correct" ambiguous genitalia, including but not limited to[5]:

- clitoroplasty—surgical modification of the clitoris so that it appears more typical under binary norms of "female" anatomy
- vaginoplasty—surgical intervention to create, enlarge, or open a vaginal canal so the genitals conform to typical expectations of "female" anatomy
- removal of gonads

These surgeries inflict actual harm[6]:

- infertility and sterilization (including the need for lifelong hormone replacement treatment)
- chronic pain and scarring
- inaccurate sex/gender assignment
- loss of bodily autonomy
- loss of sexual sensation and function
- mental health conditions
- surgical complications

Positions of leading medical societies:

- UN considers these surgeries human rights violations[7]
- interACT, a globally recognized group advocating for people with intersex identities, opposes such surgeries

    - “Some kids may grow up and want to change their bodies, or be glad that their bodies were changed. Many other kids and adults live with incredible pain and trauma because these choices were made for them. When we act early, we never know who will feel which way. Waiting is the best way to avoid irreversible harm.”[1]
- WHO: “Intersex persons, in particular, have been subjected to cosmetic and other non-medically necessary surgery in infancy, leading to sterility, without informed consent of either the person in question or their parents or guardians.”[8]
- AAP: Surgical interventions should be postponed until child is old enough to provide informed assent[9]
- ACOG, AAFP, and AMA offer similar positions[6, 10, 11]

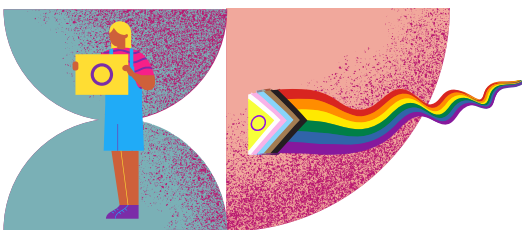
Policy Climate in the US and Abroad

- No US laws or policies protect children and youth with intersex conditions from non-consesnual surgery.
- Exemptions in state bans on healthcare for transgender adolescents permit such surgeries exist.[12]
- In 2019, European Parliament passed a resolution calling on all member states to end surgeries, however no laws pausing nonconsensual surgeries have been established.[13]
- Bills to prohibit infant intersex surgery have been introduced in 5 US states. None have passed.
    - In March 2021, members of the Rhode Island State House of Representatives introduced H6171, designed to protect intersex youth from such surgeries, however it died in committee.[14]

Recommendations

- Connecticut should amend existing nondiscrimination statutes to recognize the multidimensionality of biological sex and to protect the bodily autonomy of those with intersex conditions
- Further, we should adopt policy adjusting current insurance reimbursement to discourage such surgeries and protect those who have been harmed by them
    - Stopping insurance coverage for such procedures
    - Mandating insurance coverage for sequelae of such procedures (i.e. lifelong hormone replacement)

Biological sex and gender identity are different and highly nuanced. Policy that works for everyone takes this into account.



References

1. interACT. What is intersex? Frequently Asked Questions and Intersex Definitions. Interact Advocates. Updated November 5, 2025. https://interactadvocates.org/faq/
2. Fausto-Sterling A. Sexing the Body: Gender Politics and the Construction of Sexuality. New York, NY: Basic Books; 2000.
3. American Academy of Ophthalmology. Eye Color: Unique as a Fingerprint. 2017 Dec 5.
4. Cunningham AL, Jones CP, Ansell J, Barry JD. Red for danger? The effects of red hair in surgical practice. *BMJ*. 2010;341:c6931. doi:10.1136/bmj.c6931
5. Human Rights Watch. *“I Want to Be Like Nature Made Me”: Medically Unnecessary Surgeries on Intersex Children in the US*. Human Rights Watch; July 25, 2017.
6. American Academy of Family Physicians. Genital Surgeries in Intersex Children. AAFP policy.
7. Méndez JE. *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. United Nations Human Rights Council; 2013. Published February 1, 2013. Report No. A/HRC/22/53.
8. World Health Organization; Office of the High Commissioner for Human Rights; UN Women; UNAIDS; UNDP; UNFPA; UNICEF. *Eliminating forced, coercive and otherwise involuntary sterilization: An interagency statement*. Geneva: World Health Organization; 2014.
9. American Academy of Pediatrics. Explaining Disorders of Sex Development & Intersexuality. HealthyChildren.org. Updated November 21, 2015.
10. American College of Obstetricians and Gynecologists. Health care for transgender and gender diverse individuals. ACOG Committee Opinion No. 823. *Obstet Gynecol*. 2021;137:e75–e88.
11. American Medical Association. Report of the Board of Trustees: B of T Report 7-I-16 — Supporting Autonomy for Patients with Differences of Sex Development (DSD). Chicago, IL: American Medical Association; 2016.
12. Mar SA, Earp BD, Indig G, et al. US Laws Restricting Medical Care for Transgender Minors: Statutory Inconsistencies Involving Intersex and Other Individuals. JAMA Health Forum. 2025;6(11):e-4157. doi:10.1001/jamahealthforum.2025.4157
13. European Parliament. Motion for a resolution B-8-2019/0101: Resolution on the rights of intersex people. European Parliament; 2019.
14. Rhode Island H 6171. Protection of Children — Physical Sex Characteristics Surgery Act. 2021.

UCONN | UNIVERSITY OF CONNECTICUT

Require Alcohol and Cancer Warning Messages in Connecticut Package Stores

Zexin "Marsha" Ma, PhD, Assistant Professor of Communication (zexin.ma@uconn.edu)
Jacob A. Rohde, PhD, MPH, Assistant Professor of Allied Health Sciences (jacob.rohde@uconn.edu)

Drinking alcohol causes cancer

Alcohol consumption is the third leading cause of preventable cancer in the U.S. and accounts for nearly 100,000 cancer cases and 20,000 cancer-related deaths each year.[1] In 2022**,** Connecticut ranked 11th highest in the U.S. in all alcohol-associated cancer diagnoses, with 6,511 cases being reported by the state.[2] Despite this burden, alcohol consumption in Connecticut is higher than the national average and the state is regularly ranked in the top 10 for drinking.[3]

Warning messages about alcohol and cancer are effective

Only one-third of U.S. adults know that drinking alcohol causes cancer.[1] In 2025 the U.S. Office of the Surgeon General issued an advisory recommending action be taken to increase public awareness about this risk.[1] In August 2025, Alaska began requiring alcohol beverage retailers to display a sign stating, "Alcohol use can cause cancer, including breast and colon cancer" (Figure 1).[4] This initiative aligns with current public sentiment toward the topic, as approximately half of U.S. adults support implementing stronger alcohol control policies.[5] Moreover, evidence suggests that exposure to alcohol and cancer warnings can reduce alcohol purchase intentions, increase knowledge, and improve risk perceptions about the cancer risk associated with drinking.[6-8]

Figure 1. Warning required in Alaska retail stores.

Policy recommendation

Connecticut should require cancer warning messages to be displayed in all package stores licensed to sell alcoholic beverages. Ours and others' work has tested strategies to most effectively communicate the alcohol-cancer risk to the public.[6, 9, 10] These communication strategies include:

- Use of strong causal language
- Inclusion of a simple graphic (e.g., warning sign)
- Reference to either specific or multiple cancers

Based on these strategies, we provide an example warning message (Figure 2) that we recommend be displayed in Connecticut package stores at point-of-sale.

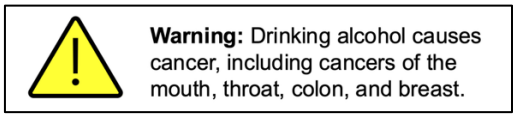


Figure 2. Example point-of-sale warning for Connecticut package stores.

Public health implications for Connecticut adults

Connecticut adults disproportionally experience high rates of preventable, alcohol-associated cancers. Connecticut has an opportunity to be a leader in public health by requiring state package stores to display alcohol and cancer warnings. This initiative is an effective, evidence-based strategy that can save lives and reduce the overall cancer burden in the state.

References:

1. U.S. Office of the Surgeon General. Alcohol and cancer risk. 2025.
2. U.S. Centers for Disease Control and Prevention. Cancer Statistics Data Visualizations Tool. 2022.
3. Center for Prevention Evaluation and Statistics (CPES). Connecticut epidemiological profile: Alcohol. 2022.
4. Alaska Beacon. Alaska becomes first state to require warnings about alcohol link to colon, breast cancers. 2025.
5. Grummon et al. Support for alcohol control policies among US alcohol consumers. *JAMA Network Open*. 2025;8(10):e2535337.
6. Correia et al. Effect of alcohol health warning labels on knowledge related to the ill effects of alcohol on cancer risk and their public perceptions in 14 European countries: An online survey experiment. *Lancet Pub Health*. 2024;9(7):e470–e480.
7. Zuckermann et al. The effects of alcohol container labels on consumption behaviour, knowledge, and support for labelling: A systematic review. *Lancet Pub Health*. 2024;9(7):e481–e494.
8. Ma et al.. Designing cancer warning labels for alcoholic beverages: Examining the impact of visual elements. *Health Educ Behav*. 2023;50(5):586–594.
9. Payne et al. Warning label messages about the cancer risk associated with alcohol: Effects of causal language. *Addict Behav*. 2025;170.
10. Grummon et al. New alcohol warnings outperform the current US warning in a national survey experiment. *J studies on alcohol and drugs*. 2025:jsad. 25–00226.

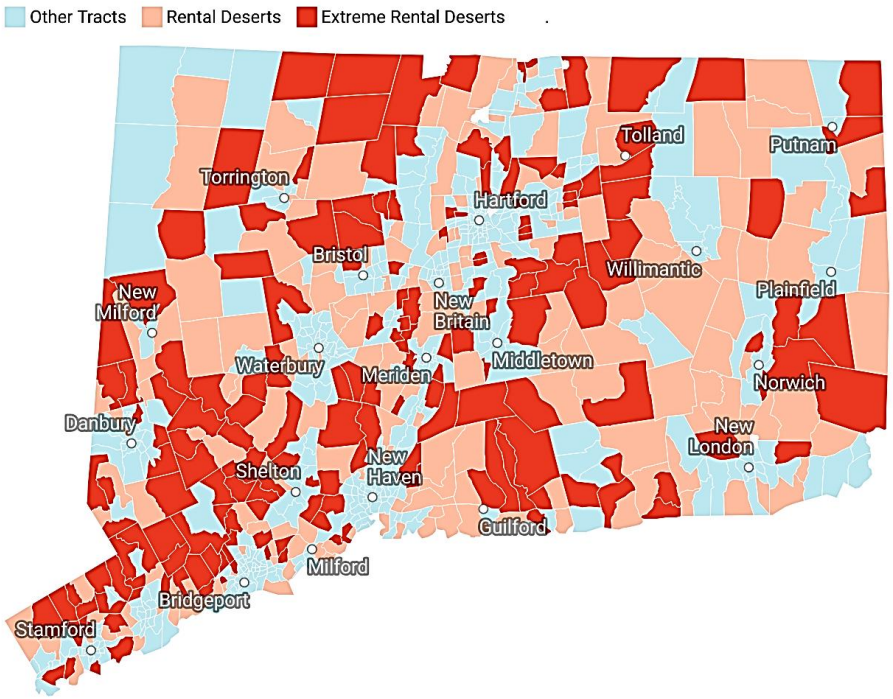
PARTNERSHIP FOR STRONG COMMUNITIES

The Prevalence of Rental Deserts in Connecticut and The Impact on Housing Choice.

Samaila Adelaiye, PhD.

Across Connecticut, renters face significant limits on where they can find housing. This challenge is particularly acute for lower-income households, young people, and seniors seeking to downsize. Their ability to live in communities of their choice or remain in communities that best serve them is constrained by the simple fact that many towns across the state have little to no rental housing. In other words, households looking to rent have limited neighborhood options.

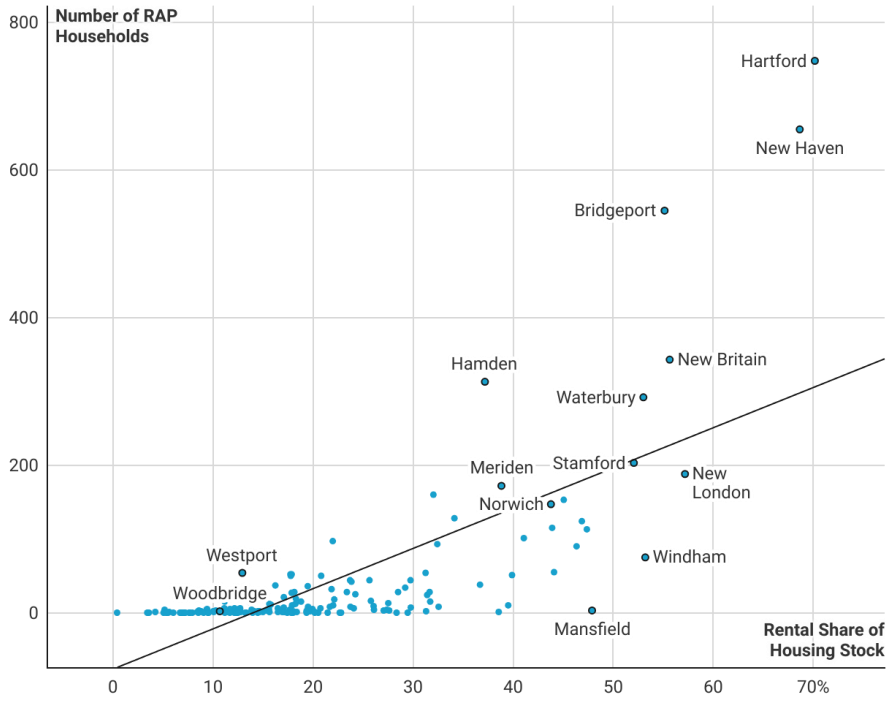
Although about 33% of Connecticut's housing stock consists of rental units, rental housing accounts for less than 20% of the housing in 61% of the state's 169 towns and less than 10% in 30 towns.



Source: American Community Survey 5-year estimates, 2023.

Rental deserts are widespread in Connecticut. A neighborhood is considered a rental desert when less than 20% of its housing stock consists of rental units, and when rental housing makes up less than 10%, it is classified as an extreme rental desert. **Rental options are very limited in these areas, with 40% of Connecticut's census tracts falling into rental deserts and about 20% into extreme rental deserts.** Even in towns with more rental housing, this often means that rental units are concentrated in certain neighborhoods while absent from others.

Rent-assisted households are less likely to live in areas with limited rental housing. The number of rental housing units available in a town is directly related to the number of voucher holders. Towns where rental housing makes up a larger share of the housing stock tend to have more Connecticut Rental Assistance Program (RAP) vouchers. RAP vouchers are portable statewide; the lack of rental housing in many towns undermines the program's effectiveness in increasing choice of community for recipients. **Almost a quarter of Connecticut's towns do not host any RAP-assisted families**. Towns with a scarcity of rental housing tend to have fewer RAP-assisted households.



Created with Datawrapper

Source: Connecticut's Department of Housing and J. D'Amelia & Associates LLC, and American Community Survey 5-year estimates, 2023

Five CT Classification	Percent Rental Desert	Percent Extreme Rental Deserts	RAP Vouchers Per 1000 Renter HH
Rural	56.8%%	21.6%%	6.66
Suburban	72.1%%	41.1%%	6.36
Urban core	2.4%%	0.0%%	19.06
Urban periphery	31.4%%	13.7%%	13.93
Wealthy	67.3%%	40.8%%	7.57

Created with Datawrapper

Source: Connecticut's Department of Housing and J. D'Amelia & Associates LLC, and American Community Survey 5-year estimates, 2023

Rental deserts are concentrated in suburban, rural, and wealthy towns, where the share of RAP-assisted households is also very low. There is a shortage of rental housing in Connecticut, and most neighborhoods where rental housing is scarce reflect this pattern. In suburban areas, only about 6.4 out of every 1,000 renters use RAP vouchers, as 72% of all neighborhoods in suburban towns are rental deserts, and 41% are extreme rental deserts. By contrast, in the urban core, 19.1 out of every 100 renters use RAP vouchers, and only 2.4% of neighborhoods are rental deserts, with none being extreme. **Even when a family receives a voucher and wants to move to the suburbs, their choices are minimal because rental deserts are so prevalent**.

Exclusionary zoning and policy bias have shaped these patterns. Restrictive zoning regulations, combined with a historical policy preference for homeownership, have limited the development of multifamily and rental housing. This, in turn, reinforces racial and economic segregation. **Consequently, it is no surprise that most rental deserts are located in areas where fewer than 10% of housing units are classified as affordable under Connecticut's Affordable Housing Appeals Act (8-30g).** In fact, about 63% of all census tracts in these towns are rental deserts, compared to just 16% in towns that meet the affordability threshold.

Policy recommendations

- Strengthen the Affordable Housing Appeals Act to ensure its effectiveness.
- Increase investment in the creation and preservation of more affordable homes.
- Upzone more neighborhoods to allow for higher lot density, increasing rental housing options.
- Invest in public housing authorities to develop more rental homes in more communities.

Read a full version of the report here.

Moving Beyond Implications 2026 conference

Brief: **Nursing Home, Hospice Agency, and Healthcare Policy Influences on Hospice Care for Individuals with Nursing Home Stays Near the End-Of-Life**

Julie Robison, PhD	Professor	UConn Center on Aging	jrobison@uchc.edu
Ellis Dillon, PhD	Associate Professor	UConn Center on Aging	edillon@uchc.edu
Chae Man Lee, PhD	Healthcare Data Analyst	UConn Center on Aging	chlee@uchc.edu
Doreek Charles, MSW	Clinical Research Associate 2	UConn Center on Aging	dcharles@uchc.edu
Wenqi Gan, PhD	Associate Professor	Dept. of Public Health Sciences, UConn Health	wgan@uchc.edu
Germine Soliman, MD	Assistant Professor	UConn Center on Aging	soliman@uchc.edu

Corresponding Author: Julie Robison, PhD

Primary Legislative Committee: Public Health
Secondary Legislative Committee: Aging

Research Question:
Why is hospice underutilized in Connecticut nursing homes, given the high prevalence of nursing home stays at the end of life?

How this research affects Connecticut:
Our research team has identified numerous barriers to providing hospice care in nursing home settings, including multiple policy disincentives at both the state and federal level. In response to requests from CT OPM and DPH, we have presented our study results to both state agencies. DPH is currently revising hospice regulations, making this a critical time to consider potential state legislative responses as well. According to OPM, the Governor's office has expressed interest in addressing CT citizen concerns about access to hospice for nursing home residents.

State of knowledge:
Hospice care enhances care quality and quality of life and is especially underutilized in Connecticut. Connecticut has the 7th oldest population in the nation with almost 20,000 people living in nursing homes (NHs), 71% with care paid by Medicaid. Underutilization of hospice care in NHs, despite overall growth in hospice care, is a significant concern. Compared to people receiving hospice in the community, nursing home residents are much more likely to be enrolled in hospice for a week or less. Given the high prevalence of NH stays in the last 90 days of life, NHs are an important site for influencing end-of-life care quality and experience. Yet NHs vary dramatically in their organizational structure, populations served, and quality of care provided, which may impact hospice use and end-of-life care.

This mixed methods study asked what influences the use of hospice care in Connecticut NHs. We analyzed Connecticut Medicaid, Medicare, Minimum Data Set, and NH characteristics data; and thematically analyzed 14 in-depth interviews with hospice and NH professionals in

Connecticut about experiences with and beliefs about hospice care in NHs. The cohort included 39,633 Medicaid-insured decedents with serious illnesses in Connecticut from 2017-2023. Overall, 24,512 (61.9%) individuals had NH stays and 18,428 (46.5%) received hospice care ≤ 6 months of death, 7,265 (39.4%) with short hospice length of stay (≤ 7 days). Individuals with NH stays (versus without) had higher rates of hospice use (49.0% versus 42.4%). However, in multivariable analysis long-term NH stays were associated with *reduced* odds of hospice use. Among those with NH stays, the odds of receiving hospice care were higher for individuals with stays at NHs that were part of a chain, had an Alzheimer's unit, and had lower CMS quality ratings.

Our thematic analysis of interviews with NH and hospice professionals found multi-level intersecting influences of the individual and family, NH, hospice, NH-hospice collaboration, healthcare policy, medical culture, and societal culture. Interviews revealed barriers to hospice use including the focus on rehabilitation, policy disincentives, NH workflows/priorities, and staffing. Facilitators include acute care use triggering hospice discussions, hospice benefiting NH patients and staff, and leveraging care planning meetings for hospice education and discussions.

Policy influences included Medicare rules about short-term rehab and hospice ("If they go on hospice, they would have to pay full price for their stay,") Medicare's specific eligibility criteria ("Medicare is very, very, very specific on the criteria for each disease process, what they're qualifying under. Especially Alzheimer's."), Medicare requirement that people receiving hospice stop other curative treatments/tests/etc., problems with Medicaid hospice room & board pass through payments, and the overall burden of regulations in NHs leading to a focus on compliance rather than quality of life. The culture of medicine, focused on cures and "treatment", and wider societal reluctance to discuss death and dying, had ripple effects across multiple levels.

Overall, Connecticut Medicaid individuals with NH stays had lower odds of receiving hospice care, and certain NH characteristics, workflows, education, and policies influenced the likelihood of receiving hospice care and could be mechanisms for policy and practice change. Promising areas for enhancing hospice and EOL care in NHs include expanding and improving goals-of-care conversations, NH processes for earlier discussion/identification of hospice-eligible individuals, enhancing education and training for NH staff on hospice and EOL care, and techniques for enhancing hospice-NH-family communication. Given the influence of Medicare policies, it may be warranted to revisit and question certain policies, e.g. why Medicare pays for short-term NH stays for someone receiving rehabilitation, but not hospice care, and to what extent this is leading to an increase in rehab and a decrease in hospice care.

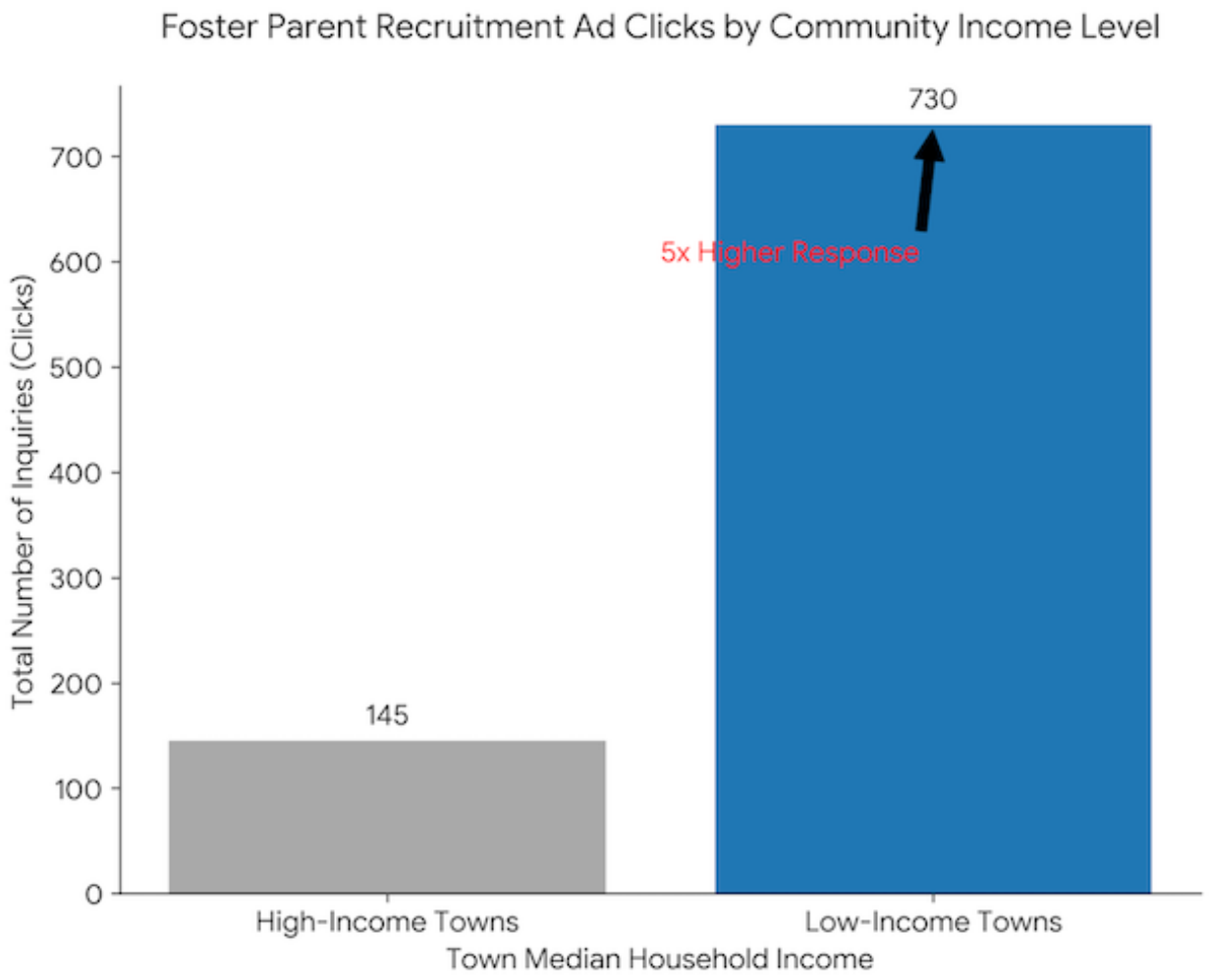
Key policy takeaways or levers:

- Some CT nursing homes do not contract with any hospice agencies; their residents would have to transfer to enroll in hospice. Coud a State law require CT NHs to contract with hospice agencies?
- CMS quality measures do not include any end-of-life indicators. Could CT's State NH quality initiative include a measure of hospice use and quality end-of-life care?
- Should DPH hospice regulations broaden education requirements about end-of-life care in NHs?
- Numerous Federal policies create financial disincentives for NHs to work with hospice agencies. How can CT lawmakers support efforts to reform Federal policies?

Title: Solving Connecticut's Foster Parent Shortage: A Data-Driven Approach to Recruitment

Authors: Subroto Roy, Ph.D. *Professor of Marketing, University of New Haven Former Visiting Scholar, Yale University Founder, StartFosterCare.org*
Jayanti Roy, Ph.D. *Professor of Psychology, Goodwin University*

Executive Summary: The Hidden Efficiency Gap Connecticut faces a persistent shortage of foster parents, a crisis that destabilizes vulnerable children and strains the Department of Children and Families (DCF) budget. Despite significant investment in recruitment, the gap between supply and demand remains.



New research conducted in Connecticut reveals a critical inefficiency: current recruitment efforts may be targeting the wrong populations with the wrong assumptions. Our data shows that residents in lower-income communities are **500% more likely** to inquire about fostering than those in affluent areas, yet recruitment dollars often fail to prioritize these high-response geographies. Furthermore, the long-held "taboo" against mentioning financial support (stipends) is unfounded; discussing support does not deter qualified candidates.

Key Findings: Geography Predicts Interest, Stipends Do Not In a 207-day study of digital recruitment behavior across Connecticut, we analyzed the anonymous search and click patterns of prospective foster parents. Two distinct findings emerged:

1. **The "Stipend" Myth is Busted:** There was no statistical difference in interest between recruitment ads that explicitly mentioned the financial "stipend" and those that did not. The fear that discussing money attracts "wrong" candidates is not supported by data.
2. **The 500% Opportunity:** Geography was the single strongest predictor of interest. Residents in towns below the median household income were **5 times more likely** to click on a foster parent recruitment ad than residents in towns above the median income.

Policy Recommendations: A Call to Action To close the foster parent gap, Connecticut policymakers must pivot from broad "awareness" campaigns to targeted, data-driven acquisition.

1. **Mandate a Recruitment Audit:** The legislature should require an audit of all DCF and contracted-agency recruitment spending to map *where* marketing dollars are currently being spent versus *where* the inquiries are actually coming from.
2. **Fund a "High-Response" Pilot Program:** Re-allocate a portion of the existing recruitment budget to fund a pilot program that specifically targets high-response communities using digital precision marketing. This pilot should be executed by data specialists to ensure optimized ROI.

Conclusion We cannot solve a 2026 problem with 1990s recruitment strategies. By aligning state resources with the actual behavioral data of Connecticut residents, we can increase the number of stable foster homes while ensuring taxpayer dollars are spent with maximum efficiency.

About the Research This brief is based on the study *"Does money motivate prospective foster parents?"* published in *Child Abuse Review* (2024). The study utilized Google Search advertising data to track the real-time, anonymous behavior of thousands of Connecticut residents to determine true drivers of interest in foster parenting.

Contact: Dr. Subroto Roy sroy@newhaven.edu | www.StartFosterCare.org