



**Maternal and Child Health Services  
Title V Block Grant**

**State Narrative for  
New Hampshire**

**Application for 2013  
Annual Report for 2011**



Document Generation Date: Monday, September 24, 2012

# Table of Contents

I. General Requirements .....	4
A. Letter of Transmittal.....	4
B. Face Sheet .....	4
C. Assurances and Certifications.....	4
D. Table of Contents .....	4
E. Public Input.....	4
II. Needs Assessment.....	8
C. Needs Assessment Summary .....	8
III. State Overview .....	12
A. Overview.....	12
B. Agency Capacity.....	25
C. Organizational Structure.....	35
D. Other MCH Capacity .....	39
E. State Agency Coordination.....	44
F. Health Systems Capacity Indicators .....	51
IV. Priorities, Performance and Program Activities .....	59
A. Background and Overview .....	59
B. State Priorities .....	60
C. National Performance Measures.....	64
Performance Measure 01:.....	64
Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated .....	68
Performance Measure 02:.....	69
Performance Measure 03:.....	73
Performance Measure 04:.....	76
Performance Measure 05:.....	80
Performance Measure 06:.....	83
Performance Measure 07:.....	87
Performance Measure 08:.....	89
Performance Measure 09:.....	92
Performance Measure 10:.....	95
Performance Measure 11:.....	99
Performance Measure 12:.....	101
Performance Measure 13:.....	105
Performance Measure 14:.....	108
Performance Measure 15:.....	111
Performance Measure 16:.....	113
Performance Measure 17:.....	117
Performance Measure 18:.....	119
D. State Performance Measures.....	122
State Performance Measure 1: .....	122
State Performance Measure 2: .....	125
State Performance Measure 3: .....	128
State Performance Measure 4: .....	131
State Performance Measure 5: .....	133
State Performance Measure 6: .....	137
State Performance Measure 7: .....	140
State Performance Measure 8: .....	143
State Performance Measure 9: .....	147
State Performance Measure 10: .....	150
E. Health Status Indicators .....	153
F. Other Program Activities .....	163
G. Technical Assistance .....	165

V. Budget Narrative .....	169
Form 3, State MCH Funding Profile .....	169
Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds.....	169
Form 5, State Title V Program Budget and Expenditures by Types of Services (II) .....	170
A. Expenditures.....	170
B. Budget .....	174
VI. Reporting Forms-General Information .....	181
VII. Performance and Outcome Measure Detail Sheets .....	181
VIII. Glossary .....	181
IX. Technical Note .....	181
X. Appendices and State Supporting documents.....	181
A. Needs Assessment.....	181
B. All Reporting Forms.....	181
C. Organizational Charts and All Other State Supporting Documents .....	181
D. Annual Report Data.....	181

## **I. General Requirements**

### **A. Letter of Transmittal**

The Letter of Transmittal is to be provided as an attachment to this section.

***An attachment is included in this section. IA - Letter of Transmittal***

### **B. Face Sheet**

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

### **C. Assurances and Certifications**

Assurances and certifications are maintained on file in the New Hampshire Title V program's central office at:

Maternal and Child Health Section  
NH DHHS  
29 Hazen Drive  
Concord, NH 03301

Assurances and certifications are available on request by contacting the New Hampshire Maternal and Child Health Section, Division of Public Health Services, Department of Health and Human Services at the above address, or by phone at 603-271-4517, by email at [dlcampbell@dhhs.state.nh.us](mailto:dlcampbell@dhhs.state.nh.us), or via the NH MCH website at: <http://www.dhhs.state.nh.us/DHHS/BMCH/CONTACT+INFO/default.htm>

### **D. Table of Contents**

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

### **E. Public Input**

In order to validate the work of the Title V professionals in the state agency and in the field, it is imperative to have family and community input into priority setting and program evaluation. Public Input for the Title V 2010 Needs Assessment and 2011 Annual Report were combined and in mid-2009, the Title V developed and administered an on-line (Survey Monkey) and paper survey to collect public input on the health needs of NH families. A link to the on-line version was placed on the DHHS website and distributed electronically to statewide contacts of Title V staff, including Title V-funded health care agencies, other state agencies, committees, advisory groups, task forces and others. A total of 689 people returned the paper surveys and 299 people responded to the Survey Monkey version.

The paper survey was distributed to Title V-funded health care agencies and to the ten DHHS District Offices (welfare offices) statewide that provide TANF, Medicaid, food stamps and other services to low-income clients. Paper surveys, aimed at clients of services and families, were available in Spanish and Portuguese. Clients were asked to complete the surveys and office staff returned them to MCH. The demographic results suggest that by providing both electronic and paper surveys, we succeeded in reaching two different populations, a population of advocates, providers and professionals and a population of clients, families and consumers of Title V services.

On the electronic survey (299 responses): the average age of the respondent was 46; 96% were white; 70% had children under 21; 48% were not employed; 4% had no insurance; 3% had Medicaid; and 82% had employment-based health insurance.

On the paper survey (689 responses): the average age of the respondent was 35; 90% were white; 58% had children under 21; 7% were not employed; 25% had no insurance; 15% had Medicaid; and 26% had employment-based health insurance.

The following were the needs and priorities identified by survey respondents. There were not overall significant differences between groups.

1. Access to health insurance
2. Alcohol and other drug use/misuse
3. Overweight and obesity in youth
4. Access to dental health services
5. Access to mental health services
6. Access to specialty health care
7. Tobacco use in youth and pregnant women
8. Autism
9. Teen suicide
10. Adequate respite care/Asthma (tie)

It is interesting to note, that although it affected a smaller number of families (those with CSHCN) access to adequate respite care was always a paramount concern for those who needed it most.

Surveys provided ample opportunity for narrative comments. Responses that were repeatedly reported included:

- "Insurance for low income moms. Dental for adults"
- "Loss of health care when a child turns 19. There is a huge population of uninsured 19-23 year olds."
- "Teen Depression." "Teen Pregnancy." "Teen Suicide"
- "Disability services for disabled children & ADHD specialists"
- "More awareness of special programs for young moms"
- "Nutrition"

In order to gather more public input, a Town Hall-style meeting was held in November 2009 to help in the prioritization process for the 2010 Needs Assessment. Participants at this meeting included staff from other state agencies, nonprofit organizations, including March of Dimes, New Hampshire Endowment for Health, NH Family Voices, community health centers, health care providers and others. At this meeting, Tricia Tilley, Title V Director, Liz Collins CSHCN Director, and David Laflamme, MCH Epidemiologist, also presented data on identified needs in the three Title V population subgroups, and information from the public input surveys. Participants were asked to rank their top five priorities using a "Pennies for Priorities" method. Each participant received fifteen pennies and a list of the preliminary priorities and was asked to rank their top five priorities. Fifteen baskets, each labeled with a priority area, were placed in the front of the auditorium. Participants were instructed to place 5 pennies in the basket labeled with their highest priority, four in the basket of their next highest priority, three for their third, two for their fourth and one penny for their lowest priority. An extra basket collected participants' written lists of up to three emerging issues that they were aware of in their work.

After the public input from professionals, advocates and families, there was no clear cut ranking across 10 priorities. But what did emerge was the fact that what still matters most to advocates and families is access to:

- Health Insurance
- Mental Health Care
- Substance Abuse/Alcohol Treatment

- Dental Care for Adults and Medicaid Clients
- Respite For Those Who Need It

In addition to public input regarding the Title V system as a whole, input was also gathered about particular systems, including early childhood services and services for children with special health care needs. In 2009, MCH modified a Zero to Three, the National Center for Infants, Toddlers, and Families survey that assessed early childhood health, strong families, positive early learning experiences, and collaboration and system building. In November 2009, SMS, utilized the Champions for Inclusive Communities survey to assess the organization and accessibility of NH's community-based service systems so that family's can easily use them. Each of these information-gathering sessions informed priority setting and directed future planning. /2012/As it relates to services for CSHCN a population specific Needs Assessment was completed for the families of children and youth with Epilepsy. This NA captured feedback on the families'/youth's access to specialty care, Medical Home experiences, and adequacy of coordination of care. This included 3 focus groups one of which targeted families whose first language was not English and translators were available. It also included a statewide survey of families. The response was strong and families responded from every county in the state. Families whose first language was not English completed the survey with the assistance of translators. //2012//

Title V plans to continue to utilize surveys and research the utility of social media of gathering public input, for specific interest areas or population groups in Title V as well as the Title V program as a whole, for future Annual Reports.

/2012/

New Hampshire places a high value on community and family participation and public comment in planning and priority setting. In an effort to increase access to New Hampshire's plans, the MCH Block Grant and Needs Assessment is available on the NH DHHS website on the MCH webpage <http://www.dhhs.nh.gov/dphs/bchs/mch/> for viewers and families to review and provide feedback.

Title V has continued to reach out directly to professionals, advocates and families through an annual electronic survey to gather input on our priorities. The five-minute survey is distributed to statewide contacts of Title V staff, including Title V-funded health care agencies, other state agencies, committees, family advocacy groups, advisory groups, task forces among others and all are invited to forward the survey along to their respective partners, friends, families and contacts so that it becomes "viral". This has been a successful strategy for New Hampshire and within a matter of days, Title V receives very specific input from around the state from traditional and non-traditional partners and families.

In June 2011, Title V partners simultaneously distributed this survey and within a matter of days over 200 public input surveys from health care professionals, state agency directors, school nurses, and families, were completed. Similar to years past, respondents noted the following as the things that they most needed to keep their family healthy:

- Health insurance that doesn't cost too much
- High quality doctors and nurses
- Dentists you can afford
- Mental health doctors and counselors you can afford
- Trained care for children with special health care needs

Although statistically almost undistinguishable, the highest scoring priorities for the state and for Title V were:

- Affordable healthcare
- Ensuring children have health insurance
- Affordable mental health services

- High quality mental health services
- High quality services for children with special healthcare needs -
- Addressing the needs of overweight children

More than 60 detailed, narrative comments were also provided urging Title V to address priorities as varied as the impact of state budget reductions in safety net services, substance abuse treatment and prevention, diabetes education, Katie Beckett and in home supports for children with special health care needs, environmental health, among others.

As a whole, these suggestions and comments help confirm the direction of New Hampshire's Title V current priorities. Next year, New Hampshire intends to revise the survey instrument based on feedback on the survey itself and to better reflect current priorities. Plans are being developed to use additional forms of social media such as Twitter to further spread the tool while capturing a different audience. While New Hampshire embraces electronic and social media as a way to easily and quickly elicit and analyze diverse opinions from around the state, we acknowledge that we may be missing some of the most disenfranchised voices. In an effort towards continuous quality improvement, additional strategies will be considered such as those used for the five-year needs assessment to ensure that a wide net is cast and that the input continues to help shape future policy and priorities.

//2012//

/2013/

Due to the consistency of responses over the last 2 years, Title V did not repeat the survey instrument from last year. The plan is to revise the tool for administration in 2013. There were a variety of other Title V initiatives that reflect a statewide approach to elicit public input on services and needs. The first effort of note was the Stakeholder heavy process used for strategic planning for SMS. Stakeholders invited to participate included representatives from all MCH programs (& on the leadership group), other DHHS agencies, community services providers, families, health care providers, parent professionals. There was also a series of focus groups related to the system of care for children and youth with epilepsy targeting individuals most likely to be experiencing access issues. A focus group was held in Northern NH, in Manchester NH with families whose primary language was not english and a focus group for young adults. SMS also initiated a new comprehensive Survey of families receiving services for CSHCN. SMS received 1358 returned surveys offering input on Satisfaction (87% rated satisfaction as good/excellent), Unmet Health Care Needs, Impact to Families and Unmet Social Service Needs. These results will be used to address service design and quality improvement efforts.

//2013

***An attachment is included in this section. IE - Public Input***

## II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

### C. Needs Assessment Summary

New Hampshire's 2010 needs assessment process was based on MCHB guidance and best practices. Criteria used to choose top priorities were based on public health principles and included the magnitude of the need; disproportionate effects among population subgroups; problems resulting in significant economic costs; cross-cutting problems that have life span effects; and the feasibility of NH's Title V program to impact the problem. Assessment of Title V capacity was conducted using a modified version of CAST-5.

#### Public Input

Utilizing an on-line and paper survey, input on priority needs was obtained from nearly 1,000 individuals, families, advocates and health care providers. The survey was also available in Spanish and Portuguese and was completed by clients in the state-funded health care agencies and DHHS district offices, enabling the acquisition of input from an often difficult to reach population.

#### Priority needs

Determining Title V priorities is a complex process that requires weighing multiple factors, including known data, capacity and service gaps, state priorities, and emerging issues. The importance of cultural competence in local and state MCH programs and the need to create supports and enhance services for minority populations seamlessly within the state service system is recognized as a focus for NH's Title V program. Similarly, recognition of the social determinants of health -- poverty, education, and availability of affordable housing, for example -- are seen as guiding themes that are interwoven throughout all priorities and activities. Priorities have been developed that are purposefully broad and systems-focused, and likely to respond to evidence-based interventions.

From extensive research of current state data and an internal and external capacity review, combined with public input, ten priorities emerged that adequately described the needs of the Title V population subgroups of women, infants, families and children with and without special healthcare needs.

***//2013/ NH continued to assess and review its priorities throughout the year. In order to keep each of the ten Title V Priorities top of mind and to facilitate communication across programs individual priority areas were assigned as special topics to regular standing MCH meetings. Priority leaders invited partners to join Title V managers to share updates and ongoing strategies for each priority. These rolling meetings have been invaluable in keeping our work current and responsive to the changing environment***

***Title V has worked collaboratively on assessing needs, particularly those of families and providers. SMS brought together over 70 stakeholders to create a new mission and strategic plan. //2013//***

1. To improve access to children's mental health services

Public input and data suggest significant mental health needs in children and adolescents and a lack of mental health services and skilled professionals in the State. Suicide is the 2nd leading

cause of injury-related death among NH adolescents, and NH's teen suicide rate exceeds the U.S. average. Mental health safety net systems are overtaxed, with long waiting lists.

/2012/ Improving access to children's mental health services remains critically important. Families through the MCH public input process are continuing to identify this issue as one of the highest needs for our state. While NH faces significant budget reductions for community mental health services and additional reductions for primary care services, it is imperative that Title V focus on building partnerships, identifying resources and understanding the data regarding access to care. //2012//

#### 2. To decrease pediatric overweight and obesity

Obesity is an increasing problem in NH. Available data reveal that over 29% of NH 10-17 year olds were overweight or obese in 2007 (34% of CSHCN), and the numbers are increasing. Disproportionate obesity rates are observed in those with low socioeconomic status.

/2012/ In the 2009 New Hampshire Healthy Smiles - Healthy Growth survey of third graders, 33% were overweight or obese. The Survey also showed regional differences in childhood obesity: 3rd grade students in the Belknap-Merrimack region (24%) and Coos County (22%) had the highest prevalence of obesity and nearly 46% of 3rd grade boys in Coos County were overweight or obese. Because of these trends, Title V is partnering with childcare professionals to work with young families to increase positive healthy behaviors and help professionals create new food and physical activity policies. //2012//

#### 3. To decrease the use and abuse of alcohol, tobacco and other substances among youth, pregnant women and families

New Hampshire's rates of tobacco, alcohol and other substance use and abuse among youth and women are higher than the US rates. Substance abuse treatment capacity continues to be a problem in NH. Smoking during pregnancy can result in low-birth weight infants, pre-term deliveries and infant deaths. Smoking rates are higher among young pregnant women and among those on Medicaid.

/2012/ Use and abuse of tobacco, alcohol and other substances is a marker for a myriad of health concerns from prematurity to increased risk of victimization from sexual violence. Approximately one-half of the cases of sexual violence involve alcohol consumption by the perpetrator, victim, or both. Twenty-seven percent of young adults, 18-25 report binge drinking (2010 BRFSS). MCH has piloted innovative strategies using social media to reach this population. //2012//

#### 4. To improve the availability of adequate insurance and access to health care and maintain the infrastructure of safety net providers/services

The percent of uninsured NH adults in 2009 was the highest in the Northeast and is increasing. Adults who live in rural areas, are young, low income, or members of racial and ethnic minority groups suffer disproportionately. Rising unemployment and reductions to state programs create the potential for decreasing access to care and worsening health indicators among women and children, including CYSHCN.

/2012/ Access to high quality healthcare and affordable health insurance continues to be among the highest concerns reflected in the public input to the MCH Block Grant and Needs Assessment process. The consequences of legislative changes to New Hampshire's Medicaid program for FY12 and 13 are unknown. Significant budget reductions to the state's community health centers will also impact each community. Early indicators are that CHCs are cutting services such as access to clinical and behavioral health services. MCH will continue to monitor health indicators

among women and children, including CYSHCN for trends.//2012//

5.To improve access to standardized developmental screening for young children

Nationally, less than 50% of children with a developmental delay are identified before starting school, impacting readiness to learn. NH has a fragmented system for screening that is ripe for improvement.

/2012/

Title V continued to support the expansion of Watch Me Grow, a comprehensive screening and referral system for NH families of children aged birth to six years. This work is done in tandem with the NH Council on Autism Spectrum Disorders as established by the state legislature to improve services and supports. A new website was created to provide a single point of entry to a comprehensive body of information about NH services and the best practice guidelines [www.nhcouncilonasd.org](http://www.nhcouncilonasd.org)//2012//

6.To decrease unintentional injury, particularly those resulting from falls and motor vehicle crashes, among children and adolescents

Unintentional injuries rank as the leading cause of death for children and adolescents in NH and nationally, killing more in this age group than all diseases combined. Many of these deaths are preventable.

/2012/ Among NH injury deaths for those 0-44, 73% are unintentional, 25% result from violence and the remaining 2% are either undetermined or the result of legal intervention, compared to 68% unintentional, 29% from violence and 3% undetermined/legal intervention for the US. Violent deaths are far more often suicides than homicides. While nationally, there are 1.9 suicides for each homicide; in NH the ratio is 7.4.//2012//

7.To reduce exposure to lead hazards, asthma triggers and other environmental hazards to assure safe and healthy home environments

Asthma is the most prevalent chronic condition among children and a leading cause of ED visits for children. Young children are also vulnerable to the effects of lead poisoning. Children with lower SES have poorer outcomes for asthma and are at increased risk for lead poisoning.

8. To improve oral health and access to dental care

Dental care access is a problem in NH, specifically for the poor, under and uninsured. Approximately 44% of NH 3rd grade students experienced tooth decay. Tooth decay was higher and the prevalence of dental sealants was significantly lower in several rural NH counties.

9. To increase family support and access to trained respite and childcare providers

The National Survey of CSHCN and NH state data indicate a lack of adequate respite and childcare services available to this population, including the need for workforce development. A statewide effort is needed to provide support for workforce development to serve CSHCN.

/2012/ A survey of caregivers related to respite needs has been initiated by SMS and the Lifespan Respite Coalitions //2012//

10. To decrease the incidence of preterm birth

Younger mothers and those with Medicaid as a payer source have increased rates of smoking while pregnant and are at increased risk of premature birth. These findings point to potential intervention areas, such as anti-smoking efforts.

//2012/ NH is continuing to focus on perinatal smoking cessation among low income women as a way to impact prematurity. In 2009, almost 33% of births with Medicaid as a payor had a mother who reported smoking while pregnant, as compared to 6% for other payers.//2012//

### III. State Overview

#### A. Overview

**GEOGRAPHY:** New Hampshire shares boundaries with Canada to the north, Maine and the Atlantic Ocean to the east, Vermont to the west and Massachusetts to the south. New Hampshire is one of the 3 northern New England states, which along with Maine and Vermont, are more rural than the southern tier: Massachusetts, Connecticut and Rhode Island. According to the State definition of rural, approximately 37% of the population and 84% of the landmass in New Hampshire is considered rural. The majority of New Hampshire towns are considered non-urban or rural, with urban and near urban areas located in the south east and south central regions and primarily rural areas in the western, central and northern sections. The three most urban areas are Manchester, Nashua and Concord, all located in the State's southern tier.

New Hampshire's scenic rivers, mountain ranges, lakes and agricultural lands define the state's culture and geography but also create boundaries and barriers to the resources that improve health. Many New Hampshire residents depend on family and friends to get to and from food shopping, work and community events. Access to oral, mental, primary, specialty and/or reproductive health care can be a significant challenge, whether it's a few blocks or several hours away. The White Mountain National Forest separates the northernmost rural section of the state, which consists of Coos County. Coos County, known as the North Country, has the largest landmass of any county but the smallest population.

**DEMOGRAPHICS:** New Hampshire has a growing population, estimated at 1,324,575 in 2009, representing a 7% increase since the 2000 census. (1) The population growth rate has slowed over the past two years. (2) While the state's population is still 93.1% white (not-Hispanic), minority populations are steadily increasing. The State's largest racial minority is Asian, representing 1.9% of the population, followed by Black/African American at 1.2%. Hispanics (of all races) make up 2.6% of the population. Most minority populations live in the southern tier of the state. As might be expected based on the differing racial and ethnic proportions in younger age groups, births in NH are also becoming more ethnically and racially diverse. In 2008 and in 2009, over 17% of resident births were to parents where at least one reported a race/ethnicity other than non-Hispanic white, compared to only 7.6% of births in 1998. (3) ***//2013/ On July 1, 2011, the U.S. Census Bureau estimated that there were 1,318,194 residents in New Hampshire. The population change from 2010 to 2011 was 1,387, the third year in a row that net population gain for New Hampshire was minimal -- a sign that the state's population growth has stalled. Economists are attributing the decline to domestic out-migration-residents moving out of the state. Census data reflect that the state's five most southeastern, more urban counties are currently experiencing growth, while the more rural northern counties are experiencing decline or stagnation. //2013//***

Although New Hampshire's population is slowly growing, it is also aging. Over 25% of the population is 55 years of age or older. An analysis of the percentage change in population by age group concluded that the 55-74 year old segment of the population will be proportionally larger in New Hampshire than the rest of the nation in 2010. An increase in the overall aging of the population is a trend that influences needs in our communities. Women represent half of the population of the State, and women of childbearing age make up nearly 39% of the total female population and nearly 20% of the total New Hampshire population. The fertility rate in New Hampshire has remained steady, even as the national rate has increased. In 2009, there were 13,683 births in New Hampshire. But there has been a shift in the state as to where those babies are born and this has impacted community services. For a hospital, a low frequency of births makes it both economically unfeasible and limits the quality of services to operate a separate unit with specialized staff and equipment. Due to declining births, two hospitals closed maternity units within the past two years (Weeks Medical Center in Lancaster in 2008, Huggins Hospital in Wolfeboro in 2009). This followed the closing of maternity units by three community hospitals that had occurred between 2002 and 2005 (New London Hospital in 2002, Upper Connecticut

Valley Hospital in Colebrook in 2003, and Franklin Regional Hospital in 2005). Currently, there is only one hospital in Coos County (the state's largest county in geographic size) with a maternity unit.

**POLITICAL ENVIRONMENT:** New Hampshire operates under a unique Governor & Council (G&C) form of government. Five Executive Councilors, each representing 1/5 of the population, are elected separately from the Governor, though for the same two-year term. The Councilors participate in the active management of the business of the state. Together, the G&C has the authority and responsibility over the administration of the affairs of the state as defined in the New Hampshire Constitution, its' statutes and the advisory opinions of the New Hampshire Supreme Court and the Attorney General. All state departments and agencies must seek approval of both receipt and expenditures of state and federal funds, budgetary transfers within the department and all contracts with a value of \$10,000 or more. New Hampshire also has the third largest legislative body in the English-speaking world, consisting of 24 senators and 400 representatives. The structure and size of New Hampshire's executive and legislative branches, respectively, ensure that citizens are well represented in matters of the state. NH's "citizen legislature", so called because each legislator is paid a sum of \$100 annually, is historically rooted in a philosophy of limited government and protection of personal privacy.

In January 2005, democratic Governor John Lynch took office, with a platform dedicated to making progress on the issues important to NH families -- education, health care costs, the environment, and employment.

As with many states, New Hampshire is experiencing significant budget challenges as a result of the national economic recession. The DHHS Commissioner, Nicholas Toumpas and Director of DPHS, Dr. Jose Montero, are leading efforts for increased efficiencies in this resource challenged environment. The biennium budgeting process has brought continued fiscal challenges to both the State and DHHS, as New Hampshire strives to achieve balance with the burden of providing services to an aging population in a downward spiraling economy. Almost two thirds of New Hampshire appropriations were for education (including public K-12 and the university system) and health and human services. Public policy debate about changes in the state employee retirement system, the state's Medicaid county-based long term care services for the elderly, and state education funding inevitably have involved conversations about the 'shifting financial burden of public services' from general state taxation to the local property tax. (4)

Budget deficits have been attributed to increasing caseloads in Medicaid, TANF and other human services and decreasing revenues in business and real estate taxes. Trends in Medicaid caseloads far exceeded budget projections and indicate a \$1.1 million shortfall for the elderly and \$6.7 million for non-elderly payments including hospital inpatient and outpatient services, provider payments and pharmacy. In March 2010, there was a 10.1% year over year increase in the number of Medicaid enrollees. Rates have been reduced to providers and controls have been proposed on Medicaid codes for Title V services such as home visiting and child and family health supports.

Similar trends have been seen in TANF. Caseloads have exceeded projections in the State Budget causing deficits. Year to date in SFY2010, there has been a 21% increase in TANF recipients. At this rate, the budget can expect a \$2.4 Million shortfall for cash assistance for families.

In addition to increased caseloads, state revenues have been significantly lower than expected. Without a general sales tax or a personal income tax, New Hampshire's tax revenues rely primarily on two forms of business taxes, the Business Profits Tax and the Business Enterprise Tax. The next highest sources of revenue are the Meals and Rooms Tax and Liquor Sales and Distribution. Currently, all of these revenue sources are below budgeted expectations.

The impacts of the state budget crisis are felt throughout the system. State employees were laid

off in October 2009. MCH was impacted by hiring freezes for currently vacant positions (Adolescent Health Coordinator and Prenatal Coordinator) and the Childhood Lead Poisoning Prevention Program (CLPPP) lost state general funding for two environmental lead specialists, as well as funding for its compliance project manager. This reduction of three staff members, along with two federally funded vacancies challenged the CLPPP to re-allot the resources necessary to meet goals and objectives. Adding to these difficult changes was the discontinuation of funding for blood lead testing and paint and dust sampling analyses by New Hampshire's Public Health Laboratory (PHL), also due to budget reductions in October 2009.

As previously described, Medicaid rates to providers have been reduced and additional controls for cost savings are being explored. Additionally, programs like Home Visiting New Hampshire, that have historically used innovative, collaborative approaches for funding are in jeopardy of ending due to the increased pressure from programs like Medicaid and TANF to focus on their core mission and thus, discontinue support for these joint ventures.

Looking forward, there are no easy answers to reconcile the revenue and expenditure disconnect in New Hampshire. It is clear that social services and health care will continue to be costly to the state General Fund. While perhaps moving the population towards more healthy lifestyles and preventive care in the long run, the federal Patient Protection and Affordable Care Act will have unknown financial impacts to the state in the next five years. Although the federal government will pay for increased Medicaid payments for fee-for-service and for primary care services provided by primary care doctors for 2013 and 2014 the full fiscal impact of expanding Medicaid eligibility is unclear.

/2012/

In 2011, New Hampshire experienced political changes similar to many states in the nation. Both legislative bodies saw significant turnover in the past election and the new majority party of incoming representatives and senators is committed to a leaner, more fiscally conservative state budget with a more limited role of state government.

Concurrently, the NH Center for Public Policy, among others, have described NH as having a long-term structural budget deficit in the sense that for the scope of desired programs and current revenue system (no broad based sales or income tax), expenditures grow automatically faster than revenues. (36) The current pattern among elected officials is to reconcile the revenue and expenditure disconnect by further expenditure reductions.

Further impacting the state budget and the political environment, NH continues to feel the effect of the national recession which began in late 2007. Although it may have officially ended, enrollment in state supported systems of care has not begun to recede to pre-recession levels. Dependence on state and federal programs continues to place significant fiscal burdens on the state budget. The good news is that the growth in unduplicated individuals receiving services has slowed. In SFY10, the year over year growth rate was 11.3%; the first eight months of SFY11 has seen the growth rate moderate to 5.6%. Medicaid enrollment, specifically experienced a 8.9% growth rate in SFY10 and now has a more moderate growth rate 2.8 % for the first eight months of SFY11. In fact, caseloads slightly decreased in January and March 2011.

//2012//

**SOCIO-ECONOMIC ENVIRONMENT:** New Hampshire has an overall median household income significantly above the national average: \$68,175 compared to \$51,233 nationally. (U.S. Census Bureau, 2007-2008 two-year average). (5) By this estimate, New Hampshire's median household income was the highest in the nation during this period. New Hampshire's 2008 per capita personal income was \$3,400 above the national average of \$40,208 and ranked eleventh highest among the states. In 2007, per capita income varied widely by county, from a low of \$31,179 in northernmost Coos County to a high of \$47,196 in Rockingham County, bordering Massachusetts. (6)

Although, New Hampshire is fortunate to boast a high median income, it belies the fact that many families are struggling. Statewide averages often mask differences among subpopulations in the state. The structure of New Hampshire's economy has changed in recent years, from one in which a variety of well paying jobs were available, to a "boutique economy" in which good paying jobs are available only to those with high educational levels and skills. The wage disparity has increased between the lowest wage earners and the highest, and the lowest wages have remained stagnant or fallen while the highest have increased, even in a weak economy. Jobs that pay a livable wage are declining, making it more difficult for some families to meet basic needs. (7)

Many occupations and industries have experienced declines in employment during the economic downturn that began in December 2007. New Hampshire's seasonally adjusted unemployment rate eventually hit 7.2 % in September 2009. (8)

The current recession period continues to have a negative impact on the housing market. Housing values have continued to decline. New residential building permits are at historically low levels and the number of foreclosures is at a historically high level. (9) The median gross rent rose for all unit types including utilities from \$946 in 2007 to \$969 per month in 2008. While rents continued to rise, so did vacancies. New Hampshire's vacancies increased from 4% in 2008 to 5.3 % in 2009. The state's vacancy rate had not exceeded 5% since 1993, during the last recession in New Hampshire. Often an increase in vacancy rates can be attributed to renters moving towards home ownership. Instead, current economic conditions are likely contributing to the recent rise in vacancy rates and increase in insecure housing arrangements for many New Hampshire families. (10)

***//2013/ While New Hampshire's poverty rate is markedly lower than that for the entire country, it is still substantially higher than it was several ago, reflecting ongoing difficulties in bouncing back from the recession. But when applying an even longer lens, new Census data reveals that New Hampshire's socio-economic landscape has remained fairly consistent over the past three decades, at least in terms of our oldest and youngest residents. No county in the 1980 or 2010 Census registered poverty rates among the young or old over 20 percent. The good news is that poverty among seniors has significantly decreased, however poverty among children continues to rise. //2013//***

Homelessness greatly impacts the health and well being of children and youth. Compared to children with homes, homeless children are more likely to have health problems, developmental delays, mental health problems such as anxiety and depression, behavioral problems and lower academic achievement. As much as 12% of the homeless population is estimated to consist of youth between the ages of 16 and 24 years old who are not living in families. Homelessness creates enormous negative health and social costs for young people. These youth have high poverty rates and are often runaways or throwaways who have experienced physical and/or sexual abuse, childhood homelessness, parental substance abuse, foster care and/or juvenile detention. It is estimated that 25% of foster children have experienced homelessness within 2 to 4 years of leaving foster care. Homeless youth have an increased risk of physical and sexual abuse on the streets and in adult homeless shelters, with sexual assault rates of homeless youth estimated at 15 to 20 percent and physical assault at 50%. Obtaining accurate data on homelessness is challenging; these data often undercount the true population. A one-day count of the homeless in New Hampshire in 2009 found 3,328 single adults; 788 adults in 670 families; and 840 children living in shelters. (11) Other homeless families in New Hampshire often live in seasonal rentals, moving several times per year between campgrounds in the summer and motels and apartments in the winter. Children in these settings are often forced to leave school in the spring when they must leave a winter rental before the school year ends, disrupting their education and social networks.

Certain demographic and geographic subpopulations in the state experience much higher poverty rates and these disparities have increased over the past decade. Rural residents in New

Hampshire experience poverty disproportionately. Gender also is associated with economic inequality. Nearly 22% of New Hampshire families headed by a woman with no husband present had incomes below the poverty level compared to 5.6% of family households overall. (12) This percentage has increased since 2000, when 17.6% of female householder families lived below the poverty level. (13) In 2003, an estimated 19.4% of New Hampshire family households were headed by a woman with no husband present. A higher percentage of women overall (8.4%) live below 100% of poverty compared to men (6.8%).

Children and adolescents are disproportionately affected by poverty, with 9.3% of New Hampshire residents under age 18 living below 100% of the federal poverty level in the previous 12 months, compared to 7.0% of individuals aged 18 to 64 years old and 7.7% of residents aged 65 and older. (14) Poverty and uninsurance among those in late adolescence (18-24 years) is also significantly higher than among other age groups: 16% of youth ages 18-24 (16,000 youth) live in poverty (15) and 30% of adolescents ages 18-24 lack health insurance. (16)

**HEALTH CARE ENROLLMENT:** New Hampshire is often considered one of the healthiest states in the nation and has one of the highest percentages of residents with health insurance. (17) New Hampshire compares favorably to other states on many indicators of health, ranking among the top five healthiest states between 1995 and 2004. (18,19) Rankings are based on a combination of indicators, including health outcomes, community, environment and health policies.

New Hampshire's strengths include consistently comparing favorably among other states regarding teen birth rates, rates of children under age 18 in poverty, rates of children ages 19-35 months who are fully immunized, infant mortality rates, among others. But statewide averages mask differences among subpopulations in the state. Closer analysis of New Hampshire data reveals statistically significant differences in health behaviors and outcomes, poverty, access to health care and other health and socioeconomic indicators by race, age group and region.

To achieve many of the positive health outcomes, and perhaps also the cause of many of the challenges, an intense amount of private resources and a significant amount of public funds has been invested in health care. Increases in health care costs have been far larger than increases in wages over the last decade. There has also been an increase in the number of uninsured persons, putting an extra burden on the current health care system resulting from uncompensated care. (20) The financial burden is important to consider as health status among all populations.

**Medicaid & SCHIP:** Healthy Kids Gold (HKG), Medicaid, provides coverage for infants up to 300% of federal poverty level (FPL) and children age 1-18, up to 185% of FPL. Children ages 1 - 18 at 185-400% FPL qualify for Healthy Kids Silver (HKS) with premiums based on income. Effective September 2009, the New Hampshire Healthy Kids program was authorized to expand coverage to young adults ages 19 to 26 years who cannot be included in their family's health insurance plan, and whose incomes are at or below 400% of FPL. Due to budget considerations, and uncertainties of federal health reform, no effective date has been set to implement this expansion.

Pregnant teens to age 19 are eligible for Healthy Kids Gold (<185% FPL) or Silver (186-300% FPL). Pregnant women age 19 and over with incomes up to 185% of FPL are eligible for HKG. Medicaid has been growing as the payer for an increasing number of births in the state. In 2003, Medicaid was the payment source for 20.3% of all births in the state. By 2009, that number has grown to 31%. Of women obtaining prenatal care in MCH-supported community health centers, 68% received Medicaid and 12.8% were self-pay, or uninsured, in 2009. These women are eligible for enhanced prenatal services including social services, nutrition, care coordination and client education provided during a home or clinic visit.

New Hampshire Medicaid has a "Katie-Beckett"-like eligibility pathway called Home Care for

Children with Severe Disabilities (HC-CSD). This allows children up to the age of 19 to qualify for Medicaid based on their need for institutional level of care and solely considers the income and resources of the applicant. Currently there are approximately 1750 --1800 children that are covered by Medicaid through this eligibility.

The State's Children's Health Insurance Program (CHIP) provides health coverage for uninsured children in families with incomes too high to qualify for Medicaid but too low to afford private insurance. New Hampshire's SCHIP is a unique partnership between the NH DHHS and the New Hampshire Healthy Kids Corporation (NHHK). NHHK administers CHIP health insurance programs, outreach and coordination. Enrollment in SCHIP has decreased since 2008, while enrollment in Medicaid, or Healthy Kids Gold has increased. It is assumed that this is directly related to statewide economic indicators.

/2012/

New Hampshire's total budget for SFY10 was \$5.47 Billion (state, federal, and other funds combined). Of this amount, \$1.42 Billion, or 25.9% of all state expenditures, was accounted for by Medicaid (second only to Education at 26.9% of state spending). As rising unemployment, falling income, and decreased availability of job-based insurance left more people uninsured, increasing numbers of people have turned to Medicaid for health care coverage. However, even with a significant drop in the unemployment rate in SFY10, Medicaid enrollment has continued to increase at the rate of 4.6% during the year. In SFY10, Medicaid provided health care for 132,476 members on average, per month serving 165,609 unduplicated persons over the course of the year. Low income children represent 58% of the members, but only 22% of the program's expenditures.(38)

New Hampshire Healthy Kids (NHHK) administers the state's Children's Health Insurance Program, also known as Healthy Kids Silver. Healthy Kids Silver provides subsidized health insurance to approximately 8,600 children with family incomes between 185 and 300 percent of the federal poverty level (FPL). Enrollees are provided care by Harvard Pilgrim Health Care HMO. NHHK also administers a health insurance buy-in program for approximately 875 children with family incomes between 300 and 400 percent of FPL by providing them with non-subsidized, lower-priced insurance premiums. Buy-in program enrollees pay full premiums and have the same network and benefits as Healthy Kids Silver enrollees.

Current budget proposals by the legislature and Governor all require administrative and policy changes for NHHK. The Governor originally proposed to convert Healthy Kids Silver enrollees into Medicaid members and transition the entire program into the existing Medicaid fee-for-service system as of July 1, 2011. Under the House and Senate budgets, Healthy Kids Silver enrollees will still be converted into Medicaid members, but will be transitioned into a new Medicaid Managed Care program, with a target implementation date of July 1, 2012. Children with incomes between 185 and 300 percent of FPL would continue to receive health insurance coverage and continue paying the same monthly premiums, but their care will be managed by a managed care vendor yet to be selected. The buy-in program for children with incomes 300-400 percent of FPL will be discontinued. Additionally, coverage will be discontinued for children who participate in NHHK through the buy-in program because they are legal residents but do not yet meet the 5 year residency requirement for Medicaid. Lisa Bujno, Bureau Chief of the Bureau of Population Health and Community Services, where MCH resides, will represent the Division of Public Health Services in the workgroup crafting these strategies. //2012//

/2013/

***TRANSITIONING TO MEDICAID MANAGED CARE: Nearly every state in the United States currently uses Managed Care Payment Plans in Medicaid Programs except for Wyoming, Alaska and New Hampshire. New Hampshire followed suit when Senate Bill 147 passed in 2011, legislated that NH DHHS "shall employ a managed care model for administering the Medicaid program and its enrollees...for all Medicaid populations throughout New Hampshire..." by July 2012. There are several challenges to this mandate: the legislation***

***required an aggressive timeline for implementation, including contract negotiations; few states have experience putting all populations in capitated plans; and a number of significant waivers must be obtained from CMS before roll out can begin.***

***Under a care management approach, New Hampshire's Medicaid program will provide services through companies that will be paid a set rate for members. Three managed care organizations, Boston Medical Center Health Net, Centene, and Meridian Health Plan, have negotiated contracts with NH DHHS to serve the entire Medicaid population of New Hampshire in all areas of the state.***

***In the first step of the program, anyone currently enrolled in New Hampshire's Medicaid and Children's Health Insurance Programs as well as newly qualified individuals will be enrolled in the Care Management Program for their medical services. In the second step, long term care services, including specialty services and community based care, will become part of the program. Step 2 is expected to begin one year after the first step.***

***NH DHHS will conduct a series of forums in the summer of 2012 to discuss care management and Step 1 implementation. The Department will encourage and seek volunteers to participate in Step 2 design. While Step 2 is focused on those with Developmental Disabilities, volunteers representing those from all populations served by Medicaid will be invited and encouraged to provide feedback.***

***The transition of the "Healthy Kids-Silver" program, which is also known as the Children's Health Insurance Program (CHIP), also a result of changes to the NH State law, as described above, will take effect July 1, 2012. Under the changes, "Healthy Kids Silver" and "Healthy Kids Gold" will no longer exist. Both programs will simply be called NH Medicaid. NH Medicaid will cover kids under the age of 19, up to 300 % of the federal poverty level. This means a family of 4 may be eligible for NH Medicaid coverage when the family's total monthly income is at or below \$5,763. NH Medicaid coverage has no copayments for children and the state offering a temporary premium holiday. In addition to no out of pocket expense, with the transition to Medicaid administered by DHHS, children will have coverage for additional services that were not available on "Healthy Kids Silver" coverage.***

***AFFORDABLE CARE ACT: Should the individual mandate of the Affordable Care Act remain intact after the Supreme Court decision in June 2012, New Hampshire policymakers have chosen to enter into the federally run health insurance exchange, in accordance with the federal legislation.***

***New Hampshire passed and Governor Lynch has signed HB 1297 prohibiting the state from planning, creating, or participating in a state-run health care exchange. The bill also establishes guidelines for interaction with a federally facilitated exchange created for New Hampshire. New Hampshire is one of only three states to pass such legislation. //2013//***

Strengthening the Safety Net: In response to the need for care to be available to vulnerable and low-income populations throughout the state, Title V partners with community-based and patient-driven health centers and organizations to serve populations with limited access to health care. These populations include low-income families and individuals, the uninsured, those with limited English proficiency and those experiencing homelessness. Many, but not all, of the MCH-funded health centers have received federal health center designations that define their scope of care and reimbursement structure. Fifteen agencies throughout the state provide perinatal care and enabling services such as case management, nutrition counseling, tobacco cessation interventions, and patient-specific social services. Of these, thirteen are considered primary care agencies, offering the full spectrum of health care services to all ages; the other two are 'categorical' agencies, offering access to reproductive health, prenatal care, and enabling services through various models that meet

their community's needs. Eleven agencies provide contracted reproductive health services through Title X funds; six of these are primary care agencies.

In total, Title V-supported comprehensive primary care programs, including community health center and health care for the homeless programs, served 104,622 men, women and children with 477,086 encounters in 2009. Forty-five percent of those served were 185% below poverty. Twenty-four percent of the total patient population was uninsured and 47% received Medicaid, however insurance status is disproportionate among age groups. Children and pregnant women are more likely to receive public insurance and other adults are more likely to be uninsured.

In 2009, the 15 MCH-supported prenatal agencies served 1758 prenatal clients, approximately 13% of NH's pregnant women. Of pregnant women served by MCH agencies, 68% were enrolled in Medicaid for the pregnancy, 12% were uninsured, 14.2% were between 15 and 19 years of age, and 34.7% were between 20 and 24 years of age. (21) Seventy-six percent of pregnant women receiving care in an MCH-supported agency started care in their first trimester, with agencies ranging in performance from 68% to 85%. Ninety-seven percent received counseling for tobacco cessation, as appropriate, and 89% received screening for substance use. (22)

#### HEALTH STATUS:

Preconception and Perinatal Health: Title V and Title X, together, are examining the way services are delivered and designed to better incorporate preconception care in order to improve the health of women and couples, before conception of a first or subsequent pregnancy. In doing so, MCH aims to improve health outcomes that include improving birth outcomes and subsequently decreasing unintended pregnancies. New Hampshire has begun work towards the development of a model designed around the ten CDC recommendations aimed at achieving the following four goals: 1) improve the knowledge and attitudes and behaviors of men and women related to preconception health; 2) assure that all women of childbearing age receive preconception care services (i.e., evidence-based risk screening, health promotion, and interventions) that will enable them to enter pregnancy in optimal health; 3) reduce risks indicated by a previous adverse pregnancy outcome through interventions during the interconception period, which can prevent or minimize health problems for a mother and her future children; and 4) reduce the disparities in adverse pregnancy outcomes. The work to date has included the research of best practices, interviews with key programmatic partners (e.g. family planning, home visiting, prenatal, WIC); and initial drafting of a logic model.

This integrated approach is of greater importance as an increasing percentage of New Hampshire births (31% in 2009) are paid by Medicaid, (23) placing a strain on an already weakened system. This compares to 13.4% of the general population of 18-64 year olds in New Hampshire who have Medicaid as their health insurance. (24) With a greater reliance on public insurance on publicly funded health care delivery systems, it is important that programs are well coordinated and integrated to promote optimal health outcomes.

Substance use among pregnant and postpartum women is a serious public health problem in New Hampshire. National survey data consistently show that pregnant women report using tobacco, alcohol and other substances. Early exposure to substance abuse impacts children's life use, dependence, abuse, as well as development, mental health, violence, injury, pregnancy, and infection rates. Screening efforts indicate that 29% of NH prenatal clients report drinking prior to pregnancy. (25) This could result in 8-31 babies born with FAS and 23-92 with FASD annually. (26) Every year, an estimated 703 New Hampshire infants (4.6% of all) are exposed to marijuana and 2,903 (19.0%) are exposed to alcohol during the first trimester of pregnancy.(27)

Smoking during pregnancy accounts for 20-30% of low-birth weight babies, up to 14% of pre-term deliveries and about 10% of all infant deaths. (28) In New Hampshire from 2005-2007, 16% of women smoked during pregnancy. (29) In 2007, 21.7% of New Hampshire women of childbearing age reported smoking, compared to 21.2% of women overall in the U.S. (30) These women are at risk for smoking during pregnancy. Title V works in partnership with the New Hampshire

Tobacco Prevention and Control Program to promote evidence based prevention and cessation services for all of those affected by tobacco, especially pregnant women.

Infant Mortality: Nationally and in New Hampshire, the causes of infant mortality, in order of occurrence, are: congenital malformations; disorders related to preterm birth and low birthweight; SIDS/SUIDS; effects from maternal complications from pregnancy; complications of the placenta; cord and membranes; unintentional injuries; respiratory distress; bacterial sepsis; neonatal hemorrhage; and other causes. New Hampshire follows the nation with SIDS being the leading cause of death of infants one month to one year of age. New Hampshire routinely ranks favorably when compared to other states. Although in 2006, mortality data slipped to a rate of 6.1/1000 births and New Hampshire ranked 17th, dropping from 1st in the nation the year before. While these comparisons are compelling, they sometimes fail to highlight the hidden complexity or subtlety of the numbers behind the ranking process. Particular caution should be used when looking at movement year to year in the rate due to the very small numbers of infant deaths in New Hampshire. Many states are clustered together at the top so there is minimal difference between similarly performing states. More importantly, although each death is tragic for each family, fewer than 100 infant deaths occur per 13,500-14,000 births annually in New Hampshire suggesting that it is more important that we look at trends rather than year by year outcomes alone, given New Hampshire's small numbers. Regardless, this shift prompted policymakers to legislate an Infant Mortality Review that will take effect in July 2010.

Newborn Screening: New Hampshire continues to keep pace with the nation in the fast paced world and science of newborn screening. As of July 1, 2010, screening for Tyrosinemia will be added to the New Hampshire mandated screening panel. Our state screening panel now includes 33 disorders. In addition to program changes among screening panels, programs are evolving their fundamental roles. Other New England states are actively exploring how to implement long term follow up (LTFU) programs within their newborn screening programs. LTFU is a quality assurance component within the newborn screening systems. Monitoring includes case follow-up of basic census data to determine whether individuals identified by newborn screening continue in appropriate care, as well as evaluation of selected outcome indicators in order to evaluate the efficacy of the newborn screening system. In this way, LTFU assists the program in evaluating whether or not the newborn screening system is accomplishing its intended goal of improving health outcomes. NH has not yet begun this type of long term follow-up at the state level, but is actively engaged in discussions with state and regional partners to better assess the state's capacity to provide this type of service and its potential outcomes and impact. **/2013/ In the evolving world of Newborn Screening, New Hampshire has moved forward with the passage of a new law requiring all birth facilities and/or providers to perform a pulse oximetry screening for Critical Congenital Heart Disease (CCHD), according to the recommendations of the American Academy of Pediatrics, on every newborn child. Title V and the NH Newborn Screening Advisory will work with community partners to help support and coordinate a population-based approach for this screening. //2013//**

CSHCN: In New Hampshire, 16.6% of children are considered to have special needs (n= 50,365) compared to 13.9% nationally. (2005-2006 National Survey) There are 21.9% of CSHCN children whose daily activities are affected; 12.6% CSHCN miss 11 or more days of school due to illness. Over two-thirds of families of NH SSI CSHCN surveyed reported that they provide health care for their child at home. Ninety percent of these families engaged in over 11 hours of direct care per week. In addition, half of the families of the SSI CSHCN reported having to cut work hours to care for their child even while experiencing financial distress. Though New Hampshire, in general, (consistent with all of Region I) has high rates of insurance for CSHCN, when compared to the rest of Region I, New Hampshire is ranked lowest for the percentage of CSHCN who were insured for the entire previous year. **/2013/ Of note, according to the 2009/2010 NS-CSHCN the population of CSHCN in NH as increased from 16.6% to 19.0% since the 2005/2006 survey.//2013//**

Pediatric Obesity: The problem of pediatric obesity in New Hampshire mirrors the national picture. The number of children and adults in New Hampshire who are overweight has increased over the last several years. Of children enrolled in WIC, the percentage of children ages 2 -- 5 years with a BMI at the overweight level was slightly higher (17.8%) than national (16.5%) and the percent with a BMI indicating obesity was approximately the same (14.4% vs. 14.8%). A NH survey of third graders in 81 NH public schools revealed that one in three students (33%) was above a healthy weight and more boys (21%) than girls (15%) were obese. In a chart review of 1,453 children (in the 6-9 year old and the 10-12 year old age groups) receiving health care in 25 NH primary care practices, 32.8% of the children were overweight or obese. MCH will be working with the state's new Obesity Prevention Program, funded by CDC. The program's goal is to prevent and control obesity and other chronic diseases through healthy eating and physical activity targeting the increase of breastfeeding, physical exercise, and fruit and vegetable consumption, and the decrease of sugar sweetened beverage consumption, energy-dense food, and television viewing.

Teen Births: Teen mothers and their children face poorer educational, health, developmental and economic outcomes than their peers who delay childbearing. Repeat teen births compound these problems. The percentage of teen births that are repeat teen births generally mirrors a state's percentage of teen births. Factors associated with repeat births include Hispanic ethnicity and non-Hispanic Black race.(31) New Hampshire's low proportion of minority populations may account for the low rates of teen births and repeat teen births.

Similar to national rates, New Hampshire's teen birth rate had steadily decreased since 1990, when it was over 30 births/1000 females ages 15-19. In 2003, NH's teen birth rate had declined to 18.1, compared with the US white rate of 27.5 , however an increase to 18.7 percent in 2006 indicates an increasing trend mirroring national data. A decrease in non-marital births occurred across all age groups and was highest among adolescents less than age 20, where 88.1% of births were to single mothers. Three-quarters of New Hampshire's teen births are to 18-19 year olds. In 2005, 11.3% of teen births in New Hampshire were to young women who were already mothers and in 2006 this increased to 13%. ***//2013/ New Hampshire's teen birth rate continues to trend downward. Resources for Teen Pregnancy Prevention such as Abstinence Education and PREP have been coordinated and are tightly focused based on needs assessments. Funds are contracted to communities with high rates and relatively higher numbers of teen births, where resources could potentially make the most difference. These communities include the City of Manchester with a diverse, urban population and Sullivan County, a more remote county dotted with small, declining mill towns and rural areas. Evidence-based programs and vendors have been selected. Programs are now ramping up and working together, with clinical partners in each community towards a spectrum of coordinated Teen Pregnancy Prevention. //2013//***

Youth Injury: Unintentional injuries are the leading cause of death for ages 1-24 in New Hampshire . In the time period of 1999 through 2006, there were 527 deaths in ages 1-24 due to unintentional injuries with a rate of 16.31 deaths per 100,000 people in that age category . Nationally, the rate for the same time period and age range was 20.02 deaths per 100,000 so New Hampshire is significantly below that. The rate of unintentional injury deaths increases by approximately 300% between the ages of 14 and 16 . Thus, adolescents are more likely to die by unintentional injuries than are younger children (even though unintentional injuries are still the leading cause of death for children one and above).

Many of these deaths are preventable. The majority of unintentional injury deaths from age 6 to 24 are due to motor vehicle crashes.

Adolescents are the age group with the highest incidence and rate of motor vehicle related death and injury. Although adolescents hold only 7% of the driver licenses in the state of New Hampshire, their death rate due to motor vehicle crashes is substantially higher than any other age group. The risk of motor vehicle crashes is higher among 16- to 19-year-olds than among

any other age group. In fact, per mile driven, adolescent drivers ages 16 to 19 are four times more likely than older drivers to crash. In New Hampshire, adolescents accounted for 6.5 percent of the population and 17 percent of the total amount of motor vehicle crashes.

It is interesting to note that adolescents had a higher inpatient discharge rate for injuries due to motor vehicle traffic crashes for adolescents 15 to 17, but lower a emergency department visit rate for injuries due to motor vehicle crashes for adolescents 15 to 17, within a five-year period (2001-2005). Adolescents, ages 15-24, have a higher rate of hospitalizations for motor vehicle crashes than any other age group. In general, emergency medical responders attended to more injuries to 16-year-olds due to motor vehicle crashes, than any other adolescent age group (2007 and 2008 data). Males were more likely to be hospitalized, while females were more likely to be seen in the emergency department and discharged (2001-2005).

Most of the crashes occurred on local roads, where speed, inexperience, and drug use were contributing factors. Adolescent drivers, just starting out, have several risk factors working against them. First is their inexperience behind the steering wheel. The second is their greater likelihood of engaging in risky driving behaviors such as speeding, driving under the influence, and following other vehicles too closely. New adolescent drivers tend to overestimate their own driving abilities and underestimate the dangers on the road. In 2001-2006, speed was the number one cause of fatal New Hampshire crashes involving 16 and 17 year olds and the majority happened between 9 p.m. and midnight.

Nationally, falls are the leading cause of unintentional injuries among children 0 to 19. They're also responsible for approximately one-quarter of all childhood unintentional injury costs. In New Hampshire, falls are also the leading cause of unintentional injury emergency department visits and hospitalizations for ages 0 to 24. The falls rate in New Hampshire was approximately 1,000 hospitalizations/100,000 for ages 0 to 17 (2000-2004) and approximately 12,000 emergency department visits/100,000 for ages 0 to 17 (2000-2004).

Nonfatal fall rates nationally are highest among children ages one to four. In New Hampshire, rates for hospitalizations due to falls (2001-2005) were highest in 15 to 17 year olds among the focus age groups. Rates for emergency department visits (2001-2005) were highest in the zero to four and 10 to 14 age groups.

Emergency department visits due to falls from furniture (beds and chairs were the most common) were a significant issue for children 0 to four years of age in New Hampshire, but gave way to slips and trips and falls with sports equipment from age five on (2000-2006). Within the category of sports equipment, falls from playground equipment occurred the most often. Fractures and contusions were the result of most fall related emergency department visits during the same time period (2000-2006).

Oral Health: Improving access to oral health services for vulnerable populations continues to be a high priority for DHHS, but barriers to realizing this goal persist. Data indicate that oral health problems such as dental caries in children and tooth loss in adults are still common in New Hampshire. Effective preventive measures such as water fluoridation and dental sealants are under-utilized; individuals who have lower incomes or less education are substantially more likely to report having dental problems.

Data from the 2009 Healthy Smiles-Healthy Growth Third Grade Survey indicate that statewide the oral health of New Hampshire's children has improved since the first survey conducted in 2001: Caries experience has decreased from 52.0% to 43.6%; untreated decay has decreased from 21.7% to 12.0% and the presence of dental sealants has increased from 45.9% to 60.4%. The 2009 survey also provided the first regional children's oral health data that show marked disparities in oral health by socio-economic status. Children in northern Coos County have significantly higher rates of dental disease and have lower rates of preventive services as their peers in other regions.

Community water fluoridation has long been regarded as the most cost-effective method of preventing dental decay. In addition, it benefits all residents without regard to socioeconomic status. In New Hampshire, only ten communities fluoridate their water. Just one of these municipalities is located in Coos County, while Grafton and Carroll Counties have no fluoridated communities. Since the State's largest city, Manchester, fluoridated its water supply in 1999, it is estimated that approximately 43% of New Hampshire residents have access to fluoridated community water systems.

Title V works in collaboration with the New Hampshire DHHS, DPHS New Hampshire Oral Health Program. Through the Preventive Health and Health Services (PHHS) Block Grant, the DHHS funds school-based preventive programs and community dental centers, some in community health centers or mobile clinics. In 2009, 21 school-based preventive dental programs served 20,262 students in 181 (59%) of New Hampshire schools. Community-based oral health programs provide services using a traditional dental practice model in 14 dental centers across the state. In 2009, 17,104 residents received oral health care through publicly funded dental centers and community-based oral health programs.

Five school-based preventive dental programs serve some of the schools in Coos, Carroll and Grafton counties, and Rochester, New Hampshire, while all public schools are served in Manchester. In the northern regions of the state, where many disparities exist, many schools still do not have sealant programs, largely due to lack of funding. Finding dentists to treat children identified as needing treatment is difficult in these same regions because there are fewer dentists, a limited number that take Medicaid children, and even fewer that take uninsured children.

Mental Health: Access to mental health services continues to be a gap in New Hampshire's strained health care infrastructure. While community mental health centers are available, in some regions they are increasingly unable to meet the demand for services. All centers have waiting lists at some point during each year. In some cases, fees are beyond the reach of low-income families. A primary issue is workforce recruitment and retention for mental health care providers, especially those specializing in care for children particularly young children. One small piece of the solution is the need for increased coordination and integration of behavioral health services. Recognizing this, MCH developed a funding strategy that supports community health centers on a tiered system based upon the level to which they integrate behavioral health services. In an ideal, fully integrated system, mental health and primary care providers would share the same sites, the same vision and the same systems in a seamless web of services. Providers and patients would have the same expectations for treatment and all would have access to the same level of care regardless of income or insurance status. However, few organizations have completely achieved that level of integration. Title V and State General Funds have provided funding within each community to move away from fragmented services towards a vision of family centered care, enhanced communication, and aligned systems among providers and patients across the lifespan. Additionally, for CSHCN SMS has leveraged funds to secure psychology and psychiatry consultation for SMS enrollees.

Healthy Housing: As New Hampshire continues to work toward the goal of eliminating childhood lead poisoning as a public health problem, a program shift is under way for the CLPPP to move from a single focus to address multiple environmental, health and safety risk factors affecting families. This strategic planning process involves extensive collaboration between a large and diverse group of statewide experts from the fields of public health, public safety, housing agencies, historic preservation and resources, charitable foundations, the medical community, Community Action Programs (CAPs), Visiting Nurses Associations (VNAs), Community Health Centers, local and state non-profit agencies, as well as the US Centers for Disease Control and Prevention (CDC) and the US Environmental Protection Agency (EPA). Consistent state data is providing a baseline to help structure the Program. The CLPPP maintains an extensive blood lead surveillance system for the purpose of monitoring trends in blood lead levels (BLL) in adults and children in New Hampshire. In 2009, 118 of the 15,051 children tested for lead poisoning

had elevated BLLs above or equal to 10 micrograms per deciliter of blood (mcg/dL). The majority of these children (90%) lived in pre-1950 homes and approximately one-third lived in or regularly visited homes built prior to 1978 that had recently undergone renovation. In New Hampshire, approximately 10% of adults and 8% of children currently have asthma, costing the state an estimated \$46 million each year. Asthma rates in New Hampshire are higher than the national averages, but similar to those of other New England states. Asthma triggers and lead are present in homes where other health hazards exist, such as radon, tobacco, mold, excess moisture, allergens (i.e., dust mites, mice, and cockroaches), carbon monoxide and other safety hazards.

**EDUCATION:** On average, New Hampshire is a relatively wealthy, well-educated, small state with pockets of growing diversity. New Hampshire is fortunate to be known for high achieving students; youth generally perform well on standardized tests and compare favorably to other students in other states. Since 2003, eighth graders in NH schools have averaged eight points higher on math and ten points higher on reading than the national average for the National Assessment of Education Programs (NAEP), commonly referred to as the Nation's Report Card. Between 2000 and 2009, college-bound seniors scored consistently higher than the national average on both the reading and math tests. As national scores have declined, New Hampshire scores have risen, widening the gap between NH and the rest of the country. (33)

However, as described throughout this Overview, averages can mask the disparities in vulnerable populations. When children are not served well by our education system, they too often grow to be disconnected young adults who leave school, sometimes too early, without the skills necessary to succeed in the current and emerging array of careers available in the state. In New Hampshire, 9% of 18-24 year olds may be considered disconnected due to their education, incarceration, employment status, poverty and/or familial status. Although New Hampshire was fortunate to have the lowest rate of "out of school unemployed" in 2006 among 16-19 year olds, it is unclear what impact the current economic recession has had on this population of adolescents and young adults. (34)

One important and early indicator of achievement is the educational level of parents. A child born to a mother who has not completed high school faces increased challenges to school readiness, is at higher risk to drop out of high school, and is more likely to be living in poverty. The good news is that the data for this indicator has improved for the state as a whole. Year after year smaller proportions of children are born to mothers without a high school diploma or GED. On average, 78% of high school freshmen graduate with a high school diploma, 5% more than the national average. Yet, in the 20% of poorest communities, 12.2% of the births are to mothers without a high school diploma, compared to the 80% of the rest of the state, where the rate is 5.7%. (35)

**ACCESS TO CHILD CARE- TANF REDUCTIONS:** Learning opportunities that begin in early childhood prepare children for success in school and throughout their lives. A quality early care and education environment can be a foundation for success, but that opportunity is not available to all NH children. Preliminary estimates of the number of families served by the Child Care Development Fund scholarship program were expected to increase from 4900 in 2005 to 5300 in 2009 and the number of children served was expected to increase from 7100 to 7700. However, under the biennium budget restrictions of 2009 and 2010 and due to an increase in the number of families seeking child care assistance through the Child Care Development Fund, DHHS instituted a Child Care Scholarship Wait List in the fall of 2009. In June 2010, there were 2,137 children on a wait list for child care scholarship opportunities.

In addition, the number of child care providers who received scholarship payment for children in their care dropped from 3387 in 2005 to only 2539 providers in 2008. This, combined with the wait list, indicates a reduction in the availability of affordable care for low-income families, which may indicate lower quality care options for young children. In 2009, it was estimated that 30% of eligible children were in unlicensed care.

## SUMMARY:

National attention is increasingly being directed to social and economic determinants of health and to developing interventions from a life course perspective, with an understanding of the critical life stages in which to intervene to improve health outcomes. Health is a developmental process occurring throughout the lifespan. This framework often causes a shift in focus to the early part of the life span, when long-term health programming can be more intense and early childhood development, allows for interventions that may exact greater returns on resources invested. Sometimes, promoting optimal lifelong health may be best achieved through means other than "traditional" health care interventions. This fits well with the history and culture of Title V that has embraced the need to support a full range of infrastructure, enabling and supportive services in addition to clinical services.

In addition to understanding how a lifecourse perspective may frame the overview and challenges particular to our state, it is also critical to acknowledge how social, ethnic, and demographic changes may also require new priorities and new solutions. The American population, as a whole, is rapidly changing as a result of immigration patterns and significant increases among racially, ethnically, culturally and linguistically diverse populations. State government, community based organizations and systems of care must implement systemic change in order to meet the health needs of a population growing in its diversity. Nowhere are the divisions of race, ethnicity and culture more sharply drawn than in the health of the people in the United States. Although New Hampshire may not be experiencing these demographic changes as dramatically as the rest of the country, our state is still changing in significant ways, especially in the southern and urban areas. Language and differences in cultural practices and beliefs may present potential barriers to care as well as challenges for health care providers. More significantly in New Hampshire, health disparities abound based upon social inequalities such as poverty, socioeconomic status, insurance and employment status.

Each year, as part of the Annual Report, Title V will attempt to describe New Hampshire's data as a whole and among socio-economic, racially, ethnically, culturally and linguistically diverse populations in order to examine disparities in health care access and health outcomes. Guided by a belief that health equity will only exist when all residents have the opportunity to attain their full health potential, free from limitations by social or economic position or circumstance, MCH will continue to work towards its mission of improving availability of and access to preventive and primary health care for all children and reproductive health care for all women and their partners, regardless of their income. ***/2013/It is our goal that the Annual Report will serve as a tool to highlight how the New Hampshire Title V Program ensures access to services, ensures quality care, ensures integration across systems, and ensures appropriate measurement of outcomes./2013/***

Please see attachment for endnote

## **B. Agency Capacity**

Data from multiple public and private sources reveal that NH has one of the highest quality healthcare systems in the country. Its infrastructure and health outcomes rank favorably compared to the best states. But NH's health care is expensive, and measures of public health and access, by contrast, show opportunities for improvement. Like the state's public health system, in general, the Title V program is limited in scope, but fortunately rich in partnerships and collaborations that serve to promote and protect the health of women, children and families.

New Hampshire's health care delivery system for the Title V population consists of an array of public and private health service providers. This system, which varies regionally, presents special obstacles to the attainment of a seamless system of health care services for all citizens. Much of the state is designated as medically underserved or health professional shortage areas. While

NH's two largest cities have public health departments, there is no statewide network of local health departments providing direct health care services. Instead, New Hampshire has built its safety net of health care services on a public private partnership. In 2006, of the 88,184 members enrolled in Medicaid, 34% received care in private office-based settings; 15% in hospital-owned primary care offices; 15% in Dartmouth Hitchcock Clinics; 10% in Federally Qualified Community Health Centers or Look a-likes; 5% in Rural Health Centers; and 21% had no assignment of care.

#### PREVENTIVE & PRIMARY CARE SERVICES FOR WOMEN, MOTHERS & INFANTS

Aside from population based activities, MCH contracts with community agencies to provide prenatal, reproductive health care, and home visiting services for low income and underserved populations. Fifteen agencies statewide provide prenatal care and enabling services such as case management, nutrition counseling, tobacco cessation interventions, and individual social services. Of these, thirteen are primary care community health centers (CHC), offering the full spectrum of health care services to all ages; the others are 'categorical', offering access to reproductive health, prenatal care, and enabling services through various models that meet their community's needs. Eleven agencies provide contracted reproductive health services through Title X funds, and 15 agencies provide home visiting services for pregnant women, and mothers and their infants through age one. //2012/ Unfortunately new reductions in State General Funds, federal Title X funds and potential reductions in Title V funds has weakened the strength of this safety net of primary and preventive care. As of July 2012, health centers will see funding reductions of 38 to almost 50 percent for direct health care for New Hampshire's most vulnerable populations. At this time, it is unclear what the impact of these reductions will be. //2012// **//2013/ Data from the community health centers from SFY11, even prior to the budget cuts, indicate an overall downward trend in the numbers of individuals served from SFY10. The reductions are not consistent across the State. While agencies have anticipated serving fewer children in the North Country, as the population ages and decreases, other agencies in more populated areas of the State also saw reduced numbers in their pediatric primary care panels. However, other agencies find the demand for services for both Medicaid populations and the uninsured exceeds their capacity.//2013//**

Of the thirteen CHCs, eight have Federally Qualified Health Center status. These agencies generally utilize family practice physicians and advanced practice nurses for care provision, and offer full-time service with evening and weekend hours for easy access. Of the two categorical prenatal agencies, one provides direct clinical care and the other provides a rich assortment of supportive enabling services, such as home visiting, case management, etc. and direct, clinical prenatal care through subcontract with local physicians. //2012// As of July 1, 2012, due to budget constraints, one of the categorical prenatal agencies will no longer receive funding for services. This decision was made because one of the CHCs is now operating in an adjacent town with on-site, clinical prenatal services and with limited resources available, it was determined that funds should be directed at maintaining a basic infrastructure of direct care services. //2012// All MCH-funded agencies receiving funds for perinatal care must provide, social services, nutritional counseling, and referral for high-risk care. **//2013/ However, because of the significant reduction in funds available to state-contracted agencies, maternal nutritional support has been negatively affected. MCH has seen a decrease in the frequency of nutritional assessments and counseling, especially by a nutritionist, available to pregnant women. //2013//**

**//2013/ As of July 2011, the Family Planning Program contract with Planned Parenthood of Northern New England (PPNNE) was rejected by the Governor and Executive Council, reducing the State's Family Planning Program ability to serve, approximately 16,000 individuals, or half of the population historically served. As PPNNE did not ultimately receive State or Federal Title X funding for their 6 clinical sites through the State level project, the Federal Office of Population Affairs awarded a sole source agreement to serve these communities to PPNNE directly. //2013//**

MCH also contracts with 15 community-based agencies in 18 sites across the state to provide home visiting services for Medicaid eligible pregnant and parenting women. Home Visiting New Hampshire (HVNH) is a preventive program that provides health, education, support and linkages to other community services. These comprehensive, community-integrated programs are evidence based and offer a comprehensive curriculum based on the national Parents As Teacher's early literacy program, and a public health curriculum designed to address, in part, smoking reduction and cessation, maternal depression and family planning. Each family has a team of home visitors that includes a nurse and a parent educator. Parent educators can be highly trained paraprofessionals, or professionals with expertise in social work, family support or early childhood studies. Families are supported in their roles as their child's first and best teacher and learn ways to enhance their child's learning and development. ***//2013/ In SFY12, in response to changes in Medicaid rules that restricts eligibility for MCH-funded HVNH and Child and Family Health Support programs, MCH developed a plan that will merge the two programs into one "hybrid" program for SFY13. MCH re-aligned 10 service areas and issued a competitive bid that resulted in contracts in nine of the areas (one had no bidders). Two agencies are new MCH grantees. In addition to the reduction in number of agencies providing MCH-funded home visiting services, and the restriction by Medicaid in billable visits allowed, Medicaid Managed Care goes into effect January 1, 2013. It's not yet clear how the home visiting agencies will be able to be reimbursed for home visits to pregnant women and children on Medicaid. //2013//***

HVNH served over 900 pregnant women and their infants in SFY09. By funding almost two thirds of program sites in counties with a higher than the state average poverty rates, the program is able reach vulnerable populations. Additionally, HVNH sites are located in a variety of community-based agencies from traditional VNA programs to hospitals, family resource centers to mental health centers. By utilizing a variety of platforms, HVNH can reach families using supports embedded within each unique community.

There are several sources of support for home visiting services and each source of funds is directed towards a different need in the community. Agencies use these funds to provide a comprehensive set of services to families. HVNH supports a public health and family support mission with rigorous performance measures. Comprehensive Family Support is a more flexible primary prevention support available for families. Child and Family Health Support is available to fill gaps to ensure that families' immediate health care needs can be met. Successful agencies coordinate these funding sources within their agencies and communities. DPHS and DCYF have worked together and participated on joint site visits to agencies that receive both sets of funds to ensure coordination. MCH will continue this collaboration with DCYF with new federal funding for Home Visiting in FY2011.

*//2012/* MCH was identified as lead agency for the Affordable Care Act, Maternal, Infant, and Early Childhood Home Visiting (MIEC HV) program for NH. New Hampshire's Updated State Plan for Home Visiting, supported by all required consensus partners including DCYF, identifies goals for MIEC HV that address serving at-risk communities; use of an evidence-based home visiting model; and a coordinated home visiting system. Beginning in November 2011, all five regions identified in the initial needs assessment, including Carroll County, Coos County, the city of Manchester, Strafford County and Sullivan County will begin implementation of the Healthy Families America model. Local providers in each of these regions provided input and ultimately support for selecting this model as the "best fit" for these communities. The Home Visiting Task Force includes representation from the NH Early Childhood Advisory Council and will work to ensure that this model is integrated with, and connected to, other early childhood and family support programs within these communities. Using MIEC funds, MCH hired a fulltime Home Visiting Program Coordinator whose full focus is on home visiting and the coordination of the growing state system of home visiting, that will advance the development of a comprehensive, high quality early childhood system at the state level. *//2012//*

Prenatal Disparities: Section IIIA of this application presents data clearly delineating disparities in

prenatal care access and health outcomes for privately insured women versus those uninsured or on Medicaid. Title V -- supported community health centers saw approximately 14% of the state's pregnant women in 2009. Many of these women represent vulnerable populations, because of their low income and other psych-social risk factors including young maternal age, health risks, insecure housing, etc. Because of these factors, they are at increased risk for negative birth outcomes. Therefore, Title V prenatal programs have additional requirements for nutritional support, alcohol, substance abuse and mental health screening, and other enabling services.

The Prenatal Data Linkage Project was formed to link prenatal clinic records and NH birth data to assure that MCH is able to monitor and evaluate MCH prenatal program data. This project has begun to assist in program management, policy development, and evaluation of health services to pregnant women and newborns.

Additional partnerships are needed to support the general population of pregnant women in the state. New legislation was passed in 2010 establishing a Maternal Mortality Review Panel. Title V will partner with the Northern New England Perinatal Quality Improvement Network and providers to to conduct comprehensive, multidisciplinary reviews of maternal deaths in New Hampshire. The multi-disciplinary reviews will ultimately result in recommendations for systemic improvements to the perinatal systems in the state. ***//2013/ In June 2012, a multi-disciplinary team reviewed its first maternal mortality case. They will share their findings with the larger panel in July 2012. Team participants completed a written evaluation of the process and the data is currently being reviewed and analyzed to determine if changes needed to be made before the process is finalized. //2013//***

***//2013/ The SSDI Program Planner, Marie Kiely, and the MCH Epidemiologist, David Laflamme submitted a successful application to CDC in January 2011 for the Pregnancy Risk Assessment Monitoring System (PRAMS), and New Hampshire was awarded funding in the Fall of 2011. The project is currently in the start up phase, with data collection expected to begin in Fall 2012. Sufficient data will be available for analysis one year after data collection begins.//2013//***

## PREVENTIVE & PRIMARY CARE SERVICES FOR CHILDREN AND ADOLESCENTS

In 2009, the DHHS Office of Medicaid Business and Policy completed the nation's first comparison of children in Medicaid, SCHIP, and commercial plans using administrative eligibility and claims data. Children enrolled in New Hampshire Medicaid and the state's SCHIP program, Healthy Kids Silver, generally do as well or better than their counterparts nationally in accessing and utilizing care. For example, among children aged 3-6 years those using Medicaid 69.9% had a well child visit in 2008; 82.7% of SCHIP; and 77.7% of commercially insured. The NCQA managed care national rate for this age group is 65.3% for Medicaid and 67.8% for Commercial. The children who do not fare as well in routinely accessing care, however, tend to be older children and teens; children in poorer households; and children in Colebrook Franklin, Woodville and Lancaster, which includes some of the most Northern and most remote areas of the state.

Title V's historical responsibility in maintaining Direct and Enabling Services for children has led to the continued clinical oversight and contractual relationships with a statewide network of child health agencies that provide preventive and primary care services. MCH contracts with 14 community agencies throughout the state to provide direct child health care services to low-income, underserved children from birth through age 19. Thirteen of these are the primary care community health centers described above; one is a 'categorical' pediatric clinic, in the state's largest urban community, which utilizes a multi-disciplinary care model. Strategically focusing efforts on access and support for low-income families, services at the child health direct care agencies include the full spectrum of family practice, such as well-child visits, immunizations, acute care visits and a spectrum of integrated behavioral and oral health services. In 2009, MCH-funded child health direct care agencies saw 17,414 children ages 12 and under, and 10,957 children ages 13-19.

Enabling Services are often the invisible glue that help hold all of the direct health care services together for vulnerable families or families at-risk. Support of these services is also what sets Title V apart from many other public health and government entities. As NH has continued to strengthen the safety net of direct care providers by supporting community health centers with State General Funds, MCH continues to assess its child health resource allocation to assure that low-income children and families have full access to these services and support in using them appropriately.

Since 2000, MCH has had a two-fold approach to child and family health support and home visiting. The purpose of the Child and Family Health Support Services is to promote the health and well being of children ages birth through 18, with priority given to children birth through age ten. These services include assistance with enrollment in health care, referrals, case management and care coordination, education and counseling relative to the child and family, and are most often conducted through home visits.

The evolution of the Child and Family Health Support Services program arose with the blending of categorical "well baby clinics" into newly developed community health centers throughout the state, and the emergence of New Hampshire Healthy Kids - the state's non-profit organization providing access to low cost and free health coverage options for its uninsured children and teens. Although children now had better access to medical care, their parents still needed the education and support services that the "well baby clinic" programs had provided, and needed assistance in enrolling on Healthy Kids, and utilizing the health services.

The range of Child and Family Health Support Services are flexible and specialized to meet the needs of the family. Services are guided by individualized care plans developed following an assessment of the child/family needs by agency staff. In SFY09, 1,205 children received services through the nine contracts at eight agencies via 5,186 home visits, 732 telephone contacts and 588 office encounters, and made 2,062 referrals to a variety of health, dental, and social service providers. //2012/ In SFY10, 1,254 children received services through the nine contracts at eight agencies via 5,336 home visits, 784 telephone contacts and 628 office encounters, and made 1,355 referrals to a variety of health, dental, and social service providers.//2012// Programs are strategically placed in communities that have disparate need due to geographic access and high proportion of low-income families.

All child health agencies providing direct care and all CHCs screen children for developmental delay and refer them to specialty services as appropriate, though the screening tools used vary widely. In part to address this varied approach to developmental screening, Watch Me Grow (WVG), is a new comprehensive screening and referral system for families with children from birth to six years of age. The system is founded on the principles that families are better able to help their young children grow and learn when they have information about their child's health and development; access to screening; and referral to appropriate services.

//2012/ In 2008, 12 Family Resource Centers throughout the state applied to serve as regional pilot sites. Participating Family Resource Centers, which were already under contract to NH DHHS/DCYF to promote family strengths and prevent child abuse and neglect, received \$4,000 to \$5,000 each in additional funding to participate in WVG. DCYF amended its contracts with these centers to include the following requirements for WVG sites: (1) serve as regional "hubs" for the WVG system, adhering to system philosophy, guidelines, and quality assurance standards; (2) establish networks of organizations and agencies in their communities providing developmental screening to young children and their families; (3) provide and/or collect data from community partners on screenings in their areas; and (4) submit bi-annual progress reports and quarterly data reports to the WVG Steering Committee.

The evidence-based screening tools currently used in the WVG system include the Ages and Stages Questionnaires, 3rd edition (ASQ-3) for children from 1 month to 60 months of age and

Ages and Stages Questionnaires: Social Emotional (ASQ: SE) for children aged 3 months to 66 months. The ASQ and ASQ: SE were designed to be completed by parents and other caregivers

During the pilot phase, WMG sites collectively received 176 hours of on-site and/or telephone training and technical assistance to support their efforts, and more than 283 individuals in eight regions were trained to use the ASQ-3 and ASQ-SE. Each site also received a set of screening tools.

At this time, NH's WMG may be characterized as a "fledgling" system, with a basic state and community infrastructure in place, dedicated community partners on board, a clear vision and guidelines to set direction, and identified components to be implemented using evidence-based practices. Collaboration on screening has begun within all WMG regions, and sites are submitting some screening data to the state (i.e., data were received on 279 children from 2010 to 2011). However, there is much work to be completed before WMG moves from a system under development to a viable, effective, fully accessible one. Future goals include (1) further development into a sustainable, quality system that includes a web-based data system (2) expansion of screening tools to include the M-CHAT (Modified Checklist for Autism in Toddlers) and the M-CHAT follow-up interview, (3) provide additional resources for families and professionals on mental health resources, and (4) assure that access to screening, early identification of behavioral and mental health concerns in young children and timely referral to appropriate supports and services for families are readily available throughout the state.//2012//

To further this more unified approach, SMS in collaboration with the NH Pediatric Society hosted two statewide Open Forums on Universal Developmental Screening in 2009 and 2010. Primary care as well as a variety of community based service providers participated in education and discussion about screening recommendations, tools, billing and community supports.

With the release of the revised Bright Futures Guidelines, MCH changed its clinical pediatric and adolescent site visit tool, and is working with the Title V funded agencies to assess the impact of the recommendations, such as any subsequent training needed. The changes in developmental screening and surveillance, including universal autism screening at the 18 and 24-month visits, align with recommendations from a legislative autism commission report issued May 2008. The report of the Commission, of which MCH, representing DPHS, was a member, urges the Department of Health and Human Services to take the lead in providing technical assistance and other supports to ensure that all pediatric primary care settings screen for Autism Spectrum Disorders.

Maps are attached to this Section.

#### SERVICES FOR CSHCN [Section 505(a)(1)]

#### REHABILITATION SERVICES FOR BLIND AND DISABLED INDIVIDUALS LESS THAN 16 YEARS OF AGE:

When the results of the 2001 National Survey of Children with Special Health Care Needs (NS CSHCN) were reviewed Special Medical Services determined that there was a need for additional data collection regarding children in NH who were receiving SSI for their own disability. The results from the NS CSHCN survey are meaningful; however, there is a subpopulation of SSI-receiving CSHCN that the national survey was not able to sufficiently capture. SMS completed a follow up survey with the known population of children receiving SSI in NH, the New Hampshire Survey of Parents of Children of Special Health Care Needs Receiving SSI for Their Own Disability, 2004. It was determined that because eligibility for SSI requires both means testing and diagnostic criteria, it was important to have an accurate picture of the needs of this population to guide strategic planning for the Title V program.

The overall results of this survey indicated that this group of children and their families experience

an array of health-related difficulties, which may have a more severe impact on the family than the impact of difficulties experienced by families of NH CSHCN in general. The medical and financial eligibility requirements for SSI benefits are sufficiently restrictive to assure that the children receiving Supplemental Security Income for their own disability are, by definition, in a heightened state of need for this assistance. The cost-of-care burden is greater for these families than for the families of NH CSHCN in general. The NH survey also indicated that these children are evidencing a greater need for comprehensive, community-based, care coordination and well-organized service systems. Specific deficits are indicated in the areas of mental health services and the transition to adult services.

Given that the majority of children receiving SSI for their own disability will continue to meet the financial and medical criteria for this assistance, it appears imperative that New Hampshire's programs for CSHCN specifically and pro-actively address the unique needs of this subpopulation, as they age into adulthood.

In response to this information Special Medical Services has a designated care coordinator to follow-up on all children/youth who are new recipients of SSI. The SMS coordinator provides outreach and support to all new recipients with a medical diagnosis and provides an outreach resource letter for all new recipients with a mental health or developmental diagnosis. In addition, SMS financial assistance for health related needs is available for this population.

The MICE (Multi-Sensory Intervention through Consultation and Education) program is administered by the Parent Information Center in cooperation with the Bureau of Developmental Services to serve children (0-3) for whom there is a concern relative to vision and/or hearing. Children may be referred to the Area Agencies for intake and developmental evaluation, in conjunction with Early Supports and Services (ESS) staff. The emphasis is on the impact of a diagnosed visual/hearing impairment on learning and development. Consultation and technical assistance are provided to ESS teams, and direct services to children and families.

#### CAPACITY TO PROVIDE FAMILY-CENTERED COMMUNITY-BASED, COORDINATED CARE:

SMS capacity regarding this element is highlighted throughout most of the SMS-specific service and system descriptions, as well as the Needs Assessment. Care Coordination is one of the programs available for children and youth with special health care needs and their families enrolled at Special Medical Services. Community Based Care Coordination for SMS means working together with families and their health care providers, community agencies and schools to help obtain access to needed health care and related services. Following assessment, comprehensive health care plans, responsive to the needs and priorities of the child/family, are developed. Central staff and contractors provide coordination of health related services with other community providers and schools, to ensure continuity of care, and family support. SMS has Care Coordinators available for all regions of the state and services are designed to incorporate home/community visits. All coordinators work with transition age youth to identify strengths and needs and develop a healthcare transition plan. SMS has had a strong focus on supporting the development of care coordination in the medical home by offering expert consultation and support.

/2012/ SMS applied for and received funding through a HRSA State Implementation Grant - Project Access/Phase III, to focus on improving the system of care for children and youth with Epilepsy/Seizure Disorders. A primary focus of this initiative, called FACETS of Epilepsy Care in NH, is to improve the coordination of care across all areas in the state. The activities will include Care Coordinator Summits to bring together SMS Coordinators as well as practice based, school and community program coordinators to facilitate increased communication and planning for families of children/youth with Epilepsy. This initiative will also focus on applying these processes to all CSHCN. //2012//

#### CULTURAL COMPETENCE & THE TITLE V PROGRAM:

While New Hampshire's population is still 93.1% white (not-Hispanic), minority populations are steadily increasing. The State's largest racial minority is Asian, representing 1.9% of the population, followed by Black/African American at 1.2%. Hispanics (of all races) make up 2.6% of the population. The vast majority of the state's minority populations live in the southern tier of the state, including the two cities of Manchester and Nashua in Hillsborough County. Approximately 17% of Manchester residents speak a language other than English at home.

Births in New Hampshire are also becoming more ethnically and racially diverse. The percentage of births to racial and ethnic minority groups has more than doubled over the past decade. In 2008 and in 2009, over 17% of resident births were to parents where at least one reported a race/ethnicity other than non-Hispanic white, compared to only 7.6% of births in 1998.

In addition, New Hampshire has resettled over 6000 refugees since the early 1980's, over 4,800 between 1997 and 2008. The majority of refugees have come from countries in Europe (74% from Bosnia) and Africa (58% from Somalia and Sudan), with smaller populations from Asia and the Middle East. Of the nearly 3000 refugees settled between fiscal years 2002 and 2009, 61% settled in Manchester, 26% in Concord, 8% in Laconia, with smaller populations in other cities and towns. These new residents can experience a range of health and mental health issues including poor nutrition, parasitic infections, communicable diseases and lead poisoning, with maternal and child health issues predominating.

Achieving cultural competence is more difficult for agencies in rural and non-urban areas where numbers of minorities are smaller. Community-based health agencies are aware of the need for case management, outreach and interpretation services for this population and are working to develop capacity in this area. All SMS contracts for direct or enabling services for CSHCN have had a funded line item for Linguistic/Cultural Needs incorporated. The New Hampshire Endowment for Health reported that provider organizations varied widely in their collection, analysis and use of medical interpretation data. They identified a lack of systematic data collection within healthcare facilities. Providers in Hillsborough County, which includes the state's most diverse communities, serve a much greater proportion of patients with Limited English Proficiency (LEP), about one in seven (14%) patients in those facilities that reported their LEP volume, compared with about 2 percent among the non-Hillsborough providers. Facilities that responded in Nashua reported a third of their encounters (32%) were with LEP patients. The interpreter resources that facilities reported using with the greatest frequency were, in descending order, externally paid interpreters, bilingual clinical staff, bilingual non-clinical staff, and telephone services. Cost and scheduling were significant barriers to facilities in providing consistent, quality services. Providers also identified the difficulty in securing translators for languages less common, including Asian languages, Portuguese, and American Sign Language.

Since mid 2009, a group facilitated by the Asthma Control Program has been meeting to discuss commonalities amongst vulnerable populations and the Division of Public Health's work with them. Meeting monthly, this group has fostered a closer working relationship between MCH and the Office of Minority Health.

Medicaid Client Services provides telephone access in the three languages most spoken by non-native Medicaid consumers, Spanish, Arabic and Bosnian, and all District Offices have mechanisms to facilitate language barrier reduction for their consumers. SMS continues to allocate funds for cultural and linguistic support services for the CHS Child Development, Community Care Coordination and Neuromotor programs. Applications and letters have been translated into Spanish, to better serve the state's Latino population.

In addition to race/ethnicity and language barriers impacting health care access, Title V programs are addressing other issues of cultural competence among MCH populations. These include homelessness, behavioral health, and substance abuse. One issue affecting service availability, accessibility and timely provision, is the lack of comprehensive planning, resource sharing and

funding mechanisms, among the state, community-based non-profits, and the private sector. Until recently, health data specific to NH residents was minimal. The MCH and SMS Sections are assessing the new data, to improve health care service and quality, and reduce disparities. SMS has been working on improvements to its electronic data system and as of July 1, 2010 race and ethnicity information will be a formal data set.

***/2013/ Special Medical Services has completed the Organizational Self-Assessment created by the National Center for Cultural Competence, with the assistance of staff from NH's Office of Minority Health and Refugee Affairs (OMHRA). Special Medical Services has also incorporated the CDC recommended questions set on Race/Ethnicity into its application and data system. //2013//***

The following statutes provide Title V adequate statutory authority to promote and enforce legal requirements as well as assess and monitor MCH status.

#### NH REVISED STATUTES ANNOTATED (RSA) RELEVANT TO TITLE V

RSA 125, General Provisions, describes the responsibilities of the Department of Health and Human Services' (DHHS) Commissioner to "take cognizance of the interests of health and life among the people". RSA 126 establishes the DHHS to "provide a comprehensive and coordinated system of health and human services as needed to promote and protect the health, safety, and well being" of New Hampshire citizens and mandates that services "shall be directed at supporting families, strengthening communities, and developing the independence and self-sufficiency of New Hampshire citizens".

RSA 132, Protection for Maternity and Infancy, provides broad authority for MCH and CSHCN services "to protect and promote the physical health of women in their childbearing years and their infants and children". It authorizes the Commissioner to: accept federal funds; employ staff; cooperate with federal, state and local agencies to plan and provide services; supervise contracts with local agencies; make rules and to conduct studies as necessary to carry out the provisions of the law. CSHCN services are defined in the law as diagnoses, hospitalization, medical, surgical corrective and other services and care of such children. This law also allows for administration of the WIC program.

RSA 132:10A mandates newborn screening, requiring health care providers attending newborns to test for metabolic disorders. This RSA was amended to clarify wording that allowed funds from the newborn screening filter paper purchases to be used to cover laboratory analysis and related newborn screening program costs. It also deleted the need for the newborn Screening Advisory Committee to have a public hearing before adding any recommended tests to the screening panel.

RSA 132:13 II adopts the definition for Children With Special Health Care Needs as: children who have or are at risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

RSA 611, Medical Examiners, requires the medical examiner to file a record with MCH of any death determined to be the result of result of sudden unexplained infant death.

RSA 137G, Catastrophic Illness Program, defines catastrophic illness to include cancer, hemophilia, end-stage renal disease, spinal cord injury, cystic fibrosis and multiple sclerosis which require extensive treatment such as hospitalization, medication, surgery, therapy or other medical expenses such as transportation. Eligible individuals may have services paid for by DHHS; eligibility and services to be covered are set forth in rules. ***/2013/ Due to funding cuts this program was suspended as of July 1, 2011. //2013//***

RSA 126 contains provisions establishing a division of juvenile justice services; allowing for DHHS quality assurance activities; establishing an Advisory Council on Child Care to plan for improved child care services, report to the Legislature and Governor, and to act as a forum to receive child care related information; the development of primary preventive health services for low-income and uninsured populations; establishing an emergency shelter program, a council for children and adolescents with chronic health conditions and their families, and the Tobacco Use Prevention Funds; and restricts sale of tobacco products to minors.

RSA 126-M:1 recognizes the importance of prevention and early intervention programs and creates a formal network of family resource centers.

RSA 130-A, Lead Poisoning Prevention and Control, provides for public education, comprehensive case management services, an investigation and enforcement program and the establishment of a database on lead poisoning in children.

RSA 135-C allows DHHS to establish, maintain, and coordinate a comprehensive system of mental health services.

RSA 141-C, Immunization, and Reporting Communicable Diseases, prohibits enrollment in school or child care unless immunization standards are met, requires reporting of specified communicable diseases to the State Department of Public Health, prohibits mandatory genetic testing and requires informed consent, except for establishment of paternity and for newborn metabolic screening.

RSA 169-C mandates reporting of suspected child abuse.

RSA 318B:12A allows substance abuse treatment without parental consent at age 12.

RSA 141-C:18 allows adolescents to receive testing and treatment for sexually transmitted diseases without parental consent at age 14.

RSA 265: A prohibits driving while under the influence of alcohol or drugs.

RSA 265:107 A requires the use of child passenger restraints up to age 6 or 55 inches, whichever comes first, and then seat belts in all positions up to age 18 and seat belts up to age 18.

RSA5-C:2 establishes the Division of Vital Records within the Department of State.

RSA 141-J: establishes a statewide, population-based public health surveillance program on birth conditions

RSA 171-A30 allows a voluntary state registry which include a record of all reported cases of autism spectrum disorder (ASD) that occur in NH and other relevant information so as to conduct surveys of ASD

RSA 171-A:32 established a council on autism spectrum disorders to provide leadership in promoting comprehensive and quality education, health care, and services for individuals with autism spectrum disorders and their families.

RSA 254:144:X, Riding on Bicycles, No person less than 16 years of age may operate or ride upon a bicycle on a public way unless he or she wears protective headgear of a type approved by the commissioner of health and human services.

RSA 263:14 outlines a system of graduated licensing for youthful operators.

RSA 132:30 Maternal Mortality Review Panel: establishes a maternal mortality review panel to

conduct comprehensive, multidisciplinary reviews of maternal deaths in NH.

RSA 318-E:1: establishes a pharmaceutical drug take-back program. This bill has been passed by both the NH House and Senate and is expected to be signed by the Governor.

RSA 132:32: prohibits abortion providers from performing an abortion on unemancipated females without giving 48 hours' written notice, in person or by certified mail, to a parent or guardian unless a medical emergency exists. The bill provides a procedure for alternate notice in certain circumstances.

***/2013/ SB 348 An act relative to the pulse oximetry test for newborns was passed in May 2012 and was signed by Governor Lynch. This act adds the pulse oximetry test to the medical screenings required for newborns and takes effect 60 days after its passage, August 10, 2012.***

***HB 1297 An act relative to federal health care reform and health care exchanges. This act prohibits New Hampshire from planning, creating, or participating in a state health care exchange. The bill also establishes guidelines for interaction with a federally-facilitated exchange created for New Hampshire. It was signed by Governor Lynch in June 2012. //2013//***

The full, official text of these statutes may be accessed on the State's website at: [www.state.nh.us](http://www.state.nh.us).

Information on Title V program activities related to these statutes can be found in Sections IIIC, IIIE, and IV of this application.

### **C. Organizational Structure**

NH's Title V Program is located within the New Hampshire Department of Health and Human Services (DHHS). DHHS is headed by Commissioner Nicholas Toumpas reporting directly to Governor John Lynch.

Administration of the Title V Block Grant is assigned jointly to the Maternal and Child Health Section (MCH) for services to women, infants and children and the Special Medical Services Section (SMS) for children with special health care needs (CSHCN). As of July 1, 2010, MCH will reside in the DPHS, Bureau of Population Health and Community Health Services (BPCHS) with population health services such as Chronic Disease and Prevention Programs, and Nutrition and Physical Activity Programs, including WIC.

This re-alignment is focused on linking initiatives and using scarce resources more efficiently through better integration. The overall strategic direction includes:

- Implementation of cross-program integration to increase population-health impact
- Integration of data systems to monitor population-health status
- Strategic use of partnerships to implement population-health approaches
- Focus on chronic disease prevention, diagnosis, treatment and intervention
- Allocation of resources externally to support strategic goals
- Development and implementation a health messaging strategy

SMS resides in the Bureau of Developmental Services, Division of Community Based Care Services. This affiliation aligns services for CSHCN in the same division as other Home and Community Based services for the elderly/disabled adults, individuals with intellectual disabilities and those with mental health issues.

Organizational Charts are attached to visually describe the structure of each program.

Each Title V Program Director (MCH and SMS) is responsible for her own staff, budget, and assuring that activities proposed under the MCH Block Grant are carried out. The MCH Director assumes coordinating responsibilities for the Block Grant submission.

While each program is distinct administratively, they coordinate frequently at the programmatic level. New Hampshire's approach to the 2010 Needs Assessment purposefully incorporated an integration of the MCH and CSHCN populations. This integration began with the planning process and was carried through to the reporting process. References to the Title V population throughout both the Needs Assessment and the annual Block Grant highlight this integration and represent joint evaluations and activities.

#### THE FEDERAL-STATE BLOCK GRANT PARTNERSHIP:

##### MCH PROGRAMS

**PRIMARY CARE PROGRAM:** Using 89% State General Funds and 11% Title V funds, MCH supports thirteen community health centers in providing comprehensive primary care services, including prenatal and pediatric care, for over 104,622 individuals/year. Many sites offer support and enabling services such as nutrition counseling, case management, transportation and interpretation services.

***/2013/PRIMARY CARE SERVICES FOR THE HOMELESS PROGRAM: Using 89% State General Funds and 11% Title V funds, MCH currently supports two agencies which provide outreach and case management services, primary medical and dental care, 24-hour emergency services, mental health, substance abuse counseling and treatment to individuals who are experiencing homelessness. People who are homeless suffer from health care problems at more than double the rate of individuals with stable housing and their healthcare needs are often not fully met in traditional office-based health care setting. Many are also burdened with additional needs including mental illness, substance abuse and chronic health conditions such as hypertension, diabetes, and/or HIV/AIDS. A third agency will be funded in FY 13 to more adequately meet the healthcare needs of New Hampshire's homeless individuals. //2013//***

**ORAL HEALTH PROGRAM:** The Oral Health Program will now be coordinated with MCH in the Bureau of Population Health and Community Health Services. Partnering with Title V to serve all of the Title V populations through direct, enabling and infrastructure services building services, the Oral Health Program serves children and adults through contracted community based services.

**PRENATAL PROGRAM:** Fifteen local MCH-funded agencies provide prenatal care to over 1700 women/year. Services include: medical care, nutrition, social services, nursing care, case management, home visiting and referral to specialty care./2012/ As of July 2012, due to budget constraints, one of the two categorical prenatal agencies will no longer receive funding for services. With limited resources available, it was determined that funds should be directed at maintaining a basic infrastructure within the CHC system. //2012//

**CHILD HEALTH PROGRAM:** Twenty-two community health agencies receive funding to provide child health services. Of these, fourteen are primary care centers that offer direct care to low-income children through clinics and some home visits; eight provide health and social support services to children and their families through a Child and Family Health Support Services grant. All agencies provide case management, outreach, and SCHIP enrollment assistance. In FY09, approximately 17,500 children under age 13 years received primary care services, and over 1,200 children up to age 18, but primarily middle school and younger, received Child and Family Health Support services.

**SIDS PROGRAM:** The SIDS program offers information, support and resources to families and

care providers of infants who died suddenly and unexpectedly. Information and training are provided upon request. Presentations are made frequently on reducing the risks of SIDS/promoting safe sleep environments to groups such as health care professionals, childcare providers, home visitors, and early childhood education students. The SIDS Program Coordinator has taken a lead role in the state's Child Fatality Review Committee activities, participating in the Executive Committee, chairing the Recommendations Subcommittee, and helping organize and write the bi-annual report. Maternal and Child Health (MCH), in collaboration with the Bureau of Behavioral Health and the Office of the Chief Medical Examiner (OCME), developed and sends a grief packet to the families of all children autopsied through the OCME, who died from causes other than a sudden unexpected infant death or a suicide./2012/ In 2010, in collaboration with the OCME, MCH was awarded a CDC grant to pilot the Sudden Unexpected Infant Death Web-Based Registry. Case collection began January 1, 2011./2012//

**NEWBORN SCREENING PROGRAM (NSP):** The NSP coordinates the screening and short-term follow up of all infants born in New Hampshire for heritable disorders ascertained through dried blood spot testing. As of July 1, 2010, RSA 132:10-a requires that infants be screened at birth for a panel of 33 disorders. The NH panel is in line with other state screening panels within New England and is similar to national recommendations. This statute includes a clause that allows parents or guardians to refuse this screening and also instructs the state to dispose of all specimens within 6 months of collection to ensure privacy /2012/ and that the remaining dried blood sample may not be used for any other purpose without the written consent of a parent or guardian. As of September 1, 2010 the filter paper fee was increased to \$71 each. This fee now includes all program costs and has made the program self-sustaining with no dependence on State General Funds. //2012//

**BIRTH CONDITIONS PROGRAM:** In a collaborative effort between Dartmouth Medical School (DMS) and DHHS, NH has maintained a birth conditions surveillance program. Its purpose, in part, is to detect trends in the occurrence of birth conditions. In June 2008, the program was established in law to be under the authority and direction of DHHS. While it will continue to be housed at DMS, an advisory structure monitors the program. MCH will also have new roles in oversight of the "opt out" process for inclusion in the program.

**EARLY HEARING DETECTION & INTERVENTION (EHDI):** EHDI promotes screening all newborns for hearing loss, and helps assure appropriate follow-up and intervention. In 2009, 97.3% of all infants born in NH hospitals were screened. The program has become well established with its Coordinator, along with the consulting Audiologist, as the mainstay of the tracking and quality assurance activities. The program's Family Advocate works with parents whose infant did not pass the screening to get further testing and other services as needed. Activities are planned to work with the state's lay certified midwives to increase screenings of infants delivered by these non-hospital providers.

**ADOLESCENT HEALTH PROGRAM:** The Adolescent Health Program promotes adolescent-friendly health care through one adolescent specific clinic, Child Health Services in Manchester and thirteen primary care sites. MCH provides technical assistance regarding adolescent health; participates in population-based activities; and coordinates forums for networking around adolescent issues.

/2012/ **PERSONAL RESPONSIBILITY EDUCATION PROGRAM (PREP):** Title V will utilize PREP funds to target efforts in Sullivan County and the City of Manchester, as these two areas showed the highest rate and number of teen births in the State. Whereas three-quarters of the teen births in NH occur among 18-19 year olds, the targeted population will be 17-19 year olds and pregnant/parenting women up to age 21. The model will include the strengthening of partnerships between Adolescent Health, Home Visiting, Family Planning and education, both at the State and local level. //2012//

**ABSTINENCE EDUCATION PROGRAM:** This program seeks to reduce unintended pregnancies

among children ages 10-14 years through community agreements to implement abstinence-only curricula. MCH has awarded Catholic Medical Center (CMC) the Leadership in Abstinence Education Program. In turn, it supports community agencies statewide to provide abstinence education. This program has not been funded since the beginning of State Fiscal Year 10. However, MCH is currently awaiting the new federal funding for abstinence education, approved under health care reform, and will submit a proposal consistent with past strategies (ie, funding the Leadership in Abstinence in Education Program).

HOME VISITING NEW HAMPSHIRE (HVNH): HVNH promotes healthy pregnancies and birth outcomes, safe and nurturing environments for young children, and enhances families' life course and development for pregnant women and families with children up to age one. Eighteen projects currently serve in excess of 1000 families per year. Recognizing the importance of promoting healthy development and improving maternal and child health outcomes, the Affordable Care Act will soon provide funding for a needs assessment and ultimately new programming related to Maternal, Infant, and Early Childhood Home Visiting Programs in NH. New federal funds will use evidence-based home visiting strategies to help families create a nurturing environment for young children and connect to a range of services including health, early education, early intervention.

HEALTHY CHILD CARE NEW HAMPSHIRE (HCCNH): HCCNH focuses on improving the quality of health and safety in child care environments by increasing the number and expertise of child care health consultants and by incorporating content expertise and collaboration of other state and community programs with the child care industry in NH.

INJURY PREVENTION PROGRAM (IPP): The IPP seeks to reduce morbidity and mortality due to intentional and unintentional injuries. The IPP is also responsible for violence prevention, including sexual assault and domestic violence, funds the State Injury Prevention Center, and is the liaison to the poison control educator associated with the state's Poison Control Center contractor, Northern New England Poison Center of the Maine Medical Center. ***//2013/ The IPP has received a Core Violence and Injury Prevention Program grant from the CDC. Increased surveillance, evaluation and interventions will be focused on four priority areas, including motor vehicle crashes; falls; poisoning; and injuries as a result of trauma "struck by or against". //2013//***

STATE SYSTEMS DEVELOPMENT INITIATIVE (SSDI): SSDI is improving data capacity through linking data sets with infant birth and death registries. A major goal is to link birth certificate and NSP data to assure all babies are screened.

TITLE X FAMILY PLANNING PROGRAM (FPP): The FPP provides confidential reproductive health care for low-income women and teens to over 30,000 individuals/year. ***//2013/ Because state program oversight was reduced by half due to no longer directly funding Planned Parenthood of Northern New England (PPNNE), the NH DHHS project currently covers approximately 16,000 individuals at our remaining 10 delegate sites. //2013//***

CHILDHOOD LEAD POISONING PREVENTION PROGRAM (CLPPP): As of July 1, 2010, the CLPPP will no longer reside within the MCH. The CLPPP is moving toward a more holistic approach to housing, and will become a healthy homes program in the newly formed Healthy Homes and Environments Section within the Bureau of Public Health Protection.

#### SMS PROGRAMS

Federal funding supports a portion of all sixteen SMS contracts. More specifically, these contracts for direct services are supported 68% with New Hampshire general funds and 32% with Federal Block Grant funds. This Federal-State Partnership includes the following programs:

CHILD DEVELOPMENT PROGRAM: The Child Development Services Network is comprised of five Child Development Programs contracted through DHMC and local community health

agencies to provide a community-based multidisciplinary approach to state-of-the-art diagnostic evaluation services, to children (0-6) suspected of or at risk for altered developmental progress.

**PEDIATRIC SPECIALTY CLINICS:** SMS operates Pediatric Specialty Clinics for Neuromotor Disabilities in 6 locations statewide. These family-centered, community-based, multidisciplinary clinics utilize treatment approaches that encourage parents/children to fully participate in care planning. The clinic coordinator and consultant staff are supported by SMS. The team addresses issues of physical therapy, orthopedics, and developmental pediatrics, with access to SMS nutrition and psychology services.

**NUTRITION, FEEDING AND SWALLOWING PROGRAM:** The SMS Nutrition, Feeding and Swallowing Program offers community-based consultation and intervention services statewide. Dietitians and feeding & swallowing specialists provide services utilizing a home visiting framework. SMS offers specialized training for all network providers assures a coordinated, outcome-oriented approach that is family-centered and community-based.

**FAMILY EDUCATION & SUPPORT SERVICES:** Funding received from NH Title V CSHCN supports New Hampshire Family Voices (NHFV) in its mission to assist families with CSHCN. NHFV provides information, support and referral to families with the 800 line provided by SMS. NHFV maintains a comprehensive lending library, specializing in children's books for families and publishes a quarterly newsletter, "Pass It On". NHFV publishes an annual listing of support group/organizations, and operates a comprehensive website. The staff are parents of CSHCN who can personally relate to the issues and concerns raised by individuals seeking their assistance.

**PSYCHIATRY & PSYCHOLOGY CONSULTATION:** SMS contracts with both a child psychologist and psychiatrist to provide access and services for CSHCN. Psychology services include statewide information and referral, educational services consultation and education/training to SMS staff as well as partner agencies. Psychiatry services include direct assessment, consultation and short-term condition/medication management while CSHCN are establishing primary care management of their mental health needs.

***An attachment is included in this section. IIIC - Organizational Structure***

## **D. Other MCH Capacity**

### **STAFFING**

The Maternal and Child Health Section (MCH) is headed by an Administrator, who is the MCH Title V Director and responsible for all MCH activities. MCH employs 20 FTEs (fulltime staff equivalents); 12 positions are paid in some part through Title V funds. The five main programmatic units within MCH include: Child Health and Infant Screening (Child Health, SIDS, EHDI, NSP-- 4 FTEs); Injury Prevention and Adolescent Health ( 2 FTEs) Women's Health (Family Planning, Preconception Health, 3 FTEs); Data and Decision Management ( SSDI, Program Evaluation and Quality Assurance 3 FTEs); Young Families ( HVNH, HCCCNH, Perinatal 4 FTEs). ***/2013/ Young Families (HVN, HCCNH, ECCS, Perinatal 3.5 FTEs). The Secretary position was eliminated because of staffing realignments and funding reductions. The Perinatal position has been combined with the QI Consultant. //2013//*** All MCH staff are centrally located at the DPHS building in Concord, NH.

***/2013/***

***The Injury Prevention Program received a Core Injury and Violence Prevention Program grant in August 2011. This grant has allowed for the expansion of the program internally by the hiring of an Injury Surveillance Program Coordinator, JoAnne Miles. Ms. Miles' position provides injury related epidemiological statistics, data interpretation, and recommended courses of action to the state program as well as to other colleagues in the state involved in injury prevention, federal health officials, state officials, researchers, and the general public in order to improve understanding of injury trends and issues. The***

**funding has also enabled another contract, approved this past fiscal year, with the Injury Prevention Center at Dartmouth, to provide additional surveillance, evaluation, and coordination capabilities.**

**The Adolescent Health Coordinator position has not been filled due to budget reductions. However, MCH currently supports 0.5 FTE of Suzanne Allison, a public health nurse working with the Healthy Homes and Lead Poisoning Prevention Program. Within MCH, Ms. Allison focuses on special projects including facilitating the clinical chart reviews during primary care site visits for adolescents. She is also involved with reviewing work plans for the one dedicated adolescent primary care program. Ms. Allison is cross-training to provide back-up support for the the early hearing and newborn screening programs. It is hoped that Ms. Allison's adolescent responsibilities will increase in the next fiscal year. //2013//**

The MCH Data Team consists of those staff with an interest or expertise in data collection, analysis and dissemination; the SSDI Program Planner, Program Evaluation Specialist, Quality Assurance Nurse Consultant and contractual MCH Epidemiologist all participate in this team. MCH also employs administrative support staff (6.5 FTEs). / 2013/ The MCH Data Team is in transition. In 2011, the SSDI Program Planner, the Program Evaluation Specialist, and contracted MCH Epidemiologist maintained the core functions of this group. In late 2011 the newly hired, Quality Assurance Nurse Consultant/ Perinatal Coordinator joined MCH and began participating. With the addition of PRAMS and the CORE Violence and Injury Prevention Program (VIPP) Grants, new data-related staff will join as they begin on-boarding to MCH.//2013//

**MCH manages three contracts and one MOU to provide specific consulting capacity to MCH. These include: an MOU for OB-GYN medical consultation with Dr Maureen McCarty; contractual relationships for a consulting audiologist, a pediatric metabolic consultation and an MCH epidemiologist. The audiologist, Mary Jane Sullivan, MA, CCC-A, consults to the EHDI program, bringing experience in pediatric audiology and hospital-based newborn hearing screening programs. MCH epidemiologic support is provided by David LaFlamme, through a contract with the University of New Hampshire's Institute of Health Policy and Practice. Mr. LaFlamme has a PhD from Johns Hopkins University School of Public Health. He devotes three days per week to MCH issues, providing expertise in data analysis and health policy. Dr. Harvey Levy, pediatric metabolic specialist, provides support to medical providers managing clinically significant newborn screening results.**

**The EHDI Program also has a contractual relationship with the M.I.C.E. (Multisensory Intervention through Consultation and Education) Program of the Parent Information Center to provide parent support, education and advocacy to families of infants who were referred for diagnostic testing or confirmed with a hearing loss.**

**In addition, MCH houses Jocelyn Vilotti, New Hampshire's health education liaison from the New England Poison Control Center. /2012/ Ms. Vilotti was replaced by Laurie Warnock, who works 0.6FTE.//2012//**

**The Special Medical Services (SMS) Section is headed by an Administrator, who is the Title V CSHCN Director and responsible for all CSHCN activities. SMS has 18 FTE positions and 16 of them are funded in whole or in part by Title V funds. Some SMS staff do provide Enabling services in addition to the work that contributes to infrastructure building. SMS Care Coordinators have direct caseloads and/or run specialty clinics; 5 coordinators, 1 financial coordinator and 4 support staff work to meet these responsibilities. There is also a Senior state physician who provides direct service to underserved populations and contributes to infrastructure building. There are 4 management level staff (reviewed below) and 1 contract manager. In addition, SMS administers the Partners in Health program, which is funded by the Social Services Block**

*Grant, and the staff for this program include a Program Manager and a Program Assistant. /2012/ SMS had 3 vacant positions (a Public Health Nurse Coordinator, a Program Specialist/Contract Manager, and a Medical Secretary) that were eliminated as part of the budget process. This has resulted in fewer positions funded by Title V funds, currently 13 positions are funded in whole or in part by Title V funds. //2012//*

**SENIOR LEVEL MANAGEMENT BIOGRAPHIES: MCH**

*Patricia M. Tilley, MS Ed, Administrator Ms. Tilley holds a Master of Science in Education from the University of Pennsylvania. She has over 10 years experience in public health in New Hampshire and 15 years experience in education and social services. Previous to becoming Administrator of MCH and Title V Director, she was the Early Childhood Special Projects Director in MCH managing home visiting, Early Childhood Comprehensive Systems, Healthy Child Care NH and other early childhood projects. Prior to state service, she was the Director of a family resource center in rural, western Pennsylvania.*

**Audrey Knight, MSN, RN, Child Health Nurse Consultant**

*Ms. Knight has a Masters degree in nursing from Yale University and has held the position of MCH Child Health Nurse Consultant since 1986. She is the SIDS program coordinator and manages the Child Health, SIDS, PSVHSP, NSP and EHDI programs. Ms. Knight has expertise in preventive and primary care for children.*

*Rhonda Siegel, MS Ed, manages the Prenatal, Injury Prevention, Adolescent Health, and Abstinence programs. She has close to twenty-five years experience in the public health field. With both her undergraduate and graduate degrees from the University of Pennsylvania, Ms. Siegel has worked in the state system for the last ten years and prior to that was the health educator community outreach coordinator/clinic coordinator for a primary care health center and metropolitan medical center.*

**Michelle Ricco, BS, Family Planning Program Manager/Title X Director**

*Ms. Ricco has a BS degree from the University of New Hampshire. Ms. Ricco has 10 years of experience in public health, with an emphasis on program development and management.*

**Marie Kiely, MS, SSDI Program Planner**

*Ms. Kiely manages the MCH Data Team and has a Masters degree in Public Health from Tufts University. Ms. Kiely has nearly 20 years of experience in public health programs, including previous management of the New Hampshire Injury Prevention Program and Cancer Registry.*

*Deirdre Dunn, MS, was hired in October 2008 as the Early Childhood Special Projects Coordinator in MCH managing Home Visiting, Early Childhood Comprehensive Systems, Healthy Child Care NH and other early childhood projects. Ms. Dunn has a MS in Early Childhood Education with a focus on Leadership and Policy, from Wheelock College and over 20 years experience in community based early childhood programs.*

**Beverly McGuire, MS, BSN, Quality Assurance Nurse Consultant**

*Ms. McGuire has a Masters degree in Health Administration and a Juris Doctorate degree. She was hired in 2004 to measure the quality assurance efforts of the funded local agencies. She has 25 years of experience in community health as the CEO of a VNA./2012/ Ms McGuire retired in October 2010 leaving this role vacant as of June 2011.//2012//*

*/2013/Jill Fournier, RN, BSN, Quality Assurance Nurse Consultant and Perinatal Coordinator. Ms. Fournier has a BSN from Boston University. She has 18 years experience in public health programs in New Hampshire including previous management of the Tuberculosis Program. Ms. Fournier joined the MCH team in November 2011.*

***Previous to her public health experience, Ms. Fournier worked for 8 years as an OB/GYN staff nurse in a local hospital. //2013//***

#### SENIOR LEVEL MANAGEMENT BIOGRAPHIES: SMS

Elizabeth Collins, RN-BC, MS, BSN, BA, Administrator, Title V CSHCN Director  
Ms. Collins holds a Master of Science Degree in Nursing from the University of New Hampshire. She had over 20 years working with vulnerable populations in direct care and 3 years working with CSHCN through Title V prior to becoming the Title V CSHCN Director. She has completed the NH LEND program and is ANCC certified in Psychiatric Mental Health Nursing. /2012/ Ms. Collins has been accepted into the 2011-2012 cohort of the Maternal Child Health - Public Health Leadership Institute (MCH-PHLI). //2012//

Kathy Higgins Cahill, MS, Clinical Program Manager  
Ms. Cahill was hired for this position in Dec. 2006. This position manages all statewide care coordination activities including oversight of state and contracted coordinators. She is also the Project Coordinator for SMS' youth transition activities. Ms. Cahill had worked as a part-time staff to SMS for many years, assisting with the formation of the Child Development Program and providing care coordination and clinic management services. Prior to accepting this position she had worked full-time as a Program Specialist.

Margaret Bernard, SMS Data Specialist  
Ms. Bernard was hired for this position in 2008. She has excellent skills in database construction, knowledge of the SMS data systems, and expertise in the State Medicaid data systems. Her prior experience includes working for the State Medicaid Service Utilization Review Section and direct service provision for individuals with Behavioral Health issues.

Sharon Kaiser, RN, BS, Early Childhood Systems Specialist.  
Ms. Kaiser was hired in Dec. 2006. She has a BS from Keene State College. She has expertise in state systems related to Early Childhood Health and CSHCN. Her previous experience includes statewide Care coordination and prior to that she dedicated herself to residential programming and quality care for children with developmental disabilities. She brings considerable partnership experience with public and private service agencies. She was the Director of a non profit, residential facility for CSHCN for 26 years and a MCH nurse in the community for 7 years.

#### PARENTS OF CHILDREN WITH SPECIAL NEEDS

New Hampshire Family Voices is supported by Title V funds. This includes funding for three staff who are parents of CSHCN. Martha-Jean Madison (the parent of eight CYSHCN) and Terry Ohlson-Martin (the parent of one CYSHCN) are Co-Directors of the project and Sylvia Pelletier (the parent of two children who are cancer survivors) is the Outreach Coordinator. ***//2013/ Three additional parents (Sally Weiss, Erika Downie and Kristen Costley) have joined NHFV, as part-time staff, and one young adult (Nicole Tucker) has joined NHFV as a Youth Coordinator.//2013//***

#### STAFFING CHANGES

The most significant staffing change to MCH will take effect July 1, 2010. The entire Childhood Lead Poisoning Prevention Program will move from MCH to a newly organized Bureau of Public Health Protection where it will be re-formed as the Healthy Homes and Environment Section combining Lead Poisoning and Asthma Control. This Bureau will also house the Radiologic Health Section; Food Protection Section and Health Officer Liaison.

Budgetary issues continue to make it challenging to fill positions. Currently, MCH has several vacant positions including its Perinatal Coordinator, Adolescent Health Coordinator and support staff. As new federal funding from the Patient Protection and Affordable Care Act becomes available, it will become more clear how these positions may or may not be filled or funds be

leveraged with new opportunities. Currently SMS has one FTE and one 0.5 FTE vacant positions that have been "frozen".

*/2012/*

The budgetary climate has remained challenging. It has become evident that it is unlikely that without new federal funds, the Adolescent Health Coordinator will not be filled. Upon the retirement of the Quality Assurance Nurse Consultant, that role was restructured to assume the responsibilities of the Perinatal Coordinator, as well. Although tentative approval has been granted to fill this position, a suitable candidate has yet to be found. The most positive staffing update has come from the ACA Maternal Infant and Early Childhood (MIEC) Home Visiting Program. Shannon Wood, MS was hired in February 2011 as the Home Visiting Program Coordinator. She has a MS in Early Childhood Education with a focus on Leadership and Policy from Wheelock College, 8 years of experience in early childhood education, and 3 years experience as a college faculty member and Early Childhood Education trainer. She has used her considerable writing skills to help MCH prepare the Home Visiting Needs Assessment and Updated State Plan. We are looking forward to her continued contributions to our team.//2012//

*/2013/*

***Having a sufficient and trained workforce continues to be one of the greatest threats to the infrastructure of Title V in New Hampshire. Budget reductions and budget policy, even when federal funds are available, make hiring an arduous process. For example, upon the retirement of the Quality Assurance Nurse Consultant, that role was restructured to assume the responsibilities of the Perinatal Coordinator, as well. The part-time perinatal position was vacant for over one year and the new combined role of Perinatal Quality Assurance Nurse Consultant took over five months to fill.***

***MCH was extraordinarily pleased when Ms. Fournier filled the Quality Assurance Nurse Consultant position in November 2011. She coordinates the primary care site visits, writes post-assessment reports, and follows up with all agencies that have "required actions". Ms. Fournier also conducts independent site visits to agencies receiving funding to support primary care services for the homeless. In addition, Ms. Fournier participates in several MCH perinatal initiatives related to maternal mortality, smoking cessation, and the promotion of exclusive breastfeeding. She is an active member of the PRAMS Steering Committee.***

### **MCH COMPETENCIES**

***While there may be challenges to maintaining a sufficient workforce, NH's Title V is committed to supporting the quality of the workforce that we do have. To be a leader in Maternal and Child Health requires specific knowledge, skills, personal characteristics, and values. MCH staff were asked to evaluate themselves using the MCH Leadership Competencies Assessment developed by MCHB. To make the process easier, the Title V Director created a SurveyMonkey version of the competencies. MCH staff identified several competencies where they felt they needed more growth, such as: identifying ethical dilemmas and issues that affect MCH population groups and the ethical implications of health disparities within MCH populations MCH staff also rated themselves as needing to more fully operationalize the "family centered care" philosophical ideals. Areas of self rated strengths included: the ability to apply evidence based practice guidelines; the ability to identify practices and policies that are not evidence based but are of sufficient promise that they can be used in situations where actions are needed; and the ability to interact with others and solve problems in an ethical manner.***

***MCH will use the feedback from the survey to guide training and technical assistance requests. Information from the survey will used as part of a Coordinated Chronic Disease Plan to support workforce. MCH will also share the results of this survey with the Division of Public Health Services as it goes through its Accreditation process as additional***

**evidence of workforce development.**  
**//2013//**

## **E. State Agency Coordination**

New Hampshire's Title V Program has a long history of maximizing limited financial and human resources through the development of partnerships and coalitions. By establishing common goals and objectives in a multitude of collaborative relationships, Title V has greatly expanded its reach throughout the state and within communities. Because of our limited capacity, Title V utilizes its many partners to help us accomplish our priorities.

Coordination of program activities takes place through joint efforts by Title V and others on topics of mutual interest and concern. Community and national health issues and available data drive the investigation, analysis and development of strategies to respond to these concerns.

Partnerships Impacting and Impacted by the Political Environment:

Because of Title V's broad reach and population health approach, Title V staff have been appointed and been invited to participate in numerous executive and legislative-level committees and workgroups including the:

- Brain and Spinal Cord Injury Advisory Council
- Coordinated School Health Council
- Council for Children and Adolescents with Chronic Health Conditions
- Mental Health Planning and Advisory Council **//2013/ Name changed to Behavioral Health Advisory Council//**
- NH Autism Council**
- NH Birth Conditions Advisory**
- NH Child Care Advisory Council**
- NH Child Fatality Review Committee-**  
**//2013/ - NH Maternal Mortality Review Panel //2013//**
- NH Childhood Obesity Expert Panel
- NH Children's Advocacy Network
- NH Early Childhood Advisory Council **//2013/ now re-designated by Governor Lynch as, Spark NH //2013//**
- NH Early Hearing Detection and Intervention Advisory
- NH Newborn Screening Advisory
- NH Non-Public School Advisory Committee
- NH Teen Driving Committee
- Suicide Prevention Council
- Vital Records Improvement Fund Advisory Committee  
**//2013/ - NH Strategic Highway Safety Plan**  
**- NH Sudden Unexpected Infant Death Review Group //2013//**

The role of Title V staff, either as leaders of these groups or active participants, is to provide expertise on the needs of women, children and families and through these partnerships identify and implement cross-cutting activities to help meet priority needs.

During the 2009-2010 legislative session, the NH General Court established the Committee on Committees as a response to the large number of legislatively created Non-Regulatory Boards, Commissions, Councils, Advisories and Task Forces across state government. The charge of the Committee on Committees was to engage in a thorough decision making process to determine which of the committees should remain in effect, be consolidated, or be sunsetted immediately or within one or two years. The rationale for this review and ultimate reduction of committees is part

of an overall strategy of the legislature to reduce costs and conserve state agency staff resources.

At the time of publication, it is understood that the Early Hearing Detection and Intervention Advisory will be terminated and it is unclear whether the Newborn Screening Advisory Council will be consolidated with another Advisory Council or maintained as is. It is also unclear which other important legislatively mandated committees will ultimately be affected by these changes. This speaks to the political challenges with which all executive and legislatively appointed committees, regardless of content area, are occasionally presented.

A positive example of collaboration related to the political environment has been the group effort by an extensive list of stakeholders that led to the subsequent creation of legislatively mandated Autism Council in NH. This effort began in 2001 when the NH Task Force on Autism was created by interested individuals (state and local agencies, private providers and families). They created a report on recommendations for Assessment and Interventions that was widely distributed. This stakeholder group continued to exert political pressure on the need for a more formal response to the considerable impact that Autism Spectrum Disorders (ASD) were having on families, service providers and state agencies. In 2007, the state passed legislation creating a Commission on Autism Spectrum Disorders. The NH Commission on Autism Spectrum Disorders submitted its report on Findings and Recommendations to the legislature in 2008. The legislature and governor reviewed this report and in 2008 created the NH Council on Autism Spectrum Disorders - to coordinate supports and services for individuals and their families. Title V is well represented in the Autism Council activities as workgroup members and Coordinating Committee chairs.

*/2012/* The Division of Public Health Services re-aligned in July 2010 in order to strengthen the Division's focus on protecting and promoting the population's health. Programs have been aligned for better integration to strengthen our capacity to address diabetes, heart disease, and other chronic conditions clearly linked to tobacco use, poor nutrition, and inadequate levels of physical activity that continue to cause long-term illness and disability. MCH is now in the same Bureau as WIC and other Chronic Diseases programs. New affinity groups, such as the Young Families Workgroup and Chronic Disease Integration Workgroup and Perinatal Smoking Workgroup, made up of partners across programs, address specific populations with innovative strategies that cut across the Division. *//2012//*

Partnerships to Support Families and Improve Socio-Economic Environment:

Title V has many collaborative relationships that improve supports for families. The collaborative relationships result in changes in policies, priorities, systems and resource allocation.

In New Hampshire, the Division of Family Assistance (DFA) administers programs and services for eligible residents providing financial, medical and food and nutritional assistance, help with child care costs, and emergency help to obtain and keep safe housing. Child Care Assistance assists parents engaged in work, training or educational activities leading to employment to afford quality care for their children. DFA determines eligibility based on rules and policies administered by the Child Development Bureau.

TANF & Family Planning Program (FPP):

This initiative coordinates FPP and Temporary Assistance for Needy Families (TANF) program efforts. TANF funds are allocated to the Title X Family Planning program within MCH to focus on expanding outreach to target Medicaid-eligible women and teens at risk for pregnancy. Program design was purposefully community-based, developed by family planning and primary care agencies aware of ongoing community efforts and unmet needs.

TANF, Medicaid & Home Visiting New Hampshire (HVNH):

This project supports 19 home visiting programs statewide, including one program with a focus on the state's largest minority and non-English speaking population, with TANF, Medicaid and Title V

funds. With MCH as the program administrator, and leveraging TANF funds for base funding and Medicaid support for fee for service reimbursement, HVNH provides health, education, support and linkages to other community services to Medicaid-eligible pregnant women and their families in their homes.

New Hampshire is looking forward to the opportunities that may be available through the Patient Protection and Affordable Care Act to better understand the additional home visitation needs throughout the state and then leverage additional federal resources to enhance the current core HVNH program.

#### Child Care Scholarship and Redesign:

The MCH ECCS program was a collaborative partner in the process to redesign the NH DHHS Child Care Scholarship Program establishing a more consistent payment to providers, reducing some out-of-pocket cost for families, supporting the inclusion of children with special needs, and encouraging increased quality from providers by creating a tiered Quality Rating System. Enacted in July 2009, this program was suspended in 2010 due to state budget constraints. Even with reductions in payments, a wait list has been developed for child care scholarships that is anticipated to reach more than 3,000 children by July 1, 2010.

#### Division of Children, Youth and Families (DCYF):

DCYF manages protective programs on behalf of NH's children, youth and their families. DCYF staff provide a wide range of family-centered services with the goal of meeting a parent's and a child's needs and strengthening the family system. Coordination with DCYF occurs through several Title V programs and mutual committees. The DCYF Division Director, MCH Child Health Nurse Consultant and SMS Medical Consultant are members of the NH Child Fatality Review Committee, described later in this section, and a representative of DCYF and the MCH Child Health Nurse Consultant are Board Members of the NH Children's Trust Fund. The Family Planning Program Manager is an active member with the Foster Care Health Program Advisory Committee, representing MCH, as are the CSHCN Director and Senior Physician, representing SMS. MCH and SMS are active members of the Watch Me Grow Steering Committee, a group initiated by the Title V Early Childhood Comprehensive Systems planning process, now working under the mandate of DCYF, under CAPTA and Early Supports and Services, under IDEA, for families to have universal access to developmental screening for young children. Additionally, the SMS senior state physician is now available for monthly consultation to DCYF.

#### Developmental Disabilities:

SMS is aligned organizationally as a part of the Bureau of Developmental Services (BDS). This affiliation has facilitated a great deal of informal collaboration between Title V and BDS. There have been some joint service efforts as well as overall system cooperation. The CSHCN Director is a member of the BDS Management Team and an SMS representative continues to be an appointee representing Title V on the Interagency Coordinating Committee for Part C. Other joint efforts include participation by SMS on the Council for Children and Adolescents for Chronic Health Conditions and the recent administrative transfer of oversight for the Partners in Health Program. In addition, HVNH has partnered with the Bureau of Developmental Services (BDS) by developing trainings for home visitors across professional disciplines regarding the Emotional Life of Infants and Toddlers. Currently efforts between Title V and the BDS are focused on the statewide initiative, Watch Me Grow, that is planning for statewide implementation of common developmental screening tools and guidelines to be used in a variety of settings.

#### Lifespan Respite:

Through a grant received by the Administration on Aging, Special Medical Services has initiated the creation of a Lifespan Respite Coalition and workgroups with representatives from the Bureau of Elderly & Adult Services, the Bureau of Behavioral Health, the Bureau of Developmental Services; the Division of Children, Youth & Families, New Hampshire Family Voices, NAMI-NH and Granite State Federation for Families. This initiative is working to create a state registry of respite providers (for all age groups), implementing a competency-based curriculum and

completing a pilot program on the impact of the competency-based training.

#### NH Family Voices:

Title V in NH has a very strong and longstanding collaboration with New Hampshire Family Voices (NHFV), which is also New Hampshire's Family-to-Family Health Information Center. SMS has funded parent consultation, through NHFV, for almost 20 years. In addition to the initial activities of helping families to access services, this role has evolved to incorporate leadership and policy development activities. SMS always seeks input from NHFV when making any kind of Administrative Rule or policy change. NHFV has also participated in discussions with MCH, Medicaid and Child Protective Services regarding rules, services and family needs. NHFV was an active participant in the Needs Assessment Planning Group along with related activities including the CAST-V process and the CSHCN Capacity Assessment.

#### Partnerships to Improve Health:

##### Child Fatality Review Committee (CFRC):

The CFRC is charged with reducing preventable child fatalities through systematic multidisciplinary review of child fatalities in NH. The MCH Child Health Nurse Consultant and Injury Prevention Program Manager have played key roles in the CFRC working closely with representatives from the Medical Examiner's Office, DCYF, the state police, and the Attorney General's Office. Title V staff revised the process by which committee recommendations are developed and tracked. Recommendations from the case reviews are often implemented in training provided by the Child Health Nurse Consultant to health, social service, and child care personnel, to reduce the risks of SIDS, promote safer sleeping environments for infants and toddlers, and promote referrals to parenting resources for high-risk families.

##### State Suicide Prevention Plan Committee:

The Injury Prevention Program and the Adolescent Health Programs collaborate with the DHHS Commissioner's Office, DCYF, and Behavioral Health and other statewide partners on the Suicide Prevention Council Legislated in 2008, the Suicide Prevention Council's mission is to implement the newly revised State Suicide Prevention Plan. The Injury Prevention Program facilitates the Communications Subcommittee. This committee works on both the communication of suicide prevention issues to the public and educating media on appropriate guidelines for reporting suicide.

##### The Disparate Populations Group:

Facilitated by the Division of Public Health Services, Bureau of Prevention Services Asthma Program Manager, this collaborative focuses on those sub-populations in the state with distinct health needs. This includes, but is not limited to, those who are incarcerated, the elderly, refugees and immigrants, and minority populations. This collaboration has strengthened the relationship between the Office of Minority Health and MCH. Within the past year, MCH has spearheaded interactive learning sessions with state prison and county jail medical professionals. ***2013/ This group was put on hiatus.//2013//***

##### Medicaid & Title V:

Title V strengthens the power and reach of Medicaid indirectly through the services Title V directly supports at the local level in community health centers, specialty clinics, family resource centers and through home visits. New Hampshire uses Title V and state general funds for community based agencies to provide outreach, coordination, and referral services. HVNH, a statewide home visiting network leverages TANF funds for base funding for family support, and uses Medicaid fee for service to support health education and as a strategy for EPSDT outreach and informing.

Title V has collaborated on policy and systems building initiatives with the Office of Medicaid Business and Policy to develop and implement local Medicaid codes that pay for Title V-related services, such as child and family support, nutrition and feeding services, and expanded prenatal

services. Title V staff have worked in partnership with Medicaid to revise Medicaid Rules and provide training in their appropriate use. /2012/ Medicaid and Title V have been revising the "Prenatal and Child/Family Health Care Support Services" rule, instituting new eligibility restrictions and prior authorization processes in order to provide cost-savings. //2012// Title V and Medicaid have been meeting to readopt a Memorandum of Understanding (MOU), that process has been productive but is currently on hiatus due to constraints related to internal capacity issues. /2012/ SMS worked extensively with Medicaid representatives in response to sponsored legislation directing the Department of Health and Human Services to create a proposal for a Medicaid Waiver for In Home Supports for Medically Fragile Children. Unfortunately, this legislation ultimately failed due to budget constraints and the legislative commitment to not approve any new spending. //2012// **/2013/ Medicaid and Title V have worked collaboratively on several objectives. A Medicaid representative was a core leadership member of SMS' Strategic Planning and the SMS Administrator was a member of the Medicaid communication workgroup related to the impending transition of CHIP services. Additionally, Medicaid is a collaborator on a new grant with the National Center on Ease of Use of Services.//2013//**

#### EPSDT:

The EPSDT Program works with MCH to provide data upon request, clarify program coverage issues, and work with the MCH Child Health Nurse Consultant on committees and workgroups such as the state's Child Fatality Review Committee and SCHIP quality assurance committee. The SMS Senior physician's position supports SMS activities as well as offering significant support to Medicaid including consultation on EPSDT issues, with a particular focus on issues of medical necessity.

#### Dental:

Medicaid's initiative to increase access to dental care has resulted in most reimbursement rates being raised, a strong partnership with the New Hampshire Dental Society reduced administrative burden of claims processing, ongoing parent and PCP education programs, and improved coordination of oral health programs across the DHHS. The Medicaid initiative focuses on improving access to dental care for underserved populations, such as CSHCN who continue to have limited access to dental care, through provider outreach and education efforts.

#### CSHCN:

Through a joint venture between Medicaid and SMS, there is a Nurse Care Coordinator position within SMS that is directly responsible for services to CSHCN who are newly enrolled in Medicaid. This coordinator offers outreach and support to all new enrollees in Medicaid through NH's Home Care for Children with Severe Disabilities (HC-CSD). The HC-CSD coordinator represents an ongoing link between Medicaid and Title V. This position has been integral to new rule development for Medicaid related to utilization of services for children qualified under HC-CSD criterion. This individual will continue to offer care coordination and will interface with Medicaid in an ongoing process of identifying children, who are at risk of becoming disqualified for Medicaid under this new rule, and working with their families to develop a modified service utilization plan.

#### SCHIP:

MCH collaborates with NH SCHIP and Healthy Kids to disseminate program information and policy changes to local MCH contract agencies, obtain feedback from local agencies to state level programs, and encourage local agencies to enroll all eligible children in SCHIP and Healthy Kids. SMS' care coordinators, providing services statewide, inform uninsured families about the NH Healthy Kids (Medicaid) programs and send applications. A designated care coordinator provides follow-up for families who have applied for SSI but are not receiving Medicaid or enrolled with SMS. This follow-up includes information and applications for SMS and/or Healthy Kids, as requested. The Healthy Kids program coordinator is available for consultation with SMS staff, and refers families as appropriate to NH Family Voices as well as to SMS. The MCH Child Health Nurse Consultant was a member of the SCHIP quality assurance workgroup (QCHIP) and the

workgroup overseeing three RWJ-funded ("Covering Kids and Families") pilot projects. MCH staff participated in the proposal review for the SCHIP contract with the Healthy Kids Corporation.

Title X Family Planning Program (FPP):

The New Hampshire Title X program is a major unit within MCH and is administered by the MCH Director, ensuring a seamless coordination between MCH and reproductive health services. Adolescent Health, IPP, and FPP personnel meet regularly to coordinate activities related to teens. As part of this work, the FPP Manager has spearheaded efforts to develop a plan for Preconception Care for NH. The FPP coordinates with STD/ HIV Prevention and the State Public Health Laboratory (PHL) to implement annual Chlamydia screening and treatment for female FPP clients between ages 15-24. Federal monies for this screening project are for women in the targeted category who would not otherwise be able to afford this screening. Funds are also provided to the PHL for testing and to STD/ HIV for treatment. ***/2013/ As described previously, NH's reproductive health care delivery system shifted in SFY12 when the NH Executive Council determined that the State could not contract with Planned Parenthood of Northern New England for family planning services. Additionally, state funds for sexually transmitted infections (STI) treatment have been significantly reduced and on-going funding from CDC for the Infertility Prevention Program is under modification. It is expected that future allocations will be focused more on training and technical assistance for STI's and no longer directed for clinical services, like screening and treatment. Title V, FPP, STD and Lab staff will continue to work collaboratively on coordinating efforts to monitor and screen for Sties. //2013//***

Adolescent Sexual Health Advisory Board:

Re-organized in 2009, the FPP has taken the leadership of the newly named Adolescent Sexual Health Advisory Board. This workgroup of partners representing Title V, Title X, community partners from across the reproductive health care and adolescent health spectrum have committed to engaging in a strategic planning process to ensure that all adolescents (10-19) and young adults (20-25) have access to quality health care services, as well as, skills, information and supports that promote healthy life choices. */2012/* The Adolescent Sexual Health Advisory Board convened and provided guidance to the Personal Responsibility Education Program (PREP). NH is focusing on 17-19 year olds and pregnant or parenting females up to age 21 in the City of Manchester and Sullivan County. Both of the target areas clearly show the greatest need for reducing unintended teen pregnancy due to the high number and rates of teen births. *//2012//*

Healthy Homes:

The Childhood Lead Poisoning Prevention Program (CLPPP) has resided within MCH from 2006-2010 and provides surveillance, education, comprehensive case management, investigation and enforcement on lead poisoning in children. As the CLPPP continues to work toward the goal of eliminating childhood lead poisoning, a program shift is under way to move from this single focus to address multiple environmental, health and safety risk factors. */2012/*In July 2010, the CLPPP broadened its reach and became the Healthy Homes and Lead Poisoning Prevention Program (HHLPPP). Although the HHLPPP is no longer housed within MCH, collaboration continues. CLPPP (now the HHLPPP) *//2012//* has formed a Healthy Homes Taskforce that includes other programs within DPHS, Department of Environmental Services, Bureau of Agriculture, Office of Energy and Planning, Community Action Programs, and Department of Safety, Fire Safety Program to create and implement a statewide strategic plan to better integrate services. */2012/*The taskforce, with its MCH members, has worked closely with the HHLPPP to pilot healthy homes "One Touch" projects throughout the state.*//2012//*

Early Childhood Comprehensive Systems (ECCS):

This MCHB-funded initiative is brought together partners from a wide variety of disciplines to develop a statewide plan for early childhood systems. The ECCS partners completed the Comprehensive Plan for Early Childhood Health and Development for NH that is implemented throughout partner agencies and serving in part, as the foundation for the development of the

New Hampshire Early Childhood Advisory Council, recently mandated by the Head Start Reauthorization Act. At the cornerstone of ECCS, is Healthy Child Care New Hampshire (HCCNH), a partnership of state agencies and programs that provide health and safety education and support to child care providers. The HCCNH leads the Health and Safety Committee of the Child Care Advisory Council. The HCCNH continues to liaison with DES and child care as they collaborate on innovative initiatives such as plans for integrated pest management in child care facilities

***/2013/ MCH leveraged ECCS funds and limited Title V funds to purchase "READY! For Kindergarten" in partnership with NH Department of Education (DOE). This curriculum provides parents and primary caregivers a series of 15 parent/caregiver classes. "Ready!" was used in four low-performing school districts in support of ECCS and Title V goals in that it addresses increased parental awareness of child development and standardized, validated screenings used to identify children at risk for developmental, behavioral or social delays. The success of this small pilot allowed the NH DOE to find additional resources to bring the program to larger scale. //2013//***

Rural Health and Primary Care Section (RHPCS):

RHPCS includes the Primary Care Office, the State Office of Rural Health, the Oral Health program and Workforce Development. Access to doctors, dentists, and other healthcare providers is a challenge for residents of some communities in New Hampshire. The mission of these programs is to improve access to healthcare services throughout New Hampshire particularly for those residents without commercial insurance. MCH and the RHPCS work as partners to administer contracts for 13 community health centers that provide primary care, including perinatal care, for low-income families.

WIC:

Title V works with WIC through a mutual knowledge of community agencies and a joint vision of services for women and children. Coordination of immunization, nutrition, breastfeeding promotion, injury prevention and lead screening strategies are shared across programs in both state office and in communities. For example, Title V and WIC staff also jointly participate on the New Hampshire Breast Feeding Task Force which not only meets the mutual goals of improving breastfeeding rates, but serves as an excellent platform for sharing information on a variety of perinatal topics such as co-sleeping, SUIDS risk reduction and newborn screening. ***/2013/ MCH and WIC collaborated on a successful application with the ASTPHND (Association of State and Territorial Public Health Nutritionist and Dieticians) for a mini-grant which will be used to train seven staff from MCH-funded home visiting program agencies to become certified lactation counselors. The MCH SIDS Program Coordinator has also worked with State and local WIC agency staff to develop strategies on getting safe sleep information to WIC clients, especially breastfeeding moms, including developing a prenatal packet that includes safe sleep material. //2013//***

Communicable Disease Control & Surveillance (CDCS):

The mission of CDCS is to monitor communicable diseases in NH. The Surveillance unit maintains the mandatory reportable disease system and is responsible for collecting, analyzing, interpreting and reporting infectious disease data. The Disease Control unit is responsible for infectious disease control activities, case follow-up, patient and provider education and disease outbreak investigation. MCH staff has worked with the Disease Control Program assisting in the state's H1N1 response by participating in clinical advisory groups, disseminating information in a timely manner to key stakeholders, including the local community health centers, and providing nurse staffing to cover routine disease outbreak. Title V continues to participate on workgroups for emergency planning for local response ambulatory care centers.

Data Infrastructure:

Critical to leveraging the infrastructure and capacity of MCH, the DPHS' Health Statistics Section (HSS) is a close partner in developing reports, analyzing data and acting as a technical resource.

The MCH Epidemiologist has collaborated with staff in the (HSS) to standardize data

## **F. Health Systems Capacity Indicators**

Health System Capacity Indicators (HSCIs) are helpful in tracking trends in the population and measuring progress toward our health system goals. The HSCIs are also helpful in benchmarking with other states.

The availability of information based on valid, reliable data is an important requirement for the analysis and objective evaluation of the health situation, evidence based decision-making and the development of strategies to promote health among our population. Because of our mandate to collect data regarding these HSCIs, Title V has improved its relationships with other data providers such as Medicaid and Vital Statistics who play a key role in improving data quality throughout the state.

Critical to many of the data improvement activities has been the continuation of the State System Development Initiative (SSDI) grant. SSDI has enhanced the data capacity of New Hampshire's Title V programs by improving existing and establishing new data linkages and surveillance systems. Current linkages between the birth files, perinatal care data files, and newborn screening data will enable in depth analyses, which identify priority needs for programs and interventions. It has also provided the infrastructure for the MCH Data Team to interface and develop relationships with other data stewards to ensure that MCH has timely access and accurate analysis of other data sources.

### **Health Systems Capacity Indicator 01 ASTHMA STRATEGIES**

Nationally, childhood lead poisoning, injuries, and respiratory diseases such as asthma have been linked to substandard housing conditions. The New Hampshire MCH Section and the Healthy Homes and Environments Section (which includes the Healthy Homes/Lead Poisoning Prevention Program (HHLPPP) and the Asthma Control Program) partner with the National Center for Healthy Housing (NCCH) and numerous NH stakeholders including MCH-funded primary care, child health, home visiting and child care funded agencies, to implement priorities from the 2009 New Hampshire Healthy Homes Statewide Strategic Action Plan.

MCH staff works closely with the Asthma Program to discuss ways to educate MCH contract agencies about how to keep children with asthma healthy and how to prevent acute episodes resulting in office, emergency room, and in-patient visits. Housing conditions associated with asthma and other respiratory illnesses include the presence of mold, excess moisture, allergens (i.e., dust mites, mice, and cockroaches) and tobacco smoke.

As of FY13, Community Health Centers will be required to follow the national Guidelines for the Diagnosis and Management of Asthma, 2007. At the June 2012 MCH Coordinators' meeting, the newly hired Asthma Program Clinical Quality Improvement Advisor for DHHS will be reviewing the guidelines with agency representatives. MCH staff will be altering its current site visit tool to include checking charts for adherence to this.

Due to the success of three healthy homes "One Touch" pilot projects, the Home Visiting NH-Healthy Families America program contracts now include "One Touch" requirements whereby home visitors help assess for healthy home risk factors and make referrals to housing resources like weatherization programs, HUD, and others.

### **Health Systems Capacity Indicator 02, 03 & 7A EPSDT SCREENING, MEDICAID SERVICES STRATEGIES**

Title V recognizes that New Hampshire's investment in its Healthy Kids Program has been critical to ensuring that all children have access to preventive health care and EPSDT. MCH and SMS have participated in numerous workgroups to provide leadership and technical assistance for policy makers and program specialists to ensure that kids have timely access to care so that the State can maintain its favorable outcomes. In 2011, 95% of children receiving Medicaid less than one year who received at least one initial or periodic screening. In NH, SCHIP had the same eligibility as Medicaid so the outcomes and data are the same. Beyond infancy and beyond those necessarily enrolled, 78% potentially Medicaid-eligible children received a service paid by the Medicaid Program.

Title V participates in the New Hampshire Children's Alliance that creates an annual list of priorities for children. Access to health insurance is always a priority and a critical part of any action steps leading to improved child health and safety.

Staff of MCH-funded Home Visiting NH agencies work with parents of infants to educate them on the importance of getting preventive care on schedule, and assist with transportation and other issues that may pose obstacles.

MCH reviews charts at its funded primary care agency site visits for adherence to the American Academy of Pediatrics (AAP)/Bright Futures Periodicity schedule for preventive visits and key health screenings. Almost all of the 13 community health agencies and the one pediatric primary care agency will be on, or is in the process of transitioning to, an electronic medical record system which will enhance the agency's ability to assure that children receive the necessary periodic visits on schedule.

Agencies use a variety of techniques such as reminder calls and postcards prior to a visit to enhance compliance, and follow up with phone and letters when a visit is missed. The increase of an electronic medical record system (EMR) that can generate postcards has helped facilitate the process. Infants, with the high number of required immunizations and more frequent acute care visits, tend to have a better show rate than children over one year of age.

Community agencies funded for MCH's Child and Family Health Support Services grant are required by their contract's Scope of Services to assure that children referred to their program for services have a primary health care provider/medical home, and they must monitor adherence to the AAP periodicity schedule.

With the community health centers and the eight community agencies that have received Child and Family Health Support Services, community-based organizations will continue their focus on helping families not only to enroll in SCHIP, but to maintain their eligibility and re-enroll without a gap in coverage. Because funding for community health centers has been in jeopardy and because the demographics of New Hampshire are changing, the overall numbers of children age 0-19 served by MCH-funded agencies was reduced by 5% between SFY10 and SFY11. There were fewer teens seen proportionately than children aged 0-12. Although the North Country saw significant reductions in this population, as to be expected because of overall reductions in the demographics, lower numbers of pediatric panels were also seen in some community health centers in areas of the state that are not experiencing the same out migration or decrease in population. At the same time, in the southeast corner of the state, pediatric populations in community health centers were growing.

MCH monitors its community health centers and community support programs through the contract agencies' required workplan performance measure of Percent of Eligible Children Enrolled in Medicaid/Healthy Kids Gold. In FY11, the community health centers had an average rate of 89%, with a range of 61--100%. The average rate for the Child and Family Health Support grantees was 98%, with a range of 93--100%.

One of the performance measures for Child and Family Health Support grantees is the percent of children aged 12 months to 19 years with at least one primary care provider preventive care visit in FY 2011. This is based on HEDIS measure definition on access to primary care practitioners. In CY2011, the average for this measure was 98%, with a range of 94-100%.

MCH staff conduct quality assurance site visits to the state-funded community health centers approximately every two years. Included in the chart audit is whether or not the child is receiving age-appropriate developmental screening, developmental surveillance, or autism screening (and the tool used, if any) according to the AAP recommended periodicity schedule. In general, agencies have shown great improvement in screening children according to the schedule, and use the MCHAT for autism screening. The completed MCHAT tool is typically scanned into the electronic medical record.

Developmental screening is covered as part of EPSDT. This coverage as part of the bundled service, however, does sometime present a challenge to collecting specific data on frequency of screening and what screens are used by practitioners since there are not separate billing records for them, nor are there added supports or resources for providers.

Two major changes in Medicaid services are anticipated. Starting on July 1, 2012, because of changes to NH State law, coverage under "Healthy Kids- Silver" and "Healthy Kids-Gold" will move to NH Medicaid coverage which will cover kids under the age of 19, up to 300% of the federal poverty level.

NH Department of Health and Human Services is holding 11 information sessions in June and July 2012 on the new Medicaid Care Management program. The meetings are for those who use Medicaid services as well as family members and caregivers and for human service agency case managers or service coordinators who work with them. Information covered will be on the first step of the new Medicaid Care Management program scheduled to launch later this year. The first step encompasses those Medicaid services that address medical needs, such as doctor visits, inpatient and outpatient hospital visits, prescriptions, mental health services, home health services, speech therapy and audiology services. Enrollment for the new program is projected to begin in October and services in December. Meeting topics will include basic information about: when the new program will start; what people will have to do when signing up for the program; how people can pick a Care Management health plan; and how the new program will work. Managed Care will thoroughly support all of EPSDT.

#### Health Systems Capacity Indicator 7B DENTAL SERVICES

In 2011, 67.1% of Medicaid eligible New Hampshire children aged 6 through 9 years received a dental service. This number is only slightly down from 2010 at 68%, and may reflect a leveling off of an upward trend of the past several years.

It is impressive that the percent of EPSDT eligible children ages 6-9 who received any school-based dental service has continues to increase in lieu of the fact that direct support for infrastructure for oral health services was reduced between 2009 and 2010. Two NH school-based oral health programs that serve students in 11 elementary schools did not receive state or local funding.

Perhaps even more importantly, the number of enrolled Medicaid dental providers has increased due to streamlined paperwork, modest rate increases and outreach efforts from the NH DHHS.

NH School-based oral health programs also provide preventive services to children enrolled in Head Start and the Women, Infants and Children's (WIC) Program. Most children enrolled in Head Start and WIC are enrolled in NH Medicaid. They are at-risk for dental disease but may not have access to a "dental home.". External grants for Head Start and WIC dental projects have

provided on-site preventive services and have raised family awareness of the importance of oral health to children's total health and the need to have a child's first dental visit by age one.

MCH staff conduct quality assurance site visits to the state-funded community health agencies approximately every two years. Chart audit items include documentation of age-appropriate oral health risk assessment, indication of a dental home or a referral to one, the drinking water source, fluoride content if the source is well water, and if indicated, an age-appropriate fluoride supplement according to the documented well water content. MCH continues to provide free well water analysis for fluoride content for all low income New Hampshire residents enrolled in the state-funded community health centers.

MCH continues to invite DPHS Dental Consultant, Nancy Martin, to its MCH Coordinators' Meetings periodically, to educate the agency staff on the importance of oral health care in the life course model. MCH disseminates information via email as appropriate to keep agency staff up to date on the latest findings, and on health education material that can be shared with MCH-funded program clients, in English and Spanish.

#### Health Systems Capacity Indicators 04, 5C and 5D: ADEQUACY OF PRENATAL CARE UTILIZATION

MCH in New Hampshire contributes funding to community health agencies throughout the state to provide prenatal care for underinsured and uninsured women, as well as those covered by Medicaid. The fifteen agencies provide a safety net of accessible prenatal care throughout much of New Hampshire, serving 16% of pregnant women in New Hampshire, with funding amounts based on a formula that accounts for need/poverty within the each community; the level to which behavioral health services and oral health services are integrated into basic care; accreditation efforts; and limited support for basic infrastructure and special provisions. This funding is critical to serving a population that is more likely to not receive adequate prenatal care, as indicated by the percent of women (15 through 44) with a live birth in the reporting year whose observed to expected prenatal visits were greater than or equal to 80 percent on the Adequacy of Prenatal Care Utilization (APNCU) Index or Kotelchuck Index. In New Hampshire, the total APNCU Index for 2010 was 80.6% among women receiving Medicaid and 90.4% among those not receiving Medicaid.

Unfortunately, there were significant state budget cuts in SFY12 and SFY13 impacting the community health centers where many low income pregnant women receive care. MCH ceased funding one categorical prenatal program in Sullivan County that primarily provided enabling services, although a community health center in the county will remain accessible for clinical and supportive services for all women regardless of ability to pay. In SFY 11, 2,098 prenatal women received care. This number is slightly lower than in years past and may be reflective of a decreasing birthrate in New Hampshire, although the proportion of pregnant women receiving care in the community health centers is higher than in years past.

This safety net of prenatal care helps ensure that women have access to prenatal services early in their pregnancy and have the support to receive consistent care. MCH monitors the community health centers' contract agencies' required workplan performance measure of prenatal entry to care. In FY11, the community health centers had an average rate of 82%, with a range of 73--100%, higher than the overall statewide rate of Medicaid recipients receiving care in the first trimester. Variation among the communities is attributed to cultural differences in accessing care and variation among clinics with small numbers.

In order to further support vulnerable populations within the state and try to find perinatal women who may not be getting the care that they need, MCH will use a federally approved data collection plan to measure the percent of women enrolled in the Home Visiting NH-Healthy Families America program receiving "adequate" Prenatal care among those scoring adequate or below using the APNCU Index a.k.a. Kotelchuck Index; specifically the "Adequacy of Received

Services" dimension. Women in the program who enrolled in the first or second trimester of their pregnancy, gave birth in the last year, and scored "Adequate" or below on the "Adequacy of Received Services" dimension of the APNCU Index, for whom the program has records with complete data for calculating the APNCU Index. The definition of improvement includes a comparison of Cohort 1 to Cohorts 2 and 3 combined to ensure that adequate data is available to make the comparison by the 10/1/14 reporting deadline. Limiting the denominator in this way eliminates the high-risk pregnancies that will score "adequate-plus" due to the need for more prenatal visits.

#### Health Systems Capacity Indicator 05B INFANT DEATHS

Although New Hampshire is fortunate in that its infant mortality rates typically compare favorably to national rates, communities and Title V professionals continue to focus on efforts to ensure that every baby has a first birthday. State averages may mask the fact that disparities that are evident in other regions of the county also exist in New Hampshire. Disparities exist between those who receive Medicaid who have an infant death rate of 5.9 per 1,000 live births and those who do not receive Medicaid who have an infant death rate of 2.0 per 1,000 live births.

Approaches and strategies to impact infant mortality and to ensure greater equity vary. Some address general maternal health such as efforts to reduce chronic disease and improve healthy behaviors among pregnant women and women of reproductive age. Others efforts emphasize ensuring access to a safety net of health care services including, health education, prenatal counseling, prenatal care and preconception and interconception health preventive care. New Hampshire has embraced population based strategies such as Text4baby, as a way to leverage social media health messaging literally into the hands of pregnant and parenting women who are primed to make behavior changes. Still other approaches are more specific, concentrating on reducing the incidence of Sudden Infant Death Syndrome or Sudden Unexpected Infant Death (SIDS/SUID), which is the leading cause of death for babies from one to 12 months of age.

In late 2010, MCH was awarded one of seven CDC grants to pilot a Sudden Unexpected Infant Death Registry. Data collection began with deaths January 1, 2011. The grant is being carried out in collaboration with the NH Office of the Chief Medical Examiner, which has the authority to collect infant death investigation information. Child Death Review in New Hampshire, coordinated by staff at the Department of Justice, has traditionally been clustered reviews of similar deaths from the last few years and includes an educational component and a strong emphasis on drafting prevention recommendations. The SUID Case Registry grant captures all infant deaths referred to the Medical Examiner's office. It has modified child death case reviews and has aimed to improve timeliness of data analysis. Information from the data collection will help MCH better understand the demographics and contributing risk factors so that prevention strategies can more effectively targeted.

Six Sudden Unexpected Infant Death (SUID) Review meetings were held between June 2011 and May 2012 to review nine of the eleven SUIDS that occurred in 2011. Two cases that were not reviewed remain open by state or local Attorney General Offices as possible neglect or homicide deaths. These two cases had data entered into the case registry but were not openly reviewed. Recommendations were developed by the multi-disciplinary review group not only to reduce the risk of SUID, but also to improve death scene investigations, such as that included disseminating laminated developmental milestone "cheat sheets" for death scene investigators to use at infant death scene investigations to better assess accuracy and correlation of witness' story with findings; educating hospital nursery providers about revised AAP recommendations, including no blankets, no side propping; changing the practice at Medical Examiner's Office to use Preemie Growth Charts to plot preemie growth measurements for Autopsy Report, and educating home visiting programs on the importance of viewing infant sleep setting and including safe sleep education during visit. The eleven SUID cases included five with final diagnosis of "Undetermined" and two of SIDS. Clustering deaths from SIDS, Undetermined, and Deaths from

Accidental Suffocation and Strangulation in Bed, puts this cluster as the number one cause of infant deaths for infants one month to one year of age, and number two cause of death for all infants in the state. New Hampshire has applied for CDC SUID Registry Building Capacity funding to continue the work of this SUID Project, focusing on decreasing time that cases are identified, reviewed, and completed data are entered. Additionally, plans include analyzing the data to develop a findings report to develop and implement actionable prevention strategies, and doing a public and professional educational outreach campaign when the new national Safe Sleep material is released.

Continuing to focus more broadly on prevention, home visitation programs have demonstrated positive outcomes in several areas related to infant mortality, including improved pregnancy and infant health outcomes, reductions in child abuse and neglect, and helping parents identify and access appropriate health care for their children. The federal Maternal, Infant, & Early Childhood Home Visiting (MIECHV) Program is designed to assure effective coordination and delivery of home visiting services, within a quality, comprehensive statewide early childhood system, to ultimately improve health and development outcomes for at-risk families.

In New Hampshire, the MIECHV program is being implemented in five communities identified through a Needs Assessments completed in SFY10 and SFY 11 as having concentrations of premature birth, low-birth-weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health, poverty, crime, domestic violence, high rates of high-school drop-outs, substance abuse, unemployment, or child maltreatment.

Looking forward, with the support of a competitive MIECHV expansion and evaluation grant, the program is being expanded to the remaining counties in the state, that were also identified as having pockets of high risk. The evidence-based national home visiting model being implemented in New Hampshire through the MIECHV program is Healthy Families America, a model proven to improve outcomes for families in the areas of maternal and child health, positive parenting practices, and family economic self-sufficiency. Specifically related to infant mortality, the Healthy Families America model has led to reductions in infants with low-birth weight, child abuse and neglect, and improved safety practices and safe home environments.

#### Health Systems Capacity Indicator 08 SSI BENEFICIARIES

SMS has an outreach program that targets all families of children (with chronic health conditions) newly accepted for SSI. This process incorporates written and telephone contact from a Nurse Care Coordinator to assess the needs of families and to connect them with the appropriate resources, including Special Medical Services.

All new SSI enrollees with a primary medical diagnosis - whether they have Medicaid or not - receive an outreach letter indicating what services SMS might be able to offer them with contact information for the SSI Coordinator. The written outreach letter has also been translated into Spanish to better connect with those who speak Spanish as their primary language. In addition, outreach letters are sent for all new enrollees with a primary mental health or Autism diagnosis, indicating which community and state services and agencies are intended to support their needs.

There has been a noted increase in both SSI applicants and of the number of children granted SSI benefits for their own disabilities.

The rate of children, in New Hampshire, under the age of 16 receiving SSI benefits has increased in each of the last 4 years. It is possible that the rationale for this is related to negative changes in the economy, resulting in more children meeting the financial eligibility criteria. There is also a need to consider a correlation with the significant rate of children being diagnosed with Autism Spectrum Disorders as part of this increase. The percentage of those children being served by

Special Medical Services through outreach has also increased. It is possible that SMS' efforts at outreaching to community agencies to make better connections has been successful. The consistent increase in children qualifying for SSI has been matched by a consistent increase in the number of children with SSI being service by Title V, through SMS. This is undoubtedly due to the ongoing collaboration with the Social Security office for identification of these individuals and the now routine process of outreach to all new SSI enrollees.

#### Health Systems Capacity Indicator 09A GENERAL MCH DATA CAPACITY

SSDI funding enables MCHS to access to timely and accurate data for both internal and external users. Through collaborative efforts with all data stewards and users, MCHS will increase its ability to obtain vital records and Medicaid data for reporting on Title V performance measures and ongoing needs assessment, and increase the ability and skills of project staff to analyze these data routinely.

The Section continues to improve linkages between birth certificate and Newborn Hearing Screening Program and Newborn Screening Program data to assure that all newborns are screened for hearing loss and metabolic and other disorders at birth. The system to link birth and prenatal data is completed and now contains 3.5 years of complete data. MCH has begun analysis of the data and created reports for the contracted prenatal care agencies. MCH staff is continuing to work on enhancements to improve the record linkage rate and other functions to make the system more usable. The Data Mart, which will eventually house all linked MCH data, continues to mature as progress is made in carrying out the linkage plan. Planned expansions of data linkages include linking Medicaid and WIC data with MCH program data. These linkages will assist the Section in assessing the MCH population and evaluating MCH programs.

The development phase of the MCH Data Mart, which will house all MCH-related data sets, was completed in 2010. The database contains in-state birth data linked with Newborn Screening Program (NSP) and AURIS data (Early Hearing (EHD), Perinatal client, Birth Conditions), as well as value-added fields (cleaned and reformatted race/ethnicity, gestational age, including imputed values, etc.). Annual progress included analyses of the AURIS and NSP data, programming, functional and system design work, and completion of the system requirements documentation. The project is currently in the user acceptance-testing phase.

A change in leadership of the New Hampshire Division of Vital Records Administration in 2009 resulted in an improved working relationship and significant updates to the dataset. The manual process of entering NH resident births into the vital records system remains a barrier to timely data. However, the NH Division of Vital Records Administration (DVRA) has demonstrated a commitment to improving this by implementing the State and Territorial Exchange of Vital Events (STEVE) standards to electronically and securely exchange records with other states. A barrier has been the lack of STEVE capability in our neighboring states. Since most of the out-of-state NH resident vital events occur in Massachusetts, their recent progress in implementing a new electronic vital records system is very encouraging for improving NH data timeliness within the upcoming project period. The MCH Epidemiologist has been working closely with the State Registrar and DVRA Director to resolve this issue, because of the importance of out of state records to the PRAMS survey (approximately 8% of NH births occur out of state). This effort recently met with success when Massachusetts provided the birth records from 2011 that had been missing for over a year, and DVRA staff completed entry of the records into the database where they are available for analysis.

Implementation of NH Vital Records Information Network (NHVRIN) II is scheduled for October 1, 2012 and is expected to further improve data quality. The MCH Epidemiologist has been consulted by DVRA on the issue of cleaning and standardizing vital records data across years and certificate versions as the data are transitioned to the new NHVRIN II database structure.

The most significant data systems accomplishment has been the progress of the Pregnancy Risk Assessment Monitoring System (PRAMS) project, awarded to New Hampshire in the Fall 2011. The project is in the start up phase, with data collection to begin Fall 2012.

#### Health Systems Capacity Indicator 09B TOBACCO

In order to address smoking among youth, it is important to address environmental access. New Hampshire continues to make positive progress among retailers as they help enforce state policy and law. Tobacco merchant compliance with laws concerning tobacco sales to youth in New Hampshire continues to increase. The rate of retailers selling to youth dropped to 7.8% in 2011. This number is down from 8.6% in 2010, and a dramatic decline from 14% in 2009. Research demonstrates that lower tobacco use by youth also decreases the chance that they will use drugs or alcohol.

In 2011, the Youth Risk Behavior Survey (YRBS) revealed that:

8.9% of the students smoked a whole cigarette for the first time before age 13 years. This is a linear decrease from 2009 results, but not significant. 10.1 % of males answered affirmatively as did 7.6% of females.

19.8% of the students smoked cigarettes on one or more of the past 30 days. This is a linear decrease from 2009 results, but not significant one. 22.1 % of males answered affirmatively as did 17.5% of females.

9.7% of the students smoked cigarettes on 20 or more of the past 30 days. This is no different from 2009 results. 11.6 % of males answered affirmatively as did 7.9% of females.

8.4% of the students used chewing tobacco, snuff, or dip on one or more of the past 30 days

## **IV. Priorities, Performance and Program Activities**

### **A. Background and Overview**

New Hampshire recognizes that the needs assessment process is continuous. Data and public input about our programs, populations and maternal and child health issues must be systematically reviewed annually. Results from the 2010 Statewide Needs Assessment, state and national performance measures, health systems and capacity indicators, public comment and community stakeholders provided an even richer, more comprehensive picture of the Title V needs and capacities in our state. Together, the priorities represent each of the four levels of the MCH pyramid and all MCH population groups.

State government, community based organizations and systems of care must implement systemic change in order to make substantive improvements for the Title V population. To affect needed change, Title V must select among many possible priorities. This is a complex process that requires weighing multiple factors, including known data, capacity and service gaps, state priorities, and emerging issues. In the past decade, NH's Title V planning and prioritization process has become stronger, more structured and much more deliberate in order to meet the health needs of a population growing in its diversity. It is imperative to continue to methodically move towards reducing health disparities and enhance the cultural competency of local and state MCH programs. Similarly, recognition of other social determinants influencing health outcomes -- poverty, education, and availability of affordable housing, for example -- are seen as guiding themes that are interwoven throughout all priorities and activities. Priorities and State Performance Measures (SPM) have been developed that are purposefully broad and systems-focused, and likely to respond to evidence-based interventions.

SPM 1: The rate of psychotherapy visits for adolescents ages 12-18 years, with a diagnosed mental health disorder.

Addresses Priority 1: To improve access to children's mental health services.

SPM 2: Percent of 3rd grade children who are overweight or obese.

Addresses Priority 2: To decrease pediatric overweight and obesity

SPM 3: Percent of 18-25 year olds reporting binge alcohol use in past month.

Addresses Priority 3: To decrease the use and abuse of alcohol, tobacco and other substances among youth, pregnant women and families.

SPM 4: Percent of Community Health Centers providing on-site behavioral health services.

Addresses Priority 4: To improve the availability of adequate insurance and access to health care and maintain the infrastructure of safety net providers/services.

SPM 5: The percent of parents who self-report that they completed a standardized, validated screening tool used to identify children at risk for developmental, behavioral or social delays.

Addresses Priority 5: To improve access to standardized developmental screening for young children.

SPM 6: The rate (per 100,000) of emergency department visits among youths aged 15-19 resulting from being an occupant/driver in a motor vehicle crash

Addresses Priority 6: To decrease unintentional injury, particularly those resulting from falls and motor vehicle crashes, among children and adolescents.

SPM 7: The percent of households identified with environmental risks that receive healthy homes assessments.

Addresses Priority 7: To reduce exposure to lead hazards, asthma triggers and other environmental hazards to assure safe and healthy home environments.

SPM 8: Percent of New Hampshire communities with fluoridated water systems that fluoridate within the optimal range.  
Addresses Priority 8: To improve oral health and access to dental care.

SPM 9: The percent of families with children/youth diagnosed with severe emotional disturbance, moving into permanency placement through DCYF, who have access to a trained respite provider for up to 50 hours during the first year of placement.  
Addresses Priority 9: To increase family support and access to trained respite and childcare providers.

SPM 10: The percent of preterm births to mothers who reported smoking before pregnancy.  
Addresses Priority 10: To decrease the incidence of preterm birth.

Once priorities are set and the appropriate metrics for evaluation are assigned, it is critical that strategies and interventions are aligned with existing Title V capacities and leveraged with collaborative partnerships.

For example, children and youth from low-income families are at an increased risk for mental health disorders and in NH, the Medicaid population presents with twice the service use prevalence for mental health services compared to privately insured children. In rural areas, the prevalence of children with mental disorders is similar to that in urban areas, but there are increased barriers to care, resulting in delayed treatment. There are additional significant geographic disparities in capacity. The northernmost counties do not have the mental health workforce, especially those who are trained to meet the needs of children. Community health centers, among other providers, are left to try, at best, innovative and integrated methods to address growing needs. Therefore, to measure access to service, Title V will measure the rate at which adolescents on Medicaid with a documented mental health disorder have a documented annual psychotherapy visit. This measure, also used by the NH Office of Medicaid Business and Policy, will help us better understand whether or not adolescents are receiving appropriate care. Further analysis will allow us to look for regional disparities.

Several of NH's priorities and performance measures lend themselves to collaborative and integrated interventions. Title V will utilize strategies like Text4Baby, a mobile phone-based health promotion program, while developing new partnerships to build infrastructure and strengthen enabling services. By measuring smoking prevalence rates, NH will maintain focus on one area where our state does not compare as favorably when compared to other states. Through continued multi-pronged efforts like social media messages to quality improvement efforts to increase adherence to the 5 A's, Title V ultimately will impact the rate of preterm birth.

Annual report accomplishments, current activities, and planned activities for each of the 18 National Performance Measures and other outcome measures and indicators are discussed in the following sections.

## **B. State Priorities**

### STATE PRIORITIES

The New Hampshire Title V Needs Assessment is intended to be a living document that will inform stakeholders and community partners and focus the direction of program design and resource allocation. It is anticipated that the activities described below will be modified as they are continuously evaluated.

To improve access to children's mental health services

Access to mental health services continues to be an identified need in New Hampshire, and the need for these services is great. An estimated 20% of New Hampshire children aged 5-19 have a

diagnosed mental disorder, 3-5% of children are estimated to have attention disorder and 0.7% were diagnosed with an autism spectrum disorder. Mental and behavioral health disorders can impact a child's emotional, intellectual, and behavioral development and can hinder proper family and social relationships. Treatment capacity for mental health issues is limited in the state, and concerns about cost are a considerable barrier for families seeking care, regardless of insurance status.

Because of these needs, activities in the following year will include: maintenance of community health center (CHC) funding that provides incentives for increased integration of behavioral health services in primary care; education of CHC staff about use of validated screening tools for specific MCH populations including early childhood, adolescence and perinatal periods; partnerships with experts in psychopharmacology to provide training to CHCs; statewide collaborative activities on perinatal depression; and recommendations for statewide systems improvements in Maternal Mortality Review

Strategies for CHYSCN include: exploration of using Title V/CSHCN funds to create psychiatrist consultation available for primary care providers for children managing psychiatric medications and participation in DHHS evaluation of feasibility of an In-Home Supports Waiver for children with diagnosed mental health disorders.

To decrease pediatric overweight and obesity.

Obesity in children and adolescents in the United States of America has become a critical health problem with enormous health and economic costs. More than 29% of NH school aged children are overweight or obese. There are disproportionate effects among low-income families, families of certain ethnic groups and families where there is parental obesity. Children living in poverty in less educated families as well as children of Hispanic and African American background are more likely to be overweight.

Title V will take an integrated approach to address this issue that has life course and population health ramifications. Strategies will include: increased breastfeeding training for providers; education of CHCs about recommended protocols to follow when BMI is > 85 percentile; education and strategies about family engagement and how to talk to parents about overweight/obesity issues, and ensuring all eligible families are enrolled in WIC. SMS coordinators will document the BMI of children with special health care needs newly enrolled in the Care Coordination program upon receipt of primary care records and identify appropriate referrals for those overweight or obese children. All children in the Neuromotor clinic will have their BMI assessed at clinic visits and identify appropriate referrals for those overweight or obese children. Both SMS and MCH staff will continue participation in I Am Moving, I Am Learning trainings for childcare providers. Additionally, technical assistance from the Region I Knowledge to Practice resource will focus on understanding the lifecourse implications and strategies for including CSHCN into statewide overweight and obesity initiatives. This is scheduled for the Fall 2010 with expert assistance from Boston University.

To decrease the use and abuse of alcohol, tobacco and other substances among youth, pregnant women and families.

Smoking during pregnancy accounts for 20-30% of low-birth weight babies, up to 14% of pre-term deliveries and about 10% of all infant deaths. In NH in 2007, 21.7% of women of childbearing age smoked, compared to 21.2% of women overall in the U.S. YRBS data reveals that 45% of NH high school students had an alcoholic drink in the past 30 days and 28% participated in binge drinking. Over 50% of NH young adults 18-25 participate in binge drinking.

Because of the cross cutting health and social needs related to tobacco, alcohol and substance abuse, the following strategies are being implemented: CHCs will use validated screening tools for specific MCH populations including adolescence and perinatal period; innovative

collaborations, such as the home visiting partnership with Child and Family Services, to provide home --based TWEAK assessment and referrals for treatment to alcohol abusing pregnant women; social media messaging with high school students combining binge drinking and sexual violence messages. MCH will continue partnerships to address smoking cessation activities with specific MCH populations including youth, adolescents and pregnant women.

To improve the availability of adequate insurance and access to health care and maintain the infrastructure of safety net providers/services

Uninsured children are at higher risk for negative long-term effects on health and economic productivity than insured children.(9) The uninsured use fewer screening and prevention services and delay care when sick, so when they do enter the medical care system, they tend to be sicker and at more advanced disease stages than the insured. This contributes to higher rates of morbidity and mortality for the uninsured both in general and for specific diseases.(11) Although NH compares favorably to the U.S. for rates of uninsured children, there are age and income disparities.

Title V staff will continue to work with Community Health Center staff as they track/monitor when children's Medicaid coverage is about to lapse in order to decrease "churning" thereby increasing retention and improving "re-determination" rates. MCH will continue to monitor performance measures of direct and enabling services, which ensure that all eligible children are continuously enrolled. NH Family Voices and SMS staff provides assistance via phone and mail out packets regarding what to bring to the District DFA Office when applying for TANF and HKG, including HC-CSD. At the state systems level, Title V staff will continue to collaborate with SCHIP and Medicaid staff on state/local level on initiatives.

Beyond simply having access to an insurance product as a means to care, Title V will specifically work with community health centers to increase their capacity to integrate mental health services with primary care to enhance access. To accomplish this agencies will provide training for primary care staff about behavioral health issues; provide training for behavioral health staff on the use of the electronic medical record; and encourage case management to coordinate primary care and behavioral health care. MCH will fund a variety of models of care and will facilitate the exchange of information from successful programs to others.

To improve access to standardized developmental screening for young children

Nationally, 17% of children have a developmental or behavioral disability such as autism, intellectual disability (also known as mental retardation), or Attention-Deficit/ Hyperactivity Disorder (ADHD); there are additional children with delays in language or other areas. Less than half are identified before starting school, impacting future development and readiness to learn. Improved standardized developmental screening identifies these delays early and enables children to receive early intervention services to be better prepared to learn when entering school.

Title V will coordinate with partners across systems to ensure that families have access to developmental screening for their children and will assist parents with the completion of ASQ & ASQ/SE through Home Visiting New Hampshire programs and the Watch Me Grow initiative. MCH and SMS will also work with partners to: promote and support connections between professional organizations and service providers; participate in workgroups of the Autism Council and collaborate on submission for funding opportunities to create regional teams of experts on autism.

To decrease unintentional injury, particularly those resulting from falls and motor vehicle crashes, among children and adolescents.

Injuries are among the most serious and under-recognized public health problem. In New Hampshire and in the U.S., unintentional injuries are the leading cause of death and hospitalization to children and adolescents, killing more in this age group than all diseases combined. Injuries are predictable and preventable through a public health approach. In the time period 1999 through 2006, there were 527 deaths in ages 1-24 due to unintentional injuries with a rate of 16.31 deaths per 100,000 people in that age category. The majority of unintentional injury deaths from age 6 to 24 are due to motor vehicle crashes. In NH, falls are also the leading cause of unintentional injury emergency department visits and hospitalizations for ages 0 to 24.

Activities for motor vehicle injury prevention will include: development of a website hosted by the Department of Transportation geared towards parents of novice drivers; implementation of parent survey on graduated drivers licensing; facilitation of NH Teen Driving Committee on a monthly basis; revision of teen driving component of Strategic Highway Safety Plan.

To reduce exposure to lead hazards, asthma triggers and other environmental hazards to assure safe and healthy home environments

A growing body of evidence links housing conditions to health outcomes such as asthma, lead poisoning, lung cancer, and unintentional injuries. Children, especially those under age 6, are more likely to suffer persistent developmental delays, learning disabilities and behavioral problems as a result of their exposure to lead. Approximately 30% of New Hampshire housing stock was built prior to 1950 when lead paint was commonly used.

Morbidity associated with asthma is high. Emergency department use, hospitalization, decreased lung function and death can characterize the experience of both adults and children with uncontrolled asthma. Approximately 10% of NH adults and 8% of children currently have asthma and the prevalence is increasing. Approximately one-third of all New Hampshire children live in homes where a person smokes, making exposure to tobacco smoke a significant problem for these children. Health disparities for asthma occur by gender, age, educational level and household income.

By taking a "Healthy Homes " approach to these issues, MCH will address the environment and systems that affect the lives of families throughout the state. MCH will work with state and local partners to increase the number of Healthy Homes Specialists credentialed in throughout the state; create an operational checklist, protocols, and referral network for healthy homes activities; and increase home visits for healthy homes assessment, education, outreach.

To improve oral health and access to dental care

Tooth decay is the most common chronic childhood disease, and is largely preventable through a combination of community, professional and individual strategies. Like the adult population, many children from low-income, uninsured families do not have access to regular oral health care and education. Many dentists do not accept Medicaid clients, nor do they have a sliding fee scale. Community water fluoridation is underutilized in New Hampshire. The NH Third Grade Healthy Smiles-Healthy Growth Survey found that approximately 44% of NH 3rd grade students experienced tooth decay and 12% of students had untreated decay at the time of the survey. Regional disparities in oral health were detected. Children attending schools with a higher free and reduced lunch program participation rate, as well as all students in Coos County, were more likely to have experienced decay, have untreated decay, and be in need of treatment, and they were less likely to have dental sealants.

In addition to traditional direct and enabling services to increase access to oral health care, Title V will work in partnership with the DPHS Oral Health Program and the NH Department of Environmental Services (DES) to enhance the quality of the fluoridation of municipal fluoridation systems. The state fluoridation administrator will be responsible for managing the fluoridation

system by promoting water fluoridation while the Title V staff will liaison with local systems to encourage appropriate levels of added fluoride in their systems. To build capacity and infrastructure, MCH will help facilitate fluoridation courses with DES to train water plant operators.

To increase family support and access to trained respite and childcare providers.

Over two-thirds of families of NH SSI CSHCN surveyed reported that they provide health care for their child at home; half of these families reported having to cut work hours to care for their child even while experiencing financial distress. The need for respite care for CSHCN is increasing, and availability of providers is limited. There are no coordinated respite services and extremely limited funding; what is available is not equally distributed throughout the State in the area of developmental disabilities. There is no respite funding available for behavioral health and an extremely limited number of respite providers with training.

Because this need was so strongly stated by families who most need this service, SMS plans to build public awareness and education about respite resources. SMS will create a competency-based curriculum with competency-based training and registry of respite providers and coordinate a Lifespan Respite Coalition.

To decrease the incidence of preterm birth

Preterm birth has enormous health, social and economic costs. Smoking during pregnancy accounts for 20-30% of low-birth weight babies and up to 14% of pre-term births. Of women using MCH-funded prenatal clinics (during the period 7/1/07-6/4/09), 43.2% smoked 3 months prior to becoming pregnant. Disparities are evident among racial, ethnic and socioeconomic groups. Since 1990, teens and young adults have had the highest rates of maternal smoking during pregnancy. Thirty-seven percent of NH women on Medicaid smoked during pregnancy. Interventions such as reducing maternal smoking have the potential to reduce the preterm birth rate and improve the health of infants and children and are within the scope of Title V responsibilities in expanding preconception care.

In order to address and understand the many causes and drivers of preterm birth, MCH will work with partners to develop the Maternal Mortality Review Panel; build the capacity of CHCs to better support smoking cessation to pregnant women and women of reproductive age; and develop a plan for preconception health that integrates models of chronic disease prevention and reproductive health.

### C. National Performance Measures

**Performance Measure 01:** *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	23	23	27	14	20
Denominator	23	23	27	14	20
Data Source		screening records	screening records	screening records	screening records

Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	100	100	100	100	100

**a. Last Year's Accomplishments**

**DAILY TASKS:**

Continued to manage the essential daily tasks of the Newborn Screening Program including: daily reporting out of results back to birth hospitals; daily data linkage with vital records to assure that all newborns receive newborn screening; technical assistance to birth hospitals, midwives and providers as needed; tracking and follow-up of infants who missed screening or who need repeat screenings or further evaluation by specialists. (PB)

The linkage rate between the birth certificate and Newborn Screening Program data is currently at 90% for the period 1/1/12 --5/31/12. This rate has been consistent for some time. Newborn Screening Program Coordinator matches the remaining 10% of records manually. With New Hampshire's low number of births (approximately 12,000 per year), a 90% linkage rate is considered sufficient, and manually linking 10% of births does not overburden the Coordinator. (PB)

Monitored numbers of both refusals and misses in order to better target educational efforts. (PB)

**SYSTEMS BUILDING:**

Planned and completed site visits to 16 of 21 NH birth hospitals. (IB)

Provided QA Report to New Hampshire birth hospitals biannually with statistics on their performance regarding newborn screening. Worked with Dartmouth student on project to evaluate effectiveness of this tool. (IB)

Revised/reprinted state newborn screening brochure to include information on NH state policies regarding storage and ownership of residual DBS specimens. (E)

Utilized the services of the Metabolic Medical Consultant in reporting out of clinically significant newborn screening results. (IB)

Created new budgetary structure for Newborn Screening program for SFY12 and SFY13, which made program self-sustaining. (IB)

Developed RFP for laboratory services, as current contract with UMASS lab expired on June 30, 2011.

**REGIONAL AND NATIONAL EFFORTS:**

Participated in regional activities including NERGG, New England Metabolic Consortium Annual Meeting and New England Genetics Collaborative (NEGC) grant opportunity including the Long Term Follow-up Workgroup effort. (IB)

Participated in Regional Symposium regarding Emergency Preparedness in Newborn Screening. Findings from this symposium were incorporated into New Hampshire's Hospital Preparedness

Program and Public Health Emergency Preparedness (PHEP) submission. (IB)

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to manage the essential daily tasks of the program.			X	
2. Continue to support the work of the Newborn Screening Advisory Committee around screening for CCHD and SCID.				X
3. Provide formal feedback via the QA Report to New Hampshire birth hospitals and home birth providers biannually with statistics on various aspects of the newborn screening process.				X
4. Perform the Data Linkage Process daily and monitor findings (refusals and misses) of this process.				X
5. Support educational efforts regarding newborn screening through periodic presentations and dissemination of newborn screening brochures.				X
6. Utilize the services of the Metabolic Medical Consultant via the Service Delivery Agreement for handling clinically significant metabolic screening results.				X
7. Participate in regional efforts including NERGG, New England Metabolic Consortium, and New England Genetics Collaborative (NEGC) grant effort.				X
8. Work with MPH intern on a process to evaluate reporting out of hemoglobinopathy traits.				X
9. Participate in regional demonstration project around screening for CCHD, recently awarded to Monica McClain, UNH				X
10.				

**b. Current Activities**

**DAILY TASKS:**

Continue to manage the essential daily tasks of the program. (PB)

Respond to requests for educational presentations and provide educational brochures to New Hampshire birth hospitals and providers as needed. Expand use of newborn screening brochures into prenatal offices. (PB) (E)

**SYSTEMS BUILDING:**

Provide QA Reports to New Hampshire birth hospitals biannually with statistics on their performance regarding newborn screening. (IB)

Issue individual QA report to Home Birth/Birth Center on their statistics. (IB)

Plan and complete site visits to remaining 3 of 20 birth hospitals not yet visited. (IB)

Work with Dartmouth interns to evaluate effectiveness of QA Reports to hospitals. (IB)

Renew the service delivery agreement for the Medical Consultant Services. (IB)

Developed a web-based resource for midwives in the state on newborn screening. (IB)

Continue to support the work of the Newborn Screening Advisory Committee. Meetings planned regarding screening for CCHD and SCID. (IB)

Provided technical support to the Division of Public Health Services (DPHS) Legislative Liaison and others regarding legislation for CCHD and pulse oximetry. (PB)

#### REGIONAL AND NATIONAL EFFORTS

Participate in regional activities including NERGG, New England Metabolic Consortium Annual Meeting and New England Regional Collaborative (NERC) grant opportunities, including CCHD/pulse ox screening demonstration. (IB)

Attend National Newborn Screening meeting to be held in San Diego, California in November 2011.

***An attachment is included in this section. IVC\_NPM01\_Current Activities***

#### **c. Plan for the Coming Year**

Continue to manage the essential daily tasks of the program, including: Daily reporting out of results back to birth hospitals; daily data linkage with vital records; provide technical assistance to birth hospitals and providers as needed; tracking and follow-up of infants who missed screening or need repeat screenings or further evaluation. (PB)

Monitor numbers of both refusals and misses in order to better target educational efforts. (IB)

Respond to requests for educational presentations and provide educational brochures to New Hampshire birth hospitals, midwives and providers as needed. (PB) (E)

#### SYSTEMS BUILDING:

Continue to support the work of the Newborn Screening Advisory Committee. Plans include meetings to discuss screening for CCHD and then SCID. Legislation was passed in May 2012 requiring that all infants in New Hampshire will be screened for CCHD with pulse oximetry. The bill mandates that screening being 60 days after signing, however it did not require that CCHD or be placed upon the Newborn Screening Panel, nor did it specify a role for the Newborn Screening Program. The Newborn Screening Advisory Committee met throughout 2012 and considered the implications of placing CCHD on the NH state panel. (IB)

Provide QA Report to New Hampshire birth hospitals biannually with statistics on their performance regarding newborn screening. (IB)

Provide QA Report to New Hampshire home birth/birth centers biannually with statistics on their performance regarding newborn screening. (IB)

Utilize the services of the Medical Consultant via a Service Delivery Agreement and assess the benefits of this service for state medical providers. (IB)

Develop internal protocols for inclusion in the Internal Operations Manual. (IB)

Work with MPH intern on project to review and improve reporting out of hemoglobinopathy traits. (IB)

The NBS program anticipates partnering with Dartmouth Children's Environmental Health and Disease Prevention Center as we explore opportunities for the use of residual dried blood spots in a study of the association between birth outcomes and arsenic exposure in NH. (PB)

#### REGIONAL AND NATIONAL EFFORTS:

Participate in regional activities including NERGG, New England Metabolic Consortium Annual Meeting and New England Genetics Collaborative (NEGC) grant opportunity.

Actively participate with the New England Genetics Collaborative in a newly funded demonstration project for screening for critical congenital heart disease (CCHD). The goal of this project is to develop processes for CCHD screening that will set the stage for improved health outcomes for newborns with CCHD, and their families. This project aims to enhance and expand existing networks among state public health departments and birthing facilities, and to share resources in developing CCHD newborn screening protocols, educational materials and programs, and program evaluation, including the development of new data collection systems, among five New England states. (PB, IB)

### Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

<b>Total Births by Occurrence:</b>	<b>13080</b>					
<b>Reporting Year:</b>	<b>2011</b>					
<b>Type of Screening Tests:</b>	<b>(A) Receiving at least one Screen (1)</b>		<b>(B) No. of Presumptive Positive Screens</b>	<b>(C) No. Confirmed Cases (2)</b>	<b>(D) Needing Treatment that Received Treatment (3)</b>	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	13045	99.7	22	0	0	
Congenital Hypothyroidism (Classical)	13045	99.7	140	8	8	100.0
Galactosemia (Classical)	13045	99.7	6	0	0	
Sickle Cell Disease	13045	99.7	2	2	2	100.0
Biotinidase Deficiency	13045	99.7	6	0	0	
Cystic Fibrosis	13045	99.7	47	8	8	100.0
Homocystinuria	13045	99.7	81	0	0	
Maple Syrup Urine Disease	13045	99.7	19	0	0	
beta-ketothiolase deficiency	13045	99.7	1	0	0	
Tyrosinemia Type I	13045	99.7	14	0	0	
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	13045	99.7	2	0	0	
Argininosuccinic Acidemia	13045	99.7	0	0	0	
Citrullinemia	13045	99.7	0	0	0	
Isovaleric Acidemia	13045	99.7	1	0	0	
Propionic Acidemia	13045	99.7	2	0	0	
Carnitine Uptake Defect	13045	99.7	4	0	0	

3-Methylcrotonyl-CoA Carboxylase Deficiency	13045	99.7	2	0	0	
Methylmalonic acidemia (Cbl A,B)	13045	99.7	2	0	0	
Multiple Carboxylase Deficiency	13045	99.7	0	0	0	
Trifunctional Protein Deficiency	13045	99.7	0	0	0	
Glutaric Acidemia Type I	13045	99.7	3	0	0	
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	13045	99.7	55	0	0	
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	13045	99.7	3	2	2	100.0
Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency	13045	99.7	0	0	0	
3-Hydroxy 3-Methyl Glutaric Aciduria	13045	99.7	0	0	0	
Methylmalonic Acidemia (Mutase Deficiency)	13045	99.7	2	0	0	
Argininemia (Arg)	13045	99.7	3	0	0	
HHH	13045	99.7	0	0	0	
Ornithine transcarbamylase deficiency	13045	99.7	0	0	0	
Carnitine palmitoyltransferase II deficiency	13045	99.7	1	0	0	
TOXO	13045	99.7	1	0	0	
Multiple Acyle-CoA Dehydrogenase Deficiency	13045	99.7	0	0	0	

**Performance Measure 02:** *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	55.9	61	60	60	60
Annual Indicator	60	60	60	60	74.9
Numerator					
Denominator					

Data Source		National Survey of CSHCN 2005-2006	National Survey of CSHCN 2005-2006	National Survey of CSHCN 2005-2006	2009/2010 National Survey of CSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	75	75	75	75	79

**Notes - 2011**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

**Notes - 2009**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

**a. Last Year's Accomplishments**

SMS continued contract arrangements to support NH Family Voices (\$168,068). This represented the 19th year that Family Leaders were paid in consultant positions to SMS. Parents continued to participate in the MCH block grant preparation and the review process with federal partners. All SMS supported programs (contract and state supported) were required to conduct and submit parent satisfaction surveys focusing on quality of care indicators.

Child Health Services, the primary contractor for services continued to administer their family satisfaction survey and responses were very favorable. Care Coordination services received a rating of 100% for "sensitivity to our values and customs" that was adequate to excellent. These numbers indicate that families have a cooperative and receptive platform for communication and collaboration about their children's services. This is especially significant since the counties

served by CHS have the highest percentage of families in NH who indicate that English is their second language.

Since SFY 2009 all agency contracts with SMS had a funded line item for cultural and linguistic supports in order to make services more accessible and responsive to families. Through Title V support, NH Family Voices identified and served 1,267 new individuals, including 962 new families. Many families (1,222) maintained an ongoing relationship with NH Family Voices. Educational resources that were supported with SMS funding included a 2,454 title lending library, a periodic newsletter, community resource guide, a variety of brochures/information sheets and several awareness and community trainings. NH Family Voices has also been supported to participate in a number of State of NH and affiliated committees and advisories to insure that families are represented and that their needs are incorporated.

SMS is the administering agency for a Family Support and community integration program called Partners in Health (PIH). This program is run in local communities (13 different sites) statewide with a focus on Family involvement and oversight. Each PIH site has a Family Council that leads the service visioning and community activity agenda. The Family Councils also determine the parameters and oversee distribution of flexible funding that is available through the program. This small amount of funding (\$20,000 per site) was made available to help meet the diverse needs of families so that they can focus on meeting the healthcare needs of their children with chronic health conditions. Access to these funds is not needs based and there is great flexibility in the utilization of the funds due to the nature of the funding source, which is the Social Services Block Grant (SSBG). The SSBG is intended to help states "furnish social services best suited to meet the needs of the individuals residing within the State".

A new project was initiated, in September 2010, through MCHB funding under the State Implementation Grant, Project Access. The goal was to focus on the advantages and strength of parent and youth involvement in health care design. The project plan utilized Regional Parent/Youth forums addressing leadership and the role of parent/youth partners in medical homes. It was also set up to increase parent and youth involvement in health care design to facilitate family centered approaches and advancement of medical home components. The first mode of change incorporated active family and youth participation in Learning Collaboratives to promote change that supports family/professional partnerships in a medical home. A second mode of change was education and leadership training across the spectrum of parents, youth and providers. The educational programs will be developed and implemented in collaboration with all participating partners. The major effort of this grant activity focused on completing a comprehensive Needs Assessment. Family and youth were a major focus of the needs assessment process. Parents were surveyed (via paper surveys) ninety-three (93) parent surveys were completed. Focus groups were conducted to solicit feedback from parents. Two (2) focus groups for parents were held with twenty-four (24) participants. The focus group tool provided by the Epilepsy Foundation was modified for a Youth Focus Group and one (1) focus group for youth was held three (3) participants. Family feedback was obtained from every county in NH (see attached).

***An attachment is included in this section. IVC\_NPM02\_Last Year's Accomplishments***

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to contract directly with NH Family Voices for family to family health education and program consultation				X
2. Collaborate with NH Family Voices and practice based parent partners working with clinical sites for Project Access		X		X
3. Require annual parent satisfaction surveys from all clinical	X	X		X

programs				
4. Recruit and involve parents and YSHCN on all planning and advisory groups				X
5. Increased coordination with Partners in Health program and statewide family councils				X
6. Statewide Needs Assessment on system of care for children/youth with epilepsy included parent and youth focus groups and a survey with representation from parents from all NH counties			X	X
7.				
8.				
9.				
10.				

**b. Current Activities**

Special Medical Services remains committed to supporting Family partnership and involvement through a contract with NHFV. NHFV staff will act as the project Coordinator for the Project Access initiative. This project resulted in 6 Regional Family Forums with robust attendance.

NHFV had undertaken a statewide assessment of Family-to-Family connections. The initial report was completed and they continue to coordinate stakeholder meetings to create recommendations for services. SMS invited NHFV to play a significant role in Strategic Planning and both Co-Directors were active members of the Leadership Group.

SMS applied for and was chosen to have the services of a MCHB funded Graduate Student Intern. In August of 2011 her final work product was available. She completed a statewide needs assessment of caregivers, with strong CSCHN family response (see attached), to ascertain their respite needs and compiled a report so that the results could inform service design.

SMS' continued administration of the Partners in Health program offered the opportunity to collaborate on a statewide family satisfaction survey. This year a PIH Stakeholder group began meeting and includes providers and representatives from Family Councils. One of the long-term objectives will be for it to also act as a Family Advisory to SMS.

Also an SMS coordinator (Allen) has worked with the developers of "Powerful Tools for Caregivers" to create a training for families of CSHCN, on how to care for themselves.

***An attachment is included in this section. IVC\_NPM02\_Current Activities***

**c. Plan for the Coming Year**

Special Medical Services has institutionalized its commitment to supporting Family partnership and involvement. This will represent an ongoing contract relationship and the budget will be unchanged from the previous year. MCH and SMS have recommitted to a collaborative relationship with NH Family Voices including participation of NHFV in the Title V Block Grant reporting and planning meetings.

The family to family stakeholder group will continue to meet and work on recommendations for continued services in the State of NH. SMS will review these recommendations and begin to put in place the supports and structure needed to implement them.

SMS also applied for and was chosen to have the services of a MCHB funded Graduate Student Intern. In August of 2012 her final work product should be available. The goal of which is to complete a statewide needs assessment of families of children with Autism Spectrum Disorders and young adults with ASD as well. This survey will have widespread dissemination to insure that responses adequately represent family experiences and needs in NH related to their child's

ASD.

The relationship between SMS and the project coordinator (NH Family Voices staff) for the Project Access activities will continue. SMS is responsible to maintain and spread these efforts which relies heavily on the expertise of the project coordinator. She will insure involvement of the parent partners and youth coordinator at clinical sites and coordination of additional Family Forums.

SMS was able to successfully write for a small grant from the National Center on Ease of Use of Services. This grant incorporates the collaboration of several partners, including NH Family Voices to create an Action Learning Collaborative. The group will be working to craft messaging and community events that will meet the needs of Latino Families of CSHCN so that they can understand the significant changes being made to NH's Medicaid system.

SMS' continued administration of the Partners in Health program is an opportunity to incorporate additional family input into statewide services for CSHCN. It will also offer the opportunity to further develop the Stakeholder group and it's role as a Family Advisory to Special Medical Services.

**Performance Measure 03:** *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	56.9	50	50	50	50
Annual Indicator	49.6	49.6	49.6	49.6	49.4
Numerator					
Denominator					
Data Source		National Survey of CSHCN 2005-2006	National Survey of CSHCN 2005-2006	National Survey of CSHCN 2005-2006	2009/2010 National Survey of CSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	50	50	50	50	55

**Notes - 2011**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

#### **Notes - 2010**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

#### **Notes - 2009**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

#### **a. Last Year's Accomplishments**

For the fifth consecutive year, Medical Home development efforts for CSHCN have been supported with a contractual arrangement between SMS and the Center for Medical Home Improvement (CMHI) CMHI co-directors McAllister and Cooley are nationally recognized experts in Medical Home. This collaboration continued policy level initiatives, infrastructure development, and planning and technical support regarding the advancement of Medical Home activities in NH. The focus is to influence macro system change; increase political and public understanding. In addition, this funding was utilized to support 2 separate practices serving CSHCN to benefit from the CMHI TAPPPTM (Gap) Analysis to assess readiness and competency for Medical Home NCQA certification. The Analysis is a medical home assessment tool combining CMHI's validated Medical Home Index and a comprehensive assessment of practice structures, processes and outcomes in each of five TAPPP domains: 1. Teamwork; 2. Access & Communication; 3. Population Approach; 4. Planned, Coordinated Care; and 5. Patient & Family-Centered Care. CMHI also worked on integration of medical home development and collaboration with State Stakeholders. The final area of focus was assisting policy development in the State of New Hampshire to be consistent and in keeping with the principles of a patient and family-centered, effectively coordinated, medical home.

The involvement of SMS in the 2nd phase of the Project Access SIG (for which the Hood Center was the grantee) continued due to a "no cost continuation". Due to the support for a Title V leadership track the CSHCN Director (Collins) continued her participation in the final Learning Collaborative and in promoting Title V program development using the Learning Collaborative framework. SMS applied for and received funding for Phase III of the Project Access Initiative with a major focus on enhances Medical Home services through parent/youth education and partnerships and facilitation of improved health care coordination. This was specifically chosen partly to focus on improving NH's ratings on the NS-CSHCN and in response to a NHFamily Voices survey that revealed that few families (14%) indicated that they knew what a medical home was, and even among that group their interpretation was inaccurate most of the time. The NH Project Access activities include completing 12 regional family forums to review specialty care and the role of family/youth as partners in their Medical Homes.

The SMS Administrator also has been a member of the New England Genetics Collaborative (NEGC) workgroup on Medical Home, which has focused on issues of primary and specialty care co-management.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. SMS Administrator actively participated in final Learning collaborative for Project Access Phase 2 facilitated by NICHQ			X	X
2. SMS Administrator participated in review meeting with federal funders and NICHQ to complete recommendations for Title V CSHCN involvement in HRSA funded initiatives				X
3. SMS Administrator participated in Medical Home workgroup of the New England Genetics Coalition			X	X
4. Ongoing efforts to participate and advocate for state of NH efforts at incorporating Medical Home language and tenets into services				X
5. Continued contract with the Center for Medical Home Improvement for NH initiatives				X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Special Medical Services continues its support for Medical Home Improvement through a funded contract. The Center for Medical Home Improvement continues to be the vendor for this contract. Our ongoing goal for the future is to enhance existing health care systems in New Hampshire for CSHCN, to provide explicit, proactive care including identification, care coordination, advocacy and patient / family education. Based on identified issues, expectations of the funded project include but are not limited to, the following:

- Initiation of communication regarding The Medical Home Model with community based agencies and within the health care system.
- Development of awareness efforts to include hospital and health network leadership, parent and families.
- Support for improved practice based health care transition

SMS' role in the State Implementation Grant for Epilepsy care (Project Access) continues. The clinical activities emphasize both Parent/Youth involvement and coordination of care efforts across domains statewide. This activity is building on Medical Home investment in the state as well as working to unify all past participants in Medical Home quality improvement initiatives across the state.

Overall activities this year have focused on:

1. Medical Home outreach and awareness;
2. Policy development;
3. Statewide medical home improvement activities;
- and 4. Availability to interface with State of NH Medicaid to incorporate medical home initiatives into planning.

**c. Plan for the Coming Year**

Special Medical Services will continue to support Medical Home Improvement through a funded contract with the Center for Medical Home Improvement. Our ongoing goal will continue to be to enhance existing health care systems in New Hampshire for CYSHCN, to provide explicit, proactive care including identification, care coordination, advocacy and patient / family education. Obstacles to improving primary care for CYSHCN include limited consumer involvement, inadequate provider reimbursement, poorly defined professional roles and a lack of systematic approaches to care. Based on these issues, expectations of the funded project will include, but not be limited to, the following:

- Initiation of communication regarding The Medical Home Model with community based agencies and within the health cares system.
- Development of awareness project of The Medical Home Model to include hospital and health network leadership, parent and families.
- Facilitation of dialogue with public/private payors regarding reimbursement for care coordination activities within Medical Home
- Provision of technical assistance to interested medical practices.
- Support for improved practice based health care transition

The issue of transition is intertwined with Medical Home concepts. Therefore CMHI's role as the National Health Care Transition Center (NHCTC) "Got Transition" will be more fully integrated in the activities associated with the contract with SMS. A stakeholder group will be utilized to develop a Health Care Transition Learning Community. Overall this will provide NH Title V's linkages and engagement with CMHI at several levels and within the NHCTC promotion and dissemination of transition information as it relates to medical home

SMS' activities for the State Implementation Grant -- Project Access will continue to have a strong focus on Parent/Youth involvement and coordination of care efforts statewide, both major components of Medical Home development. Activities will include distribution of reference material about Medical Home and parent roles in Medical Homes. The primary venue for this education will be Regional Family Forums. The Care Coordination Forums will continue and will focus on role identification, incorporating family/youth perspective into planning and communication across domains. This will foster development of a system of communication that interconnects coordination of care across all domains impacting the health and well-being of children and youth. We envision a statewide coalition of coordinators from medical, community and school domains. We expect this coalition to address the value of shared information. Additionally, planned work on the Core Competencies of Care Coordination will also increase and improve the Medical Home experience for children, youth and families.

**Performance Measure 04:** *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	62.9	68	67	67	68
Annual Indicator	67.3	67.3	67.3	67.3	66.2
Numerator					
Denominator					

Data Source		National Survey of CSHCN 2005-2006	National Survey of CSHCN 2005-2006	National Survey of CSHCN 2005-2006	2009/2010 National Survey of CSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	66.5	66.5	66.5	66.5	70

**Notes - 2011**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

**Notes - 2009**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

**a. Last Year's Accomplishments**

SMS continued to participate in statewide and programmatic planning to improve the percentage of children with adequate insurance. These efforts have been related to those CSHCN who are 0-18 years old and also includes the needs of young adults 18-21 year old.

The HC-CSD Coordinator (Allen) continued to work with Medicaid (Disability Determination and Prior Authorization departments) and Family Voices to provide intake services, care coordination and service utilization for children newly accepted for Medicaid by the HC-CSD eligibility pathway ("Katie-Becket like"). SMS continued to receive the list from SSI of children from NH who were newly approved for SSI. Outreach to children and youth newly enrolled in SSI was expanded. SMS outreach was offered to any child or youth, newly enrolled in SSI, with a medical diagnosis even if they had Medicaid. This resulted from previous surveys of families that indicated that the

assumption that children/youth with Medicaid were having their questions/needs met was erroneous. In addition, SMS continued to send written outreach letters with information about local resources to those families of children with developmental and mental health/emotional/behavioral diagnoses. This effort has also been replicated in our population of children newly enrolled in Medicaid through HC-CSD.

In SFY 2011, of the 457 children/youth newly enrolled in SSI (who were not already affiliated with SMS) ninety-seven families received outreach and follow-up for their child with a medical condition and three hundred and fifty-five families received outreach resource letters for their children with developmental, learning, PDD or mental illness diagnoses. In SFY 2011, there were 245 children newly enrolled in Medicaid through HC-CSD (Home Care for Children with Severe Disabilities). Ninety-three (93) of them received outreach for support. This was a 25% increase over last years population qualifying for active outreach. One hundred and thirty-two (132) received outreach resource letters for the statewide systems available to meet the needs of children with ASD, Developmental Disabilities and Mental Health diagnoses.

Timely and accurate data on insurance status is integral to developing effective initiatives and the SMS Data Specialist (Bernard) is the primary contact for the SMS Data Integrity Enhancement Initiative for data clean up and system enhancements to streamline the SMS database, to insure more efficient analysis and reporting in the future.

SMS' alignment with the Bureau of Developmental Services has allowed for collaboration with other programs that offer support to families (Area Agencies, Early Intervention and Partners in Health). This effort continues to improve the process of family centered services. SMS continues to participate in planning discussions about ideal sources of support as well as when it is appropriate to collaborate and "braid" funding to meet the needs of CSHCN.

SMS sponsored/contracted services (i.e.: clinics, nutrition, feeding & swallowing) continued to explore and expand third party reimbursement. This has helped to build the infrastructure necessary to allow for increased capacity to serve those children without insurance. Care coordinators continued to familiarize themselves with options for insurance and other financial resources (local, state, regional and national) for families to access. Care planning by SMS coordinators illustrated planning for supporting families and youth in efforts to attain and maintain consistent insurance and financial resources for health related costs. In addition, SMS continued to maintain its Equipment Bank, which allowed children to access DME that has been used but refurbished by a Certified Equipment Vendor.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Follow up on all SSI referral transmittals with information and referral and outreach		X	X	
2. Outreach and short-term coordination for families of children enrolled in Medicaid based on their chronic health condition		X	X	
3. Exploration of strategies for insurance re-imburement for nutrition services continue			X	X
4. Revision of SMS policy/procedure and data collection methods continue				X
5. Collaboration on statewide coalitions and groups addressing access to services in NH				X
6.				
7.				
8.				

9.				
10.				

**b. Current Activities**

The HC-CSD Coordinator (Allen) continues to provide intake services, care coordination and service utilization for children newly accepted for Medicaid by the HC-CSD eligibility pathway ("Katie-Becket like"). SMS also continues to outreach to children and youth newly enrolled in SSI . Care coordinators have continued to familiarize themselves with options for insurance and other financial resources (local, state, regional and national) for families to access, this includes being aware of ACA reforms and state Medicaid changes.

SMS has continued to support the costs of some health related needs for children and youth, who meet financial eligibility criteria (>185% of FPL). SMS budgeted monies to support these needs (ex: DME, medications, specialty services/providers and transportation). The need for these funds as it relates to Insurance coverage and Insurance adequacy has increased.

Generally SMS does not assist with premiums but with the economic changes it has been a dilemma when the realistic outcome of this denial is no insurance coverage at all. The population that SMS has seen the greatest need from are children who are legal residents but have been so for less than 5 years (and therefore are not eligible for Medicaid) and for youth ages 18-21 who age out of HC-CSD and/or their parents private health insurance (which they find to expensive to continue).

SMS' Administrator has been involved in the communications workgroup for CHIP coverage transitioning to Medicaid.

**c. Plan for the Coming Year**

The new issue for families in the next fiscal year is expected to be related to major Medicaid system changes. These include the elimination of the "Buy In" program that had been available through the NH agency administering the CHIP program. This program was available to families whose income fell between 300-400% of the FPL It was also available to families of CSHCN who were legal aliens but had not been so for more than 5 years, since NH did not apply for the CHIPRA expansion that would have allowed these children to be eligible for Medicaid. It is anticipated that some of the families who invested in the "Buy In" program did so because they had a CSHCN and wanted to insure ongoing access to care. As of July 1, 2012 these "Buy In" children (approximately 800) will need assistance in finding health coverage or in covering the costs of health care.

The second Medicaid change is the transition to a Managed Care system. This will take place at the end of 2012. Families whose children are on Medicaid will need additional assistance to make sure that they understand the Managed Care Organizations options that they will have to chose from. There will also be a one year "opt out" option for Children with Special Health Care Needs and SMS will have to work closely with Medicaid and community partners to make sure families have accurate information about how to best insure their child's access to healthcare.

SMS does have a cooperative relationship with Medicaid and will continue to advocate for the needs of CSHCN. SMS will continue to work with identified partners in New Hampshire who are interested in improving the access to and adequacy of insurance for children, including CSHCN. These groups include the NH Children's Advocacy Network, the Council for Children and Adolescents with Chronic Health Conditions and NH's new Autism Council. The Autism Council is charged with the need to improve public and private insurance coverage for recommended services for those children and youth diagnosed with Autism Spectrum Disorder, SMS' Administrator (Collins) is a workgroup chair.

**Performance Measure 05:** *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	79.4	86	86	86	86
Annual Indicator	85.8	85.8	85.8	85.8	67
Numerator					
Denominator					
Data Source		National Survey of CSHCN 2005-2006	National Survey of CSHCN 2005-2006	National Survey of CSHCN 2005-2006	2009/2010 National Survey of CSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	67	67	67	67	70

**Notes - 2011**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

**Notes - 2009**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

#### **a. Last Year's Accomplishments**

SMS continues to outreach to newly identified CSHCN with chronic medical conditions or disabilities. This includes information and referral services to the families of CSHCN identified by SSI enrollment as well as those identified by HC-CSD (Katie Beckett) Medicaid enrollment. Children with primary Mental Health, Intellectual Disabilities or Autism Diagnoses received timely outreach and information about community based services and agencies. Enrollment in SMS services indicates that they are accessible and available in all counties, as seen in the map of state with locations of all served for FY 11 (see attached).

In addition to the longstanding Community Based Care Coordination that SMS offers, SMS assumed administrative oversight responsibility for a statewide program of Community Family Support called the Partners in Health (PIH) program, funded by the Social Services Block Grant. Partners in Health (PIH), is a unique NH statewide community based family support program for families of children with chronic health conditions. PIH provides local access to resources and individual family support. Much collaborative work has been done between the Community Based Care Coordination and the PIH Family Support programs, including through twice-yearly joint meetings.

SMS continued integrated and collaborative work with NH Family Voices. Also continued was collaboration and active dialogue with other agencies that are serving children and families in the state. In addition many medical practices received updated information about SMS services as part of the transition project outreach. A revision of a prior electronic case management system was piloted to improve data and coordination.

SMS applied for and was chosen as a grantee for a State Implementation Grant to improve the system of care for children with epilepsy. The Project Access grant, Phase III project period began September 2010. The NH project is named FACETS of epilepsy care in NH and includes a major focus on coordination of care statewide for children with epilepsy as well as for all CSHCN. This will include a series of community forums that will target all stakeholders who "coordinate care" and begin the discussion of what coordination is, how to create a plan to insure families needs are met without duplication services and how to communicate with the family and each other regarding that plan.

SMS' experience with the collaborative care coordination model has shown that it can effectively enhance access of families to community resources. In the FACETS proposal SMS incorporated this philosophy (e.g., family participation and community stakeholders) into the plan for a series of Regional Family/Youth Forums. Locations for these forums mirror the locations of the 13 PIH family support councils to encourage participation by those members.

The links between families, childcare providers, schools and medical providers is another important component of coordinated care. The FACETS project became the platform to impact greater collaboration amongst these groups. In addition the first 3 months of the project period were devoted to a comprehensive needs assessment process that linked feedback from a myriad of stakeholders and incorporated a strong family feedback component.

NH has a strong network of school nurses and SMS has assumed responsibility for a robust web-based listserve for this group. This affiliation has improved recognition amongst school nurses as to the supports Title V has to offer and has allowed SMS to have direct and consistent communication with school nurses, therefore improving the coordination of care for CSHCN.

**An attachment is included in this section. IVC\_NPM05\_Last Year's Accomplishments**

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuous improvement activities for care coordination-complexity /levels of care tools and piloted electronic care plan				X
2. Collaboration with Partners in Health Program through joint meetings and shared data.		X		X
3. Care coordination is offered statewide		X		X
4. Grant to continue quality improvement in the system of care for children with Epilepsy (and all CSHCN)	X		X	X
5. Outreach to all coordinators of services for children with special health care needs through the Who's Coordinating Whom? Series about roles.				X
6. Continued collaboration with NH Family Voices			X	X
7. Completion of SMS Satisfaction Survey for Care Coordination and Neuromotor clinic coordination.		X		X
8. Ongoing supervision and support for current coordinators and orientation for new coordinators		X		X
9.				
10.				

**b. Current Activities**

SMS continues to outreach to newly identified CSHCN. This past year the care coordinators have continued using the Complexity Scale and Levels of Care and SMS is analyzing how to best use this data in planning care and caseloads. All the coordinators include health care transition assessment as part of their care plans.

Planning with CBCCs for new training is ongoing. A number of health care relevant topics for presentation at monthly meetings will be reviewed. The SMS contracted educational Psychologist will provide consultation and education to the coordinators in two forums -three sessions a year at monthly coordinator meetings and quarterly for case discussions. Exploration of care coordination core competencies was initiated this year with the help of a master's level nursing student working on a Capstone project.

There is continued collaboration with the PIH Family Support Coordinators and their Program Manager to assure best practices with families and clearer delineation of roles. We will continue to offer 2 joint meetings yearly. A family satisfaction survey for the both programs was developed and completed. It also included a Needs Assessment that matched selected NS-CSHCN questions, in order to offer the ability to make some data comparisons.

The FACETS project began hosting community forums titled "Who's Coordinating Whom?" to facilitate the discussion about having a truly coordinated effort of coordination across service domains (see attached).

**An attachment is included in this section. IVC\_NPM05\_Current Activities**

**c. Plan for the Coming Year**

All of SMS' coordinators have included transition assessment as part of their care plans, however to date there has not been a systematic checklist of topics to be completed prior to the conclusion of SMS services at age 21. SMS will review existing tools and develop a self- audit tool/checklist for the health record to assure all topics have been broached and that the transfer to adult health care has been completed or planned.

Planning with CBCCs for new initiatives and in-service topics of interest is ongoing. A number of health care relevant topics for presentation at monthly meetings will be reviewed. The SMS contracted educational Psychologist will provide consultation and education to the coordinators in two forums -three sessions a year at monthly coordinator meetings and quarterly for case discussions. CBCCs will increase focus on how to perform as experts and increase knowledge about certain more common conditions within SMS caseloads. Collaboration with the Partners in Health Family Support Coordinators and their Program Manager will continue to assure best practices with families and clearer delineation of roles.

The plan is to pilot an Information and Referral process that was developed with leadership from both the health care coordinators and the family support coordinators- PIH. This will help staff find the best initial support needed by families with children with chronic health conditions and disabilities.

In the area of health care transition SMS will review existing tools and develop a self- audit tool/checklist for the health record to assure all topics have been broached and that the transfer to adult health care has been completed or planned.

As follow up the work on Core Competencies for Care Coordination SMS will discuss and use an on-line training program that is based on the article "Making Care Coordination a critical component of the pediatric health system: a multidisciplinary Framework by Antonelli, McAllister and Popp May 2009. This is a continuous training tool. Use of the core competencies as part of orientation for new Coordinators will begin. This will interface smoothly with the plan to expand the FACETS Care Coordinators Forums to incorporate a web based meeting option to facilitate access. The first Webinar will revolve around the Core Competency concept. An additional plan is to increase efforts to incorporate formal family choice in the types of services needed and provided, based on the Levels of Care Coordination model.

The existing policies and protocols for the Care Coordination Program operations will be reviewed and this information will be made readily available to the coordinators. A new SMS application has been developed and reviewed by staff and will be in use in FY 13.

**Performance Measure 06:** *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	5.9	52	52	52	52
Annual Indicator	51.6	51.6	51.6	51.6	49
Numerator					
Denominator					
Data Source		National Survey of CSHCN 2005-2006	National Survey of CSHCN 2005-2006	National Survey of CSHCN 2005-2006	2009/2010 National Survey of CSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5					

events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	50	50	50	50	55

**Notes - 2011**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

**Notes - 2009**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

**a. Last Year's Accomplishments**

The Health Care Transition Coalition (HCTC) was formed in 2005 as part of New Hampshire's involvement in the Champions Grant. The HCTC core group is comprised of parents and other professionals. It is co-chaired by SMS and NH Family Voices. The HCTC serves as an advisory group to both organizations in that one or the other agency usually does the work that is generated. As an example in 2008 the youth members of the HCTC formed the YEAH (Youth Educating Adults About Healthcare) Council and Family Voices took on the management of this group.

The HCTC works on transition promoting projects. A major effort focused on helping health care providers improve their health care transition knowledge and activities with the "Ticket to Adult Health Care Independence" campaign. Materials were developed by the HCTC and YEAH that

included a catchy poster and specific educational materials for providers to give to parents and youth to start the health care transition dialogue. The campaign was launched in May 2010 and enlisted SMS Care Coordinators & the Family Support Coordinators from Partners in Health sites, the HCTC and YEAH group members with a plan to present these educational packets to approximately 130 pediatric and family physician practices. A significant portion of the outreach activity on the "Ticket to Adult Health Care Independence" Campaign took place in FY 2011, after the initial planning and orientation in FY 10. Initially the project design included individuals visiting practices and speaking with providers one on one. It was difficult for all the project participants to visit practices in this manner. Therefore, in addition to individual practice visits several other models emerged. The most interesting and popular format was that of speaking to groups of practices at hospital-based meetings. Another model was practice "drop-ins" to leave off and review the packet of materials with the practice coordinator/office manager. The third was individual outreach by the SMS Transition Coordinator. SMS' plan was to evaluate the success of this campaign by comparing pre and post visits provider change in adopting various transition services such as maintaining a medical summary, creating a practice transition policy and assessing youth knowledge about their condition.

A Health Care Transition webpage is posted on the SMS website. A more dynamic webpage was started through NHFV. SMS Care Coordinators offered transition assessment and education to families and youth on an ongoing basis. In November 2010 Kathy Cahill from SMS and Terry Ohlson-Martin from NHFV presented a workshop "What's Health Got to Do with Transition?" to the Community of Practice on Transition Summit conference and Kathy Cahill also participated on a transition education panel for parents in the North Country. The Health Care Transition Coalition continued to meet quarterly and did a strategic planning session in June 2011 and identified Parent Education and Marketing health care transition as two goals for FY 2012. The SMS Transition Coordinator and the SMS Administrator were invited to participate in the newly formed Got Transition Advisory group. Both attended the first meeting of the National Health Care Transition Center Advisory Group in Washington DC, in February 2011.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote and coordinate health care transition activities				X
2. Complete outreach to practices as part of the Ticket to Adult Health Care Independence campaign and evaluate the campaign.		X	X	
3. Meet quarterly with the Health Care Transition Coalition to implement the new initiatives to increase health care transition marketing efforts and target family education about health care transition and expand membership to school nurses and other t				X
4. Care Coordinators include health care transition as part of care planning.		X	X	
5. Participate in and present at collaborative educational programs with community partners to describe health care transition.		X		X
6. Collaborate with NH Family Voices and the YEAH Council on projects, including development of internet presence.		X	X	X
7. Provide a poster session to the AMCHP conference about the 2008 Survey of Adult Providers and the Ticket to Adult Health Care Independence Campaign.				X
8. Participate as members of the National Health Care Transition Center Advisory group for Got Transition and participate in the GotTransition NH Learning Collaborative			X	X

9. Provide health care perspective on Transition on state committees for post secondary transition and ASD as well as participation in the NEGC transition workgroup.		X		
10.				

**b. Current Activities**

The Health Care Transition Coalition (HCTC) meets quarterly to identify new initiatives such as outreach to families and review progress of ongoing initiatives. Provider outreach for the Ticket to Adult Health Care campaign continued into the fall of 2011. Findings indicated that awareness about health care transition needs improved yet it was difficult to implement change in the practice routines. UNH LEND trainees worked with SMS to evaluate the "Ticket" project and create a poster for presentation at the 2012 AMCHP conference about the campaign.

SMS Care Coordinators offer transition assessment and education to families and youth on an ongoing basis. A Health Care Transition webpage is posted on the SMS website and the NHFV website. We have a Facebook page for the NH HCTC. The SMS Administrator and Transition Coordinator continue to participate in Got Transition as members of the Advisory Group. The SMS Transition Coordinator continues to collaborate with statewide and regional stakeholders, including participation in the NH Community of Practice on Transition, the Autism Council Independent Living workgroup, the Region I NEGC Transition workgroup and the GotTransition NH Learning Collaborative.

***An attachment is included in this section. IVC\_NPM06\_Current Activities***

**c. Plan for the Coming Year**

SMS will write a summary and findings for the Ticket to Adult Health Care Independence Campaign and post on the SMS and NH Family Voices websites as well as the NH HCTC Facebook Page. There were 69 offices originally contacted that received the transition packets. Of these, 40 filled out the pre survey and were therefore included in this analysis. A total of 21 total paired pre and post surveys were used to complete the data analysis. The Health Care Transition Coalition decided that while the information given to providers might be useful and important (checklists, posters, and other best transition practice materials) there was very little request for these materials and it is thought that there could be more of an impact by focusing on educating parents and youth. The Got Transition National Health Care Transition Center is educating practices through learning collaboratives and other means.

The HCTC through Family Voices will lead focus groups to determine what materials families would find helpful. The Health Care Transition website on the NH Family Voices website will be expanded. The group will consider setting up a NH HCTC website and how to maintain the various Internet sites, including the HCTC Facebook page. The HCTC will work on messaging about transition and how to get the word out to schools, parents and youth. SMS will work with the care coordinators to produce a formal transition checklist to assure that certain basic knowledge and skills are assessed, reviewed and in place prior to discharge from SMS at age 21. SMS will try to integrate its care coordination transition efforts into pediatric and family practice transition plans, especially if there is no practice coordinator. We will support practice coordinators as well. SMS will support the YEAH facilitator's outreach to school nurses as part of HCTC activities. The plan is to outreach to area agency transition coordinators about adding health assessment to their work.

HCTC members plan to do a session at the Community of Practice Summit on Transition to introduce health care issues as part of a life skills assessment that needs to happen for all YSHCN in various agencies including the education system. SMS has a collaborative and contractual relationship with the Center for Medical Home Improvement (CMHI), the grantee for the National Healthcare Transition Center. The focus of activities for the SMS contract with CMHI will include dissemination and spread within NH of important lessons and recommendations

made by Got Transition. NH HCTC wants to work with GotTransition to prevent duplication. The SMS Administrator and Transition Coordinator will continue to participate in the national efforts of Got Transition as members of the Advisory Group. The SMS Transition Coordinator actively collaborates with statewide and regional stakeholders and will continue her participation in the NH Community of Practice on Transition and on the Region I NEGC workgroup on Transition.

**Performance Measure 07:** *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	87	82	85	85	86
Annual Indicator	76.3	84.6	81.0	75.8	86.8
Numerator	10860	12041	11528	10788	
Denominator	14233	14233	14233	14233	
Data Source		CDC Survey	CDC Survey	CDC Survey	HRSA Email sent 5/16/12
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	87	88	89	90	91

**Notes - 2011**

Rate is for vaccination coverage for the 4:3:1:3:3 series among children 19 to 35 months, US National Immunization Survey 2010, per recommendation of Vanessa Lee (HRSA) in email sent May 16, 2012. Unlike previous years, MCH did not adjust CDC rate according to its most recent two-year old Census Population figure. Rate of 86.8 is + or - 5.9.

**Notes - 2010**

Data is from Colleen Haggerty of the NH Immunization Program. 75.8% represents the mid-year National Immunization Survey rate for Qtr3/2009-Qtr2/2010. The rate is for 4:3:1:3:3:1:4 (DTaP4; JPV3; MMRI; Hib3; HepB3; Var1; PCV4). This puts NH at #1 in the country. If Hib is removed from the survey due to an issue with how the Hib series is assessed on an up-to-date status, the NH rate for 4:3:1:0:3:1:4 stays at 75.8%. In this case, the NH ranking drops to 7 or 8, however.

**Notes - 2009**

The numerator was obtained by using the most recent CDC National Immunization Survey rate for NH (Qtr 1/2009-Qtr 4/2009) - available from the NH Immunization Program for 4:3:1:3:3:1 - and applying it to the denominator. The denominator is two year olds in NH in 2007, from the US Bureau of the Census Estimates Branch.

**a. Last Year's Accomplishments**

**BACKGROUND:**

DHHS through its Immunization Program buys all the recommended vaccines for every child in NH, regardless of insurance or income. By combining State general funds, federal funds and contributions from health insurance companies that do business in NH, DHHS is able to purchase enough vaccine to provide every NH child with all recommended vaccinations. Health plans have been assisting with funding for many years.

**STRATEGIES AND PARTNERSHIPS:**

To get more consistent and updated information on MCH contract agency immunization results, and to discuss ways to improve collaboration and information sharing between the MCH and the Immunization Program, the MCH Child Health Nurse Consultant met with the Immunization Program Quality Assurance Nurse in Fall 2010. Instead of getting immunization rates at the end of the fiscal year, from agency workplan results, which were either the agencies' own internal assessments or the results of the Immunization Program's Immunization Assessment & Vaccine Management site visits and Co-CASA immunization audits, MCH developed a plan to receive the information directly from the Immunization Program on a routine basis to have consistent, real time data. To better understand agencies' successes and barriers in achieving immunization targets, the focus has been changed from reporting in the workplan to learning more by in-depth discussion at site visits. In SFY11, the MCH-funded community health centers reported that 86% of two year olds in their panels had received a full schedule of immunizations. Although two year old immunization status will no longer be a specific performance measure of primary care contracts for community health centers, it is anticipated that immunization will be monitored through collaboration with the DPHS Immunization Program and through this Performance Measure. (IB)

The MCH Child Health Nurse Consultant, along with representatives from many of the MCH contract agencies, attended the NH Immunization Program's annual conference. Agencies also received updates from MCH and the Immunization Program via emails, and the Immunization Program's monthly conference calls. (IB)

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with the NH Immunization Program on any state or local activities.				X
2. Communicate immunization policy changes and immunization updates to Title V-funded agencies.				X
3. Collaborate with the NH Immunization Program in using Co-CASA results and Immunization Assessment & Vaccine Management site visits results from Title V-funded community health agencies for quality assurance activities including site visits informat				X
4. Continue to include immunizations in the information updates to the MCH Home Visiting contract agencies, and to Healthy Child Care New Hampshire child care health consultants.				X
5. Continue to provide immunization update information directly to the MCH contract agencies from the Immunization Program via mailings, monthly conference calls, email updates, Immunization Program workshops and its annual conference.				X
6.				
7.				
8.				
9.				

10.				
-----	--	--	--	--

**b. Current Activities**

MCH staff continues to work with staff from the 13 community health centers and one pediatric primary care center and the NH Immunization Program to improve agency immunization rates. It is transitioning from its past practice of learning about agency immunization results and success/obstacles from agency workplans to site visit discussions and obtaining real time results directly from the Immunization Program on a regular basis. (IB)

The Immunization Program staff continues to disseminate information to the MCH contract agencies, MCH Home Visiting contract agencies, and to Healthy Child Care New Hampshire (HCCNH) child care health consultants on any immunization changes. The Immunization Program now offers nursing contact hours for its monthly immunization phone updates, increasing agency participation. (IB).

MCH now attends the twice-yearly meetings that the Immunization Program staff holds with hospital-owned practices. This has been a valuable partnership and has allowed MCH to be further updated on immunization-community activities which both directly and indirectly impact the MCH-funded agencies. (IB, PB)

MCH supports the New Hampshire Health Alert Network (HAN), especially among providers at community health centers and other support programs such as home visiting. This was re-enforced when the first case of measles in NH since 2006 was confirmed on June 24, 2011. This particular case involved international travel. (IB, PB)

**c. Plan for the Coming Year**

**STRATEGIES AND PARTNERSHIPS:**

With MCH's new Quality Assurance Nurse Consultant working with the MCH Child Health Nurse Consultant, attention to community health center immunization rates, successes and barriers, will be a new focus for site visits. MCH will also focus on getting real time agency immunization rates on a quarterly basis from the Immunization Program. (IB)

MCH will continue to share the latest immunization information with its MCH-funded contract agencies through emails/mailings and by inviting Immunization Program staff to an FY13 MCH Coordinators' meeting. (IB, PB)

MCH will continue to keep abreast of the latest changes in immunizations by attending the annual NH Immunization Conference, participating in the Immunization monthly conference calls, and attending the twice-yearly hospital-owned practice meetings. (IB, PB)

MCH will continue to provide public health leadership to other early childhood collaborative efforts such as SPARK NH, the State's Early Childhood Advisory Council whose mission is to provide a comprehensive, coordinated, sustainable early childhood system that achieves positive outcomes for young children and families. One of its priority areas of focus in the coming year will be to ensure that all children receive immunizations appropriate to their age, development and medical status. SPARK NH will engage in Strategic Planning and a Needs Assessment in the coming year and family input regarding access to culturally appropriate care will be included. (IB, PB)

**Performance Measure 08:** *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	6.9	7.3	7.2	7.5	6.7
Annual Indicator	7.4	7.7	6.8	6.0	6.0
Numerator	203	212	187	164	164
Denominator	27473	27473	27473	27155	27155
Data Source		Birth data	Birth data	Birth data	Birth data
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	5.9	5.8	5.7	5.6	5.5

**Notes - 2011**

Out of state data is unavailable. 2010 data is used as an estimate.

**Notes - 2010**

Updated with 2010 birth data. Last year, 2009 was used as an estimate. Denominator is from latest ACS 2008-2010 survey.

**a. Last Year's Accomplishments**

**BACKGROUND:**

Although the overall New Hampshire teen birth rate is low, focusing on state averages obscures the high teen birth rates that face many New Hampshire cities and towns. Manchester is the city which had the highest teen birth rate at 39.4 births per 1,000 from the years 2000-2006. Nine percent of births in Manchester were to teen mothers in 2007, which had a teen birth rate of 42.3 per 1000. The county with the highest teen birth rate of 41.0 births per 1,000 from years 2000-2006 was Sullivan County. New Hampshire used this data and other feedback from key informants through a "Getting To Outcomes" process to develop a strategic plan to address how to further reduce teen pregnancy within our state.

**STRATEGIES:**

MCH continued to administer the federal abstinence education funds. New Hampshire's Abstinence Education Plan utilized a grassroots approach by contracting with a community based Leadership in Abstinence Education Program, Catholic Medical Center, to provide outreach and education within communities in need. The abstinence education state advisory committee provided guidance and oversight to the program. (PB, IB)

A federal proposal and state plan was written for the administration of the Personal Responsibility Education Program (PREP) funds. An RFP was drafted to target teen pregnancy prevention dollars with providers in the targeted areas of our state with the highest percentage and number of teen births (Sullivan County and the City of Manchester).(PB, IB)

MCH continued to monitor and provide technical assistance to MCH-funded prenatal and primary care agencies that provided comprehensive prenatal care to low income, uninsured and underinsured women. (DS, ES, IB)

The FPP continued to offer confidential reproductive health services to adolescents as required by Title X. Education and reproductive health services have continued through teen clinics.

Statewide access of the program is contingent upon continued funding. (DHC)

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Administration of the abstinence education funding with Catholic Medical Center.			X	X
2. Administration of the Personal Responsibility Education Program funding with providers in Sullivan County and the City of Manchester.			X	X
3. Monitoring and technical assistance to MCH funded prenatal and primary care agencies.	X	X		X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

New Hampshire is proud to once again have the lowest teen birth rate in the country. According to data from the National Center for Health Statistics, NH's teen birth rate for 2010 was 15.6 per 1,000 births (among 15 to 19 year-olds); 6.7 per 1000 for 15-17 year olds. About 3/4's of those teen births occur in 18 to 19 year-olds.

In 2011, 47.5% of NH high school seniors reported ever having sex on the YRBS, similar to, although slightly higher than, the 2009 national rate of 46%. But in NH, among those teens who do have sex, a greater proportion of them use contraception to prevent pregnancy than do teens in the rest of the country.

**STRATEGIES:**

MCH continues to oversee and manage federal funds for the administration of abstinence education services through a contract with Catholic Medical Center. The abstinence education state advisory committee meets regularly and provides guidance and oversight to the abstinence education program. (PB, IB)

MCH continues to oversee and manage federal funds for the administration of Personal Responsibility Education Program (PREP) funds through a contract with two local providers in the targeted areas of Sullivan County and the City of Manchester, as they have the highest rate and numbers of teen births in the state. (STI), and HIV

MCH continues to monitor and provide technical assistance to MCH-funded prenatal and primary care agencies that provide comprehensive prenatal care to low income, uninsured and underinsured women. (DS, ES,

**c. Plan for the Coming Year**

MCH will continue oversight and management of federal funds for the administration of abstinence education services through a contract with Catholic Medical Center. The Abstinence Education Program will primarily focus on two communities, Sullivan County and the City of Manchester, where data suggests there are disproportionately high numbers and rates of teen births. The abstinence education state advisory committee will continue to meet and provide

guidance and oversight to the abstinence education program. (PB, IB)

MCH will continue oversight and management of federal funds for the administration of Personal Responsibility Education Program (PREP) funds through a contract with two local providers in the targeted areas of Sullivan County and the City of Manchester, as they have the highest rate and numbers of teen births in the state. (STI), and HIV. (IB)

MCH will re-convene the Adolescent Sexual Health Task Force to finalize a strategic plan that will incorporate the abstinence and PREP services. The task force will be made up of a collection of key partners from around the state to include: family planning, adolescent health, Department of Education, TANF, home visiting, family planning providers, home visiting providers, higher education, minority health office, physicians and nurses. (IB)

MCH will continue to monitor and provide technical assistance to MCH-funded prenatal and primary care agencies that provide comprehensive prenatal care to low income, uninsured and underinsured women. (DS, ES, IB)

**Performance Measure 09:** *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	42.4	42.4	44	54.5	54.5
Annual Indicator	42.4	42.4	54.5	54.5	54.5
Numerator	249	249	1644	1644	1644
Denominator	587	587	3015	3015	3015
Data Source		2006 3rd grade survey	2009 3rd grade survey	2009 3rd grade survey	2009 3rd grade survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	54.5	54.5	60	60	60

**Notes - 2011**

Statewide oral health data for NPM #9 is generally collected every five years through the Oral Health Survey of Third Grade Children. The data for 2011 is the same as for 2009 and 2010. Future objectives reflect the fact that new data will not be available until 2014.

Please note: statewide prevalence estimates are weighted to represent NH third grade students, and to account for selection probability and non-response. Using the weighting, the result for this measure is 60.4%, not 54.5.

**Notes - 2010**

Statewide oral health data for NPM #9 and SPM #4 is generally collected every five years through the Oral Health Survey of Third Grade Children. The data for 2010 is the same as for 2009. Please note: statewide prevalence estimates are weighted to represent NH third grade students, and to account for selection probability and non-response. Using the weighting, the result for this measure is 60.4%, not 54.5.

**Notes - 2009**

Statewide oral health data for NPM #9 and SPM #4 is generally collected every five years through the Oral Health Survey of Third Grade Children. The data for 2009 is the same as for 2008.

Please note: statewide prevalence estimates are weighted to represent NH third grade students, and to account for selection probability and non-response. Using the weighting, the result for this measure is 60.4%, not 54.5.

**a. Last Year's Accomplishments**

**DATA ANALYSIS:**

The Oral Health Program (OHP) collected and analyzed oral health data and provided feedback on the presence of dental sealants among NH's students enrolled in 19 school-based sealant programs in 158 (52%) of NH's elementary schools. (IBS, PBS, ES.)

The OHP contributed to a report by the NH Division of Public Health Services (DPHS) Chronic Disease Epidemiologist, "Utilization of Hospital Emergency Departments for Non-Traumatic Dental Care in New Hampshire, 2001-2008." The article was published in the Journal of Community Health, November 2010 and results were presented by the OHP at the 2011 National Oral Health Conference.

**SYSTEMS BUILDING:**

With the NH Dental Society and oral health stakeholders, the OHP convened a dinner meeting of publicly supported oral health programs and acknowledged the effectiveness and sustainability of school sealant programs that link identified children with restorative care and a "dental home." (IB, PBS, ES, DS)

With the NH DHHS Medicaid Dental Director, the NH Office of Head Start Collaboration, the NH Pediatric Dental Society and general dentists in Nashua, the OHP focused on Nashua and northern NH to implement promising practices to improve access to preventive and restorative care for Head Start children at higher risk for ECC, untreated decay, and history of decay. (IB, ES, PBS, DS).

The OHP collaborated with the Women, Infants and Children (WIC) Program and the Northeast Delta Dental Foundation to expand successful Enfield /Lebanon dental clinics to improve access to preventive and restorative oral health care for WIC enrolled Laconia children at higher risk for ECC, untreated decay, and history of decay. (IB, ES, PBS, DS).

The OHP collaborated with the New Hampshire Technical Institute Allied Health Department to assure a competent dental public health workforce through the development of six high-quality core educational courses that will lead to a public health certificate for dental hygienists working in non-traditional settings.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The OHP will collect, analyze and report on oral health data, specifically the percent of second and third grade students with dental sealants on their molar teeth.			X	X

2. The OHP will continue collaboration with the Chronic Disease Epidemiologist on the publication of articles in reputable national journals that contribute to the growing body of oral health knowledge.			X	X
3. The OHP will collaborate with the Head Start State Collaboration Office, the NH Dental Society, the NH Pediatric Dental Society, public health hygienists and Head Start parents and staff to provide ongoing early oral health education, preventive serv	X	X	X	X
4. The OHP will collaborate with WIC programs at the state and regional levels and public health hygienists to offer staff, parents and enrolled children ongoing early oral health intervention, education, and links to dental homes.	X	X	X	X
5. The OHP will collaborate with the New Hampshire Technical Institute Allied Health Department to assure a competent dental public health workforce through the development of high-quality core educational courses that will lead to a public health certi		X	X	X
6. The OHP will collaborate with three rural school-based oral health programs and Dr. Rick Niederman form Forsyth Institute, Boston to improve the clinical effectiveness and cost effectiveness of rural school-based caries prevention programs.	X	X	X	X
7.				
8.				
9.				
10.				

**b. Current Activities**

**DATA ANALYSIS:**

The OHP works with the Chronic Disease Epidemiologist to annually collect and analyze data and provide programmatic feedback on the presence of dental sealants among NH's students. (IBS, PBS, ES.)

**SYSTEMS BUILDING:**

The OHP works with the Medicaid Dental Director, the NH Dental Society, and dental public health professionals to increase the effectiveness and sustainability of school sealant programs that link identified children with a "dental home." (IB, PBS, ES, DS)

The OHP sponsors the annual Calibration Clinic for school hygienists to discuss new more efficient and effective techniques so programs can incorporate sealant application into NH middle schools even when resources are limited (IB, PBS, ES, DS.)

The OHP works with the NH Pediatric Dental Society, NH Office of Head Start Collaboration, WIC and child caregivers offering early OH interventions to improve access to care for at-risk children while educating parents and caregivers on the importance of oral health to a child's total health. (IB, ES, PBS, DS).

The OHP continues collaboration with the New Hampshire Technical Institute Allied Health Program to develop high-quality continuing educational courses as part of curriculum development as hygienists work to earn a public health certificate for those working in non-traditional settings. (IBS, PBS, ES.)

Lisa Bujno, Bureau Chief of the Bureau of Population Health and Community Services, where MCH resides, represents DPHS in the NH Oral Health Coalition. (IB)

**c. Plan for the Coming Year**

**DATA ANALYSIS:**

The OHP will work with the DPHS Chronic Disease Epidemiologist to annually collect, analyze and report on oral health data providing program-specific feedback on the presence of dental sealants among NH's students enrolled in 19 school-based sealant programs. In spite of limited resources, the OHP has successfully used NH-specific data to secure external funding for projects by demonstrating unmet need in NH and improved oral health status. Two recent examples of how data driven programs are "Utilization of Hospital Emergency Departments for Non-Traumatic Dental Care in New Hampshire, 2001-2008" and "Improvements in the Oral Health Status of NH Children, 2010. (IBS, PBS, ES.)

The OHP will work with the DPHS Chronic Disease Epidemiologist to publish "The Importance of Sub-State Surveillance in Detection of Geographic Inequalities in a Small State" in the August 2012 edition of the Journal of Public Health Management and Practice. (IBS)

**SYSTEMS BUILDING**

Following the completion of an oral health data collection project conducted from June to December 2011 at seven WIC clinics, the OHP will secure funding from HNHfoundation to sustain WIC dental clinics in seven locations and add Franklin and Pittsfield so public health hygienists can continue to provide early oral health education, preventive services and links for families to dental homes. (IB, ES, PBS, DS).

With technical assistance from the Association of State and Territorial Dental Directors (ASTDD) the OHP will collaborate with the DPHS Chronic Disease Epidemiologist, the Obesity Prevention Program, and the CDC Assignee to design the survey sample for the 2013-2014 Oral Health/ BMI Survey Third Grade Survey to assess the oral health and height and weight status of NH's children. (IBS)

The OHP and three rural school-based oral health programs will participate in an NIH funded project under the direction of Dr. Rick Niederman, Forsyth Institute, Boston. The project will assess selected programs. Then, by introducing a greater number of preventive interventions, improve the clinical effectiveness and cost effectiveness of rural school-based caries prevention programs. (IBS, PBS, ES, DS.)

**Performance Measure 10:** *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

**Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	60	80	0	0	0
Annual Indicator	1.2	1	1	1	1
Numerator	3				
Denominator	241716				
Data Source		Vital Records	Vital Records	Vital Records	Vital Records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5			Yes	Yes	Yes

and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	0.8	0.6	0.4	0.2	0

**Notes - 2011**

Calendar year 2011 out of state data is unavailable. 2008 is the most recent final data.

Starting with the year 2005, NH is using the following document as guidance for injury data: Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

At the annual federal review in August of 2009, it was decided that it would be more appropriate for NH to use the small numbers box than to use the Standard Ratio Methodology as outlined in the Block Grant guidance. The small numbers box is used when "there are fewer than 5 events and when the average number of events over the last 3 years is fewer than 5, and therefore a 3-year moving average cannot be applied".

**Notes - 2010**

Calendar year 2010 out of state data is unavailable.

Starting with the year 2005, NH is using the following document as guidance for injury data: Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

At the annual federal review in August of 2009, it was decided that it would be more appropriate for NH to use the small numbers box than to use the Standard Ratio Methodology as outlined in the Block Grant guidance. The small numbers box is used when "there are fewer than 5 events and when the average number of events over the last 3 years is fewer than 5, and therefore a 3-year moving average cannot be applied".

**Notes - 2009**

Starting with the year 2005, NH is using the following document as guidance for injury data: Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Calendar year 2009 is unavailable. At the annual federal review in August of 2009, it was decided that it would be more appropriate for NH to use the small numbers box than to use the Standard Ratio Methodology as outlined in the Block Grant guidance. The small numbers box is used when "there are fewer than 5 events and when the average number of events over the last 3 years is fewer than 5, and therefore a 3-year moving average cannot be applied".

**a. Last Year's Accomplishments**

New Hampshire Child Passenger Safety Program:

Two four-day car seat certification training took place in the past year in order to build even greater capacity in child passenger safety. Thirty-one additional technicians were trained and passed the certification exam. (IB)

A car seat technician update was held in April of 2011, which focused on the newest version of the Lower Anchor and Tether Restraint System (LATCH). In addition, there was a session on car seats in school buses. (IB)

In the past year, there were 30 child passenger safety inspection stations in New Hampshire. At these stations, families made appointments to get their seats checked by certified car seat technicians on a specific day and time. Most stations have checks on the same day every month. They are located in agencies such as the local police and fire department and hospitals across the state. (PB)

A performance indicator related to the use of car seat checks by families enrolled in the new Maternal Infant and Early Childhood (MIEC) Home Visiting Program was developed to reduce childhood injury in motor vehicle crashes and ensure local coordination of injury prevention activities. It was the intent to work with the Injury Prevention Program to help facilitate the completion of this performance indicator. (IB, PB)

Materials focusing on new restraint guidelines from the National Highway Traffic Safety Administration and the American Academy of Pediatrics were dispersed in a variety of different means statewide, such as through Safe Kids NH's electronic listserve, on their website and as a tweet that went along with a press release from MCH. The materials used for booster seat education as part of the new guidelines were updated including a version in Spanish. These recent guidelines encourage parents to keep their toddler rear facing until at least two or until the weight and height limitations of the seat. In addition, a greater amount of seats are being manufactured for higher weights and heights allowing children to be in a car seat until the recommended age of eight or four feet nine inches tall. (PB)

There were approximately 178 certified car seat technicians in the state during the last year. Certification continues to be through SafeKids USA and is for a two-year period. MCH's Injury Prevention Program Manager is a certified car seat technician and has been one for almost 13 years. She participates in a local child passenger safety inspection station on an every other month basis. (IB)

Much of the focus in the New Hampshire Child Passenger Safety Program in the past year was on strengthening the connection of more seasoned technicians with those who are newer to the field. Encouraging new technicians to work at an inspection station on a monthly basis is one method of doing this. The Injury Prevention Program Manager works at a station to keep her skills fresh, since she does not interact with the public on a daily basis. (IB)

New Hampshire Teen Driving Committee (TDC):

The Teen Driving Committee partnered with the Department of Transportation and the WEDU marketing firm to design the Strategic Highway Safety Plan with its goal of "Driving Towards Zero". There are several sections in the plan designed to reduce deaths of those 14 and under, including the restraint usage section, highway design, and teen drivers. (IB)

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Train and certify child passenger safety technicians and instructors with a special focus on home visitors.				X
2. Continue to promote and distribute booster, convertible, and infant seats.			X	
3. Facilitate car seat checks.			X	
4. Incorporate results of surveys into materials designed for legislators and parents on graduated drivers licensing.			X	X
5. Work with the Department of Transportation on its "Driving Towards Zero" campaign.			X	X
6. Under the auspices of the Teen Driving Committee and			X	

funded by the AAP/AllState grant, work with five high schools on increasing seat belt usage.				
7. Under the CDC core injury grant, write an implementation and evaluation plan for a strategy designed to reduce deaths and injuries in children due to motor vehicle crashes.				X
8.				
9.				
10.				

**b. Current Activities**

New Hampshire Child Passenger Safety Program:

Two four-day car seat inspection trainings are taking place, with an estimated 20 new technicians hoping to pass the certification exam. (IB)

A car seat technician training just took place, which 60 technicians attended. The agenda highlighted the many new car seats available on the market. A special session focused on the utilization of car seats in emergency response vehicles.

New Hampshire Teen Driving Committee (TDC):

The TDC continues its analysis of the surveys on parent attitudes with respect to components of graduated driver licensing. Survey results are being compiled as part of what is going to be used in educational materials for both parents and legislators on graduated drivers licensing. (IB, PB)

The TDC is working with five high schools as part of a grant funded by the AllState Foundation and the American Academy of Pediatrics. The purpose of the grant is to increase seat belt usage amongst students in schools with a lower than average response to the seat belt question on the Youth Risk Behavior Survey. (PB).

**c. Plan for the Coming Year**

New Hampshire Child Passenger Safety Program:

Two additional four-day car seat certification-training programs will take place. (IB)

A grant was submitted to the New Hampshire Highway Safety Agency to allow for the development of a train the trainer program on restraint use in emergency medical service vehicles, such as ambulances. The intent is to train emergency medical service providers to train their colleagues on the best use of passenger restraints, including car seats, in emergency vehicles. (IB)

The State's Child Passenger Safety Program will be facilitating car seat observational surveys in areas of the state (to be determined) that have historically not been high in adult seat belt usage. It is known that the likelihood of a child being restrained correctly has a lot to do if the parent or other adult in the car is also restrained. (PB).

The Injury Prevention Program will be working with the Maternal Infant and Early Childhood (MIEC) Home Visiting Program on an issue/data brief specific to childhood injuries and focusing on restraint issues. (IB)

New Hampshire Teen Driving Committee (TDC):

The TDC will continue to work with the Department of Transportation on its "Driving Towards Zero" campaign. This will include work in the five AllState/AAP schools on increasing seat belt usage. It also includes the distribution of materials on graduated driver licensing to legislators and parents. (PB)

**Performance Measure 11:** *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	45	50	49	56	52
Annual Indicator	48.7	46.8	55.1	50	58.2
Numerator					
Denominator					
Data Source		CDC report card	CDC report card	CDC report card	CDC report card
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	60	62	64	66	68

**Notes - 2011**

Data is from the CDC Breast Feeding Report Card, 2011: Outcome Indicators (www.cdc.gov). A numerator and denominator are not available.

**Notes - 2010**

Data is from the CDC Breast Feeding Report Card, 2010: Outcome Indicators (www.cdc.gov). A numerator and denominator are not available.

**Notes - 2009**

Data is from the CDC Breast Feeding Report Card, 2009: Outcome Indicators (www.cdc.gov). A numerator and denominator are not available.

**a. Last Year's Accomplishments**

**STRATEGIES AND PARTNERSHIPS:**

The MCH-funded community health programs and home visiting programs continue to carry out workplan activities regarding promoting WIC enrollment and promoting/supporting breastfeeding among their clients. (IP)

At the Fall 2010 MCH Coordinators' Meeting, the WIC State Breastfeeding Promotion Coordinator reviewed the 2010 Breastfeeding Report Card, 2009 CDC Pediatric Nutrition Surveillance System breastfeeding data and shared highlights of the new WIC approved foods, emphasizing the benefits and incentives for breastfeeding mothers. Agency representatives were encouraged to share ideas on what was successful, or obstacles encountered in carrying out their new workplan activities regarding encouraging breastfeeding through 6 months of age and also encouraging enrollment in WIC. (IB)

MCH shared educational offerings and electronic informational updates from WIC with the MCH contract agencies. (IB)

The MCH Child Health Nurse Consultant represented MCH on the NH Breastfeeding Task Force

and attended this year's conference. (IB)

MCH participates in the Division of Public Health Services' Breastfeeding Integration Committee. Tasks included strategic planning for data collection, review of the US Surgeon General's Breastfeeding Call to Action and review of NH DHHS Breastfeeding Policy.(IB)

The MCH Child Health/SIDS Program Coordinator promotes breastfeeding in public and professional information activities focused on SIDS risk reduction and safe sleep practices. (PB)

In June 2011, MCH initiated the NH Sudden Unexpected Infant Death (SUID) Review Committee, a subgroup of the state's Child Fatality Review Committee, as a requirement of a 2-year CDC grant to be a SUID web-based registry pilot site. The project is coordinated by MCH's Child Health Nurse Consultant, and has been reviewing all SUID deaths by a multidisciplinary team for comprehensive data on the infant and its death. A lactation consultant who is a member of the NH Breast Feeding Task Force was recruited for the Review Group and is an active and vocal participant.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support the MCH contract agencies' efforts to promote initiation and duration of breastfeeding among clients, via workplan monitoring and reporting, and via site visits.				X
2. Share information about breastfeeding education with MCH contract agencies.				X
3. Participate in committees and workgroups targeting improving breastfeeding rates.				X
4. Promoting breastfeeding as an infant death risk reduction strategy during SIDS/Safe Sleep activities.			X	
5. Collaborate with the WIC Program on any activities that can improve the breast feeding rates of both the state and the MCH contract agencies.			X	X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

NH continues to show steady improvement in breastfeeding rates. In support of this progress, over 16% of infants were born in Baby Friendly Facilities.

**CONTINUED STRATEGIES:**

MCH will work with WIC in July and August 2011 to promote World Breastfeeding Week (August 1-8). (IB, PB)

MCH will continue to work with the MCH contract agencies to improve breastfeeding initiation and duration, and WIC enrollment, by requiring the related workplan performance measures and assessing progress via end of the year reports and site visits. (IB)

MCH will continue to share educational offerings, printed nutrition and breastfeeding materials

and electronic informational updates from WIC with the MCH contract agencies. (IB)

The MCH Child Health Nurse Consultant will continue to represent MCH on the NH Breastfeeding Task Force and attend the annual conference. (IB)

MCH will continue to participate in the DPHS Breastfeeding Integration Committee. Tasks will include collaborating to support adoption of one or more action steps from the US Surgeon General's Call to Action, including, promotion and support of Baby Friendly Hospitals, continued support for mother-to-mother breastfeeding support through WIC's peer counseling program, and initial support and training for breastfeeding friendly child care settings. (IB)

The MCH Child Health/SIDS Program Coordinator will continue to promote breastfeeding in public and professional information activities focused on SIDS risk reduction and safe sleep practices.

**c. Plan for the Coming Year**

**STRATEGIES AND PARTNERSHIPS:**

MCH will work with WIC in July and August 2012 to promote World Breastfeeding Week (IB,PB)

In Fall 2012, MCH and WIC will follow up on best-practice collaboration efforts conducted two years prior with local MCH and WIC agency representatives. A survey and subsequent learning collaborative had been held to assess and increase WIC enrollment of eligible children in MCH-funded agencies and referrals/utilization of WIC's breast feeding supports for breast feeding women in MCH-funded agencies. A follow up survey will be conducted to local WIC and MCH agency staff to assess progress in collaboration in the past two years and identify training needs. (IB)

The MCH Child Health Nurse Consultant will continue to represent MCH on the DPHS Breastfeeding Integration Committee, the NH Breastfeeding Task Force and will attend the Task Force's annual conference. (IB)

The MCH Child Health/SIDS Program Coordinator will continue to promote breastfeeding in public and professional information activities focused on SIDS risk reduction and safe sleep practices. (PB)

If in receipt of the CDC SUID Building Capacity grant, the Project will focus on analyzing its data, develop a findings report, and develop actionable prevention strategies, including a statewide public and professional campaign. Breastfeeding as a protective risk factor will be included in all of the recommendations, strategies, and educational promotions. (IB, PB)

MCH in collaboration with WIC will offer the MCH-funded home visiting agencies the opportunity to apply to be one of the six ASTPHND-funded slots for the Fall 2012 five-day training to become Breastfeeding Certified Lactation Counselors. (IB, PB)

**Performance Measure 12:** *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
--	-------------	-------------	-------------	-------------	-------------

Annual Performance Objective	98	99	98	98	98
Annual Indicator	98.2	97.4	97.3	97.5	97.4
Numerator	13683	13279	12968	12702	12549
Denominator	13937	13629	13327	13027	12880
Data Source		screening records	screening records	screening records	screening records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	98	98	98.5	98.5	99

**Notes - 2011**

Numerator is actual number of infants screened. Denominator is number of occurrent births.

**Notes - 2010**

Numerator is actual number of infants screened. Denominator is number of occurrent births.

**Notes - 2009**

Numerator is actual number of infants screened. Denominator is number of occurrent births.

**a. Last Year's Accomplishments**

**DAILY TASKS:**

The EHDI staff used birth certificate data to ensure that every infant born in a facility with hearing screening equipment was offered a hearing screening. The online data tracking system was used to ensure that infants who do not pass their hearing screening were referred for diagnostic testing, that referred infants received audiologic testing and deaf or hard of hearing infants are referred for early intervention services. (IB, PB)

**SYSTEMS BUILDING:**

The EHDI staff trained inexperienced hearing screening staff in several birth hospitals to decrease the number of infants who need a repeat hearing screening or diagnostic testing. Entries in the tracking system were matched with birth certificate data to ensure that all newborns have a hearing screening. Data entries were monitored to assure that infants complete hearing screening by one month of age, diagnostic evaluation by three months of age and enrollment in early intervention by six months of age. (IB, PB)

With supplemental funding from the federal newborn hearing screening program, the NH EHDI Program staff focused on strategies to improve the number and percent of infants born in freestanding birth centers or at home who are offered newborn hearing screening. Previous attempts to encourage families to seek newborn hearing screenings at local hospitals had not been successful. Midwives were told by their families that they did not want to take their infants into hospitals due to being uncomfortable in an institution, the cost of services, and risk of exposing their newborn to germs. Therefore, EHDI worked directly with the NH Midwives Association to provide education, training and equipment for midwives to do the screening themselves. EHDI purchased additional hearing screening equipment for use by certified lay midwives. With equipment at one additional freestanding birth facility between September and December, 2011, 38.7% of infants born in any freestanding birth facility had a hearing screening.

**LOSS TO FOLLOW-UP:**

The follow-up coordinator contacted families of infants who did not pass their final hearing screening to assure that they receive timely and appropriate follow-up for their infants. She offered assistance in the scheduling and timeliness of appointments. If the follow-up coordinator cannot reach a family, the EHDI Program staff contacted the infant's primary care provider for assistance in scheduling timely diagnostic testing.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The EHDI staff will provide technical assistance to birth hospitals, use birth certificate data to assure that all newborns receive a hearing screening, and assure that infants receive needed follow-up.			X	X
2. The EHDI staff will use performance measures to assess the performance of staff at all newborn hearing screening programs and distribute annual performance measure reports to the program managers.				X
3. The EHDI staff will monitor the performance of audiologists at Pediatric Audiology Diagnostic Centers to ensure that all audiologists adhere to the 2007 Joint Committee on Infant Hearing (JCIH) Guidelines for audiologic evaluations.				X
4. The EHDI staff will develop and maintain qualified Pediatric Audiology Diagnostic Centers in New Hampshire.		X		
5. The EHDI staff will develop and disseminate strategies that assure timely diagnostic audiologic testing.				X
6. The EHDI staff will contact primary care physicians if they are unable to connect with the families of infants who need diagnostic testing.				X
7.				
8.				
9.				
10.				

**b. Current Activities**

**DAILY TASKS:**

EHDI staff completes the essential tasks of providing technical assistance to birth hospitals; using birth certificate data to assure that all newborns receive a hearing screening; and assuring timely follow-up for infants who need additional hearing screenings or diagnostic evaluations. (IB, PB)

**SYSTEMS BUILDING:**

EHDI staff supports newborn hearing screening at freestanding, non-hospital, birth facilities by providing hearing screening equipment to midwives and training them to use the equipment, making appropriate referrals and reporting results through an online tracking system. (IB)

EHDI staff monitors staff performance at all newborn hearing screening programs and sends performance measure reports to all program managers annually. (IB)

EHDI staff meets with audiologists from diagnostic centers to provide updates, new information and continuing education. (E)

EHDI staff monitors the performance of audiologists at Pediatric Audiology Diagnostic Centers to ensure compliance with the Joint Committee on Infant Hearing (JCIH) 2007 Guidelines for infant

audiologic evaluations. (IB)

EHDI staff and a family representative are participating in a yearlong Learning Collaborative to improve the hearing screening, audiologic testing and early intervention systems provided by the National Initiative for Children's Healthcare Quality. (E)

**LOSS TO FOLLOW-UP:**

EHDI staff works with audiologists to maximize the number of appointments at each Pediatric Audiology Diagnostic Centers.

***An attachment is included in this section. IVC\_NPM12\_Current Activities***

**c. Plan for the Coming Year**

**DAILY TASKS:**

EHDI staff will provide TA to birth hospitals, use birth certificate data to assure that all newborns receive a hearing screening, and assure that infants receive needed follow-up. (IB, PB)

The EHDI staff will discuss newborn hearing screening with midwives at the only freestanding non-hospital birth facility not offering newborn hearing screening. (IB)

EHDI staff will use performance measures to monitor the performance of staff at all newborn hearing screening programs and send annual performance measure reports. (IB)

EHDI staff will monitor the performance of audiologists at Pediatric Audiology Diagnostic Centers to ensure that all audiologists adhere to the 2007 Joint Committee on Infant Hearing (JCIH) Guidelines for audiologic evaluations. (IB)

**SYSTEMS BUILDING:**

EHDI staff will support development of qualified Pediatric Audiology Diagnostic Centers in New Hampshire. (E)

EHDI staff will continue to devote resources to improve the accuracy and reporting options for reports available in the Auris tracking system. In the current year, it came to the staff's attention that calculations for measures, such as the number of infants who referred on the initial screening who also referred on the rescreen, displayed the percentage of all infants who were screened who referred on their rescreen. The EHDI staff will continue to work with the developers of the AURIS system to resolve the problems so that accurate and timely reports can be made for quality assurance and monitoring. (IB)

**LOSS TO FOLLOW-UP:**

EHDI staff will promote activities that help parents obtain diagnostic audiologic testing for infants who do not pass their final hearing screening. The EHDI Program maintains a list of diagnostic facilities with qualified audiologists. All audiologists must be licensed as an audiologist and have additional training in pediatric testing. The diagnostic facility must have specific equipment before their facility is added to the list. In March 2012, the EHDI Program was notified by the practice manager at an otolaryngology practice in a highly populated area of the state that the audiologist would not be available to test infants. Forty infants born in 2011 were tested at this facility. The only other audiologist in the area has limited time to test infants and restricts referrals to a smaller area. The staff at the other diagnostic centers are aware of the closing. EHDI staff is available to assist families in scheduling diagnostic testing at other NH diagnostic centers or at nearby diagnostic testing sites in Maine or Massachusetts. (IB)

EHDI staff will continue to support QA activities that improve loss to follow up at the hospital level, such as making audiologic testing appointments before discharge or faxing the referral information to the testing facility selected by the family. (IB)

The EHDI staff will contact primary care physicians if they are unable to connect with the families of infants who need diagnostic testing. (IB)

**Performance Measure 13:** *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	5.5	5.5	4	4	4
Annual Indicator	6.0	4.3	4.3	4.0	5.0
Numerator	19402	12921	12921	11900	14000
Denominator	323309	298439	298439	297500	280000
Data Source		2007 Nat'l Survey of Children's Health	2007 Nat'l Survey	Kaiser Foundation State Health Facts	Kaiser Foundation State Health Facts
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	4	4	4	4	4

**Notes - 2011**

Data is from the Kaiser Family Foundation State Health Facts: "New Hampshire: Health Insurance Coverage of Children 0-18, States (2009-2010), US (2010)

<http://www.statehealthfacts.org>

**Notes - 2010**

Data is from the Kaiser Family Foundation State Health Facts: "New Hampshire: Health Insurance Coverage of Children 0-18, States (2008-2009), US (2009)

<http://www.statehealthfacts.org>

**Notes - 2009**

Data is from the 2007 National Survey of Children's Health, a project of the Child and Adolescent Health Measurement Initiative.

There are multiple sources for the uninsured population - with discrepant results. For example, the Kaiser Family Foundation Website ([statehealthfacts.org](http://statehealthfacts.org)) shows 5.1% uninsured children in NH. Their uninsured estimates are based on the Census Bureau's March 2007 and 2008 Current

Population Survey (CPS: Annual Social and Economic Supplements).

We have chosen to use the number from a national survey instead of census estimates.

#### **a. Last Year's Accomplishments**

##### **BACKGROUND:**

While much of the country has focused on national health care policy, New Hampshire has looked internally to contain costs and develop plans to ensure high quality services for the Medicaid population, including children and pregnant women. In the 2010-2011 legislative season, to achieve budgetary savings, the Governor proposed to convert enrollees in the NH SCHIP program, Healthy Kids Silver, into enrollees of Medicaid and transition the entire program into the existing Medicaid fee-for-service system as of July 1, 2011. Under the House and Senate budgets, Healthy Kids Silver enrollees will still be converted into Medicaid members, but will be transitioned into a new Medicaid Managed Care program, with a target implementation date of July 1, 2012. Children with incomes between 185 and 300 percent of FPL would continue to receive health insurance coverage and continue paying the same monthly premiums, but their care will be managed by a managed care vendor yet to be selected. The buy-in program for children with incomes 300-400 percent of FPL will be discontinued. Additionally, coverage will be discontinued for children who participate in NHHK through the buy-in program because they are legal residents but do not yet meet the 5 year residency requirement for Medicaid. Lisa Bujno, Bureau Chief of the Bureau of Population Health and Community Services, where MCH resides, represented the Division of Public Health Services workgroups crafting these strategies.

##### **STRATEGIES TO MAINTAIN COVERAGE:**

While policy makers focused on financing the larger delivery system for Medicaid, MCH and community partners continued to focus on ensuring that families received the benefits to which they were currently entitled.

MCH continued to monitor the Title V contract agencies' percentage of children without health insurance, percent of eligible children enrolled on NH Healthy Kids and activities to enhance Medicaid/NH Healthy Kids Gold enrollment through review of statistics and quality assurance and quality improvement plans. In FY11, agencies averaged 88% enrollment on Medicaid of eligible children receiving services at a state-funded primary care center, with a range of 61- 100%. (IB)

MCH has had a long history of supporting a flexible, needs-based home visiting service that focused on activities such as assisting families with enrollment in health care, referrals, case management and care coordination, education and counseling relative to the child and family. Community based agencies use evidence-based, time-limited parenting education curriculum to help support resiliency and improve child, parent, and/or family functioning. In SFY 11, 98% of children served by MCH-funded Child and Family Health Support Services, who were eligible, were enrolled in Medicaid/Healthy Kids Gold. In SFY 11, 98% of children aged 12 months to 19 years served by DPHS-funded Child and Family Health Support Services, had at least one primary care provider preventive care visit in FY2010. (IB, ES)

MCH held a half-day workshop in Fall 2010 in collaboration with Medicaid and its Surveillance and Utilization Review Services (SURS) unit to orient MCH contract agency staff about changes in a revised Medicaid rule that allows MCH contract agencies to bill for education and support services, some of which are used to work with families to get eligible children enrolled on Healthy Kids Gold. Changes to this rule in eligibility and service units has a profound impact upon Title V home visiting programs, feeding, nutrition and swallowing programs, and a pediatric primary care contract. (IB)

#### **Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to fund a safety net of primary care providers through the community health centers with a primary goal of ensuring that children maintain access to health insurance.				X
2. Monitor the Title V contract agencies' percentage of children without health insurance, percent of eligible children enrolled on Medicaid and CHIP/Medicaid and activities to enhance Medicaid enrollment through review of statistics and quality improve				X
3. Monitor appropriate documentation of client financial status at site visits to MCH funded community health centers.				X
4. In partnership with the Office of Medicaid Business and Policy, provide technical assistance to community based agencies, including community health centers, regarding possible enrollment policy changes.				X
5. Provide information, as needed, to the NH Insurance Department regarding ACA Health Reform Implementation.				X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Select members of NH DHHS were very busy this year preparing and reviewing contracts for Medicaid Managed Care for a legislated start date of July 1, 2012. Title V worked with community partners so that they could work directly with families and providers and communicate impending changes. Medicaid benefits will stay the same in the Care Management Program. (IB, PB)

Effective July 1, 2012 the SCHIP Healthy Kids Program will be managed by the State Medicaid Program. Medicaid staff will present an overview of the changes at the June 2012 MCH Coordinators' Meeting. (IB, PB)

In May 2012, the NH Governor and Executive Council approved \$2.2 billion in contract awards to three national companies who will administer Medicaid Managed Care (MMC), due to be implemented December 2012 (later than expected). This is a significant change from the current fee for service system for the MCH-contract agencies and community health centers who currently bill Medicaid for visits to assist families stay enrolled on Medicaid. MCH is exploring how to best assist agencies in contacting the new MMC organizations to help them become a part of this new service delivery system so that needed home visiting services will be paid for by the managed care organizations. (IB)

Due to new rules for the optional Medicaid billable home visiting services, MCH merged two of its home visiting grants to one hybrid proposal, posted for competitive bid for FY13. (IB)

**An attachment is included in this section. IVC\_NPM13\_Current Activities**

**c. Plan for the Coming Year**

**MEDICAID MANAGED CARE:**

Care management is a way to coordinate health benefits for people enrolled in New Hampshire's Medicaid Program. Under a care management approach, NH's Medicaid program will provide services through companies that will be paid a set rate for members. Three managed care organizations, Boston Medical Center Health Net, Centene, and Meridian Health Plan, the advent of Medicaid Managed Care negotiated contracts with NH DHHS to serve the entire Medicaid

population of New Hampshire in all areas of the state.

There is a multi-step approach and an aggressive implementation timetable. In the first step of the program, anyone currently enrolled in New Hampshire's Medicaid and Children's Health Insurance Programs as well as newly qualified individuals will be enrolled in the Care Management Program for their medical services. In the second step, long term care services, including specialty services and community based care, will become part of the program. Step 2 is expected to begin one year after the first step.

NH DHHS will conduct a series of forums in the summer of 2012 to discuss care management and Step 1 implementation. The Department will encourage and seek volunteers to participate in Step 2 design. While Step 2 is focused on those with Developmental Disabilities, volunteers representing those from all populations served by Medicaid will be invited and encouraged to provide feedback.

Instructions on how to sign up with a plan will be sent to families directly. If a Managed Care Organization is not selected, DHHS will automatically assign a plan to each individual. There will be a period of time after this auto-assignment to change plans should individuals wish to do so.

Members will be able to pick their own medical home, provided that the medical provider meets the requirements for being a medical home.

ACA:

NH has opted, through statute, to enter into the federally run health insurance exchange.

**STRATEGIES TO MAINTAIN COVERAGE:**

MCH will continue to monitor the Title V contract agencies' percentage of children without health insurance, percent of eligible children enrolled on CHIP/Medicaid, and on Medicaid, and activities to enhance Medicaid enrollment through review of statistics and annual workplans. (IB)

MCH will continue to work in partnership with Medicaid to inform providers of changes so that community health centers and other agencies can assist families with seamless transitions. (IB)

MCH will administer and evaluate the new FY 13 "hybrid" home visiting contracts which include efforts to enroll children on health insurance in its scope of services, will explore collaborating with DCYF on merging its "hybrid" contract with DCYF prevention grant contracts for FY14. and will reassess the viability of such contracts in the future. (IB)

**Performance Measure 14:** *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	35	33	32	31	30
Annual Indicator	33.6	32.5	32.2	31.3	31.5
Numerator	2437	2691	2886	2698	2598
Denominator	7254	8286	8963	8621	8249
Data Source		NH WIC program	NH WIC Program	NH WIC Program	NH WIC Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over					

the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	29	28	27	27	26

**Notes - 2011**

Data is from Lisa Richards, NH WIC program, from CDC Pediatric Nutrition Surveillance System.

**Notes - 2010**

Data is from Lisa Richards, NH WIC program, from CDC Pediatric Nutrition Surveillance System.

**Notes - 2009**

Data is from Lisa Richards, NH WIC program, from CDC Pediatric Nutrition Surveillance System.

**a. Last Year's Accomplishments**

WIC staff spoke at the Fall 2010 MCH Coordinators' Meeting on the revised WIC risk criteria, and at the June 2011 meeting on changes at local WIC agencies, WIC infant formula changes, and on the 2010 NH PEDNSS data results on obesity, anemia, and breastfeeding. (IB)

MCH monitored the activities of the community health centers pertaining to documenting and graphing BMI, and age and gender-appropriate BMI percentiles as part of the quality assurance site visits to the state-funded community health centers, and through reviews of past, current, and proposed workplan activities. (IB)

MCH collaborated with DPHS WIC and Obesity Prevention Program Staff, and solicited input from the MCH contract agencies, to change the obesity related performance measure required in MCH-funded community health centers' workplans. The current measure on BMI percentile documentation will be replaced by one requiring documentation of the components 5-2-1-0 Healthy NH program. (IB)

The MCH Child Health Nurse Consultant represented NH DHHS on the Advisory Board for the pediatric obesity Healthy Tomorrows AAP/MCHB grant held by a northern community health center. (IB)

MCH shared information electronically with MCH-funded agencies on new initiatives, research, educational material, or suggestions for working with families to prevent or reduce pediatric obesity. (IB, PB)

MCH participated in a 2-day retreat to launch a DPHS Chronic Disease Integration initiative that will include a focus on preventing obesity through a lifecourse approach. (IB)

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue participation in any statewide obesity prevention and control activities representing MCH, including the Chronic Disease Integration initiative, as they develop.			X	X
2. Collaborate with WIC and the Obesity Prevention Program in sharing trainings, educational material, and obesity data with the				X

MCH contract agencies.				
3. Continue to monitor BMI use by the community health centers through site visits, focusing on what guidelines are followed for children whose BMI indicates overweight or obesity status.				X
4. Work with the Child Development Bureau, the Obesity Prevention Program and the Tobacco Prevention and Control Program to increase physical activity among preschoolers through training to child care providers and improving licensing rules pertaining t			X	X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The Child Health Nurse Consultant continues to participate in any statewide obesity prevention and control activities representing MCH, including the Chronic Disease Integration initiative. (IB, PB)

MCH distributed posters and handouts with its MCH contract agencies from the Obesity Prevention Program on the 5-2-1-0 Campaign at an MCH Coordinators' Meeting. (IB, PB)

MCH is working with its contract agency staff in developing workplan activities to support the new required obesity measure on the 5-2-1-0 Healthy NH program. (IB)

MCH collaborates with WIC and with the Obesity Prevention Program in sharing trainings, educational material, obesity data, and speakers with the MCH contract agencies. (IB)

MCH Staff served as consultants to an ARRA CPPW project to improve child care licensing rules pertaining to nutrition, physical activity/screen time, and tobacco exposure. In collaboration with the DPHS Obesity Prevention Program and Tobacco Prevention and Control Program, the project assessed the feasibility of implementing improvements to nutrition, physical activity, and smoking regulations in licensed child care settings. (IP, PC)

**c. Plan for the Coming Year**

The MCH Child Health Nurse Consultant, in collaboration with MCH's new Quality Assurance Nurse Consultant and the DPHS Obesity Prevention Program, will continue to monitor BMI use by the community health centers through the results of its annual workplan and at site visits. Attention at site visits will be paid regarding documented follow up for children whose BMI indicates overweight or obesity status and what national guidelines for follow up are being adhered to. (IB)

MCH will continue to participate in any statewide obesity prevention and control activities representing MCH, including the Chronic Disease Integration initiative. (IB, PB)

MCH will continue to collaborate with WIC and with the Obesity Prevention Program in sharing trainings, educational material, obesity data, and speakers with the MCH contract agencies. (IB)

In Fall 2012, MCH and WIC will follow up on best-practice collaboration efforts conducted two years prior with local MCH and WIC agency representatives. A survey and subsequent learning collaborative had been held to assess and increase WIC enrollment of eligible children in MCH-

funded agencies and referrals/utilization of WIC support for breast feeding and nutrition education and support services. A follow up survey will be conducted to local WIC and MCH agency staff to assess progress in collaboration in the past two years and identify training needs. (IB)

MCH will continue to collaborate with the Child Development Bureau, the Obesity Prevention Program and the Tobacco Prevention and Control Program to increase physical activity among preschoolers through training to child care providers and improving licensing rules pertaining to nutrition, physical exercise, screen time and tobacco exposure. (IB, PB)

**Performance Measure 15:** *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures  
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	12	13	12	11.5	11
Annual Indicator	13.3	12.0	11.6	11.9	11.9
Numerator	1681	1627	1542	1529	1529
Denominator	12621	13606	13319	12797	12797
Data Source		Birth Certificate	Birth Certificate	Birth Certificate	Birth Certificate
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	11.5	11	10.5	10	9.5

**Notes - 2011**

Out of state data is unavailable. 2010 data is used as an estimate.

**Notes - 2010**

Updated with 2010 data. In last year's application, this was estimated from 2009 data.

**a. Last Year's Accomplishments**

**QUALITY ASSURANCE:**

MCH monitored and provided technical assistance to MCH-funded prenatal and primary care agencies that provide comprehensive prenatal care to low income, uninsured and underinsured women. (DS, ES, IB)

MCH provided smoking cessation services to pregnant women through Home Visiting NH. Data from FY 2011 showed a 59% quit rate in pregnant program participants by the time their baby was born.

**COLLABORATION AND SYSTEMS BUILDING:**

MCH worked with the Tobacco Control Program to offer Nicotine Replacement Therapy (NRT) to

those MCH funded primary care centers that are interested in clinical systems change. (DS, ES)

The Tobacco Control Program piloted a plan to adopt a modified 5 A's protocol using EMR and HL7 technology within a MCH-funded CHC. The goal was to have medical providers refer patients to the Quitline via Health-E link -a software tool able to interface with the EMR, by extracting referral info and returning a receipt that closes the loop with the referring provider. (DS, ES)

MCH and the Tobacco Control Program and worked with two MCH's funded prenatal programs and one home visiting program in a multi-state learning collaborative on perinatal tobacco screening, referral, and cessation. Each site performed an intensive QI Cycle aimed at improving rates of completed referrals to the Quitline. (IB)

The Title V Director and other DPHS staff participated in a 10- week Dartmouth Institute Clinical Microsystems course focusing on a project aimed at aligning public health systems focused on perinatal smoking cessation. (IB)

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH will continue to actively participate on the Maternal Mortality Review Panel.				X
2. Continue to participate in the multi-state learning collaborative.				X
3. Monitor tobacco performance measure data. Promote 2 A's & R smoking cessation training by the NH Tobacco Program in those agencies who do not reach their target goal within 10%. (IB)				X
4. Launch the Pregnancy Risk Assessment Management System (PRAMS) project. Monitor and analyze PRAMS data. Share findings with stakeholders.				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

MCH monitored and provided TA to MCH-funded prenatal and primary care agencies that provide comprehensive prenatal care to low income, uninsured and underinsured women with particular attention to a performance indicator on prenatal tobacco screening and referral. (DS, ES, IB)

The Tobacco Control Program adopted a modified 5 A's protocol using EMR and HL7 technology within a MCH-funded CHC. Providers currently refer patients to the Quitline via Health-E link. (IB)

Using MCHB TA funds, MCH highlighted via social media a story of a young woman who used Text4Baby to quit smoking. (PB)

**QUALITY ASSURANCE/QUALITY IMPROVEMENT:**

MCH continue to disseminate the information from the multi-state learning collaborative on perinatal tobacco screening, referral, and cessation. Participating agencies presented their findings to other perinatal and home visiting programs. Four WIC programs replicated process and embarked on a perinatal smoking cessation QI process in their sites. Training was done to

support their efforts. (IB)

MCH staff monitor the MCH-funded prenatal programs use of a modified 5 A's smoking cessation protocol, 2 A's and an R, through annual workplans, performance data and chart audits. (IB)

MCH continues to provide smoking cessation services through Home Visiting NH and the new ACA-funded home visiting sites and collect data on the number of women who report quitting by the time baby is born. A new data system is under development to collect comprehensive data about families.

**c. Plan for the Coming Year**

**QUALITY ASSURANCE:**

MCH will continue to monitor and provide technical assistance to MCH-funded prenatal and primary care agencies that provide comprehensive prenatal care to low income, uninsured and underinsured women with particular attention to the revised performance indicator on prenatal tobacco screening and referral from 5 A's to 2 A's and R best practice model. In State Fiscal Year 13, MCH will pay particular attention to the rate referred to the Quitline. It is anticipated that health centers will need additional training in order to capture this measure consistently across the State. Feedback from providers indicates that there is significant variation as to the understanding of what "counts" as a referral, even when detailed definitions are provided. (DS, ES, IB)

**COLLABORATION AND SYSTEMS BUILDING:**

MCH will continue to work with the Tobacco Control Program and any other community health centers interested in replicating the modified model of the 5 A's protocol using EMR and HL7 technology. Anecdotally, it appears that few, if any other CHCs, nationally, have successfully accomplished this task of seamlessly referring patients, including perinatal patients, directly to the State's Quitline via Health-E link. (DS, ES)

MCH plans to expand Healthy Families America home visiting model from five to eleven at-risk communities to bring the system statewide. Agencies will be required to provide data that relate to improved maternal and newborn health including parental use of alcohol, tobacco, or illicit drugs. (IB)

MCH will continue to participate in the multi-state learning collaborative and will disseminate information on perinatal tobacco screening, referral, and cessation from the partnership to stakeholders.

The PRAMS project will be launched in the Fall of 2012. Several questions are related to tobacco use in the mother and in the home. PRAMS data will be analyzed over time to identify strengths and weakness, which will be used in program planning.

**Performance Measure 16:** *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	102	30	0	2	7
Annual Indicator	5.1	3	8.9	8.9	8.9
Numerator	5		9	9	9

Denominator	98207		100630	100630	100630
Data Source		Vital Records	Vital Records	Vital Records	Vital Records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	7	6	5	4	3

**Notes - 2011**

Out of state data is unavailable. 2009 data is used as an estimate.

**Notes - 2010**

Out of state data is unavailable. 2009 data is used as an estimate.

**Notes - 2009**

Starting with the year 2005, NH is using the following document as guidance for injury data: Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

**a. Last Year's Accomplishments**

Suicide Prevention Council (SPC):

Evaluations from the New Hampshire Humanities Council Project, "A Discourse on Suicide Through Film" suggested future screenings. These took place throughout the state utilizing the films "Ordinary People", "Sensation of Sight" and "Helen". Members of the SPC Communications Subcommittee facilitated the showings and post-film discussions. (IB, PB)

The SPC's Communications Subcommittee facilitated two classes at the University of New Hampshire. This past year, the professor who previously taught journalism was assigned instead to creative non-fiction. The classes continued to focus on the reporting of suicide according to the media guidelines, but also contained a section on creative non-fiction. A review of student pieces from the website [www.reachout.com](http://www.reachout.com) centering on depression and suicide was added. These written narratives were vetted for safe messaging by the Inspire Foundation in a national young adult writing contest.

Amongst the two classes, the average starting answer to the question "How would you rate your knowledge of suicide and reporting guidelines before the session" was a 1.96 (out of five), much lower than previous classes dedicated solely to journalism. One hundred percent of the students increased their answers to this question post session to an average score of 4.1 (out of five). (PB)

New reporting guidelines were released (April 2011) from the Centers for Disease Control and Prevention, National Institute of Mental Health, Office of the Surgeon General, Substance Abuse and Mental Health Services Administration, American Foundation for Suicide Prevention, American Association of Suicidology, and the Annenberg Public Policy Center. The SPC Communications Subcommittee sent the new guidelines electronically to the entire list of media contacts in the state (revised repeatedly by the Department of Health and Human Services' Public Information Office) along with a personalized letter. In addition, to honor suicide prevention awareness week, the SPC held a press conference focusing on prevention efforts in the state. Every reporter there received a press packet with the new guidelines. (IB, PB)

The SPC Communications Subcommittee continued monitoring the reporting of suicides in the state. Forty-five articles reporting on a suicide were analyzed with respect to adherence to the evidence based media guidelines this past year. Communication back to the reporter/editor only took place if upon review, the article was deemed grossly negligent with respect to the guidelines or if the reporting was thought to be above par (also with respect to the guidelines). Feedback was solicited for every one of the 45 articles from the entire Communications Subcommittee. Out of the 45, nine articles were responded to, eight of which received negative letters and one positive. The negative letters identified what was inappropriate about the reporting (e.g. picture of place where suicide took place, identification of means, front page placement, etc.) yet at the same time thanked the journalist for reporting and referenced the guidelines.

Since the state of New Hampshire is fairly small, the evolution of reporting can be seen, particularly amongst several journalists. There is one journalist in a heavily populated area of the state that has done more than her share of reporting on suicides. In fact, she has reported on suicides more than any other journalist in the state. Her reporting garnered several negative letters in the first few years. However, this past year, in addition to a positive letter, she received an award for reporting from the New Hampshire Chapter of the National Alliance on Mental Illness, one of the leaders in suicide prevention in the state and a colleague of Maternal and Child Health.

This was a particularly unusual year since the number of public suicides (e.g. suicide by fire in front of a courthouse, etc.) went up. One of the editors of the local paper in a town with a public suicide wrote an op-ed piece about the decision to report the way his staff did. Although not initially consistent with reporting guidelines, the editor and his staff were willing to meet with the Communications Subcommittee on what could potentially be done in the future. The editor's public piece generated a lot of conversation on the reporting of suicides within the professional journalism community in the state. His piece is now used in teaching the journalism students. (IB, PB)

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to monitor MCH funded adolescent health programs and community health centers on integration of behavioral health and appropriate screening, referral and follow up.	X			X
2. Work with state partners, the SPC, and the various subcommittees to implement the Statewide Suicide Prevention Plan			X	X
3. In coordination with the Communications Subcommittee of the Suicide Prevention Council, monitor media reporting; offer guest lectures to journalism students in suicide reporting guidelines; and coordinate film-screening events.			X	X
4. Provide leadership to the HB 1436 committee regarding New Hampshire's participation in the National Violent Death Reporting System.				X
5.				
6.				
7.				
8.				
9.				
10.				

## **b. Current Activities**

Suicide Prevention Council (SPC):

The annual Suicide Prevention Conference took place in the fall of 2011, with almost 200 participants. It had a communications track, with a plenary session on the research behind the new guidelines, which was well attended. (PB, IB)

The SPC Communications Subcommittee is also continuing its monitoring of the reporting of suicides in the state. When a suicide has been reported in an egregious manner, a letter is sent to the media outlet highlighting the guidelines. (PB)

House Bill 1436 required a report issued from the Attorney General and the Commissioners of Safety and Health and Human Services to the Governor, the Speaker of the House of Representatives, and the President of the Senate. The Injury Prevention Program Manager chaired the committee, which developed and wrote this report. The report suggests a mechanism by which New Hampshire could feasibly participate in the Centers for Disease Control and Prevention's National Violent Death Reporting System, if funding were to become available. (IB)

Adolescent Health:

MCH staff continues to monitor its funded adolescent health programs and community health centers on the integration of behavioral health into clinical services. This includes the provision of mental health screening for all adolescents, including appropriate referral and follow up with those at risk or diagnosed with a mental health disorder. (PB, DS)

## **c. Plan for the Coming Year**

Guided by the New Hampshire Suicide Prevention Plan, MCH will continue its efforts in reducing the rate of suicide deaths through strategic partnerships with community based practitioners, advocacy, education, and policy development. (PB, IB)

Suicide Prevention Council (SPC):

The annual Suicide Prevention Conference is taking place in the Fall of 2012, again with a communications track. Five years of past conference participants were surveyed to determine what types of conference sessions would be of interest. Those surveyed consistently reported that an advanced level of training in all areas of suicide prevention would be desirable. Thus, the upcoming conference offers workshops geared towards the practitioner with at least several years in the field. (IB, PB)

The SPC Communications Subcommittee is continuing monitoring of the reporting of suicides. The Communications Subcommittee will be working with the National Suicide Prevention Resource Center in the upcoming year on adapting a subjective matrix for the evaluation of articles in accordance with the guidelines. A suicide coalition in California has developed a draft and through initial research has determined that consensus when using the matrix is greater than in merely having the guidelines as a resource. (IB, PB)

Film screenings will continue to be scheduled. The Communications Subcommittee is previewing additional feature length films, such as Gods and Monsters and Summer Solstice. (PB)

The SPC Communications Subcommittee, along with several media colleagues, will be hosting a joint forum on the guidelines to be scheduled during Suicide Prevention Awareness week in September 2012. (IB, PB)

The SPC will be updating the State's Strategic Suicide Prevention Plan. This revision will also be included in the revised Injury Prevention Strategic Plan, to be done under the auspices of the Core Injury and Violence Prevention grant. During the past year, the Injury Prevention Program received a five-year infrastructure grant from the Centers for Disease Control and Prevention. (IB)

**Performance Measure 17:** *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	86	79	89	90	83
Annual Indicator	78.0	87.5	81.3	78.2	78.2
Numerator	92	91	87	86	86
Denominator	118	104	107	110	110
Data Source		Birth Certificate	Birth Certificate	Birth Certificate	Birth Certificate
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	87	88	89	90	91

**Notes - 2011**

Out of state data is unavailable. Data from 2010 is used as an estimate

**Notes - 2010**

Updated with 2010 data. In last year's application, data was estimated using 2009 data.

**a. Last Year's Accomplishments**

**QUALITY ASSURANCE:**

The MCH Epidemiologist presented how birth certificate data could be used for QI projects within hospitals to the Northern New England Perinatal Quality Indicators Network (NNEPQIN). Detailed information about risk factors for high-risk deliveries and transfer was included in this presentation. (IB)

MCH monitored and provided technical assistance to MCH-funded prenatal and primary care agencies that provide comprehensive prenatal care to low income, uninsured and underinsured women. (DS, ES, IB)

The Perinatal Client Data Linkage (PCDF) project's goal is to ensure that prenatal and birth data was available to providers for quality improvement purposes as well as to guide public health policy in maternal and child health. Problems with linking birth certificates and PCDF data were worked on, but remained an issue with some patients who delivered out of state. (IB)

**SYSTEMS DEVELOPMENT:**

New Hampshire began the development of a Maternal Mortality Review Panel. Panel members were selected and the process for case identification, abstraction, review and reporting was drafted. (IB)

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Meet with prenatal agencies to review their reporting needs, which will assist in developing future improvements to the perinatal data linkage system.				X
2. MCH will continue to facilitate Prenatal Coordinators' meetings on a biannual basis.				X
3. MCH will continue to actively participate on the Maternal Mortality Review Panel.				X
4. Launch the Pregnancy Risk Assessment Management System (PRAMS) project. Monitor and analyze PRAMS data. Share findings with stakeholders.				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

**QUALITY ASSURANCE:**

MCH continues to monitor and provide technical assistance to MCH-funded prenatal and primary care agencies that provides comprehensive prenatal care to low income, uninsured and underinsured women. (DS, ES, IB)

The Perinatal Coordinator worked with one contract agency to overcome barriers that had prevented them from submitting PCDF data to MCH as required under contracted services. This agency began transmitting data to MCH in the spring. MCH now receives PCDF data from all of its contract agencies at least quarterly. (IB)

The data linkage project that collects prenatal and birth data is ongoing. There continues to be a data capture problem with those patients (approximately 10%) who deliver out of state. The prenatal care information (including entry) is recorded differently making it not comparable between birth certificates. This is making population assessment difficult. The MCH Epidemiologist is waiting for other states to adopt the 2003 revised birth certificate making population based data for the state accessible. (IB)

The MCH Epidemiologist will analyze the linked data sets, birth certificates and maternal discharge data, in order to produce reports on infant readmission within 30 days and maternal readmission within 30 days. (IB)

**SYSTEMS DEVELOPMENT:**

MCH continues to facilitate Prenatal Coordinators' meetings on a biannual basis.

MCH will continue to facilitate the Maternal Mortality Review Panel.

**c. Plan for the Coming Year**

**QUALITY ASSURANCE:**

MCH will monitor and provide technical assistance to MCH-funded prenatal and primary care agencies that provides comprehensive prenatal care to low income, uninsured and underinsured women. (DS, ES, IB)

The PCDF data linkage project that collects prenatal and birth data is ongoing. We are confident

that past problems in terms of linking the birth certificate and PCDF will be resolved. The plan is to analyze and used this data on a regular basis for quality improvement purposes as well as to guide public health policy in maternal and child health.

The PRAMS project will be launched in the fall of 2012. Many survey questions are related to prenatal care including health education; high-risk maternal conditions such as diabetes; and high-risk maternal behavior including tobacco, alcohol, and substance use before and during pregnancy. PRAMS data will be analyzed over time to identify strengths and weakness, which will be used in program planning.

**SYSTEMS DEVELOPMENT:**

MCH will continue to facilitate the Maternal Mortality Review Panel. Administrative Rules have been drafted and will be revised then reviewed after a trial case is done in July 2012. It is anticipated that the panel will be fully seated and functional by January 2013. Initial data queries suggest that there may be 5-10 potential cases per year of pregnancy related and/or pregnancy associated deaths in New Hampshire. A pregnancy-associated death is the death of any woman, from any cause, while pregnant or within 1 calendar year of termination of pregnancy, regardless of the duration and the site of pregnancy.

Representatives from MCH will continue to attend Statewide Perinatal Nurse Manager Meetings and Transport Conferences coordinated by Dartmouth Hitchcock to promote communication and coordination between providers and Public Health initiatives. Topics for joint discussion in 2013 will include Critical Congenital Heart Disorder/Pulse Oximetry Screening,

**Performance Measure 18:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	82	83	84	84	85
Annual Indicator	82.0	82.7	83.6	83.5	83.5
Numerator	9233	8960	8986	8504	8504
Denominator	11263	10837	10753	10183	10183
Data Source		Birth Certificate	Birth Certificate	Birth Certificate	Birth Certificate
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	84	85	86	87	89

**Notes - 2011**

Out of state data is unavailable. Data from 2010 is used as an estimate.

**Notes - 2010**

Updated for FY13 application. In the FY12 application, 2009 data was used as an estimate.

**a. Last Year's Accomplishments**

**QUALITY ASSURANCE:**

In lieu of a dedicated Perinatal Coordinator, other program managers were assigned tasks and specific agencies to monitor as MCH continued to provide technical assistance to MCH-funded prenatal and primary care agencies that provide comprehensive prenatal care to low income, uninsured and underinsured women. Analysis and trending of entry into care within the first trimester performance measures was a priority. In SFY11, 82% of women enrolled in perinatal programs, received prenatal care beginning in the first trimester of pregnancy. Health center performance ranged from 73%-100%. Special emphasis focused on those agencies with a low percentage of women coming into first trimester care. (DS, ES, IB)

The Perinatal Client Data Linkage (PCDF) project ensured that prenatal and birth data is available to providers for quality improvement purposes as well as to guide public health policy in maternal and child health. Problems with linking birth certificates and PCDF data were worked on by the contractor but it remained an issue. (IB)

Program Managers collaborated with the NH Refugee Resettlement Program on a project that captured perinatal provider's perspectives of the needs of immigrants and refugee women in the Manchester and Concord areas of the state. Surveys encompassed the needs of the refugee and immigrant population and focused on access into care. Five barriers to quality perinatal care were identified: language, transportation, cultural differences, provider limitations, and systematic limitations. The use of a bilingual doula role was identified as being a solution to many of the challenges identified however, participants expressed reservations about how such a role would be funded. (IB)

MCH received approval to fill a new position that combines the roles of a Quality Assurance Nurse Consultant with a Perinatal Coordinator. (IB)

**SYSTEMS DEVELOPMENT:**

New Hampshire continued to actively promote Text4Baby, engaging 18-24 year olds with social media about the importance of early and consistent prenatal care, and led the nation in the proportion of users compared to births. This was accomplished with traditional community partners in all healthcare settings as well as partners in the business community like WalMart and Hannafords Grocery Stores.(PB)

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Prenatal vitamins were recently obtained from the March of Dimes and will be distributed to several MCH-funded prenatal care agencies at no cost to the agency.		X	X	
2. Launch the Pregnancy Risk Assessment Management System (PRAMS) project.				X
3. Continue participation in March of Dimes Planning Committee.				X
4. Promote Text4Baby when interacting with pregnant women and new parents/grandparents or people who work with these groups of individuals.		X	X	
5. Continue making site visits to contracted agencies every two years. Schedule follow-up visits to provide additional support as needed.				X
6.				

7.				
8.				
9.				
10.				

**b. Current Activities**

In late fall, MCH filled a new position that combined the roles of a Quality Assurance Nurse Consultant with a Perinatal Coordinator. A priority of this new staff member was to coordinate a clinic assessment schedule in which a team of MCH staff make site visits to verify that contracted agencies are operating in compliance with state and federal requirements. A post-assessment report is mailed to each agency within one month of the visit and includes a set of recommended and required actions that reflect evidenced-based best practices. (IB)

MCH continues to provide technical assistance to MCH-funded prenatal and primary care agencies that provide comprehensive prenatal care to low income, uninsured and underinsured women. Analysis and trending of the first prenatal performance measure, which looks at entry into care within the first trimester, continues to be a priority. (DS, ES, IB)

The Perinatal Coordinator worked with one contracted agency to overcome barriers that had prevented them from submitting PCDF data to MCH as required under contracted services. This agency began transmitting data to MCH in the spring. MCH now receives PCDF data from all of its contracted agencies at least quarterly. (IB)

The data linkage project that collects prenatal and birth data is ongoing. The matching algorithm between the PCDF and Birth Certificate continues to be a work in progress with increasing success. (IB)

NH continues to actively promote Text4Baby. (PB)

**c. Plan for the Coming Year**

**QUALITY ASSURANCE:**

Continue the clinic assessment process with additional follow-up in those agencies that require additional support completing required actions necessary for state and/or federal compliance.

The PCDF data linkage project that collects prenatal and birth data is ongoing. We are confident that past problems in terms of linking the birth certificate and PCDF will be resolved. The plan is to analyze and used this data on a regular basis for quality improvement purposes as well as to guide public health policy in maternal and child health.

**SYSTEMS DEVELOPMENT:**

MCH will monitor and provide technical assistance to MCH-funded prenatal and primary care agencies that provides comprehensive prenatal care to low income, uninsured and underinsured women. Special emphasis will continue to be aimed at those agencies with a low percentage of women coming into first trimester care. Anecdotal information from those agencies has indicated that because of community demographics including a higher percentage of racial and ethnic minority populations that women perceive greater barriers to care and/or do not perceive a need for care early in pregnancy. (DS, ES, IB)

MCH will evaluate the Personal Responsibility Education Program (PREP) as it focuses on teen pregnancy prevention in the City of Manchester and Sullivan County, communities with disproportionately high rates of teen births. The programs will aim to increase the percentage of young women who are provided with preconception health counseling and who participate in creating a reproductive life plan, including receiving timely prenatal care, when, and if needed. (IB, ES)

MCH staff will continue to participate on the March of Dimes Program Planning Committee to ensure the efforts for improving birth outcomes are linked. Activities such as Centering Pregnancy are promoted through community grants. Centering Pregnancy is a multifaceted model of group care that integrates the three major components of care: health assessment, education, and support, into a unified program within a group setting. Eight to twelve women with similar gestational ages meet together, learning care skills, participating in a facilitated discussion, and developing a support network with other group members. Each pregnancy group meets for a total of 10 sessions throughout pregnancy and early postpartum. The practitioner, within the group space, completes standard physical health assessments. (IB)

NH will continue to actively promote Text4Baby engaging all pregnant women with social media about the importance of early and consistent prenatal care. (PB)

The PRAMS project will be launched in the Fall 2012. Three questions are related to pregnant women accessing prenatal care. PRAMS data will be analyzed over time to identify strengths and weakness, which will be used in program planning. (PB, IB)

## D. State Performance Measures

**State Performance Measure 1:** *The rate of psychotherapy visits for adolescents ages 12-18 years, with a diagnosed mental health disorder*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					48
Annual Indicator				45.7	45.7
Numerator				4086	4086
Denominator				8939	8939
Data Source				NH Medicaid Claims Data	NH Medicaid Claims Data
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	50	52	54	56	58

### Notes - 2011

2011 data is unavailable, so 2010 data is used.

### a. Last Year's Accomplishments

#### BACKGROUND:

Access to mental health services in New Hampshire, particularly for adolescents and children, was identified as an extreme need in the 2010 Title V Needs Assessment. An estimated 20% of children aged 5-19 in the state, approximately 56,000 kids, have a diagnosed mental disorder. In 2010, 8,939 adolescents aged 12-18, enrolled in Medicaid, had a mental health diagnosis. Mental health disorders are more common than childhood asthma or obesity, yet most children in need of care don't receive it. Mental and behavioral health disorders can impact a child's emotional, intellectual, and behavioral development and can hinder proper family and social relationships. Adolescents have high rates of risk-taking behaviors, such as unprotected sex, drug and alcohol use, regular tobacco use, fighting, inadequate physical activity, and poor nutritional habits. National survey data have suggested that almost 80% of adolescents who require a mental

health evaluation do not receive one. Treatment capacity for mental health issues is limited in this state, and concerns about cost are a considerable barrier for families seeking care, regardless of insurance status.

**Infrastructure Building:**

The Title V Director and Chief of Bureau of Population and Community Health Services participated in the Children's Behavioral Health Collaborative, which has been focusing on the creation of a strategic plan for improving the children's behavioral health system in NH. There is a draft of the plan, which is now going through the appropriate approval processes.

This collaborative worked in partnership with family organizations, NAMI-NH and the Granite State Federation of Families for Children's Mental Health, as well as other advocacy groups and funders including, NH Children's Alliance, the Endowment for Health and NH Charitable Foundation. The benefits of this work include: increased understanding of mental health treatment co-occurring disorders and systemic approaches to care and coordinating system improvements of government and non-government agencies, healthcare, providers and family organizations. (IB)

MCH staff continue to share appropriate educational opportunities and resources with funded community health centers. (IB)

The State's Medicaid program continued to monitor this performance measure. (IB)

In response to regional and MCHB feedback and a desire to explore a common regional performance measure, NH participated in a Region I training sponsored by MCHB TA, "Social Connectedness: Introduction, Overview, Literature and Data Sources". No consensus on a regional measure was gathered. However, New Hampshire is continuing to explore whether or not an indicator is warranted based on the information gathered in this training session. (IB)

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Facilitate clinical chart reviews at site visits looking for both screening and follow up on mental health diagnoses and referral.				X
2. Continue to encourage integration of behavioral health into primary care.				X
3. Work with Medicaid to further analyze the claims data related to this measure in order to explore geographic disparities in care, and better understand the mix of professionals providing care to this population.				X
4. Serve as a resource for educational opportunities and potential funding.				X
5. Share continuing education opportunities with agencies to increase their knowledge and expertise about caring for primary care patients with behavioral health issues.				X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

To promote adolescent access to behavioral health office visits, MCH supports integration within community health centers. CHCs were surveyed in 2012 to determine the level of their integration: Tier I: Formal process (i.e. MOU/A) for referring health center patient population to services; Tier II: On site services based on health center sliding fee scale available to some but not all populations of patients; or Tier III: Fully integrated services based on health center sliding fee scale available to all patients. While all have Tier II integration, 84% of the CHCs said that they have Tier III, which are fully integrated services for all patients. This is in comparison to last year's result, which was 66% of the agencies reporting a Tier III. (IB)

#### Integration:

With budget cuts to the DPHS-supported CHCs in SFY12 ranging from 38%- 50%, there were concerns that access to care is limited. MCH has conducted primary care site visits to establish a new baseline of service assessment. The visits have shown that behavioral health services are being provided by different methods, including direct care on site, integration into primary care, providing a "warm handoff" and referral to off-site services, and integration into a co-located contracted service provider. Even within the challenging fiscal parameters, CHCs have made decisions to prioritize the integration of behavioral health services based on population (pediatric vs adult) or by acuity.

### **c. Plan for the Coming Year**

#### **MEDICAID MANAGED CARE**

As described throughout this update, Medicaid consumers of behavioral health services, including children, are required to enroll with one of the three new Medicaid Managed Care Organizations for behavioral health and all other physical health needs by December 1, 2012. Developmental Services consumers are required to enroll for their physical health and acute care services by December 1, 2012. Medicaid Managed Care Step 2 begins on July 1, 2013 and includes all Developmental Services. MCH will work with health care providers and monitor enrollment of children to help facilitate these transitions. (IB, ES)

#### INFRASTRUCTURE:

MCH staff will meet with their counterparts from the Bureau of Behavioral Health (BBH). BBH is the part of the overall Department of Health and Human Services that contracts Federal funds with ten local community mental health centers statewide. During MCH site visits, contracted community health centers have described their experiences with their local community mental health centers. Ideally, there is cooperation and collaboration between all local entities. Various questions and concerns have come up that need to be discussed at a State level between MCH and BBH. (IB)

Further complicating a spirit of comprehensive and coordinating planning, The Disability Rights Center has filed a class action lawsuit against the state of New Hampshire for its failure to provide adequate mental health services to citizens with mental illness. While this does not specifically impact MCH-funded entities, it amplifies needs throughout systems of care for adolescents with diagnosed mental health disorders.

MCH will continue to participate in the Children's Behavioral Health Collaborative, which should be releasing its statewide plan this coming year. Activities surrounding the introduction of the plan have been discussed, which MCH will participate in as appropriate. (IB)

#### INTEGRATION:

MCH will continue to visit all of its community health centers including health care for the homeless, to assess how behavioral health services are provided to its clients. (IB)

MCH will continue to share information about training and education opportunities and potential funding, for staff of community health centers to increase their knowledge about caring for

primary care patients with behavioral health issues. This also includes a potential roundtable at future MCH Directors' meetings where ideas such as the following can be discussed:

- Routinely utilizing a behavioral health staff member to go into the exam rooms during primary care sick visits and preventive visits, as needed, to do assessments and address issues.
- Leveraging private and foundation funding for additional on-site behavioral health services.
- Utilization of MDs, APRNs, LCSW, and other appropriate clinical and behavioral health professionals to create the best team for increasing access to psychotherapy, as well as medication management, for primary care patients. (DC, ES, IB)

**State Performance Measure 2:** *Percent of 3rd grade children who are overweight or obese*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					33.6
Annual Indicator			33.6	33.6	33.6
Numerator			1037	1037	1037
Denominator			3082	3082	3082
Data Source			NH 3rd Grade Healthy Smiles Healthy Growth Survey	NH 3rd Grade Healthy Smiles Healthy Growth Survey	NH 3rd Grade Healthy Smiles Healthy Growth Survey
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	33.6	33.6	30	30	30

**Notes - 2011**

No new data for 2011. Survey will not be repeated until 2014, as long term changes are not statistically significant in a short time frame.

Objectives are based on the NH Comprehensive Cancer Collaboration's Cancer Control Plan (2010-2011) that says "Reduce the average biennial increase in prevalence of overweight and obese youth to 0 %".

**Notes - 2010**

No new data for 2010. Survey will not be repeated until 2014, as long term changes are not statistically significant in a short time frame.

Objectives are based on the NH Comprehensive Cancer Collaboration's Cancer Control Plan (2010-2011) that says "Reduce the average biennial increase in prevalence of overweight and obese youth to 0 %".

**Notes - 2009**

Data is from the New Hampshire "Third Grade Healthy Smiles-Healthy Growth Survey" conducted between September, 2008 and June, 2009. ([www.dhhs.state.nh.us/DHHS/NHP/obesity.htm](http://www.dhhs.state.nh.us/DHHS/NHP/obesity.htm))

Numerator is number of children considered obese and number considered overweight using CDC's BMI-for-age growth chart percentiles and classifications. Denominator is number of consenting NH third graders participating in the survey.

**a. Last Year's Accomplishments**

**BACKGROUND:**

In the 2009 New Hampshire Healthy Smiles--Healthy Growth survey of third graders, 33 percent were overweight or obese. The survey also showed regional differences in childhood obesity: third grade students in the Belknap-Merrimack region (24 percent) and Coos County (22 percent) had the highest prevalence of obesity and nearly 46 percent of third grade boys in Coos County were overweight or obese.

**PARTNERSHIPS AND STRATEGIES:**

MCH staff worked with the Obesity Program and WIC Program staff to change the pediatric performance measure required in the workplans of the community health centers from one involving BMI percentile documentation of children age two through eighteen, to one for FY12 requiring documentation of addressing the components of the 5-2-1-0 Healthy NH Campaign. (IB)

Three parts of the state received contracts to carry out the "NAP SACC Nutrition and Physical Activity Assessment in Child Care" initiative. (IB) The Healthy Child Care NH Program Coordinator was one of three DHHS staff that received training to share their skills from the "I am Moving, I am Learning" initiative. (IB)

An integrated task force of DPHS programs, the Young Families Work Group, including MCH, established the "Public Health Excellence in Child Care Award" and presented it to 11 childcare agencies that implemented NAP SACC (Nutrition and Physical Activity Self-Assessment in Child Care) in 2010-2011. The award was announced at the annual Celebration of Early Childhood Professionals, during the Week of the Young Child, in April 2011. (IB, PB)

The Obesity Prevention Program funded the printing of material from the 5-2-1-0 Healthy NH Campaign which was distributed to WIC and MCH agency staff. (PB)

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assess what MCH-funded community health centers are doing re: providing education and follow up to children obese or overweight as noted in quality assurance site visits and record reviews.				X
2. Continue to partner with childcare consultants assessing nutrition and physical activity policies through the "Nap Sack Nutrition and Physical Activity Assessment in Child Care" initiative.				X
3. Continue to collaborate with other public health and childcare leaders to institutionalize healthy eating and physical activity training through the "I am Moving, I am Learning" initiative.				X
4. Continue to explore and provide education and training opportunities for MCH contract agency staff on topics related to obesity prevention/healthy lifestyle/nutrition.			X	X
5.				
6.				
7.				

8.				
9.				
10.				

**b. Current Activities**

MCH staff participates in a Chronic Disease Integration initiative among the Division of Public Health Programs focusing on programmatic and policy changes which uses a life course approach to integrate obesity prevention into all of its programs. Childhood obesity has been identified as a priority.(IB)

MCH is continuing the work of the "NAP SACC Nutrition and Physical Activity Assessment in Child Care" and the "I am Moving, I am Learning" initiatives which involve collaboration with a variety of other DPHS programs to encourage young children to be healthy and active. (IB)

MCH collaborates with WIC and the Obesity Prevention Program to share information and training opportunities to MCH agency staff on nutrition, healthy lifestyle, and obesity prevention. (IB, PB)

DPHS advocated for the passage of school nutrition rules for foods available to students during the school day. The rule requires schools to select a national nutrition standard for vending, a la carte foods, and other foods made available to students during the school day. These standards will improve access to healthy foods and decrease access to unhealthy foods. The NH State Board of Education adopted changes to the NH Administrative Rules for Education, Minimum Standards for Public School Approval, including Ed 306.02, Ed 306.04, and Ed 306.11 regarding food and nutrition services.

The full rule and the technical advisory released by DOE are available here: <http://www.education.nh.gov/standards/docum> (IB, PB)

**c. Plan for the Coming Year**

MCH staff will assess the results of a new Performance Measure required of MCH funded community health centers regarding educating on the 5-2-1-0 Healthy NH Campaign if a child is considered overweight or obese per their BMI percentile. "5-2-1-0 Healthy NH" is a statewide public education campaign to bring awareness to the daily guidelines for nutrition and physical activity. Its message is simple and clear and represents some of the most important steps families can take to prevent childhood obesity: Eat fruits and vegetables at least 5 times a day; Cut screen time to 2 hours or less a day; Participate in at least one hour of moderate to vigorous physical activity every day; Restrict soda and sugar-sweetened sports and fruit drinks. Instead, drink water and 3-4 servings/day of fat-free/skim or 1% milk. Strategies for success will be shared with the agencies. (IB, PB)

At site visits to MCH-funded community health centers, MCH staff will be assessing through chart audits, the follow-up of children documented as being overweight or obese to assess if national guidelines are being adhered to. (IB)

**PARTNERSHIPS AND STRATEGIES:**

MCH staff will continue to participate in the Chronic Disease Integration initiative among the Division of Public Health Programs focusing on programmatic and policy changes which uses a life course approach to integrate obesity prevention into all of its programs. (IB)

MCH will continue to provide leadership to the Young Families workgroup of early childhood content specialists from the Bureau of Population Health and Community Services including Healthy Child Care NH; Obesity Prevention Program; Healthy Homes and Lead Poisoning Prevention Program; Immunization Program; Diabetes; Tobacco Prevention Program; Oral Health; WIC and Home Visiting. This integrated workgroup seeks to establish coordinated

messaging to the early childhood community relative to the Bureau's work with and on behalf of the maternal and child health population. (IB)

**State Performance Measure 3: Percent of 18-25 year olds reporting binge alcohol use in the past month**

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					51
Annual Indicator		53.7	53.7	53.7	53.6
Numerator		72000	72000	72000	72000
Denominator		134153	134153	134153	134453
Data Source		National Survey on Drug Use and Health			
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	49	47	45	43	42

**Notes - 2011**

Data is the most recent from the National Survey on Drug Use and Health. This data is 2007. Indicator for 2006 was 51%.

**Notes - 2010**

Data is the most recent from the National Survey on Drug Use and Health. This data is 2007. Indicator for 2006 was 51%.

**Notes - 2009**

Data is the most recent from the National Survey on Drug Use and Health. This data is 2007. Indicator for 2006 was 51%.

**a. Last Year's Accomplishments**

**BACKGROUND:**

According to the 2011 Youth Risk Behavior Survey (YRBS), thirty-eight percent of New Hampshire high school students reported current alcohol use and 24 percent reported binge drinking. This was not considered a change from the 2009 Survey (40 and 24 percent respectively in 2009).

**QUALITY CARE:**

MCH funded community health centers were required to screen adolescents and pregnant women for alcohol and other drug risk factors using a validated tool. This screening was advocated for all patients at risk during the history and physical. During MCH clinical chart reviews at all of the funded community health centers, it was noted whether this took place. (DC)

**SYSTEMS DEVELOPMENT:**

MCH, with its partners in the New Center of Excellence and Bureau of Drug and Alcohol Services (BDAS), wrote a grant to SAMHSA to increase the proportion of clinical sites conducting brief alcohol and drug counseling and interventions or SBIRT (Screening, Brief Intervention, and Referral to Treatment). Unfortunately, after the grant was submitted, SAMHSA retracted the request for proposals because funding was eliminated. (IB)

Turning Points Network (TPN), located in Claremont, secured funding for a project, to research the role of alcohol in sexual assault and to develop a multimedia campaign that was prevention focused. The project team conducted multiple focus group sessions in order to develop a media messaging campaign directed toward teens about sexual assault and the role alcohol may play in this crime. Overall, it was evident from all groups that they had knowledge about the effects of alcohol on the mind and body, either through school programs such as health class or community youth-oriented programming. Alarmingly, the information learned about alcohol, when combined with or applied to knowledge about sexual assault, was less clear. The Media Messaging Project team worked with three Core Groups to design and develop the media campaign that included reviewing the website and developing PSAs. The PSAs will be available on the TPN website, through Facebook and YouTube. (PB, IB)

MCH used "Binge Drinking" as an indicator of risk in New Hampshire's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Needs Assessment (2010). NH selected Healthy Families America as the model of evidence-based home visiting for the new federal program because it most addressed the needs identified in the Needs Assessment. (IB)

At the State level, the Early Childhood Advisory Council's Home Visiting Task Force (ECAC-HVTF) was designed specifically to ensure cross-agency and cross-sector collaboration in the home visiting initiative. First year membership included state level representatives from the Bureau of Drug and Alcohol Services. (IB)

In one of the target areas for MIECHV, the City of Manchester, Child and Family Services (CFS) had a federal contract with Northrop Grumman for Fetal Alcohol Spectrum Disorder Prevention. As a long-time MCH partner and a multi-contract holder for high quality home visiting services, CFS includes the TWEAK, a screening for use of alcohol use during pregnancy (and brief interventions in the case of a positive screen), to reduce the incidence of Fetal Alcohol Syndrome and its persistent effects. Some HVNH programs, but not all, are also using TWEAK. (PB)

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH will continue to provide training about validated screening tools for specific populations.			X	X
2. MCH will monitor agencies' use of a validated screening tool for adolescents that detect alcohol and other substance abuse.			X	X
3. MCH will use MIECHV funding to support a Home Visiting Capacity Building contract.				X
4. The Quality Assurance Nurse Consultant will monitor agencies' compliance with use of validated screening tool for alcohol.			X	X
5. MCH will explore alternate sources of funding for Screening, Brief Intervention, and Referral to Treatment with a Trauma Modules (SBIRT-TM).		X		
6. MCH will continue innovative partnerships.				X
7.				

8.				
9.				
10.				

**b. Current Activities**

TPN completed the evaluation component of the social media project in February 2012. MCH collaborates with TPN to distribute prevention messaging products through social media. Video PSAs were launched in October along with a post-test to measure changes in behavior. The audio PSA was launched in November. All PSAs are available on You Tube, TPN's website, and TPN's Facebook page. (PB)

MCH agency staff is educated about the use of validated screening tools for specific MCH populations including adolescents and women during the perinatal period. MCH, WIC, and BDAS facilitate training to MCH contract agencies on best practices in drug and alcohol prevention and intervention. "Public Health Strategies Around Alcohol, Tobacco, and Other Drug Abuse" includes separate tracks for clinical and support staff to improve assessment and referral skills. Topics include families, addiction, tobacco, screening, and referral. Continuing education units are available for those who qualify. (IB)

MCH monitors contract agencies adherence to using validated screenings for drug and alcohol use. (IB)

MCH continues its innovative partnerships, such as that with the New Hampshire Center on Excellence, regional prevention networks, and home visiting agencies to provide training and best practice information and resources to community-based organizations. (IB)

MCH assists with the distribution of the Youth Risk Behavior Survey and continues to explore alternate sources of funding for an SBIRT grant.

**c. Plan for the Coming Year**

**QUALITY ASSURANCE:**

MCH will continue to provide training to contract agency staff about the use of validated screening tools for specific MCH populations including adolescence and perinatal period. MCH will monitor agencies' use of a validated screening tool for adolescents that detect alcohol and other substance abuse. The Home Visiting Capacity Building contractor intends to review the ASSIST in greater depth to determine if it might serve as an effective, evidence-based and more global measure that can be used throughout New Hampshire. (IB)

The Quality Assurance Nurse Consultant will monitor compliance with use of validated screening tool for alcohol use during site visits through interviews and random chart audits. (ES)

**SYSTEMS DEVELOPMENT:**

MCH will continue to explore alternate sources of funding for Screening, Brief Intervention, and Referral to Treatment with a Trauma Modules (SBIRT-TM). (EB)

MCH will continue innovative partnerships, such as the home visiting partnership with Child and Family Services, to provide home-based TWEAK assessment for and referrals to treatment to alcohol abusing pregnant women. In addition, MCH will continue to participate in NO FAS NH activities and promote the use of the TWEAK in HVNH/CFHS and HVNH/HFA programs. (PB)

Maternal Infant and Early Childhood (MIECHV) Home Visiting programs, throughout the state will also continue to promote the use of TWEAK, to reduce the incidence of Fetal Alcohol Syndrome and its persistent effects. This data will be entered into a new Home Visiting data system that will be linked to the MCH Data Mart for use in more robust evaluation than had been previously available in the State. (IB, ES)

The Title V Director will continue to provide leadership as one of the founding members of the NO-FAS (Fetal Alcohol Syndrome) NH Board of Directors. NOFAS NH is "Turning up the Volume" on Fetal Alcohol Spectrum Disorder issues and concerns in New Hampshire through an emphasis on public awareness, primary prevention, education, appropriate treatment, and support. The ultimate goals of this collaboration are to build and maintain a strong system of supports and services to prevent FASD and to meet the needs of people and families in New Hampshire who are affected by this life-long disability. NO FAS NH will continue to promote primary prevention education about binge drinking among young adults and the relationship between FASD. (PB,IB)

**State Performance Measure 4:** *Percent of Community Health Centers providing on-site behavioral health services*

Tracking Performance Measures  
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					100
Annual Indicator				100.0	100.0
Numerator				15	14
Denominator				15	14
Data Source				Email survey of contracted CHCs	Email survey of contracted CHCs
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	100	100	100	100	100

**Notes - 2011**

Data obtained from May, 2011 email survey to the 13 state-funded Community Health Centers, plus 1 pediatric primary care agency, assessing level of on-site behavioral health services. Options were:

- Tier 1: Formal process (i.e., MOU/A) for referring health center patient population to services
- Tier 2: On site services based on health center sliding fee scale available to some, but not all, populations of patients
- Tier 3: Fully integrated services based on health center sliding fee scale available to all patients.

One (Pediatric Primary Care) agency falls into both Tier 1 and Tier 2. One falls into Tier 2 for 2 of its 3 sites, and Tier 3 for its third site. The other 12 are in Tier 3.

**Notes - 2010**

Data obtained from May, 2011 email survey to the 15 state-funded Community Health Centers, assessing level of on-site behavioral health services. Options were:

- Tier 1: Formal process (i.e., MOU/A) for referring health center patient population to services
- Tier 2: On site services based on health center sliding fee scale available to some, but not all, populations of patients
- Tier 3: Fully integrated services based on health center sliding fee scale available to all

patients.

Five agencies indicated Tier 2. Ten agencies indicated Tier 3. All fifteen indicated on-site services.

**a. Last Year's Accomplishments**

**BACKGROUND:**

New Hampshire's community mental health system for children and adults is strained and insufficient to meet current needs. The Disability Rights Center has filed a class action lawsuit against the state of New Hampshire for alleging a failure to provide adequate mental health services to citizens with mental illness.

Families want accessible, timely, integrated, and comprehensive community-based services that are based upon individual need, not ability to pay.

Critical to ensuring access to a high, quality, integrated system of care for all populations, the state's community health centers have the unique opportunity to help shape the infrastructure of this system of care for all MCH populations.

Title V-funded community health centers each have unique relationships and levels of coordination with behavioral and mental health services within each community. Recognizing that, Title V leverages its funds to encourage each entity to move further along a continuum of integrated services.

In an ideal, fully integrated system, mental health and primary care providers would share the same sites, the same vision and the same systems in a seamless web of services. Providers and patients would have the same expectations for treatment and all would have access to the same level of care regardless of income or insurance status. Collaborative meetings would be held regularly in which all providers and the patient and the patient's family would have equal access and control of the treatment plan.

**INTERGRATED SERVICES:**

A brief email survey was sent to the community health centers in May 2011 asking which of the three tiers of providing on site behavioral health services: Tier I: Formal process (i.e. MOU/A) for referring health center patient population to services; Tier II: On site services based on health center sliding fee scale available to some but not all populations of patients; or Tier III: Fully integrated services based on health center sliding fee scale available to all patients, they considered themselves. Responses indicated that one-third, (five of the fifteen agencies) assessed their level as Tier II, and the remaining two-thirds (ten of the fifteen) assessed their level as Tier III. (IB)

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Share continuing education opportunities with agencies to increase their knowledge and expertise about caring for primary care patients with behavioral health issues.				X
2. Conduct site visits to learn about how behavioral health services are provided to its clients.				X
3.				
4.				
5.				
6.				

7.				
8.				
9.				
10.				

**b. Current Activities**

With budget cuts to the DPHS-supported community health centers in SFY12 ranging from 38%-50%, there were concerns that integrated services were being significantly impacted and access to care limited. With its newly hired Quality Assurance Nurse Consultant, MCH has been busy conducting primary care site visits to establish a new baseline of service assessment. Visits include discussion with staff as well as chart audits. The visits have shown that behavioral health services are being provided in a myriad of combinations, including direct care on site, integration into primary care, providing a "warm handoff" and referral to off-site services, and integration into a co-located contracted service provider. Recognizing the increased need for behavioral health services with the challenging financial times, agencies have attempted to retain such services but some have had to make adjustments, as one agency did by decreasing social worker visits with pregnant women from once each trimester to twice during the pregnancy. (IB)

MCH continues to define integrated behavioral services on a continuum:

- Tier 1: A formal process for referring health center patient population to services
- Tier 2: On site services based on health center sliding fee scale available to some, but not all, patients
- Tier 3: Fully integrated services based on health center sliding fee scale available to all patients

100% have Tier 2 services and 84% have fully integrated Tier 3 services for all patients. (IB)

**c. Plan for the Coming Year**

MCH will continue to visit all of its community health centers including health care for the homeless, to assess how behavioral health services are provided to its clients. (IB)

MCH will encourage sharing of successful strategies at a FY13 MCH Coordinators' meeting. (IB)

MCH will continue to share information about training and education opportunities and potential funding, for staff of community health centers to increase their knowledge and expertise about caring for primary care patients with behavioral health issues. (IB)

During the summer of 2012, MCH provided leadership for a collaborative proposal for SAMHSA, Project LAUNCH. If successful, MCH will work in partnership with SPARK NH, the State's Early Childhood Advisory Council and community partners in the City of Manchester to expand and enhance of evidence-based mental health services for young children and their families. The Manchester team will increase screening and assessment; integrate behavioral health interventions into primary care practice; increase identification and treatment of behavioral health issues in child care and Head Start; improve social and emotional well-being of young children through enhanced home visiting services; and improve families' ability to support the multidimensional needs of their children through training and education. Manchester Community Health Center will be a key partner this initiative.

**State Performance Measure 5:** *The percent of parents who self-report that they completed a standardized, validated screening tool used to identify children at risk for developmental, behavioral or social delays*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective	2007	2008	2009	2010	2011
------------------	------	------	------	------	------

<b>and Performance Data</b>					
Annual Performance Objective					28
Annual Indicator		26.5	26.5	26.5	26.5
Numerator		18921	18921	18921	18921
Denominator		71450	71450	71450	71450
Data Source		National Survey of Children's Health			
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	30	32	34	36	38

**Notes - 2011**

The most recent data available is for 2007. Data is currently being collected for 2011-2012. Expected release date of 2011 data is January, 2013.

**Notes - 2010**

Data is from 2007, the most recent available.

**Notes - 2009**

Data is from 2007, the most recent available.

**a. Last Year's Accomplishments**

**SYSTEMS DEVELOPMENT:**

The NH Association for Infant Mental Health (NHAIMH) was awarded funds from the Endowment for Health (EFH) to improve the availability of and access to integrated, high quality early childhood and family mental health (ECFMH) supports and services for NH's young children (aged birth to six years) and their families by expanding access to ECFMH screening, referral and parent/caregiver education through the Watch Me Grow (WVG) system. The work will occur in SFY 12 -- 14. (IB)

A web-based data collection tool was developed through a contract with Welligent that was paid for by a DHHS multi-agency collaborative that included the Division of Developmental Services, Part C; Division of Children, Youth and Families, Head Start Collaboration Office; and the MCH/ Early Childhood Comprehensive Systems. There were some technical glitches as the system went "live" that required oversight from the Steering Committee. Throughout the year, data was made available for screening results and referral tracking. (ES, IB)

Watch Me Grow Annual Stakeholders' Meeting was held to report on the progress of the initiative that grew from three pilots to a statewide screening and referral system that began helping families recognize development of their children through a supportive process of educating with a validated developmental screening tool. The Department of Education (DOE)-Office of Early Childhood and The New Hampshire Pediatric Society expressed interest in collaborating. A consultant was hired to provide training in local communities on the correct use of the ASQ/ASQ-SE that expanded to include Infant Mental Health teams and child care providers. Some community agencies reported success with Motivational Interviewing training. The consultant provided group training and networking opportunities both on- and off-site. Evaluations completed

by participants following these sessions were positive and indicated the consultant is implementing successful strategies. A web-based data collection tool is now available for screening results and referral tracking. (ES, IB)

MCH and SMS provided leadership at the Act Early Summit and assisted with the follow-up mini-grant awarded to develop a family guide to services following a screening. The WMG Steering committee distributed these materials. (ES)

MCH continued to use TANF funding to make grants to Home Visiting NH (HVNH) agencies that provide developmental screenings to children enrolled in the programs who have reached the age of 8 weeks and tracked referrals to agencies including primary care physicians and early supports and services community agencies. (ES)

Sixty-seven percent of children enrolled in HVNH during State Fiscal Year 2011, who scored below the cutoff on the ASQ developmental screening tool, received further evaluation and/or early intervention services. In most (10 of 13) agencies, more than 90% received additional services; three did not report accurate data, which skewed the results. (PB)

**AUTISM REGISTRY**

The NH Registry for Autism Spectrum Disorders was created in 2008 and requires physicians, licensed clinical psychologists, and other healthcare professionals who diagnose a NH resident with ASD to report the diagnosis, using an online reporting form. The registry collects no identifiable information. During the reporting period of period July 1, 2010, June 30, 2011, 107, NH residents were diagnosed with ASD and added to the online registry for ASD. One third of new ASD diagnoses were made for children under the age of three, and the majority of diagnoses (83%) were made in elementary school age children under the age of nine.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH will continue to support the implementation of the Watch Me Grow system for early childhood developmental screening.			X	
2. Ages and Stages Questionnaire 3 (ASQ3) is administered to children in Home Visiting NH programs including HVNH/CFHS and HVNH-HFA.			X	
3. Through ECCS, MCH will continue to increase knowledge of services for family practitioners, pediatricians, and community based health care providers, about early screening and intervention.		X		
4. Through efforts such as MIEC Home Visiting and Watch Me Grow, support partnerships for cross-disciplinary training for all early childhood providers to increase the availability of screening.				X
5. Early Childhood Systems work will continue with the Act Early Ambassador, Rae Sonnenmeier to coordinate widespread distribution of developmental screening information.			X	X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

#### SYSTEMS BUILDING:

Funds from EFH provide cross-system training on WMG/ECFMH-related and TA to each WMG site. Steering Committee continues to explore the inclusion of the M-CHAT in the WMG system.

WMG sites and partners identify and disseminate ECFMH-related educational materials and resources to families. WMG sites submit screening and referral data and progress reports to DCYF and the Steering Committee. (PB, ES, IB)

Consultants supported by the DHHS multi-agency collaborative, compile progress report information, and utilize the data/information to improve the system. The establishment of interagency agreements between Watch Me Grow (WMG) sites and NH's 2-1-1 system and the Family Resource Connection promotes the coordination of referrals and information dissemination. MCH and ECCS supported an Evaluator to improve the WMG database and to make recommendations on how to make the screening process more efficient. (PB, IB)

WMG sites continue to engage the NH Pediatric Society, NH Chapter of the American Association of Family Physicians, school nurses and other healthcare professionals to encourage referrals and participation in regional networks. MCH will continue to provide leadership for the Watch Me Grow System through Early Childhood Special Projects (ECCS). (PB, ES, IB)

HVNH-HFA agencies use the ASQ-3 with all families under the new MIECHV funded programs and will use this measure to report on benchmarks on School Readiness and Coordination of Community Resources.

#### **c. Plan for the Coming Year**

##### SYSTEMS DEVELOPMENT:

MCH will continue to improve access to standardized developmental screening for young children through participation in the WMG Steering Committee, The NH Autism Council and the Act Early Team.

MCH will continue to provide cross-systems training and TA on WMG/ECFMH related topics through funds from the federal MIECHV grant. The scope of services in each HVNH/CFHS and HVNH/HFA contracts require that home visitors assist families, beginning at 8 weeks, with the completion of the ASQ-3 developmental screening. The EFH grant will continue to provide funds to enhance capacity for, evaluate, and develop a sustainability plan for the WMG system. (IB)

Data collected from HVNH agencies and the WMG system will be used in the Needs Assessment for Spark NH, the State's Early Childhood Advisory Council. (IB)

MCH expects to fund ten agencies to provide HVNH/CFHS services that will include a requirement to provide ASQ-3 Developmental Screenings and to coordinate findings with the WMG agency in their community. In addition, MCH will fund Healthy Families America home visiting in each of NH's ten counties and the state's largest city, Manchester. This program will collect data showing level or increased percent of children who receive at least one ASQ-3 screening by 5 months of age. This will be used as baseline data that will be compared to data from the third year of program (2015). (IB)

MCH will continue to play a leadership role and participate in the Watch Me Grow Steering Committee. (IB)

MCH will continue to provide leadership to SPARK NH, the State's Early Childhood Advisory Council whose mission is to provide a comprehensive, coordinated, sustainable early childhood system that achieves positive outcomes for young children and families, investing in a solid future for the granite state. One of its priority areas of focus in the coming year will be to ensure that all

young children with social-emotional or behavioral issues and their families have access to trained professionals to assess, diagnose, and treat them. SPARK NH will engage in strategic planning and a needs assessment in the coming year and will include family input regarding access to screening. (IB)

**State Performance Measure 6:** *The rate (per 100,000) of emergency department visits among youths aged 15-19 resulting from being an occupant in a motor vehicle crash*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	2300	2200	2100	2000	1775
Annual Indicator	1,807.3	1,794.2	1,794.2	1,402.1	1,402.1
Numerator	1753	1762	1762	1394	1394
Denominator	96995	98207	98207	99421	99421
Data Source		Vital Records	Vital Record	Vital Record	Vital Record
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	1400	1350	1300	1250	1200

**Notes - 2011**

Most recent \*updated\* data is 2008. This is used as an estimate for 2011.

**Notes - 2010**

Most recent \*updated\* data is 2008. This is used as an estimate for 2010.

**Notes - 2009**

Out of state data is unavailable. Final 2008 data is used as an estimate.

**a. Last Year's Accomplishments**

During the last year, the MCH Injury Prevention Program continued to enhance current partnerships and developed new relationships to implement evidence-based education and policy development. (IB, PB)

Teen Driving Committee:

The Teen Driving Committee (the Committee), facilitated by the Injury Prevention Program Manager and the Highway Safety Specialist from the Injury Prevention Center, met on a monthly basis. The Committee is made up of professionals from across the state, all concerned about the safety of adolescents in motor vehicles, either as a passenger or driver. (IB)

The New Hampshire Strategic Highway Safety Plan (SHSP) was updated in the past year. The Committee was the lead author and implementer of the teen driving section. The Injury Prevention Program Manager is also in the management group, who oversees the implementation of the SHSP, representing the Division of Public Health Services. She recently presented the teen section to a group of Commissioners, including Safety, Transportation, and Health and Human Services. This was directly prior to gaining the Commissioners' signatures, thus in effect garnering their support of the contents of the plan.

The SHSP's teen driving section focuses on the strategies of strengthening the State's graduated driver licensing (GDL) laws as well as increasing parental and community involvement in safe teen driving practices. This includes the use of parent-teen driving contracts. Ongoing strategies in the SHSP include updating driver education instructors' skills and competencies, increasing enforcement of the State's primary seat belt law until the age of 18 and increasing the availability

of monitoring technologies and driving simulators. (IB, PB)

As part of the SHSP update, an advertising firm, WEDU, was hired by the New Hampshire Department of Transportation through a competitive bid process. The goal is to develop a marketing plan and website. The Committee worked and continues to do so with WEDU to take its draft-marketing plan specific to teenagers and incorporate it into the larger SHSP marketing picture. This also meant that the website dedicated to parents of novice drivers would eventually be a subset of the larger SHSP's website. This is ongoing and has not resulted in a finished product at this time. (IB, PB)

The Injury Prevention Program Manager participated in a SHSP Peer-to-Peer Support Program, which enabled traffic safety colleagues from North Carolina and Utah to visit and share information necessary for successful highway safety campaigns. (IB)

The Injury Prevention Center's Traffic Safety Specialist, the co-chair of the Committee, presented on best practices in graduated driver licensing at the annual Highway Safety Conference. Approximately 40 people attended the session with over 200 traffic safety professionals at the entire conference. (PB)

The Teen Driving Committee has overseen the implementation of the American Academy of Pediatrics (AAP) grant to the New Hampshire Pediatric Society. This grant enables the teen seatbelt usage project to take place in four schools in the state. The schools, all- scoring below the state average in seatbelt usage (as reported on the Youth Risk Behavior Survey) are Dover High School, Spaulding High School, Epsom High School and the Great Bay E-Learning Center. Two Committee members, the Injury Prevention Center Highway Safety Specialist and the Director of the Loving Volvo Family Foundation, are in charge of implementing the project. They have facilitated trainings on baseline observational seatbelt surveys in the schools, two of which were completed. (IB, PB)

The two Committee members have also presented Room to Live (<http://buckleupnh.org.ipage.com/2252.html>), an educational presentation on the benefits of wearing seatbelts, at each of the four schools. In addition, they are working with designated group at each school. Each of the groups was already in existence (such as peer counselors or students against destructive decisions) and the goal is facilitate peer led programming on safe driving. Schools receive a modest stipend for work. (IB, PB)

The Injury Prevention Program Manager and the Brain Injury Association of NH have worked to ensure that a Department of Transportation funding proposal makes it way through the appropriate State and Federal procedures. This funding will enable the activities done underneath the AAP grant to be taken to additional schools. (IB)

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Facilitate monthly meetings of the Teen Driving Committee.				X
2. Work with the marketing firm WEDU on the development of materials on GDL for parents and for legislators.			X	X
3. Facilitate the completion and analysis of the parent survey to be done by the UNH survey center.				X
4. Implement policy strategy on GDL.				X
5. Work with the Teen Driving Committee and the New Hampshire Pediatric Society on implementing the teen seatbelt usage project.				X

6. Work with the Brain Injury Association to ensure that funding through the Department of Transportation goes through the appropriate channels.				X
7. Work with the Department of Transportation and other colleagues to implement the strategies outlined in the teen driving section of the Strategic Highway Safety Plan.			X	X
8. Develop an implementation and evaluation plan regarding a motor vehicle crash prevention strategy under the Core Injury grant.				X
9.				
10.				

**b. Current Activities**

Teen Driving Committee:

The Committee is working with the marketing firm WEDU on two sets of materials with information on GDL; one to be distributed to legislators and one to parents of novice drivers. The objectives are slightly different for each target group. The parents will receive information on the concepts of GDL including the importance of passenger restrictions and limitations on nighttime driving. The focus will be on protecting their children, as well as supporting them in setting strict limits even if the current law does not require it. Most parents of novice drivers do not know that they have the ability to rescind their teens' licenses and this information will also be noted. It is likely that the parent materials will be web-based instead of in hard copy. The marketing of these materials is to be determined. (IB, PB)

Legislative materials will most likely be in hard copy format and will focus on the research supporting best practice GDL. They will also contain a cost analysis of GDL and a state comparison of teen motor vehicle crash rates. (PB)

An additional parent survey will go live during the summer of 2012. It will replicate in part the University of North Carolina survey of 2010 that asked about knowledge of GDL concepts. The results will be added into the information presented in the WEDU materials. (PB)

The teen seatbelt usage project is continuing. (PB)

The SHSP website will be up by the end of the year, incorporating a section on teen driving. (PB)

**c. Plan for the Coming Year**

Teen Driving Committee:

The Committee will be continuing its work overseeing the teen seatbelt usage project. Representatives from all four high schools will present at the next annual Highway Safety Conference on their programming. (PB)

One of the students at Great Bay E Learning Center is taking the lead creating a video on seat belt safety. This video will be based on the death of one of their classmates who was killed last year during the 2010-1011 school year when she was ejected from her vehicle because she was unbelted. This video will be filmed by the local cable television station and will involve interviews with the victim's friends, her mother and, hopefully, the law enforcement officer involved. Filming will take place during the next year and the video will be distributed throughout the state as well as shown on youtube. (PB)

All of the schools will be facilitating another observational seat belt survey to take place exactly one year post initiation of the program. It is hoped that there will be an increase from the baseline (which at Spaulding was 67% for male and 65% for female drivers and at Epping was 37% for male and 67% for female drivers). (PB)

All four schools will be participating in a session provided by a teen survivor of a motor vehicle crash. The survivor sustained damage from the crash, which left him with permanent traumatic brain injuries. (PB)

WEDU and the Committee will be finishing their materials on GDL for parents and for legislators and will begin implementation of a marketing plan for both audiences. An evaluation plan will also be put in place. (PB)

**MCH STRATEGIES:**

The Injury Prevention Program will be working with the Home Visiting Program on an issue/data brief specific to childhood injuries and focusing on restraint issues. (IB)

The Injury Prevention Program received a Core Violence and Injury Prevention grant from the Centers for Disease Control and Prevention. Part of this grant requires a focus on four injury areas to be chosen by the Injury Prevention Advisory Council, the program's advisory group. This group chose motor vehicle crashes, in particular those involving adolescents and children, as one of its focal areas. An intervention will be designed based on best practice and research and will be implemented during the next five years. (IB, PB)

MCH will work with the NH DHHS Public Information Office to send out social media messages via Twitter and Press Releases to aimed at specific populations such as teens and parents of teens regarding seat belt usage, teen driving and GDL. (PBL).

**Adolescent Health:**

MCH staff will continue to monitor its funded adolescent health programs and community health centers including the provision of anticipatory guidance (e.g questions on seatbelt use) in clinical services. (PB, DS)

**State Performance Measure 7: *Percent of households identified with environmental risks that receive healthy homes assessments.***

**Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					100
Annual Indicator				74.5	62.7
Numerator				38	37
Denominator				51	59
Data Source				Staff assessments	Healthy Homes & Lead Poisoning Prevention Progra
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	100	100	100	100	100

**Notes - 2011**

Re future objectives: any number would be invalid, thus 100 has been used as a "placeholder". Not entering a number was not possible to complete this measure.

**Notes - 2010**

Since the New Hampshire Healthy Homes and Lead Poisoning Prevention Program (HHLPPP) started conducting healthy homes assessments on September 1, 2010, the HHLPPP has conducted 51 assessments to date. Of those 51 assessments, which are initially conducted on the home of a child with an elevated blood lead level, 38 homes or 75% were found to have an additional environmental health hazard.

The healthy homes assessment questionnaire was developed in cooperation with the CDC and additional state stakeholders. The data currently being collected includes education performed with the residents, and referrals made to other agencies to mitigate additional environmental hazards found within the home during the initial healthy homes assessment. Data is based on HHLPPP staff assessments only.

The HHLPPP is currently working with the CDC to get the Healthy Homes and Lead Poisoning Surveillance System (HHLPSS) installed and operational for the second year of data collection. The HHLPPP estimates that the initial testing and deployment will be finished by December 31, 2011. This estimate is based on the time it has taken other states to test and deploy the HHLPSS. Once the installation of the HHLPSS is complete, the HHLPPP will begin pursuing additional assessments from contracted agencies. At this time, however, there is no mechanism to collect, store and analyze healthy homes assessment data from other stakeholders.

PLEASE NOTE re future objectives: any number would be invalid, thus 100 has been used as a "placeholder". Not entering a number was not possible to complete this measure.

#### **a. Last Year's Accomplishments**

The New Hampshire Healthy Homes and Lead Poisoning Prevention Program (HHLPPP) started conducting healthy homes "One-Touch" assessments on September 1, 2010. The healthy homes (HH) assessment questionnaire was developed in cooperation with the CDC and additional state stakeholders. During this timeframe, 51 assessments were performed. (PB)

The HHLPPP and Asthma Control Program (ACP) staff continued to attend MCH Coordinators' Meetings to share information updates with Title V funded Child Health and Primary Care. (IB)

The HHLPPP worked with the CDC to purchase hardware to pursue the CDC's Healthy Homes and Lead Poisoning Surveillance System (HHLPSS) to collect, store and analyze HH assessment data from other stakeholders. (IB)

New Hampshire's piloted two "One-Touch" healthy housing initiatives, managed by Ellen Tohn, Tohn Environmental Strategies, with funding from the HUD and the U.S. Department of Agriculture. The pilots included home visitors along with home visiting energy auditors employed by weatherization programs. (PB)

The HHLPPP assisted University of New Hampshire Masters in Public Health Capstone Program interns with completion of on-line "One-Touch" training tools that included on-line video and webinar features for statewide partners. (ES, IB)

The statewide "One-Touch" HH initiative was featured on a local television show, NH Chronicle. This program has an audience of 30,000 people. The episode can be found at: <http://www.wmur.com/chronicle/27979895/detail.html>. (IB)

The first New Hampshire Healthy Homes statewide meeting was held in November 2010 with an attendance of over 70 partners of health professionals, building code officials, environmental professionals, housing and weatherization professionals, building and remodeling contractors, health officers, real estate agents, Healthy Homes Committees (HHCs) and federal partners. (ES, IB)

The HHLPPP began providing a monthly electronic Healthy Homes Newsletter which provides

the most current local, regional and federal funding opportunities to over 500 partners. (IB)

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The HHLPPP will continue to coordinate HH trainings and TA for partners, including home visitors and MCH-funded agencies and programs to build the capacity to perform HH assessments and in-home interventions.		X	X	X
2. The HHLPPP will continue to share educational material from literature toolkit with families of children with elevated blood lead levels, facilitate referrals to 4 agencies, and collect information using the HH questionnaire.				X
3. The HHLPPP and ACP will continue to attend MCH Coordinators' Meetings to share information updates with Title V funded Child Health and Primary Care.				X
4. The HHLPPP will continue to provide a monthly electronic Healthy Homes Newsletter which provides the most current local, regional and federal funding opportunities to over 500 partners.				X
5. The ACP will continue Town Meetings with housing authorities, property owners and tenants to introduce Breathe Better in Healthy Homes, an initiative to make multi unit properties smoke-free.				X
6. The HHLPPP will continue the statewide Healthy Homes Steering Committee and six Workgroups monthly to implement healthy homes priorities statewide and within public health regions.				X
7.				
8.				
9.				
10.				

**b. Current Activities**

The HHLPPP continues to plan the implementation of the CDC HHLPSS. (IB)

The HHLPPP and ACP staff continue to attend MCH Coordinators' Meetings to share HH, asthma and "One-Touch" initiatives, with Title V funded Child Health and Primary Care. (IB)

Through contracts, the HHLPPP transitioned childhood lead poisoning case management, regional HH needs assessments, strategic planning as well as "One-Touch" activities to seven public health regions to integrate these services into communities. (ES, PB, IB)

The HHLPPP hosted the first annual one-day HH Conference with 185 attendees that provided an outreach and education opportunity to a diverse group of partners in October 2011. (PB, IB)

The HHLPPP coordinated HH trainings and technical assistance for partners throughout the state, including HUD grantees, regional HH Committees, health and code officials, energy auditors, home visitors, MCH-funded agencies and programs such as the Maternal, Infant and Early Childhood Home Visiting Program, to build the capacity to perform HH assessments and in-home interventions. (ES, PB, IB)

The ACP is implementing and evaluating Motivational Interviewing trainings with Head Start sites

and other partners to increase the effectiveness of healthy homes interventions with families. (IB)

The ACP conducts Town Meetings with housing authorities, property owners and tenants to introduce Breathe Better in Healthy Homes, an initiative to make multi unit properties smoke-free. (IB)

**c. Plan for the Coming Year**

The HHLPPP and its stakeholders will modify the New Hampshire Healthy Homes Statewide Strategic Action Plan to include current progress and partnerships, and to identify resources and measurable goals for sustainability. MCH will continue to jointly fund a nurse position with HHLPPP. (IB)

The HHLPPP will convene the statewide Healthy Homes Steering Committee and six workgroups monthly to implement healthy homes priorities statewide and within public health regions. (IB)

The HHLPPP will continue planning with the implementation of the CDC HHLPPSS, a new data management system including Healthy Homes variables. (IB)

The HHLPPP and ACP staff will continue to attend MCH Coordinators' Meetings to share information updates with Title V funded Child Health and Primary Care. (IB)

The HHLPPP will coordinate Healthy Homes trainings and technical assistance for partners throughout the state, including HUD grantees, regional HH Committees, health and code officials, energy auditors, home visitors and MCH-funded agencies and programs to build the capacity to perform HH assessments and in-home interventions. (ES, PB, IB)

The HHLPPP and the HH Steering Committee will plan the second one-day Healthy Homes Conference that will provide an outreach and education opportunity to involve a diverse group of partners across the state. (PB, IB)

The ACP will implement and evaluate Motivational Interviewing trainings with stakeholders to increase the effectiveness of healthy homes interventions with families. (IB)

The ACP will conduct Town Meetings with housing authorities, property owners and tenants to introduce Breathe Better in Healthy Homes, an initiative to make multi unit properties smoke-free. (IB)

The HHLPPP and ACP will utilize the DPHS' NH Health WISDOM (Web-based Interactive System for Direction and Outcome of Measures) to further the goal of streamlining and organizing data so that it can be gathered and used more quickly and efficiently internally. (IB)

The HHLPPP will provide a monthly electronic Healthy Homes Newsletter which provides the most current local, regional and federal funding opportunities to over 500 partners. (IB)

**State Performance Measure 8:** *The percent of public water systems that optimally fluoridate the water system on a monthly basis.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>

Annual Performance Objective					4
Annual Indicator			20.0	30.0	10.0
Numerator			2	3	1
Denominator			10	10	10
Data Source			NH Dept of Environmental Svcs	NH Dept. of Environmental Svcs	NH Dept. of Environmental Svcs
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	3	4	5	6	7

**Notes - 2011**

For reporting year 2011, the numerator (number of systems that optimally fluoridate 80% of the days measured and reported each month) has dropped to one. The DPHS Oral Health Program believes the decline in optimal fluoridation is because the US Department of Health and Human Services has not yet released it's final recommended level of added fluoride required to reach a new optimal range for community water fluoridation. The Oral Health Program has worked closely this year with the NH Department of Environmental Services, Drinking Water and Ground Water Bureau, to standardize community reporting and data entry in order to ease management of the Water Fluoride Reporting System (WFRS.)

With improved reporting and data entry, the Oral Health Program plans to rewrite the State Performance Measure next year to identify fluoridated communities within the range of optimal fluoride levels ten months each year.

**Notes - 2010**

To achieve optimal community water fluoridation a water system must test the water for flouride 80% of the days in each month. Fluoride levels must be within the optimal fluoride range 80% of the days when the water is tested. Denominator is number of community water systems that fluoridate.

**Notes - 2009**

To achieve optimal community water fluoridation a water system must test the water for flouride 80% of the days in each month. Fluoride levels must be within the optimal fluoride range 80% of the days when the water is tested. Denominator is number of community water systems that fluoridate.

**a. Last Year's Accomplishments**

**BACKGROUND:**

Community water fluoridation has been a safe and healthy way to effectively prevent tooth decay. This simple, and inexpensive public health intervention has contributed to a significant decline in tooth decay throughout the 20th and now 21st Century. The benefits of community water fluoridation reach nearly 74% of the U.S. population served by community water systems. Access to this intervention in NH is mixed. Although only 10 NH communities add fluoride to their public water systems, 43% of the State's population has access to fluoridated water due to the larger populations in the cities that do fluoridate.

In January 2011, the U.S. Department of Health and Human Services (HHS) and the U.S. Environmental Protection Agency (EPA) announced preliminary changes to the guidelines on

fluoride in drinking water. HHS recommendations were to lower the level of fluoride in drinking water to the lowest end of the current optimal range to prevent tooth decay, while continuing to provide maximum protection, especially for children and assuring better dental health for the American people. These guidelines and standards have not been finalized or required. Without a final standard, there is greater interpretation as to the "optimal level" for fluoridation in community water systems.

In February 2011, soon after the release of proposed recommendations to lower the level of optimal fluoride in municipal water supplies, residents in Dover, NH petitioned the city to include an article on the town warrant to remove fluoride from the public water supply. Dover voters rejected the warrant article and voted to continue to fluoridate the public water supply.

**SYSTEM BUILDING:**

The DPHS Oral Health Program (OHP) Manager and the Maternal and Child Health (MCH) Clinical Quality Assurance Coordinator attended the New England Water Works Association (NEWWA) Fluoridation Training in Attleboro, MA. (IBS, PBS, ES)

The OHP applied for and received technical assistance from the federal MCHB to support fluoridation training for ten NH water system engineers and staff. (IBS, PBS)

The OHP answered inquiries from water departments, the media and interested individuals following the January 2011 CDC release of new recommendations for optimal fluoride levels in community water supplies. (IBS, PBS, ES)

The OHP collaborated with representatives from NH DES and the NEWWA in the development of a NH-specific fluoridation training for staff from ten NH fluoridated public water systems. (IBS, PBS, ES.)

The OHP collaborated with the MCH Clinical Quality Assurance Consultant to develop a presentation for water systems staff on the health benefits of optimally fluoridated water. (IBS, PBS, ES.)

The OHP oversaw the entry of monthly fluoridation data submitted to DES by ten fluoridated water systems followed by the submission of that data into CDC's WFRS. (IBS, PBS)

The OHP made a presentation to NH Maternal and Child Health Program Directors about the changes in CDC recommendations on the optimal level of added fluoride in community water systems. (IBS, PBS, ES.)

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Oral Health Program (OHP) collects monthly reports about the quality of fluoridation.			X	X
2. The OHP monitors CDC communications about the release of final recommendations on the optimal level of added fluoride for community water supplies.		X	X	X
3. The OHP attended the New England Water Works Association (NEWWA) Fluoridation Training.			X	X
4. The OHP collaborated with NH DES and the NEWWA in the development of a NH-specific fluoridation training for fluoridated public water systems.			X	X
5. The OHP collaborated with the MCH Clinical Quality Assurance Consultant to develop a presentation for water			X	X

systems staff on the health benefits of optimally fluoridated water.				
6. The OHP made a presentation to NH MCH Program Directors on the changes in CDC recommendations for the optimal level of added fluoride in community water systems.		X	X	X
7. The OHP provides technical support to the Division of Public Health Services (DPHS) Legislative Liaison on bills proposed in the NH Legislature related to community water fluoridation.			X	X
8. The OHP developed and distributed a survey monkey to water department staff to determine which fluoridated communities have already adjusted their fluoride levels to match the DRAFT CDC recommendations.			X	X
9.				
10.				

**b. Current Activities**

**SYSTEMS BUILDING:**

The Oral Health Program (OHP) provides technical support to the Division of Public Health Services (DPHS) Legislative Liaison on bills proposed in the NH Legislature related to community water fluoridation. (IBS, PBS, ES)

The OHP monitors CDC communications about the release of final CDC recommendations on the optimal level of added fluoride for community water supplies. (IBS, PBS, ES)

The OHP collects monthly reports received by NH Department of Environmental Services (DES) about the quality of fluoridation activities in ten NH water systems. (IBS, PBS)

The OHP utilizes staff from the Chronic Disease Prevention and Screening Section to efficiently manage monthly data entry of fluoridation levels for ten NH water systems. (IBS, PBS)

The OHP developed and distributed a survey monkey to ten fluoridated water department staff that indicates that seven of the ten fluoridated NH communities have already adjusted their fluoride levels to match the DRAFT HHS recommendations on the optimal level of added fluoride for community water systems. (IBS, PBS, ES)

**c. Plan for the Coming Year**

**SYSTEMS BUILDING:**

The Oral Health Program (OHP) will continue to collaborate with the Department of Environmental Services (DES) on fluoridation trainings conducted every two years for water supply utility staff from 10 NH fluoridated communities. (IBS, PBS, ES)

Five (50%) NH communities that add fluoride to their public water supply will optimally fluoridate the water supply within the range specified under the new CDC guidelines. (IBS, PBS.)

The OHP will maintain ongoing contact with community water supply utility staff to provide quarterly feedback on WFRS data and promote continuous quality improvement related to optimal fluoridation of Community Water Systems. (IBS, PBS, ES)

Following the period for public comment, the OHP will disseminate CDC's final new guidelines on optimal fluoride levels to ten fluoridated NH community water systems. (IBS, PBS, ES.)

The OHP manager will seek and sustain staffing to provide data entry and maintenance of the WFRS. (IBS, PBS)

The OHP and MCH will develop and pilot a new, web based data collection system to better manage the data entry and analysis of fluoridation levels for the ten NH water systems. (IBS, PBS)

OHP will collaborate with DES on fluoridation trainings conducted every two years for water supply utility staff from 10 NH fluoridated communities. (IBS, PBS, ES)

The OHP Manager will continue to seek ways to support additional fluoridation training for DPHS staff and/or water engineers from the ten NH water systems through NEWWA or CDC workshops. (IBS, PBS, ES.)

**PLANS FOR STATE PERFORMANCE MEASURE:**

Because national guidelines have been in flux, and practices are changing among the water systems managers, MCH and the OHP propose re-defining this measure in the next year to better reflect current practice.

**State Performance Measure 9: REVISED: The number of individuals who have completed a competency based training for respite providers.**

**Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective				36	15
Annual Indicator				9	14
Numerator					
Denominator					
Data Source				SMS Training Record & CDS	SMS Training Records
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	20	20	20	20	25

**Notes - 2011**

This is a manual indicator, therefore the numerator and denominator fields are blank

**Notes - 2010**

The activities of this performance measure were linked to a federal funding opportunity from the Administration on Aging. This funding was awarded in September 2009. However, completion of the competency based training did not take place until June 2010 and the first completed training was in September 2010 (not within this reporting timeframe)

**a. Last Year's Accomplishments**

The working group on the NH Lifespan Respite initiative has included: representatives from Title V staff, parent consultants, State Behavioral Health (BBH), State Bureau of Developmental Services (BDS), a partner knowledgeable in medically fragile children from a private sector, State Bureau of Elderly and Adult (BEAS), State Division of Children and Youth (DCYF), family members and a NH local community based agency for competency based training. These individuals are on the Advisory/Planning (A/P) workgroup who met quarterly to review the work plan of the NH Lifespan Respite Care (LRC) Grant. The grant was received by SMS from the U.S. Administration on Aging (AoA) in 2009.

The intent of the NH Lifespan Respite Care Project is three fold: to launch a competency-based curriculum to train respite providers and create a registry of those trained; to facilitate the creation of a statewide Respite Coalition and; to complete a pilot program-reviewing the impact of respite services on permanency placements of children with severe emotional disturbance (SED) involved with DCYF. The A/P workgroup divided into sub work groups (Pilot, Curriculum Development, Marketing & Recruitment, Registry (Respite Locator) and Coalition development) the latter group developed the Vision and Mission for the NH LRC. The grant mandated a development of NH LRC Coalition. The A/P Group as a whole did not want to become the LRC Coalition for NH.

In January and February 2011, a group of stakeholders representing organizations with constituents who have a variety of chronic conditions met with A/P Group members to discuss the opportunities for a NH LRC Coalition. A core group of stakeholders meet monthly to move ahead with the work of a coalition. Utilizing the College of Direct Support (CDS) competency-based web curriculum from the University of Minnesota and administered by one agency (the Moore Center) in NH, a three-tier implementation of training was designed to include a module on SED developed by the Institute on Disability (IOD) at the University of NH (UNH). The first tier (approx, 20+hrs) is mandatory before providing any respite care for the pilot group families enrolled in the program. The pilot is under the surveillance of SMS and the A/P Group to identify any changes necessary to meet the needs of the respite providers, the caregivers and their families using pre-post surveys with the Pilot group. The Pilot identified as adoptive families or reunified families from DCYF system who have a child with SED. The trained respite providers can provide up to 50 hours of service at \$10.00 per hour to the identified family.

The NH Provider Respite Locator designed by SMS and piloted with Service Link, a NH contract agency through the BEAS to establish links for trained respite providers was not suitable as the barrier of it's "agency only" access did not allow family access. Exploration for other options for a locator is ongoing. Marketing materials with NHLRC logo was developed. SMS will continue to collaborate with outside agencies and state groups to identify respite/childcare needs and assist with infrastructure building. SMS presented the NH LRC at the Poster Session at AMCHP in March of 2011.

SMS applied for and was chosen as a site for an MCHB funded intern through the Graduate Student Intern Program. The Graduate Student Intern (GSI) began at SMS in May 2011 and remained until August 2011. She was offered experiences to further develop skills and knowledge of CYSHCN and family-centered care across populations. She developed the Caregiver Needs Assessment in Survey Monkey, and funneled it through the LRC Coalition partners/stakeholder List Serves.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Manage activities of the LRC Grant and present progress for review to the Advisory Planning Group representing families, state agencies and private not-for-profits.				X
2. Review the pilot pre-post surveys of families and trained respite providers for changes necessary to the curriculum.				X
3. Meeting with individuals and groups in state agencies and communities regarding respite/childcare needs for medically and behaviorally complex children.				X
4. Participating in Federal, State and local activities that are associated with respite/childcare to help build collaboration and infrastructure.				X
5. Assist with coordination activities for the LRC Coalition to develop its' infrastructure for sustainability of the respite training				X

program.				
6. Provide oversight for Graduate Student Intern (GSI) from Maternal & Child Health Information Resource Center (MCHIRC) (2011) in creating, distribution, tabulation, and summarizing a needs assessment, of caregivers across populations in NH.				
7. Provide marketing and recruitment with materials for the NH LRC Provider Training through variety of State and Local of settings including the adult population.				X
8.				
9.				
10.				

**b. Current Activities**

Surveys continue to show a need for respite services in NH throughout all ages of life. In October 2011, at the NH LRC Summit the GSI presented the results of the survey to NH Caregivers across the lifespan and trained LRC Providers, with other presenters (U.S. AoA, National ARCH Respite, trained provider, family caregiver and the IOD) The IOD has a federal grant for "Direct Support", that provides workforce development utilizing the CDS curriculum. Results from the Summit provided the LRC Coalition members guidance for respite activities in NH. Originally the intent was to primarily use "natural supports" as respite providers. The majority of families enrolled have not been able to identify available "natural supports". Therefore, the A/P group continues to brainstorm and identify new sources of provider recruitment. Outreach through list serves from our stakeholders/collaborators and other sources like Craig's List were identified. New providers entering training are required to participate in the pilot. The pilot group was expanded statewide via the DCYF District Offices (DO). A web-based platform for the Respite Locator with easy access is in explorative stages. NH LRC in partnership with the ARCH Respite presented at AMCHP February 2012.

**c. Plan for the Coming Year**

The NH Core Coalition members are continuing to meet monthly. The NH LRC Grant ends September 30, 2012, and SMS will request a no-cost extension to complete the work with the locator, continue to evaluate the respite training to include expansion of the pilot project- open to serve those throughout the lifespan, and to see if further modules are necessary for safe LRC. Starting July 1, 2012, the training will be funneled through the IOD, at UNH through the "Direct Connect" program that utilizes the CDS for training. This will be an opportunity for those who have trained with the LRC Grant to receive additional training and for the respite locator to receive individuals who have been trained through Direct Connect if interested to become a respite provider and listed on the respite locator when the final platform for the locator is made.

The NH LRC Coalition needs guidance to take more responsibility for NH Respite Program and develop membership reaching out to businesses and providers. The draft logic model needs to be further developed to include the infrastructure building of the coalition. The LRC Provider training and the Family Satisfaction Survey will continue to be monitored for any changes that are needed to the curriculum to meet the families' and provider's needs. SMS was eligible to submit a proposal through the U.S. Department of AoA for "Building Integrated and Sustainable Respite Care Programs" grant. In May 2012 with support from the NH Lifespan Core Coalition members, This would substantially support the needs in NH to identify Respite Care and Caregiver needs through out the lifespan with a statewide Environmental Scan and Asset Mapping in 6 of the 10 counties that will be the foundation for networking caregivers and support through replication of a successful project that was done in 4 of the 10 counties in NH through a private foundation grant. This grant would provide additional funding for the statewide family friendly respite locator. Marketing through relationships has been successful and will continue with outreach efforts to: agencies (State and Local), organization (Private and non-profit), and families (NH Family Voices).

NH LRC presentation at the "International Short Break Conference" is scheduled for October 2012 in Toronto Ontario Canada.

**State Performance Measure 10:** *Of women who had a preterm birth: Percent who reported smoking before pregnancy*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					18
Annual Indicator			19.4	18.8	18.8
Numerator			223	199	199
Denominator			1148	1059	1059
Data Source			Vital Records	Vital Records	Vital Records
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	17	16	15	14	13

**Notes - 2011**

2011 data is unavailable. 2010 data is used as an estimate.

**Notes - 2010**

Final for resident occurrent births.

**a. Last Year's Accomplishments**

**BACKGROUND:**

Because smoking increases the risk and incidence of preterm delivery, among other negative health outcomes, it is imperative that Title V support tobacco use reduction through multiple modalities.

Given the limited resources available, and in partnership with the Division of Public Health Services, Tobacco Prevention and Control Program, MCH has primarily focused on tobacco use cessation activities at MCH-funded prenatal clinics within community health centers (CHCs). In some communities, cessation activities have evolved to a "Ask-Advise-Refer", 2A's and an R, method in lieu of the more comprehensive, 5 A's. (DC, ES )

**SYSTEMS DEVELOPMENT:**

In 2011, MCH participated in a developing partnership between the NH DPHS and The Dartmouth Institute to promote increased opportunities for learning and performance improvement in public health. Several DPHS staff members, including the Title V Director, enrolled in an intensive 10-week microsystems class and selected the perinatal smoking cessation systems at DPHS as their case study microsystem. MCH and DPHS partners incorporated several of the recommendations that resulted from this intensive case study such as: created an integrated workgroup across DPHS programs focused on perinatal smoking; aligning policy for smoking cessation best practice and expectation across programs, including scopes of work for contracted agencies; and create a better understanding of smoking-related data sets among DPHS programs. As a result of this work, all new contracts for SFY13 had similar contractual expectations and/or performance measures for perinatal smoking cessation and data collection. (IB)

Home Visiting NH provided women with information and support around the dangers of smoking during pregnancy and exposure to environmental tobacco smoke. Using the method of "Ask-Advise-Refer", pregnant woman are asked at enrollment if they or anyone in their household

smokes. If yes, they are advised of the health risks and provided with information about quitting, including the NH Tobacco Helpline 1-800-QUIT-NOW, and taking it outside. (ES,PB)

New Hampshire, like all states, had the opportunity to plan for additional home visiting services for families most at risk through the Affordable Care Act, Maternal Infant Early Childhood Home Visiting Program (MIEC). Clearly, smoking cessation was identified as a need for families to prevent negative health outcomes. Community providers identified that they were in need of additional training to prepare new home visitors for providing evidence based practice and motivational interviewing.(ES,PB)

The Tobacco Prevention and Control Program (TPCP) offered nicotine replacement therapy (NRT) to practioners willing to embrace to clinical systems change. TPCP provided NRT for one community health center prenatal program. The adoption was complex - but was a successful completion. The CHC developed a robust plan to adopt a modified 5 A's protocol using EMR and HL7 technology that will allow providers to refer patients to the New Hampshire Tobacco Helpline via Health-E link - a software tool able to interface with any EMR - in order to extract the referral and return a receipt, thus closing the loop with the referring provider. (IB, ES)

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor tobacco performance measure data. Promote 2 A's & R smoking cessation training by the NH Tobacco Program in those agencies who do not reach their target goal within 10%.				X
2. Actively promote Text4Baby.			X	X
3. MCH staff will continue to make site visits to contracted agencies every two years. Schedule follow-up visits to provide additional support as needed.				X
4. Launch the Pregnancy Risk Assessment Management System (PRAMS) project.				X
5. Monitor and analyze PRAMS data.				X
6. Share early PRAMS findings with stakeholders through informational data breifs and social media press releases.				X
7. Continue participation in March of Dimes Planning Committee.				X
8. Actively promote Centering Pregnancy in all community health centers.				X
9. Utilize traditional and social media to highlight prematurity awareness for ASTHO Prematurity Challenge.			X	
10.				

**b. Current Activities**

**SYSTEMS DEVELOPMENT:**

MCH continues support Prenatal Care programs within community health centers that provide counseling on how to quit or reduce tobacco use. When prenatal patients begin care, they are evaluated for smoking status and appropriateness for smoking cessation program. Agencies maintain records of prenatal patients specifically to track smoking cessation efforts across pregnancy and report progress on the percent of pregnant women identified as tobacco users upon entry who received a provider intervention based on the 2A's and Refer best practice model. Agencies work with the Tobacco Cessation and Prevention Program (TPCP) to provide quick referrals to QuitWorks on agency-designated form and fax QuitWorks form. Agencies are also implementing Plan, Do Study, Act (PDSA) cycle until goal is met.

New CDC/ARRA funds that have focused on Obesity Prevention and Tobacco Free

environments for children have resulted in strengthened partnerships within DPHS to target child care programs. This work continues through the DPHS Young Families Workgroup focusing on local policy change and systems development.

MCH began Home Visiting NH-Healthy Families America (HVNH-HFA) services with MIEC Home Visiting funding in fall of 2011 which includes smoking cessation activities for pregnant and parenting women under the age of 25. MCH partnered with (TCP) to provide additional training at the community level in evidence based practice, data collection and motivational interviewing.

### **c. Plan for the Coming Year**

#### **SYSTEMS DEVELOPMENT:**

Continue to collaborate with the Tobacco Prevention and Control Program on evidenced-based ways to decrease tobacco use in pregnant women and in household contacts. (PB)

MCH will continue to work with the Tobacco Prevention and Control Program and any other community health centers interested in replicating the modified model of the 5 A's protocol using EMR and HL7 technology. Anecdotally, it appears that few, if any other CHCs, nationally, have successfully accomplished this task of seamlessly referring patients, including perinatal patients, directly to the State's Quitline via Health-E link. (DS, ES)

MCH plans to expand Healthy Families America home visiting model from five to eleven at-risk communities to bring the system statewide. Agencies will be required to provide data that relate to improved maternal and newborn health including parental use of alcohol, tobacco, or illicit drugs. (IB)

New Hampshire will continue to actively promote Text4Baby when interacting with pregnant women and new parents/grandparents or people who work with these groups of individuals. (PB)

The PRAMS project will be launched in Fall 2012. Several questions are related to tobacco use in the mother and in the home. PRAMS data will be analyzed over time to identify strengths and weakness, which will be used in program planning.

MCH staff will continue to participate on the March of Dimes Program Planning Committee to ensure the efforts for improving birth outcomes are linked. Centering Pregnancy is a multifaceted model of group care that integrates the three major components of care: health assessment, education, and support, into a unified program within a group setting. Eight to twelve women with similar gestational ages meet together, learning care skills, participating in a facilitated discussion, and developing a support network with other group members. Each Pregnancy group meets for a total of 10 sessions throughout pregnancy and early postpartum. The practitioner, within the group space, completes standard physical health assessments. (IB)

In addition, New Hampshire has signed on to the Association of State and Territorial Health Officials (ASTHO) and March of Dimes challenge to improve birth outcomes by reducing infant mortality and prematurity in the United States. Specifically, the ASTHO goal is to decrease prematurity in the United States by 8% by 2014. The National Center for Health Statistics (NCHS) estimated New Hampshire's 2009 Preterm Birth rate at 9.9%, or 1,323 premature births out of a total of 13,377 live births. An 8% reduction goal for New Hampshire would be 9.1%, or a reduction of approximately 106 preterm births. MCH is committed to working with community health centers, providers and the March of Dimes to make this ambitious goal a reality.

## **E. Health Status Indicators**

### Health Status Indicators Introduction

Overall, the Title V Health Status Indicators serve as useful tools in assessment, monitoring, and evaluating programmatic activities. The following narrative describes trends in New Hampshire followed by a broader assessment of NH's capacity to utilize these and other Title V indicators to direct public health efforts.

The NH Title V program is limited in fully utilizing all of these indicators to direct public health efforts, provide surveillance and monitoring, and to evaluate the effectiveness of programs. The primary limitation is the scope to which Title V can affect population-based indicators. Through our partnerships with community health centers, community based organizations and other state agencies, however, Title V provides assistance and leadership in developing promising practices and strategies to address the needs that these indicators illustrate. The limitation occurs in the amount of resources Title V can provide to support these efforts. In the past, Title V has also encountered infrastructure challenges in accessing and using the most current data that MCHB requests as health status indicators. The NH Division of Vital Records (VR) moved from the Department of Health and Human Services to the Department of State in 2003. A change in leadership at VR occurred in 2009 and has resulted in an improved working relationship. A memorandum of understanding addressing, among other issues, the timeliness of data entry was signed in 2009.

### Health Status Indicators 1A-2B

#### LOW BIRTHWEIGHT:

Low birth weight (LBW) is a strong predictor of infant health and survival. LBW babies may face serious health and development complications such as respiratory disorders, intestinal complications and developmental delays. Infants born below 5.5 pounds (2,500 grams) are low birth weight.

There are two main reasons why an infant may be born with low birth weight.

**Premature birth:** Babies born before 37 completed weeks of pregnancy are called premature. About 67% of low-birth weight babies are premature. Some premature babies born near term do not have low birth weight, and they may have only mild or no health problems as newborns.

**Fetal growth restriction:** These babies are called growth-restricted, small-for-gestational age or small-for-date. These babies may be full term, but they are underweight. Some of these babies are healthy, even though they are small. They may be small simply because their parents are smaller than average. Others have low birth weight because something slowed or halted their growth in the uterus.

Preterm birth has enormous health, social and economic costs. It increases the risks of infant mortality and of serious health consequences throughout the lifespan. Preterm birth rates have been slowly climbing nationally and in NH, but the data suggests that there may be possibly a trend towards a decrease beginning in 2007. Disparities are evident among racial, ethnic and socio-economic groups. Interventions such as maternal smoking cessation have the potential to reduce premature births, and thus reduce the impact of low birthweight, and are well within the scope of Title V activities.

New Hampshire's LBW rate has been relatively stable in recent years and remains consistently lower than national rates although it does not negate the emotional, medical, and economic costs of LBW babies. In 2010, 6.8% or 874 New Hampshire infants were born with low birth weight. This is down slightly from the previous year (6.9%). There are no significant regional differences in outcomes throughout the State so this creates a powerful incentive to address prevention efforts throughout NH communities.

Disparities do occur however, when the data is analyzed by age or payor. For example, births to teens and mothers of advanced maternal age (35 years and over) account for only 23% of all births, but they represent 26% of all low birth weight births.

Smoking is an important determinant of health and a significant factor contributing to low birth weight births. In New Hampshire, 16% of women report smoking during pregnancy and may account for 20 to 30% of low birth weight babies. Disparities do occur however, when the data is analyzed by age or payor. For example, births to teens and mothers of advanced maternal age (35 years and over) account for only 23% of all births, but they represent 26% of all low birth weight births.

Smoking is an important determinant of health and a significant factor contributing to low birth weight births. In New Hampshire, 16% of women report smoking during pregnancy and may account for 20 to 30% of low birth weight babies.

The New Hampshire Title V program has elevated tobacco use among pregnant women and women of reproductive age as one of strategic priorities because 43% of women receiving prenatal care in MCH-funded community health centers reported smoking 3 months prior to becoming pregnant. MCH agencies continue to work in partnership with DPHS Tobacco Prevention and Control Program to strengthen cessation programs through innovative learning collaboratives such as NH Quitworks in MCH-funded community health centers.

Programmatically, MCH is committed to working with partners on collaborative efforts aimed at smoking cessation for all pregnant women and women of reproductive age. Through projects such as the Robert Wood Johnson's Multi-State Learning Collaborative Quality Improvement Learning Teams (QuILT), three teams of community health centers are developing best practices and system changes in promoting all of the 5A's in clinical settings. Notably, teams used their newly acquired PCDF data to form baselines and monitor success. Best practices will be disseminated statewide when the project is completed.

MCH monitors its community health centers and community support programs through the contract agencies' required workplan performance measures. In addition, site visits are conducted by MCH staff to these health centers to verify that an agency is operating in compliance with state and federal requirements through chart audits and discussions on how to improve outcomes.

The Prenatal Data Linkage Project (PCDF) was formed to link MCH-funded prenatal clinic records and NH birth data to assure MCH is able to fully understand and respond to the needs of, and threats to, pregnant women and newborns. Additionally, this project will greatly assist in program management, policy development, and evaluation of health services to pregnant women and newborns.

Data from this linkage will be used in comparison with several indicators in this section to more accurately describe the health of the vulnerable populations that receive care in MCH funded health agencies. Data on all clients entering care at MCH-funded prenatal clinics on or after July 1, 2007 has been entered into the system. Comparison data from the PCDF was presented at the Spring 2010 MCH Directors' meeting. Agencies were given numbers privately identifying their own agency while comparisons on different performance measures were shown onscreen. This type of activity is intended to increase awareness of the quality of prenatal care for some of the most vulnerable pregnant women in the state.

The prevalence of low birth weight babies and premature deliveries may also be from populations that do not generally receive care in community health centers, including high-risk women with multiple births. Since the 1980s, multiple births have increased substantially in the United States. The increase in multiple births has been attributed to an increased use of Artificial Reproductive

Technology and delayed childbearing. In 2006, in New Hampshire, there were 236 deliveries as a result of ART with 304 infants born. Forty-four percent were born in multiple birth deliveries; 41% in twin deliveries and 2% in higher order deliveries. Nationally, 6.3% of all ART infants were born with very low birth weight. Almost two percent (1.9%) of singletons were VLBW, 8.5% of twins were VBLW and 34.3% of triplets or higher order multiples were VLBW. (MMWR, June 12, 2009)

Innovative strategies like text4baby are used to engage all women early in their pregnancy to reduce risk factors associated with negative birth outcomes, including low birth weight. The free health-related text messages for pregnant and newly parenting women reference the importance of early prenatal care and promotes healthy birth outcomes. One example is "For a healthy baby, visit a doctor or midwife early & keep all of your appointments. Hear your baby's heartbeat. See how fast she grows!"

Centering Pregnancy is an evidenced-based model for the delivery of prenatal care that focuses on health assessment, education, and support within a group setting. Women are empowered to choose health-promoting behaviors that can lead to better neonatal outcomes including a decrease in low birth weight and premature deliveries. Patients and medical providers express high levels of satisfaction with this model. At least one MCH funded health agency currently offers Centering Pregnancy as well as the traditional model for the delivery of care. In addition, several other agencies are exploring the possibility of offering this evidenced-based model in the future.

In order to best understand the entire population of vulnerable infants, increased surveillance is needed. The linkage between birth datasets, maternal discharges and birth certificates (by social security numbers), was recently approved and received for analysis. The MCH Epidemiologist will utilize these linked datasets to address birth outcome disparities among hospital service areas. Analyses that are being worked on include, but are not limited to induction of labor, elective cesarean section, and maternal mortality.

The MCH Epidemiologist is also part of the Northern New England Perinatal Quality Indicators Network (NNEPQIN), based at Dartmouth Hitchcock Medical Center. They are attempting to obtain AHRQ status.

The formation of an Infant Mortality Review Panel and Maternal Mortality Review Panel was signed into law in June 2010. Information regarding low birth weight, prematurity, and other related data is shared with each panel.

Even though New Hampshire continues to compare favorably in the nation for the rate of very low birth weight babies, the growing consensus is that the complex issues surrounding LBW call for a broad, new strategy, that incorporates a lifecourse perspective to address chronic health problems, such as obesity, diabetes, and heart disease, that impact pregnant women.

New Hampshire has signed on to the Association of State and Territorial Health Officials (ASTHO) and March of Dimes challenge to improve birth outcomes by reducing infant mortality and prematurity in the United States. Specifically, the ASTHO goal is to decrease prematurity in the United States by 8% by 2014. NCHS estimated New Hampshire's 2009 Preterm Birth rate at 9.9%, or 1,323 premature births out of a total of 13,377 live births. An 8% reduction goal for New Hampshire would be 9.1%, or a reduction of approximately 106 preterm births. MCH is committed to working with community health centers, providers and the March of Dimes to make this ambitious goal a reality.

#### Health Status Indicators 3A-4C UNINTENTIONAL INJURIES

The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

The New Hampshire Injury Prevention Program within MCH received a CORE Injury and Violence Prevention Program (CORE VIPP) grant from the Centers for Disease Control and Prevention. This grant is designed to enhance the Injury Prevention Program's ability in maintaining and enhancing systems for determining the best ways to prevent injuries, implementing best practice, sharing information with the public, and evaluating the outcomes. The grant will eventually increase the infrastructure within the Injury Prevention Program in MCH to meet those identified with best practice in state health departments. This funding has allowed for the hiring of an Injury Surveillance Program Coordinator, JoAnne Miles. Her job is to provide injury related epidemiological statistics, data interpretation and recommended courses of action to the state program as well as other colleagues in the state involved in injury prevention, federal health officials, state officials, researchers, and the general public.

One of the first tasks of the Injury Surveillance Program Coordinator is to facilitate the completion of, "Infant and Early Childhood Injury Data, New Hampshire Special Emphasis Report". This report will be in collaboration with MCH's Sudden Unexpected Infant Death (SUID) Program and the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) and will focus on the causes of injury related emergency department visits, hospitalizations and deaths among children newborn-five years of age. The intent is to complement the data that the SUID and MIECHV programs are currently collecting, such as MIECHV's performance indicator that measures child visits to the emergency department for all causes. Another objective is to increase collaboration and understanding of the importance of injury prevention in early childhood.

Additionally, MCH is a member of the state's Abusive Head Trauma Coalition which has been working with the New Hampshire Children's Trust to establish the Period of PURPLE Crying Program in birth hospitals statewide.

The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

There continue to be 30 child passenger safety inspection stations in New Hampshire. At these stations, families can make appointments to get their seats checked by certified car seat technicians on a specific day and time. Most stations have checks on the same day every month. They are located in agencies such as the local police and fire department and hospitals across the state. The Injury Prevention Program Manager, a certified car seat technician, participates when possible, at the Concord Hospital inspection station, located near the state office buildings at the Concord Fire Department.

The Maternal Infant and Early Childhood Home Visiting program has a benchmark related to the incidence of child injuries requiring medical attention, measured by the reduction of auto-related injuries due to incorrectly installed car sets. Training will be provided to make inspections available at Family Resource Centers and other agencies providing home visiting and family support services. The expectation is that the program will result in an increase in the rate of families who receive an annual car seat check by a certified inspector.

The CDC Core Violence and Injury Prevention grant, which the MCH Injury Prevention Program received this past year, necessitates a focus on four injury areas. One of these focus areas, chosen by the program advisory group, the Injury Prevention Advisory Council, is motor vehicle crashes, in particular those involving adolescents and children. One of the initial efforts is to gain an understanding of what parents in the state currently know about booster seat use. The state's law currently mandates the use of a child passenger seat until a child is 6 years of age or 55 inches tall or whichever comes first. Although best practice is 4 feet 9 inches and at least 8 years of age, some parents (as known through observational surveys and car seat inspections), don't even follow the current law. Thus, a phone survey is being facilitated through the University of New Hampshire's survey center to determine current knowledge of child passenger safety laws and potential support for a policy that is consistent with best practice.

The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.

The Teen Driving Committee, facilitated by MCH's Injury Prevention Program, was recently awarded a grant in conjunction with the New Hampshire Pediatric Society. The grant, awarded through the American Academy of Pediatrics with funding from Allstate Foundation. The first objective of the project is to increase teen seat belt usage amongst four high schools. These schools scored below the state average in seat belt usage as reflected in answers on the Youth Risk Behavior Survey. The schools, Dover High School, Spaulding High School, Epping High School, and Great Bay E Learning Center also have existing peer leadership programs in place, whereby the seatbelt and other traffic safety initiatives could be incorporated. Schools also get a small incentive grant to spend on incentives or any other item deemed necessary.

The four schools will engage in two full academic years of peer led activities designed to increase seat belt usage, with the hope that additional funding will be found to expand the program to other schools and increase the time. Changing school culture to one of traffic safety is a goal and that can take several years.

The other piece of this grant is the development of materials around the concepts of graduated driver licensing (GDL). These are passenger restrictions, night driving constraints, and phases of permitting. The materials will reflect the reasons why these components of GDL are necessary and even life saving. The Department of Transportation has utilized a marketing company in the State, WEDU, to design a marketing campaign around the newly revised Strategic Highway Safety Plan. GDL is part of this and as such, WEDU is working with the Teen Driving Committee in developing the aforementioned materials, specifically for parents of novice drivers and for legislators. As part of this effort, The MCH Injury Prevention Program has also actively participated in the NH Department of Transportation's, Driving Towards Zero campaign. The Driving Toward Zero's public/private collaborative mission is to create a safety culture where even one roadway fatality is one too many. Together with the Strategic Highway Safety Plan, Driving Towards Zero combines education, enforcement, engineering, and emergency management and focuses on the risky behaviors such as driving under the influence of alcohol or other drugs, distracted driving, speeding, not using helmets and seatbelts, and driving aggressively. The Injury Prevention Program has helped provide content and collateral material for the website, Facebook page, Twitter and other social media, especially regarding teen driving. <http://www.nhdtz.com/>

The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.

Laurie Warnock is the New Hampshire Poison Educator for the Northern New England Poison Center (NNEPC), the State's contracted poison center. Ms. Warnock recently conducted a gorilla marketing campaign (The Graffiti Project) in Coos County, the State's most northern and rural county. The Graffiti Project is targeting adolescents with messaging on prescription drug abuse, inhalant abuse and energy drinks. The campaign utilizes visuals put on a sticker created by a student at the Seacoast School of Technology (not in Coos County) and distributed by student leaders of the Prevention Youth Coalition, representing nine high schools in Coos County. The sticker has a QR code on it, by which people with that application on their phones can be immediately connected to the relevant section of the NNEPC's website at <http://www.nnepc.org/poison-prevention-education/education-programs/poison-is-bad>. The website will be able to record how many hits it receives in 2012.

The NNEPC answers, on average 20,000 calls from New Hampshire. More than 12,000 calls are about poisonings. There are no other poison centers serving New Hampshire. Typically, the NNEPC helps almost 75% of callers with first aid they can do at home, keeping them out of doctor's offices and emergency departments. However, DPHS, the Department of Safety and the Governor's Office have all been working diligently on coming up with an alternative funding solution.

For over ten years, MCH chaired the State's Child Health Month Coalition, developing and disseminating information on a variety of health and safety-related topics to health care, child care, social service and home visiting providers, with great success. With staffing and budget cuts, the Coalition ended its work two years ago, but has now updated and released some of its most requested handouts, renamed "Family Health and Safety Fact Sheets", which are available on a variety of websites including the NH DHHS's Child Health Program web page.

The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.

The Core VIPP funds have allowed for the continuation of the Injury Prevention Advisory Council or IPAC. The IPAC was created as an advisory body to MCH's Injury Prevention Program and to all injury activities occurring within the state. The IPAC's goal is to reduce injury related morbidity and mortality by providing advice and expertise in the preparation, implementation, and periodic review of the injury prevention program and the New Hampshire Injury Prevention Plan. The plan describes the magnitude of injuries in the state, including those due to motor vehicle crashes. The IPAC meets on a quarterly basis and as needed.

A policy subcommittee of the IPAC has been created. This committee focuses on the policy piece of the Injury Prevention Plan. Policy in this context can mean public policies, such as a child restraint law. It can also mean regulatory policies such as the fact that CMS will allow for payment of child restraints for children with special healthcare needs. Organizational policies are ones like those instituted in the State's Medical Examiner's Office, which allows for the sharing of data for appropriate purposes.

The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

In the 2011 Youth Risk Behavior Survey, 10.7% of the students that participated answered yes to "Never or rarely wore a seatbelt when riding in a car driven by someone else". This has steadily decreased since 1993 when 27.6 % answered yes to the question. However, the trend is both linear and quadratic, which means that although decreasing, it is now leveling off.

According to the New Hampshire Highway Safety Agency 2011 annual seat belt survey (observational), adolescent drivers are less likely to buckle up than are adult drivers, 57.1% compared to 71.2%. Adolescent males were less likely to wear seatbelts than females, particularly when they were drivers. While there's been some variation over the years, male adolescent drivers' seat belt usage has rarely exceeded 50%. On the 2011 Youth Risk Behavior Survey, males were also less likely to buckle up than females, this time as passengers. Given the death and injuries sustained, any increase in adolescent seat belt usage in the State is likely to make a great impact.

#### Health Status Indicators 05A & 05B: CHLAMYDIA

Chlamydia (CT) incidence continues to have an increasing presence in NH with as it has for the last several years. The NH STD Prevention Program, Title V and Title X Family Planning Program (FPP) continue to associate the increase in cases to the continuation of screening and enhanced surveillance both in the private provider settings and publicly funded sites.

In 2011, there were a total of 499 CT cases amongst 15-19 year olds females (32% of the female cases). CT continues to be a female dominated infection with 73% female cases. Screening of males at Family Planning clinics is limited to partners of women who test positive for the disease and/or are symptomatic for CT. These individuals are tested and/or treated in accordance with the CDC STD treatment guidelines.

Due to women under the age of 25 (inclusive of adolescents) being at high risk for chlamydia, the FPP and STD programs prioritize this age group for follow-up education, assurance that treatment was completed, encourage follow-up testing per CDC guidelines, and provide partner notification. FPP currently contracts with 10 agencies (20 clinical sites). These contracted agencies will target the following related objectives in their workplans:

1. Screening of all women <25 for CT
2. Treatment of women with a positive CT within 14-30 days of specimen collection
3. Re-screening of women diagnosed with chlamydia 3-4 months after the completion of their treatment

These efforts are further supported through the FPP partnership with the STD program and the DPHS Lab as we oversee NH's involvement with the Infertility Prevention Project (IPP). Currently one juvenile detention center and fourteen eligible Family Planning Clinics (clinic sites with a minimum 3% positivity rate) participate in the IPP. These clinic sites target:

1. All women <25 annually
2. Women >25 who are symptomatic or have had new or multiple partners since their last tested
3. Partners of women who have had a positive test; and any client who had a positive CT within the past 3-4 months and has not been re-tested.

The STD Program and the FPP take several steps to assure that all publicly funded programs are adhering to CDC STD Treatment Guidelines and accordingly supporting practices that will ultimately reduce infection carriage. They are investigating the proportion of positive cases who either don't get timely treatment (within 30 days of diagnosis) or who are not retested within 3-4 months of a positive test result. With this information, they are identifying barriers to implementing these recommended treatment standards and training sites on ways to overcome them.

State general funds to support STD prevention clinical services were discontinued for SFY12 and SFY13. Due to this, all contracted services to provide STD testing and treatment services and HIV counseling, testing and referral services ended after June 30, 2011. DPHS worked with both federal and state partners to develop an effective service model to provide STD/HIV clinical support, including support for CT screening, throughout the state in lieu of state support. The FPP and STD program reached out to local providers interested in being on a referral list for folks with positive STDs to receive treatment and follow-up screening. The State STD program maintains a list of local providers who have agreed to do this; however this agreement and listing does not obligate local providers to ensure affordable, accessible services.

#### Health Status Indicators 06A & 06B RACIAL AND ETHNIC DEMOGRAPHICS OF CHILDREN

To better understand this Health Status Indicator, it is important to recognize that New Hampshire's population is aging. Over 25% of the population is 55 years of age or older. The 55-74 year old segment of the population will be proportionally larger in New Hampshire than the rest of the nation in 2010. New Hampshire is now tied with Florida with the fourth highest median age in the nation and the third highest in the New England region at 40.2 years. New Hampshire stands with its neighbors, Maine and Vermont among the oldest the Whitest states in the country.

Children and adolescents (ages 0 to 24 years) represent over 30 % of New Hampshire's total population. The overall population of New Hampshire children is declining; New Hampshire Office of Energy and Planning population projections suggest that the cohort of children ages 5-19 will continue to decline over the next 15 years.

However, where there is growth in the state, especially in the southern tier, there is growing diversity and as might be expected based on the differing racial and ethnic proportions in younger

age groups, births in New Hampshire are also becoming more ethnically and racially diverse. The percentage of births to racial and ethnic minority groups has more than doubled over the past decade. In 2008 and in 2009, over 17 percent of resident births were to parents where at least one reported a race/ethnicity other than non-Hispanic white, compared to only 7.6 percent of births in 1998.

Almost half of all the minorities in the state live in the Manchester-Nashua urban area in the southern tier of the state. According to a University of New Hampshire, Carsey Institute Report on the Changing Demographics of Manchester and Nashua, minority population growth and migration accounted for almost all the growth in these communities from 2000-2007. This area is the most racially diverse in the state, with nearly 11% of the total population belonging to a minority group. Asians are the largest single racial minority of children in New Hampshire.

Three percent of New Hampshire's children and young adults are of Hispanic ethnicity. Hispanic children are generally proportionately represented across all age groups. As with racial minorities, approximately half of the ethnic minorities in New Hampshire live in the urban areas of Manchester and Nashua in Hillsborough County. Providers in these communities are growing their capacity to provide quality services that are culturally competent and linguistically relevant.

Further illustrating this point, it follows that nearly half (44%) of diverse births occur in the two major cities of Manchester and Nashua. Manchester and Nashua residents account for 12% and 8% of all births, but account for 25% and 20% of all diverse births in the state. Thirty-six percent of births in Manchester and 41% of births in Nashua have at least one parent who reported something other than a single non-Hispanic white race. In response, outreach efforts to racial and ethnic minority communities have grown.

In 2010, 16.6% of all New Hampshire infants were born to a parent who reported something other than single non-Hispanic white. Although a slight dip from 2009, at 17.2%, the trend has mirrored national trends upward with increasing diversity. This trend also marks a racial and ethnic difference between older and younger populations, since 95% of the entire population of New Hampshire is White.

Health Status Indicators 07A & 07B:  
RACIAL AND ETHNIC DEMOGRAPHICS / Live births to women

This Health Status Indicator allows Title V to analyze the maternal population in another way to better understand the demographics of our state and potential risk factors.

Although New Hampshire has grown faster than other states in New England this decade overall, it has begun to experience a leveling off in population growth. New Hampshire and other New England states are losing population share to faster-growing states in other regions of the country. The population change from 2010 to 2011 was 1,387. Economists are attributing the decline to domestic out-migration- to residents moving out of the state. Census data reflect that the state's five most southeastern, more urban counties are currently experiencing growth, while the more rural northern counties are experiencing decline or stagnation. Much of this movement has to do with a decline in economic opportunities at home coupled with economic growth in other states.

The second reason is demographically driven and not specific to New Hampshire. Young people tend to be the most mobile, and with fewer ties to their communities. They tend to "leave the nest" and spend time in other states. Only time will tell if the recently publicized credit crunch and decline in the housing market will serve to keep young people more rooted. (New Hampshire Economic Analysis Report 2008)

Particular to this Health Status Indicator, the fertility rate in New Hampshire has trended downward. The U.S. birth rate has dropped as well, to the lowest rate in a century in 2009.

Consistently, New Hampshire has a lower fertility rate compared to the national average. Popular theories point to the economy as the reason for the shrinking number of infants. When the economy is uncertain and people are uncomfortable about their financial future, they tend to postpone having children. That was the trend in the Great Depression the 1930s and it appears to be the trend as the economy stagnates today.

Demographers predict that the current cohorts of individuals in their early 20s have implications for New Hampshire fertility trends. If historical trends prevail, these young women, plus the likely in-migration of women in their 30s, as the recession wanes, will produce a concentration of women in their prime childbearing years later in this decade. In addition, many young women who delayed marriage and/or children because of the recession may soon begin to start families. This could produce an increase in births in New Hampshire later in this decade.

(<http://www.carseyinstitute.unh.edu/publications/Report-Johnson-Demographic-Trends-NH-21st-Century.pdf>, accessed 6/29/12)

The most populous counties (Hillsborough and Rockingham) show the largest decreases in the number of births in recent years.

New Hampshire is fortunate to consistently have one of the lowest teen birth rates in the country. In 2010, there were a total of 164 births to women age 17 and under, and among those births 141 were to white mothers; 16 were to women for whom race was not recorded or was unknown; 5 to women of more than one race; two births to Black/African American women; and zero births to American Indian, Asian, or Native Hawaiian in this age cohort.

The largest population having children are women age 20-34. Although, New Hampshire has a significant number women of advanced maternal age. This can lead to complications such as increased risk for prematurity and low birthweight.

These data once again also describe a state that is predominantly White, with a small minority population. While the State's population is still 95% white (non-Hispanic), minority populations are increasing. The State's largest racial minority is Asian, representing 1.9% of the total population, followed by Black/African American at 1.2%. Hispanics (of all races) make up 2.6 % of the total population.

However, the age groups have disproportionate numbers of racial and ethnic minorities. Younger age groups are increasingly diverse. The percentage of births to racial and ethnic minorities has doubled over the past decade. In 2008 and 2009, over 17% of resident births were to parents where at least one parent reported a race or ethnicity other than non-Hispanic white, compared to 7.6% in 1998. Interestingly, this number has slightly decreased in 2010 to 16.6%. Time will tell if this is a blip in the trend.

Approximately 4% of New Hampshire's mothers are of Hispanic ethnicity. The data suggests that women of Hispanic ethnicity are not proportionately represented across all age groups. They tend to be more represented in younger age cohorts, including ages 15-17, where in 2010, approximately 10% of mothers report Hispanic ethnicity. This data should be interpreted carefully, however, due to the relatively large number of women for whom ethnicity is not reported.

As with racial minorities, approximately half of the ethnic minorities in New Hampshire live in the urban areas of Manchester and Nashua in Hillsborough County. Providers in these communities are growing their capacity to provide quality services that are culturally competent and linguistically relevant.

Health Status Indicators 08A & 08B:  
DEATHS OF INFANTS AND CHILDREN / RACE & ETHNICITY

New Hampshire is in the fortunate position of having few child deaths. The Child Fatality Review,

in which MCH participates, is able to investigate deaths that appear troublesome or from which state systems can learn lessons and develop strategies to prevent further injury or death. There are so few child deaths in the state annually (162 deaths in children age 0-24 in 2010) that any analyses on the data require the use of multi-year trends, especially in regard to differences among ethnic or racial groups.

The limit of 20 deaths is a convenient, if somewhat arbitrary, benchmark, below which rates are considered to be too statistically unreliable for presentation or analysis. With only six known Hispanic or Latino child deaths, age 0-24, in 2010, and seven deaths where ethnicity was not reported, New Hampshire has yet to do the sort of multi year analysis needed to better understand if these ethnic groups are disproportionately effected. Similar small numbers occur across all racial groups.

#### Health Status Indicators 09A: CHILDREN ENROLLED IN STATE PROGRAMS

These data are complex and tell many stories. By looking at the numbers of children in certain programs such as WIC and Food Stamps, it is apparent that poverty is affecting the lives of NH residents; the percentage of children receiving food stamps and number of individuals receiving Medicaid is at its highest point in a decade. It is critical that Title V continue to work with all social service safety net programs component and coordinate efforts as we support community health centers and other programs such as home visiting. Title V programs understand that with limited resources, health care providers must leverage all possible supports for the families that they serve. It is important to understand the racial disparities in poverty and access to services, but some services still do not track race and ethnicity, possibly due NH's historically small minority population.

Across all populations, TANF, Food Stamps, and Medicaid have seen exponential growth in the past five years. In 2010, there was a 10.1% year over year increase in the number of Medicaid enrollees. Rates were reduced to providers, controls were implemented on multiple services, and as described throughout this update, the State's Medicaid delivery system is transitioning from the fee for service model to care management.

Similar trends have been seen in TANF. Caseloads exceeded projections in the State Budget causing deficits. SFY 11 brought relief to the budget, and more importantly to families as the percentage of families receiving TANF benefits went from 2.8% in SFY10 to 1.9% in SFY11.

As need continues, MCH and WIC have worked together to better integrate services through performance measures to increase outreach and enrollment for WIC at MCH-agencies. An October 2011 survey suggests that WIC participants are shifting towards healthier eating patterns including increased consumption of fruits, vegetables, whole grains, and low-fat/fat-free milk. MCH and WIC are continuing this partnership for joint training of primary care and home visiting staff as Certified Lactation Counselors in 2012.

#### Health Status Indicators 11 & 12: Percent at the Federal Poverty Level.

Children, in New Hampshire, as they are nationally, are disproportionately affected by poverty. By monitoring the changes in levels of poverty, MCH can better anticipate the needs of community-based safety net providers that provide care to low income and vulnerable families. By using this data, Title V examines the allocation of resources for community health centers and other safety net providers.

At 7.8% (2011), New Hampshire boasts one of the best statewide child poverty rates in the country. However, child poverty levels are varied by location. Overall poverty levels are higher in the North Country and along the Maine Border. For example, 12.4 % of the population and 21.6

% of the children in the city of Rochester are below the poverty line. Pockets of high child poverty also exist in the Concord-Manchester-Nashua corridor alongside high wage earners. In fact, there are several areas within the corridor where poverty levels are twice that of the state as a whole. In the City of Manchester, 24 % of all children are below the poverty line. (<http://www.carseyinstitute.unh.edu/publications/Report-Johnson-Demographic-Trends-NH-21st-Century.pdf> accessed 6/29/12) It is only when you look closely at the data that local disparities are evident.

## **F. Other Program Activities**

**NEW HAMPSHIRE BIRTH CONDITIONS PROGRAM:** Dartmouth Medical School (DMS), SMS, MCH, WIC, and Early Intervention continue to collaborate on the implementation of a birth defect surveillance system for NH. Funded through a CDC cooperative agreement, the project is: establishing a high quality, statewide, comprehensive birth defect surveillance system; expanding NH folic acid education and birth defect prevention activities; and improving access to health care and early intervention services for infants with birth defects. In June 2008, the program was established in law to be under the authority and direction of DHHS. While it will continue to be housed at DMS, a new advisory board structure monitors and provides oversight to the program. The MCH & SMS Directors are active members of the project's Advisory Council. MCH also provides oversight of the "opt out" process for inclusion in the program. MCH provides support as appropriate, such as development of the MOU between DHHS and Dartmouth, and a letter outlining the project to encourage hospital participation. ***/2013/ SMS and the Birth Conditions program are now synchronizing data to assess what percentage of identified children actually received Title V follow up. //2013//***

**ELDERLY FALLS:** Preventing falls, particularly among older adults, can greatly impact injury-related deaths. Falls are not an inevitable consequence of aging and proven effective strategies exist for decreasing the risk. The Injury Prevention Program within MCH facilitates the New Hampshire Falls Risk Reduction Task Force (Task Force). In 2009, the Task Force attended to the prioritized goals it set for itself during 2008's yearlong web-based process survey. A website is in development and is planned to launch on National Falls Awareness Day on September 21st, 2010.

The Task Force continues to promote routine falls screening in primary care settings, coinciding with the release of the new American Geriatrics Society guidelines in the winter of 2010. This work is happening in collaboration with the Northern New England Geriatric Education Center at Dartmouth Hitchcock Medical Center.

The Task Force also completed a survey of E-911 calls during one week each in the winters and summers of 09 and 10 , resulting not only in informative season specific data, but also confirming that falls are the number one E-911 call in the state. Results indicated approximately 30% more calls during the winter weeks. There was more of an equitable share of calls between men and women in the weeks in winter than in the summer when women were three times more likely to call. Geographic locations varied and were not consistent.

**SEXUAL VIOLENCE PREVENTION:** The Injury Prevention Program with funding from the Centers for Disease Control (Sexual Violence Grant and Preventive Health and Health Services Grant) contracts with the New Hampshire Coalition Against Domestic and Sexual Violence who in turn subcontracts with 13 local crisis centers to provide primary sexual assault prevention education activities within local communities throughout the state.

The sexual violence prevention plan was completed and will guide the efforts of grant-funded activities. New Hampshire's plan places a large emphasis on infrastructure building & professional development, which is consistent with what is happening on a national level.

#### POISON PREVENTION:

The Poison Center is currently focusing its outreach efforts on two large projects. One focuses on seniors in rural Coos County regarding medication safety and involves distribution of revised brochure as well as performances by a senior acting troupe. The other revolves around the Community Partner Program, whereby community members take online courses in Poisoning 101, Medication Misuse, and Inhalant Abuse.

HEALTHY CHILDCARE NH (HHCNH) has continued to work with Child Care Licensing and the Child Development Bureau to support all child care providers with health and safety best practices, including mandated training in medication administration. Also, HCCNH has been the liaison with childcare in developing strategies for obesity prevention programs such as the "I am Moving, I am Learning" curriculum.

TEEN DRIVING: The teen driving group is coordinated by the Adolescent Health/Injury Prevention Program and includes region-wide professional groups. The group is pursuing a seatbelt initiative in schools and collaborating on law revisions for extended graduated driver's licensing (GDL).

AUTISM LEGISLATIVE COMMISSION- MCH staff have been participating in a commission mandated by NH House Bill 236, to develop a report and recommendations, released spring 2008, on improving awareness, services, training, and reimbursement related to serving the needs of children and young adults with Autism Spectrum Disorders. Among the recommendations was that a council be formed to continue the work of the commission. In 2008, legislation was passed to form the NH Autism Council to continue the work of the Autism Commission. SMS & MCH staff participate in several of the workgroups including Screening and Early Diagnosis Workgroup.

NH HEALTHY HOMES -- MCH has been part of spearheading the planning process to move the Childhood Lead Poisoning Prevention Program (CLPPP) to a Healthy Homes Program, and to move statewide implementation efforts of a "One Touch" information and referral system. The CLPPP has formed a Healthy Homes Steering Committee to review the priorities of the statewide strategic plan and to be the coordinating body to oversee and assist in implementing healthy homes activities statewide.

TEXT4BABY: MCH & WIC have co-sponsored an initiative to promote this innovative mobile phone based health promotion campaign for pregnant and parenting mothers. Since the inception of the program in New Hampshire on April 2010, over 300 women have signed up for this free service. Pregnant women send a text message to receive three texts a week about maternal and child health specially geared toward their child's due date until the baby's first birthday. ***/2013/ A new partnership with the Department of Education increased the outreach efforts and helped NH lead the way to winning 2nd place in the National text4baby State Enrollment Contest. //2013//***

***/2012/ ORAL HEALTH PROGRAM: The Oral Health Program & WIC are collaborating to provide on-site oral health assessments, preventive services, and links to reparative dental treatment for WIC enrolled children and families when they come in for recertification or to pick up vouchers. //2012// /2013/ The Oral Health Program further developed a pilot project to provide oral health education, screening, cleaning and fluoride varnish application to children 0-5 years enrolled in WIC at 7 WIC sites across the state. An external partner will fund planning and implementation of a sustainable expansion of the WIC "dental clinics" in SFY13. //2013//***

EMERGENCY SERVICES for CSHCN: Several State of NH entities have been working together to try to improve the outcomes of emergency response situations for children with complex and chronic health conditions. These groups are: Department of Safety-Division of Emergency Services, New Hampshire Family Voices, the EMSC, and SMS. Surveys responses from EMS

responders and Hospital staff will guide future activity.

/2012/

ABUSIVE HEAD TRAUMA COALITION: Funded by ARRA, and in collaboration with the NH Brain Injury Association, the Abusive Head Trauma Coalition represents the evolution of the state's Shaken Baby Coalition. This new coalition has focused on initiating Period of Purple Crying programs in several of the larger birth hospitals.//2012//

/2012/ LIFESPAN RESPITE COALITION: SMS activity through AoA funding to create a statewide coalition. Stakeholders include caregivers, state & public representatives for the elderly, developmentally disabled, mental health, child protection and condition specific advocates.//2012//

## **G. Technical Assistance**

In March 2010, the New Hampshire Maternal and Child Health Section (MCH) utilized technical assistance from Mr. Russell Funk, Independent Consultant from Louisville, Kentucky and author of many books such as "Reaching Men: Strategies for Addressing Sexist Attitudes, Behaviors, and Violence" to help address the State priority of maintaining safe and healthy environments for pregnant women, families and children. Mr. Funk worked in collaboration with staff from MCH and the NH Coalition Against Domestic and Sexual Violence (Coalition) to help advance the work of NH Sexual Violence Prevention Plan.

The two-day workshop, held on March 25th and 26th 2010 was based on the following:

- Best science and practical strategies in engaging adolescent boys/men in violence prevention (particularly sexual violence prevention).
- Incorporation of above strategies into existing primary prevention activities and practices
- Gender stereotyping, specifically as it relates to violence and sexual violence prevention.

Approximately forty participants, including at least two staff from each of 13 Coalition member programs (crisis centers) attended. All participants completed ten open-ended questions at the end of day two to evaluate the success and learning opportunities of the training session.

One of the goals of the technical assistance was to increase the current and future capacity of prevention educators and other colleagues in the state in the primary prevention of sexual violence. This was in addition to utilizing this as a piece of the core competency training outlined in the new state sexual violence prevention plan. The development of the core- competency training guidelines has not been finished. The former goal was met by the answers to the questions, "How useful did you find this training?" and "How can you apply what you've learned today to your everyday work?"

"Very useful in that it provided exercises and information that I can use when speaking to men, I am trying to engage them in discussion about the work to end violence."

"Great frameworks and tools for organizing around engagement."

"Good review of many theories/philosophies that I was familiar with but hadn't applied to engaging men. I learned a lot about the complexity of addressing sexist violence with men you're trying to engage (defensiveness, the connection between sexism and violence not being obvious to men)".

"Increased awareness of opportunities to involve men. Approaching current activities from a new perspective."

"At the end of my presentations with the high schools I will dedicate some time to specifically ask questions to the students regarding why a male should care about sexual assault".

"That you engage men doesn't mean bringing them from 0-60 in one push, that even a little positive change is a win".

Most participants valued this training as a basic component of violence prevention.

"Make this discussion a regular long term component pertaining to how we work to end violence".

"Build engagement into existing work, recognize existing allies".

"Add this part to advocate and prevention training; change our agency policies about how we approach male clients, both formal and informal; change format of presentation to more dialogue".

Some of the participants listed challenges to implementation.

"This was helpful for thinking through but implementing is another thing and it's hard to think through without the rest of the organization. Sometimes it was like having homework in a class and having the class keep going before you've been able to do or process your homework and the fullness of the first lesson. So much but I'm still processing so it is tough to articulate."

"Our most limited resource is time".

"System based sexism that is hard to recognize yet is constantly present to reinforce wrong behaviors".

"At the Coalition level I think there is still resistance to engaging men in a manner that meets them where they are at on the continuum of understanding DV/SA/IPV/sexism".

At six months and one-year post workshop, there will be another evaluation to see what technical assistance participants continue to need as well as completed implementation.

#### ADDITIONAL REQUESTS:

Looking forward, MCH anticipates that technical assistance will be needed from federal partners as New Hampshire establishes its first Maternal Mortality Review Panel and Infant Mortality Review Panel.

The Maternal Mortality Review Panel was established in law in June 2010 to conduct comprehensive, multidisciplinary reviews of maternal deaths. The Panel, which includes the Title V Director, shall submit an annual report beginning on June 1, 2011 to the legislative oversight describing adverse events reviewed by the panel, including statistics and causes, and outlining, in aggregate, corrective action plans, and making recommendations for system change and legislation relative to state health care operations. As per the legislation, the NH DHHS Commissioner may delegate to the Northern New England Perinatal Quality Improvement Network (NNEPQIN) the functions of collecting, analyzing, and disseminating maternal mortality information, organizing and convening meetings of the panel, and other substantive and administrative tasks as may be incident to these activities.

Because this process is new to New Hampshire, Title V hopes that federal partners from CDC, HRSA and peers from other states have standards, experience, and best practices to share as we develop Administrative Rules and protocols.

Much like the Maternal Mortality Review, the Infant Mortality Review Panel was also newly

enacted in June 2010 to study New Hampshire's rate of infant mortality and develop proposals for remediation. Unlike the Maternal Mortality Review Panel, this legislation did not specify community and professional partners to be present and active on the committee. It is unclear what role the legislature would like Title V to play in the development in this committee, but we feel it is important to have technical assistance ready for their use, if appropriate.

/2012/NH participated in a Region I training, "Social Connectedness, Introduction, Overview, Literature and Data Sources" No consensus on a regional measure was gathered. New Hampshire is continuing to explore whether a new indicator is warranted based on the information gathered in this training session. //2012//

**/2013/**

***With the support of MCHB TA funds, over 60 NH DPHS and Title V staff participated in "Storytelling: Tapping the Power of Narrative" and "Why Bad Presentations Happen to Good Causes". This one-day event was offered to staff from MCH and throughout the Division of Public Health Services. It was preceded by screenings of Unnatural Causes, the acclaimed PBS documentary that explores the root causes of our nation's socio-economic and racial inequities in health (not part of the TA request), and followed by three in-depth storytelling webinar workshops for 20 staff. The goal was to assist staff in developing storytelling and presentation skills and to improve their understanding of the links among Title V services, health inequities and the determinants of health.***

***Over 60 DPHS staff participated in the half day on-site training and 20 staff participated in a series of interactive webinars. Each of the 20 staff members that participated in the webinars created their own "story" with detailed feedback from the consultant to be used in communication of their specific program area. In addition to the personal growth and substantive changes made to presentations from those who attended the training, MCH is now housing those stories in a "Story Bank", aligned thematically with our DPHS strategic plan and vision so that we can better communicate the work of public health.//2013//***

## TECHNICAL ASSISTANCE FOR SPECIAL MEDICAL SERVICES (CSHCN Program)

### I. Strategic Planning

Special Medical Services (SMS) will be requesting technical assistance, consultation, and facilitation to conduct a formal Section-level strategic planning process to include the review of care coordination, clinic services, program design, needs assessment, cultural & linguistic competence and public awareness/marketing. This process will take into account all identified priorities for NH CSHCN and all National and State Performance Measures for CSHCN.

Assistance is needed to help guide the SMS staff in the identification of the technology, policies, and funding strategies necessary to achieve the goals of SMS. Special Medical Services offers infrastructure-building expertise to develop the NH systems of health care for CSHCN, in balance with the direct provision of community-based care coordination.

To fully actualize the principles of family-centered, community-based care, both the direct provision of service by state coordinators, and the provision of consultation to other public and private providers, is crucial. Facilitated planning will encompass the priorities and needs of NH CSHCN, their families, and the provider community. The core issue is the defining of future applications of the SMS resources and determining the nature and extent of direct services provided by SMS staff and contractors, within the overall CSHCN health care system. Defining exactly which CSHCN subpopulations, which geographic areas of the state, what family impact factors, eligibility criteria, and other such specifics, is necessary in order to target the limited resources to the identified priority needs in the most effective manner.

SMS has significantly changed the direction of its services but formal reflection and strategic

planning has not taken place. SMS needs to develop a vision and mission statement and a planned approach to meet the needs of CSHCN in NH

*/2013/*

***SMS received MCHB TA funds to support the process of Strategic planning. With the help of an expert consultant, 80 stakeholders and a leadership group of 15 the process was successfully completed. The SMS 2020 Strategic Intentions and Mission statement (see attachments) were completed and shared with the public at the SMS Reflection on 75 years of service. This celebration drew 100 participants with great success. //2013//***

II. Disparities and CSHCN in NH.

SMS has seen a significant increase the number of diverse populations accessing services. A formal evaluation is needed related to incorporating cultural and linguistic appropriate components into provided services. The intent is to request technical assistance to conduct this evaluation. This will be done in concert with a formal plan on program evaluation that is being completed by an MCH funded intern Summer 2010. This will be a standardized and comprehensive framework for ongoing program evaluation for SMS for the next five years that is responsive to the needs of families of CSHCN and to federal and

## V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

### Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>1. Federal Allocation</b> <i>(Line1, Form 2)</i>	2002759	1989112	1987694		1976838	
<b>2. Unobligated Balance</b> <i>(Line2, Form 2)</i>	0	0	0		0	
<b>3. State Funds</b> <i>(Line3, Form 2)</i>	7122044	5727359	5710745		5658150	
<b>4. Local MCH Funds</b> <i>(Line4, Form 2)</i>	0	0	0		0	
<b>5. Other Funds</b> <i>(Line5, Form 2)</i>	870000	730445	888860		929675	
<b>6. Program Income</b> <i>(Line6, Form 2)</i>	0	0	0		0	
<b>7. Subtotal</b>	9994803	8446916	8587299		8564663	
<b>8. Other Federal Funds</b> <i>(Line10, Form 2)</i>	687964	729233	1854258		3909368	
<b>9. Total</b> <i>(Line11, Form 2)</i>	10682767	9176149	10441557		12474031	

### Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>I. Federal-State MCH Block Grant Partnership</b>						
<b>a. Pregnant Women</b>	763762	655612	633146		615233	
<b>b. Infants &lt; 1 year old</b>	1285982	1105981	1035351		1011046	
<b>c. Children 1 to 22 years old</b>	3863084	3339538	2858518		2833493	
<b>d. Children with</b>	3041788	2547866	3348904		3372123	

<b>Special Healthcare Needs</b>						
<b>e. Others</b>	561147	485707	406298		404365	
<b>f. Administration</b>	479040	312212	305082		328403	
<b>g. SUBTOTAL</b>	9994803	8446916	8587299		8564663	
<b>II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).</b>						
<b>a. SPRANS</b>	0		0		0	
<b>b. SSDI</b>	100000		97260		100000	
<b>c. CISS</b>	140000		140000		150000	
<b>d. Abstinence Education</b>	0		93342		100149	
<b>e. Healthy Start</b>	0		0		0	
<b>f. EMSC</b>	0		0		0	
<b>g. WIC</b>	0		0		0	
<b>h. AIDS</b>	0		0		0	
<b>i. CDC</b>	297964		304200		681340	
<b>j. Education</b>	0		0		0	
<b>k. Home Visiting</b>	0		0		2461379	
<b>k. Other</b>						
<b>NH Univ Newborn Hear</b>	150000		0		166500	
<b>Personal Responsibil</b>	0		250000		250000	
<b>ACA Home Visiting</b>	0		607315		0	
<b>Awareness and Access</b>	0		164093		0	
<b>NH Univ Newborn He</b>	0		198048		0	

**Form 5, State Title V Program Budget and Expenditures by Types of Services (II)**

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>I. Direct Health Care Services</b>	3533845	3085437	2803465		3039565	
<b>II. Enabling Services</b>	2298251	2016029	1745951		1761744	
<b>III. Population-Based Services</b>	911878	805803	844110		838849	
<b>IV. Infrastructure Building Services</b>	3250829	2539647	3193773		2924505	
<b>V. Federal-State Title V Block Grant Partnership Total</b>	9994803	8446916	8587299		8564663	

**A. Expenditures**

Expenditure trends:

The following factors have had, or are likely to have, an impact on MCH-related expenditures

#### Cost Allocation and Administrative Costs:

As noted SMS will continue to work with financial management to insure that budget planning for the next biennium will more clearly reflect planned spending and revenue.

#### Other State Budget Reductions:

It can be anticipated that the primary impact of State line item freezes or budget reductions will be the expenditure of fewer dollars than planned. Title V has focused a great deal on engineering any budget reductions so that they have least impact on services possible. However, as more reductions are anticipated in the next fiscal year this will become increasingly difficult.

#### Staffing Vacancies:

Title V is currently experiencing some capacity issues related to both "frozen" vacancies and some position reassignments/layoffs. Currently all vacant DHHS positions are "frozen" until such a time as a request to fill the position is granted by the Commissioner. DHHS guidance for additional budget reductions are focusing on transformation of operations to maximize efficiencies. However, this does reflect as decreased expenditures than what had been planned with the expectation was that Title V programs would be fully staffed.

For the purpose of this application, "significant expenditure variation" is defined as an expended amount in any line item that is greater than 10% above or below the budgeted amount for that year. The following lines on Forms 3-5 adhere to this criterion:

#### Form 3:

The expended amount for Line 3, State Funds, was 11% less than originally budgeted. This line is reflective of the many mandatory state budget reductions in travel, supplies, equipment and hiring freezes that began in SFY09. Reductions in expenditures are also reflective of an effort of Special Medical Services (SMS) work within its new organizational alignment to better understand administrative costs to get at a "truer" budget of State General Funds.

The expended amount for Line 5, Other Funds, was 22% less than originally budgeted. These funds represent Filter Paper Fees paid by hospitals for Newborn Screening. Due to a continued declining number of births, the contract for newborn screening has been less than originally budgeted, as well as contracts for Metabolic Consultation.

#### Form 4:

Line le: The expended amount for Others was less than the budgeted amount by 14%, due mostly to the re-assignment and ultimately the elimination of the Catastrophic Illness Program from SMS. The program was reorganized to another Bureau and the funds were all State General Funds.

Line lf: The expended amount for Administration was less than the budgeted amount by more than 37%. This significant reduction was due, in part, to the cost allocation method used by New Hampshire, in addition to a reduction in administrative functions within MCH. It should be noted that in the current structure between MCH and SMS, SMS does not capture "administrative" costs. This is also a significant driver in the discrepancy between the budgeted amount and the expended amount.

#### Form 5:

In order to move towards the MCH pyramid, funds have slowly moved "down" the pyramid of services to support increased infrastructure, population based, and enabling services. Both arms of Title V, MCH and SMS have made efforts to fund less direct services and provide more support for the foundation of the pyramid.

This budget also continues to reflect the overall downsizing of the Title V Partnership, due to the combined factors of state budget cuts and "right sizing" budgets of previous years.

Line I represents a 15% decrease in Direct Services. Fewer clinical services were provided directly by SMS staff.

Line II shows an 13% reduction in enabling services. This is due to reduced staff time in SMS devoted to providing direct enabling services for families.

The remaining lines in population based activities and infrastructure did not have significant budget variation.

/2012/

#### State Budget Reductions:

New Hampshire continues to feel the impact of State and Federal budget reductions. All expenses are scrutinized and austerity measures are in place. State line item freezes and continued budget reductions create expenditures less than planned.

In 2010, Title V managed to maintain most cost containment activities to infrastructure and administration within NH DHHS so that it had less impact on direct or enabling services. Future budgets will show that significant State Funds will be lost and services to families will be affected.

For the purpose of this application, "significant expenditure variation" is defined as an expended amount in any line item that is greater than 10% above or below the budgeted amount for that year. The following lines on Forms 3-5 adhere to this criterion:

#### Form 3:

The expended amount for Line 5, Other Funds, was 23% less than originally budgeted. These funds represent Filter Paper Fees paid by hospitals for Newborn Screening. Even with an expanded panel, due to the continued decline in the number of births and other contractual savings, the contract for newborn screening has been less than originally budgeted.

The expended amount for Line 8, Other Federal Funds, was 20% less than originally budgeted. This can be accounted for primarily due to unanticipated changes in two grants. The 510 Abstinence Education grant was awarded, but not funded in FY 2010. It was subsequently funded in FY2011. The CISS/SECCS total federal funds authorized were less than anticipated. Other grants such as the CDC Sexual Violence Prevention Grant (formerly RPE) and HRSA SSDI also had downward funding adjustments during this fiscal year that contributed to reduced expenditures.

#### Form 4:

Line Id: The expended amount for Children with Special Health Care Needs included both encumbered (contracted) and unencumbered funds. Due to department and state budgetary constraints all unencumbered spending was critically evaluated and limited. This resulted in the 11% discrepancy noted between anticipated spending and actual spending.

Line If: The expended amount for Administration was less than the budgeted amount by more than 21%. The FFY10 budget as projected was in error. The Title V amount of \$105,555 was duplicated in the total. The total projected was \$452,911, however, the correct amount for admin should have read \$347,356.

#### Form 5:

Title V has continued to try to align its funding along the MCHB pyramid structure. However, the variation in expenditure FFY10 was a mixed result of administrative constraint and changes in the demographics of the state.

Line I represents a 12% decrease in Direct Services. There appear to be two primary drivers to the variation in budget and expenditure.

1.) This line included both encumbered (contracted) and unencumbered funds from SMS. Due to department and state budgetary constraints all unencumbered spending was critically evaluated and limited. This resulted in the discrepancy noted between anticipated spending and actual spending.

2.) The Newborn Screening Program ("other funds") budget in FFY10 / Direct Care was \$870,000. Actual University of Mass contract expenditure was \$672,454, contributing approximately \$200,000 to the overall difference.

The remaining lines did not have significant budget variation.

//2012//

**/2013/**

**State Budget Reductions:**

***New Hampshire began implementation of an austere biennium budget for SFY 11 and 12. State General Funds have been reduced throughout the Department of Health and Human Services, including in Title V, specifically for the Community Health Centers. All expenses continue to be scrutinized. Specific State line items are frozen and other processes, such as hiring and contracting, are strictly monitored and managed.***

***For the purpose of this application, "significant expenditure variation" is defined as an expended amount in any line item that is greater than 10% above or below the budgeted amount for that year. The following lines on Forms 3-5 adhere to this criterion:***

**Form 3:**

***The expended amount for Line 3, State Funds, was 20% less than originally budgeted. This is in large part due to a legislated \$2 Million reduction in State General Funds in SFY11 and SFY12 for the State's Community Health Centers. Each of the 13 Primary and Perinatal Care and two Healthcare for the Homeless contracts managed by MCH experienced between a 42%-48% reduction in funds.***

***The expended amount for Line 5, Other Funds, was 16% less than originally budgeted. These funds represent Filter Paper Fees paid by hospitals for Newborn Screening. Due to the continued decline in the number of births and other contractual savings, the contract for newborn screening continues to come in less than budgeted. MCH has re-negotiated the program costs that can be paid using these funds in future years so that we can more efficiently manage these funds.***

**Form 4:**

***Because of the \$2 million reduction in funds for the Community Health Centers and smaller austerity savings throughout the Title V budget, expenditures were less than originally budgeted for every population group in FFY11.***

***Line 1a: The expended amount for Pregnant Women was less than the budgeted amount by more than 15%.***

***Line 1b: The expended amount for Infants was less than the budgeted amount by more than 14%.***

***Line 1c: The expended amount for Pregnant Women was less than the budgeted amount by more than 14%.***

***Line Id: The expended amount for Children with Special Health Care Needs was less than the budgeted amount by more than 16%. Special Medical Services did not spend approximately \$489,492 of their original SFY11 budgeted General Funds.***

***Line Ie: The expended amount for Others was less than the budgeted amount by more than 13%.***

***Line If: The expended amount for Administration was less than the budgeted amount by more than 35%. This significant reduction was due, in part, to the cost allocation method used by New Hampshire, in addition to a reduction in administrative support functions within MCH. The cost allocation method is highly reflective of staffing capacity and it should be noted that during much of FFY 11 there were significant vacancies.***

***Form 5:***

***Title V has continued to try to align its funding along the MCHB pyramid structure. However, the variation in expenditure FFY11 continues to be delicate balance between current state policy, prudent financial stewardship and providing mechanisms for effective delivery for care within local communities.***

***Title V uses our financial job coding and contracting system to track how Title V funds support each level of the pyramid. In this year of budget reductions, the impact was clearly cross-cutting. Yet, NH continues to make significant investments of State Resources specifically earmarked for safety net providers, such as the Community Health Centers. While NH's formula represents some of these dollars as "Direct Services", it should be made clear that they are contracted to community-based health centers to ensure access to care; improve quality; promote integration across systems and support appropriate performance measurement.***

***Line I represents a 13% decrease in Direct Services. As stated above, this is directly linked to the reductions in General Funds for Community Health Centers.***

***Line II represents a 16% decrease in Enabling Services. In addition to Community Health Center funding, Child and Family Health Support Home Visiting Contracts were reduced.***

***Line III represents a 12% decrease in Population-Based Services. Although as in other areas of the pyramid, there was a reduction in spending at this level, as well, it is clear that there was less of an impact in this area because it is supported with other funds such as Federal Funds for Early Hearing Detection and Intervention and Newborn Screening Hospital Filter Paper Fees for newborn screening.***

***Line II represents a 22% decrease in Infrastructure Services. This is also reflective of the overall reduction in General Funds for Community Health Centers as well as reductions in overall MCH administrative support.***

***//2013//***

## **B. Budget**

### **HOW FEDERAL SUPPORT COMPLEMENTS THE STATE'S TOTAL EFFORTS**

Federal support is essential to the preservation of a comprehensive Title V program in New Hampshire. The Title V Maintenance of Effort and required match help assure a basic funding

level for state and local maternal and child health programs. During times of necessary fiscal constraint, difficult decisions must be made about decreasing or eliminating programs and services. In these situations, Title V block grant dollars work to remind all states of the importance of funding MCH activities.

At the community level, Title V dollars help fund numerous local agencies and projects that provide a wide variety of services to MCH populations. In these communities, Title V dollars also help leverage funds from municipalities, businesses, and private foundations to serve the Title V mission. Often, simply the fact that an agency contracts with MCH gives them increased credibility with other funders and an increased ability to leverage funds from small, community foundations, the United Way, or other fundraising efforts.

#### AMOUNTS UTILIZED IN COMPLIANCE WITH THE 30%-30% REQUIREMENTS

As shown on Form 2, New Hampshire complies with Federal 30%-30% requirements. Services for CSHCN are provided through the SMS; \$834,088, or 41.65% of New Hampshire's Title V allocation, is appropriated to the SMS budget for FY 2011. Using a memorandum of understanding (MOU) developed between the two sister programs in 2008, and revised in 2009, that clearly delineates the roles, responsibilities and commitments between the two programs, funds are easily appropriated through a well-defined methodology. The ultimate goal of using this formalized approach was to ensure that expenditures continued to be more closely aligned with the proportions suggested by the MCH pyramid while providing a mechanism to ensure collaboration in joint Title V goals.

Preventive and primary care services for children are provided through the MCHS; costs include direct care and support services through contracts with community agencies, population based program costs, and infrastructure costs for all MCHS children's services. The total of \$795,173, the amount projected for children's services for FY 2011, is 39.54% of the Title V allocation. Administration is projected to remain at 5.041% at \$108,440.

#### SOURCES OF OTHER FEDERAL MCH DOLLARS, STATE MATCHING FUNDS & OTHER STATE FUNDS USED TO PROVIDE THE TITLE V PROGRAM

Sources of other Federal dollars, as indicated on Form 2, include grants from the Maternal and Child Health Bureau (MCHB) and other Federal agencies.

##### SSDI Grant: \$100,000

These funds are used to address New Hampshire's capacity to improve performance on Health Systems Capacity Indicator 09A and to develop linkages between MCH program datasets and New Hampshire birth files.

//2012/ In FY 2012, SSDI is budgeted to receive \$97,260. This funding source is critically important to the infrastructure of MCH. Currently the MIEC Home Visiting Program is supporting 0.25 FTE of the SSDI Coordinator which will enable the MIEC Home Visiting Data System to be completely integrated with MCH program datasets in addition to providing more security and funding sustainability to the SSDI initiatives.//2012//

##### Universal Newborn Hearing Screening Grant: \$150,000

These funds are used to establish New Hampshire's universal newborn hearing screening program, including implementation of quality assurance standards and a data-tracking initiative.

##### ECCS Grant: \$140,000

This grant is used to fund a strategic planning project for early childhood comprehensive systems. This planning project is in its final year, and will address strategies to strengthen the five focus areas highlighted in the MCHB Strategic Plan for Early Childhood. The ECCS Coordinator plays a

critical role in aligning early childhood efforts throughout DHHS and is the key liaison for the Early Childhood Advisory Council and the key contact for the Affordable Care Act Home Visiting initiative.

/2012/

ACA Maternal Infant Early Childhood Home Visiting Program (MIEC HV):

Work on the ACA MIEC HV program began approximately a year ago with the release of the Funding Opportunity Announcement on June 10, 2010. Governor John Lynch designated the Maternal and Child Health Section as the lead agency to administer funds under this program that would meet the criteria identified in the ACA legislation. NH developed and submitted an application for funding that included plans for the statewide home visiting needs assessment based on the identification and inventory the data and information currently available. MCH developed work teams to address the components of the home visiting needs assessment: data analysis, coordination, survey, capacity, program model selection and benchmarking.

Next, MCH conducted a needs assessment of home visiting services in NH to identify communities in need of intensive, evidence-based services that would enhance Title V services being delivered through community agencies. Following the submission of the Needs Assessment, in September 2010, MCH was awarded \$607,315 to develop a state plan for implementation within these at-risk communities. With these funds, MCH hired a full time Home Visiting Program Coordinator; the first position with 100% focus on home visiting programming. In addition, the MIEC program includes 0.25 FTE of the Program Planner from SSDI who is accountable for the data reporting requirements, including gathering, analyzing and reporting data for the needs assessment and evaluation activities. Travel expenses include MCH staff attendance at the AMCHP annual conference, the Home Visiting Summit and upcoming grantee meetings as required. In addition, funds were budgeted to set-up the workstation for new staff. MCH has contracted with the NH Children's Trust, Inc. to provide capacity building services that support implementation of Home Visiting NH activities, expand performance/quality improvement for Home Visiting NH, improve and integrate with other early childhood services, and facilitate the production of the Home Visiting State Plan, submitted in June 2011. With statewide input from a wide range of early childhood supporting agencies including home visiting, Head Start, family resource centers, community health centers, early supports and services, and the Early Childhood Advisory Council, MCH selected Healthy Families America as the evidence-based model NH will use in the MIEC programs.

Currently MCH is working with the DoIT (Department of Information Technology) to purchase (or create) a web-based data collection system, preparing a response to the Funding Opportunity Announcement for MIECHV programs to support the development of statewide home visiting programs and anticipates implementation of HVNH-HFA in November 2011. //2012// MCH has continued to work with DoIT to develop an RFP and procure the Data Collection System for HVNH-HFA. This has been a rigorous, competitive, and detailed process. A vendor has been selected, but the contract has not yet been signed by New Hampshire's Governor and Executive Council. It is anticipated that the contract will begin Late Summer 2012, thus delaying expenditures. //2013//

***CDC funds include support for the Rape Prevention and Education Grant (RPEG), \$160,196 and Early Hearing Detection and Intervention (EHDI) program, \$150,000.***

/2012/

***Awareness and Access to Care for Children and Youths with Epilepsy. In September 2011 SMS received funding from HRSA for improvement of the system of care for children and youth with Epilepsy under Project Access/Phase III. This is a 3 year grant and will build upon recent lessons and advances resulting from involvement as a non-funded collaborative in Project Access/Phase II. The focus of this Project Access extension initiative will be the spread to primary care providers in medically underserved and rural***

**areas, with an emphasis on improving coordination of care efforts across all domains. This project will use the learning collaborative structure to increase the consistency and effectiveness of epilepsy care. It will also focus on the advantages and strength of parent and youth involvement in health care design. The project will utilize the expertise presented at the national Learning Sessions and emphasize continued Learning Collaborative activities within the state in conjunction with Regional Parent/Youth forums addressing leadership, the role of parent/youth partners in medical homes, and standards of epilepsy care.**

**//2012//**

**NH does not receive funding for PRAMS. /2013/ The New Hampshire Department of Health and Human Services (DHHS) Division of Public Health Services (DPHS), Maternal and Child Health Section will soon be able to survey mothers of newborns to learn why some babies are born healthy and some are not. In late Fall 2011, New Hampshire was awarded a cooperative agreement for \$164,584 annually from the Centers for Disease Control and Prevention (CDC) to conduct the Pregnancy Risk Assessment Monitoring System (PRAMS), joining 39 other states in the country in a joint effort to improve the health of moms and babies. Funding will allow MCH to hire new staff and redirect existing infrastructure. //2013//**

All State matching funds, as indicated on Form 2 and explained previously in Achievement of Required Match, are appropriated from the New Hampshire General Fund during the State's biennium budget process.

Due to the configuration of New Hampshire's public health infrastructure and its system of contracting with local agencies to provide MCH services, there are no sources of "Local MCH" or "Other State" funds included in the MCH or SMS appropriations, as indicated on Form 2.

#### SIGNIFICANT BUDGET VARIATIONS FROM FORMS 3-5

For the purpose of this application, "significant budget variation" is defined as an increase or decrease in any budgeted line item that is greater than 10% from the budgeted item in the previous year. The following lines on Forms 3- 5 adhere to this criterion:

Form 3:

FY2011 reflects significantly fewer Other Federal Funds than in FY2010. The leading contributor to this is the loss of the 510 Abstinence Grant. Although the Affordable Care Act has noted that there will be opportunities for Abstinence funding in FY 2011, it is unclear at the publication of the Annual Report what the funding will be and if NH will apply for it. Additionally, other federal grants, especially those from CDC, such as Rape Prevention and Education (RPEG) and Early Hearing Detection and Intervention (EHDI) have all seen smaller decreases in the past year that contribute incrementally to this decrease in federal funds.

It should be noted however that in next year's Annual Report, that New Hampshire anticipates additional Home Visiting, Teen Pregnancy (PREP) funds and perhaps other federal opportunities that will more than offset these reductions. It is just unclear at this time what those final budgeted amounts will be.

Form 4:

No budgeted amounts per population served for FY 2011 differ more than 10% from amounts for FY 2010.

Form 5:

Form 5 is reflective of the slow shift of moving Title V services down the MCH pyramid. While there is no significant difference in the amount Expended in 2009, Budgeted in FY 2010 and Budgeted in 2011, in Direct Health services, these funds continue to decrease. The significant changes occur in the below in Lines III and IV where there are increases are reflected in the amount that is budgeted for Population-based activities and Infrastructure Building Services. Contributors to this shift include fewer the final shift of the Catastrophic Illness Program out of SMS (thus out of Direct Services); increased allocation of time to injury prevention (Population-based services); increased newborn screening fees (Population-based services); and increased federal funds for Early Childhood Comprehensive Systems (Infrastructure-building).

/2012/

Like so many states, New Hampshire is facing significant budget challenges. In June 2011, the New Hampshire House and Senate compromised on a State Biennium Budget for SFY12 and 13. Governor John Lynch allowed the budget to become law without signing it. Although he stated publicly that he did not agree with many of its details, he also stated that he believed that vetoing it would most likely not lead to a better budget. Budget cuts are felt across virtually all sectors of the human service safety net. Among the many cuts include:

- Significant reductions for community mental health services and primary care services for both children and adults
- Virtual elimination of alcohol prevention programs and drastic reductions in treatment, possibly leaving more than 30,000 individuals without access to these services.
- Significant reduction in State General Funds for Family Planning Services.
- Re-creation of a child-care subsidy waitlist.
- Elimination of core funding for Family Resource Centers.
- Elimination of adoption subsidies, limiting the number of families that will be financially able to adopt children, many of whom have special needs, from foster care.

When budgeting for Title V in FY 12, New Hampshire was reminded of how essential both federal and state support is to the preservation of a comprehensive Title V program in New Hampshire. In times of fiscal constraint, the Title V Maintenance of Effort and required match continues to assure a basic funding level for state and local maternal and child health programs.

#### SIGNIFICANT BUDGET VARIATIONS FROM FORMS 3-5

As described above, for the purpose of this application, "significant budget variation" is defined as an increase or decrease in any budgeted line item that is greater than 10% from the budgeted item in the previous year. The following lines on Forms 3- 5 adhere to this criterion:

Form 3:

The FY12 budget reflects significantly fewer State General Funds than in FFY2011. The largest line item reduction for MCH will be for the state's community health centers. The Governor and subsequently the House and Senate all approved a \$2Million reduction for the state's safety net providers. It is important to note that even with this significant reduction, New Hampshire continues to meet its Maintenance of Effort and required match funding partnership.

Line 3. State Funds are reduced by 20% in FFY12. This is due primarily to the reduction in primary care funds for the community health centers.

Line 8. Other Federal Funds is increased in FFY12 by 40% than budgeted in FFY11. This increase is due to the ACA Maternal Infant Early Childhood Home Visiting Program (MIEC HV), Personal Responsibility Education Program (PREP), resumption of the Abstinence Education Program and Sudden Unexpected Infant Death (SUID) Grant.

Form 4:

Unlike the FY 10 and 11, almost all MCH populations experience a budgeting difference greater than 10% between FY 11 and 12. This is overwhelmingly due to the significant State Fund reduction for primary care. Pregnant women and infants were less affected by the cuts because historically New Hampshire has used a greater proportion of Federal Title V funds for these populations, so there were slightly less impacted by the cuts.

Line 1a. Pregnant Women are budgeted at an 18% reduction.

Line 1b. Infants are budgeted at an 20% reduction.

Line 1c. Children are budgeted at an 27% reduction.

Line 1e. Others are budgeted at an 27% reduction.

Form 5:

Form 5 is not only reflective of the slow shift of moving Title V services down the MCH pyramid, it is also reflective of the significant MCH budget reduction for FY12. Because these funds had previously been appropriated for community health centers, Direct and Enabling Services were most impacted. No other lines exceeded 10%.

The community health centers are currently revising their budgets and workplans for SFY12. Cuts to individual community health centers range from 39% to 50% in annual funding from MCH. It is unclear what the ultimate community impact will be of these reductions.

I Direct Services is reduced by 20% in FY12.

II Enabling Services is reduced by 25% in FY12.

//2012//

**/2013/**

***As described last year, New Hampshire is in the middle of a complex and difficult budget biennium. While there have been significant cuts to State General Funds that have resulted in 40-50% cuts to perinatal and primary care services for community health centers, there has been continued and new support for Federal Programs like MIEC Home Visiting, PRAMS, CORE Violence and Injury Prevention Program (VIPPP).***

***Title V will continue to refine our financial job coding and contracting system to determine how Title V funds support each level of the pyramid. It is important that New Hampshire's formula accurately reflects the complexity of how contract dollars are used within each of our communities. As described in the Expenditures Section, historically, for example, a significant proportion of the funds directed to community health centers has been coded as "Direct Services", when in fact the funds are used in many different ways to ensure access to care; improve quality; promote integration across systems and support appropriate performance measurement.***

#### **SIGNIFICANT BUDGET VARIATIONS FROM FORMS 3-5**

***As described above, for the purpose of this application, "significant budget variation" is defined as an increase or decrease in any budgeted line item that is greater than 10% from the budgeted item in the previous year. The following lines on Forms 3- 5 adhere to this criterion:***

**Form 3:**

***Other Federal Funds increased in FFY13 by 47% than budgeted in FFY12. This is due to significant competitive and formula grants from ACA Maternal Infant Early Childhood***

**Home Visiting Program (MIEC HV), Personal Responsibility Education Program (PREP), PRAMS, and the CORE Violence and Injury Prevention Program.**

**There were no other significant variations from FFY12.**

**Form 4:**

**No budgeted amounts per population served for FFY 2013 differ more than 10% from amounts for FFY 2012.**

**Form 5:**

**Budeted amouts per pyramid levels are remaining relatively stable. Line items for FFY 2013 do not differ more than 10% from amounts for FFY 2012.**

**//2013//**

## **VI. Reporting Forms-General Information**

Please refer to Forms 2-21, completed by the state as part of its online application.

## **VII. Performance and Outcome Measure Detail Sheets**

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## **VIII. Glossary**

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## **IX. Technical Note**

Please refer to Section IX of the Guidance.

## **X. Appendices and State Supporting documents**

### **A. Needs Assessment**

Please refer to Section II attachments, if provided.

### **B. All Reporting Forms**

Please refer to Forms 2-21 completed as part of the online application.

### **C. Organizational Charts and All Other State Supporting Documents**

Please refer to Section III, C "Organizational Structure".

### **D. Annual Report Data**

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.