New Hampshire State Action Plan Table 2026 Application/2024 Annual Report

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Women/Maternal Health					
Improve access to care and support for women and mothers experiencing perinatal mental health conditions	NPM: To increase the percent of women who were screened for depression or anxiety following a recent live birth from 90.4% in 2023 to 96.5% in 2030.	Partner with the NH Perinatal Quality Collaborative (NH PQC) to implement the Alliance for Innovation in Maternal Health (AIM) Perinatal Mental Health Patient Safety Bundle at birthing hospitals and community-based health organizations. Provide Postpartum Mental Health Navigation through the NH Mom Hub and partnership with NH Care Connections/Unite Us Closed-Loop Referral System. Collaborate with the NH Women, Infants, and Children (WIC) nutrition program to expand the postpartum depression screening from one to at least two WIC sites. Support implementation of the Maternal Health Task Force (MHTF) strategic plan in partnership with the NHPQC and three regional perinatal quality improvement coalitions focused on improving postpartum mental health, including screening and peer support. Collaborate with the NH PQC to support expansion of Perinatal Peer Recovery Coach programs in two additional perinatal settings. NH Maternal Mortality Review Committee (MMRC) and NH PQC will partner with the Suicide Prevention program to integrate suicide prevention strategies into prevention MMRC recommendations and initiatives.	ESM MHS.1 - Number of cross-sector partnerships and collaborations established to support the design, implementation, and evaluation of QI initiatives to increase postpartum mental health screening.	NPM - Postpartum Mental Health Screening	**Linked NOMs:** Maternal Mortality Infant Mortality SUID Mortality Neonatal Abstinence Syndrome Child Injury Hospitalization Women's Health Status Postpartum Depression Postpartum Anxiety
Improve access to care and support for women and mothers experiencing perinatal	NPM: To increase the percent of women who have a postpartum visit within 12 weeks after giving birth from 94.7% in 2023 to 97% in 2030 and to increase the percent who report receiving the recommended care components from 79.5% in	Develop a core messaging and outreach plan with Managed Care Organizations (MCOs) to inform and educate women enrolled in NH Medicaid about the importance of timely postpartum care, available perinatal resources, and the recent extension of NH Medicaid coverage to 12 months postpartum. Collect and analyze performance measure outcomes from MCH contracted	ESM PPV.1 - Percent of women enrolled in MCH contracted CHC prenatal programs that had a postpartum visit.	NPM - Postpartum Visit	**Linked NOMs:** Maternal Mortality Neonatal Abstinence Syndrome Women's Health Status Postpartum Depression Postpartum Anxiety

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mental health conditions	2023 to 87% in 2030.	CHCs regularly to assess trends in the percent of postpartum women enrolled in their prenatal program that received timely postpartum visits. Provide tailored technical assistance to the CHCs to increase their percentage of enrolled prenatal patients that receive timely postpartum visits. This will be achieved through regular meetings with MCH QI and Clinical Services Program staff to provide resources, best practices, workflow optimization, bringing CHCs together to share lessons learned and innovations, monitoring progress on postpartum visit QI workplans and providing feedback on an ongoing basis. Focus on addressing the Social Determinants of Health (SDoH) that affect new mothers' ability to attend postpartum visits, such as transportation needs, by collaborating with MCOs, CHCs, and other community partners. Support implementation of NH Medicaid authorization and reimbursement of doula services.			
Perinatal/Infant Health					
Support breastfeeding to ensure optimal growth and development in early life, reduce food insecurity, and decrease childhood obesity	NPM: To increase the percent of infants ever breastfed from 91% in 2023 to 95% in 2030 and to increase the percent of infants breastfed exclusively through 6 months of age from 31.3% in 2023 to 45% in 2030.	Collect and analyze performance measure outcomes from MCH contracted CHCs regularly to assess trends in the percent of infants who are ever breastfed and provide tailored technical assistance to support them in increasing their rates. Collaborate with the NH DHHS Women, Infants and Children Nutrition Program (WIC) to increase basic breastfeeding knowledge of Title V staff, CHWs, newborn navigators, home visiting staff, and CHC staff. Work with various community partners to help improve health outcomes of infants through participation in various relevant stakeholder and state-level committees or councils. Support implementation and promotion of NH Medicaid authorization and reimbursement of lactation counselors. Develop and implement a social media campaign to provide messaging that promotes the benefits of breastfeeding along with various lactation supports available to prenatal and postpartum women, and their support	ESM BF.1 - Percent of infants who are ever breastfed at MCH contracted Community Health Centers (CHCs)	NPM - Breastfeeding	**Linked NOMs:** Infant Mortality Postneonatal Mortality SUID Mortality

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		systems.			
Child Health					
Ensure access to comprehensive and coordinated healthcare for children	To increase the percentage of children ages 0-17 who have a medical home from 54% in 2023 to 68% in 2030.	Contract with Community Health Centers (CHCs) across NH to increase access to quality integrated primary healthcare services for children. Provide targeted resources related to the medical home model including education and available trainings on family-centered care to MCH contracted CHCs. Provide NH Care Connections (Unite US) training and technical support for implementation to contracted CHCs to promote whole-person care through ensuring seamless closed-loop referrals for children and their families with identified social needs which could include but are not limited to housing insecurity, inadequate health insurance, transportation barriers, and food insecurity. Collaborate with various internal and external community partners to support the adoption of medical homes throughout NH health centers.	No ESMs were created by the State.	NPM - Medical Home	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
Access to qualified providers in the developmental screening, evaluation, referral and services system.	To increase the percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year from 41% in 2024 to 47% in 2030.	Use the Learn the Signs. Act Early. checklist at Developmental screening events such a Books, Blocks & Balls and Women Infants and Children (WIC) appointments. Contract with a Federally Qualified Health Center (FQHC), to provide child development consultation, evaluation, and referral services for children with or at-risk for developmental delays. Participate in Department-wide efforts to promote and implement the use of NH Connections, the Department's Closed Loop Referral (CLR) system, for Watch Me Grow. Conduct Health Care Provider Outreach using Bureau for Family Centered Services (BFCS) Nurse Consultants and Outreach Coordinator.	ESM DS.1 - Number of health professionals and parents / families who receive information / training on developmental screening and/or monitoring ESM DS.2 - The percentage of referrals made to BFCS Child Development Clinic/Consultation Services by a Watch Me Grow partner, following a positive developmental	NPM - Developmental Screening	**Linked NOMs:** School Readiness Children's Health Status

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			screening (e.g. MCHAT, ASQ, LTSAE Milestone Checklist at the WIC visit etc.)		
Adolescent Health					
Ensure access to needed mental health treatment or counseling for adolescents	NPM: To increase the percentage of adolescents, ages 12 through 17, who receive needed mental health treatment from 88.3% in 2024 to 93% in 2030.	Collect and analyze performance measure outcomes from the MCH contracted CHCs biannually to assess trends in their performance in adolescent depression screening as well as adolescent annual well-visits. Provide tailored technical assistance to the CHCs to increase their percentage of adolescents screened for clinical depression and the percentage of adolescents attending annual well-child visits. This will be achieved through regular meetings with MCH QI and Clinical Services Program staff to provide resources, best practices, workflow optimization, connecting CHCs to share lessons learned and innovations, monitoring progress on adolescent related QI workplans and providing feedback on an ongoing basis. Promote the NH Mental Health Care Access in Pediatrics (NH MCAP) program to NH pediatric Primary Care Providers (PCPs) to increase teleconsultation utilization with the NH MCAP Child and Adolescent Psychiatrists as well as to provide PCPs training on the assessment and treatment of children with mental health concerns. Collaborate with community partners that aim to improve behavioral health outcomes of adolescents through participation in various relevant stakeholder and state level committees/councils. Partner with the NH DHHS Early Childhood, Family, & Community Health section (ECFCH) to assess opportunities to integrate adolescent mental health screening and referral into their community-based programming.	ESM MHT.1 - Percentage of patients ages 12 through 21 years-old screened for clinical depression using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen at contracted CHCs	NPM - Mental Health Treatment	**Linked NOMs:** Adolescent Mortality Adolescent Suicide Adolescent Firearm Death Adolescent Injury Hospitalization Children's Health Status Adolescent Depression/Anxiety CSHCN Systems of Care Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
Children with Special Health Care Needs					
Strengthen the system of care for CSHCN	To increase the percent of children with and without special health care needs (age 0-17) who receive	Conduct a comprehensive mapping of care coordination efforts across New Hampshire to identify existing pathways, gaps, duplication, and opportunities for integration to inform strategic alignment and strengthen	ESM MH_CC.1 - The percent of care coordinators	NPM - Medical Home; Medical Home_Care Coordination	**Linked NOMs:** Children's Health Status CSHCN Systems of Care

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prioritizing quality of life, optimal well being and flourishing for CSHCN and their families	needed care coordination from 52.5% in 2024 to 57.0% in 2030.	system responsiveness for families of CSHCN. Promote Person-Centered Planning across programs and services provided by the Division of Long-Term Services and Supports (DLTSS) Develop and support a cross-sector learning community for care coordinators across agencies and systems to foster peer learning, shared problem-solving, and the dissemination of best practices, ultimately improving service navigation and family experience.	reporting increased knowledge in serving CYSHN and their families after participating in collaborative learning community (CLC).		Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
Ensure access to needed health-related services for youth and young adults with special health care needs.	To increase the Percent of adolescents with special health care needs, ages 12 through 17, who received services to prepare for the transition to adult care from 20% in 2024 to 25% in 2030.	Leverage existing adolescent advisory council as a resource to develop tools and processes that support youth health care transition. Contract with a family-led organization to provide staff development across the system of care that serves youth and families. Nurse consultants and Complex Care Consultants use medical expertise to collaborate with existing programs and providers. Promote use of Transition Readiness Assessment Questionnaire (TRAQ).	ESM TAHC.1 - Percent of participants trained on youth health care transition concepts who report a change in knowledge, skills, or intended behavior following the training.	NPM - Transition To Adult Health Care	**Linked NOMs:** CSHCN Systems of Care
Cross-Cutting/Systems Building					
Strengthen the MCH workforce capacity through development of skills in the 12 MCH core competencies	By 2030, 75% of the Title V workforce will achieve a medium or high score on seven of the 12 MCH competencies as assessed on the MCH Navigator Self-Assessment.	All Title V staff will complete the MCH Navigator Self-Assessment tool within 30 days of hire then annually to identify MCH Core Competency strengths and areas for growth. All Title V staff will develop an Individual Development Plan (IDP) tailored to their identified competency areas for growth which they scored below a 2 indicating low knowledge/skill. Title V leadership will schedule regular group trainings on specific MCH core competency areas. Title V leadership will integrate competency goals and progress into annual staff evaluations. Title V leadership will encourage staff to enroll in MCH specific learning collaboratives and leadership development opportunities, such as the AMCHP Leadership Lab.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 1: MCH Workforce Development	