New Hampshire State Action Plan Table 2024 Application/2022 Annual Report

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
Women/Maternal Health					
Decrease the use and abuse of alcohol, tobacco, and other substances among pregnant women	Continue to monitor the number of MCH-funded Primary Care site clinical staff that complete the e-learning module, 'Supporting Pregnant and Postpartum Women to Quit Tobacco' Promote tobacco cessation for pregnant persons through collaborations with the Tobacco Prevention and Cessation Program (TPCP) for social marketing campaigns and print materials in provider offices Incorporate discussion of smoking cessation into the Plan of Safe Care, which is discussed with at-risk women during pregnancy and prior to hospital discharge after delivery	By July 1, 2023, decrease the percentage of women with Medicaid Managed Care health plans who smoke during pregnancy from 22.6% (baseline data 2021) to 21% or less among 2022 deliveries paid by NH Medicaid By July 1, 2023, decrease the percentage of women who smoke during pregnancy from 2.2% (baseline data 2021) to 2% or less among 2022 deliveries not paid by NH Medicaid By July 1, 2023, the MCH-funded Primary Care practices will screen at least 90%,according to quarterly EMR audits, of prenatal patients for tobacco use By July 1, 2023, the MCH-funded Primary Care sites will offer quit smoking assistance/resources, according to quarterly EMR audits, to 90% of pregnant women screening positive for tobacco use By July 1, 2023, 50% of OB-GYN staff at 6 of 12 (50%) of MCH-	NPM 14.1: Percent of women who smoke during pregnancy	ESM 14.1.1: Percentage of postpartum women whose infant was monitored for the effects of in utero substance exposure who had a documented Plan of Safe /Supported Care (POSC) ESM 14.1.2: Percentage of women who are screened for tobacco use during each trimester in which they were enrolled AND who received tobacco cessation counseling intervention if identified as a tobacco user (NH MCHS).	NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations NOM 3: Maternal mortality rate per 100,000 live births NOM 4: Percent of low birth weight deliveries (<2,500 grams) NOM 5: Percent of preterm births (<37 weeks) NOM 6: Percent of early term births (37, 38 weeks) NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.2: Neonatal mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.4: Preterm-related mortality rate per 100,000 live births

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		funded Primary Care practices will complete the e-learning module evaluation, 'Supporting Pregnant and Postpartum Women to Quit Tobacco' (baseline 0)			NOM 9.5: Sudden Unexpected Infant Death (SUID) rate per 100,000 live births NOM 19: Percent of children, ages 0 through 17, in excellent or very good health
Perinatal/Infant Health					
Decrease unintentional injury in children ages 0-21	Collaborate with the MIECHV HFA home visiting program on their materials and education for families on always placing their infant to sleep on their back in a separate approved sleep surface without soft objects or loose bedding. Develop a training tool for HFA home visitors, DCYF personnel, law enforcement, service providers (anyone who goes into the family's home) on safe sleep practices Utilize home visiting and PRAMS data to inform key stakeholders about safe sleep and education needed Promote public education on safe sleep Utilize the SUID committee recommendations regarding risk factors and identify possible points of intervention Utilize the Safe Sleep Workgroup to identify methods for carrying out the recommendations identified during the SUID case reviews	By January 2023, 50% of infants enrolled in MIECHV HFA home visiting will always be placed to sleep on their back, without bed-sharing or soft bedding.	NPM 5: A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding	ESM 5.1: Percent of infants enrolled in home visiting who are always placed to sleep on their back, without bed-sharing or soft bedding	NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.5: Sudden Unexpected Infant Death (SUID) rate per 100,000 live births
Child Health					
Improve access to standardized developmental screening, assessment, and follow-up	Training care providers Effective referrals Empowering families	To increase from 36% to 46% the percentage of children, ages 9-35 months, who receive a developmental screening using a parent-completed screening tool, by 2025.	NPM 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	ESM 6.1: The number of sites using ASQ/ASQ-SE screening tools and participating in the Watch Me Grow (WMG) System.	NOM 13: Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) NOM 19: Percent of children, ages 0 through 17, in excellent or very

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for children and adolescents					good health
Adolescent Health					
Decrease unintentional injury in children ages 0-21	Use of statewide partners to promote the program and increase participation of high schools previously working with program and new schools wanting to work with the program Use of peer groups within schools to increase seatbelt usage and overall teen driving safety culture Continue to explore virtual platforms to get messaging out to teen drivers Increase utilization of teen driver website Increase parental participation and understanding of teen driving issues Provide "Pool Safely" information to parents and children during at least one public event/year Raise public and professional awareness of suicide prevention Address the mental health and substance abuse needs of all residents Facilitate an annual Suicide Prevention Conference and extend invitations to high school staff Support the suicide prevention goals of the NH Suicide Prevention Council Work with the Brain Injury Association of NH to collect data from all NH high schools regarding Return to Play and Return to Learn policies	By 2022, reduce the rate of hospitalizations for non-fatal injury from 61.3 to 27.4 per 100,000 adolescents ages 10-19 years	NPM 7.2: Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19	ESM 7.2.1: Percentage of high school students who wear a seatbelt	NOM 15: Child Mortality rate, ages 1 through 9, per 100,000 NOM 16.1: Adolescent mortality rate ages 10 through 19, per 100,000 NOM 16.2: Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 NOM 16.3: Adolescent suicide rate, ages 15 through 19, per 100,000
Improve access to needed healthcare services for all MCH	Building partnerships by: (1) networking with other State Adolescent Health Coordinators; (2) collaborating with public and private partners through the NH Pediatric Improvement Partnership; (3) statewide contracting with CHCs and provision of oversight on Primary Care services; (4) establishing mechanisms to inform the public about adolescent preventive services via social media.	Increase the percentage of adolescents aged 12-21 who have had a preventive medical visit at the MCH-funded community health centers (CHCs) from a baseline of 53% in SFY19 to 64% by the end of	NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.	ESM 10.1: Percentage of adolescents ages 12-21 at MCH-contracted health centers who have at	NOM 16.1: Adolescent mortality rate ages 10 through 19, per 100,000 NOM 16.2: Adolescent motor vehicle mortality rate, ages 15

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populations	Enhancing capacity of CHCs to improve access and quality of adolescent services by: (1) establishing performance measures that align with national guidelines and promote Bright Futures recommendations; (2) ensuring contracted CHCs utilize Quality Improvement (QI) processes to increase the percentage of adolescents who have a preventive medical visit; (3) collecting and analyzing Performance Measure outcome data from contracted CHCs; (4) providing feedback to CHCs on agency performance; (5) providing education, resources, QI support and technical assistance. Increasing the number of MCH section staff who include adolescent health in their job responsibilities by establishing a new position (Child/Adolescent Health Coordinator) to support programmatic initiatives to improve child and adolescent well-being.	2025.		least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year	through 19, per 100,000 NOM 16.3: Adolescent suicide rate, ages 15 through 19, per 100,000 NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling NOM 19: Percent of children, ages 0 through 17, in excellent or very good health NOM 20: Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) NOM 22.2: Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza NOM 22.3: Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine NOM 22.4: Percent of adolescents, ages 13 through 17, who have

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					received at least one dose of the Tdap vaccine NOM 22.5: Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females
Children with Special Health Care Needs					
Improve access to needed healthcare services for all MCH populations	Health Care Professional Workforce Development Other workforce development including Title V staff, family support, MCOs, youth, families, etc. Care coordination Communication and social media Measurement and assessment	• By July 1, 2021, increase the percentage of CSHCN enrolled in Title V programs, ages 14–20, who completed a Transition Readiness Assessment Questionnaire (TRAQ) in the past year by 5% • By July 1, 2021, 60% of CSHCN enrolled in Title V programs, ages 14-20 and/or their family caregiver, will identify at least one transition goal in consultation with their Health Care Coordinator • By July 1, 2022, 70% CSHCN enrolled in Title V programs, ages 14–20 and/or their family caregiver, who identified a transition goal in the previous year, will meet at least one of the previous year's goals	NPM 12: Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care	***Inactive -*** *ESM 12.1: Percent of young adults with special health care needs, ages 18-21, who identify an adult health care provider at discharge from the Title V program* ESM 12.2: Percent of youth with special health care needs, ages 14 to 21, who achieve a goal set following completion of the Transition Readiness Assessment Questionnaire (TRAQ).	NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
Increase family support and access to trained respite and childcare	Re-determine the needs of families regarding respite Collect and analyze data to support policy development and funding for respite	To increase the percentage of families reporting access to respite care when needed, from 62% to 75% on the BFCS Needs Assessment and Satisfaction	SPM 2: Percentage of families enrolled in the Bureau for Family Centered Services (BFCS) who report access		

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providers	Review Relias trainings to support upated best practice standards Re-engage the Caregiver Integration Team and assess the capacity to continue with environmental scan and strategic planning Include respite screening and access in Quality Improvement projects Attend the ARCH national respite conference Assess the capacity to influence other sectors necessary to achieve goals	Survey, by 2025	to respite		
Cross-Cutting/Systems Building					
Increase the focus of Title V on the Social Determinants of Health and the resolution of barriers impacting the health of the MCH population	MCH requires all CHCs to submit a two-year ES work plan as a contract deliverable within 30 days the beginning of a contract period. Review ES work plans and provide feedback/technical assistance as needed to ensure agencies have included specific, measurable, achievable, realistic and, timely (or time-bound) SMART objectives/goals and a target for each State Fiscal Year (SFY). Monthly calls will occur between the MCH QI Clinical Staff and the CHC QI Staff to share updates, need for techical assistance, etc. Learning communities and communities of practice on specific ES sopics will be set up and implemented monthly. Updates to the ES workplans will be formally submitted twice per year, in January and July; MCH will review ES workplan outcome sections to determine how many have reached their target. If the target has not been attained, feedback/technical assistance will be provided and the CHC will need to submit a revised ES plan.	Increase the percentage of MCH-contracted Community Health Centers Enabling Services (ES) workplans that have met or exceeded their target(s) to 75% by SFY25	SPM 1: Percentage of MCH-contracted Community Health Centers' Enabling Services workplans that have been met or exceeded the target		
Improve access to mental health services for children, adolescents, and women in	Provide NH pediatric primary care providers with additional training on the assessment and treatment of children with mental health concerns by: 1) development of a Pediatric Mental Health Project ECHO series facilitated by the NH Pediatric Mental Health Team faculty of local subject matter experts; and 2) recruitment of pediatric primary care practices across NH to participate in the Pediatric Mental Health Project ECHO, targeting those in rural/underserved areas.	Increase the percentage of enrolled providers who receive Pediatric Mental Health Care Teleconsultation in the Pediatric Mental Health Care Access (PMHCA) Program from a baseline of 23% in 2020 to 41% in	SPM 3: Percentage of enrolled providers who received Pediatric Mental Health Teleconsultations		

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the perinatal period	Promote and provide teleconsultation opportunities as needed for primary care providers with the PMHCA pediatric mental health team faculty members. Continuation of teleconsultation services upon completion of the HRSA grant period by: 1) increased NH pediatric primary care physician satisfaction with using teleconsultation as a way to build their knowledge and confidence in treating children with mental health conditions; and 2) development of a plan for program sustainability following the end of the PMHCA grant award period.	2026			