Maternal and Child Health Services Title V Block Grant

New Hampshire

FY 2017 Application/ FY 2015 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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NH DIVISION OF Public Health Services
Improving health, preventing disease, reducing costs for all

Jeffrey A. Meyers
Commissioner

Marcella Jordan Bobinsky
Acting Director

May 16, 2016

Grants Management Officer, MCHB
HRSA Grants Application Center
901 Russell Avenue
Suite 450
Gaithersburg, Maryland 20879

Grants Management Officer, MCHB:

I am pleased to provide you with New Hampshire's SFY 2017 Application for the Maternal and Child Health Block Grant.

This Application follows the guidance issued by your Office and accurately reflects New Hampshire's plan for serving women and children.

The Title V program plays a major role in the Department initiative to promote and develop comprehensive community based systems of primary and preventative care services for women, children, children with special health care needs and families. This application reflects that role.

Should you need further information, please do not hesitate to contact me, or the Title V Director, Rhonda Siegel, at 603-271-4516.

Sincerely,

Marcella J. Bobinsky, MPH
Acting Director

MJB/sc
Enclosures

cc: Rhonda Siegel, MS Ed, Administrator,
Title V Director, Maternal & Child Health Section

Patricia M. Tilley, Bureau Chief,
Bureau of Population Health and Community Services

I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix C of the 2015 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.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 2015; expires December 31, 2017.

I.E. Application/Annual Report Executive Summary

The **New Hampshire (NH) Title V Program** is a partnership of the United States Department of Health and Human Services, Health Resources and Services Administration with New Hampshire's Department of Health and Human Services' Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN) programs. In NH, the CSHCN program is called Special Medical Services (SMS). Together, these Title V programs in NH support core public health functions including direct, enabling, population-based, and infrastructure building services in the following areas: maternal and child health; children with special health care needs; family planning; perinatal health; primary care; adolescent health; teen pregnancy prevention; home visiting; early childhood systems building; injury prevention; early hearing detection and intervention; and newborn screening.

With its Title V funding, MCH:

- contracts with 17 community health centers (CHCs) in providing comprehensive primary care, including prenatal and pediatric care;
- funds enabling services such as case management and transportation;
- funds comprehensive family support and home visiting for pregnant women and children;
- supports injury prevention activities statewide;
- sustains epidemiological and data collection related to all maternal and child health topics.

SMS funds 11 programs, including:

- a child development services network for pediatric diagnostic evaluation services;
- specialty clinics for children with neuromotor disabilities;
- a nutrition/feeding and swallowing program;
- a medical home project and psychiatry/psychology consultations for children with CSHCN.

SMS also underwrites NH Family Voices in its mission to assist families with CSHCN by providing information, support and referral.

Based on a comprehensive needs assessment facilitated in 2015, priorities were established for the state based upon severity of health consequences, the numbers of citizens affected by an issue, disparities among sub-groups or great societal and economic costs, effect across the life course and the feasibility that Title V staff could have an impact. The needs assessment process included, amongst other things, data surveillance, focus groups and wide-

spread survey distribution and analysis.

Selected Priority Areas for FFY 2016-2020

1. Improve access to needed healthcare services for all populations
2. Decrease unintentional injury
3. Improve access to standardized developmental/social/emotional screening, assessment and follow-up for children and adolescents
4. Decrease pediatric overweight and obesity
5. Increase access to comprehensive medical homes
6. Increase family support and access to trained respite and childcare Providers
7. Improve access to mental health services
8. Decrease the use and abuse of alcohol, tobacco and other substances among youth, pregnant women and families

National Performance Measures (NPMs) were chosen for each priority area, within the six Title V population domains. New this year was the development of three (3) State Performance Measures (SPMs) to address priorities not addressed by the NPMs.

In the past year, MCH and SMS staff have been making presentations on the MCH Block Grant, the NPMs, SPMs and the developing State Action Plan across the state to a variety of stakeholder meetings. Input was sought to develop the Evidence Based or Informed Strategy Measures (ESMs) to support the NPMs. Discussions were targeted to the interests of the audience and opportunities for collaboration on the ESMs.

Women/Maternal Health

NPM#1: Percent of women with a past year preventive medical visit

ESM 1.1: Percent of women who receive pre-conception counseling and services during annual reproductive (preventive) health visits

In the 2014 Behavioral Risk Factor Surveillance System, 69.3% of women reported having “seen a doctor for a routine check-up” in the past year, and 86% of women reported an excellent, very good or good overall health status. [1] However, access to cost-friendly and geographically close health care was cited as an issue with focus groups and on public surveys, particularly with respect to contraceptive usage, family planning and preconception health.

Preconception care refers to the provision of services to women and men during their reproductive years targeting the aspects of health that increase the chance of having a healthy baby. It reinforces key areas of preventive health, namely: tobacco cessation, eliminating alcohol and drug misuse, maintaining a healthy body weight and screening for sexually transmitted infections, depression, diabetes, and domestic violence. MCH’s Family Planning Program will be providing technical assistance on preconception care to its 15 contracted health care provider sites and standardized clinical protocols will be developed. Assessment will take place through a database expanded to capture medical codes showing the provision of preconception care.

Perinatal/Infant Health

NPM#5: Percent of infants placed to sleep on their backs

ESM 5.1: Percent of birth hospitals with a written safe sleep policy, including placing all infants to sleep on their backs

In general, New Hampshire statistics on perinatal and infant health are impressive. In 2015, the infant mortality rate was 4.9 per 1,000 live births, only 6.7% of its newborns were of low birth weight (<2500 grams) and 7.8% were born prematurely (<37 weeks gestation).[2] This compares favorably with a national perspective.[3] Nonetheless, racial and socio-economic disparities do exist, however small.

Between 2011 and 2015, there were 43 confirmed cases of Sudden Unexpected Infant Death (SUID). Misusing alcohol and drugs, (21 of the caregivers in the SUID deaths had a history of substance misuse), bed sharing and not putting an infant on their backs to sleep are all risk factors. MCH has been at the forefront of the state's SUID prevention efforts and will continue to do so. It provides leadership of a collaborative, state level multidisciplinary death review committee, which carries out comprehensive analyses with the objective of developing case specific recommendations and data driven strategies to reduce such deaths. This group and its affiliated safe sleep workgroup have been working with the 19 birthing hospitals in the state to initially survey and then develop and implement safe sleep policies. Results from the safe sleep questions on the state's Perinatal Risk Assessment Monitoring System (PRAMS) will also help to evaluate this measure.

Child Health

NPM#6: Percent of children, ages 10 months-71 months, receiving a developmental screening using a parent-completed screening tool

ESM 6.1: Utilization of the ASQ/ASQ-SE screening tools and participation I the Watch Me Grow (WMG) System

NPM#8: Percent of children ages 6-11 who are physically active at least 60 minutes per day

ESM 8.1: Percent of children ages 6-11 enrolled in Comprehensive Family Support Services (CFSS) who parent reports that the child gets at least one hour of physical exercise per day

As with infants, the state's children are very healthy overall. In 2014, 80.4% of children ages 19-35 months received the combined vaccine series, compared with 71.6% nationally and the Healthy People 2020 goal of 80.0%.[4] School-based oral health programs in NH have worked to reduce disparities in schools with > 50% enrollment in Free and Reduced Lunch (FRL). Results from the *2013-2014 Healthy Smiles-Healthy Growth Third Grade Survey* indicate no significant difference between the rates of dental sealants on children in high FRL schools compared to low FRL (< 25% enrollment) schools.[5]

Developmental screening is designed to identify problems or delays during normal childhood development. There are multiple access points in the system for developmental screening, in clinical as well as community-based agency settings. According to the 2011/2012 National Survey of Children's Health (NSCH), 78.7% of New Hampshire children who received developmental screening did not need follow up or referral,[6] but more than 20% of children would benefit from additional assessment and treatment. According to the New Hampshire Watch Me Grow (WMG) developmental screening, referral and information system for families of children ages birth to six years, only 3,988 children were screened from 2011 to 2015, well below the number of children of that age in the state.

In the upcoming year, MCH and SMS will work to expand the WMG system to include data from practices using other screening tools, treatment and diagnostics. Work will also be done to increase the number of locations that provide developmental screening information and services for children from four weeks to six years of age.

Pediatric overweight and obesity often originates in childhood and persists into adulthood, when most of the adverse

consequences occur. The *2013-2014 Healthy Smiles-Healthy Growth Third Grade Survey* found that 12.6% of third graders were obese and there were significant regional disparities, with the northern counties showing higher rates of obesity than the statewide average.[7]

Work with Title V funded community health centers on obesity screening and reduction will continue as MCH audits this measure at quality improvement site visits. In this stead, MCH will also screen children through the Child and Family Support Systems Home Visiting Program on physical activity. Home visitors will use *5-2-1-0 Healthy NH* (http://www.healthynh.com/5-2-1-0-healthy-nh.html), a state-wide public education campaign that identifies steps families can take to increase physical activity and thereby helping to prevent childhood obesity.

Adolescent Health

NPM#7: Rate of hospitalization for non-fatal injury per 100,000 adolescents ages 10-19

ESM 7.1: Percent of high school students who wear seatbelts

NPM#10: Percent of adolescents, ages 12-17, with a preventive medical visit in the past year

ESM 10.1: Percent of adolescents ages 12-21 who have at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year

New Hampshire continues to excel in its adolescent birthrate, with approximately 11 births per 1000 in 2014, compared to approximately 24 per 1000 nationwide.[8]

Despite this success, unintentional injuries continue to be the leading cause of death among youth aged 10-24 years, and motor vehicle crashes account for the largest proportion of these.[9] MCH staff in the Injury Prevention Program will be focusing in this area by continuing to support efforts on novice adolescent driving such as the NH Teen Driving Project. The primary goals of this effort include assisting participating teens in understanding the true risks associated with their driving experience and to educate their parents and participating community members in their understanding of these same risks.

The percentage of adolescents having a preventive medical visit has risen from 52% in 2010 to 62% in 2015.[10] MCH staff will continue work with the funded community health centers in utilizing missed opportunities such as acute visits and sports physicals to emphasize annual preventive visits.

Children with Special Health Care Needs

NPM#11: Percent of children with and without special health care needs having a medical home

ESM 11.1: Improve Medical Homes by increasing the number of Primary Care Provider practices who have adopted a Transition Policy

SPM#2: Decrease the number of families who are unable to find/receive respite when it is identified as a need

New Hampshire has approximately 59,313 CHSCN, which is 21.2% of all children of ages 0-17 in the state.[11] In general, the state has performed well on core CSHCN outcome measures such as satisfaction with care and adequacy of insurance. However, access to a medical home has a significant effect on unmet needs. Of CSHCN who needed specialty care, 100% with a medical home had no trouble getting needed referrals compared while only 55% of those without a medical home reported this ease of access.[12] SMS has been a leader in addressing access to medical homes by ongoing planning to improve a focus on coordination of care.

Another continuing issue for CSHCN is respite care. Respite services can positively impact CSHCN throughout their lives. Respite can afford the child opportunities for additional experience outside the family home; support the caregivers of the child; prevent family breakdown and /or rejection of the child and it can avoid the admission of the

child to long term residential care or the necessity for substitute family placement. NH's Title V staff has created a state performance measure dedicated to respite care.

Cross Cutting

NPM#14: Percent of women who smoke during pregnancy; percent of children who live in households where someone smokes

ESM 14.1: Number of call received by the smoking quitline in the past year

SPM#1: Percent of MCH contracted Community Health Centers with Enabling Services workplan on file with DHHS/MCH

SPM#3: Percent of Behavioral Health Professionals recruited

Tobacco use remains widespread, with the 2014 prevalence continuing to peak in the 25-34 year age group: 26.5% of women, 27.2% of men, up from 23.8% of women and 25.0% of men, in 2013.[13] The prevalence of cigarette smoking in high school youth is declining overall, but continues to rise with age, with 4.8% of 9th graders reporting smoking, up to 13.9% of 12th graders; this represents nearly a tripling of prevalence, in a three-year age range.[14] NH Title V staff will work with the Tobacco Prevention and Control Program to monitor and increase direct and indirect referrals to the state quitline.

Enabling services address the social determinants of health. While Medicaid expansion has improved access to health care, enabling services such as case management, referrals, translation/interpretation, transportation, eligibility assistance, benefits counseling and health education are needed by vulnerable populations, to bridge the gap between public health services and systems, and the actual direct services that are available and necessary to maintain optimal health. All MCH Title-V contracted community health centers are now required to submit an enabling services work plan as part of their contracted scope of services.

Mental illness is a serious cross-cutting issue. In 2014, approximately 45,000 adults had a serious mental illness within the previous year; similarly, in 2013 this figure was approximately 46,000. The percent receiving treatment was 49.7% in 2013, declining to 46.1% in 2014. Approximately 11,000 adolescents (10.6% of all adolescents) per year in 2009-2013 had at least one major depressive episode within the year prior to being surveyed. Of these, 47.1% received treatment but 52.9% did not.[15] NH's Title V staff has established a minimum 2-year contract with the Bi-State Primary Care Association's Recruitment Center to identify, recruit and retain behavioral health providers, including psychiatrists, clinical or counseling psychologists, nurse practitioners, clinical social workers, licenses professional counselors, family therapists, licensed alcohol and drug counselors and masters' level licensed alcohol and drug counselors.

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[1] Behavioral Risk Factor Surveillance System, 2014; http://nccd.cdc.gov/BRFSSPrevalence; accessed 07/08/16.

[2] New Hampshire Division of Vital Records Birth Table, accessed May 13, 2016.

[3] March of Dimes, *Peristats*, http://www.marchofdimes.org/peristats/Peristats.aspx; accessed 07/09/16.

[4] National Immunization Survey 2014. http://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/2014-released-child-teen.html; accessed 07/09/16.

[5] NH DHHS (2015). *The New Hampshire 2013-2014 Healthy Smiles-Healthy Growth Survey: An Oral Health and Body Mass Index Assessment of New Hampshire Third Grade Students*. http://www.dhhs.nh.gov/dphs/bchs/rhpc/oral/documents/thirdgradesurvey2014.pdf; accessed 07/09/16.

[6] Data Resource Center for Child and Adolescent Health, National Survey of Children's Health. http://childhealthdata.org/browse/data-snapshots/state-snapshot?geo=31; accessed 07/10/16.

[7] NH DHHS (2015). *The New Hampshire 2013-2014 Healthy Smiles-Healthy Growth Survey: An Oral Health and Body Mass Index Assessment of New Hampshire Third Grade Students*. http://www.dhhs.nh.gov/dphs/bchs/rhpc/oral/documents/thirdgradesurvey2014.pdf ; accessed on 07/10/15.

[8] NCHS; accessed March 22, 2016

[9] National Vital Statistics System (NVSS)/Web-based Injury Statistics Query and Reporting System (WISQARS) accessed April 15, 2016

[10] Personal communication with MCH Quality Improvement nurse coordinator; June 2016

[11] *National Survey of Children's Health 2011-2012*, accessed on 07/08/15 at http://childhealthdata.org/browse/snapshots/nsch-profiles?rpt=16&geo=31

[12] Centers for Disease Control and Prevention, *2009-2010National Survey of Children with Special Health Care Needs*, accessed on 07/10/15 at http://www.cdc.gov/nchs/slaits/cshcn.htm

[13] BRFSS / WISDOM; accessed April 22, 2016

[14] 2015 NH YRBS; accessed April 22, 2016

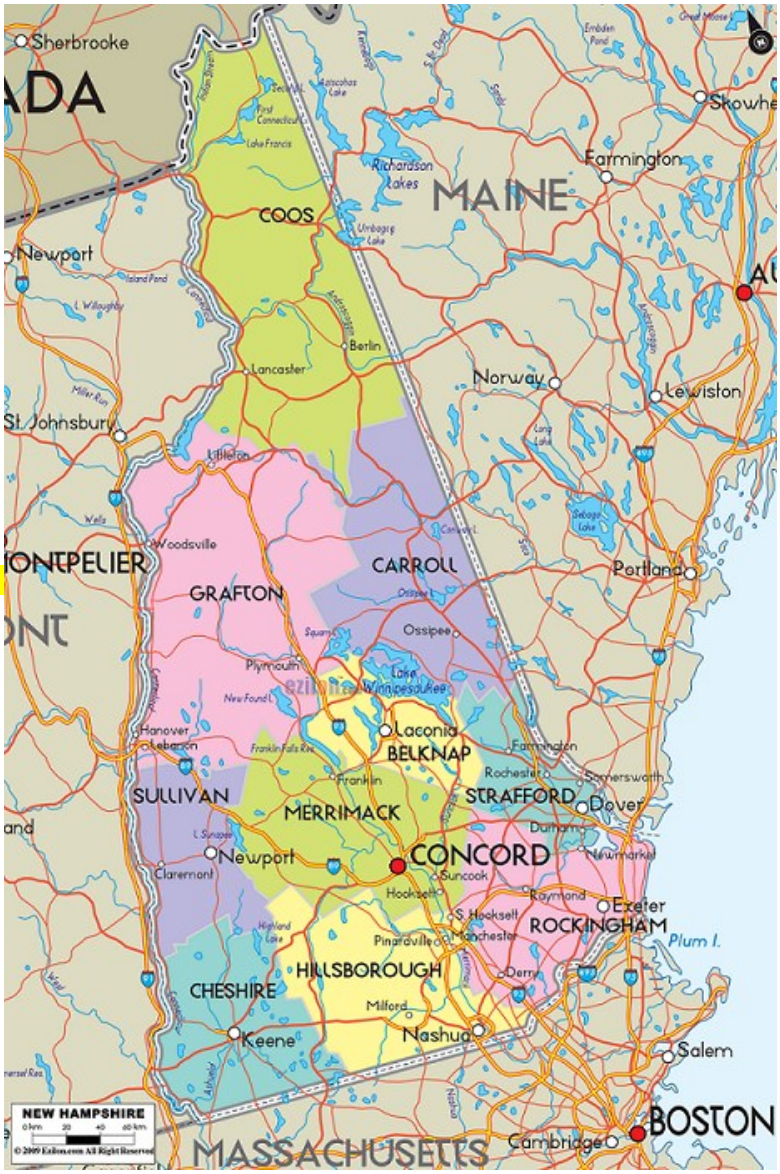
[15] Substance Abuse and Mental Health Services Administration (SAMHSA)/Behavioral Health Barometer: NH 2014; accessed May 5, 2016

II. Components of the Application/Annual Report

II.A. Overview of the State

New Hampshire's Title V Program consists of the Maternal and Child Health Section (MCH) located in the Bureau of Population Health and Community Services in the Division of Public Health Services (DPHS) and Special Medical Services (SMS) located in the Bureau of Developmental Services. Both MCH and SMS are in the Department of Health and Human Services (DHHS). The Title V Program lends its focus based on the ever changing landscape of the state in which it serves. Many factors guide its efforts.

New Hampshire's population of 1.3 million live in 9,351 mostly forested (84%[1]) square miles bordered by Canada on the north and by Massachusetts on the south. On the east is the Atlantic Ocean and Maine and on the west is Vermont. It's the 45th largest state and is only 190 miles long and 70 miles wide.

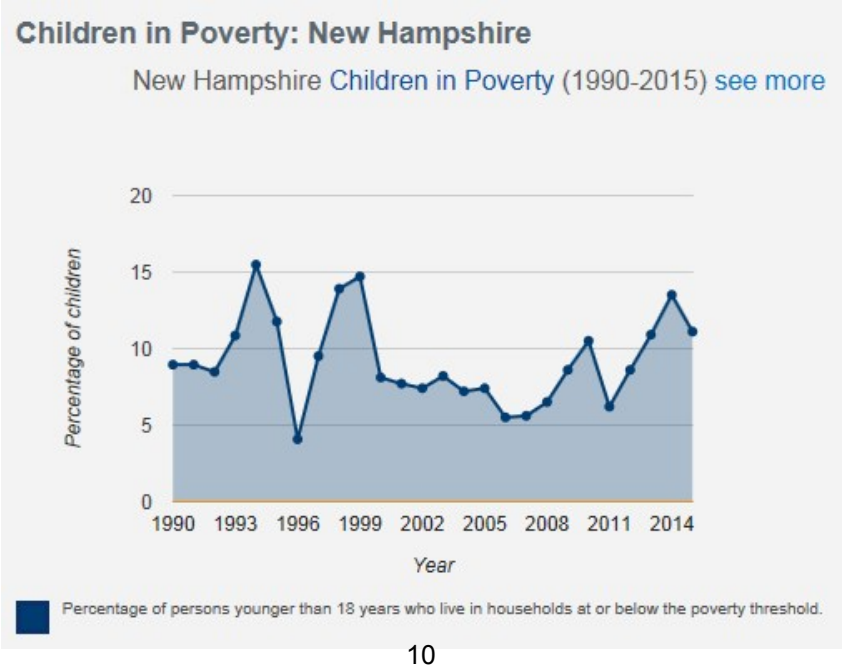


With its ten counties, approximately 47% of the population and 84% of the landmass in New Hampshire (NH) is

considered rural; mostly those communities north and west of the capital Concord. The three most urban or metro areas are Manchester, Nashua and Concord, all located in the state's southern tier where the majority or 53% of the population lives. The state's population is primarily White (94%), but its residents of color (Black, 1.2%; Asian, 2.6%; Hispanic, 3.4%)are increasing.[2]

In national rankings, NH almost always is in the top ten, both in its health care delivery system and its overall population health.[3,4] Scores are based on a composite index of metrics that give a snapshot of the health of a population or its health care. Some of the high scores can be attributed to its economic prosperity. Its unemployment rate (2.3%) is well below and its median income/per capital personal income ($73,397/$54,817) well above that of the United States as a whole.[5,6] Part of that is due to it consistently having a more educated workforce, above the national average for more than a quarter century.[7]

While NH's share of residents living in poverty is one of the lowest in the nation, the issue of households not earning enough for basic needs has steadily become more pervasive. In 2001, the share of NH residents with incomes below the federal poverty line stood at 6.0%. By 2007, it had climbed to 7.1%, and by 2015, the most recent year for which such data are available, it had reached 9.2%. The rate increases to 11.1% for children under the age of 18.[8,9] Poverty levels in children decreased in 2015 after several years of rising numbers. While this is promising, rates have usually gone up again or plateaued after any drop as shown in the graph below.



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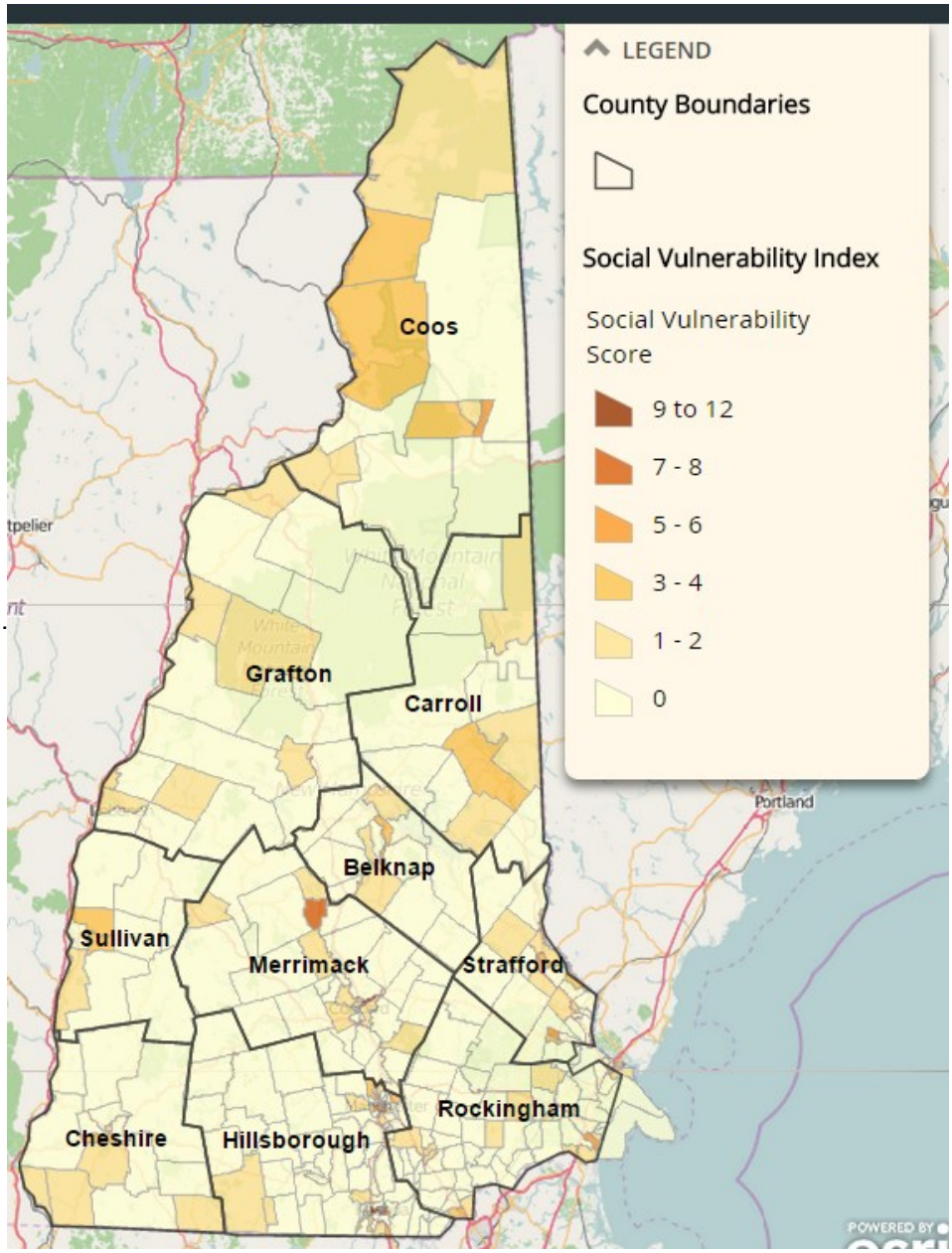
Disparities can be hidden in average rates. Coos County has the greatest percentage of poverty, but Rockingham and Hillsborough counties in the southern tier have the highest numbers of families living in poverty. It is important to evaluate the variability across locations and subpopulations. Understanding that variability exists helps the Title V Program to develop more effective strategies to address health equity and improve health at the patient and population level. With a special focus on the social determinants of health, DHHS developed a social vulnerability index taking 16 measures from the American Community Survey and mapping it statewide. This has enabled an even closer look zeroing down on census tracts for potential targeting of Title V efforts. The map below shows the number of vulnerability measures above the 90th percentile for NH census tracts.



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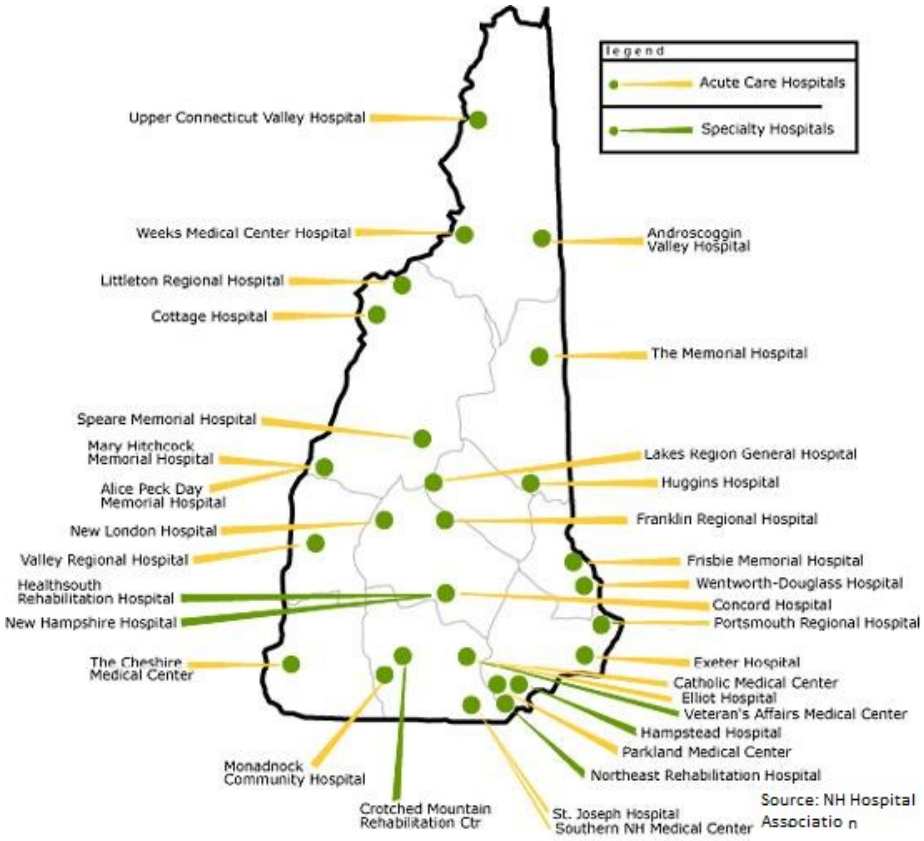
The state's health is also affected by the fact that overall, it's aging and stagnating in size. Fifteen and a half percent of the state is 65 and older compared with 14.1% nationally. The median age in NH is 41.5, while the median U.S. age is 37.3. The aging population is 21% more likely to be over the age of 65 in rural areas.[12] There are also geographic disparities to health care such as the greater distances to services, lower provider availability and an older provider base for residents in rural areas.

NH is also home to the state's resettlement of approximately 3,000 refugees in the last seven years. Most come from Asian and African countries.. Health care is affected because case management, outreach and interpretation services are all in high demand for this population. While Limited English Proficiency is found to represent only one (1) percent of the state's overall population, this issue is predominantly concentrated in the non-rural parts of the

state. A person in refugee status is granted only eight (8) months of federally funded health insurance coverage through Medicaid after resettlement. Following that period, there are significant barriers to obtaining health care; a refugee must be in the U.S. for five (5) years before applying again for Medicaid.
NH has 26 acute care hospitals, 19 of which offer birthing services, and five (5) specialty hospitals providing psychiatric and rehabilitative care.



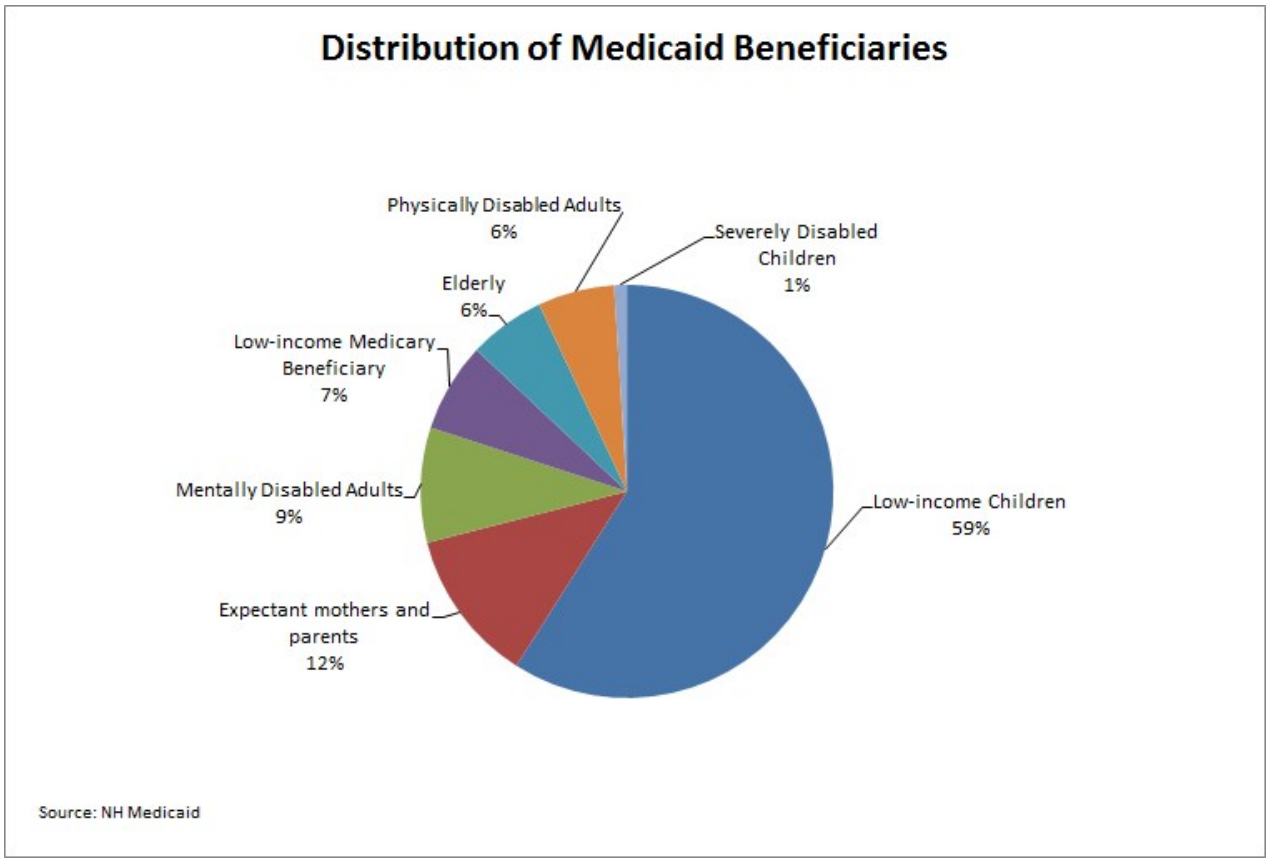
NH has a highly concentrated health care delivery system. A majority of primary care practices are hospital owned and specialty practices are increasingly following that path. In addition, most communities have only one hospital so natural market forces such as competition are not present to assist with cost containment.[13]

Medicaid Reform, Medicaid Expansion and the Affordable Care Act

In 2013, Medicaid in NH transitions from fee-for-service to a managed care model for medical services. There are currently two managed care organizations (MCOs), Well Sense and NH Health Families. Most Medicaid participants, including low income children and pregnant women, were mandated to participate in this early transition.
Children with special health care needs (CSHCN), children in foster care, children with Supplemental Security Income, and dual Medicare and Medicaid eligible were encouraged to participate on a voluntary basis, but were not initially mandated to participate. Upon request, the Center for Medicare and Medicaid Services (CMS) approved the mandatory enrollment of these populations and the timeline was set for the fall of 2015. Information sessions and public forums were held throughout the state to prepare individuals and service providers for this new phase of MCO enrollment. SMS enrollees were part of this voluntary to mandatory population. SMS staff was an active participant in the planning and work groups established by the DHHS. Stakeholders, such as NH Family Voices, were engaged in the process in an effort to reach out to families to educate and assist with the transition and insure access and continuity of care. All of the previously

voluntary populations were enrolled in MCOs as of February 1, 2016. This new addition included approximately 23,585 people with 6,432 of them being under the age of 18 and 4,586 clients of SMS provided services. Additional changes planned for the future will include the transition of Long Term Support and Services, including Medicaid Waiver services under Managed Care.

Children make up the greatest percentage of current Medicaid beneficiaries as seen in the chart below:



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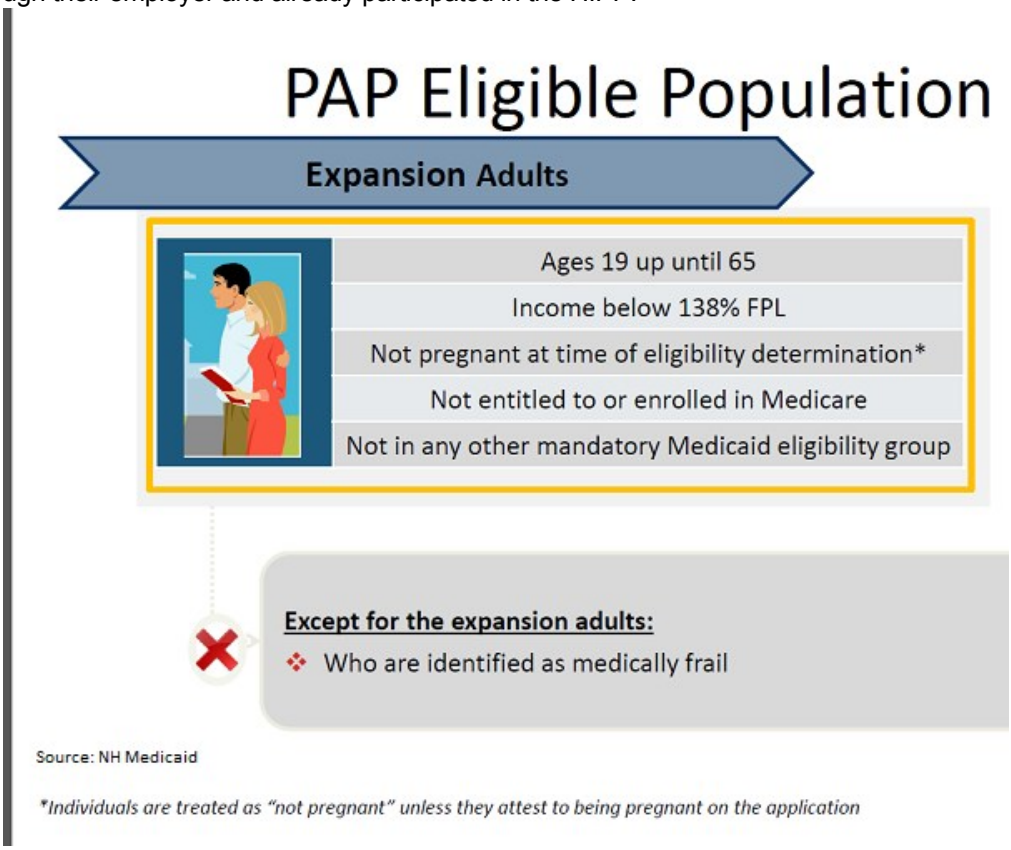
The Governor's Commission on Medicaid Managed Care reviews indicators designed to appraise the status of managed care. Recently, the Health Services Advisory Group, contracted by Medicaid for external quality reviews, presented to the Governor's Commission on two (2) years-worth of data from 2014 and 2015. Looking at HEDIS (Healthcare Effectiveness Data and Information Set) and CAPHS (Consumer Assessment of Healthcare Providers and Systems) both systems consistently rated above the national average. On the CAPHS, both systems also ranked above 70% for children and adults in the questions related to "getting needed care" and "getting care quickly."[15] Approximately 138, 518 residents were on the standard Medicaid as of the end of April 2016.[16] About 59% are children and 12% expectant mothers and parents.

Expanded Medicaid through the Health Protection Program (HPP) was signed into law March 2014. There were originally two (2) programs for coverage: the Health Insurance Premium Payment Program (HIPP) and the Bridge Program. The HIPP is for residents ages 19 to 65 who have access to health insurance through an employer and fall below certain income thresholds. The Bridge Program was also for residents ages 19 to 65 who don't have coverage. The HPP allowed those two sets of residents to be eligible if their household income was up to 138% of the Federal Poverty Level at little to no cost. However, as of December 31st, 2015, all persons in the HPP switched

to the Marketplace Premium Assistance Program (PAP) unless they were medically frail or receiving health insurance through their employer and already participated in the HIPP.



This was made possible through an 1115 Demonstration Waiver allowing the purchase of qualified health plans (QHPs) to be sold on the Marketplace for PAP enrollees. The State has ensured that all Medicaid benefits and cost sharing protections are met including the expansion of routine wellness visits to 19 and 20 year olds who qualify. This also includes family planning services and supplies. There were 48,817 people on the program as of the end of April 2016.[17] In April, Governor Hassan signed HB 1696, which will continue the expansion but proposes to add work requirements and enrollee premiums; it also proposes for the state's share to be paid for by an insurance premium tax and the Medicaid enhancement tax, as well as the enrollee premiums. The bill was signed with a clause to continue expansion even if the Federal government does not approve the work requirements.
After several years of inaction and of legislation prohibiting the state from establishing a state-based health insurance exchange, NH decided to pursue a partnership exchange giving the state control over plan management and consumer assistance functions. The federal government gave its initial approval in March 2013. The Insurance Department oversees the state's Health Insurance Marketplace. There are currently five (5) medical carriers (up from one in 2014) with 73 different plans, having all 26 acute care hospitals in-network. As of June 1st, 2016, approximately 47, 596 (not including PAP) people were enrolled.[18] This amounts to approximately 44% of the total marketplace eligible population, higher than the national average.[19] Seventy percent of those who signed up qualified for an average tax credit of $244 per month and 43% obtained coverage for $100 or less after any applicable tax credits.[20] This is less than the national average and might be explained by the fact that a very small percent of the population is eligible for tax credits in the first place. This is due to low unemployment and a low poverty rate in the state.[21]

All of these changes have helped to address financial barriers to care, however, the issue of the uninsured/underinsured remains. Overall uninsured percentages hover around 11%, but are higher among younger adults, ages 18-44, at 16.4% state wide, compared to 10.9% of uninsured adults between 45 and 64 years old.[22]

The rural percentage of the uninsured is statistically higher at 18.8% compared to 11.7% in non-rural areas, with Coos County standing out at over 24% uninsured, three quarters above the state rate. In a 2015 post Marketplace enrollment survey, it was noted that 47% of the remaining uninsured in the state are not registered to vote and tend to be politically disengaged; 60% are men: 60% are under the age of forty; 80% are not college graduated and 38% are not employed full time.

It is clear that these changes within Medicaid and the Health Insurance Marketplace closely align with Title V's priorities and goals. However, as discussed, access to insurance does not necessarily mean easy entrée into health care. The health care environment has guided both MCH and SMS into funding decisions with respect to their individual contracts. MCH uses Title V funds to contract with 15 community health centers across the state. Funding is often leveraged to provide enabling services, which the current health care system only partially pays for or does not pay for at all. For example, several community health centers use Title V funding for additional patient navigators whose mission is to get those uninsured under some type of plan and into care.

The many changes in the past few years in Medicaid have also led to a huge potential budget deficit of $31.9 million within DHHS. This primarily consists of not budgeting for managed care (per member per month) rate increases that were not fully funded in the current budget as well as static Medicaid caseloads that have not fallen as estimated.[23] Both Title V programs have a large portion of state funding in their budget line items. In the summer of 2016, the State Fiscal Year 18/19 budget process will begin. With such a large existing fiscal shortfall within DHHS, it will become increasingly difficult for both MCH and SMS to justify their state funding. Limited sources of state revenue (NH has no state income or sales tax) leaves the budget vulnerable to economic downturns or crisis such as the Medicaid deficit. In addition, because state funds are flexible, there are many competing priorities. The additional insurance coverage has also created the appearance that Title V funded agencies, particularly the community health centers, are now fully compensated for all types of services. In State Fiscal Years 15 and 16, two (2) million in state general funds were removed from the MCH line item by the legislature. This created substantial reductions in contracts, thereby impacting care and the scope of services that could be accomplished by leveraging Title V funding.

In addition, there are two large efforts that were initiated last year that will have an enormous impact on the populations that Title V serves. NH Medicaid received approval from CMS for another 1115 waiver, a Delivery System Reform Incentive Program (DSRIP). Under the special terms and conditions of DSRIP, NH has access to up to $150 million in Medicaid funds over five (5) years to expand community-based mental health and drive delivery system reform for Medicaid recipients. The funds will be used to support seven (7) Integrated Delivery Networks (IDNs), which were based on the geographical areas of the 13 Regional Public Health Networks. Currently, applications for the IDNs are being received for an independent assessment. IDNs are required to be networks of medical, behavioral health, substance use disorder and social service providers who will be tasked with:

- Improving care transitions
- Promoting the integration of physical-behavioral health
- Building mental health and substance use disorder treatment capacity

IDNs will have a menu of mandatory and optional community/state wide driven projects based on current needs assessments and reflecting the three (3) tasks mentioned above. MCH and SMS management were involved in the development, along with their Medicaid colleagues, of the project menu, including the selection of local and statewide evaluation metrics. IDNs will initially receive funding for project planning and capacity building, but will then receive performance based funding, based on a series of existing and newly developed performance measures.

It is required that the waiver must be budget neutral, meaning that the cost to the federal government with the transformation waiver will be no more than the cost without it. The DSRIP project also must ensure that IDNs participate in alternative payment models that move Medicaid payment from primarily volume based to primarily

value based payment over the course of the five (5) years.

Of particular note for Title V is that the IDNs will regionally capture many, if not most of the already existing contractors, such as the community health centers. And since children and pregnant women together make up a majority percentage of the Medicaid population, it is hoped that IDN chosen projects will center on them.

In addition, a statewide project on increasing the behavioral health workforce will be undertaken by all the IDNs led by DHHS. This complements Title V's efforts underneath State Performance Measure #1, which seeks to increase behavioral health capacity for children and pregnant women through its work with the State Loan Repayment Program, the Recruitment Center of Bi-State Primary Care Association and the Children's Behavioral Health Collaborative Workforce Development Network. Further information on these initiatives is discussed in the cross-cutting/life course domain of the State Action Plan. The second statewide project will allow for the development and adoption of health information technology (HIT) infrastructure to support the integration of behavioral health and primary care as well as designation as a Coordinated Care Practice and/or an Integrated Practice. Most of the Title V contracted community health centers are in some phase of this process right now and have utilized grant funding to do so.

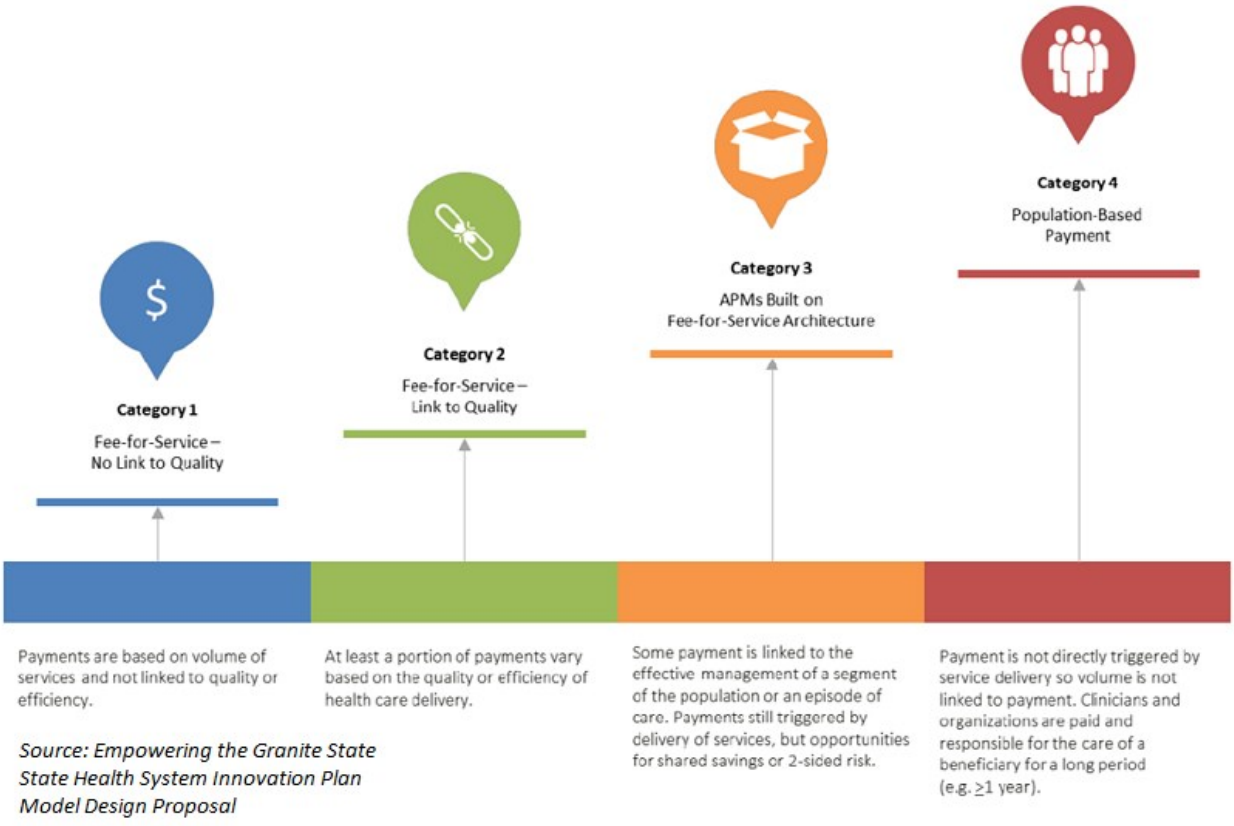
Several of the community driven projects on the menu include transitions utilizing care transition teams, enhanced care coordination and school based developmental screening, three areas in which both MCH and SMS are heavily invested in, through both staff time and contractual work. Three of the IDN performance metrics mirror State Performance Measures #1 (increasing behavioral health capacity) and #2 (decreasing unnecessary emergency department visits) as well as National Performance #10 (adolescent wellness visits). The DSRIP program will definitively have an impact on Title V populations within the state. It remains to be seen, however, just how and if Title V funding should or could be readjusted to fill in the gaps and leverage funding to the best ability possible.

The DSRIP project will need a statewide roadmap for healthcare reform, which will build off the second large statewide project initiated and completed in the last year. CMS awarded DHHS (both DPHS and Medicaid) a State Innovation Model (SIM) Initiative grant to provide financial and technical support for the development of a multi-payer health care payment and service delivery model to improve population health and improve health system performance, increase quality of care, and decrease costs. The premise is that fee for service payment systems create incentives for delivering services, regardless of their health outcomes. Medicare payment reforms in the state and through Accountable Care Organizations have started to push health care providers towards value based payment methodologies. Value based care payments are used in each state insurance carrier's model. However, they are utilized less in Coos County and with newer insurers and more with providers designated as Patient Centered Medical Homes and with large health systems owned by hospitals.[24]
Over the past year, led by an Advisory Board, partners throughout the state worked to build a state-wide foundation for health care delivery reform, including the acceleration of HIT and data exchange among providers and healthcare systems and the development of plans for value based payment among both commercial and public payers.

The recently released *Empowering the Granite State: State Health System Innovation Plan Model Design Proposal* proposes the following:[25]

- Development of Regional Healthcare Cooperative Extensions (potentially the IDNs) that will serve as hubs from which health care providers can access health care system engineers that offer consultation, technical assistance and ongoing implementation support.
- These regional entities will also facilitate local health initiatives.

- Legislate changes to require QHPs to have performance indicators and quality improvement strategy plans that expand market based incentives to align with the state's transformation priorities.
- Implement a transformation governance board or council that will develop transparent goals for moving the health care sector up the ladder of payment methods as shown below.



Source: Empowering the Granite State State Health System Innovation Plan Model Design Proposal

NH is the last of its contiguous border neighbors to undertake statewide transformation.[26] Again, it will be quite interesting to see the impact of these two large statewide efforts on Title V.

Title V funding

Funding decisions are made based on gap assessments founded on the previous discussions of the state's health care system and the needs assessment process which looks at health outcomes. The process is both static and ever changing with grant money going towards staffing infrastructure as well as contractual services for imparities in services.

Enabling Services and Healthcare Quality Improvement

Using Title V, MCH supports 15 community health centers (CHCs) in their quest to provide comprehensive primary care services, including prenatal and pediatric care, for over 119,000 individuals and 1500 pregnant women in 2015.[27] Three of the CHCs provide services specifically for the homeless population, who suffer from health care problems at more than double the rate of individuals with stable housing. Most of the funding is used for quality improvement for project such as getting adolescents into annual health care, increasing the number of pregnant women and the homeless referred for and actually receiving tobacco cessation activities and increasing the number

of highly effective contraceptive methods used among reproductive age women. Funds also go to support enabling services such as case management, transportation and interpretation services.

Child Health/Prenatal

The MCH Child Health Nurse Consultant and Prenatal Nurse Coordinator positions are funded by Title V. The former's duties include a broad spectrum of activities, ranging from involvement with pediatric focused coalitions to overseeing the pediatric service components of all MCH contracts. The latter coordinates the Maternal Mortality Committee and provides oversight to the prenatal piece of any MCH affiliated contract or program.

Home Visiting

MCH and the Division for Children, Youth and Families (DCYF) work together leveraging funding for 12 Comprehensive Family Support Services (CFSS) home visiting contracts that work by intervening at critical periods of stress and transition for pregnant women, children, and families with children up to the age of 21.

Injury Prevention (IPP)

The IPP Manager and part of the MCH/Injury Surveillance Coordinator are funded by Title V. The IPP seeks to reduce morbidity and mortality due to intentional and unintentional injuries. The IPP oversees the contracts with the Brain Injury Association, the NH Coalition for Domestic and Sexual Violence, the Injury Prevention Center and the Northern New England Poison Center.

Quality Improvement/Quality Assurance (QI/QA) Program

The QI/QA Nurse Consultant position oversees the evaluation of all MCH programming with specific recommendations and required actions to come closer to the goal of the Title V National and State Performance Measures. Title V is also used for the contract with the MCH Epidemiologist.

Title V funds a portion of all 11 SMS programs with external contracts primarily for enabling and public health services with a very small percent supporting direct services.

Child Development Program

The Child Development Services Network is comprised of five (5) child development programs contracted through Dartmouth and local community health agencies to provide a community-based multidisciplinary approach to diagnostic evaluation services, to children 0-6 suspected of or at risk for altered developmental progress.

Pediatric Specialty Clinics

SMS operates five (5) multidisciplinary clinics for neuro-motor disabilities that utilize treatment approaches that encourage families 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 services.

Nutrition, Feeding and Swallowing Program

This program offers community-based consultation and intervention services. Dietitians and feeding/swallowing specialists provide services utilizing a home visiting framework. SMS offers specialized training for all network providers and assures a coordinated, outcome-oriented approach.

Family Education & Support Services

Title V supports NH Family Voices (NHFV) in its mission to assist families with CSHCN. NHFV provides information, support and referrals through the toll-free line provided by SMS. NHFV maintains a comprehensive lending library, specializing in children's books, and publishes a quarterly newsletter. NHFV also publishes an annual listing of support group/organizations and operates a comprehensive website.

Medical Home Project
This initiative focuses on fostering care for CSHCN that is accessible, family-centered, comprehensive, coordinated and culturally effective for children from birth to 21, through policy level initiatives, infrastructure development, and planning and technical support regarding the continuation of Medical Home activities.

Psychiatry/Psychology Consultation
SMS contracts with a child psychologist and a psychiatrist to provide access to services for CSHCN. Psychology services include 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.

Statutes and other regulations that have passed or are in process within the last year and have relevance to the Title V program
This past year, the state's legislature voted to eliminate the Certificate of Need (CON) program as of July 1st, 2016 through Senate Bill 481. The CON program, managed by DPHS, required health care organizations, such as hospitals, to apply to either construct or modify health care facilities, acquire new medical equipment or offer new inpatient care beds and services. Opponents of the CON voiced concerns that it harmed competition and limited choices in the state, while increasing bureaucracy. Health care facilities will now have the ability to build freely, with the caveat in the bill that they accept all patients, including those uninsured and on Medicaid.
House Bill 1696 amended RSA 126-A:5 and extends Medicaid Managed Care for another two (2) years through December 2018. It proposes for the state's share of the expansion to be paid for by an insurance premium tax, the Medicaid enhancement tax and enrollee premiums. There's a clause in the bill to continue expansion even if the Federal government does not approve the work requirements. The bill took effect April 5, 2016.

The Newborn Screening Program Advisory Committee made the recommendation to add Severe Combined Immunodeficiency Disorder (SCID) to the screening panel as per RSA 132-10:a. The DHHS Commissioner approved the addition as well as the Committee's recommendation not to add Crabbe.

Of particular note are the Committee's recommendation and the Commissioner's approval of the addition of critical congenital heart disease (CCHD) to the newborn screening panel. Screening for CCHD is a requirement for all NH birthing facilities as per RSA 132:10-aa. However, the law did not add it to the screening panel, which would have enabled DHHS to collect data on the collection and results. One of the reasons it was not added was at the time were concerns over the costs surrounding a data transfer system. Program costs for newborn screening in general are imbedded in the filter paper fee. This fee covers the administrative and technical (laboratory) aspects of the Newborn Screening Program. However, NH has now had four (4) years of successfully implementing CCHD screening at birthing facilities. In that time, there have been limited false positives, and facilities have made adequate preparations for referral and/or consults when a newborn tests positive. In addition, the revolving fund (made up of filter paper fees) has been successfully supporting the Newborn Screening Program. It is thought that a surveillance system could be put into place with no additional costs to birthing facilities, utilizing the already existing funds. By voting to add CCHD to the newborn screening panel, the Committee was in effect supporting the surveillance of CCHD as well. MCH staff is now engaged in a Request for Information (RFI) process, whereby information on potential surveillance systems could be collected and acted upon. In addition, staff is working on updating Administrative Rule He-P 3008 to include rules for any data collection necessary as well as addition on additional disorders previously approved and added such as SCID.

Senate Bill 515 provides that evidence of a custodial parent's opioid drug abuse or dependence creates a rebuttable presumption of harm under the Child Protection Act. The bill also permits the court to order periodic drug testing. As originally drafted, SB515 proposed to alter the definition of child neglect to include Neonatal Abstinence Syndrome. This was opposed by many clinicians. The bill was ultimately amended and the final language did not change the definition of neglect. While the bill does not substantively change child protection reporting requirements, it has highlighted an issue within the clinical provider community and the child protection community about the appropriate way to support pregnant women receiving medication assisted treatment for opioid dependence whose infant is born with or without withdrawal symptoms.

Senate Bill 439 established a commission to study the shortage of home health care providers. The CSHCN Director will be one of the commission members.

II.B. Five Year Needs Assessment Summary

Needs Assessment Update (as submitted with the FY 2017 Application/FY 2015 Annual Report)

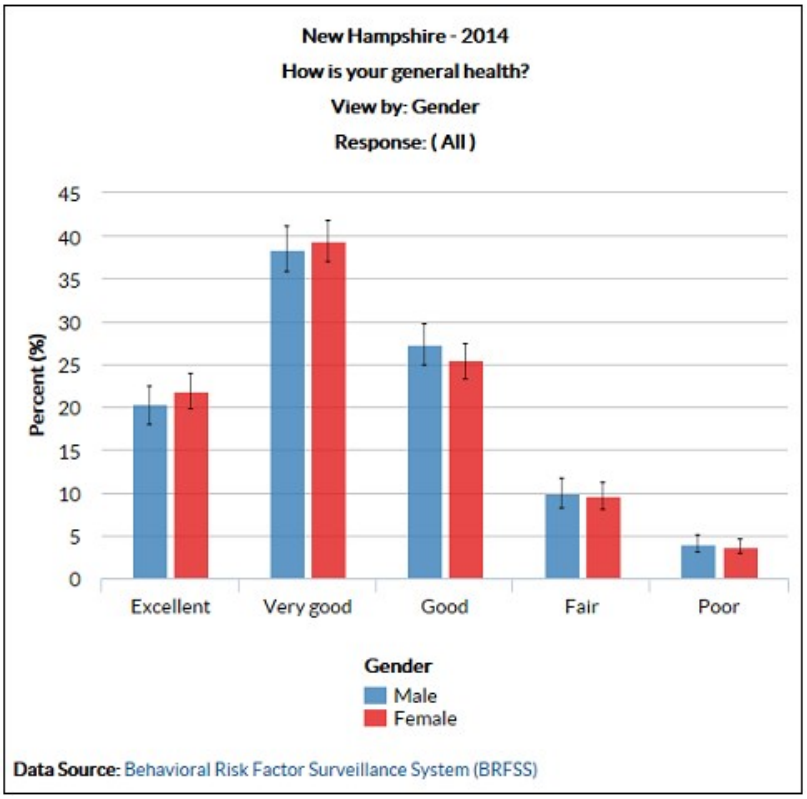
In this first interim year (FY17) of the FY16-FY20 Block Grant cycle, the process of needs assessment is ongoing. National and state surveys and reports for NH are collected and systematically reviewed. Public input is acquired through ongoing satisfaction surveys instituted in all MCH-funded contractors, including community health centers (CHCs) and home visiting agencies. Regular grantee meetings with service providers at all MCH-funded contractors provide further insight into statewide health needs and priorities, and the capacity to address those needs. The state priorities remain unchanged, namely:

1. Improve access to needed healthcare services for all populations
2. Decrease the use and abuse of alcohol, tobacco and other substances among youth, pregnant women and families
3. Increase access to comprehensive Medical Homes
4. Improve access to mental health services
5. Decrease pediatric overweight and obesity
6. Increase family support and access to trained respite and childcare providers
7. Decrease unintentional injury
8. Improve access to standardized developmental/social-emotional screening, assessment and follow up for children and adolescents

Women/Maternal Health

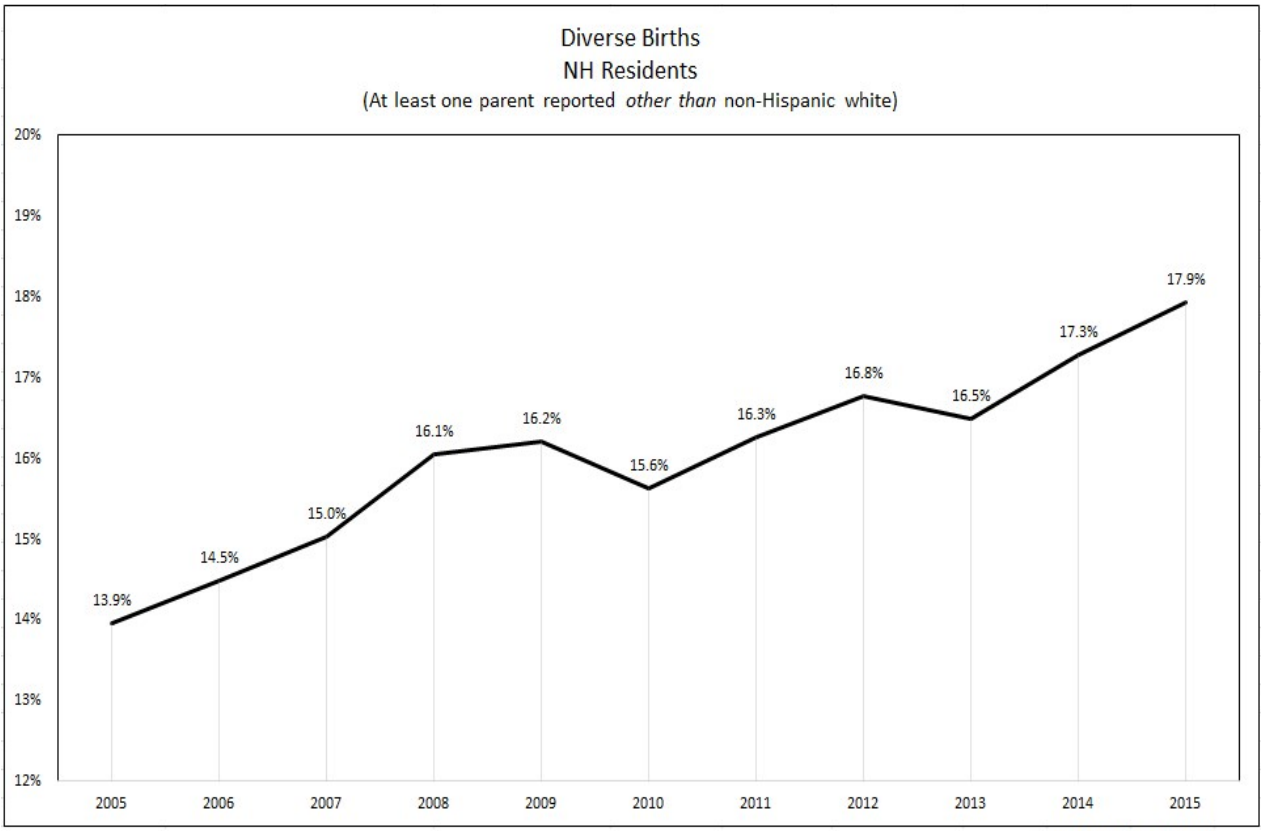
Strengths

Women's self-reported **overall health status** in 2014 is largely positive, with approximately 87% reporting good, very good, or excellent health. However, 25.9% of women reported ever having been told they had **depression**.[1]



Screening for depression was done for 73.3% of women receiving services at all CHCs in 2015; in 2014 this figure was also 73.3%, up from 68.6% in 2013.[2] In the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program, 44.8% of participating women received a depression screening in 2015.[3] At least 75.6% of women receiving services at CHCs in 2015 received **pre-natal care in the first trimester**.[4]

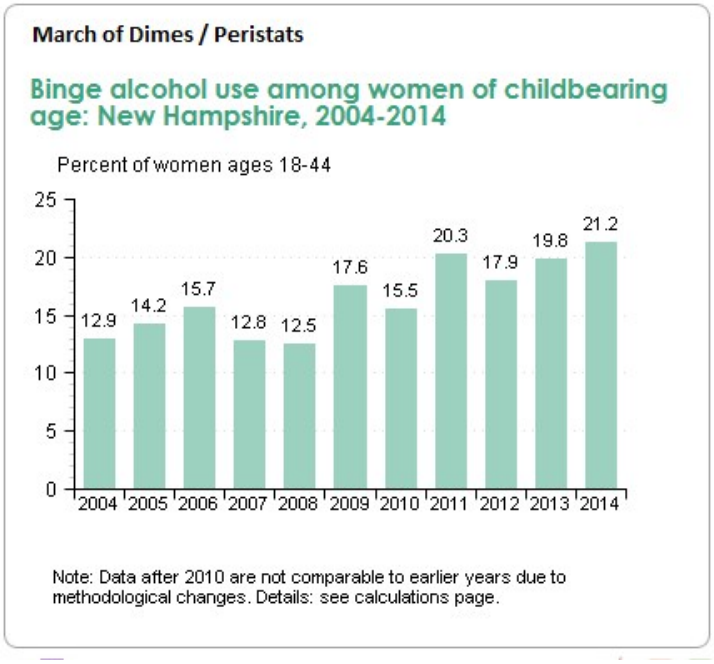
In 2015, there were 12,420 **births** to resident women; this is an uptick from previous years (12,285 in 2014 and 12,380 in 2013).[5] The percentage of births of babies of color continues to rise,[6] reflecting the increasing diversity of NH's population.



Needs

In 2014, an estimated 25.3% of women were **obese** (BMI >= 30), a slight uptick from the 2013 estimate of 24.8%. Another 29.9% in 2014 were classified overweight (BMI 25.0-29.9).[7]

Binge alcohol use in women ages 18-44 is reported in 2014 as 21.2%, compared with 16.9% nationally. In 2013 the NH figures were 19.8%, versus 17.6% nationally.[8]



In 2014, 21.6% of NH women ages 18-44 reported **smoking**, compared to 19.2% of women nationally; the 2013 NH figure was 21.2%.[9] **Smoking during pregnancy** is of ongoing concern but on the decline, with 12.2% of women reporting this in 2015, down from 13.4% in 2014 and 14.9% in 2013.[10] Smoking during pregnancy continues to be especially prevalent among women on Medicaid, although declining in this sub-group also: 30.8% in 2015, 33.5% in 2014, and 35.1% in 2013.[11]

Environmental exposure to **second-hand smoke** was assessed in over 90% of women receiving services at CHCs each year from 2013-2015; of these, 25.7% reported at least some exposure in 2013; 31.6% in 2014; and 30.6% in 2015.[12]

The use of **long-acting reversible contraceptives (LARCs)** for 2015 ranged from zero to 40.4% in 12 Title X family planning agencies, with a mean of 14.7%.[13] Among all birth control methods, LARCs, which include implants and intra-uterine devices (IUDs), are the most effective in preventing unintended pregnancies.

2015 Use (new and continuing) of LARC methods in New Hampshire

Agency	IUD clients	Implant clients	All methods # clients	Total % LARC
Ammonoosuc	16 (6%)	9 (4%)	251	10%
CAP Belknap/Merrimack	60 (9%)	27 (4%)	638	13%
Capital Region	82 (11%)	21 (3%)	758	14%
Coos County CHC	107 (16%)	42 (6%)	654	22%
Avis Goodwin	59 (14%)	5 (1%)	432	15%
Nashua	142 (10%)	30 (2%)	1435	12%
White Mountain	100 (14%)	18 (3%)	696	17%
Indian Stream	0 (0%)	0 (0%)	122	0%
Weeks Medical	5 (3%)	3 (2%)	158	5%
Child Health Services/Manchester	0 (0%)	9 (5%)	170	5%
Concord Feminist	61 (30%)	21 (10%)	203	40%
Portsmouth Feminist	14 (6%)	12 (5%)	224	11%
TOTAL	646	197	5741	13.6%

Source: NH Family Planning Program

PRAMS data on the cohort of NH resident women having a live birth in 2013 showed that after pregnancy, 4.5% of women reported using an implant, and 21.1% reported using an IUD.[14]

Perinatal/Infant Health

Strengths

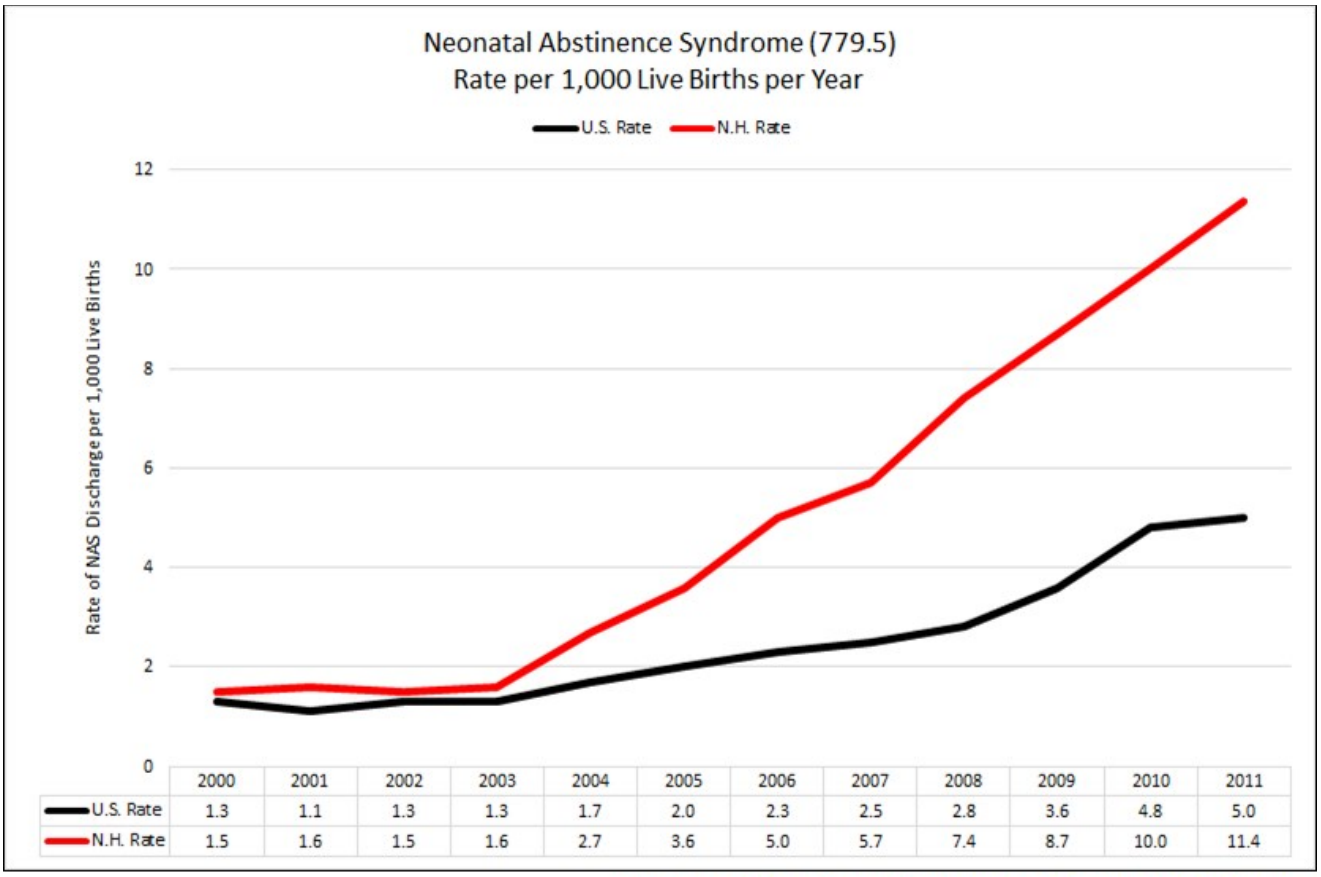
Only 6.7% of births in 2015 were **low birth weight** (<2500 g), compared to 6.9% in 2014 and 6.7% in 2013.[15]

Premature birth (<37 weeks gestation) was 7.8% in 2015, 8.2% in 2014, and 8.3% in 2013.[16]

NH's **infant mortality** rate in 2015 was 4.9 per 1000 live births, compared to 4.5 in 2014; in the national rankings, NH slipped from second place to a three-way tie for seventh place.[17]

Needs

Neonatal abstinence syndrome (NAS) has been rising steadily, even more than nationally; the rate may be substantially higher now than in 2011, which is the last year of data availability.[18] MCH's lead on NAS surveillance was like a "canary in a coal mine," alerting colleagues and health care workers alike that this issue was statewide and on the rise.



*Source: HCUP Nationwide Inpatient Sample, Agency for Healthcare Research and Quality

Between 2011 and 2015 there were 43 confirmed cases of **Sudden Unexpected Infant Death** (SUID); there are additional cases in 2015 that are still under review and not included. Of the cases with notations regarding opiate use, 12 primary and three secondary caregivers used opiates; of those 15 persons, two had a prescription for opiate medication for pain management. Twenty-one total caregivers had a history of substance abuse (including opiates, alcohol, marijuana, prescription drugs and other substances). Fifteen of the 21 caregivers with a history of substance abuse used more than one substance. Seven cases noted that both caregivers had substance abuse issues. Not all cases had two caregivers.[19]

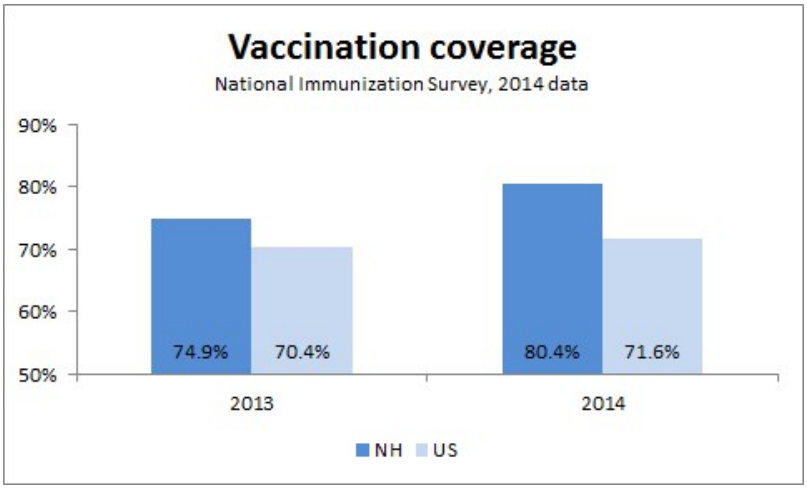
Emerging issues

MCH is applying for a funding opportunity for surveillance and intervention activities for infants with microcephaly and other adverse outcomes linked to the **Zika virus**. To-date there has been four confirmed cases of Zika infection in NH residents, two of whom were pregnant women. All four cases either travelled to areas where Zika virus occurs, or they had sex with someone who traveled to these areas.[20]

Child Health

Strengths

In 2014, 80.4% of children ages 19-35 months received the **combined 7-vaccine** series, compared with 71.6% nationally; in 2013 these figures were 74.9% for NH and 70.4% nationally.[21]



Oral Health measures for children currently meet or exceed national averages as well as related Healthy People 2020 targets, except for the fluoridation of public water supplies, where NH lags behind at 46% (in 2012), compared to 75% nationally, and the HP2020 target of 80%.[22]

Developmental Screening has increased steadily since the inception of the Watch Me Grow system in 2010, when the state had five sites and three sub-locations for promoting and tracking ASQ and ASQ-SE. Through March 2015, the system indicates that 3,988 children were screened.

Needs

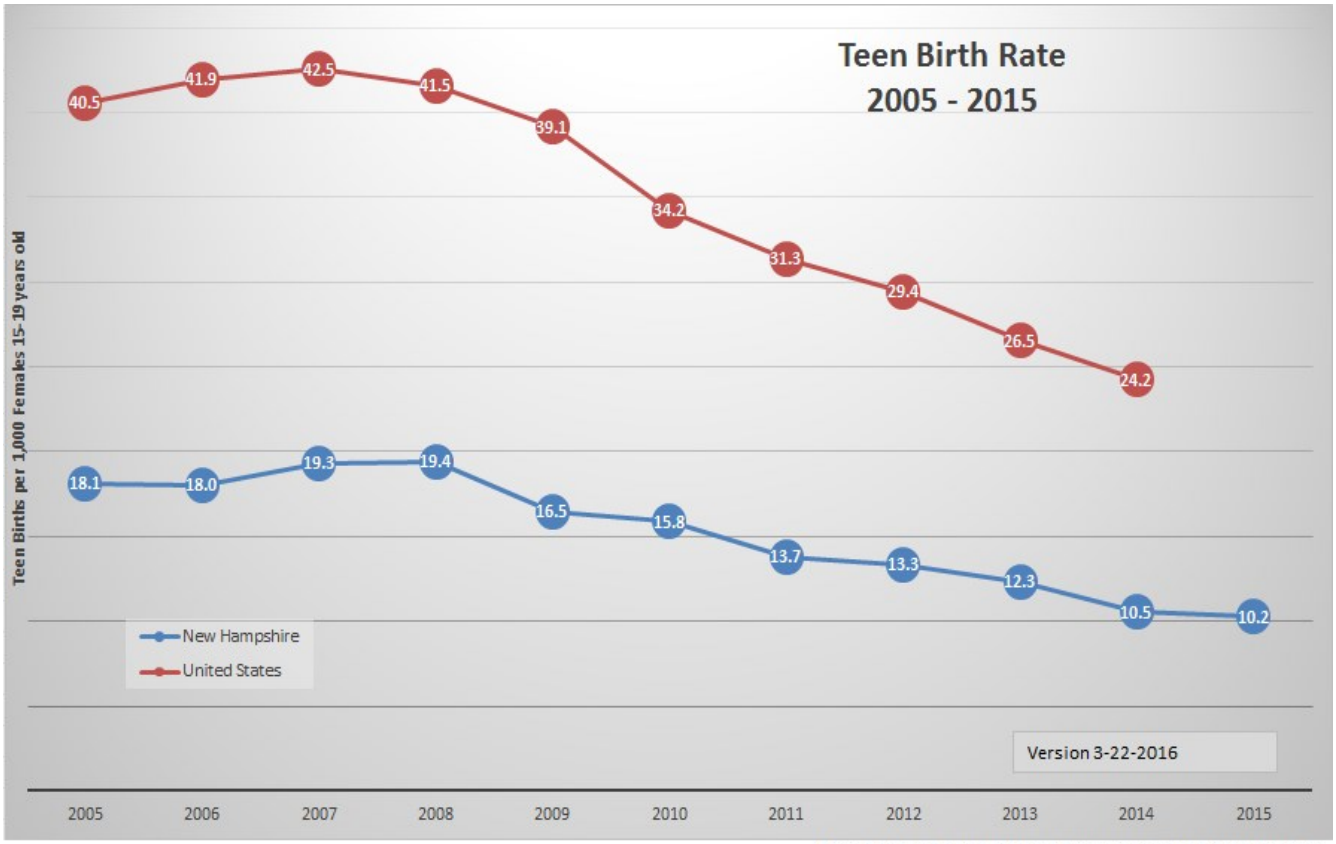
Injuries remain a leading cause of morbidity in children. The in-patient hospitalization rate for non-fatal injuries was 50.0 per 100,000 children in 2010 and 68.5 per 100,000 in 2011. Motor vehicle crashes in 2010 resulted in 103.2 emergency department visits per 100,000 children ages 0-9, and 80.4 per 100,000 in 2011[23] (more recent data is not available).

Obesity in third grade students declined from 2009 to 2014, but the prevalence remains high, with an estimated 12.6% of children classified as obese and 15.4% as overweight. Prevalence rates in the northern counties are significantly higher than the statewide average.[24]

Adolescent Health

Strengths

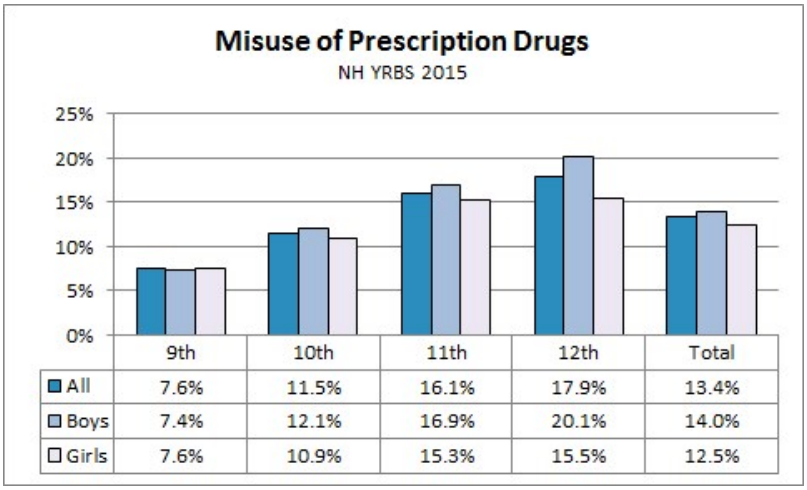
New Hampshire continues to excel in its **teen birthrate**. Teen births in 2015 numbered 468, or 10.2 per 1000 females.[25]



Sources: NH birth certificates and National Center for Health Statistics

Among high school youth, current **marijuana use** in the past 30 days continues its downward trend; current use in 2015 was reported as 22.2%, compared with 24.4% in 2013 and 28.4% in 2011. As in previous years, boys report more use than girls, with 23.9% of all boys and 20.0% of all girls reporting use in 2015.[26]

The misuse of **prescription drugs** likewise is trending downward, with 13.4% of high school students reporting having ever used prescription drugs without a prescription; in 2013 this figure was 16.5%, and 20.8% in 2011. Usage increases with age, with 7.6% of 9th graders and 17.9% of 12th graders reporting use in 2015.[27]



	9th	10th	11th	12th	Total
All	7.6%	11.5%	16.1%	17.9%	13.4%
Boys	7.4%	12.1%	16.9%	20.1%	14.0%
Girls	7.6%	10.9%	15.3%	15.5%	12.5%

Needs

Unintentional injuries remain the leading cause of death among youth aged 10-24 years, and motor vehicle crashes account for the largest proportion of these.[28] Among NH high school students, 7.7% report never or rarely wearing a **seatbelt** when driving; for 18 year olds and older, this figure is 13.9%.[29] Nationwide in 2013, NH had the lowest rate of seat belt use by all ages, only 73.0%, compared to 97.4% in California.[30]

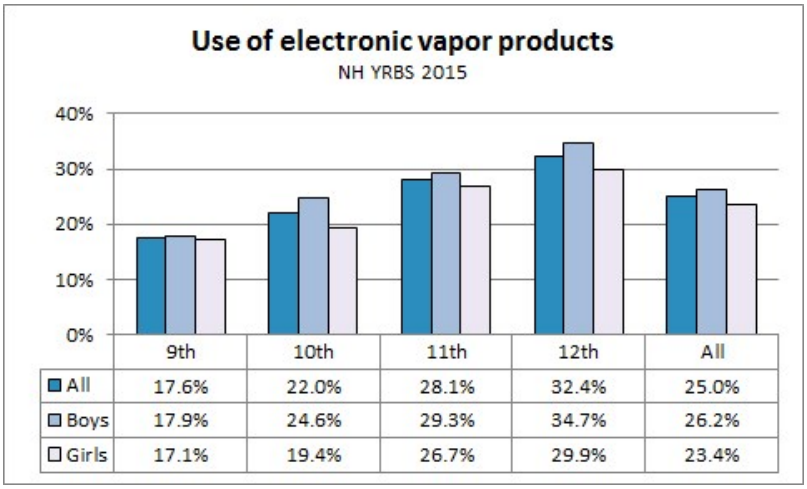
Motor-vehicle crash-related hospital ED visits			
	Age-specific rate per 10,000		
	2009	2010	2011
Boys 15-19 yrs	164	101	61.4
Girls 15-19 yrs	226	136	104

Source: NH Hospital Discharge data 2009-2011

Suicide is the second leading cause of death in 10-24 year olds: 15.3% of high school respondents (10.7% of boys, 20.1% of girls) seriously considered attempting suicide in the 12 months before the survey.[31]

The prevalence of **cigarette smoking** in high school youth is declining, to 9.3% overall (10.2% of boys, 8.0% of girls) in 2015, compared to 13.8% overall in 2013. The prevalence, however, continues to rise with age, with 4.8% of 9th graders reporting smoking (on at least one day in the past 30 days) up to 13.9% of 12th graders; this represents nearly a tripling of prevalence, in a three-year age range.[32]

Electronic vapor products have surpassed cigarettes in prevalence of use, with 25% of all 9th-12th graders (26.2% of boys, 23.4% of girls) reporting usage on at least one day in the past 30 days.[33]



Approximately 11,000 adolescents (10.6% of all adolescents) per year in 2009-2013 had at least one **major depressive episode** within the year prior to being surveyed. Of these, 47.1% received treatment but 52.9% did not.[34]

Thirteen of 15 contracted CHCs serve the adolescent population. The percentage of adolescents having a **preventive medical visit** has risen from 52% in 2010 to 62% in 2015.[35] Two of the 13 CHCs are undertaking a Quality Improvement project focusing on adolescent preventive medical visits.[36]

Drinking alcohol (at least one drink on at least one day in the previous 30 days) was reported by 29.9% of students (28.6% of boys, 31.1% of girls). **Binge drinking**, defined as five or more drinks in a row, was reported by 16.8% of students (17.2% of boys, 16.1% of girls).[37]

CSHCN: Children with Special Health Care Needs

Strengths

New Hampshire has performed well on the six federal MCHB Core Outcomes. These are measures that are used across state programs, to monitor progress toward the goal of a comprehensive, family-centered, community-based, coordinated system of care for CSHCN. According to the NS-CSHCN from 2009/2010, New Hampshire ranked 1st in the Nation for CSHCN who are served by systems of care that meet all age-relevant core outcomes, 2nd for CSHCN ages 12-17 who met all six MCHB Core Outcomes and 3rd for CSHCN ages 0-11 who met all five MCHB Core Outcomes (the Transition Core Outcome does not apply to this age group).[38]

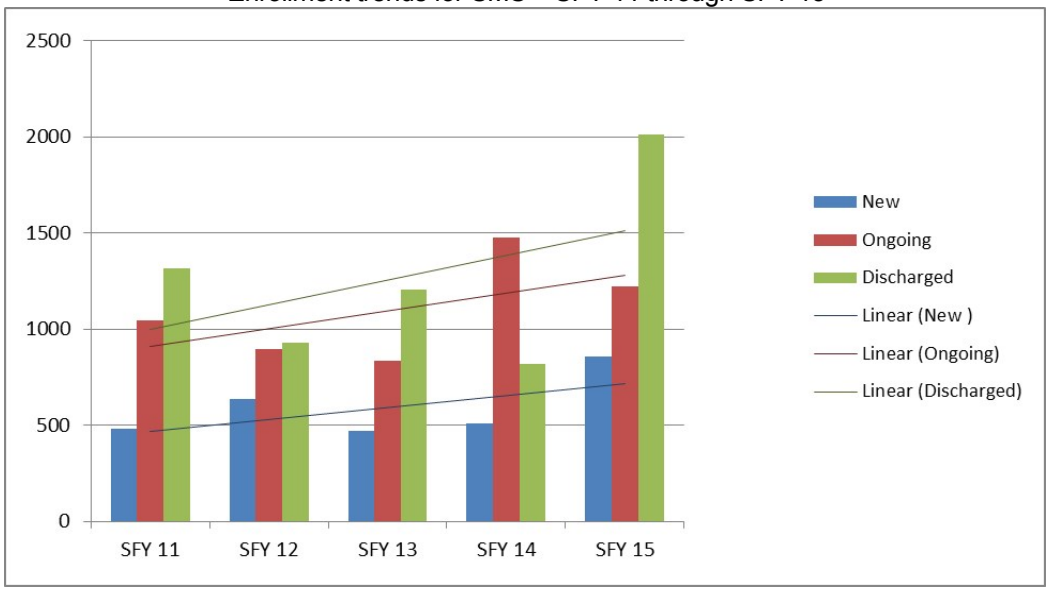
Needs

As noted above, the 2009/2010 NH-CSHCN report indicates that NH has performed very well on the MCHB Core Outcomes. Moving forward the data used will come from the NSCH and on that survey from 2011/2012 a significant negative change was noted comparing NH success on the MCBH outcomes of Medical Home, with NH ranking 24th in the Nation for CSHCN who report all criteria of a Medical Home was met. Also, while 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 2nd to the lowest for the percentage of CSHCN who were insured for the entire previous year. Efforts to assure that services are organized in a way that families find easy to utilize needs to be a strong focus on activity and service planning to facilitate access and decrease any burden or hardship that caregivers are experiencing.

Medical Home Core Outcomes

Of note - According to the NSCH 2011/2012, of NH CSHCN who needed specialty care and had a Medical Home 100% had no trouble getting needed referrals while only 55% of those without a medical home reported this ease of access. Similar discrepancies exist when it comes to the impact of Medical Home on unmet needs such as special services and equipment.
Trend data indicates that enrollment in Special Medical Services continues to grow (In 2011 enrollment numbers were cleaned to reflect services within a 12-month period), as does utilization of SMS' Information and Referral services. Services with the greatest utilization are Nutrition and Feeding & Swallowing, Child Development Clinics, Community-Based Care Coordination and Neuromotor Clinics, respectively.

Enrollment trends for SMS – SFY 11 through SFY 15



Respite

There has been ongoing work to create a competency based respite curriculum for families and providers of respite

care and a web based registry of those providers statewide. Ongoing efforts will focus on providing data to justify the need for continued funding for respite and comprehensive recruitment and training of providers.

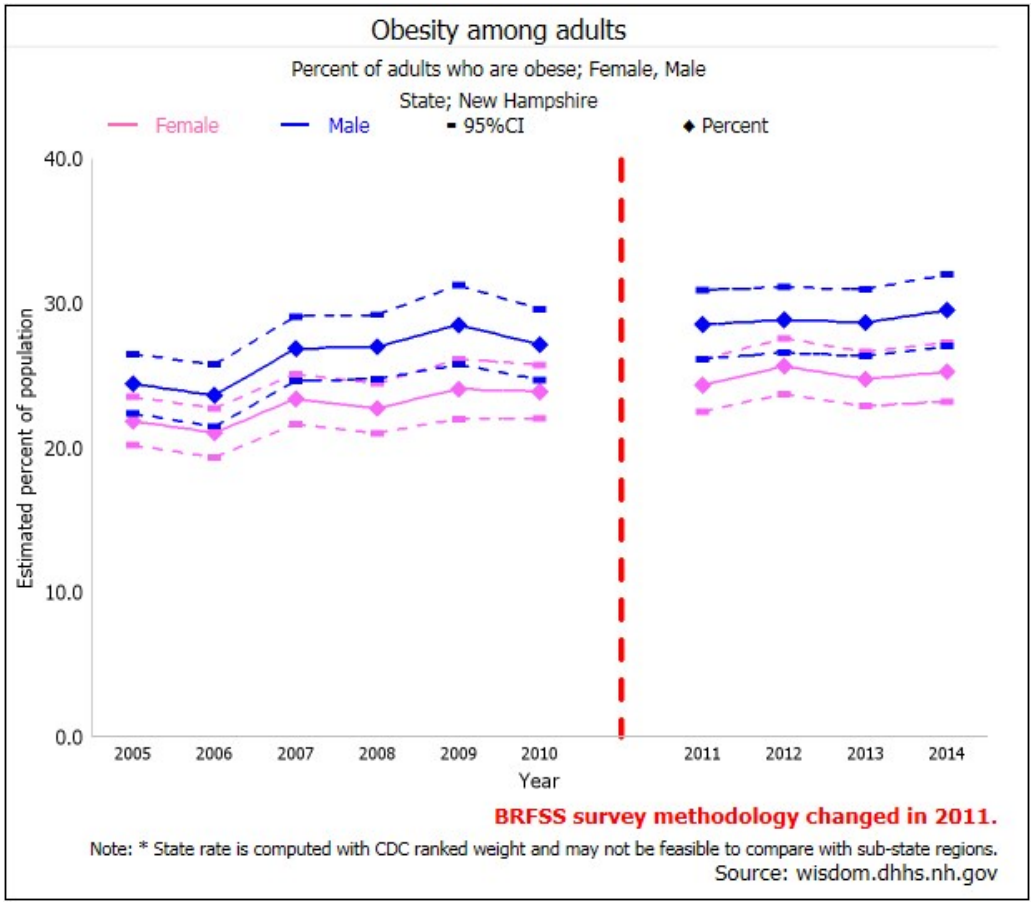
Cross-cutting/Life course

Needs

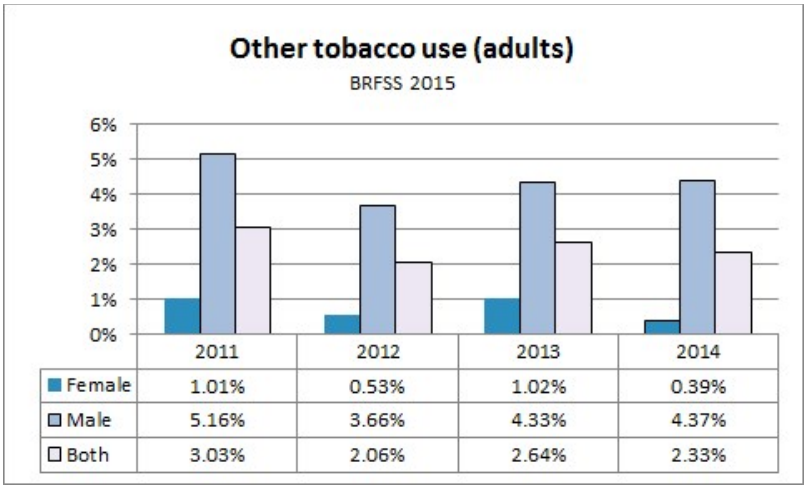
In 2014 around 45,000 adults (4.3% of all adults) had a serious **mental illness** within the previous year; in 2013 the figures were around 46,000 adults (4.5% of the adult population). The percent receiving treatment was 49.7% in 2013, declining to 46.1% in 2014.[39]

Binge drinking or heavy drinking in the best NH counties is estimated at 15% of adults; the worst counties report 19%; the statewide average is 18%, while nationally the best counties report 10%.[40]

Obesity in NH remains more prevalent among men than women, and the trend seems relatively stable, with 25.3% of women classified as obese in 2014 (compared to 24.8% in 2013 and 25.7% in 2012) and 29.5% of men classified obese in 2014 (compared with 28.7% in 2013 and 28.9% in 2012).[41]

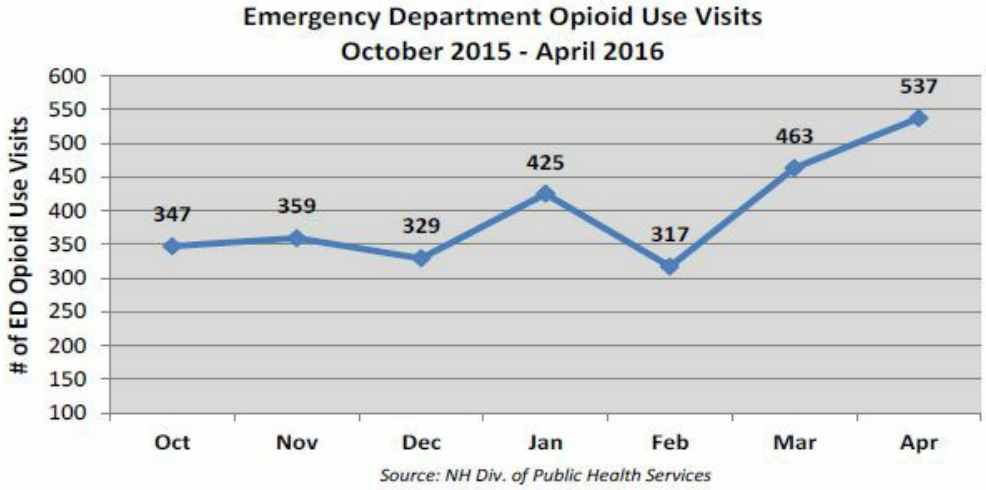


Tobacco use remains widespread, with the 2014 prevalence continuing to peak in the 25-34 year age group: 26.5% of women, 27.2% of men, up from 23.8% of women and 25.0% of men, in 2013. Prevalence data on the use of other (smokeless) tobacco products has been collected since 2011, as shown on the table below:[42]



	2011	2012	2013	2014
Female	1.01%	0.53%	1.02%	0.39%
Male	5.16%	3.66%	4.33%	4.37%
Both	3.03%	2.06%	2.64%	2.33%

Opioid use is increasing. The number of opioid-related Emergency Department (ED) visits was reported at 537 in April 2016, up from 463 the prior month.[43] MCH's participation in the distribution of naloxone to its contracted agencies has helped to potentially decrease these deaths.



In the past three months (February - April 2016), most opioid ED cases have been male, and young, in their 20s or 30s.[44]

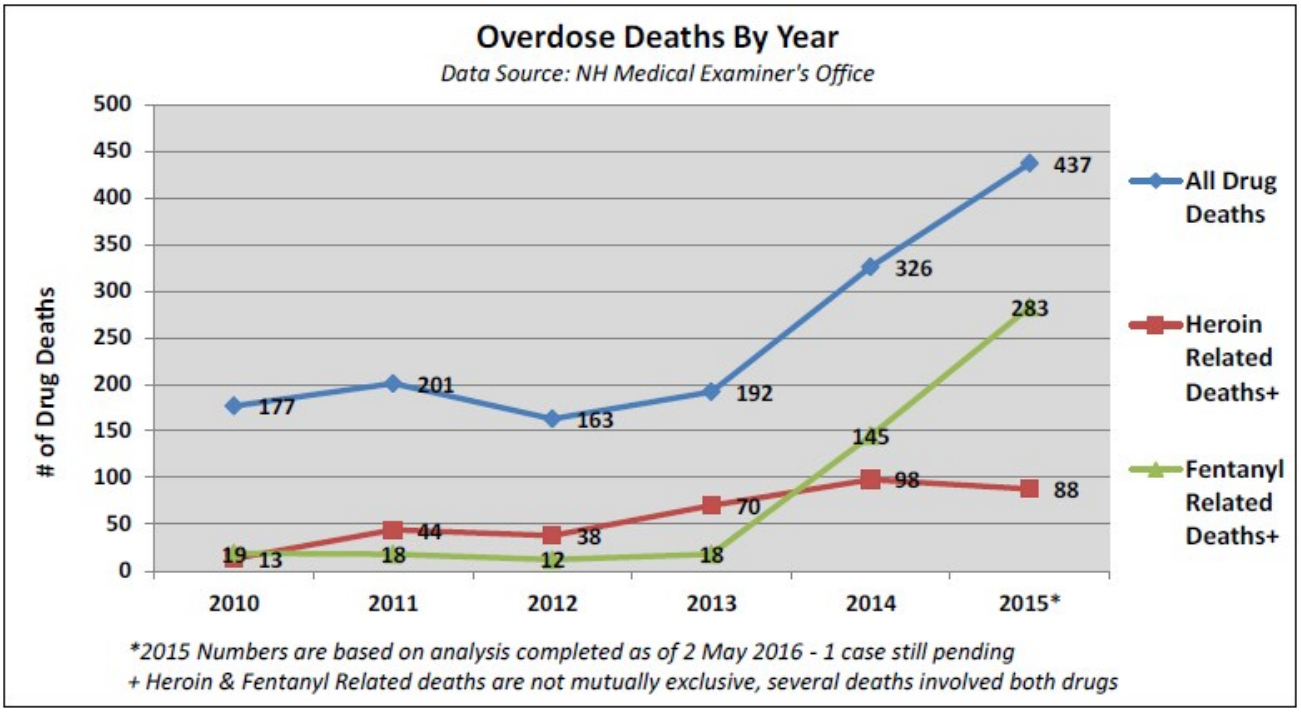
Gender	Feb	Mar	Apr	% Change
Female	158	208	233	12%
Male	159	255	304	19%
Totals	**317**	**463**	**537**	**16%**

Source: NH Div. of Public Health Services

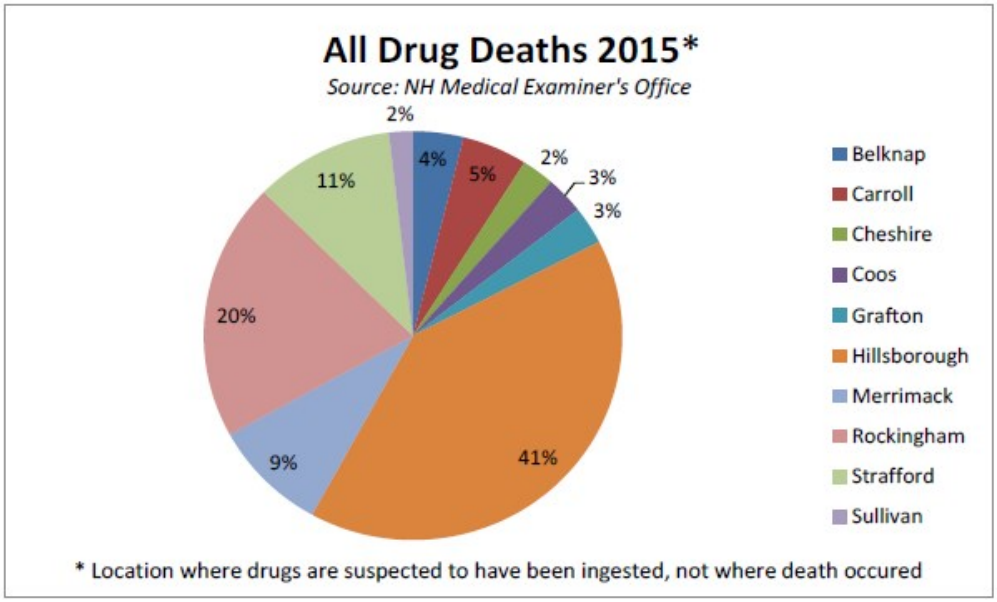
Age	Feb	Mar	Apr	% Change
0-9	0	0	1	Incalculable
10-19	12	12	22	83%
20-29	136	188	215	14%
30-39	86	143	183	28%
40-49	34	60	60	0%
50-59	29	38	38	0%
60+	20	22	18	-18%
Totals	**317**	**463**	**537**	**16%**

Source: NH Div. of Public Health Services

The number of drug overdose deaths is increasing, from 326 in 2014 to 437 in 2015, a 34% increase in one year. Fentanyl has largely surpassed heroin as the cause of death.[45]



Hillsborough county, the location of NH's three largest urban areas, represents 41% of the drug fatalities in 2015.[46]



Emerging issues

Lead contamination of drinking water supplies has been of significant concern in some areas of the country, in the past year. The NH PRAMS survey, after consulting with the NH Healthy Homes and Lead Poisoning Prevention project, has added testing for lead to its questions on testing of drinking water, as of April 2016.

Five-Year Needs Assessment Summary
(as submitted with the FY 2016 Application/FY 2014 Annual Report)

II.B.1. Process

Goals and framework

The process of needs assessment is ongoing. This document is a summary of New Hampshire (NH)'s needs assessment activities and findings since 2010. Data and public input were collected and systematically reviewed. NH's vision for the five-year review was a complete analysis of the health of the state's population of women, mothers and infants, children and adolescents including children and youth with special health care needs. Combined with specific input from the public and other stakeholders and a capacity assessment, a list of priority issues emerged which will direct programming over the next five years. This collaborative and evidence-based approach is most likely to leverage the greatest improvement on the health of the NH population.

Stakeholder involvement

Stakeholder involvement took many forms. A variety of state surveys and assessments were conducted in the last five years. These included a Special Medical Services (SMS) Satisfaction/Needs Assessment survey, a School Nurse Survey, focus groups on the experiences of pregnant and parenting women who have substance use disorders, a Home Visitor Qualifications survey, an MCH Breastfeeding & WIC survey, a Medicaid Provider Communication survey, the *Nashua Community Health Assessment*, and many others (space limitations prevent a full listing).

External reports were reviewed, such as the March of Dimes *2012 Premature Birth Report Card*, *Child Health USA 2014*, CDC's *2014 Breastfeeding Report Card*, *America's Health Rankings 2014*, the *Nashua Community Health Assessment*, and the *NH Kids Count Data Book 2015*, to name a few. Additionally, SMS completed a strategic planning initiative in 2012 that included capacity assessment for *Achieving a Community-Based Service System for Children and Youth with Special Health Care Needs (CSHCN)*, an assessment of gaps and barriers and priority setting.

Stakeholders' meetings were used to gather input. Participants of two statewide meetings of directors of Title V funded community health centers (CHCs) and MCH coordinators of grant activities in these agencies were asked to rank the health needs and priorities as seen in their work.

The general public and clients of MCH-funded community health agencies were surveyed online, and a hardcopy version of the survey was also circulated. Two focus groups were organized to get qualitative input from the general public in two distinct geographic areas.

Some of the participating groups in the needs assessment process included Spark NH Early Childhood Advisory Council; Family Resource Centers; NH Autism Council; Safe Kids NH; Injury Prevention Advisory Council; Nashua Division of Public Health and Community Services; and New Hampshire Family Voices.

Quantitative and qualitative methodology and data sources

Quantitative public input via an online (https://www.surveymonkey.com/s/F3S9ZVF) and hardcopy survey were collected from clients of CHCs and from Department of Health and Human Services (DHHS) district offices, which serve clients for TANF, Medicaid and Food Stamps. Some stakeholders were specifically invited to complete the online or hardcopy survey, but many other participants were unsolicited. The online survey was available from a

link on the MCH website. There were 517 survey participants. The survey was not random, so while the results cannot be generalized for the entire population of the state, they are nonetheless indicative of current trends and perceptions, especially given the high degree of agreement in the findings among service-providers and care recipients.

Qualitative public input was solicited via focus groups held in the northern (essentially rural) and the southern (predominantly urban) parts of the state. Participants were NH residents aged 18-49 years. The northern group consisted of eight clients of the Tri-County Community Action Program, of Berlin, NH and the southern group consisted of twelve participants in Families in Transition, of Manchester, NH. The focus groups were implemented by the Community Health Institute of Bow, NH, as a consultancy.

Input from participants of a CHC directors' meeting and an MCH Coordinators' meeting was also obtained through a voting process. All 15 of NH's Title V funded CHCs were represented at these meetings. Participants, who have their finger on the pulse of the health of their community populations, were asked to discuss and vote on needs and priorities evident in their agencies. Voting was based on public health principles that included the magnitude of need, disproportionate effects among population domains, problems resulting in significant economic costs, cross-cutting problems that have life-span effects, and feasibility or likelihood of NH's Title V program to impact the problem (for more information, see the section "State Selected Priorities").

While the number of opinions collected in these meetings and surveys was not large and not random, this information nonetheless serves as a snapshot of the health status of the population of NH. It also matches and upholds the findings and conclusions of external assessments of health and health care in NH, which were also reviewed and their findings considered in this needs assessment summary.

A full-day Capacity Assessment for State Title V (CAST-V) meeting was attended by 29 staff from the MCH section, the SMS section, and from NH Family Voices (NHFV). CAST-V is a set of assessment and planning tools to assist Title V programs in examining their capacity to carry out key program functions. The resources analyzed are structural (e.g. sufficient authority and funding), data/information systems (e.g. timely access to data and supportive environment for data sharing), organizational relationships (e.g. state, local, and private providers), and competencies/skills (e.g. communications skills, expertise in working with communities).

Five of the ten Essential Services in Public Health (the lowest ranked in 2010, when a CAST-V meeting was last held) were examined and discussed. A SWOT (Strength, Weakness, Opportunities, Threats) analysis was performed to review the current situation for each of the services. Participants voted for three services they perceived as priorities to address. Factors for consideration in voting were: feasibility, SWOT, timeframe, sphere of control, acceptability of solution and potential for broad impact.

Essential Service #9 (Evaluate the effectiveness, accessibility, and quality of personal health and population-based MCH services) was selected as the highest priority. Essential Service #3 (Inform and educate the public and families about MCH issues) and Essential Service #7 (Link women, children and youth to health and other community and family services, and assure access to comprehensive, quality systems of care) tied for second place, with #3 being a greater priority for MCH and #7 a greater priority for SMS/NHFV. These essential services will be at the center of MCH and SMS plans and activities in the next five years (for more information on the CAST-V process, see the section "MCH Workforce Development and Capacity").

Reports summarizing the focus group results, the stakeholders' meetings voting results, and the CAST-V meeting were prepared and disseminated to MCH, SMS and NHFV staff. Data from the surveys was compiled and presented at a priority-setting meeting attended by key staff. All results, quantitative (surveys, epidemiologic data,

voting results) and qualitative (focus groups, CAST-V) were discussed and priorities were determined, which culminated in the selection of national performance measures.

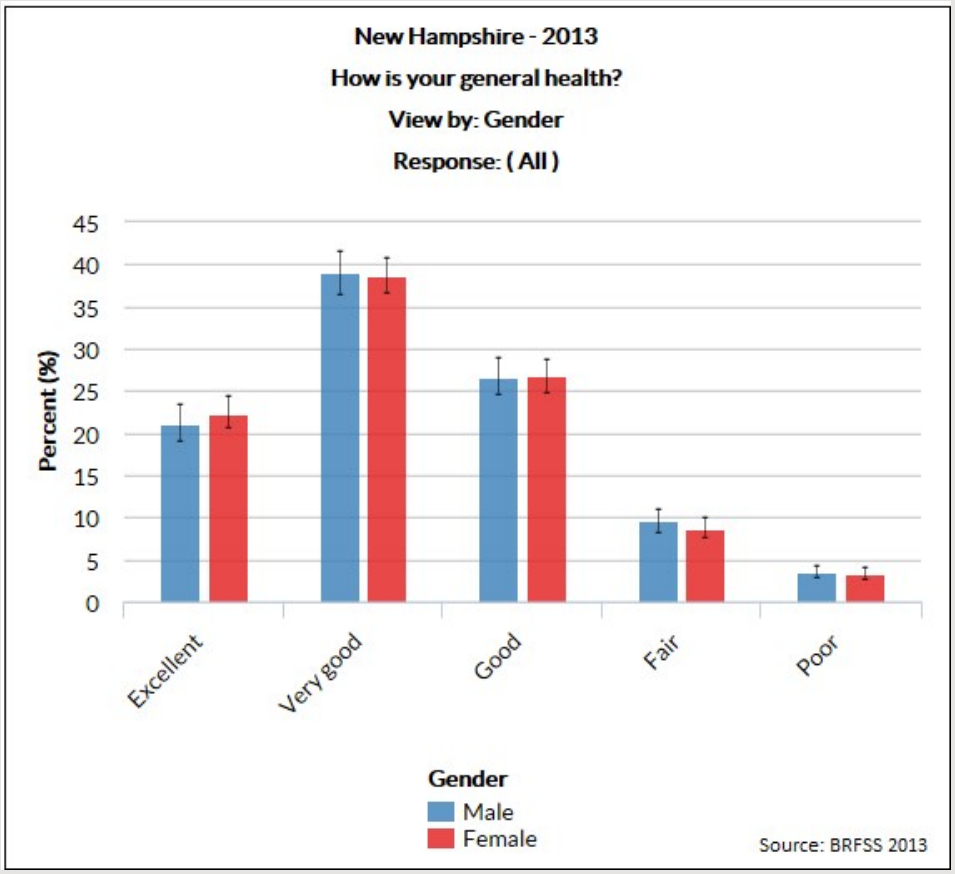
II.B.2. Findings

II.B.2.a. MCH Population Needs

Women/Maternal Health

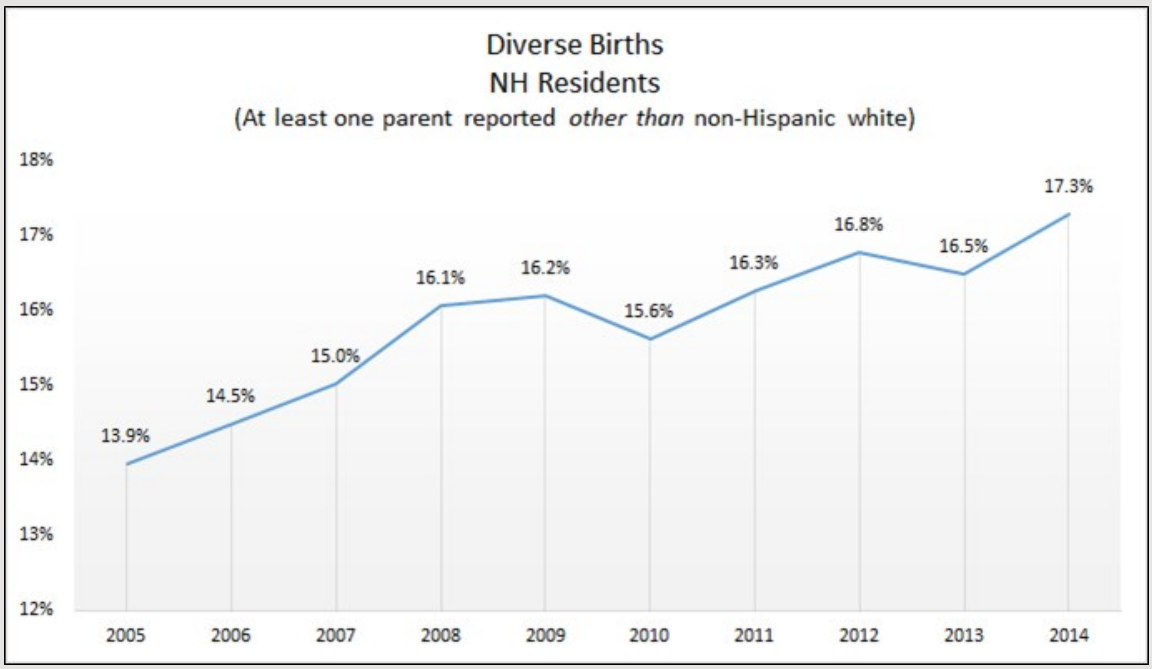
Strengths

Women's self-reported **overall health status** is largely positive, with over 87% reporting good, very good, or excellent health status 2013.[15]



Mental health self-reports, however, are not as positive, with 39% of women reporting poor mental health status in 2011-2013.[16] **Screening for depression** was done for 73.3% of women receiving services at Title V funded CHCs in 2014; this figure is up from 68.6% in 2013.[17] At least 79% of women receiving services at MCH-funded CHCs in 2014 received **pre-natal care in the first trimester** of pregnancy; in 2013 this figure was 77%.[18]

In 2014, there were 12,281 births to resident women, and 12,377 births in 2013. While births continue to decline slightly, the percentage of diverse births is on the rise,[19] reflecting the increasing diversity of NH's population as a whole.

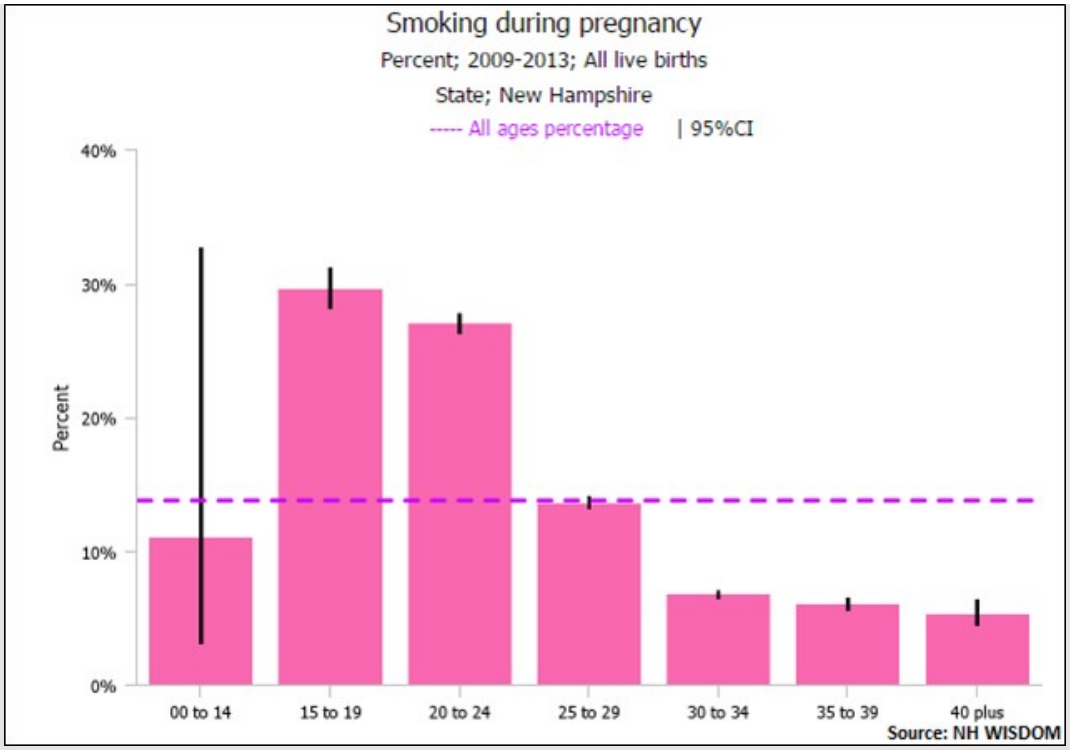


Needs

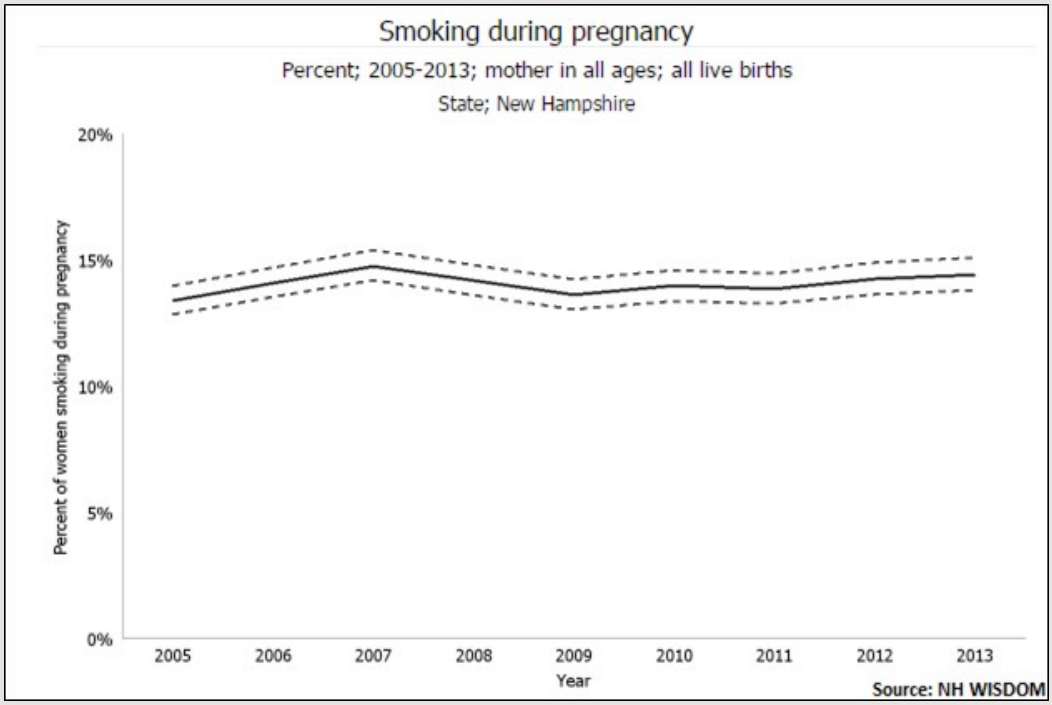
In 2013, an estimated 24.8% of women were **obese** (BMI >=30), down from 26.04% in 2012. In 2013 some 26.7% of the total population (both genders) were classified as obese[20] and these numbers change little from year to year (see the Cross-cutting section).

According to the 2013 March of Dimes Peristats, 19.8% of women ages 18-44 reported **binge drinking** in the past month, and 17.4% reported **smoking**. However, the number of women smoking is declining: in 2011, 24.3% of women of childbearing age smoked, compared to 21.2% in 2013.[21]

Smoking during pregnancy is virtually unchanged since 2001, with the highest rate among younger women: 29.7% of all 15-19 years olds giving birth in 2009-2013 reported smoking during pregnancy.[22] Smoking is especially prevalent among women on Medicaid: 34% were smokers in 2014, compared to 6% among non-Medicaid women.[23]

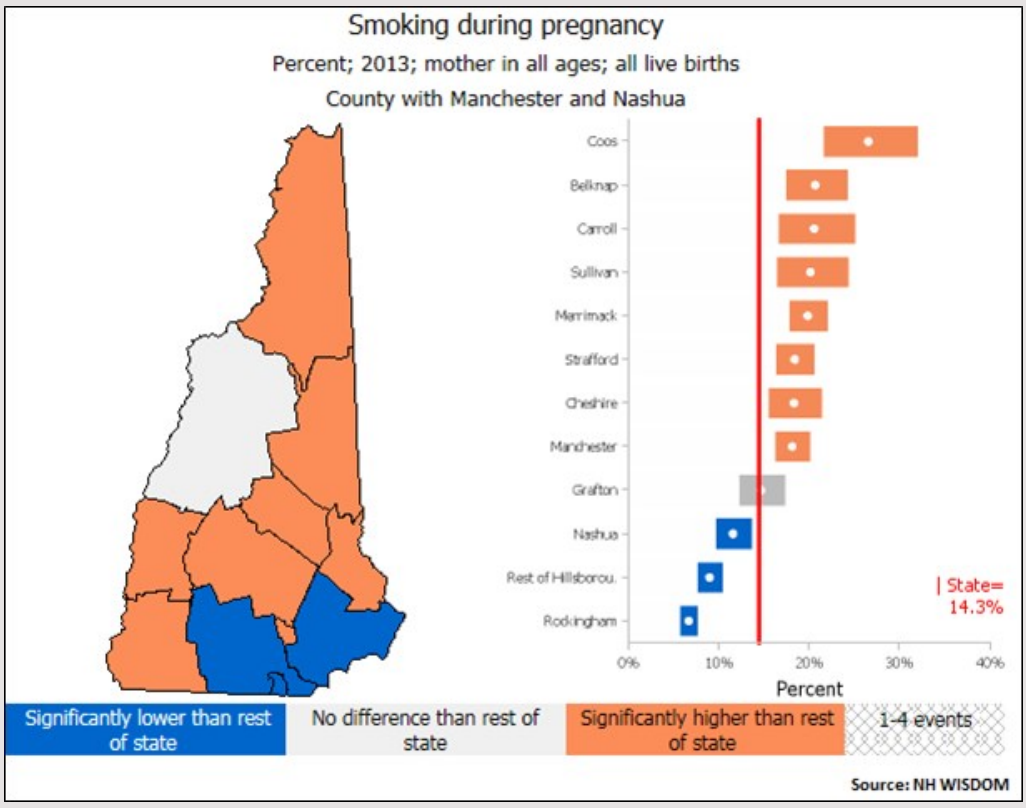


Births to mothers (all ages) who smoked during pregnancy in 2012 was reported as 15%; this figure has been stable over several years.[24]



Regional disparities are evident, with significantly higher rates of smoking than the statewide average in seven of ten counties and one city.[25] Clearly more needs to be done to encourage women, especially pregnant

women, to change their smoking behavior.



Environmental exposure to **second-hand smoke** was assessed in over 90% of women receiving services at CHCs in 2013 and 2014; of these, 25.7% reported at least some exposure in 2013, and 31.6% in 2014.[26]

A series of focus groups on the experiences of pregnant and parenting women with **substance use disorders** was conducted from November 2013 – January 2014.[27] Twenty-two participating women reported an average age at first use of 14.9 years; ten women used alcohol and twelve used other drugs. There is a strong social/familial component to substance use, with ten of the 22 participants reporting having a family member who also used drugs/alcohol or had a substance use disorder.

The use of **long-acting reversible contraceptives (LARCs)** is currently quite low, ranging from zero to 22% in ten family planning agencies, with a mean of 9% (personal communication from NH FPP Director). Among all birth control methods, LARCs, which include implants and intra-uterine devices (IUDs), are the most effective in preventing unintended pregnancies.

Use (new and continuing) of LARC methods in NH (January – July 2015)

Agency	IUD clients	Implant clients	All methods # clients	Total % LARC
Ammonoosuc	16 (6%)	9 (4%)	251	10%
CAP B/M	43 (10%)	22 (5%)	445	15%
Capital Region	37 (9%)	9 (2%)	422	11%
Coos Co. CHC	74 (15%)	34 (7%)	485	22%
Avis Goodwin	37 (11%)	5 (1%)	350	12%
Nashua	84 (8%)	20 (2%)	1010	10%
White Mountain	58 (13%)	9 (2%)	433	15%
Indian Stream	0 (0%)	0 (0%)	101	0%
Weeks Medical	2 (2%)	1 (1%)	104	3%
Child Health Services/Man.	0 (0%)	5 (6%)	90	6%
Concord Feminist	Unknown	Unknown	-	-
Portsmouth Feminist	Unknown	Unknown	-	-
PPNNE	Unknown	Unknown	-	-
TOTAL	**351**	**114**	**3691**	**9%**

Source: NH Family Planning Program

Perinatal/Infant Health

Strengths

Of the 12,281 births in 2014, 6.9% were of **low birth weight** (<2500 grams) and in 2013, 6.7% of births were low birth weight.[28] This compares favorably with the national 2014 figure of 8% low birth weight.[29]

Premature birth (<37 weeks gestation) in NH in 2013 is reported as 9.0% of live births; since 2002 the rate of infants born preterm has declined one percentage point. Racial disparities are evident in the 2010-2012 preterm birth data, with the following racial distribution: 13.4% for black infants, 11.3% for Hispanics, 9.3% for whites, and 8.6% for Asians.[30]

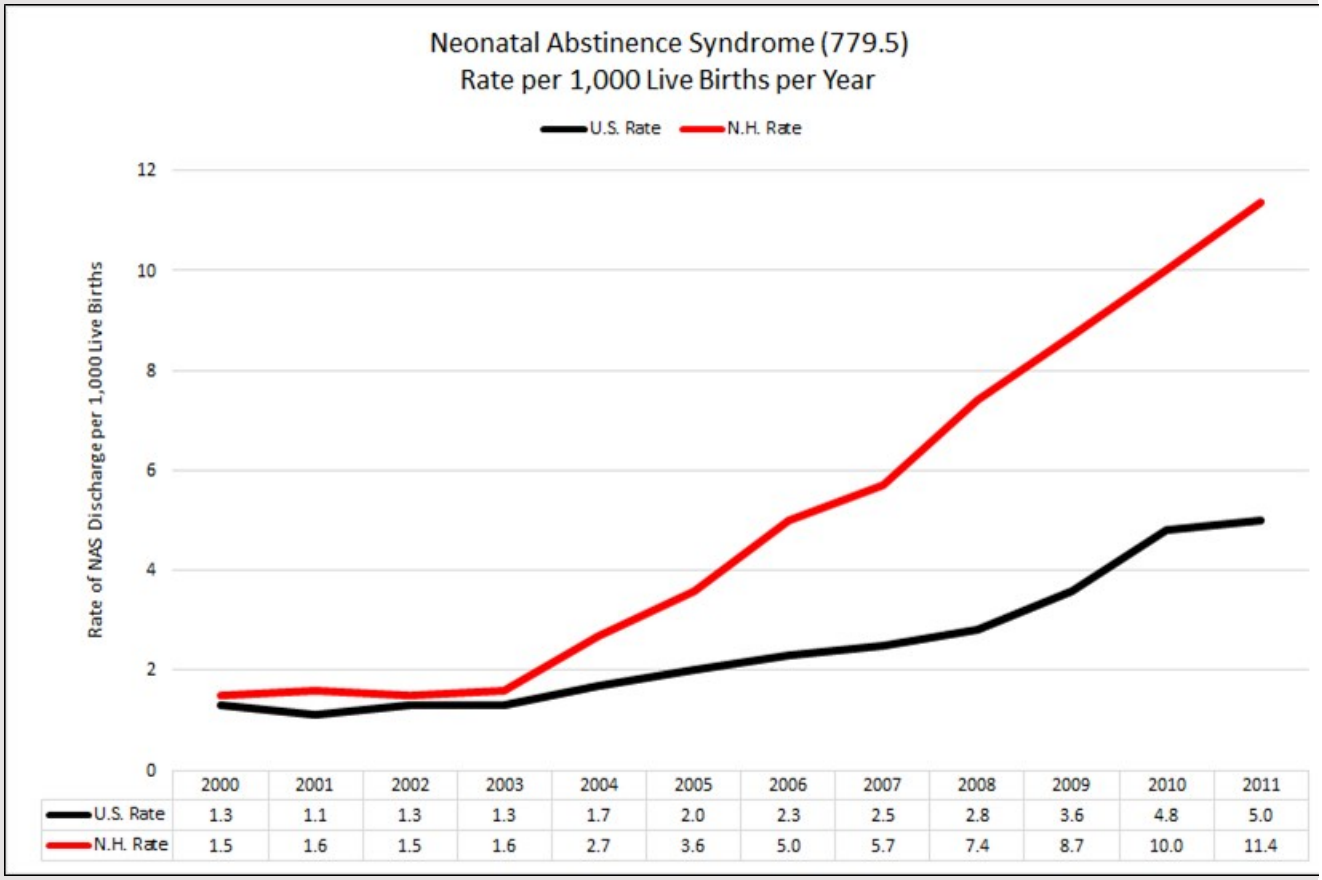
NH's **infant mortality** rate in 2014 was 4.5 per 1000 live births, ranking second in the nation; nationally the rate was 6.0 per 1000 live births.[31] Infant mortality, pre-term birth and low birth weight are areas in which NH excels, although disparities have been noted.

The National Immunization Survey of 2011 births shows that 86.4% of NH's infants received at least some **breastfeeding** ("ever breastfed"), with 57.6% still breastfeeding at six months. The Healthy People 2020 Objectives (81.9% ever breastfed and 60.6% breastfeeding at six months of age) are therefore already met and nearly met. Professional breastfeeding support is likewise quite high, with 7.33 International Board Certified Lactation Consultants per 1,000 live births in NH, compared with 3.48 per 1,000 live births nationally.[32]

Needs

Neonatal abstinence syndrome (NAS) occurs in newborns exposed to addictive illegal or prescription drugs during gestation, such as heroin, codeine, oxycodone, methadone or buprenorphine. Symptoms are varied and can include excessive crying, hyperactive reflexes, seizures, tremors, diarrhea, vomiting, sleep problems and

slow weight gain. NAS in NH has been rising steadily, even more so than nationally, and the rate may be substantially higher now than in 2011, which is the last year of data availability.[33] Staff from MCH actively participate in the Perinatal Substance Exposure Task Force and the associated Methadone Dosing workgroup. [Author's note: NH data does not match the Federally Available Data (FAD) due to a discrepancy in the method of calculation; we will review the FAD method as per the FAD Resource Document (dated June 19, 2015) and make appropriate adjustments as necessary.]



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
U.S. Rate	1.3	1.1	1.3	1.3	1.7	2.0	2.3	2.5	2.8	3.6	4.8	5.0
N.H. Rate	1.5	1.6	1.5	1.6	2.7	3.6	5.0	5.7	7.4	8.7	10.0	11.4

Three in ten children aged birth to 15 months receiving Medicaid did not receive the recommended number of **well-child home visits** and one in four children aged 3-6 years on Medicaid did not receive recommended child visits.[34] NH's active home visiting efforts have set their sights on this statistic for improvement.

In 2011-2014, there were 37 **Sudden Unexpected Infant Deaths (SUID)** in NH. Of those, 59% reported bed-sharing and 95% used soft bedding. Despite recommendations that all healthy infants be placed on their backs to sleep, the NH SUID Review Group found that only 50% of the cases reviewed had been placed on their backs.[35] NH's CoIIN (Collaborative Improvement and Innovation Network) team has selected safe sleep as a targeted action area, and the PRAMS project will begin collecting expanded information on sleep practices and behavior as of April 2016.

Child Health

Strengths

In 2013, 74.9% of children ages 19-35 months received the combined **vaccine** series, compared with 70.4% nationally[36] and the Healthy People 2020 goal of 80.0%.
The 2011-2012 National Survey of Children's Health reported that 91.2% of children aged 0-17 received a **preventive medical visit** and 85% received **preventive dental care** in the past year.[37]

School-based **oral health** programs in NH have worked to reduce disparities in schools. Results from the 2013-14 Third Grade Healthy Smiles - Healthy Growth Survey showed that 35.4% of third grade students statewide experienced tooth decay and 8.3% had untreated decay. In contrast, the 2008-09 survey found that 43.6% of students had decay experience, and 12.0% had untreated decay. There were no differences in the prevalence of oral health indicators by sex. Students attending schools with 50% or greater participation in Free and Reduced Lunch (FRL) Program had a greater need for urgent care, more untreated decay, and treated decay than students in schools with less than 25% participation in FRL. There was no statistically significant difference in the prevalence of dental sealants by FRL participation, indicating that the NH school-based oral health programs have been successful in reducing oral health disparities by targeting at-risk children for the application of evidence-based protective dental sealants.[38]

Variable	Number of Students	Percent	95% Confidence Interval
Decay experience	1,305	35.4	31.0-39.7
Untreated decay	298	8.2	6.7-9.7
Treated decay	1,161	31.8	27.6-35.9
Dental sealants	2,042	60.9	57.4-64.4
Need treatment	289	8.1	6.6-9.7
Need urgent treatment	26	1.0	0.3-1.7

Source: NH 2013-14 Healthy Smiles - Healthy Growth Survey report

Needs

Injuries are a leading cause of morbidity in children. The in-patient hospitalization rate for non-fatal injuries was 50.0 per 100,000 children in 2010 and 68.5 per 100,000 in 2011. Motor vehicle crashes account for a sizeable number of hospital visits for non-fatal injuries: in 2010, there were 103.2 emergency department visits per 100,000 children ages 0-9, and 80.4 per 100,000 in 2011.[39]

One in five preschoolers through the teen years have an emotional disorder that impacts their daily functioning at home, in school, or in their community. Of those children receiving **mental health services**, approximately 43% are diagnosed with a co-occurring alcohol or drug use disorder. Daily, over 250 NH children are living and receiving care in a residential placement or treatment facility.[40] As of 2012, about one third of children ages 2 to 17 with problems requiring mental health counseling did not receive it.[41]

Obesity is a life-course issue but it is noteworthy to highlight its importance in child health because it often originates in childhood and persists into adulthood, when most of the adverse consequences occur. In 2013, 993 children enrolled in WIC (14.1% of enrollees) were found to be obese.[42]

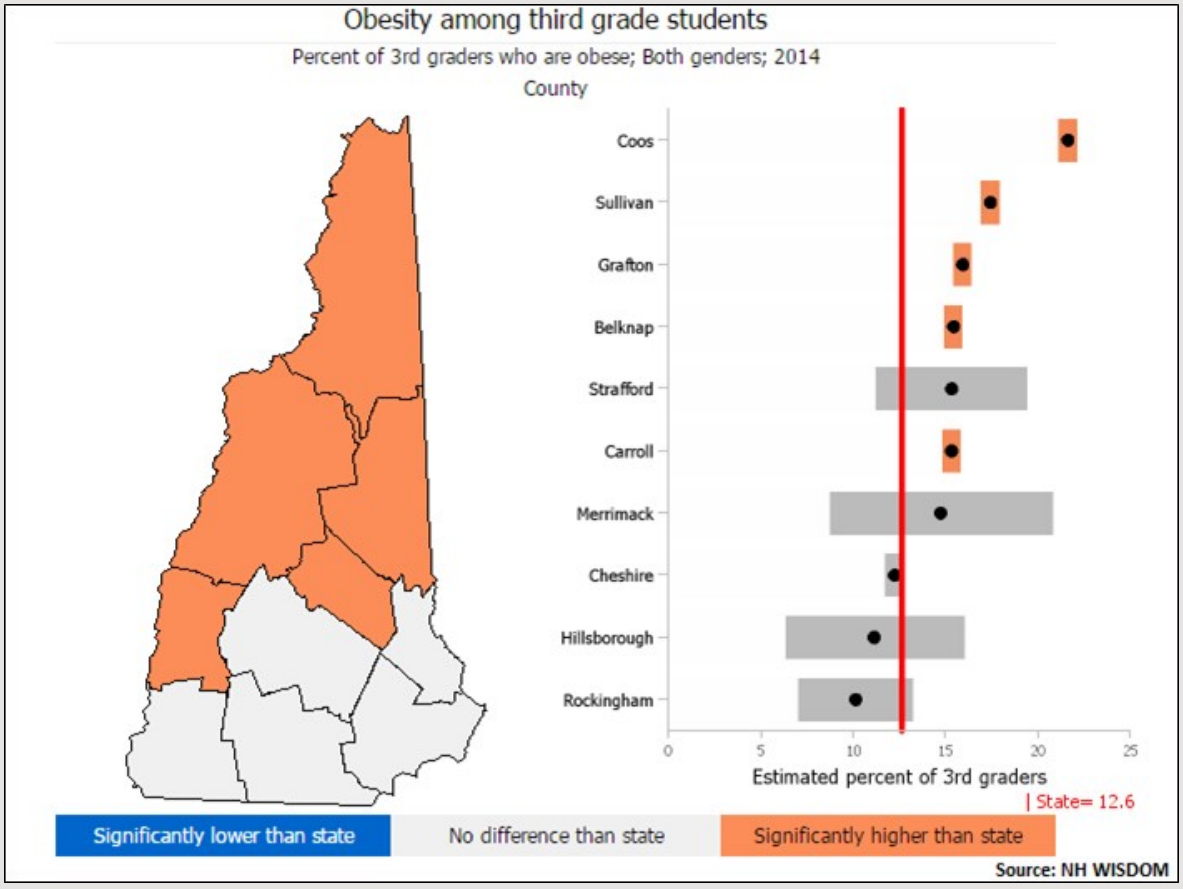
Obesity among WIC enrolled children

State; New Hampshire

Source: NH WISDOM

	Number of WIC children who are obese	Total number of WIC children evaluated	Percent of WIC children who are obese	Percent LCL	Percent UCL
2007	1,150	7,254	15.9%	15.0%	16.7%
2008	1,255	8,082	15.5%	14.8%	16.3%
2009	1,289	8,963	14.4%	13.7%	15.1%
2010	1,226	8,620	14.2%	13.5%	15.0%
2011	1,169	7,980	14.6%	13.9%	15.4%
2012	1,085	7,556	14.4%	13.6%	15.2%
2013	993	7,044	14.1%	13.3%	14.9%

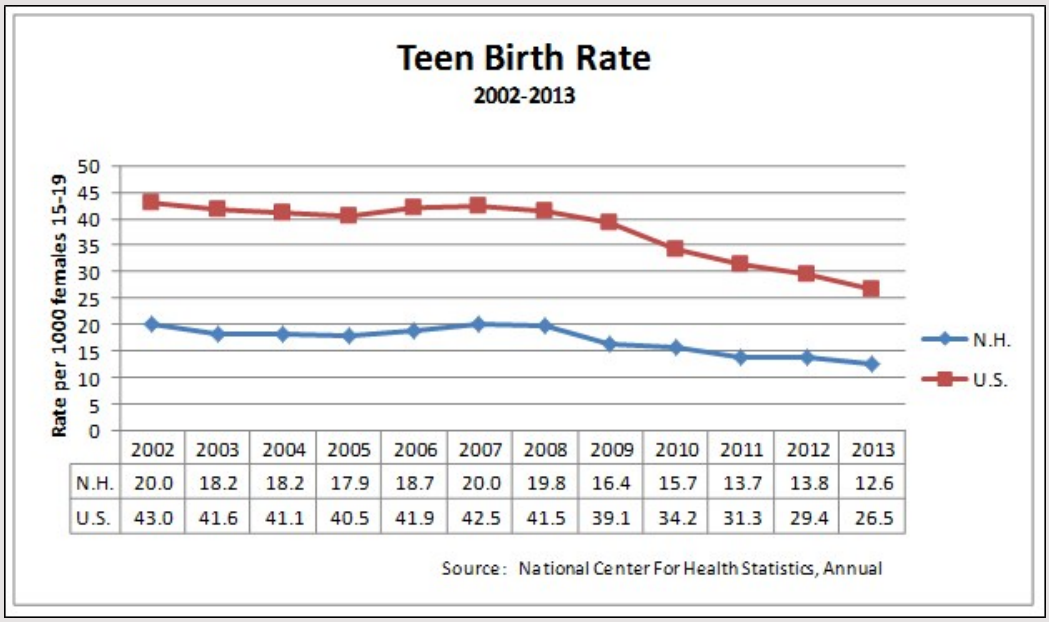
Data from the New Hampshire 2013-2014 Third Grade Healthy Smiles - Healthy Growth Survey found that 12.6% of third graders were obese, compared with 18.0% in 2009; this reflects a substantial improvement but there were strong regional disparities, with the northern counties showing significantly higher rates of obesity than the statewide average.[43]



Adolescent Health

Strengths

Each week in NH, 12 babies are born to teen mothers, ages 15-19.[44] Nonetheless, NH has the lowest **teen birthrate** in the nation. with approximately 13 births per 1000 women in 2013, compared to approximately 27 per 1000 nationwide.[45]



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
N.H.	20.0	18.2	18.2	17.9	18.7	20.0	19.8	16.4	15.7	13.7	13.8	12.6
U.S.	43.0	41.6	41.1	40.5	41.9	42.5	41.5	39.1	34.2	31.3	29.4	26.5

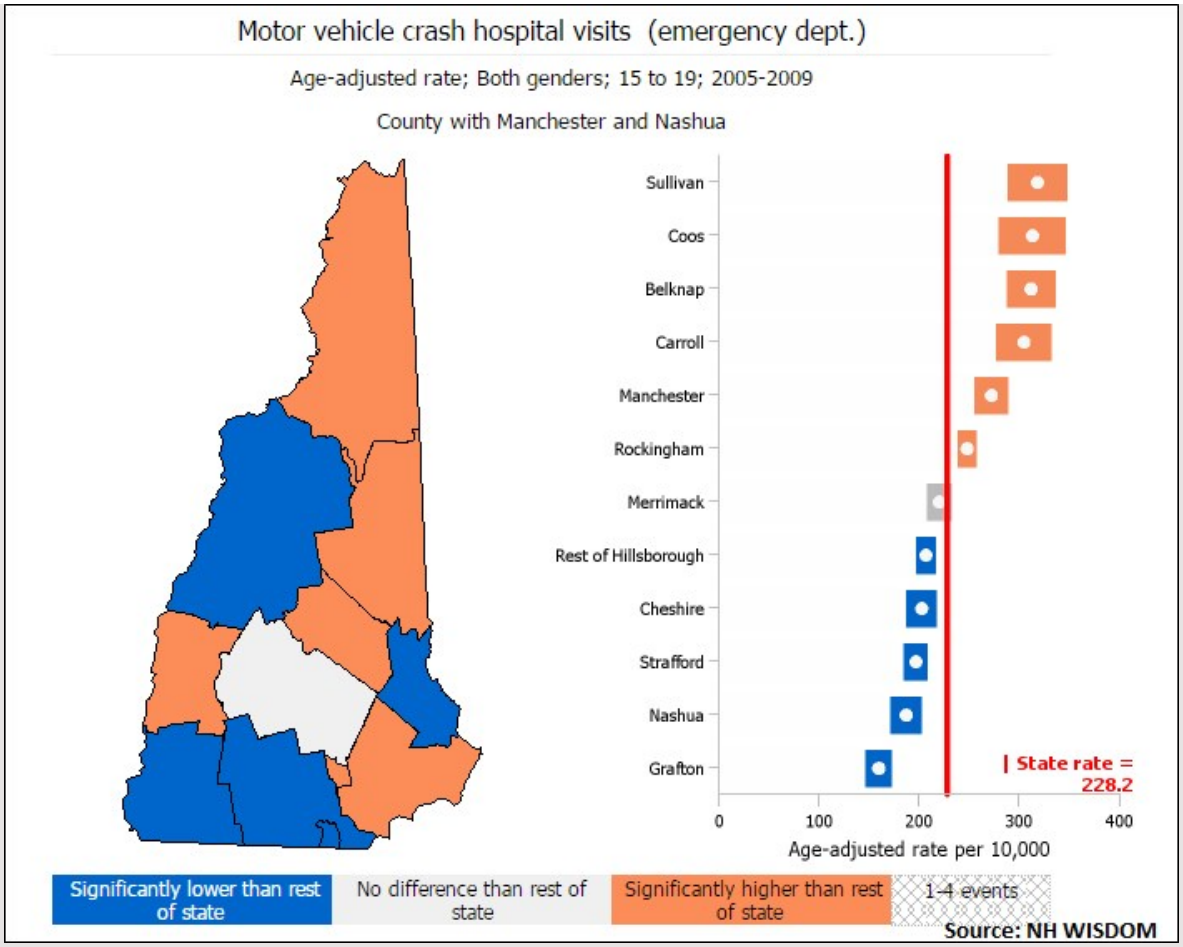
Teen births in 2014 numbered 486 (3.96% of 12,281 total births). Of these, 110 (0.9% of total births) of the mothers were 15-17 years old, and 374 (3.0% of total births) were 18-19 years of age.[46]

Needs

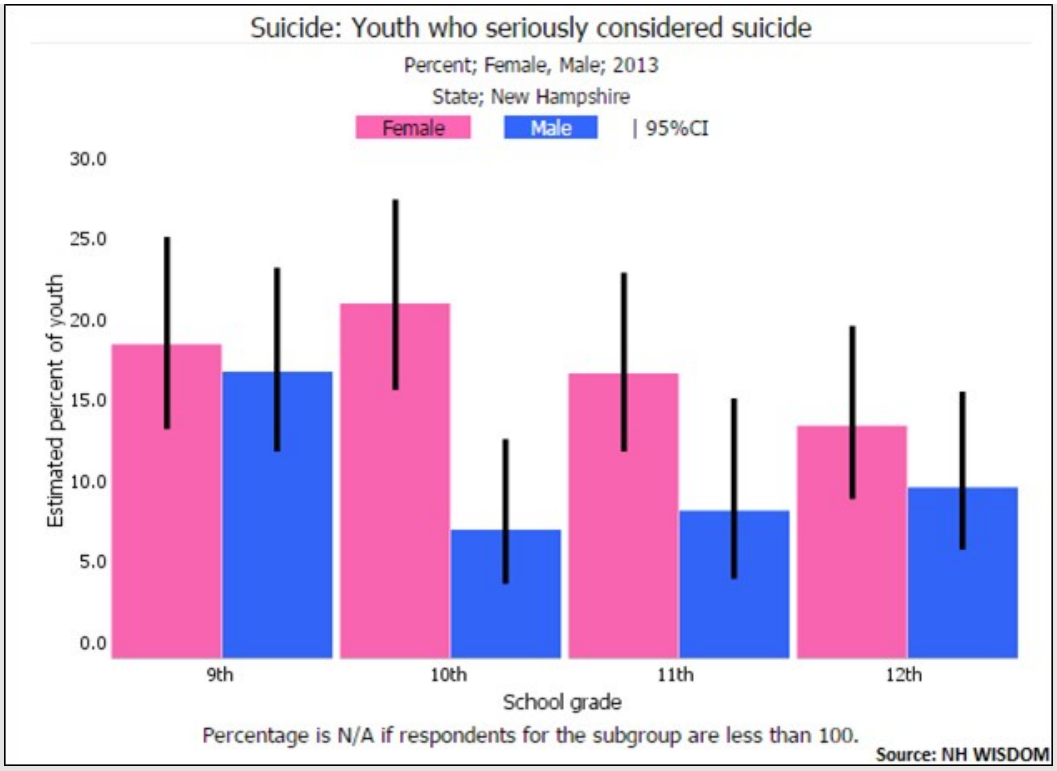
Unintentional injuries are the leading cause of death among youth aged 10-24 years,[47] and motor vehicle crashes account for the largest proportion of these. Motor vehicle crash-related hospital emergency department (ED) visits for adolescents 15-19 years have been steadily declining since 2000, but rates for girls, while also dropping, continue to be substantially higher than for boys:

Motor-vehicle crash-related hopsital ED visits			
	Age-specific rate per 10,000		
	2009	2010	2011
Boys 15-19 yrs	164	101	61.4
Girls 15-19 yrs	226	136	104
Source: NH Hospital Discharge data 2009-2011			

Significant regional disparity exists: for both genders together, rates in 2005-2009 are significantly higher than the state average in five of ten counties and one city.[48]



Suicide is the second leading cause of death in 15-34 year olds in NH. Suicide is more often attempted by females than by males, but males are more likely to die. Females have significantly more hospital visits and hospitalizations than males, due to suicide attempts or other self-harm. In 2013, 18.5% of ninth grade girls and 16.9% of ninth grade boys seriously considered suicide; for twelfth graders, this figure was 13.7% for girls and 10.2% for boys.[49]



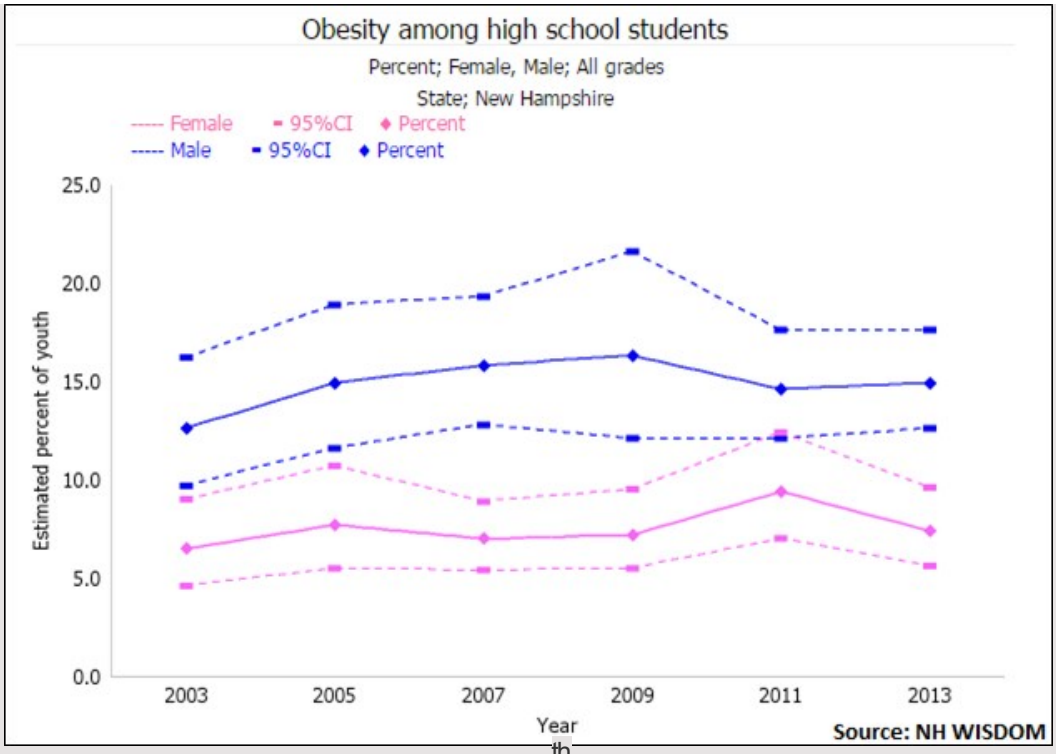
Violence is a stark reality that many adolescents live with, as the following statistics show:

- Students in a physical fight one or more times during the past 12 months, in 2011: all students 23.8%, boys 31.1% girls 16.2%
- Students who were bullied on school property during the past 12 months, in 2011: all students 25.3%, boys 23.7%, girls 27.4% [50]

The percent of students who had a **preventive visit** with a health care provider in the previous 12 months was 68.0% in 2009 and 71.8% in 2011, a slight improvement.[51] However, in 2014 only 61% of adolescents who were seen at CHCs received an annual health maintenance visit in the previous year.[52]

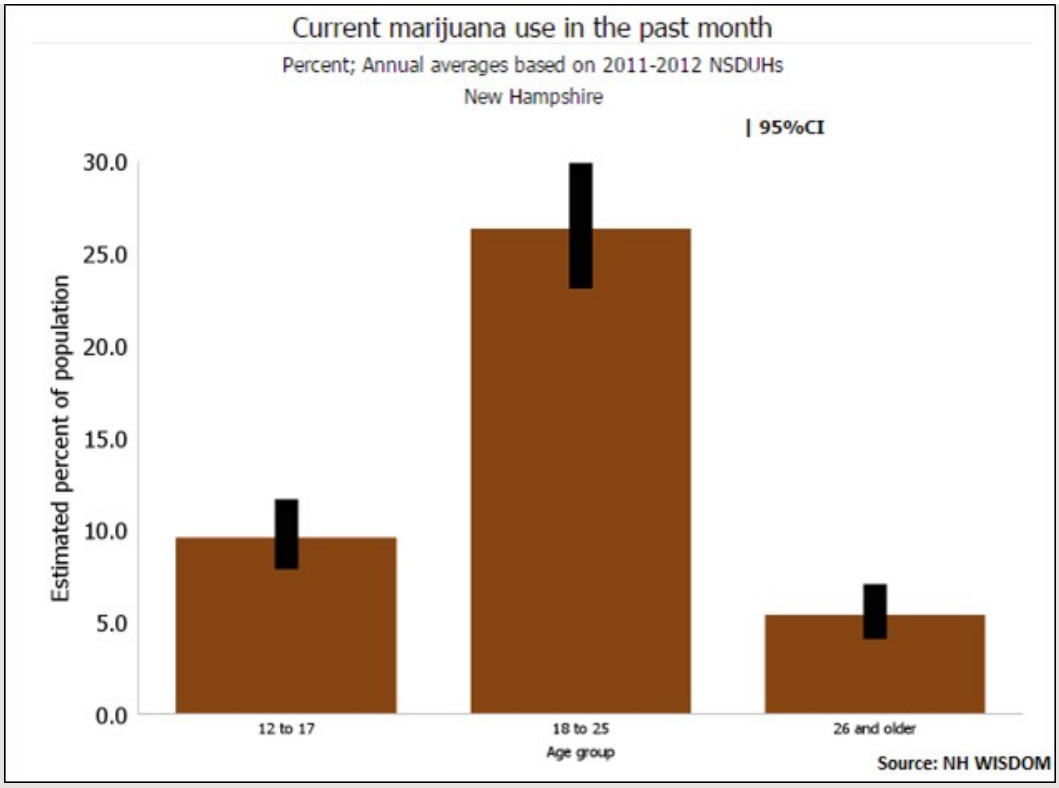
Around 10,000 youth (10.2% of all NH youths) per year in 2008-2012 had at least one **major depressive episode** within the year prior to being surveyed; 51.4% received treatment for depression, but 48.6% did not. The percentage receiving treatment through the public mental health system who reported improved functioning was lower in NH (57.8%) than in the US as a whole (70.0%).[53] Improved access to mental health services was cited as a need in all activities that were carried out for this report.

Overweight and obesity are ongoing issues beyond childhood into adolescence. **Obesity** (>95th percentile BMI-for-age) among high school students is pronounced, and significantly more frequent in boys than in girls: in 2013 14.9% of boys were obese, and 7.4% of girls. These figures are relatively unchanged since 2003.[54]



Students who were **overweight** (at or above 85th percentile BMI-for-age) were 13.5% among boys, 14.2% among girls.[55]

Illicit drug use is widespread among adolescents, and **marijuana** is the illicit drug most likely to be used by teens and young adults. A majority of persons admitted to treatment programs cite marijuana as a primary or secondary reason for seeking treatment. Current marijuana use in NH in the past 30 days is most frequent in the 18-25 year age group.[56]



Among high school youth, current marijuana use is the past 30 days is reported at 24.4% in 2013; for 12th graders, this figure was 36.1% for boys and 27.3% for girls.[57]

High school age youth who used marijuana in past 30 days

Percent; Female, Male; 2013

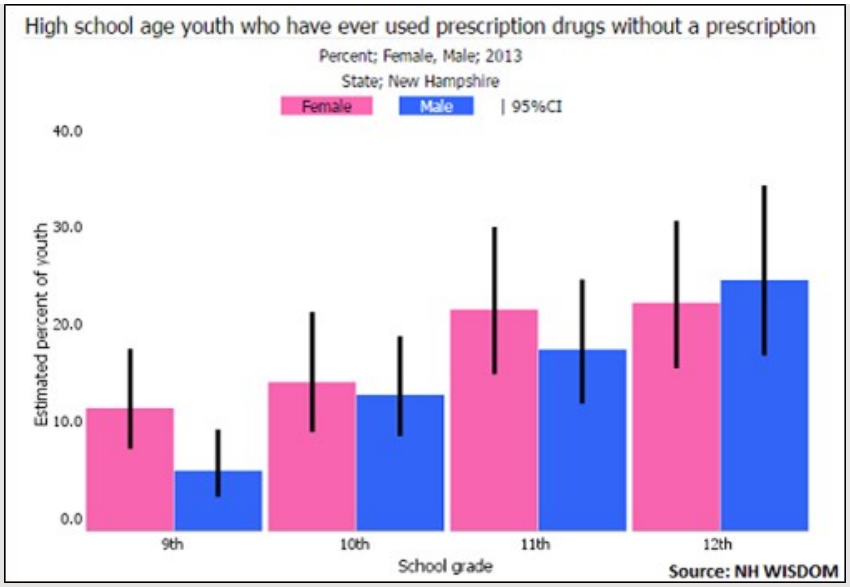
State; New Hampshire

		Estimated percent of youth	Lower confidence interval	Upper confidence interval
9th	Female	15.6	11.0	21.8
	Male	15.6	10.9	21.8
10th	Female	18.9	13.0	26.7
	Male	23.3	18.4	29.1
11th	Female	29.1	22.3	37.1
	Male	29.1	21.8	37.6
12th	Female	27.3	21.2	34.4
	Male	36.1	29.8	43.0

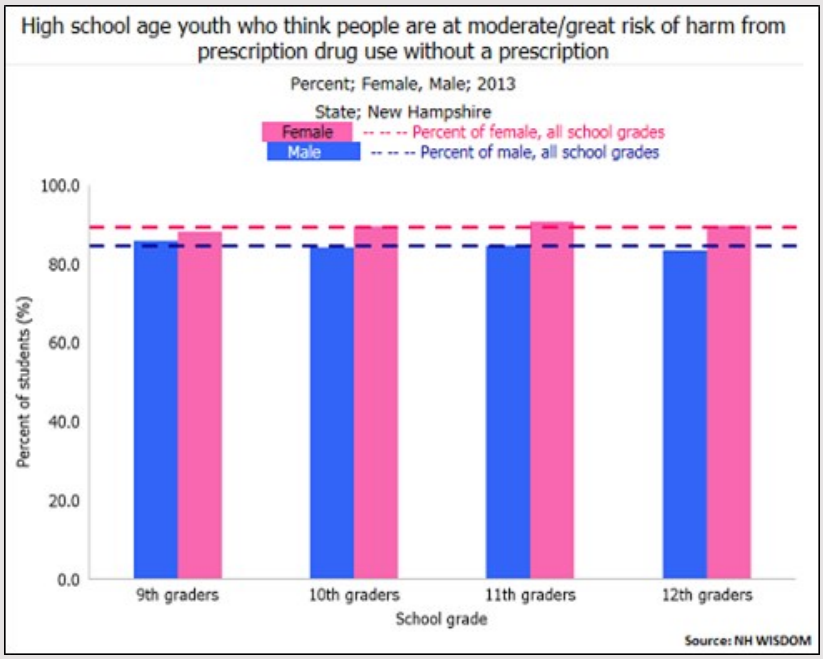
Percentage is N/A if respondents for the subgroup are less than 100.

Source: NH WISDOM

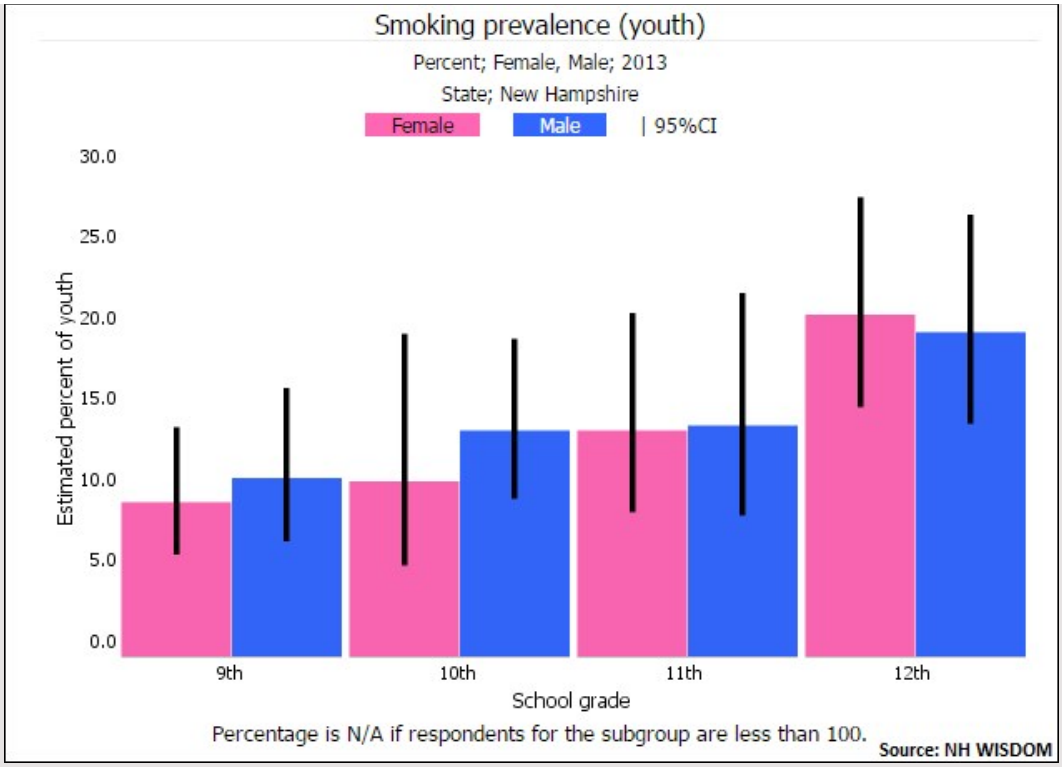
The misuse of **prescription drugs** poses significant health risk and it can be a contributing factor to misuse of other drugs and a cause of unintentional overdose and death. In 2013, 22.4% of 12th grade girls and 24.6% of 12th grade boys reported ever having used prescription drugs without a prescription; for 9th graders these figures were 12.1% for girls and 5.9% for boys.[58]



Surprisingly, in view of the usage rates increasing with age, the percent of high school youth who perceive a risk in using prescription drugs is high and stable with age (at least through high school), ranging from 84-86% among boys and 88-91% among girls.[59] Increasing use is therefore not indicative of a diminished perception of risk, but increased risk-taking behavior.



The prevalence of **cigarette smoking** in high school youth was reported as 13.8% in 2013; the rate increases progressively from 9th through 12th grade for both sexes. The use of other tobacco products was reported at 7.3% with a similar progressive increase through the high school grades. Cigarettes are used equally by boys and girls, but other tobacco products are mainly used by boys (13.3% of boys vs. 5.5% of girls, in 12th grade).[60]



Current **electronic cigarette** use among US middle and high school students tripled from 2013 to 2014, according to the CDC and the USFDA Center for Tobacco Products. Findings from the 2014 National Youth Tobacco Survey show that current e-cigarette use among high school students increased from 4.5% in 2013 to 13.4% in 2014. Among middle school students, current e-cigarette use more than tripled from 1.1% in 2013 to 3.9% in 2014. This is the first time since the survey started collecting data on e-cigarettes in 2011 that current e-cigarette use has surpassed current use of tobacco products overall. E-cigarettes are not replacing tobacco, as no decline was seen in overall tobacco use among middle or high school students, and use of multiple tobacco products was common.[61]

CSHCN: Children with Special Health Care Needs

Data from the 2011/2012 National Survey of Children's Health (NSCH) indicates that New Hampshire has approximately 59,313 children 0-17 years of age with special health care needs. This is 21.2% of the population of all children 0-17 years of age in the State of New Hampshire. The data available ranks New Hampshire as having the 17th highest percentile of CSHCN compared to non-CSHCN in the nation. New Hampshire's population of CSHCN compares to the rest of the nation as follows:[62]

In New Hampshire:	NH%	Nation%
More CSHCN are female	20.5%	17.0%
The ratio of male to female CSHCN is smaller	21.9% to 20.5%	22.5% to 17.0%
CSHCN are more likely to have Public insurance	30.3%	23.4%
CSHCN are less likely to have all components of a Medical Home	32.5%	23.2%

Strengths

New Hampshire has performed well on the MCHB Core Outcomes. A primary measure for Title V CSHCN programs in the US are the six federal Maternal and Child Health Bureau Core Outcomes. These are measures that are used across state programs to monitor progress toward the goal of a comprehensive, family-centered, community-based, coordinated system of care for CSHCN. According to the NS-CSHCN from 2009/2010, New Hampshire ranked 1st in the Nation for CSHCN who are served by systems of care that meet all age-relevant core outcomes, 2nd for CSHCN ages 12-17 who met all six MCHB Core Outcomes and 3rd for CSHCN ages 0-11 who met all five MCHB Core Outcomes (the Transition Core Outcome does not apply to this age group).[63]

Needs

As noted above, the 2009/2010 NS-CSHCN report indicates that NH has performed very well on the MCHB Core Outcomes. Moving forward the data used will come from the NSCH and on that survey from 2011/2012 a significant negative change was noted comparing NH success on the MCBH outcomes of Medical Home, with NH ranking 24th in the Nation for CSHCN who report all criteria of a Medical Home was met. Though New Hampshire in general has high rates of insurance for CSHCN (consistent with all of Region I), when compared to the rest of Region I New Hampshire is ranked 2nd to the lowest for the percentage of CSHCN who were insured for the entire previous year. Efforts to insure that services are organized in such a way that families find them easy to utilize will be a strong focus on activity and service planning to facilitate access in order to decrease any burden or hardship that caregivers are experiencing.

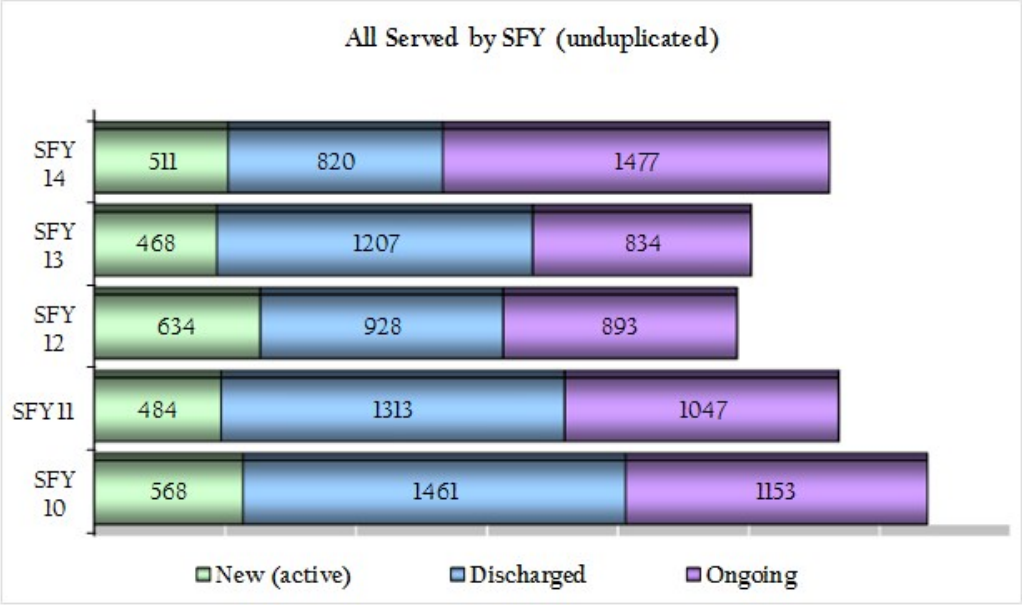
Medical Home Core Outcomes

It is critical to identify the needs associated with these; more available and effective medical homes should conceivably limit difficulties accessing any health related services. In NH the difference between CSHCN and non-CSHCN is significant when reporting that their care meets all of the criteria for having a medical home.[64] New Hampshire non-CSHCN ranked this outcome as 71.4% (2nd in the Nation) but CSHCN only ranked this outcome as 48.2% (24th in the Nation).

Access to a Medical Home has a significant effect on unmet needs. Of CSHCN who needed specialty care, 100% of CSHCN with a medical home had no trouble getting needed referrals, while only 55.1% of those without a medical home reported this ease of access. Similarly, when asked about unmet needs for 15 specific services/equipment 93.6 % of respondents with a medical home reported that they had no unmet needs while only 78.9% of those without a medical home reported the same level of access.

According to the NSCH, CSHCN were three times more likely than non CSHCN to have needed health care that was not received.[65] This unmet health care is typically specialty care or therapies/treatments since NH CSHCN report that they have annual preventative care at a slightly higher rate than non-CSHCN. Ongoing planning to work on Medical Home System improvement with a focus on Coordination of Care will address this need.

From a statewide perspective there are several indicators of the types of services necessary for New Hampshire's CSHCN. Trend data indicates that enrollment in Special Medical Services continues to grow (in 2011 enrollment numbers were cleaned to reflect services within a 12-month period), as does utilization of SMS' Information and Referral services. Services with the greatest utilization are Nutrition and Feeding & Swallowing, Child Development Clinics, Community-Based Care Coordination and Neuromotor Clinics, respectively.



Respite

Care of CSHCN strains the physical, emotional, mental, financial, and social well-being of caregivers. Families are the largest providers of long-term care for children with disabilities. Long-term medical care of children with complex conditions can be overwhelming and can lead to poor psychological outcomes in caregivers.

Respite services can positively impact CSHCN throughout their life. Respite can afford the child opportunities for additional experience outside the family home; support the caregivers of the child; prevent family breakdown and /or rejection of the child and it can avoid the admission of the child to long term residential care or the necessity for substitute family placement.

In New Hampshire, the capacity of the system to address this need has been assessed to have gaps in certain areas (i.e., the lack of trained staff both in terms of number and skill level; limited and fragmented funding). Other input from stakeholders indicated that while child care programs in New Hampshire receive some health care consultation, the staffs of these programs are not adequately trained to provide care for behaviorally/medically fragile children and often decline to enroll them. It is clear that a statewide effort is needed to promote and provide instrumental support for workforce development to serve this population of CSHCN.

There has been ongoing work to create a competency based respite curriculum for families and providers of respite care and a web based registry of those providers statewide. Ongoing efforts will need to focus on providing data to justify the need for continued funding for respite and comprehensive recruitment and training of providers.

Cross-cutting/Life course

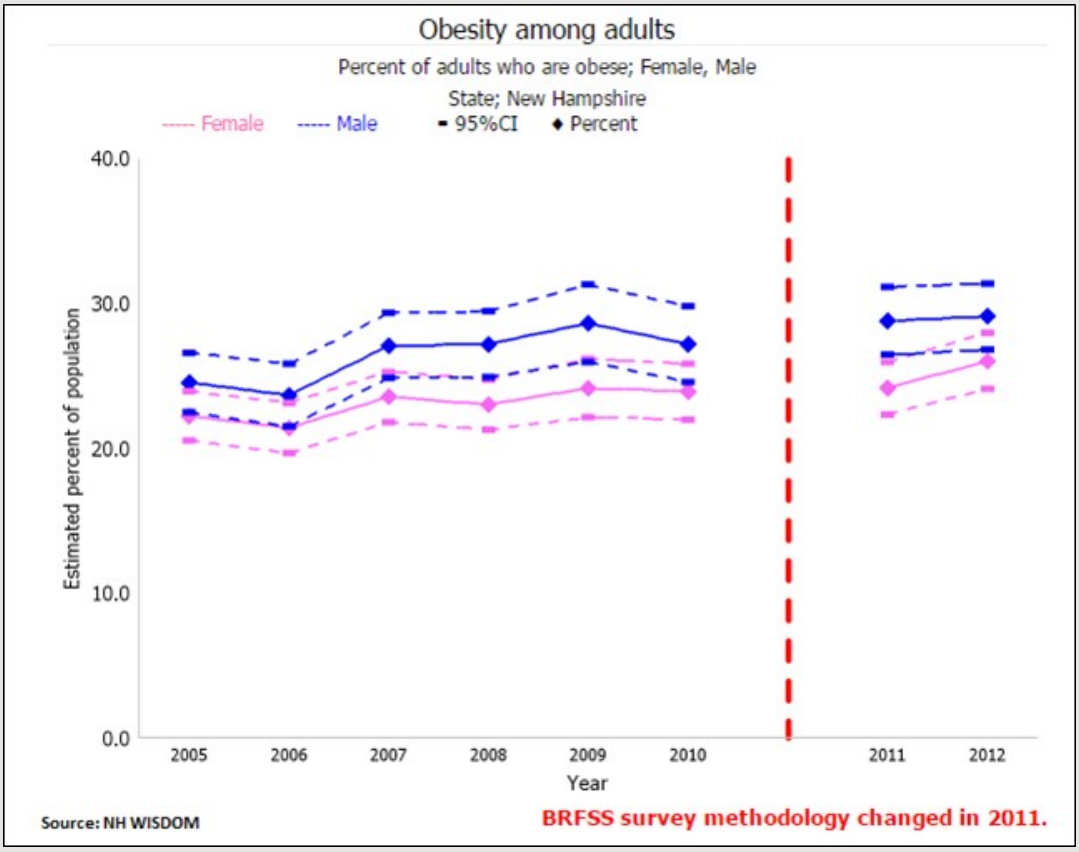
Needs

Mental illness is a serious cross-cutting issue. In NH, about 46,000 adults (4.5% of all adults) per year in 2008-2012 had a serious mental illness within the year prior to being surveyed; of these, 50.3% did not receive

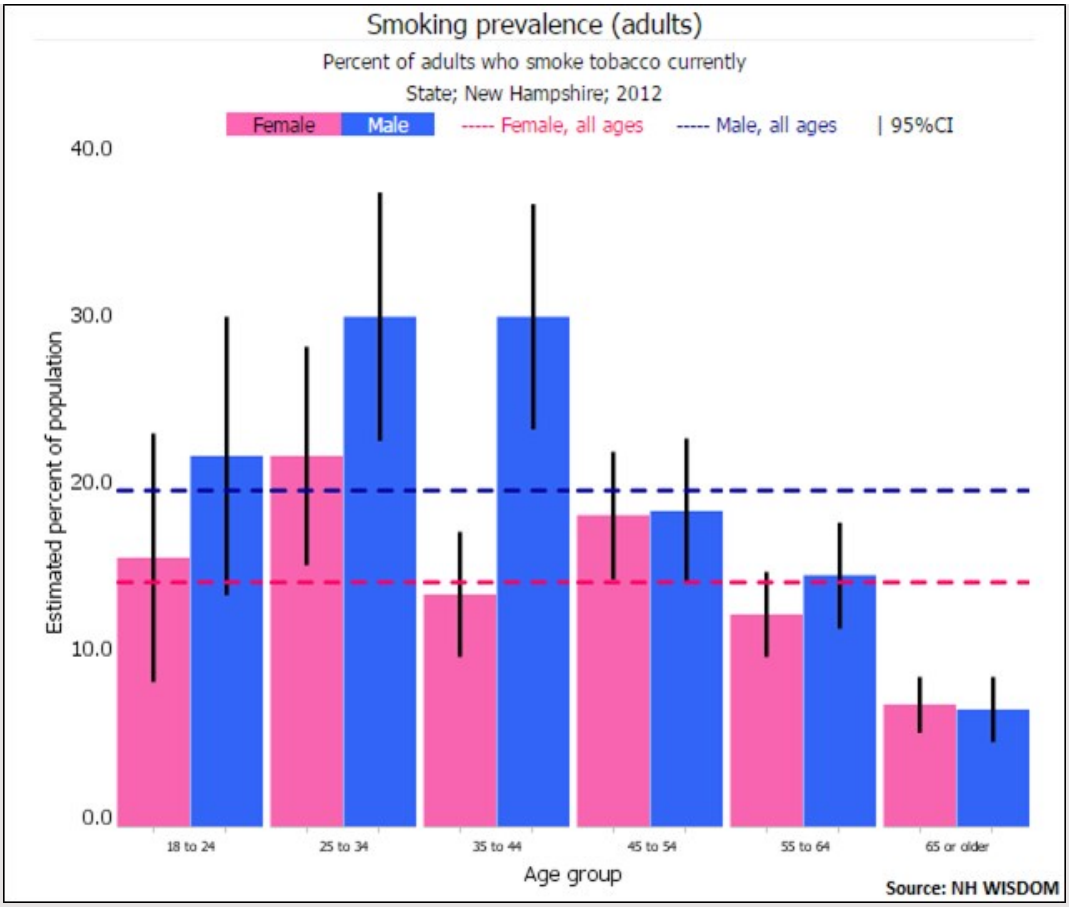
treatment. The percentage of adults receiving treatment through the public mental health system who reported improved functioning was lower in NH (59.2%) than in the US as a whole (71.2%).[66]

A statewide public **mental health** consumer survey was conducted in 2013; a total of 1,538 surveys were collected from adult, family and youth consumers of state funded community mental health centers. Results showed that 14% of adult consumers and 6% of youth consumers had a co-occurring substance use problem, and only 34% of youths and 40% of adults who reported drug/alcohol problems had substance use services as part of their treatment plan.[67]

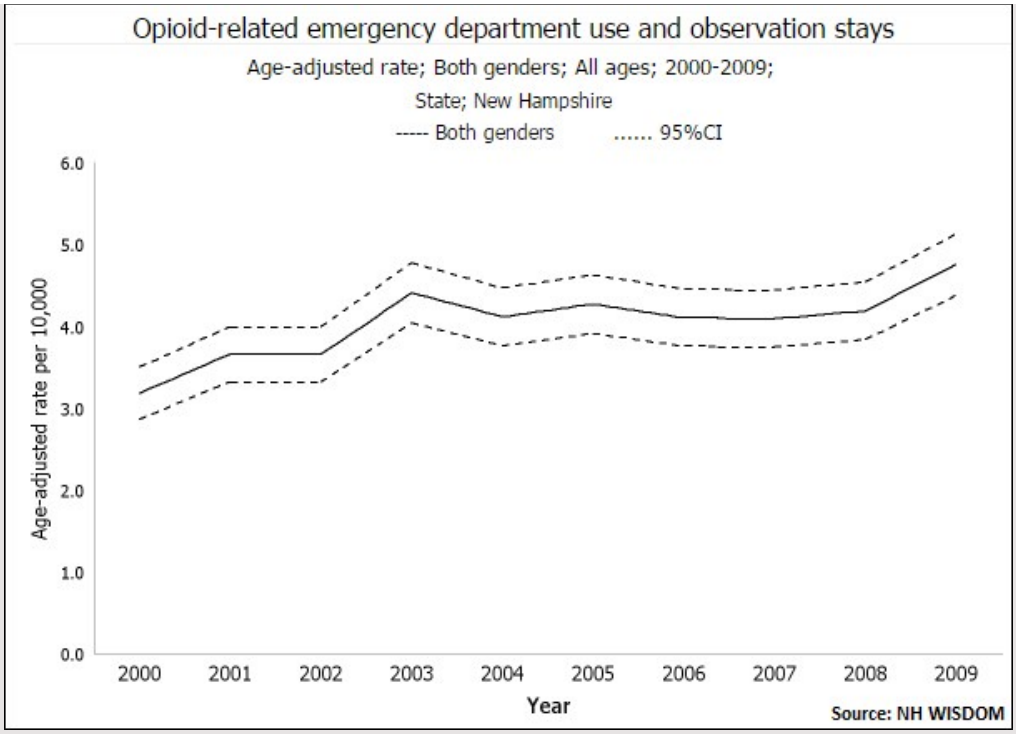
Obesity is a complex life course issue. Obesity in NH is more prevalent among men than women, and obesity trends seem to be worsening, with 26.04% of women and 29.11% of men considered obese in 2012, compared with 24.15% of women and 28.79% of men in 2011.[68]



Tobacco use remains widespread, with 16.2% of adults reporting smoking in 2013; three-quarters of these report smoking daily. Tobacco use is the single most preventable cause of death and disability. Smokers are mainly young and male. The use of other tobacco products was estimated at 2.98% in 2011 and 2.16% in 2012. Over 81% of deaths in 2011-2012 from trachea, lung or bronchus cancer are attributable to smoking.[69]

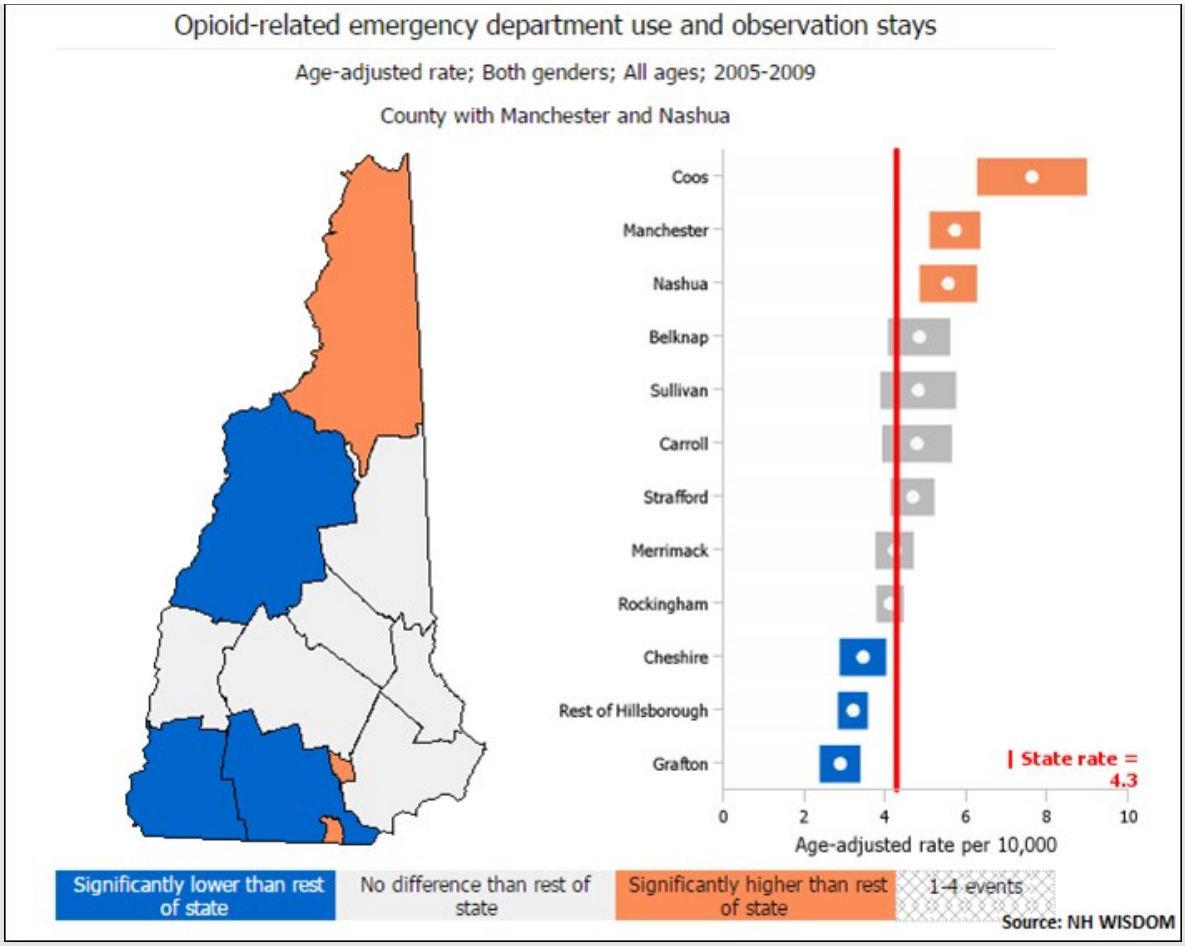


Opioid use is increasing. Lifetime use of heroin in all age groups is rising, and in 2009, 4.79 persons per 10,000 population had opioid-related emergency department use and observation stays.[70]



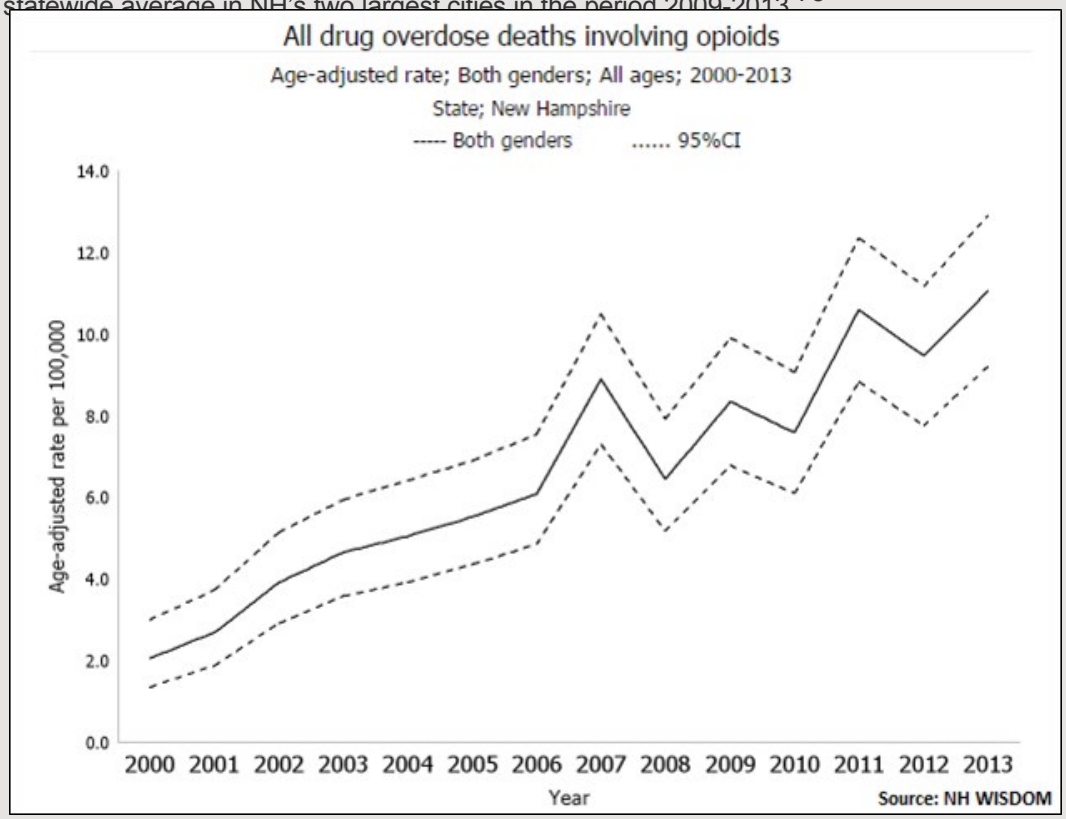
More recent data reports 600 emergency department visits in 2013 (of which 307 were females, 293 males), and 1051 in 2014 (373 females, 678 males).[71]

Regional disparities have been noted, with one rural county and two cities reporting significantly higher rates than the statewide average in the period 2005-2009.[72]



Opioid-related overdose deaths are likewise rising, from 2.10 deaths per 100,000 in the year 2000, to 11.06 per

100,000 in 2013. Regional disparities exist here also, with statistically higher rates of overdose deaths than the statewide average in NH's two largest cities in the period 2009-2013.[73]



II.B.2.b Title V Program Capacity

II.B.2.b.i. Organizational Structure

NH's Title V Program is located in the NH DHHS overseen by a Commissioner reporting directly to the Governor.

Administration of Title V is assigned jointly to MCH and SMS.

MCH resides in the Division of Public Health Services (DPHS), within the Bureau of Population of Health & Community Services (BPHS), which houses other population health services such as Chronic Disease, WIC, Rural Health and Primary Care.

The SMS section resides in the Division of Community Based Care Services (DCBCS), within the Bureau of Developmental Services (BDS), which aligns services for CSHCN with the elderly/disabled adults, individuals with intellectual disabilities and those with mental health issues.

Each Title V Section Administrator is responsible for her own staff, budget, and for assuring that activities proposed under Title V are carried out. While each program is distinct administratively, they coordinate frequently at the programmatic level to ensure broad and integrated services.

See Supporting Documents for organizational charts.

MCH Programs Receiving Title V Funding

Primary Care
MCH supports 15 CHCs in providing comprehensive primary care services, including prenatal and pediatric care, for over 116,000 individuals and 1500 pregnant women in 2014 (NH MCH UDS tables, 2014). Three of the CHCs provide services specifically for the homeless population, who suffer from health care problems at more than double the rate of individuals with stable housing. Two utilize mobile vans to provide services as opposed to the traditional office-based setting. Funding for primary care includes support and enabling services such as case management, transportation and interpretation services. One additional agency is funded solely for prenatal care.

Child Health/Prenatal
The Child Health Nurse Consultant and Prenatal Nurse Coordinator positions are funded by Title V. The former's duties include a broad spectrum of activities, ranging from involvement with pediatric focused coalitions to overseeing the pediatric service components of the primary care contracts. The latter coordinates the Maternal Mortality Committee and provides oversight to the prenatal service components of the primary care contracts.

Home Visiting
In an effort to improve services to families in need, MCH and the Division for Children, Youth and Families (DCYF) worked together to blend the former Home Visiting New Hampshire and Title V funded Child and Family Health Support programs with the currently existing Family Resource Center program (DCYF funded) into bundled **Comprehensive Family Support Services (CFSS)** contracts that work by intervening at critical periods of stress and transition. Twelve sites implement CFSS for pregnant women, children, and families with children up to the age of 21.

Injury Prevention (IPP)
The IPP Manager and part of the Surveillance Coordinator are funded by Title V. The IPP seeks to reduce morbidity and mortality due to intentional and unintentional injuries. The IPP oversees the contracts with the NH Coalition for Domestic and Sexual Violence, the Injury Prevention Center and the Northern New England Poison Center.

Quality Improvement (QI) Program
The QI Nurse Consultant position is funded by Title V. This position oversees a variety of projects such as assessments of MCH-funded clinics with chart reviews and specific recommendations and required actions to fulfill contracted services.

SMS Programs Receiving Title V Funding

Federal funding supports a portion of all eleven SMS programs with external contracts. These contracts are primarily for Enabling Services with some Public Health Services and a very small percent supporting direct services.

Child Development Program
The Child Development Services Network is comprised of five Child Development Programs contracted through Dartmouth and local community health agencies to provide a community-based multidisciplinary approach to

diagnostic evaluation services, to children 0-6 suspected of or at risk for altered developmental progress.

Pediatric Specialty Clinics
SMS operates clinics for Neuromotor Disabilities in five locations. These multidisciplinary clinics utilize treatment approaches that encourage families 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 services.

Nutrition, Feeding And Swallowing Program
This program offers community-based consultation and intervention services. Dietitians and feeding/swallowing specialists provide services utilizing a home visiting framework. SMS offers specialized training for all network providers and assures a coordinated, outcome-oriented approach.

Family Education & Support Services
Title V supports NH Family Voices (NHFV) in its mission to assist families with CSHCN. NHFV provides information, support and referrals through the toll-free line provided by SMS. NHFV maintains a comprehensive lending library specializing in children's books, and publishes a quarterly newsletter. NHFV also publishes an annual listing of support group/organizations and operates a comprehensive website.NHFV staff are parents of CSHCN who can personally relate to the issues and concerns raised by individuals seeking their assistance.

Medical Home Project
This initiative focuses on fostering care that is accessible, family-centered, comprehensive, coordinated and culturally effective for children from birth to age 21, through policy level initiatives, infrastructure development, and planning and technical support for the continuation of Medical Home activities as they relate to CSHCN.

Psychiatry/Psychology Consultation
SMS contracts with a child psychologist and a psychiatrist to provide access to services for CSHCN. Psychology services include 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.

II.B.2.b.ii. Agency Capacity

Data from multiple sources reveal that NH has one of the highest quality healthcare systems in the country. Its infrastructure and many health outcomes continue to rank favorably nationwide (America's Health Rankings 2014), but health care is expensive, and measures of public health and access show opportunities for improvement. Public input referred repeatedly to issues of cost and access.

NH's health care delivery system for the Title V population consists of a partnership of public and private health service providers. This system varies regionally, which presents challenges in attaining a seamless system of health care services. Much of the state is designated as medically underserved or health professional shortage areas. Below is a summary of ongoing agency activities within MCH and SMS, broken down by population domain.

Women's Health

The Family Planning Program (FPP) provides funding to 13 community health agencies at 27 physical locations

(often the same agencies providing primary care). Services include contraception, testing for pregnancy and sexually transmitted infections, treatment and counseling, as well as related reproductive health services. The program has a special emphasis on serving low-income clients. In 2014, the FPP provided reproductive health care to 17,000 women and men.

Adolescent Health

In addition to supporting clinical services, the FPP administers the Personal Responsibility Education Program **(**PREP) in two sites where data indicates disproportionately high numbers and rates of teen births. Last year, PREP helped 141 adolescents build skills and confidence around sexuality and preventing pregnancy.

Perinatal Health

The Newborn Screening Program (NSP) and the Early Hearing Detection and Intervention (EHDI) Program staff work closely with hospitals and pediatric primary care providers; NH state law (RSA 132:10a) requires that all infants born in the state be screened. The NSP staff follow up with providers if any babies miss their screening, or if/when any samples are deemed inadequate by the testing lab. Likewise the EHDI staff follow-up with birthing centers and testing facilities to ensure that hearing screening has been performed and that referrals for further services are provided as needed.

Child Health

Child Health Program activities involve collaboration with a variety of state and community agencies, because child health is multi-disciplinary, involving medical care, psychosocial services, nutrition, injury prevention, etc.

MCH was identified as lead agency for the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program. Under this HRSA-funded program, NH administers *Healthy Families America*, an evidence-based home visiting model proven to improve child health. MCH currently contracts with seven community-based agencies in 11 sites to provide home visiting services for Medicaid eligible pregnant and parenting women, to improve maternal and child health, prevent child abuse and neglect, encourage positive parenting, and promote child development and school readiness.

Watch Me Grow is a comprehensive screening and referral system for families with children from birth to six years of age. The evidence-based screening tools include the Ages and Stages Questionnaires, 3rd edition (ASQ-3) and Ages and Stages Questionnaires: Social Emotional (ASQ: SE). Some 283 individuals in eight regions were trained to use the ASQ-3 and ASQ-SE.
Project LAUNCH aims to improve coordination across early childhood-serving systems by improving identification and treatment of behavioral health issues in childcare as well as improving the social and emotional well-being of young children. Project LAUNCH focuses its efforts on families with children under age eight whose household income is below 185% of the poverty line. Project LAUNCH grantees are guided by state and local Young Child Wellness Councils, which provide comprehensive, coordinated leadership and strategies for the implementation of evidence-based services.

SUID and SDY (Sudden Death in the Young) have active multidisciplinary review groups composed of representatives from state agencies or programs such as home visiting, Medicaid, DCYF, Drug and Alcohol Services, child care licensing, behavioral health, and representatives from the private sector who represent hospitals, lactation consultants, pediatricians, obstetricians and neonatologists. This multi-sectorial public-private collaboration ensures statewide systems of services that are comprehensive, community-based, coordinated,

and family-centered.

CSHCN

SMS is involved in many of the initiatives previously mentioned to insure communication and collaboration that is consistent across Title V activities for children's services, including CSHCN, such as Spark NH and the NSP. Additional efforts aimed at protecting and promoting the health of CSHCN include the following:

SSI Outreach has been a strong focus for CSHCN. SMS has a designated care coordinator to provide outreach and support to all new recipients with a medical diagnosis in addition to providing 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 Multi-Sensory Intervention through Consultation and Education (MICE) program has been administered by the Parent Information Center in cooperation with the BDS to serve children 0-3 for whom there is a concern with vision and/or hearing. This program was closely aligned with the Family Centered Early Supports and Services (FC-ESS) staff. In the coming year these services will be embedded in the FC-ESS agencies. The emphasis will remain on the impact of a diagnosed visual/hearing impairment on learning and development. Consultation and technical assistance resources to ESS teams, and direct services to children and families will be identified and leveraged.

Family-centered community based, coordinated care is one of the foundation supports offered by SMS for CSHCN and their families. Community Based Care Coordination for SMS means working together with families of CSHCN 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 applied for and received funding through a HRSA grant, FACETS of Epilepsy Care in NH, to improve the coordination of care across all areas in the state, improve access to specialty care and to develop a model for transition from pediatric specialty to adult care. Activities will facilitate increased communication and planning for families of children with epilepsy. Partners involved in this grant include the NH Pediatric Improvement Partnership and the Epilepsy Foundation of New England.

An additional Federal grant was received to develop an Autism State Plan; the proposal and grant activities are a collaboration of SMS, MCH, NHFV, NH's statewide advisory Council on ASD and the NH LEND Program. The two-year project will address the need for a State Plan for comprehensive and coordinated care for children and youth with ASD that sets measurable objectives for systems change.

Cross-Cutting

MCH provides data trend tables (example below) to its agencies that receive funding for primary/prenatal care. Each report presents information collected from MCH performance measures and includes data ranges and averages. Agencies are encouraged to use this information to set priorities and plan quality improvement activities.

Data Trend Table

Performance Measure #2

Percent of at-risk children who were screened for blood lead between 18 and 30 months of age.

SFY	Range	Average	Your Agency	Additional # Needed to Reach Average
14	**41% - 100%**	**84%**	**81%**	**2**
13	50% - 97%	81%	78%	2
12	41% - 98%	89%	63%	
11	28% - 96%	82%	66%	
10	28% - 98%	81%	78%	

II.B.2.b.iii. MCH Workforce Development and Capacity

MCH Staffing

The state level MCH workforce consists of 22 positions, including a contracted .8FTE Epidemiologist, 17 FTEs and four part-time staff making up an additional 2.7 FTEs. Ten of the positions are funded in some way by Title V. MCH has five programmatic units, which are headed by the management team including an additional QI Nurse Consultant and Program Assistant that report directly to the Administrator. The programmatic units are Child Health and Infant Screening (six positions), Data and Decision (five positions), Young Families (four positions), Women's Health (two positions) and Injury Prevention (two positions).

This past year, MCH welcomed a new IPP Manager, FPP (Women's Health) Manager and Early Hearing Coordinator thus enabling the section to have no personnel openings for almost a year. Unfortunately, several staff are leaving their positions by the end of July 2015, including the QI Nurse Consultant, the PRAMS Coordinator and the Nurse Coordinator within Child Health and Infant Screening. Two of these three positions are funded in part by Title V. The State is currently under a hiring freeze and all positions must go through at least one level of a waiver process. It is anticipated that filling these positions could take up to six months.

Rhonda Siegel, MSEd, is the Title V Administrator. She holds a Master of Science degree in Education from the University of Pennsylvania. She has 30 years' experience in Public Health, with the last 17 in the state system in the field of Injury Prevention.

Audrey Knight, MSN, RN, Child Health Nurse Consultant, has a Master's degree in nursing from Yale University and has held the position of MCH Child Health Nurse Consultant since 1986. She is the Program Coordinator for SUID, SDY and Child Health Programs, and manages the NSP and EHDI programs.

Albert Willis, MS, was hired as the IPP Manager in December 2014. Mr. Willis has a MS degree in Organizational Management/Leadership from the Springfield College School of Human Services.

Felicia Fielding, MPH, is the FPP Manager. Ms. Fielding has more than 25 years of global public health experience and joined the FPP in November 2014.

Paulette Valliere, MPH, is the SSDI Program Planner; she manages the MCH Data Team and serves as

PRAMS Director. She has an MPH degree from Tulane School of Public Health and nearly 15 years' experience in public health programs. The MCH Data Team includes the MCH Epidemiologist and a Program Evaluation Specialist.

Deirdre Dunn Tierney, MSEd, is the Early Childhood Special Projects Coordinator. Ms. Dunn Tierney oversees the MIECHV, Early Childhood Comprehensive Systems (ECCS), and Project LAUNCH Federal grants. She earned a Master of Science Degree in Early Childhood Education from Wheelock College.

MCH manages four contracts and one MOU to provide specific consulting capacity. These include contractual relationships for a consulting audiologist, a pediatric metabolic consultant, an OB-GYN medical consultant and an MCH epidemiologist.

MCH epidemiology support has been provided since 2003 by Dr. David Laflamme, through a contract with the University of New Hampshire's Institute of Health Policy and Practice. Dr. Laflamme has a PhD from Johns Hopkins University Bloomberg School of Public Health. He devotes four days per week to MCH issues, providing expertise in data analysis and health policy.

SMS Staffing

Elizabeth Collins, RN-BC, MS, BSN, BA, is the SMS Administrator/Title V CSHCN Director. Ms. Collins holds a Master of Science Degree in Nursing from the University of New Hampshire. She has over 20 years experience working with vulnerable populations in direct care. She has completed the NH LEND program and the Maternal Child Health - Public Health Leadership Institute.
Kathy Higgins Cahill, MS, is the Clinical Program Manager. This position manages all 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.
Sharon Kaiser, RN, BS, is the Early Childhood Systems Specialist. She has a BS from Keene State College. She has expertise in state systems related to Early Childhood Health and CSHCN and is the Respite Coalition Liaison. Her previous experience includes statewide Care coordination and residential programming for children with developmental disabilities.
PARENTS OF CHILDREN WITH SPECIAL NEEDS
NHFV includes funding for staff who are also parents of CSHCN. Martha-Jean Madison and Terry Ohlson-Martin are Co-Directors of the project. Sylvia Pelletier is the Medical Home and FACETS of NH Coordinator. Jenn Pineo has joined NHFV as the Autism Planning Grant Coordinator. Four additional parents (Sally Weiss, Erika Downie, Robin deAlmeida and Kristen Costley) work for NHFV as part-time staff.

Cultural competence

DHHS requires all contractors to provide culturally and linguistically appropriate programs and services in compliance with applicable federal civil rights laws. Bidders are expected to consider the need for language services for individuals with Limited English Proficiency as well as other communication needs likely to be encountered in the eligible service population.
In 2014-15, MCH collaborated with the Institute on Disability at the University of New Hampshire to evaluate the physical accessibility to health care in all MCH-funded CHCs. Evaluators started in the facility's parking lot and followed a patient's typical path. An agency-specific report that included recommendations on ways to improve

usability for people with disabilities was provided to each facility.
In addition to race/ethnicity, language and physical 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. SMS 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. SMS has also incorporated the CDC recommended questions set on Race/Ethnicity into its application and data system.

II.B.2.c. Partnerships, Collaboration, and Coordination

NH's Title V Program has a long history of maximizing outcomes by leveraging limited resources through the development of partnerships. Through this approach, Title V has greatly expanded its reach within communities statewide. Title V staff currently participate in numerous executive committees and workgroups, such as the NH SUID Review Group, the NH Teen Driving Committee, the NH Autism Council and the NH Association for Infant Mental Health, where they provide expertise on the needs of women, children and families, and through these partnerships identify and implement activities to help meet priority needs. A summary of collaborative efforts, by population domain, follows.

Women/Maternal Health

Maternal Mortality Review Panel

As per RSA 132:30, Title V has partnered with the Northern New England Perinatal Quality Improvement Network to conduct comprehensive, multidisciplinary reviews of maternal deaths. These reviews result in recommendations for systemic improvements to the perinatal systems in the state.

TANF/FPP

This collaboration coordinates the FPP and Temporary Assistance for Needy Families (TANF) program efforts; TANF funds are allocated to the FPP within MCH to focus on expanding outreach to target Medicaid-eligible women and teens at risk for unintended pregnancy.

FPP/Primary Care Client Satisfaction Surveys

Both programs require all partner agencies to conduct Client Satisfaction Surveys each year. These surveys are designed to elicit feedback, capturing their ideas and concerns which are fed back into program activities and quality improvement initiatives.

Intra-DPHS partnership

The Tobacco Prevention and Control Program sends information on safe sleep to all pregnant women who subscribe to the statewide Quit Line, which it oversees.

Perinatal/Infant Health

Women, Infants and Children (WIC)

MCH and WIC staff participate jointly on the NH Breastfeeding Task Force, an excellent platform for sharing information on topics such as SUID risk reduction and newborn screening. MCH and WIC collaborated on two successful mini-grants with the Association of State and Territorial Public Health Nutritionists and Dieticians: (1) to train staff from MCH-funded home visiting agencies to become certified lactation counselors; (2) training focused on weight-related health messages for pregnant women and new mothers.

Child Health

Child Health Program

The Child Health Program is involved in several multidisciplinary groups who have family or consumer representatives as partners. The CHCs that receive monitoring and technical assistance for the pediatric component of their primary care are federally required to have consumer representation on their board. Input from their consumer representatives have resulted in improved access to services such as more user-friendly hours and days of operation, and the co-location or integration of behavioral health, mental health, WIC, pharmacy, and oral health services for easier one-stop shopping.

Early Childhood Comprehensive Systems (ECCS)

This HRSA funded initiative has brought together partners from several disciplines to develop the Comprehensive Plan for Early Childhood Health and Development. This plan is implemented throughout partner agencies and serves as the foundation for the development of the NH Early Childhood Advisory Council (Spark NH), as mandated by the Head Start Reauthorization Act.

Child Fatality Review Committee

The Child Fatality Review Committee (CFRC) is tasked with reducing preventable child fatalities through systematic multidisciplinary review of child fatality cases. The MCH Child Health Nurse Consultant and Injury Prevention Program Manager have played key roles in the CFRC, collaborating closely with representatives from the Medical Examiner's Office, DCYF, and the Attorney General's Office. Recommendations from case reviews are often implemented in training provided by MCH to health, social service, and child care personnel.

Project LAUNCH / SPARK NH

Project LAUNCH communities increase the quality and availability of evidence-based programs for children and families, improve collaboration among child-service organizations, and integrate physical and behavioral health services and supports. Lessons learned from communities guide systems changes and policy improvements at the state level.

Family engagement is an ongoing challenge for SPARK NH and other member organizations as most of the consumers of such services are parenting young children and/or working jobs that do not support their absence to attend committee meetings.

Adolescent Health

Injury Prevention Program

The Injury Prevention Program is small and it relies on collaboration with other agencies, such as the Department of Transportation on its Teen Driving Project, a pilot project with 15 schools dedicated to increasing seatbelt usage and fostering a positive safe driving climate.

CSHCN

Developmental Disabilities and Family Centered Early Supports and Services

SMS is aligned organizationally, along with Family Centered Early Supports and Services, as part of the BDS. 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 which has strong family involvement in its leadership. SMS is also the DHHS representative on the Council for Youths with Chronic Conditions, which has at least 50% family representation.

Lifespan Respite

SMS has initiated the creation of a Lifespan Respite Coalition which includes state agency representation, parent-

run organizations including NAMI-NH and the Granite State Federation for Families as well as individual family members. This initiative has facilitated the implementation of a state registry of respite providers and a competency-based curriculum.

NH Family Voices (NHFV)

Title V in NH has a strong and longstanding collaboration with NHFV, which is NH's Family-to-Family Health Information Center. SMS has funded parent consultation through NHFV, for almost 20 years. In addition to the initial role of helping families access services, this partnership has evolved to incorporate leadership and policy development activities. SMS consistently seeks input from NHFV when making any rule or policy change. NHFV has also participated in discussions with MCH, Medicaid and DCYF 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.

NH Healthcare Transition Coalition

SMS and NHFV have partnered together for 10 years to address the area of healthcare transition for CSHCN. The group convenes monthly and is jointly led by SMS and NHFV; its members are clinical providers, community providers and parents. The New Hampshire YEAH Council (Youth for Education, Advocacy and Healthcare) meets monthly to discuss issues involved in being a young adult with a chronic health condition, and how best to transition to the adult health care system. They work to educate other youth on how to handle transition as well as educating medical professionals on how they can facilitate. the transition.

Cross-cutting

Medicaid & Title V

Title V strengthens the power and reach of Medicaid indirectly through the services that it supports at the local level in CHCs, specialty clinics, family resource centers and through home visits. Title V has collaborated on policy and systems building initiatives with the Office of Medicaid Business and Policy and the Bureau of Drug and Alcohol Services to provide a new SUD (substance use disorder) and SBIRT (screening, brief intervention, referral to treatment) Medicaid benefit.

Rural Health and Primary Care Section (RHPC)

RHPC includes the Primary Care and State Office of Rural Health, the Rural Hospital Flexibility and Improvement Programs, the State Loan Repayment Program and the J1 Visa Waiver Program. Access to doctors, dentists, and other healthcare providers is a challenge for many NH residents, as was repeatedly conveyed in focus groups and surveys. The core functions of RHPC will help improve access to services for the MCH population.

II.C. State Selected Priorities

No.	Priority Need
1	Improve access to needed healthcare services for all populations.
2	Decrease the use and abuse of alcohol, tobacco and other substances among youth, pregnant women and families.
3	Increase access to comprehensive Medical Homes.
4	Improve access to mental health services.
5	Decrease pediatric overweight and obesity.
6	Increase family support and access to trained respite and childcare providers.
7	Decrease unintentional injury.
8	Improve access to standardized developmental/social emotional screening, assessment and follow-up for children and adolescents.

One of the core tasks of the five-year needs assessment process was to apply a logical methodology and scientific rigor to the selection of Title V priorities for the next five years. Qualitative as well as quantitative methods were utilized, resulting in several emergent themes.

The following preliminary list of MCH health sector needs/priorities was identified based on a review of state and local topics, National and State Title V Performance Measures, the *New Hampshire State Health Improvement Plan 2013-2020* (NH SHIP), internal discussions with Title V program managers, key informants, and research/surveys by program experts and key stakeholders.

- Alcohol and drug use
- Alzheimer's disease and other elderly health issues
- Asthma
- Autism
- Cancer
- Childhood lead poisoning
- Chlamydia and other sexually transmitted infections
- Community safety
- Dental health care
- Diabetes
- Early childhood screening
- Emergency health care
- Emergency preparedness
- Family violence
- Fertility
- High blood pressure / heart disease
- Infant health problems due to premature births
- Infectious disease
- In-home care, such as respite services
- Mental health care
- Overweight and obesity

- Serious injuries, such as car crashes and falls
- Sexual violence
- Specialty health care (for example, psychiatry, orthopedics)
- Suicide
- Teen pregnancy
- Tobacco use in pregnant women
- Tobacco use in youth

To begin the prioritization process, a priority-rating tool developed by the University of California San Francisco was utilized, slightly modified. The priority topics were voted on, according to the same criteria and weights utilized in 2010:

Issue has **serious health consequences** that could result in severe disability or death (weight=3)
1 = life-threatening or disabling to individuals or community
2 = not life-threatening but sometimes disabling
3 = moderately life-threatening or disabling
4 = moderately life-threatening but strong likelihood of disability
5 = high likelihood of death and disability
Large number of individuals are affected by the problem (weight=2)
1 = relatively few individuals affected
2 = moderate number of individuals affecting in particular subgroups
3 = moderate number of individuals affected across entire population
4 = large number of individuals affected in particular subgroups
5 = large number of individuals affected across entire population
Disproportionate effects among subgroups of the population (weight=2)
1 = no group is disproportionately affected by the problem
2 = one or more groups disproportionately affected, but difference not statistically significant
3 = statistically significant differences exist and one group is at least 1.25 to 1.75 times more likely to have a poor outcome
4 = statistically significant differences exist in more than one group
5 = statistically significant differences exist in one or more groups and at least one of the disadvantaged groups is greater than 1.75 times more likely to have a poor outcome
Issue results in **significant economic/social cost** (weight=1)
1 = economic or societal cost is minimal
2 = some potential increased costs
3 = likely to be moderate increased costs
4 = likely to be substantial increased costs
5 = great economic and societal cost
Issue is **crosscutting** to multiple domains / life-span effect (weight=3)
1 = limited to one life stage and is not associated with other problems
2 = minimally impacts entire life course and is associated with multiple problems
3 = moderately impacts entire life course and is associated with multiple problems
4 = severely affects either entire life course or is associated with multiple problems
5 = severely impacts entire life course and is associated with multiple problems
Feasibility (weight=1)
1 = not feasible
2 = not very feasible
3 = moderately feasible
4 = feasible
5 = very feasible

Voting with this tool was implemented in two meetings of statewide MCH-funded CHC Directors and MCH Agency Coordinators. For each topic the total weighted scores were ranked, giving a prioritized list of health issues. The same top six issues emerged for both groups, namely: drugs & alcohol, mental health, obesity, smoking, chronic disease, and access to care.

Primary care agencies meeting (15 agencies) October 2014		MCH Coordinators' meeting (21 participants) November 2014	
1. Chronic disease	78%	1. Drugs & alcohol	85%
2. Obesity	77%	2. Mental Health	82%
3. Access to care	76%	3. Obesity	79%
4. Mental health	73%	4. Smoking	78%
5. Drugs & alcohol	72%	5. Chronic Disease	76%
6. Smoking	71%	6. Access to care	73%
7. Cardiovascular	67%	7. Violence	73%
8. Oral health	65%	8. Cardiovascular	71%
9. Reproductive health	63%	9. Oral health	66%
10. Developmental screening	58%	10. Infant mortality	60%
11. Violence	57%	11. Developmental screening	60%
12. Infant mortality	54%	12. Reproductive health	54%
13. Unintentional injury	53%	13. Unintentional injury	54%

Similarly, priority concerns of the focus groups centered on the cost of and access to health services, particularly mental health and substance abuse treatment.

Broader public input was solicited via an online and hardcopy survey, developed in the 2010 needs assessment process. A link to the online version was distributed to all statewide contacts of Title V staff, including MCH-funded health care agencies, other state agencies, committees, advisory groups, task forces and others. The paper surveys were distributed to DHHS district offices (welfare offices) that provide temporary assistance to needy families (TANF), Medicaid, food stamps and other services to low-income clients. A total of 517 respondents provided input; 43% were the parent or guardian of a child under 21, and 16% were the parent or guardian of a child with special health care needs. The survey was not random, so results cannot be generalized statewide. However, the results are indicative of current trends and perceptions, as seen in the high degree of agreement among service-providers and care recipients as well as the findings from other assessment activities.

The survey consensus was that alcohol/drug use and overweight/obesity were the two top issues by far (ranked first priority by 189 and 180 respondents, respectively)—no other issue received a first place vote.

Difficulties in getting services varied slightly in ranking, from one category of health care to another (e.g., mental health services vs. substance abuse services), but overall the main difficulties were ones of access (e.g. finding available services, 37%; getting to/from appointments, 54%) and cost (e.g. affording the cost of services, 53%; high deductibles and co-pays, 52%).

When asked which services should MCH/SMS focus on, 67% of respondents indicated mental health care, 52% drug & alcohol treatment, and 46% dental health care, followed by parent services and supports 41% and transportation to services 32%.

A full-day Capacity Assessment for State Title V (CAST-V) meeting resulted in the selection of three Essential Services areas being selected as priorities for Title-V staff for the next five years:

> Essential Service #9: Evaluate the effectiveness, accessibility, and quality of personal health and population-based maternal and child health services.

Essential Service #3: Inform and educate the public and families about the maternal and child health issues.

Essential Service #7: Link women, children and youth to health and other community and family services, and assure access to comprehensive, quality systems of care.

All data (focus groups, epidemiological statistics, surveys, voting, CAST-V) were compiled and presented in a meeting of MCH and SMS key staff including representation from NH Family Voices. Following discussion, the following final list of priorities was reached by consensus:

1. Improve access to needed healthcare services for all populations

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

3. Increase access to comprehensive Medical Homes

4. Improve access to mental health services

5. Decrease pediatric overweight and obesity

6. Increase family support and access to trained respite and childcare providers

7. Decrease unintentional injury

8. Improve access to standardized developmental/social-emotional screening, assessment and follow up for children and adolescents

This list reflects the high priority placed on access to services by the general public, by service providers, and by state Title V staff. This overall ranking was similar but not identical to the 2010 ranking, in the following ways.

2015 Priority 1	Improve access to needed health care services for all populations
Domain	Women / Maternal Health
Performance Measure	Percent of women with a past year preventive medical visit
Domain	Adolescent Health
Performance Measure	Percent of adolescents ages 12-17 who had a preventive medical visit in the past year

Access to health insurance (selected in 2010) was replaced by the broader construct of access to healthcare services. The Affordable Care Act (ACA) was conceived and implemented to make health care accessible to all. It was evident from public input that insurance is only one component of access. Cost of services and insurance, including deductibles and co-pays, is an impediment to healthcare. Access issues also included availability of providers (especially in rural areas), availability of timely appointments, distance/time required to travel to service providers, availability of transportation in getting to appointments and availability of child care during appointment times. Well-woman or preventive visits are an essential service covered by the ACA. This priority will be addressed in two domains, Women/Maternal Health and Adolescent Health.

2015 Priority 2	Decrease the use and abuse of alcohol, tobacco and other substances among youth, pregnant women and families
Domain	Cross-cutting
Performance Measure	A) Percent of women who smoke during pregnancy B) Percent of children who lie in households where someone smokes

Decreasing the use and abuse of alcohol, tobacco and other substances continues to rank very highly, as in 2010. Alcohol remains the most prevalent substance misused. Underage drinking, binge drinking, regular heavy drinking and drinking during pregnancy are some forms of alcohol misuse that pose highest risk. Smoking during pregnancy remains high. The misuse of prescription drugs creates significant risk which can result in unintentional overdose and death. Opioids are among the most addictive drugs and are associated with fatal overdose and infectious diseases such as HIV and hepatitis. In the past two years, drug deaths increased from 11.2 to 14.5 per 100,000 population.[1] Marijuana is the illicit drug most likely to be used by teens and young adults. A majority of persons admitted to treatment programs in NH cite marijuana as the primary or secondary reason for seeking treatment. This priority is maintained.

2015 Priority 3	Increase access to comprehensive Medical Homes
Domain	CSHCN
Performance Measure	Percent of children with and without special health care needs having a medical home

Increased access to Medical Homes for all children was a new priority for 2015. For all children, and especially for children with special health care needs, access to comprehensive Medical Homes is strongly correlated to parent reports of access to care and decreased unmet needs. An even more significant distinction has become apparent for unique subgroups. In NH, lack of access to comprehensive Medical Homes and the subsequent benefits has been shown to be more of a barrier for children with conditions resulting in significant functional difficulty, multiple co-morbid conditions, emotional/behavioral health impairment, and those who were Hispanic and non-Hispanic other. [2] Caregivers must navigate through a maze of varying eligibility requirements and benefit criteria, as well as provide detailed information on available/missing resources. For persons with limited English proficiency, lower income or educational status, and/or inadequate insurance coverage, the barriers to services become difficult to overcome.

2015 Priority 4	Improve access to mental health services
Domain	Cross-cutting
Performance Measure	Percent of behavioral health professionals recruited

Improving access to mental health services is maintained from 2010 to 2015. This priority need was cited often and ranked high. The main difficulties in getting mental health services were finding available services (72% of surveyed respondents) and affording the cost of services (52%), followed by long wait times for appointments (48%). Mental health disorders can manifest at any time, and women may be particularly susceptible to depression after childbirth. Maternal depression can have a significant impact on children's development, potentially leading to mental health issues in the children themselves, which may result in imparted socialization and learning, with lifetime repercussions.

2015 Priority 5	Decrease pediatric overweight and obesity
Domain	Child Health
Performance Measure	Percent of children ages 6-11 who are physically active at least 60 minutes per day

Decreasing pediatric overweight and obesity is maintained as a priority. NH ranks 19th in the nation for children aged 10-17 who are obese (15.5%). Obesity during childhood is predictive of obesity later in life, and is therefore of great concern, since obesity in adulthood is associated with many chronic diseases such as diabetes, heart disease, high blood pressure, fatty liver disease, gallstones, orthopedic problems, and depression. Nearly one-third of children aged 2-11 years were overweight or obese in 2011-2012,[3] and nearly two-thirds of adults were overweight or obese in 2014.[4] Increasing physical activity will promote healthy growth and aid in controlling excessive weight gain.

2015 Priority 6	Increasing family support and access to trained respite and childcare providers
Domain	CSHCN
Performance Measure	Percent of families enrolled in SMS who report access to respite

Increasing family support and access to trained respite and childcare providers is an ongoing priority. Access to trained providers is a multi-faceted issue based on a wide range of caregiver needs, workforce deficits and funding limitations. Following the 2010 Title V Needs Assessment, respite was identified as one of the top 10 priorities for 2010-2015. Despite a statewide effort to improve respite services, it continues to be one of the least available services, with consistently high unmet need (22.6%) across SMS programs and services.[5] There is a specifically high unmet need in the four of seven counties in NH with more than one in four families indicating respite was not available or accessible.

Access to affordable child care is a critical need for families with young children. Child care programs are crucial for efforts to improve cognitive, social and behavioral outcomes, with a goal of narrowing early learning disparities among all children. The limited availability of high quality child care is one of the biggest barriers for NH families living on low incomes, and access to child care for families of children with special health care needs, of all incomes, is even more limited. According to Child Care Aware of America, areas of "quality" weakness for NH child care centers included the level of provider training requirements, class size, and licensing oversight caseload.

2015 Priority 7	Decrease unintentional injury
Domain	Perinatal / Infant Health
Performance Measure	Percent of infants placed to sleep on their backs
Domain	Adolescent Health
Performance Measure	Percent of adolescents ages 12-17 who had a preventive medical visit in the past year

Prevention of unintentional injury as a priority in 2015 is a broadening of the 2010 priority, which focused on injuries resulting from falls and motor vehicle crashes among children and adolescents. Unintentional injuries are among the most serious and under-recognized of public health issues in NH, and they are the leading cause of death and hospitalization for children and adolescents. Injuries in the total population are mainly caused by falls, motor vehicle crashes, suicide, and unintentional poisoning. Teens ages 15-19 have the highest rates for emergency departments visits due to motor vehicle crash injuries, with girls having significantly higher rates than boys.

In 2011-2015, there were 43 sleep-related infant deaths among NH residents, several of which were preventable; an examination of the data showed that many safe-sleep recommendations are not being followed. Safe sleep was selected by NH's CoIIN (Collaborative Improvement and Innovation Network) team, so this measure is one that will receive regular scrutiny and its inclusion here will support that effort.

2015 Priority 8	Improve access to standardized developmental/social emotional screening, assessment and follow-up for children and adolescents
Domain	Child Health
Performance Measure	Percent of children ages 10-71 months who receive a developmental screening using a parent-completed screening tool

Access to standardized developmental/social emotional screening, assessment and follow up is maintained from 2010 to 2015. Since early identification of developmental disorders is critical to the well-being of children, the AAP recommends that all children be screened for developmental delays and disabilities during regular well-child doctor visits at 9, 18, and 24 or 30 months of age. Additional screening might be needed for children at high risk for developmental problems due to preterm birth, low birth-weight, or other reasons.

Many children with developmental delays are not identified early, and may not get needed help in time to do well in early childhood settings (for example, in school). In the US, about 13% of children 3-17 years of age have a developmental or behavioral disability such as autism, intellectual disability, (also known as mental retardation), and

attention-deficit/hyperactivity disorder (ADHD). In addition, many children have delays in language or other areas that can affect school readiness. However, fewer than half of children with developmental delays are identified before starting school, by which time significant delays might already have occurred, resulting in missed treatment opportunities.

There were four priority areas in 2010 that were dropped or otherwise replaced in 2015:

1. Improving access to insurance was replaced by a broader focus of improving access to healthcare services for all.

2. Reduction of exposure to lead hazards, asthma triggers and other environmental risks was dropped; this was not mentioned as a significant concern by the general public or by service providers, nor backed by epidemiological data.

3. Improving oral health and access to dental care, while it did continue to rank highly, can be included in the umbrella of 'healthcare services' for all.

4. Decreasing the incidence of preterm birth also was not retained; NH has a very small number of preterm births (7.8% of livebirths in 2015, per NH DVRA).

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[1] American's Health Rankings 2015 Annual Report

[2] 2009/10 National Survey of Children with Special Health Care Needs." NS-CSHCN 2009/10. Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health

[3] Child Health USA 2014

[4] BRFSS

[5] Special Medical Services Survey and Needs Assessment conducted 2014

II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

- NPM 1 - Percent of women with a past year preventive medical visit
- NPM 5 - Percent of infants placed to sleep on their backs
- NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool
- NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19
- NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day
- NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
- NPM 11 - Percent of children with and without special health care needs having a medical home
- NPM 14 - A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

NPM #1: Percent of women with a past year preventive medical visit
Domain: Women/Maternal Health
To address priority need #1: Improve access to needed healthcare services for all populations

Improved access to healthcare services is a fundamental aim of the Affordable Care Act (ACA) and New Hampshire's Health Protection Program (HPP), which provides financial assistance to make insurance coverage more affordable. As in the previous five-year needs assessment process, access to quality health care services was cited repeatedly by service providers as well as by the general population, as an important unmet need. This is a far-reaching phenomenon occurring in all population domains, from pregnant women and infants, through childhood and adolescence, into adulthood. Both genders are implicated as well. In 2014, 13.3% of women reported having only fair or poor health status, up from 12.9% in 2011-2013; and 10.3% reported not having a personal doctor or health care provider, up from 8.8% in 2011-2013.[1]

In order to focus efforts on the feasible and measurable, and to have the most impact, NH has selected to address this concern as a priority in the target domain Women/Maternal Health, knowing that improvements for women will likely also result in improvements for babies, children and adolescents. MCH-funded community health centers will strongly encourage all women to see a healthcare provider regularly, at least on an annual basis. Many indicators of women's health are relatively good in New Hampshire, but well-woman visits can assess many conditions (e.g. overweight) and life-style choices or habits (e.g. smoking), as well as life stressors (e.g. underemployment), and subsequently provide counseling or referrals to appropriate social, psychological, and/or medical services. NH will promote pre-conceptual health and usage of long-acting reversible contraceptives (LARCS).

NPM #5: Percent of infants placed to sleep on their backs
Domain: Perinatal/Infant Health
To address priority need #7: Decrease unintentional injury

Safe sleep was selected as one of New Hampshire's CoIIN target areas, so the selection of this NPM is in part an effort to concentrate and coordinate MCH and other stakeholder efforts. Sudden unexpected infant deaths (SUID) are among the most extreme of unintentional injuries. They are always tragic, and many may be prevented. Of 43 SUID cases in New Hampshire between 2011 and 2015, ten were determined to be SIDS but 30 were of undetermined cause and two were due to asphyxia; at least some of these latter 32 deaths were likely preventable. In 25 of the cases, the primary and secondary caregivers were both low income; 30 of the infants were covered by Medicaid. Thirty-three of the primary caregivers had a high school education or less, as did 26 of the secondary caregivers; nine caregivers had a college education. Further, 35% of primary caregivers and 16% of secondary caregivers had a history of substance abuse.[2]

New Hampshire DHHS promotes the American Academy of Pediatrics (AAP) recommendations that infants should

sleep alone (no bed-sharing), on their backs, on a firm, flat surface in a safety-approved crib, bassinette or portable play area, without any soft objects or loose bedding. Parents are not always practicing safe sleep and hospitals are not always role-modeling or educating on safe sleep.[3] PRAMS data will be available on sleep position as well as other sleep-related behaviors such as co-sleeping, room-sharing, and advice on sleeping practices offered by health care providers. This measure will inform the NH SUID multidisciplinary review group and the Safe Sleep Campaign workgroup (both chaired by MCH staff), as well as the MCH CoIIN team.

NPM #6: Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Domain: Child Health

To address priority need #8: Improve access to standardized developmental/social emotional screening, assessment and follow-up for children and adolescents

Early identification of developmental disorders is critical to the health and well-being of children, and it is an essential function of primary care medical homes. As recommended in the NH SHIP, MCH promotes and supports comprehensive preventive pediatric care in community health centers to ensure that developmental screenings are implemented, as per AAP guidelines. MCH monitors and provides technical assistance to MCH-funded community health centers and home visiting agencies to ensure that providers utilize formal, validated screening tools and that screening is timely and appropriate.

MCH and SMS participate in Spark NH, the state's early childhood advisory council in support of programs to engage in quality early identification, screening and referral activities and the expansion of state developmental screening, early identification and referrals. According to the Spark NH 2014 Needs Assessment, one in four children aged three (3) to six (6) years on Medicaid did not receive recommended child visits. Title V will continue to support the expansion of Watch Me Grow, a comprehensive screening and referral system for families of children aged birth to six (6) years. This work is done in partnership with the NH Council on Autism Spectrum Disorders as established by the state legislature (RSA 171-A:32) to improve services and supports.

NPM #7: Rate of hospitalization for non-fatal injury per 100,000 adolescents ages 10 through 19

Domain: Adolescent Health

To address priority need #7: Decrease unintentional injury

More people ages 15-44 die of injuries in New Hampshire than of any other cause,[4] and non-fatal injuries are the leading reason for hospitalization of children and adolescents. Many injuries can be prevented through a combination of strategies including behavioral and cultural change, education, the re-engineering of environments and technology, as well as effective policy and enforcement. For example, New Hampshire is addressing distracted driving with the passage of a state law effective July 1, 2015, banning the use of mobile electronic devices while driving (RSA 265:79-c).

Another approach to injury prevention is indirect, through a reduction of substance use and abuse, from tobacco and alcohol to prescription drugs and opioids. Decreasing the prevalence of use of these substances is New Hampshire's priority need #2, and success in this area will be reflected in a reduction of hospitalizations, especially among adolescents. MCH will continue tracking hospitalizations and emergency department visits among children and adolescents; this data is available in graphical format in NH WISDOM (https://wisdom.dhhs.nh.gov/wisdom/).

NPM #8: Percent of children ages 6 through 11 who are physically active at least 60 minutes per day

Domain: Child Health

To address priority need #5: Decrease pediatric overweight and obesity

Obesity is an issue that often begins in early childhood and persists throughout adulthood, when most of the adverse consequences occur; targeting obesity in childhood lays the groundwork and cultivates a mindset for a future reduction in adult obesity. Childhood obesity increases the risk for many chronic diseases such as asthma, heart disease, high blood pressure, stroke, diabetes, and cancer. The NH 2013-2014 Healthy Smiles–Healthy Growth Third Grade Survey found that 12.6% of third graders were obese, and among children enrolled in WIC in 2013,

14.1% were classified obese. The situation persists through high school, with 16.3% of boys and 7.9% of girls classified as obese in 2015, compared to 14.9% for boys and 7.4% for girls, in 2013.[5]

Nutritional support is necessary but not sufficient to bring about permanent change in the phenomenon of obesity in the American culture. Title V will continue to promote strategies that include: increased breastfeeding training for providers; education of CHC personnel on recommended protocols to follow when BMI is above the 85th percentile (the definition of 'overweight'); education and strategies on family engagement and how to talk to parents about overweight/obesity issues. But further efforts, encouragement and incentives are required to address obesity, namely, by increasing physical activity.

NPM #10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year

Domain: Adolescent Health

To address need #1: Improve access to needed healthcare services for all populations, and the rationale is the same for adolescents as outlined above for women (NPM #1)

In 2011-12, 91.2% of children had a preventive medical visit in the past year, but only 66.3% of children with problems requiring counseling received mental health care.[6] And in 2014 only 61% of adolescents seen at CHCs received an annual health maintenance visit in the previous year.[7] Preventive medical visits provide opportunities to assess a variety of issues such as obesity/overweight, bullying, violence, suicide, mental health, as well as substance use and abuse, including alcohol, tobacco, prescription drugs, marijuana or opioids. All of these conditions or behaviors are relatively common among adolescents, and regular medical visits may detect them and subsequently provide counseling or referrals to appropriate additional services.

NPM #11: Percent of children with and without special health care needs having a medical home

Domain: CHSCN

To address need #3: Increase access to comprehensive Medical Homes

For all children in New Hampshire, and notably for children with special health care needs, access to comprehensive Medical Homes is highly consistent with parental report of access to care and decreased unmet needs. Among sub-groups of families with children who have conditions resulting in significant functional difficulty, multiple co-morbid conditions, or emotional or behavioral health impairment, access to comprehensive Medical Homes is even more important for meeting their health care needs. Families who are Hispanic or non-Hispanic other, report access to comprehensive Medical Homes as crucial but particularly onerous to maneuver, requiring navigation through a bureaucratic network with non-uniform eligibility prerequisites and benefit criteria, and applicants must furnish evidence of available or absent resources. For parents with lower educational status, lower income, inadequate insurance coverage, or limited English proficiency, barriers to services become even more burdensome. The Patient Centered Primary Care Collaborative reports that children with a stable and continuous source of health care (i.e. a comprehensive medical home) are more likely to receive appropriate and timely preventive care, including immunizations; they are less likely to require hospitalization for preventable conditions; and they are more likely to be diagnosed early for chronic conditions.[8]

NPM #14: A) Percent of women who smoke during pregnancy
B) Percent of children who live in households where someone smokes

Domain: Cross-cutting

To address priority need #2: Decrease the use and abuse of alcohol, tobacco and other substances among youth, pregnant women and families

This priority regarding substance use and abuse ranked highly in the needs assessment process, as it did in the previous five-year cycle. This NPM focuses on tobacco use, which is the single most preventable cause of death and disability in New Hampshire. Women who smoke during pregnancy are more likely to experience a fetal death or deliver a low birth weight baby. Exposure to environmental tobacco smoke (ETS) affects everyone, notably children, who do not use tobacco on their own. Second-hand smoke has been classified as a known human carcinogen by the US Environmental Protection Agency (EPA) and other national professional groups. Adverse effects of parental smoking on children have been documented since the 1986 Surgeon General's Report; effects include increased frequency of ear infections, acute respiratory illnesses, severe asthma, lower respiratory tract infections leading to

hospitalizations, and SUID. In addition to second-hand ETS, third-hand smoke is generally considered to be residual nicotine and other chemicals left on a variety of indoor surfaces by tobacco smoke that builds up over time. Third-hand smoke residue contains cancer-causing substances, posing a potential health hazard to those exposed to it, especially children.

In New Hampshire, smoking during pregnancy has begun to decline. Smoking during pregnancy is especially prevalent among women on Medicaid, although it is declining in this group as well.[9] Among cases of SUID in 2011-2015, only 23% of cases reported no cigarette smoke exposure to the infant during or after pregnancy, and 51% of the infants were exposed to second-hand smoke (NH SUID data 2011-15).[10] Smoking rates are higher in pregnant teens, as well as those with low income or low education. Children from lower income families are more likely to be exposed to ETS in their own homes or in the vehicles that they ride in. Smoking among pregnant women has been the subject of several core questions in the PRAMS survey, and several new questions on children's exposure to ETS were added to the PRAMS survey, effective April 2016.

After pregnancy, a high proportion of women take up smoking again soon after giving birth. Women may stop smoking "spontaneously" during pregnancy, due to factors such as concern for the health of the fetus, social expectation, physical aversion to cigarette smoke and decreased withdrawal symptoms due to the physiological changes of pregnancy. But the motivation to "stay quit" is often not strong enough to prevent new mothers from taking up the habit again within a year of the baby's birth. The stress of caring for a new baby, sleepless nights, unhelpful partners, and a sense of loneliness and loss of identity may all contribute to relapse.[11]

Research indicates that tobacco prevention and treatment programs not only reduce smoking and save lives, but also save money by reducing tobacco-related health care costs. Assisting those who are tobacco dependent and preventing children and youth from starting tobacco use can save many lives and health care dollars.

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[1] BRFSS Prevalence & Trends table; accessed June 16, 2016

[2] NH SUID data 2011-2015

[3] Ibid.

[4] WISQARS 2014; accessed May 6, 2016

[5] NH YRBS 2015; accessed May 6, 2016

[6] NSCH, accessed May 6, 2016

[7] NH MCH Data Trend Tables, accessed May 6, 2016

[8] https://www.pcpcc.org/content/statements-support, accessed June 16, 2016

[9] NH DVR birth tables, accessed May 16, 2016

[10] NH SUID data 2011-2015

[11] http://jabfm.org/content/17/4/264.full, accessed May 16, 2016

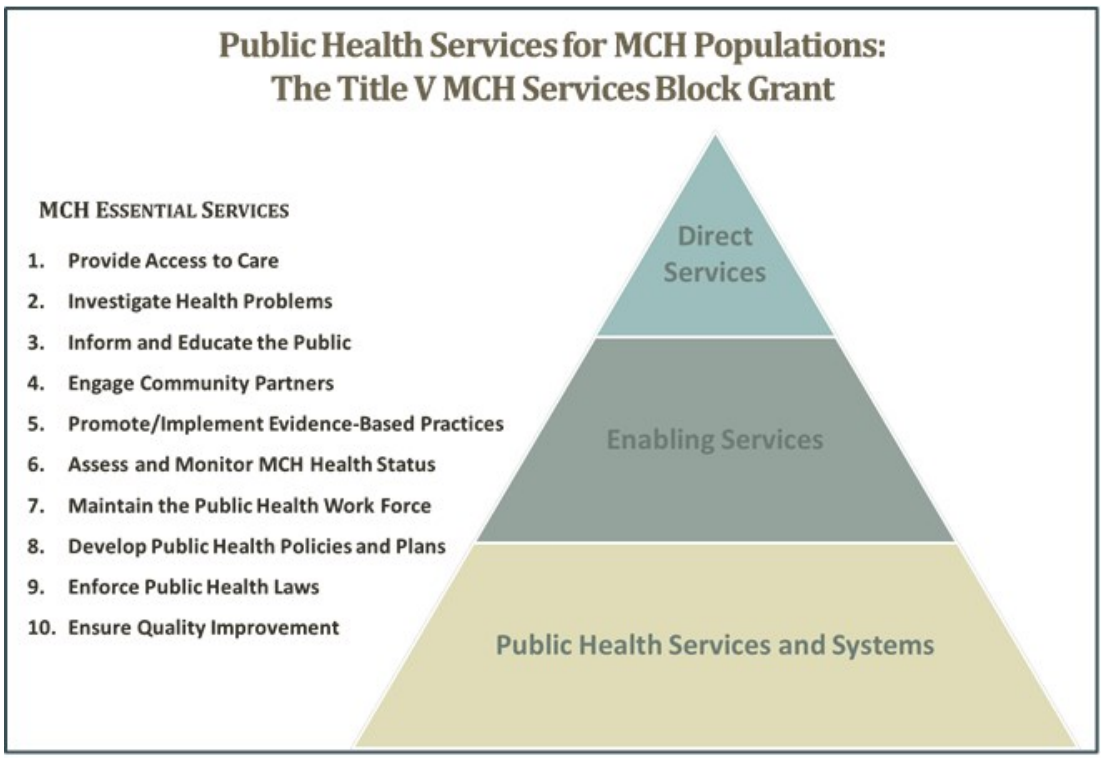
II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

- SPM 1 - Percentage of MCH-contracted Community Health Centers with Enabling Services workplan on file with DHHS/MCH.
- SPM 2 - Percentage of families enrolled in SMS who report access to respite
- SPM 3 - Percentage of behavioral health professionals recruited

SPM #1: Percentage of MCH contracted Community Health Centers with **Enabling Services** workplan on file with DHHS/MCH
Domain: Cross-cutting / Life course
This measure was selected to address priority need #1: Improve access to needed healthcare services for all populations.

While access to healthcare has improved with Medicaid expansion, enabling services that address the social determinants of health are needed by vulnerable populations to get optimal use of their new insurance benefits. This is the next step in the improvement of access to services.

MCH-funded CHCs provide a wide range of primary and preventive health services, as well as chronic care management. Services that are not clinical but that facilitate access to needed care can be life-changing. Generally known as “enabling services” (ES), they constitute the middle tier of the redefined framework of MCH services.



Enabling services can include case management, referrals, translation/interpretation, transportation, eligibility assistance, benefits counseling, health education and supportive counseling, health literacy, and outreach; these are

mechanisms by which individuals or families are linked to essential medical, behavioral health and social services. The exact nature of ES will vary from community to community, but the purpose is the same: to break down barriers to and improve quality of care by ensuring that services are delivered in socially, culturally and linguistically appropriate settings.

ES are becoming more crucial as growing numbers of health center patients are diagnosed with chronic illness requiring long-term services, or they experience barriers to care such as limited English proficiency or lack of child care during appointment times. New patients may be particularly reliant on ES to overcome whatever has kept them from accessing health care in the past. ES are key features of health centers and yet health centers are likely to be inadequately reimbursed or funded for their ES, obliging them to absorb the costs at the expense of other services. Medicaid prospective payment rates and federal health center grants have not kept up with the new paradigm and cost of patient care.

With a shift in patient insurance mix and an influx of new communities served, ES will play an increasingly important role in promoting access to and quality of healthcare, and improving health outcomes for high-risk populations. Reaching new communities previously not served may also require additional ES to overcome ingrained barriers to care. A full range of ES is critical to achieving full primary care access and utilization by all populations served.

MCH's funding of CHCs includes funding for ES, to promote enhanced utilization of CHC healthcare and therefore decreased client recourse to hospital emergency departments. Funded CHCs' enabling services workplans are submitted to the MCH section and reviewed yearly.

SPM #2: Percentage of families enrolled in SMS who report access to **respite services**
Domain: CSHCN
This measure was selected to address priority need #6: Increase family support and access to trained respite and childcare providers.

Respite care is temporary care provided to caregivers of a child or adult with special needs. Respite programs provide short-term breaks for families and other unpaid caregivers in order to support and maintain the care-giving relationship. Respite is most effective when it provides a positive experience for the person receiving care as well as for the caregiver. Even though families may adamantly want to provide care to their loved ones, the physical, emotional and financial consequences for the family caregiver can be overwhelming without some support. Family members who provide care to individuals with chronic or disabling conditions are themselves at risk. Emotional, mental, and physical health problems arise from complex caregiving situations and the strains of caring for frail or disabled relatives. Sixty percent of family caregivers age 19-64 surveyed by the Commonwealth Fund reported fair or poor health, one or more chronic conditions, or a disability, compared with only 33% of non-caregivers.[1]

The need for respite and childcare services was expressed in previous cycles of the Title V Block grant and needs assessment reports. It continues to be identified as a need. Based on surveys of families with CSHCN enrolled in Title V, the need for respite impacts approximately one quarter of children served.[2] For those families that do identify respite as a need, it is cited as being of paramount concern. National surveys such as the 2009/2010 NS – CSHCN and state surveys conducted among SMS-enrolled families have indicated a lack of availability of adequate respite services. Over two-thirds of families of NH Supplemental Security Income (SSI) CSHCN surveyed reported that they provide health care themselves for their child at home; half of these families reported having to reduce work hours to care for their child even while experiencing financial distress.[3] The need for respite care for CSHCN

appears to be increasing based on these data reviewed, and availability of providers is limited. Currently, there is not a single point of access for coordinated statewide respite services for CSHCN and funding is limited in amount and by service agency. At this time there is no respite funding available for children with behavioral health needs. The number of respite providers who have participated in standardized training is limited to those who have completed the competency-based curriculum created under the Lifespan Respite Grant.

SMS has fostered the creation of a Lifespan Respite Coalition (LRC), comprised of representatives of various state agencies as well as family members and parent consultants. The Coalition was formed upon award of a Lifespan Respite grant from the US Administration on Aging in 2009. This grant was used to design a competency-based curriculum to train respite providers and create a registry of trained providers; 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. Grant activities spanned several years from 2009 until 2012. Sustainable outcomes from this grant include the creation and ongoing operation of a Statewide Respite Locator (http://www.rewardingwork.org/Respite-Resources/New%20Hampshire), a web-based tool where respite providers can be found, the Lifespan Respite Coalition, and the competency based training curriculum, completed online. Current funding for respite activities is a combination of Title V (staff time), Social Services Block Grant and the benefit of having a VISTA volunteer working from the Coalition.

Results from the NH LRC Summit in 2011 provided the NH LRC members guidance for respite activities in NH. Based on guidance from the Summit, all respite activities have an embedded approach that works with families to identify “natural supports” as respite providers whenever possible. The competency based curriculum is available to these “natural support” providers as well.

Respite care and caregiver needs across the lifespan continue to be a priority need that will be addressed not only by Title V efforts. They will also be addressed in partnership with the NH LRC and other State of NH Agencies working to improve access to respite, such as the Children’s Behavioral Health Section that is working on a 1115 waiver that will meet behavioral health needs using a Wraparound approach including respite services. Ongoing evaluation of progress will be monitored using the NSCH survey and the SMS Biannual Satisfaction/Needs Assessment Survey.

SPM #3: Percentage of **behavioral health professionals** recruited
Domain: Cross-cutting / Life course
This measure was selected to address priority need #4: Improve access to mental health services.

Worldwide about 10% of pregnant women and 13% of women who have just given birth experience a mental disorder, primarily depression;[4] in the US, 25.9% of women report ever having been told they had depression.[5] Virtually all women can develop mental disorders during pregnancy and in the first year after delivery, but poverty, migration, extreme stress, exposure to violence (domestic, sexual and gender-based), emergency and conflict situations, natural disasters, and low social support generally increase risks for specific disorders. Very young infants are highly sensitive to their environment and quality of care, and are likely to be affected by mothers with mental disorders. Prolonged or severe mental illness hampers the mother-infant attachment, breastfeeding and infant care. Maternal depression is a risk factor for childhood physical abuse and neglect, so this issue extends into the lives of children and families, with repercussions potentially over long periods of time—children’s growth and development may be negatively affected by their mother’s condition, and the children may have mental health issues themselves.

Mental disorders among children are described as serious changes in the way children typically learn, behave or handle their emotions, which cause distress and problems in daily life. Childhood mental disorders include attention-deficit/hyperactivity disorder (ADHD) and oppositional defiant disorder, among others. Symptoms may start in early childhood, and the diagnosis is often made in the school years. Untreated, childhood mental disorders can have repercussions through the lifespan.

This priority need is maintained from the previous Title V Block Grant cycle. During the needs assessment process, mental health was cited often; it was ranked second and fourth in needs rankings done by the directors and the coordinators of MCH-funded agencies, and focus groups likewise indicated that mental health services were of great concern, including difficulties with availability, access, and cost. The majority (67%) of needs assessment survey respondents indicated that mental health care was a service that MCH/SMS should focus on, and nearly three quarters (72%) reported that one of the main difficulties in getting mental health services was simply finding them. According to the National Surveys on Drug Use and Health, 7.9% of NH adults had a major depressive episode (yearly average for 2013-2014); 4.7% had serious mental illness; 20.9% had any mental illness; and 4.1% had serious thoughts of suicide.[6] Among adolescents, 15.3% of high school students reported seriously considered attempting suicide in the previous 12 months.[7]

Primary care providers in NH play a large role in treating children and youth with behavioral health disorders, with most childhood psychiatric medications prescribed by pediatricians. The frequency of well-child check-ups and the relationships families develop with their primary care professional provides an opportunity to identify behavioral health concerns early and to coordinate services and supports.[8]

Children's behavioral health needs are served by a range of community-based providers, including the state's ten community mental health centers. These and other provider agencies have been increasingly financially under-resourced in recent years with notable gaps in services, including adolescent substance abuse and co-occurring disorder treatment. Community mental health centers now handle approximately 10,000 children with increasingly complex needs, a number that has remained constant in recent years, despite significant budget reductions.[9]

In January 2016, the Centers for Medicare and Medicaid Services approved NH's request for expenditure authority to operate its section 1115(a) Medicaid demonstration, entitled Building Capacity for Transformation, a Delivery System Reform Incentive Payment (DSRIP) program. Under DSRIP, the State will make performance-based funding available to regionally-based Integrated Delivery Networks (IDNs) that serve Medicaid beneficiaries, with the goal of transforming the behavioral health delivery system by strengthening community-based mental health and substance use services and combatting the opioid crisis.

The DSRIP program aims to transform the way care is delivered to Medicaid beneficiaries as well as to individuals with undiagnosed or untreated behavioral health conditions. A number of factors make behavioral health transformation a priority, including the expansion of coverage through the state Premium Assistance Program (NH PAP) to cover the new adult group, an estimated one in six of whom have extensive mental health or substance use needs. In addition, NH now covers substance use disorder (SUD) services for the NH PAP population, and the state is targeting extension of the SUD benefit to the entire Medicaid population in state fiscal year 2017. Finally, the expansion of coverage for new populations and new services coincides with an epidemic of opioid abuse.[10]

Under the DSRIP program, diverse health and social service providers within regions across the state will create IDNs to implement evidence-supported programs that address the needs of Medicaid beneficiaries with behavioral health conditions. The principle elements will include:

- Integrating physical and behavioral health to better address the full range of needs
- Expanding mental health and substance use disorder treatment capacity to address behavior health needs in appropriate settings
- Reducing gaps in care during transitions across care settings through improved coordination

Each IDN will be required to ensure that behavioral health conditions are routinely and systematically addressed in the primary care setting. Primary care providers, behavioral health providers, and social services organizations will partner to implement an integrated care model that reflects the highest levels of collaboration/integration as defined in the SAMHSA Levels of Integrated Healthcare. IDNs must participate in this project and fulfill state-specified requirements in order to be eligible for DSRIP incentive payments.

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[1] A Look at Working-Age Caregivers' Roles, Health Concerns, and Need for Support, Alice Ho, Sara R. Collins, Ph.D., Karen Davis, Ph.D., and Michelle M. Doty, Ph.D., The Commonwealth Fund, August 2005
[2] Special Medical Services Survey and Needs Assessment conducted 2014
[3] ibid.
[4] WHO 2016
[5] CDC/BRFSS 2015
[6] NSDUH, accessed May 16, 2016
[7] 2015 NH YRBS, accessed June 16, 2016
[8] NH Children's Behavioral Health Collaborative, 2013
[9] NH DHHS
[10] NH DSRIP Planning Protocol 2016

II.F. Five Year State Action Plan

II.F.1 State Action Plan and Strategies by MCH Population Domain

Women/Maternal Health

State Action Plan Table

State Action Plan Table - Women/Maternal Health - Entry 1

Priority Need

Improve access to needed healthcare services for all populations.

NPM

Percent of women with a past year preventive medical visit

Objectives

By July 1st 2017 all Title X Family Planning clinics will have at least one staff member proficient in LARC insertion

Increase utilization of Long-Acting Reversible Contraception (LARC) by 5% each year

By July 1st 2017, all Title X Family Planning clinic staff will have completed Preconception Health services training

Strategies

Nexplanon and IUD Training -- building capacity to provide long-acting contraception

Professional training / capacity-building

ESMs

ESM 1.1 - Percentage of women who receive pre-conception counseling and services during annual reproductive health (preventive) visit at family-planning clinics (Title X)

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

NOM 5.1 - Percent of preterm births (<37 weeks)

NOM 5.2 - Percent of early preterm births (<34 weeks)

NOM 5.3 - Percent of late preterm births (34-36 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

Measures

NPM 1 - Percent of women with a past year preventive medical visit

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	65.7	67	68.3	69.5	70.8	72.0

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	63.2 %	2.5 %	135,006	213,754
2013	66.5 %	2.1 %	143,303	215,448
2012	63.3 %	2.1 %	135,903	214,633
2011	66.7 %	2.0 %	149,777	224,709
2010	64.9 %	2.1 %	147,372	226,919
2009	71.5 %	2.0 %	164,521	230,094

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 1.1 - Percentage of women who receive pre-conception counseling and services during annual reproductive health (preventive) visit at family-planning clinics (Title X)

Annual Objectives

	2017	2018	2019	2020	2021
Annual Objective	20.0	25.0	30.0	35.0	40.0

Women/Maternal Health - Plan for the Application Year

National Performance Measures: 2016-2020

National Performance Measure #1:
Percent of women with a past year preventive medical visit

Preventive health care visits will be measured by the proportion of women who receive Preconception health services in Title X family planning clinic sites. Provision of preconception care represents the types of preventive services typically provided for women.

Evidence Based or Informed Strategy Measure:
Percent of women who receive Pre-conception Health services during annual preventive health care visit (reproductive health) at Title X clinics

Preconception health refers to the health of women and men during their reproductive years, and focuses on taking steps to protect the health of mother (parents) and future children by targeting the aspects of health that have shown to increase the chance of having a healthy baby. It helps overall by reinforcing key aspects of preventive health such as: tobacco cessation, reducing alcohol use, maintaining a healthy body weight, eliminating illicit drug use, obtaining important vaccinations, and screening for sexually transmitted infections, depression, diabetes, and domestic violence. For women planning pregnancy, pre-conception health services and counseling has a direct effect on

health outcomes for both mother and baby. Being healthy before pregnancy reduces preterm births and low birth weight babies, giving the newborn a healthy start in life. Since more than 50% of births in the USA result from unplanned pregnancy, offering these services to all women of reproductive age in Title X clinics is an effective strategy to improve health outcomes for mother and baby.

The plan for this coming year and afterwards, is to bolster provider capacity to offer preconception care services (PCC) consistently for every (annual) visit with women of childbearing age. Currently, many of the services are offered separately, and not in a deliberate package which includes a set of defined services. Sexually transmitted infection testing and treatment is common, as is screening for tobacco; however, screening for depression, diabetes, drug use, and domestic violence is less frequent. Many clinics in NH do not have written protocols in place to outline the concept and delivery of Pre-conception care, and many providers are not fully clear on what constitutes this type of preventive health care, and its importance to offer it to women coming in for reproductive health care. In a study conducted in partnership with the Office of Population Affairs (Robbins et al., *Am. Journal of Preventive Medicine*, 2016) Title X clinics have a higher rate of offering these services than other public clinics.

To accommodate this important initiative, the Family Planning service providers (15 sites) will receive technical assistance on preconception care, and standardized clinical protocols will be developed. To capture data to assess the frequency of delivery of these services and education, the family planning regional database will be updated; medical codes and service options will be expanded to include all the preconception services. This will allow NH to monitor and assess what services within the package are more commonly offered, and which are not, and make corrections accordingly. Performance measures for PCC will start relatively modest, given the current low rate of consistent provision of these services (~20-25%), and will increase with each year as these services become a more integral part of women's preventive health care.

Long-acting reversible contraception (IUDs and implants) are long term birth control methods that are proven to be the most highly effective in prevention of pregnancy, for women of all ages. Currently in New Hampshire, long-acting methods (LARC) represent ten percent (10%) of the method mix utilization rates, comparable to other states in the USA.

To increase utilization of long-acting methods, some providers will need training. Nexplanon (implant) training has been completed (June 2016), and IUD training, including refresher training, is planned for 2017. IUD training will be led by the family planning program Medical Consultant (Ob/GYN), offering a three-stage model of training: 1) theory, 2) use of anatomical models, 3) a field practicum with insertions using shadowing and mentorship, and a 6-month follow up. Among the 15 service delivery sites, there are five (5) which do not offer LARC methods, however among the rest of the clinics, there still remains low capacity in IUD insertion. Next year's IUD training will build new capacity and update skills of those providers wanting to refresh their skills using new products, such as the low-cost Liletta IUD, which is growing in popularity due to its price of only $50. This small three-year product requires a slightly modified insertion technique. IUD training will begin in Autumn 2016.

Women/Maternal Health - Annual Report

National Performance Measures 2011-2015

National Performance Measure #11:
Percentage of mothers who breastfeed their infants at six months of age

Data Analysis

New Hampshire has been ranked No. 1 in maternity practices that support infant nutrition and care since 2007, when the Centers for Disease Control and Prevention (CDC) first started collecting birthing facility survey data. New Hampshire does very well in indicators of infants that were ever breastfed. Maintaining that progress through exclusive breastfeeding and duration continue to be more challenging. However, at 57.6% of mothers who breastfeed at 6 months, it is evident that many strong systems are in place to support women and families.

Systems Building

MCH and its partners have historically worked together to implement interventions to increase breastfeeding initiation, to increase exclusive breastfeeding, and to increase breastfeeding duration. Choosing the most appropriate intervention for a given setting and population can be challenging given the many evidence –based possibilities. CDC has recommended focusing on, Maternity Care Practices; Support for Breastfeeding in the Workplace; Peer Support; Educating Mothers; Support for Clinicians, Healthcare Systems and Professionals; and Media and Social Marketing.[11]

Hospitals are a particularly important setting for supporting breastfeeding mothers and babies. The Maternity Practices in Infant Nutrition and Care (mPINC) reports that the percentage of hospitals providing breastfeeding support and advice, as well as prenatal instruction, has increased. In New Hampshire, the percentage of live births occurring at Baby Friendly facilities has increased from 16% in 2007 to 36% in 2014.

Despite the State's high mPINC scores in initiating breastfeeding at the hospital, rooming in, and hospital staff teaching new mothers about the benefits of breastfeeding and infant feeding cues, more work can be done around staff training. The mPINC report identified a weakness in training new staff and having a comprehensive breastfeeding policy for the facility.

MCH Specific Activities

Because of our shared commitment to improving maternity care practices and a joint desire to increase initiation, duration and exclusivity of breastfeeding, MCH partnered with WIC and the NH Breastfeeding Task Force Together on an Association of State and Territorial Health Officials (ASTHO) project to enable additional hospitals to pursue credentials for becoming Baby Friendly®. The core components of the project focused on healthcare provider and clinician breastfeeding education. The multi-disciplinary group updated the breastfeeding training curriculum for hospital staff, developed and offered a three (3) hour physician education training with CMEs, and hosted on-site clinical competency training for two (2) hospitals. The 16 module online curriculum is now available to all clinicians and healthcare providers for assistance in achieving the required education for the Baby Friendly designation. As a result of project activities, local WIC agencies want to get more involved with efforts to support Baby Friendly hospitals through coordinated prenatal education, discharge planning and consistent messaging around breastfeeding support and education. Other successes include the initial development of a safe formula preparation brochure for WIC agencies, hospitals, and pediatric providers (as required for Baby Friendly).

MCH also collaborated with WIC on an extension of a mini-grant from the Association of State and Territorial Public Health Nutritionists and Dieticians to sponsor Joyce Kelley, RN, MPH, who presented on “Prenatal Education for Support of the Ten Steps to Successful Breastfeeding” at the June 2015 MCH contract agencies’ coordinators’ meeting, and offered nurse contact hours for this educational session.

Information from WIC was also shared with MCH contract agencies on how local agencies could promote breastfeeding during August, national Breast Feeding Awareness Month. Agencies were encouraged to partner with their local WIC agency to enhance the community’s activities.

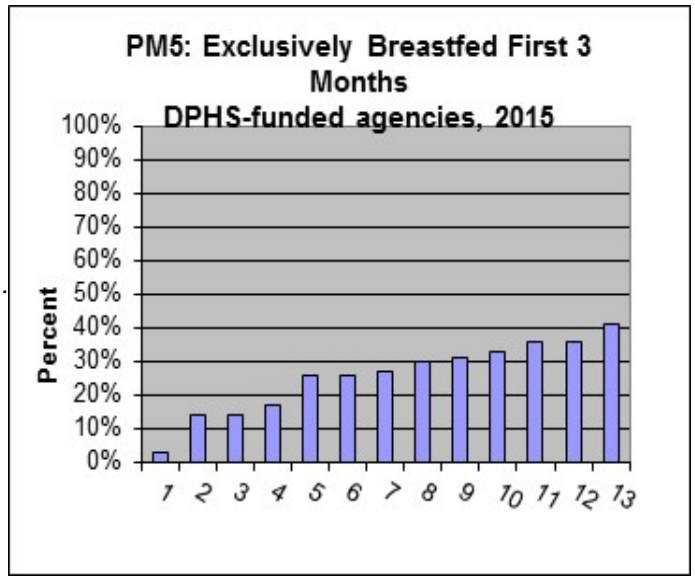
The Lactation Consultant member of the NH Sudden Unexpected Infant Death Review Group who is active on the NH Breast Feeding Task Force made several presentations in FY15 on the importance of breastfeeding, and in correct positioning to promote breastfeeding and reduce the risk of SUID. Presentations were made to the 25 attendees of the birth hospitals’ Perinatal Nurse Managers’ November 2014 meeting, and to the 15 members of the Breast Feeding Task Force, also in November 2014. This Lactation Consultant was also on a panel speaking on integrating safe sleep, for breastfeeding women, at a Northern New England Perinatal Quality Improvement conference attended by 120 perinatal hospital and outpatient staff.

The MCH Child Health/SIDS/SUID Project Coordinator continued to promote breastfeeding in public and professional information activities focused on SIDS/safe sleep risk reduction practices by presenting at ten (10) conferences or workshops, attended by a total of over 385 attendees consisting of nurses, home visitors, DCYF staff, NH Safe Kids Coalition members, psychology or public health major New England College students, New England VNA Health System agency representatives, and child care workers and early education specialists. MCH

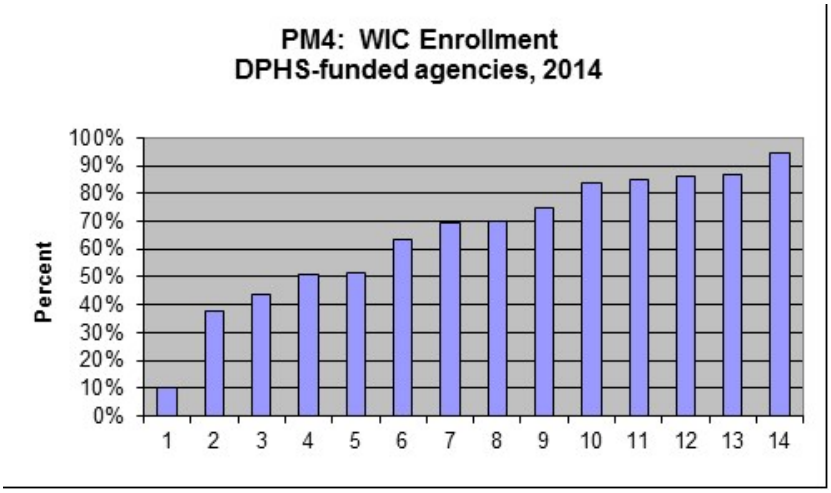
continued to include a WIC staff member and a lactation consultant on its SUID Review Group and its Safe Sleep Campaign workgroup to develop strategies to promote breastfeeding while reducing the risk of SIDS and unsafe sleep environments. In addition, material was showcased at an MCH display table, or distributed at a conference, at over 15 state conferences on a broad variety of topics such as the annual NH Immunization Program conference, the Early Learning NH conference, the Tb/STD/HIV annual conference, the annual breakfast for NH state legislators, and Dartmouth Hitchcock Medical Center's Pediatric Grand Rounds.

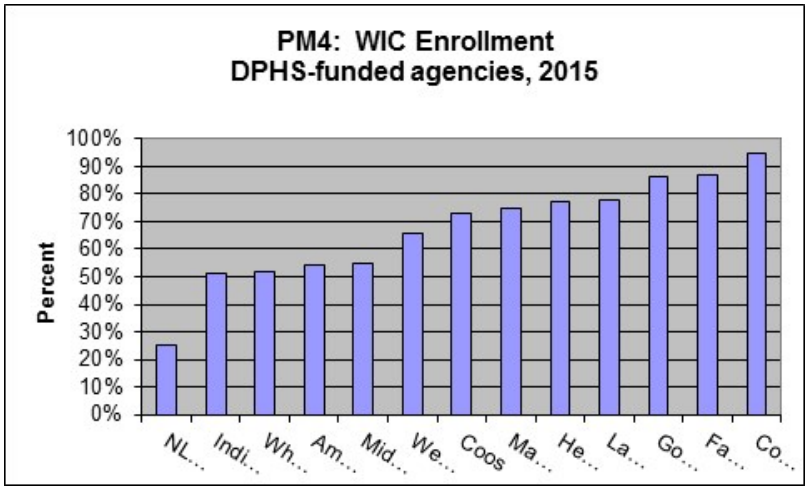
MCH continued to share nutrition-related information, resources, webinars and training opportunities from WIC to MCH-contract agencies including the October 2014 Maternal Nutrition Intensive Training webinar, offered by the University of Minnesota, through the NH WIC Program. MCH-contract agencies also participated in three-day lactation training "Grow and Glow" given by the state WIC Breast Feeding Consultant, on lactation training, in spring 2015.

MCH continued to monitor efforts by the MCH-funded 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. With FY15 input from the community health centers, the MCH performance measure for FY16 was changed from infants still exclusively breastfed for the first three months to those ever breastfed, to capture the initiation effort made by agency staff. The range of FY15 results for the breastfeeding performance measure was 14% to 37% with an average of 22%.



As noted in the charts below, WIC enrollment of children in MCH-funded home visiting and community health centers was essentially the same, with an average of 65% in FY14, to 67% in FY15. This continues to be a focus of MCH contract agency meetings and site visits in order to boost enrollment and reinforce education and support on breastfeeding and other related nutrition and health topics.





National Performance Measure #8:
Rate of birth (per 1,000) for teenagers aged 15-17 years

Data Analysis

New Hampshire continues to experience the same downward trend in teen births as seen throughout the United States. At 4.0/1000 births, New Hampshire's teen birth rate among 15-17 year olds is lowest in the country. In 2015, the percentage of High School students who ever had sexual intercourse decreased to 39.4% and the total of currently sexually active high school students was 31.3%. Only 7.1% of sexually active High School students reported not using any method of contraception to prevent pregnancy.[2] Although the overall New Hampshire teen birth rate is low, just looking at the state averages doesn't tell the whole story. Sullivan, Coos, and Belknap counties continue to have higher teen birth rates compared to other larger and less rural counties. Large cities such as Manchester and Nashua continue to have higher rates and numbers of teen births.

Systems Building

Even though New Hampshire continues to see positive trends, public health, education and community members remain focused on preventing unintended teen births. It is essential that health centers, clinicians, schools and community organizations throughout New Hampshire continue to leverage federal and state funding sources to build a system that offers consistent and reliable support to adolescents and young adults. Identification and support of strategies like evidence based pregnancy prevention curricula, reproductive health education, access to confidential

reproductive health care and home visitation for pregnant and parenting teens, will help adolescents and young adults make healthy decisions about their sexual health. The challenge, however, remains in reaching even deeper into the communities where there are significant disparities; where the cycle of poverty and low educational attainment puts adolescents at heightened risk for teen pregnancy and teen birth.

MCH Specific Activities

The Maternal and Child Health Section continues to manage a teen pregnancy prevention program called "PREP" (Personal Responsibility Education Program). This program contracts with two local health and education providers in the targeted areas of Sullivan County and the City of Manchester, where data indicates there are disproportionately high numbers and rates of teen births. These two communities have a growing urban population and a larger and more diverse teenage population.

The contracted providers are implementing an evidence-based curriculum called *FOCUS*. This curriculum teaches young people about reproduction, sexually transmitted disease, including HIV, contraception (family planning), abstinence, and parental involvement in decision making. In addition, it offers students life skills training in topics such as 1) Healthy Relationships – positive self-esteem and relationship dynamics; 2) Adolescent Development – healthy attitudes and values about adolescent growth, body image, and racial and ethnic diversity; and 3) Healthy Life Skills – goal setting, negotiation, decision making, communication, stress management, and interpersonal skills. Historically, these two programs only served female adolescents, but future efforts will include their male counterparts. Last year, the two programs helped 150 adolescents build skills and confidence around sexuality, and preventing teenage pregnancy. While these numbers may seem low, the process from initial class to follow up takes place over a period of six (6) months, and NH PREP is only in its fourth year. Nonetheless, the teen birth rate in New Hampshire (age 15-19) is the lowest in the U.S., at 10.2 births per 1000 adolescents (2015). The birth rate among teens aged 15-17 is 4.1 (2015).

Data captured from PREP program activities over the past four (4) years provides good evidence of the positive effect of these programs. Perceived change in self-efficacy six (6) months after completion of the training program improved considerably among program participants. Confidence among the teen participants to utilize contraception, choose abstinence, and gain knowledge about pregnancy and STI prevention is assessed three times: pre-test, post-test, and a six month follow up questionnaire. Prior to completing *FOCUS*, 43.3% of participants reported that they were "Not at All," "Somewhat" or "Moderately Confident" in their ability to refuse sex unless birth control was used. After completing *FOCUS*, 92.5% of participants reported that they were "Confident" or "Extremely Confident." At the six month follow up, 95.6% of respondents reported they were not pregnant; 59.7% of respondents reported they were not sexually active and 95% of respondents reported a behavior to reduce risk of pregnancy and STI. Prior to completing *FOCUS*, 39% of participants reported that they were "Not At All", "Somewhat" or "Moderately Confident" in their ability to use birth control every time. After completing *FOCUS*, 90% of participants reported that they were "Confident" or "Extremely Confident" in their ability to use birth control effectively. Among those who were sexually active prior to *FOCUS*, 46.9% reported "Always" using a method of birth control to prevent pregnancy. Among those who were sexually active at the six month follow up, 66.7% reported "Always" using a method of birth control to prevent pregnancy. These data illustrate the effectiveness of the programs, and the critical importance to continue this work, to ensure teenage pregnancy rates remain low.

In addition to the PREP program, for nearly 40 years MCH has administered a state-wide Family Planning program, targeting the needs of adolescents, young women and men, uninsured, and low income individuals. Provision of free or low cost contraception to adolescents in New Hampshire is very important. Voluntary, confidential services for family planning, in tandem with other reproductive health services serve adolescents as well as older adults. Youth aged 15 through 17 can also access services without parental involvement or parental health insurance; however the importance of understanding choices such as abstinence, and parental involvement in reproductive health are valuable messages provided through adolescent contraceptive and counseling services. The NH Family Planning Program will continue its work to enable adolescents to control their fertility and timing of parenthood.

National Performance Measure 15:
Percentage of women who smoke in the last three months of pregnancy

Data Analysis

Maternal smoking during pregnancy is consistently reported as a predictor of adverse birth outcomes such as preterm birth and low birth weight as well as fetal and infant mortality.

The February 2016 ***National Vital Statistics Reports*** noted that in 2014, 13.7% of pregnant women in New Hampshire smoked at some time during pregnancy. By third trimester, 10.7% of women continued to report smoking. These rates are significantly higher than the national averages of 8.4% of smoking anytime during pregnancy and 6.6% in the third trimester.[3]

Systems Building

Tobacco use is the single most preventable cause of disease, disability, and death in the United States. In New Hampshire alone, over 1900 deaths a year are attributable to tobacco.[4] Quitting smoking before or during pregnancy is one of the most important steps a woman can take to improve health outcomes for herself and her baby. The CDC's Best Practices for Comprehensive Tobacco Control Programs—2014 is an evidence- based guide that recommends the following strategies for states as they plan comprehensive tobacco control programs: State and Community Interventions; Mass-Reach Health Communication Interventions; Cessation Interventions; Surveillance and Evaluation; and Infrastructure, Administration, and Management of a Comprehensive Tobacco Control Program.[5] These strategies can help inform specific activities focused on both clinical, environmental and policy interventions for pregnant women. MCH has had an increasingly close relationship with the Tobacco Prevention and Control Program as both program focus on the common State Health Improvement Plan objective of reducing the number of women who report smoking cigarettes during pregnancy from 13.6% (2011) to 12% by 2015 and 10% by 2020.

MCH Specific Activities

MCH uses its unique relationship with community health centers and community based home visiting programs to support professional development for Community and Cessation Interventions. By monitoring and supporting quality improvement activities, Title V can focus activities among populations most at risk for tobacco use. Initiatives like PRAMS and the Sudden and Unexpected Infant Death (SUID) Review assist with increased surveillance and evaluation.

MCH monitored and provided assistance to MCH-funded prenatal and primary care agencies that provide comprehensive prenatal care to low income, uninsured and underinsured women.

MCH continued to partner with the Tobacco Prevention and Control Program (TPCP) to provide MCH-funded Home Visiting Agencies and CHCs support and training in evidence-based practice, data collection and motivational interviewing. TPCP provided training to home visitors in the Ask, Assist, and Refer (2As &R) smoking cessation intervention program as well as information about the benefits of using the QuitWorks-NH helpline. A similar training was provided to CHC staff via Web-Ex. Ten CHC staff registered for the original Web-Ex training and the webinar remained archived and accessible through June 30, 2016. Nicotine patches are available at no charge to QuitWorks-NH participants who are receptive to a counseling session and state they are ready to quit smoking within 30-days. Eleven pregnant women completed a Screener/Intake through QuitWorks-NH, which included speaking with an Enrollment Assistant for at least 5 minutes while completing demographic and tobacco use questions. Those who complete this session are eligible to receive 2 weeks of Nicotine Replacement Therapy patches at no charge. A pregnant woman may receive the patches only with the approval of her health care provider. Six coaching sessions are provided to each client and pregnant clients may receive more sessions at no cost. An independent evaluator of the NH Tobacco Quitline surveys clients 6 months post treatment and reported a 34% Quit Rate (% who report not having a cigarette-even a puff, in the previous 30 days) for SFY16.

For FY16, MCH implemented a preventive health performance measure to gather data from 13 MCH funded Prenatal and Primary Care contracted agencies that serve prenatal women: *Percent of women who are screened for tobacco use during each trimester AND who received tobacco cessation counseling intervention if identified as a tobacco user*. This data is to be reported to MCH biannually in January and July. In January 2016 the 6 month data from 10 of the 13 contracted agencies for this measure was 76% (218/288). The remaining agencies were in

process of building capacity to pull this data and are anticipated to report their annual data by the end of July.

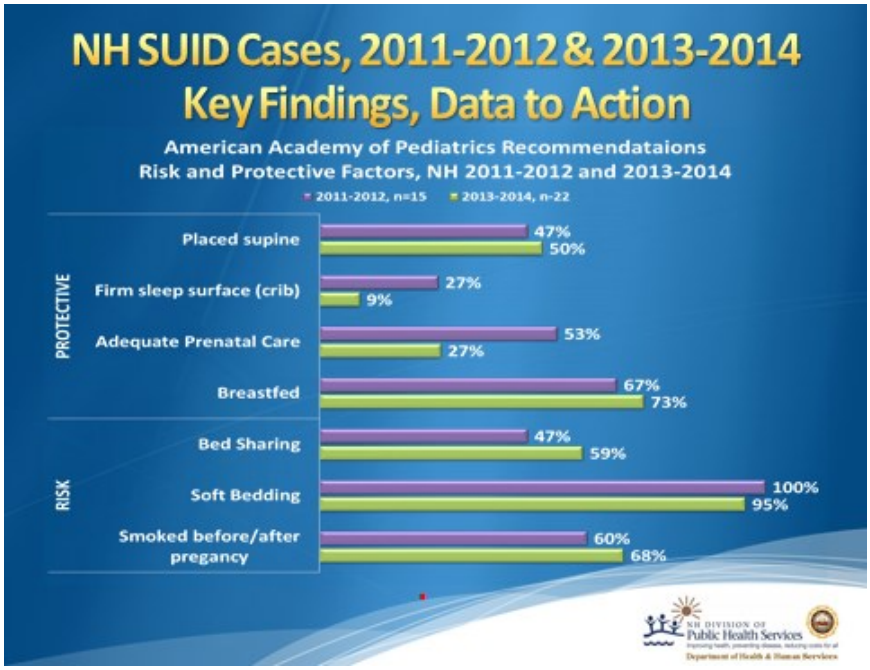
MCH chairs the NH DPHS Sudden and Unexpected Infant Death (SUID) Review group. Data from the infant death cases reviewed by this group showed that in 60% of the fifteen 2011-2012 deaths, and in 68% of the twenty-two 2013-2014 cases, the infant's mother smoked before and/or after the pregnancy, indicating the importance of getting information on the risk of tobacco in relation to SIDS out to pregnant and postpartum women.

The MCH SIDS/SUID Project Coordinator continued to integrate the risk of smoking and tobacco exposure for SIDS in any SUID/Safe Sleep presentations during SFY16. Eleven presentations or workshops were given, with a total of over 300 attendees consisting of nurses, home visitors, DCYF staff, NH Safe Kids Coalition members, perinatal hospital staff, childbirth educators, Assistant Deputy Medical Examiners, staff from an inpatient drug rehabilitation facility, child care providers and early education specialists. Evaluations from almost all participants indicated they had increased their prior understanding of the smoking and tobacco exposure as a SIDS risk. At least three other members of the SUID Review Group, the Lactation Consultant who represents the NH Breast Feeding Task Force, the Chief Forensic Investigator for the Medical Examiner's Office, and the Chair of the NH Child Fatality Review Committee, each made at least one presentation in SFY16 which also included the tobacco smoke/SIDS link.

In addition, material on this topic was included among information that was showcased at a MCH display table, or distributed at over 17 state conferences sponsored by a broad variety of organizations, such as the annual NH Immunization Program conference, the Early Learning NH conference, WIC agency trainings, a DCYF adoptive and foster parent annual conference, the Brain Injury Association annual conference, the annual Emergency Department Symposium, the Healthy Homes annual conference, the annual breakfast for NH state legislators, and the Department of Justice Advocate conference, to name a few.

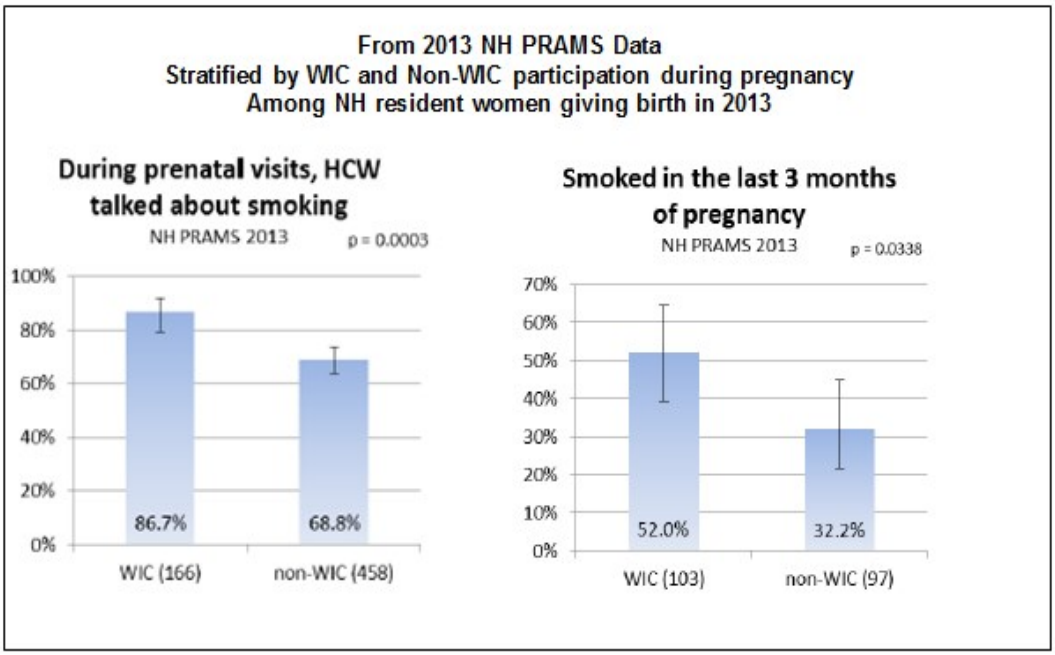
Tobacco/SIDS risk information was also shared through social media during October, Safe Sleep/SUID Awareness month, with information available on the Division of Public Health's webpage. This effort included three Facebook postings by the DHHS Public Information Office featuring Safe Sleep/SUID related infographics and resulted in 173 hits in October and 27 in November of 2015. Eight tweets were sent from the Public Information Office, which included the following message sent on October 7, 2015, "Tobacco smoke exposure increases a baby's risk of #SIDS. https://www.nichd.nih.gov/sts/pages/default.aspx". The tweets were followed by 948 recipients. In November, 2015, State Epidemiologist Dr. Benjamin Chan spoke on the topic of decreasing the risk of SIDS/SUID, including the tobacco risk, on "Health Headlines," a show on WMUR, a major New Hampshire TV station.

The Tobacco Treatment Specialist from the NH DPHS Tobacco Prevention and Control Program continued to be a participant of the Safe Sleep Campaign workgroup. Women who connect to the NH Quit Line and indicated they are pregnant continued to receive information on tobacco exposure as a SIDS risk in their mailed packet.



For FY16, MCH implemented a preventive health performance measure to gather data from 13 MCH funded Prenatal and Primary Care contracted agencies that serve prenatal women: *Percent of women who are screened for tobacco use during each trimester AND who received tobacco cessation counseling intervention if identified as a tobacco user*. This data is to be reported to MCH biannually in January and July. In January our 6 month data from 10 of our 13 contracted agencies for this measure was 76% (218/288). The remaining agencies were in the process of building capacity to pull this data and are expected to report their annual data at the end of July.

NH continues to promote Text4Baby, the free phone app which provides timely messages on a variety of health and safety topics to pregnant women and new mothers. Text4Baby engages pregnant women with social media about the importance of avoiding tobacco products and second-hand smoke exposure. Text4Baby tear off pads are distributed to prenatal programs as requested, during clinic assessment site visits, and at a variety of in-state conferences. The NH Division of Public Health's Text4Baby Project Coordinator presented an update on the project at the June 2015 meeting of MCH-funded primary care and prenatal program agencies. There have been 5160 individuals from New Hampshire enrolled in Text4Baby since the NH Division of Public Health began promoting the program in 2010.



State Performance Measures 2011-2015

State Performance Measure #10:
Percent of women who had a preterm birth who reported smoking prior to pregnancy

Data Analysis

Because of New Hampshire's higher than average rates of smoking (13.7%) while pregnant when compared to the US (8.4%), it is likely that tobacco use may be disproportionately contributing to New Hampshire's prematurity rate. Of women who had a preterm birth, 22% report smoking prior to pregnancy. Despite community and clinical interventions to support tobacco cessation, the trend for this measure is going in the wrong direction. In 2011, 18.6% women who had a preterm birth reported smoking prior to pregnancy.

Systems Building

As described in *National Performance Measure 15: Percentage of women who smoke in the last three months of pregnancy*, MCH has had an increasingly close relationship with the New Hampshire Tobacco Prevention and Control Program as both programs focus on the common New Hampshire State Health Improvement Plan objective of reducing the number of women who report smoking cigarettes during pregnancy from 13.6% (2011) to 12% by 2015 and 10% by 2020. Together, they utilize clinical, environmental and policy interventions to address tobacco use at both the population level and at the individual level and specifically among pregnant women.

MCH Specific Activities

MCH continued to monitor and provide assistance to MCH-funded prenatal and primary care agencies that provide comprehensive prenatal care to low income, uninsured and underinsured women. For FY16, MCH implemented a preventive health Performance measure to gather data from 13 MCH funded Prenatal and Primary Care contracted agencies that serve prenatal women: *Percent of women who are screened for tobacco use during each trimester AND who received tobacco cessation counseling intervention if identified as a tobacco user*. This data is to be reported to MCH biannually in January and July. In January our 6 month data from 10 of our 13 contracted agencies for this measure was 76% (218/288). The remaining agencies were in process of building capacity to pull this data and are anticipated to report their annual data by the end of July.

MCH continued to partner with the Tobacco Prevention and Control Program (TPCP) to provide MCH-funded Home Visiting Agencies and CHCs support and training in evidence-based practice, data collection and motivational interviewing.

MCH monitored and provided assistance to MCH-funded home visiting agencies that provide services to pregnant women. TPCP provided training to home visitors in the Ask, Assist, and Refer (2As &R) smoking cessation intervention program as well as information about the benefits of using the QuitWorks-NH helpline. Home visitors provided information and support to pregnant and parenting women around the dangers of smoking during pregnancy and exposure to environmental tobacco smoke. Home visiting tracks the number of smoking cessation interventions given to mothers who are pregnant or have recently given birth who also smoke. From 9/1/14-9/30/15, 1054 smoking cessation interventions using the 2R&A model were provided to smoking participants in the home visiting program. These interventions included access to the Quitline (1-800-QUIT-NOW), education about how smoke impacts children's health, and nicotine patches at no charge.

In addition to the training provided to home visitors, TPCP implemented a similar training for CHC staff via Web-Ex. Ten CHC staff registered for the original Web-Ex training and the webinar remained archived and accessible through June 30, 2016.

Nicotine patches are available at no charge to QuitWorks-NH participants who are receptive to a counseling session and state they are ready to quit smoking within 30-days. During SFY16 eleven pregnant women completed a Screener/Intake through QuitWorks-NH, which included speaking with an Enrollment Assistant for at least 5 minutes while completing demographic and tobacco use questions. Those who complete this session are eligible to receive 2 weeks of Nicotine Replacement Therapy patches at no charge. A pregnant woman may receive the patches only with the approval of her health care provider. Six coaching sessions are provided to each client and pregnant clients may receive more sessions at no cost. An independent evaluator of the NH Tobacco Quitline surveys clients 6 months post treatment and reported a 34% Quit Rate (% who report not having a cigarette-even a puff, in the previous 30 days) for SFY16.

MCH continued to participate in PRAMS. MCH staff provided a PRAMS update at the June 2016 meeting of MCH-funded primary care and prenatal program agencies. The first set of NH Data from 2013 was made available by the CDC in the fall of 2015. MCH staff analyzed the data and published a *2013 NH PRAMS Data Book* in January 2016. An additional analysis stratified by WIC and Non-WIC participants was completed in March of 2016. Presentations were made to several stakeholder groups during March-June 2016 including the WIC Directors, the Maternal Mortality and Morbidity Review Panel, the Sudden and Unexpected Infant Death Review Panel, the Perinatal Substance Exposure Task Force, and the Primary Care Coordinator's Meeting (MCH-funded primary care and prenatal program agencies). Data shared with these groups included that related to smoking before, during, and after pregnancy as well as help or advice to quit smoking. Identified strengths and weaknesses will be used in program planning and data will be trended over time as subsequent years of data become available.

2013 NH PRAMS Data
NH resident women giving birth in 2013

32. Have you smoked any cigarettes in the *past 2 years?*

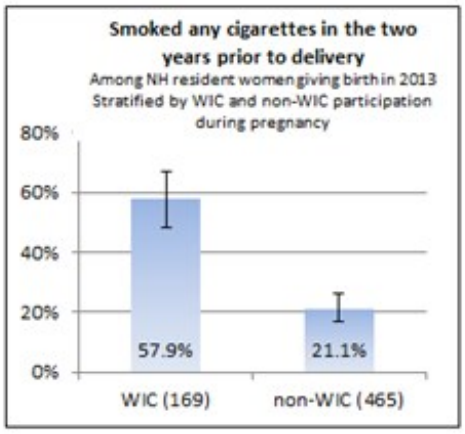
Total respondents: 634	Percent	95% CI		Yes	Population
[SMK2YRS]	Yes	Lower	Upper	Responses	Estimate
Smoked one or more cigarette in the last 2 years	31.0	26.8	35.7	200	3745

33. In the *3 months before* you got pregnant, how many cigarettes did you smoke on an average day?
**Only women answering Yes to Q32 were instructed to answer this question.

Total respondents: 200	Percent	95% CI		Yes	Population
[calculated from collapsed answers to SMK6_3B]	Yes	Lower	Upper	Responses	Estimate
Did smoke	86.1	78.8	91.1	174	3223
Did not smoke then	13.9	8.9	21.2	26	522

34. In the *last 3 months* of your pregnancy, how many cigarettes did you smoke on an average day?
**Only women answering Yes to Q32 were instructed to answer this question.

Total respondents: 200	Percent	95% CI		Yes	Population
[calculated from collapsed answers to SMK6_3L]	Yes	Lower	Upper	Responses	Estimate
Did smoke	42.2	33.7	51.1	97	1578
Did not smoke then	57.8	48.9	66.3	103	2166



[1] Shealy KR, Li R, Benton-Davis S, Grummer-Strawn LM. The CDC Guide to Breastfeeding Interventions. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2005.

[2] http://education.nh.gov/instruction/school_health/documents/nhyrbsresultsgraphs.pdf

[3] Curtin SC, Mathews TJ. Smoking prevalence and cessation before and during pregnancy: Data from the birth certificate, 2014. National vital statistics reports; vol 65 no 1. Hyattsville, MD: National Center for Health Statistics. 2016.

[4]

[5] https://www.tobaccofreekids.org/facts_issues/toll_us/new_hampshire

Centers for Disease Control and Prevention. Best Practices for Comprehensive Tobacco Control Programs—2014. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.

Perinatal/Infant Health

State Action Plan Table

State Action Plan Table - Perinatal/Infant Health - Entry 1

Priority Need

Decrease unintentional injury.

NPM

Percent of infants placed to sleep on their backs

Objectives

By January 1, 2017, 100% of New Hampshire's 19 birth hospitals will have a safe sleep policy in writing.

By June of 2017, 75% of New Hampshire's 19 birth hospitals will have indicated an improvement in their staff's safe sleep practice from what it had been in the fall 2015 practice survey.

Strategies

Utilize SUID (Sudden Unexpected Infant Death) case registry, to describe the distribution of risk factors and identify possible points of intervention

Data collection from the Pregnancy Risk Assessment Monitoring System (PRAMS)

Participation in Infant Mortality Collaborative Improvement and Innovation Network (IM CoIIN)

Promote safe sleep policy development and change within birthing facilities

Training of providers working with infants (e.g. labor and delivery nurses, child care providers)

Public education

ESMs

ESM 5.1 - Percentage of birth hospitals with a written safe sleep policy, including placing all infants to sleep on their back

NOMs

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 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Measures

NPM 5 - Percent of infants placed to sleep on their backs

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	89.6	89.7	89.8	89.9	90	90.1

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	88.9 %	1.5 %	10,497	11,815

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% and should be interpreted with caution

ESM 5.1 - Percentage of birth hospitals with a written safe sleep policy, including placing all infants to sleep on their back

Annual Objectives					
2017	2018	2019	2020	2021	
Annual Objective	60.0	75.0	90.0	100.0	100.0

Perinatal/Infant Health - Plan for the Application Year

National Performance Measures: 2016-2020

National Performance Measure #5:
Percent of infants placed to sleep on their backs

Evidence Based or Informed Strategy Measure:

Percent of birth hospitals with a written safe sleep policy, including placing all infants to sleep on their backs

Data Analysis

New Hampshire has been consistent with national data in ranking Sudden Infant Death Syndrome (SIDS), as one of the leading causes of infant deaths. SIDS is defined as the death of an infant less than one year of age, which remains unexplained after a thorough case investigation, including a complete autopsy, death scene investigation, and a review of the infant's clinical history. With the success of the national "Back to Sleep" campaign, reminding parents and childcare providers to put infants to sleep on their backs on a firm, flat mattress, the rate of SIDS cases nationally has been dropping significantly since the early 1990's; however, although SIDS has declined, the rate of sudden and unexpected infant deaths, or SUID, has increased. In New Hampshire, SIDS rates have decreased, but there is no statistically significant difference between year groups.

[1]Top Ten Leading Causes of Natural Death in 2013, Infants (under age 1 year)

Leading Causes of Natural Infant Death	2003-2013	2013
Newborn affected by maternal factors and by complications of pregnancy, labor and delivery	106	15
Respiratory and cardiovascular disorders specific to the perinatal period	88	11
Congenital malformations, deformations and chromosomal abnormalities	123	10
Disorders related to length of gestation	114	4
Hemorrhagic and hematological disorders of fetus and newborn	19	3
Diseases of the respiratory system	15	3
Digestive system disorders of fetus and newborn	12	3
Sudden Infant Death Syndrome (SIDS)	39	2
Diseases of the circulatory system	20	2
Endocrine, nutritional and metabolic diseases	8	2

[2]New Hampshire Residents, Deaths from SIDS, 3-year Groups

Year Group	SIDS	BIRTHS	Rate per 10,000 Births	Lower 95% CI	Upper 95% CI
1999-2001	21	43,292	4.9	3.0	7.4
2002-2004	17	43,374	3.9	2.3	6.3
2005-2007	29	42,965	6.7	4.5	9.7

2008-2010	12	39,946	3.0	1.6	5.2
2011-2013	9	37,585	2.4	1.1	4.5

The SUID category includes those deaths due to SIDS, Accidental Suffocation and Strangulation in Bed, and those deemed Undetermined in unsafe sleep situations. According to a study in Pediatrics, 2009[3], the rate of deaths from accidental suffocation and strangulation in bed quadrupled in the past two decades.

Deaths from several ICD10 codes (R95, R99 and W75) that include SIDS, "Undetermined", and deaths from accidental suffocation and strangulation in a bed setting as a cause of death cannot simply be grouped and counted in the category of "Sudden Unexpected Infant Death" (SUID) as not all R99 (Undetermined) deaths were connected to unsafe sleep.

Upon further investigation, in 2013, 11 of the 12 cases noted in the death certificate data met the CDC criteria for Sudden Unexpected Infant Death (SUID). Manner of death in these cases were natural for some, accidental or undetermined for others.

[4]New Hampshire Residents, Infants (under age 1 year), 2013, Manner and Cause of Death Fields from Death Certificate Data

Where Underlying Cause of Death (ICD10) was code R95, R99 or W75

ICD10 Cause of Death Code	Manner of Death	Count	Cause of Death A	Cause of Death B
R95	Natural	2	SUDDEN INFANT DEATH SYNDROME	
R99	Pending	1	OTHER ILL-DEFINED AND UNSPECIFIED CAUSES OF MORTALITY	
R99	Undetermined	7	UNDETERMINED	
W75	Accidental	1	POSITIONAL ASPHYXIA	
W75	Accidental	1	ASPHYXIA	SUFFOCATION AND/OR CHEST COMPRESSION
	Total	**12**		

[5]New Hampshire Residents, Deaths with Possible SUID IDC10 Codes Compared to SUID Cases upon Review, Infants (under age 1 year), 2013

Year	ICD10 Cause of Death Code Possible SUID	SUID Cases after investigation
2011	8	7
2012	8	8
2013	12	11

Compared to all natural manner of death cases, 12 possible cases of SUID would fall as the second leading cause of death. Death due to complication of pregnancy and delivery is the leading cause of natural death and SUID is the second leading cause of infant death.

[6]New Hampshire Residents, Causes of Death Counts,

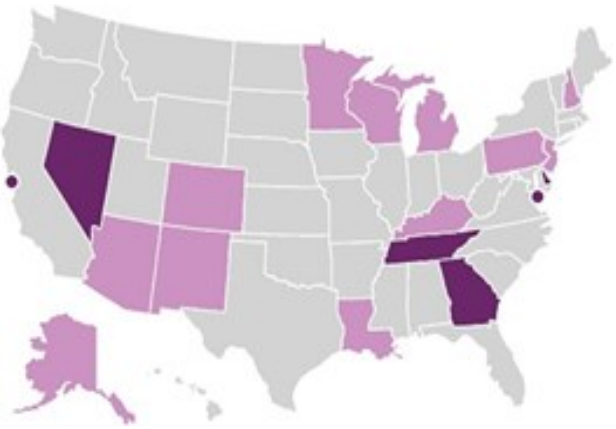
Infants (under age 1 year), 2011 to 2013

Cause of Death	Manner of Death	2011 Count	2012 Count	2013 Count	Total Count
Newborn affected by maternal factors and by complications of pregnancy, labor and delivery	Natural	31 (53%)	35 (67%)	38 (56%)	**104 (58%)**
SUID (ICD 10 Code: R95, R99, W75)	Accidental	1 (2%)		2 (3%)	**3 (2%)**
	Undetermined	3 (5%)	3 (6%)	7 (10%)	**13 (7%)**
	Natural	4 (7%)	5 (10%)	2 (3%)	**11 (6%)**
	Pending			1 (1%)	**1 (1%)**
Congenital malformations, deformations and chromosomal abnormalities	Natural	10 (17%)	6 (12%)	10 (15%)	**26 (15%)**
Diseases of the respiratory system	Natural	1 (2%)	1 (2%)	3 (4%)	**5 (3%)**
Diseases of the circulatory system	Natural	2 (3%)		2 (3%)	**4 (2%)**
Endocrine, nutritional and metabolic diseases	Natural			2 (3%)	**2 (1%)**
Assault	Homicide	1 (2%)			**1 (1%)**
Certain infectious and parasitic diseases	Natural	1 (2%)			**1 (1%)**
Diseases of the digestive system	Natural		1 (2%)		**1 (1%)**
Diseases of the nervous system	Natural			1 (1%)	**1 (1%)**
Drowning	Accidental	1 (2%)			**1 (1%)**
Neoplasms	Natural	1 (2%)			**1 (1%)**
Unknown	Pending	2 (3%)			**2 (1%)**
	Undetermined		1 (2%)		**1 (1%)**

Total	**58 (100%)**	**52 (100%)**	**68 (100%)**	**178 (100%)**

Systems Building

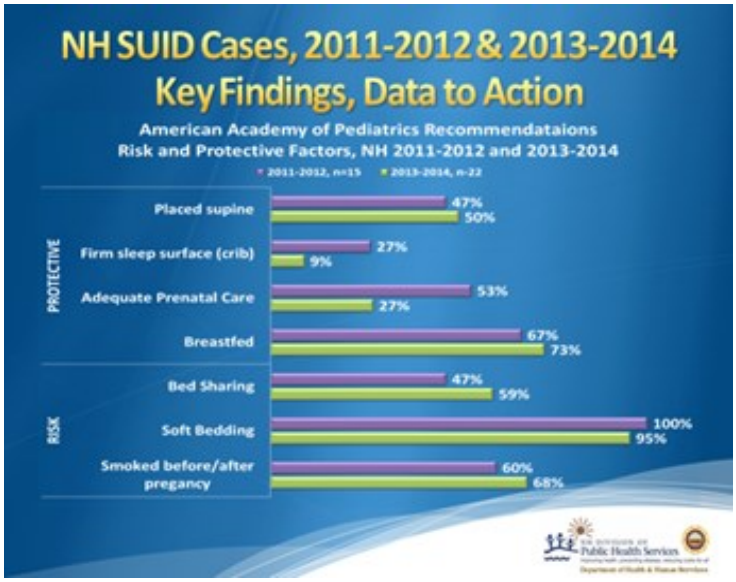
Since 2011, the Maternal and Child Health Section (MCH) has been one of the ten (10) CDC grantees for the Sudden Unexpected Infant Death (SUID) Registry.



Light purple - CDC's Division of Reproductive Health funds the following states: Arizona, Colorado, Louisiana, Michigan, Minnesota, New Jersey, New Mexico, New Hampshire, Wisconsin, Alaska, Kentucky, and Pennsylvania. ***Dark purple*** - The National Institutes of Health and CDC Epilepsy fund the following states and jurisdictions (noted by circles): Delaware, Georgia, Tennessee, Nevada, the city and county of San Francisco, and the Tidewater Region of Virginia.

Through a Memorandum of Agreement, MCH collaborates closely and successfully with the NH Office of Chief Medical Examiner (OCME), which has the legislative authority to request case information relative to the child's death investigation. A multidisciplinary SUID Review Group meets on the alternate months from the state's Child Fatality Review Group, of which many SUID Review Group are also members. The SUID Review group has the addition of numerous perinatal-related representatives, such as a home birth provider, a certified nurse midwife, an ob-gyn, neonatologist, State WIC Program representative, state and local agency Home Visiting agency representative. At each meeting, the direct care staff that was involved with the deceased infant is invited to attend, contribute information, and participate in the recommendation development following the case discussion. This includes the infant's home visitor, first responder, birth hospital perinatal nurse manager and lactation consultant, primary care provider and prenatal care provider. These guests not only contribute valuable case data not necessarily obtained from the medical records requested by the OCME for the SUID registry, but also contribute to a richer case discussion and more realistic recommendations generated. A secondary and more significant gain from inviting the actual direct care providers is increased buy-in from those attending. Anecdotal information has shown that numerous changes were made in the local provider or local birth hospital staff policy and practice as a result of seeing the death scene investigation slides of an unsafe sleep environment.

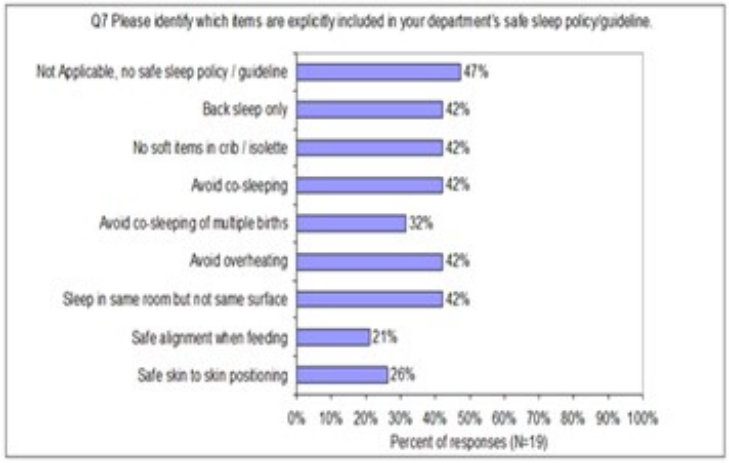
Data from cases reviewed by the SUID Review Group below show that babies were placed supine in 47% of the deaths in 2011-2012, and 50% of the deaths 2013-2014, which is when the NH Safe Sleep Workgroup became more active.[7]



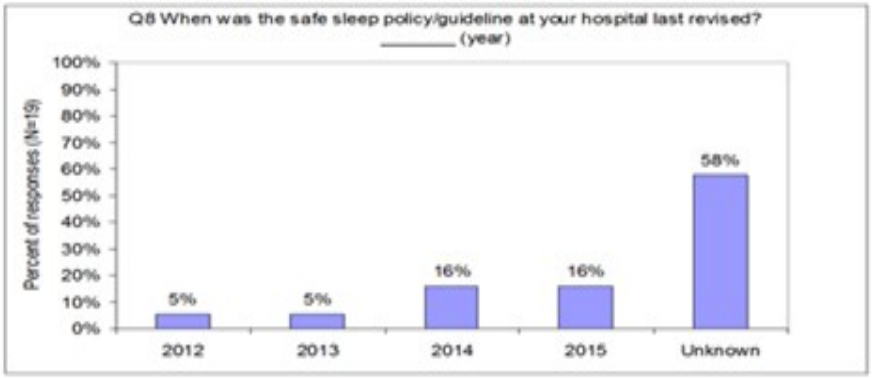
Through the case reviews, the SUID Review Group learned that visiting nurses were often told by parents that they did not receive safe sleep information at the birth hospital. As a follow up to a recommendation, MCH surveyed all 19 of the birth hospitals on their safe sleep policy and practices in July –August 2015. A tool utilized by the Massachusetts Department of Health, developed by the Harvard School of Public Health, was used with some minor word changes and with the addition of questions related to infant crying. This was done concurrently with the NH Safe Sleep Campaign's, chaired by Maternal and Child Health staff, integration and reinforcement of the *Period of Purple Crying* material into all of its presentations and display opportunities. The premise is to decrease the chances that a frustrated parent would be tempted to bring a crying baby into bed as a soothing strategy, thereby increasing the risk of SUID.

The survey project was chaired by MCH staff in collaboration with colleagues from the NH Safe Kids Coalition, which has been active in promoting the Period of PURPLE Crying; the Foundation for Healthy Families (which represented the NH Hospital Association as well); and the Regional Program for Women's and Children's Health APN Forum 2016 & Director of Operations, NNEPQIN, Dartmouth-Hitchcock Medical Center, all of whom are active on the SUID Review Group and the NH Safe Sleep Workgroup. The tool was sent in written form, with a cover letter signed by the Director of the NH DPHS, to the birth hospital's Executive Director, to alert them to the survey, and via electronic survey monkey with an email cover note, to the perinatal manager. Follow up emails and calls were made to the perinatal nurse managers in mid to late August to overdue responders by MCH staff.

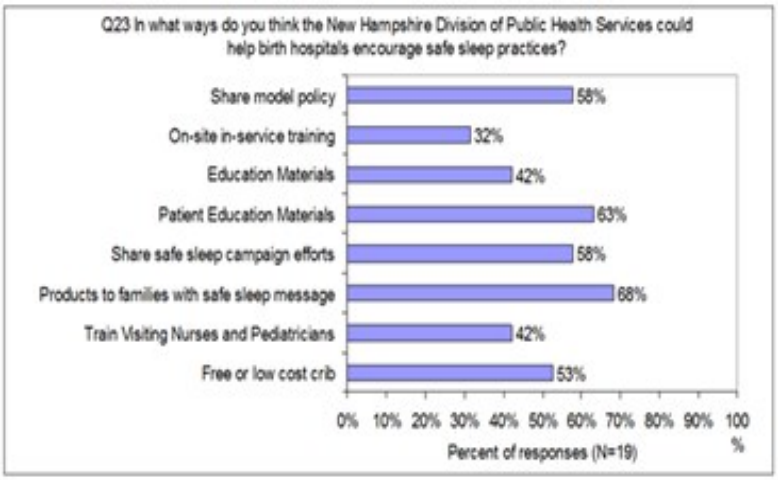
The survey yielded 100% compliance with a surprising 42% (8/19) of the birth hospitals indicating they had a written safe sleep policy or guideline. This provided the baseline for the ESM for this performance measure. Policies contained a myriad of items.



However, a majority of hospitals did not remember the last time their policy was updated indicating that guidance from MCH might be warranted.



Fifty-eight percent (11/19) of responding birth hospitals did indeed indicate that MCH could in fact provide technical assistance by sharing a model policy in addition to several other forms of expertise as shown:



It is interesting to note that respondents provides several barriers to implementing safe sleep policies including little time to educate parents (16%), other competing priorities (16%), language barriers (11%), patients' beliefs (79%), lack of appropriate educational materials (5%) and staff beliefs (21%). Several of these, including the beliefs of patients and staff are difficult to address because they suggest that even with education and a definitive policy on safe sleep, erroneous attitudes persist. Others such as lack of educational materials can be remedied fairly quickly.

A copy of the aggregate results and a sample hospital safe sleep policy was sent to each birth hospital's Executive Director (paper) and to the nursery staff member who had completed the survey (electronic) with one (1) of two (2) cover letters, depending on their facility's response to the written policy question.

In June 2016, a follow up email was sent to the perinatal nurse managers whose birth facility had indicated they did not have a written policy. This email was sent prior to their June 28,2016 Perinatal Nurse Managers' meeting, which had a focus on continuing the Safe Sleep discussion, by the meeting host, who is the NNEPQIN representative mentioned above.

The email stated: "As you may remember, the NH Department of Health and Human Services sent out a Safe Sleep Survey last fall. The Nurse Leader who completed the survey for your hospital indicated NO to the question copied below. As we prepare to resurvey hospitals this fall, we would like your thoughts on this question. Would you say it is accurate that you do NOT have a written safe sleep policy or guideline? Look forward to your thoughts on how we might improve safe sleep practices among staff and patients in NH Birth Hospitals. " Results from this informal email survey showed that of the ten (10) hospitals that said they didn't have a written policy, and the one (1) that wasn't sure, six (6) hospitals responded with a variety of answers ranging from yes, now has a policy to policy in development process, to yes, have a policy but it's integrated with other policies such as a falls prevention policy.

The survey results were reviewed at the June 28, 2016, Perinatal Nurse Managers' meeting, and attendees were encouraged to provide input on how best to capture what is happening at their facility, as anecdotal information has shown that some hospitals are now doing a variety of safe sleep/SUID risk reduction activities. A fall 2016 follow up survey is planned.

This survey project, along with a conference sponsored by NH AWHONN (Association of Women's Health, Obstetric and Neonatal Nursing) September 21, 2015 (see agenda below), in collaboration with the NH DPHS, were activities identified by the NH Infant Mortality/Safe Sleep CoIIN initiative. MCH staff attended the July 2015 CoIIN meeting in Boston, along with the NNEPQIN representative mentioned above to learn safe sleep strategies.

"Why Just Saying Back to Sleep Isn't Enough"

Sept 21, 2015 - Wentworth Douglass

Presented by NH AWHONN and NH Division of Public Health Services

8:30 – 9:00 Registration

9:00 – Welcome from Nora Fortin, NH AWHONN Chapter Chair

9:05 - 10:30 Keynote Speaker; Michael H. Goodstein, MD, FAAP, Neonatologist, Clinical Associate Professor of Pediatrics (Penn State U.), Director, York County Cribs for Kids Program, York Hospital. *Dr. Goodstein will address current guidelines, controversial areas, national landscape of the problem, the program in place in York, and the Cribs for Kids national certification.*

10:30 - 10:40 Break

10:40 – 11:00 Audrey Knight, MSN, RN, Child Health Program Manager & New Hampshire SUID Program

Coordinator for NH Division of Public Health's Maternal and Child Health Section. *Audrey will review the state of NH safe sleep initiatives and statistics from the Center for Disease Control and SUID registry.*

11:00 – 11:30 Kim Fallon, BS, Chief Forensic Investigator for NH Office of Medical Examiner. *Kim will review death scenes from NH, SUID, and what an unsafe sleep environment looks like.*

11:30 – 12:00 Victoria Flanagan MS, RN, Regional Program for Women's and Children's Health APN Forum 2015 & Director of Operations, NNEPQIN, Dartmouth-Hitchcock Medical Center. *Vicki will discuss the results of her pilot bedside safe sleep audit at Dartmouth and the results of the NH hospital summer survey.*

12:00 – 12:45 Lunch

12:45 – 1:45 Alison Palmer, MS, RN, Women's Health and Psychiatric-Mental Health Nurse Practitioner - Manchester OBGYN Associates. NH state coordinator for Postpartum Support International and Perinatal mental health nurse coordinator at Elliot Hospital. *Alison will present "Sleep Deprived, Distressed, and Depressed: Integrating Maternal Self-care and Newborn Safe Sleep Practices"*

1:45 – 2:45 Panel discussion with the experts. *We will spend a few minutes getting to know our panelist, and why they are committed to safe sleep, then the discussion will turn to the participants in the room. We encourage thoughtful questions and look forward to an educational 'round-table'.*

- Cyndy Carbone, RN, Coordinator of the Newborn Home Visit Program at Exeter Hospital
- Gail Coppins Gettens, MS, NH ECPDS Master Professional - Infant/Toddler Specialist Endorsement Concord, NH
- Michael H. Goodstein, MD, FAAP, Neonatologist, Clinical Associate Professor of Pediatrics (Penn State U.), Director, York County Cribs for Kids Program, York Hospital
- Paula Oliveira BSN, RN, IBCLC, Lactation Coordinator, Concord Hospital

2:45 – 3:00 Questions/Evaluations

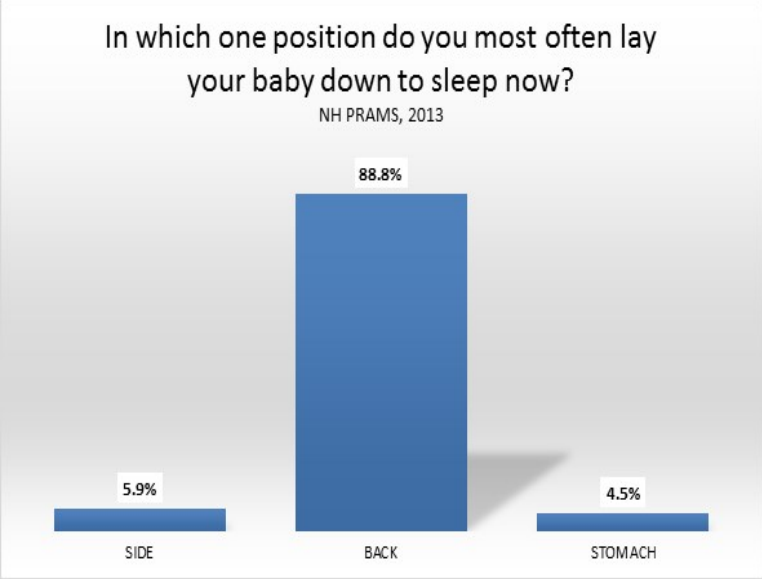
Please take some time before, after and during the breaks to visit the representatives from a number of organizations which promote infant safety, including: NH Division of Public Health Services, Cribs for Kids, Home Care Association of NH, March of Dimes, NH Children's Trust, NH Breastfeeding Task Force, Safe Kids NH, and Halo.

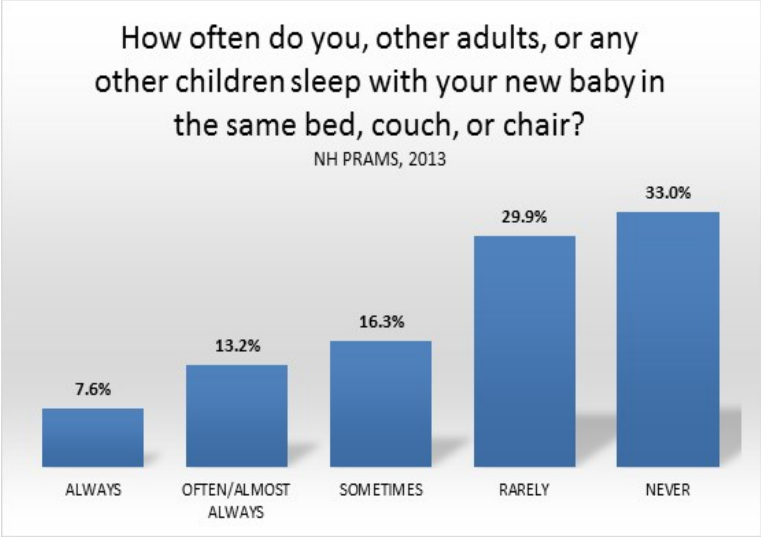
Evaluations from this September 2015 conference, attended by over 75 inpatient and outpatient ob-gyn nurses, midwives, home visitors, and lactation consultants, showed that 91.5% indicated they would change practice after attending the conference.

Although a repeat survey to the birth hospitals will hopefully indicate improvement in policy and practice related to safe sleep, including educating and modeling putting infants to sleep on their backs, anecdotal information about actual practice, and data from NH PRAMS will be a the mechanism for evaluation.

MCH Specific Activities

MCH's PRAMS Project released its first set of data from 2013 births in fall 2015 (see below) which showed that 88.8% of respondents answered that back position was the one position they most often lay their baby down to sleep and that only 33.0% of respondents "never" co-slept with their infant. With several years of safe sleep activities since 2013, it is hoped that the subsequent years of PRAMS data will show improvement in safe sleep practice by parents.





To continue the work of improving safe sleep practice a presentation was added to the June 2016 perinatal nurse managers' meeting, entitled " Findings From Home Visiting Program: How are Safe Sleep Principles Being Implemented?". Presenters included a home visiting nurse from a local visiting nurse agency contracted by MCH with MIECH-V and CFFS funds. The other two (2) panelists were home visiting nurses from local hospital home visiting programs (Wentworth-Douglass and Exeter). Two (2) of the presenters have been keeping data and anecdotal information on unsafe sleep environments observed at their home visits, and parents' perception of previous safe sleep education done.

Over the past few years, in addition to the above safe sleep activities, a broad variety of other activities were carried out by the MCH staff and the Safe Sleep Workgroup members, and members of the SUID Review Group.

In FY16 alone, 11 presentations or workshops were given, attended by a total of over 300 attendees consisting of nurses, home visitors, DCYF staff, NH Safe Kids Coalition members, perinatal hospital staff, child birth educators, Assistant Deputy Medical Examiners, staff from an inpatient drug rehab facility, child care providers and early education specialists. Evaluations from almost all participants indicated they had increased their prior understanding of SIDS risk factors, including the importance of supine sleeping. At least three (3) other members of the SUID Review Group, the Lactation Consultant who represents the NH Breast Feeding Task Force, the Chief Forensic Investigator for the Medical Examiner's Office, and the Chair of the NH Child Fatality Review Committee, each made

at least one presentation in SFY16, on SIDS risk factors, including the need for supine sleeping.

In FY16, Safe sleep material was included among that showcased at an MCH display table, or distributed at a conference, at over 17 state conferences sponsored by a broad variety of organizations, such as the annual NH Immunization Program conference, the Early Learning NH conference, WIC agency trainings, a DCYF adoptive and foster parent annual conference, the Brain Injury Association annual conference, the annual Emergency Department Symposium, the Healthy Homes annual conference, the annual breakfast for NH state legislators, and the Department of Justice Advocate conference, to name a few.

The importance of supine sleeping was also shared through social media during October, Safe Sleep/SUID Awareness month, with information available on the Division of Public Health's webpage, including three (3) Facebook postings by the DHHS Public Information Office, which posted Safe Sleep/SUID related infographics, which resulted in 173 hits in October and 27 in November, 2015. Eight tweets were sent from the Public Information Office (http://www.nichd.nih.gov/sts/Pages/default.aspx for 949 views and https://www.nichd.nih.gov/sts/Pages/default.aspx also for 949 views).

State epidemiologist Dr. Benjamin Chan spoke on WMUR Television's "Health Headlines" show on the topic of decreasing the risk of SIDS/SUID, including supine sleeping, and the DHHS Public Information Office put out a press release to accompany the appearance (http://www.dhhs.nh.gov/media/pr/2015/10-oct/10262015safesleep.htm).

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[1] New Hampshire Child Fatality Review Committee, *Committee Report 2015*. http://doj.nh.gov/criminal/victim-assistance/documents/child-fatality-report-2015.pdf accessed 07/04/16.

[2] ibid.

[3] Shapiro-Mendoza, C.K., Kimball, M., Tomashek, K.M., Anderson, R.N., and Blanding, S. (2009) US Infant Mortality Trends Attributable to Accidental Suffocation and Strangulation in Bed From 1984 Through 2004: Are Rates Increasing? *Pediatrics*, 123, 533–539.

[4] New Hampshire Child Fatality Review Committee, *Committee Report 2015*. http://doj.nh.gov/criminal/victim-assistance/documents/child-fatality-report-2015.pdf accessed 07/04/16.

[5] ibid.

[6] ibid.

[7] JoAnne Miles, Injury Prevention Program Manager, Presentation to SUID Review Group, 2016.

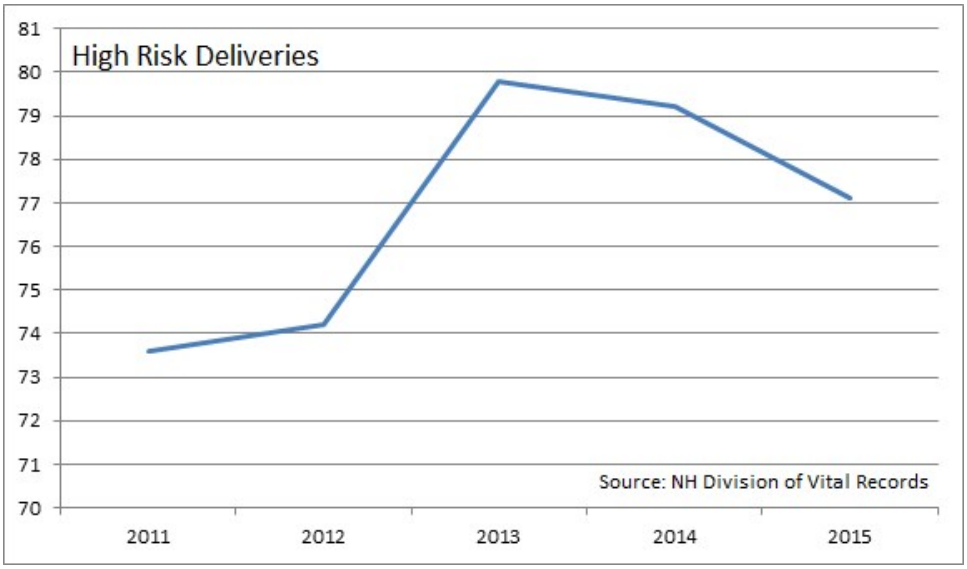
Perinatal/Infant Health - Annual Report

National Performance Measures 2011-2015

National Performance Measure #17:
Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates

Data Analysis

This measure initially went up from 73.6% in 2011 to a high of 79.8% in 2013 and then down again to 77.1% in 2015.



There are three (3) Level III and four (4) Level II classified hospitals (have facilities for high risk deliveries and neonates) out of the 19 birthing hospitals in New Hampshire. New Hampshire's infant mortality rate for 2015 was 4.9 births/1,000 live births[1], relatively low in the nation and only 6.7% of the newborns were of low birth weight. [2] Thus, even though the percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates continues to hover in the mid-70th percentiles, these same infants are then transported very quickly for appropriate care and most do fine. Transport meetings take place on a regular basis amongst providers for quality improvement, which MCH staff often attends.

Systems Building

MCH continued to monitor and provide technical assistance to MCH funded prenatal and primary care agencies that provide comprehensive prenatal care and enabling services to low income, uninsured and underinsured women.

Clinic assessments were conducted in 13 of the 14 agencies that provide prenatal care services. Alcohol and substance use screening of pregnant women during each trimester (Prenatal PM #3) was validated during site visits through chart audits. Sixty-five randomly selected prenatal records and sixty post-partum records were reviewed. Seventy-five percent of the prenatal patients were screened for alcohol and substance use each trimester. An additional 2% were screened at least once (usually the first trimester) during their pregnancy. Sixty percent of post-partum patients were screened for alcohol and other substance use during the post-partum period.

MCH continued to collect FY 16 data related to alcohol and substance. Pregnant women were screened using a formal valid screening tool for substance use (drug and alcohol) during each trimester they were enrolled in the prenatal program. If positive, these women received a brief intervention and referral to services. FY15 Performance Outcome Measurements were submitted annually via data trends tables (DTT) for MCH review and to guide agency QI and program planning. Starting in FY16, DTT is being submitted twice each year.

MCH continued to participate in PRAMS. MCH staff provided a PRAMS update at the June 2015 meeting of MCH-funded primary care and prenatal program agencies. The first year's data was analyzed by CDC and was made available as a data book by NH PRAMS staff in January 2016. An analysis of the data stratified by WIC participation was also completed and compiled in a data book. Presentations were made to several stakeholder groups during March-June 2016 including the WIC Directors, the Maternal Mortality and Morbidity Review Panel, the Sudden and Unexpected Infant Death Review Panel, the Perinatal Substance Exposure Task Force, and the Primary Care Coordinator's Meeting. Staff will continue to analyze data over time to identify strengths and weakness. This information will be used in program planning.

2013 PRAMS Birthweight Survey Data:

Among NH residents giving birth in 2013

Total respondents: 639	Percent	95% CI		Yes	Population
[STRATUM1]	Yes	Lower	Upper	Responses	Estimate
Low birth weight	5.3	5.2	5.4	243	643
Normal birth weight	94.7	94.6	94.8	396	11483

2013 PRAMS birthweight data stratified by WIC participation

	Percent	95% CI		Yes	Population
[STRATUM1]	Yes	Lower	Upper	Responses	Estimate
Low birth weight					
WIC participants (169)	6.2	4.9	7.7	75	200
Non-WIC (465)	4.9	4.5	5.4	165	435
Normal birth weight					
WIC participants (169)	93.8	92.3	95.1	94	3047
Non-WIC (465)	95.1	94.6	95.5	300	8381

MCH Specific Activities

MCH continued to coordinate Maternal Mortality Reviews and two staff are on the Maternal Mortality Review Panel (MMRP). The Northern New England Perinatal Quality Improvement Network (NNEPQIN) case abstraction team and the NH DHHS Perinatal Program Coordinator met on December 8, 2015 to review 11 cases from 2013 - 2015. The Maternal Mortality Review Panel met June 30, 2015 and finalized 6 cases. They met again on March 8, 2016 and finalized the remaining 9 open cases from 2013-2014 and 2 cases from 2015. In late Spring an additional case was identified from 2013 will be reviewed at the next NNEPQIN case abstraction meeting. A comprehensive legislative report will be written in the summer and will include key findings from the 2012 – 2015 cases.

Staff continued to participate in regional and national conference calls related to Critical Congenital Heart Disorder (CCHD)/Pulse Oximetry Screening. MCH began exploring the possibility of adding CCHD to its newborn screening panel and of becoming further involved in a follow up monitoring program.

MCH continued to actively participate in the NH Statewide Partnership on Prenatal Substance Exposure and Alcohol Exposure, attending related Partnership meetings and conferences. The SUID Review Group noticed an increase in the number of SUID deaths that involved prenatal substance abuse, birth mothers receiving methadone treatment, and infants born with Neonatal Abstinence Syndrome. The SUID Review Group had numerous discussions and follow up recommendations on improving communication among in and out-patient perinatal care providers, drug treatment facilities, and home visitors to improve care and support to the birth mother and her infant to reduce infant deaths.

MCH continued to collaborate with the Bureau of Drug and Alcohol services to promote SBIRT in the CHCs. Performance measures related to SBIRT were added to the FY 16 Primary Care (PC) and PC for the Homeless contracts.

National Performance Measure #1:

Percent of newborns that are screened and confirmed with conditions mandated by their state sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) and who receive appropriate follow-up and referral as defined by their state

Data Analysis

This measure has consistently been 100% over the last five (5) years. This can be attributed to a combination of the

state's Newborn Screening Program and the health care system as a whole.

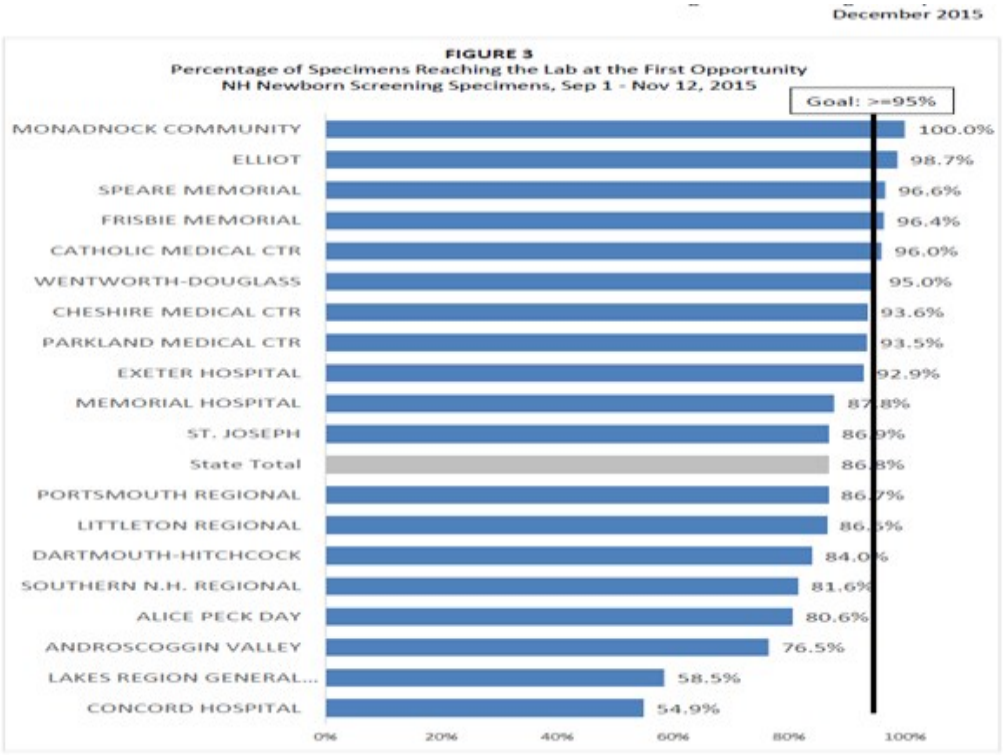
Systems Building

The coordinator of the Newborn Screening program participated in regional activities including the New England Regional Genetic Group (NERGG), the New England Metabolic Consortium (NEMC) Annual Meeting and the New England Genetics Collaborative (NEGC). Being part of these organizations increased the knowledge of the Newborn Screening Coordinator in applying best practice strategies to meet the goals of the program and improve services.

The Newborn Screening Coordinator participated in several national surveys designed to inform the government how incorporating additional screening conditions affected state programs.

MCH Specific Activities

The NH Newborn Screening Program continued to accomplish essential daily tasks. The program staff performed monitoring of hospital and laboratory services to insure that stated performance measures were met and that educational efforts were targeted to the needs of the participants. For example, the following is a graph from the December 2015 report comparing birth hospitals' times for specimens reaching the testing laboratory against the goal



The program staff responded to requests for educational presentations and provided program information to hospitals and medical offices. Program staff began working on a joint prenatal informational brochure with the NH EHDI program. The brochure, co-written by both programs, is being vetted by the Community Health Institute to several focus groups containing the target audience. Feedback will be utilized to refine the brochure with a planned distribution in early Fall 2016.

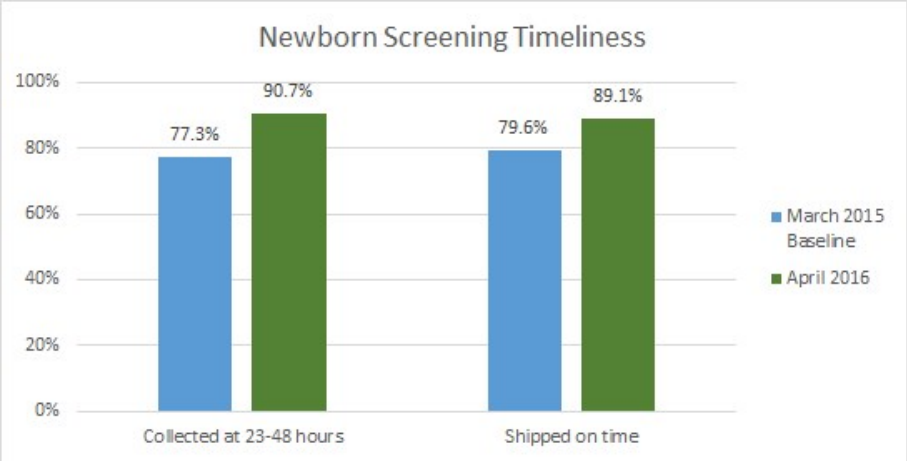
Program staff continued to work with the NBS Advisory Committee to insure the highest quality services to the infants born in NH. The Advisory Committee recommended that Severe Combined Immunological Deficiency (SCID) screening be added to the screening panel as part of the October 2014 meeting. The recommendation was accepted by the Commissioner and screening began on 7/1/15. Prior to the screening, the Newborn Screening

Coordinator put an infrastructure in place which included notifications to all of the involved professional groups and to the hospital labs about the screening, paperwork and referrals involved. So far to date, one (1) infant has been diagnosed with SCID and is awaiting a transplant.

The relationship with Dr. Harvey Levy, who serves as the program's metabolic consultant, continued as a valuable resource. Follow up testing and treatment was easily scheduled with Dr. Levy's assistance. Currently, there are no practicing metabolic specialists in the state. When the screening panel was expanded in 2010 to include metabolic disorders, Dr. Levy was contracted as a consultant to the program. This contract has been updated or renewed every two (2) years. In FY 15, three (3) metabolic disorders were diagnosed and there were another ten (10) presumptive positives that needed Dr. Levy's consultation.

In the ever changing world of newborn screening there is a need to keep up with that change through educational and informational endeavors. The program continued to develop and update internal protocols for inclusion in the program's Internal Operations Manual. A protocol for sending reports directly to the primary care providers was developed in May 2016. Many other protocols were updated with information that made them more user friendly.

The coordinator interacted with staff from Newsteps to participate in a National QA project on improving timeliness of reporting of newborn screening results. Newsteps was funded by HRSA to provide technical and educational support to state newborn screening programs. Participation with this 16 month project began with an in person meeting in Silver Spring Maryland in January 2015. This project was funded by a HRSA grant given to the Association of Public Health Laboratories. The program sent out a base line report and one (1) quarterly report in FY 15 and four (4) in FY 16 to the birth hospitals on the two performance measures identified, age at specimen collection and time from collection to arrival at the lab, both measures the hospitals have control over. To further improve timeliness, Saturday pickup, delivery and testing was added to the laboratory's contract in July 2015. A third performance measure, unsatisfactory specimens, was added to the December 2015 report. All three factors impact the overall timeline between birth and reporting of screening results to the healthcare provider. Minimizing this time can save infant lives through early detection and intervention. Between a March 2015 baseline and an April 2016 report, timeliness increased in both collection and shipment.



The state has contracted with UMass/New England Newborn Screening program since 1999. Throughout the years since, they have always provided quality and responsive services by reporting out abnormals in a timely fashion as well as providing coverage of the reporting process when the Program Coordinator is away from the office. Because of the long standing relationship, a new sole source contract was negotiated that added SCID screening and Saturday specimen pickup, delivery and testing that began July 1, 2015.

The program continued to work with the state's midwives, those working independently or in non-hospital birthing centers, on making sure they have the necessary equipment and training to perform accurate Pulse Oximetry. In September, 2015, overnight shipping services for specimens to the lab was offered to these midwives to help improve the timeliness of their specimens reaching the lab. Not all of the targeted midwives have taken advantage of this to date. Any information on improving the transit time will be available when all have done so.

National Performance Measure #12:
Percent of newborns who have been screened for hearing before hospital discharge

Data Analysis

The data for this measure has slowly risen from 97.3% in 2011 to 97.9% in 2015, which exceeded the goal objective of 97.6%. Most of the 2.1% of newborns that were not screened for hearing before discharge were born either in non-hospital birth centers or were delivered at home. There is often a lack of both equipment or the knowledge of how to properly use the screening equipment. MCH's Early Hearing Detection and Intervention Program (EHDI) has been working with the non-hospital birth providers on obtaining training and technical assistance to decrease the gap.

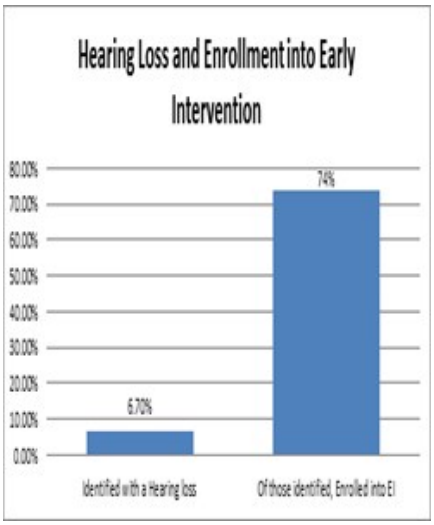
Systems Building

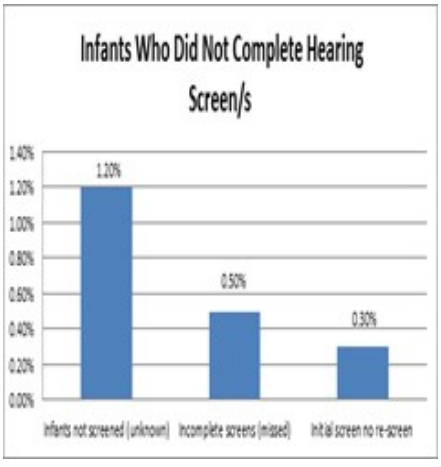
EHDI has worked with the data vendor, Welligent Inc., to address technical challenges with the data collection system to ensure that NH can be confident that birth facility data accurately captures how the state is increasing access to screening for infants, especially for infants born in non-hospital settings; the type and severity of hearing loss; and demographic data on infants with hearing loss. Technical challenges that occurred were infants who were transferred, both in state and out of state, were not omitted from the report infants missed hearing screen, infants who received a third outpatient hearing screen were not omitted from infants not passing the hearing screen, and a lack of documentation of homebirths hearing screens. The EHDI program renewed the data vendor contract for three (3) years 2015, 2016 and 2017.

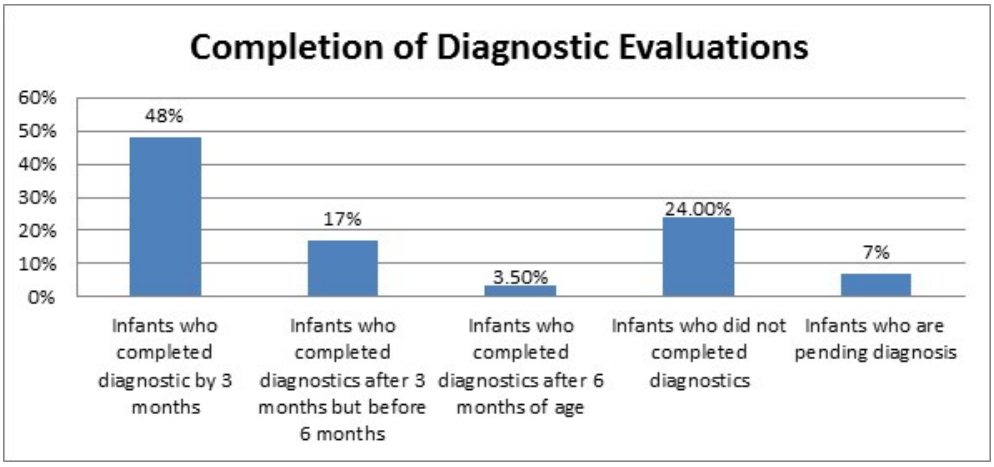
The EHDI program revised and updated the newborn hearing screen referral brochure.

The EHDI program continues to recruit members for the Quality Improvement (QI) committee. The QI members worked on three (3) 'Plan Do Study Act" (PDSA) cycles to identify: (1) birth facility challenges; (2) diagnostic center referrals for infants who do not pass (refer), and (3) annual performance summary, "report cards" for all birth facilities.

The annual performance summary, is a "report card" that is sent to birth facilities. The annual performance summary was sent to all birth facilities in March, 2015. It is a review of the birth facilities past year on meeting the national and state guidelines for newborn hearing screening. It has evolved to include a list of action items which include infants who have not been screened, incomplete hearing screens, and infants who referred on initial screen and not rescreened. It also includes statistics on diagnostic testing and statewide hearing loss. Some aggregate charts from the performance summaries are shown below:







The EHDI program completed a conference call, in May, 2015, with diagnostic centers to enhance efforts in timeliness data entry and reporting for infants who have been identified with either normal hearing or any type and degree of hearing loss. From the conference call, diagnostic centers have improved timeliness of entering diagnostic results. The Follow-up Coordinator infrequently reached out to audiologists to enter diagnostic results.

The EHDI staff continued to contact families, pediatricians, and primary care physicians by telephone, fax, and U.S. mail to ensure that infants who do not pass (refer) their final hearing screening receive diagnostic testing.

The EHDI program continues to work with the Quality Improvement Committee on the implementation of a standardized referral guidelines for birth facilities. The standardized referral guidelines are to ensure that infants who refer on the final newborn hearing screen receive the proper information and have either a direct fax referral to a diagnostic center or a scheduled appointment prior to discharge home.

The EHDI program has focused on daily tasks of the program to ensure that infants are screened, diagnosed, and receive early intervention services for hearing loss according to the recommend national guidelines.

The EHDI program continued to provide technical assistance to birth hospitals, diagnostic centers and midwives. The technical assistance that was provided to birth hospitals was for increased final refer rates, omissions in the database system, and errors in data entries. Diagnostic centers received technical assistance on increased inconclusive results and timeliness of entering diagnostic results. Midwives received technical assistance on the importance of faxing all births, home or birth center births, regardless of if a hearing screen was completed or not. The EHDI program continues to work with midwives at the freestanding birth centers to offer newborn hearing screening to every family at their facility.

MCH Specific Activities

Numerous changes in EHDI Program staffing occurred in FY2015. The EHDI Program Coordinator, who started with the EHDI program since its inception eleven years prior, retired in October, 2014. A new Program Coordinator, who learned the program quickly, was hired in February, 2015. The contracted Follow-Up Coordinator left the position in April, 2015 and was replaced in July of that year. The EHDI Program Coordinator worked closely with staff in the Bureau of Developmental Services as numerous changes occurred impacting the state's early intervention agencies and their ability to provide services to children identified with hearing loss. The Multi-sensory Intervention through Consultation and Education (M.I.C.E.) program closed in May of 2015 due to funding. The M.I.C.E. program provided early supports and services to the birth to three (3) population who had been identified as deaf or hard of hearing. With the closer of the M.I.C.E. program, the area agencies will be responsible for providing services to the birth to three (3) population. From the closer of the M.I.C.E. program, the EHDI Program has collaborated with Part C to ensure that infants who are identified with a hearing loss are enrolled into early intervention services and receive the appropriate services for their type of hearing loss.

National Performance Measure # 18:

Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester

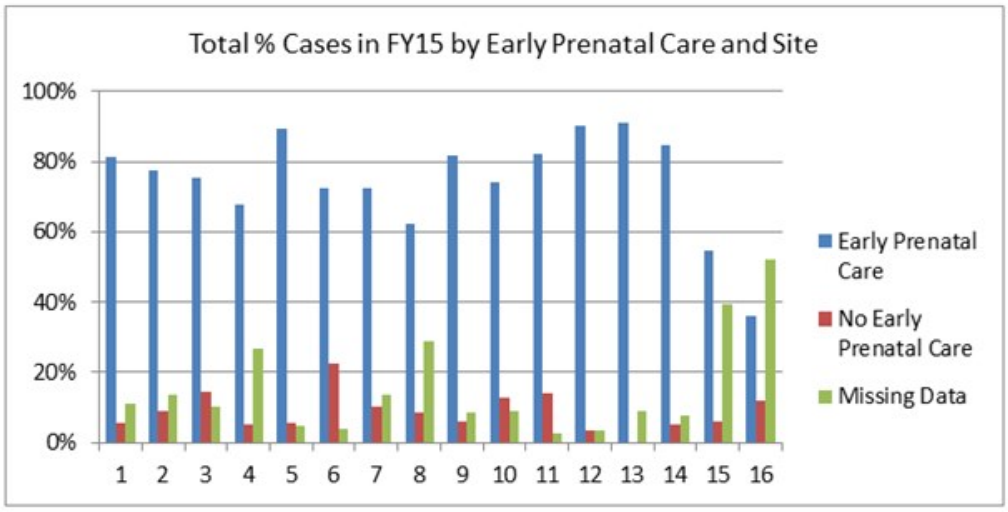
Data Analysis

This statewide measure has stayed consistent over the last five years ranging from 82.5% in 2011 to 82.7% in 2015. The average percent of infants born to pregnant women receiving care beginning in the first trimester of MCH funded CHCs in 2015 was 75%[3]. This too has stayed stagnant over the last five (5) years. According to PRAMS data, the most often cited reason (39%) for not receiving first trimester care is that they did not know about the pregnancy. Thirty-seven percent of pregnancies were unplanned of the respondents to the PRAMS survey.[4] Title X Family Planning data suggest that more than 50% of pregnancies are unplanned.[5]

Systems Building

MCH continued to monitor and provide assistance to MCH-funded prenatal and primary care agencies that provide comprehensive prenatal care and enabling services to low income, uninsured and underinsured women.

MCH continued to collect data related to early entry into prenatal care in FY15. Over 1500 pregnant women were served through prenatal and primary care contracts in FY 15. Seventy-five percent of those women received prenatal care beginning in the first trimester.

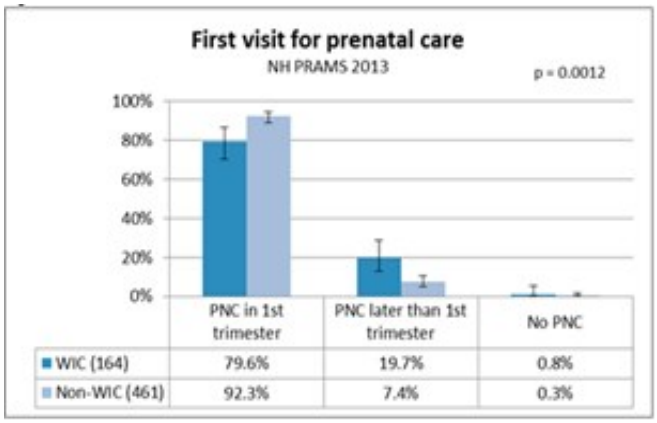


Clinic assessments were conducted in 13 of the 17 MCH-funded agencies that provide primary care and/or prenatal care services. The clinic assessment process is a comprehensive, efficient, and effective way to monitor contracted services at CHCs. It includes an administrative and environmental self-assessment by the CHC; a site visit that includes a discussion with agency staff regarding the self-assessment findings, review of agency specific performance measure data, and a chart review; and a post-assessment report that includes recommendations and required actions based on best practice models. Sixty-five prenatal records were randomly selected for review. Technical support was provided to those agencies that required assistance completing required actions necessary for state and/or compliance. PCDF data was monitored for completeness and timely reporting by contracted agencies. Agencies are encouraged to use the data for QI within their prospective agencies.

The Disability Accessibility Assessment collaborative project continued and an additional 14 of 17 agencies that provide primary care and/or prenatal care services were assessed using The Outpatient Health Care Usability Profile (OHCUP) a valid and reliable tool that considers a patient's path of travel to and within the health center. Each agency received a report that included agency-specific recommendations related to increasing accessibility to care for clients with disabilities. As of SFY16, MCH has 2 new contracted Family Planning agencies and 1 previously contracted Primary Care agency that have not had these assessments. MCH plans to have these assessments completed during the next site visits to these facilities.

MCH Specific Activities

MCH continued to participate in PRAMS. MCH staff provided a PRAMS update at the June 2015 meeting of MCH-funded primary care and prenatal program agencies. Data related to pregnant women accessing prenatal care was collected and the first year of NH PRAMS data was made available in the *2013 NH PRAMS Data Book* in January of 2016. An additional analysis stratified by WIC and Non-WIC participants was completed in March of 2016. Data including that related to prenatal care was presented to several stakeholder groups during March-June 2016 including the WIC Directors, the Maternal Mortality and Morbidity Review Panel, the Sudden and Unexpected Infant Death Review Panel, the Perinatal Substance Exposure Task Force, and the Primary Care Coordinator's Meeting (MCH-funded primary care and prenatal program agencies). In addition, identified strengths and weakness will be used in program planning and data will be trended over time.



Kotelchuck index (Adequacy of prenatal care index)

	Percent	95% CI		Yes	Population
[KOTELCHUCK]	Yes	Lower	Upper	Responses	Estimate
Inadequate					
WIC participants (166)	10.4	5.7	18.2	18	337
Non-participants (453)	6.4	4.1	9.9	25	551
Intermediate					
WIC participants (166)	.	.	.	.	.
Non-participants (453)	6.1	3.9	9.3	24	520
Adequate					
WIC participants (166)	35.4	26.8	45.1	48	1147
Non-participants (453)	42.6	37.3	48.0	158	3652
Adequate plus					
WIC participants (166)	49.7	40.1	59.3	93	1610
Non-participants (453)	45.0	39.6	50.4	246	3859

During FY14 the Maternal, Infant, and Early Childhood Home Visiting Program collected data related to adequacy of prenatal care using the Kotelchuck Index. Data demonstrated a 26% increase (from 57% - 83%) in the percent of women who receive adequate prenatal care. During FY15, programs demonstrated improvement with adequacy of prenatal care using the same index increasing to 87% overall.

NH continued to actively promote Text4Baby engaging pregnant women with social media about the importance of early and consistent prenatal care. The NH Division of Public Health's Text4Baby Project Coordinator presented an update on the project at the June 2015 meeting of MCH-funded primary care and prenatal program agencies.

MCH continued to promote LEAN activities within MCH and included the completion of a four (4) year Blood Pressure Best Practice project that included a chart review of approximately 900 patients (including prenatal and post-partum). Results indicated a 95% rate of BP screening in 2013 and 97% in 2015.

[1] New Hampshire Vital Records, Birth Certificate Data retrieved 07/13/16.

[2] ibid.

[3] Maternal and Child Health Section, Perinatal Client Data Form data retrieved 07/12/16.

[4] Maternal and Child Health Section, PRAMS data retrieved 07/13/16.

[5] Maternal and Child Health Section, Family Planning Program data retrieved 07/13/16.

Child Health

State Action Plan Table

State Action Plan Table - Child Health - Entry 1

Priority Need

Decrease pediatric overweight and obesity.

NPM

Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Objectives

By July 1st of 2017, increase the average by at least five percentage points overall of children who have had a high BMI and documentation of counseling/referral at the MCH funded CHCs in state fiscal year 17 (ends June 30th 2017).

Strategies

Screening and intervention on physical activity among MCH-funded contract agencies (i.e. home visiting agencies and community health centers)

Professional training on increasing physical activity

ESMs

ESM 8.1 - Percentage of children ages 6-11 enrolled in Comprehensive Family Support Services (CFSS) whose parent reports that the child gets at least one hour of physical exercise per day.

NOMs

NOM 19 - Percent of children in excellent or very good health

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

State Action Plan Table - Child Health - Entry 2

Priority Need

Improve access to standardized developmental/social emotional screening, assessment and follow-up for children and adolescents.

NPM

Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Objectives

To increase from 30.6% (2011-12 FAD baseline) to 45.0% the percent of children, ages 10 months to 71 months, who receive a developmental screening using a parent-completed screening tool, by 2020.

Strategies

Train professionals to utilize the ASQ and ASQ-SE screening tools

SMS provides leadership and group facilitation to Watch Me Grow and the Act Early Screening and Diagnosis Committee

Conduct environmental scan

Promote developmental screening and participation in Watch Me Grow

Educate the public

ESMs

ESM 6.1 - The number of sites using ASQ/ASQ-SE screening tools and participating in the Watch Me Grow (WMG) System.

NOMs

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

NOM 19 - Percent of children in excellent or very good health

Measures

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	33	36	39	42	45	48

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	30.6 %	3.0 %	19,643	64,194
2007	18.1 %	2.5 %	12,737	70,235

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 6.1 - The number of sites using ASQ/ASQ-SE screening tools and participating in the Watch Me Grow (WMG) System.

Annual Objectives					
2017	2018	2019	2020	2021
Annual Objective	50.0	55.0	62.0	69.0	75.0

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day (Child Health)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	35.9	36.6	37.3	38	38.7	39.4

Data Source: National Survey of Children's Health (NSCH) - CHILD

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	35.5 %	2.6 %	32,640	92,044
2007	38.9 %	2.7 %	37,805	97,239
2003	32.0 %	2.2 %	31,410	98,239

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 8.1 - Percentage of children ages 6-11 enrolled in Comprehensive Family Support Services (CFSS) whose parent reports that the child gets at least one hour of physical exercise per day.

Annual Objectives					
2017	2018	2019	2020	2021
Annual Objective	25.0	30.0	35.0	40.0	45.0

Child Health - Plan for the Application Year

National Performance Measure #6:
Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool

Evidence Based or Informed Strategy Measure:
Utilization of the ASQ/ASQ-SE screening tools and participation in the Watch Me Grow (WMG) system

Data Analysis

As described in New Hampshire's **State Performance Measure 5**, data for this indicator comes from the 2011-2012 National Survey of Children's Health is a national telephone interview conducted from February 2011 through June 2012 by the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics. Because updated data is not available, New Hampshire continues to report 2012 results. New Hampshire's percent of parents who self-report that they completed a standardized, validated developmental screening tool at 30.6% is comparable to the national response of 30.8%.

Systems Building

As described in State Performance Measure 5, New Hampshire has a system that incorporates multiple paths for access to screening, evaluation and services for children at risk for developmental delays. There are multiple access points in the system for developmental screening, including the *Watch Me Grow* system. Screening occurs in clinical as well as community-based agency settings. Screenings conducted in clinical settings include routine well-child visits with a primary care provider office or clinic, and encounters with other providers, such as those providing mental health services. If a primary care provider suspects a child is developmentally delayed, the provider may refer the family to early supports and services to be evaluated for appropriate services, or may refer to one of the Multidisciplinary Child Development Clinics or an Autism Clinic for diagnostic evaluation.

According to the 2011/2012 National Survey of Children's Health (NSCH), 78.7% of New Hampshire children who received developmental screening did not need follow up or referral. This tells part of the story; more than 20% of those children would benefit from additional assessment and treatment. According to the *Watch Me Grow* (WMG) developmental screening, referral and information system for families of children ages birth to six years, only 3,988 children were screened. While the table here demonstrates an increase over time, it is still well below the number of children in the state under the age of six.

Watch Me Grow Screenings and Results by Calendar Year and Total from Data Base Establishment to Present

	2011	2012	2013	2014	2010-15**
Total Screenings	529	816	2,044	2,428	6,408
Children (unduplicated)	451	677	1,362	1,615	3,988
Referred*	22%	6%	8%	10%	9%
Recheck**	10%	10%	13%	12%	12%

*Rounded to the nearest percent

**As of May 22, 2015

MCH, SMS/Family Centered Early Supports and Services (ESS), and Head Start State Collaboration Office (HSSCO) provide leadership for the system, which promotes the Ages & Stages and Ages & Stages – Social Emotional Questionnaires (ASQ and ASQ-SE).In 2015, the Title V Director for CSHCN, Project Director from NH's Pediatric Improvement Partnership (NHPIP), the MIECHV Director, the CDC Act Early Ambassador and members of the NH State Autism Council's Screening and Diagnosis Committee formed the Act Early State Team. In July 2015, this team attended the 2015 Northeast Regional Developmental Screening, Referral and Response Conference and created a Blueprint for Change (Blueprint) that envisions a comprehensive screening, response, referral and diagnostic and treatment system. In addition to exploring the potential for a comprehensive data system for use by all agencies, the Blueprint calls for increased awareness and investment in early childhood initiatives to assist in funding a comprehensive system that is sustainable.

Following the conference, the Act Early State Team met with members of the WMG Steering Committee to suggest that WMG and Title V co-convene a 2016 Stakeholders Meeting as a forum for a facilitated discussion about expanding the WMG developmental screening system in NH. The purpose of the meeting held January 2016, was two-fold. First, the event provided an update to stakeholders regarding status of the WMG and other developmental screening initiatives in the state. Secondly, the meeting provided a forum to generate input regarding the potential to expand WMG into a comprehensive developmental screening, response, referral, treatment and diagnostic system in NH.

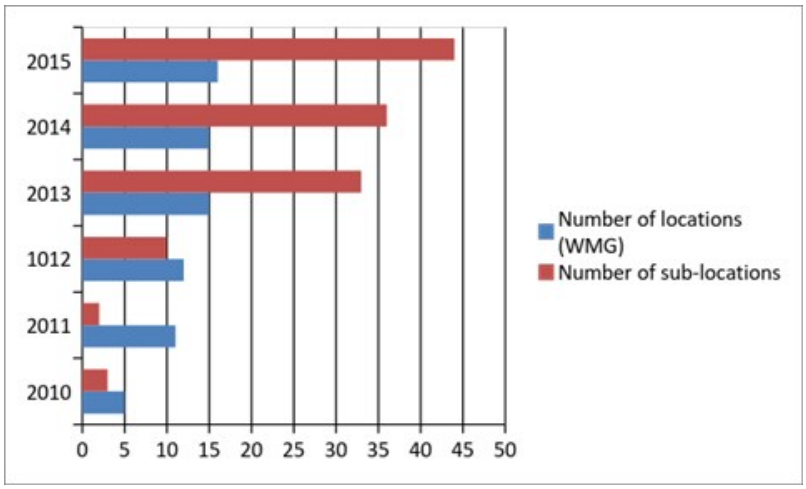
In addition, Title V agencies have coordinated with partners across systems to ensure that families had access to developmental screening for their children and assisted parents with the completion of ASQ and ASQ:SE through

MIECHV program, Comprehensive Family Support Services, and WMG. MCH and SMS worked with partners to promote and support connections between professional organizations and service providers; participated in workgroups of the Autism Council and collaborated on submissions for funding opportunities to create regional teams of experts on autism.

Next year (2016 -2017)

SMS recently hired a Family Support Systems Specialist who will start late-July 2016. As the former Learn the Signs Act Early (LTSAE) state ambassador and an active member of the Act Early State Team, Jennifer Doris will increase the capacity of SMS to provide leadership for the expansion of the system. In the coming year, NH's Title V agencies will work collaboratively with the Act Early State Team and WMG to increase awareness and availability of screening across the state.

New Hampshire leaders will continue to engage in cross system planning and coordination of activities as they have done for many years. While working to expand the system to include data from practices using other screening tools, treatment and diagnostics, MCH will further collaborate with WMG, the NHPIP, and Family Resource Centers to increase the number of locations that provide developmental screening information and services for children from four weeks to six years of age. WMG data indicates the success from 2010 to 2015, during which time the numbers of WMG locations increased from five to 16 and the number of sub-locations (that provided data to WMG sites) grew from three to 44 during the same time.



Recruitment will include the provision of training and technical assistance to individuals and/or programs that are willing to input screening data into the WMG data system.

The ASQ and ASQ-SE are now available on-line in NH. Once the testing phase is complete, parents will be able to complete the screening tool electronically and consent to share the results with the local Family Resource Center (i.e. WMG site) and the child's primary care physician (PCP). WMG is piloting the online system with Dover Pediatrics practice in the summer 2016. Feedback from the pilot will inform the WMG Steering Committee's decision about the technical assistance needed to add family resource centers and health care practices.

To further the work outlined in the Blue Print, Spark NH has generously offered an expert facilitator to work with the Act Early State Team over the next six months, to develop a strategic plan for a comprehensive system. Spark NH's Data Committee, led by Elizabeth Collins, Title V Administrator for CSHCN, will conduct an environmental scan of developmental screening data being collected across the early childhood system (health, early learning and family support). A gap analysis will then be conducted to determine the data needs of the system. Using this information, the committee will explore what other states are doing to collect data for their comprehensive developmental screening, response, referral and diagnostic system. These activities will improve the knowledge base in New Hampshire regarding what developmental screening data is currently being collected and by whom.

National Performance Measure #8:
Percent of children ages 6 through 11 who are physically active at least 60 minutes per day

Evidence Based or Informed Strategy Measure:
Percent of children ages 6-11 enrolled in Comprehensive Family Support Services (CFSS) whose parent reports that the child gets at least one hour of physical exercise per day

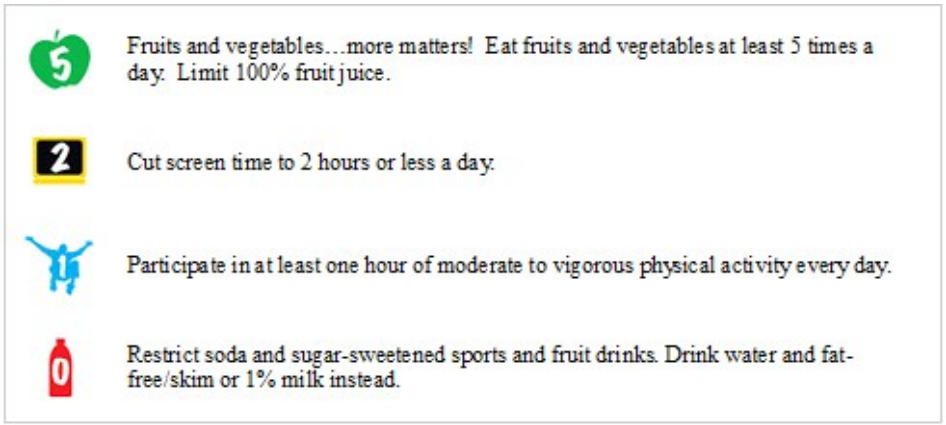
Systems Building

CDC recommends that schools and after school child care settings can help children be active by requiring quality physical education, recess, and other structured opportunities for age-appropriate physical activity. The Division of Public Health Services Chronic Disease Prevention and Screening Section, Diabetes, Heart Disease, Obesity and School Health program and MCH coordinate to leverage strategies to improve physical activity The Chronic Disease Program works closely with schools and child care throughout the state to implement environmental strategies that reinforce healthful behaviors and expand access to healthy choices. MCH works closely with health care providers and other community based child serving agencies to promote parent education, health systems interventions, and community and clinical interventions.

MCH Specific Aactivities

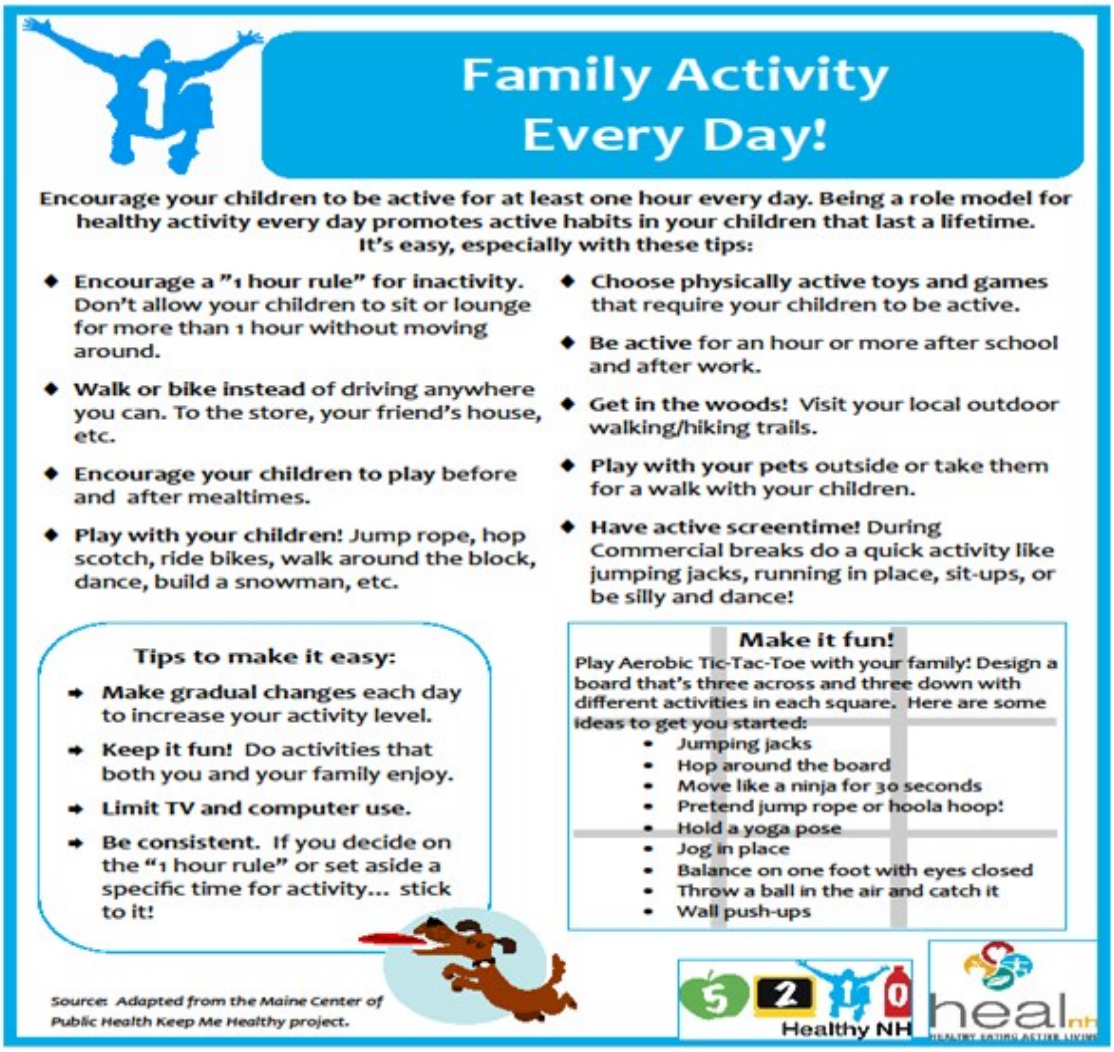
MCH provides Title V funding leveraged with that from the Division of Children, Youth and Families (DCYF) under the Comprehensive Family Support Services (CFSS) program to 11 agencies doing home visiting with low income families with children. This program provides education, support, coordination of care and the prevention of child abuse. In an effort to expand the focus of a healthy family, this performance measure will focus on working to improve the physical health of enrolled children and their families by focusing on increasing physical activity, to promote a healthy lifestyle. In SFY15, a total of 1,048 families, were served by these funded services, of which 1,926 were children. Services were provided primarily at the agencies' CFSS Family Support Centers, but also at home visits, some of which were reimbursable by Medicaid. As of May 2016, for FY16, a total of 528 new families entered service.

The strategy being used is that of the "5-2-1-0 Healthy NH", (http://www.healthynh.com/5-2-1-0-healthy-nh.html) a statewide public education campaign to bring awareness to daily recommendations for nutrition and physical activity which identifies steps that families can take to prevent childhood obesity:



The CFSS agencies will focus solely on the physical activity step. Upon enrollment into the CFSS program, if there is a child ages six (6) through eleven in the family, the parent will be asked if the child currently participates in at least one (1) hour of moderate to vigorous physical activity every day. A data element will be added to the DCYF

electronic data collection form. During subsequent contact with the family, the agency staff will talk to the parent about the importance of physical activity, giving suggestions on how a parent can easily implement the strategy. If the parent has indicated that the child does already do at least an hour per day, the staff member will praise and reinforce this. Regardless of the answer, the staff member will give and review the handout from the campaign that focuses on this topic.



At discharge, or at the end of one year, whichever comes first, the parent of the child will be asked again about exercise, and again, data will be made into DCYF's electronic data collection form. As this is a new initiative for these grantees, there is no baseline, and initial results are anticipated to be low since the majority of these families are considered high risk, with numerous social factors, and lifestyles where physical exercise is not considered a priority.

In addition to this project, MCH is working with Medicaid on one (1) of the MCO's Performance Improvement Projects (PIP) involving assessing physical activity during a child wellness visit. PIPs are a federal regulation for state approved MCOs and must be validated by the external quality review process. Currently finishing year two (2) of a four (4) year PIP, the MCO is reporting on rates as well as processes to improve the following measure "Increase the % of eligible members aged 3 - 17 years with evidence of counseling for physical activity". It is hoped that the PIP can inform MCH's efforts with the home visiting agencies and the other way around. MCH staff, including the QI/QA Nurse Consultant work with the two (2) MCOs on a consistent basis.

National Performance Measures 2011-2015

National Performance Measure # 9:
Percent of third grade children who have received protective sealants on at least one permanent molar tooth

Data Analysis

The DPHS Oral Health Program (OHP) used the results of NH's 2014 *Healthy Smiles-Healthy Growth Third Grade Survey* to guide public health programming, monitoring, evaluation, and allocation of limited resources. The New Hampshire 2013-14 Third Grade *Healthy Smiles – Healthy Growth Survey* was conducted between September 2013 and June 2014 and published in October 2014. The statewide survey was coordinated by the NH Division of Public Health Services and funded by the HNH Foundation and Northeast Delta Dental. Data were collected at public elementary schools in each county throughout New Hampshire, with oversampling at schools in the socioeconomically and racially/ethnically diverse city of Nashua, NH. The statewide data showed a marked improvement from the previous survey in 2008-2009 and clearly demonstrated progress in reducing health disparities in both obesity and oral health status. Over sixty percent of third grade students had received protective sealants on at least one permanent molar tooth; there was a 20.4% increase from the 2008-2009 survey in dental sealants in schools with more than 50% of students who qualify for Free or Reduced Lunch. While 35.4% of students had experienced tooth decay and 8.2% of students had untreated decay, there was 31.7% decrease in untreated tooth decay statewide from the 2008-2009 survey. In one of the poorest and most rural areas of the state, Coos County, there was a 54.4% decrease in untreated decay. This suggests that the overall oral health and access to preventive treatments of New Hampshire children has improved.

Results of the 2014 assessment of student oral health, body weight, and height also indicated that there were still pockets of unmet need among New Hampshire's children. There was no statistically significant difference in the prevalence of dental sealants by Free and Reduced Lunch participation, indicating that the New Hampshire school-based oral health programs have been successful in reducing oral health disparities by targeting at-risk children for the application of evidence-based protective dental sealants. Regional disparities in oral health were detected. Students in Coos County were more likely to have experienced decay, have untreated decay, and least likely to have dental sealants.

In regions where children from low-income families had limited access to oral health care, the Healthy New Hampshire Foundation, whose primary mission is to improve children's oral health, funded restorative treatment for students identified by the school-based dental program as needing urgent or early attention.

Systems Building

In the New Hampshire State Health Improvement Plan (SHIP), one of three oral health recommendations for action by state governments is to "Support and promote school-based and school-linked dental sealant delivery programs to prevent or reduce tooth decay among children".(*CDC Guide to Community Prevention Services. April 2013).* The SHIP lists two oral health actions being taken by the Oral Health Program related to school-based sealant programs: (1) Supporting and analyzing assessment of annual oral health status of children in schools to determine need for preventive and restorative services and (2) Supporting the provision of on-site preventive services and referrals for restorative treatment in local dental practices.

In April 2015, the PEW Charitable Trusts published a report on each state's progress on reaching 4 benchmarks related to dental sealants for children. As in 2011, 2014 data earned New Hampshire a perfect score on all of the benchmarks.

For the 2014-2015 school year, 15 school-based/linked sealant programs reported annual oral health data to the Oral Health Program. Ten of the programs receive funding from State General Funds and the Preventive Health and Health Services Block Grant through contracts with the Oral Health Program. All of the programs are supported by activities such as an Annual Calibration Clinic and varying levels of other on-going supports such as consultation and

advice. The following data about sealants was reported:

	All School-based Sealant Programs		School-based Sealant Programs with OHP Contracts	
	# of Students	% of students	# of students	% of students
Eligible students pre-K Through gr. 5	26,122		16,999	
Screened PreK-5	12,118	46	9,311	55
Received preventive services	3,207	26	2,165	23
Received sealants	1,514	47	634	29
Screened 2nd and 3rd graders	6,352		4,908	
Existing sealants on 1 or more Permanent Molars of 2nd and 3rd graders	3,111	49	2,263	46
Sealants applied for 2nd and 3rd graders	825	13	552	11

With HRSA funding, the OHP supported the recent opening of two rural FQHCs (both also funded by MCH/Title V) dental clinics and assured that vulnerable children and adults living in rural NH had access dental sealants and oral health care.

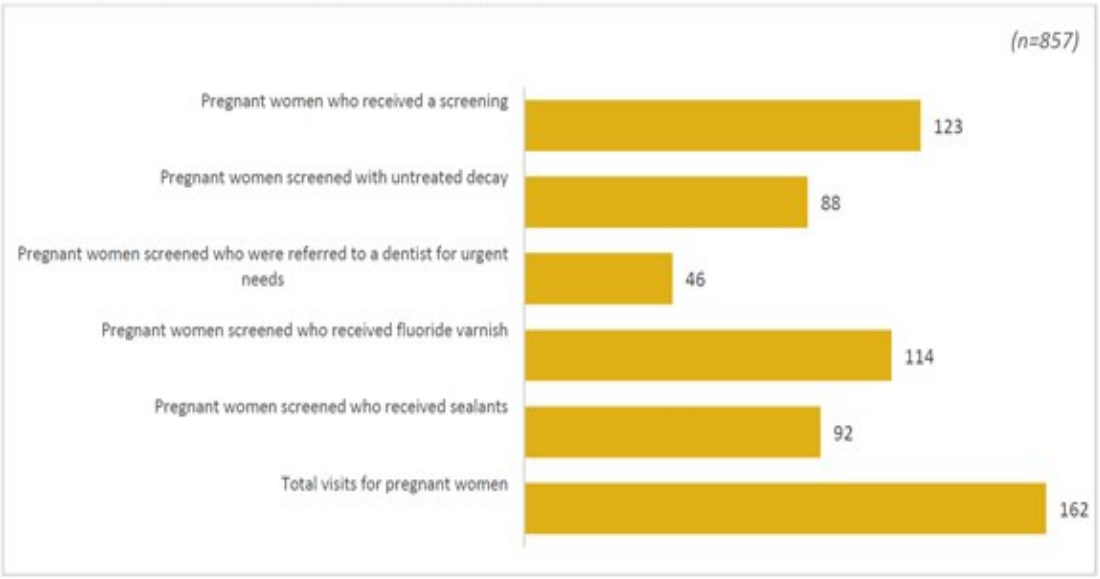
The OHP collaborated with a new FQHC sponsored high school-based portable oral health program in rural NH and assured that vulnerable adolescents living in rural NH had access to protective dental sealants and oral health care.

In collaboration with the Medicaid Dental Director, the OHP participated in Year Two (2) of the CMS Oral Health Learning Collaborative pilot project to develop a sustainable WIC model for on-site delivery (at three sites) by public health hygienists of oral health education, screening, application of fluoride varnish and dental sealants and linked pregnant women and young children to dental homes.[2] The project collected several measures including:

- Number of WIC beneficiaries seen per day, per dental clinic site
- Baseline oral health of WIC beneficiaries, including a medical history and completed dental chart
- Change in oral health at subsequent visits, including oral health behaviors (e.g. brushing frequency, etc.)
- Type and number of preventive services delivered
- Receipt of Medicaid reimbursement for preventive services provided.

Initial results showed a definitive need (particularly among the mothers at the WIC clinics) and good participation. In this pilot project,

Exhibit 2: WIC *Pay-for-Prevention* Initial Results – Pregnant Women



[3]

WIC clinics provided the clients and locations for the dental clinics, while Medicaid reimbursed for the applicable preventive services and the OHP provided administrative support. Staff found that for many of the mothers who participated in the clinics, the familiar location of the WIC clinic allayed their deep rooted fears of visiting the dentist. Education and sometimes translation helped them to understand what was going to happen.

Additional funding from the Healthy New Hampshire Foundation and the Jessie B. Cox Foundation, allowed the continuation of the pilot project, the WIC dental clinics in two sites, Concord and Keene. A robust project evaluation report will be completed by the end of the summer 2016.

In collaboration with Dr. Rick Niederman, Director of Evidence-Based Dentistry at New York University, the OHP and four (4) rural school-based oral health programs completed year three (3) of the National Institute of Health Effectiveness and Improvement of Rural, School-Based, Caries Prevention Programs Project. The programs assessed comprehensive preventive interventions (including the application of dental sealants) to improve the clinical and cost effectiveness of rural school-based caries prevention programs.

The OHP also collaborated with the New Hampshire Technical Institute Allied Health Program and imbedded five (5) core courses and a clinical component into the dental hygiene curriculum. Core course requirements for Public Health Certification expanded the scope of practice for dental hygienists who serve vulnerable populations in non-traditional settings. Thirty -three NH licensed dental hygienists were certified to work in public health settings with an expanded scope of services that included application of Interim Therapeutic Restorations (ITRs.)

In the fall of 2015, MCH's colleague, the Pediatric Improvement Partnership, distributed an on-line survey to try to understand current oral health preventive services delivered by primary care clinicians serving children under six (6) years, as well as the barriers and facilitator to optimize their delivery. Completed by 106 respondents, approximately 75% were either "very familiar" or "somewhat familiar" with the American Academy of Pediatrics recommendations for maintaining and improving the oral health of young children. Almost 70% of respondents did not apply fluoride at any well-child visit. The top barriers faced in delivering oral health services by primary care physicians included 1) lack of time (29%); 2)lack of knowledge about how to correctly do it (17%); 3) Unsure of where to refer child for dental home (16%); 4) reimbursement issues (14%) and 5) adapting the clinical process workflow (12%).

National Performance Measure #7:

Percent of 19-35 month olds who have received full schedule of age appropriate immunization for measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, haemophilus influenza, hepatitis B

Data Analysis

Vaccines remain one of the most effective tools available for the prevention of childhood diseases. At 84.3 %, New Hampshire's percent of 19-35 month olds who have received full schedule of age appropriate immunization for measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, haemophilus influenza, hepatitis B has remained fairly stable with minor fluctuations. As with the rest of the Northeast, New Hampshire's coverage remains high, but there continue to be opportunities for parent education and better public health and clinical policies and practices that facilitate receipt of booster doses recommended for the second year of life, when routine health care provider visits are less frequent.

Systems Building

New Hampshire was the final state in the nation to implement an Immunization Information System, a recognized component in a standard of care that consolidates a listing of all immunizations an individual has received, providing for a comprehensive and accurate record for both patient and health care provider. In May 2016, after considerable legislative debate, the NH Joint Legislative Committee for Administrative Rules authorized administrative rules establishing this immunization registry in New Hampshire. This secure, confidential, centralized immunization information system will provide many benefits for New Hampshire residents, health care providers, communities, and public health practitioners. It will prevent the administration of duplicate immunizations, especially when a patient may be seen in another health care practice, an emergency room, or an urgent care center. It will also track vaccine lots in one location and during an outbreak of disease it would enable public health officials to identify those who may need vaccination or medication to prevent the spread of potentially life-threatening illness. The IIS will also allow the public to easily obtain comprehensive immunization records they may need for employment, education, travel and other activities. It is anticipated that the IIS will be an additional tool to help public health and clinical providers to improve immunizations rates.

MCH Specific Activities

In addition to supporting larger policy efforts, MCH collaborated with other programs, coalitions, and early childhood efforts such as SPARK NH, the State's Early Childhood Advisory Council, and "Child Care Aware" (the state's child care resource and referral network) to assure that every effort is made to get all children appropriately immunized. In doing outreach through this network information and resources are provided to parents and providers.

MCH shared the latest immunization information with its MCH-funded contract agencies through emails/mailings. Issues regarding Medicaid payment for specific vaccines, that were brought up as concerns by the agencies were communicated to the Medicaid Program. There was an issue with refugees receiving immunizations; however, that issue has been resolved and Medicaid now covers the cost of those immunizations.

MCH continued to keep abreast of the latest changes in immunization practices by receiving Immunization Program email updates, attending the annual NH Immunization Conference, participating in the Immunization monthly conference calls, and attending the twice-yearly hospital-owned practice meetings, and encouraged similar participation by the agencies.

Prior to MCH staff conducting MCH Quality Improvement primary care site visits to state-funded community health centers, MCH staff contacted the NH Immunization Program staff about any issues of note. Agency immunization rates, and areas of concern/recommendations to improve, were shared with the MCH staff that could then check in on the status of these at the MCH site visit and communicate any progress or obstacles with the Immunization Program.

National Performance Measure # 14:
Percent of children age 2-5 who receive WIC services with a Body Mass Index (BMI) at or above the 85th percentile

Data Analysis

Data to determine BMI rates for two (2) to five (5) year olds comes from The Pediatric Nutrition Surveillance System (PedNSS) a program-based surveillance system that monitors the nutritional status of low-income infants, children, and women in The Special Supplemental Nutrition Program for Women, Infants, and Children Program (WIC). In 2012-2014, approximately 16.9% of children from two (2) to five (5) years of age enrolled in WIC were classified as overweight with a BMI between the 85-95th percentile. There were no significant variations between the years. The highest rates were in Sullivan County (southwestern part of the State) and lowest in Coos County (northernmost part of the State and the most rural). For that same time period, approximately 14.3 % of children from two (2) to five (5) years of age enrolled in WIC were classified as obese with a BMI at or above the 95th percentile. Once again, there was no significant variation between years and the highest rates were in Sullivan County with the lowest in Coos County.

It should be noted that in New Hampshire, as throughout the US, WIC enrollment has steadily declined for the past five years. In New Hampshire in 2010, 18,588 families were enrolled in WIC and in 2015, 13,276 families were enrolled. The implications of decreased caseload are serious. Eligible families are missing out on important nutrition supports and education and public health practitioners are losing an opportunity to engage with young families.

Systems Building

Reducing obesity is one of New Hampshire's top priorities for improved health. By developing policies, practices and education focused on our very youngest children and their families, the aim is to promote healthy growth patterns and healthy behaviors before the onset of poor health outcomes. Solutions to childhood obesity require early intervention strategies that are supported by community efforts.

The Chronic Disease Prevention and Screening Section, Diabetes, Heart Disease, Obesity and School Health program has worked with a total of 15 licensed child care programs, that care for more than 800 children ages birth to five years, to complete the Go NAP SACC program. Each program was asked to make no fewer than three nutrition and sodium-reduction improvements to the nutrition policies and/or practices at their sites.

Between July 1, 2015, and June 30, 2016, the physical activity coordinator for the Chronic Disease Prevention and Screening Section delivered nine trainings, attended by 142 child care professionals from 94 licensed child care programs, on how to improve the physical activity and nutrition environments at their programs. These 94 child care programs care for a total of 2,923 children, ages birth to five years.

MCH continued to provide leadership to the Young Families workgroup of early childhood content specialists from the Bureau of Population Health and Community Services. This group 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.

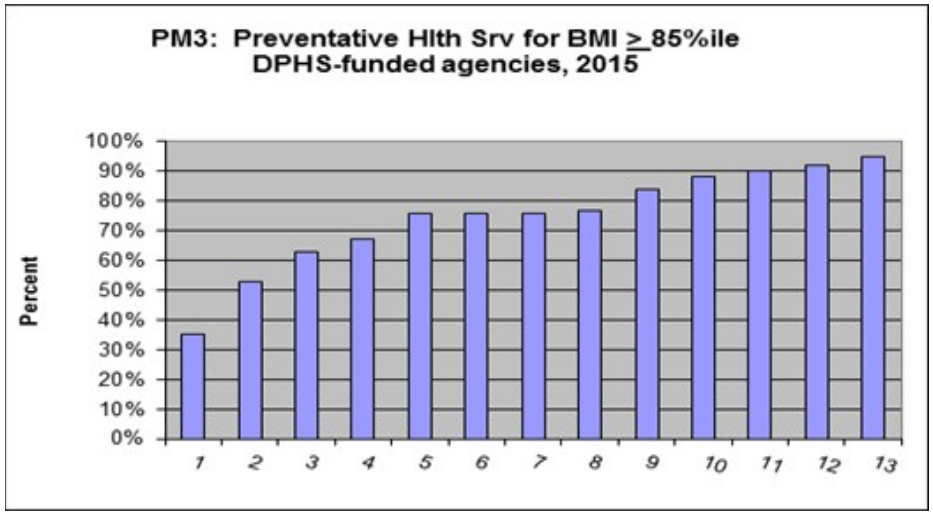
MCH collaborated with the Child Development Bureau, and the Tobacco Prevention and Control Program to increase physical activity among preschoolers through training to child care providers. The Physical Activity Coordinator of the Chronic Disease Prevention and Screening Section presented five (5) workshops to 87 early childhood and child care staff on physical activity and nutrition-related policies and related topics. The participants of these trainings serve 2,386 children. MCH and other Bureau staff began to review and give input to potential revisions to the child care licensing rules pertaining to nutrition, physical exercise, screen time and tobacco exposure, due to be released in 2017.

MCH Specific Activities

MCH continued to share nutrition-related information, resources, webinars and training opportunities from WIC to MCH-contract agencies including the October 2015 Maternal Nutrition Intensive Training webinar, offered by the University of Minnesota, through the NH WIC Program. MCH-contract agencies also participated in three-day lactation training, "Grow and Glow" given by the state WIC Breastfeeding Consultant in spring 2015.

MCH audited pediatric charts at its community health center quality improvement visits for BMI and follow up of children with BMI indicating overweight or obesity status according to national guidelines. An average of 74.3% of children screened with a BMI $\geq$ 85th percentile were referred for further nutritional and preventative health services

within the 13 community health centers audited.



MCH worked to change its required performance measure from "71% of children age two to nineteen years receiving primary care preventive health services with a Body Mass Index percentile greater than or equal to the 85th percentile will have documented discussion of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks." from FY15, to an FY16 measure of "Percentage of patients aged 2 until 17 who had evidence of BMI percentile documentation and who had documentation of counseling for physical activity during the measurement year". This new measure is a HRSA UDS measure. MCH also worked with its contract agencies to encourage WIC enrollment of eligible children by monitoring WIC enrollment via site visits and workplan performance measure results.

National Performance Measure #10:

Rate of deaths in children aged 14 years and younger caused by motor vehicle crashes per 100,000 children

Data Analysis

Because of the small number of deaths among children aged 14 and under caused by motor vehicle crashes, New Hampshire continues to use the *Small Numbers Box* instead of calculating a rate using the Standard Ratio Method.

Systems Building

While New Hampshire is fortunate to have fewer than 5 deaths per year among children aged 14 years and younger caused by motor vehicle crashes, nationally motor vehicle injuries are a leading cause of death among children.

New Hampshire stands alone in the country with no seat belt law for adults, safety belt New Hampshire does require all occupants under age 18 to use a seat or safety belt. Children ages five and younger are required to use a child safety restraint system. Additionally, *The New Hampshire Strategic Highway Safety Plan*: *2012-2016* calls for amending the existing primary seat belt law to include proper restraints for children ages eight years and younger.

The Community Preventive Services Task Force recommends car seat laws and car seat distribution plus education programs to increase restraint use and decrease injuries and deaths to child passengers. In New Hampshire, approximately 1500 car seats were inspected and/or installed by technicians this past year according to the state's Child Passenger Safety Program at the Injury Prevention Center (IPC) at Children's Hospital at Dartmouth.[4] The IPC is both a collaborator and contractor of MCH's Injury Prevention Program. There were 164 certified Passenger Safety Technicians in the state: 32 new and 132 recertified from previous years, and 56 inspections stations, up from 31 in 2014. Child Passenger Safety Technicians are certified every two years through Safe Kids International. Current technicians have two (2) years to fulfill their recertification requirements, which include earning at least six (6)

continuing education units (CEUs), participation in a public event and demonstration of proficiency with a certified instructor. According to Safe Kids annual report for 2014, New Hampshire had a 47% recertification rate, well below the national average of 56%. A pilot program enabled the IPC to pay the recertification fee of $50.00. In addition, the Child Passenger Safety Program Coordinator (a certified instructor) travelled throughout the state to make it easier for technicians to receive their sign off on proficiencies. As a result, the recertification renewal rate in 2015 went up to 68.4%. Three (3) child passenger safety technician trainings took place during the previous year.

Inspection stations, which also increased in 2015, are typically located at a local law enforcement or fire station, hospital and/or child care center. Inspection times are held on a monthly basis. The public can call a toll free Child Safety Seat Phone Line (877-783-0432), monitored by the IPC Administrative Assistant, or download a pamphlet (http://www.chadkids.org/documents/pdf/inspection_site_list_with_addresses_oct_2015.pdf) for questions and locations of inspection stations.

The Child Passenger Safety Program Coordinator also taught a class entitled, "*An Introduction to Child Passenger Safety for Law Enforcement*" at the state's law enforcement training academy. Although the law (RSA 265:107-a) requires a seat be "properly adjusted and fastened" for those under seven (7) and/or 57 inches high, many law enforcement personnel do not know how to recognize seat misuse. The law is also primary, which enables law enforcement to stop a vehicle and issue citations for seat misuse, even if another law has not been broken (e.g. speed, etc.) It is imperative that troopers understand the importance of child passenger safety and know how to spot misuse when on patrol.

New this past year was a child safety seat recycling program. A strong recycling program helps reduce misuse by removing potentially dangerous, recalled seats, which may also have missing parts or other damage associated with age. A large statewide event recycled 85 seats, with most of the seats and parts going to a variety of organizations (including the local animal shelter, which accepted the seat covers).

Additional sessions of the Home Visiting Injury Prevention curriculum were presented to two more groups of MIECHV Home Visitors. The curriculum was also put on line for easier access.

A two-day course for Child Passenger Safety technicians entitled "Transporting Children with Special Health Care Needs" was offered this year with continuing education units provided.

All of this work by MCH and its partners was done in alignment with the NH Department of Transportation's implementation of *The New Hampshire Strategic Highway Safety Plan: 2012-2016.*

National Performance Measure # 13:
Percent of children without health insurance

Data Analysis

While health insurance alone does not guarantee access to health care, uninsured children are more likely than insured children to have health problems. Using data from the Kaiser Family Foundation, approximately 4% of of New Hampshire children are uninsured. This compares favorably to a national rate of 6%. Between 30% and 31% of New Hampshire's children are enrolled in Medicaid, a smaller proportion than the national estimate of 39%.

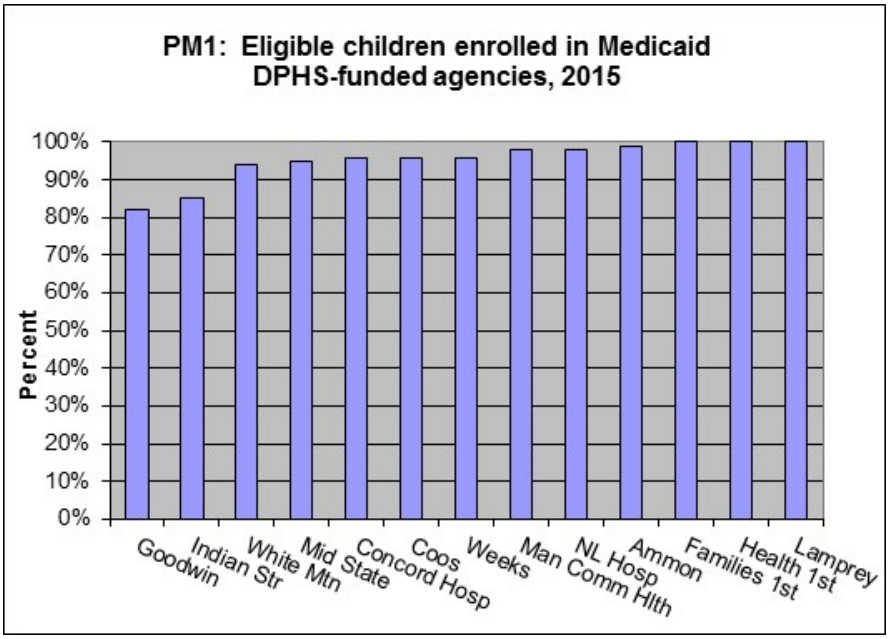
Systems Building

Medicaid is a critical health care safety net for thousands of low-income children in New Hampshire. The New Hampshire Division of Family Assistance improved its Medicaid application process and now offers online services through NH EASY Gateway to Services, an Electronic Application System. In April 2016 new service options were added including increased account management, and a responsive web design that is easy to navigate whether on a computer, tablet or smartphone. NH EASY Gateway to Services makes it easy to apply for services such as Medicaid, Food Stamps and Cash Benefits, manage accounts and learn about additional services that are available.

MCH Specific Acitivities

MCH works through its contracted community based agencies to ensure that all eligible children have access to all available services, including Medicaid.

With the implementation of managed care, MCH staff has worked to help its funded home visiting agencies and community health centers work with Medicaid and the two MCOs to better understand how and when to bill for services, as appropriate. MCH continued to monitor the Title V contracted community health centers' percentage of children without health insurance, percent of eligible children enrolled on Medicaid, and activities to enhance Medicaid enrollment through review of statistics, annual workplans, and discussions at twice yearly program meetings and local contract agency site visits.



MCH staff also collaborated with DCYF in their newly combined FY15 MCH/DCYF-funded Child and Family Support Services (CFSS) home visiting program, participated in monthly contract agency phone meetings, and began work on a tool to be used at the upcoming joint MCH/DCYF- site visits. MCH has been receiving the monthly and quarterly reports required by DCYF for these contracts. This collaborative project has helped provide seamless services to clients and has reduced the burden of local agencies to contract with and report to multiple state agencies (both MCH and DCYF) for similar and overlapping services. MCH worked with DCYF, Medicaid, and the DPHS Rulemaking staff to amend the current Administrative Rule allowing the CFSS agencies who are not under current contract with MCH, to be able to bill the allowable $15 per 15 minutes of service for education, support and care coordination services. This rule, when originally enacted, was available only to MCH-contract agencies.

State Performance Measures 2011-2015

State Performance Measure # 2:
Percent of 3rd grade children who are overweight or obese

Data Analysis

The New Hampshire 2013-14 Third Grade *Healthy Smiles – Healthy Growth Survey* was conducted between September 2013 and June 2014 and published in October 2014. The statewide survey was coordinated by the NH Division of Public Health Services and funded by the HNH Foundation and Northeast Delta Dental. Statewide, 12.6% of third grade students were obese, 15.4% were overweight and 2.5% were underweight. The statewide data showed a marked improvement from the previous survey in 2008-2009 and clearly demonstrated progress in

reducing health disparities in both obesity and oral health status. In particular, there was a 30% decrease statewide in obesity prevalence and a 34.8% decrease in obesity among students in schools that have more than 50% of students eligible for Free or Reduced Lunch.

Results of the 2014 assessment of student oral health, body weight, and height also indicated that there were still pockets of unmet need among New Hampshire's children. Statewide, children attending schools with a higher proportion (>50.0%) of students participating in the Free or Reduced Lunch program experienced an increased burden of obesity compared with students in schools with <25% of students participating. Those living in Coos and Sullivan Counties had the highest prevalence of obesity among New Hampshire's third grade students. [6]

Systems Building

Reducing obesity is one of New Hampshire's top priorities for improved health. Strategies for youth must focus on supporting families as they make healthier food and beverage choices and encourage physical activity in places that they live, learn and play.

HEAL (Healthy Eating Active Living) New Hampshire (http://www.healnh.org/), a network of state and community partners working on population-based approaches to reduce the prevalence of obesity and chronic disease in the state is one of the few state-wide efforts addressing obesity. Many of the MCH-funded community health centers are involved in their local HEAL groups and project activities which impact its citizens of all ages, including third graders.

In addition, New Hampshire's Regional Public Health Networks (RPHNs) were established to ensure coordinated and comprehensive delivery of essential public health services regionally. Thirteen agencies are funded by NH DHHS to convene, coordinate, and facilitate an ongoing network of partners to address regional public health needs. Nine of the 13 RPHNs have specifically targeted obesity as a priority for their community, with objectives that include increasing physical activity opportunities in early childhood settings, schools, workplaces, food pantries, neighborhoods, and public and private recreational facilities; supporting schools and early learning centers in meeting nutritional, physical activity, and screen time guidelines; and "Prescribe the Y"- allowing pediatricians to prescribe a YMCA membership to overweight and obese children at no cost to the family.

MCH Specific Activities

Although MCH did not target third graders, or school aged children in any population-based or agency-specific activities, it continued to share information to promote healthy lifestyle and obesity prevention to its state-funded community health centers as available. Information and training opportunities from WIC were also shared and promoted including the October 2014 Maternal Nutrition Intensive Training webinar, offered by the University of Minnesota, through the NH WIC Program.

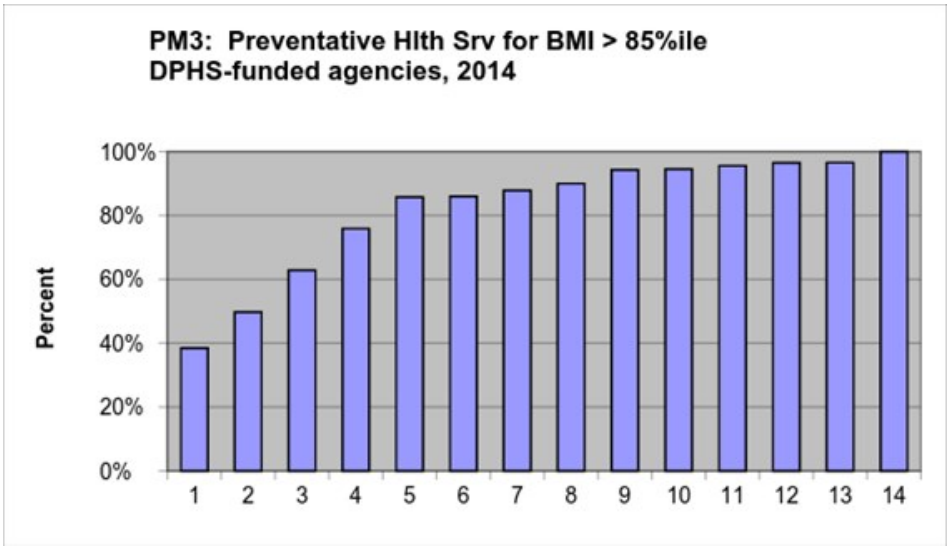
MCH encouraged use of the 5:2:1:0 Healthy NH campaign materials, available through the Foundation for Healthy Communities (http://www.healthynh.com/index.php/5-2-1-0-healthy-nh.html).

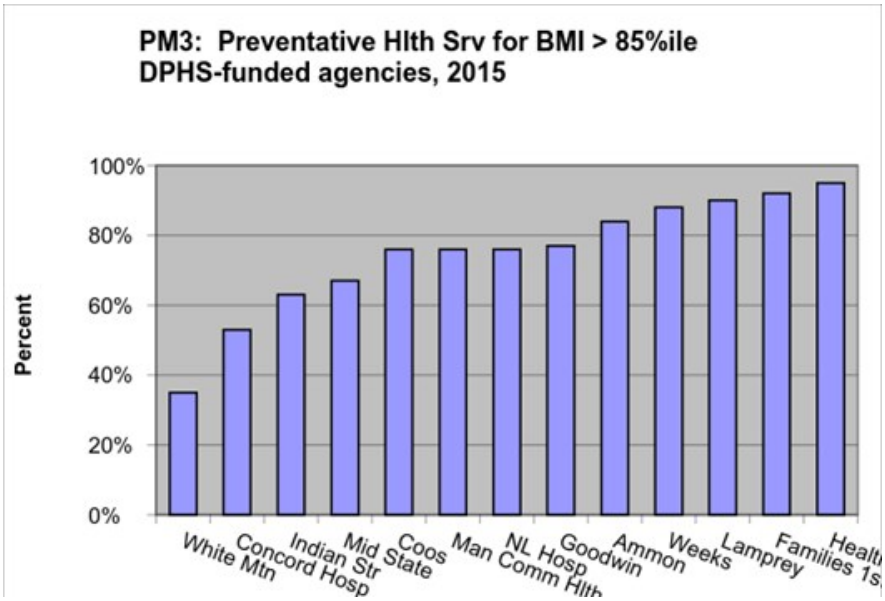
MCH audited pediatric charts at its community health center quality improvement visits for BMI and follow up of children with BMI indicating overweight or obesity status according to national guidelines. Thanks to the electronic medical record systems, all agencies have documentation of height, weight, BMI, and BMI percentile, and graphing, easily available. Follow up of overweight and obese children tend to be handled by the primary care provider with frequent monitoring for adherence to diet, physical exercise, and decreased screen time adherence rather than a referral to an on-site, or off site by referral nutrition consult.

MCH explored changing its BMI performance measure for FY16 to one more in line with a national measure. In 2015, it worked to change its required performance measure from "71% of children age two to nineteen years receiving primary care preventive health services with a Body Mass Index percentile greater than or equal to the 85%ile will have documented discussion of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks." to an FY2016 measure of "Percentage of patients aged 2 until 17 who had evidence of BMI percentile documentation and who had documentation of counseling for physical activity during the measurement year. This new measure is a HRSA UDS measure.

Although the graphs below do not isolate third graders, results of the FY14 and FY15 agency workplan reports on

their performance measure related to providing counseling on those with a BMI percentile of 85%ile or above show a slight decrease, from an average of 82% to 75% indicating obesity is still a problem needing attention.





State Performance Measure #5 :

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

Data Analysis

Data for this indicator comes from the 2011-2012 National Survey of Children's Health is a national telephone interview conducted from February 2011 through June 2012 by the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics. Because updated data is not available, New Hampshire has continued to report 2012 results. New Hampshire's percent of parents who self-report that they completed a standardized,

validated developmental screening tool at 30.6% is comparable to the national response of 30.8%.

Systems Building

In 2013 New Hampshire State Health Improvement Plan identified developmental screening for autism as one of its priorities and promoted screening within comprehensive pediatric care in community health centers as well as within the *Watch Me Grow* (WMG) developmental screening system to ensure high quality, accessible and coordinated screening, information and referral services and supports to New Hampshire families. MCH, SMS/Family Centered Early Supports and Services (ESS), and Head Start State Collaboration Office (HSSCO) have provided the leadership for WMG, which promotes the Ages & Stages and Ages & Stages – Social Emotional Questionnaires (ASQ and ASQ-SE) since 2011.

In 2015, the Title V Director for CSHCN, Project Director from NH's Pediatric Improvement Partnership (NHPIP), the MIECHV Director, the CDC Act Early Ambassador and members of the NH State Autism Council's Screening and Diagnosis Committee formed the Act Early State Team. In July 2015, this team attended the 2015 Northeast Regional Developmental Screening, Referral and Response Conference and created a Blueprint for Change (Blueprint) that envisions a comprehensive screening, response, referral and diagnostic system. In addition to exploring the potential for a comprehensive data system for use by all agencies, the Blueprint called for increased awareness and investment in early childhood initiatives to assist in funding a comprehensive system that is sustainable.

Representatives from the Act Early State Team met with WMG leadership to discuss building on the framework of WMG, to reach parts of the Blueprint that had not been part of the existing system. The conversation focused on the need for Title V to think beyond screening and referral to include assessment, diagnosis and treatment. Rational for expanding the system included the results of the National Survey on Children's Health show New Hampshire was lagging behind nationally and regionally in developmental screening. Other limitations of WMG include its focus solely on ASQ and ASQ:SE and the lack of participation from primary practices are participating.

The group planned to update the Blueprint for presentation to WMG stakeholders at the annual meeting in 2015/16. In addition, the Act Early State Team developed a formal request to WMG in an effort to implement the Blueprint for Change. There was some resistance to adding more screening tools to the system. Title V staff were suggested that in order for the system to be comprehensive, it would need to accept data from healthcare practices using other developmental screening tools that are reliable and validated.

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[1] The New Hampshire 2013-14 Third Grade Healthy Smiles – Healthy Growth Survey: An Oral Health and Body Mass Index Assessment of New Hampshire Third Grade Students, October 2014. http://www.dhhs.nh.gov/dphs/bchs/oral/documents/thirdgradesurvey2014.pdf

[2] Center for Health Care Strategies, Inc., *Advancing Oral Health Through the Women, Infants and Children Program: A New Hampshire Pilot Project*. http://www.chcs.org/resource/advancing-oral-health-through-the-women-infants-and-children-program-a-new-hampshire-pilot-project/ accessed 07/03/16.

[3] Ibid.

[4] Injury Prevention Center at Children's Hospital at Dartmouth, Child Passenger Safety Program Statistics. http://www.chadkids.org/injury_prevention/injury_center_programs_traffic_passenger.html accessed 07/02/16.

[5] State of New Hampshire, http://www.gencourt.state.nh.us/rsa/html/xxi/265/265-107-a.htm accessed 07/02/16.

[6] The New Hampshire 2013-14 Third Grade Healthy Smiles – Healthy Growth Survey: An Oral Health and Body Mass Index Assessment of New Hampshire Third Grade Students, October 2014. http://www.dhhs.nh.gov/dphs/bchs/oral/documents/thirdgradesurvey2014.pdf

Adolescent Health

State Action Plan Table

State Action Plan Table - Adolescent Health - Entry 1

Priority Need

Decrease unintentional injury.

NPM

Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Objectives

By June of 2018, increase seatbelt usage in the 15 high schools participating in the Teen Driving Project by 8% over the baseline of 70%.

By June of 2018, at least 75% of the schools in the state will have implemented the NH Concussion Law and/or will have written policies.

Strategies

Use of peer groups within schools to increase seatbelt usage and overall teen driving safety culture

Increase parental participation and understanding of teen driving issues

Analyze concussion policies within school systems and make recommendations for potential change

ESMs

ESM 7.1 - Percentage of high school students who wear seatbelts

NOMs

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

State Action Plan Table - Adolescent Health - Entry 2

Priority Need

Improve access to needed healthcare services for all populations.

NPM

Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Objectives

By July 1st of 2017, increase the average percentage of adolescents who have had a preventative medical visit at the MCH funded CHCs from a baseline of 61% in state fiscal year 14 to 67% in state fiscal year 17 (ends June 30th 2017).

Strategies

Professional education

Quality improvement projects to focus on adolescent visits

Leverage missed opportunities to discuss wellness visits (e.g. acute care)

ESMs

ESM 10.1 - Percentage of adolescents ages 12-21 at MCH-contracted health centers who have at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year

NOMs

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

NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children in excellent or very good health

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

NOM 22.2 - Percent of children 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 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

Measures

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19 (Adolescent Health)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	225.8	219.9	213.9	208	202	196.1

Data Source: State Inpatient Databases (SID) - ADOLESCENT

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009	231.4	11.4 %	411	177,593
2008	230.4	11.3 %	413	179,250

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

ESM 7.1 - Percentage of high school students who wear seatbelts

Annual Objectives

	2017	2018	2019	2020	2021
Annual Objective	93.4	94.2	94.9	95.7	96.5

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Annual Objectives

	2016	2017	2018	2019	2020	2021
Annual Objective	89.6	90.5	91.3	92.2	93.1	94

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	88.7 %	1.8 %	93,302	105,151
2007	91.8 %	1.3 %	102,499	111,719
2003	84.3 %	1.6 %	97,796	116,053

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 10.1 - Percentage of adolescents ages 12-21 at MCH-contracted health centers who have at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	64.0	66.0	68.0	70.0	72.0

Adolescent Health - Plan for the Application Year

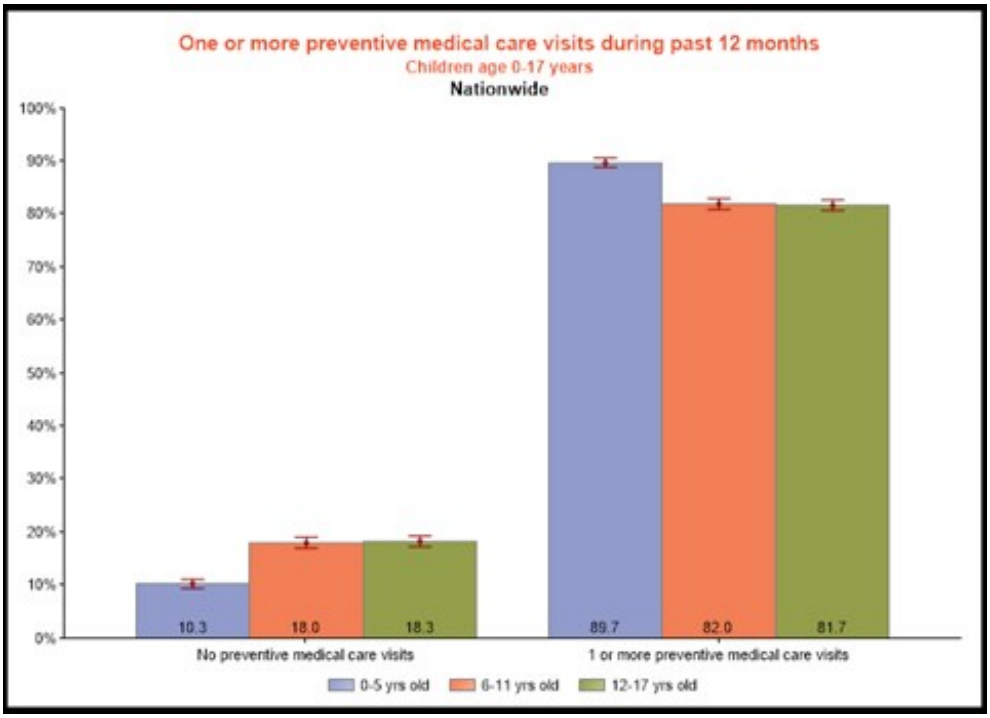
National Performance Measures: 2016-2020

National Performance Measure #10:
Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year

Evidence Based or Informed Strategy Measure:
Percent of Adolescents ages 12-21 who have at least one comprehensive well-care visit with a PCP or OB/GYN practitioner

Data Analysis

According to data from the National Survey of Children's Health adolescents aged 12-17 are less likely to have an annual preventive care visit as compared to younger children. 2011/12 Data from this survey indicates 81.7% of 12-17 year olds had an annual preventive care visit as compared to 89.7% of 0-5 year olds and 82% of 6-11 year olds[1]. As 12-17 year olds are less likely to have annual visits during the stage of their life in which they are developing health habits and are more likely to engage in high risk behavior MCH has selected percentage of adolescents aged 12-17 (NPM) and percentage of adolescents aged 12-21 (SPM) having annual well-care visit as a priority area for this five year reporting cycle.

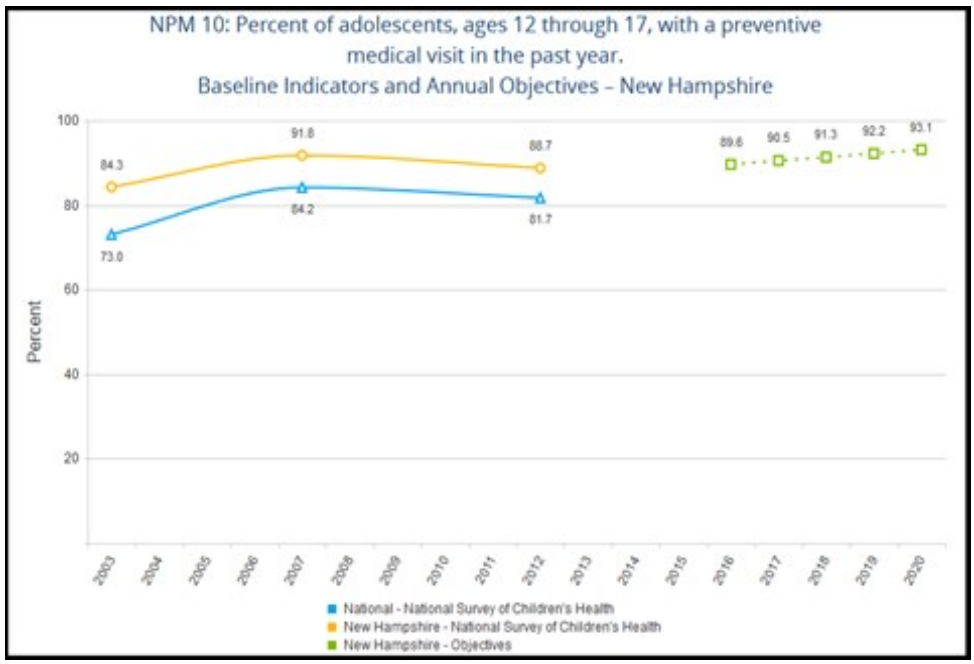


Data Source: National Survey of Children's Health. NSCH 2011/12

The well care visit is a prime opportunity for health care providers to screen, counsel and provide preventive intervention for key areas including:

- Mental and behavioral health
- Tobacco and substance use
- Violence and injury prevention
- Sexual behavior
- Nutritional health

Overall, the State of New Hampshire has a relatively high percentage of adolescents aged 12-17 having a preventive medical visit as compared to the National average 88.7% vs 81.7%[2]. However, when the age group is expanded to include ages up to 21 NH Medicaid and MCH data indicates this percentage decreases. According to 2014 Medicaid data 62.5% of NH's Medicaid enrolled adolescents aged 12-21 had at least one comprehensive well-care visit with a PCP or an OB/GYN[3]. This Medicaid data is consistent with MCH data collected from MCH contracted CHCs (SFY15 agency average 62%).



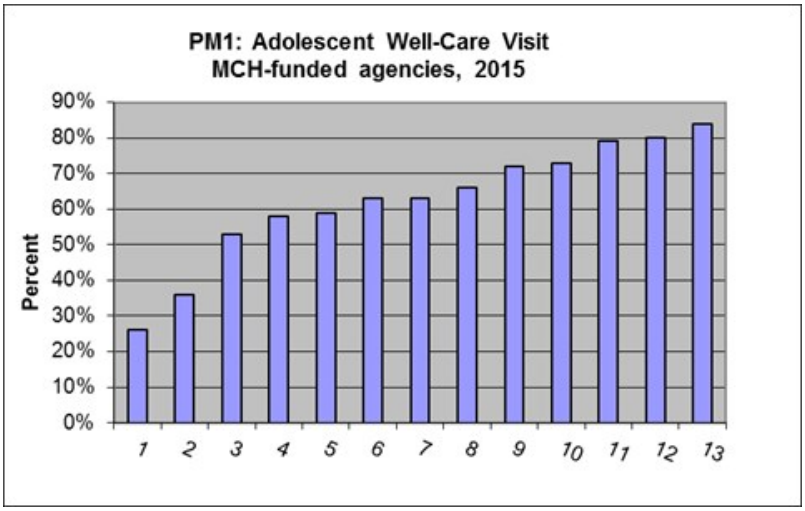
Data Source: https://mchb.tvisdata.hrsa.gov/PrioritiesAndMeasures/NationalPerformanceMeasures

Systems Building

Recognizing that adolescent health is largely impacted by behavioral patterns developed during this developmental period MCH seeks to increase access to health care and promote adolescent well care visits through collaboration with state and local partners.

For over 25 years, MCH has utilized Title V funding to contract agencies to support primary care and prenatal services. MCH provides agency oversight and ensures accountability by specifying reporting requirements and conducting site visits. In 2009, MCH implemented the adolescent well care visit (ages 10-21) as a pilot performance measure for the 13 MCH contracted CHCs who serve the adolescent population. In 2015, the MCH performance

measure definition was changed to ages 12-21 to align with HEDIS performance measure definition. By contracting with CHCs throughout the state MCH has been able to collect adolescent visit data from of all of New Hampshire's geographical regions. Until SFY16 data was reported to MCH annually. Aware that some agencies only reviewed their agency data when reporting was due to the state MCH encouraged agencies to review their own data more frequently (quarterly) and in 2015 MCH revised Primary Care contracts to require CHC's to submit MCH performance measure data to the state twice per year. MCH staff (QI/QA nurse consultant) collects and analyzes CHC performance measure data. Following data analysis MCH QI/QA nurse consultant reviews data results with MCH staff (Child Health nurse consultant and MCH program administrator) for internal discussion. The MCH QI/QA nurse consultant then disseminates all-agency data and graphs (see below) and provides recommendations for improvement activities to CHCs. MCH encourages CHCs to review all-agency data to understand how they compare to other MCH contracted agencies and to consider incorporating MCH QI recommendations.



Data Source: NH DHHS, Maternal & Child Health Section

MCH also requires MCH contracted CHCs to submit annual Quality Improvement (QI) Workplans to describe agency QI project activities (see below QI Workplan for example). While all MCH contracted CHCs are required to submit QI workplans MCH has allowed CHCs to self-select their QI project topic as long as the focus is directly related to Primary Care contract scope of services. For the current contract period (SFY16-17) two (2) out of the thirteen (13) contracted CHCs selected adolescent visit for their QI Workplan. In the future, MCH will increase the number of CHCs selecting adolescent visit for QI Workplans by targeting and selecting QI Workplan topics for each CHC based on past agency performance. QI Workplans are collected and reviewed by MCH staff (QI/QA nurse consultant, child health nurse consultant, MCH program administrator). After internal review the MCH staff forwards feedback to the CHCs and requests revision if needed.

Identify MCH Performance Measure that QI Project Addresses:
Preventive Health, Adolescent Well-Care Visit: Percent of adolescents, aged 12-17, with a preventive services visit in the last year.

Project Goal:
To enhance adolescent health by assuring recommended annual adolescent well-visits; to decrease adolescent overweight and obesity; to improve the availability of adequate insurance and access to healthcare and maintain the infrastructure of safety net providers and services; decrease the use and abuse of alcohol, tobacco, and other substances among adolescents; and to decrease unintentional injury, particularly falls and motor vehicle crashes.

Project Objective:
The percentage of adolescents, aged 12-17, that received preventive services over the SFY will be 61%

INPUT/RESOURCES	PLANNED ACTIVITIES
• All clinical personnel • Administrative personnel • QI personnel • Staff QI Committee • EMR utilization-reports • Training and continuing education • Improved efficiencies in outreach and documentation	1. Nursing and MA staff to perform quarterly reviews to identify patients in need of adolescent well-care visit and will contact the family. 2. Improve daily use of protocol assessment tool in the EMR by clinical staff to identify adolescents in need of well-care visit. 3. Parents and adolescents will be counseled and encouraged to come in for annual health visits by their PCPs and nurses.
	EVALUATION ACTIVITIES
	1. QI Coordinator will review data on a quarterly basis and share with the Staff QI Committee and in clinical staff meetings to identify opportunities for improvement and potential tests of change. 2. Measure results will be reported to the BOD QI Subcommittee on a semi-annual basis. 3. The action plan will be reassessed and re-evaluated if the annual target is not met or the quarterly reviews indicate lack of progress or need of revision.

WORKPLAN PERFORMANCE OUTCOME (To be completed at end of SFY)

SFY 16 Outcome Measure: *Insert your agency's data/outcome results here for July 1, 2015-June 30, 2016*

_____ Target/Objective **Met**
Narrative: *Explain what happened during the year that contributed to success i.e. PDSA cycles etc.*

_____ Target/Objective **Not Met**
Narrative for Not Meeting Target: *Explain what happened during the year, why measure was not met, improvement activities, barriers, etc.*

Proposed Improvement Plan: *Explain what your agency will do (differently) to achieve target/objective for SFY17*
_____ **Revised Workplan Attached** (Please check if workplan has been revised)

Source: NH DHHS, Maternal and Child Health Section

MCH data is also shared and discussed with CHCs twice per year during scheduled Primary Care Coordinator meetings. These face to face meetings allow an opportunity for agencies to build QI capacity and learn from one another in a group setting as MCH staff facilitates interactive discussions and presents evidenced-based quality improvement tools/strategies. 94% (16/17) of meeting participants from the most recent meeting (Spring 2016) rated the overall quality of the meeting highly (responded as excellent or very good on 5 point Likert scale). The majority of participants also highly rated the four meeting speakers (range76-100%) and degree to which four learning objectives were met (range 83-100%). Written comments from participants indicated they found the meeting and information useful, would have liked entire day to continue conversations and want future opportunity to further discuss performance measures, QI best practices and sharing of what agencies are doing with staff to improve outcomes.

MCH additionally provides agency support and performance oversight by reviewing CHC data and workplans in

person with CHC staff by conducting Primary Care site visits. Site visits have been scheduled with every MCH contracted CHC at least once every two (2) year contract period. Site visits have provided an opportunity for MCH to:

- Determine compliance with contracted services such as: assessing if agency is providing culturally and linguistically appropriate care and meeting Standards of Care for Primary Care, and Preventive services (Bright Futures Guidelines)
- Explore how MCH funds are utilized
- Review and discuss agency specific data
- Review and discuss agency specific Workplans and QI projects
- Address agency identified needs

MCH's data demonstrates overall performance improvement (aggregated data from all MCH contracted agencies) as the aggregated data from all MCH contracted agencies for percentage of adolescents having annual well care visits has increased from 52% in FY10 to 62% in 2015. However, MCH data also indicates a variable level of performance improvement among agencies. Per the most recent MCH data (SFY 15) performance measure outcome results among contracted CHCs ranged from 26% to 84%. MCH staff has provided support and QI recommendations to lower performing agencies via email and face to face (meetings & site visits).

Adolescent Visit: 13 MCH contracted agencies (aggregated data)						
	2010	**2011**	**2012**	**2013**	**2014**	**2015**
SPM: Percent of adolescents 12 to 21 years of age, who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year	52%	55%	65%	56%	61%	62%

Source: NH DHHS, Maternal and Child Section

Individual MCH contracted agency data (13 agencies), 2015												
Percent of adolescents 12 to 21 years of age, who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year	**66%**	**26%**	**63%**	**73%**	**72%**	**59%**	**53%**	**63%**	**79%**	**84%**	**80%**	**58%**	**36%**

Source: NH DHHS, Maternal and Child Section

MCH staff also promotes Title V activities by participation in NH Pediatric Improvement Partnership (NHPIP). NHPIP is a state-level multi-disciplinary collaborative of private and public partners dedicated to improving child health care quality through the use of systems and measurement-based quality improvement processes. The MCH QI/QA nurse consultant and program administrator are members of the NHPIP steering committee members. Recently, this committee began discussions to include adolescent well visit as a focus for Quality Improvement. Through NHPIP MCH will be provided an opportunity to collaborate with other stakeholders (pediatric providers, private and public payers etc.) to address this issue.

MCH Specific Activities

The following table lists MCH targets for this five year reporting cycle for the adolescent visit NPM (age 12-17) and SPM (age 12-21):

Performance Measure Definition	2017	2018	2019	2020	2021
NPM 10: Percent of adolescents age 12-17 with a preventive services visit in the last year.	90.5%	91.3%	92.2%	93.1%	94%
SPM: Percent of adolescents 12 to 21 years of age, who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year	64%	66%	68%	70%	72%

Proposed MCH activities

In order to achieve the above targets set for adolescent visit MCH will continue performing the current activities described above and proposes the following:

1. MCH seeks to improve performance measure outcome results among MCH contracted CHCs as follows:

   · Summer/Fall 2016: In August, the MCH QI/QA nurse consultant will be reviewing the SFY16 performance measure data (submitted by all agencies) and adolescent visit QI Workplan (submitted by two CHCs). After the data is analyzed the QI/QA nurse will be forwarding a newly created document known as the Performance Measure Outcome Report (PMOR) to CHCs that did not submit an adolescent QI Workplan and did not meet their agency target for this measure (due September 2, 2016). The PMOR is where CHCs will explain what happened during the year i.e. why measure was not met, what barriers/challenges agency faced, what improvement activities took place during the year to correct along the way (PDSA cycles) etc. Completed PMORs will be reviewed by the QI/QA nurse consultant who will then with input from MCH staff (Child Health nurse consultant and program administrator) provide feedback and QI recommendations to agencies (October 2016).

   · Summer/Fall 2016: MCH will provide education (Bright Future Guidelines, evidenced-informed strategies, resources) and QI support to CHC's by developing an adolescent visit presentation and facilitated QI collaborative learning session for the Fall Primary Care Coordinator's meeting. Presentation to include: Bright Future Guidelines, evidenced-based

   · Winter/Spring 2017: The MCH QI/QA nurse consultant will make contact (face to face, phone or email) with lower performing agencies to provide additional QI support as needed.

   · Summer/Fall 2017: MCH will increase the number of MCH contracted CHCs having an adolescent visit QI Workplan by adding language into the FY18 & 19 Primary Care Contract Scope of Services which will require agencies to select QI project topic(s) from a list predetermined by MCH based on MCH priority areas and agency past performance.

2. MCH will seek opportunities for stakeholder collaboration:

   · MCH will be releasing a Primary Care Services Request for Proposal (RFP) (*Insert time frame)* which will allow an opportunity for any NH Primary Care agency to apply for MCH funding. If selected for funding MCH will form new connections with Primary Care agencies not previously contracted with MCH.

   · MCH seeks to connect with NH Pediatric Improvement Partnership (NHPIP) members (pediatric providers, MCOs etc.) to develop state level strategies for increasing the number of annual adolescent visits i.e. leveraging missed opportunities (acute visits & family planning visits), reviewing incentives and reimbursement methods (billing mechanism to allow preventive services on same day as treatment visit), building social media capacity

- MCH will consider participating in the Adolescent and Young Adult Health Collaborative Improvement and Innovation Network (CoIIN) once second round becomes available

3. MCH will promote/participate in other activities as needed:

   - Educating health professionals and general public about the value of assuring access to health care, endorsing practice guidelines (Strong recommendation for annual visit from PCP)

   - Training health professionals in adolescent preventive services

   - Providing Technical Assistance QI

National Performance Measure #7:
Rate of hospitalization for non-fatal injury per 100,000 adolescents ages 10-19

Evidence Based or Informed Strategy Measure:
Percent of high school students who wear seatbelts

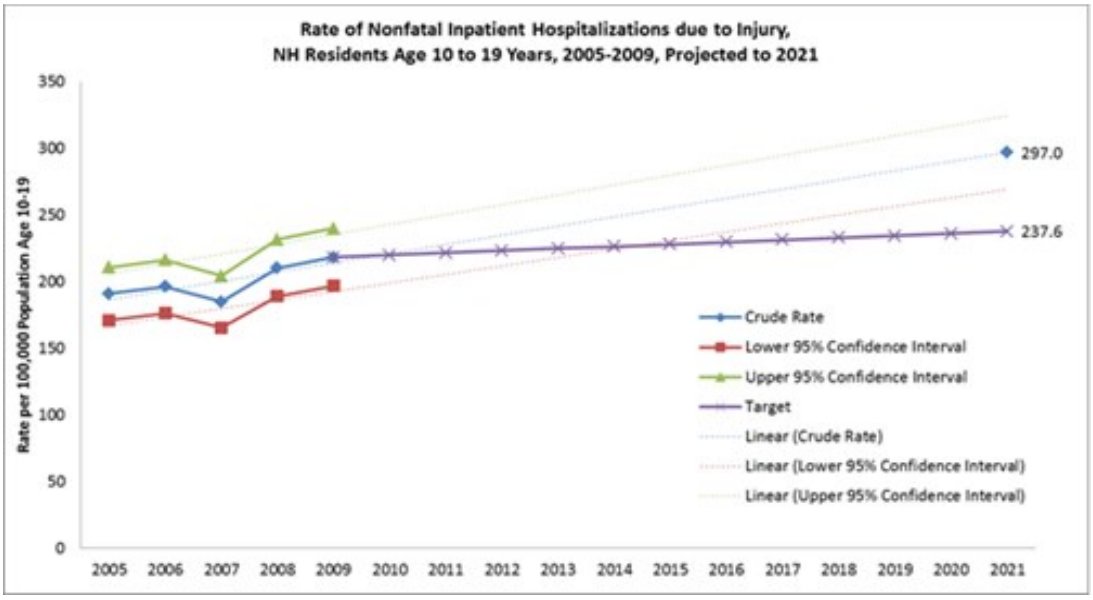
Data Analysis

Non-fatal injuries present a significant burden to the health care system and, in particular, to urgent care facilities, and emergency department (ED) utilization. Unintentional injuries accounted for the majority of all injury-related visits. Emergency department visits from unintentional injuries are largely seen in both children and young adults. The highest rate of these visits is in the older adolescent (15-24) age group. Many ED injury-related visits are caused by crashes involving motor vehicles, bicycles, pedestrians, and recreational vehicles.
The rate of non-fatal injury inpatient hospital discharges in NH residents aged 10 to 19 years has shown an increasing trend. This trend is not statistically significant year to year, but by 2021, if no change in effected in the trend, the rate will be significantly higher than it was in 2009 (See Figure 1 graph and table). The target on the graph represents a decrease in the rate of increase seen in the trend when prevention efforts are successfully implemented.

The hospital discharge data used to create this projection is limited. Due to data collection issues in 2010 and 2011, those years are not recommended for use. Also, with the adoption of ICD10 codes, older data collected using ICD9 codes may not be directly comparable. When 2015 hospital discharge data becomes available, comparability to older data will be re-assessed, and a new baseline may be set.

Affecting all the causes of non-fatal injury is too broad for a goal. For the upcoming Title V MCH Block Grant, NH DPHS staff and their partners intend to target injury prevention efforts on prevention of motor vehicle crash injury in youth as 15 to 19 as a major cause of injury. NH MCH will also be targeting prevention of concussion for all causes in youth age 10-19, which overlaps the outcome of motor vehicle crash.

Figure 1.



NPM #7 Targets for Non-fatal Injury Hospital Discharges, NH Residents

Aged 10-19 Years, Rate per 100,000

Year	2016	2017	2018	2019	2020	2021
Rate	229.6	231.2	232.8	234.4	236.0	237.6

Teen Driving

Speed and the inexperience of novice drivers are the major causes of fatal crashes amongst adolescents in New Hampshire. Adolescent novice drivers (16 and 17 years of age) are also involved in more motor vehicle crashes per licensed driver than any other age group in the state. In addition and despite the fact that the State has a primary seat belt law for people under the age of 18, surveys show that adolescents don't always buckle up. On the 2015 YRBS, adolescent males, as passengers, were also less likely to buckle up than females. Given the death and injuries sustained, any increase in adolescent seat belt usage in the state is likely to make a great impact.

"Work loss costs are the total estimated salary, fringe benefits, and value of household work that an average person—of the same age and sex as the person who died—would be expected to earn over the remainder of his or her lifetime. Motor vehicle crash deaths disproportionately affect younger people, who have the potential to contribute to the workforce for many years. Therefore, when a younger person dies, the result is a higher work loss cost."

Source: http://www.cdc.gov/Motorvehiclesafety/statecosts/nh.html

Motor vehicle crash injury continue to be the number one cause of deaths for adolescents and new drivers (aged 16-20, see Figure 2), and also represent the highest number of crashes among the different age groups of licenses drivers in the state[4]. The trend in teen motor vehicle crash injuries continued to decline toward the 2020 goal of 42.4 per 100,000 (see Figure 3) largely due to successful prevention programs provided to dates.

Since there are issues with hospital discharge data in New Hampshire after 2009, the selection of a new interim goal and measurement became necessary. The Interim Goal will be to increase the percent of NH students responding to

the Youth Risk Behavior Survey (YRBS) with, “Sometimes, most of the time, or always wore a seatbelt (when riding in a car driven by someone else)” from 91.8 % in 2015 to 96.5% in 2021 (see Figure 4).

Figure 2.

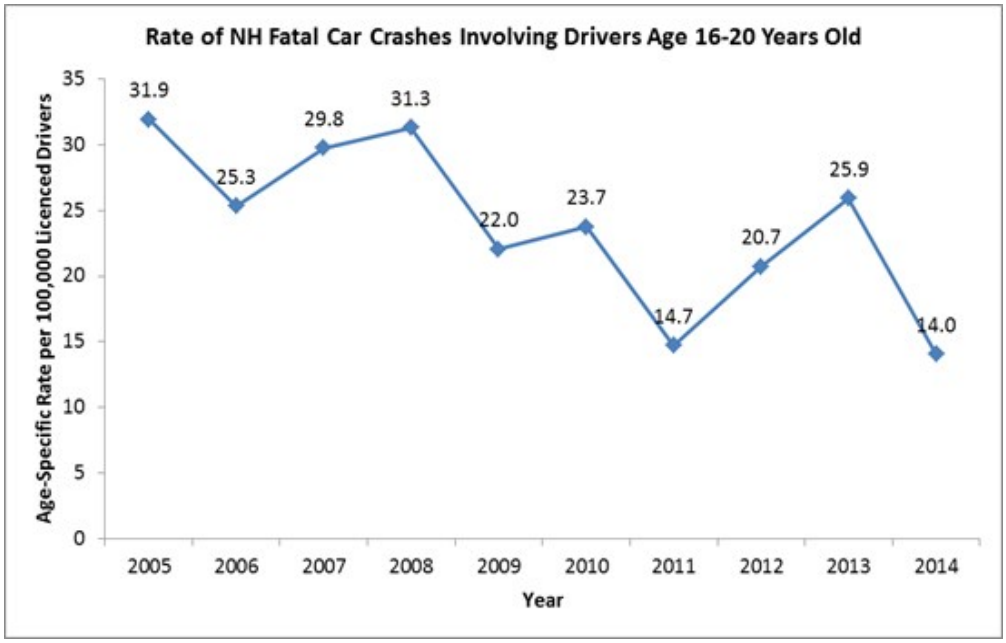


Figure 3.

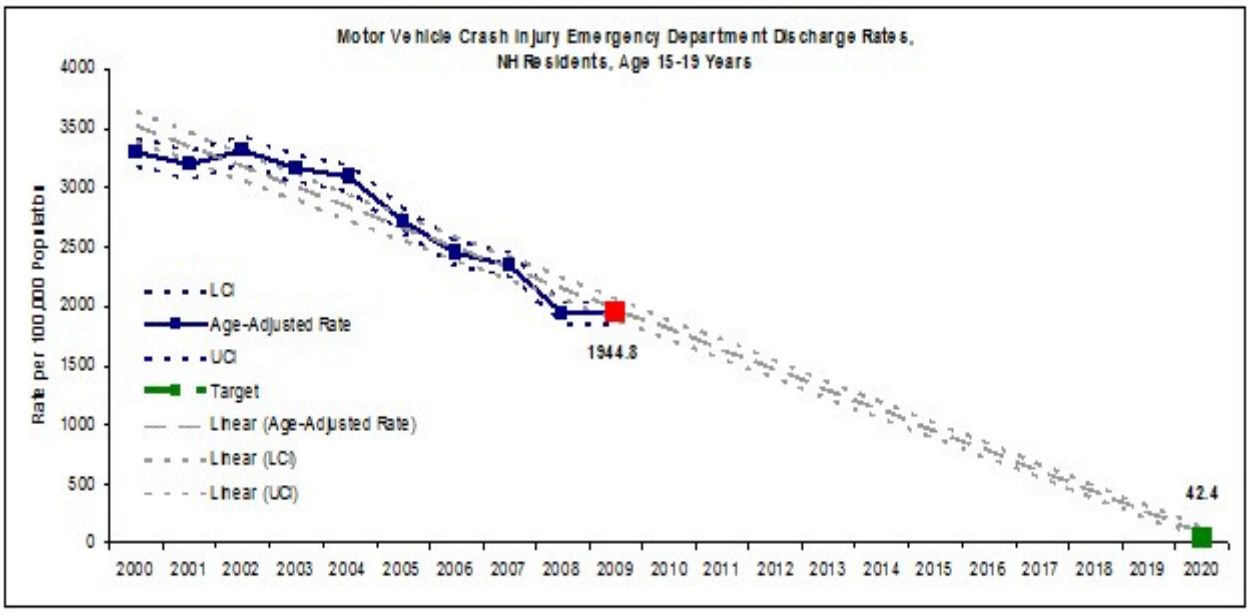


Figure 4.

Sometimes, most of the time, or always wore a seat belt (when riding in a car driven by someone else)
Source: YRBS Data on: https://nccd.cdc.gov/youthonline

Year	Percent	Lower 95% CIi	Upper 95% CI
2005	87.0	84.0	89.5
2007	88.3	85.6	90.5
2009	87.1	84.3	89.5
2011	89.3	86.9	91.3
2013	90.3	88.1	92.1
2015	91.8	91.2	92.5
2017	93.3	estimated goal	
2019	94.9	estimated goal	
2021	96.5	estimated goal	

YRBS is a survey of high school-aged students which is conducted in NH during odd numbered years. The question reviewed for this measure is: “How often do you wear a seatbelt when riding in a car driven by someone else?” Excluding the “Unknown” and “Never” response gives a measurement of students who do wear seatbelts. Units: Percentage of student respondents to the YRBS in NH.

The 2015 NH Youth Risk Behavior Survey (YRBS) indicate that of the respondents, 8.2% never or rarely wore a seat belt when riding in a car driven by someone else. The New Hampshire percent has gone down significantly since 2003, 12.6%, when it was first asked. An additional question on not wearing a seatbelt in this case as the driver, was added in the 2013 YRBS and was answered affirmatively by 8.7% of respondents and went down to 7.7% in 2015. It is interesting to note that on another relatively new motor vehicle question, 43.7% of respondents responded affirmatively to having emailed or texted while driving in 2015. This is down only by a small percentage from 47.7% in 2013, despite a "Hands Free" law being passed in NH that forbids texting while driving.

Graduated Driver Licensing (GDL) is a system developed to phase in new adolescent drivers to full driving privileges as they become older and develop their driving skills. Inexperienced drivers simply do not have the skills required for dealing with complex on road situations. Research indicates that graduated driver licensing programs have reduced crashes among new adolescent drivers. The rate for fatal crashes among 16 year olds reduced from 23.9 (per 100,000) in 2003 to 7.8 in 2013, and in 17 year olds fatal crashes reduced from 33.2 in 2003 to 12.5 in 2013. (Insurance Institute for Highway Safety/National Highway Traffic Safety Administration, 2015). All 50 States had some GDL components in place. The laws in 49 states do not allow driving during certain nighttime hours. Laws in 45 states limit the number of passengers allowed with a driver with a provisional license. (http://www.iihs.org/iihs/topics/laws/graduatedlicenseintro, 2016). Several studies document and support that nighttime and passenger GDL restrictions reduce teenage driver crashes and injuries. Also, studies show that states with more strict GDL law have a greater reduction in fatal crashes among novice drivers.

Seat belt use in 2015 in the United States ranged from 69.5 percent in New Hampshire to 97.3 percent in California and Georgia according to the National Highway Traffic Safety Agency (NHTSA). The National Occupant Protection Use Survey (NOPUS) in 2015 found that seat belt use for occupants in heavy traffic increased significantly from 89%

in 2012 to 91% in 2015. Seat belt use for occupants in the Northeast has increased significantly from 80% in 2012 to 88% percent in 2015. Also seat belt use continued to be higher in the States in which vehicle occupants can be pulled over solely for not using seat belts ("primary law States") as compared with the States with weaker enforcement laws ("secondary law States") or without seat belt laws.

Among adolescent drivers, those at especially high risk for motor vehicle crashes are:

- Males: Between 2005 and 2014, the motor vehicle death rate for male drivers and passengers ages 16 to 19 were more than two times that of their female counterparts (CDC WISQARS)
- Adolescents driving with passengers their same age: The presence of adolescent passengers increases the crash risk of unsupervised young drivers. This risk increases with the number of adolescent passengers
- Newly licensed adolescent: Crash risk is particularly high during the first months of licensure

In the ten year period from 2005-2014, CDC-WISQARS data reports motor vehicle crashes were the number one cause of fatalities for New Hampshire's adolescents ages 10 to 24. They are also a leading cause of emergency department visits and hospitalizations for this age group. Serious disabling injuries from motor vehicle crashes are common and include traumatic brain injuries than can have a lifelong effect on cognitive ability. Not wearing one's seatbelt is also cause for alarm. The use of a seatbelt is the most effective action to protect oneself from serious injury and death in a roadway crash. The Injury Prevention Advisory Council (IPAC) works closely with collaborative efforts to increase seat belt use among teens. See the NH State Injury Prevention Plan for more details: http://www.dhhs.nh.gov/dphs/bchs/mch/documents/nh-injury-prevention-plan-2014-2018.pdf

Many things make adolescents particularly vulnerable to getting into and getting hurt from motor vehicle crashes, including, but not limited to, their lower use of seatbelts, and their greater likelihood to speed and to underestimate dangerous or hazardous situations (see Figure 6).

Figure 6.

Teen Occupant Injuries, Age 15-19 New Hampshire

Table 5a: Teenage Motor Vehicle Occupant Deaths and Hospitalizations

	Deaths[1] (2009-2013)	Deaths[1] per 100,000	Hospital Admissions[2] (2012)	Hospital Admissions[2] per 100,000	Total Hospital Days	Median Hospital Days
Total Occupants	*	*	n/a	n/a	n/a	n/a
Vehicle	46	9.87	n/a	n/a	n/a	n/a
Motorcycle	*	*	n/a	n/a	n/a	n/a

Table 5b: Restraint and Helmet Use of Teen Occupants Killed in Crashes[1]

Vehicle occupants not restrained	71.4%
Motorcycle riders not wearing a helmet, or wearing non-DOT-compliant helmet	33.3%

Table 5c: Alcohol Involvement in Crashes Where a Teen Occupant is Killed[1]

Any driver reported by police as alcohol-involved	34.7%
Teen driver of teen killed reported by police as alcohol-involved	24.5%

Table 5d: Driver Cell Phone Use in Crashes Where a Teen Occupant is Killed[1]

Drivers reported using a cellphone (2010-2013)	2.6%

Data Sources: Population counts from the U.S. Bureau of the Census. [1] Fatal Analysis Reporting System, 2009-2013, National Highway Traffic Safety Administration. [2] State Inpatient Databases, 2012, Healthcare Utilization Project, Agency for Healthcare Research and Quality.

* = Less than 10.

n/a = Not available.

Source: Children's Safety Network State Fact Sheets, Children's Safety Network Economics and Data Analysis Resource Center (CSN EDARC), at the Pacific Institute for Research and Evaluation (PIRE), Calverton, MD, April, 2016. https://www.childrenssafetynetwork.org/sites/childrenssafetynetwork.org/files/New%20Hampshire2016.pd

Systems Building/MCH Specific Activities

MCH staff, particularly in the Injury Prevention Program, are continuing to support efforts on novice adolescent driving such as the NH Teen Driving Project. The primary goals of this effort include assisting participating teens in understanding the true risks associated with their driving in-experience and to educate their parents and participating community members in their understanding of these same risks. Peer Lead Teen Drive Safety Programs: The NH Teen Driving Committee, which MCH's Injury Prevention Program co-leads, oversees the NH Teen Driving Project (NHTDP). The NHTDP's primary goals include assisting participating teens in understanding the true risks associated with their driving experience and to educate their parents and participating community members in their understanding of these same risks. The program also attempts to change the "driving culture" for New Hampshire's teens by making it socially unacceptable, through peer to peer evidence based education, for them to drive while distracted or impaired, to speed or to not wear their seat belts. The program also includes working towards both strengthening and understanding the State's Graduated Drivers Licensing laws. Graduated

Drivers Licensing or GDL involves stepped licensing of novice drivers and has been proven to be effective in reducing the number of crashes and fatalities. Bonds with parents are also stressed as this is also an evidence based practice, particularly with the use of contracts between parents and novice drivers.

The Teen Driving Committee (TDC) will continue oversight of the NHTDP. Schools, once vetted for participation and chosen, will facilitate initial observational seat belt surveys. The current fifteen schools will continue to implement the Teen Driving Project (e.g. the teen seat belt usage project). This will include the identification of a staff champion/mentor to work with the peer-to- peer student highway safety teams. Student led assemblies, implementation of safety activities developed by students themselves, and various other projects using different learning strategies took place in the schools during the 2015-2016 and 2016-2017 academic years.

The TDC will continue to partner with the Department of Transportation, the Department of Education and the Brain Injury Association in order to implement the *Parent's Tool Kit* created in 2015 ((http://nhparentsofteendrivers.com/). The Purpose of this website is to assist in the development of new drivers. The website offers information and training for parents, teen drivers, educations, and communities. Resources and statistics are also available.

The TDC completed its NH Seat Belt Challenge 2015. Twenty-five New Hampshire high schools took part in this event. Schools competed to safety and seat belt skill checks in order to be crowned New Hampshire safest teen driving school. On May 14, 2015, the NH Highway Safety Agency, in cooperation with the Injury Prevention Center at Dartmouth, hosted the twenty- second annual Seat Belt Challenge. Twenty five teams representing high schools and driver education programs throughout the state participated. Since this statewide seat belt challenge event, the Buckle Up NH coalition has spent significant time researching and discussing options to improve the educational potential of this event. At minimum, during 2016 participating schools will be required to conduct in-school seat belt educational programs before the statewide challenge. Also, each of the participating school will be required to conduct pre and post seat belt observational surveys. The data from these surveys will be used to guide future program enhancements. Since the activities have had a positive response, they will continue to be offered in 2016-2017and 2017-2018 academic years.

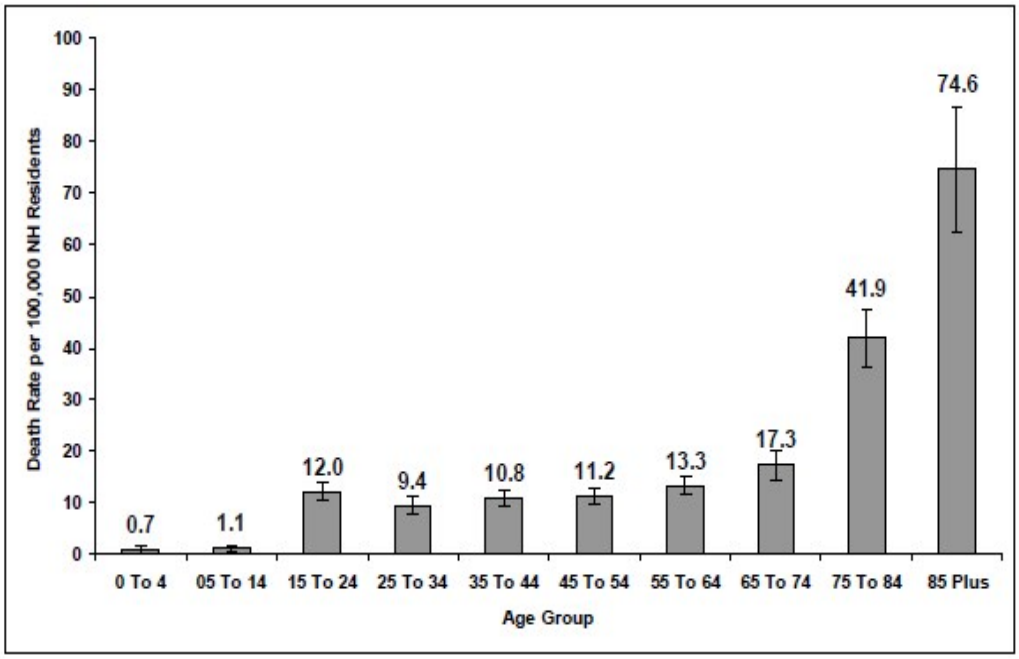
The TDC and the New Hampshire Drivers' Educator Association will co-facilitate a survey on the current status of parent information meetings during the course of driver education. Questions will not only include if a parent meeting is taking place, but what types of information are shared. Parent information meetings are not mandated under State rules, just encouraged. However, integrating parents into their children's learning to drive is a best practice.

Concussion

Data Analysis

The *Traumatic Brain Injury Occurrence and Mortality in New Hampshire* Report by NH DPHS, Injury Surveillance Program September 2012 showed the impact of Traumatic Brain Injury (TBI) in NH. Below are some tables from that report:

TBI-Related Age-Specific Death Rates, 2001 – 2009



ED Discharges for TBI, Occurrence by Age and Year, 2001-2009

Age Group	2001	2002	2003	2004	2005	2006	2007	2008	2009
0 To 4	845	810	825	828	885	1,051	1,065	1,084	1,415
05 To 14	1,141	1,114	1,085	1,198	1,286	1,355	1,363	1,351	1,886
15 To 24	1,514	1,607	1,745	1,904	2,099	2,222	2,439	2,273	2,740
25 To 34	765	802	790	826	946	972	1,087	1,112	1,276
35 To 44	806	808	884	844	934	947	1,051	981	1,191
45 To 54	514	549	570	612	734	886	984	996	1,233
55 To 64	262	257	369	430	458	502	624	726	770
65 To 74	231	204	290	275	327	359	442	500	596
75 To 84	244	256	310	370	473	457	536	605	685
85 Plus	192	149	188	234	349	351	397	430	514
Total	**6,514**	**6,556**	**7,056**	**7,521**	**8,491**	**9,102**	**9,988**	**10,058**	**12,306**

The death rate for TBI in age 0 to 24 is low, but the same age group has the highest number of emergency department visit by far. The age-adjusted rates for causes of injury, for TBI Inpatient discharges identify falls as the most common cause, followed by motor vehicle crashes. People ages 15 to 24 are more likely to have hospital stay for TBI from a motor vehicle crash. Most ED discharges for TBI are for falls of young children (ages 0 to 4) and the elderly (ages 75 and older). The second most common TBI ED discharges are for being “struck by or against” in ages 0 to 24 years, followed by motor vehicle crashes in the 15 to 24 year old age group.

Systems Building/MCH Specific Activities

Many of the causes of TBI are predictable and preventable. Prevention includes, but is not limited to:

- Wearing a seat belt every time you drive or ride in a motor vehicle.
- Never driving while under the influence of alcohol or drugs.
- Wearing a helmet while riding a bicycle, skateboard, motorcycle, snowmobile or all-terrain vehicle. Also wear head protection when you bat or run bases, ski, skate, ride a horse, or play a contact sport.
- Installing safety features in your home, such as handrails on stairways, non-slip mats in the bathtub, grab bars

in the bathroom, window guards, and safety gates on the top and bottom of stairs (especially when young children are around) to limit falls.

MCH's Injury Prevention Program will also be working with the Brain Injury Association to assess the implementation and effectiveness of NH's school concussion law, RSA 200:49-52 (http://www.gencourt.state.nh.us/rsa/html/xv/200/200-mrg.htm). The primary objective is to determine which specific elements of the law have been implemented. This includes the establishment of a concussion policy with regards to return to play and school and the distribution of information to both students and parents. Another objective is to determine what parts of the law are difficult in terms of implementation and if MCH and the Brain Injury Association can be of any help in decreasing barriers. Recommendations will be written up and brought to the Injury Prevention Advisory Council's Policy Subcommittee for any potential additional actions.

The NH MCH Injury Prevention Staff will work with the Brain Injury Association of NH (BIANH) on the following projects to develop a better understanding of the nature of brain injury and how to address it.

- A focus group during the summer of 2016 with teachers and nurses, to get more details from pilot schools specifically around Return to Learn: what's working and what's not, what further tools/training would be helpful and some additional feedback around support for NH legislation for Return to Learn. Lynne is researching this further.

- A focus group, possibly in the fall of 2016, with principals and administrators that would be partly educational (sharing concussion survey findings) with an opportunity to gauge support for NH legislation around Return to Learn

- The next step for BAINH Return to Learn legislation and develop an information campaign to raise awareness and get support for the legislation.

- Recommendations for BIANH to do more proactive speaking at professional associations and conferences, since those are top information sources on the issue of concussions – and to augment that activity with more information via push emails to BIANH's website, media features etc.

A PowerPoint presentation by Jackson Jackson & Wagner (www.jjwpr.com) shared the "Findings Brain Injury of NH 2016 School Concussion Survey," which was done on February 8-15, 2016. There were 122 respondents, a 13% response rate. Respondents included school nurses (74%), athletic directors/trainers (22%), and school principals (4%).

Key Findings

Formal Policy

In the last five (5) years, much progress has been made on adopting a formal policy on concussions in the schools. Almost 2/3rds (73%) of all respondents have a formal policy on concussions. Athletic directors/trainers report differently: 96% report a formal policy vs. 66% of nurses who do.

About half (49%) of all respondents say they've had a formal policy on concussions for 2-5years, while only 11% say they've had one over 5 years. Nineteen percent (19%) of all respondents say they still have no formal policy, only guidelines; more nurses (24%) report "guidelines only" versus athletic directors/trainers (4%)

Return to Play

More schools have a "return to play" policy than have a "return to learn" policy. Over 3/4ths of all respondents (80%) report a "return to play" policy vs. 59% of all respondents who say there is a "return to learn" policy. Athletic directors/trainers report greater compliance – 100% of them say there is a "return to play" policy, 64% say there is a "return to learn" policy. Of school nurses, 72% report a "return to play" policy, 57% report a "return to learn" policy

Baseline Testing

The majority say they have a baseline concussion testing program; 69% of overall respondents say they have baseline testing; 100% of athletic directors/trainers report this vs. 58% of nurses

Required Training

Respondents are less certain about requirements for parents, students and teachers to participate in a concussion training session than they are about the existence of policies.

Policy Followed

Athletic Director/Trainers are the most adamant that the school concussion policy is strictly followed.

- 33% of all respondents say the policy is followed with absolutely no exceptions compared to 76% of Athletic Director/Trainers and 21% of nurses.
- Concussion policies are more strictly followed by schools "over 500" 48% vs. 24% "251- 500" and 21% "under 250"

Reasons Not Followed

When asked what prevents the concussion policy from being followed consistently, all respondents agree the top 2 reasons:

1) “Students are not honest about how they are feeling” and

2) “Lack of communication between parents, students, teachers and coaches”

Doctor notes are mentioned as a key reason for “exceptions” to the policy. It is noted that policy doesn’t apply to concussions that occur outside of the school.

Sources of Info

The top two (2) sources for all respondents for information on concussions are "professional conferences" (78%) and "subject matter expert organizations" (42%). The "CDC" comes to mind more frequently (21%) than the "Brain Injury Association of NH" (5%).

Sources of Information on Concussions	
Professional Conferences	78%
Subject Matter Experts/organization	42
CDC	21
School Handbook/Website	21
Other	16

When presented with a list of potential resources for information on the topic of concussions and brain injury, the CDC (38%) and the Brain Injury Association of NH (17%) were the most frequently-selected by all respondents.

Use of BIANH

Only slightly more than 1/5th of all respondents (22%) say they have ever contacted BIANH to get information on concussions. Of those, the top 2 most frequent behaviors by all respondents are “visit the website/download information about concussions” (35%) or “attend a workshop sponsored by BIANH” (24%).

	Yes	No	Not sure Don't know
Visited website	35.0%	54.0%	11.0%
Called for info	10.0	83.0	7.0
Invited to speak	8.0	85.0	7.0
Attended a workshop	24.0	65.0	11.0
Worked with on Baseline Testing	8.0	85.0	7.0

State Law

Almost 3/4ths (72%) of all respondents are aware of NH's state law 200:49-52 on Head Injury Policies for Student Sports and about 2/3rds (66%) say they would be very likely to support strengthening the NH state concussion law.

- Athletic directors/trainers have a higher level of awareness about the state law (84%) than nurses (68%)
- Nurses are even more likely than athletic directors/trainers to support strengthening NH's state concussion law. 92% of nurses are "very" or "somewhat" likely to support it vs. 84% of athletic directors/trainers

Aware of NH's state law 200:49-52 on Head Injury Policies? (Q12)	
Yes	72.3%
No	23.2
Don't know/not sure	4.5

Likelihood of supporting strengthening NH concussion law (Q13)	
Very Likely	66.1%
Somewhat likely	24.1
Not very likely	2.7
Not likely at all	1.8*

There is a small percentage of all respondents (5%) who say they are not likely to support strengthening the law and point to several reasons, including "consider each on a case-by case basis", "already strict enough", "should cover more than sports injuries" and "State shouldn't be involved".

Would you support a return to learn policy as a way to strengthen NH's state concussion law?	
Yes	85.7%
No	1.8
Don't know/not sure	12.5

A vast majority (86%) of all respondents say they would support a "return to learn" policy as a way to strengthen NH's concussion law.

[1] National Survey of Children's Health. NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved [mm/dd/yy] from www.childhealthdata.org.

[2] https://mchb.tvisdata.hrsa.gov/PrioritiesAndMeasures/NationalPerformanceMeasures (accessed 6/3/16)

[3] Office of Medicaid and Business Policy. Medicaid Quality Program. NH Medicaid Quality Website. Report generated on Jun 29 2016 at 09:25. [http://medicaidquality.nh.gov]

[4] ** Fatality Analysis Reporting System (FARS), http://www-nrd.nhtsa.dot.gov/departments/nrd-30/ncsa/STSI/33_NH/2014/33_NH_2014.htm, **NH Department of Highway Safety*

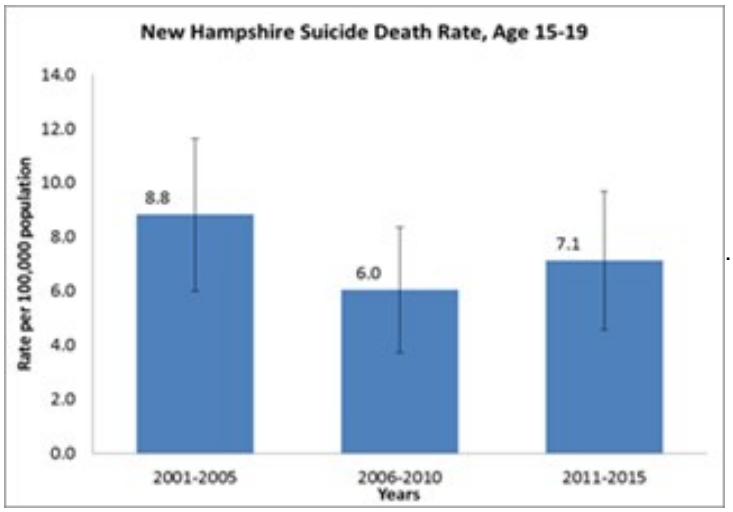
Adolescent Health - Annual Report

National Performance Measures 2011-2015

National Performance Measure #16:
Rate (per 100,000) of suicide deaths among youths age 15-19

Data Analysis

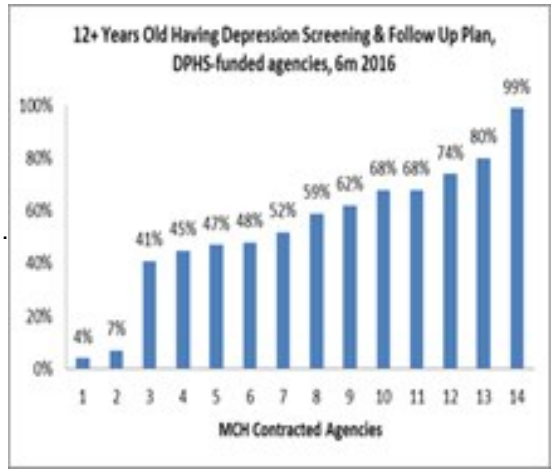
The count of suicide deaths among youth age 15-19 averages about seven (7) per year; this count is too low to generate statistically sound annual rates. The graph below represents rates based on 5-year aggregations.



Primary Care data is being reported to MCH twice per year (January & July). Depression screens and follow up referrals are required as a performance measure for MCH funded CHCs. The performance measure itself is below:

- Percent of patients ages 12 and older 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 (NQF 0418, UDS).

Data from the first six months of State Fiscal Year 16 (July 1, 2015 through December 30th, 2015) were reported and are shown below. With an average of 54%, the low was 4% and the high 99%, essentially all over the span.



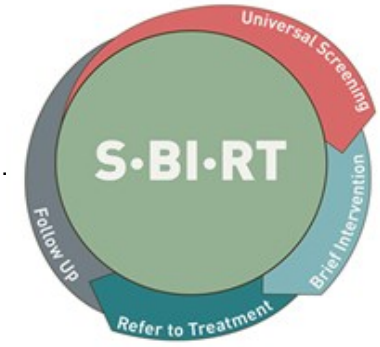
The National Violent Death Reporting System (NVDRS) grant has allowed NH to obtain additional demographics for all violent deaths, including suicide. It's a national web-based data system that collects information from the death certificate, police reports and the medical examiner. This includes items such as toxicology reports and method identification. This allows a fuller picture of the suicide to be presented, enabling prevention colleagues to zero in on risk factors.

Systems Building/MCH Specific Activities

SFY16 data is due from MCH contracted agencies July 31, 2016. An improvement is expected as agencies have had more time to educate staff, put referral mechanisms into place and work out data extraction bugs.

MCH partnered with the Medical Examiner's Office to respond to the CDC's Request for Proposals for implementation of the National Violent Death Reporting System (NVDRS). This was done in accordance with previously organized inter-departmental plans written in response to 2012 legislation, House Bill 1436. The NVDRS grant was awarded to New Hampshire and data collection for 2015 is complete.

MCH continued to monitor its funded CHCs on the integration of behavioral health and appropriate screening, referral and follow up. This included newly funded Screening, Behavioral Intervention, and Referral to Treatment (SBIRT) programs in all of the community health centers with both the Bureau of Drug and Alcohol federal funds (put into the MCH contract) and funds from the New Hampshire Charitable Foundation through the Conrad Hilton Foundation.



- SBIRT Initiative (http://sbirtnh.org/about-sbirt-initiative/)

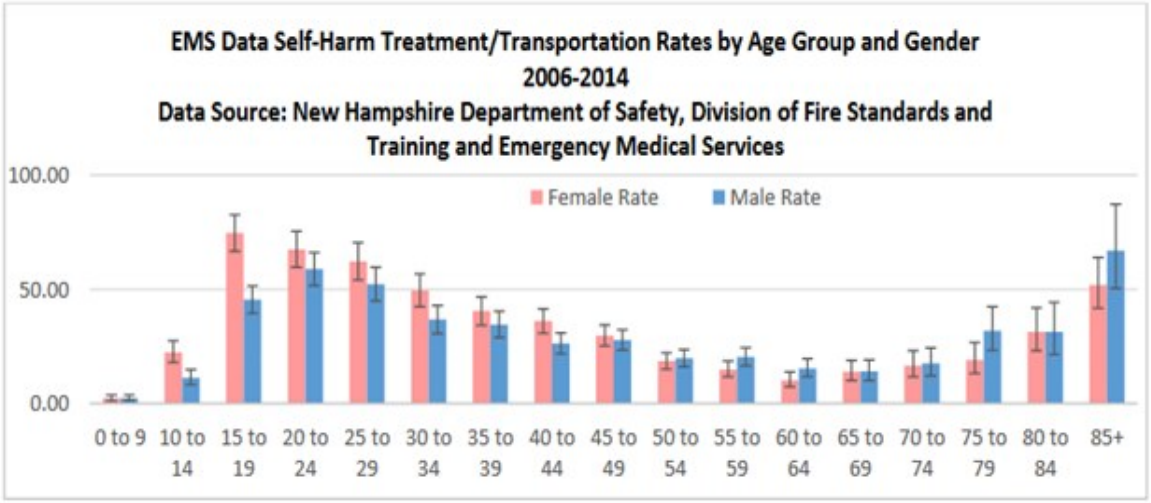
SBIRT addresses a primary goal of the statewide strategic plan developed by the Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment: *Collective Action – Collective Impact*. This

strategic plan calls for the implementation of SBIRT in primary care throughout New Hampshire as an effective prevention, intervention and public health strategy. The global aim of the New Hampshire Youth SBIRT Initiative is universal screening of adolescents and young adults in pediatric primary care practices as a proven strategy for reinforcing healthy behaviors; identifying problematic drug and alcohol use early; reducing substance misuse; and referral to treatment.

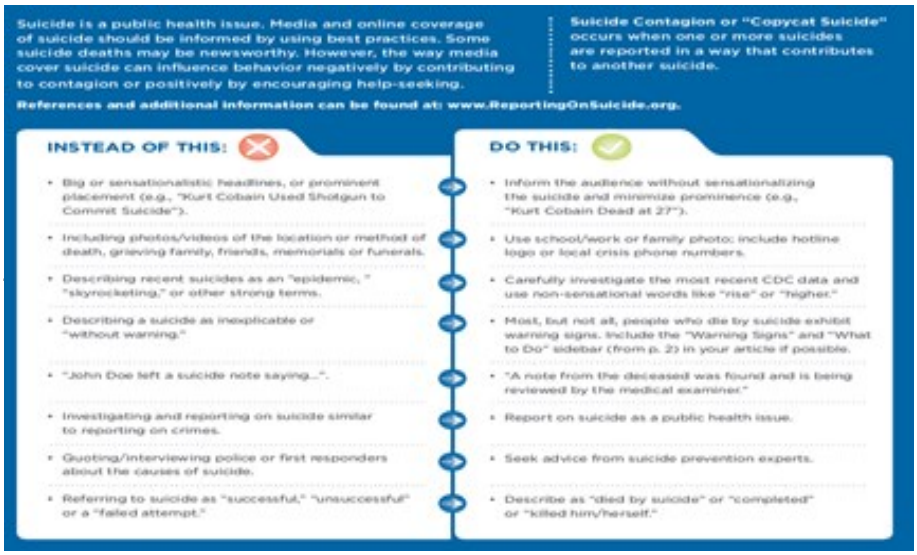
Suicide Prevention Council (SPC):

Guided by the *New Hampshire Strategic Suicide Prevention Plan* (http://www.dhhs.nh.gov/dphs/bchs/spc/documents/2013-suicide-prevention-plan.pdf), MCH continued it efforts in reducing the rate of suicide deaths through strategic partnerships with community based practitioners, advocacy, education, and policy development. This plan was developed to focus and coordinate suicide prevention efforts statewide. The SPC (http://www.dhhs.nh.gov/dphs/bchs/spc/index.htm), coordinated by the Bureau Chief for Population Health and Community Services (which houses MCH), and its partners guide and implement these activities by engaging public and private stakeholders. The plan is based on evolving best practices, as well as the strengths and constraints of the current political and economic climate. The MCH Administrator serves as the SPC Communications Subcommittee Chair and the Injury Prevention Program Manager on its Data Subcommittee. Thus, MCH and DPHS as a whole are heavily invested programmatically in suicide prevention efforts.

The SPC provides an annual report (http://www.dhhs.nh.gov/dphs/bchs/spc/documents/2014-spc-annual-report.pdf) to the Governor pursuant to statute RSA 126-R: 2. Emergency Medical Services (EMS) data, which includes individuals treated and/or transported by EMS for a self-inflicted injury, is presented in the annual report for the first time ever. The data from this source is similar to what has been seen in hospital and emergency department discharge data with females ages 15 to 24 presenting the highest rates of self-inflicted injuries, and females in general having higher rates than males.



The SPC Communications Subcommittee continued to monitor and respond to state media outlets regarding national *Recommendations for Reporting on Suicide* (http://reportingonsuicide.org/). Special emphasis was given to training first responders, who are often the media's initial call after a suicide has occurred. The Subcommittee's informal media analysis showed that reports were still listing details of the method of suicide as well as the location. By training first responders on the media recommendations and their background, it is hoped that the percentage of articles that do not contain method and location will increase.



State Performance Measures 2011-2015

State Performance Measure #6:

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

Data Analysis

The rate of emergency department visits for adolescents (15-19) in a motor vehicle crash has decreased, from 1,482.7/100,000 in 2009 to 891.3/100,000 in 2011, the last year known. This far exceeded the original objective of 1,775.0/100,000 for 2011. Part of that can be attributed to the initiatives of MCH staff and their contractor, the Injury Prevention Center (IPC) at Children's Hospital at Dartmouth.

Systems Building

The Injury Prevention Program within MCH and the co-chair the Teen Driving Committee (TDC) continued its oversight of the expanded New Hampshire Teen Driving Program (NHTDP), and enlarged the project to 15 schools in the 2015/2016 academic year. The NHTDP's primary goals include assisting participating teens in understanding the true risks associated with their driving experience and to educate parents and participating community members in their understanding of these risks. The program also attempts to change the "driving culture" for New Hampshire's teens by making it socially unacceptable, through peer-to-peer evidence based education, for them to drive while distracted or impaired, to speed or to not wear their seat belts.

The NHTDP process for participation and evaluation is as follows:

- Identify participating schools based on risk factors: YRBS, etc.
- Identify school champions
- Creation of student peer to peer program in each high school
- Guide students on determining program priorities, i.e. seat belt use, distracted and impaired driving, etc.
- Assist students in creating and presenting educational programs

- Perform observation surveys and driving culture evaluations
- Analyze survey results

Schools vetted for participation, once chosen, facilitated initial observational seat belt surveys. This included the identification of a staff champion/mentor to work with the peer-to-peer student highway safety teams. Student led assemblies, implementation of safety activities developed by students themselves, and various other projects using different learning strategies took place in the schools during the 2014/2015 and 2015/2016 academic years.

The Peer to Peer Observational Seat Belt Survey Analysis from the NHTDP showed that between 2012/2013 (the academic year the program started) and 2015/2016 academic years all schools conducted unannounced observational seatbelt use surveys at the beginning and at the end of the academic year. Of those schools, 83% showed an increase in seatbelt usage. Pre-intervention surveys ranged from 49% to 90% seatbelt usage. Post-intervention surveys ranged from 55% to 90% seatbelt usage. During the school year, many schools were forced to cancel teen driving assemblies and activities to address the state opioid problem. The loss of these opportunities had a direct impact on reaching the goal of 8%. The 5% increase in seatbelt use was partly due to administrative and student champions who used some different outreach techniques to get the entire student body involved in the process. Seatbelt Safety Day and Safety Awareness Week are a few examples of activities developed to increase seatbelt usage. During Seatbelt Safety Day, students shared stories of their safety concerns, discussed why seatbelt usage is so important, the consequences of not wearing a seatbelt, and the proper use of seatbelts. Safety Awareness Week provided students the opportunity to be creative in illustrating their vision of the importance of seatbelt usage. Students created posters, signs, and other forms of messaging, which were displayed throughout the school.

One strategy for encouraging schools to continue their participation in the Teen Driving Project was to provide them with data on the progress made in their respective schools. For example, one school, John Stark Regional High School, which started at a baseline of 70% student seatbelt usage, increased their numbers to 81.3% usage as of June 2015. This increase in student seatbelt usage illustrates success and fosters support for the NHTDP.

The Winnipesaukee Public Health Network, one of the 13 Regional Public Health Networks in the state, partnered with Belmont High School in support of the NHTDP under the auspices of its Students Against Destructive Decisions club (SADD). This club was established to address and evaluate students' current knowledge of high-risk driving behaviors and provided them with the tools to implement safe driving skills. Over 16 students volunteered to be a part of this club and developed activities throughout the school year, which raised awareness of driving and safety issues. Also, Winnipesaukee Public Health Network sponsored some national speakers that presented to Belmont High School students on safe driving. Posters with driver safety messaging were placed throughout the school, which saw to a 6% increase in student seatbelt usage from January 2015 to June 2015.

The TDC partnered with the DOT, DOE and the Brain Injury Association in order to design and create the *Parent's Tool Kit* (http://nhparentsofteendrivers.com/) in electronic format. The purpose of this website is to assist in the development of new drivers; it offers information and training for parents, teen drivers, educators, and communities. Resources and statistics are also available. Utilization of the *Parent's Tool Kit* website from June 2015 to September 2015 included 524 sessions by 462 users, and 610 page views.

A Seat Belt Challenge event was held on May 17, 2016 involving 22 schools and 96 teens; it was held in cooperation with the NH Highway Safety Agency and the IPC. Participating schools conducted in-school seat belt educational programs before the statewide challenge. Each participating school was required to conduct pre and post seat belt observational surveys. The data from these surveys can be used to guide future program enhancements. Ninety-four percent of the students participating in the Seatbelt Challenge reported through a

post-event survey that the event “exceeded” or “met” expectations. When asked, “What educational programs can we provide within your school to educate your peers about the importance of seat belt use?” students’ responses included:

- Continue the seat belt challenge
- Watch *Red Asphalt* together (a series of videos, which can be downloaded on YouTube, that have graphic details of motor vehicle crashes involving teens)
- Public speakers
- *Room to Live* presentation (a presentation by the IPC on the importance of seatbelts)
- Have a teen come and talk about how their life changed after an accident

Before coming to the Seat Belt Challenge, 77 students (80% of all respondents) reported wearing a seat belt all of the time. Of the 19 students who did not wear their seat belts all the time, 100% of them stated that after the event, they now understand the importance of wearing them. Seventy-four percent (74%) of the students support a seat belt law in NH for people 18 years old and over. Legislation RSA 265:107-a requires seat belts for all adolescents below the age of 18. This is a primary law, which means that law enforcement can stop and potentially issue a citation solely based on the wearing of a seat belt. However, New Hampshire has no law, primary or secondary (have to stop a person for another reason-fast driving, etc.), for seat belt use for those 18 and over.

The NH Youth Risk Behavior Survey (YRBS) reports 91.8% seatbelt usage in 2015. YRBS data is self-reported, and teens may be exaggerating their usage to meet perceived expectations.

Year	Percent	Lower 95% CIi	Upper 95% CI
2005	87.0	84.0	89.5
2007	88.3	85.6	90.5
2009	87.1	84.3	89.5
2011	89.3	86.9	91.3
2013	90.3	88.1	92.1
2015	91.8	91.2	92.5

The TDC and the New Hampshire Drivers' Educator Association co-facilitated a survey on the current status of parent information meetings during the course of driver education. Questions not only included if a parent meeting was taking place, but what types of information were shared. Parent information meetings are not mandated under State rules, just encouraged. However, integrating parents into their children's learning to drive is a best practice. Result from this survey from March 2016 showed that 89% of NH driver’s education courses (16 of 18 respondents) held a parent night. Thirteen respondents (13 of 15, 87%) stated that this event is mandatory for parents of driver’s education students. Nine (9 of 15, 60%) stated that students were required to attend with their parent.

Responses to the types of information on the parent night agenda included:

- Expectations of driver education class: 16 - Yes
- Class syllabus: 12 – Yes 2 - No
- Driving logs: 16 – Yes
- Graduated licensing (GDL) concepts: 16 – Yes
- Parent teen driver agreements (another best practice): 13 – Yes 3 – No
- Division of Motor Vehicle (DMV) handbook : 14 yes

Instructors also review distracted driving, teen issues, friends, texting, drugs, drinking, and statistics. They stated that making parent attendance mandatory greatly improves their attendance and shows a positive changed in the parents' attitudes about drivers' education. Mandatory attendance also conveys the idea of creating a three-way partnership (teacher, parent, and student) to provide for a life-time of safe driving.

MCH Specific Activities

The State Health Improvement Plan (SHIP) contains a section on injury prevention, which includes an emphasis on teen driving issues along with a long term objective consistent with the MCH indicator on emergency department visits. During the SHIP planning process, input was sought from partners from the diverse sectors, agencies and organizations that address population health. Using that input, the state public health system identified 10 priority areas for improvement with measurable objectives and targets for health outcomes, areas for needed attention in public health capacity, and recommendations for evidence-based interventions and actions. The NHSHIP priorities and objectives are intended to provide support, guidance, and focus for public health activities throughout the state. Injury Prevention is one of these priority and teen driver safety was identified as an important focus area within that priority.

New Hampshire was selected, under the leadership of MCH, to become part of the Child Safety Collaborative Improvement & Innovation Network (CoIIN) out of the Children's Safety Network. Through the Child Safety CoIIN MCH is working with the TDC on a team approach to increase the adoption of teen motor vehicle related evidence-based policies, programs, and practices. The MCH Administrator is on the Child Safety CoINN's National Advisory Committee. The CoIIN is a 12- to 18-month process.

The State's role throughout the CoIIN is to:

- Participate in three (3) Learning Sessions
- Motivate stakeholders to engage and work collaboratively
- Review strategy team monthly reports (about two hours/month)
- Periodically attend strategy team meetings
- Communicate CoIIN progress with related state agencies and departments
- Plan to spread successful changes

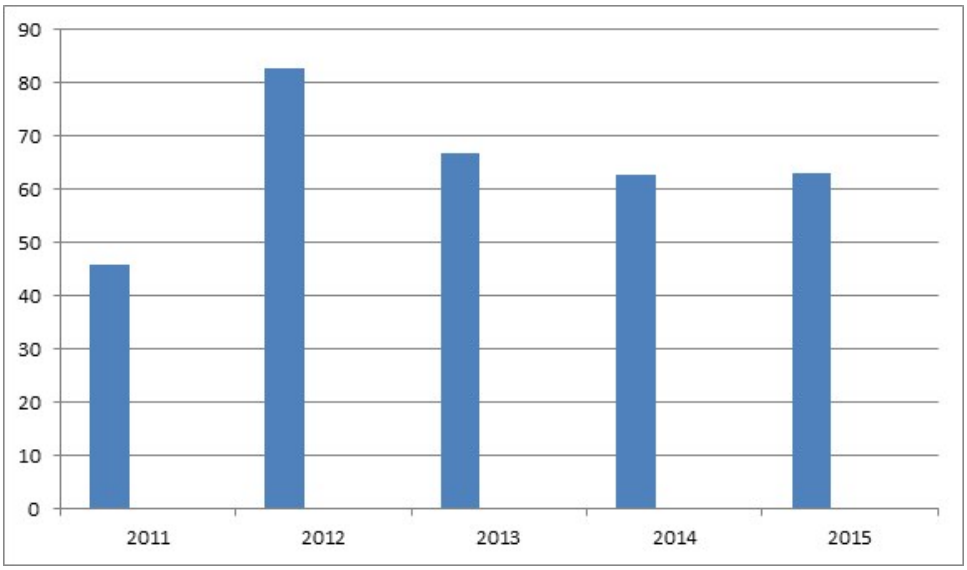
Participation in CoIIN required the development of a goals, objectives and activities. These are consistent with the ESM for the injury NPM under the MCH Block grant. Activities with the CoINN are tracked using Plan-Do-Study-Act (PDSA) cycles. All of this information is kept on the Children's Safety Network website so progress can be reviewed and shared with other's participating in CoIIN. Learning opportunities, successes and barriers can also be shared nationwide with other CoIIN participants on monthly conference calls and webinars.

State Performance Measure #1:

Rate of psychotherapy visits for adolescents ages 12-18 years who have a diagnosed mental health disorder

Data Analysis

The outcome of this measure is 2015 is significantly higher than the baseline in 2011, but has really stagnated over the past three (3) years.



This may be attributed to New Hampshire's struggle to keep up with the growing need for psychiatric care, particularly in the field of pediatrics (and even within the field specializing in adolescents), of its residents. A mental health strategy report out of DHHS found that declining Medicaid funding and lack of available inpatient alternatives were significant barriers to obtaining treatment.[1]

Systems Building

New Hampshire is also in the midst of trying to implement changes to the mental health system necessary to meet the terms of a class action lawsuit, *Amanda D, et al. v. Hassan, et al. 2014*. Many of these changes focus on enabling a class of adults, not children nor adolescents, with serious mental health illness to receive needed services in the community through the use of mobile crisis teams amongst other strategies. However, the recently received Medicaid/CMS 1115 DSRIP Waiver (described previously) has as one of its goals to expand the behavioral health workforce, thereby increasing access to services for Medicaid enrollees in the state, of which children, including adolescents, comprise the majority of cases. MCH staff have been actively involved in all DSRIP activities including a second goal which focuses on the integration of behavioral health into primary care.

MCH Specific Activities

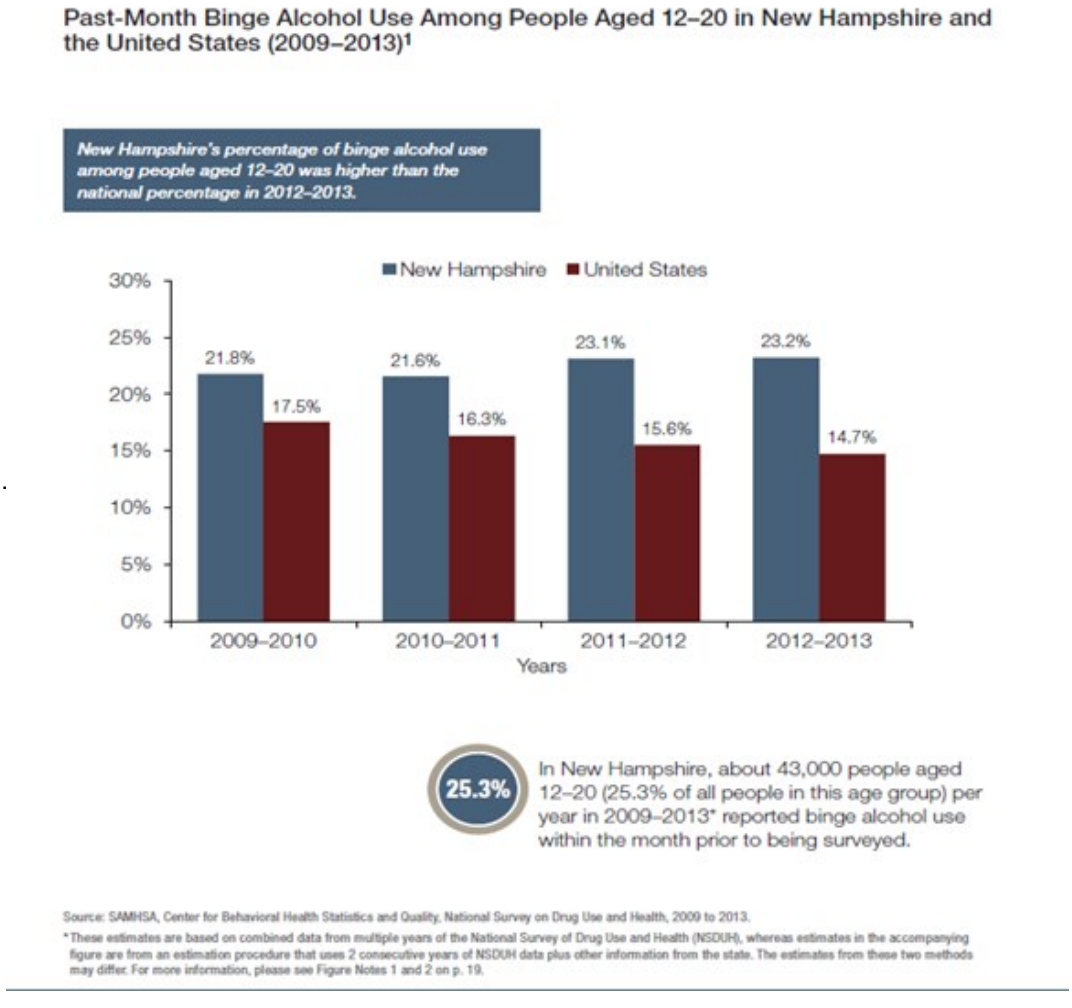
MCH staff also has been working with the Children's Behavioral Health Collaborative (CHBC) on the implementation of "*Transforming Children's Behavioral Health Care: A Plan for Improving the Behavioral Health of New Hampshire's Children*". The MCH Administrator is part of the CHBC's Workforce Development Network, which develops and delivers cross-disciplinary education and training activities for professionals who work with children and adolescents with behavioral health issues. The mission of this workgroup is to ensure a "highly effective diverse workforce by building a sustainable, responsive and effective cross sector system of workforce development". [2] The workgroup has developed: 1)

children's behavioral health core competencies; 2) online training modules on topics related to children's behavioral health; 3) cross-walked the core competencies with undergraduate and graduate programs in behavioral health in the state and 4) a system and selection of a wraparound model of services.

State Performance Measure #3:
Percent of 18-25 year olds reporting binge alcohol use in the past month

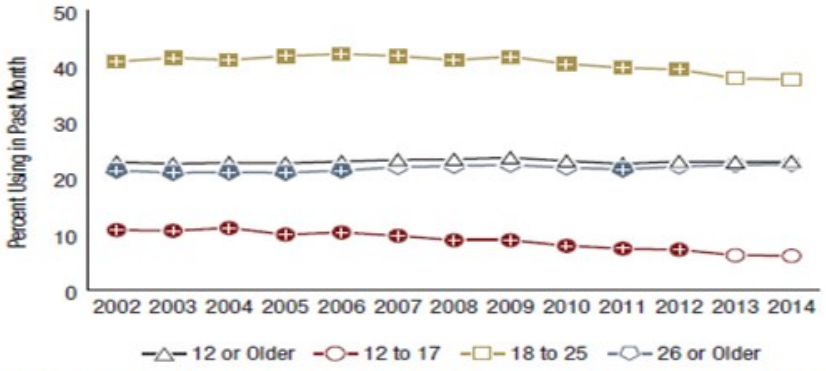
Data Analysis

According to the most recent National Survey of Drug Use and Health, 23.2% of NH's 12-20 year olds reported binge drinking in the past 30 days, which has been consistently higher than the national average. [3]



Nationally, 18-25 year olds have the highest percentage of binge drinking[4].

Figure 26. Past Month Binge Alcohol Use among People Aged 12 or Older, by Age Group: Percentages, 2002-2014



+ Difference between this estimate and the 2014 estimate is statistically significant at the .05 level.

Figure 26 Table. Past Month Binge Alcohol Use among People Aged 12 or Older, by Age Group: Percentages, 2002-2014

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
12 or Older	22.9	22.6	22.8	22.7	23.0	23.3	23.4	23.7	23.1	22.6	23.0	22.9	23.0
12 to 17	10.7+	10.6+	11.1+	9.9+	10.3+	9.7+	8.9+	8.9+	7.9+	7.4+	7.2+	6.2	6.1
18 to 25	40.9+	41.6+	41.2+	41.9+	42.3+	41.9+	41.2+	41.8+	40.5+	39.8+	39.5+	37.9	37.7
26 or Older	21.4+	21.0+	21.1+	21.0+	21.4+	22.0	22.2	22.4	21.9	21.6+	22.1	22.4	22.5

+ Difference between this estimate and the 2014 estimate is statistically significant at the .05 level.

Systems Building/MCH Specific Activities

MCH has collaborated for many years with the Bureau of Drug and Alcohol Services (BDAS) to disseminate public education materials and messages, such as BDAS Resource Guide for Promoting Prevention and Recovery, to youth, families, and individuals served by its programs and systems.

In the Manchester community, Project LAUNCH focuses on promotion and prevention activities including validated screenings such as those for parental/family alcohol use, depression and child development. As the local pilot lead, the Manchester Community Health Center contracts with several agencies to coordinate and expand screening in a range of child-serving settings.

Workforce development activities in the childhood system increased staff knowledge about screening and appropriate referral services for alcohol and other substance abuse. Through a contract with Community Health Institute (CHI), MCH used ECCS funds to provide a Train-the-trainer program focused on Trauma Informed Care and 663 childhood service providers were trained. The goal of this program was to increase awareness of the impact of toxic stress on brain development and thus the potential for long-term consequences for young families experiencing trauma.

MCH facilitates a statewide partnership that examines and analyzes data about prescription drug and other opioid use during pregnancy and its impact on babies. Some objectives and strategies for this partnership may have crossover impact for the population of young adults binge drinking.

Through a collaborative contract with MCH, NH's Division for Children, Youth, and Families procured a contact with family resource centers, statewide, to provide Comprehensive Family Support Services. One of the services provided through these contracts is home visiting to pregnant women, their infants and families. Additional home visiting services are available to help promote healthy development of children through the teen years. They also facilitated identification and evaluation of programs/services, using the North Carolina Family Assessment Scale General for families experiencing conditions that include, but are not limited to history of, or current, parental or caregiver substance abuse.

The Family Resource Center of Gorham currently serves both Coos and Grafton counties. They have engaged a

Fetal Alcohol Spectrum Disorder (FASD) trainer to bring further awareness to the importance of talking to pregnant women and those of childbearing age about how any alcohol exposure in utero can negatively affect a child's development. The Community Action Partnership of Belknap/Merrimack (CAP Belknap) counties has a Memo of Understanding (MOU) with Horizons Counseling Center, the communities organization that provides comprehensive, confidential and affordable outpatient treatment and referral services to individuals and families dealing with substance use and co-occurring mental health disorders. CAP Belknap also has a MOU with Genesis Behavioral Health, the community mental health center. Staff from this and other home visiting local implementing agencies (LIAs) have attended training around substance use and identified this as an area of importance regarding staff development. This LIA also refers families to organizations and support groups such as Stand up Laconia, NA, AA, and Families Sharing without Shame.

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[1] NH DHHS, *Addressing the Critical Mental Health Needs of New Hampshire's Citizens, A Strategy for Restoration*. http://www.dhhs.nh.gov/dcbcs/bbh/documents/listeningsessions.pdf accessed on 07/06/16.

[2] New Hampshire Children's Behavioral Health Collaborative, Workforce Development Network. http://www.nh4youth.org/collaborative/workgroups/workforce-development-network accessed 07/06/16.

[3] Substance Abuse and Mental Health Treatment Administration, *Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health*. http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf accessed 06/21/16.

[4] Substance Abuse and Mental Health Treatment Administration, *Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health*. http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf accessed 06/21/16.

Children with Special Health Care Needs

State Action Plan Table

State Action Plan Table - Children with Special Health Care Needs - Entry 1

Priority Need

Increase access to comprehensive Medical Homes.

NPM

Percent of children with and without special health care needs having a medical home

Objectives

To increase from 48.2% (2011-12 FAD baseline) to 60.0% the percent of children with special health care needs having a medical home by 2020

Strategies

Improvement of Family Partnerships with primary care providers

Collaboration with the NH Pediatric Improvement Partnership

Support and advocacy of embedding Medical Home components into Medicaid Care Management contracts/quality indicators

Outreach and education to the public and providers to improve Medical Home awareness and understanding

Support for integrated care coordinator including planning and support for transition

Facilitate incorporation of the evidence informed six core elements of transition into medical homes, in accordance with Got Transition™ recommendations

ESMs

ESM 11.1 - The number of Primary Care Provider practices who have adopted a Transition Policy

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM 19 - Percent of children in excellent or very good health

NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

NOM 22.2 - Percent of children 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 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

State Action Plan Table - Children with Special Health Care Needs - Entry 2

Priority Need

Increase family support and access to trained respite and childcare providers.

SPM

Percentage of families enrolled in SMS who report access to respite

Objectives

To increase the number of families reporting access to respite care when needed from 61% to 66%, on the SMS Satisfaction Survey, by 2021

Strategies

Facilitation of the Statewide Respite Coalition

Ongoing support and public awareness of NH respite provider locator (web based)

Analysis of available data to support policy development and support for respite

Measures

NPM 11 - Percent of children with and without special health care needs having a medical home

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	49	49	50	55	60	65

Data Source: National Survey of Children's Health (NSCH) - CSHCN

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	48.2 %	3.5 %	27,555	57,176
2007	54.6 %	3.3 %	34,822	63,725

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH) - NONCSHCN

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	71.4 %	1.7 %	153,485	215,060
2007	73.5 %	1.5 %	164,642	223,934

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 11.1 - The number of Primary Care Provider practices who have adopted a Transition Policy

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	10.0	15.0	20.0	25.0	30.0

Children with Special Health Care Needs - Plan for the Application Year

National Performance Measure #11:
Percent of children with and without special health care needs having a medical home

Evidence Based or Informed Strategy Measure:
Number of Primary Care Providers who have adopted a Transition Policy

Data Analysis

The data for this indicator, related to CSHCN, comes from the 2009/2010 National Survey of Children with Special Health Care Needs (NS-CSHCN). The NS-CSHCN was a telephone survey led by the National Center for Health Statistics at the Centers for Disease Control and Prevention under the direction and sponsorship of the federal Maternal and Child Health Bureau (MCHB). The survey is currently being integrated into the National Survey of Children's Health. Because data from the new NSCH is not yet available NH continues to report 2009/2010 results. NH has generally performed well on the Medical Home measure for CSHCN, in comparison to the national numbers. The areas of coordination and communication have fallen below the national average. For NH CSHCN only 20.6% of parents reported that they received any help with arranging or coordinating care and only 51.1% were satisfied with communication between doctors and school, when needed.[1]

The NS-CSHCN results for NH identified a significant need particularly related to youth getting support from their Medical Home to assist with successful transition to adult care. Only 49% of NH's youth, age 12-17 years, indicated that their doctors usually/always encourage increasing responsibility for self-care and (when needed) have discussed transitioning to adult health care, changing health care needs, and how to maintain insurance coverage. Pairing efforts to facilitate greater access to Medical Homes with improved attention to transition needs is an appropriate and effective approach.

The data for children without special health care needs comes from the 2011/2012 National Survey of Children's Health. In NH, 56.3% of the parents surveyed, reported that care meets the criteria for having a medical home.[2]

Systems Building

For the ninth consecutive year, Medical Home development efforts for CYSHCN are being supported with a contractual arrangement funded by SMS. NH Family Voices is the vendor awarded this contract. NHFV has a history of involvement in statewide activities supporting medical practices' efforts on quality improvement. The coming year's efforts will focus on integration of medical home development and collaboration with State Stakeholders and assisting practices with improvement that is in keeping with the principles of a patient and family-centered, effectively coordinated, medical home.

Improvement of Family Partnerships with primary care providers

NHFV has a Primary Care champion to participate in their efforts and they have secured an open invitation to the meetings of the NH AAP Chapter (NH Pediatric Society). They will continue to identify new practices to work with and to increase knowledge of the Medical Home Model via training, marketing and collaborative efforts across the healthcare system. One example is the spread of a new campaign they have created called the "Healthcare Heroes Campaign". Additional practices have requested support to use this campaign, which consists of poster and brochures of families/individuals within a practice, dressed up like superheroes, encouraging participation in the

Patient Family Advisory Committee (PFAC). Additional support and development of PFACs in other practices will continue.

Outreach and education to the public and providers to improve Medical Home awareness and understanding

NHFV will continue to act as the technical assistance center in NH for providers. They have resources and materials that will be available for phone consultation, training regarding care planning/care notebooks, education for families and professionals regarding treatment including medications, and training regarding care coordination. SMS Health Care Coordinators and the PIH Family Support coordinators will educate and support clinicians and families on the importance and use of care plans through collaborative development and management of integrated care plans. SMS will survey all enrolled families to identify their understanding of Medical Home and self-report rating, regarding their satisfaction with their child's Medical Home. As a part of the management of FACETS of Epilepsy Care in NH, SMS and NHFV will continue to focus on offering practices support and addressing the ongoing issue of defining components of care coordination for children with epilepsy, across service sectors. SMS/NHFV will significantly upgrade the supports available to practices for communication and coordination of care along with the creation of standards for a transition process, with a Medical Home emphasis. Families of children with Epilepsy will also be surveyed, statewide, to identify their awareness and satisfaction regarding Medical Homes.

Support for integrated care coordination including planning and support for transition

NH's Health Care Transition Coalition, jointly led by NH Family Voices and Special Medical Services, has an active

group of families and professionals continuously working to improve resources and information about health care transition. The current effort – just made available and poised for widespread distribution- has been well received. They produced a 5"x7" colorful card with a magnetic back that invites the holder to "Level Up" (graphics have an electronic game theme) to health care independence. It displays questions that direct the youth or the parent to think about how they are managing health care issues. With the right app the holder can use the QR icon to access our YEAH Council – youth for education, advocacy and health. That site delves more deeply into the issues facing YSHCN and also establishes a contact with a peer group.

The plan is to continue to disseminate this tool to our Title V enrolled teens, to parents, to school transition coordinators and nurses, to health care providers –anyone working with youth, especially those with special health care needs who are developing independent living skills. It was posted to the NH Department of Education special project called NextSteps-NH.org as a link and a resource. In addition the FACETS of NH project has developed a survey for youth with epilepsy (and their caregivers) for transition awareness and the quality of their transition readiness/self-management skills for their healthcare. As a follow up to these assessments education and healthcare information has been developed and shared to assist them with skill acquisition. In the coming year these approaches and tools will be reviewed for a more widespread application to CSHCN and incorporated in the Medical Home project. The Medical Home project will begin an evaluation of current NH practices that have adopted a Transition Policy and will build an outreach and awareness campaign with offered technical assistance to expand the number of practices who have adopted a policy, consistent with the recommendations of GotTransition™ as New Hampshire's ESM.

SMS' efforts regarding the development of care coordination competencies will address transition as well as increased collaboration across service providers to assure an effective system of care. SMS will also begin a process of having Health Care Coordinators and Family Support Coordinators implement new processes that will contribute to evaluation of transition readiness. There will be 2 measures that Coordinators will be asked to report on in Annual Reports. They will be asked to outreach to all enrolled CSHCN who turn 14 to begin readiness assessments and for youth who turn 21 they will be asked to report on the success rate of having identified an Adult Health Care Provider.

Collaboration with the NH Pediatric Improvement Partnership

The New Hampshire Pediatric Improvement Partnership (NHPIP) is a state-level multi-disciplinary collaborative of private and public partners dedicated to improving child health through the use of measurement-based quality improvement processes in primary care settings. This will be accomplished by:

- Promoting collaboration and communication
- Conducting results-driven QI projects
- Building the capacity of clinicians and other stakeholders to engage in pediatric QI

The NH PIP, started in 2013, is coordinated by the Institute for Health Policy and Practice at UNH, with Medical Director leadership from the Children's Hospital at Dartmouth. A Steering Committee serves in an advisory capacity to NH PIP staff, providing feedback and insight about implementation of strategic priorities and emerging needs/opportunities. The NH PIP Steering Committee is comprised of representatives from all stakeholder organizations/agencies participating in the NH PIP, MCH, SMS and NHFV are all represented on the Steering Committee.

The Medical Home Project will approach NH PIP to discuss the potential for working together to develop a MOC Part IV offering for PCPs regarding transition; this inquiry will include exploration of additional partners such as the Dartmouth Institute.

Support and advocacy of embedding Medical Home components into Medicaid Care Management contracts/quality indicators

As NH continues to evaluate and improve care provided by the contracted Managed Care Organizations progress with Bright Futures standards will be a contract reference and additional quality indicators related to CSHCN will be monitored to assure the adequacy of services provided to this population that now has mandatory enrollment. The

CSHCN Director is a participant on the Department's MCO organization review team with a variety of other DHHS members. The MCO contract language has been clarified to state that instead of requiring that MCO simply develop a plan they must now submit a written plan that describes the development, implementation and evaluation of programs to assess and support, wherever possible, primary care providers to act as a patient centered medical home. A patient centered medical home shall include all of the five key domains outlined by the Agency for Healthcare Research and Quality (AHRQ):

10.3.1.2.1. Comprehensive care;

10.3.1.2.2. Patient-centered care;

10.3.1.2.3. Coordinated care;

10.3.1.2.4. Accessible services; and

10.3.1.2.5. Quality and safety.

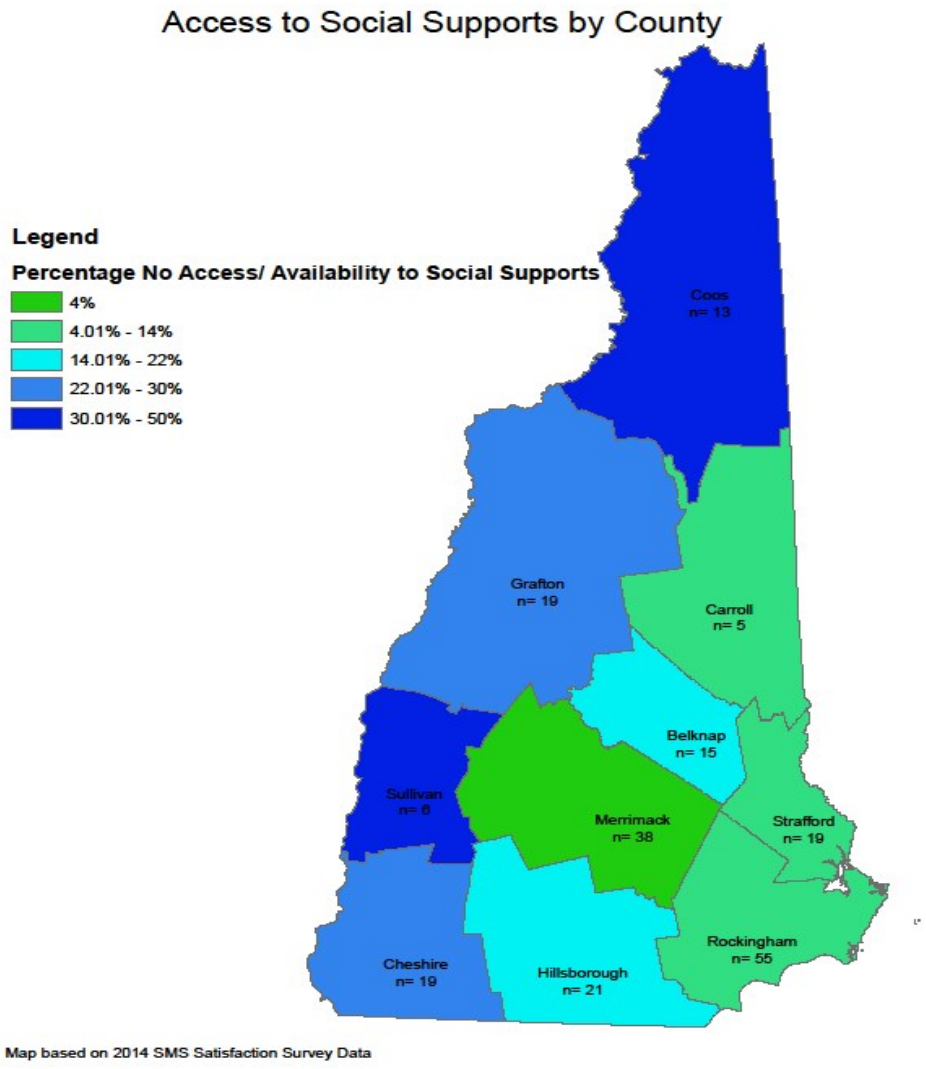
State Performance Measure #2:
Percent of families enrolled in SMS who report access to respite

Data Analysis

The data for this indicator, related to CSHCN, comes from a statewide needs assessment Respite survey completed by SMS along with a Title V CSHCN survey completed in 2014.
Following the 2010 Title V Needs Assessment respite was identified as one of the top 10 priorities. Despite a concerted statewide effort to improve respite services, it continues to be one of the least available services, with consistently high unmet need (20% or more) across SMS programs and services. There is a specifically high unmet need in the following counties with more than 1 in 4 families indicating respite was not available or accessible:

- Cheshire 25%
- Coos 26%
- Belknap 32%
- Sullivan 40%

Sullivan County had a particularly significant number of families 6 (40%) out of 15 reporting limited access to respite care. When comparing insurance providers there was no significant difference between access to respite and provider type.



Systems Building

In 2009, Special Medical Services (SMS) was the first Children's agency to be the recipient of a Lifespan Respite grant. Several agencies worked in collaboration with SMS on grant activities, including the Bureau of Elderly and Adult Services (BEAS), Bureau of Developmental Disabilities (BDS), Bureau of Behavioral Health (BBH), Division of Children and Youth and Families (DCYF), National Alliance on Mental Illness - New Hampshire (NAMI-NH), New Hampshire Family Voices (NHFV), and the College of Direct Support (CDS). Grant activities resulted in the creation of a Lifespan Respite Coalition populated by these partners and other stakeholders. The LRC Coalition to meet, monitor and guide respite efforts.

Lifespan Respite Activities

The NH Provider Link continues to provide SMS and the NHLRC Coalition data (NH respite care utilization, available trained respite providers, etc.). The training needs and opportunities for Provider training are ongoing. The application for respite provider training continues to be accessible on the http://www.nh providerlink.org/. The NH Lifespan Respite Coalition developed a role for a VISTA volunteer to meet the NH LRC Strategic Plan goal to have an Outreach Coordinator who will work with identified groups, representing a variety of local agencies/organizations,

which have identified an interest in addressing the need for respite in NH's 10 Counties. The next VISTA volunteer with be recruited in the summer/fall of 2016 to continue and expand the work done last year. SMS continues to coordinate activities for the NH Respite Program but expects the NH LRC will seek the funding through grants or other measures in coming years.

Coordination of Family Support and Respite Activities

Based on the national work, coordinated by AMCHP and the Lucile Packard Foundation that recently developed standards for systems of care for CYSHCN, NH will focus on the standards identified for respite:

- Respite service, both planned and emergency, are available to all families and caregivers of CYSHCN
- Families are informed about available respite services and helped to access them
- When out of home respite services are needed, transportation is available to help a child and family access these services
- Health providers and plans screen families and caregivers of CYSHCN for respite care needs, make them aware of available respite services in their community, and provide them with appropriate and timely referrals to providers that are qualified to serve CYSHCN
- Health providers and plans have a system in place for ensuring timely referrals for families of CYSHCN with emergency respite.[3]

Organizational placement in the states Bureau of Developmental Services allows for coordination and improvement of statewide respite services. The BDS network of Area Agencies is responsible for Family Support services including respite. The Title V CYSHCN Director has recently assumed administrative responsibility for Family Support, which lends itself to additional coordination and improvement of statewide respite services. The ongoing work on the Respite Locator is due to a more formal partnership with one of the Area Agencies. These partnerships will be optimized to strengthen the Lifespan Respite Coalition, continue to support and improve public awareness of the NH Respite provider locator and to analyze available data to support respite policy development.

[1] Child and Adolescent Health Measurement Initiative. 2009/10 National Survey of Children with Special Health Care Needs Medical Home State Profile. Data Resource Center for Child and Adolescent Health website. Retrieved [07/13/2016] from http://childhealthdata.org/browse/medicalhome.
[2] National Survey of Children's Health. NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved [07/13/16] from www.childhealthdata.org.
[3] Standards for Systems of Care for Children and Youth with Special Health Care Needs, a product of the National Consensus Framework for Systems of Care for Children and Youth with Special Health Care Needs Project, March 2014

Children with Special Health Care Needs - Annual Report

Final Report for previous National Performance Measure #2:

Percent of CSHCN age 0-18 years whose families partner in decision making at all levels and are satisfied with the services they receive (CSHCN Survey)

Special Medical Services has had a long standing commitment to Family partnership and involvement. This has been supported by a formal funded relationship with NH Family Voices (NHFV) for more than 20 years. This

partnership has developed into the current model used for 2 additional Federal Grants, in which SMS is the grantee but through contracts with NHFV parents (employees of NHFV) are the coordinators for these important Quality and System of Care Improvement efforts. One of these grants (awarded in 2014) is an Autism Planning Grant. Family involvement has been integral to the activities of this grant including statewide Family Focus groups (2 of them hosted for Spanish speaking families), World Cafes, and family and self-advocate involvement in workgroup meeting and compilation of the NH Autism State Plan (released May 2016). The other grant is the Improving Awareness and Access for Epilepsy grant (FACETS) which has incorporated family input annually and participation of a Family Leader in the pediatric practice improvement work.

Additionally, SMS administered a statewide family satisfaction survey on all service areas with a significant component of Needs Assessment related to the Core Outcomes for CSHCN. The survey's response rate, in 2014, was approximately 22% and was a proportionate representation of program enrollment. Survey respondents represented a cross section of families served in each area of the state, in the catchment areas of each program, and from a diverse cross section of served family members. Family satisfaction with services was high, rated as good or excellent by 80.5% of respondents and 84.7% of respondents indicated that they were likely to refer a friend or family member for these services. SMS applied for and was chosen to have the assistance of a MCHB funded Graduate Student Intern. The intern evaluated the SMS Satisfaction Survey and Needs Assessment in detail and offered guidance on how to use the results as part of the 5 Year Needs Assessment report. The intern also worked with SMS to identify how the newly released Standards for Systems of Care for CSHCN could be braided with the survey results.

The funded support for NHFV is ongoing in the form of a contract for Family to Family Health Information Services and Medical Home Improvement. The FACETS and the Autism Planning Grant activities are expected to conclude in August 2016. MCH and SMS remain committed to a collaborative relationship with NH Family Voices including participation of NHFV in the Title V Block Grant reporting and planning meetings. All SMS supported programs (contract and state supported) will continue to be required to conduct and submit parent satisfaction surveys focusing on quality of care indicators. Since SFY 2009 all agency contracts with SMS have had a funded line item for cultural and linguistic supports in order to make services more accessible and responsive to ALL families.

SMS is also the administering agency for a Family Support and community integration program called Partners in Health (PIH). This program is run in local communities (12 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. A PIH Stakeholder group has been meeting several times a year and includes families, 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.

Final Report for previous National Performance Measure #3:
Percentage of CSHCN age 0-18 who receive coordinated, ongoing, comprehensive care within a medical home (CSHCN Survey)

and

Annual Report for new National Performance Measure #11:
Percent of children with and without special health care needs having a medical home

Special Medical Services has been supporting Medical Home Improvement through a funded contract for several years. The ongoing focus has been 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. Obstacles to improving primary care for CSHCN include limited consumer involvement, inadequate provider reimbursement, poorly defined professional roles and a lack of systematic approaches to care.

Prior to 2014 the contractor had been the Center for Medical Home Improvement but this changed in 2014 when NH Family Voices was awarded the contract. NHFV has focused on increasing political and public understanding from a grassroots perspective. Their activities have placed significant emphasis on addressing the role of family partnerships in Medical Homes in order to spread the model. National attention has been brought to forefront related to the fact that a Family partnership has been the component of Medical Homes that continues to need the most attention/support.

Medical Home Improvement efforts for CSHCN are being led by NH Family Voices. NHFV is working on integration of medical home development and collaboration with State Stakeholders and 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. NHFV efforts incorporate a Primary Care champion to participate in their efforts. NHFV reports that their Medical Home activities 'support the development of and engagement of family members to service in an advisory capacity to primary care practices committed to state of the art medical home practices'. They are using a multi-pronged approach of training, marking, and collaborative efforts across the health care system. This has included conference workshops on Medical Home and a learning collaborative retreat of patient/provider teams with a keynote offered by Eileen Forlenza, a leader and expert on Parent Engagement.

NH's opportunity to have the Family to Family Organization lead the systems improvement efforts inherently incorporate a focus on family partnership development, this work featured training opportunities and continued support of medical practices' efforts to meaningfully engage consumers as advisors, as part of their ongoing quality improvement and actualization of Medical Home.

Additionally, SMS' grant activities related to Epilepsy and Autism have both incorporated components to assess family perspective/need of Medical Homes along with improvements to the self-report of these CSHCN as experiencing health care in Medical Homes.

Final Report for previous National Performance Measure #4:

Percent of CSHCN age 0-18 whose families have adequate private and/or public insurance to pay for the services they need (CSHCN Survey)

SMS continued to participate in statewide and programmatic planning to improve the percentage of children with adequate insurance. These efforts have been focused on those CSHCN who are 0-18 years old as well as young adults 18-21 years old. SMS continued to work with identified partners in New Hampshire who were interested in improving the access to and adequacy of insurance for children, including CSHCN. These groups included the NH Children's Advocacy Network, the Council for Youths with Chronic Conditions and NH's 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.

SMS' alignment with the Bureau of Developmental Services has allowed for collaboration with other programs that offer support to families. 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. In addition, SMS continues to maintain its Equipment Bank, which allowed children

to access DME that has been used but refurbished by a Certified Equipment Vendor.

The SMS HC-CSD Coordinator continued 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 continued 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 included being aware of ACA reforms and state Medicaid changes. SMS supports the costs of some health related needs for children and youth needs (ex: DME, medications, specialty services/providers and transportation), who met financial eligibility criteria (>185% of FPL). The need for these funds as it relates to Insurance coverage and Insurance adequacy or lack thereof has increased.
SMS has been an advocate for highlighting the needs of children who are legal residents but had been so for less than 5 years (and therefore were not eligible for Medicaid). The population of youth ages18- 21 who aged out of Medicaid (HC-CSD pathway) was also in need of additional support regarding insurance coverage. Some were eligible for coverage under their parents private health insurance but due to the expense related to this option they remained without insurance. NH did opt to implement an expansion of Medicaid and this has been beneficial in meeting the needs of youth ages 18-21. NH created a program named the NH Health Protection Program. This program began enrollment in July 2014 and enrollees began to receive services in August 2014. The opportunities for Young Adults with Special Health Care Needs to be covered by the NH Health Protection Program have begun a core component of coordination for youth who are aging out of their Children's Medicaid coverage (or private insurance coverage through a parent).

NH's transition to a Managed Care Model has been another component of assuring adequate insurance coverage. Initially, the population of CSHCN enrolled in Medicaid was granted Voluntary status and they had the option to enroll in a managed care plan or to remain in fee for service. The state received approval from CMS to change the status of all Voluntary populations to Mandatory status. Families whose children were on Medicaid but had opted out of Managed Care (approximately 60% of SMS enrollees) were in need of additional assistance to make sure that they understand the Managed Care Organization (MCO) options that they had to choose from.

The CSHCN Director is a member of the Department's planning team as well as the communication group for this voluntary to mandatory change in coverage. SMS Care Coordinators met with MCO coordinators to discuss the needs of individual CSHCN. SMS is organizationally aligned with Medicaid and will continue to advocate for the needs of CSHCN from eligibility through access to needed services. The HC-CSD Coordinator (a SMS staff person) works 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").

Final Report for previous National Performance Measure #5:

Percent of CSHCN age 0-18 whose families report the community-based service systems are organized so they can use them easily (CSHCN Survey)

Special Medical Services (SMS) has had a longstanding collaboration with the NH Social Security office and the NH Medicaid office that allows for these entities to share with SMS the contact information for children/youth newly enrolled in their programs, when the child qualifies based on their own health condition. SMS has continued to outreach to these newly identified CSHCN through regular referrals as well as case finding via our SSI Transmittal Outreach project. This outreach is also provided for children approved for Medicaid through Home Care for Children with Chronic and Severe Disabilities. Those with primary mental health and developmental conditions received

Information and Referral packets with local and regional contacts and resources. Those with primary medical conditions received written and phone contact with some short-term outreach, by a Nurse Coordinator, and if indicated enrollment in Care Coordination. The health care coordinators and neuromotor clinic coordinators continued using the Complexity Scale and Levels of Care tools (developed by SMS) as part of their assessment and care planning with families to take into consideration the implications of each child's health condition as well as social and family needs.

There was ongoing work related to adopting/creating Core Competencies for Care Coordination. SMS used the 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. Collaboration with the Partners in Health Family Support Coordinators and their Program Manager continued to assure best practices with families and clearer delineation of roles. Collaborative work was done between the Health Care Coordinators and the PIH Family Support Coordinators including joint meetings and presenting and participating in a state wide Collaboration meeting among child serving agencies. Communication between the two programs has been a focus and on July 1, 2016 a new PIH data system was initiated that allows for data sharing between the programs.

NH has a strong network of school nurses and SMS has assumed responsibility for a robust web-based listserv 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. Through the FACETS Grant SMS has built upon the platform of partners to impact greater collaboration amongst these groups. These condition specific efforts have demonstrated a positive impact on relationship building regarding other conditions and the overall system of care for CSHCN. This has included sponsoring training and completing a school nurse survey.

In SFY 2014 and SFY 15 a great amount of effort was directed to educating SMS families about the managed care companies that began coverage in January 2014. This included issues specific to CSHCN and how to choose or opt out of the programs (as enrollment in Managed Care for CSHCN was voluntary). NH Family Voices provided an in-service on the ACA, a session on how families deal with their child's cancer diagnosis, help with Managed Care and also were valuable in orienting new staff. Internally, SMS also improved the systems for referral and updating applications. SMS has been working with a variety of intra departmental partners such as DCYF, Medicaid, Behavioral Health and external partners including school nurses, parent and advocacy groups and others to improve the organize and communication about services.

The NH Family Centered Early Supports and Services (FC-ESS) program had been organizationally paired with Special Medical Services within the Bureau of Developmental Services (BDS). Staff changes within BDS resulted in an opportunity for additional alignment and FC ESS was moved to fall under the Administrative oversight of the CSHCN Director. This has offered a wonderful opportunity to better integrate services so that services across programs are better organized and easier for families to use. There is an interest in developing a more natural process for referral from FC-ESS to SMS. The emphasis would be on delineating the roles of each of our programs for infants up to age three. Inherent in the process is the need to assure that infants with chronic, complex medical conditions are referred to Health Care Coordination by age 27-30 months so that we can assist the family with the transition and help with any pre-school planning or needed care coordination.

Final Report for previous National Performance Measure #6:

Percent of youth with special health care needs who received the services necessary to make transition to all aspects of adult life (CSHCN Survey)

SMS and NH Family Voices have collaborated on transition initiatives since 2005 when the NH Health Care Transition Coalition (HCTC) was formed. The HCTC is co-chaired by SMS and NH Family Voices. Some projects have included development of the youth transition group Youth for Education, Advocacy and Healthcare. (YEAH), surveying Adult Health Care Providers about transition, and developing the Ticket to Adult Health Care Independence Project.

A Health Care Transition web page is posted on the NHFV website and there is a Facebook page for YEAH. SMS Health Care Coordinators offered transition assessment and education to families and youth on an ongoing basis. SMS has in the past participated on the Got Transition National Advisory Committee (both the Title V CSHCN Director and the Transition Coordinator) and the SMS Transition Coordinator attended the Got Transition Learning Collaborative.

The SMS Transition Coordinator worked with the SMS health care coordinators to produce standards to assure that certain basic knowledge and skills are assessed, reviewed and in place prior to discharge from SMS at age 21 supported by previous review and presentation of data that focused on a 10-year data set of transition readiness surveys from NH's Neuromotor Specialty Clinics.

The Health Care Transition page on the NH Family Voices website was expanded to include materials used during the Ticket to Adult Health Care Independence project, such as the assessment tools and the Medical Summary forms as well as providing links to other national resources such as the GotTransition™ website. A pamphlet called "Growing Up Health Care Transition for Teens with Chronic Conditions - Tips for parents" was distributed to SMS families of children 12 and older who are enrolled in our health care coordination and Neuromotor clinic programs when their annual application updates are sent out. This was intended to provide a bridge to the conversations that staff might have with a family.

The SMS Program Manager/Transition Coordinator continued her active participation in the NH Community of Practice on Transition, the Autism Council Independent Living Workgroup, and the Region I NEGC Transition workgroup. The SMS Program Manager/Transition Coordinator has worked on a transition education process for the Partners in Health program as one of their initiatives. There was also an active effort that continues to be made to engage primary care providers in transition and discuss how to integrate SMS' work with pediatric and family practice transition plans as well as to ask at school meetings if health care transition topics can be addressed in the IEP.

Work on the FACETS of Epilepsy grant has emphasized transition and created tools that will be utilized for other CSHCN. These include assessing readiness for independence in health management from both the youth and parent perspective and new tools for enhancing readiness.

Final Report for previous State Performance Measure #9:

REVISED: The number of individuals who have completed a competency based training for respite providers

The AoA issued the first grants for Lifespan Respite projects in 2009 and New Hampshire received one of the ten grants awarded. NH was the only state whose lead agency was not an AoA agency. New Hampshire's proposal represented a strong collaboration amongst the agencies within DHHS, especially within the Division of Community-Based Care Services, with the Lead Agency identified as Special Medical Services (SMS). This was done with the assistance of the Advisory Planning Group (Title V staff, parent consultant, State Behavioral Health (BBH) staff,

Parent/Director Council for Youths with Chronic Conditions (CYCC), State Bureau of Developmental Service (BDS) staff, a partner, knowledgeable in medically fragile children from the private sector, State Bureau of Elderly and Adult (BEAS), and the Division of Children and Youth (DCYF), and family members to meet the lifespan representation as well as a NH local community based agency for competency based training. The 3-year grant period ended September 29, 2012; however SMS requested and received a no-cost extension for one year ending September 2013.

Strategic Planning in April-May 2013 led Stakeholders and Coalition members to take more responsibility for the NH LRC Program. They created a draft job description and a design for State infrastructure building for respite. There were also changes made to the curriculum to meet families' and provider's needs upon completion of a Family Satisfaction Survey review. Infrastructure building has continued with the NHLRC Coalition. The Coalition met with Gateways (a community based Area Agency in NH Developmental Services system) re: fiscal management and collaboration activities to assist with mission and vision of LRC throughout NH. The respite training continues through Relias (a web based platform) with SMS as a site administrator for the application and criminal and registry checks. Interested trained respite providers are listed on the NH Provider Link through the Rewarding Work locator platform, which was created in collaboration with Gateways and became active in May 2014 (http://www.rewardingwork.org/State-Resources/New-Hampshire.aspx). Marketing for use of the locator to the Area Agencies, other state agencies, and organizations (private and non-profit) and individuals started in June 2014. This website is a resource for trained respite providers and for caregivers' short break needs across the lifespan.

The NH Provider Link continues to provide SMS and the NHLRC Coalition data (NH respite care utilization, available trained respite providers, etc.). Gateways develops and distributes marketing materials for NH regarding respite and use of the system. Two NH Coalition members are REST (Respite Education Support Tool) trainers for volunteers. NH LRC Provider Training applicants continue to be recruited and processed as the NH Provider Link has gone statewide and is fully marketed by Gateways. The application for respite provider training is on the http://www.nh providerlink.org/.

The Provider Link data regarding Respite providers in NH is:

Number of Provider in the NH Database	388
Willing to provide respite care	132
Willing to serve Adults	200
Willing to serve Elders	196
Willing to serve Children	102
Able to work with individual with difficult/severe behavioral issues	168
Experience with respite	107
Able to work with individuals with difficult/severe behavioral issues	207
Completed LRC Respite Training	34

As a result of the NH Lifespan Respite Coalition's completion of a Finance Plan for Sustainability with assistance of the TA Grant from the Finance Project at Chapel Hill and ARCH National Respite the Coalition produced a request for a VISTA volunteer to meet the NH LRC Strategic Plan goal to have an Outreach Coordinator who will work with identified groups, representing a variety of local agencies/organizations, which have identified an interest in addressing the need for respite in NH's 10 Counties. The agencies/organizations will meet regularly to identify needs of caregivers, use of NH Provider Link and share respite resources in their regions. The VISTA request was granted and in her 1 year placement the new Outreach Coordinator regularly met with and provided each County's

information to the NH LRC. The NH LRC anticipates seeking grants for financial resources for the above activities and to continue the training activities. Recruitment for another VISTA volunteer is underway for next year.

The NH LRC is aware of the CSHCN Standards regarding Respite. SMS continues to coordinate activities for the NH Respite Program but expects the NH LRC will continue to explore options for the funding through grants or other measures this to continue their work more autonomously. NH LRC will continue to find ways to connect with caregivers such as Website linkages and facebook.

Cross-Cutting/Life Course

State Action Plan Table

State Action Plan Table - Cross-Cutting/Life Course - Entry 1

Priority Need

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

NPM

A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Objectives

14A1. By July 1, 2020, decrease the percentage of women who smoke during pregnancy to ≤28% among deliveries paid by NH Medicaid.

14A2. By July 1, 2020, decrease the percentage of women who smoke during pregnancy to ≤4.8% among deliveries not paid by NH Medicaid.

14B. By July 1, 2020, all of the MCH funded CHCs will have referral sources documented along with follow up for patients who smoke in their electronic medical records.

Strategies

Increase the utilization of NH Quitworks and other tobacco cessation programs

Facilitate enrollment into tobacco cessation programs by making referrals for both providers and clients easier (e.g. electronic two-way system)

Professional education on best practices in tobacco cessation

Facilitate two-way communication between tobacco cessation programs and health care providers to enhance patients' likelihood of quitting

ESMs

ESM 14.1 - Number of calls received by the smoking quitline in the past year

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

NOM 5.1 - Percent of preterm births (<37 weeks)

NOM 5.2 - Percent of early preterm births (<34 weeks)

NOM 5.3 - Percent of late preterm births (34-36 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

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

NOM 19 - Percent of children in excellent or very good health

State Action Plan Table - Cross-Cutting/Life Course - Entry 2

Priority Need

Improve access to mental health services.

SPM

Percentage of behavioral health professionals recruited

Objectives

Increase the recruitment of behavioral health professionals by ten percentage points over five years, from estimated baseline of 25%, to 35%.

Strategies

Assess the current Behavioral Health workforce

Determine the factors that recruit and retain workforce

Establish a vacancy tracking system with employers

Establish relationships with professional training programs for pipeline development

Social marketing, to attract Behavioral Health professionals

State Action Plan Table - Cross-Cutting/Life Course - Entry 3

Priority Need

Improve access to needed healthcare services for all populations.

SPM

Percentage of MCH-contracted Community Health Centers with Enabling Services workplan on file with DHHS/MCH.

Objectives

Increase the percentage of MCH-contracted CHCs with an Enabling Services (ES) work plan on file with DHHS from 2015 baseline of 60% (9 of 15) to 80% (12 of 15) by October 2017.

Increase the capacity to measure the impact of ES by implementing a standardized ES performance measure by July 1, 2017.

Strategies

Require MCH-contracted CHCs to submit an ES work plan by writing this requirement into contracted Scope of Services for SFY18 and SFY19.

Provide Technical Assistance and support to CHCs as they develop their ES work plan.

Identify proxy measures for ES (e.g. rate of preventable ER visits)

Collect data from Claims Data Base

Collaborate with CHCs to assess feasibility for them to capture agency-specific data

Measures

NPM-14 A) Percent of women who smoke during pregnancy

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	15.0	14.9	14.7	14.6	14.4	14.3

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	13.7 %	0.3 %	1,650	12,060
2013	15.2 %	0.3 %	1,843	12,126
2012	15.1 %	0.3 %	1,811	11,998
2011	14.6 %	0.3 %	1,802	12,365
2010	15.5 %	0.3 %	1,806	11,641
2009	15.3 %	0.3 %	1,838	12,038

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NPM-14 B) Percent of children who live in households where someone smokes

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	24.6	24.3	24.1	23.8	23.6	23.3

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	24.8 %	1.4 %	68,828	277,643
2007	26.9 %	1.4 %	79,729	296,746
2003	32.5 %	1.3 %	86,885	267,270

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 14.1 - Number of calls received by the smoking quitline in the past year

Annual Objectives					
2017	2018	2019	2020	2021
Annual Objective	11.0	22.0	44.0	88.0	176.0

Cross-Cutting/Life Course - Plan for the Application Year

National Performance Measures: 2016-2020

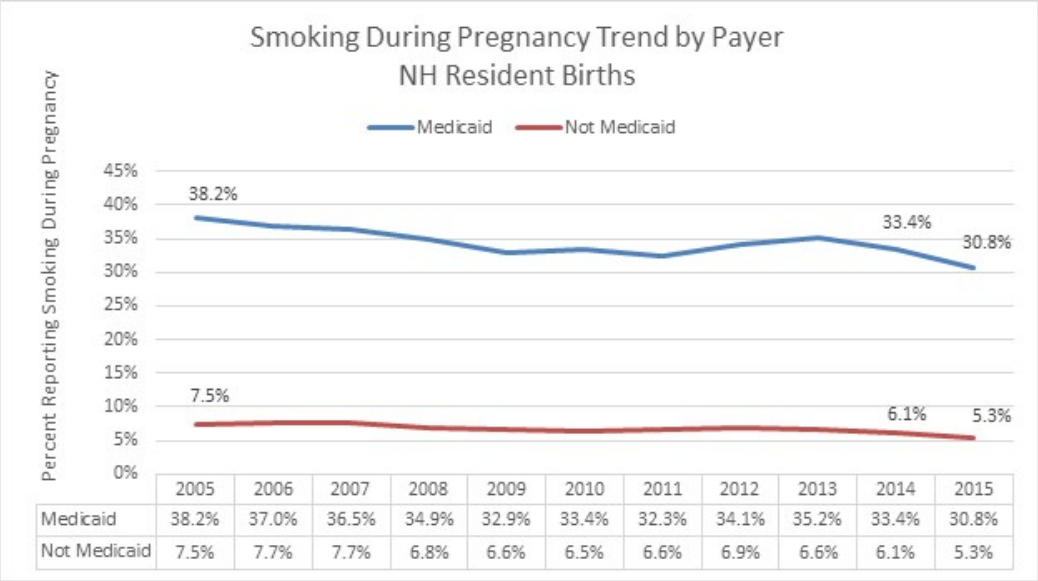
National Performance Measure #14:
A) Percent of women who smoke during pregnancy
B) Percent of children who live in households where someone smokes

Evidence Based or Informed Strategy Measure:
Number of calls received by the smoking quitline in the past year

Data Analysis: Last year's objectives for measure 14A were:

- By July 1, 2016, decrease the percentage of women who smoke during pregnancy to ≤32% among deliveries paid by NH Medicaid.
- By July 1, 2016, decrease the percentage of women who smoke during pregnancy to ≤5.7% among deliveries not paid by NH Medicaid.

The graph below shows that the target objectives for smoking during pregnancy among deliveries paid by NH Medicaid was exceeded, as well as among deliveries not paid by NH Medicaid.



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Medicaid	38.2%	37.0%	36.5%	34.9%	32.9%	33.4%	32.3%	34.1%	35.2%	33.4%	30.8%
Not Medicaid	7.5%	7.7%	7.7%	6.8%	6.6%	6.5%	6.6%	6.9%	6.6%	6.1%	5.3%

Last year's objectives for measure 14B were:

- Within five years, decrease the percentage of children 0 to 17 years of age who live in households where someone smokes to ≤23%.

The data needed to track this measure come from the National Survey of Children's Health (NSCH), which is typically conducted approximately every 4 years. This measure has improved from 26.9% in 2007 to 24.8% in 2011/12. The survey is currently being conducted again by the Census Bureau in 2016, with initial data expected in 2017.[1]

Children who live in households where someone smokes
Children age 0-17 years
New Hampshire vs. Nationwide

	NH	LCI	UCI	Pop. Est.		**US**	LCI	UCI	Pop. Est.
2007	26.9%	24.1%	29.6%	79,729		26.2%	25.4%	26.9%	19,141,944
2011/12	24.8%	22.0%	27.6%	68,828		24.1%	23.5%	24.7%	17,573,277

Source: National Survey of Children's Health (2007, 2011/12).
Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website.
Retrieved 6-11-2015 from http://childhealthdata.org.
LCI/UCI: Lower and Upper 95% Confidence Interval

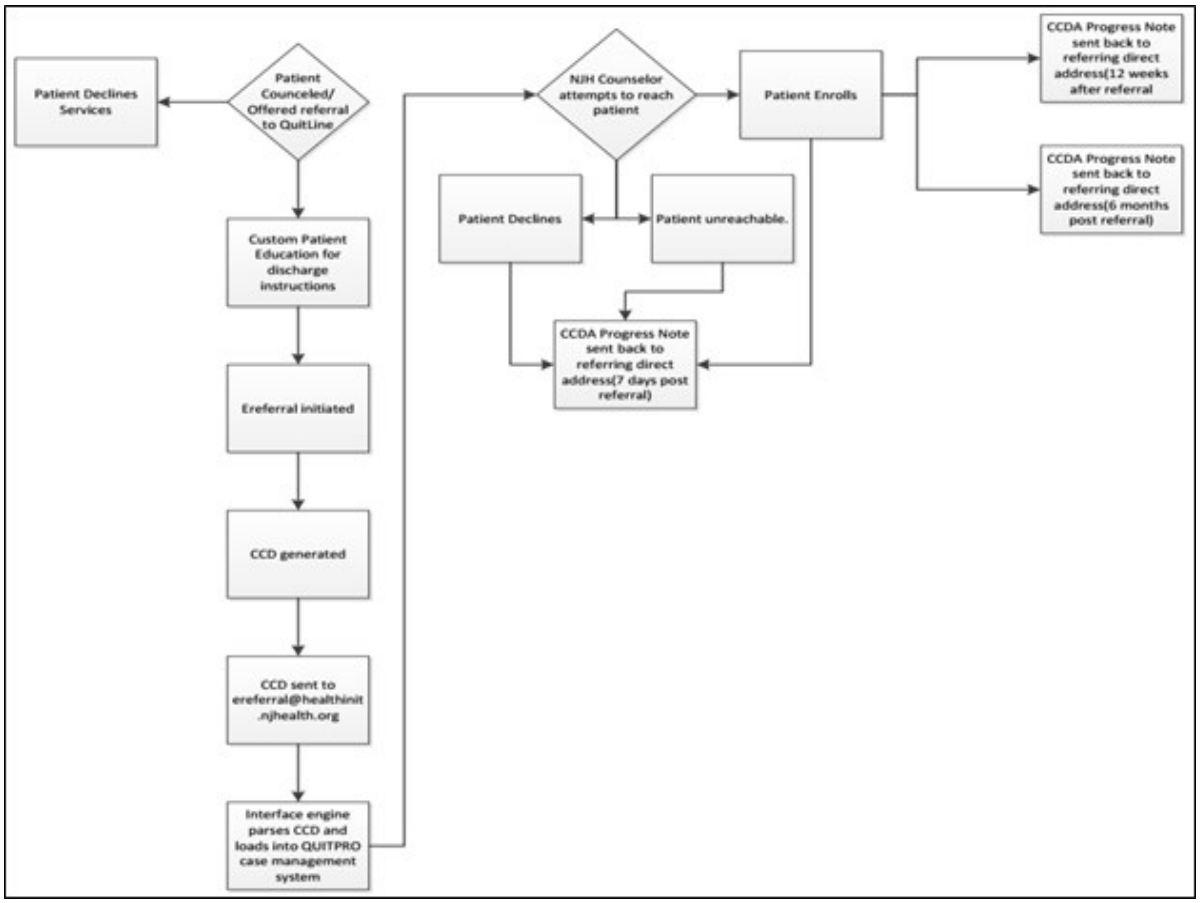
Additional data from WIC estimates that approximately 3.5% of WIC households, from the Pediatric Nutrition Surveillance System (PedNSS) reporting smoking in the home during 2012-2014, with the highest rates in Sullivan and Cheshire (Southwestern part of the State) and lowest rates in Grafton County Central western part of the State).

Systems Building

MCH's colleague within DPHS, the Tobacco Prevention and Cessation Program (TPCP) contracts with National Jewish Health for the quitline services in the state. National Jewish Health is a leading respiratory hospital in the

United States and has developed a tobacco cessation program, QuitLogix that empowers participants to overcome their tobacco addiction. The program provides personalized coaching and online resources. Participants work with a coach to prepare a quit plan, set a quit date, understand tobacco triggers, manage cravings and address relapses. As participants progress through the program, they complete a series of coaching calls which offer support and guidance throughout their quit attempt. The program has a 40% responder quit rate and a 90% participant satisfaction rate.[2]

MCH and TPCP recruited a Title V-funded CHC to design and pilot a secure, direct electronic referral (e-referral) system from the agency to National Jewish Health in the 2015-2016 fiscal years. Transmission to and from National Jewish Health was successful as of early 2016 and the staff were trained during the initial implementation period. The process logic of the e-referral system is shown in below. Several lessons learned will be shared with all Title V-funded CHCs and home visiting agencies, and referrals will be monitored for improvement over the next year. It is hoped that several additional agencies can be recruited for the project.



MCH Specific Activities

In addition to seeking to replicate the e-referral implementation in other Title V funded agencies, MCH and TPCP plan to recruit additional agencies to participate in an improvement project designed to increase calls to the QuitLine from pregnant women in New Hampshire. NH QuitLine records show only 11 pregnant women participated in the program in 2015. A Dartmouth medical resident has committed to working on this project over the next several months.

A linkage between NH QuitLine records and births (vital records) was completed and confirmed the validity of the

pregnancy indicator in the NH QuitLine database. In addition, the linked data indicate that several participants called just prior to, or just after, becoming pregnant (i.e. these participants had linked births, but were not recorded as pregnant by the NH QuitLine because they were not pregnant during intake). Nonetheless, only 34 women who called the NH QuitLine in 2015 were "near" pregnancy. We continue to explore the data from our new QuitLine vendor.

Prior to recruiting agencies and designing a project, a literature review will be undertaken to assess the potential to use mobile phone technology (text messages or apps) to further support the referral and quitting process. NH PRAMS data show that more than 94% of NH women giving birth in 2013 reported sending or receiving a text message in the last 12 months. Only 1.4% reported not having a cell phone. Among those at or below 200% of the federal poverty level, 92% reported having sent a text message in the last 12 months. We believe there is significant untapped potential to harness mobile technology in our efforts to improve smoking cessation.

To bolster efforts, MCH will be funding the airing of some of the stories from CDC's successful *Tips (Tips From Former Smokers)* media campaign. *Tips* was launched in 2012 and profiles real people who are living with smoking related-diseases and the toll these conditions have taken on them. One, a pregnant woman "Amanda" started smoking at age 13. Initially not knowing she was pregnant, she continued to smoke a pack a day. "Amanda's" baby was born two (2) months early and spent weeks in a hospital neonatal intensive care unit.[3] Study results in 2014 of the cost effectiveness of the *Tips* media campaign thus far, showed that based on the number of people estimated to have quit smoking for good (about 100,000 people), the campaign will also have prevented at least 17,000 premature deaths and helped gain about 179,000 years of healthy life.[4]

State Performance Measure #1:

Percentage of MCH-contracted Community Health Centers with Enabling Services work plan on file with DHHS/MCH

Purpose: MCH seeks to improve access to high quality comprehensive Primary Care and Preventive services by funding MCH contracted Community Health Centers for the provision of Enabling Services.

Data Analysis

For over a quarter of a century, MCH has utilized Title V funding to contract agencies to support primary care and prenatal services. Historically, this funding has been used by the agencies to fill gaps in medical care, i.e. direct care of uninsured patients. In response to revision of the MCH Block grant pyramid (which placed direct services at the top of the pyramid) and the implementation of the Affordable Care Act in 2014 (which MCH anticipated would lessen the need for financial support of direct care services) MCH began to encourage MCH contracted primary care agencies to direct MCH funding toward other public health activities such as Quality Improvement projects and Enabling Services in 2015. It is important to note that although MCH contracted CHCs have experienced reduced numbers of un-insured individuals 19% (15,667/120,000) of patients continue to be uninsured in 2015[5]. According to MCH contracted agencies, CHCs continue to need financial support to care for not only their uninsured patients, but also their underinsured patients who are determined eligible for sliding scale fee by the agency due to un-affordable out of pocket expenses.

Enabling Services are non-clinical support services which generally link individuals to essential medical, behavioral health and social services. Although Enabling Services add value by supporting the delivery of basic primary care and preventive services, there are limited mechanisms currently in place to reimburse agencies for the delivery of Enabling Services. Enabling Services are the means by which agencies "do the work" needed to care for their patients. Therefore, it is essential for CHCs to receive financial support for ES until alternative payment models (i.e. value based payment) are in place to sustain such services.

Enabling Services, Current Activities

In 2015, nine (9) of the fifteen (15) MCH funded CHCs elected to utilize MCH funding to provide enabling services for the contract period SFY16-17. Each agency was allowed to determine the type of enabling services to be provided

by their CHC based on the unique needs of their organization and community. The following enabling services are currently being provided by MCH/Title V funded CHCs:

- Case management
- Benefit counseling
- Eligibility assistance
- Health education and supportive counseling
- Interpretation
- Outreach
- Transportation
- Education of patients and the community regarding the availability and appropriate use of health services

While not all CHCs elected to utilize MCH/Title V funding for enabling services, all CHCs are required to maintain accountability to MCH through reporting requirements and site visits. CHCs are provided MCH oversight for Enabling Services through the contracted Request for Proposal processes. MCH releases a Request for Proposal which outlines contract and service expectations. CHCs apply for funding by completing the RFP. Following award selection, CHCs are required to submit an Enabling Service Workplan (see below examples). The Enabling Service Workplan serves as a logic model and communicates the Enabling Service project goals, objectives, inputs/resources, planned activities and evaluation methods. The Enabling Service Workplan is submitted electronically for review and comment. This allows an opportunity MCH staff to provide feedback to the CHCs and for revision if needed.

The following examples provide an illustration of how Enabling Services are being implemented by three (3) of MCH's contracted CHC (referred to below as Agency #1, #2 and #3):

Agency #1:

> Agency Description: Located in rural Northern NH, this CHC had 12,005 patients with 48,377 encounters in 2015.[6]
>
> Enabling Service Workplan:

Project Goal: Care Management Nurses will contact patients 24-48 hours after hospital discharge or an ER visit.	
Project Objective #1: 85% of patients will be contacted by care management nurses 24-48 hours per transition of care.	
INPUT/RESOURCES	**PLANNED ACTIVITIES**
Care Management Nurses Providers, Nurses and Support Staff (Medical Teams) Data/QI: Chief Operating Officer Data Source: IT Team Crystal Reports to Capture Data	• Care management nurses will contact patients 24-48 hours after hospital discharge or an ER visit. • A medical home note will be documented with all medical updates and sent to the medical team. • An appointment will be made within 2 weeks after a hospital discharge or an ER visit (as appropriate). • The care management nurses will coordinate care for other health services such as home health, home care, physical therapy, etc. • The medical team and care management nurses will develop a care plan with the patient to prevent readmissions and /or decrease ER visits. • The care management nurses will educate patients about appropriate ER use and encourage patients to contact the Triage nurses or care management nurses with non-urgent medical concerns. • The medical team will notify the care management nurses if the patient is high risk/complex patients and needs ongoing coordination of care. • Care management nurses will collaborate with local hospital care management nurses and meet at least quarterly to coordinate care for high risk/complex patients, develop workflow efficiencies and improve communication with home health agencies.
	EVALUATION ACTIVITIES
	COO will: • Perform chart audits/crystal report reviews to determine percentage of patients contacted by care management. • Share audit/report results with staff and QI Committee. • Recommend corrective action to decrease readmission within 30 days, decrease ER utilization and increase continuity of care with same day appointment access. • Report results to the Board of Directors via Quarterly Statistical Report. • Use ACO data to help benchmark trends. IT will: • Update EMR templates to capture data. • Offer lunch and learn trainings to update staff on EMR changes.

Source: NH DHHS, Maternal & Child Health Section, SYF16-SFY17 QI Workplan

Based on the above Enabling Services workplan MCH was able to get a sense of the Enabling Services to be delivered by Agency #1. Recent data requested from the CHC indicates that during the first 6 months of SFY '16 (July 1, 2015 to December 31, 2015) the agency's case management nurses successfully contacted 92% (2,333/2514) of all patients discharged from the hospital, nursing home, and/or rehabilitation center and patients that had an ER visit are consulted within 24-48 hours after their transition of care. Per the agency, the care management nurses performed the following activities:

- Medication reconciliation
- Appointment scheduling with the patient's PCP within 7-14 days or same day if appropriate
- Appointment scheduling with specialists, physical therapy, and home health services
- Assistance with community resources such as: day care, transportation and fuel assistance, WIC and Head Start
- Care management and support for patients at risk due to complex medical or behavioral health conditions and/or high ER/Hospital use
- Patient education: appropriate ER use and the importance of continuity of care with their PCP

This CHC has utilized a two (2) step process to collect Enabling Services data. First, their EMR has the capacity to directly link with their local hospital and specialty clinics. This integrated EMR system allows the CHC to capture the "medical home" note automatically from any transition of care. From the "medical home" notes the CHC is able to generate a "transition of care" report which is forwarded to the care management team to prompt patient contact by the care management nurse. As an estimated 90% of the CHC's patients use the local hospital for ER and specialty services having a shared EMR systems improves communication and reduces errors of handoff. Second, the CHC receives reports from some of the private and public insurers (Anthem and Well Sense). These reports provide extensive information about the event: day of week, time of day, reason and if avoidable, number per month, per year, etc. These more detailed reports allow the CHC to better understand how to ensure patients connect with their medical home as a usual source of ongoing care.

The CHC is currently working with Anthem and Well Sense to identify other opportunities to decrease ER utilization. They have developed a rack card that is displayed at both the CHC and the local hospital. One side educates

patients on reasons to go to the ER and the other side educates on primary care services. They have a medical home pamphlet that is shared with patients that again stress appropriate ER use and primary care use. The CHC also participates in insurer provided trainings and webinars on transitions of care and ER utilization.

Agency #2:

Agency Description: Located in one of NH's smallest cities, this CHC had 9,688 patients with 42,567 encounters in 2015.[7]

Enabling Service Workplan (2 Objectives):

Project Goal: To utilize the available enabling services funding to assist us in our goal of achieving the Triple Aim: to improve the quality of care we provide to our patients, to reduce the costs of care our patients receive, and to enhance the patient experience.	
Project Objective #1: The Community Health Worker will promote appropriate primary care utilization and prevent primary care-related emergency department utilization	
INPUT/RESOURCES	**PLANNED ACTIVITIES**
Community Health Worker	• Outreach to Care Managed patients with 4 or more emergency department visits within a 6 month period and assess needs of clients. Outreach will be performed using Care Managed reports on at least a weekly basis. • Provide peer-to- peer counseling and connect medical underserved patients with Goodwin Community Health services and other related support services. • Provide education to Care Managed about the importance of primary care, assist with appointment scheduling and follow up with patients to monitor and address additional barriers. • Outreach to patients on insurance "hot spotter" reports at least on a monthly basis • Outreach to patients on chronic disease reports at least on a monthly basis • On a monthly basis at the minimum, collaborate with Community Partners regarding high emergency department utilization. • Outreach to Care Managed patients that have a history of at least two "no showed" appointments. Outreach will be performed two days prior to scheduled primary care appointment.
	EVALUATION ACTIVITIES • Insurance "hot spotters" will be tracked and trended on a monthly basis and reviewed by QI Manager on quarterly basis • Evaluation data is reviewed monthly by the CEO and shared with the CQI group, senior management and BOD quarterly. Care Managed patients for high emergency department utilization will be tracked and trended monthly.

Project Objective #2: To ensure that all uninsured patients are aware of available health insurance options and assisted with enrollment.	
INPUT/RESOURCES	**PLANNED ACTIVITIES**
Patient Advocates Outreach and Enrollment Practice Manager	• Upon uninsured patients checking in for a medical visit, the patient advocate will ask the parent if they are interested in learning more about the Affordable Care Cat (ACA) and Medicaid program. • Upon income verifications, the patient advocate will notify the patient that they are eligible for the Medicaid program. • The patient advocate will assist in providing and completing a Medicaid Application with guardian or adult. • The patient advocate will assist with enrolling the patient in the marketplace exchange. • Outreach and Enrollment workers will assist, educate and evaluate all families that are interested in the health exchange products and enroll them as needed.
	EVALUATION ACTIVITIES A monthly report runs on the uninsured. The Outreach and Enrollment staff will call and re-educate and encourage the patient to come in to get assistance with the application process. Practice Manager to review report monthly.

Source: NH DHHS, Maternal & Child Health Section, SYF16-SFY17 QI Workplan

Based on the above Enabling Services Workplan MCH was able to get a sense of the Enabling Services to be delivered by Agency #2. Recent data requested from the CHC indicates that

Agency #3:

Agency Description: Located in one of NH's largest cities, Agency #3 is one (1) of three (3) MCH contracted agencies who specifically provide Primary Care-Homeless services. The agency had 1,261 Health Care for the Homeless clients with 8,289 encounters in 2015.[8]

Enabling Service Workplan (2 Objectives):

Enabling Project Goal: To improve access to HCH care and public entitlements for all persons who are homeless in [redacted] and surrounding areas.	
Project Objective #1: To increase access by enrollment of patients into HCH program by daily Outreach Tours and weekly Health Ed sessions; 20% of annual patient enrollment / intakes will be due to Outreach effort and 10% of annual patient enrollment will be due to Health Education efforts by the end of FY17.	
INPUT/RESOURCES	**PLANNED ACTIVITIES**
• Street Outreach Nurse • Community Health Worker (CHW) • Health Educator • LICSW • Cell phone access for team communication • Laptops / cell cards for access to EMR during outreach • partnership with MHCGM and CFS outreach teams • partnership with MPD, DOC, Probation & Parole • partnership with local ER's and the MSW's therein	• HCH Street Outreach Nurse tours community, woods, riverbanks and smaller shelters in town on a daily basis to assess homeless and to assess/ engage / encourage patients to come in for care. • HCH CHW joins Outreach Nurse on tours; in addition CHW conducts outreach to local ER's • HCH Health Educator joins CHW and Outreach Nurse as needed; in addition Health Educator conducts Health Ed classes for homeless patients at several local shelters, day centers and accessible venues. Health Ed classes offered at least twice weekly. • HCH LICSW joins Street Outreach Nurse, Health Ed and CHW on tours as • HCH OE team assists all patients with ACA Health Insurance Marketplace and Medicaid Applications • HCH staff collaborates with MHC/ ER's/ local police / probation / parole to identify persons in need. **EVALUATION ACTIVITIES** • Track number & % of new patients enrolled via Outreach efforts • Track number & % of new patients enrolled via Health Ed classes • Track number of Health Ed classes and attendance to verify twice weekly schedule • Track number of Medicaid and HIE insurance applications submitted and enrolled

Enabling Goal: All HCH patients will receive Nursing Care Coordination related to the primary care and behavioral health plans of care.	
Project Objective #2: To insure adherence to care plans; to insure successful completed referrals; to minimize broken appointments and lost to follow up. Broken appointment rate for referrals will remain below 20% by end of FY17.	
INPUT/RESOURCES	**PLANNED ACTIVITIES**
• Outreach Nurse • LICSW • CHW • Bus tickets/Taxi Vouchers • Medication Assistance Programs • CHW escort	• Clinic discharge Nurse educates each patient about care plan and its details • Transportation is arranged and Bus tkts/Taxi vouchers are provided as needed • Medication assistance is arranged as needed • CHW escorts patients to referral appointments when necessary • Street Outreach Nurse finds and assesses HCH patients during outreach tours • Street Outreach Nurse engages those lost to follow up • LICSW finds and assesses HCH patients during outreach tours • LICSW finds and assesses those lost to follow up as needed • Patients are called when possible for reminders about future appointments • Referral partners are queried as needed to verify successful follow through by patients to referral destination **EVALUATION ACTIVITIES** • Track and tally Outreach contacts and encounters • Track and tally successful referrals • Track Broken Appointment rate • Track and quantify value of Medication Assistance Program

Source: NH DHHS, Maternal & Child Health Section, SYF16-SFY17 QI Workplan

Based on the above Enabling Services Workplan MCH was able to get a sense of the Enabling Services to be delivered by Agency #3.

Agency #3 outreach activities include:

- Street Outreach Nurse tours the city and surrounding area to meet homeless people who are not yet enrolled in HCH Care on a daily basis.
- Street Outreach Nurse, LICSW and Health Educator conduct outreach together to smaller shelters, addiction care centers, libraries and parks to meet and engage homeless people not yet in care.
- Community Health Worker (CHW) visits the local hospital Emergency Rooms to meet patients who are homeless and who need to be enrolled into HCH care.
- Outreach staff is also available to assist inpatient hospitalist staff and social workers with discharge planning for homeless patients on an "on call" basis.
- Most recently, the OUTREACH team has added outreach sites such as the: local county jail and parole

office to enroll former inmates and assist with their transition into the community.

- Outreach Team efforts to meet new people in need is supported by word of mouth referral/reporting among homeless population.

Agency #3 health education activities include:

- Health Education effort entails regularly scheduled classes each week offered at various shelter and addiction care venues in town. Topics cover health related or psycho-education content such as Smoking Cessation, Nutrition, Fitness, Depression, and Addiction. There is also a regularly offered series of Mindfulness Based Stress Reduction classes for groups of homeless persons and Mindfulness Based Relapse Prevention for groups of patients suffered with addiction.

Recent data requested from Agency #3 indicates the following occurred during Calendar Year 2015:

- 26% of all new patients were enrolled into Health Care for the Homeless (HCH) due to the OUTREACH team effort and the Health Education effort
- 297 Outreach contacts were made to homeless people living on the streets, in parks, on river banks
- 127 Health Education groups were conducted
- 154 one on one Health Ed encounters were completed

As the Enabling Service Workplan is intended to be a tool for continuous improvement, CHC's are encouraged to review their Workplan quarterly to determine if they are on course to achieve their targeted objectives and to identify actionable opportunities for improvement. At the end of the SFY (June 30, 2016), CHCs will be required to report their annual Workplan Outcomes. The end of the year Workplan submission allows an opportunity for the CHC to communicate to the MCH their outcome results as well as the quality improvement activities performed during the year (See below). Completed workplans are reviewed by the MCH QI/QA Nurse Consultant who then provides feedback to agencies as part of continuous improvement.

WORKPLAN PERFORMANCE OUTCOME (To be completed at end of SFY)

SFY 16 Outcome Measure:

Insert your agency's data/outcome results here for July 1, 2015-June 30, 2016

____ Target/Objective **Met**

Narrative: *Explain what happened during the year that contributed to success i.e. PDSA cycles etc.*

____ Target/Objective **Not Met**

Narrative for Not Meeting Target: *Explain what happened during the year, why measure was not met, improvement activities, barriers, etc.*

Proposed Improvement Plan: *Explain what your agency will do (differently) to achieve target/objective for SFY17*

____ **Revised Workplan Attached** (Please check if workplan has been revised)

Source: NH DHHS, Maternal & Child Health Section, SYF16-SFY17 QI Workplan

Per contracted reporting requirements each CHC collects and reports to MCH their individual agency specific data for their particular Enabling Service activities. Although this method provides MCH with specific information about individual agency activities the data currently available is limited in that it does not allow MCH to compare performance among CHCs nor does it provide a standardized measurement of the impact of Enabling Services. Recently, MCH sought to determine a standardized performance measure applicable to all agencies. As Enabling Services link individuals to the CHC as a usual source of care for non-urgent or preventable conditions, MCH has

selected reduction of preventable Emergency Department visits as a proxy measure for Enabling Services (see Enabling Services, Proposed MCH Activities).

MCH provides additional oversight by reviewing Enabling Services Workplans in person with CHC staff Primary Care site visits scheduled within each two (2) year contract period. Site visits have provided an opportunity for MCH to explore how funds have been utilized. MCH has heard from CHCs examples of how Enabling Services are improving health outcomes and reducing costs. For example:

- One agency described a patient who had been identified as a high Emergency Department (ED) utilizer having frequent subsequent hospital admissions. This patient was connected with their Case Management services. The case manager assessed the patient's physical and psychosocial status and collaborated with the client to develop a plan of care based on the patient's individual needs. As the case manager identified anxiety as a major contributor of high ED/hospital utilization the patient was referred to behavioral health services, educated to contact her medical home first (before accessing the ED) and was provided support through regularly scheduled check ins. In addition, the agency's front line staff was educated in ways to respond to this patient when she called into the office. Initially, the patient did not access the ED but was calling into the office frequently. Over time with ongoing support, education, routine Primary Care follow-up and behavioral health services the calls from the patient declined to a point where the case manager would place a call to check in with her when the agency did not hear from her for extended periods. The CHC reported improved patient outcomes and satisfaction as well as reduced cost as a result of the Enabling Services which prevented avoidable ED and hospital utilization.

Systems Building

MCH recognizes both the public health value of Enabling Services and the importance of maintaining accountability for Enabling Services provided by MCH contracted agencies. Therefore, MCH proposes to 1) expand the number of contracted agencies offering Enabling Services and 2) implement a standardized measurement to determine impact of Enabling Services as outlined below for next contract period SFY'18-19.

Enabling Service Objective 1:

MCH seeks to increase the percentage of MCH contracted CHCs with Enabling Services Workplan on file with MCH from 2015 baseline of 60% (9/15) to 80% (12/15) by October 2017. In order to attain this objective:

- MCH staff will revise contract language which will require all Primary Care contracted agencies to develop an Enabling Service Workplan for SFY18 & 19 (January 2016). The MCH QI/QA Nurse Consultant will initiate conversation with current Primary Care contracted agencies to inform them of this change during the Fall Primary Care Coordinators Meeting. MCH will provide this information in writing to agencies via the Primary Care Services, Scope of Services during the Request for Proposal process (Spring 2017).

- MCH staff will provide QI and technical support to agencies to ensure all agencies are successful in developing an Enabling Service Workplan.

Measure 1: Percentage of MCH contracted CHCs with Enabling Services Workplan on file with MCH (data source DHHS, Maternal & Child Health Section).

Numerator: Number of MCH contracted CHCs with Enabling Services Workplan on file with MCH

Denominator: Number of CHCs contracted with MCH for Primary Care Services

Enabling Service Objective 2:

MCH seeks to standardize the way MCH contracted Primary Care agencies measure the impact of Enabling

Services by July 1, 2017. In order to attain this objective MCH will:

- Review agencies Enabling Service Workplans to determine Performance Measure that reasonably applies to all agencies -Completed by QI/QA Nurse Consultant July, 2016. Rate of preventable Emergency Department visits per 1,000 population members per year.

- Review available methods to collect data -Completed by QI/QA Nurse Consultant July, 2016. Data sources: DHHS, Hospital Discharge Data System and All Payers Claims Data.

- Assess data limitations: Completed by QI/QA Nurse Consultant July, 2016. Currently MCH contracted agencies do not have equal capacity to collect data related to preventable Emergency Department visits. MCH will therefore seek to collect data from hospital discharge data systems and/or insurance claims data. MCH acknowledges that while not without some limitations hospital data and/or claims data will adequately serve as a data proxy for the direct automated flow of information. MCH is also cognizant that other funding (1115 waiver) is likely to increase the capacity for MCH to maintain such data sources.

- Initiate data collection: The QI/QA Nurse Consultant will make data query from DHHS, Hospital Discharge Data System and All Payers Claims Data to collect data for the last 3 measurement years (as available) to serve as a baseline data -To be completed within the next 6 months.

- Explore future opportunity for MCH contracted agencies to collect agency specific data. To be initiated within the next 6 months.

Measure 2: Rate of preventable Emergency Department (ED) visits per 1,000 population members per year (data source DHHS, Hospital Discharge Data System).

Numerator: Number of Ambulatory Care Sensitive Conditions (ACSC) ED visits

Denominator: Total population

MCH Specific Activities

MCH maintains responsibility for the oversight of MCH Primary Care contracted agencies and ensures program accountability and quality by the performance of the following activities by MCH staff (positions partially/fully supported by Tittle V funds):

- Contracting Process: Agencies who have submitted a Request for Proposal have their proposal reviewed by MCH staff and DHHS Contracting Unit. This process allows MCH to ensure that agencies demonstrate capacity to fulfill contracted Primary Care and Preventive Services prior to the awarding of MCH funds.

- Primary Care Services, Scope of Services: This contract document is developed by MCH staff (Program Administrator, Program Assistant, QI/QA Nurse Consultant, Child Health Nurse Consultant) prior to each two year contract cycle to clearly communicate (in writing) Primary Care contracted services and reporting requirements (Workplans, Outcome Reports, Data Trend Tables, Uniform Data Set Tables, Perinatal Client Data Form). The Scope of Services document is made available to agencies who consider applying for MCH funds prior to applying for funding.

- Fiscal Monitoring: MCH staff ensures fiscal responsibility by reviewing MCH contracted agency budget, budget justification, sources of revenue and program staff list annually. MCH staff ensures that Workplan inputs/resources are accounted for in agency's financial documents. MCH staff communicates budget discrepancies to contracted agencies for reconciliation.

- Performance Measures: MCH staff work in collaboration with other DHHS programs including: Chronic Disease Prevention and Screening Section, Bureau of Drug and Alcohol Services (BDAS), Tobacco Prevention and Cessation Program and to develop Performance Measures for MCH contracted agencies prior

to each two year Primary Care contract cycle. As the majority of Primary Care contracted agencies continue to receive MCH funding MCH elicits input from MCH contracted agencies by reviewing proposed Performance Measures and Definitions prior to implementing the measures for the next contract cycle. MCH staff review agency feedback and revise Performance Measures as needed (i.e. to better align with a comparable measure for which agencies are federally required to collect data). MCH has selected the following Primary Care, Breast and Cervical Cancer Program (BCCP), & Screening, Brief Intervention and Referral to Treatment (SBIRT) Performance Measures for SFY16 & 17:

1. Percent of infants who are ever breastfed (Title V PM #10)

2. Percent of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday (CMS, Hedis)

3. Percent of adolescents, 12 through 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year (Hedis, Title V PM #7)

4A. Percentage of patients ages 12 and older 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. (ACO 18, NQF 0418)

4B. Percentage of women who are screened for clinical depression during the post-partum visit using an appropriate standardized depression screening tool **AND** if positive, a follow-up plan is documented on the date of the positive screen (Developmental: Not required for reporting until FY 17)

5A. Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record **AND** if the most recent BMI is outside of normal parameters, a follow-up plan is documented. (ACO 16, NQF 0421, HRSA UDS)

5B. Percent of patients aged 2 through 17 who had evidence of BMI percentile documentation **AND** who had documentation of counseling for nutrition **AND** who had documentation of counseling for physical activity during the measurement year (HRSA UDS)

6A. Percent of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months **AND** who received tobacco cessation counseling intervention if identified as a tobacco user. (ACO 17, NQF 0028, HRSA UDS)

6B Percent of women who are screened for tobacco use during each trimester **AND** who received tobacco cessation counseling intervention if identified as a tobacco user. (Title V, PM #15)

7. Percentage of patients aged 18 through 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year. (ACO 28, NQF 0018)

8. Percent of patients aged 65 years and older who were screened for future fall risk at least once within 12 months. (ACO 13, NQF0101)

BCCP 1. Percent of female patients age 24-64 years of age screened for cervical cancer per USPSTF guidelines.

BCCP 2. Percent of female patients age 52-74 years of age screened for breast cancer per USPSTF guidelines

SBIRT 1. Percent of patients aged 18 years and older who were screened for substance use, using a formal valid screening tool during an annual physical **AND** if positive, who received a brief intervention or referral to services

Source: NH DHHS, Maternal & Child Health Section, 2016

- Data Collection & Analysis: At the beginning of each fiscal year the MCH QA/QI Nurse Consultant requests MCH contracted agencies to set and submit their individual agency's target for each Performance Measure. The QI/QA Nurse Consultant reviews submitted agency targets to ensure individual agencies are setting Performance Measure Outcome data is reported to MCH twice per year (January and July) via excel spreadsheets known as "Data Trend Tables" (DTT). DTTs are updated and forwarded with instructions for completion by the MCH QA/QI Nurse Consultant to contracted agencies (30 days prior to due date). Completed DTT are then reviewed and analyzed by the MCH QI/QA Nurse Consultant. The QA/QI Nurse Consultant reviews current and past data to monitor individual agency and all-agency performance outcome trends. Lower performing agencies, agencies not making improvement and performance measures not

showing overall improvement among all agencies are targeted for QI activities. Additional individual QI support from MCH QA/QI Nurse Consultant is provided as needed.

- Site Visits: MCH staff conduct Site Visits at each MCH Primary Care contracted agency at least once per each two year contract cycle to: maintain relationships with CHC staff, explore how MCH funds are utilized, review and discuss agency specific data, Workplan(s) and QI project(s), address agency identified needs, provide individual agency support, conduct chart reviews (to assess if following Bright Futures Guidelines) and monitor program compliance.

- Technical Support: MCH staff provides technical support via conference calls, Site Visits, and PC Coordinators meeting.

- Education: MCH staff disseminates information, resources and provide education via phone, emails and face to face interactions (meetings and site visits).

- Individualized agency support: MCH staff foster relationships with contracted agency staff and are available to contract agency staff as needed via phone and email.

- Quality Improvement: The MCH QA/QI Nurse Consultant collaborates with Primary Care contracted agencies to build agency capacity and staff QI skills via email, phone and face to face interactions (Meetings & Site Visits). The level of support provided by the MCH QA/QI Nurse varies as the degree of QI capacity among individual agencies varies (as described below).

Overall MCH's currently contracted agencies have moderately high to high QI capacity. The majority of MCH Primary Care contracted agencies regularly monitors performance and set goals for improvement. They have embedded QI into their agency culture by having a designated "QI team" led by a full time "Quality Assurance Manager". This type of agency allots a certain number of hours every 1-2 weeks for staff members (representing all agency roles) to participate in "QI projects". The agency sets an expectation that all staff member will participate in 1-2 QI projects each year. This expectation has become part of each staff members annual performance review. Also, the agency typically has the capacity to easily (automatically) generate data reports allowing the QI team to analyze data monthly/quarterly. These agencies have little difficulty submit their MCH data and reports on time. Furthermore, their agency typically demonstrates high level of performance per their performance measure outcomes as they regularly monitor their performance and have set thresholds that trigger deep dives or PDSA (Plan, DO, Study, Act) cycles when their data is out of range data. In essence these agencies have "their fingers on the pulse"…they are quick to respond, strategic in their QI plan and know where resources should be directed to make improvements.

· Ten (10) out of fifteen (15) agencies are Federally Qualified Health Centers and/or NCQA recognized level 3 Patient Medical Center Homes as such they are required to have an ongoing QI/QA program.

· Nine (9) out of fifteen (15) MCH Primary Care contracted agencies currently contract for clinical and administrative system infrastructure support with a Health Center Controlled Network known as the "Community Health Access Network" (CHAN). CHAN provides a computer network system responsible for integrating Electronic Medical Records, Practice Management and Accounting systems. As CHAN is responsible for writing these agency's data queries the MCH QA/QI Nurse Consultant has established contact with a specific CHAN staff member to discuss issues related to Performance Measure data collection i.e. feasibility of collecting particular data, how to align MCH Performance Measures with other federally required measures, etc. Through CHAN data reporting and analytical functions have been automated allowing CHAN affiliated QI the ability to generate real time data displays.

Although the majority of MCH Primary Care contracted agencies demonstrate the above level of QI capacity MCH does contract with two (2) or three (3) agencies that provide excellent Primary Care services but have limited QI capacity. This type of agency may assign QA/QI to a current staff member who has limited QI education/experience who may not have designated time allotted to perform QA/QI activities. Instead this staff member is likely to "stay late" after they finish their "real job" to complete mandatory QI activities. This agency

may have IT systems that do not easily capture data from the EMR. Due to limited QI/QA capacity the agency may only submit to MCH what is minimally required (one workplan). The agency may panic when they receive documents from MCH to complete their reporting requirements. The agency may struggle to generate data reports when they are due and are surprised when their data shows poor performance. They may disregard their performance outcome data as they "know" they do a good job. This type of agency receives additional individual support from the QA/QI Nurse Consultant by email, phone or in person as needed to build staff QA/QI knowledge and skills so they can improve their QI initiatives and successfully complete MCH reporting requirements.

State Performance Measure #3:
Percent of behavioral health professionals recruited (# of "active" contacts/# of contacts)

Data Analysis

This is a brand new measure so has no existing or historical data to review. However, the outcome of the previous five (5) year state performance measure related to mental health "the rate of psychotherapy visits for adolescents' ages 12-18 years who have a diagnosed mental health disorder" has stagnated over the last three (3) years in the low 60s.

As was discussed previously, New Hampshire has struggled to keep up with the growing need for any type of behavioral health care, particularly in the field of pediatrics. A mental health strategy report out of DHHS found that declining Medicaid funding and lack of available inpatient alternatives were significant barriers to obtaining treatment.[9] Wait times for new and old patients for psychiatry services are often over 30 days.[10]

New Hampshire is also in the midst of trying to implement changes to the community mental health system necessary to meet the terms of a class action lawsuit, *Amanda D, et al. v. Hassan, et al. 2014*. Many of these changes focus on enabling a class of adults with serious mental health illness to receive needed services in the community through the use of mobile crisis teams amongst other strategies. A recent report however from the court appointed monitor on the case, states that New Hampshire has continued to miss deadlines, particularly for the expansion of Assertive Community Treatment Teams and Mobile Crisis Units, leaving some "patients without treatment, waiting in hospital emergency rooms for high-level care or institutionalized when they could otherwise be receiving care through community clinics and services". [11] It is estimated that the number of patients needing in-patient behavioral health care waiting on an average day in hospital emergency rooms in New Hampshire rose to 28 in state fiscal year 16 from 24 in state fiscal year 14.[12] The number of people waiting for inpatient admissions is usually indicative of a need for enhanced crisis response and high intensity community supports. Community mental health centers have pointed to severe workforce shortages as a reason for the problem.

The Children's Behavioral Health Collaborative recently released report *Improving Child and Community Health: Addressing Workforce Challenges in Our Community Mental Health Centers* [13] states that community mental health centers have a high staff turnover, as high as one (1) in five (5) per year for children's providers. Reasons include low wages and a high burden of paperwork. Suggested interventions include those of a financial (state loan repayment, higher insurance payments) and management (peer and mentor support, generous professional training) state.[14]

New Hampshire has slightly increased its overall Medicaid funding available to the community mental health centers via the contracts with the two MCOs. However, the community mental health centers are still in the last stages of negotiating sub-capitation contracts with the MCOs so all is not set.

Systems Building/ MCH Specific Activities

MCH has just established at the minimum a two (2) year contract with the Bi-State Primary Care Association's Recruitment Center (the Recruitment Center). The Recruitment Center is the regions only non-profit state focused recruitment resource. For many years, the Recruitment Center had identified and matched primary care doctors, dentists, nurse practitioner, physician assistants and nurse midwives with practices and communities throughout New Hampshire that met their personal and professional needs. The Recruitment Center has had a contract with the

Rural Health and Primary Care Section (MCH's colleague within DPHS) and the state's Medicaid Program. Recently, the Division of Behavioral Health out of NH DHHS, which includes the Bureau of Children's Behavioral Health, the Bureau of Behavioral Health and the Bureau of Drug and Alcohol Services enhanced the Recruitment Center's contract to include behavioral health providers, which in this instance means psychiatrists, clinical or counseling psychologists, nurse practitioners, clinical social workers, licenses professional counselors, family therapists, licensed alcohol and drug counselors and masters prepared licensed alcohol and drug counselors. MCH leveraged that funding with additional monies and increased the behavioral health piece of the Recruitment Center's contract with the Division of Behavioral Health. However, MCH's piece focuses on recruiting behavioral health providers for its Title V funded agencies (including home visiting) and also for the behavioral health referral sources for its MIECHV home visiting agencies.

The overall objective of this measure is to increase the recruitment of behavioral health professionals by ten percentage points from an estimated baseline of 25% to 35%. This is an estimation from the Recruitment Center based on their primary care workforce recruitment activities.

One of the first tasks for the Recruitment Center will be to conduct an assessment of the behavioral health workforce needs of the agencies involved as well as establishing a vacancy tracking system. This will be done as part of the larger behavioral health needs assessment as part of their (the Recruitment Center) total contract. It will also take into account efforts to date in the state such as the Children's Behavioral Health Collaborative previously discussed report, which states that recruitment and retention issues must be addressed before anything else.

The work of the Recruitment Center also includes establishing relationships with training programs in the state/region for pipeline development. Research shows that where one does an end degree training program (e.g. residency, fellowship, internship, etc.) is more predictive of future practice location than is graduate or medical school. [15] Data from the most recent physician survey from the Rural Health and Primary Section show that the top five (5) residencies where the most recently graduated practicing physician trained were almost all New England/New York. [16] This data is a key resource in recruitment initiatives.

Different activities will be implemented to attract behavioral health providers to the state including using national publications, targeted mailings, direct recruitment with colleges and universities and direct contact with practicing providers. Information on barriers and best practices will be shared with MCH and other vested stakeholders such as the Children's Behavioral Health Collaborative and NAMI NH. Numbers of contacts will be tracked. A contact is considered "active" if that person has sent a resume or expressed interest to the recruitment center in seeking a position. Those active contacts divided by the number of total contacts is the percentage of recruited professionals. From an "active" status, an individual is then referred for matching to the recruiting agency for potential interviews, etc.

The MCH Administrator will also continue working with the Children's Behavioral Health Collaborative (CHBC) on the implementation of "*Transforming Children's Behavioral Health Care: A Plan for Improving the Behavioral Health of NewHampshire's Children*". The MCH Administrator is part of the CHBC's Workforce Development Network, which develops and delivers cross-disciplinary education and training activities for professionals who work with children and adolescents with behavioral health issues. The mission of this workgroup is to ensure a "highly effective diverse workforce by building a sustainable, responsive and effective cross sector system of workforce development". [17] The workgroup has developed: 1) children's behavioral health core competencies; 2) online training modules on topics related to children's behavioral health; 3) cross-walked the core competencies with undergraduate and graduate programs in behavioral health in the state and 4) a system and selection of a wraparound model of services.

There are also several other statewide endeavors around behavioral health workforce recruitment including the previously described Medicaid 1115 DSRIP waiver which focuses on behavioral health and primary care integration through seven (7) IDNs throughout the state and the Citizens' Health Initiative Behavioral Health Integration Learning Collaborative. The DSRIP Waiver has as one of its goals to expand the behavioral health workforce, thereby increasing access to services for Medicaid enrollees in the state. MCH staff have been actively involved in all DSRIP activities including a second goal which focuses on the integration of behavioral health into primary care.

A proposed grant at a grant at Antioch University New England would enable post graduate psychologists to get a

training salary at seven (7) designated integrated behavioral health and primary care sites across the state. The Governor's Primary Care Workforce Commission is also working with the Commissioner of the Insurance Department to investigate reimbursing integrated behavioral health and primary care providers for additional health/behavior codes.

[1] http://childhealthdata.org/learn/NSCH Accessed July 5, 2016.

[2] National Jewish Health, QuitLogix. https://www.nationaljewish.org/Health-Initiatives/Tobacco-Cessation/About-Quitlogix accessed 07/12/16.

[3] Centers for Disease Control and Prevention, *Tips* Media Campaign. http://www.cdc.gov/tobacco/campaign/tips/stories/amanda.html accessed 07/11/16.

[4] Centers for Disease Control and Prevention, Tips Media Campaign. http://www.cdc.gov/tobacco/campaign/tips/about/impact/campaign-impact-results.html accessed 07/11/16.

[5] NH DHHS, Maternal & Child Health Section: Uniform Data Set Table, 2015

[6] NH DHHS, Maternal & Child Health Section, 2015 UDS data

[7] NH DHHS, Maternal & Child Health Section, 2015 UDS data

[8] NH DHHS, Maternal & Child Health Section, 2015 UDS data

[9] NH DHHS, *Addressing the Critical Mental Health Needs of New Hampshire's Citizens, A Strategy for Restoration*. http://www.dhhs.nh.gov/dcbcs/bbh/documents/listeningsessions.pdf accessed on 07/06/16.

[10] Rural Health and Primary Care Section, Results of Physician Survey communicated through professional email 07/10/16.

[11] New Hampshire Community Mental Health Agreement, Expert Reviewer Report Number Four, June 29, 2016. http://www.dhhs.nh.gov/dcbcs/bbh/documents/cmha-report-07052016.pdf accessed 07/10/16.

[12] ibid.

[13] Children's Behavioral Health Collaborative, *Improving Child and Community Health: Addressing Workforce Challenges in Our Community Mental Health Centers*. http://www.endowmentforhealth.org/uploads/resources/id107/CMHC_Workforce_Full_Report_2016.pdf accessed 07/11/16.

[14] ibid.

[15] DHHS Rural Health and Primary Care Section, Physician Survey 2015. Internal communication with staff.

[16] ibid.

[17] New Hampshire Children's Behavioral Health Collaborative, Workforce Development Network. http://www.nh4youth.org/collaborative/workgroups/workforce-development-network accessed 07/06/16.

Cross-Cutting/Life Course - Annual Report

State Performance Measures 2011-2015

State Performance Measure #4 Percent of Community Health Centers providing on-site behavioral services

Data Analysis

MCH conducts site visits and an annual survey to its funded CHCs including those providing care for the homeless, to assess how behavioral health services are integrated into routine health care for clients. Assessment is done based on the following categories of integration:

#1: Preferred Referral: Agency has an agreement or relationship with a specialty organization to accept referrals or "work them in" based on need.

#2: Collocation: Agency has specialty behavioral health that's provided on-site either full-time or part-time that provides traditional care based on referral; may be in a bidirectional approach.

#3: Enhanced collocation: Agency has specialty behavioral health care provider on site full-time or part-time that provides traditional care and some in-room sessions for patients within primary care; focused on mental health issues.

#4: Fully Integrated: Agency has a skilled behavioral health care provider embedded full-time or part-time on primary care team that serves the primary care population through brief interviews and longer traditional care.

In the most recent survey (June 2016), 33% of the agencies fell under category three (3) and 53% under category four (4) with only two agencies (14%) each respectively in a category one (1) and two (2). It's interesting to note that out of the latter two agencies, one is neither an FQHC nor a RHC, and thus does not have either the funding or the mechanism for additional reimbursement that the other CHCs do. The other is a RHC owned by a hospital, which is gearing up towards implementing a category two (2) this coming year as part of a large building renovation. Several of the category three (3) and four (4) agencies that are also FQHCs have received federal HRSA and/or SAMHSA grant funding for behavioral health integration projects which have enabled them to achieve their status.

Systems Building

In State Fiscal Years 16/17, CHCs were allowed to utilize MCH funding for enabling services such as care coordination and quality improvement. Some agencies utilized a portion of the funding to provide otherwise non-billable mental health. For example, a CHC that provides services for the homeless hired a part-time psychiatric nurse practitioner by braiding Title V with other sources of funding. Since this addition, the agency has been able to address co-occurring mental health/substance use disorders promptly on site. This has been crucial because in the past when referring homeless patients, they would often get lost to follow-up or sometimes not even go to the referral because of distance and fear. The psychiatric nurse practitioner participates weekly with medical providers on the homeless team to discuss cases and to conduct care management.

MCH Specific Activities

MCH staff also worked with the Bureau of Drug and Alcohol Services to integrate funding into its FY16/17 primary care agency contracts for a Screening, Brief Intervention, and Referral to Treatment (SBIRT) program to be provided and recorded for all qualified individuals ages 18 to 65. Because of behavioral health integration, many of the MCH/Title V funded CHCs were able to provide a "warm hand off" from the physical health staff because a fully integrated team is always present.

MCH is also continuing to implement its SAMHSA funded Project LAUNCH (Linking Access to Unmet Needs in Children's Health) in the community of Manchester, where integrating behavioral health into primary care practice (in this case Manchester Community Health Center, an MCH/Title V funded CHC) is a focal intervention.

MCH continued to share information about training and education opportunities and potential funding sources, for staff of community health centers to increase their knowledge and expertise about caring for primary care patients with behavioral health issues. One of these opportunities, the New Hampshire Behavioral Health Integration Learning Collaborative (BHILC), began this past year. Out of the state's Citizens Health Initiative and funded by the Endowment for Health, the goals of the BHILC include:

- Advancing the status of participating organizations on the continuum of primary care behavioral health integration.
- Developing sustainable payment models to support the practice of integrated care.
- Demonstrating improvement on key quality and cost measures, using EMR reporting tools and claims-based analytic reports.

Initially, the level of behavioral integration existing in participating practices (of which there are one third of the fifteen MCH funded CHCs involved among the other primary care practices, health systems, behavioral health providers, health care payers and other stakeholders) was identified and progress is being tracked over time. The Learning Collaborative, which also includes the MCH Administrator and QI/QA Nurse Consultant, focuses on improving care for common behavioral health conditions, such as depression, in the context of primary care practice. The following visual shows the topics of the monthly webinar and in person Learning Series:

[1]

The April 2016 BHILC session on “Payment, Contractual and Financial Models for Integrated Behavioral Health in Primary Care” involved many conversations highlighting themes such as:

- The need for more conversation around payment and services
- Clinical staff’s limited understanding of the way to maximize reimbursement
- Integrating cultures across multiple disciplines and specialties
- Electronic medical records are not integrated between behavioral and physical health
- Gap between clinical and information technology systems within and across agencies, large systems and communities

In September, there will be a full day, in-person learning symposium where outcome data will be shared. It is hoped that MCH funded CHCs continue to take advantage of learning opportunities such as the BHILC and the upcoming focus on behavioral integration in the implementation of the large CMS 1115 Waiver DSRIP process that the state is beginning.

MCH continued to work with the Children's Behavioral Health Collaborative on the implementation of *Transforming Children's Behavioral Health Care: A Plan for Improving the Behavioral Health of New Hampshire's Children*. The MCH Administrator also sits on the Primary Care Workforce Committee, a legislated group that works on issues with

respect to improving the availability of workforce, including behavioral health practitioners working in primary care.

State Performance Measure #7: Percent of households identified with environmental risks that receive healthy homes assessments

Data Analysis

The 2015 objective (67%) was exceeded this year by an indicator of 69.2%, up from 62.7% in 2011. Many factors go into this including a full cadre of staff in the Healthy Homes and Lead Poisoning Prevention Program (HHLPPP).

Systems Building

The HHLPPP continued working with the Department of Information Technology (DoIT) building program capacity for the implementation of the CDC Healthy Homes and Lead Poisoning Surveillance System (HHLPSS), a new data management system for collecting and storing children and adult blood lead data that includes a module for healthy homes variables and nurse case management. It is anticipated that the HHLPSS will be implemented in February 2017 and will replace the current CDC STELLAR system, which is a 23 year old DOS based surveillance system. This web-based system can be accessed remotely by Lead Nurse Case Managers in the Cities of Manchester and Nashua Health Departments.

The HHLPPP and the program Epidemiologist continued to collaborate with the DPHS' NH Health WISDOM (Web-based Interactive System for Direction and Outcome of Measures) to design an online portal for the organizing and community access of Healthy Homes data. This has not been finalized.

The HHLPPP successfully collaborated with the Childhood Lead Stakeholders Group to support legislation that was signed into law that provided education and outreach to all families and property owners with elevated blood lead above 5 micrograms per deciliter (RSA 130-A:1 http://www.gencourt.state.nh.us/rsa/html/x/130-a/130-a-mrg.htm).

The HHLPPP collaborated with the Childhood Lead Stakeholders Group to support legislation that was passed into law that supported a commission to look at barriers to increasing lead poisoning screening rates for 1 and 2 year olds to 85% by the year 2017 (RSA 130-A:19 http://www.gencourt.state.nh.us/rsa/html/x/130-a/130-a-19.htm).

MCH Specific Activities

The HHLPPP continued to convene the statewide Healthy Homes Steering Committee and/or workgroup on a monthly basis that coordinated and implemented healthy homes priorities. Both the Injury Prevention Program Manager and the MIECHV Coordinator sit on this committee.

The Healthy Homes Steering Committee successfully coordinated the 5th Annual New Hampshire Healthy Homes Conference on October 2015. A total of 275 people from across the state were in attendance learning about the connection between housing and health as it pertains to lead, asthma triggers, poisons and slips, trips and falls. Over 95% of the attendees found the conference beneficial to their day-to-day job.

The HHLPPP successfully collaborated with the Healthy Home Steering Committee and provided a two (2)-day *Essentials for Healthy Home Practitioners* training that was offered to Title V funded Community Health Centers.

The HHLPPP continued to provide technical assistance to partners throughout the state that included HUD grantees, regional healthy homes committees, health and code officials, energy auditors, home visitors and MCH-funded agencies and programs to build Healthy Homes *One-Touch* Home visiting capacity to assess homes for hazards, educate families and make referrals for in-home interventions. An estimated 26 home visiting agencies statewide, with approximately 100 home visitors use *One-Touch* resulting in over 300 homes annually that have been checked.

The HHLPPP successfully developed technology to transition the Healthy Homes *One-Touch* surveillance data from a paper collection system to an on-line portal through Fluidsurvey. With Fluidsurvey, home visitors are able to use tablets onsite to collect housing information which can translate into referrals for health and housing interventions.

MCH continues to invite HHLPPP staff to its Primary Care Coordinators' Meetings.

State Performance Measure #8: The percent of public water systems that optimally fluoridate the water system on a monthly basis

Data Analysis

Although not meeting the 2015 objective of 70%, the 2015 indicator of 60% is way above the starting 10% in 2011. In 2014, the Oral Health Program (OHP) incorporated an evaluation of NH's Water Fluoridation Reporting System (WFRS) into New Hampshire's first CDC Cooperative Agreement, the *NH Oral Disease Prevention Program.* To be considered optimized by the CDC, a fluoridated water system's monthly average fluoride level must be within the optimal range 80% of the days it is producing water for at least 9 months a year. The 2014 evaluation reported that during in 2013, 8 of 19 operating wells (and 4 water systems) among the ten NH fluoridating systems were optimally fluoridating their water. As part of the evaluation, the OHP surveyed the ten (10) fluoridated water systems to determine NH-specific community water fluoridation gaps and needs and gathered suggestions for systems improvements. Eight representatives of the 10 NH water systems that are fluoridated responded to the survey. In order to increase fluoridation optimization rates, 63% agreed that water systems needed to replace old fluoridation equipment with new improved equipment. The OHP submitted a proposal in June 2015 to use newly available funds from the Preventive Block Grant to replace outdated fluoridation equipment that was denied.

Systems Building

Based on recommendations from the 2014 evaluation NH WFRS, the NH Department of Public Health Services (DPHS) collaborated with the NH Department of Environmental Services (DES), to convene fluoridation training for staff from the ten (10) fluoridated water departments. The peer training event took place at the Laconia Water Works. Staff from DES, DPHS, OHP and employees from fluoridated water systems across the state learned about routine operations at the Laconia Water Works. Participants also heard about recent improvements in the Fluoride Monthly Operating Reports (MORs) sent from water facilities to NH DES and the OHP. MORs provided water system staff with timely feedback that contributed optimized levels of added fluoride to NH public water systems. DES and the OHP completed the fourth community water fluoridation training organized through the DES/OHP partnership.

With CDC funding to build program leadership capacity, the Oral Health Program Coordinator attended a three (3) day CDC sponsored Community Water Fluoridation Workshop in Murfreesboro, TN to develop knowledge and skills on the collection, analysis, and reporting of fluoridation data.

The OHP posted NH specific fluoridation data on NH's Web-based Information System for Data and Outcome Measurement (WISDOM) and linked it to CDC's site, *My Water's Fluoride*.

The OHP enhanced its contact with fluoridated water systems staff and with Kip Duchon, CDC Fluoridation Engineer, in order to increase the number of fluoridated water treatment systems that are optimized.

The OHP provided technical assistance to communities interested in community water fluoridation as the most effective means of improving the public's oral health across all age and income groups.

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[1] Citizen's Health Initiative, http://www.citizenshealthinitiative.org/behavioral-health-integration-learning-collaborative accessed 06/28/16.

Other Programmatic Activities

No content was entered for Other Programmatic Activities in the State Action Plan Narrative section.

II.F.2 MCH Workforce Development and Capacity

The state level MCH section workforce currently consists of 22 positions, including a contracted .8FTE

Epidemiologist, 17 FTEs and four part-time staff making up an additional 2.4 FTEs. Ten of the positions are funded in full or part by Title V. MCH is headed by an Administrator who is the MCH Title V Director and responsible for all of its activities. MCH has five (5) programmatic units, which are headed by the management team including an additional QA/QI Nurse Consultant, Executive Secretary and Program Assistant that report directly to the Administrator. The programmatic units are Child Health and Infant Screening (five positions), Data and Decision (five positions), Young Families (four positions), Women's Health (two positions) and Injury Prevention (two positions). The MCH management team meets bi-monthly and monthly for a dedicated finance meeting.

SMS has also undergone significant change in the past year. The major catalyst was the addition of the Family Centered Early Supports and Services program (FCESS), NH's Part C Early Intervention Program. FCESS brought three (3) FTEs and 10 contracts with community agencies. Although not funded by Title V, FCESS is designed for children birth through age three (3) who have a diagnosed condition that has a high probability of resulting in delay, are experiencing developmental delays or are at risk for substantial developmental delays if supports and services are not provided. SMS currently has 17 FTE positions which are all filled; however, two (2) will be retiring soon.

Although MCH has 22 positions, only 18 of those are filled. This year brought many changes, including the loss of the new Injury Prevention Program Manager, the Executive Secretary, the Newborn Screening Program Specialist and the Early Childhood Special Projects Coordinator (who managed home visiting and Project LAUNCH). Two (2) of the four (4) are funded by Title V. However, with loss comes the opportunity to re-evaluate and perform an internal staffing needs assessment. The Injury Prevention Program Manager's role was recently filled by the long standing Injury Surveillance Coordinator. The Early Childhood Special Projects Coordinator position is proposed to be split into two positions, a Home Visiting Administrator and an Early Childhood Comprehensive Systems Manager. Both of these changes require additional internal processes including job reclassification and establishing a new position. This must occur prior to posting and interviewing. It is anticipated that all of these steps could take up to six months, if not more. The Young Families unit is also in the process of extending the Young Child Wellness Advisor position to full time and establishing a Home Visiting Data Coordinator. Rounding out the list of potential changes is revamping the Program Evaluation Specialist Position into an Adolescent Health Coordinator and revising the duties of the Injury Surveillance Coordinator to include the full spectrum of maternal and child health data systems.

Higher learning institutions in the state have expanded the pool of applicants searching for a career in public health. This past year, Colby Sawyer College instituted a B.S. in public health. This has increased the number of interns within DHHS. In addition, the University of New Hampshire (UNH) and Dartmouth continue to expand their Master's and Doctoral programs in public health and many DHHS personnel attend classes. Title V has a strong relationship with the UNH/Institute on Disability's Leadership in Neurodevelopmental Disabilities Program (LEND). Both the MCH and SMS Administrators are on their Advisory Board. SMS and LEND have an MOU that details their ongoing collaboration for trainee placement and development. Three (3) MCH personnel are currently attending the Clinical Microsystems Improvement class this semester at the Dartmouth Institute for Health Policy and Clinical Practice. The class focuses on quality improvement in clinical focus areas.

Evaluation, public health sciences and financial management were identified as workforce development areas during last year's SMS/MCH CAST-V (Capacity Assessment for State Title-V) and DPHS's internal workforce assessment. Several short presentations on these and other topics were given at the bi-monthly MCH management team meeting, which were open to the whole section. Additional focused presentations will be given during the next year. Several MCH staff is certified yellow belts in Lean Six Sigma offered by DPHS's quality improvement team and have taken on projects within the section.

SMS and MCH staff participate in the MCH Navigator which is specific to Title V leadership competencies. This will enable staff to identify training needs to create a personalized learning plan. In addition, staff will be offered the 5-Minute MCH Program to enhance their competencies. SMS is also working on creating core competencies and core

training requirements for Care Coordination. MCH management is participating in AMCHP's new Workforce Development Solution Series with the all managers attending the first session on "Building Bench Strength."

MCH works in tandem with the Rural Health and Primary Care Section (RHPC) within DPHS who are responsible for coordinating the Health Professional Shortage Area (HPSA), Medically Underserved Area/Populations (MUA/P), and Rural Health Clinic (RHC) designation processes. In the next year, the RHPC will be submitting two HPSA designations in the only two large geographic areas that have no designation at all (Sullivan and Cheshire counties).

Within the past year, the MCH Administrator was invited to sit on the Legislative Commission on Primary Care Workforce Issues, facilitated by the RHPC. Meeting monthly, the group is charged with recommending policies and programs to increase the number of individuals in health professions serving rural and underserved areas, with a focus on primary care. Many of its members are practitioners at MCH/Title V funded agencies. This body has had many successes this year including increasing the available loan repayment monies for the State Loan Repayment Program (SLRP), a commitment from the Board of Medicine to support legislation authorizing a survey requirement for both physicians and physician assistants, and establishing a group to discuss and explore regional opportunities for family practice residencies in the state.

Because of the additional funds for the SLRP, the RHPC determined that it could be used to leverage support of the one MCH/Title V supported community health center that does not have any federal designation, Concord Hospital Family Health Center (CHFHC). Currently, there are 45 active SLRP participants in the state (with a waiting list), with 33 of those being at designated rural agencies and the majority being MD/DOs and APRNs.

There are presently 53 active J-1 Visa waiver participants practicing in the state. In the past year, nine (9) practitioners were receiving funds from the National Health Service Corps.

MCH has supported the RHPC's efforts to continue the NH Physician Survey (NHPS) underneath the NH Professional Data Center (HPDC). Both allow the state to collect the current and anticipated supply of health care professionals who make up the healthcare workforce and the current and anticipated demand for healthcare services in the state. The NHPS questions utilize at their core a national minimum data set. Surveys go out with licensure renewal. The NHPS and the HPDC are a coordinated approach to the collection of the state's primary care workforce data on a consistent basis, and will collect data from all practicing, licensed providers in New Hampshire. Because the regulatory body, the Board of Medicine, anticipated an administrative rules change to mandate the survey, strong language incentivized approximately 90% of New Hampshire practicing physicians who were due to renew their medical license (approximately 50% of licensed physicians) to complete the survey. However, the Office of Legislative Services determined that the Board of Medicine did not have the authority to require survey completion through an administrative rules change. In the upcoming year, legislation will be introduced authorizing health professions' licensing boards to require survey completion as a condition of license renewal.

MCH meets on a monthly basis with staff from the RHPC in addition to the Bi-State Primary Care Association (Bi-State). Bi-State's Recruitment Center provides, along with the RHPC, workforce assistance and candidate referrals to FQHCs, RHCs and private and hospital-sponsored physician practices. This includes many of MCH's contracted CHCs who have benefited from these services. The number of vacancies rose from 44 last year to 77 currently. MCH will be leveraging carryover MIECHV funds with additional Medicaid, RHPC, and Bureau of Drug and Alcohol Services' dollars to increase funding to Bi-State's Recruitment Center to expand their efforts and manage the state's workforce pipeline. MCH's share is specifically focused on the behavioral health workforce serving the pediatric and perinatal populations.

II.F.3. Family Consumer Partnership

Building and strengthening family and consumer partnerships, including the assurance of cultural and linguistic competency and the promotion of health equity is very important in the work of the Title V program.

Maternal and Child Health Section

During the course of the past year, MCH staff and management have intensified their effort to increase understanding of and their involvement with family consumer partnerships. MCH is committed to creating a culture where family engagement and equal partnerships are a given amongst staff and contractors. This is evident through the following examples of MCH specific strategies and activities:

Professional Development: MCH's Administrator, Rhonda Siegel, joined AMCHP's one year Family Engagement Community of Practice in December 2015. Its goal is to increase Title V capacity to engage families by offering a platform to share ideas, lessons learned and best practices from subject matter experts. Twelve state administrators meet by phone monthly with members taking turns facilitating calls. It is interesting to note that Ms. Siegel is the only MCH affiliated administrator involved. All other colleagues are CSHCN administrators. Discussion topics have included:

- Institutionalizing family engagement
- Training and professional development/Introducing Title V

Ms. Siegel has been sharing the ideas and resources discussed with her bi-monthly MCH management team. Of particular interest and importance was the discussion on the method of engagement (advisory councils, etc.) and tools on evaluating the level of engagement and resources for introducing family members to Title V in general.

The MCH Administrator and a representative from NHFV have also been participating in the statewide Family and Youth Engagement Workgroup sponsored by the Department of Education: Office of Student Wellness (SAMHSA's Project Aware Safe Schools/Healthy Schools recipient) and the Endowment for Health (NH's largest health related philanthropic agency). This group is designed to expand and improve parent and youth engagement in community and state activities that promote the social-emotional development and behavioral health of NH children. A study of best practices in parent/caregiver engagement and leadership development was commissioned, but is still in draft format. A second, simultaneous step, also in draft, was the preparation of an environmental scan which will present information about current state practices related to parent and youth engagement and leadership development. Involvement in this workgroup has enabled MCH to continue gaining a deeper understanding of successful family engagement as well as create partnerships with agencies (other than existing ones with NHFV and LEND) that provide leadership training to families such as the Granite State Federation of Families for Children's Mental Health.

Advisory Committees: MCH is most likely to involve families within their several programmatic advisory committees including, but not limited to, the Injury Prevention Advisory Council, the Newborn Screening Advisory Committee (which has several members with children with diagnosed metabolic disorders) and the Newborn Hearing Quality Improvement Committee. However, it is often difficult to get families and consumers to a statewide committee, which often meets far from their residence and at inconvenient times.

This past year, when discussing the addition of Krabbe to the screening panel, the Newborn Screening Program reached out to the Hunters Hope, a parent run national advocacy organization. As a result of this engagement, two distinct things happened. The first was that Hunter's Hope enabled the Newborn Screening Advisory Committee to hear via webinar a presentation from Dr. Joanne Kurtzberg, a leading authority whose team has treated more children with rare genetic diseases than any other center in the world. Dr. Kurtzberg is seldom available and it was only through Hunter's Hope that the connection was made. The second was the group's encouragement of a local family's involvement and advocacy with respect to the Newborn Screening Program.

In addition, MCH CHCs, the majority of which receive Federal Section 330 grants as an FQHC or look-alike, are required to be governed by a board of directors. The board must include a majority (at least 51%) of active, registered users of the health center who are representative of the populations served.

Quality Improvement: MCH requires their funded CHCs to submit patient surveys on an annual basis. FQHC status also requires this as does Medical Home Certification by the National Committee for Quality Assurance. The majority of MCH funded CHCs have applied and received or are in the application process for a variety of levels of Medical Home certification. Most of the patient surveys include questions on satisfaction with respect to access, information, communication, coordination of care, comprehensiveness of care and self-management support and

shared decision making.

The Newborn Hearing Quality Improvement Committee, which meets three times a year, asks for input/feedback from representatives from hospitals, parents, and Part C-Early Intervention Services. Recently, it asked for input on the performance measures sent to all birth facilities. Based on feedback, the performance measure reports were improved to include a list of infants that were not entered into AURIS, the secure web base data system, and a list of infants who received an initial screen and no rescreen. Including a list of infants not entered into AURIS provides the hospital with data so that overall screening percentages can be increased. The 2014 statewide screening rate was 96.5%. By asking hospitals to enter infants identified as not being entered in AURIS, the screening rate increased to 97.2% with a decrease in infants not screened from 3.5% to 2.8%.

Materials Development: There are several instances where MCH programs routinely involve consumers in materials development:

The Family Planning Program requires that brochures and informational materials given out within the context of Title X services be approved and vetted for accuracy and context by an Information and Education Committee. It is recommended that these groups have patient and/or adolescent representation.

In the upcoming year, the Newborn Screening and Newborn Hearing Screening Programs are jointly working on an informational brochure being market tested with focus groups of families across the state. This project, facilitated through a contract with the Community Health Institute, will result in materials on newborn screening that are truly client informed.

Special Medical Services
SMS has a very strong and longstanding collaboration with NHFV, which is also the state's Family-to-Family Health Information Center. SMS has funded parent consultation through NHFV for more than 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 consistently seeks input from NHFV when making any kind of administrative rule or policy change. This partnership includes the provision of in-kind office space, allowing NHFV and SMS to be co-located. NHFV has also participated in discussions with other DHHS agencies, including MCH, Medicaid and DCYF, regarding rules, services and family needs. In this past year, family partnership was integral to the successful transition of CSHCN into mandatory managed care coverage. The CSHCN Director was successful in getting NH Family Voices invited to the Communication Workgroup for this project. They were active members and generated family friendly educational materials to assist families in understanding what managed care is and how it works.

SMS has worked closely with NHFV on QI activities. The SMS Administrator is the Principal Investigator on two federal grants for *Improvement of the System of Care for Children and Youth with Epilepsy* and for the development of an Autism State Plan. These proposals were designed to embed family engagement in all activities. NHFV is the contracted Project Coordinator for each. This model has worked well for the state's Medical Home activities, which focus on the development of family advisories at the practice level. The proposal for development of an Autism State Plan had a major emphasis on family and consumer partnership and participation. This included focus groups and workgroups that included parents, family members and self-advocates.

SMS has representatives working with a variety of advisories and councils with strong family participation. These include the Autism Council, the Council for Youth with Chronic Conditions, the Behavioral Health Advisory Council, and the Interagency Coordinating Council. Additionally, SMS benefits from feedback from a stakeholder group hosted by the Partners in Health Program.

II.F.4. Health Reform

MCH has continued to implement the advancement of the ACA in several ways. Last year, the MCH performance measures for the 15 Title V funded CHCs were re-aligned during a large collaborative project to mirror those that were already being reported to the centers' affiliations with accountable care organizations (ACOs), the National

Committee for Quality Assurance's medical home designation, Medicaid Managed Care, the Federal Government's designation status as an FQHC or RHC and most importantly the MCH selected Title V National and State Performance Measures. All but four (4) of the 15 contracted CHCs are FQHCs. Two (2) of the remaining four (4) are designated as RHCs. All are at varying different levels of being certified as Patient Centered Medical Homes. Many of MCH's contracted CHCs are also members of a variety of ACOs including, but not limited to, the North Country ACO and New Hampshire (NH) Accountable Care Partners. Several are also part of the NH Accountable Care Project, a collaboration of the Citizens Health Initiative and the Institute for Health Policy and Practice, who also work to align efforts across payers and payment/quality initiatives.

An initial set of MCH performance measures was included as part of the community health centers' two year contract, which started July 1st of 2015. Throughout the past year, MCH staff, particularly the QA/QI Nurse Consultant, have been working with the community health centers respective quality improvement teams to refine these measures. A key player in these efforts has been the QI Director from the Community Health Access Network (CHAN). CHAN is the only Health Center Controlled Network (HCCN) in NH and supports the EMR for nine (9) of MCH's CHCs. This is particularly important since CHAN provides the lead on clinical and operations report development and production for its member sites. Other key players in this work have included the newly formed DHHS Office of Quality Assurance and Improvement (QAI). Overseeing efforts primarily within Medicaid, QAI has oversight over the Medicaid Quality Improvement System (MQIS), which hosts the performance measures reported by the two Medicaid MCOs and an external quality review organization, the Health Services Advisory Group.

With the assistance and collaborative work of all of these partners, MCH has instituted performance measures that are consistent with current national instruments. In addition, the majority of the new performance measures reflect the selected MCH Block Grant National Performance Measures (NPMs). The following are examples of the primary care performance measures with their reference to other standard measures including the Title V NPMs.

- Percent of patients aged 2 through 17 who had evidence of BMI percentile documentation and who had documentation of counseling for nutrition and who had documentation of counseling for physical activity during the measurement year (HRSA UDS, Title V NPM #8).
- Percent of adolescents 12 to 21 years of age, who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year (HEDIS, Title V NPM #10)
- Percent of women who are screened for tobacco use during each trimester and who received tobacco cessation counseling intervention if identified as a tobacco user (Title V NPM #14A)
- Percent of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months and who received tobacco cessation counseling intervention if identified as a tobacco user (ACO 17, NCQA 0028, HRSA UDS, Title V NPM #14B)

MCH is also helping to advance the ACA in its emphasis on "gap" services, in this case the focus on enabling services and quality improvement projects in the funded CHC contracts. The majority of funding in these contracts, which started July 2015, has enabled the implementation of two-year quality improvement projects which have to enhance clinical workflow/improve patient outcomes (e.g. alerts, guidelines, etc.). The projects, which will reported on in next year's grant, must lead to measurable improvements on any of the performance measures identified in the contracts. Enabling services, all of which aren't compensated by any other sources, are allowed to include, but are not limited to, case management, benefits counseling, eligibility assistance, health education and supportive counseling, interpretation, outreach, transportation and the education of patients and the community regarding the availability and appropriate use of health services.

Many of the CHCs utilize their MCH/Title V funding for staffing that is not alternatively paid for by other grants or fee

for services through insurance. Much of the funding is leveraged against other sources, making for full time employment.

Four (4) of the CHCs utilized Title V funding for increasing their use of benefits counseling and eligibility assistance, otherwise known as patient navigators. These positions' chief role is to provide impartial information about the NH Marketplace, to help patients understand and evaluate all of their options, to apply for federal tax subsidies to lower the cost of premiums and out-of-pocket costs, to assist patients through the enrollment process and to essentially help them access care. Those agencies that do not use Title V funding have other federal or local grants or utilize the services of the Bi-State Primary Care Association (Bi-State), the professional organization in the state advocating for primary care for the underserved, which has a federal navigator grant. MCH meets monthly with Bi-State and gets regular updates on its navigator program. Bi-State leads the NH Safety Net Coverage Collaborative, which is an established consortium of five (5) of the CHCs. Bi-State monitors the work of all of its members' patient navigators, ensuring that efforts can be leveraged and not duplicated.

Several of the CHCs utilize Title V funding for positions alternately called community health workers, patient education specialists, community educators and outreach workers. All have varying responsibilities and professional backgrounds, but again the core functions are to both access and improve the quality of care. These skilled employees are particularly useful with the homeless population. All three (3) of the CHCs serving the homeless utilize the funding for community outreach education. One, Manchester Health Department, in the state's largest city, attributed 26% of all of its new patients to the outreach workers. In one year, approximately 300 outreach contacts were made to people living on the streets, in parks and on river banks. This agency's outreach effort is a comprehensive one, including the Outreach Worker/Educator and an Outreach Nurse who tour not only the "outside" of the city, but the smaller shelters, libraries and the local county jails, hooking people up to care. Regularly scheduled groups and one-on-one education sessions are offered in the same places toured. Topics cover smoking cessation, nutrition, depression and addiction.

Another agency, Families First, which is located in the seacoast area of the state, has two (2) contracts with MCH, one for its "regular" clients and another for its homeless. It utilizes its MCH funded community health worker who visits the emergency room of local hospitals, looking for homeless patients and/or already enrolled patients who have high emergency department utilization. This agency has created a pamphlet, specifically for those "frequent flyers" that use the emergency department for conditions that are potentially treatable in primary care.

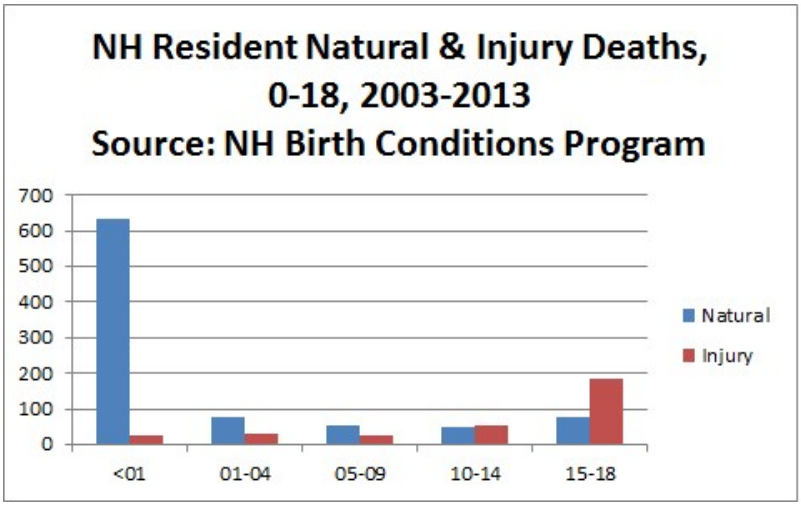
MCH is a member of the NH Community Health Worker Coalition, based out of the Southern Area Health Education Center (Southern AHEC). Southern AHEC offers the only community health worker training in the state.

MCH monitors the status of all of their contracted CHCs annually through site visits and bi-annual reporting. MCH's QI/QA Nurse Consultant has changed the site visit tool to better reflect both the quantitative and qualitative reporting for the quality improvement and enabling services updates. Prior to this past year, CHC site visits encompassed clinical chart reviews. However, with the focus of the contracts shifting and many of the centers undergoing clinical reviews for federal grants and accreditation purposes, charting like this is no longer necessary.

When managed care was first implemented, CSHCN were exempt from mandatory enrollment and were granted voluntary status. Based on this status they had the option to enroll in a MCO or to remain in fee for service. CMS granted approval to change the status of all voluntary populations to mandatory status as of February 2016. SMS Care Coordinators were actively engaged in informing families of the transition and auditing the MCOs to determine readiness to meet the needs of CSHCN. NHFV worked collaboratively with SMS and the communication group to support and educate families. This included the creation of a toolkit to assist in both selecting and working with MCOs. SMS and MCH have been invited to participate in a DHHS group being formed for ongoing MCO operations oversight, which will allow for review and input regarding evolution of managed care.

II.F.5. Emerging Issues

With the advent of the Zika virus and the potential for infants born with microcephaly, more attention is being put upon birth defects. Of the approximately 12,000 plus babies born in New Hampshire (NH) per year, about 350 are affected by one or more major birth defects. Birth defects are the leading cause of death in the state.

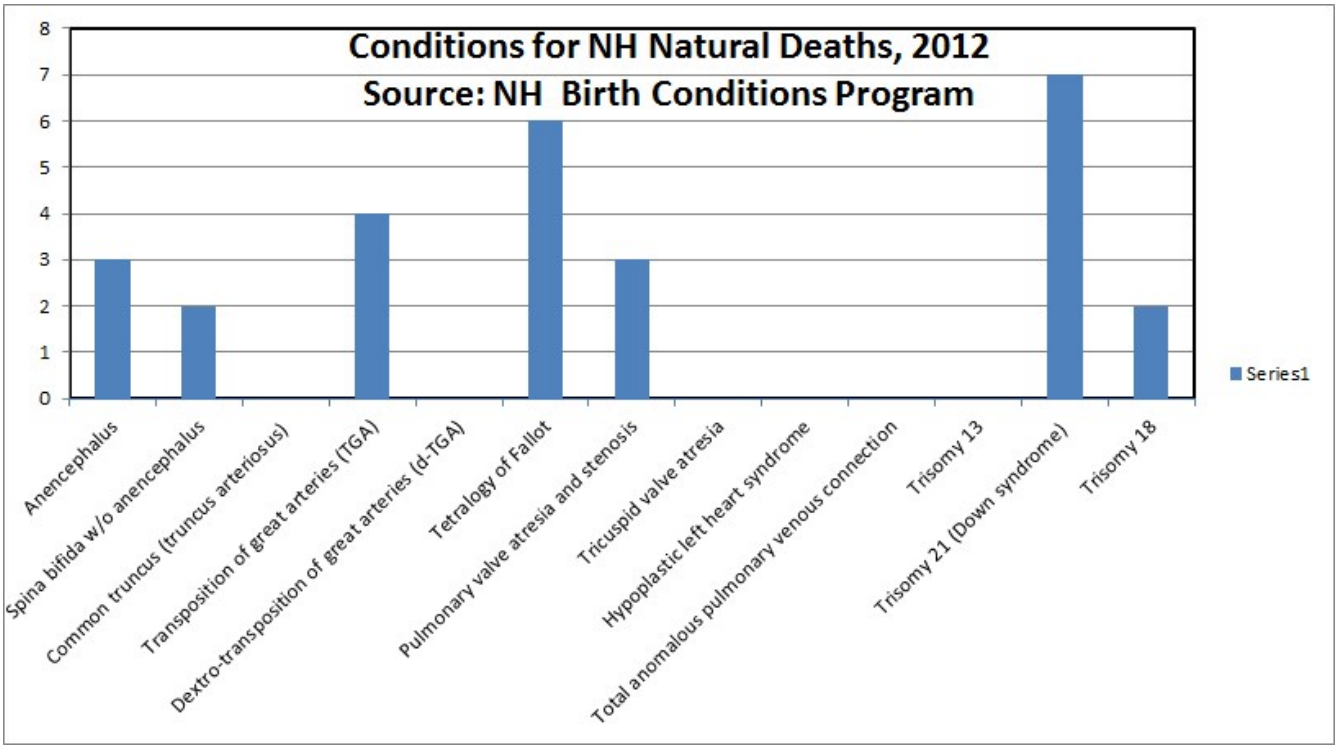


Babies born with birth defects have a greater chance of illness, long-term disability and are more likely to be born pre-term. Medicaid paid an average of $7,500,000 per year in medical services for children born with birth defects. [1]

Most birth defects are thought to be caused by an intricate mix of genetic, behavioral and environmental factors, although for many birth defects, the specificity of how these factors work together is not known. There are several known potential risk factors including obesity/overweight, diabetes and alcohol and tobacco use. Protective factors include taking folic acid for the prevention of neural tube defects. Women of reproductive age in NH are:

- 22% obese
- 24% smoke cigarettes
- 60% do not take folic acid[2]

Dartmouth has acted as DPHS's proxy in facilitating the state's Birth Conditions Program (BCP) since 1998. Working closely with MCH and DPHS's Health Statistics and Data Monitoring Section, the BCP tracks babies that have a structural birth defect that meet the diagnostic criteria for more than 46 conditions using active surveillance.



The BCP is essential for understanding the impact of birth defects in the state, quantifying its morbidity and mortality and using this data for improved surveillance, health care service delivery and prevention. The program has worked to identify babies, collected data about the condition and connected families with birth defects to services, such as those provided by SMS and Family Voices.

The BCP partnered with SMS so long term follow-up could be generated and matched. SMS in turn provided resource materials for families contacted by the BCP.

Data for the BCP utilized the AURIS system designed by Welligent, MCH's contractor for its overall Data Mart. The Data Mart contains the following data sets besides birth conditions: births, deaths, hospital discharges, maternal Medicaid delivery claims, home visiting client records, WIC Pregnancy Nutrition Surveillance System, WIC Pediatric Nutrition Surveillance System, perinatal client data forms (PCDF) from the CHCs, NHQuitworks, all newborn screening and PRAMS.

However, as of May 2016, the BCP lost its sole grant funding. Currently neither MCH nor SMS have the funding to dedicate an FTE for the position. However, MCH is using carryover SSDI funds to continue to keep the data on an encrypted drive in the Data Mart and to save the framework for a potential restart in the future.

The emergence of Zika and microcephaly has improved recognition of the importance of tracking birth defects in every state. That has led to new potential funding sources. MCH has submitted a grant to the CDC to establish a Zika Birth Registry with an FTE for a Nurse Coordinator. The funding could potentially jumpstart staffing, on which other sources could be leveraged to expand the registry to all birth conditions.

Another emerging issue of particular relevance to National Performance Measure #14 around smoking is the rise in calls on poisoning in small children (0-5 years) due to liquid nicotine. Vaporizers, vape pens, hookahs, e-cigarettes and e-pipes are some of the many types of Electronic Nicotine Delivery Systems (ENDS) with the liquid heated into an aerosol that the user inhales. With the Federal Drug Administration's 2016 finalized rule extending its authority to cover ENDS, a new spotlight has helped expand information to the general public.
A recent national study[3] looking at calls to all poison centers reported that exposure to liquid nicotine increased by

approximately 1500% during the 40 month study period. Children exposed to liquid nicotine had 5.2 times higher odds of health care facility admission and 2.6 times higher odds of severe medical outcomes than children exposed to cigarettes alone. Northern New England Poison Center, the state's poison center and one of MCH's contractors, reported calls on pediatric (0-5 years) exposures to all nicotine products that have hovered around 50 for the last five (5) years. However, calls specific to liquid nicotine quadrupled (from zero to 11 in the past five years). Although a small number, poison center calls are often the "canary in the coal mine" and point towards a need for a deeper dive into emergency department and emergency medical services calls which the MCH data team will facilitate in the upcoming year.

Family violence was identified as one of the five (5) top health issues in the 2015 needs assessment. Senate Bill 244 recently established the Commission to Review Child Abuse Fatalities. The purpose was not to take over the responsibilities of the existing Child Fatality Review Committee, but to specifically review DCYF abuse and neglect investigations. This group is set to end June 2016, but in an interim report cited the need for around the clock DCYF coverage. In response, DHHS has taken vacant positions to create a noon to 8 p.m. shift. In addition, increased law enforcement access to DCYF records was suggested to enable greater understanding and perhaps stepped up attention to local families at risk. It is unknown how these changes will affect the issue of family violence in the state, but increased coverage and cooperation can only be for the better.

New Hampshire is also experiencing the impact of an emerging health care workforce shortage. According to an Executive Order issued by Governor Hassan in April 2016 "NH is facing a healthcare workforce shortage in fields ranging from direct care workers to pediatric nurses to psychologists, which is increasingly threatening our ability to meet the health care needs of our citizens and making it harder to provide home and community-based care." Governor Hassan used this executive order to create the Governor's Commission on Health Care Workforce. While it is difficult to calculate exact data regarding the areas affected by this shortage, the subspecialty of pediatric nurses is indeed impacted. Families and the media have been placing a great deal of emphasis on this shortage. These efforts have included an approach of sharing family stories to increase awareness and support for a statewide response to address the need. In addition to the creation of the Governor's Commission, a bill was passed in May 2016 creating a commission to more specifically study the shortage of nurses and other skilled health care for home health care services and post-acute care services. This commission includes a wide array of members representing professional associations, parents/individuals utilizing home nursing and the SMS Administrator.

Finally, MCH's work on the increase of opioid deaths in the state will continue with the expansion of surveillance (due to a CDC grant) and involvement with prevention of NAS.

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[1] http://www.cdc.gov/ncbddd/birthdefects/states/newhampshire.html accessed 05/23/16.
[2] NH Behavioral Risk Factor Surveillance System, 2015.
[3] http://pediatrics.aappublications.org/content/early/2016/05/05/peds.2016-0041 accessed 05/24/2016.

II.F.6. Public Input

During the years when there is not an expansive needs assessment process taking place (when electronic surveys and focus groups were being facilitated), it is often harder to feasibly and in a meaningful way gather public input. The process often requires innovative thinking on the part of the Title V staff. It's imperative to have this input in order to validate the work of the State's Title V programs, MCH and SMS. During the past year, the MCH Administrator, Rhonda Siegel, reviewed many other states' mechanisms for assembling public input. In addition, she reviewed the document, "Facilitating Public Comment on the Title V Block Grant: A Report on States' FY 2005 Practices" (http://mchb.hrsa.gov/grants/publiccomment2005.pdf).

Outreach to specific stakeholders: Much of the effort in the past year has been on taking a customizable presentation on the MCH Block Grant and the State Action Plan across the state to stakeholder meetings.

The discussions held were modified to center around the interests of the audience. For example, the talk and dialogue with the Pediatric Improvement Partnership focused on those performance measures and activities focused on children, adolescents and some within the cross-cutting domains. Presentations and accompanying discussions were held with the following partner organizations/groups:

- Pediatric Improvement Partnership
- Bi-State Primary Care Association
- New Hampshire Legislative Health and Human Services Oversight Committee
- MCH Primary Care Coordinators
- MCH Home Visiting Coordinators
- New Hampshire Regional Public Health Networks
- Division of Public Health Services monthly staff meeting
- Spark NH

Input has been generally favorable and have centered on the ways in which MCH and the particular group can collaborate towards the goals and objectives of the State Action Plan.

MCH presents to the Legislative Health and Human Services Oversight Committee several times during each year to report on legislated committees such as Maternal Mortality and Newborn Screening. Thus, it was appropriate to add on information about the MCH Block Grant and State Action Plan.

A shorter presentation has been delivered at annual site visits to the 15 community health centers, which get funding through the Block Grant. Site visits were restructured this year to include a section specific to the contractual performance measures that are in alignment with the MCH National Performance Measures. For example, community health centers have as two of their performance measures, "Percent of adolescents 12 to 21 years of age, who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year" and "Percent of patients age 18 years and older who were screened for tobacco use at least once during the measurement year or prior year and who received cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user". These correspond with National Performance Measures 10 and 14 respectively. In addition, community health centers are facilitating quality improvement projects on one or more of their performance measures, also sometimes in alignment with the National Performance Measures. To date, there has been fruitful dialogue back and forth between community health center and MCH staff. This is particularly important since the community health center contracts make up a majority of the contractual money from the MCH Block grant and assist a preponderance of the clients served. Input from community health center staff often center on feasibility issues. "Will this evidence informed strategy be compatible with the client base?" or "Can we reach this goal and objective number in five years?"

Additionally, the MCH QI/QA Nurse Consultant will be working with community health centers individually to review their patient satisfaction surveys under a block grant framework. This means gathering information with existing or added questions specific to MCH Block Grant funded services as well as overall MCH needs. "How has this health coach helped you to sustain your cessation from smoking? Or "What other health needs do you have or suggestions on how to better access care?" are example questions. MCH utilizes the community health centers to distribute their own five year needs assessment surveys, but perhaps the annual patient satisfaction survey can be utilized more frequently for input.

The state's regional public health networks also hold annual community listening sessions. Again, the networks are a venue for distributing the MCH five year needs assessment survey. Perhaps, they can also be utilized for ongoing input into the MCH Block Grant, particularly the State Action Plan. Many of the MCH priority areas and accompanying strategies are shared with the regional public health networks, who just wrote their own community health improvement plans based on local needs assessments. MCH management has read and analyzed all of these

assessments and associated plans for overlap with the Title V State Action Plan.

A variety of needs assessment are taking place during this upcoming year including ones for SMS and the Home Visiting, Rural Health and Primary Care and Family Planning programs. These assessments, while not all directly related to Title V, bring in feedback from clients, community members, and providers alike. Assessing the quality and type of clinical services and challenges that must be overcome, they will help to highlight places for improvement and modifications for service delivery. The SMS survey focuses on satisfaction and needs related to the services intended to address the Performance Measures identified in the Block Grant as well as asking specifically about unmet needs. In addition to electronic and paper surveys, focus groups for each of the previously listed programs will be done to further assess likes and dislikes, patterns of use, barriers to access and suggestions for improvement.

Web posting: The Application/Annual Report is usually being written concurrently with the analysis and/or update part of the needs assessment. There aren't any formal mechanisms for public input during the actual writing, but certainly during its development. The full Application/Annual Report, selected data tables, the Executive Summary and an overview (modeled after the states of Hawaii and Rhode Island, respectively) of the New Hampshire's Title V Program and its chosen priorities and national performance measures was put on both MCH and SMS's website, http://www.dhhs.nh.gov/dphs/bchs/mch/index.htm and http://www.dhhs.nh.gov/dcbcs/bds/sms/index.htm with a link to HRSA's state specific website https://mchb.tvisdata.hrsa.gov/uploadedfiles/2016/submittedFiles/stateSnapshot/NH_StateSnapshot.pdf. Executive summaries were also put at the 11 district DHHS offices across the state as well as the State Library.

New this coming year, comments will be solicited through a survey on the website. The survey, designed after ones written by the states of Tennessee and Nebraska, will generate observations on the current status of the MCH Block Grant and accompanying State Action Plan as well as future and immediate needs. MCH hopes to aggregate and analyze these comments on a regular basis as the State Action Plan is being implemented.

During the past year, there were 11, 262 web hits to MCH's pages.

Public hearings: Public hearings were discontinued in New Hampshire several years ago due to poor attendance. This is the same for public notices, which were costly and generated little to no response. However, many of the programmatic meetings, particularly those legislated such as the Newborn Screening Advisory Committee, are open to the public. Legislated committee meetings are noted the month prior on the DHHS website, where agendas and previous meeting minutes are also available.

Advisory Council Review: MCH does not have a dedicated advisory council. However, many of its programs do have these groups, including, but not limited to the following:

- Newborn Screening Advisory Committee
- PRAMS Advisory Council
- Injury Prevention Advisory Council
- National Violent Death Reporting System Advisory Committee
- Early Hearing Detection Quality Improvement Committee
- Home Visiting Coordinating Committee
- Partners in Health Stakeholder Group

MCH staff have been presenting to these advisory groups on the MCH Block Grant and the State Action Plan in order to both educate and receive input.

Social Media: MCH uses both the DHHS and the Bureau of Population Health and Community Services' twitter accounts, @NHDHHSPIO and @nhpophealth to inform the public on a host of maternal and child health subject

matters. In the past year, MCH released 225 tweets with 78,300 impressions. An impression means that a tweet has been delivered to the Twitter stream of a particular account. In the future, tweets will be used to inform the public about Title V policies and priorities eliciting input through the survey previously discussed.

Six press releases on MCH issues were released to the media this past year, including topics such as the new PRAMS report, safe sleep, tobacco prevention and cessation and adding severe combined immunodeficiency to the newborn screening panel.

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II.F.7. Technical Assistance

Perhaps the most useful part of the 2016 AMCHP meeting in Washington, D.C. was the two-day technical assistance session sponsored by MCHB. During this cumulative 15 hour facilitated session, population similar states discussed and shared their respective State Action Plans with potential activities and ESMs by domain area. A shorter New Hampshire specific replication would be welcomed by both the staff of MCH and SMS. It could take the form of a day or day and a half, dependent upon timing and staff availability. Members of both sections contribute to and write sections of the Title V Block Grant, but most neither see the grant in its entirety nor see the overlaps in each other's work.
The first goal would be for all MCH and SMS staff to review and understand the newly minted State Action Plan, as a footprint for both sections efforts for at least the next four years, if not longer. The ideal time to have this technical assistance would be in the fall, shortly after the Title V Block Grant review at the Region 1 office and the re-submission of the corrected grant in September. Having this facilitated would take the burden off both section's administrators and enable them to be part of the discussion. The second goal would be for staff to understand their role in the State Action Plan and how it connects with the day-to-day work of their peers in both sections. An objective could include: "By the end of the first part of the work session, 100% of participants will increase their knowledge of the State Action Plan as a whole and the same percentage will understand how their job responsibilities intersect." This could be done through a post-work session survey.

Much of the State Action Plan's designated undertakings have been in areas that MCH and SMS have been involved in for many years. However, there are several NPMs and SPMs where this is not the case. For example, the topics of access to children's and prenatal/postpartum mental health services, increasing physical activity for children and evaluating enabling services embedded in primary care are areas in which both MCH and SMS have not had leadership roles in the past. For those staff members assigned to these topic areas and even to those not, listening and discussing the new ESMs and accompanying objectives would be very valuable. This could be the second part of the work session. Three consecutive, individual sessions could be facilitated and include collaborative partners such as the Healthy Eating Active Living Program at the Foundation for Healthy Communities, Bi-State Primary Care Association and the New Hampshire Children's Behavioral Health Collaborative. These partners would also get the perspective of their activities being part of a larger Title V Statewide Action Plan. The first goal for this part of the technical assistance would be for staff to gain some initial knowledge in these new topical areas. The second would be for staff and collaborative partners to further define and discuss activities associated with each area. Objectives could potentially look like: 1) "By the end of the second and final part of the work session, staff members not directly involved in the new ESMs and SPMs would have increased their knowledge in those subject areas" and 2) "By the end of the second and final part of the work session, additional clarification of roles and responsibilities in new ESMs and SPMs would be noted."

The locally based Community Health Institute (CHI) could potentially serve as the facilitator for the entire session of

the first technical assistance request. CHI was the contractor for some of last year's Title V Needs Assessment responsibilities and led the MCH/SMS CAST V process. Thus, they have current insight into the Title V Block Grant and New Hampshire's program.

The second technical assistance request is a half day workshop on evaluating collaborations and partnerships. New Hampshire Title V staff routinely engages in their professional responsibilities by involvement and facilitation of groups and coalitions. It is infrequent that the groups themselves are evaluated, however. Half day technical assistance training is requested on utilizing tools such as the *Coalition Effectiveness Inventory* and the *PARTNER Tool.* The training will be open to all MCH and SMS employees as well as interested collaborative partners. The goal would be to increase understanding of public health tools utilized in the evaluation of collaborative efforts/coalitions/partnerships. The objective is "By six months post training, participants will have evaluated at least one collaborative effort and have written a summation report."

The third technical assistance request is the provision of 16 hours (approximately two full days) of evaluation expertise provided to MCH's Injury Prevention Program (IPP) by the Center for Program Design and Evaluation (CPDE) at Dartmouth's Geisel School of Medicine. Ms. Beth Boucher of CPDE has assisted the IPP with evaluation and logic model design of three of its fundamental programs (older adult falls, adolescent driving and unintentional poisoning). These evaluation models and design are still in place and being implemented. However, these topics cover only a portion of the breadth of the IPP's programmatic area. With the IPP facilitating the implementation of an ESM towards meeting NPM #7, it is essential to have additional tutoring in identifying measurable objectives and setting up a methodology to track progress. This would enhance the overall implementation of the State Action Plan, not just the injury section. This technical assistance could lead to the identification of ways to streamline program activities, strengthen partnerships and document processes. The objective is "By the end of the evaluation consultation, the IPP will have in place an evaluation plan connected to the implementation of the injury prevention ESM and meeting the goal of NPM#7."

III. Budget Narrative

	2013		2014	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,976,838	$1,421,854	$1,967,556	$1,915,606
Unobligated Balance	$0	$0	$0	$0
State Funds	$5,658,150	$4,296,193	$6,560,499	$5,420,315
Local Funds	$0	$0	$0	$0
Other Funds	$929,675	$797,265	$889,518	$707,205
Program Funds	$0	$0	$0	$0
SubTotal	$8,564,663	$6,515,312	$9,417,573	$8,043,126
Other Federal Funds	$3,909,368	$4,103,535	$4,378,195	
Total	$12,474,031	$10,618,847	$13,795,768	$8,043,126

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2015		2016	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,954,157	$1,986,075	$1,985,385	
Unobligated Balance	$0	$0	$0	
State Funds	$7,352,499	$5,634,464	$5,254,187	
Local Funds	$0	$0	$0	
Other Funds	$931,486	$737,314	$990,468	
Program Funds	$0	$0	$0	
SubTotal	$10,238,142	$8,357,853	$8,230,040	
Other Federal Funds	$4,519,197	$5,065,539	$4,703,848	
Total	$14,757,339	$13,423,392	$12,933,888	

	2017	
	Budgeted	Expended
Federal Allocation	$1,986,075	
Unobligated Balance	$0	
State Funds	$5,751,467	
Local Funds	$0	
Other Funds	$993,154	
Program Funds	$0	
SubTotal	$8,730,696	
Other Federal Funds	$7,084,728	
Total	$15,815,424	

III.A. Expenditures

The following factors have had an impact on **MCH-related expenditures**:

Two year expenditure cycle

The final financial report (FFR) is almost always drawn down to zero because of the two year expenditure cycle. Thus, the column shows an estimated full expenditure.

Staffing Vacancies

Title V is currently experiencing vacancies, which may sway expenditures in the future.

Significant (i.e. greater than 10%) year to year expenditure variations that appear on Forms 2 and 3

There were no significant variations appearing on Forms 2 and 3.

III.B. Budget

How Federal support complements the State's total Title V 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. This is primarily made up of state/general funds. 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 maternal and child health and children with special health care needs activities.

At the community level, Title V dollars help fund numerous local agencies and projects that provides 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.

The Continuing Resolution that was put into place as of July 1st 2015 was resolved early in the fall of 2015. In the State Fiscal Years 16 and 17 biennium budget process that took place January through June 2015; a two million dollar decrease in state general funds was made to the MCH line item. This went into effect. It did not affect the Maintenance of Effort. It is important to note that even with this significant anticipated reduction, New Hampshire continues to meet its Maintenance of Effort and required match funding partnership. However, MCH had to reduce its contracted agencies' budgets, particularly those of the community health centers. These contracts come from a percentage of state/federal funding. The contract reduction was somewhat offset by increasing the percentage of federal to state funds.

Amounts utilized in compliance with the 30%-30%-10% requirements

As shown on Form 2, New Hampshire complies with the federal 30%-30% requirements (at least 30% for CSHCN; at least 30% for preventive and primary care for children and at the maximum 10% for administrative costs). Services for CSHCN are provided through SMS; $804,879, or 40.5% of New Hampshire's Title V allocation, is appropriated to the SMS budget for federal fiscal year 2017. 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 appropriated through a 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. The MOU will be revised once again in 2017.

Preventive and primary care services for children are provided through MCH; costs include direct care, enabling and support services through contracts with community agencies, population based program costs, and infrastructure costs for all MCH children's services. The total of $767,328, the amount projected for children's services federal fiscal year 2017, is 38.6% of the Title V allocation. Administration is projected at 8.0% at $158,092.

Sources of other federal MCH Dollars, state matching funds and other state funds used to support NH's Title V Program

Sources of other Federal dollars, as indicated on Form 2, include grants from the Maternal and Child Health Bureau (MCHB), the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Population Affairs (OPA) and other federal agencies. This year, MCH added its Title X Family Planning funding and SMS added its funding sources to make a complete picture of the Title V system in the state.

State System Development Initiative (SSDI) grant from HRSA: $100,000. These funds are used to maintain a 1.0 FTE whose responsibilities include supervision and implementation of the Title V five year needs assessment and ongoing data needs to support the overall functioning of MCH. This funding is also utilized to continue functioning of the MCH data warehouse, which links MCH program datasets to other files such as birth records and WIC.

Universal Newborn Hearing Screening and Interventions grant from HRSA and an **Early Hearing Detection and Intervention (EHDI)** from CDC: $175,000 and $164,900 respectively. These two grants are used to fund the

implementation of the state's universal newborn hearing screening program including 1.5 FTEs in house for administration, database maintenance, quality assurance and a contracted consulting audiologist and a follow-up coordinator.

Early Childhood Comprehensive Systems (ECCS): Building Health through Integration grant from HRSA: $140,000. This grant is used to fund part of the Early Childhood Special Projects Coordinator (currently vacant), who oversees the home visiting and young families work of MCH. The funding is also utilized to implement the *New Hampshire Comprehensive Strategic Plan for Early Childhood* and for support of its early childhood advisory council, Spark NH. MCH responded to a federally released competitive RFP with this grant in spring of 2016 and is waiting to hear the award results. Because only approximately 15 states will be receiving this award for federal fiscal year 17, this grant may or may not be part of NH's Title V program in upcoming years.

State Personal Responsibility Education Program (PREP) grant through the Administration for Children and Families (ACF): $250,000. The PREP grant is used for the implementation of an evidence based adolescent pregnancy prevention curriculum. Contracted through local agencies, the program takes place in two areas of the state with the highest adolescent birth rates.

Family Planning Program (Title X) grant through the Office of Population Affairs: $829,000. Title X funds 2.0 FTEs to manage the program which provides educational and clinical services to help low income women, men and adolescents maintain their reproductive health and to prevent unintended pregnancy. These services are provided at 15 sites statewide. Clinical services include routine exams, screening for cervical and breast cancer and sexually transmitted infections (including HIV), as well as the offer of a wide range of contraceptive methods. Services also include pregnancy testing and counseling, and education on reproductive health and sexuality.

Pregnancy Risk Assessment Monitoring System (PRAMS) grant from the CDC: $164,584. This grant is used to carry out the PRAMS, which is a survey that collects state-specific, population-based data on maternal attitudes, behaviors and experiences before, during and after pregnancy. The funding allows for execution of the survey, including 1.6 FTEs to manage it.

Project Linking Actions for Unmet Needs in Children's Health (LAUNCH) from SAMHSA: $839,650.This grant allows for contracting in the state's largest city, Manchester, to 1) enable screening and assessment in a range of child-serving settings; 2) integrate behavioral health into primary care settings; 3) enable mental health consultation in early care and education; 4) enhance home visiting through increase focus on social and emotion well-being and 5) engage in family strengthening and parent skills training. The funding also enables funding to the Early Childhood Advisory Council to provide technical assistance. This grant also pays for an FTE at the state level to coordinate Project LAUNCH.

Maternal, Infant and Early Childhood Home Visiting (MIECHV) grant from HRSA: $3,654,449.00.These three (3) combined federal grants, the largest in unison that MCH receives, allows for the contracting of agencies across the state to deliver home visiting for the maternal and child health population based on the *Healthy Families America* model. MIECHV enables approximately 2.0 FTEs at the state level for administration as well as an evaluation contract with the University of New Hampshire, a data systems contract with Social Solutions and a technical assistance contract with the Community Health Institute.

Rape Prevention and Education (RPE) grant from the CDC: $251,700.The RPE grant, overseen by MCH's Injury Prevention Program, funds the contract with the New Hampshire Coalition Against Domestic and Sexual Violence and its 13 member agencies. These agencies or crisis centers provide sexual violence prevention across the state as well as a large evaluation component.

Sudden Death in Youth (SDY) and Sudden Unexpected Infant Death (SUID) grants from the CDC: $25,000 and $26,774 respectively. These grants allow for collaboration with the Office of the Chief Medical Examiner (OCME) to collect data on all SUID and SDY deaths in the state. It also entails MCH facilitated SUID and SDY review committees, the former focusing on the issue of safe sleep.

National Violent Death Reporting System (NVDRS) grant from the CDC: $144,606. The NVDRS grant, like SDY and SUID, also is in conjunction with the OCME. It collects data on all violent deaths in the state, which is useful for prevention efforts. MCH's Injury Prevention Program has oversight of this grant.

Awareness and Access to Care for Children and Youth with Epilepsy grant from HRSA: $358,173. This grant was awarded to SMS to continue development of NH's system of care for children and youth with epilepsy. As the sub-recipient, NHFV conducted a Needs Assessment and convened clinical teams to work toward increasing the state's capacity to provide this population with quality health care and necessary family and community supports.

State Planning Grants for Improving Services for Children and Youth with Autism Spectrum Disorder and other disorders from HRSA: $62,539. This grant provided funds for a statewide Needs Assessment in Year 1 and the development and early implementation of the *State Plan to Improve Supports and Services for Individuals with ASD/DD and Their Families* in Year 2. Currently NHFV is leading the development of an Action Plan to address the recommendations made in the State Plan. Child Health Services is also under a sub-contract with NHFV to develop a Rapid Assessment Team. In this pilot project, children who are identified as needing further assessment and services are provided with a "fast track" to services.

Grants to States for Medical Assistance Programs from the Centers for Medicare and Medicaid Services (CMS): $319,065. This grant enables staffing for SMS and is braided with Title V funding for the provision of care coordination for Medicaid clients who are seen through the Nutrition and Feeding and Swallowing Consultation, the Child Development Clinics and in consultation with the Neuro-Motor Clinics.

All of these aforementioned grants contribute significantly to the work of Title V in the state.

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.

The **"Other Funds"** column of $993, 154 come from the state's designated or "revolving" fund dedicated specifically for the newborn screening program. Funds are generated by fees from the newborn screening filter paper and are paid by the state's birthing hospitals dependent upon the number of births. Thus, it fluctuates from year to year with the incidence of births.

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"** funds included in the MCH or SMS appropriations, as indicated on Form 2.

Variations on Forms 2 And 3

Form 3A, row 1B Non-Federal MCH Block Grant, #2, Infants <1 year includes funding from the newborn screening "revolving" or designated funds.

Title V will continue to refine financial job coding and contracting system to further 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 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.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - TitleVandMedicaidMOU.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - Combined_Org_Charts.pdf

Supporting Document #02 - FY 15 - SMS all served.pdf

Supporting Document #03 - Glossary of Acronyms Utilized in the Title V Block Grant.pdf

Supporting Document #04 - Footnotes.pdf

Supporting Document #05 - TitleV blurb ver2.pdf

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: New Hampshire

	FY17 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 1,986,075	
A. Preventive and Primary Care for Children	$ 767,328	(38.6%)
B. Children with Special Health Care Needs	$ 804,879	(40.5%)
C. Title V Administrative Costs	$ 158,092	(8%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 5,751,467	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 993,154	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 6,744,621	
A. Your State's FY 1989 Maintenance of Effort Amount $ 2,872,257		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 8,730,696	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 7,084,728	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 15,815,424	

OTHER FEDERAL FUNDS	FY17 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 250,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 164,900
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Violent Death Registry	$ 144,606
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 164,584
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 251,700
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Unexpected Infant Death (SUID) Case Registry Program	$ 26,774
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	$ 3,654,449
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	$ 140,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 175,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 829,000
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project LAUNCH	$ 839,650
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Title XIX -- Grants to States for Medical Assistance Programs	$ 319,065
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Death in the Youth (SDY) Reistry	$ 25,000

	FY15 Application Budgeted		FY15 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 1,954,157		$ 1,986,075	
A. Preventive and Primary Care for Children	$ 780,015	(39.9%)	$ 757,359	(38.1%)
B. Children with Special Health Care Needs	$ 818,188	(41.9%)	$ 818,188	(41.2%)
C. Title V Administrative Costs	$ 95,949	(4.9%)	$ 158,092	(8%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0		$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 7,352,499		$ 5,634,464	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 931,486		$ 737,314	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 8,283,985		$ 6,371,778	
A. Your State's FY 1989 Maintenance of Effort Amount $ 2,872,257				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 10,238,142		$ 8,357,853	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 4,519,197		$ 5,065,539	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 14,757,339		$ 13,423,392	

OTHER FEDERAL FUNDS	FY15 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 250,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 125,478
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Violent Death Registry	$ 1,638
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 121,823
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 251,670
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Unexpected Infant Death (SUID) Case Registry Program	$ 16,719
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	$ 1,934,650
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	$ 137,125
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 61,474
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 119,855
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 935,133
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project LAUNCH	$ 682,724
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Death in the Youth (SDY) Registry	$ 6,538
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Awareness & Access to Care for Children & Youth with Eplepsy	$ 358,173

OTHER FEDERAL FUNDS	FY15 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Planning Grants for Improving Serv for Children & Youth with Autism Spectrum Disorder and othe	$ 62,539

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children**
	Fiscal Year:	**2017**
	Column Name:	**Application Budgeted**
	Field Note: Form 2 #1.a. per the category description, this line does not include dollars for pregnant women/prenatal.	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: Form 2. #1.A. - per the category description, this does not include dollars for pregnant women/prenatal.	
3.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: Admin costs have been steadily increasing over the past several years, and are expected to continue.	
4.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: The amount of State funds over the past few years has changed significantly as budget issues are dealt with in state government.	
5.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: Other Funds represents the Newborn Screening Program. There is primarily 1 large contract for laboratory & courier services. Occasionally the cost of testing and the number of babies being tested varies.	

Data Alerts: None

Form 3a

Budget and Expenditure Details by Types of Individuals Served

State: New Hampshire

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	$ 63,944	$ 63,112
2. Infants < 1 year	$ 230,198	$ 227,204
3. Children 1-22 years	$ 537,130	$ 530,143
4. CSHCN	$ 804,879	$ 818,188
5. All Others	$ 191,832	$ 189,337
Federal Total of Individuals Served	$ 1,827,983	$ 1,827,984

IB. Non Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	$ 166,066	$ 208,132
2. Infants < 1 year	$ 1,590,992	$ 1,486,589
3. Children 1-22 years	$ 1,394,956	$ 1,748,308
4. CSHCN	$ 2,557,537	$ 1,797,160
5. All Others	$ 498,197	$ 624,396
Non Federal Total of Individuals Served	$ 6,207,748	$ 5,864,585
Federal State MCH Block Grant Partnership Total	$ 8,035,731	$ 7,692,569

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2017**
	Column Name:	**Application Budgeted**
	Field Note: We interpret Form 2 1.A. "Preventive and Primary Care for Children" (no age specified) to include Infants and Children 1-22 yrs. We are reflecting budget and expended calculations accordingly.	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: We interpret Form 2 1.A. "Preventive and Primary Care for Children" (no age specified) to include Infants and Children 1-22 yrs. We are reflecting budget and expended calculations accordingly.	

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: New Hampshire

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Direct Services	$ 428,371	$ 438,124
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 82,684	$ 81,752
B. Preventive and Primary Care Services for Children	$ 153,555	$ 151,825
C. Services for CSHCN	$ 192,132	$ 204,547
2. Enabling Services	$ 831,835	$ 876,249
3. Public Health Services and Systems	$ 725,869	$ 671,702
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 5,430
Physician/Office Services		$ 233,792
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 15,790
Laboratory Services		$ 0
Other		
Nutrition and Feeding & Swallowing Consultation		$ 141,178
Child Development Clinic (Clinical Consultation)		$ 31,192
Neuromotor Clinic (MD Consultantion)		$ 5,917
Family Support (Home Modificaiton/Hosp Visits Etc)		$ 4,825
Direct Services Line 4 Expended Total		$ 438,124
Federal Total	$ 1,986,075	$ 1,986,075

IIB. Non-Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Direct Services	$ 2,123,924	$ 1,875,308
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 1,078,946	$ 902,023
B. Preventive and Primary Care Services for Children	$ 434,471	$ 513,373
C. Services for CSHCN	$ 610,507	$ 459,912
2. Enabling Services	$ 2,478,706	$ 2,461,200
3. Public Health Services and Systems	$ 2,141,991	$ 2,035,270
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 16,716
Physician/Office Services		$ 790,283
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 35,147
Laboratory Services		$ 625,591
Other		
Nutrition and Feeding & Swallowing Consultation		$ 314,235
Child Development Clinic (Clinical Consultations)		$ 69,428
Neuromotor Clinic (MD Consultation)		$ 13,169
Family Support (Home Modification/Hosp Visits Etc)		$ 10,739
Direct Services Line 4 Expended Total		$ 1,875,308
Non-Federal Total	$ 6,744,621	$ 6,371,778

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIA. - 1. C. Services for CSHCN**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: This category of services continues to address the support needed for children who are uninsured, including legal aliens who have not been in the country for more than 5 years and therefore do not qualify for Medicaid. Additionally, it includes services that are critical to families but are not covered by insurance such as: compounded medications, some specialty formulas, some types of durable medical equipment etc. The SMS Nutrition/Feeding and Swallowing Consultation services is of great benefit to CSHCN and these funds help to cover the infrastructure of the program and services not otherwise covered by insurance.	
2.	**Field Name:**	**IIA. - 4. Pharmacy**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: For CSHCN this included the cost of medications for children who did not have insurance or that were not covered by insurance.	
3.	**Field Name:**	**IIA. - 4. Physician/Office Services**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: For CSHCN this amount primarily reflects services that were not covered by insurance.	
4.	**Field Name:**	**IIA. - 4. Durable Medical Equipment and Supplies.**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: For CSHCN these funds covered items such as specialty formulas and other DME not covered by insurance. For example, a child may have an electric wheelchair covered by Medicaid which is needed to access their school environment and for which the school must provide wheelchair transportation to and from the home. However, the family may not have a wheelchair van and therefore in order to participate in family and community activities they also need a manual wheelchair that can be transported in a traditional vehicle. Medicaid will not pay for a second wheelchair and Title V monies may be used for this purpose.	

Form 4

Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: New Hampshire

Total Births by Occurrence: 12,494

1. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Core RUSP Conditions	12,494 (100.0%)	618	22	22 (100.0%)

Program Name(s)				
Methylmalonic acidemia (methylmalonyl-CoA mutase)	Methylmalonic acidemia (cobalamin disorders)	Isovaleric acidemia	3-Methylcrotonyl-CoA carboxylase deficiency	3-Hydroxy-3-methyglutaric aciduria
Holocarboxylase synthase deficiency	ß-Ketothiolase deficiency	Glutaric acidemia type I	Carnitine uptake defect/carnitine transport defect	Medium-chain acyl-CoA dehydrogenase deficiency
Very long-chain acyl-CoA dehydrogenase deficiency	Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	Trifunctional protein deficiency	Argininosuccinic aciduria	Citrullinemia, type I
Maple syrup urine disease	Homocystinuria	Classic phenylketonuria	Tyrosinemia, type I	Primary congenital hypothyroidism
Congenital adrenal hyperplasia	S,S disease (Sickle cell anemia)	S, βeta-thalassemia	S,C disease	Biotinidase deficiency
Critical congenital heart disease	Cystic fibrosis	Hearing loss	Severe combined immunodeficiences	Classic galactosemia
Adrenoleukodystrophy	Mucopolysaccharidosis, type I	Propionic acidemia	Propionic acidemia	

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Early Hearing Detection and Intervention Program	12,129 (97.1%)	419	54	27 (50.0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

We do not do long term follow. Our surveillance of a diagnosed child ends when they have been connect to care. The long term follow up is the responsibility of the specialist and the PCP."

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Early Hearing Detection and Intervention Program - Referred For Treatment**
	Fiscal Year:	**2015**
	Column Name:	**Other Newborn**

Field Note:
Of the 54 confirmed cases, 33 cases had permanent hearing loss; 21 cases had temporary hearing loss and were not eligible for support services. Of the 33 cases of permanent hearing loss (eligible for support services), 6 cases declined, or were in process, or were ineligible for support services due to the specific type of hearing loss.

Data Alerts: None

Form 5a
Unduplicated Count of Individuals Served under Title V

State: New Hampshire

Reporting Year 2015

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	1,526	72.0	0.0	15.0	12.0	1.0
2. Infants < 1 Year of Age	12,420	27.0	0.0	67.0	2.0	4.0
3. Children 1 to 22 Years of Age	32,673	29.0	0.0	52.0	19.0	0.0
4. Children with Special Health Care Needs	3,223	56.0	1.0	29.0	14.0	0.0
5. Others	87,322	26.0	0.0	53.0	21.0	0.0
Total	137,164					

Form Notes for Form 5a:

In SFY15 , 1,048 families, and 3,430 individuals (1,926 were children; the balance was pregnant women and/or mothers of infants under one year of age) were seen by the Comprehensive Family Support Services grant. This involved contacts at activities at the Family Support Centers funded by the grant, or home visits. This grant is a mix of several funding streams from MCH and DCYF, who administers the grants to the eleven contracted agencies.

Field Level Notes for Form 5a:

None

Form 5b
Total Recipient Count of Individuals Served by Title V

State: New Hampshire

Reporting Year 2015

Types Of Individuals Served	Total Served
1. Pregnant Women	1,526
2. Infants < 1 Year of Age	12,420
3. Children 1 to 22 Years of Age	32,673
4. Children with Special Health Care Needs	6,057
5. Others	87,322
Total	139,998

Form Notes for Form 5b:

None

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2015**
	Field Note: Served in primary care agencies and Comprehensive Family Support Services home visiting program.	
2.	**Field Name:**	**Infants Less Than One Year**
	Fiscal Year:	**2015**
	Field Note: Infants served by the Newborn Screening Program, and the newborn Early Hearing Detection and Intervention program.	
3.	**Field Name:**	**Children 1 to 22 Year of Age**
	Fiscal Year:	**2015**
	Field Note: Children served by the Comprehensive Family Support Services home visiting program and primary care agencies.	
4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2015**
	Field Note: The number is calculated as follows: 1. Unduplicated count served by New Hampshire Family Voices (NHFV): 1028 2. NHFV-CSD Outreach: 150 3. NHFV Information & Referral (lending library): 316 4. SMS SSI outreach: 702 5. SMS HC-CSD outreach: 60 6. SMS Information and referral: 578 7. The unduplicated count (Form 5a) of children enrolled directly in SMS' CSHCN program: 3223 Additionally, NHFV has a very active website while it is not possible to link these contacts directly to NH CSHCN it is significant to report the contacts: NHFV web hits (unique): 645,238	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2015**
	Field Note: Adults (not pregnant women, infants, children) served by primary care agencies and injury prevention outreach.	

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: New Hampshire

Reporting Year 2015

I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	12,494	11,224	178	14	433	14	141	490
Title V Served	12,494	11,224	178	14	433	14	141	490
Eligible for Title XIX	3,356	2,945	94	99	45	4	58	111
2. Total Infants in State	12,420	10,890	204	19	443	9	196	659
Title V Served	12,420	10,890	204	19	443	9	196	659
Eligible for Title XIX	3,307	2,905	94	8	45	4	58	193

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	11,587	644	263	12,494
Title V Served	11,587	644	263	12,494
Eligible for Title XIX	3,060	267	29	3,356
2. Total Infants in State	11,508	631	281	12,420
Title V Served	11,508	631	281	12,420
Eligible for Title XIX	3,005	273	29	3,307

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: New Hampshire

A. State MCH Toll-Free Telephone Lines	2017 Application Year	2015 Reporting Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 852-3345 x4517	(800) 852-3345 x4517
2. State MCH Toll-Free "Hotline" Name	DHHS Maternal and Child Health Section	DHHS Maternal & Child Health Secion
3. Name of Contact Person for State MCH "Hotline"	Shari Campbell	Shari Campbell
4. Contact Person's Telephone Number	(603) 271-4517	(603) 271-4517
5. Number of Calls Received on the State MCH "Hotline"		520

B. Other Appropriate Methods	2017 Application Year	2015 Reporting Year
1. Other Toll-Free "Hotline" Names	SMS Toll-Free Information Line, DHHS Toll-Free Information Line	SMS Toll-Free Information Line, DHHS Toll-Free Information Line
2. Number of Calls on Other Toll-Free "Hotlines"		578
3. State Title V Program Website Address	www.dhhs.nh.gov/dphs/bchs/mch/index.htm; www.dhhs.nh.gov/dcbcs/bds/sms	www.dhhs.nh.gov/dphs/bchs/mch/index.htm; www.dhhs.nh.gov/dcbcs/bds/sms
4. Number of Hits to the State Title V Program Website		11,262
5. State Title V Social Media Websites	Multiple websites	Multiple sites
6. Number of Hits to the State Title V Program Social Media Websites		225

Form Notes for Form 7:

The number of hits to state Title V social media websites is unknown, but there have been 225 Tweets; and 78, 300 "Impressions." An "impression" means that a tweet has been delivered to the Twitter stream of a particular account.

Form 8
State MCH and CSHCN Directors Contact Information

State: New Hampshire

1. Title V Maternal and Child Health (MCH) Director	
Name	Rhonda Siegel
Title	MCH Administrator / Title V Director
Address 1	29 Hazen Drive
Address 2	
City/State/Zip	Concord / NH / 03301
Telephone	(603) 271-4516
Extension	
Email	Rhonda.Siegel@dhhs.nh.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Elizabeth Collins
Title	Administrator/Title V CSHCN Director
Address 1	129 Pleasant Street
Address 2	Thayer Building
City/State/Zip	Concord / NH / 03301
Telephone	(603) 271-8181
Extension	
Email	Elizabeth.Collins@dhhs.nh.gov

3. State Family or Youth Leader (Optional)	
Name	Jennifer Pineo
Title	NH Family Voices Autism Coordinator
Address 1	129 Pleasant Street
Address 2	Thayer Building
City/State/Zip	Concord / NH / 03301
Telephone	(603) 271-4525
Extension	
Email	jsp@nhfv.org

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: New Hampshire

Application Year 2017

No.	Priority Need
1.	Improve access to needed healthcare services for all populations.
2.	Decrease the use and abuse of alcohol, tobacco and other substances among youth, pregnant women and families.
3.	Increase access to comprehensive Medical Homes.
4.	Improve access to mental health services.
5.	Decrease pediatric overweight and obesity.
6.	Increase family support and access to trained respite and childcare providers.
7.	Decrease unintentional injury.
8.	Improve access to standardized developmental/social emotional screening, assessment and follow-up for children and adolescents.

Form 9 State Priorities-Needs Assessment Year - Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Improve access to needed healthcare services for all populations.	Replaced	
2.	Decrease the use and abuse of alcohol, tobacco and other substances among youth, pregnant women and families.	Continued	
3.	Increase access to comprehensive Medical Homes.	New	
4.	Improve access to mental health services.	Continued	will develop a new State Performance Measure for Federal Fiscal Year 17.
5.	Decrease pediatric overweight and obesity.	Continued	
6.	Increase family support and access to trained respite and childcare providers.	Continued	will develop a new State Performance Measure for Federal Fiscal Year 17.
7.	Decrease unintentional injury.	Continued	
8.	Improve access to standardized developmental/social emotional screening, assessment and follow-up for children and adolescents.	Continued	

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10a
National Outcome Measures (NOMs)

State: New Hampshire

Form Notes for Form 10a NPMs, NOMs, SPMs, SOMs, and ESMs.

Although these numbers increase year to year, they take into account the increasing trend. The goal is to decrease the rate of increase.

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	84.8 %	0.3 %	10,293	12,145
2013	81.1 %	0.4 %	9,830	12,116
2012	82.4 %	0.4 %	9,923	12,036
2011	82.1 %	0.3 %	10,192	12,417
2010	83.2 %	0.4 %	9,551	11,474
2009	83.5 %	0.3 %	9,915	11,879

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009	104.5	9.0 %	135	12,922
2008	109.9	9.2 %	144	13,105

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2010_2014	NR	NR	NR	NR
2009_2013	NR	NR	NR	NR
2008_2012	20.0	5.5 %	13	65,137
2007_2011	19.4	5.4 %	13	66,953
2006_2010	19.0	5.3 %	13	68,480
2005_2009	18.6	5.2 %	13	70,026

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	6.9 %	0.2 %	852	12,280
2013	6.8 %	0.2 %	841	12,378
2012	7.3 %	0.2 %	898	12,343
2011	7.1 %	0.2 %	911	12,835
2010	6.9 %	0.2 %	881	12,859
2009	6.9 %	0.2 %	925	13,365

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.1 - Notes:

None

Data Alerts: None

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	1.1 %	0.1 %	130	12,280
2013	1.1 %	0.1 %	141	12,378
2012	1.0 %	0.1 %	122	12,343
2011	1.3 %	0.1 %	160	12,835
2010	1.1 %	0.1 %	147	12,859
2009	1.1 %	0.1 %	147	13,365

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.2 - Notes:

None

Data Alerts: None

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	5.9 %	0.2 %	722	12,280
2013	5.7 %	0.2 %	700	12,378
2012	6.3 %	0.2 %	776	12,343
2011	5.9 %	0.2 %	751	12,835
2010	5.7 %	0.2 %	734	12,859
2009	5.8 %	0.2 %	778	13,365

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.3 - Notes:

None

Data Alerts: None

NOM 5.1 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	8.2 %	0.3 %	1,013	12,289
2013	8.3 %	0.3 %	1,020	12,369
2012	8.6 %	0.3 %	1,057	12,315
2011	8.5 %	0.3 %	1,093	12,799
2010	8.4 %	0.3 %	1,064	12,724
2009	8.7 %	0.3 %	1,153	13,207

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.1 - Notes:

None

Data Alerts: None

NOM 5.2 - Percent of early preterm births (<34 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	2.4 %	0.1 %	297	12,289
2013	2.4 %	0.1 %	296	12,369
2012	2.3 %	0.1 %	278	12,315
2011	2.4 %	0.1 %	306	12,799
2010	2.5 %	0.1 %	320	12,724
2009	2.4 %	0.1 %	311	13,207

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.2 - Notes:

None

Data Alerts: None

NOM 5.3 - Percent of late preterm births (34-36 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	5.8 %	0.2 %	716	12,289
2013	5.9 %	0.2 %	724	12,369
2012	6.3 %	0.2 %	779	12,315
2011	6.2 %	0.2 %	787	12,799
2010	5.9 %	0.2 %	744	12,724
2009	6.4 %	0.2 %	842	13,207

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.3 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	19.7 %	0.4 %	2,416	12,289
2013	19.1 %	0.4 %	2,360	12,369
2012	19.7 %	0.4 %	2,420	12,315
2011	21.0 %	0.4 %	2,681	12,799
2010	20.6 %	0.4 %	2,621	12,724
2009	21.4 %	0.4 %	2,827	13,207

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014/Q2-2015/Q1	3.0 %			
2014/Q1-2014/Q4	4.0 %			
2013/Q4-2014/Q3	4.0 %			
2013/Q3-2014/Q2	3.0 %			
2013/Q2-2014/Q1	2.0 %			

Legends:

Indicator results were based on a shorter time period than required for reporting

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.8	0.7 %	72	12,427
2012	5.4	0.7 %	67	12,383
2011	5.2	0.6 %	67	12,882
2010	3.4	0.5 %	44	12,900
2009	5.7	0.7 %	77	13,417

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.6	0.7 %	69	12,396
2012	4.2	0.6 %	52	12,352
2011	4.5	0.6 %	58	12,851
2010	3.9	0.6 %	50	12,874
2009	4.9	0.6 %	66	13,377

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	4.0	0.6 %	49	12,396
2012	3.2	0.5 %	40	12,352
2011	3.2	0.5 %	41	12,851
2010	2.1	0.4 %	27	12,874
2009	3.4	0.5 %	46	13,377

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	1.6	0.4 %	20	12,396
2012	1.0	0.3 %	12	12,352
2011	1.3	0.3 %	17	12,851
2010	1.8	0.4 %	23	12,874
2009	1.5	0.3 %	20	13,377

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	185.5	38.7 %	23	12,396
2012	218.6	42.1 %	27	12,352
2011	171.2	36.5 %	22	12,851
2010	124.3	31.1 %	16	12,874
2009	231.7	41.7 %	31	13,377

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	96.8	28.0 %	12	12,396
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	93.2	26.9 %	12	12,874
2009	NR	NR	NR	NR

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	13.0 %	1.6 %	1,562	12,032

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009	12.4	1.0 %	160	12,922
2008	11.4	0.9 %	149	13,105

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	13.8 %	1.1 %	36,062	261,967

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	11.3	3.0 %	14	124,036
2013	14.3	3.4 %	18	126,163
2012	14.1	3.3 %	18	128,055
2011	10.0	2.8 %	13	130,716
2010	14.9	3.3 %	20	134,568
2009	12.5	3.0 %	17	135,834

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	24.9	3.8 %	42	168,795
2013	22.8	3.7 %	39	170,981
2012	22.4	3.6 %	39	173,906
2011	18.8	3.3 %	33	176,005
2010	24.1	3.7 %	43	178,240
2009	22.1	3.5 %	40	181,369

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012_2014	10.3	1.9 %	28	272,708
2011_2013	9.0	1.8 %	25	276,615
2010_2012	9.7	1.9 %	27	279,537
2009_2011	10.3	1.9 %	29	282,090
2008_2010	11.9	2.0 %	34	285,577
2007_2009	11.1	2.0 %	32	289,465

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012_2014	8.1	1.7 %	22	272,708
2011_2013	6.5	1.5 %	18	276,615
2010_2012	7.2	1.6 %	20	279,537
2009_2011	8.5	1.7 %	24	282,090
2008_2010	8.1	1.7 %	23	285,577
2007_2009	6.6	1.5 %	19	289,465

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	21.2 %	1.3 %	59,313	280,057
2007	22.0 %	1.3 %	65,519	298,439
2003	21.3 %	1.1 %	64,983	305,278

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	23.8 %	1.9 %	11,932	50,124

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	1.8 %	0.5 %	4,323	239,503
2007	1.2 %	0.3 %	2,924	254,688

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	9.5 %	1.0 %	22,592	238,007
2007	6.8 %	0.8 %	17,189	254,672

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	66.4 %	5.6 %	15,363	23,136
2007	64.3 %	5.4 %	14,223	22,125
2003	64.2 %	4.6 %	13,108	20,421

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	91.0 %	1.0 %	254,807	280,057
2007	90.6 %	1.0 %	270,414	298,439
2003	91.7 %	0.7 %	279,701	305,116

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	26.0 %	2.0 %	35,631	136,975
2007	29.4 %	2.0 %	41,110	139,629
2003	27.3 %	1.7 %	40,400	147,962

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	31.9 %	0.6 %	2,006	6,295

Legends:

Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	25.1 %	1.1 %	14,021	55,942
2011	26.2 %	1.6 %	15,341	58,603
2009	24.8 %	1.6 %	15,435	62,334
2007	25.7 %	1.5 %	16,507	64,262
2005	24.4 %	1.5 %	14,802	60,641

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	5.2 %	0.7 %	13,935	268,072
2013	3.5 %	0.5 %	9,550	272,247
2012	4.2 %	0.8 %	11,423	273,099
2011	3.2 %	0.5 %	8,873	280,509
2010	4.9 %	0.8 %	13,919	285,256
2009	4.6 %	0.6 %	13,140	287,655

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	80.4 %	3.1 %	15,193	18,898
2013	74.9 %	3.5 %	14,399	19,232
2012	80.1 %	2.9 %	15,168	18,942
2011	70.8 %	3.6 %	14,031	19,814
2010	63.3 %	3.8 %	13,162	20,782
2009	39.1 %	3.6 %	8,443	21,602

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2015	64.2 %	2.4 %	167,923	261,562
2013_2014	64.0 %	1.9 %	170,511	266,475
2012_2013	59.2 %	2.3 %	157,314	265,758
2011_2012	53.6 %	2.5 %	144,785	270,007
2010_2011	54.3 %	3.5 %	145,250	267,495
2009_2010	52.1 %	2.3 %	138,076	265,021

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Female

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	71.1 %	3.7 %	28,544	40,178
2013	68.0 %	4.2 %	28,038	41,241
2012	52.2 %	5.4 %	21,911	42,003
2011	65.8 %	3.9 %	28,228	42,921
2010	49.6 %	4.2 %	21,154	42,676
2009	60.0 %	4.4 %	26,546	44,224

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Male

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	56.1 %	4.0 %	24,014	42,822
2013	41.4 %	4.3 %	18,192	43,904
2012	20.5 %	3.7 %	9,147	44,600
2011	NR	NR	NR	NR

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	94.5 %	1.3 %	78,391	82,999
2013	94.8 %	1.5 %	80,671	85,145
2012	96.3 %	1.1 %	83,380	86,603
2011	95.0 %	1.2 %	83,929	88,390
2010	87.9 %	2.0 %	77,104	87,681
2009	72.2 %	2.9 %	65,556	90,800

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	90.6 %	1.6 %	75,216	82,999
2013	85.6 %	2.3 %	72,848	85,145
2012	83.1 %	2.9 %	71,949	86,603
2011	80.6 %	2.7 %	71,258	88,390
2010	73.8 %	2.8 %	64,714	87,681
2009	67.8 %	3.0 %	61,570	90,800

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

Form 10a
National Performance Measures (NPMs)

State: New Hampshire

NPM 1 - Percent of women with a past year preventive medical visit

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	65.7	67.0	68.3	69.5	70.8	72.0

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	63.2 %	2.5 %	135,006	213,754
2013	66.5 %	2.1 %	143,303	215,448
2012	63.3 %	2.1 %	135,903	214,633
2011	66.7 %	2.0 %	149,777	224,709
2010	64.9 %	2.1 %	147,372	226,919
2009	71.5 %	2.0 %	164,521	230,094

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 5 - Percent of infants placed to sleep on their backs

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	89.6	89.7	89.8	89.9	90.0	90.1

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	88.9 %	1.5 %	10,497	11,815

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	33.0	36.0	39.0	42.0	45.0	48.0

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	30.6 %	3.0 %	19,643	64,194
2007	18.1 %	2.5 %	12,737	70,235

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19 (Adolescent Health)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	225.8	219.9	213.9	208.0	202.0	196.1

Data Source: State Inpatient Databases (SID) - ADOLESCENT

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009	231.4	11.4 %	411	177,593
2008	230.4	11.3 %	413	179,250

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day (Child Health)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	35.9	36.6	37.3	38.0	38.7	39.4

Data Source: National Survey of Children's Health (NSCH) - CHILD

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	35.5 %	2.6 %	32,640	92,044
2007	38.9 %	2.7 %	37,805	97,239
2003	32.0 %	2.2 %	31,410	98,239

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	89.6	90.5	91.3	92.2	93.1	94.0

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	88.7 %	1.8 %	93,302	105,151
2007	91.8 %	1.3 %	102,499	111,719
2003	84.3 %	1.6 %	97,796	116,053

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 11 - Percent of children with and without special health care needs having a medical home

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	49.0	49.0	50.0	55.0	60.0	65.0

Data Source: National Survey of Children's Health (NSCH) - CSHCN

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	48.2 %	3.5 %	27,555	57,176
2007	54.6 %	3.3 %	34,822	63,725

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH) - NONCSHCN

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	71.4 %	1.7 %	153,485	215,060
2007	73.5 %	1.5 %	164,642	223,934

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 14 - A) Percent of women who smoke during pregnancy

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	15.0	14.9	14.7	14.6	14.4	14.3

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	13.7 %	0.3 %	1,650	12,060
2013	15.2 %	0.3 %	1,843	12,126
2012	15.1 %	0.3 %	1,811	11,998
2011	14.6 %	0.3 %	1,802	12,365
2010	15.5 %	0.3 %	1,806	11,641
2009	15.3 %	0.3 %	1,838	12,038

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 14 - B) Percent of children who live in households where someone smokes

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	24.6	24.3	24.1	23.8	23.6	23.3

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	24.8 %	1.4 %	68,828	277,643
2007	26.9 %	1.4 %	79,729	296,746
2003	32.5 %	1.3 %	86,885	267,270

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

Form 10a
State Performance Measures (SPMs)

State: New Hampshire

SPM 1 - Percentage of MCH-contracted Community Health Centers with Enabling Services workplan on file with DHHS/MCH.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	60.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10a SPMs:

None

SPM 2 - Percentage of families enrolled in SMS who report access to respite

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	61.0	63.0	63.0	66.0	66.0

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2018**

Field Note:
SMS Surveys are completed every other year: 2016, 2018, 2020.

SPM 3 - Percentage of behavioral health professionals recruited

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	27.0	29.0	31.0	33.0	35.0

Field Level Notes for Form 10a SPMs:

None

Form 10a
Evidence-Based or-Informed Strategy Measures (ESMs)

State: New Hampshire

ESM 1.1 - Percentage of women who receive pre-conception counseling and services during annual reproductive health (preventive) visit at family-planning clinics (Title X)

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	20.0	25.0	30.0	35.0	40.0

Field Level Notes for Form 10a ESMs:

None

ESM 5.1 - Percentage of birth hospitals with a written safe sleep policy, including placing all infants to sleep on their back

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	60.0	75.0	90.0	100.0	100.0

Field Level Notes for Form 10a ESMs:

None

ESM 6.1 - The number of sites using ASQ/ASQ-SE screening tools and participating in the Watch Me Grow (WMG) System.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	50.0	55.0	62.0	69.0	75.0

Field Level Notes for Form 10a ESMs:

None

ESM 7.1 - Percentage of high school students who wear seatbelts

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	93.4	94.2	94.9	95.7	96.5

Field Level Notes for Form 10a ESMs:

None

ESM 8.1 - Percentage of children ages 6-11 enrolled in Comprehensive Family Support Services (CFSS) whose parent reports that the child gets at least one hour of physical exercise per day.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	25.0	30.0	35.0	40.0	45.0

Field Level Notes for Form 10a ESMs:

None

ESM 10.1 - Percentage of adolescents ages 12-21 at MCH-contracted health centers who have at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	64.0	66.0	68.0	70.0	72.0

Field Level Notes for Form 10a ESMs:

None

ESM 11.1 - The number of Primary Care Provider practices who have adopted a Transition Policy

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	10.0	15.0	20.0	25.0	30.0

Field Level Notes for Form 10a ESMs:

None

ESM 14.1 - Number of calls received by the smoking quitline in the past year

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	11.0	22.0	44.0	88.0	176.0

Field Level Notes for Form 10a ESMs:

None

Form 10b
State Performance Measure (SPM) Detail Sheets

State: New Hampshire

SPM 1 - Percentage of MCH-contracted Community Health Centers with Enabling Services workplan on file with DHHS/MCH.
Population Domain(s) – Cross-Cutting/Life Course

Goal:	To reduce inappropriate emergency department utilization by promoting Enabling Services (access and coordination services) provided by MCH-funded Community Health Centers (CHCs).
Definition:	**Numerator:** number of CHCs contracted with DHHS/MCH for Primary Care Services who have an Enabling Services workplan on file with DHHS/MCH **Denominator:** number of CHCs contracted with DHHS/MCH for Primary Care Services **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	none
Data Sources and Data Issues:	1. Hospital Discharge Data System is anticipated to be available by new vendor by the end of 2016. - Strength: Ambulatory Care Sensitive Condition (ACSC) date is anticipated to be available from all NH hospitals. Data can be broken down by zip code regions to represent geographical areas served by MCH-contracted Primary Care agencies. -Weakness: Data system transferred to new vendor (historical data may not be available), data will be not MCH-contracted agency-specific and will include NH residents who are not their enrolled patients 2. All Payers Claim Data (APCD -Weakness: data will not include the uninsured 3. NH Medicaid Claims data -Strength: Data is readily available per 1,000 member months -Challenge: Data only represents Medicaid population, rate per member months is difficult to interpret in a meaningful way 4. MCH-contracted agencies: -Strength: data would be agency-specific -Challenge: High burden for data collection; data is not readily available; agency would need to create data query; EMRs are no automated to populate ER data. Unlikely that RMR would be able to determine "preventable" ER visits, more likely to identify patients with high ER utilization (i.e. number of patients with three of more ED visits in last 12 months).

Significance:	A high ER utilization may be indicative of: inadequate access to care, absent/ineffective care management, or poor choices on the part of the patient (Dowd, 2014). NH DHHS/MCH seeks to promote Primary Care Enabling Services to support the delivery of basic primary care services and facilitate access to comprehensive patient care.

SPM 2 - Percentage of families enrolled in SMS who report access to respite
Population Domain(s) – Children with Special Health Care Needs

Goal:	To increase the number of families reporting access to respite care when needed
Definition:	**Numerator:** number of families enrolled in SMS programs who found and received respite care **Denominator:** number or families enrolled in SMS who completed the biannual survey and identified respite care as a need **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	N/A
Data Sources and Data Issues:	Families enrolled in SMS programs are surveyed every two years. Survey results from 2012, 2014 and 2016 focus on "families' access to a break or respite." NH plans to develop additional questions for the 2018 survey to better assess families' satisfaction with respite services.
Significance:	Respite improves child health status, and reduces high parental stress that can negatively affect physical and emotional health; improves overall family well-being and stability; improves marriages, sibling and other family relationships; and reduces hospital costs and helps avoid or delay more costly foster care, institutional or other out-of-home placements (Kagan & Kaiser, 2012).

SPM 3 - Percentage of behavioral health professionals recruited
Population Domain(s) – Cross-Cutting/Life Course

Goal:	To increase the Behavioral Health professional workforce in the State of NH
Definition:	**Numerator:** # of active Behavioral Health professionals recruited **Denominator:** # of Behavioral Health professionals reached **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Related to Mental Health and Mental Disorders (MHMD) Objectives 5-12, on Treatment Expansion.
Data Sources and Data Issues:	Bi-State Primary Care Recruitment Center
Significance:	Statewide data for 2015 from the NH Healthy Families America (HFA) program show that some 18% (overall) to 24% (high risk areas) of families describe themselves as having a substance use disorder and/or mental health needs. The NH DHHS MCH section is a partner in the Workforce Development Network of the NH Children's Behavioral Health Collaborative, whose mission is to have a highly skilled and sustainable children's behavioral health workforce to serve children, youth and families. A recent study by the Workforce Development Network has pointed to the need for additional recruitment and retention efforts regarding behavioral health providers. The NH DHHS Bureau of Primary Care and Rural Health's Physician Survey results support research which suggests that residency location, even more than medical school location, is predictive of future practice location. NH MCH section will work with the Bi-State Primary Care Recruitment Center to recruit and retain behavioral health professionals into local residencies. Behavioral health providers are defined as psychiatrists, clinical or counseling psychologists, nurse practitioners, clinical social workers, licensed professional counselors, family therapists, licenses alcohol and drug counselors, and masters prepared licenses alcohol and drug counselors.

Form 10b
State Outcome Measure (SOM) Detail Sheets

State: New Hampshire

No State Outcome Measures were created by the State.

Form 10c
Evidence-Based or –Informed Strategy Measure (ESM) Detail Sheets

State: New Hampshire

ESM 1.1 - Percentage of women who receive pre-conception counseling and services during annual reproductive health (preventive) visit at family-planning clinics (Title X)
NPM 1 – Percent of women with a past year preventive medical visit

Goal:	To increase the number of women who receive pre-conception health counseling during an annual preventive health visit
Definition:	**Numerator:** number of women receiving pre-conception counseling **Denominator:** all family planning clients of Title X FP clinics **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	JSI Regional Title X database
Significance:	Fifty-one percent of all pregnancies are unintended. Offering pre-conception health care services, including counseling and education, is important to improve maternal health and newborn health outcomes.

ESM 5.1 - Percentage of birth hospitals with a written safe sleep policy, including placing all infants to sleep on their back
NPM 5 – Percent of infants placed to sleep on their backs

Goal:	To increase the number of birth hospitals with a written safe sleep policy, including placing all infants to sleep on their back
Definition:	**Numerator:** number of birth hospitals with a written safe sleep policy **Denominator:** number of birth hospitals **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	NH DPHS Birth Hospital Survey, conducted yearly
Significance:	The American Academy of Pediatrics recommends that infants be put to sleep on their back to reduce the risk of Sudden Infant Death Syndrome (SIDS); also that health care professionals including hospital staff endorse, model and implement the safe sleep recommendations from birth.

ESM 6.1 - The number of sites using ASQ/ASQ-SE screening tools and participating in the Watch Me Grow (WMG) System.
NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Goal:	To increase from 43 (WMG, 2015) to 75 the number of provider sites including, but not limited to, child care centers, health care providers and other community-based organizations completing and reporting ASQ/ASQ-SE results to WMG
Definition:	**Numerator:** Number of sites reporting ASQ/ASQ-SE results to WMG **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	NH's statewide developmental screening system, Watch Me Grow (WMG), maintains a database that tracks individual ASQ/ASQ-SE results, referrals and information regarding the providers administering the tool. The data is generally reported on annually. The data system is being evaluated for capacity to follow up on referrals and outcomes.
Significance:	According to the Spark NH's Framework for Action 2016, 1 in 5 New Hampshire children under the age of 5 are at risk for developmental or behavioral concerns. Yet the majority of New Hampshire's children do not receive standardized screening designed to identify these concerns in the early years (Spark NH, 2015). As a result, some children with delays do not have access to early identification and services that could change the trajectory of their learning and ability to thrive.

ESM 7.1 - Percentage of high school students who wear seatbelts
NPM 7 – Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Goal:	Increase the percent of high school students wearing seatbelts
Definition:	**Numerator:** number of students reporting seatbelt use **Denominator:** total number of students responding to this question on YRBS **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	NH YRBS data (https://nccd.cdc.gov/youthonline) YRBS is a self-reported survey and students may respond positively to questions about wearing a seatbelt because there is a law in NH requiring people under 18 to wear seatbelts. School participation in the survey is voluntary, so data is not captured from 100% of NH students. The number of students who do respond is considered high enough to be representative of the state as a whole, but data is not reliable at a sub-state level.
Significance:	Unintentional injuries among children and young adults up to age 24 are a significant cause of premature deaths and serious injuries, many of which have life-altering impacts. Motor vehicle crashes are the leading cause of these injuries; many of these would be mitigated or even prevented if seatbelts were used consistently.

ESM 8.1 - Percentage of children ages 6-11 enrolled in Comprehensive Family Support Services (CFSS) whose parent reports that the child gets at least one hour of physical exercise per day.
NPM 8 – Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Goal:	100% of children ages 6-11 years receiving CFSS will get at least one hour of physical activity per day
Definition:	**Numerator:** number of children 6-11 enrolled in CFSS who parent reports at least one hour/day of physical activity at time of discharge from program **Denominator:** number of children ages 6-11 enrolled in CFSS at time of discharge **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Data compiled by CFSS-funded pilot agency at time of discharge
Significance:	AAP and CDC recommend that all children should receive at least one hour per day of physical activity. This is part of the "5:2:1:0 Let's Go", a nationally recognized childhood obesity prevention program.

ESM 10.1 - Percentage of adolescents ages 12-21 at MCH-contracted health centers who have at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Goal:	To increase the percent of adolescents ages 12-21 at the MCH-contracted health centers who have at least one comprehensive well-care visit with a PCP or OB/GYN practitioner each year
Definition:	<table><tr><td>**Numerator:**</td><td>number of adolescents 12-21 years of age at the MCH-contracted health centers who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year</td></tr><tr><td>**Denominator:**</td><td>total number of adolescent patients ages 12-21 years of age at the MCH-contracted health centers by the end of the measurement year</td></tr><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr></table>
Data Sources and Data Issues:	DHHS will collect adolescent well-care visit data from MCH-contracted Community Health Centers per Primary Care contracts exhibit A. The MCH Performance Measure was changed from 12-17 years of age to 12-21 years of age as of July 1, 2015. During the January 2016 reporting DHHS determined that this change caused some issues with data collection and reporting. DHHS has provided technical support to reduce reporting issues.
Significance:	Recognizing that the health of adolescents is largely impacted by behavioral patterns developed during this developmental period, NH MCH collaborates with state and local partners to increase access to health care and promotes annual well-care visits for families and adolescents. The well-care visit is a prime opportunity for health care providers to screen and counsel adolescent/family about key areas including: mental and behavioral health, tobacco and substance use, violence and injury prevention, sexual behavior and nutritional health.

ESM 11.1 - The number of Primary Care Provider practices who have adopted a Transition Policy
NPM 11 – Percent of children with and without special health care needs having a medical home

Goal:	Children with and without special health care needs will receive the services necessary to transition to adult health care as an integral part of the care they receive from their Medical Home
Definition:	**Numerator:** Number of practices who have adopted a Transition Policy **Denominator:** n/a **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	SMS has a contracted agency that supports statewide Medical Home improvement. This contracted agency will develop a process for surveying practices, educating and supporting them regarding adoption of a Transition Policy (in accordance with the recommendations of Got Transition) and will track the count of practices who have adopted a Transition Policy
Significance:	In accordance with the evidence embedded in Got Transition™ (http://gottransition.org) the significance of improving transition processes is that these efforts optimize health and assist youth in reaching their full potential. In order to achieve this goal it is the recommendation of Got Transition™ that what is required is an "organized transition process to support youth in acquiring independent health care skills, preparing for an adult model of care, and transferring to new providers without disruption in care". The adoption of a Transition Policy that details a consistent approach and informs youth, caregivers and providers alike is the foundation for achieving this goal.

ESM 14.1 - Number of calls received by the smoking quitline in the past year
NPM 14 – A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

<table>
<tr><td>Goal:</td><td>Promote increased use of the state-funded quitline</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>number of quitline calls received</td></tr>
<tr><td>Denominator:</td><td>N/A</td></tr>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>12,500</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Source: QuitLogix Tobacco Quitline database (New Hampshire), operated by National Jewish Health

Total number of quitline calls received is defined as:
1. linked to NH birth record
AND...
2. Up to 3 months prior to estimated conception date OR
3. During pregnancy OR
4. Up to 3 months after live birth

Establish cohort of NH mothers with live birth between April 1, 2017 through September 30, 2017. This allows a full assessment of the time window (see above) around pregnancy.

Linkage to birth certificate data is possible for pregnancies resulting in a live birth (NH residents).

Timing of quitting may be prior to the pregnancy, during pregnancy, or postpartum.

Pregnancies not resulting in a live birth may not be captured, though the system does have a data field to capture responses to question regarding currently pregnancy (very small number flagged for 2015).

Time window of three months prior to pregnancy through three months after live birth narrows the cohort of mothers (by about 50%) who can be comprehensively assessed for this measure.

De-duplicate mothers (i.e. adjust for multiple births).

Can provide context by citing percent of cohort reporting smoking on birth certificate, but this is not appropriate to use as a denominator due to data quality. Analysis of NH birth records and PRAMS data show significant underreporting of smoking on the birth certificate.</td></tr>
<tr><td>Significance:</td><td>Promoting increased use the state-funded quitline is included in the April 2016 Sample Strategies and Evidence-Based or Informed Strategy Measures compiled by the Strengthen the Evidence for Maternal and Child Health Programs Initiative and is a strategy supported by the associated Environmental Scan of Strategies for NMP #14.</td></tr>
</table>

Form 10d
National Performance Measures (NPMs) (Reporting Year 2014 & 2015)

State: New Hampshire

Form Notes for Form 10d NPMs and SPMs

None

NPM 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.

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	20	26	25	19	22
Denominator	20	26	25	19	22
Data Source	screening records	screening records	screening records	Screening records	Screening records
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

None

Data Alerts: None

NPM 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)

	2011	2012	2013	2014	2015
Annual Objective	60.0	75.0	75.0	75.0	75.0
Annual Indicator	74.9	74.9	74.9	74.9	74.9
Numerator					
Denominator					
Data Source	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: For 2011-2015, 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.	
2.	**Field Name:**	**2014**
	Field Note: For 2011-2015, 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.	
3.	**Field Name:**	**2013**

Field Note:
For 2011-2015, 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.

4. **Field Name:** **2012**

Field Note:
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.

5. **Field Name:** **2011**

Field Note:
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.

Data Alerts: None

NPM 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)

	2011	2012	2013	2014	2015
Annual Objective	50.0	50.0	50.0	50.0	50.0
Annual Indicator	49.4	49.4	49.4	49.4	49.4
Numerator					
Denominator					
Data Source	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: For 2011-2015, 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.	
2.	**Field Name:**	**2014**
	Field Note: For 2011-2015, 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.	
3.	**Field Name:**	**2013**

Field Note:
For 2011-2015, 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.

4. **Field Name:** **2012**

Field Note:
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.

5. **Field Name:** **2011**

Field Note:
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.

Data Alerts: None

NPM 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)

	2011	2012	2013	2014	2015
Annual Objective	68.0	66.5	66.5	66.5	66.5
Annual Indicator	66.2	66.2	66.2	66.2	66.2
Numerator					
Denominator					
Data Source	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: For 2011-2015, 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.	
2.	**Field Name:**	**2014**
	Field Note: For 2011-2015, 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.	
3.	**Field Name:**	**2013**
	Field Note: For 2011-2015, 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.	
4.	**Field Name:**	**2012**

Field Note:
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.

5.	**Field Name:**	**2011**

Field Note:
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.

Data Alerts: None

NPM 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)

	2011	2012	2013	2014	2015
Annual Objective	86.0	67.0	67.0	67.0	67.0
Annual Indicator	67.0	67.0	67.0	67.0	67.0
Numerator					
Denominator					
Data Source	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: For 2011-2015, 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.	
2.	**Field Name:**	**2014**
	Field Note: For 2011-2015, 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.	
3.	**Field Name:**	**2013**

Field Note:
For 2011-2015, 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.

4. **Field Name:** **2012**

Field Note:
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.

5. **Field Name:** **2011**

Field Note:
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.

Data Alerts: None

NPM 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.

	2011	2012	2013	2014	2015
Annual Objective	52.0	50.0	50.0	50.0	50.0
Annual Indicator	49.0	49.0	49.0	49.0	49.0
Numerator					
Denominator					
Data Source	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:
For 2011-2015, 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.

2. **Field Name:** **2014**

Field Note:
For 2011-2015, 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.

3. **Field Name:** **2013**

Field Note:
For 2011-2015, 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.

4. **Field Name:** **2012**

Field Note:
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.

5. **Field Name:** **2011**

Field Note:
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.

Data Alerts: None

NPM 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.

	2011	2012	2013	2014	2015
Annual Objective	86.0	87.0	86.0	88.0	89.0
Annual Indicator	86.8	79.7	81.9	80.9	84.3
Numerator					
Denominator					
Data Source	HRSA Email sent 5/16/12	HRSA Email sent 5/2/13	National Immunization Survey	National Immunization Survey	National Immunization Survey
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: Data is for vaccination coverage for the 4:3:1:3:3 series complete; among children 19 to 35 months; from US National Immunization Survey. Data from NH Immunization Program.	
2.	**Field Name:**	**2014**
	Field Note: Data is for vaccination coverage for the 4:3:1:3:3 series complete; among children 19 to 35 months; from US National Immunization Survey; 2013 data reported in 2014 Data from CDC.gov website via Suzanne Allison in DPHS Immunization Program.	
3.	**Field Name:**	**2013**
	Field Note: Rate is for vaccination coverage for the 4:3:1:3:3 series complete; among children 19 to 35 months; from US National Immunization Survey; 2012 data reported in 2013. Data from CDC.gov website. Rate is 81.9 + or - 5.6.	
4.	**Field Name:**	**2012**
	Field Note: Rate is for vaccination coverage for the 4:3:1:3:3 series among children 19 to 35 months, US National Immunization Survey 2011, per recommendation of Ellen Volpe (HRSA) in email sent May 2, 2013. Unlike previous years, MCH did not adjust CDC rate according to its most recent two-year old Census Population figure. Rate of 79.7 is + or - 6.1.	

5.	**Field Name:**	**2011**

Field Note:
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.

Data Alerts: None

NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

	2011	2012	2013	2014	2015
Annual Objective	6.7	5.9	5.8	4.5	4.4
Annual Indicator	5.6	6.3	4.6	4.3	4.0
Numerator	142	160	118	110	102
Denominator	25,323	25,323	25,670	25,670	25,670
Data Source	Vital Records Birth data	Vital Records Birth Data	Vital Records Birth Data	Vital Records Birth Data	Vital Records Birth Data
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2011**

Field Note:
Population updated using 2010 Census.

Data Alerts: None

NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

	2011	2012	2013	2014	2015
Annual Objective	54.5	54.5	54.5	60.0	62.0
Annual Indicator	54.5	54.5	54.5	61.4	61.4
Numerator	1,644	1,644	1,644	2,042	2,042
Denominator	3,015	3,015	3,015	3,328	3,328
Data Source	2009 3rd grade survey	2009 3rd grade survey	2009 third grade survey	2014 third grade survey	2014 third grade survey
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: Statewide oral health data for NPM #9 is collected every five years through the Oral Health Survey of Third Grade Children. Therefore, the data for 2015 is the same as for 2014.	
2.	**Field Name:**	**2013**
	Field Note: Statewide oral health data for NPM #9 is collected every five years through the Oral Health Survey of Third Grade Children. The data for 2013 is the same as for 2009, 2010, and 2011. Future objectives reflect the fact that new data will not be available until the summer of 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.	
3.	**Field Name:**	**2012**
	Field Note: 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 2012 is the same as for 2009, 2010, and 2011. 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.	
4.	**Field Name:**	**2011**

Field Note:
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.

Data Alerts: None

NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

	2011	2012	2013	2014	2015
Annual Objective	0.0	0.8	0.6	0.4	0.2
Annual Indicator	0.0	1.0	0.0	0.0	0.0
Numerator					
Denominator					
Data Source	Health Statistics	Health Statistics	Health Statistics	Health Statistics	Injury Surveillance Program
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:
Calendar year 2014 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".

2. **Field Name:** **2014**

Field Note:
Calendar year 2014 out of state data is unavailable. Also, starting in 2014, estimated population data is compiled by NH-DHHS-HDSM from data provided by Claritas.

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".

3. **Field Name:** **2013**

Field Note:
Calendar year 2013 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".

4. **Field Name:** **2012**

Field Note:
Calendar year 2012 out of state data is unavailable. 2009 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".

5. **Field Name:** **2011**

Field Note:
Calendar year 2011out 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".

Data Alerts: None

NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.

	2011	2012	2013	2014	2015
Annual Objective	52.0	60.0	62.0	56.0	58.0
Annual Indicator	58.2	60.0	53.6	57.6	57.6
Numerator					
Denominator					
Data Source	CDC report card	CDC report card	CDC report card	2014 CDC Report Card	2014 CDC Report Card
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: Not available. It is expected to be available in August of 2016.	
2.	**Field Name:**	**2013**
	Field Note: Data is from the CDC Breast Feeding Report Card, 2013 (www.cdc.gov). A numerator and denominator are not available. 2013 was the first year that cell phone data was included, so comparing against previous years needs to be done with caution. In addition, NH is a small population state where numbers have historically gone both up and down.	
3.	**Field Name:**	**2012**
	Field Note: Data is from the CDC Breast Feeding Report Card, 2012: Outcome Indicators (www.cdc.gov). A numerator and denominator are not available.	
4.	**Field Name:**	**2011**
	Field Note: Data is from the CDC Breast Feeding Report Card, 2011: Outcome Indicators (www.cdc.gov). A numerator and denominator are not available.	

Data Alerts: None

NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.

	2011	2012	2013	2014	2015
Annual Objective	98.0	98.0	97.4	97.5	97.6
Annual Indicator	97.3	97.3	97.2	97.3	97.9
Numerator	12,733	12,236	12,115	12,053	12,116
Denominator	13,080	12,578	12,466	12,391	12,373
Data Source	screening records	screening records	screening records	Screening records	Screening records
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: Numerator is actual number of infants screened. Denominator is number of occurrent births.	
2.	**Field Name:**	**2014**
	Field Note: Numerator is actual number of infants screened. Denominator is number of occurrent births.	
3.	**Field Name:**	**2013**
	Field Note: Numerator is actual number of infants screened. Denominator is number of occurrent births.	
4.	**Field Name:**	**2012**
	Field Note: Numerator is actual number of infants screened. Denominator is number of occurrent births.	
5.	**Field Name:**	**2011**
	Field Note: Numerator is actual number of infants screened. Denominator is number of occurrent births.	

Data Alerts: None

NPM 13 - Percent of children without health insurance.

	2011	2012	2013	2014	2015
Annual Objective	4.0	4.0	4.0	6.0	5.0
Annual Indicator	5.0	7.0	6.8	6.8	6.8
Numerator	14,000	19,900	19,900	19,900	19,900
Denominator	280,000	284,286	294,500	294,500	294,500
Data Source	Kaiser Foundation State Health Facts	Kaiser Foundation State Health Facts	Kaiser Foundation State Health Facts	Kaiser Foundation State Health Facts	Kaiser Foundation State Health Facts
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: Data is from the Kaiser Family Foundation State Health Facts: "New Hampshire: Health Insurance Coverage of Children 0-18, States (2011-2012), US (2012) http://www.statehealthfacts.org	
2.	**Field Name:**	**2014**
	Field Note: Data is from the Kaiser Family Foundation State Health Facts: "New Hampshire: Health Insurance Coverage of Children 0-18, States (2011-2012), US (2012) http://www.statehealthfacts.org	
3.	**Field Name:**	**2013**
	Field Note: Data is from the Kaiser Family Foundation State Health Facts: "New Hampshire: Health Insurance Coverage of Children 0-18, States (2011-2012), US (2012) http://www.statehealthfacts.org	
4.	**Field Name:**	**2012**
	Field Note: Data is from the Kaiser Family Foundation State Health Facts: "New Hampshire: Health Insurance Coverage of Children 0-18, States (2010-2011), US (2011) http://www.statehealthfacts.org	
5.	**Field Name:**	**2011**

Field Note:
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

Data Alerts: None

NPM 14 - Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

	2011	2012	2013	2014	2015
Annual Objective	30.0	29.0	29.0	29.0	28.0
Annual Indicator	31.5	31.6	30.1	30.1	30.1
Numerator	2,598	2,453	2,191	2,191	2,191
Denominator	8,249	7,763	7,271	7,271	7,271
Data Source	NH WIC Program	NH WIC Program	NH WIC Program	NH WIC Program	NH WIC Program
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: Updated data is not available.	
2.	**Field Name:**	**2014**
	Field Note: Updated data is not available. We hope to have it available in January of 2016.	
3.	**Field Name:**	**2013**
	Field Note: Pediatric Nutrition Surveillance System, New Hampshire Department of Health and Human Services, 2013.	
4.	**Field Name:**	**2012**
	Field Note: Pediatric Nutrition Surveillance System, New Hampshire Department of Health and Human Services, 2012.	
5.	**Field Name:**	**2011**
	Field Note: Data is from Lisa Richards, NH WIC program, from CDC Pediatric Nutrition Surveillance System.	

Data Alerts: None

NPM 15 - Percentage of women who smoke in the last three months of pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	11.0	11.5	11.0	11.0	10.5
Annual Indicator	11.2	11.7	11.6	10.6	9.8
Numerator	1,432	1,424	1,415	1,294	1,207
Denominator	12,743	12,220	12,232	12,213	12,358
Data Source	Birth Certificate	Birth Certificate	Birth Certificate	Birth Certificate	Birth Certificate
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2011**

Field Note:
2010 provisional data used in FY13 application is updated to 2011 final data.

Data Alerts: None

NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

	2011	2012	2013	2014	2015
Annual Objective	7.0	7.0	8.0	7.0	6.5
Annual Indicator	9.6	5.4	7.7	9.6	6.5
Numerator	9	5	7	9	6
Denominator	93,620	92,612	90,698	93,699	92,907
Data Source	Health Statistics	Health Statistics	Health Statistics	Health Statistics	Injury Surveillance Program
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2013**
	Field Note: 2013 death data is provisional and subject to change.	
2.	**Field Name:**	**2011**
	Field Note: Out of state data is unavailable. 2009 data is used as an estimate.	

Data Alerts: None

NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

	2011	2012	2013	2014	2015
Annual Objective	83.0	87.0	76.0	81.0	82.0
Annual Indicator	73.6	74.2	79.8	79.2	77.1
Numerator	89	89	95	76	74
Denominator	121	120	119	96	96
Data Source	Birth Certificate	Birth Certificate	Birth Certificate	Birth Certificate	Birth Certificate
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2012**

Field Note:
Final data is available for 2012.

Data Alerts: None

NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

	2011	2012	2013	2014	2015
Annual Objective	85.0	84.0	85.0	83.0	84.0
Annual Indicator	82.5	82.9	81.0	81.5	82.7
Numerator	9,056	8,946	8,986	9,153	9,330
Denominator	10,976	10,785	11,097	11,224	11,286
Data Source	Birth Certificate	Birth Certificate	Birth Certificate	Birth Certificate	Birth Certificate
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

None

Data Alerts: None

Form 10d
State Performance Measures (SPMs) (Reporting Year 2014 & 2015)

State: New Hampshire

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

	2011	2012	2013	2014	2015
Annual Objective	48.0	50.0	85.0	87.0	89.0
Annual Indicator	45.7	82.8	66.8	62.6	63.2
Numerator	4,086	6,187	5,854	5,542	5,302
Denominator	8,939	7,475	8,758	8,849	8,386
Data Source	NH Medicaid Claims Data	NH Medicaid Claims Data	NH Medicaid Claims Data	NH Medicaid Claims Data	NH Medicaid Claims Data
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

   Field Note:
   Data from Sandy Connolly. MMIS data as of 5/9/2016.

2. **Field Name:** **2014**

   Field Note:
   Data from Sandy Connolly. MMIS data as of 5/9/2016.

3. **Field Name:** **2013**

   Field Note:
   Data and note from Andrew Chalsma, Office of Medicaid Business and Policy.

   The lower rate for this measure is thought to be for two reasons:
   NH Medicaid is using different systems to extract the data this year. In addition, most 12-18 year olds went into Care Management in December, and we do not yet have encounter data from the health plans doing managed care.

4. **Field Name:** **2011**

   Field Note:
   2011 data is unavailable, so 2010 data is used.

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	33.6	33.6	33.6	30.0	30.0
Annual Indicator	33.6	33.6	33.6	28.0	28.0
Numerator	1,037	1,037	1,037	1,112	1,112
Denominator	3,082	3,082	3,082	3,971	3,971
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	2013-2014 NH Healthy Smiles Healthy Growth Survey	2013-2014 NH Healthy Smiles Healthy Growth Survey
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

   Field Note:
   No new data available. The survey is done every 5 years.

2. **Field Name:** **2012**

   Field Note:
   No new data for 2012. 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 %".

3. **Field Name:** **2011**

   Field Note:
   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 %".

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	51.0	49.0	49.0	47.0	45.0
Annual Indicator	51.3	51.3	49.3	49.3	49.0
Numerator	72,000	72,000			
Denominator	140,300	140,300			
Data Source	National Survey on Drug Use and Health	National Survey on Drug Use and Health	National Survey on Drug Use and Health	National Survey on Drug Use and Health	National Survey on Drug Use and Health
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2015**
	Field Note: National Survey on Drug Use and Alcohol. NSDUH 2012/13. SAMHSA.gov website. Retrieved 04/28/16 from www.samhsa.gov/data/sites/default/files/NSDUHsaeSpecificStates2013/NSDUHsaeNewHampshire2013.pdf	
2.	**Field Name:**	**2014**
	Field Note: The latest data from The National Survey on Drug Use and Health, 2010-2011 shows in 49.32% for 18-25 yr olds reporting binge alcohol use in the past month j has not changed. There is no numerator and denominator available. http://samhsa.gov/data/NSDUH/2k11State/NSDUHsae2011/ExcelTabs/NSDUHsaeTables2011	
3.	**Field Name:**	**2013**
	Field Note: The latest data from The National Survey on Drug Use and Health, 2010-2011 shows in Table 10 that the estimate is now 49.32% of 18-25 yr olds reporting binge alcohol use in the past month. There is no numerator and denominator available. http://samhsa.gov/data/NSDUH/2k11State/NSDUHsae2011/ExcelTabs/NSDUHsaeTables2011.pdf	
4.	**Field Name:**	**2012**
	Field Note: Data is the most recent from the National Survey on Drug Use and Health. This data is 2008-2009.	
5.	**Field Name:**	**2011**
	Field Note: Data is the most recent from the National Survey on Drug Use and Health. This data is 2008-2009.	

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	14	14	16	16	16
Denominator	14	14	16	16	16
Data Source	Email survey of contracted CHCs	Email survey of contracted CHCs	Email survey of contracted CHCs	Email survey of contracted CHCs	Email survey of contracted CHCs
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2012**

Field Note:
Data obtained from March, 2014 email survey received from the 13 state-funded Community Health Centers, 1 pediatric primary care agency, and 2 primary care for the homeless programs; 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.

All but three agencies indicated they were Tier 3. The other three agencies were Tier 2.

2. **Field Name:** **2011**

Field Note:
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.

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	28.0	30.0	32.0	34.0	36.0
Annual Indicator	30.6	30.6	30.6	30.6	30.6
Numerator	19,643	19,643	19,643	19,643	19,643
Denominator	64,194	64,194	64,194	64,194	64,194
Data Source	National Survey of Children's Health	National Survey of Children's Health	National Survey of Children's Health	National Survey of Children's Health	National Survey of Children's Health
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2015**
	Field Note: National Survey of Children's Health. NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent health website. Retrieved 04/28/16 from www.childhealthdata.org.	
2.	**Field Name:**	**2014**
	Field Note: Data from NSCH 2011-2012, Indicator 4.16	
3.	**Field Name:**	**2013**
	Field Note: Data from NSCH 2011-2012, Indicator 4.16	
4.	**Field Name:**	**2012**
	Field Note: Data from NSCH 2011-2012, Indicator 4.16	
5.	**Field Name:**	**2011**
	Field Note: Data from NSCH 2011-2012, Indicator 4.16	

Data Alerts: None

SPM 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

	2011	2012	2013	2014	2015
Annual Objective	1,775.0	1,400.0	1,450.0	1,400.0	1,350.0
Annual Indicator	1,482.7	1,482.7	1,166.4	819.3	819.3
Numerator	1,410	1,410	1,092	766	766
Denominator	95,099	95,099	93,620	93,498	93,498
Data Source	Health Statistics	Health Statistics	Health Statistics	Health Statistics	Health Statistics
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2015**
	Field Note: "Recent quality assurance checks of 2010 and 2011 NH hospital discharge data have shown that data is missing from some hospitals. And data for 2015 is not available. We have used 2014 data as an estimate, and a place holder, until 2015 is fully collected; and quality assurance checks have been done.	
2.	**Field Name:**	**2014**
	Field Note: There is no data available for 2014. Data used is from 2011. Hospital discharge data from 2010 on were collected using a different methodology, field names differ from previous years, and only in-state discharges are available. Therefore, data from 2010 on is not comparable to previous years. Population data is from Claritas	
3.	**Field Name:**	**2013**
	Field Note: NEW NOTE FOR 2013: There is no data available for 2013. Data used is from 2010. Hospital discharge data from 2010 on were collected using a different methodology, field names differ from previous years, and only in-state discharges are available. Therefore, data from 2010 on is not comparable to previous years. 2000-2013 population data is from census.	
4.	**Field Name:**	**2012**
	Field Note: Most recent updated data is 2009. This is used as an estimate.	
5.	**Field Name:**	**2011**
	Field Note: Most recent updated data is 2009. This is used as an estimate.	

Data Alerts: None

SPM 7 - Percent of households identified with environmental risks that receive healthy homes assessments.

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	63.0	65.0	67.0
Annual Indicator	62.7	61.5	37.5	26.0	69.2
Numerator	37	91	24	20	45
Denominator	59	148	64	77	65
Data Source	Healthy Homes & Lead Poisoning Prevention Progra	Healthy Homes & Lead Poisoning Prevention Progra	Healthy Homes & Lead Poisoning Prevention Progra	Healthy Homes & Lead Poisoning Prevention Progra	Healthy Homes & Lead Poisoning Prevention Progra
Provisional Or Final ?				Provisional	Final

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2013**

Field Note:
Data is from the Healthy Homes & Lead Poisoning Prevention Program data surveillance system. The numerator is the number of "one-touch" forms completed. The denominator is nurse case management visits.

In 2013, there were a significant number of environmentalists and nurse staff turnovers and vacancies. The former position was vacant most of the year; and the nurse position was vacant about half the year. Our nurse did not start until about halfway through the year, and the environmentalist position was vacant most of the year. For these reasons, numbers for 2013 are skewed. We believe that in 2014 there will be a significant increase in both numbers and percentage.

2. **Field Name:** **2011**

Field 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.

Data Alerts: None

SPM 8 - The percent of public water systems that optimally fluoridate the water system on a monthly basis.

	2011	2012	2013	2014	2015
Annual Objective	4.0	3.0	50.0	60.0	70.0
Annual Indicator	10.0	40.0	50.0	60.0	60.0
Numerator	1	4	5	6	6
Denominator	10	10	10	10	10
Data Source	NH Dept. of Environmental Svcs	NH Dept. of Environmental Svcs	NH Dept. of Environmental Svcs	NH Dept. of Environmental Services	NH Dept. of Environmental Services
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2013**

Field Note:
For reporting year 2013, the numerator (number of systems that optimally fluoridate 80% of the days measured and reported each month) dropped to one system. The DPHS Oral Health Program believes there are three reasons for the decline in optimal fluoridation by 10 water systems for all 12 months in 2013: 1- US Department of Health and Human Services still had not finalized the recommended level of added fluoride required to reach a new optimal range for community water fluoridation; 2- Reporting included months before the March 5, 2013 fluoridation training, convened for water operators by DES and DPHS, to explain the pending change to CWF recommendations and introduce a new fluoridation monthly operating report (FMOR). The fluoridation training included a live link to Kip Duchon, CDC Fluoridation Engineer who answered many questions posed by NH water operators. In spite of the fact that CDC had not finalized its CWF recommendations, NH DES adopted the new lower optimal range for assessing quality water fluoridation. 3- Water operators' adoption of the new electronic FMOR was slower than expected in 2013, but we did note a monthly increase among early adopters in the number of optimally fluoridated water systems. In 2014 widespread adoption of the new FMOR will simplify performance measurement by DPHS, improve performance management by DES, and increase the number of municipalities that optimally fluoridate their water systems all 12 months of the year.

2. **Field Name:** **2012**

Field Note:
The percent is based on an annual average of NH fluoridated water systems that optimally fluoridate their water based on monthly reporting.

In 2013 the Centers for Disease Control and Prevention released an adjusted target range (0.6-0.8 mg/l.) for fluoridated community water systems for use in achieving optimized fluoridation of water delivered to customers. Prior to release of CDC's final recommendation, New Hampshire water systems were using the two different target ranges making it difficult to track systems' performance. A March 2013 fluoridation training workshop convened by the NH Oral Health Program in collaboration with the NH Department of Environmental Services, Ground Water and Drinking Water Bureau incorporated a NH specific webinar featuring Kip Duchon, CDC's Fluoridation Engineer, presenting CDC's final recommendation on the target range to achieve optimal community water fluoridation. Enabled by a DPHS Quality Improvement project, DES and DPHS have cooperated to develop a new Monthly Fluoridation Reporting (MOR) form for 10 fluoridated NH water departments that calculates the daily addition of fluoride to the water supply to determine the average monthly value and whether or not the system has optimized fluoridation during the month. This relatively simple change to the MOR provides instant feedback to water operators indicating if the system's monthly value falls within the new lower target range. Feedback from water operators has been extremely positive. The new form and consequent buy-in from water departments will simplify performance measurement by DPHS and improve performance management by DES.

3. **Field Name:** **2011**

Field Note:
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.

Data Alerts: None

SPM 9 - REVISED: The number of individuals who have completed a competency based training for respite providers.

	2011	2012	2013	2014	2015
Annual Objective	15.0	20.0	20.0	20.0	20.0
Annual Indicator	14.0	19.0	19.0	4.0	6.0
Numerator					
Denominator					
Data Source	SMS Training Records	SMS Training Records	SMS Training Records	SMS Training Records	SMS training records
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2015**
	Field Note: This the final year for reporting on this measure. No new providers completed the entire competency training. In this year providers began enrolling in individual components of the training. The total number of providers who have completed the training and are signed up to provide respite on the NH Respite Locator is 34.	
2.	**Field Name:**	**2014**
	Field Note: This is a manual indicator, therefore the numerator and denominator fields are blank. In this year 10 individuals signed up for the competency based training, four completed the training and 2 more have almost completed the training.	
3.	**Field Name:**	**2013**
	Field Note: This is a manual indicator, therefore the numerator and denominator fields are blank	
4.	**Field Name:**	**2012**
	Field Note: This is a manual indicator, therefore the numerator and denominator fields are blank	
5.	**Field Name:**	**2011**
	Field Note: This is a manual indicator, therefore the numerator and denominator fields are blank	

Data Alerts: None

SPM 10 - Of women who had a preterm birth: Percent who reported smoking before pregnancy

	2011	2012	2013	2014	2015
Annual Objective	18.0	17.0	18.0	18.0	17.0
Annual Indicator	18.6	21.6	22.1	22.1	22.2
Numerator	204	224	221	222	209
Denominator	1,096	1,036	1,001	1,003	942
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	Vital Records
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

None

Data Alerts: None

Form 11
Other State Data

State: New Hampshire

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the current application/annual report.

State Action Plan Table

State: New Hampshire

Please click the link below to download a PDF of the full version of the State Action Plan Table.
State Action Plan Table

Abbreviated State Action Plan Table

State: New Hampshire

Women/Maternal Health

State Priority Needs	NPMs	ESMs	SPMs
Improve access to needed healthcare services for all populations.	NPM 1 - Well-Woman Visit	ESM 1.1	

Perinatal/Infant Health

State Priority Needs	NPMs	ESMs	SPMs
Decrease unintentional injury.	NPM 5 - Safe Sleep	ESM 5.1	

Child Health

State Priority Needs	NPMs	ESMs	SPMs
Decrease pediatric overweight and obesity.	NPM 8 - Physical Activity	ESM 8.1	
Improve access to standardized developmental/social emotional screening, assessment and follow-up for children and adolescents.	NPM 6 - Developmental Screening	ESM 6.1	

Adolescent Health

State Priority Needs	NPMs	ESMs	SPMs
Decrease unintentional injury.	NPM 7 - Injury Hospitalization	ESM 7.1	
Improve access to needed healthcare services for all populations.	NPM 10 - Adolescent Well-Visit	ESM 10.1	

Children with Special Health Care Needs

State Priority Needs	NPMs	ESMs	SPMs
Increase access to comprehensive Medical Homes.	NPM 11 - Medical Home	ESM 11.1	
Increase family support and access to trained respite and childcare providers.			SPM 2

Cross-Cutting/Life Course

State Priority Needs	NPMs	ESMs	SPMs
Decrease the use and abuse of alcohol, tobacco and other substances among youth, pregnant women and families.	NPM 14 - Smoking	ESM 14.1	
Improve access to mental health services.			SPM 3
Improve access to needed healthcare services for all populations.			SPM 1