HRSA
Health Resources & Services Administration

Title V MCH Block Grant Program

NEW HAMPSHIRE

State Snapshot

FY 2017 Application / FY 2015 Annual Report

November 2016

Title V Federal-State Partnership - New Hampshire

The Title V Maternal and Child Health Block Grant Program is a federal-state partnership with 59 states and jurisdictions to improve maternal and child health throughout the nation. This Title V Snapshot presents high-level data and the executive summary contained in the FY 2017 Application / FY 2015 Annual Report. For more information on MCH data, please visit the Title V Federal-State Partnership website (https://mchb.tvisdata.hrsa.gov)

State Contacts

MCH Director	CSHCN Director	State Family or Youth Leader
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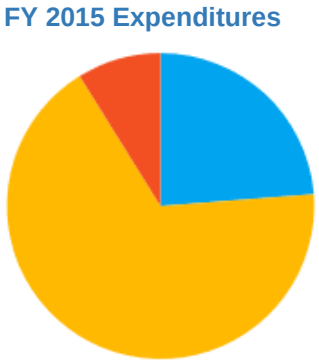
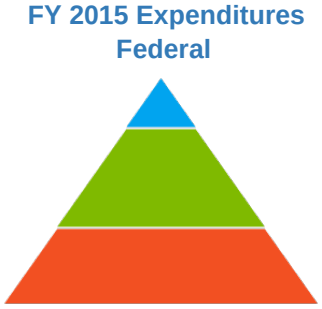
Funding by Source

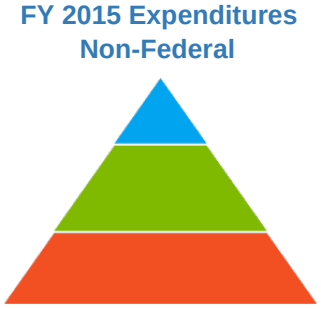
Source	FY 2015 Expenditures
Federal Allocation	$1,986,075
State MCH Funds	$5,634,464
Local MCH Funds	$0
Other Funds	$737,314
Program Income	$0



Funding by Service Level

Service Level	Federal	Non-Federal
Direct Services	$438,124	$1,875,308
Enabling Services	$876,249	$2,461,200
Public Health Services and Systems	$671,702	$2,035,270





Total Reach of Title V in Serving MCH Populations

Populations Served	Individuals Served	FY 2015 Expenditures	%
Pregnant Women	1,526	$271,244	3.5%
Infants < 1 Year	12,420	$1,713,793	22.3%
Children 1-22 Years	32,673	$2,278,451	29.6%
CSHCN	6,057	$2,615,348	34.0%
Others *	87,322	$813,733	10.6%
Total	139,998	$7,692,569	100%

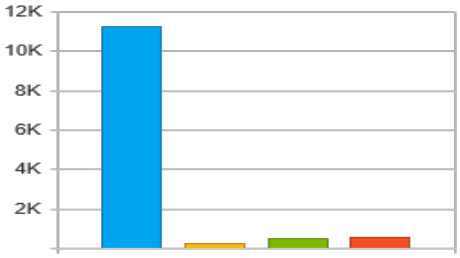
*Others– Women of childbearing age, over age 21, and any others defined by the State who are not otherwise included in any of the other listed classes of individuals.

FY 2015 Expenditures

FY 2015 Individuals Served

Communication Reach

Communication Method	Amount
State Title V Website Hits:	11,262
State Title V Social Media Hits:	225
State MCH Toll-Free Calls:	520
Other Toll-Free Calls:	578



Selected National Performance Measures

Measure #	Measure Short Name	Population Domain
NPM 1	Well-Woman Visit	Women/Maternal Health
NPM 5	Safe Sleep	Perinatal/Infant Health
NPM 6	Developmental Screening	Child Health
NPM 7	Injury Hospitalization	Child Health, Adolescent Health
NPM 8	Physical Activity	Child Health, Adolescent Health
NPM 10	Adolescent Well-Visit	Adolescent Health
NPM 11	Medical Home	Children with Special Health Care Needs
NPM 14	Smoking	Cross-Cutting/Life Course

Evidence-Based or –Informed Strategy Measures

NPM #	NPM Short Name	ESM #	ESM Title
NPM 1	Well-Woman Visit	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 5	Safe Sleep	ESM 5.1	Percentage of birth hospitals with a written safe sleep policy, including placing all infants to sleep on their back
NPM 6	Developmental Screening	ESM 6.1	The number of sites using ASQ/ASQ-SE screening tools and participating in the Watch Me Grow (WMG) System.
NPM 7	Injury Hospitalization	ESM 7.1	Percentage of high school students who wear seatbelts
NPM 8	Physical Activity	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 10	Adolescent Well-Visit	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 11	Medical Home	ESM 11.1	The number of Primary Care Provider practices who have adopted a Transition Policy
NPM 14	Smoking	ESM 14.1	Number of calls received by the smoking quitline in the past year

State Performance Measures

SPM #	SPM Title	Population Domain(s)
SPM 1	Percentage of MCH-contracted Community Health Centers with Enabling Services workplan on file with DHHS/MCH.	Cross-Cutting/Life Course
SPM 2	Percentage of families enrolled in SMS who report access to respite	Children with Special Health Care Needs
SPM 3	Percentage of behavioral health professionals recruited	Cross-Cutting/Life Course

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 (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.

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.

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.

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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.

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.

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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

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.

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