Maternal and Child Health Services Title V Block Grant

New Hampshire

FY 2019 Application/ FY 2017 Annual Report

Created on 9/26/2018 at 4:01 PM

Table of Contents

I. General Requirements	**4**
I.A. Letter of Transmittal	4
I.B. Face Sheet	5
I.C. Assurances and Certifications	5
I.D. Table of Contents	5
II. Logic Model	**5**
III. Components of the Application/Annual Report	**6**
III.A. Executive Summary	6
III.A.1. Program Overview	6
III.A.2. How Title V Funds Support State MCH Efforts	11
III.A.3. MCH Success Story	11
III.B. Overview of the State	12
III.C. Needs Assessment	32
FY 2019 Application/FY 2017 Annual Report Update	32
FY 2018 Application/FY 2016 Annual Report Update	37
FY 2017 Application/FY 2015 Annual Report Update	54
Five-Year Needs Assessment Summary (as submitted with the FY 2016 Application/FY 2014 Annual Report)	67
III.D. Financial Narrative	99
III.D.1. Expenditures	101
III.D.2. Budget	104
III.E. Five-Year State Action Plan	108
III.E.1. Five-Year State Action Plan Table	108
III.E.2. State Action Plan Narrative Overview	109
III.E.2.a. State Title V Program Purpose and Design	109
III.E.2.b. Supportive Administrative Systems and Processes	111
III.E.2.b.i. MCH Workforce Development	111
III.E.2.b.ii. Family Partnership	113
III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts	117
III.E.2.b.iv. Health Care Delivery System	120
III.E.2.c State Action Plan Narrative by Domain	122
Women/Maternal Health	122
Perinatal/Infant Health	156
Child Health	194

Adolescent Health	227
Children with Special Health Care Needs	281
Cross-Cutting/Systems Building	306
III.F. Public Input	336
III.G. Technical Assistance	342
IV. Title V-Medicaid IAA/MOU	**344**
V. Supporting Documents	**345**
VI. Organizational Chart	**346**
VII. Appendix	**347**
Form 2 MCH Budget/Expenditure Details	348
Form 3a Budget and Expenditure Details by Types of Individuals Served	354
Form 3b Budget and Expenditure Details by Types of Services	356
Form 4 Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated	360
Form 5a Count of Individuals Served by Title V	363
Form 5b Total Percentage of Populations Served by Title V	366
Form 6 Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX	369
Form 7 State MCH Toll-Free Telephone Line and Other Appropriate Methods Data	371
Form 8 State MCH and CSHCN Directors Contact Information	373
Form 9 List of MCH Priority Needs	376
Form 10a National Outcome Measures (NOMs)	379
Form 10a National Performance Measures (NPMs)	419
Form 10a State Performance Measures (SPMs)	431
Form 10a Evidence-Based or –Informed Strategy Measures (ESMs)	434
Form 10b State Performance Measure (SPM) Detail Sheets	443
Form 10c Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets	447
Form 11 Other State Data	455

I. General Requirements

I.A. Letter of Transmittal

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
BUREAU OF POPULATION HEALTH AND COMMUNITY SERVICES

Jeffrey A. Meyers
Commissioner

Lisa M. Morris
Director

29 HAZEN DRIVE, CONCORD, NH 03301
603-271-4524 1-800-852-3345 Ext. 4524
Fax: 603-271-8705 TDD Access: 1-800-735-2964
www.dhhs.nh.gov

April 13, 2018

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 2019 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,

Lisa Morris, MSSW
Director

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

Sia Cherala, Bureau Chief,
Bureau of Population Health and Community Services

The Department of Health and Human Services' Mission is to join communities and families in providing opportunities for citizens to achieve health and independence.

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 F of the 2018 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 *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: December 31, 2020.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: December 31, 2020.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

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 (HRSA) with New Hampshire's Department of Health and Human Services' Maternal and Child Health (MCH) and Children and Youth with Special Health Care Needs (CYSHCN) programs. In NH, the CYSHCN program is called Special Medical Services (SMS). Together, these Title V programs 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; adolescent health; teen pregnancy prevention; family planning; primary care; perinatal health; home visiting; early childhood systems building; injury prevention and surveillance; newborn screening and early intervention and surveillance and information delivery about the MCH and CYCHCN population.

New Hampshire's Title V MCH programming focus comes from the MCH population's priority needs, which are assessed on an ongoing basis. A five-year needs assessment was conducted in 2015 and is supplemented yearly. In conjunction with a comprehensive data review, specific input from the public and other stakeholders as well as a capacity assessment, a list of priority issues emerged and became the basis of programming through 2020. Additional information, data and stakeholder/public input are gathered routinely within the scope of work of each MCH program. This collaborative and evidence-based approach is most likely to leverage the greatest improvement on the health of the NH population.

Some of the participating groups in the needs assessment process included Spark NH Early Childhood Advisory Council; Family Resource Centers; Division of Family Assistance; NH Autism Council; Safe Kids NH; Injury Prevention Advisory Council; Brain Injury Association; Nashua Division of Public Health and Community Services; Family and Youth Services Bureau; Bureau of Drug and Alcohol Services; Drug Free NH; NH Pediatric Improvement Partnership; and NH Family Voices.

Title V staff by consensus established the following list of priorities to steer programming through the five-year period 2015-2020:

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

In the past year, during the course of routine activities of MCH staff with MCH-contracted agencies (Primary Care, Title X Family

Planning, Home Visiting), opinions were solicited and the following observations and concerns were noted, all of which are highly concordant with the current list of eight (8) priority needs:

- Increased opioid use, mainly among young to middle aged adults, impacts the needs and well-being of children and other family members
- Insufficient mental health services, notably for children and adolescents
- The costs of health care—even with the ACA many individuals have high out-of-pocket expenses, putting even basic care out of reach
- Health care worker shortage
- Community Health Centers report insufficient reimbursement mechanisms, with the result that not all individuals have equal access to "routine" testing or services

Likewise a public input survey conducted in 2018 (see description below) showed that the eight selected priority needs were considered Highly Important or Important by a large majority of respondents, demonstrating that these eight priorities remain highly pertinent.

In order to address the State's priority needs and in keeping with the Title V framework, Title V staff selected the following National Performance Measures (NPMs) and State Performance Measures (SPMs) which are driving program planning and strategies in the various population domains:

NPM#1: Percent of women with a past year preventive medical visit
This measure was selected to address priority need#1: Improve access to needed healthcare services for all populations; it is used in the domain **Women/Maternal Health**.

NPM#5: Percent of infants places to sleep on their backs
This measure was selected to address priority need #7: Decrease unintentional injury; it is used in the domain **Perinatal/Infant Health**.

NPM#6: Percent of children, ages 9 through 35 months, receiving a developmental screening using a parent-completed screening tool in the past year.
This measure was selected to address priority need #8: Improve access to standardized developmental/social emotional screening, assessment and follow-up for children and adolescents; it is used in the domain **Child Health**.

NPM#7.2: Rate of hospitalization for non-fatal injury per 100,000 adolescents ages 10 through 19.
This measure was selected to address priority need #7: Decrease unintentional injury; it is used in the domain **Adolescent Health**.

NPM#8.1: Percent of children ages 6-11 who are physically active at least 60 minutes per day.
This measure was selected to address priority need #5: Decrease pediatric overweight and obesity; it is used in the domain **Child Health**.

NPM#10: Percent of adolescents, ages 12-17 with a preventive medical visit in the past year.
This measure was selected to address priority need #1: Improve access to needed healthcare services for all populations; it is used in

the domain **Adolescent Health**.

NPM#11: Percent of children with and without special health care needs who have a medical home
This measure was selected to address priority need #3: Increase access to comprehensive medical homes; it is used in the domain **Children with Special Health Care Needs**.

NPM#14.1: Percent of women who smoke during pregnancy
This measure was selected to address priority need #2: Decrease the use and abuse of alcohol, tobacco and other substances among youth, pregnant women, and families; it is used in domain **Women/Maternal Health**.

SPM#1: Percentage of MCH-contracted Community Health Centers with an Enabling Services workplan on file with MCH
This state-specific measure was created to address priority need #1: Improve access to needed health care services for all populations; it is used in domain **Cross-cutting/Systems-building.**

SPM#2: Percentage of families enrolled in Special Medical Services who report access to respite services
This state-specific measure was created to address priority need #6: Increase family support and access to trained respite and childcare providers; it is used in domain **Children with Special Health Care Needs**.

SPM#3: Percentage of behavioral health professionals recruited
This state-specific measure was created to address priority need #4: Improve access to mental health services; it is used in domain **Cross-cutting/Systems-building**.

Strategies aiming to improve these performance measures are delineated in each population domain, in the State Action Plan table of this report.

Access to services is highlighted in five (5) of the eight (8) state priorities. Consequently, New Hampshire's Title V program has taken on the role of enhancing access to quality health care services for the MCH population. Many Title V contracted agencies utilize the funding they receive to keep family and community health services available when no other resources can be utilized. Title V funding decisions are based on gap assessments founded on discussions of the state's health care system and the needs assessment process which looks at health outcomes. Grant funds go towards agency staffing infrastructure as well as contractual services.

Title V leads by calling attention to emerging issues in the field, thinking strategically and facilitating analysis about what is currently happening on a local level and nationally, and educating on best practices. Title V is a convener as well as a participant in many different statewide workgroups. Title V staff members created, organized and currently facilitate several programmatic advisory committees, mortality review groups as well as collegial workgroups.

With Title V funding, New Hampshire's MCH program supports 14 Community Health Centers (CHCs) in their mission to provide accessible and affordable comprehensive primary care services, including prenatal and pediatric care, for some 126,250 individuals and 2468 pregnant women in 2017. Most of the funding is currently being used for quality improvement for projects 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. MCH uses Title V funds to support injury prevention activities statewide; funds also go to support enabling services such as case management, transportation and interpretation services.

The SMS section, through their Title V funds, support 11 programs including a child development services network for pediatric

diagnostic evaluation services; an interdisciplinary clinic for neuro-motor disabilities and a new Complex Care Network that incorporates statewide interdisciplinary clinics and specialty consultation to providers serving children and youth with special health care needs; a nutrition/feeding and swallowing program with community-based consultation and intervention services utilizing a home visiting framework; and a medical home project and psychiatry/psychology consultations. SMS also underwrites NH Family Voices (NHFV) in its mission to assist families with CSHCN by providing information, support and referral.

The stewards of Title V do not work in a vacuum. All efforts are undertaken in conjunction with many partners, both state and federal, who focus on maternal and child health, including children and youth with special health care needs. Title V monies are usually leveraged with other funding to ensure access to quality health care and needed services for the MCH population. For example, many of the MCH-contracted CHCs utilize their Title V funding for staffing that is not otherwise covered by other grants or fees for services through insurance.

An Intra-Agency Agreement (IAA) between NH Title V stewards (Maternal and Child Health, and Special Medical Services) and the NH Office of Medicaid Services sets out the framework and conditions for joint planning, coordination and improvement of programs under Title V MCH and Title XIX Medicaid. The IAA outlines and codifies:

- Collaboration on the development and implementation of quality health standards.
- Improvement in referral processes and access to and utilization of health services.
- Implementation of processes for making intra-agency decisions and coordination of policies.
- Reduction of duplicative services and implementation of innovative solutions to health care issues.
- Assurance of compliance with federal and state statutes.
- Promotion of joint planning, monitoring and evaluation of a health care system for the Title V MCH and Title XIX Medicaid populations.

A new element in this agreement is the assignment of a seat for MCH on the Medicaid Medical Care Advisory Committee (MCAC) which advises the Medicaid Director on policy and planning. Members of the MCAC must be familiar with the comprehensive needs of low-income population groups and with the resources required for their care, which is consistent with the professional responsibilities of Title V staff.

The IAA reaffirms the commitment to have Title V funded agencies identify, enroll and re-enroll Medicaid-eligible clients and to refer those clients to appropriate services. Many CHCs utilize Title V funds for sustaining or increasing staff capacity to assist with client insurance needs, since up to one-third of clients coming into their agencies for the first time are uninsured, and other federal funding for patient navigators has greatly diminished. As part of its Title V funded contract with SMS, NH Family Voices (whose staff are trained as navigators) also offers assistance with understanding options and accessing Medicaid.

MCH and the Medicaid Office of Quality Assurance and Improvement (QAI) are collaborating on an evaluation of Medicaid policy change regarding coverage of labor and delivery services and contraception services, to determine the impact on pregnancy intention and pregnancy timing. Medicaid and SMS together created an option for families whose child is experiencing developmental delay to be able to receive rehabilitative services through Medicaid and still be eligible to receive services through Part C Early Intervention.

SMS has a very strong and longstanding collaboration with NH Family Voices (NHFV). SMS has funded parent consultation and support through NHFV for more than 20 years. This partnership includes the provision of office space, allowing NHFV and SMS to be co-located. In addition to the initial activities of helping families to access services, this partnership has evolved to include leadership and policy development, including administrative rules changes.

MCH and the Division for Children, Youth and Families (DCYF) together leverage funding for 12 Comprehensive Family Support

Services home visiting contracts that function by intervening at critical periods of stress and transition for pregnant women, children, and families with children up to the age of 21.

SMS braids funding with DHHS's Bureau of Developmental Services for a contract that enhances access for children and youth with special health care needs to psychiatric assessment, consultation and short-term condition/medication management.

NH Title V is requesting technical assistance in three areas. For enhanced family engagement, NH Title V is requesting assistance for an environmental scan of family engagement and partnership within all of its MCH programming efforts, and the elaboration of a draft plan specific to each MCH program, with guidelines on how to increase both family partnerships and engagement, including the identification of any professional training necessary. Secondly, NH Title V is requesting assistance for the MCH Injury Prevention Program for the design of interventions to address NPM#7.2, the rate of hospitalization for non-fatal-injury among adolescents. Thirdly, NH Title V is requesting assistance directed to the SMS section, regarding policy and procedures for data sharing with partner agencies; regarding a more formalized approach for consistency of effort and reduction in duplication of services among partner agencies; and for consultation and training on the development of a standardized formula for establishing caseload standards and limits.

III.A.2. How Title V Funds Support State MCH Efforts

The 1989 Maintenance of Effort required match helps to assure a basic state funding level for Title V programming within New Hampshire. These funds have been augmented throughout many biennium budget periods and the State now provides almost seven million dollars in funding to MCH and SMS as a whole. During times of necessary fiscal constraint, difficult decisions must be made about decreasing or eliminating programs and services and state funding has gone up and down, often significantly within a short time frame. Therefore, federal support through the nearly three million New Hampshire receives in the Block Grant is crucial in sustaining and preserving a comprehensive Title V program. Title V funds are the "glue" that enables the mission of improving the health and well-being of the State's maternal and child health population. Title V enables the health care provider to spend two hours on improving the quality of obstetrical care by conferencing with colleagues; pays for the nutritional consultation on a child with complicated swallowing needs; and helps to educate new parents on safe sleep in a language they can understand.

Federal support often increases credibility with other funders, increasing leveraging possibilities. Funding sources complement one another since none are able to adequately and fully sustain needed services. Increased financial accountability and sub-recipient monitoring ensures that Title V funds support each level of the public health pyramid.

III.A.3. MCH Success Story

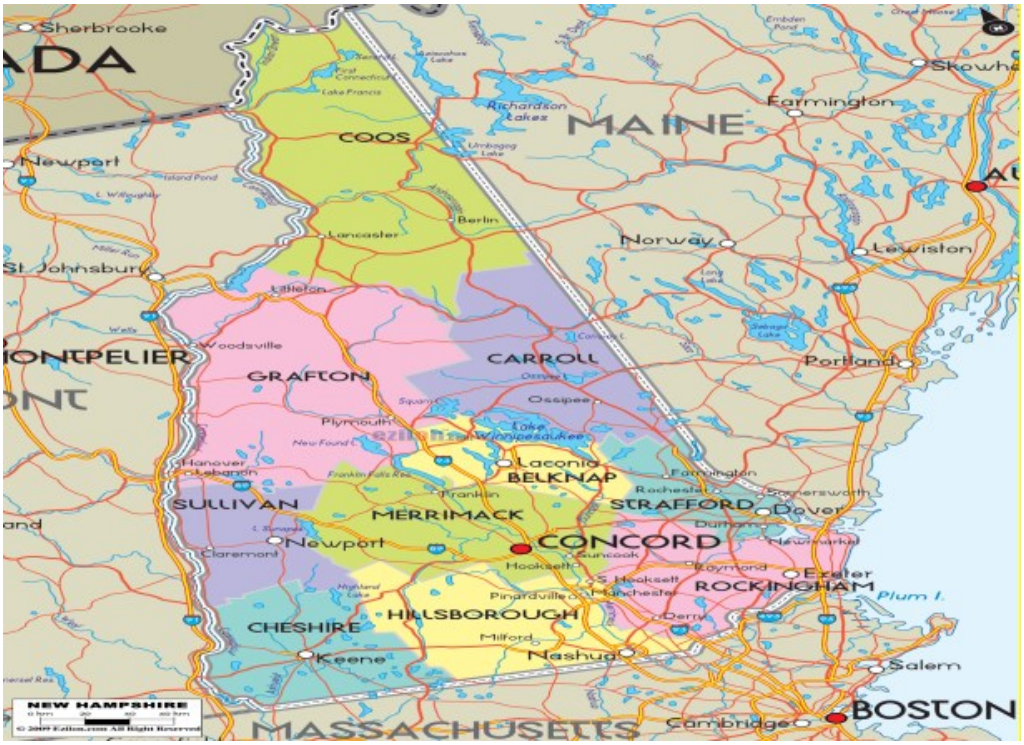
MCH is participating in an 18 month long Adolescent and Young Adult Health (AYAH) Collaborative Improvement and Innovation Network (CoIIN) Cohort 2 in collaboration with their colleagues, the New Hampshire Pediatric Improvement Partnership (NH PIP) and sponsored by the Adolescent and Young Adult Health National Resource Center. The goal is to increase access and quality of preventive health services delivered to adolescents and young adults and is directly connected with NPM 10, increasing attendance at the adolescent well visit.

The project not only has improved access and quality health care to date as evidenced by changes in both national outcome measures and the national performance measure, but is strengthening the relationship between MCH, NH PIP and the latter's partnership network of statewide stakeholders. This network includes private and public organizations such as the University of NH, NH Medicaid and Managed Care Organizations, Family Voices, health care providers, hospitals/clinics, and state programs. The momentum gathered by this collaborative effort have opened discussions about how to further leverage the collective resources provided by the AYAH CoIIN partnership to identify other adolescent health initiatives, such as access to adolescent specific mental health services that may be addressed by the group. Participation with national colleagues and other Title V states enables a broader collective impact than anything MCH or NH could have done by itself.

III.B. Overview of the State

Demographics, Geography, Economy and Urbanization: New Hampshire (NH) is one of the oldest states in the country; it was originally a land grant in 1623 and became a state in 1775. NH's population of 1.34 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.

With its 1,300 lakes and ponds, 40,000 miles of river and 18 miles of seashore NH is the 45th largest state at 190 miles long and 70 miles wide. The state's landscape lends itself to many different types of outdoor recreation. However, that same topography lends itself to difficult driving and long distances between places, particularly in the winter months.



With its ten counties, approximately 47% of the population and 84% of the landmass in NH is considered rural; most of the land area lies north and west of the capital Concord. The three (3) most urban or metro areas are Manchester, Nashua and Concord, all located in the state's southern tier where the majority (53%) of the population lives. The state's population is primarily white (94%), but its residents of color are increasing.[2]

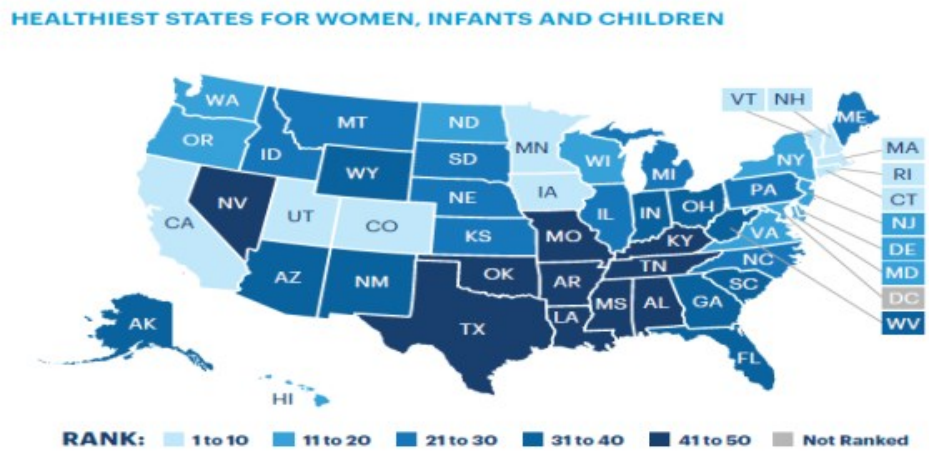
New Hampshire's Title V Program consists of the Maternal and Child Health Section (MCH) located in the Bureau of Population Health and Community Services in the Division of Public Health Services (DPHS), and the Bureau of Special Medical Services (SMS) located in the Division of Long Term Supports and Services (DLTSS). Many factors guide its efforts.

Both DPHS and DLTSS reside within the New Hampshire Department of Health and Human Services (DHHS), the state's largest agency made up of approximately 10,000 employees and the bulk of the state's budget (with Medicaid being the most costly line item). NH DHHS is overseen by a Commissioner, appointed by the Governor for what typically is a four-year term. Both MCH and SMS are physically located in the capital city of Concord. However, much of their Title V work takes place in funded agencies across the state in the form of community health centers, specialty health clinics, human services agencies which provide home visiting

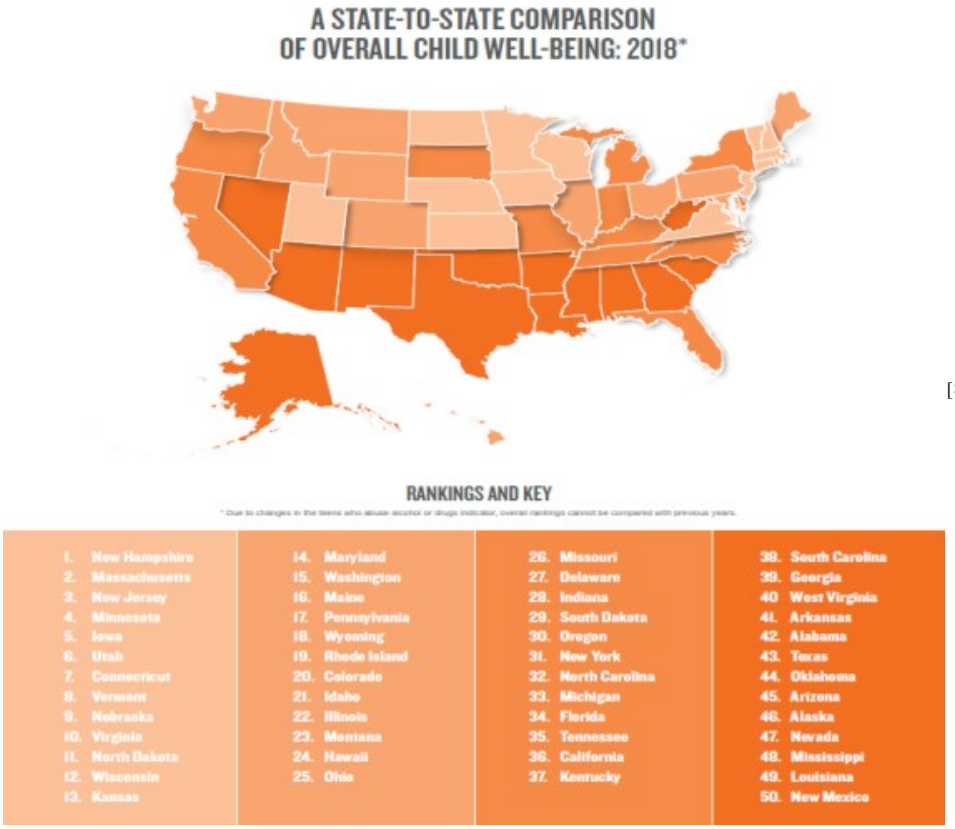
and the like. The Title V Program focuses on the ever-changing landscape of the state in which it serves.

New Hampshire has the largest bicameral legislature in the English-speaking world,[3] with 24 Senators and 400 Representatives, and operates under a unique Governor and Council (G&C) system. Five (5) Executive Councilors, each representing 1/5 of the population, are elected separately from the Governor, though for the same two-year term. All state departments and agencies must seek approval of both receipt and expenditure of state and federal funds, budgetary transfers within the department and all contracts with a value of $25,000 or more. Title V policy and funding is heavily influenced by both the Legislature and G&C.

Unique strengths and challenges that impact the health status: In national rankings, New Hampshire often is in the top ten, in its health care delivery system as well as in population health and overall well-being.[4],[5],[6]



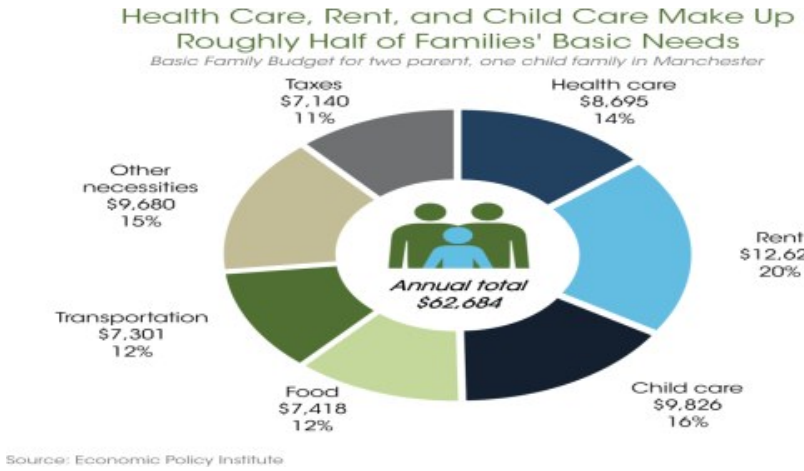
[7]



[8]

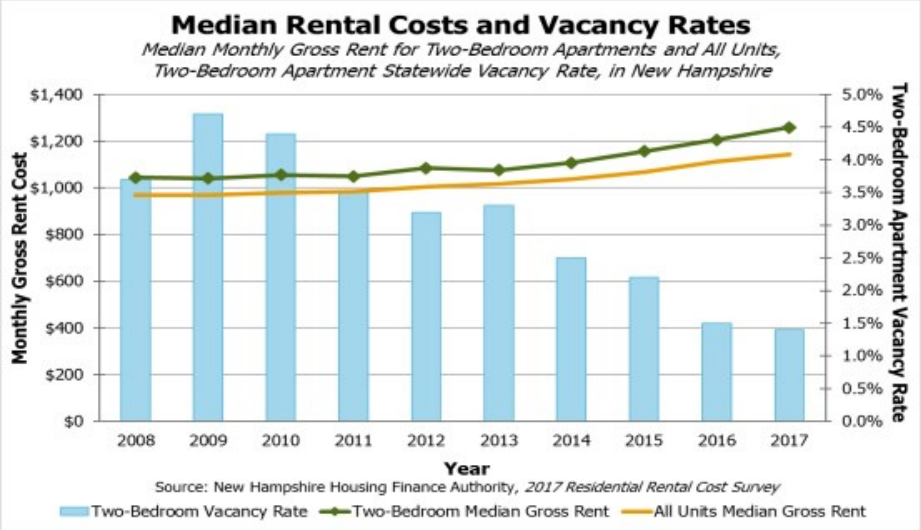
Scores are based on a composite index of metrics that give a snapshot of the health of a population or its health care. Some of the high scores can be attributed to the state's economic prosperity. The unemployment rate (2.6%) is well below and the median income/per capita personal income ($76,260/$57,574) well above that of the United States as a whole.[9],[10] Part of that is due to consistently having a more educated workforce, above the national average for more than a quarter century.[11],[12]

Another factor is that New Hampshire consistently has the nation's lowest poverty rate (7.3%).[13],[14] However federal poverty rates do not necessarily take into account differences in geographical distribution and are based on food costs, not housing, health care and child care. The figure below shows an approximate budget (in 2016) for a household of two (2) adults and one (1) child in Manchester, the state's largest city.[15],[16] This figure ranks in the top fifth of the 618 family budget areas analyzed by the Economic Policy Institute[17],[18] and more expensive than 80% of United States (US) communities.[19],[20]



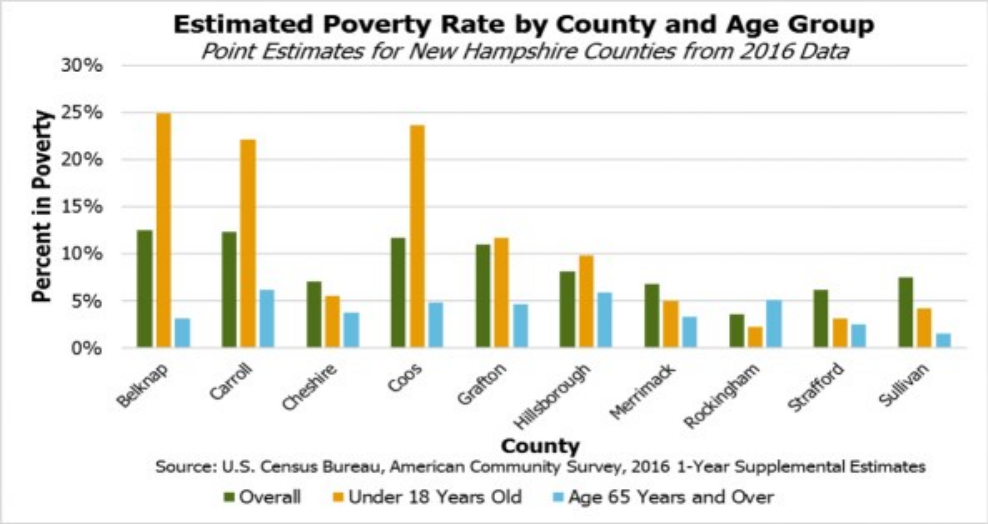
[21]

Costs for housing and childcare are greater in the Northeast US. From recent research,[22] an estimated 6.2% of NH families with young children are below the poverty level. If they did not pay out-of-pocket for child-care, roughly half of these families would not be poor.[23] In addition, housing stock in NH is limited, with prices increasing due to lack of supply.



[24]

The federal poverty rate also hides differences within NH itself, both in terms of geographical location and age. The disparities are greatest amongst children. Approximately half of the NH Medicaid rosters have for many years been consistently comprised of those less than 18 years of age.



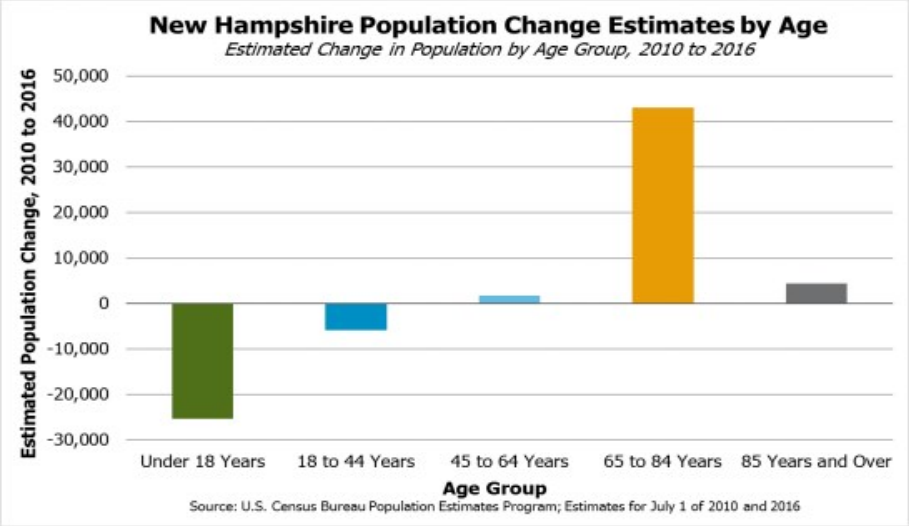
[25]

The NH Title V Program recently did an analysis of the data on Adverse Childhood Experiences (ACES) from the state's 2016 Behavioral Risk Factor Surveillance System (BRFSS) data set. The ACES variables as well as other variables of interest, such as chronic conditions, were explored as they related to one another.

ACEs include a broad range of events that constitute childhood trauma. They include verbal, physical or sexual abuse as well as dysfunctional family conditions or events such as mental illness, substance abuse, domestic violence or incarceration, that occurred in the first 18 years of life. ACEs have been linked to adverse health outcomes in adulthood, including depression, substance abuse, cardiovascular disease, and premature mortality.

Analysis of the NH data set reflects findings in the literature that persons engaging in unhealthy behaviors and/or having negative health outcomes had experienced more ACEs in childhood (i.e. had higher ACE scores) than those who did not engage in unhealthy behaviors and/or who had better health outcomes. Those who reported no unhealthy behaviors and/or better health outcomes more frequently had an ACE score of zero. Population sub-groups were described in terms of their ACEs exposure. For example, 54% of men reported zero ACEs and 8% reported four or more ACEs, while among women, 47% reported zero ACEs and 12% reported four or more ACEs.[26] MCH staff is working with colleagues in the state who will be assisting with framing this information and disseminating messages for stakeholders' and public information.

The State is also affected by the fact that it is aging and stagnating in size. Seventeen percent of the state is 65 and older compared with 15.2% nationally. And 2010 Census data reflects that Northern and Central New Hampshire already contain a substantially larger proportion of residents age 65 and over than do other parts of the state.[27] New Hampshire is tied with six (6) other states for the highest percentage of its population enrolled in Medicare (82% of which qualified based on age alone).[28] Twenty-seven percent of the current healthcare workforce is 55 years of age or older signaling a decrease in the future workforce, but also increasing the overall (current and future) demand for health care.[29]



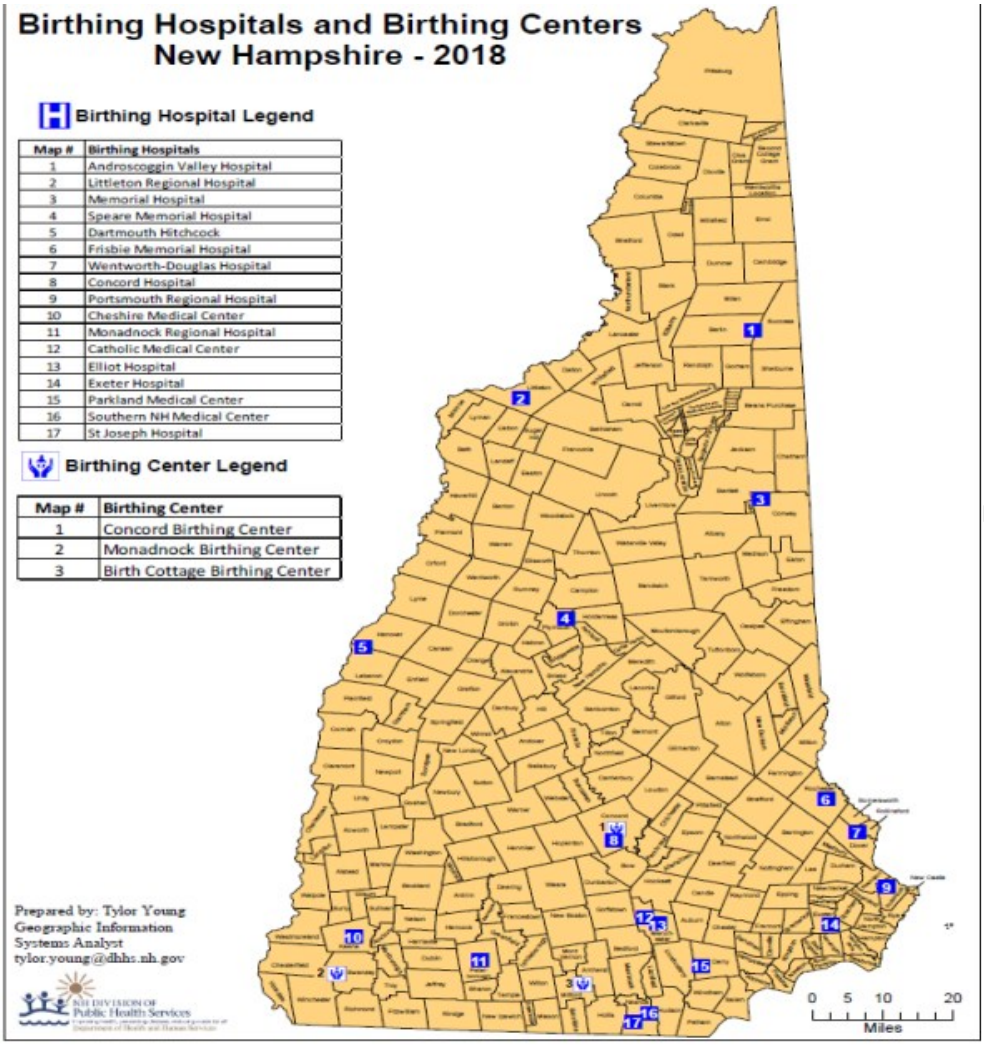
[30]

Components of the state's systems of care: New Hampshire's Title V population is served by its 26 acute care hospitals. Thirteen of the 26 are designated as critical access hospitals, which have 25 beds or less and are the smaller, rural systems. Five (5) specialty hospitals provide psychiatric and rehabilitative care with a total of 498 beds. Dartmouth Hitchcock is the largest medical system in the state with its flagship hospital having the only Level 1 designated trauma classification.

New Hampshire has a highly concentrated health care delivery system. Acute care hospital systems are more than just inpatient and emergency room services. Many of NH's hospitals have evolved to include the majority of the medical and primary care practices in the state as well as ownership of ambulatory surgery centers, health centers, assisted or skilled nursing care facilities and home care and hospice. This has resulted in the hospital sector having among the highest employment and income numbers in the state.

[31]

There are also 14 Federally Qualified Health Centers (FQHCs), one (1) FQHC look-alike and 14 Rural Health Clinics (RHCs), most of which are hospital-affiliated. However, of concern particularly to the MCH population, is the closure of nine (9) hospital labor and delivery units in the past 16 years, two (2) within 2018 alone. As of July 15, 2018, there will be only 17 hospital birthing units and three (3) non-hospital birthing centers in NH. Only six (6) of the critical access hospitals now offer obstetrical services presenting a distance issue.



[32]

This is not unique to NH. Obstetrical services have high fixed costs and low reimbursement rates.[33] Small volume hospitals (like critical access) in NH typically have a higher percentage of patients that give birth paid for by Medicaid (up to 60%).[34]

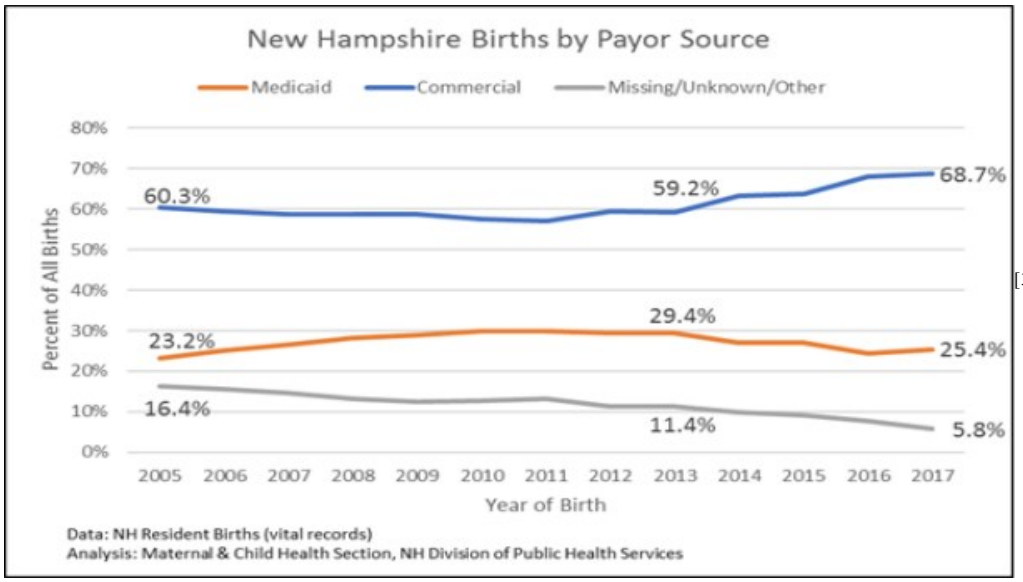
New Hampshire Hospital Births by Payer, 2016-2017
Sorted by Percent Medicaid

Birth Hospital	Medicaid	Commericial	Missing/ Unknown /Other	2-year Volume (residents)
ANDROSCOGGIN VALLEY HOSPITAL	60.30%	37.40%	2.30%	174
LAKES REGION GENERAL HOSPITAL	50.00%	39.10%	10.90%	596
MEMORIAL HOSPITAL	48.50%	46.90%	4.60%	371
FRISBIE MEMORIAL HOSPITAL	46.50%	46.90%	6.60%	574
PARKLAND MEDICAL CENTER	46.10%	50.50%	3.50%	317
LITTLETON REGIONAL HEALTHCARE	42.10%	50.90%	6.90%	475
SPEARE MEMORIAL HOSPITAL	40.60%	54.00%	5.40%	315
CHESHIRE MEDICAL CENTER	39.40%	57.40%	3.20%	723
CATHOLIC MEDICAL CENTER	33.70%	61.80%	4.50%	2155
DARTMOUTH-HITCHCOCK MEDICAL CTR	32.20%	64.50%	3.30%	1504
CONCORD HOSPITAL	29.00%	66.20%	4.90%	2400
MONADNOCK COMMUNITY HOSPITAL	26.90%	68.50%	4.60%	648
SOUTHERN NH MEDICAL CENTER	26.30%	68.20%	5.50%	2367
ALICE PECK DAY MEMORIAL HOSPITAL	23.00%	73.50%	3.50%	287
ELLIOT HOSPITAL	19.40%	76.40%	4.30%	3737
EXETER HOSPITAL	17.80%	77.80%	4.40%	1235
PORTSMOUTH REGIONAL HOSPITAL	17.70%	72.50%	9.80%	734
WENTWORTH-DOUGLASS HOSPITAL	15.40%	72.00%	12.60%	1966
ST. JOSEPH HOSPITAL	6.80%	85.60%	7.60%	893
Out-Of-State Hospital	5.00%	83.60%	11.30%	2323

Notes:
NH Resident Hospital Births, excluding NH hospitals with less than 10 births in time period.
The payer as recorded in the birth data may not always be the actual payer after adjudication.
Excludes births that occurred outside of hospitals.
Data: NH Resident Births (vital records)
Analysis: Maternal & Child Health Section, NH Division of Public Health Services

[35]

Over the last decade, Medicaid has consistently paid for approximately one quarter of all NH births. [36]



[37]

Recent research has shown there is a reason to be concerned with closures precipitating increases in births that occurred in hospitals without obstetric services (higher for counties not adjacent to urban areas), increases in out-of-hospital births (including those that occurred in homes and freestanding birth centers) and decreased outpatient prenatal care.[38]

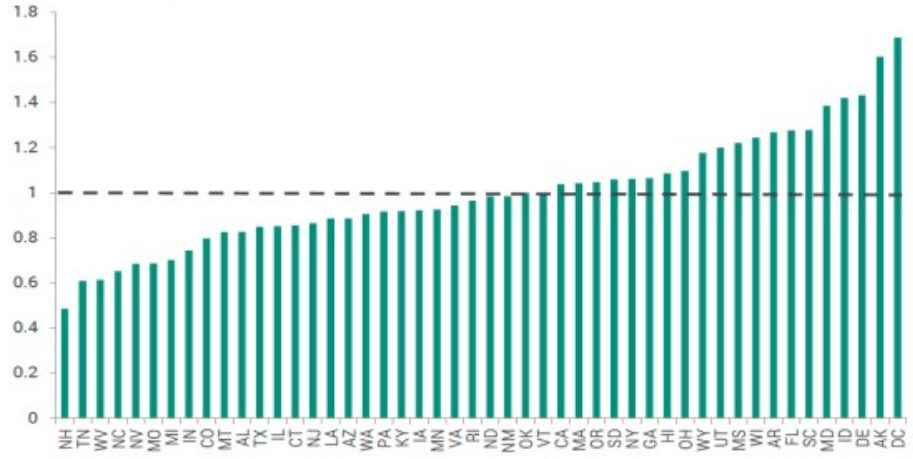
MCH and its partner, the Northern New England Perinatal Quality Improvement Network (NNEPQIN) are collaborating with a small team of investigators from the Urban Institute (going for a separate research grant) to investigate the following questions:

- Why exactly are hospitals in rural New Hampshire closing their labor and delivery floors?
- What are the consequences of those closures for mothers, infants and communities?
- What potential community-minded solutions might moderate the effects of these closures?

The team plans to use a mixed-methods approach to investigate these questions. Actionable information resulting from the project may inform the work of various stakeholders. Recently NNEPQIN presented an all-day training in the emergency department of one (1) of the hospitals who closed their obstetrical facilities in 2018. Local emergency medical personnel were also invited to the presentations which focused on unexpected deliveries including the immediate postpartum care of mother and infant. A high fidelity manikin was utilized to discuss events such as postpartum hemorrhage. The hospital was also provided with a decision making flow chart to help guide such situations in the future.

Financing of services for the MCH population: NH Medicaid pays one of the lowest reimbursement rates in the United States. In calendar year 2010, NH Medicaid fee for inpatient service payments to hospitals were the lowest in the country. From July 1, 2009 through June 30th of 2018, NH Medicaid rates for all services will have risen only 7.6%. [39],[40] NH is among the states that receives a 50% match, the lowest rate available for hospitals and other health care providers. This match is computed from a formula that takes into account the average per capital income relative to the national average (NH is higher).The federal government then multiplies that figure by a rate that varies from year to year but is dependent on every dollar the state spends on Medicaid (NH is lower than average).

FIGURE 1. Medicaid Inpatient FFS Payment Index, CY 2010



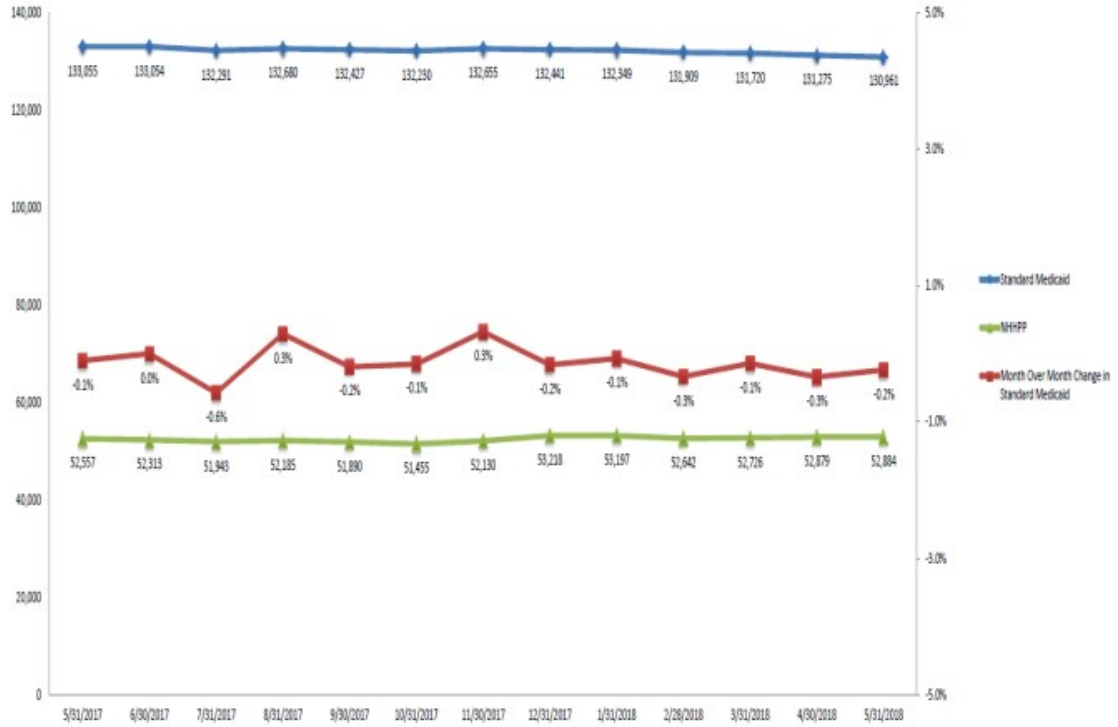
[41]

Policy experts believe that NH simply does not generate enough revenue (most likely because of a lack of a broad based tax) to get a good federal matching rate for its Medicaid patients.[42],[43],[44], [45] This can provide a struggle for the state's providers and health systems in achieving financial sustainability due to a payment system that is insufficient to cover the costs of delivering needed care to the state's most vulnerable citizens.[46]

In 2013, Medicaid in New Hampshire transitioned from fee-for-service to a managed care model for medical services. There are currently two managed care organizations (MCOs), Well Sense and New Hampshire Healthy Families. The two (2) MCO contracts were renewed just recently for an additional year with a new Request for Proposals coming out within the next year.

As of the end of May 2018, approximately 183,845 New Hampshire residents, nearly 14% of the state's population, were on

Medicaid, including 52,884 people who were added to the rolls with Medicaid expansion.[47]



[48]

Notes: Non-NHHPP excludes refugees and those beneficiaries without full Medicaid coverage who only have Medicare savings plan or family planning coverage

CHIP and Non-CHIP children are presented on separate rows because of the higher federal financial participation for the CHIP group

Where age and category are not in agreement, category was given precedence

End of month totals will not match beginning of month totals in any health plan focused reporting because of members with in-and-out spend down eligibility that builds throughout month as deductibles are met

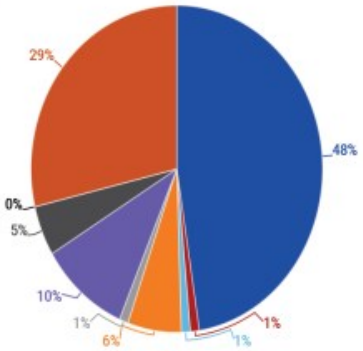
Source: New Heights data in Enterprise Data Warehouse, point in time as of the end of the month.

Medicare Savings Programs: QMB-Qualified Medicare Beneficiary;SLMB-Specified Low-Income Medicare Beneficiary 120;QDWI-Qualified Disabled and Working Individuals; SLMI-Specified Low-Income Medicare Beneficiary 135

Children continue to make up the greatest proportion of the NH Medicaid roster, as previously stated, with the expansion population second.

TABLE 1 AND FIGURE 1 MEDICAID ENROLLMENT, BY ELIGIBILITY CATEGORY, 2018[4]

Eligibility Category	# Of People Enrolled in Medicaid
Low-Income Children (Age 0-18); including CHIP	88,330
Children With Severe Disabilities (Age 0-18)	1,443
Foster Care & Adoption Subsidy (Age 0-25)	2,378
Low-Income Non-Disabled Adults (Age 19-64)	10,962
Low-Income Pregnant Women (Age 19+)	2,078
Adults With Disabilities (Age 19-64)	18,052
Elderly & Elderly With Disabilities (Age 65+)	8,957
Breast and Cervical Cancer Program (Age 19-64)	149
NH Medicaid Expansion Population (NHHPP)	53,197
TOTAL	185,546



[49]

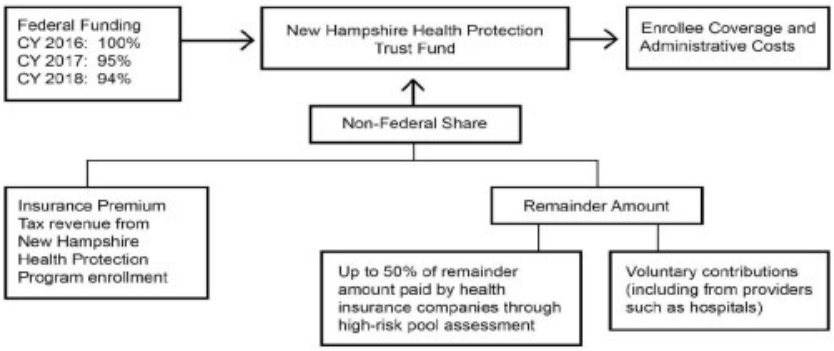
The State also operates a partnership health insurance exchange with the Federal government, with the Department of Insurance having control over plan management and consumer assistance functions on the federal Marketplace. There will be three (3) medical

carriers with 17 plans for individuals and 12 for small groups, having all 26 acute care hospitals in-network for the new enrollment period starting in November 2018. Although it is up from the one (1) carrier in 2014, it is also down from the five (5) carriers and 73 plans in 2016. The New Hampshire Health Exchange Advisory Board sits in an advisory capacity to the Health Insurance Marketplace with public health representation including the Director of one of MCH's Title V funded community health centers.

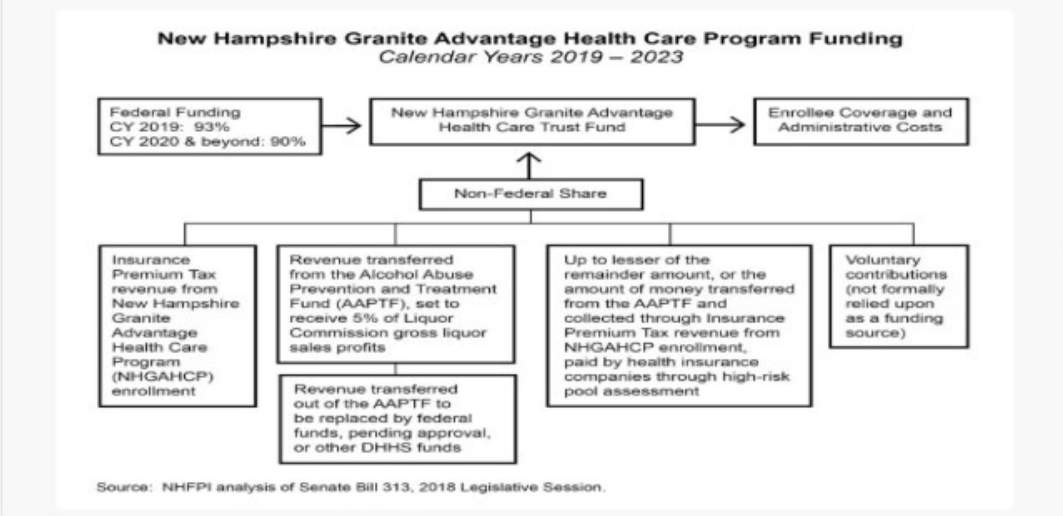
New Hampshire is one of only a few states to expand its Medicaid coverage through a waiver of Medicaid program rules, allowing it to purchase a plan on the federal Marketplace offered by one of the commercial insurance companies, on behalf of a person. This is known as the Premium Assistance Program (PAP). Residents who are medically frail are excluded from PAP, but not the Health Protection Program (HPP). However, over the next year, the state will transition to a new coverage model for Medicaid expansion called the "Granite Advantage Program" and will implement a demonstration waiver including a work and community engagement requirement, approved by CMS in May of 2018 (and to start January of 2019). Those who are not medically frail or otherwise exempt must engage in certain work, public service or educational activities for 100 hours a month after 75 days or more of enrollment in a Granite Advantage Program MCO. The enrollee must also remain under 138% of the Federal Poverty Level to remain eligible for Medicaid coverage in the program. Recent research[50] shows that an individual would need to earn an hourly wage of less than $14/hour for 100 hours a month in order to stay under 138% of the Federal Poverty Level. This program, approved by the NH legislature, will extend Medicaid expansion through 2023 with a switch from PAP to the MCOs.

The legislature also changed the way the state's share of the Medicaid expansion funding is generated. In July 2017, the federal government identified concerns with the NH HPP's reliance on donations from providers to fund the non-federal share and indicated NH may be out of compliance. Thus, starting in calendar year 2019, in addition to insurance premiums and high risk pool assessments, the non-federal share will be paid for out of revenue transferred from the Alcohol Abuse Prevention and Treatment Fund (which will in turn be replaced by DHHS or other federal funds). [51]

New Hampshire Health Protection Program Funding
Calendar Years 2017 – 2018



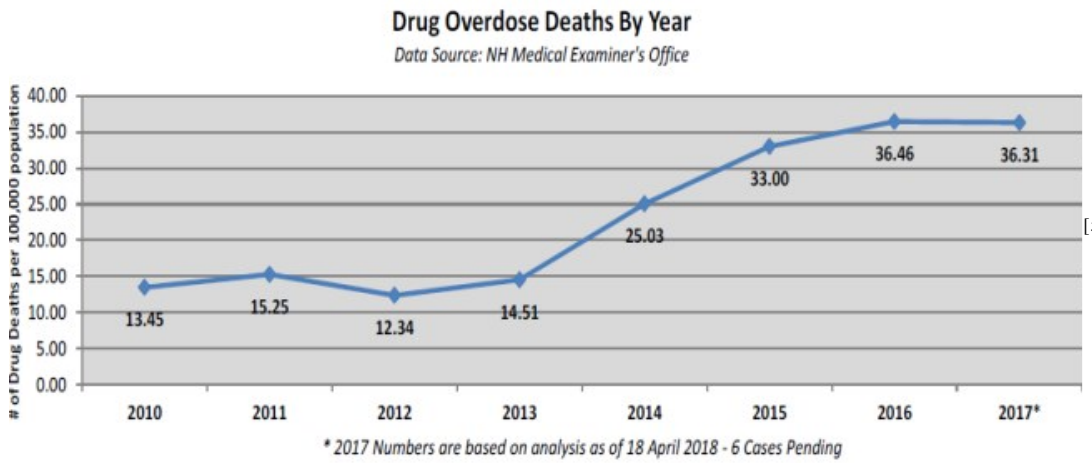
Source: NHFPI analysis of Chapter 13, Laws of 2016; RSAs 126-A, 400-A and 404-G.



[52]

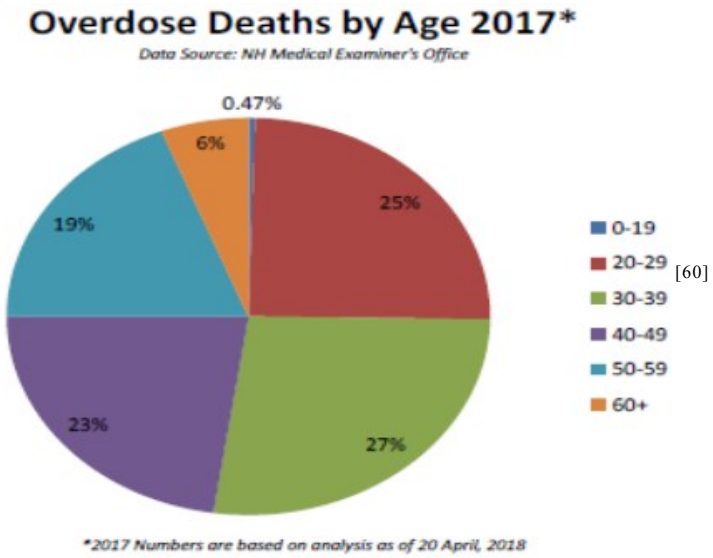
All of these changes have helped to address financial barriers to care. Over the past five (5) years, the rate of the uninsured in NH has gone down 5% to approximately 7% in 2017.[53], [54] However, the issue of the uninsured or underinsured remains. For the MCH population, most children under the age of 18 are insured (97%). Yet 12% of the 18-34 population remain uninsured, the highest of any age category. Seventy percent of the 35-64 year old age group had employer sponsored insurance, again the highest of any age category.[55] The rural percentage of the uninsured continues to remain higher at 11%. A closer look at the state done by the Bi-State Primary Care Association with data from the U.S. DHHS Office of the Assistant Secretary for Planning and Evaluation, Small Area Health Insurance from the U.S. Census Bureau, NH Employment Security County Profiles, the Henry Kaiser Family Foundation, Enroll America Research and Maps, and the Uniform Data System (UDS) Mapper reveals pockets of high uninsured rates in places such as the northern rural areas, particularly among young adults, and in the southern urban areas among Hispanics.[56] Bi-State is one of the remaining agencies in the state with a federally funded patient navigator grant. Based on the accumulation of data, they will be targeting the remaining uninsured: males, particularly between 34–54 years; immigrants and Hispanics; the justice-involved population; consumers needing substance use disorder treatment and mental health services; low income women; individuals living in low income housing and young adults.[57]

Another health issue of particular concern to the MCH population is the high rate of opioid overdoses and deaths plaguing the state for almost a decade and severely straining the health care system as a whole. In 2017, at 447 deaths, New Hampshire had the third highest drug overdose death rate in the country (39 people out of 100,000).[58] The mortality rate has increased significantly since 2010.



[59]

The age group with the largest number of drug overdose deaths is the 30-39 year olds, which represent 27% of all overdose deaths for 2017.



[60]

For the MCH population, this has been particularly tragic. One of the leading causes of maternal mortality in the state is accidental drug overdose.[61] While young and middle aged males are being disproportionately affected, there continues to be an increase in infants born with neonatal abstinence syndrome (NAS). In the ten years from 2005 to 2015, the number of infants diagnosed with NAS increased fivefold from 52 to 269.[62] In addition, the number of children removed from parental care increased from 358 in 2012 to 547 in 2016 and the percent that included a substance-related allegation doubled from 30 to 60 percent. Five (5) percent of children removed from parental care in 2016 were born drug-exposed, up from 2% in 2012.[63]

These circumstances have led to an acceleration of Title V program collaborative efforts and leadership in the field of substance misuse. Partners include the DHHS's Division of Behavioral Health Services notably the Bureau of Drug and Alcohol Services, the Bureau of Behavioral Health, and the Bureau of Children's Behavioral Health; the Governor's Commission on Alcohol and Drug Abuse; the Secretary of State's Division of Vital Records Administration; the Office of the Chief Medical Examiner; and the Department of Safety's Bureau of Emergency Medical Services and Drug Monitoring Initiative, among many others. Activities

include:

(1) increasing surveillance: MCH received a Centers for Disease Control and Prevention (CDC) Enhanced State Opioid Surveillance (ESOOS) grant in 2016 which has improved timeliness of opioid-related morbidity and mortality data and dissemination to stakeholders, has been facilitating the CDC National Violent Death Reporting System since 2015 and recently added opioid exposure to its situational surveillance fields on the birth certificate;

and (2) prevention: MCH continues its facilitation of the Perinatal Task Force on Substance Misuse and Treatment; and MCH's Title V funded community health centers all facilitate Screening, Brief Intervention and Referral to Treatment (SBIRT) in all populations and many are providing Medically Assisted Treatment (MAT) for substance use disorders.

MCH and SMS are also part of a DHHS team set to allocate NH's share of funds from the federal Comprehensive Addiction and Recovery Act which has included the establishment and replication of services for pregnant substance misusing women in the state. Currently, MCH is working with its DPHS colleagues in leading the effort to establish a highly focused public health oriented plan to spend a major one-year increase in federal opioid surveillance and treatment dollars, $23 million up from just $3 million in 2017.

As part of its effort to address substance misuse as well as the physical distances between health systems and the rurality of the state, MCH is participating in the Northern New England ECHO Collaborative which was formed to advance the use of *Project ECHO*® (Extension for Community Healthcare Outcomes) by Maine Quality Counts, the Vermont Program for Quality Health Care, and the NH Citizen's Health Initiative. The model virtually links expert specialist teams at academic hubs with primary care clinicians in local communities. The first virtual series is focusing on the continuity of care for substance uses and exposure during the perinatal period

The mental health care system in the state also affects the Title V population in very important ways. Title V's mental health colleagues within DHHS help to support through federal and state dollars ten (10) community mental health clinics, which often work in tandem with the community health centers. Severe workforce shortages have been reported particularly for mental health professionals at the community mental health clinics. New Hampshire is also 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* and is in the midst of writing its ten (10) year Mental Health Plan, due by legislation the fall of 2018.

A recently released CDC report showed that NH's suicide rates were up 48.3% from 1999-2016, third behind Vermont and North Dakota.[64] MCH has played a pivotal role in suicide prevention with its staff co-founding the Youth Suicide Prevention Assembly more than 20 years ago and its leadership positions on the current NH Suicide Prevention Council. Title V funds have enabled the integration of behavioral health and primary care, something that is receiving a lot of focus in the state at this time. MCH and its funded colleagues helped to pioneer this concept over a decade ago and continue to do so today. DHHS will be creating a cross-agency team in Fall 2018 to focus on integration and coordination of efforts on suicide prevention and to work collaboratively with the Suicide Prevention Council and other statewide efforts.

In 2016, NH Medicaid received approval from CMS for an 1115 waiver for the Delivery System Reform Incentive Payment program (DSRIP), under which the state has access to up to $150 million in Medicaid funds over five (5) years to expand community-based mental health and to drive delivery system reform for Medicaid recipients. The funds are being utilized to support seven (7) Integrated Delivery Networks (IDNs) covering the entire state. IDNs are networks of medical, behavioral health, substance use disorder and social service providers (including all of MCH's funded community health centers) tasked with:

- Improving care transitions
- Promoting the integration of physical and behavioral health

- Building mental health and substance use disorder treatment capacity

All seven (7) IDNs selected community and state-wide projects based on needs assessments and reflecting the three (3) tasks mentioned above. Children make up a majority of the Medicaid population, yet are not necessarily the highest risk population, with the exception of the developmentally disabled and those with severe emotional disorders. For that reason, most of the IDNs selected as their community projects care transition, care coordination for the high need population, and expansion of substance use disorder treatment.

Region 1

Administrative Lead & Community Projects:	• *Mary Hitchcock Memorial Hospital (Fiscal Agent) & Cheshire Medical Center* *C1 – Care Transition Teams* *D3 – Expansion in Intensive SUD Treatment Options* *E5 – Enhanced Care Coordination for High Need Population*

Region 2

Administrative Lead & Community Projects:	• *Capital Region Health Care (CRHC) Comprised of Concord Hospital, Riverbend and the Concord Regional Visiting Nurse Association (VNA)* *C2 – Community Re-entry Program for Justice-Involved Adults and Youth* *D1 – Medication Assisted Treatment of Substance Use Disorders* *E5 – Enhanced Care Coordination for High Need Population*

Region 3

Administrative Lead & Community Projects:	• *Southern New Hampshire Health (SNHH)* *C1 – Care Transition Teams* *D3 – Expansion in Intensive SUD Treatment Options* *E4 – Integrated Treatment for Co-Occurring Disorders*

Region 4

Administrative Lead & Community Projects:	• *Catholic Medical Center* *C1 – Care Transition Teams* *D3 – Expansion in Intensive SUD Treatment Options* *E4 – Integrated Treatment for Co-Occurring Disorders*

Region 5

Administrative Lead & Community Projects:	• *Partnership for Public Health on behalf of Community Health Services Network (CHSN)* *C2 – Community Re-entry Program for Justice-involved Adults and Youth* *D3 – Expansion in Intensive SUD Treatment Options* *E5 – Enhanced Care Coordination for High Need Population*

Region 6

Administrative Lead & Community Projects:	• *Strafford County* *C1 – Care Transition Teams* *D3 – Expansion in Intensive SUD Treatment Options* *E5 – Enhanced Care Coordination for High Need Population*

Region 7

Administrative Lead & Community Projects:	• *North Country Health Consortium* *C1 – Care Transition Teams* *D3 – Expansion in Intensive SUD Treatment Options* *E5 – Enhanced Care Coordination for High Need Population*

Several of the community driven projects on the menu include transitions utilizing care transition teams and enhanced care coordination, two (2) areas in which both MCH and SMS are heavily invested, through both staff time and contractual work.

In addition, the statewide project on increasing the behavioral health workforce complements Title V's efforts towards 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 Legislative Commission on Primary Care Workforce Issues, the Recruitment Center of Bi-State Primary Care Association and the Children's Behavioral Health Collaborative Workforce Development Network. The second statewide project will allow for the development and adoption of health information technology 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. There has been continued progress in 2018 within the IDNs along the framework for integrated primary and behavioral healthcare including:

- Implementation of shared care plans and event notification (admission, discharge and transfer)
- Statewide adoption of a standardized comprehensive assessment and closed loop referral process
- Multi-disciplinary team meetings on behalf of individuals with significant behavioral health and/or chronic medical conditions
- Workforce initiatives including recruitment, retention and training
- Incentive payments tied to outcome metrics.[65]

From 2018-2020, fiscal incentives to the IDNs will be based on the achievement of pre-determined metrics. It is particularly gratifying that three (3) 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 is beginning to have an impact on Title V populations within the state, and the SMS Administrator is a member of the DSRIP Policy Committee. 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.

Statutes and other regulations that have passed or are in process within the last year and have relevance to the Title V program: The signing of SB 247 made NH a universal lead-screening state meaning that blood level testing of all one (1) and two (2) year old children is now required. DPHS is also at this time required to alert parents/guardians of a blood lead level of >3 ug/dL, reduced from >5 ug/dL, and to take action on a home at >7.5 ug/dL in 2019 and >5 in 2020, reduced from >10 ug/dL.

The newborn screening (including newborn hearing screening) rules He-P 3008 are expiring June 30, 2018. A revision is in process which will include the addition of Critical Congenital Heart Defects (CCHD) to the screening panel. This will enable MCH to collect CCHD data, the screening of which is required by state law.

Newborn screening also dealt with another legislative attempt to add a disorder to the panel instead of doing so by committee as in statute. This was not successful.

RSA 141-J enables the Birth Conditions Program to have full legislative authority to implement its surveillance and follow-up activities. During the program's previous dormancy, accompanying administrative rules He-P 3013 expired. In July 2017, interim rules were approved by the NH Joint Legislative Committee on Administrative Rules (JLCAR) and final rules approved in December 2017, expiring in 2028. The program's advisory committee worked on the draft rules engaging lawmakers in a discussion and revision of the "opt out" component.

SB 549-FN-A requires a plan of safe care if an infant is identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure or a fetal alcohol spectrum disorder. The plan of care must be submitted to DHHS only if the infant is thought to be abused or neglected. Several additional fields to the birth certificate will be added enabling MCH to gather additional data on prenatal drug and/or alcohol exposure.

DPHS staff were involved with the study committee for HB 1822-FN, enabling pharmacists to dispense hormonal contraceptives pursuant to a standing order entered into by health care providers. The bill, recently signed into law, will require the Boards of Pharmacy, Medicine and Nursing along with DHHS to work together in developing a model statewide protocol and the content/format of an information sheet.

---

[1] Division of Forests and Lands, New Hampshire Department of Natural and Cultural Resources. Retrieved on 06/11/2018 from https://www.nhdfl.org/reports/forest-statistics.
[2] United States Census Bureau (2018). *Quick Facts New Hampshire*. Retrieved on 06/11/2018 from https://www.census.gov/quickfacts/fact/table/NH/PST045217.
[3] Citizens Count New Hampshire (2018) Retrieved on 06/11/2018 from http://www.lfda.org/issues/legislative-process.
[4] Commonwealth Fund, Health System Data Center. Retrieved on 06/12/2018 from http://datacenter.commonwealthfund.org/scorecard/state/31/new-hampshire/.
[5] Annie E. Casey Foundation (2018). 2018 Kids Count Data Book: State Trends In Child Well-Being. Retrieved on 06/12/2018 from http://www.file.aecf.org/m/resourcedoc/aecf-2018kidscountdatabook-2018.pdf.
[6] United Health Foundation, *America's Health Rankings*. Retrieved on 06/12/2018 from https://assets.americashealthrankings.org/app/uploads/ahr_hwc_2018_report_summary_022818a.pdf.
[7] Ibid
[8] Annie E. Casey Foundation (2018). 2018 Kids Count Data Book: State Trends In Child Well-Being. Retrieved on 06/12/2018 from http://www.file.aecf.org/m/resourcedoc/aecf-2018kidscountdatabook-2018.pdf.
[9] Federal Reserve Bank of St. Louis (2018). *Economic Research* retrieved on 06/12/2018 from https://fred.stlouisfed.org/series/NHPCPI.
[10] Portland Press Herald (2018). *The State with the highest median income is…New Hampshire?* Retrieved on 06/15/2018 from https://www.pressherald.com/2017/09/13/the-state-with-highest-median-income-is-new-hampshire/.
[11] Ibid.
[12] Center for American Progress (2018). Talk Poverty. Retrieved on 06/15/2018 from https://talkpoverty.org/state-year-report/new-hampshire-2016-report/.
[13] Center for American Progress (2018). Talk Poverty. Retrieved on 06/15/2018 from https://talkpoverty.org/poverty/.
[14] United States Census Bureau. *Quick Facts New Hampshire*. Retrieved on 06/17/2018 from https://www.census.gov/quickfacts/fact/table/NH/PST045217.
[15] Economic Policy Institute (2017). Retrieved on 06/17/2018 from http://www.epi.org/.
[16] New Hampshire Fiscal Policy Institute (2016). *Taking the Measure of Need in the Granite State*. Retrieved on 06/17/2018 from http://nhfpi.org/research/state-economy/taking-the-measure-of-need-granite-state.html.
[17] Ibid.
[18] Economic Policy Institute (2017). Retrieved on 06/17/2018 from http://www.epi.org/.
[19] Ibid.
[20] New Hampshire Fiscal Policy Institute (2016). *Taking the Measure of Need in the Granite State*. Retrieved on 06/17/2018 from http://nhfpi.org/research/state-economy/taking-the-measure-of-need-granite-state.html.
[21] Ibid.
[22] University of New Hampshire, Carsey School of Public Policy (2017). Child Care Expenses Push Many Families into Poverty. Retrieved on 06/17/2018 from http://scholars.unh.edu/cgi/viewcontent.cgi?article=1303&context=carsey.
[23] Ibid.
[24] New Hampshire Fiscal Policy Institute (2018). *New Hampshire's Economy: Strengths and Constraints*. Retrieved on 06/17/2018 from http://nhfpi.org/research/state-economy/new-hampshires-economy-strengths-and-constraints.html.
[25] Ibid.

[26] 2016 Behavioral Risk Factor Surveillance System data analyzed by MCH, 06/20/2018.
[27]NH DHHS, Division of Public Health Services, Rural Health and Primary Care (2016). *NH Statewide Primary Care Needs Assessment to Analyze Unmet Need, Disparities and Health Workforce Issues*.
[28] HealthInsurance.Org (2018). New Hampshire Health Insurance: Medicaid expansion and a partnership exchange in a state with a GOP Trifecta. Retrieved on 06/29/2018 from https://www.healthinsurance.org/new-hampshire/.
[29] NH Works (2018). *The New Hampshire Health Care Sector Partnership, NH Works and Jobs for the Future.* Retrieved on 06/20/2018 from http://www.nhworks.org/uploads/NH_Health_Care_Asset_Map_3-2-17.pdf.
[30] New Hampshire Fiscal Policy Institute (2018). *New Hampshire's Economy: Strengths and Constraints*. Retrieved on 06/17/2018 from http://nhfpi.org/research/state-economy/new-hampshires-economy-strengths-and-constraints.html.
[31] NH Hospital Association (2018). Map of Hospitals. Retrieved on 06/18/2018 from http://www.nhha.org/index.php/nh-hospitals/map-of-hospitals.
[32] DPHS, NH DHHS (2018). Personal Communication with Tyler Young, Geographic Information Systems Analyst on 06/19/2018.
[33] Kozhimannil, K. et al. Association Between Loss of Hospital-Based Obstetric Services and Birth Outcomes in Rural Counties in the United States. *JAMA*. 201; 319(12):1239-1247.doi:10.1001/jama2018.1830.
[34] Medicaid Claims Data/Vital Records Data analyzed by MCH, 06/20/2018.
[35] Ibid.
[36] Ibid.
[37] Ibid.
[38] Kozhimannil, K. et al. Association Between Loss of Hospital-Based Obstetric Services and Birth Outcomes in Rural Counties in the United States. *JAMA*. 201; 319(12):1239-1247.doi:10.1001/jama2018.1830.
[39] Ibid.
[40] Nilsen, Ella. "New Hampshire Medicaid match among nation's lowest". Concord Monitor, 25 March 2017. Retrieved on 06/21/2018 at http://www.concordmonitor.com/new-hampshire-medicaid-payments-are-already-the-lowest-in-the-nation-8728019.
[41] Medicaid and CHIP Payment and Access Commission (April 2017). *Medicaid Hospital Payment: A Comparison Across States and to Medicare*. Retrieved on 06/21/1018 at https://www.macpac.gov/wp-content/uploads/2017/04/Medicaid-Hospital-Payment-A-Comparison-across-States-and-to-Medicare.pdf.
[42] Personal Communication, New Hampshire Hospital Association, June 25, 2018.
[43] Nilsen, Ella. "New Hampshire Medicaid match among nation's lowest". Concord Monitor, 25 March 2017. Retrieved on 06/21/2018 at http://www.concordmonitor.com/new-hampshire-medicaid-payments-are-already-the-lowest-in-the-nation-8728019.
[44] Medicaid and CHIP Payment and Access Commission (April 2017). *Medicaid Hospital Payment: A Comparison Across States and to Medicare*. Retrieved on 06/21/1018 at https://www.macpac.gov/wp-content/uploads/2017/04/Medicaid-Hospital-Payment-A-Comparison-across-States-and-to-Medicare.pdf.
[45] Kaiser Family Foundation (2018). *State Health Facts: Federal Medical Assistance Percentage for Medicaid and Multiplier*. Retrieved on 06/22/2018 from https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[46] Personal Communication, New Hampshire Hospital Association, June 25, 2018.
[47] NH DHHS New Heights Data, Enterprise Data Warehouse, accessed June 27, 2018.
[48] Ibid.
[49] University of New Hampshire, Institute of Health Policy and Practice (2018). *Covering the Care: Medicaid, Work and Community Engagement.* Retrieved on 06/27/2018 from https://chhs.unh.edu/sites/default/files/departments/institute_for_health_policy_and_practice/pdfs/focus_on_medicaid_coverage_brief.pdf.
[50] Ibid.
[51] New Hampshire Fiscal Policy Institute (2018). *Medicaid Expansion in New Hampshire and the State Senate's Proposed Changes*. Retrieved on 06/29/2018 from http://nhfpi.org/research/health-policy/medicaid-expansion-in-new-hampshire-and-the-state-senates-proposed-changes.html
[52] Ibid.
[53] Kaiser Family Foundation (2018). *Health Insurance Coverage of the Total Population*. Retrieved on 06/28/2018 from http://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&selectedRows=%7B%22nested%22:%7B%22new-hampshire%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
[54] Hodder, L. and Porter, J. (2017). Covering the Care: Health Insurance Coverage in New Hampshire. Institute for Health Policy and Practice. Retrieved on 06/17/2018 from http://chhs.unh.edu/sites/chhs.unh.edu/files/departments/institute_for_health_policy_and_practice/covering_the_care-_health_care_coverage_in_nh_060717.pdf.
[55] Ibid.
[56] Written communication with Bi-State Primary Care Association Deputy Director, 06/29/2018.
[57] Ibid.

[58] New Hampshire Drug Monitoring Initiative (2018). New Hampshire Information and Analysis Center, April 2018 Report. Retrieved on 06/30/2018 from https://www.dhhs.nh.gov/dcbcs/bdas/documents/dmi-april-2018.pdf.
[59] Ibid.
[60] Ibid.
[61] Division of Public Health Services (2018). *Annual Report on Maternal Mortality to the New Hampshire Health and Human Services Oversight Committee, Annual Report 2018*.
[62] Smith, Kristin (2017). University of New Hampshire Carsey Institute. *As Opioid Use Climbs, Neonatal Abstinence Syndrome Rises in New Hampshire*. Retrieved on 06/30/2018 from https://scholars.unh.edu/cgi/viewcontent.cgi?article=1330&context=carsey.
[63] Smith, Kristin (2018). University of New Hampshire Carsey Institute. *Parental Substance Use in New Hampshire: Who Cares For The Children?* Retrieved on 06/30/2018 from https://scholars.unh.edu/cgi/viewcontent.cgi?article=1341&context=carsey.
[64] Stone DM, Simon TR, Fowler KA, et al. *Vital Signs:* Trends in State Suicide Rates — United States, 1999–2016 and Circumstances Contributing to Suicide — 27 States, 2015. MMWR Morb Mortal Wkly Rep 2018;67:617–624. DOI: http://dx.doi.org/10.15585/mmwr.mm6722a1.
[65] Lipman, Henry, NH Medicaid Director (2018). *NH DSRIP Annual Report 2017*. Retrieved on 07/01/2018 from https://www.dhhs.nh.gov/section-1115-waiver/documents/dsrip-annual-report-2017.pdf.

III.C. Needs Assessment

FY 2019 Application/FY 2017 Annual Report Update

Ongoing needs assessment activities are diverse and include the following:

- Confidential client satisfaction surveys which are collected on an ongoing basis, including age-specific surveys (to assess youth views), at MCH-contracted Community Health Centers (CHCs).
- MCH-facilitated sub-grantee semiannual meetings, which allow clinic staff to voice thoughts, concerns, challenges and emerging issues.
- The NH Pediatric Improvement Partnership (NH PIP) Steering Committee, comprised of representative from all stakeholder organizations/agencies participating in NHPIP, including the MCH QI/QA Nurse Consultant and the CYSHCN Director, provides feedback and insight about emerging needs/opportunities and the implementation of strategic priorities.
- The Early Hearing Detection and Intervention (EHDI) program, in collaboration with NH/Maine LEND Leadership Education in Neurodevelopmental and Related Disabilities) is conducting two family surveys to help identify areas of potential improvement in the loss-to-follow-up rate: (1) at the hospital level, for initial screening and referral to audiological diagnostic testing; and (2) at the diagnostic level, assisting with scheduling appointments and how to prepare for appointments.
- A hospital survey of safe sleep policy and practice, repeated to monitor changes and improvements.
- Quarterly Safe Sleep Workgroup meetings and the multidisciplinary NH SUID (Sudden Unexpected Infant Death) Review group meetings provide information on all infant deaths in the state.
- Data is extracted from the CFSS (Comprehensive Family Support Services, with eight grantee agencies) data base to inform MCH program staff on physical activity and healthy lifestyle among children.
- The Perinatal Substance Exposure Task Force continues to meet and share pertinent updates on opioid use and abuse.
- The Injury Prevention Program (IPP) holds Advisory Council meetings to stay abreast of current injury prevention activities and possible emerging issues, as well as bills proposed in the NH Legislature regarding injury prevention and public safety.
- NH Safe Kids meetings are held quarterly to address safety issues related to children.
- The PRAMS (Pregnancy Risk Assessment Monitoring System) project is routinely collecting data on pregnancy-related attitudes, experiences and behaviors, as well as analyzing this data and disseminating it to inform stakeholders, program managers and policy makers.

Changes in the health status of the state's MCH population are sometimes positive, but even when needs are not growing, there still remains room for improvement, especially among sub-populations (geographic, cultural, socio-economic, etc.). Health updates include:

- FP contract agencies continue to increase mental health and substance misuse services for clients
- The utilization of LARCs (long-acting reversible contraceptives) is increasing
- The small number of SUID cases is essentially stable, but the number of caregivers of infants who died from SUID, who had a documented history of substance abuse, has increased from 2011 to 2016
- Concern is increasing regarding vaping and Juuling; teens in NH can get access to these products on the internet, even though the state limits purchasing of these products to people 18 years of age and older; the Juul device can contain as much nicotine as a full pack of cigarettes
- The infant mortality rate in 2017 was 4.2 per 1000 births, down from 5.0 in 2016, and first in the nation[1]
- The rate of low birth weight (<2500 grams) was 6.9% in 2017, ranking New Hampshire 12th in the nation[2]
- The prematurity rate in NH in 2016 was 7.8% or one in 13 livebirths; the US figure was 9.8% or one in 10 livebirths[3]
- The teen birth rate in NH in 2016 was 4.1% of livebirths; the US figure was 6.4% of livebirths[4]

Stakeholder verbalizations and interactions with contract agency staff all reinforce the following areas of concern voiced by respondents:

- Increased opioid use, mainly among young to middle aged adults, impacts the needs of children and other family members; the NH Medical Examiner's Office projected 36.5 deaths per 100,000 for 2017 (analysis as of 1/23/18)[5]
- Insufficient mental health services, notably for children and adolescents
- The costs of health care: even with ACA many individuals have high out-of-pocket expenses
- Health care worker shortage
- CHCs report insufficient reimbursement mechanisms, resulting in not all individuals having equal access to "routine" testing or services

In June 2018 two (2) of the current 19 birthing hospitals will close their labor and delivery units, which will leave coverage gaps in those regions of the state. There is a plan to continue to provide prenatal care in those communities, but delivery will require families to travel, thus making access more difficult.

The Contracting Unit (CU) within DHHS has been understaffed, resulting in significant delays in the release of Requests for Applications (RFAs) and contracts, and requiring retroactive payment in some cases. The CU expects to be fully staffed by the end of May.

The Child Care Licensing Unit (in the Office of Operations Support) has adopted new regulations that include the requirement that full-day programs provide at least one hour of physical activity each day, which should impact childhood obesity.

At least anecdotally, there seems to be more safe sleep information appearing in a wide variety of settings from WIC offices to outpatient drug facilities. This may be the result of increased education and outreach by DPHS, the work of the SUID Review Group members, and the Safe Sleep Workgroup. The Plan of Safe Care project includes safe sleep information in its comprehensive range of education to pregnant/new parents.

The MCH Section is not fully staffed, and there is little to no additional capacity to take on new projects, even when these are fully federally funded.

NH DHHS is undergoing substantial restructuring to improve service integration. The first major change was the establishment of the Division of Behavioral Health, which brought together alcohol and substance use services and mental health services.

Secondly was the creation of the Division of Long Term Supports and Services, which includes the Bureaus of Elderly and Adult Services, Developmental Services, Special Medical Services and Community Based Military Programs.

Thirdly was the creation of the Division of Economic and Housing Stability (DEHS) within the Human Services and Behavioral Health program, which will play a key role in promoting a more holistic, multi-generational and integrated approach for high risk individuals, families, and children. DEHS will guide this approach through a realignment of existing programs into five new Bureaus:

- Bureau of Family Assistance (combining the Division of Client Services and Division of Family Assistance)
- Bureau of Child Support Service

- Bureau of Housing Supports
- Bureau of Child Development & Head Start Collaboration
- Bureau of Employment Supports

Within the Division of Public Health Services, there is a new Chief for the Bureau of Community and Public Health Services, which houses the Maternal and Child Health Section; the new Bureau Chief is an MD MPH.

In the past year the MCH Section has also hired a new Program Manager for the MIECHV Home Visiting program, and is recruiting a new Program Manager for the Family Planning program. Other new staff include a Zika/Birth Conditions Coordinator, an Opioid Surveillance Coordinator, a Home Visiting Data Specialist, a Family Planning Health Promotion Advisor, and a Newborn Screening/Home Visiting Program Assistant. Also, the EHDI Follow-up Coordinator position will be covered in-house rather than contracted out.

There is a broad range of partnerships and ongoing collaborations inside and outside NH DHHS; these collaborations are active at many different levels, from technical guidance to program implementation. Some of the collaboration agencies include:

- Birth Conditions Advisory Committee
- Family and Youth Services Bureau
- Children's Hospital at Dartmouth (CHAD)
- Institute for Health Policy and Practice, UNH
- Institute on Disability, UNH
- NH Academy of Family Physicians
- DHHS, NH Medicaid
- NH Family Voices
- NH Pediatric Society
- SPARK NH
- Northeast Deaf and Hard of Hearing Services
- Family Centered Early Supports and Services
- Newborn Screening Multidisciplinary Advisory Committee
- SUID Review Group
- March of Dimes
- Emergency Medical Services
- DHHS, Child Care Licensing Unit
- DHHS, DPHS, Tobacco Prevention and Control Program
- Northern New England Perinatal Quality Improvement Network
- NH Pediatric Society
- DHHS, DPHS, Bureau of Infectious Disease Control
- DHHS, DPHS, Bureau of Health Statistics and Informatics
- DHHS, DPHS, Women, Infants and Children Nutrition Program (WIC)
- DHHS, Bureau of Drug and Alcohol Services
- Perinatal Substance Exposure Task Force
- Brain Injury Association
- NH Coalition Against Domestic and Sexual Violence
- NH Injury Prevention Center, Dartmouth
- Northern New England Poison Center

- NH Pediatric Improvement Partnership (NH PIP)
- NH/Maine Leadership Education in Neurodevelopmental and Related Disabilities (LEND)
- Comprehensive Family Support Services (CFSS)
- Safe Kids New Hampshire
- Secretary of State, Division of Vital Records Administration
- City of Manchester Health Department
- Community Health Institute
- DHHS, Division of Children, Youth and Families
- NH Health & Equity Partnership
- NH Home Visiting Task Force
- New Futures (NH)
- Endowment for Health
- The Children's Trust
- National Alliance on Mental Illness (NH)
- NH Breastfeeding Taskforce

Work on emerging issues

New Hampshire has reinstituted its Birth Conditions program as it implemented a Zika pregnancy surveillance grant; when the Zika grant expires the Birth Conditions program will continue to surveil birth defects; the original Birth Conditions program had been defunded and was no longer operational. While Zika infections and Zika-affected infants have been rare in the state, the surveillance system established for Zika and birth conditions can be readily adapted for the surveillance of other emerging conditions, for example other arboviruses such as Lyme disease (incidence rate 51.8 cases per 100,000 population, in 2016[6]).

In response to the opioid epidemic, the NH DHHS will expand access to residential treatment for substance use disorder (SUD) services through a federal waiver. While the State has spent more than $30 million in the past two years to expand access to SUD treatment and recovery services, NH lacks adequate capacity for SUD treatment beds. DHHS is requesting a waiver from the Centers for Medicare and Medicaid Services (CMS), allowing the State to receive federal funds for adults and adolescents who are Medicaid-eligible and who receive residential SUD treatment in an Institution for Mental Disease (IMD) for as long as is medically necessary.

The capacity challenges in the SUD treatment system are even more difficult for those under 18 years old. In 2016, the NH Legislature passed HB517, which required the State to redevelop excess capacity at the existing Sununu Youth Services Center (SYSC) to allow for expansion to a 36-bed residential SUD treatment facility for NH adolescents. The program at SYSC was designed as a Comprehensive SUD Program, in alignment with the existing SUD service delivery system. Initially sixteen beds for the program will be available upon opening in July 2018, with the remaining 20 beds to open shortly after the Federal waiver approval.

In March of 2018, the state was awarded $333,000 by the Substance Abuse and Mental Health Services Administration (SAMHSA) to increase funding for critical components of the State's response to the opioid epidemic. The funding will allow the State to further expand access to treatment services, provide enhanced supports for people in recovery and provide wraparound services. DHHS will direct the funds to enhance the nationally-recognized Safe Stations programs in the cities of Manchester and Nashua, and expand statewide Regional Access Points services (RAPs).

The Safe Stations models are community-based initiatives resulting from a collaborative effort between local fire departments, treatment providers, and key stakeholders working to address the opioid crisis. The programs provide access to substance use

screening, clinical evaluation, rapid referral to services, and interim care and stabilization, in Manchester and Nashua, which are the two largest cities in the state, and the two highest need communities in the highest risk county in the State.

The statewide RAPs program has established clinical relationships with providers in each region of the State, ensuring that people can get services in their own communities. DHHS expects the funding will allow RAPs programs to enter into formal evaluation and treatment agreements with 40 additional providers. By expanding RAPs services and operations statewide, individuals will be less likely to need to travel outside their region to access care, and resources can be more efficiently utilized in local communities. There are 13 RAPs programs across the state and RAPs in high need areas are expected to be able to expand their hours. RAPs expansion will also help people get into treatment more quickly and reduce waitlists.

MCH-funded primary care agencies (CHCs) are contractually expected to provide Screening, Brief Intervention and Referral to Treatment (SBIRT) for substance abuse. And MCH-funded family-planning agencies are encouraged to develop referral mechanisms with medication-assisted treatment (MAT) programs, and in turn to receive family planning referrals from MAT programs, to provide contraception, STI testing and related family planning services to individuals with SUD.

The MCH and SMS sections are discussing ways to **institutionalize the needs assessment process**, to include a permanent online survey instrument on the DHHS website, updated periodically to garner input on time-sensitive issues, as well as provisions written into the contracts of MCH-funded community health centers to more systematically assess the needs of the population in their catchment area, in addition to their standard customer satisfaction surveys. Other needs assessment processes are already institutionalized, with information routinely gathered from advisory councils, steering committees, and CHCs, representing MCH stakeholders and clients statewide.

---

[1] American Community Health Survey; www.americashealthrankings.org; accessed April 2, 1018
[2] Ibid.
[3] March of Dimes Peristats; www.marchofdimes.org; accessed April 2, 2018
[4] Ibid.
[5] https://www.dhhs.nh.gov/dcbcs/bdas/documents/dmi-2017-overview.pdf; accessed 4/30/2018
[6] https://www.cdc.gov/lyme/stats/tables.html accessed March 26, 2018

FY 2018 Application/FY 2016 Annual Report Update

In this second interim year (FY18) of the FY16-FY20 Block Grant cycle, the process of needs assessment continues. National and state surveys and reports for NH are collected and systematically reviewed. Public input is acquired through ongoing satisfaction surveys instituted by 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

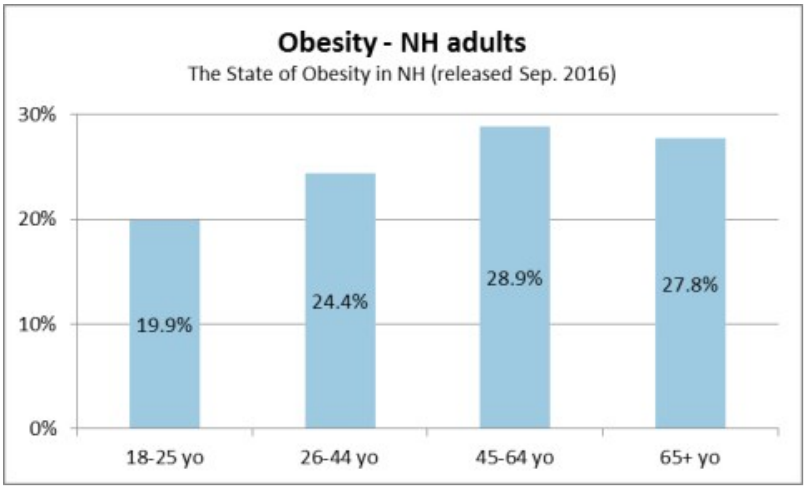
Cross-cutting/Life course

Needs

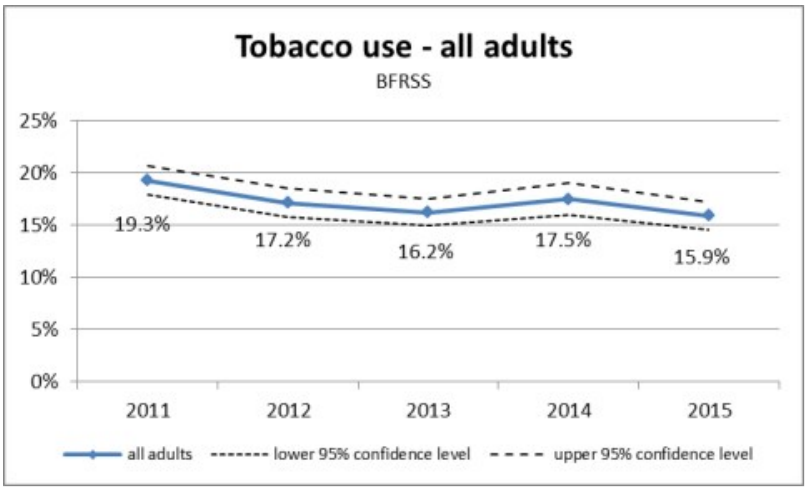
In 2013-2014 some 49,000 adults had a serious **mental illness** within the previous year; approximately 50% of these did not receive mental health treatment/counseling. The percentage of adults reporting improved functioning from treatment in the public mental health system was lower in NH (55.5%) than in the nation as a whole (70.9%).[1]

Data shows that 18.4% of adults engage in **excessive drinking**.[2] **Binge drinking** ranges from 17% in the least affected NH county, to 21% in the most affected county.[3]

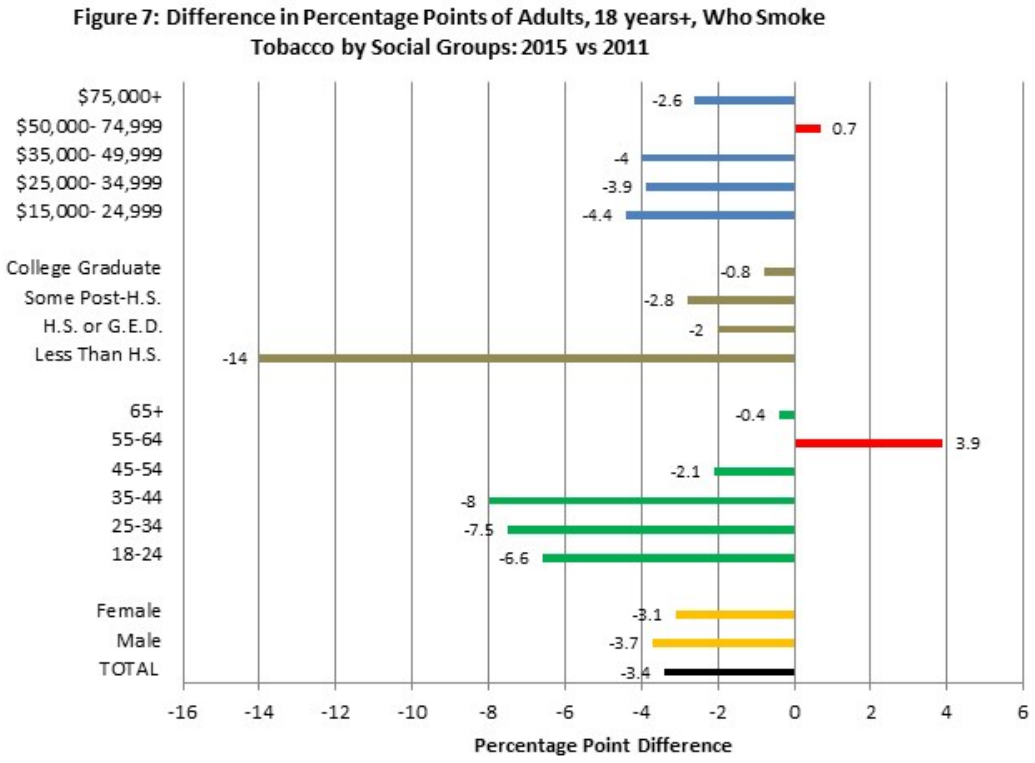
Obesity in 2015 is estimated at 24.6% in women and 28.0% in men.[4] For both genders, obesity ranges by county from 25% to 31%.[5] Obesity generally increases with age; there is no disparity by race, with 27.3% of Whites, 27.6% of Blacks, and 27.8% of Latinos rated as obese. Among other health sequelae, obesity is linked to diabetes (the 2015 adult diabetes rate is 8.1%) as well as hypertension (the 2015 adult hypertension rate is 29.2%).[6]



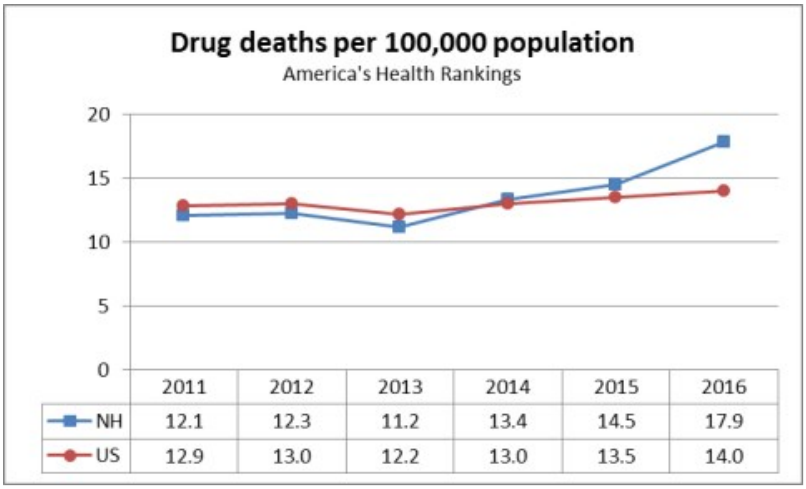
While not increasing in recent years, **tobacco use** remains widespread, with the 2015 smoking prevalence at 15.9% for both genders.[7] Prevalence by county ranges from 13% to 17%.[8] Nationally, New Hampshire ranks at number 17 in smoking prevalence.[9]



When looking at smoking data by sub-groups, the most striking finding is that smoking is decreasing for all except adults 55-64 (versus other age groups), and those towards the top of the earnings scale (see red bars on the graphic below).[10]



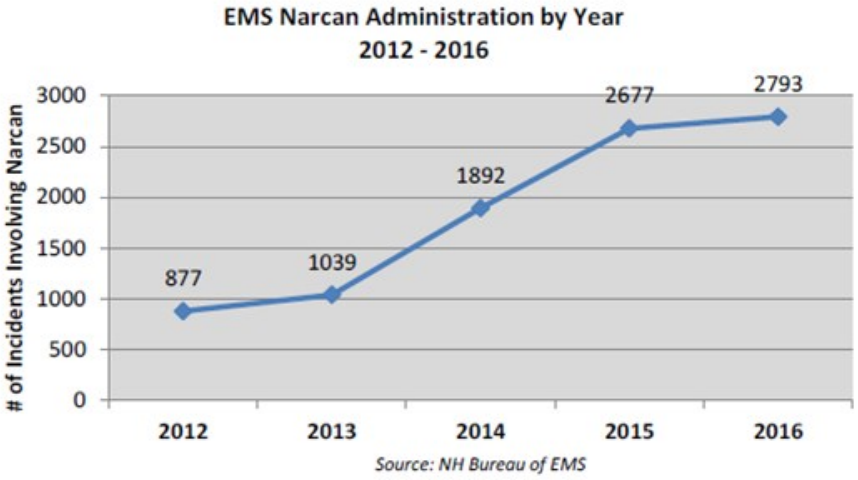
The use of illicit drugs is high, and NH's rate of drug-related deaths surpassed the national average in 2014; in 2016, NH was ranked 38th nationally.[11]



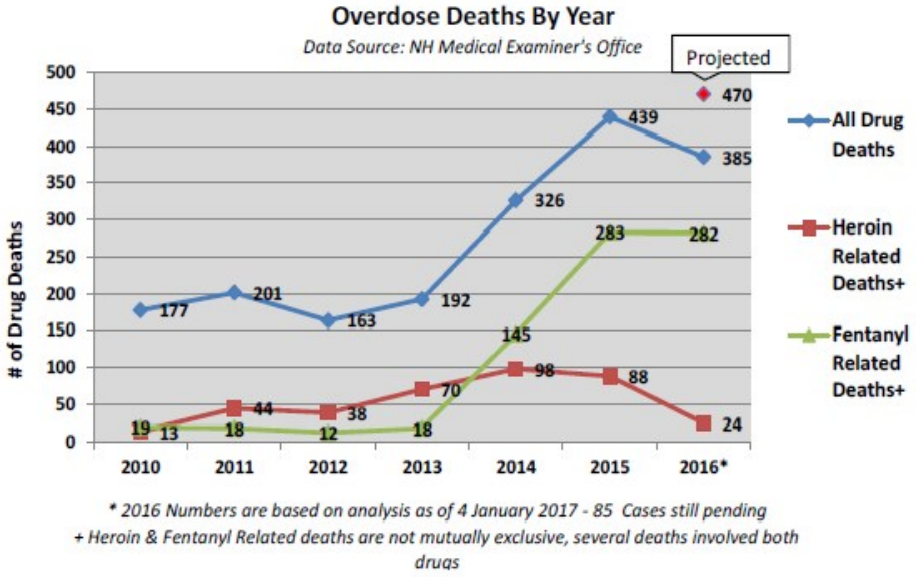
	2011	2012	2013	2014	2015	2016
NH	12.1	12.3	11.2	13.4	14.5	17.9
US	12.9	13.0	12.2	13.0	13.5	14.0

Carfentanil (a synthetic opioid approximately 100 times more potent than fentanyl) has been found in NH, with the Medical Examiner confirming on 4/25/17 that carfentanil was linked to three known deaths.[12]

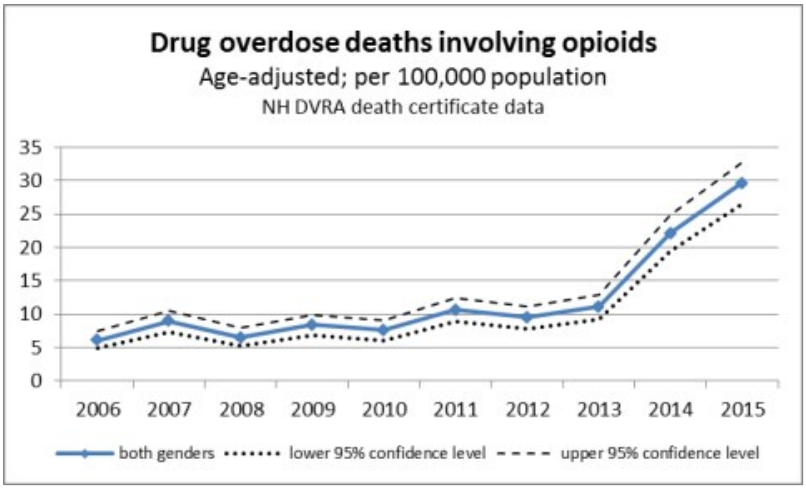
From 2012-2016 there was a 204% increase in Narcan administration by emergency medical services (EMS) personnel.[13]



The number of drug overdose deaths since 2013 has risen dramatically; since 2014 there has been a leveling off and decrease in heroin-related deaths, but a large increase in fentanyl-related deaths and in drug-related deaths overall.[14]



The age-adjusted rate for all drug overdose deaths involving opioids in 2014 was 22.1 per 100,000 population, and 29.6 per 100,000 population in 2015.[15]



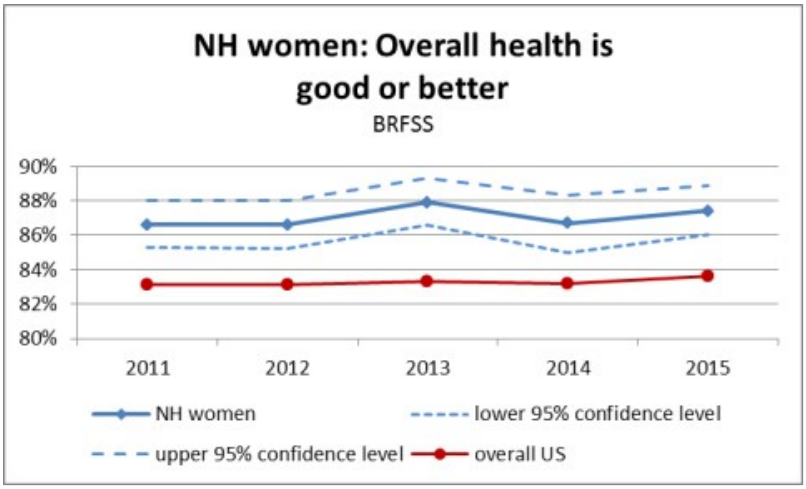
Emergent: Zika

As of May 3, 2017 there have been 13 confirmed cases and one probable case of **Zika virus infection**; all cases are travel-related, and one case is of sexual transmission. Three cases were pregnant women; two of the women have delivered; one infant was healthy and one was born with congenital Zika infection (microcephaly); one woman has not yet delivered.[16]

Women/Maternal Health

Strengths

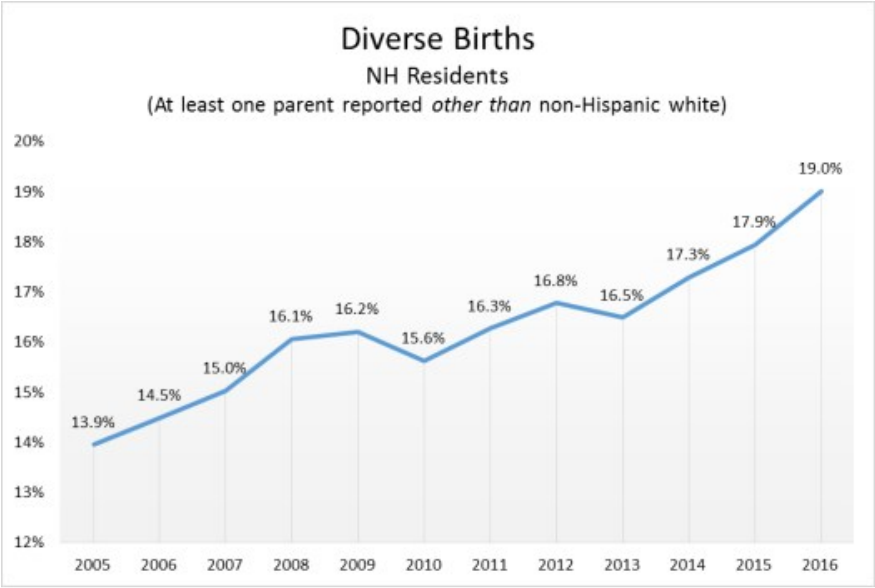
Women's self-reported **overall health** status in 2015 continues largely positive, with approximately 87% reporting good, very good, or excellent health; this is consistently slightly above the national figures. However, nearly 26% of women reported ever having been told they had **depression**, compared to 16% of men.[17]



In MCH-funded CHCs, 75.1% of women received **prenatal care in the first trimester**, as did 75.6% in 2015. Also in CHCs, 80.2%

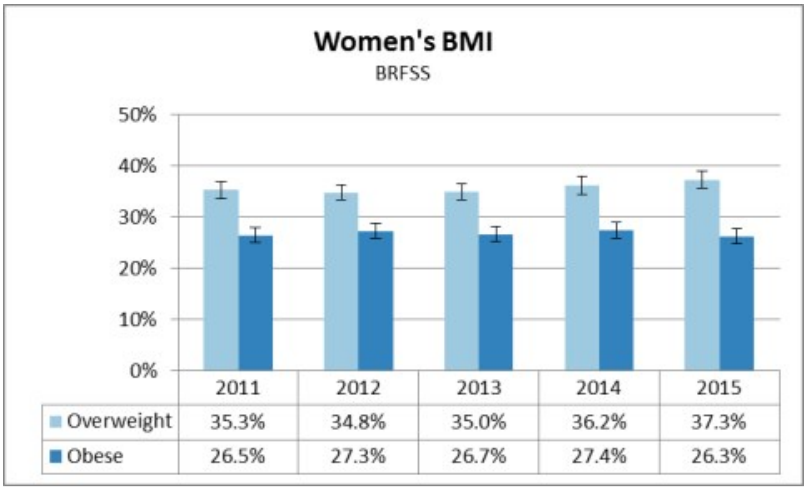
of women receiving services in 2016 were **screened for postpartum depression**; in 2015 this figure was 73.3%.[18]

In 2016, there were 12,249 **births** to resident women; this figure has been relatively stable over the past six years, ranging between 12,000-13,000 births annually.[19] The percentage of births of **babies of color** continues to rise, up to 19.0% in 2016, reflecting the increasing diversity of NH's population.



Needs

In 2015, approximately one in four women were **obese** (BMI >= 30), and one in three were overweight (BMI 25.0-29.9); these figures are essentially unchanged since 2011.[20]



	2011	2012	2013	2014	2015
Overweight	35.3%	34.8%	35.0%	36.2%	37.3%
Obese	26.5%	27.3%	26.7%	27.4%	26.3%

Binge alcohol use in 2015 is reported at approximately 16% nationally as well as statewide; for NH women, the estimate is lower but still of concern, at nearly 12%.[21]

Among the incarcerated population as of 9/1/2016, 38.3% of women (compared to 18.2% of men) had an active sentence including "Drugs" as Crime Type. Of persons receiving treatment in state FY16 for **alcohol and other drug use**, 101 were pregnant women. [22]

In 2015, nearly 15.4% of women reported being current **smokers**, with 11.0% smoking every day and 4.4% smoking on some days. In 2014 these figures were 16.7% current smokers, 12.2% smoking every day, and 4.5% smoking some days.[23] Also in 2015, 18.0% of women of **childbearing age** reported smoking, down from 21.6% in 2014. [24]

In 2014, 11.4% of women who had a live birth that year reported **smoking during the last trimester**;[25] among Medicaid participants, this figure was 25.7%.[26]

Environmental exposure to **second-hand smoke** was assessed in nearly 95% of women receiving services at CHCs in 2016; of these, 34.5% reported at least some exposure. In 2015 these figures were nearly 90% assessed and 25.7% reporting exposure.[27]

The use of **long-acting reversible contraceptives** (LARCs) in 2016 ranged from zero to 36.4% in MCH-funded Title X family planning agencies, with a statewide average of 19.9%.[28]

2016 Use (new and continuing) of LARC methods in New Hampshire				
Agency	**IUD Clients**	**Implant Clients**	**All Methods # of Female Clients**	**Total % LARC**
CAP Belknap/Merrimack	64	35	453	21.9%
Capital Region Family Health Center	115	33	1199	12.3%
Coos County Family Health	125	80	764	26.8%
Avis Goodwin CHC	112	19	651	20.1%
Nashua Area Health Center (Lamprey)	190	30	1118	19.7%
White Mountain Community Health Center	94	26	590	20.3%
Indian Stream-Dartmouth Hitchcock	0	0	93	0%
Weeks Medical Center	1	10	125	8.8%
Manchester Community Health/Child Health Services	2	9	213	5.2%
Equality Health Center	126	42	461	36.4%
Portsmouth Lovering Feminist HC	35	33	282	24.1%
NH Dept. of HHS Total:	**864**	**317**	**5949**	**19.9%**
Source: NH Family Planning Program				

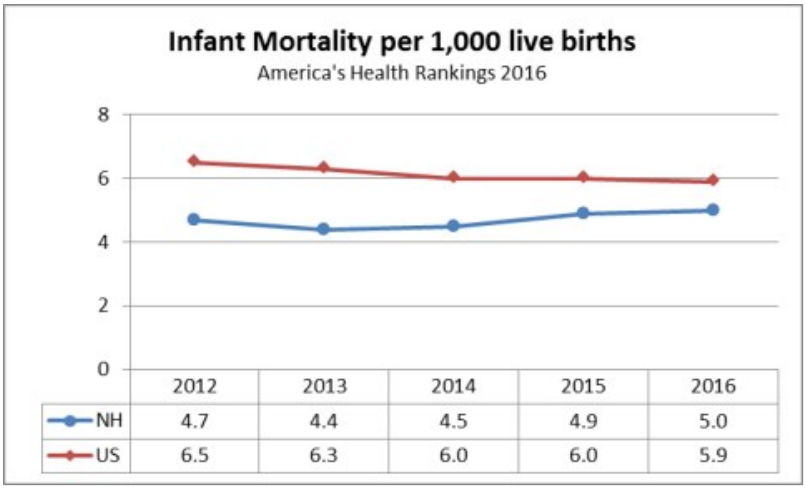
PRAMS 2014 data show that among women using postpartum contraception, 2.0% reported using an implant, and 25.6% an IUD.[29]

Perinatal/Infant Health

Strengths

In 2016, 7.7% of births were preterm, and 6.4% were of low birth weight;[30] for birth weight, NH ranks at number 11 nationally.[31]

Infant mortality was 5.0 per 1,000 livebirths, compared to 5.9 per 1,000 in the US. NH ranks at number 10 nationally for 2016.[32] While still a good performer, NH has not been progressing as steadily as the national average.



	2012	2013	2014	2015	2016
NH	4.7	4.4	4.5	4.9	5.0
US	6.5	6.3	6.0	6.0	5.9

There were ten referrals of possible cases of **Sudden Unexpected Infant Death** (SUID) in 2016; of these, four had a final diagnosis of "Undetermined;" there was one case of asphyxia; one of methamphetamine intoxication; one of lymphocytic myocarditis with cardiomegaly; and three are pending. NH has not had an infant death with a final diagnosis of SIDS (Sudden Infant Death Syndrome) since 2014; this mirrors the national trend of fewer SIDS and more deaths ruled as "Undetermined" having unsafe sleep elements in the case history or death scene investigation.[33] PRAMS 2014 data show that 89.4% of babies are placed to sleep safely, on their backs.[34]

Needs

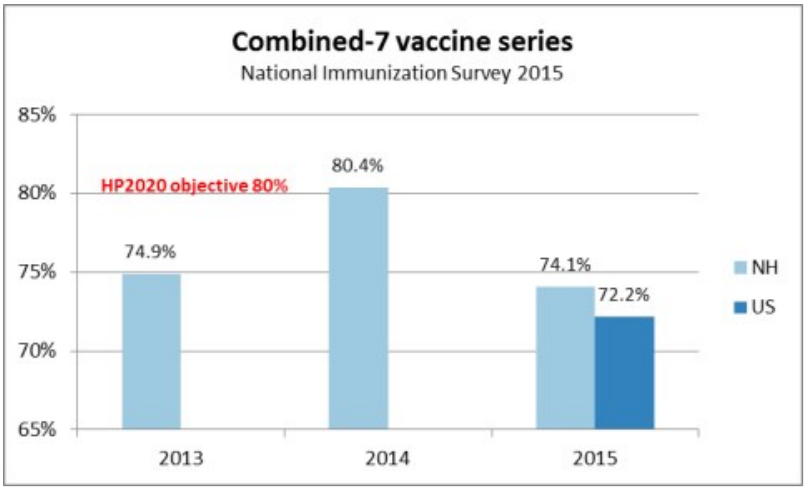
In cases of **Neonatal Abstinence Syndrome**, substantial co-morbid perinatal exposure (beyond the first trimester) to other substances has been found among opioid-exposed newborns in hospitals representing 68.5% of hospital births occurring in NH. The other substances include nicotine 60%, marijuana 33%, cocaine 12%, benzodiazepines 11%, SSRIs (selective serotonin reuptake inhibitors) 6%, alcohol 2% and other substances 13%. Overall, approximately 4.1% of newborns in these hospitals were exposed to opioids.[35]

Child Health

Strengths

In 2015, 74.1% of children ages 19-35 months received the **combined 7-vaccine series**, compared to 72.2% nationally. In 2014

the NH figure was 80.4%, and 74.9% in 2013.[36] The Healthy People 2020 target is 80%.



Needs

Injuries remain a leading cause of morbidity in children. Hospital discharge data shows a 2014 crude rate of 41.2 per 100,000 children aged 0-9 admitted for non-fatal injuries; in 2013 the crude rate was similar, at 39.8 per 100,000. The 2014 crude rate of emergency department (ED) visits due to motor vehicle crashes was 93.2 per 100,000 children aged 0-9; in 2013 the crude rate was 104.0 per 100,000.[37]

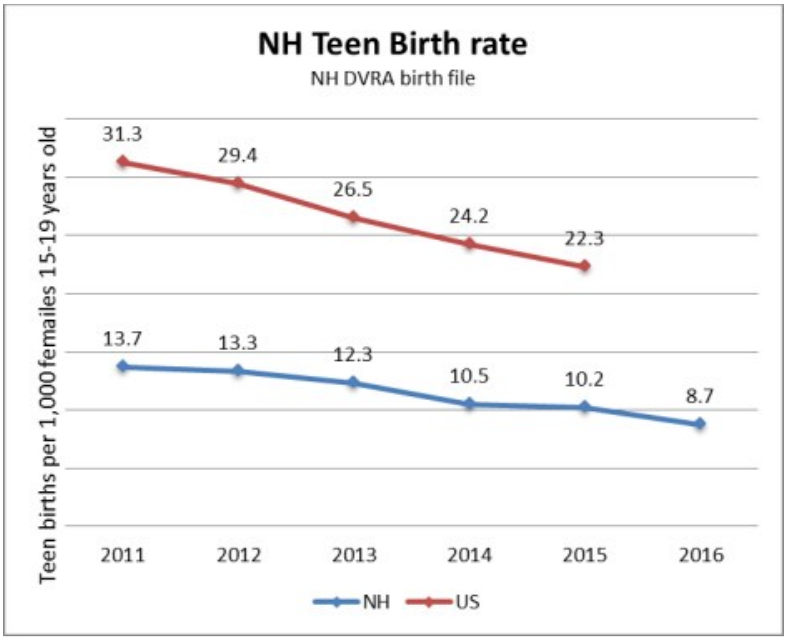
Two-to-four year old WIC participants have a current (2014) obesity rate of 15.5%, placing NH 15th in the national ranking of **childhood obesity**.[38]

NH DHHS has been leading a **pediatric cancer cluster** investigation on NH's seacoast, into cases of rhabdomyosarcoma (RMS) or pleuropulmonary blastoma (PPB). There do not appear to be any patterns to suggest a common exposure or etiology. Also, the scientific literature does not point to chemical or environmental exposures as a cause of RMS/PPB, with the majority of cases thought to occur sporadically or to be associated with genetic family cancer syndromes.[39]

Adolescent Health

Strengths

The **teen birth rate** continues trending downward, among the lowest in the country, at 8.7 per 1,000 females aged 15-19 years old in 2016; the 2015 figures were 10.2 for New Hampshire, compared to 22.3 nationally.[40]



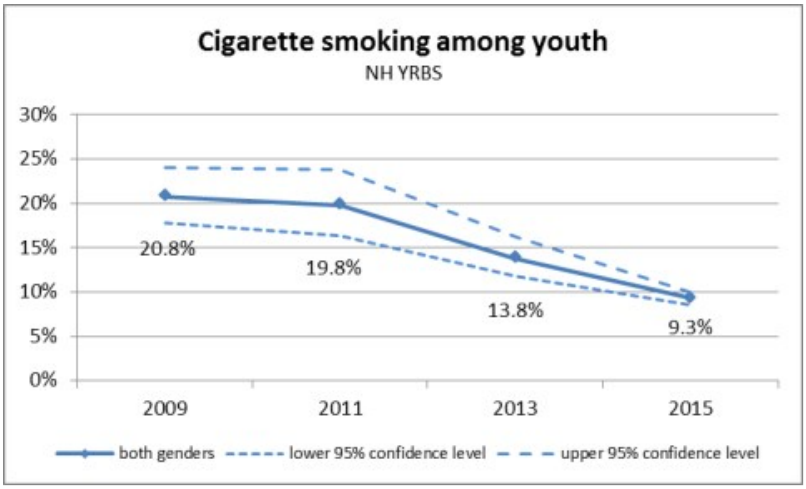
Thirteen of 15 MCH-funded CHCs provide adolescent **preventive medical visits**. The age of the targeted adolescents has risen from 10-21 to 12-21. As younger children (who are most likely to complete their annual physicals due to school immunization requirements) were excluded, a decrease in the performance outcome was expected, but the statewide average was 57% for the period 1/1/16-12/31/16, up from 50% for the period 7/1/15-6/30/16.[41]

Needs

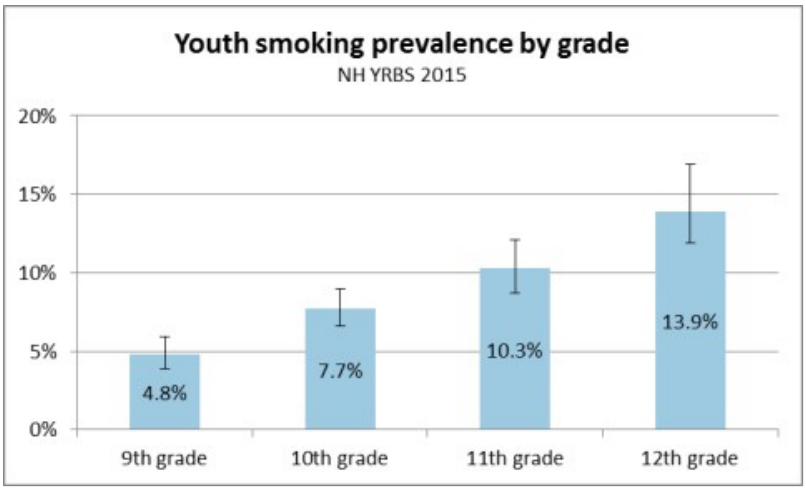
Approximately 12,000 of adolescents aged 12-17 (12% of all adolescents) per year in 2013-2014 had at least one **major depressive episode** (MDE) within the prior year. Of these, only approximately 5,000 (46.6% of all adolescents with MDE) received treatment.[42]

About 31,000 individuals aged 12-20 (19.5% of all in this age group) per year in 2013-2014 reported **binge alcohol use** within the month prior to being surveyed; nationally this figure is 14.0%.[43]

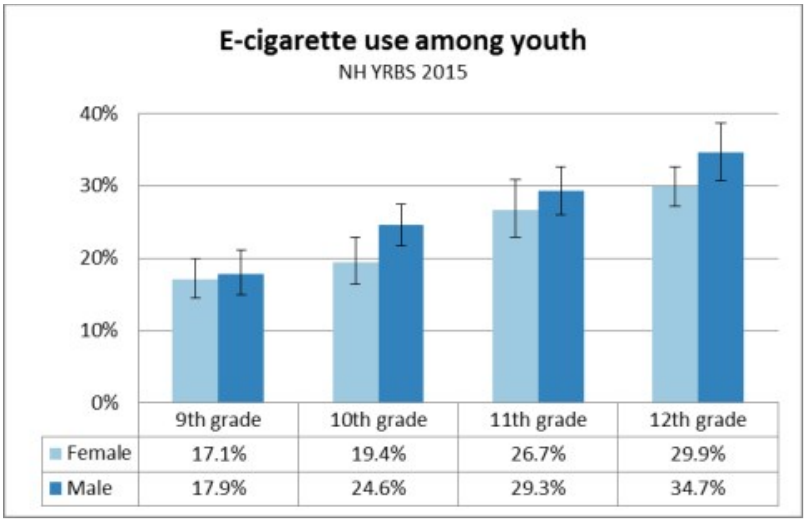
The prevalence of **cigarette smoking** in high school youth is declining overall, to 9.3% (10.2% of boys, 8.0% of girls) in 2015.[44]



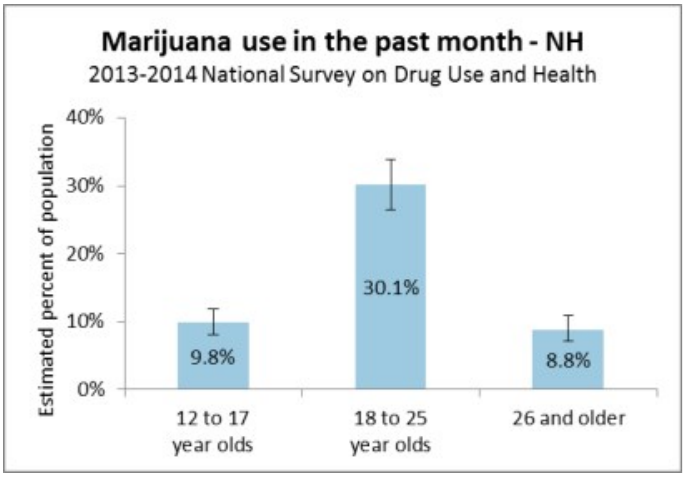
However, prevalence continues to rise with age, with 4.8% of 9th graders and 13.9% of 12th graders reporting smoking; this represents nearly a tripling of prevalence, from the 9th to the 12th grade.[45]



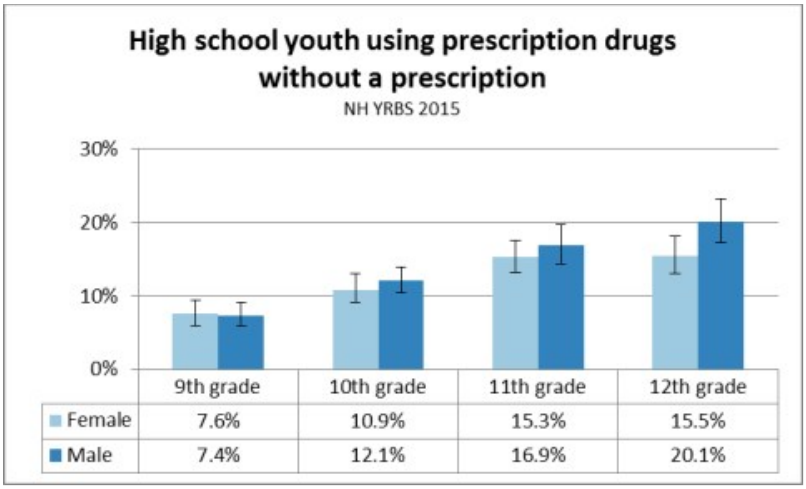
The use of **electronic cigarettes** as reported by high school youth increases with age for both genders, with boys consistently reporting slightly more use than girls:[46]



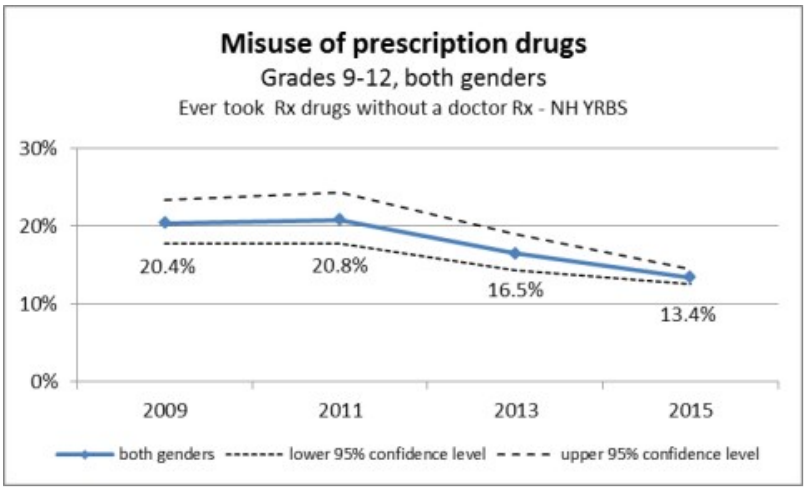
Rates of **marijuana use** among adolescents and young adults are significantly higher in NH than in the rest of the US. The state rate for 12-17 year olds is the ninth highest in the country, and the state rate for 18-25 year olds ranks fifth nationwide.[47]



The number of high school youth who have ever **used prescription drugs without a prescription** rises with age:

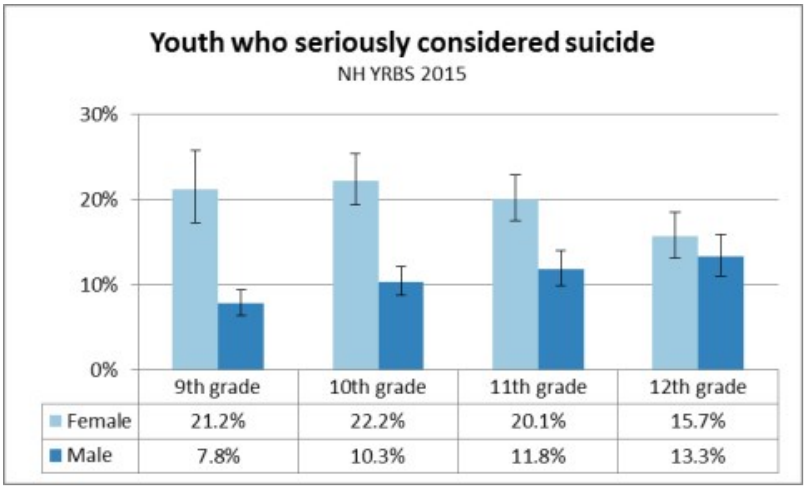


but overall has been declining in recent years, from 20.8% of students in 2011 to 13.4% in 2015.[48]



Unintentional injuries are an important source of morbidity among adolescents. The crude rate of ED visits for concussion injuries among 10-19 year olds was 640.3 per 100,000 in 2014, and 673.2 per 100,000 in 2013. The crude rate of ED visits resulting from motor vehicle crashes among 15-19 years olds was 716.1 per 100,000 in 2014, and 924.2 per 100,000 in 2013.[49]

The percentage of students who seriously considered **suicide** was higher among girls than boys; for girls, the percentage decreases over the high school years, but for boys the trend is reversed.[50]



CSHCN: Children with Special Health Care Needs

Strengths

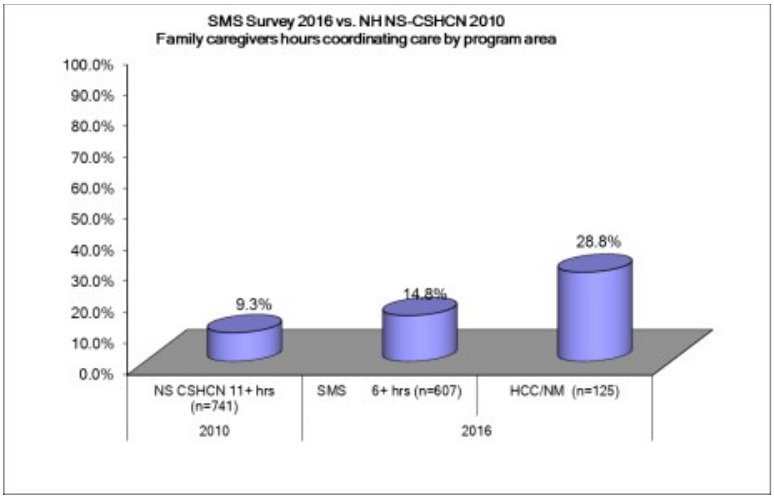
New Hampshire has performed well on the MCHB Core Outcomes. According to the NS-CSHCN from 2009/2010, New Hampshire ranked 1st in the nation for CSHCN who are served by systems of care that meet all age-relevant core outcomes, 2nd for CSHCN ages 12-17 who met all six MCHB Core Outcomes and 3rd for CSHCN ages 0-11 who met all five MCHB Core Outcomes (the Transition Core Outcome does not apply to this age group).[51]

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. Though New Hampshire, in general, (consistent with all of Region I) has high rates of insurance for CSHCN, when compared to the rest of Region I, New Hampshire is ranked 2nd to the lowest for the percentage of CSHCN who were insured for the entire previous year.[52] Efforts to assure 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.

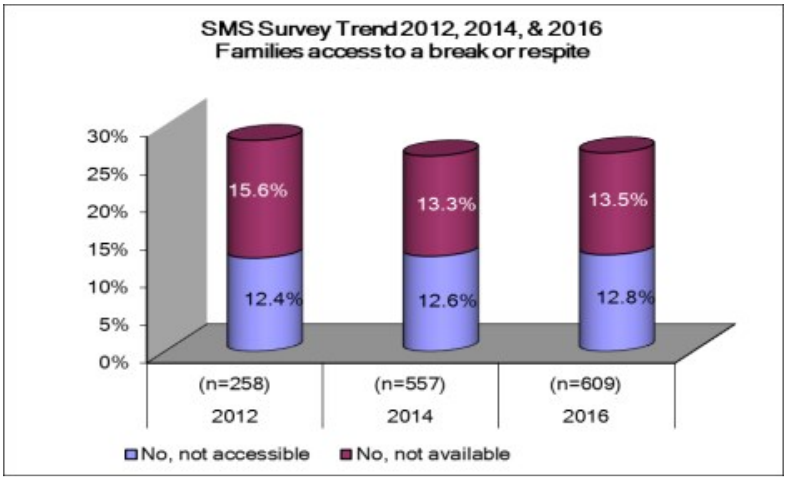
Medical Home Core Outcomes

SMS completes a survey every other year of families with CYSHCN. This survey includes questions that correlate to the national survey. SMS completed its biannual survey in 2016. Responses received indicate that the care coordination component of the Medical Home Core Outcome is a current area of need, particularly since the families enrolled in SMS report a higher need for care coordination support than the results of the last national survey.



Respite

The biannual survey completed by SMS in 2016 demonstrates that respite continues to be a significant need for families of CYSHCN. Despite a variety of efforts targeted at meeting this need the survey reveals that families report little improvement with nearly one in four families indicating that they have an unmet need for respite.



[1] Substance Abuse and Mental Health Services Administration (SAMHSA)/Behavioral Health Barometer: NH 2015; retrieved April 17, 2017 from. http://store.samhsa.gov/shin/content//SMA16-BARO-2015/SMA16-BARO-2015-NH.pdf

[2] America's Health Rankings, 2016; retrieved April 6, 2017 from http://www.americashealthrankings.org/explore/2016-annual-report/state/NH

[3] 2017 County Health Rankings – New Hampshire; retrieved April 17. 2017 from http://www.countyhealthrankings.org/sites/default/files/state/downloads/CHR2017_NH.pdf

[4] NH WISDOM (Web-based Information System for Data and Outcome Measures), citing BRFSS (Behavioral Risk Factor Surveillance System) ; retrieved April 19, 2017 from https://wisdom.dhhs.nh.gov/wisdom/

[5] 2017 County Health Rankings – New Hampshire; URL; retrieved April 17, 2017 from http://www.countyhealthrankings.org/sites/default/files/state/downloads/CHR2017_NH.pdf

[6] The State of Obesity in New Hampshire; retrieved April 6, 2017 from http://stateofobesity.org/states/nh/

[7] NH WISDOM, citing BRFSS ; retrieved April 20, 2017 from https://wisdom.dhhs.nh.gov/wisdom/

[8] 2017 County Health Rankings – New Hampshire; URL; retrieved April 17, 2017 from http://www.countyhealthrankings.org/sites/default/files/state/downloads/CHR2017_NH.pdf

[9] America's Health Rankings, 2016; retrieved April 6, 2017 from http://www.americashealthrankings.org/explore/2016-annual-report/state/NH

[10] NH Tobacco Cessation and Prevention Program; May 2017

[11] America's Health Rankings, 2016; retrieved April 6, 2017 from http://www.americashealthrankings.org/explore/2016-annual-report/state/NH
[12] NH DHHS Health Alert 20140428; New Hampshire Drug Monitoring Initiative – Situational Awareness Alert – 26 April 2017.
[13] New Hampshire Drug Monitoring Initiative – December 2016 Report; retrieved April 18, 2017 from https://www.dhhs.nh.gov/dcbcs/bdas/documents/dmi-december-16.pdf
[14] Ibid.
[15] NH WISDOM, citing NH DVRA (Division of Vital Records Administration) death certificate data; retrieved April 19, 2017 from https://wisdom.dhhs.nh.gov/wisdom/
[16] NH Zika Virus Summary Report, NH Bureau of Infectious Disease Control; May 3, 2017
[17] Behavioral Risk Factor Surveillance System (BRFSS), Prevalence & Trends Data [online] 2015; retrieve April 3, 2017 from https://www.cdc.gov/brfss/brfssprevalence/
[18] MCH Perinatal Client Data Forms (PCDF) data, accessed May 7, 2017
[19] NH Division of Vital Records Administration (NH DVRA) birth table, accessed June 13, 2017
[20] BRFSS Prevalence & Trends Data [online] 2015; retrieved April 3, 2017 from https://www.cdc.gov/brfss/brfssprevalence/
[21] Ibid.
[22] State Fiscal Year 2016 Annual Report, the NH Governor's Commission on Alcohol and other Drug Abuse, Prevention, Treatment and Recovery.
[23] BRFSS Prevalence & Trends Data [online] 2015; retrieved on April 3, 2017 from https://www.cdc.gov/brfss/brfssprevalence/
[24] NH WISDOM, citing BRFSS; retrieved April 20, 2017 from https://wisdom.dhhs.nh.gov/wisdom/
[25] NH Pregnancy Risk Assessment Monitoring System (PRAMS), 2014; retrieved April 3, 2017 from https://www.dhhs.nh.gov/dphs/bchs/mch/prams/documents/databook-2014.pdf
[26] NH PRAMS-Medicaid, 2014; retrieved May 1, 2017 from. https://www.dhhs.nh.gov/dphs/bchs/mch/prams/documents/medicaid-databook-2014.pdf
[27] MCH PCDF data, accessed May 7, 2017
[28] NH Family Planning Program, April 2016
[29] NH PRAMS 2014; retrieved april 6, 2017 from https://www.dhhs.nh.gov/dphs/bchs/mch/prams/documents/databook-2014.pdf
[30] NH DVRA birth file; accessed April 3, 2017
[31] America's Health Rankings, 2016; retrieved April 6, 2017 from http://www.americashealthrankings.org/explore/2016-annual-report/state/NH
[32] Ibid.
[33] NH Public Health Issue Brief: Sleep-Related Infant Deaths, 2011-2015 (draft April 2017)
[34] NH PRAMS 2014; retrieved April 6, 2017 from. https://www.dhhs.nh.gov/dphs/bchs/mch/prams/documents/databook-2014.pdf
[35] Statewide Neonatal Abstinence Syndrome Improvement Project 2015
[36] National Immunization Survey, ChildVaxView; retrieved April 6, 2017 from https://www.cdc.gov/vaccines/imz-managers/coverage/childvaxview/data-reports/7-series/reports/2015.html
[37] Hospital discharge data from MCH Injury Surveillance program; April 25, 2017
[38] The State of Obesity in New Hampshire; retrieved April 6, 2017 from http://stateofobesity.org/states/nh/
[39] Pediatric Seacoast Cancer Cluster Investigation – Summary of Investigation Findings as of April 30, 2017; retrieved from https://www.dhhs.nh.gov/dphs/gtfscc/documents/investigation-summary-04302017.pdf
[40] NH DVRA birth file, accessed April 25, 2017
[41] Personal communication from the MCH Quality Improvement Program Manager; April 2017.
[42] SAMHSA Behavioral Health Barometer: NH 2015; retrieved April 17, 2017 from http://store.samhsa.gov/shin/content//SMA16-BARO-2015/SMA16-BARO-2015-NH.pdf
[43] Ibid.
[44] NH WISDOM, citing CDC Youth Risk Behavior Survey (YRBS); retrieved May 3, 2017 from https://wisdom.dhhs.nh.gov/wisdom/
[45] Ibid.
[46] Ibid.
[47] Collective Action Issue Brief #4: Marijuana Use in New Hampshire; retrieved April 6, 2017 from https://www.dhhs.nh.gov/dcbcs/bdas/documents/issue-brief-marijuana-use.pdf
[48] NH WISDOM, citing YRBS; retrieved April 19, 2017 from. https://wisdom.dhhs.nh.gov/wisdom/
[49] Hospital discharge data, from MCH Injury Prevention program; April 24, 2017.
[50] NH WISDOM, citing YRBS; retrieved April 19, 2017 from. https://wisdom.dhhs.nh.gov/wisdom/
[51] National Survey of Children with Special Health Care Needs. NS-CSHCN 2009/10. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved from www.childhealthdata.org
[52] Ibid

FY 2017 Application/FY 2015 Annual Report Update

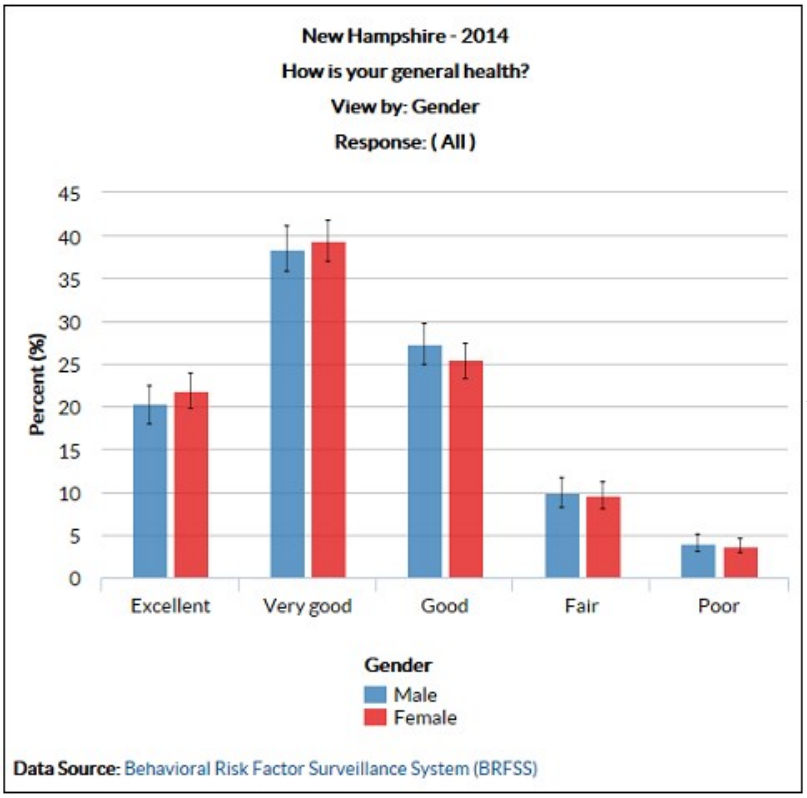
In this first interim year (FY17) of the FY16-FY20 Block Grant cycle, the process of needs assessment is ongoing. National and state surveys and reports for NH are collected and systematically reviewed. Public input is acquired through ongoing satisfaction surveys instituted in all MCH-funded contractors, 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

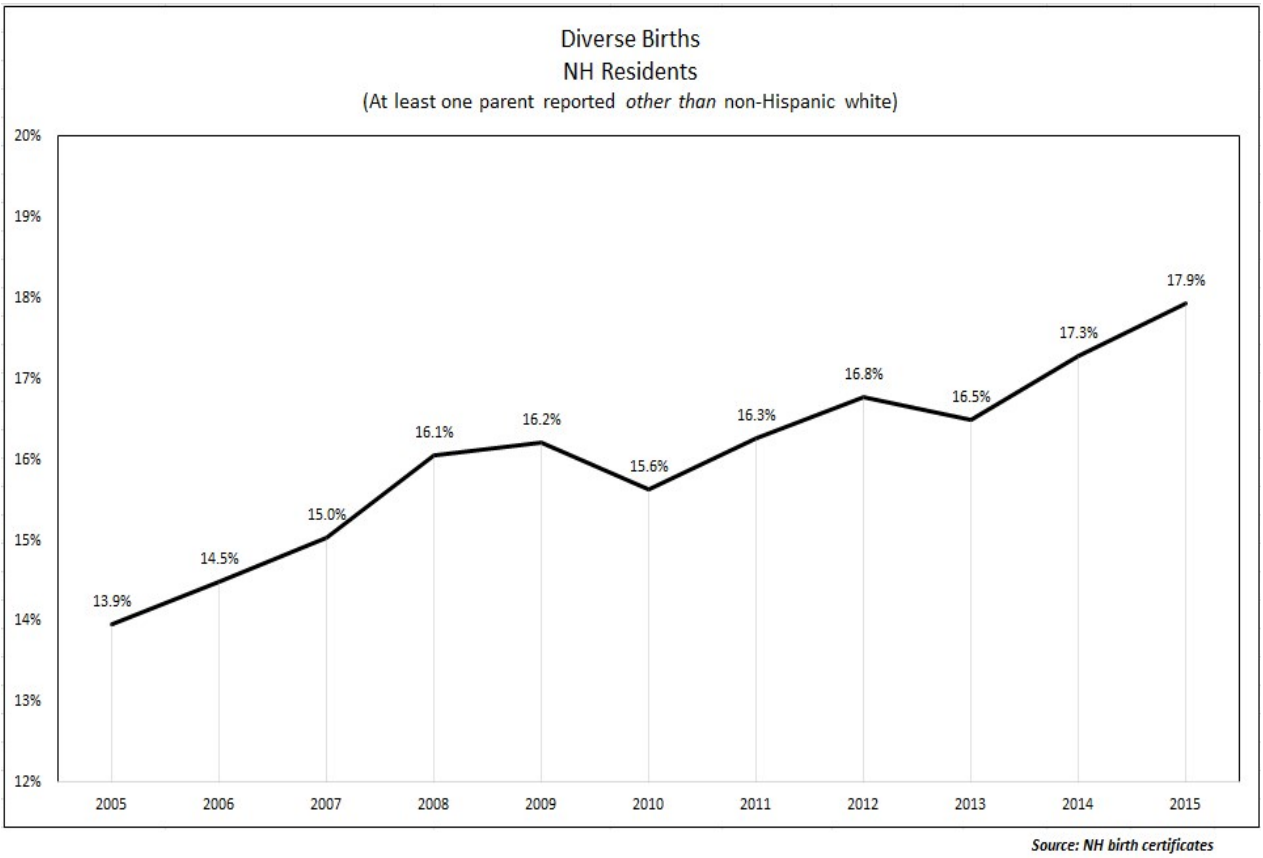
Strengths

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]

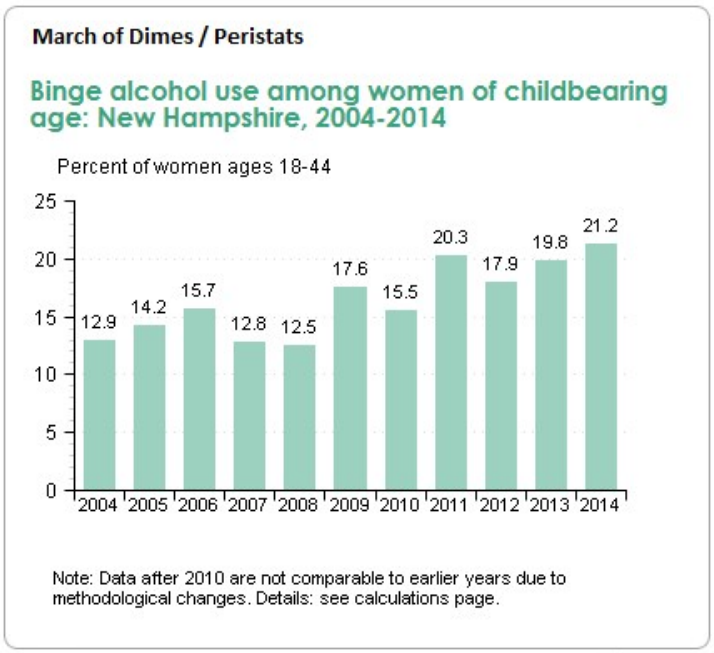
In 2015, there were 12,420 **births** to resident women; this is an uptick from previous years (12,285 in 2014 and 12,380 in 2013).[5] The percentage of births of babies of color continues to rise,[6] reflecting the increasing diversity of NH's population.



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

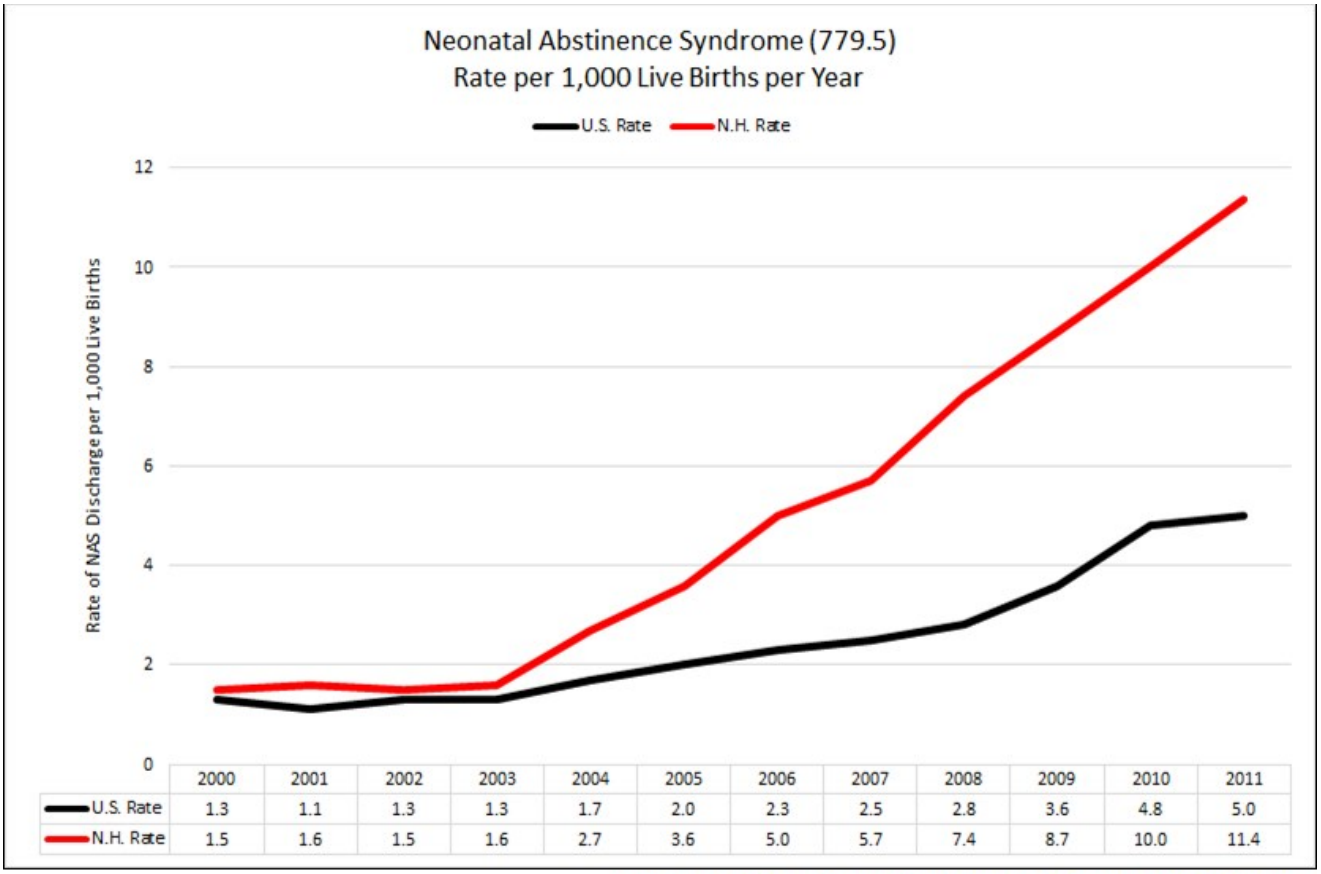
Only 6.7% of births in 2015 were **low birth weight** (<2500 g), compared to 6.9% in 2014 and 6.7% in 2013.[15]

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.



	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

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]

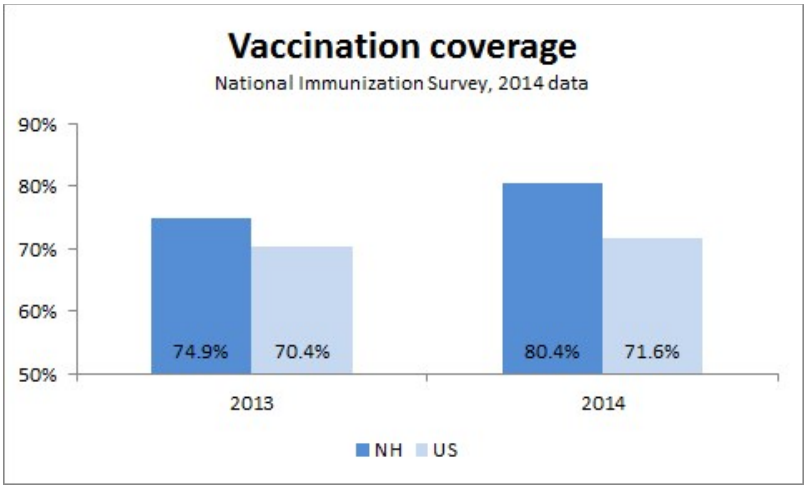
Emerging issues

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

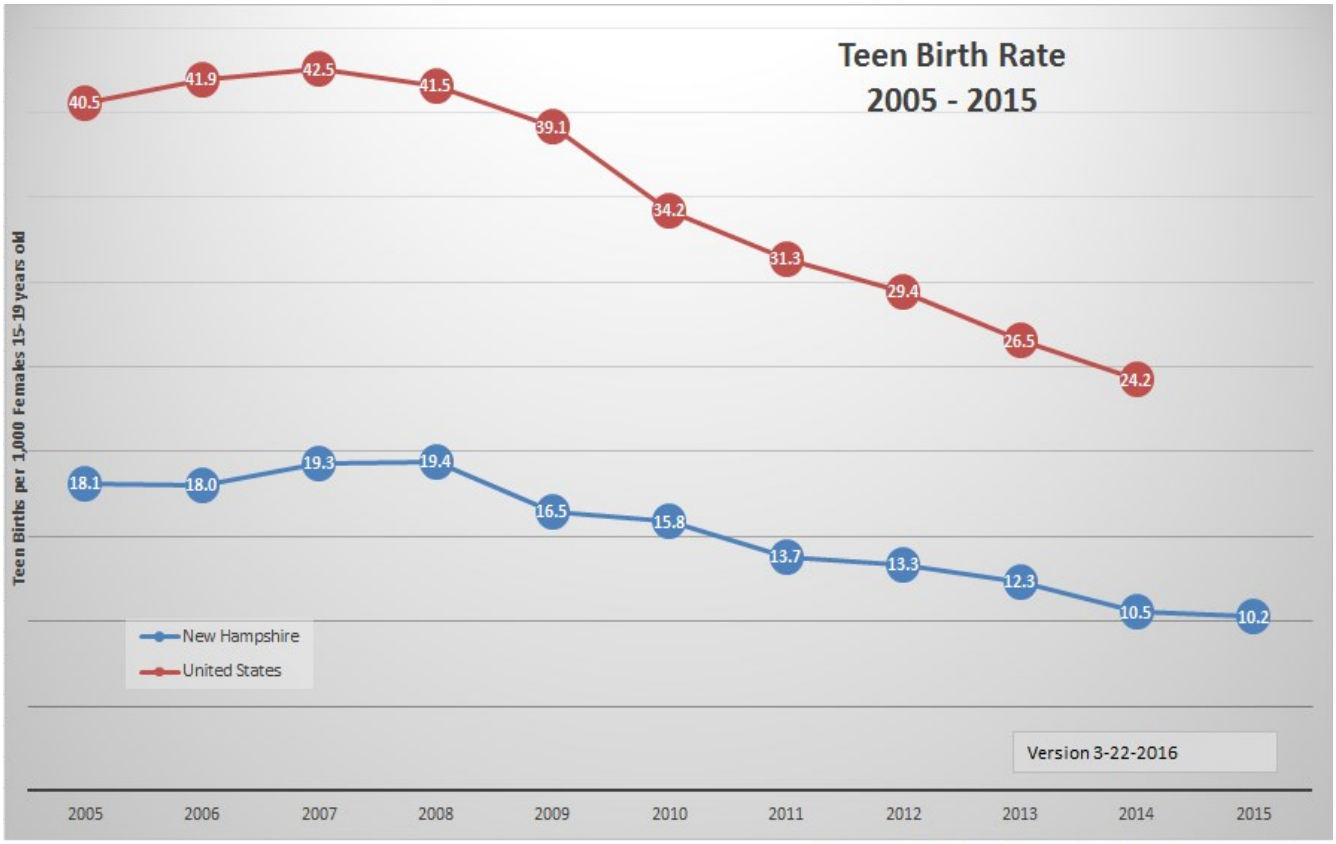
Injuries remain a leading cause of morbidity in children. The in-patient hospitalization rate for non-fatal injuries was 50.0 per 100,000 children in 2010 and 68.5 per 100,000 in 2011. Motor vehicle crashes in 2010 resulted in 103.2 emergency department visits per 100,000 children ages 0-9, and 80.4 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

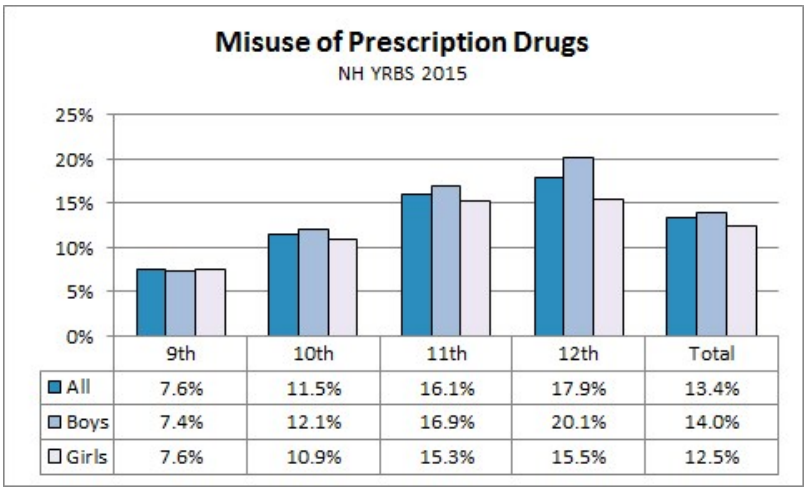
New Hampshire continues to excel in its **teen birthrate**. Teen births in 2015 numbered 468, or 10.2 per 1000 females.[25]



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

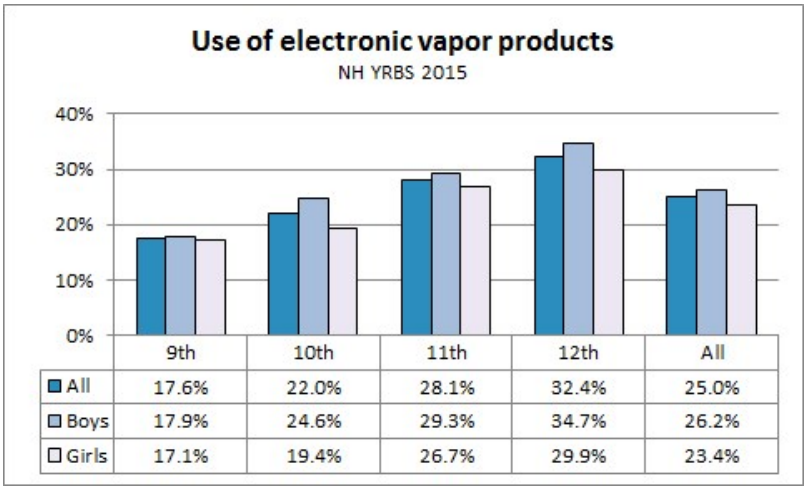
Unintentional injuries remain the leading cause of death among youth aged 10-24 years, and motor vehicle crashes account for the largest proportion of these.[28] Among NH high school students, 7.7% report never or rarely wearing a **seatbelt** when driving; for 18 year olds and older, this figure is 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 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			

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]

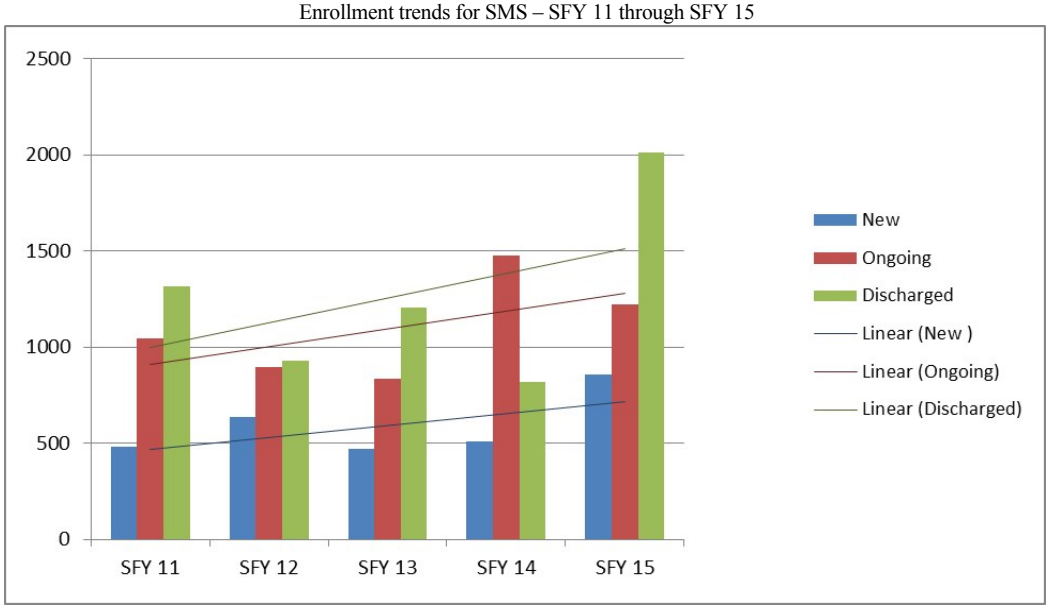
Needs

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.

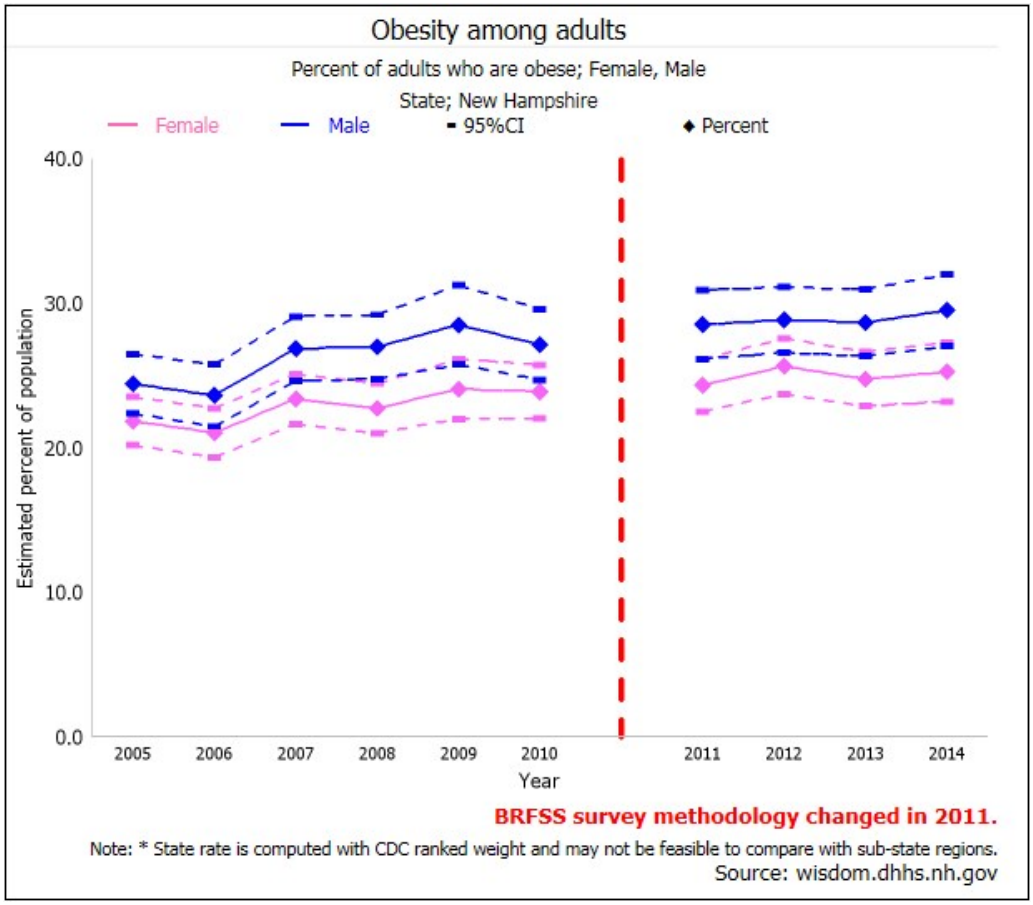
Cross-cutting/Life course

Needs

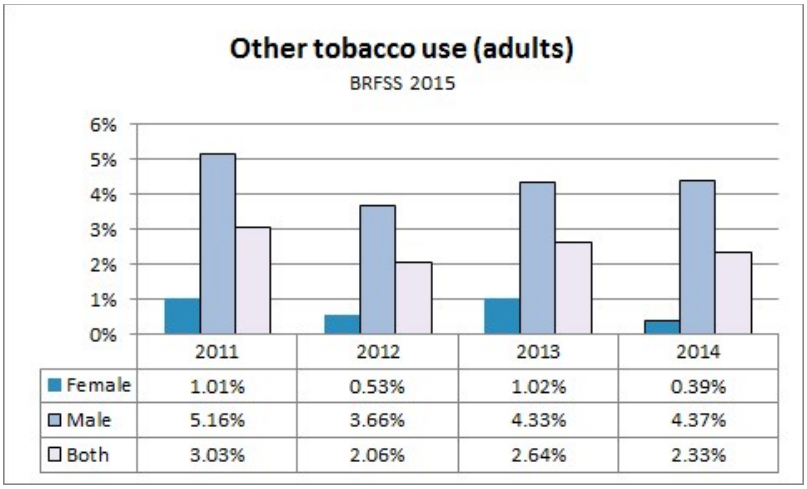
In 2014 around 45,000 adults (4.3% of all adults) had a serious **mental illness** within the previous year; in 2013 the figures were around 46,000 adults (4.5% of the adult population). The percent receiving treatment was 49.7% in 2013, declining to 46.1% in 2014.[39]

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]

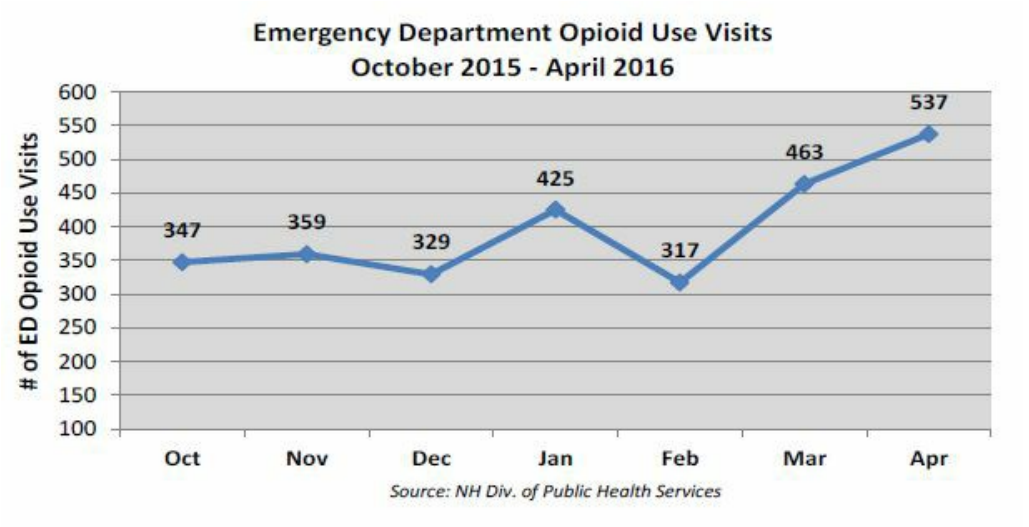
Obesity in NH remains more prevalent among men than women, and the trend seems relatively stable, with 25.3% of women classified as obese in 2014 (compared to 24.8% in 2013 and 25.7% in 2012) and 29.5% of men classified obese in 2014 (compared with 28.7% in 2013 and 28.9% in 2012).[41]



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]



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]

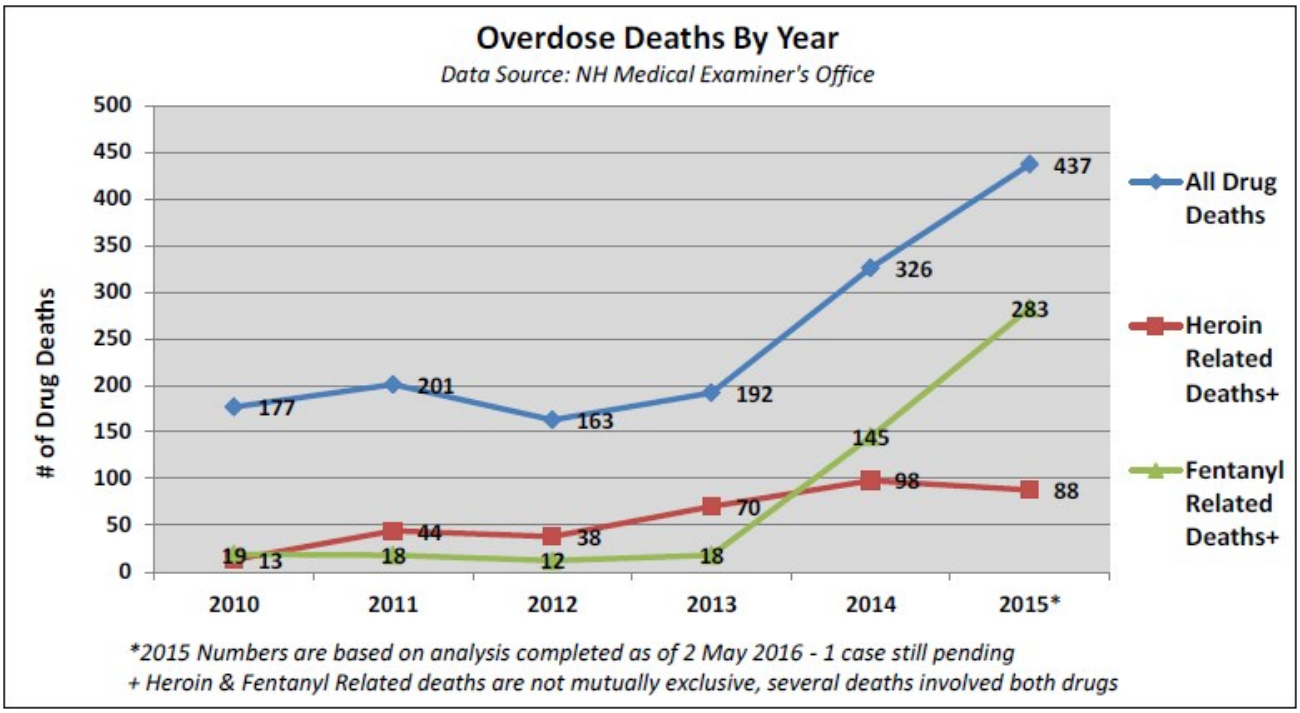
Gender	Feb	Mar	Apr	% Change
Female	158	208	233	12%
Male	159	255	304	19%
Totals	**317**	**463**	**537**	**16%**

Source: NH Div. of Public Health Services

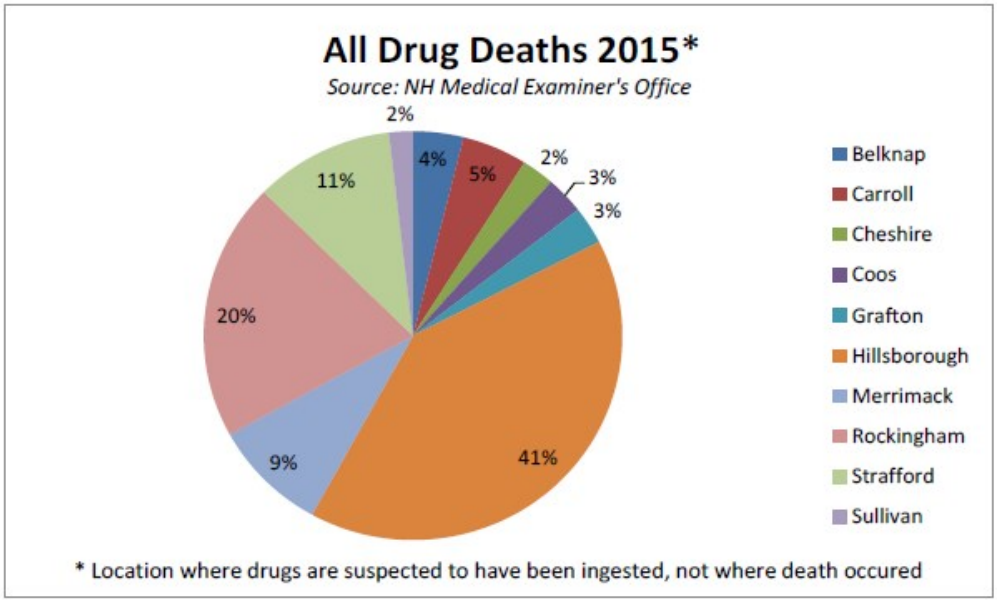
Age	Feb	Mar	Apr	% Change
0-9	0	0	1	Incalculable
10-19	12	12	22	83%
20-29	136	188	215	14%
30-39	86	143	183	28%
40-49	34	60	60	0%
50-59	29	38	38	0%
60+	20	22	18	-18%
Totals	**317**	**463**	**537**	**16%**

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.

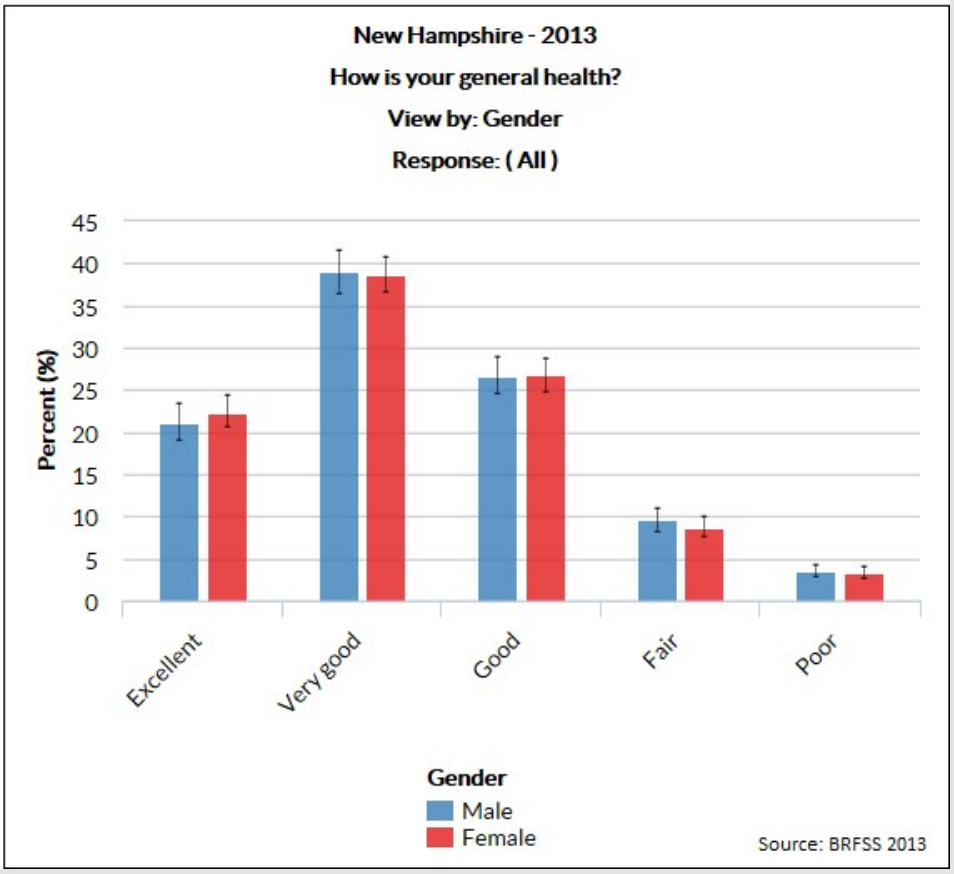
II.B.2. Findings

II.B.2.a. MCH Population Needs

Women/Maternal Health

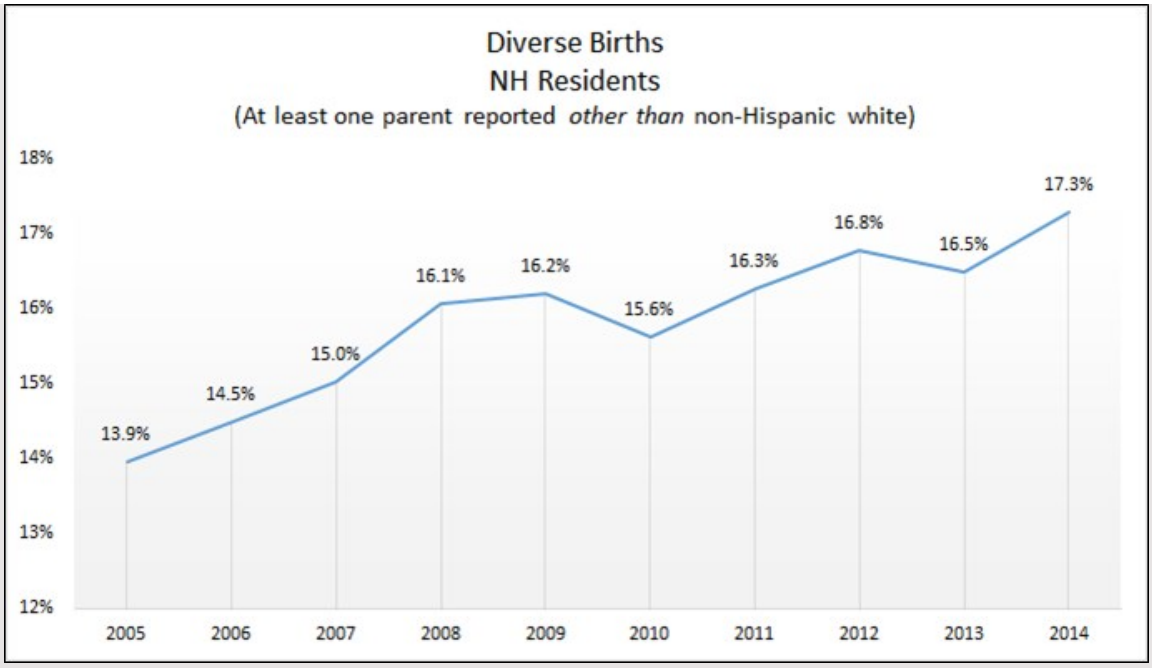
Strengths

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.

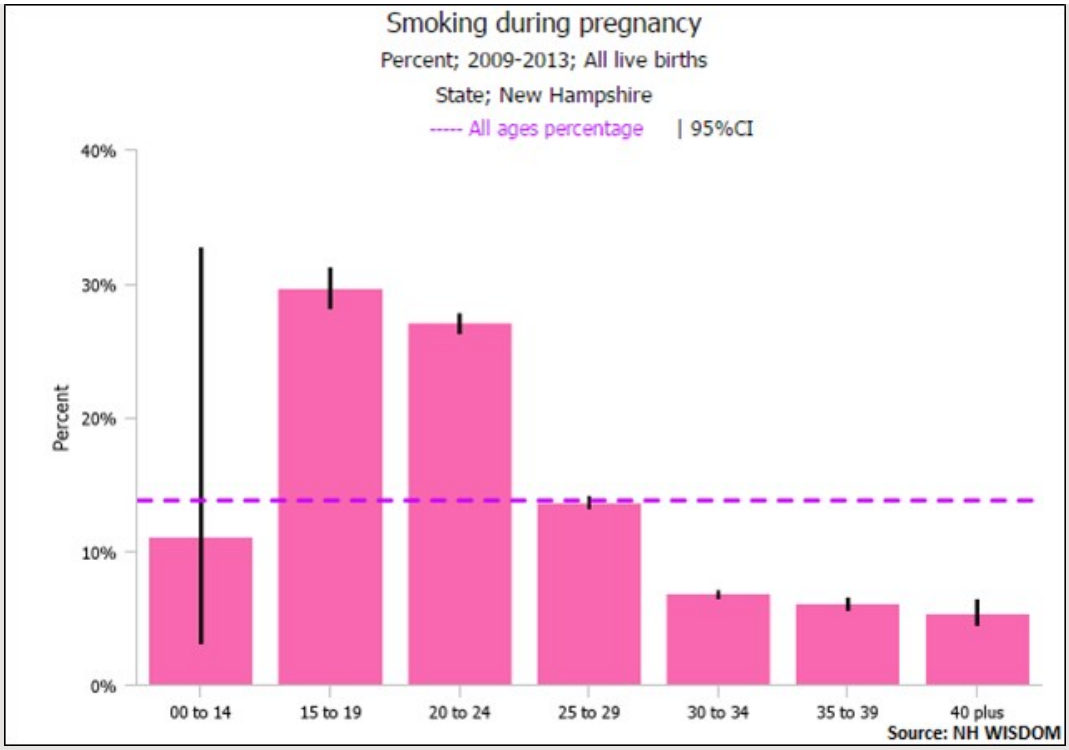


Needs

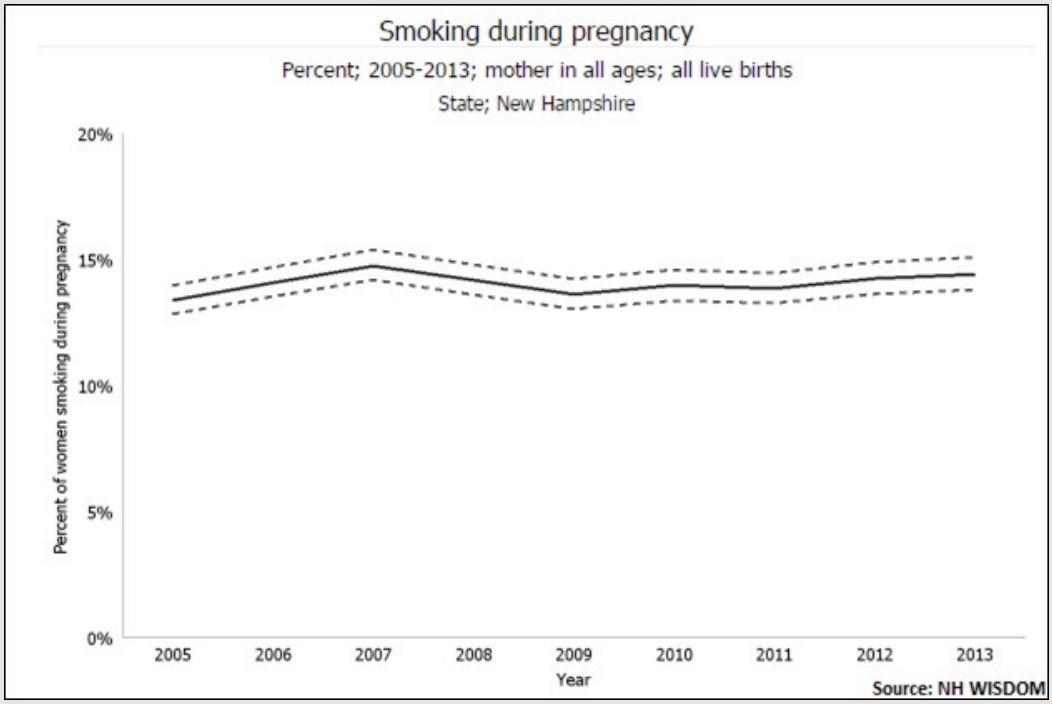
In 2013, an estimated 24.8% of women were **obese** (BMI >=30), down from 26.04% in 2012. In 2013 some 26.7% of the total population (both genders) were classified as obese[20] and these numbers change little from year to year (see the Cross-cutting section).

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]

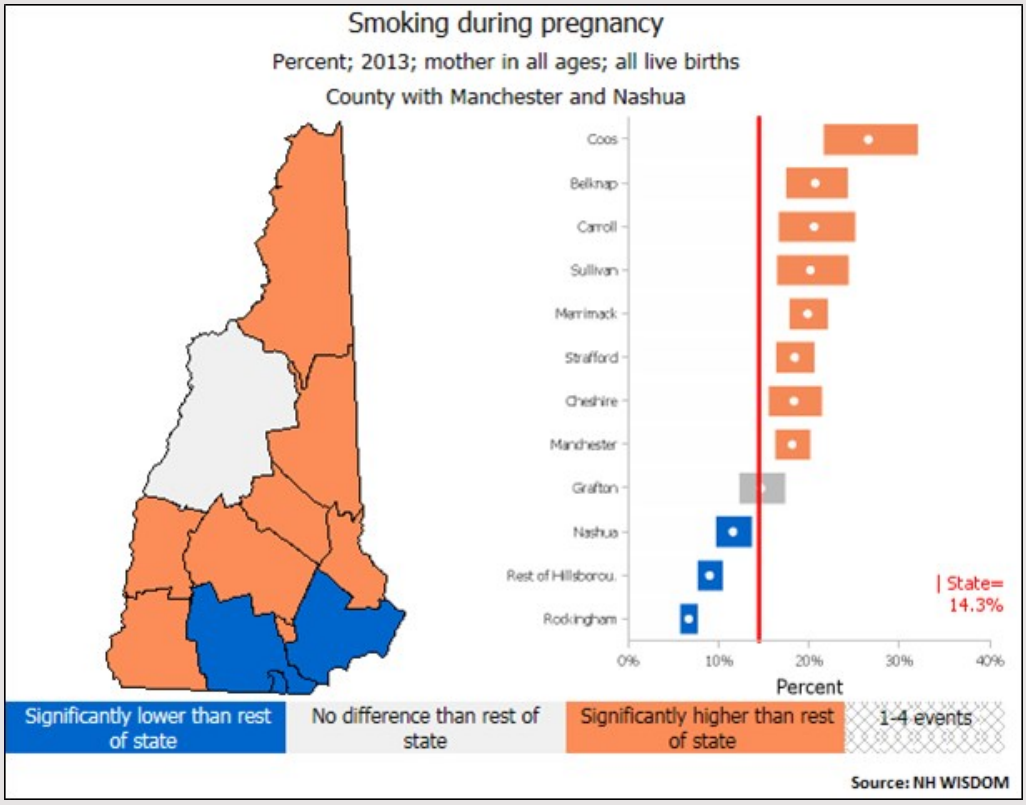
Smoking during pregnancy is virtually unchanged since 2001, with the highest rate among younger women: 29.7% of all 15-19 years olds giving birth in 2009-2013 reported smoking during pregnancy.[22] Smoking is especially prevalent among women on Medicaid: 34% were smokers in 2014, compared to 6% among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

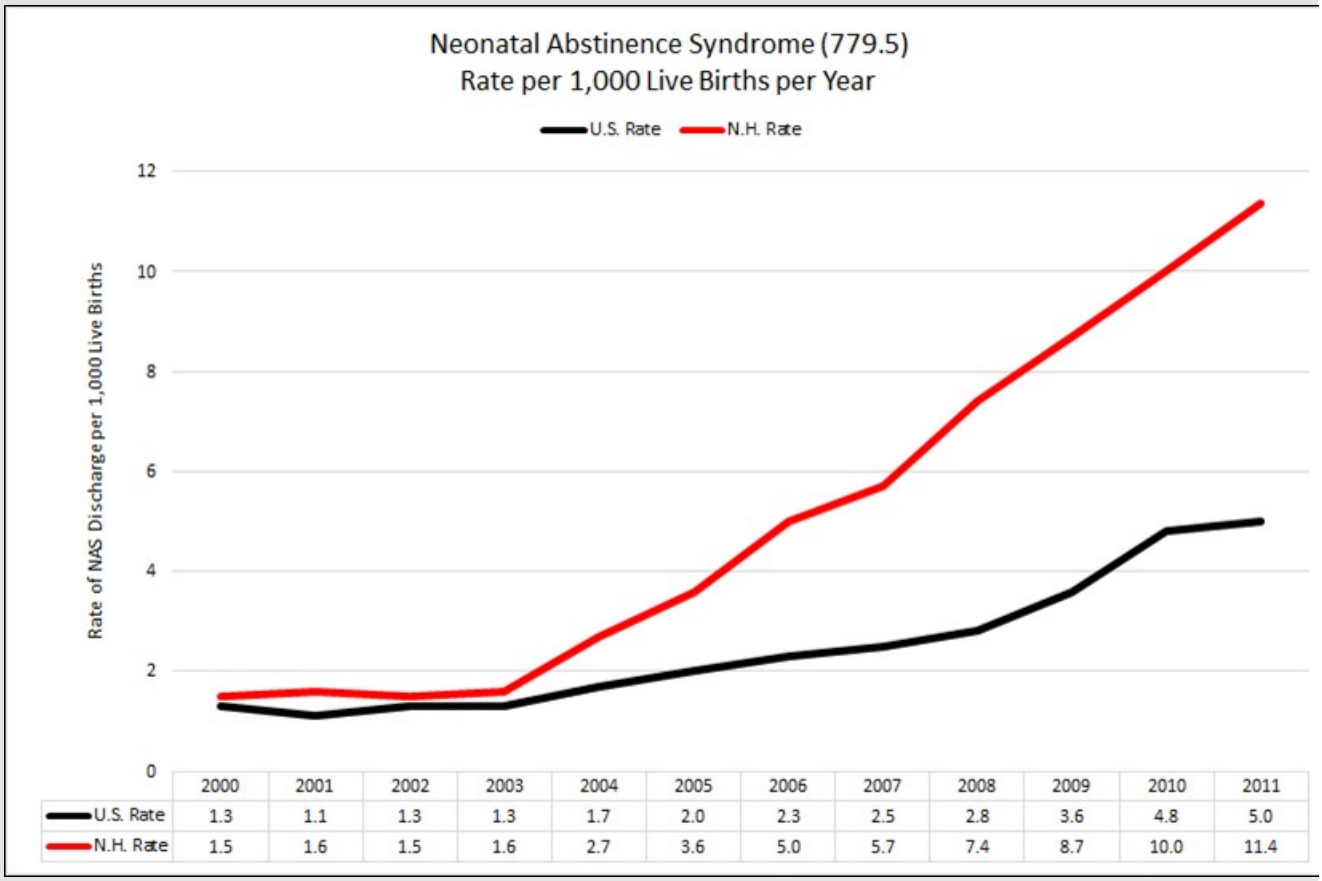
Premature birth (<37 weeks gestation) in NH in 2013 is reported as 9.0% of live births; since 2002 the rate of infants born preterm has declined one percentage point. Racial disparities are evident in the 2010-2012 preterm birth data, with the following racial distribution: 13.4% for black infants, 11.3%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

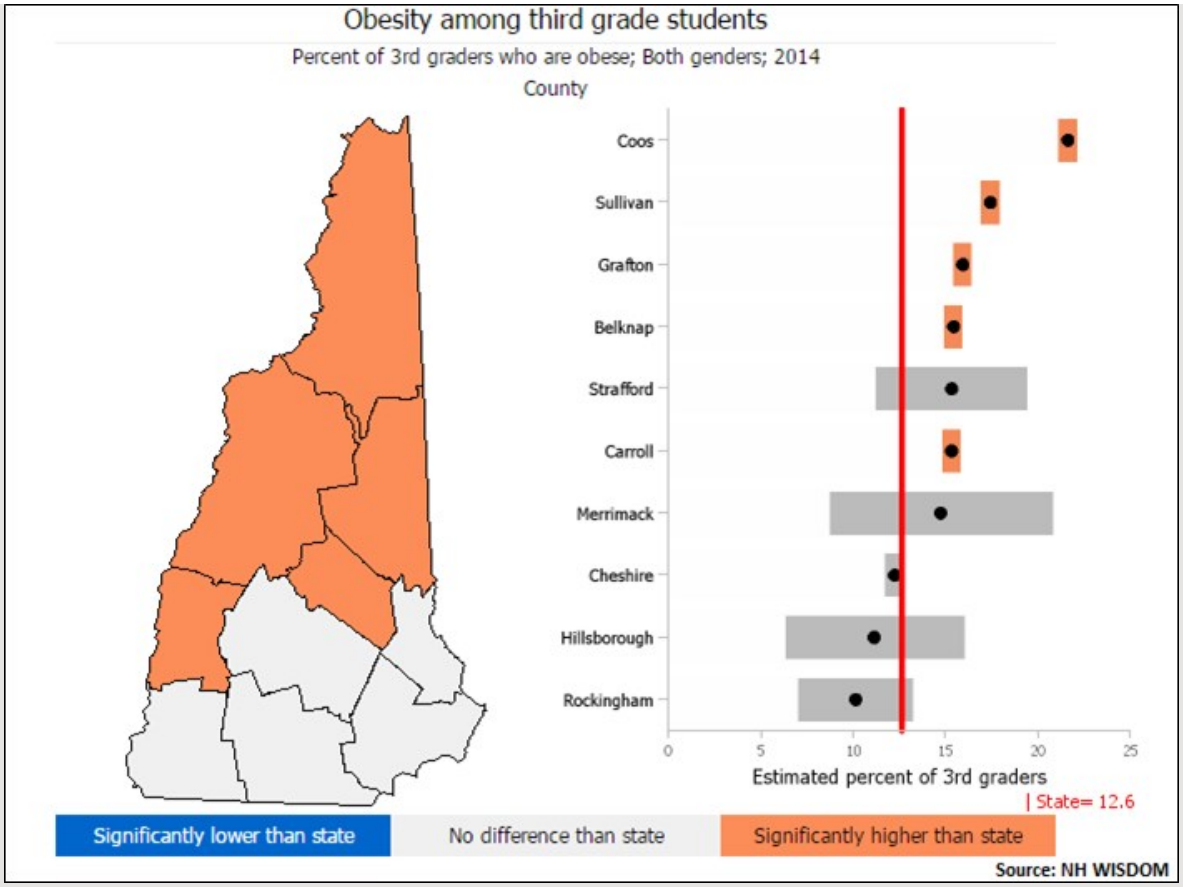
Obesity among WIC enrolled children

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%

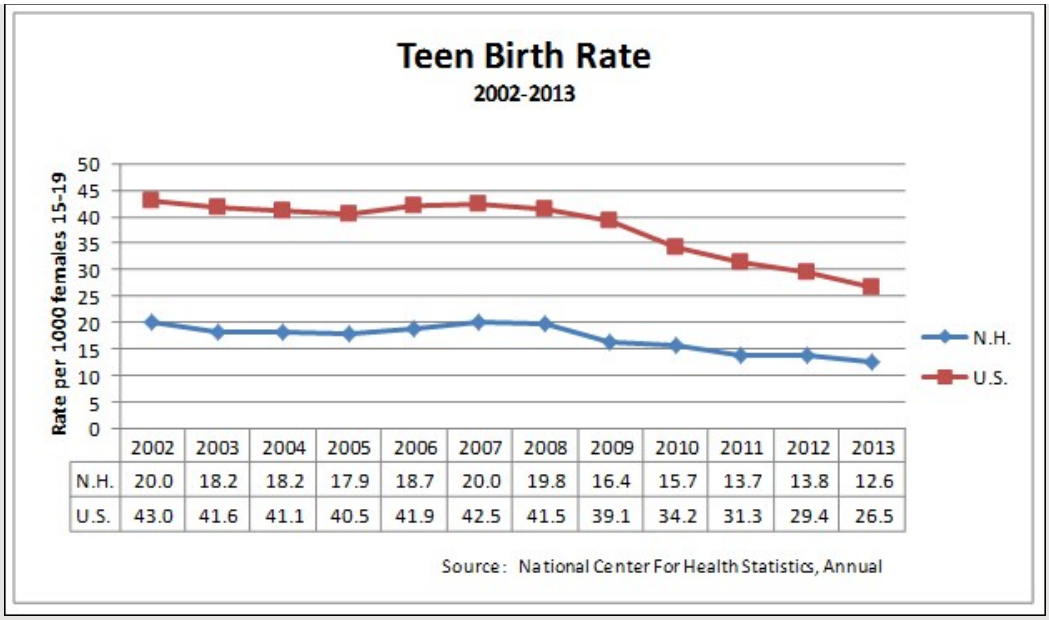
Data from the New Hampshire 2013-2014 Third Grade Healthy Smiles - Healthy Growth Survey found that 12.6% of third graders were obese, compared with 18.0% in 2009; this reflects a substantial improvement but there were strong regional disparities, with the northern counties showing significantly higher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

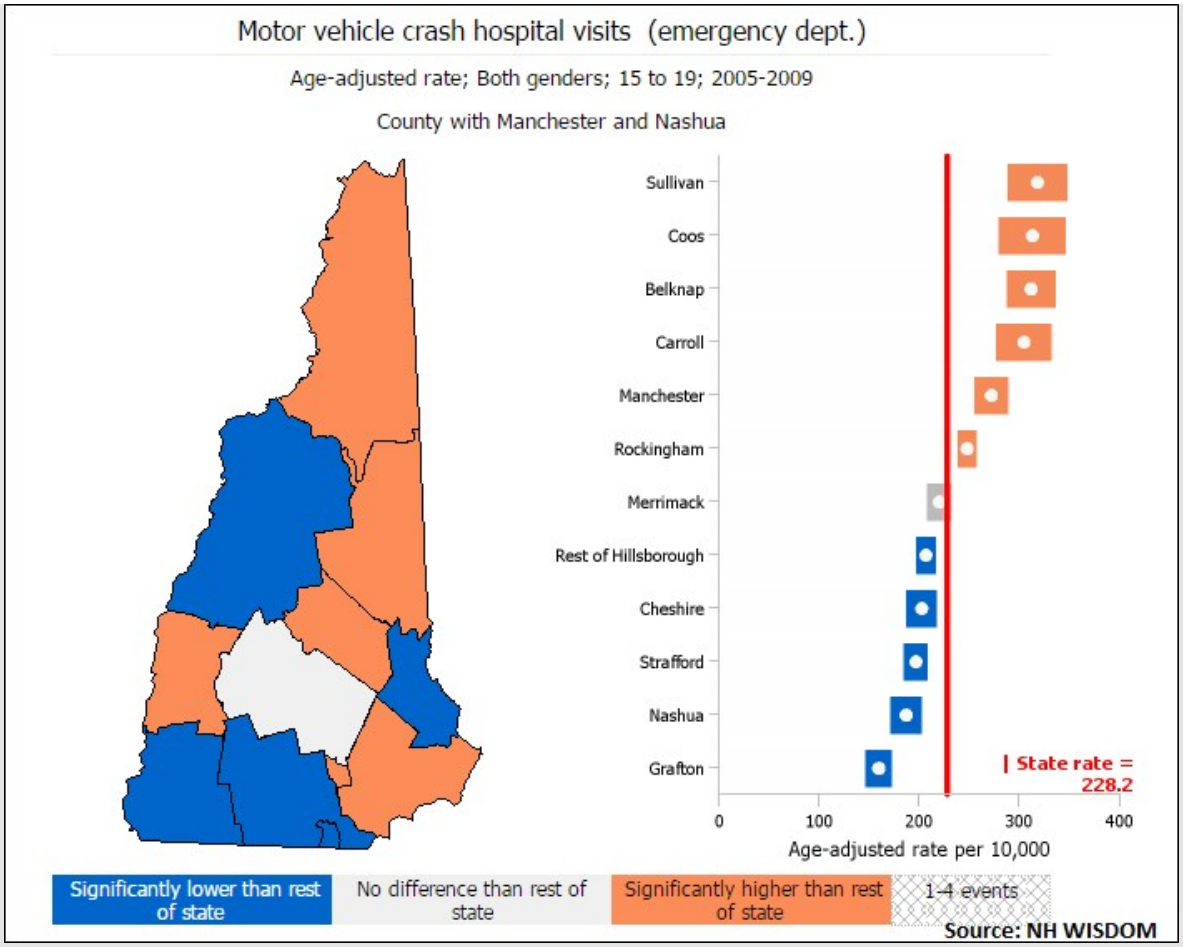
Teen births in 2014 numbered 486 (3.96% of 12,281 total births). Of these. 110 (0.9% of total births) of the mothers were 15-17 years old, and 374 (3.0% of total births) were 18-19 years of age.[46]

Needs

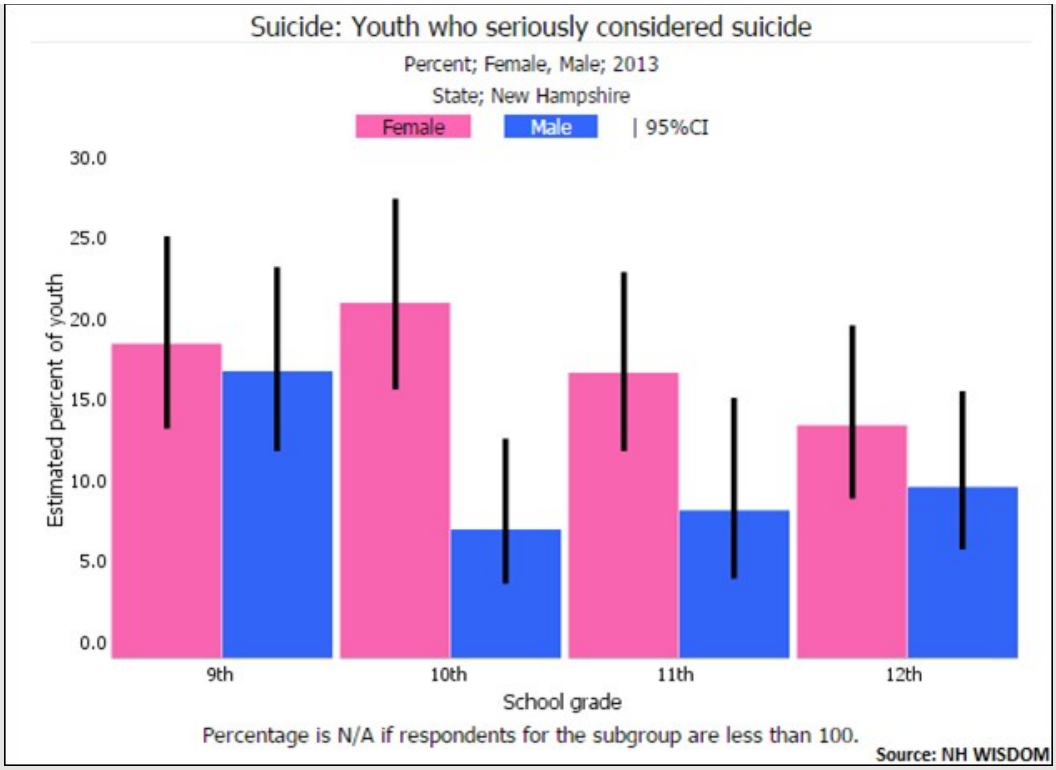
Unintentional injuries are the leading cause of death among youth aged 10-24 years,[47] and motor vehicle crashes account for the largest proportion of these. Motor vehicle crash-related hospital emergency department (ED) visits for adolescents 15-19 years have been steadily declining since 2000, but 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]



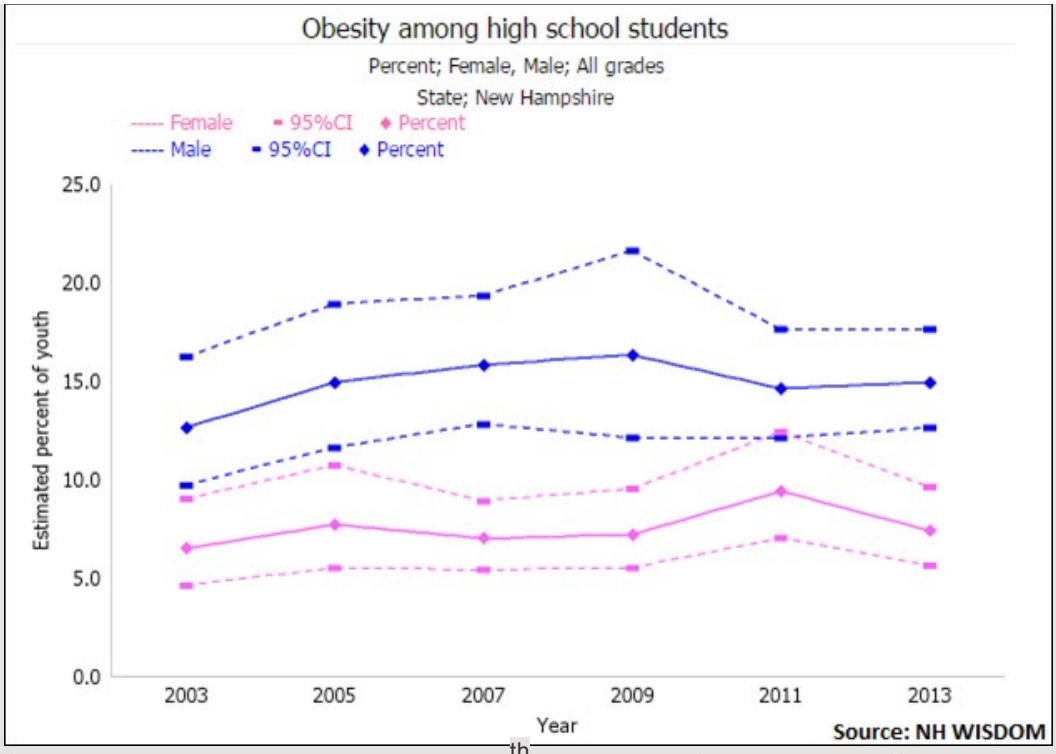
Violence is a stark reality that many adolescents live with, as the following statistics show:

- 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]

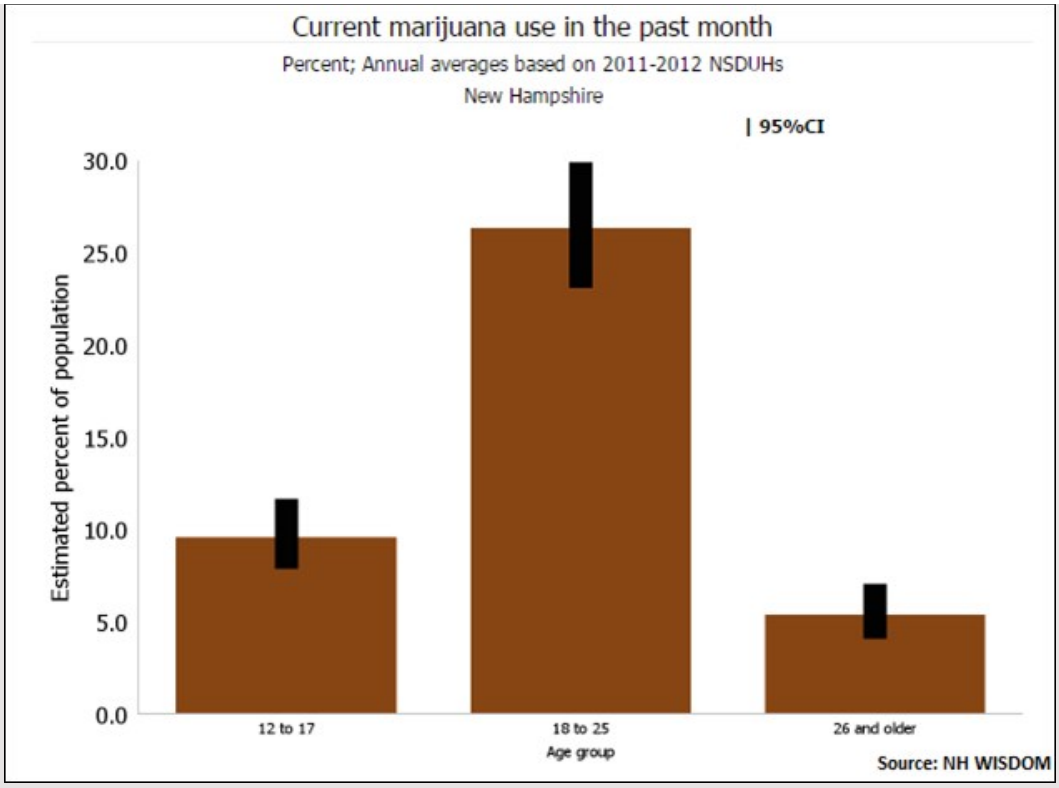
Around 10,000 youth (10.2% of all NH youths) per year in 2008-2012 had at least one **major depressive episode** within the year prior to being surveyed; 51.4% received treatment for depression, but 48.6% did not. The percentage receiving treatment through the public mental health system who reported 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

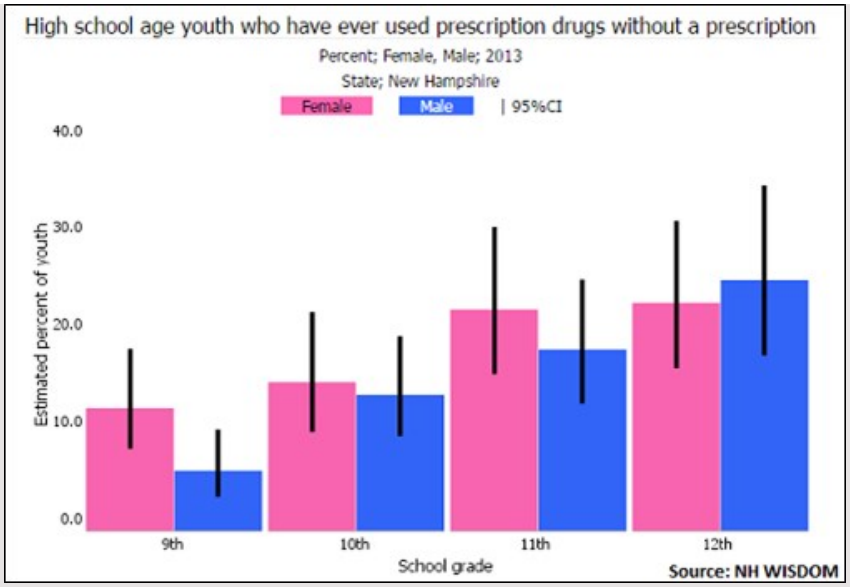
State; New Hampshire

		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

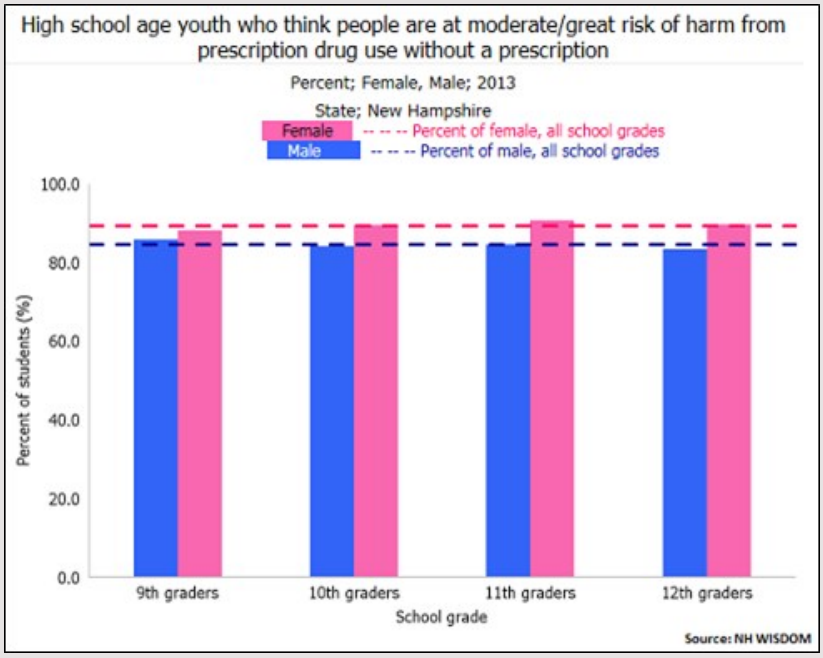
Percentage is N/A if respondents for the subgroup are less than 100.

Source: NH WISDOM

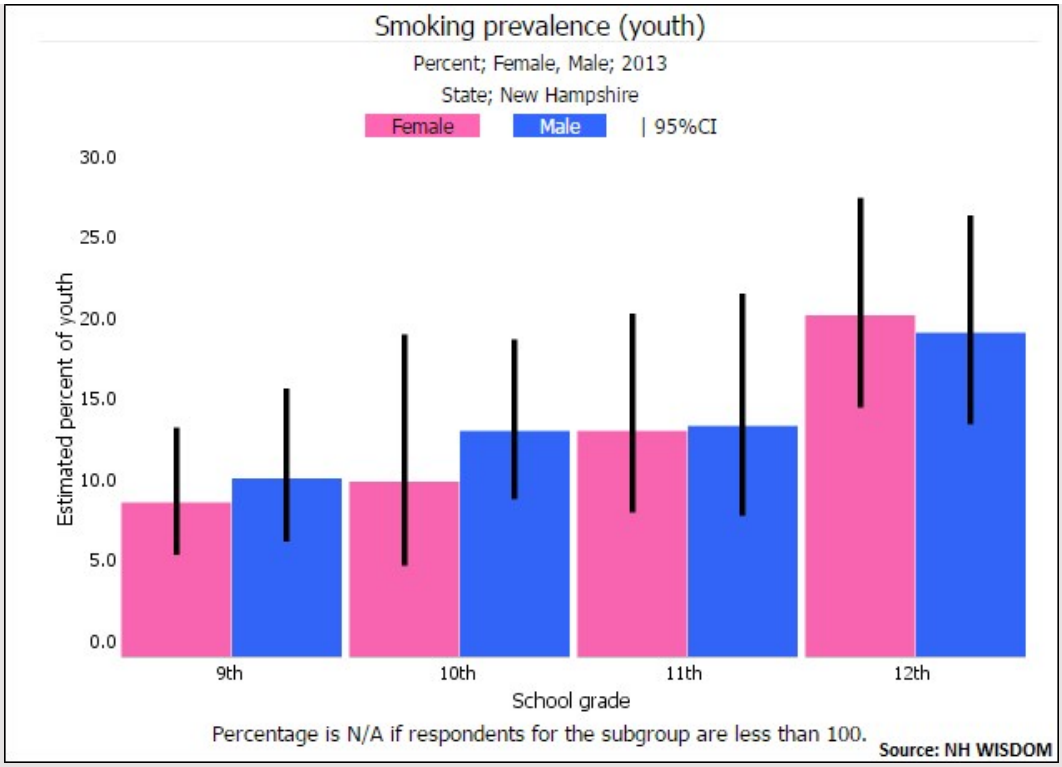
The misuse of **prescription drugs** poses significant health risk and it can be a contributing factor to misuse of other drugs and a cause of unintentional overdose and death. In 2013, 22.4% of 12th grade girls and 24.6% of 12th grade boys reported ever having used prescription drugs without a prescription; 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.

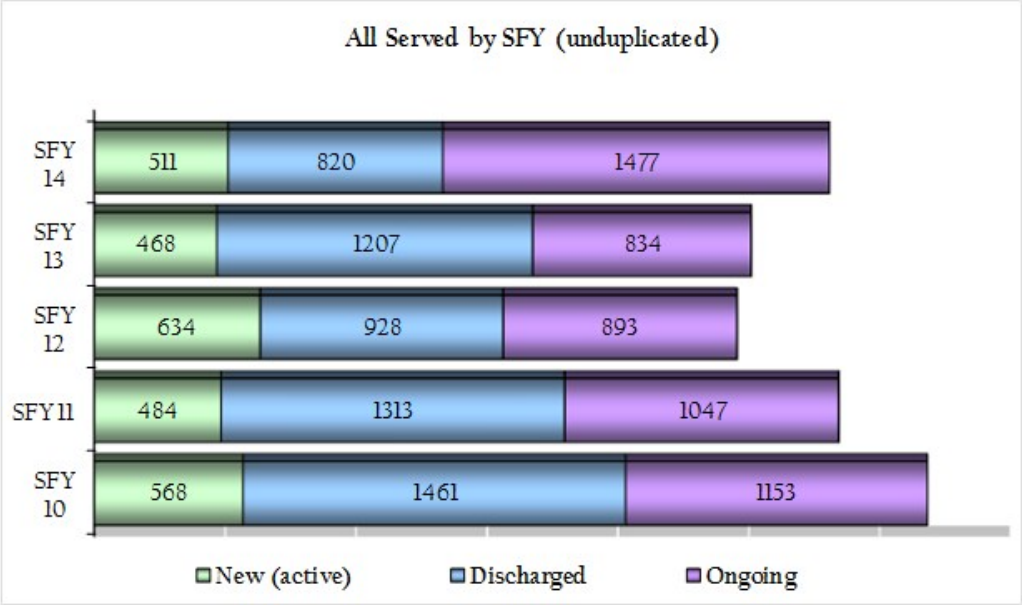
Medical Home Core Outcomes

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.

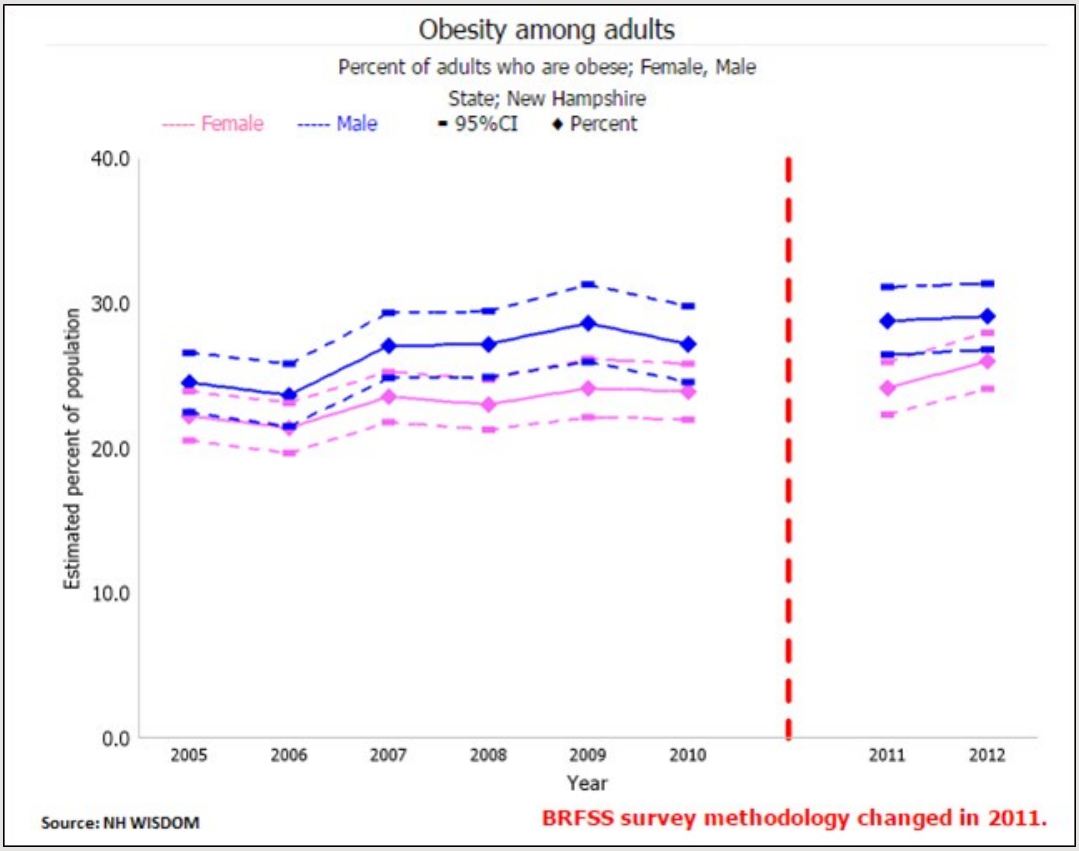
Cross-cutting/Life course

Needs

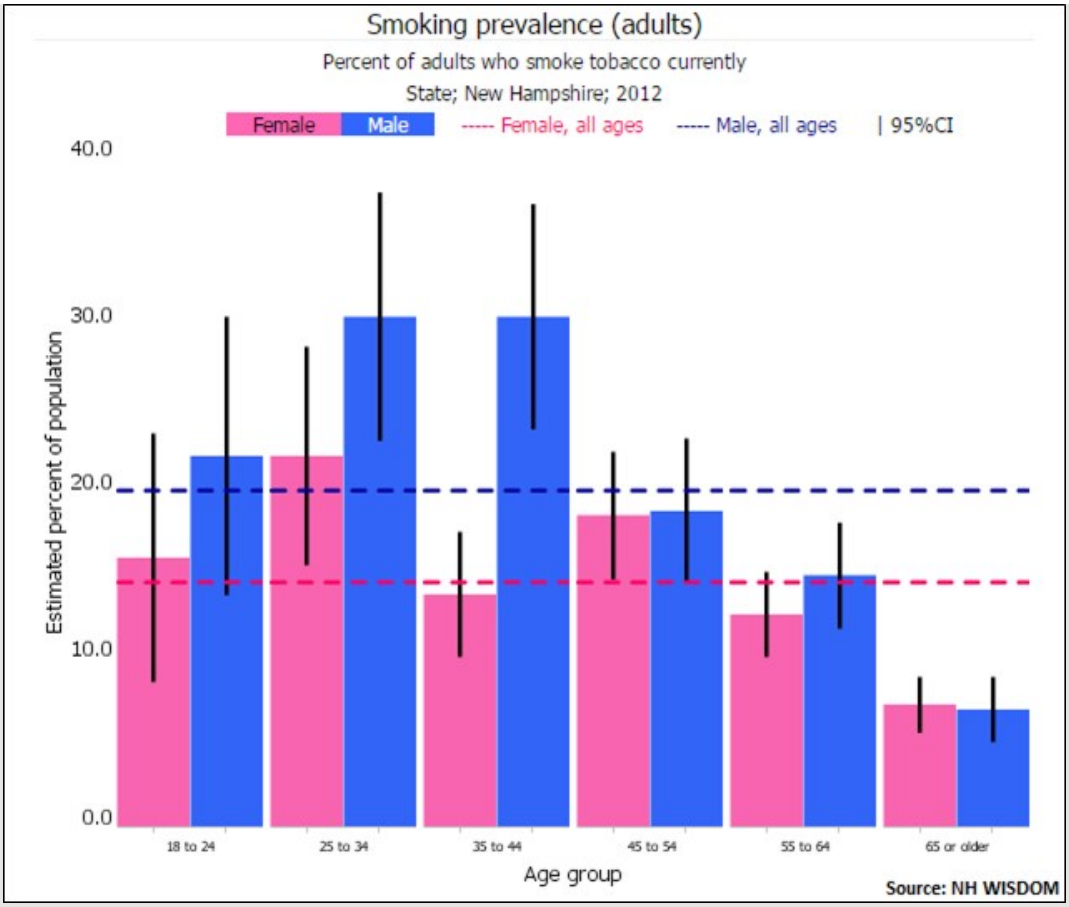
Mental illness is a serious cross-cutting issue. In NH, about 46,000 adults (4.5% of all adults) per year in 2008-2012 had a serious mental illness within the year prior to being surveyed; of these, 50.3% did not receive treatment. The percentage of adults receiving treatment through the public mental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

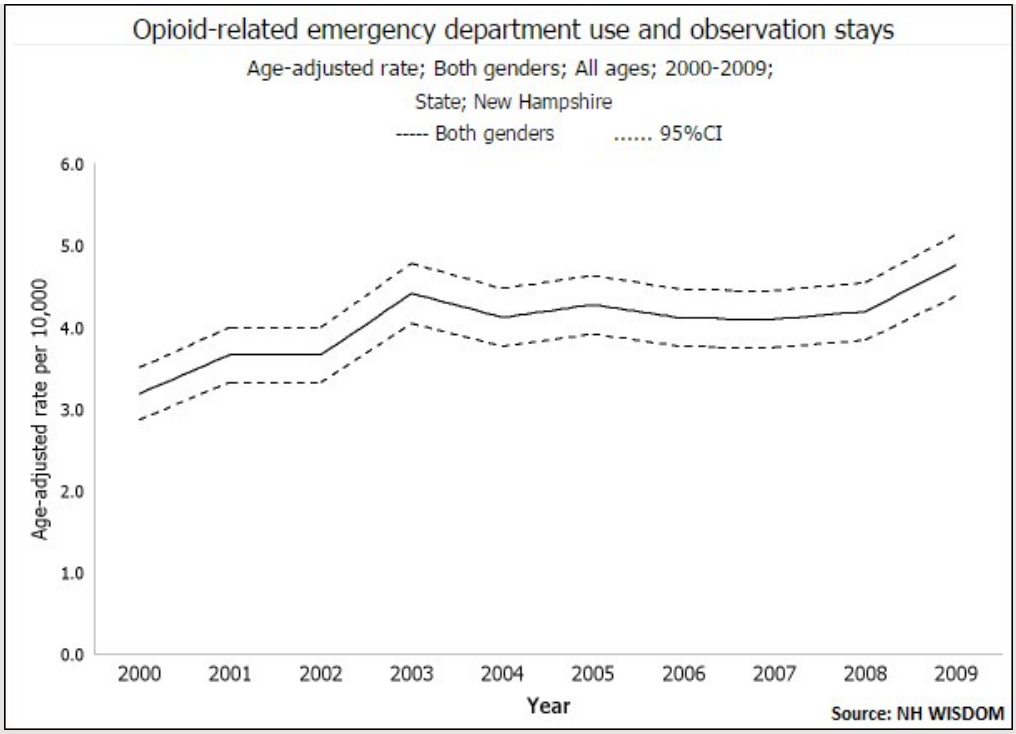
Obesity is a complex life course issue. Obesity in NH is more prevalent among men than women, and obesity trends seem to be worsening, with 26.04% of women and 29.11% of men considered obese in 2012, compared with 24.15% of women and 28.79% of men in 2011.[68]



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]

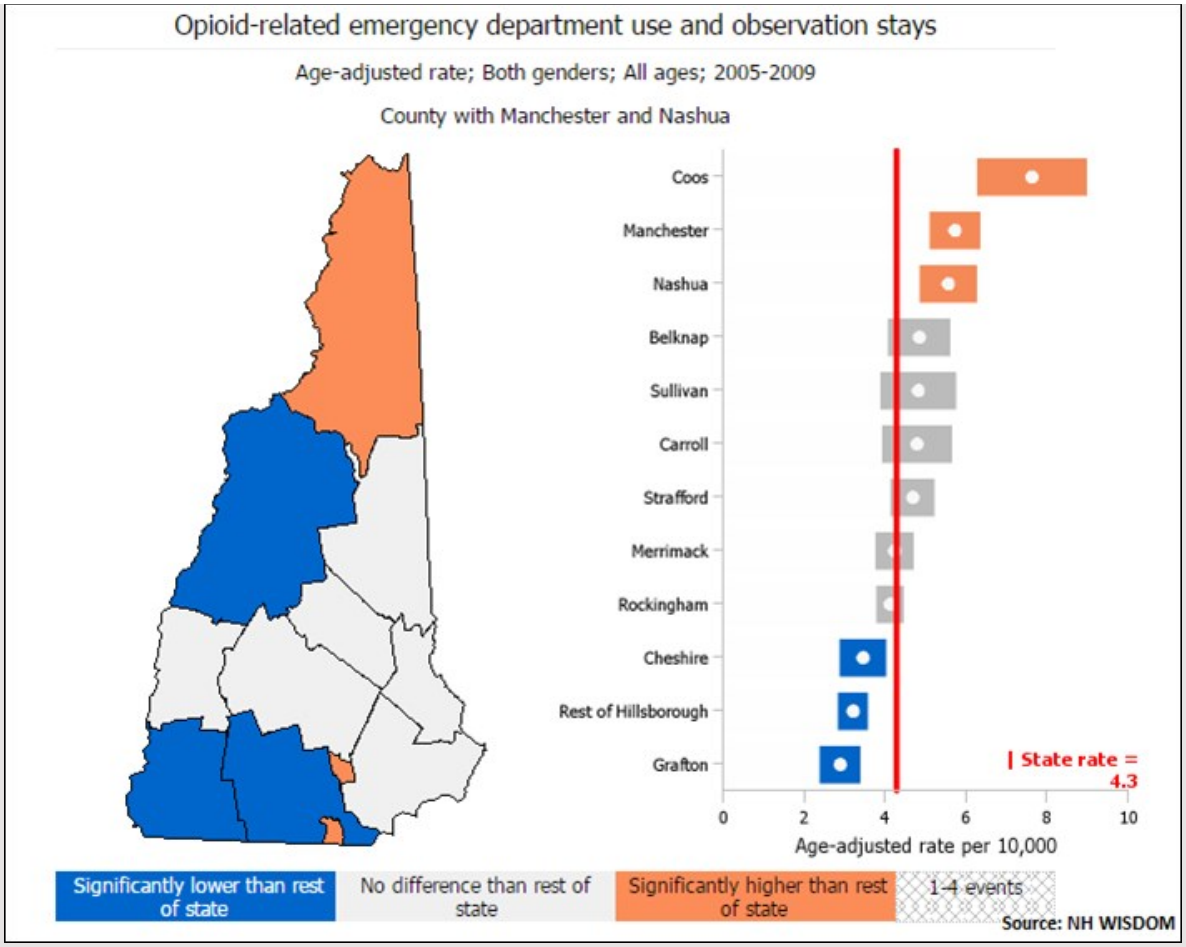


Opioid use is increasing. Lifetime use of heroin in all age groups is rising, and in 2009, 4.79 persons per 10,000 population had opioid-related emergency department use and observation stays.[70]



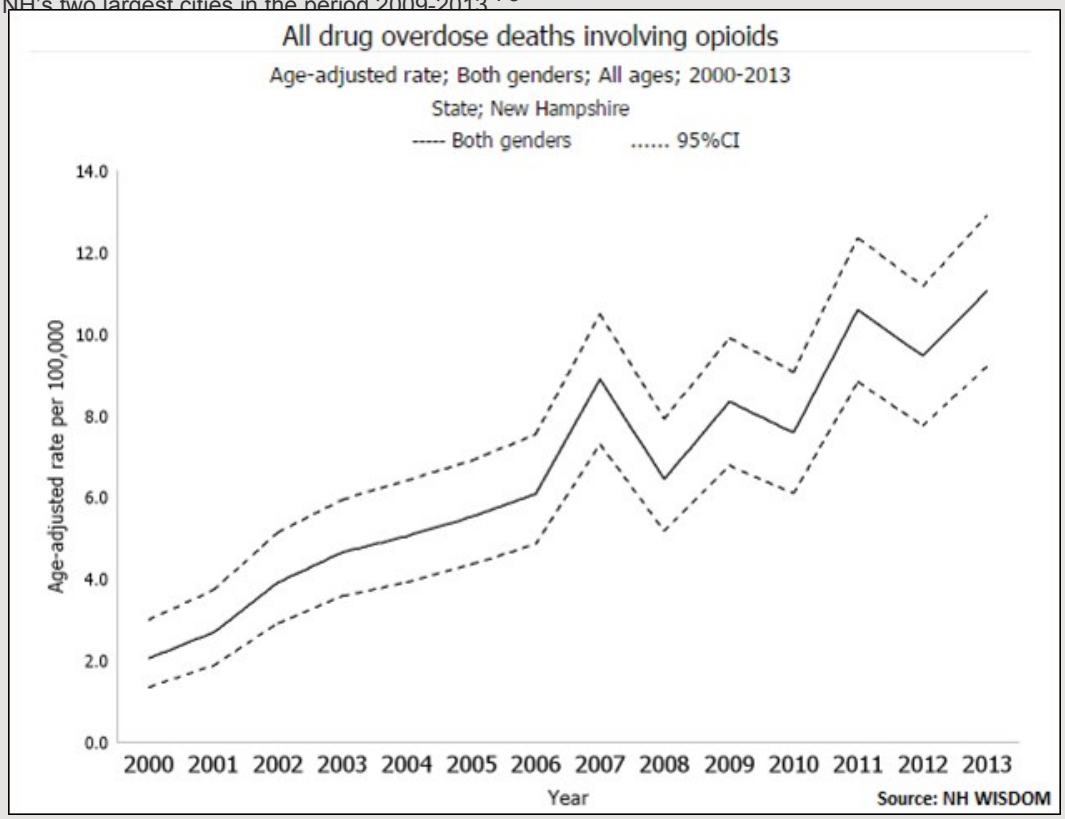
More recent data reports 600 emergency department visits in 2013 (of which 307 were females, 293 males), and 1051 in 2014 (373 females, 678 males).[71]

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.

III.D. Financial Narrative

	2015		2016	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,954,157	$1,986,075	$1,985,385	$1,979,094
State Funds	$7,352,499	$5,634,464	$5,254,187	$5,874,541
Local Funds	$0	$0	$0	$0
Other Funds	$931,486	$737,314	$990,468	$968,731
Program Funds	$0	$0	$0	$0
SubTotal	$10,238,142	$8,357,853	$8,230,040	$8,822,366
Other Federal Funds	$4,519,197	$5,065,539	$4,703,848	$4,190,811
Total	$14,757,339	$13,423,392	$12,933,888	$13,013,177

	2017		2018	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,986,075	$1,989,264	$1,989,264	
State Funds	$5,751,467	$4,561,373	$5,562,290	
Local Funds	$0	$0	$0	
Other Funds	$993,154	$1,052,350	$845,000	
Program Funds	$0	$0	$0	
SubTotal	$8,730,696	$7,602,987	$8,396,554	
Other Federal Funds	$7,084,728	$7,905,731	$9,298,290	
Total	$15,815,424	$15,508,718	$17,694,844	

	2019	
	Budgeted	Expended
Federal Allocation	$1,989,264	
State Funds	$5,743,753	
Local Funds	$0	
Other Funds	$966,336	
Program Funds	$0	
SubTotal	$8,699,353	
Other Federal Funds	$9,559,396	
Total	$18,258,749	

III.D.1. Expenditures

The Title V budget and expenditures are managed both programmatically and fiscally during the year through regular twice monthly meetings of MCH programmatic and fiscal staff and monthly check-ins between SMS programmatic and their respective fiscal staff (which is different from MCH's). There are also quarterly meetings between SMS and MCH programmatic/fiscal staff. MCH is the Primary on the Title V Block Grant and as such its fiscal staff manages the overall budget and expenditures.

Amounts utilized in compliance with the 30%-30%-10% requirements

As shown on Form 2, New Hampshire complied 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) during federal fiscal year (FFY) 17. Services for CYSHCN were provided through 44.5% of New Hampshire's Title V allocation which was appropriated to the SMS budget for FFY 17.

Special Medical Services utilized Title V Partnership funds in FFY17 to support activities and services consistent with the Performance Measures selected and the goal of improving the system of care for CYSHCN. Of the funds allocated to SMS and expended in FFY17 the majority of funds (65%) were used to support community based efforts to support infrastructure, enabling, family to family support and some direct service activities. Approximately 34% of funds were expended to support state office staff, including activities for program planning, system of care improvement, contract oversight and monitoring as well as Health Care Coordination–only about 1% was used for state office operations.

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 (2) programs, funds are appropriated through a defined methodology. The ultimate goal of using this formalized approach is 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 again the beginning of state fiscal year (SFY) 20, July 1, 2019.

The final financial report (FFR) is almost always drawn down to zero because of the two (2) year expenditure cycle. Thus, the column shows an estimated full expenditure.

There were no significant variations appearing on Forms 2 and 3.

Federal Title V Block Grant funding is the glue that helps state funding support efforts needed to meet MCH priority needs and meet the requirements of the Title V legislation. New Hampshire's priority areas of need identified and the accompanying performance measures include:

1. Improve access to needed healthcare services for all populations.
    a. Percent of women, ages 18 through 44, with a past year preventive medical visit in past year.
    b. Percent of adolescents ages 12-17 with a preventive medical visit in the past year.
    c. Percentage of MCH contracted CHCs with Enabling Services work plan on file with DHHS/MCH.

Using Title V, MCH supports 14 community health centers (CHCs) in their mission to provide accessible and affordable comprehensive primary care services for some 126,250 individuals and 2,468 pregnant women in 2017.[1] Most funding is currently used for quality improvement projects such as getting adolescents into annual care; increasing the number of pregnant women and the homeless actually receiving tobacco cessation services; and increasing the usage of highly effective contraceptive methods. Funds also go to enabling services such as case management, transportation and interpretation services.

The MCH QI/QA Nurse Consultant position, which is covered mostly by Title V, oversees the evaluation of all MCH programming with specific recommendations and required actions to meet the goals of the Title V National and State Performance Measures. She also has oversight over the adolescent health program within MCH and has been an integral participant in the national learning collaborative sponsored by AMCHP, to which NH was accepted to and has been a participant in for the last two (2) years.

2. Decrease the use and abuse of alcohol, tobacco and other substances among youth, pregnant women and families.
    a. Percent of women who smoke during pregnancy.

The MCH Perinatal Nurse Coordinator position is also funded in part by Title V and takes an active role in smoking cessation activities for the pregnant population. This past year, teaching modules were developed with the Tobacco Cessation and Prevention Program specific to quit-line services for the pregnant and parenting woman. The Perinatal Nurse Coordinator oversees the Maternal Mortality Committee and provides input into the prenatal sections of any MCH-affiliated contract or program.

MCH utilizes part of its Title V funding for an epidemiologist from the University of New Hampshire (UNH) who has worked with Title V for the past 15 years, conducting analyses of state and national data sets related to maternal and child health. The epidemiologist, Dr. David Laflamme, has become an expert in issues such as surveilling neonatal abstinence syndrome (NAS) , newborn screening timeliness and maternal morbidity. Dr. Laflamme has been instrumental this past year in setting up situational surveillance on the birth certificate as it relates to emerging issues like Zika and the utilization of the maternal mortality reporting system designed by the CDC.

3. Decrease unintentional injury.
    a. Percent of infants placed to sleep on their backs.
    b. Rate of hospitalization for non-fatal injury per 100,000 adolescents ages 10 through 19.

The Injury Prevention Program (IPP) Manager and a portion of the Injury Surveillance Coordinator's position are funded by Title V. The IPP seeks to reduce morbidity and mortality due to intentional and unintentional injuries and 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. Part of the contractual funding is from Title V. Much of the effort of these contractors is dedicated to reducing hospitalization rates for non-fatal injuries, particularly as it relates to the vector of motorized vehicles, sports, violence and poisoning. The Brain Injury Association facilitates a return-to-learn after concussion program entitled "Chalk-Talk" while the Injury Prevention Center facilitates a nationally known teen driving parent resource website and a distribution kit for schools on the peer-to-peer process with respect to driving safety.

4. Decrease pediatric overweight and obesity.
    a. Percent of children ages 6-11 who are physically active at least 60 minutes per day.

Title V money is leveraged with DHHS's Division of Children, Youth and Families (DCYF) for contracts with 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. Families with children 6-11 are assessed for level of physical activity and given suggestions on increasing timing if necessary. Many of the agencies have worked with local area recreation in sponsoring events and programs focused on physical activity.

The MCH Child Health Nurse Consultant, funded in entirety by Title V, has a broad spectrum of responsibilities ranging from involvement with pediatric coalitions encouraging physical activity; overseeing the pediatric service components of all MCH contracts, many of which have a physical activity performance measure as well, and facilitation of the sudden unexpected death reviews and

leadership of the accompanying safe sleep efforts.

5. Improve access to standardized developmental/social emotional screening, assessment and follow-up for children and adolescents.
    a. Percent of Children ages 9 through 35 months, receiving a developmental screening using a parent-completed screening tool in the past year.

Title V funds one (1) staff member in SMS, the Systems Specialist, working to enhance developmental screening who is also a CDC *Learn the Signs: Act Early* Ambassador. Through Title V, SMS has a contract in place for the Child Development Clinic Network which consists of an autism clinic and four (4) locations for interdisciplinary diagnostic evaluation services to children 0-6 years of age suspected of or at risk for altered developmental progress.

6. Increase access to comprehensive medical homes.
    a. Percent of children with and without special health care needs ages 0 through 17 who have a medical home.

The SMS Clinical Coordinator and all of the Health Care Coordinator positions, contracted and state, as well as the Medical Home Project contracted out to NH Family Voices were funded to support National Performance Measure #6.

7. Increase family support and access to trained respite and childcare providers.
    a. Percentage of families enrolled in SMS who report access to respite.

Part of the SMS Systems Specialist' duties are to work on respite issues.

8. Improve access to mental health services.
    a. Percentage of behavioral health professionals recruited.

MCH contracted with the Bi-State Primary Care Association Recruitment Center in FFY17 to assist with leveraged Title V funds (with DHHS Bureau of Drug and Alcohol Services) in the recruitment of behavioral health professionals to the state.

Components of Title V's child development clinics, psychiatry consultation, nutrition and feeding & swallowing consultation and CHCs as well as financial assistance for health care support fall under the expenditures for direct services. In order to assure that MCH Block Grant funds are not used for services that are covered or reimbursed through the Medicaid program or by other payers, both SMS and MCH have included language in both rule and contract to ensure that MCH Block Grant funds are the payer of last resort and that public and private payees are billed where applicable.

---

[1] NH MCH UDS tables, 2017.

III.D.2. 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 or statewide foundations or other fundraising efforts.

A new biennium budget for State Fiscal Years 20 and 21 (07/01/19-/6/30/21) is in the initial stages of being developed and will leave DHHS for the Governor's Office in early fall 2018. Thus SMS and MCH will programmatically be working on the budget the summer of 2018. It is at this time that discussion is held with both internal colleagues and outside advocates (such as the CHCs) to determine if additional funds could be feasibly asked for and supported. Additional staffing needs are also made at this time such as for a 1.0 FTE Adolescent Health Coordinator position being requested which will help to fulfill the responsibilities for National Performance Measures #7.2 and #10. From the Governor's office, the Biennium budget will move to the legislature where it has until June 30, 2019 to come to an agreement before the Governor's signature (or veto). There is always a concern that the MCH and SMS line items remain stable.

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 CYSHCN; at least 30% for preventive and primary care for children and at the maximum 10% for administrative costs). Services for CYSHCN are currently provided through 45% of New Hampshire's Title V allocation, which is appropriated to the SMS budget for federal fiscal year 2019. 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 (2) 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 to start at the beginning of the next state biennium budget, July 1, 2019.

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 amount projected for children's services federal fiscal year 2019 is approximately 38.6% of the Title V allocation. Administration is projected at 8.0%.

Both SMS and MCH plan to utilize Title V funds in the federal fiscal 19 application year to support activities and services consistent with the goal of improving the system of care for the MCH and CYSHCN populations in the state. Twenty-one positions are funded in full or part by Title V, within SMS and MCH together, and are strategically placed to support the identified priorities and accompanying National and State Performance Measures.

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 Office of Population Affairs (OPA) and other federal agencies.

State System Development Initiative (SSDI) grant from HRSA. 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. These two (2) grants are used to fund the implementation of the state's universal newborn hearing screening program including 2.0 FTEs in house for administration, database maintenance, quality assurance, a follow-up coordinator and a contracted consulting audiologist. Follow-up coordination came back in-house as of July 1, 2018 to be facilitated by a 0.5 FTE Birth Conditions/EHDI Follow-Up Coordinator. The HRSA grant was increased by a small amount specifically to include a new subcontract for community work with families of the deaf and hard-of-hearing.

State Personal Responsibility Education Program (PREP) grant through the Administration for Children and Families (ACF). 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 (2) areas of the state with the highest adolescent birth rates.

Family Planning Program grants through the Office of Population Affairs (OPA-Title X), state general funds and federal Temporary Assistance for Needy Families (TANF) dollars. These dollars provide 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. The 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. TANF funds are utilized by local agencies for educational outreach.

Pregnancy Risk Assessment Monitoring System (PRAMS) grant from the CDC. This grant is used to carry out the PRAMS survey, which 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. However, this grant has been decreasing in funding necessitating the appropriation of some Title V funds to continue the program's efforts.

Maternal, Infant and Early Childhood Home Visiting (MIECHV) grant from HRSA. This federal grant, the largest 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 3.5 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. 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. 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. 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. This grant funds 0.5 FTE at the OCME.

Enhanced State Surveillance of Opioid-Involved Morbidity and Mortality (Opioid Surveillance) grant from the CDC. The Opioid Surveillance grant, like NVDRS, SDY and SUID, also is in conjunction with the OCME. It collects information from many different data stewards on all opioid overdose related deaths in the state. This grant funds 1.0 FTE within MCH and another 0.5 FTE at the OCME.

Preventive Health and Health Services Block grant from CDC. This portion of the more than two (2) million dollar grant funds part of MCH's contracts for statewide injury prevention activities with the Injury Prevention Center at Dartmouth and sexual violence prevention activities with the New Hampshire Coalition Against Domestic and Sexual Violence.

Grants to States for Medical Assistance Programs from the Centers for Medicare and Medicaid Services (CMS). This grant enables staffing for SMS and is braided with Title V funding for the provision of special medical services such as the Health Care Coordination, Nutrition and Feeding and Swallowing Consultation, the Child Development Clinics and the Neuromotor and Complex Care Program.

Social Services Block Grant (SSBG) from the Office of the Administration for Children and Families. SMS administers a portion of NH's SSBG for the operation of the Partners in Health Program (PIH). PIH is a statewide community-based program that provides support to families of children with chronic health conditions that significantly impacts daily life or young adults themselves, regardless of income. PIH's role is to assist, access resources, navigate systems and build family/individual capacity to manage the chronic health condition.

Part C of IDEA from the Office of Special Education of the Department of Education. SMS administers the Part C grant in NH referred to as Family Centered Early Supports and Services (FCESS). The Program for Infants and Toddlers with Disabilities (Part C of IDEA) is a federal grant program that assists states in operating a comprehensive state-wide program of early intervention services for infants and toddlers with disabilities serving ages of birth through age two (2) years, and their families.

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 comes 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. Components of SMS' child development clinics, psychiatry consultation, nutrition and feeding & swallowing consultation as well as financial assistance for health care support fall under the category of direct services. In order to assure that Title V funds are not used for services that are covered or reimbursed through the Medicaid program or by other payers, both SMS and MCH have included language in both rules and contracts to ensure that title V block grant funds are the payer of last resort and that public and private payees are billed where applicable.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: New Hampshire

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

New Hampshire (NH) Title V is located within two (2) distinct areas within the NH Department of Health and Human Services (DHHS). The Maternal and Child Health Section (MCH) resides in the Bureau of Population Health and Community Health Services within the Division of Public Health Services (DPHS). The Bureau of Special Medical Services (SMS) sits within the Division of Long Term Supports and Services (DLTSS). MCH consists of 23 positions, ten (10) of which are funded by Title V; SMS has 16 positions, 11 of which are Title V funded. MCH currently has six (6) programmatic units, Child Health/Infant Screening, Data Support, Home Visiting, Women's Health, Early Childhood Systems and Injury Prevention; SMS has three (3) programmatic units, Family Support, Part C Early Intervention and CYSHCN Services (for children and youth with special health care needs).

Access to services is highlighted in five (5) of the eight (8) state action plan priorities. Thus, in NH Title V looks upon itself as the "enhancer" and "enabler" of access to quality health care services for the MCH population. Title V funding decisions are made based on gap assessments founded on discussions of the state's health care system and the needs assessment process which looks at health outcomes.

Title V also leads by calling attention to emerging issues, thinking strategically, facilitating analysis, and educating on best practices. Title V looks for the gaps and tries to fill them, in alignment with priority areas. For example, when timeliness in newborn screening was called out nationally, MCH partnered with birthing hospitals on where and how to make improvements. MCH's addition of questions to PRAMS on well-water testing and arsenic are specific to the state's interest and needs. MCH's long-term support of Long-Acting Reversible Contraception (LARCs) helped to change Medicaid policy on their use.

Title V also has the role of convener as well as participant in many statewide groups. Title V staff members inaugurated and currently facilitate several advisory committees, mortality review groups as well as workgroups such as the Perinatal Substance Exposure Taskforce of the Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment and Recovery; the NH Home Visiting Task Force and the NH Council on Autism Spectrum Disorders.

Using Title V, MCH supports 14 community health centers (CHCs) in their mission to provide accessible and affordable comprehensive primary care services for some 126,250 individuals and 2,468 pregnant women in 2017.[1] A 2016 study of Medicaid claims confirms total cost of care for patients in Federally Qualified Health Centers (FQHCs, 12 of the 14 NH CHCs) was 24% lower than in non-centers.[2] Most funding is currently used for quality improvement projects such as getting adolescents into annual care; increasing the number of pregnant women and the homeless actually receiving tobacco cessation services; and increasing the usage of highly effective contraceptive methods. Funds also go to enabling services such as case management, transportation and interpretation services.

The MCH Child Health Nurse Consultant, Birth Conditions Program Coordinator and Perinatal Nurse Coordinator positions are all funded in part by Title V. The former's duties include a broad spectrum of activities, ranging from involvement with pediatric coalitions to overseeing the pediatric service components of all MCH contracts. The Birth Conditions Program evolved from the Zika grant and will resume the defunct birth conditions surveillance. The Perinatal Nurse Coordinator oversees the Maternal Mortality Committee and provides input into the prenatal sections of any MCH-affiliated contract or program.

MCH utilizes part of its Title V funding for an epidemiologist from the University of New Hampshire (UNH) who has worked with Title V for the past 15 years, conducting analyses of state and national data sets related to maternal and child health.

The Injury Prevention Program (IPP) Manager and a portion of the Injury Surveillance Coordinator's position are funded by Title V. The IPP seeks to reduce morbidity and mortality due to intentional and unintentional injuries and 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.

The QI/QA Nurse Consultant position oversees the evaluation of all MCH programming with specific recommendations and required actions to meet the goals of the Title V National and State Performance Measures.

Title V funds a portion of SMS programs with seven (7) external contracts. These contracts are primarily for enabling and public health services with a very small percent supporting direct services.

Title V funds one (1) staff member in SMS working to enhance developmental screening who is also a CDC *Learn the Signs: Act Early* Ambassador. Through Title V, SMS has a contract in place for the Child Development Clinic Network which consists of an autism clinic and four (4) locations for interdisciplinary diagnostic evaluation services to children 0-6 years of age suspected of or at risk for altered developmental progress.

SMS operates an interdisciplinary clinic for neuro-motor disabilities and a new Complex Care Network that incorporates statewide interdisciplinary clinics and specialty consultation to providers serving CYSHCN that is child specific or that addresses more general questions.

The Nutrition and Feeding/Swallowing Consultation Network offers community-based consultation and intervention services utilizing a home visiting framework.

Title V supports NH Family Voices in its mission to assist families with CYSHCN, maintain a virtual resource center on their website and provide a comprehensive Lending Library.

SMS utilizes Title V funding to support statewide efforts to enhance and improve access to medical homes for all children including CYSHCN.

SMS braids funding with DHHS's Bureau of Developmental Services for a contract that enhances access for CYSHCN to psychiatry services limited to one-time direct assessment, consultation and short-term condition/medication management.

---

[1] NH MCH UDS tables, 2017.

[2] Nocon, et al. (2016) Health Care Use and Spending for Medicaid Enrollees in Federally Qualified Health Centers versus Other Primary Care Settings. *American Journal of Public Health*: 106 (11).

III.E.2.b. Supportive Administrative Systems and Processes

III.E.2.b.i. MCH Workforce Development

The MCH Section consists of 23 positions (21 FTE, a contracted .8FTE Epidemiologist, and one part-time staff making up an additional .6 FTE). Ten (10) of the positions are funded in full or part by Title V. Two (2) of the full-time positions are currently vacant and in the recruitment process. There are an additional three (3) unfunded, part-time positions "on the books," for future planning efforts.

MCH currently has six (6) programmatic units, Child Health/Infant Screening, Data Support, Home Visiting, Women's Health, Early Childhood Systems and Injury Prevention.

This past year, the Home Visiting Data Specialist was hired after several years of development and movement through the approval process. This coming year the Child Health Nurse Consultant and the Newborn Screening Program Coordinator will retire. In addition, CDC's Zika Infant Surveillance and SAMHSA's Project LAUNCH will both be ending. The Zika grant has enabled the re-development of a birth conditions program which will continue with Title V funding leveraged with HRSA's Early Hearing, Detection and Intervention (EHDI) grant for follow-up. This will support one (1) of the two (2) ending grant funded positions.

SMS includes staff working on several programs related to CYSHCN including Partners in Health (funded by the Social Services Block Grant), Part C Early Intervention (funded by the Office of Special Education) and Title V activities. Currently, there are 11 FTE positions funded by Title V, two (2) of which are vacant. A new part-time position has been created for State Fiscal Year 19.

Recruitment and retention of qualified Title V program staff is an ongoing pursuit. Establishing a new position can take up to a year or more. And even for positions vacated, it can take several months to get posted on the state's large job website. For administrative support positions such as the MCH Executive Secretary position currently vacant, there are typically many candidates that apply. However, recruitment for professional positions, like the presently available Family Planning Planning/Women's Health Program Manager requires more resources and creativity.

Many of the current Title V employees come to the State with "boots on the ground experience," such as a nurse-practitioner in a contracted agency, a labor and delivery nurse at one of the birthing hospitals and a home visitor in a local program (now the Child Health Nurse Consultant, Perinatal Coordinator, and Home Visiting Supervisor respectively). Thus, it is common to put out vacant position announcements to the many agencies that Title V both contracts with and works with on a daily basis.

Title V also works with professional training pipelines and their job boards, such as the three (3) schools giving graduate degrees in public health and the numerous schools of nursing. MCH and SMS work with interns from many programs, such as Leadership Education in Neurodevelopmental and Related Disabilities (LEND) at UNH, CDC's Public Health Associate and Fellow Programs and summer graduate school interns set up through the Association of Maternal and Child Health Programs AMCHP. Title V also post vacancies on job boards through national and state professional associations such as the Association of State and Tribal Home Visiting Initiatives, the Safe States Alliance, the National Family Planning and Reproductive Health Association and the New Hampshire Public Health Association.

Title V staff typically are employed lengthy periods of time as evidenced by the last four (4) retirees who have almost a century of work experience combined at the state level. However, over half of the workforce currently has been working in their programs for five (5) years or less and just as many, if not more, are under the age of 50. Thus, retention efforts are critical.

One arena where MCH has made an effort to improve is in the realm of supervision. The Home Visiting Supervisor introduced the concept of reflective supervision to MCH's management team who meet with their staff either weekly or bi-weekly. Reflective

supervision happens on a regular basis and focuses on the knowledge and skills necessary to fulfill job responsibilities asking questions such as, "When things aren't working, are struggles shared so that alternatives can be developed together and are concerns shared in a way that feels nonthreatening." Reflective supervision is associated with greater resilience among staff, less burnout and lower rates of turnover.[1], [2]

Title V's Family Delegate, Jenn Pinneo, is in this year's 10 month Family Leaders Cohort facilitated by AMCHP. The cohort enables in-depth learning about Title V through monthly homework, calls, and designated mentors. It is hoped that after this training, Ms. Pinneo can expand the role of Family Delegate to include both MCH and SMS specific programming.

MCH's Administrator just was initiated onto AMCHP's Family and Youth Leadership Council, where she is hoping to increase family engagement specifically amongst programs in the MCH dominion. She was also selected and has been participating in a year-long DPHS Leadership Academy focused on the book, *The 21 Irrefutable Laws of Leadership*.[3] One of the concepts discussed that has been brought to MCH management is that leaders tend to attract the same type of people to their team. However, recruiting people who are different from them is crucial in order to staff their weaknesses. If that is not done, important organizational tasks are likely to be overlooked.[4] Hence, it is now the case that interview teams consist of three (3) different staff members with different professional responsibilities.

Professional development training this year took place in several different formats. Title V staff members availed themselves of the *Speechcraft* six (6) week course offered through the Toastmasters. This program focuses heavily on developing proficiency in facilitating presentations. Staff is also involved in several national Collaborative Improvement and Innovation Networks focusing on a variety of topics including infant mortality, injury prevention in children, newborn screening timeliness and adolescent health. Participation continued in AMCHP's online Quality Improvement eLearning Series helping to create a culture of quality improvement into Title V.

DPHS is trying to align its data analysis process by having all analysts learn and utilize R, which is a software environment for statistical computing and graphics.

Unfortunately, innovations in staffing structures are rare in the officious climate of government. However, there are several new parents/caregivers who work modified and extended shifts to be able to accommodate home and family life. Since snow and ice is sometimes a factor in NH, all staff have virtual private networks (VPN) allowing them to access the state computer system off-site. Several positions in Title V are funded through the braiding of grant and general state funds.

---

[1] Neilsen-Gatti, S. et al. (2011). Step back and consider: Learning from reflective practice in infant mental health, *Young Exceptional Children*, 14(2), 32-45.

[2] Jayatilleke, N. & Mackie, A. (2013). Reflection as part of continuous professional development for public health professionals: a literature review, *Journal of Public Health*, 35(2), 308-312.

[3] Maxwell, John C. (2007). *The 21 Irrefutable Laws of Leadership*. Nashville: Thomas Nelson.

[4] Ibid.

III.E.2.b.ii. Family Partnership

Maternal and Child Health

With the revision of the Title V Block Grant guidance, additional emphasis has been put on family partnerships and engagement. In that vein, MCH has put in a Technical Assistance (TA) request for the provision of an environmental scan of family engagement and partnerships within all of its programming, facilitated by colleagues from NH Family Voices (NHFV), the state's Family-to-Family Health Information Center. Historically, NHFV has been contracted with Title V funds for programs focusing on CYSHCN. This TA will use or develop an engagement tool, discussions with all MCH program staff, and result in presentations to MCH management.

In accompaniment to the written environmental scan will be a draft plan specific to each MCH program on how to increase both family partnerships and engagement. Part of this plan will include any identified professional training necessary, as well as how to utilize family partnerships at the contractor level, such as for reviewing the Title V Block Grant on an annual basis, not just at every five-year needs assessment.

Professional Development

For a third year, the MCH Administrator has been a participant in AMCHP's Family Engagement Community of Practice. The goal throughout has been to increase Title V capacity to engage families by offering a platform to share ideas, lessons learned and best practices from subject matter experts. As an offshoot of this involvement, the MCH Administrator was invited to become a member of AMCHP's Family and Youth Leadership Council (FYLC), serving as the only MCH representative.

This year, the FYLC surveyed both family delegates and MCH/CYSHCN Directors about family delegates. It is interesting to note that 10% didn't know who the AMCHP family delegate was; 32% were only "somewhat familiar" with the duties of the delegate and 50% responded that they did not select the family delegate.[1] MCH staff in NH also does not really know what the AMCHP family delegate is nor do they know how the role can be beneficial to the state's Title V Program and family engagement in general. NH's family delegate will be working with NHFV on MCH's technical assistance request.

The MCH Administrator and NHFV have been participating in the statewide Family and Youth Engagement Workgroup to expand and improve engagement in community and state activities. In its third year, common operational definitions of family and youth leadership/engagement as well as written practice profiles are being developed. This framework is necessary to sustain a common system of access to and implementation of family/youth leadership and engagement including funding sources, curricula and quality monitoring. Involvement in this workgroup has enabled MCH to continue to gain a deeper understanding of successful family engagement as well as create partnerships with agencies that provide family leadership training.

Advisory Committees

MCH is most likely to involve families within their several programmatic advisory committees including the Injury Prevention Advisory Council, the Newborn Screening Advisory Committee and the Newborn Hearing Quality Improvement Committee. The EHDI Program has been working with a group of parents in developing a provisional Hands and Voices chapter by providing space for meetings, ASL interpreters and the use of Zoom. Hands & Voices is a non-profit, parent-driven organization dedicated to supporting families of children who are deaf or hard of hearing.

Quality Improvement

The EHDI Program's percentage of lost-to-follow-up infants has not decreased in the past two (2) years despite targeted efforts. A LEND intern from UNH developed, disseminated and analyzed two (2) family surveys designed to help identify potential improvement areas in the initial screening and referral to audiological diagnostic testing as well as the assistance and preparation for a follow-up diagnostic appointment. Conducted with 200 randomly selected families, the surveys found that not all parents were told the results of their babies' newborn hearing screening. Of those that did not pass, only 50% remember being told their baby required

a rescreen.

Materials Development

Both the Birth Conditions and Maternal Infant and Early Childhood Home Visiting (MIECHV) Programs utilized groups of parents to help revise administrative rules and develop marketing materials respectively.

MIECHV used formative research activities with parents to inform the home visiting message development process, including focus groups to gather perceptions, information-seeking behavior, communication channel preferences, behaviors, and interests. Social media messages, images and narratives for all marketing materials were focus group tested.

Special Medical Services

SMS has embedded a culture of family involvement into planning, implementation and evaluation activities.

Professional Development

SMS has funded parent consultation and support through NHFV for more than 20 years. This partnership includes the provision of office space, allowing NHFV and SMS to be co-located. In addition to the initial activities of helping families to access services, this role has evolved to incorporate leadership and policy development, including administrative rules changes.

Advisory Committees

SMS staff works with a variety of advisories and councils with strong family participation. These include the Autism Council, regional family support groups, and the Interagency Coordinating Council. Additionally, SMS benefits from feedback from a stakeholder group hosted by the Partners in Health Program.

Quality Improvement

NHFV participates with SMS in the development, implementation and revision of QI activities. This includes working with SMS coordinators to identify training needs pursuant to interventions to employ with youth and families related to transition activities; providing support to SMS in measuring family needs regarding coordination and integration of care; and conducting an examination of available tools for potential use.

Materials Development

As a part of its contract, NHFV has a primary responsibility to:

- Manage, update and enhance a Parent Lending Library including the Family Resource Connection (early childhood).
- Compile and revise health resource directories.
- Produce and coordinate a parent newsletter.
- Convene educational and social events, such as support groups, workshops, seminars and conferences, for parent, youth and professionals in collaboration with SMS reflecting current issues, changes in access to care and best practices.

- Support and assist families with navigating and accessing state services and support.

NHFV has also created two (2) podcasts, one on home care for children with severe disabilities and another on medical homes.

---

[1] Personal Communication from Michelle Jarvis, AMCHP, May 21, 2018.

III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts

New Hampshire receives funding for the State Systems Development Initiative (SSDI) grant; this funding supports one FTE (the SSDI Project Director, located in the MCH section), and project activities are accomplished through active collaboration with all MCH staff, notably the MCH Epidemiologist.

The purpose of the SSDI has been to develop, enhance, and expand data capacity for responding to needs assessments and performance measure reporting requirements. Such enhanced data capacity enables the Title V program to engage in informed decision-making and resource allocation that supports effective, efficient and quality programming for women, infants, and children, including CYSHCN. SSDI complements the MCH Block Grant by improving the availability, timeliness, and quality of MCH data. Utilization of these data is central to the state's reporting on Title V program assessment, planning, implementation, and evaluation efforts.

Data linkages have been implemented with support from SSDI; an online data system (NHIMCHIS: NH Infant, Maternal and Child Health Information System) was created in order to facilitate access to data. In addition, extensive statistical programs have been written to provide the data needed for the annual Title V MCH Block Grant application/report.

In the past five (5) years, the following data linkages have been performed linking all with the state birth file:

- Newborn Screening data
- EHDI data
- Home Visiting (MIECHV) data
- Infant deaths
- Tobacco Quitline data
- Perinatal Client Data Form data
- Maternal deaths
- Pregnancy Risk Assessment Monitoring System (PRAMS) data
- Maternal delivery discharges and claims paid by Medicaid

These linkages have made possible improved reporting for all of these programs, enabling them to monitor and evaluate progress on program objectives, performance measures, and improvements in the health and well-being of women and infants.The infant birth/death linkage has been improved as a result of a monthly check on the infant death data which is part of the standard monthly PRAMS sampling procedure.

The linkage of Newborn Screening data with the birth file has resulted in the identification of newborns not screened at birth. This information is provided to the Newborn Screening Coordinator for follow-up with birth hospitals or other birthing providers, which enhances the timeliness of screening results and potentially reduces infant mortality.

Data linkages are time-sensitive. New or updated linkages will focus on infant births, infant deaths, and maternal delivery discharge claims paid by Medicaid. These will allow an examination and analysis, for example, of severe maternal morbidity, and of the sequelae of injection drug use during pregnancy, which are topics of interest not only to the MCH section but to other stakeholders as well. Other topics will be considered as they emerge and it becomes evident that linkages would facilitate their examination and analysis.

A table for linked ID pairs' data was created with funding from the previous SSDI project cycle. This table was built to enhance the

existing NHIMCHIS, .to provide a comprehensive, integrated system of linked datasets from approved sources and make them available to select MCH/DPHS staff to meet their analytic needs. To date, the new table for linked ID pairs is populated with linked birth-newborn screening data..

The current SSDI five-year project cycle is in its first year, and its scope now includes: the provision of data, research, and writing support for the Title V MCH Block Grant application/report, for the needs assessment as well as tracking and reporting on state-selected performance measures; the performance and updating of data linkages, particularly focusing on indicators from the Minimum/Core Dataset, and emerging issues; and support for the translation and dissemination of statewide surveillance data, notably from PRAMS, through the analysis of yearly and multiyear data sets with particular focus on safe sleep, smoking during pregnancy, and the use of marijuana during pregnancy. This analysis and reporting on marijuana use will be very timely, following the passage and signing of a state law decriminalizing simple possession of marijuana (HB 640-FN, effective 9/16/2017), and the implementation of the Therapeutic Cannabis Program (RSA 126-X). Surveillance will inform stakeholders on the extent of use of marijuana among pregnant women.

During the past year, MCH worked with DVRA to support a new situational surveillance feature on the New Hampshire Vital Records Information Network (NHVRIN). Initially created and funded to capture head circumference and body length on the birth certificate for. Zika surveillance, , the pop-up surveillance question(s) can also be utilized for real-time situational surveillance of any emerging issue. This recent enhancement allows pilot testing through triggering questions based on the hospital of birth data field before system-wide implementation, thus improving data quality; this also allows for geographically targeted surveillance, when necessary. This enhanced functionality greatly increases the ability of MCH and DVRA to gather critical information when new threats emerge relevant to birth outcomes. Head circumference and body length are now fully integrated into NHVRIN.

Recently, a one-week pilot study was implemented. on paper with three (3) birthing hospitals in-state to assess the feasibility and ease of adding the following two (2) questions to NVRIN, “Was there opioid exposure at any time during pregnancy?” and “Was the infant monitored for signs of opioid withdrawal or neonatal abstinence syndrome (NAS)?” Pilot hospital staff felt the questions were clear and feasible additions with a review of medical records. With the success of this small pilot-study and the availability of the new situational surveillance feature in NVRIN, the two (2) questions will be added as of May 1, 2018. MCH and DVRA will be able to assess the real-time threat of opioid exposure in newborns. This will augment the current discharge data utilized for this issue, but will enable real-time and geographic data for immediate use.

The MCH screening programs (birth condition program and the prenatal program) are in the planning stages of developing an integrated data management system to be used for reporting hearing screening results, critical congenital heart disease (CCHD) results and birth conditions of newborns. A requirement of the database system will be the capability to interface with other data base systems (vital records and lab). The benefits of an integrated data management system will be improvement of surveillance, reporting, and referral to early intervention services if needed.

The request for proposal is for enhancement and transformation of the current functionality provided by the Auris system, MCH datamart system, and Newborn Screening system, in addition to adding new capability to capture CCHD data. DPHS is seeking a web-enabled data reporting system. The vision is to enable data providers to pull up (based on their own facility data entry) a real-time birth record and associate or link health information for each of the three programs: newborn screening, birth defects and prenatal. The vendor would provide a hosted solution, including the hardware, software and connectivity to the system. They would maintain the system, offer trainings for users, improvements to the software, and matching of birth certificates to provide accurate reporting of data.

SMS also has a data system that captures demographics and services delivered. The data is evaluated annually informing decision-making about services and resource allocation.

III.E.2.b.iv. Health Care Delivery System

Title V does none of its work in a vacuum. All efforts are done in conjunction with the many partners, both state and federal that focus on maternal and child health, including CYSHCN. As with staff time, Title V dollars are also for the most part leveraged by contractors with other funding to ensure access to quality health care and needed services for the MCH population. For example, many of the CHCs utilize their Title V funding for staffing that is not alternatively paid for by other grants or fee for services through insurance.

On November 1, 2017 an "Intra-Agency Agreement between the NH Title V Sections and the NH Office of Medicaid Services, Relative to Joint Planning, Coordination and Improvement of Health Programs under Title V and Title XIX" was signed jointly by MCH, SMS, DPHS, DLTSS (under which SMS resides) and Medicaid. Three (3) years in development, it had been 24 years since a previous intra-agency agreement had been signed. The current agreement focuses on:

- Collaboration on the development and implementation of quality health standards.
- Improvement in referral processes and access to and utilization of health services.
- Implementation of processes for making intra-agency decisions and coordination of policies.
- Reduction of duplicative services and the implementation of innovative solutions to health care issues.
- Assurance of compliance with federal and state statutes.
- Promotion of joint planning, monitoring and evaluation of a health care system for the Title V and Title XIX populations.

A new component is the assignment of a seat for MCH on the Medicaid Medical Care Advisory Committee (MCAC) which advises the Medicaid Director on policy and planning. Members of the MCAC must be familiar with the comprehensive needs of low-income population groups and with the resources required for their care, which is consistent with the professional responsibilities of Title V staff.

The Medicaid MCOs are currently operating under a contract extension ending June 30, 2019. During this time, a new request for proposals (RFP) has been in development including a brand new scope of services. MCH and SMS staff have been part of the process and all have had an opportunity to comment on the draft RFP. An example of the benefit of this participation is that the new RFP will include a "Required List of Pediatric Specialists for Network Adequacy," penned by SMS.

The newest partnership between MCH and the Office of Quality Assurance and Improvement (QAI-the Medicaid data/quality improvement section) is due to an interest in better understanding the mortality risks faced by the Medicaid population which overlaps that of MCH. Staff within MCH have a wealth of experience in creating and implementing consistent, meaningful definitions for a variety of causes of mortality, including multiple years of identifying violent deaths and unintentional opioid overdose deaths. This expertise will help to create the necessary data sets to be linked with and analyzed alongside Medicaid data. MCH is also assisting with a literature review to better understand how existing research has identified Medicaid populations as results may be sensitive to different measures and thus require a definition as consistent and meaningful as the mortalities of concern. The primary focus of the study at this point is suicide, with other topics such as opioid overdose discussed for future collaboration.

The QAI also routinely shares their data, such as monthly birth linkages (linked births and Medicaid delivery claims), with MCH for routine querying and matching for programs such as newborn screening and newborn hearing screening. This linkage enables more in-depth analyses than are possible with either dataset alone and has been used to examine issues such as early elective deliveries and currently with maternal mortality and severe maternal morbidity.

An accompanying objective to co-developing health standards is to also do the same for quality improvement activities, including the sharing of data and outcome measures. Policies are sometimes re-worked when there is evidence that a change might improve quality

of care. Such was the case when Medicaid unbundled the cost of labor and delivery services in January of 2018 allowing for a separate paid cost for IUD or implant insertion directly post-partum. MCH and the QAI are collaborating on an evaluation of this change in policy, first running monthly reports to see if postpartum LARC insertion amongst Medicaid deliveries increases. If it has not then appropriate joint outreach can be facilitated. If it has, additional data will be looked at to see if future pregnancies have been delayed, if intent was increased, etc.

Another change in policy has been related to assuring family choice in accessing rehabilitative services related to a child's developmental delay for those enrolled in Part C Early Intervention. Previously, if families chose to have their child receive Part C entitled services their only option was to also receive rehabilitative services through Part C. Medicaid and SMS worked together to create an option for families to have a choice to access these services through Medicaid and still receive entitled services through Part C.

The agreement reaffirms the commitment to have Title V funded contractors identify, enroll and re-enroll Medicaid eligible clients and to refer those clients to appropriate services. Seven (7) of the funded CHCs utilize Title V for sustaining or even increasing capacity for any type of staff helping with client insurance needs. Up to one third of the clients coming into the CHCs for the first time are uninsured.[1] For the first few years of the ACA, an increase in federal and foundation funding came into the state to support this. Staffing took the form of patient navigators whose responsibility was and continues to be the targeting of the uninsured; certified application counselors working within health centers and seeing mainly new clients and application assisters. Funding for all has severely diminished. Bi-State Primary Care Association is in their final year of a CMS funded navigator program called the NH Safety Net Coverage Collaborative, in which five (5) CHCs participate. All braid their Title V funds to maintain full-time navigators. For the last two (2) years, this program has worked with DHHS' Medicaid Client Services on joint training to strengthen the relationship between navigators and Medicaid case workers. As part of its Title V funded contract with SMS, NHFV (whose staff have been trained as navigators) also offers assistance with understanding options and accessing Medicaid to families of CYSHCN.

Since 2016, when CYSHCN became mandatory participants in MCOs, SMS and the MCO Contract Management staff have maintained a working partnership to address access and coverage issues. Additionally, the CYSHCN Director is a member of the MCO operations oversight group and reviews quarterly reports on "Appeals by Type of Resolution and Category of Service." The objective is to determine if the report identifies any "performance issues" that should be escalated to the Medicaid Director. A performance issue is defined as one that:

1. Materially affects the quality/scope of the program;
2. Violates compliance with the contract or other regulations; or
3. Negatively impacts the budget or timeline and may require resources to address.

---

[1] Personal communication with funded CHCs, 06/10/2018

III.E.2.c State Action Plan Narrative by Domain

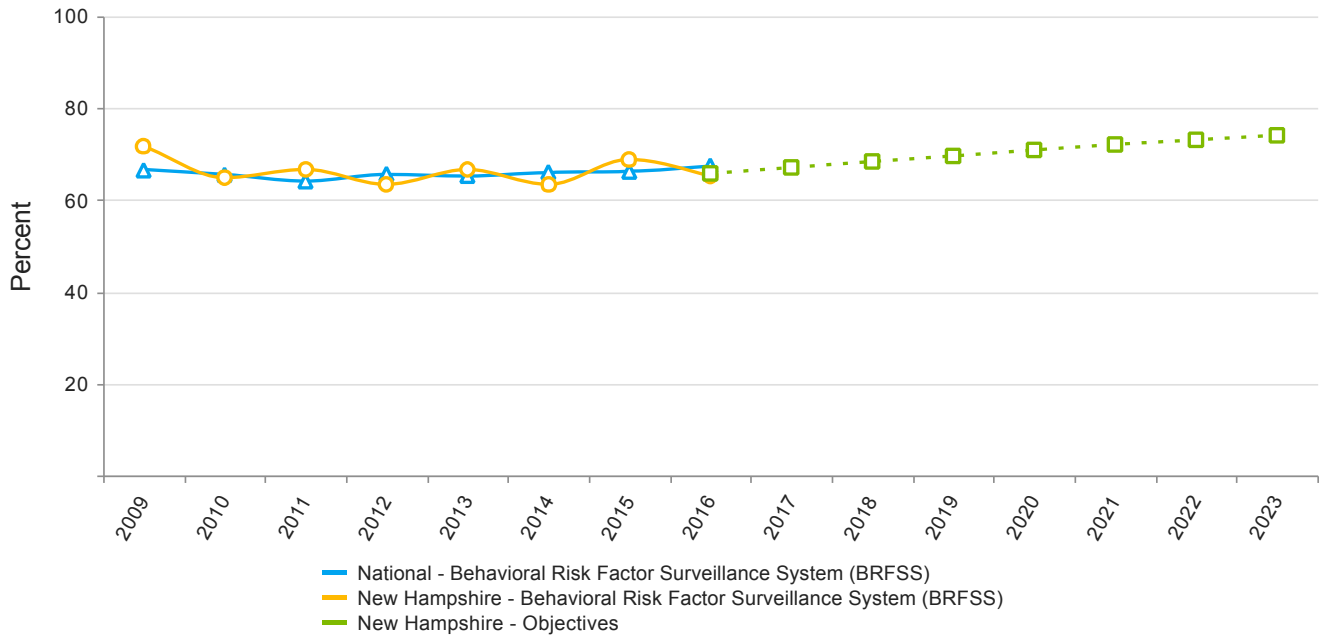
Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2009	75.5	NPM 1 NPM 14.1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2012_2016	Not Reportable	NPM 1 NPM 14.1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2016	6.4 %	NPM 1 NPM 14.1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2016	7.8 %	NPM 1 NPM 14.1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2016	21.1 %	NPM 1 NPM 14.1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2015	4.5	NPM 1 NPM 14.1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2015	4.1	NPM 1 NPM 14.1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2015	2.8	NPM 1 NPM 14.1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2015	1.3	NPM 1 NPM 14.1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2015	112.6	NPM 1 NPM 14.1
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2015	80.4	NPM 14.1
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy	PRAMS-2015	9.7 %	NPM 1
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births	SID-2009	7.1	NPM 1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	92.0 %	NPM 14.1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2016	9.3	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2015	12.9 %	NPM 1

National Performance Measures

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Baseline Indicators and Annual Objectives



Federally Available Data		
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)		
	2016	**2017**
Annual Objective	65.7	67
Annual Indicator	68.6	65.3
Numerator	147,910	140,723
Denominator	215,479	215,631
Data Source	BRFSS	BRFSS
Data Source Year	2015	2016

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	68.3	69.5	70.8	72.0	73.0	74.0

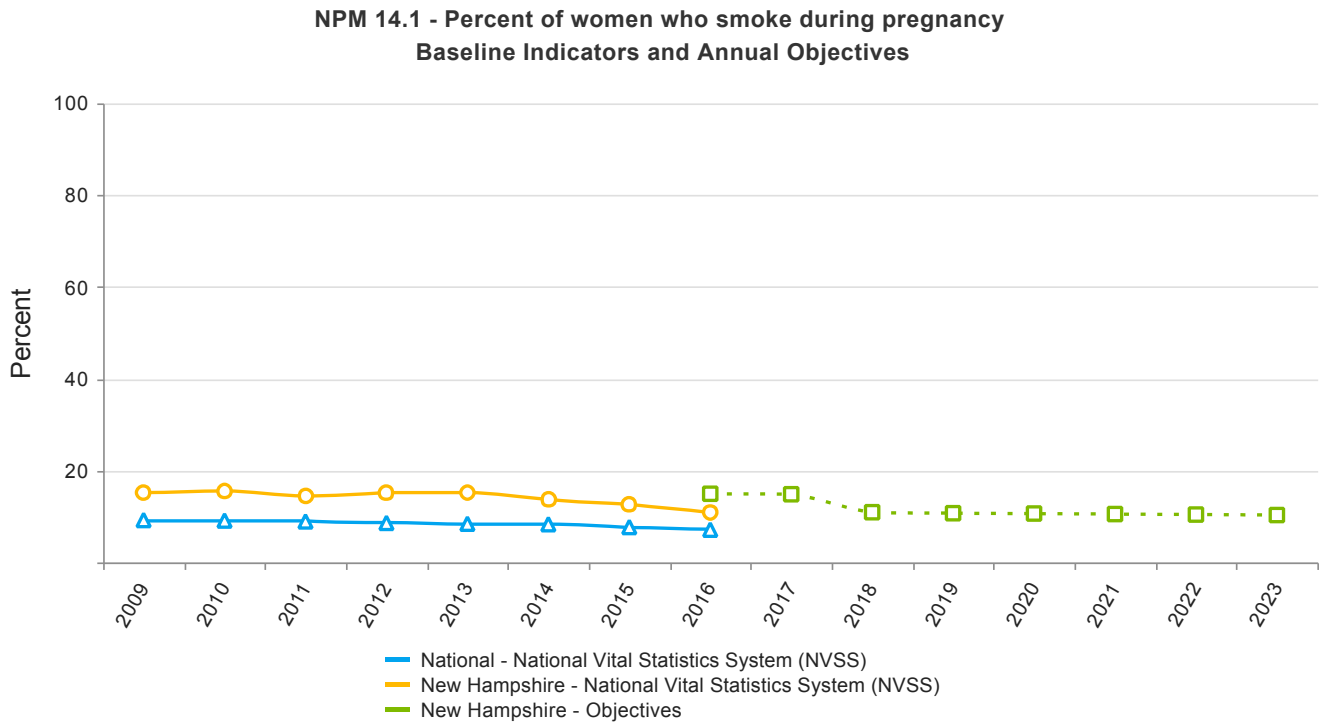
Evidence-Based or –Informed Strategy Measures

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)

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		20
Annual Indicator	25.6	35.5
Numerator	500	1,980
Denominator	1,955	5,572
Data Source	JSI database	JSI database
Data Source Year	2017	2017
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	40.0	45.0	50.0	55.0	60.0	65.0



Federally Available Data		
Data Source: National Vital Statistics System (NVSS)		
	2016	**2017**
Annual Objective	15	14.9
Annual Indicator	12.6	11.1
Numerator	1,530	1,342
Denominator	12,194	12,052
Data Source	NVSS	NVSS
Data Source Year	2015	2016

State Provided Data		
	2016	2017
Annual Objective	15	14.9
Annual Indicator	10.8	11.1
Numerator	1,321	1,343
Denominator	12,204	12,076
Data Source	NH Division of Vital Records birth table	NH Division of vital records birth table
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	11.0	10.8	10.7	10.6	10.5	10.4

Evidence-Based or –Informed Strategy Measures

ESM 14.1.1 - Number of calls received by the New Hampshire Quitline in the past year

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	13	18
Numerator		
Denominator		
Data Source	QuitNow NH, the state tobacco treatment quitline	QuitNow NH, the state tobacco treatment quitline
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	20.0	23.0	26.0	31.0	36.0	38.0

State Action Plan Table

State Action Plan Table (New Hampshire) - Women/Maternal Health - Entry 1

Priority Need

Improve access to needed healthcare services for all populations.

NPM

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Objectives

By July 1st 2021, increase the utilization of long-acting reversible contraception (LARC) from 18% to 22%

By July 1st 2019, all Title X family planning clinics will have at least one staff member proficient in LARC insertion

By July 1st 2021, preconception counseling and services will increase from a baseline of 25% to 40%

Strategies

Conduct outreach and education through community partners to inform the public on the importance of preventive care for women

Provide the public with information and resources for obtaining access to women's healthcare

Provide resources and professional trainings to contracted agencies to enhance agency capacity and staff skills related to providing preventive services for women which include contraceptive management and preconception health services

Conduct professional trainings to contracted agencies related to utilization of LARCs and LARC insertion

Collaborate with NH Governor's Commission on Alcohol & Drug Abuse, Perinatal Substance Exposure Task Force to increase access to LARCs for women at risk for substance misuse.

ESMs	Status
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)	Active

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

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

State Action Plan Table (New Hampshire) - Women/Maternal Health - Entry 2

Priority Need

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

NPM

NPM 14.1 - Percent of women who smoke during pregnancy

Objectives

1A. By July 1, 2020, decrease the percentage of women who wmoke during pregnancy to 28% or less among deliveries paid by NH Medicaid. 1B. By July 1, 2020, decrease the percentage of women who smoke during pregnancy to 4.5% or less among deliveries not paid by NH Medicaid. 2. By July 1, 2020, all of the MCH-funded Community Health Centers will have referral sources documented along with follow-up for patients who smoke in their electronic medical records.

Strategies

- Increase the utilization of Quitworks-NH and QuitNow-NH through education of health care providers and citizens - Facilitate enrollment into tobacco treatment programs by making referrals for both providers and clients easier (e.g. electronic two-way system). - Professional education on best practices in tobacco treatment through online e-learning modules - Facilitate two-way communication between QuitWorks-NH and health care providers to enhance patients' likelihood of quitting tobacco

ESMs	Status
ESM 14.1.1 - Number of calls received by the New Hampshire Quitline in the past year	Active

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

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Women/Maternal Health - Annual Report

National Performance Measure #1: Percent of women, ages 18 through 44, with a past year preventive medical visit

Evidence Based or Informed Strategy Measure: Percentage of women who receive pre-conception counseling and services during annual reproductive health (preventive) visit at family planning clinics (Title X)

Objectives:

- By July 1, 2021, increase the utilization of Long-Acting Reversible Contraception (LARC) from 18% to 22%
- By July 1, 2019, all Title X Family Planning clinics will have at least one staff member proficient in LARC insertion
- By July 1, 2021, preconception counseling and services will increase from a baseline of 25% to 40%

Strategies:

- Conduct outreach and education through community partners to inform the public on the importance of preventive care for women
- Provide the public with information and resources for obtaining access to women's healthcare
- Provide resources and professional trainings to contracted agencies to enhance agency capacity and staff skills related to providing preventive services for women, which include contraceptive management and preconception health services
- Conduct professional trainings to contracted agencies related to utilization of LARCs and LARC insertion
- Collaborate with NH Governor's Commission on Alcohol & Drug Abuse, Perinatal Substance Exposure Task Force, to increase access to LARCs for women at risk for substance misuse

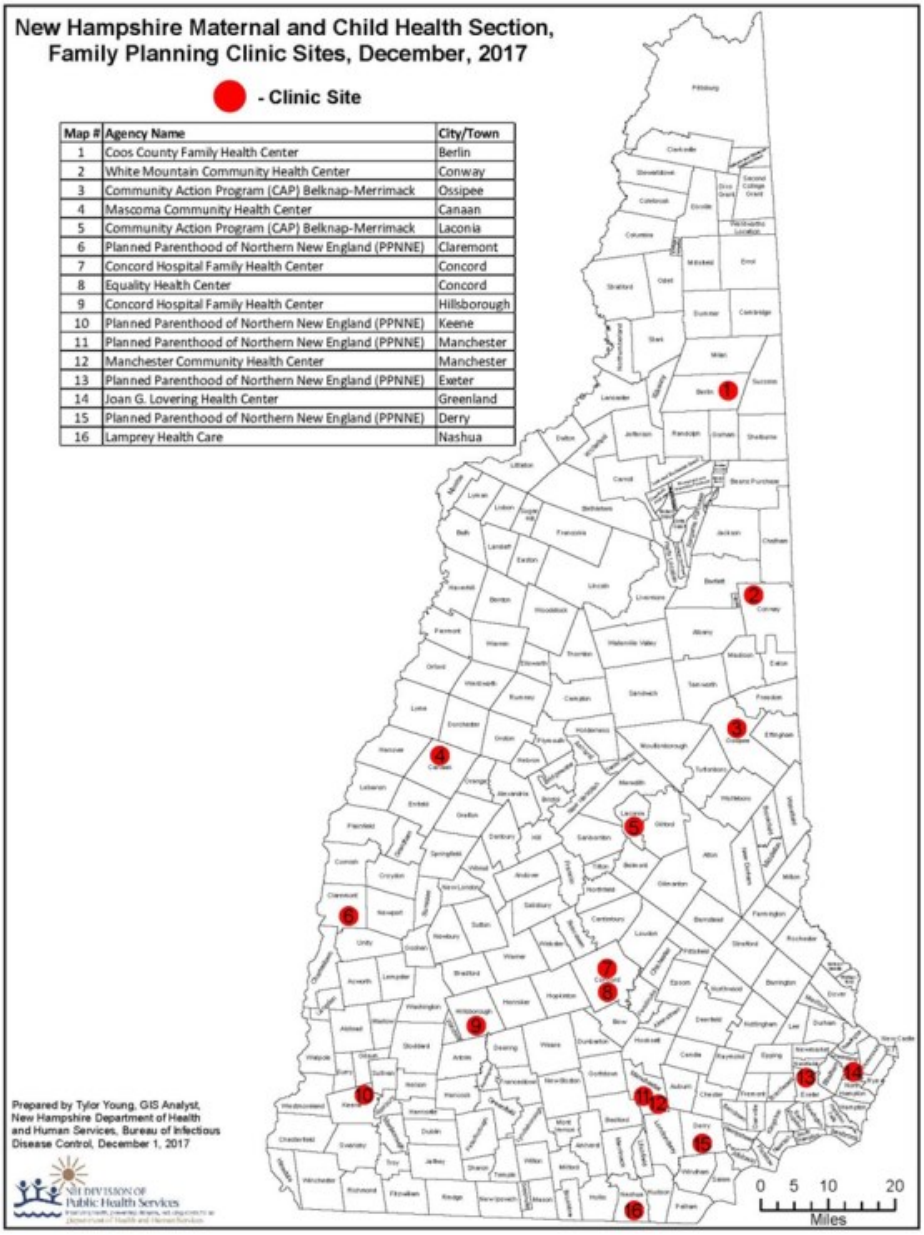
For many years, NH DPHS has partnered with more than a dozen independent health providers to ensure seamless provision of high quality care to all regions of NH. This high quality care includes women's preventive care services, preconception health care, and reproductive health services all while promoting women's health and wellness. These health care services are critical in optimizing the health of women before and between pregnancies as well as improving perinatal outcomes (NOMs 2-6; NOMs 8-9.3). The MCH section has shown its commitment to women's health through partnerships and referrals to CHCs, which are located throughout the state to ensure services are available to all women especially those who are of reproductive age.

The preventive medical visit not only includes preventive screenings and reproductive health but also incorporates counseling and screening related to overall wellness. This includes screening and counseling for substance misuse disorders. NH communities have been impacted by the drug epidemic. Nationally, from 2008-2012 more than a third of reproductive age women enrolled in Medicaid, and more than a quarter of reproductive age women insured by private insurance filled an opioid prescription. Illicit drug use has not only become a national problem but is a growing problem in NH. The National Survey on Drug Use and Health ranks NH among one of the highest in the country for illicit drug use among 18-25 year olds[1] and is facing the challenges and cross-cutting impact of the current opioid crisis. NH ranks 3rd in the nation (39.0 per 100,000) in overall rate of drug related deaths. In 2016, the states with the highest rates of death due to drug overdose were West Virginia (52.0 per 100,000), Ohio (39.1 per 100,000), and New Hampshire (39.0 per 100,000)[2] The number of drug deaths in NH continues to rise. In 2017 there were 487 drug-related deaths in NH, compared to only 201 in 2011, an increase of 145% over the six-year period.

Due to the increase in illicit drug use throughout the Granite State, the MCH-based Family Planning Program (FPP) has engaged with medically-assisted treatment (MAT) programs to promote referrals for clients to the network for family planning services. This referral mechanism ensures that individuals with addiction have the opportunity to access effective family planning methods, to postpone pregnancy while in treatment and recovery from addiction. This strategy supports the optimal health of the individual and reduces the risk of having infants born with neonatal abstinence syndrome (NAS) (NOM11 Neonatal abstinence syndrome). Additionally, NH FPP health care providers are making referrals when indicated. Increasingly, MAT such as buprenorphine is offered in primary

care settings and CHCs providing greater access for individuals. MCH is cognizant of the correlation between substance misuse, pregnancy, and sexually transmitted infections, and works to keep its sub-grantees and their medical providers informed and prepared.

There has been an effort to screen for mental health disorders during the well-woman visit (NOM24 Postpartum depression). Primary care and family planning providers have included screening for these disorders and are making referrals when indicated. MCH also has some sub-grantees who are able to refer to mental health services within their own organization. This has created a sense of trust and comfort for many women who are seeking these services. This strategy also decreases barriers women may experience in accessing needed mental health services.



Map #	Agency Name	City/Town
1	Coos County Family Health Center	Berlin
2	White Mountain Community Health Center	Conway
3	Community Action Program (CAP) Belknap-Merrimack	Ossipee
4	Mascoma Community Health Center	Canaan
5	Community Action Program (CAP) Belknap-Merrimack	Laconia
6	Planned Parenthood of Northern New England (PPNNE)	Claremont
7	Concord Hospital Family Health Center	Concord
8	Equality Health Center	Concord
9	Concord Hospital Family Health Center	Hillsborough
10	Planned Parenthood of Northern New England (PPNNE)	Keene
11	Planned Parenthood of Northern New England (PPNNE)	Manchester
12	Manchester Community Health Center	Manchester
13	Planned Parenthood of Northern New England (PPNNE)	Exeter
14	Joan G. Lovering Health Center	Greenland
15	Planned Parenthood of Northern New England (PPNNE)	Derry
16	Lamprey Health Care	Nashua

Programs like Home Visiting/Healthy Families America, have also provided referrals to CHCs for women's health services. Through their work with women and families, they provide education about the importance of preventive and reproductive health care. The program also assists women in seeking out health services and go as far as eliminating some barriers, such as transportation, to ensure that women are getting the health care services they need.

MCH contracts with CHCs for primary care services (funded by Title V and state general funds) which support women's health and preventive medical visits. The NH Family Planning Program (NH FPP), funded by Title X and State general funds, provides reproductive and preventive health care to thousands of women in New Hampshire every year (NOM23 Teen births). The NH FPP has nine (9) sub-grantees with 16 clinics statewide that allow women, especially those uninsured and with low-income, to seek preventive screenings, preconception, and reproductive health services regardless of income level. Many of the primary care sub-grantees are also family planning sub-grantees which allow women to receive preventive care as well as reproductive health care in the same location, and often with the same medical provider. MCH conducts sub-grantee site visit audits on a yearly basis to assess this performance measure. The programs and partnerships MCH has established are critical in providing women with preventive health care and health services that meet their needs.

MCH recognizes family planning services as a gateway to primary care services. MCH utilizes family planning clinics for preventive medical visits as sixty percent (60%) of women who obtain health care from a family planning clinic consider it be their usual source of health care while 40% of women consider it to be their only source of care.[3]

MCH has taken the initiative to be included in social media messaging within DPHS' social media accounts on Facebook, Twitter, and Instagram. DPHS started a division-wide social media presence (Facebook and Twitter) in April 2017 and committed to sharing two to three social media messages a day. The strategy allows the Division to actively engage with the community by raising awareness of public health issues that can improve health and prevent disease. Consistent messaging helps educate the target audience about important health matters.

MCH is an active contributor of content and each month shares 20-30 posts. The posts include information on every topic area of MCH and provide links where women can access services. Consistent posting of MCH information on social media platforms increases outreach efforts. The DPHS is also exploring marketing strategies on social media platforms to reach target populations. MCH programs are able to share information through specific targeting through the use of these marketing strategies. The targeting strategy includes demographic information such as, age, race, ethnicity, and specific location, as well as targeting based on interests. This has become a critical strategy to target health information to particular age groups as 81% of Americans use social media. Generally, social media users have multiple accounts across many platforms (73%).[4]

When looking specifically at younger populations, 71% of Americans aged 19-24 years old have an Instagram account; this age group also visits the platform multiple times during the day.[5] In this same age group, 45% are Twitter users.

Due to the success of the DPHS Facebook and Twitter accounts, in April 2018, DPHS expanded its reach to focus more on adolescents and young adults through the use of Instagram. The strategy of messaging on this platform is very new and the DPHS is actively working to increase engagement with the promotion of health related information that is valuable and relatable to youth. These topics include but are not limited to reproductive health, tobacco and e-cigarette use, adolescent wellness, preventive screenings, mental health services, and injury prevention.

ESM1.1 – Percentage of women who receive pre-conception counseling and services during annual reproductive health (preventive) visit at family-planning clinics.

MCH promotes preventive health services for all Title V populations via contracting with community health centers for primary care, primary care for the homeless, and family planning services. MCH contracts with eleven (11) CHCs for primary care services, three (3) CHCs for PC-homeless services, and nine (9) family planning sub-grantees. Five (5) CHCs are contracted for primary care and family planning services. Preventive health care visits will be measured by the proportion of women who receive preconception health services in sub-grantee clinics. Provision of preconception care represents the types of preventive services typically provided for women.

Preconception health refers to the health of women and men during their reproductive years, and focuses on taking steps to protect the health of the mother 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: reproductive cancer screenings (Pap tests), 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 (NOMs 10-11). For women planning pregnancy, preconception health services and counseling has a direct effect on health outcomes for both mother and baby (NOMs 2-6; NOMs 8-9.4). Being healthy before pregnancy reduces preterm births and low birth weight babies, giving the newborn a healthy start in life.

Since more than 45% of births in the US result from unplanned pregnancy, offering these services to all women of reproductive age in MCH sub-grantee clinics is an effective strategy to improve health outcomes for mother and baby[6] (NOMs 2-6; NOMs 8-9.4). In 2014, MCH through the NH FPP began collecting preconception counseling data as a sub-grantee performance measure. Since that time, the percentage of NH FPP clients receiving preconception counseling has steadily increased among all NH FPP sub-grantees. Baseline data indicated that 56% of NH FPP clients received preconception counseling.

To bolster provider capacity, among the nine (9) contracted NH FPP sub-grantees, to provide preconception health services to

women of reproductive age (15-44 years old), preconception training and presentation was delivered by the QA/QI Nurse Consultant at the fall of 2016 semi-annual mandatory NH FPP sub-grantee meeting. This training was the first introduction of including preconception health into the family planning services. The training was given to sub-grantee directors and to their clinical staff. To accommodate this important initiative, NH FPP provided resources and professional training to these contracted agencies. The resources given enhanced the service providers' skills and confidence in providing pre-conception health services to women. These services included not only pre-conception health but also contraceptive management. By 2017, sub-grantees reported that 79% of NH FPP clients were receiving this counseling. Efforts to improve this performance measure included technical assistance during site visits.

Preconception counseling encompasses the "One Key Question" (i.e. "Would you like to become pregnant in the next year?") and subsequent counseling on healthy behaviors and overall health to ultimately improve maternal and infant health outcomes.

To assess and monitor the frequency of delivery of preconception counseling, the Region 1 Title X database is utilized. This database was updated in late 2016 to measure preconception counseling. When the program initiated the collection of this performance measure, the program's target started out modestly at 25%. This conservative target was exceeded in year one (2014 data, reported in 2016) with an outcome of 56%.

MCH has been utilizing two separate mechanisms for agencies to report data. The first is the Data Trend Table (self-reported, extracted from medical records) and the second is the Region 1 Title X database. While MCH is seeking to achieve one system of data collection, the program has faced challenges with data quality as seen by a large variation in the data reported in these two systems. The MCH staff members (QI nurse consultant and FP Program Manager) have been working with the FP agencies to improve the quality of data reporting, but the dual data entry approach will be maintained until there is a higher concordance in the reported data. For the purpose of Title X reporting, MCH will use the more conservative number reported in the Region 1 Title X database to avoid over-reporting.

In addition to utilizing the Region 1 Title X database, the program also uses site visit audits of family planning as well as primary health care agencies to assess preconception counseling and services. By 2023, the goal is to have preconception counseling and related care services reach 50% of the agencies' population served.

Many health clinics in NH do not have written protocols in place to define the concept and delivery of preconception care and many providers are not fully aware of what constitutes this type of preventive health care. As this can pose a challenge among clinics and providers, is critical for MCH to continue its efforts to encourage family planning and primary care agencies to provide this counseling to women who are seen for reproductive health care. In a study conducted in partnership with the Office of Population Affairs[7] it was found that family planning clinics (funded by Title X) have a higher rate of offering preconception counseling and related services than other public clinics. Due to the importance of this counseling, NH FPP plans to continue stressing the importance of preconception health for providers during annual site visits and semi-annual meetings.

To promote preconception and reproductive health care visits (preventive screenings) MCH has not only worked with sub-grantees but has also featured this promotion on social media. Postings have included topics such as the importance of folic acid, the prevention of sexually transmitted infections, and medically accurate information on contraceptive methods, including Long-Acting Reversible Contraception (LARC).

NH Public Health Services
Published by Hootsuite [?] · February 14 ·

The NH Family Planning Program clinics provide reproductive health services to all men and women regardless of income. These services include contraceptives, STI testing, and preventative care. To find a clinic near you: http://ow.ly/sOZ630hu2Sb

NH Public Health Services
Published by Hootsuite [?] · March 12 ·

The IUD is gaining popularity among women. IUDs are a safe and effective birth control method but due to its rocky start in birth control history, there are still myths out there. Here are 5 myths about the IUD busted: http://ow.ly/Hi1C30hu3cw

* * * * * * * * *

National Performance Measure #14.1: Percent of women who smoke during pregnancy

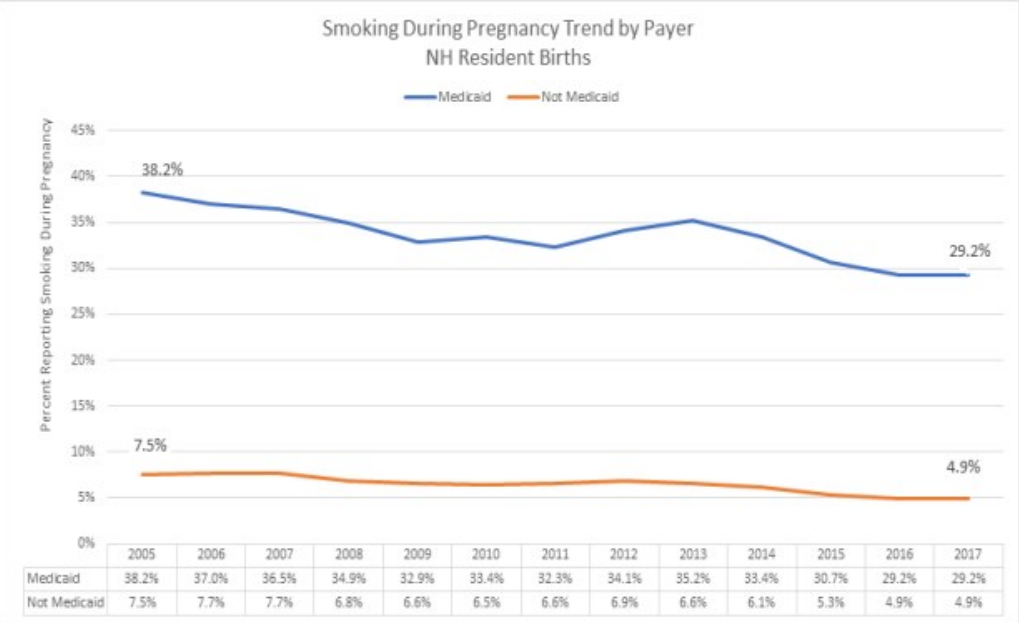
Evidence Based or Informed Strategy Measure: Number of calls received by the New Hampshire Quitline in the past year

Objectives:

- By July 1, 2020, decrease the percentage of women who smoke during pregnancy to 28% or less among deliveries paid by NH Medicaid.
- By July 1, 2020, decrease the percentage of women who smoke during pregnancy to 4.5% or less among deliveries not paid by NH Medicaid
- 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 QuitWorks-NH and QuitNow-NH through education of health care providers and citizens.
- Facilitate enrollment into tobacco treatment programs by making referrals for both providers and clients easier (e.g. electronic two-way system).
- Professional education on best practices in tobacco treatment through online e-learning modules.
- Collaborate with neighboring state to offer pregnant women an option to assist them in quitting by using a smartphone assistive program.



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Medicaid	38.2%	37.0%	36.5%	34.9%	32.9%	33.4%	32.3%	34.1%	35.2%	33.4%	30.7%	29.2%	29.2%
Not Medicaid	7.5%	7.7%	7.7%	6.8%	6.6%	6.5%	6.6%	6.9%	6.6%	6.1%	5.3%	4.9%	4.9%

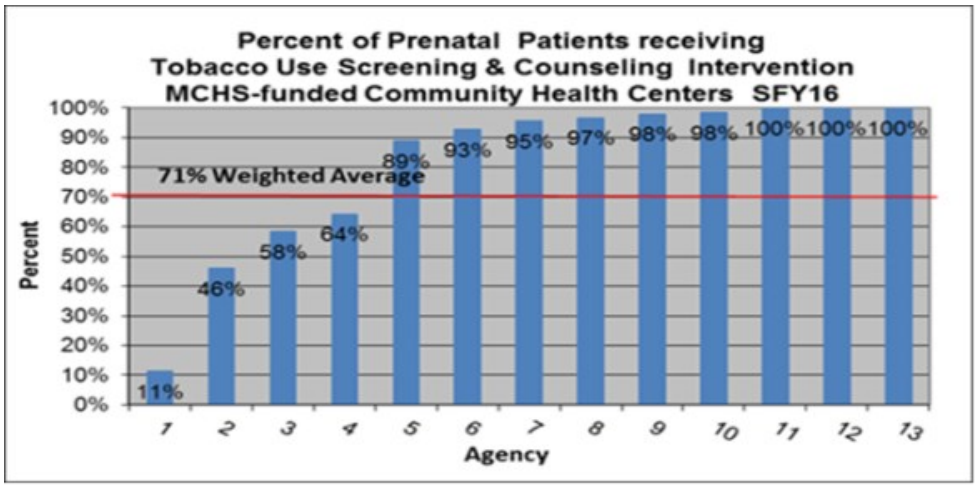
Data Source: NH Medicaid and NH Vital Records

The percentage of women who smoke when pregnant has decreased in NH as seen in the 12 years shown in the chart above. The decline has been gradual but consistent. This chart shows that the steady decline among those who are smoking during pregnancy has been in both the deliveries paid for by Medicaid and those that are not paid for by Medicaid. These numbers consistently show a notable disparity between the number of those who are smoking and are on Medicaid versus those who are smoking and are not

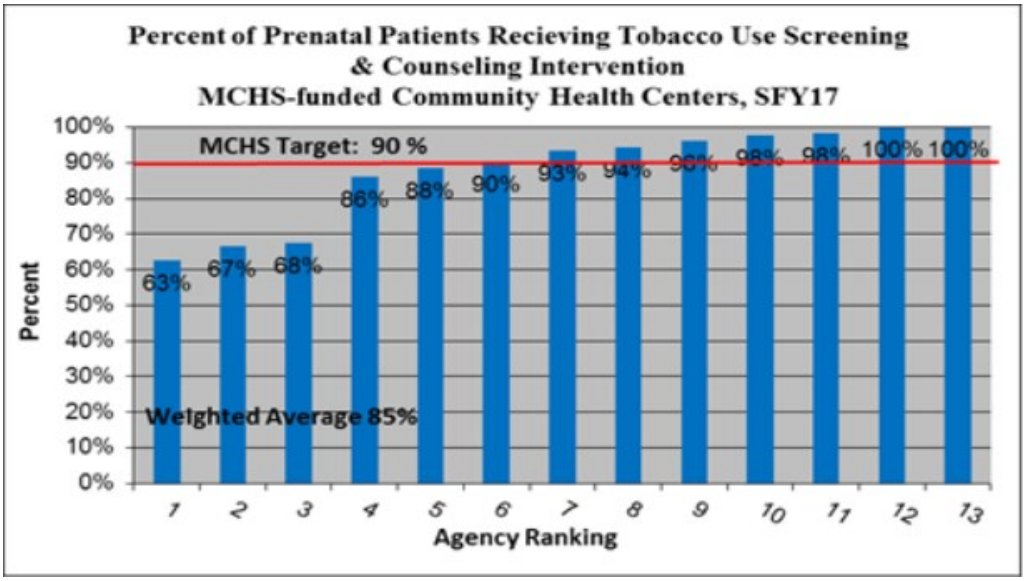
participating in Medicaid. This past year the rates for both of these groups remained unchanged from the 2016 overall percentage for each. The number of women who were pregnant and smoking and delivered in 2017 is 1335. The breakdown is 897 pregnant women smoking who were covered by Medicaid and 438 covered by other insurers.

The chart below shows the percent of prenatal patients at all 13 of NH's CHCs in 2016 who received tobacco use screening and counseling intervention.

Screening and Counseling in the CHCs for Pregnant women



The chart below shows the same CHCs in 2017. CHCs 1-4 show much improved screening for tobacco use in pregnancy. During site visits to the centers MCH staff were able to discuss in person the data collected around smoking in pregnancy. This chart shows the improvement in screening for smoking during pregnancy at those centers that showed low numbers in 2016. Each of the centers sends referrals to National Jewish Health (NJH), NH's Quitline vendor, after screenings if the patient is ready to quit. NJH, in turn, supplies the NH DPHS Tobacco Prevention and Cessation Program (TPCP) with data on the extent to which NH residents are using the program. Together, TPCP and MCH monitor this data to guide local improvement.



The NH TPCP partners with NJH for the services provided through QuitNow-NH. NJH is a leading respiratory hospital in Colorado which also offers a tobacco cessation program nationwide. This organization provides personalized coaching and online resources to those who want to quit using tobacco products. Any NH resident is able to access QuitNow-NH by calling 1-800-QUIT-NOW or by a referral from a healthcare provider. The table below shows the past three years of data.

Year of Intake	Total Female age 18-45	Total Pregnant Intakes	# Joined PPP
2015	212	10	10
2016	223	13	12
2017	351	18	13

The **Total Female age 18-45** includes all females between the ages of 18-45 who made a call to NJH or agreed to be referred to NJH from a healthcare provider.

The **Total Pregnant Intakes** indicates that a referral or call had been made to NJH and a quit coach was able to speak with that woman to discuss what the program offers and how the program would proceed over the course of the pregnancy if she chose to agree to a quit coach.

The **#Joined PPP** is the actual number who decided to go forward after that intake phone call and began the program. The chart below contains the last three years of data for New Hampshire women.

The number of women aged 18-45 who have participated in the NH Quitline has increased each year since 2015. Although the number who enroll is small, the number of pregnant women who have called the Quitline has consistently increased each year. The focus for the upcoming year is on increasing the overall number of those who call and ultimately those who enroll in the Quitline coaching. To accomplish this MCH and TCPC are engaging obstetric providers in the tobacco conversation with a module that teaches ways to approach this subject with pregnant women.

To ensure that healthcare professionals have access to evidence-driven tobacco treatment strategies, the NH TPCP created a free online training curriculum. TPCP and partners completed five modules. The topics of the modules are: Fundamentals of QuitNow-

NH; Ask, Assist, Refer: Treating Tobacco Use for Dependence; Pharmacotherapy; Motivational Interviewing; and Supporting Pregnant and Postpartum Women to Quit Tobacco.

In each of the modules the professionals offer ways to motivate patients to quit smoking and how to refer patients to QuitNow-NH. The modules can be found at http://quitworksnh.org/education-training/tobacco-treatment-professional-development/. The modules accommodate hectic clinical schedules and offer free continuing education credits for each module completed.

During pregnancy, women have more frequent contact with a health professional than when they are not pregnant. For this reason if healthcare providers are engaged in sharing the health benefits of smoking cessation during pregnancy, the patient is more likely to consider quitting. If a trusted provider shares the positive aspects of being a non-smoker and patients feel supported, when they become ready to quit they know that the provider is there to help.

MCH assisted with the Supporting Pregnant and Postpartum Women module (Module 5) which was directed specifically to providers who care for the prenatal populations who are tobacco users. The module shares the benefits of quitting and how to approach the idea with patients. The trainers in the module are NH obstetric providers, public health representatives, and others who work with pregnant women in NH.

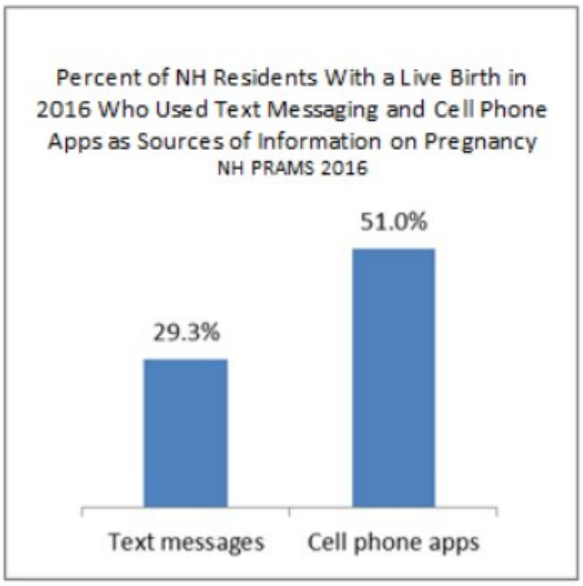
In early 2018 Module 5 was completed. This module will now be shared with NH providers as the opportunities arise. The Northern New England Perinatal Quality Improvement Network (NNEPQIN) has quarterly meetings that bring together health professionals who work with pregnant women in New England. The information to access Module 5 can be shared with providers at these meetings. QuitWorks-NH is offering free continuing education units (CEUs) to medical professionals who take part in the training. A second venue where the module can be shared is at meetings for the CHCs which are attended by managers of the health centers as well as clinical staff. Information on the module can then be brought back to the centers for wider dissemination.

Sharing Module 5 with the CHCs will hopefully continue the positive trend seen in the data around prenatal patients receiving tobacco screening and intervention. It will encourage providers and each of the people who make up the medical teams to screen and follow up with all pregnant women who are smoking. Sharing the TPCP e-learning modules described here will provide more education and resources to the centers on tobacco use screening and counseling intervention. When patients receive a consistent message surrounding tobacco use it is more likely that when they decide they are ready to quit they will consult their provider.

MCH New Project:

University of Vermont Smartphone Smoking in Pregnancy Project

The chart below from the Pregnancy Risk Assessment and Monitoring System (PRAMS) in NH shows how pregnant women use electronic methods for information gathering. Cell phones are a beneficial way to communicate with mothers and now may be a way to assist a mother to stop smoking. With this is mind when an opportunity to assist mothers in quitting smoking with use of the smartphone was offered NH pursued the opportunity.



There have been ongoing projects at the University of Vermont (UVM) that involve incentive-based rewards for women who are pregnant to quit smoking and remain abstinent from smoking postpartum. Results of these studies had been published in Preventative Medicine in 2012 showing that in the control group 9%-18% remained abstinent from smoking by the end of pregnancy but 35%-40% remained abstinent in the group that was quitting with the aid of monetary incentives. Most recently the UVM group obtained funding to broaden the geographic scope of the project and to add the use of a smartphone application. By using a smartphone the women do not need to make a trip to the clinic as in the original program. They are now instructed by phone on how the program is conducted. If the person then decides to move forward to use the smartphone incentive program to stop smoking she will be informed on how she will receive testing supplies and how to submit samples and obtain incentives for each new goal achieved in the quitting process.

In January 2018 UVM contacted MCH in an effort to invite NH pregnant women to participate in this incentive-based program to quit using tobacco products. A meeting was scheduled in NH to learn more about the past success of this program and how pregnant women in NH might become involved. The meeting included the NH Perinatal Nurse Coordinator, the NH WIC Program Manager, the NH QI/ QA Nurse Consultant, NH TPCP representatives as well as the NH Home Visiting Program Supervisor. The programs that work directly with pregnant women have begun to share the information on the Vermont study. NH women who want more information about how the program is conducted are asked to call the number given on the information sheet. The professionals conducting the study can then explain fully the program and the women can sign up to participate if interested. The inclusion of NH women in this UVM study started in May 2018.

An update on the participation of NH pregnant women in this project was provided to the NH TPCP this September. It was reported that participation has been minimal. In response to this information the Perinatal Nurse Coordinator spoke to managers of WIC and Home Visiting to help determine the likely contributors to the lack of participation in the study. In the case of the WIC program the manager learned that those working in the site chosen to participate have put out the brochure explaining the program but there has been no verbal attention brought to the opportunity. The current plan is to speak with the WIC agencies in Vermont that have offered the smartphone incentive program and gained successful participation. This discussion will assess whether the NH site can have a similar procedure for supplying information to pregnant women. If the procedure for sharing is successful it could lead to more pregnant women taking a look at this opportunity to remove smoking from their lives while gaining incentives throughout the process.

MCH Specific Activities

All MCH-funded home visiting agencies have smoking cessation as one of their performance measures. When a smoker is identified, home visitors work to encourage quitting with referral to QuitNow-NH. They meet the person where they are in the process as described by the stages of change theory. If the person wants to quit but is not ready, the home visitor will share helpful information on safe smoking practices. These include things such as washing hands after smoking and changing clothing prior to holding the baby to decrease second hand smoke exposure.

Smoking is always discussed by DHHS representatives as a risk factor for SUID. Data from the 2011-2016 NH SUID Case Registry case showed that 60% of the mothers of those infants in this registry had smoked during or after their pregnancy.

In December 2017 through March 2018 MCH funded the airing of the CDC's successful *Tips (Tips From Former Smokers)* Amanda Ad 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.[8] 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.[9] The program was also able to air the New Hampshire Dear Me Sharon and Patrick ads. These ads highlight a tobacco user writing a letter to him- or herself where they discuss all the reasons they need to quit tobacco products. The ad provides QuitNow-NH phone number and website. A report on how this media campaign's success is in being prepared. It is hoped that these tobacco-specific activities will have an impact on the following outcome measures:

NOM4 – Percent of low birth weight deliveries (<2,500 grams): 6.9% in 2015, 6.4% in 2016
NOM5 – Percent of preterm births (<37 weeks): 7.9% in 2015, 7.8% in 2016
NOM6 – Percent of early term births (37, 38 weeks); 20.6% in 2015, 21.1% in2016

Maternal Mortality Update

The Maternal Mortality Review Program in NH was established in 2010. This program was established to conduct comprehensive, multidisciplinary reviews of maternal deaths in the state. By reviewing the maternal deaths, the factors associated with the deaths are identified and recommendations are then made for system changes to improve services for pregnant women. In NH all deaths that occur during pregnancy or within one year postpartum are reviewed no matter the cause.

In September of 2017 Region 1 Maternal Mortality providers gathered in Boston for a summit that was organized by the CDC Foundation and others. This summit was gathered to bring together the New England maternal mortality review program Coordinators and others who work to support the Maternal Mortality Review process in each of the states. For example, in NH a representative from NNEPQIN and the NH MCH Epidemiologist work together with the Maternal Mortality (MM) Coordinator to find and gather information about cases and all three were present at the summit. The NH MM Coordinator participated in phone calls to assist in planning the topics for the summit. Through the planning process came discussion of the opioid crisis that is happening nationwide and how it is one of the causes of maternal deaths. Discussing substance use disorders in pregnancy led to the idea to have a midwife from the Dartmouth-Hitchcock Medical Center (DHMC) make a presentation on this subject to the MM Coordinators. This person works with the pregnant population with substance use disorders and had been in the process of developing a "tool kit" for other providers to refer to when caring for a woman who is pregnant and has a substance use disorder. This discussion is important to the work of MM Committees because they work to make changes to prevent future tragedy. The

toolkit for pregnant women with substance use disorder (SUD) was created to lead to better outcomes as well.

During the summit, each of the state MM Coordinators explained to the group the history of that state's MM program, successes, areas that need improvement and hopes for the future of each program. During the summit many attendees felt that building a connection between our New England states around the review of maternal death cases would benefit the states to improve their review process.

In July of 2018 NH will be hosting the CDC Foundation representatives as they provide a Technical Assistance meeting to support users of the Maternal Mortality Review Information Application (MMRIA). This meeting is planned for a day and a half and will focus on abstracting information for review with maternal review committees. Vermont has accepted the invitation and will attend the NH meeting and other New England states have also been invited to this potential second gathering of Region 1.

Over the past year the NH MM Coordinator has been working with the CDC Foundation and the State of New Hampshire IT department to gain access to the MMRIA system for NH. As of February 2018, NH cases that are investigated will be entered into the MMRIA system. Having access to and using the MMRIA system will lead to changes in the way in which the program collects, abstracts, and organizes data for review. The technical assistance meeting in July 2018 will provide information to assist in the new application and its capabilities.

NOM3- Maternal mortality rate per 100,000 live births

The most recent data on maternal deaths in NH is from the report including 2012-2015 deaths. These are the deaths that were reviewed in NH by the Maternal Mortality Review Committee (MMRC). A new report which will include 2016-2017 NH maternal deaths will be created after every 2017 death comes to review in the fall of 2018. The 2012-2015 data is as follows:

Twenty-four NH residents are known to have died while they were pregnant or within one year of a pregnancy ("pregnancy-associated") within the four-year period 2012–2015. Twenty (83%) of the 24 deaths occurred in NH, four (17%) occurred out-of-state. Six (25%) of the 24 pregnancy-associated deaths occurred in women who were pregnant at the time of death.

The leading causes of pregnancy-associated deaths in NH residents in 2012-2015 were accidental drug overdose and cardiovascular disorders, followed by suicide.

The majority of the 24 pregnancy-associated deaths were not "pregnancy-related" (the cause of death was not directly related to the pregnancy). The NH Maternal Mortality Review Panel (MMRP) reviewed the 23 pregnancy-associated deaths that occurred in NH and determined that two (2) were pregnancy-related (one NH resident). The MMRP was not able to review the four (4) deaths of NH residents that occurred out-of-state because cross-border data sharing was inhibited by differing privacy laws. National and regional efforts are underway to address these challenges.

Recent changes to the New Hampshire Maternal Mortality process

Another recent decision was made collaboratively with the MM Coordinator and NNEPQIN which will lead to an update on how information is abstracted from medical records for the NH Maternal Mortality Program. This change was then approved by the deputy director of DPHS. The decision was made to go in-person as appropriate to hospitals, clinics, primary care offices and any establishment where information on the maternal death might be gathered. By going in-person to discuss a death and obtain needed records, only information pertinent to the case needs to be collected. In the past the establishments supplying needed information were asked to send it via mail. Because the hospitals and offices now use electronic medical records, printing and sending entire

charts was onerous and resulted in numerous duplications. This is not only time consuming for the establishment to send the information but also for the case abstractors to go through to find new and significant information. Going forward whenever possible, the MM Coordinator and the NNEPQIN lead, who work together to abstract information for cases, will visit the locations by appointment and meet with Nurse Managers or Risk Managers at hospitals or offices where the decedents received their healthcare in order to better navigate the electronic records of each institution. This may decrease the time it takes to abstract information for review and allow the opportunity to speak with individuals out in the community who are working with the pregnant population on a daily basis. The first in-person visit was completed in May of 2018.

NOM2- Rate of severe maternal morbidity per 10,000 delivery hospitalizations

The MCH section through its involvement with NNEPQIN is participating in the Alliance for Innovation on Maternal Health (AIM) program under the auspices of the Council for Patient Safety in Women's Health Care. AIM is a national alliance to promote consistent and safe maternity care to reduce maternal mortality by 1,000 and severe maternal morbidity by 100,000 instances over the course of four years, 2014–2018. The federally-available data, utilizing State Inpatient Databases, shows that there were 89.9 cases of severe maternal morbidity per 10,000 hospital deliveries in 2008, and 75.5 per 10,000 in 2009.

Through the provision of statewide, hospital level discharge data for severe maternal morbidity measures, MCH and NNEPQIN will help AIM to develop and distribute a series of evidence-based patient safety bundles, provide benchmarking data, and encourage birthing hospitals in the state to join in the effort. Patient safety bundles are sets of evidence-based practices that when performed collectively and reliably have been proven to improve patient outcomes. The bundles, supplemental materials and technical assistance will be made freely available for any interested birth hospital registering for AIM. NNEPQIN has a history of developing patient safety bundles, which can be found at http://www.nnepqin.org/guidelines.asp.

Severe Maternal Morbidity

MCH continues to work with NNEPQIN on issues of mutual interest and benefit. The NH MCH Epidemiologist reached out to counterparts in Maine and Vermont and initiated a collaborative project to assess Severe Maternal Morbidity (SMM), which can be defined as "unintended outcomes of the process of labor and delivery that result in significant short-term or long-term consequences to a woman's health."[10]

Independently, epidemiologists in each of the three states applied a standardized methodology to the assessment of SMM using inpatient hospital discharge data from 2013-2015. The team followed the methods documented by AIM. In addition to providing standardized methods, this also served as evidence that each state has the capacity to produce the data necessary for formal participation in AIM.

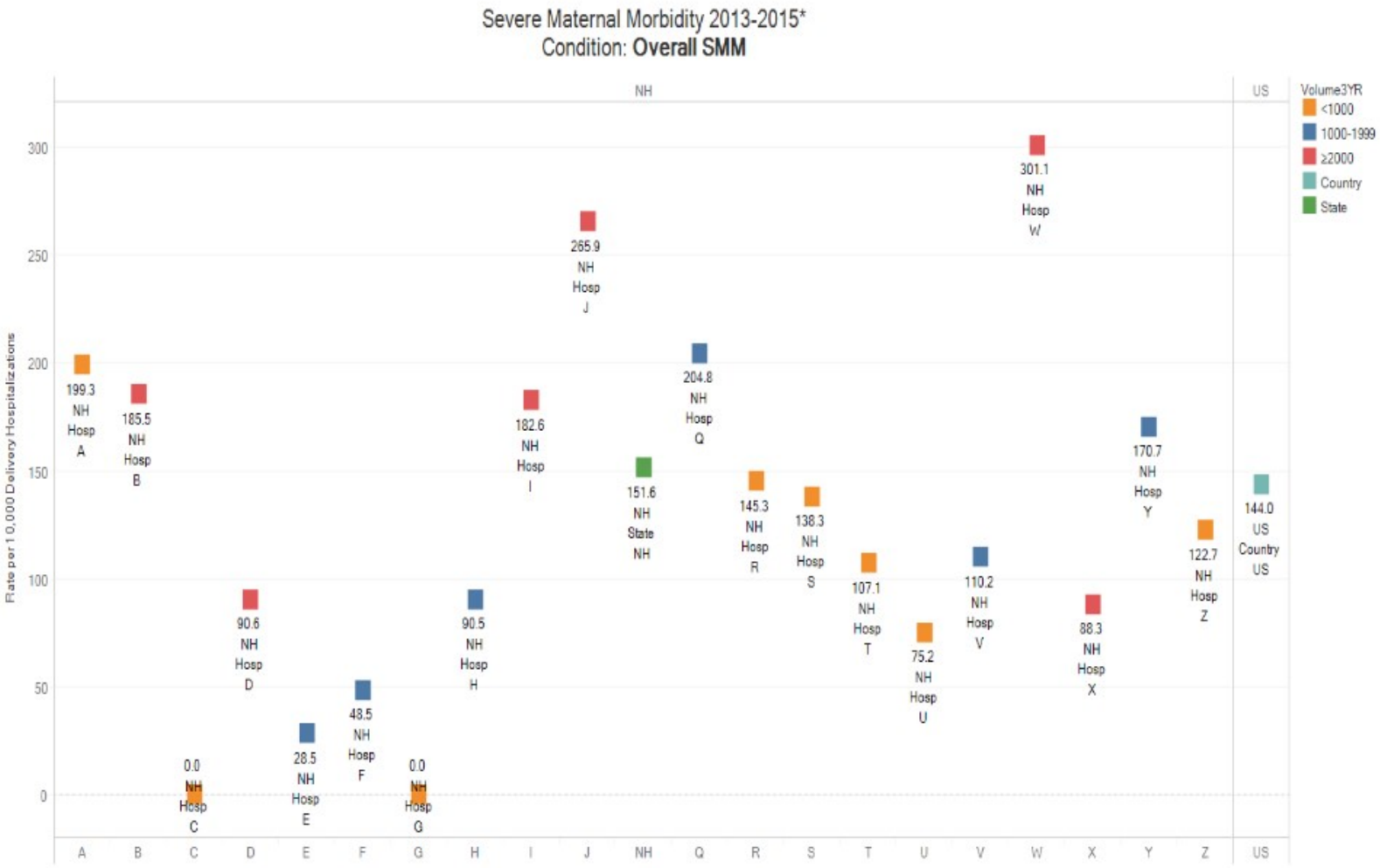
The SMM assessment included discharges in each state regardless of the residence of the patient (occurrent discharges). Resident discharges were not available within state databases if the discharge occurred out-of-state and therefore the statistics obtained were not representative of the entire state population. This can be thought of as using a systems approach rather than the typical public health approach of including all residents in the population. This was necessary due to both data availability and relevance to the hospital-based audience (who do not typically limit hospital-level statistics to residents of the state in which they are located).

The team also used de-identified birth data to describe and compare characteristics of the occurrent birth population in each state. Statistics included characteristics such as maternal age, education, principal payment source, state of residence, pre-pregnancy Body Mass Index (BMI), Cesarean deliveries, nulliparous term single vertex (NTSV) c-sections, and preterm birth.

The results of the tri-state analysis were presented at the NNEPQIN meetings in November 2017 and January 2018. Since these

were the first known estimates of SMM for these three states, one purpose of the hospital-level estimates was to explore possible data quality problems with the subset of inpatient discharge data represented in the delivery discharges. Outliers may be due to data quality issues rather than actual differences in rates. The data were presented to hospital stakeholders with the explicit acknowledgement of this possibility. Discussion during and after these presentations reinforced that some outliers were likely a result of these challenges. This finding has value in that using the data in this way can incentivize stakeholders to identify and correct potential systems issues. Collaborative exploration of these issues continues.

Overall rates of SMM are presented in the graphic below. This static image was exported from an interactive data visualization prepared for the January 2018 meeting. The interactive version include rates for NH, Maine, and Vermont and for the US overall. It allows exploration of some of the conditions that make up the overall SMM rate such as Transfusions, Hemorrhage, Eclampsia and Hypertension. Comparison of the de-identified hospitals by volume category, state, and condition is facilitated by interactive highlighting and filtering. The ability to exclude individual data points is particularly useful for exploring outliers. The y-axis re-scales appropriately after excluding outliers and better shows differences between hospitals. Hospital staff attendees were provided with the letter corresponding to their hospital on the graphic.



*U.S. data is for 2014 only and may not be directly comparable due to coding definition changes. Source: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/smm/rates-severe-morbidity-indicator.htm

Notes:
1. This analysis uncovered expected possible data quality issues that are being further explored. Outliers may be due to these data quality issues rather than an actual difference in rates.

Created on 9/26/2018 at 4:01 PM

Postpartum care and Home Visiting

Increasing maternal attendance at the post-partum medical visit is a developmental goal of Healthy People 2020[11] and yet nearly 40% of women do not attend these visits.[12] Home Visiting targets a population that has disproportionately higher rates of non-attendance of post-partum visits. A study has been done to explore the rates of post-partum visit adherence in home visited families in NH. In this study families and home visitors were surveyed to explore the knowledge, attitudes and constraints of home visitors and home visited families, in order to identify barriers to post-partum visit adherence as well as attitudes of both mothers and home visitors about their understanding of the post-partum visit and importance. Study results have not yet been officially released, but an advisory board composed of Home Visiting direct staff and supervisors, medical professionals, state Health Department personnel, staff from the Community Health Institute/JSI, and home visited families are working to provide recommendations on how to improve post-partum visit adherence based on the preliminary research results. Because post-partum visits provide an opportunity to check the health and well-being of the mother, including screening for post-partum depression, birth control options, immunizations, and changes in the family since the birth of the baby, greater attendance of mothers at the post-partum visits should be encouraged. This study will contribute to the research in ways of improving post-partum visit adherence.

* * * * * * * * *

---

[1] Anyone, Anytime. Facts about NH's heroin, fentanyl, & other opioid crisis. accessed May 14, 2018

[2] Centers for Disease Control and Prevention, Drug Overdose Death Data, December 19, 2017
National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention

[3] Guttmacher Institute, 2016 Publicly funded family planning services in the U.S. Retrieved on May 4, 2018

[4] Smith, A., & Anderson M. (2018). Social Media Use in 2018. Pew Research Center.

[5] Ibid.

[6] Finer, L. & Zolna, M. (2016). Declines in unintended pregnancy in the United States, 2008-2011. New England Journal of Medicine, 364(9), 843-852.

[7] Robbins, C., Gavin, L., Zapata, L., Carter, M.,Lachanace, C., Mautone-Smith, N. (2016). Preconception care in publicly funded U.S. clinics that provide family planning services. *American Journal of Preventative Medicine, 51*(3), 336-343.

[8] Centers for Disease Control and Prevention (2017), *Tips* Media Campaign. Retrieved on 07/03/17 from http://www.cdc.gov/tobacco/campaign/tips/stories/amanda.html.

[9] Ibid.

[10] Severe maternal morbidity: screening and review. Obstetric Care Consensus No. 5. American College of Obstetricians and Gynecologists. Obstet Gynecol 2016;128:e54–60. https://www.acog.org/Clinical-Guidance-and-Publications/Obstetric-Care-Consensus-Series/Severe-Maternal-Morbidity-Screening-and-Review

[11] U.S. Department of Health and Human Services (2014). Healthy People 2020, Objective FP5 and MICH-19. Washington, DC.

[12] American College of Obstetricians and Gynecologists (2016). Optimizing postpartum care. Committee Opinion. Obstetrics and Gynecology, 127, e 187-192.

Women/Maternal Health - Application Year

National Performance Measure #1: Percent of women, ages 18 through 44, with a past year preventive medical visit

Evidence Based or Informed Strategy Measure: Percentage of women who receive pre-conception counseling and services during annual reproductive health (preventive) visit at family planning clinics (Title X)

Objectives:

- By July 1, 2021, increase the utilization of Long-Acting Reversible Contraception (LARC) from 18% to 22%
- By July 1, 2019, all Title X Family Planning clinics will have at least one staff member proficient in LARC insertion
- By July 1, 2021, preconception counseling and services will increase from a baseline of 25% to 40%

Strategies:

- Conduct outreach and education through community partners to inform the public on the importance of preventive care for women
- Provide the public with information and resources for obtaining access to women's healthcare
- Provide resources and professional trainings to contracted agencies to enhance agency capacity and staff skills related to providing preventive services for women, which include contraceptive management and preconception health services
- Conduct professional trainings to contracted agencies related to utilization of LARCs and LARC insertion
- Collaborate with NH Governor's Commission on Alcohol & Drug Abuse, Perinatal Substance Exposure Task Force, to increase access to LARCs for women at risk for substance misuse

Long-acting reversible contraceptives, including 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. As of January 1, 2018, NH Medicaid updated its reimbursement policies to permit the insertion of LARC methods immediately following a delivery as a separately identified and paid family planning service. This policy change will increase access to contraceptive devices and remove the barrier of waiting until the first post-partum health visit, when some women might be lost to follow-up, and whose future visits for contraception might be too late or might not happen at all, if an early, unintended pregnancy occurs.

In 2017, among NH FPP contracted sub-grantees, LARC methods had a 19% utilization rate, comparable to other states. NH's goal is to increase LARC utilization from 18% to 22% in by 2021. To increase utilization of long-acting methods, providers will need clinical training. LARC-insertion training, including refresher training, is a priority for MCH and trainings are in the planning stages. The trainings will also cover LARC methods for adolescents and eliminating potential barriers.

LARC trainings have been planned for previous years but were canceled due to low registration from the contracted sub-grantee providers. To overcome this challenge, MCH will be incorporating the LARC training into the mandatory semi-annual NH FPP sub-grantee meeting. The training will be led by the NH FPP Medical Consultant (Ob/Gyn) and Medicines 360. The training will be a three-stage model of training: 1) theory, 2) use of anatomical models, 3) a field practicum with insertions using shadowing and mentorship. Due to a NH FPP staff vacancy and the on-boarding of a new Medical Consultant, as well as the feedback from NH FPP sub-grantees, the LARC training will be planned for spring 2019.

NH FPP is assisting sub-grantees in dealing with barriers that are currently limiting the utilization of LARC methods, which include provider capacity and reimbursement mechanisms. Among the nine (9) NH FPP sub-grantees, there are five (5) which do not offer LARC methods; and among the rest of the clinics, there still remains low capacity in LARC insertion. The LARC training will build new capacity and update skills of those providers wanting to refresh their skills using relatively new products, such as the low-cost

Liletta IUD, which is growing in popularity among community health centers due to its price of only $50. To ensure LARC methods are available statewide, by July 2019, all family planning contracted agencies will have at least one (1) staff member who is proficient in LARC insertion.

In addition to provider capacity, another challenge is the costs associated with the devices as there are insufficient reimbursement mechanisms as well as administrative barriers in place for community health centers wanting to offer them. This poses challenges for sub-grantees who cannot pre-order devices for same-day insertions. For some NH FPP clients, in particular those without health insurance, who represent 26% of all clients being served in NH FPP clinic sites, these costs are prohibitive, and lead to utilization of less effective methods. This consequently can lead to unplanned pregnancy. Investigating creative means to reimburse providers fully is in the plan for the upcoming year.

Lastly, contracted MCH sub-grantees will continue to provide their individual communities with information and resources to access women's preventive and preconception healthcare services. Community outreach and education will be shared with community partners to provide the general public the knowledge and the importance of preventive and preconception health care for women. In addition to outreach and education with community partners, the Family Planning Health Promotion Advisor will conduct a training in the use of social media for NH FPP sub-grantees at one of the mandatory semi-annual meetings. This training will include how to incorporate social media into current marketing strategies and will also demonstrate how to use social media campaigns to increase reach. Initiation of new strategies throughout New Hampshire will increase as the sub-grantees continue to adopt innovative strategies to increase the number of women receiving preventive, preconception, and reproductive health services.

Alliance for Innovation on Maternal Health (AIM)

In collaboration with our perinatal collaborative partner NNEPQIN, MCH has been actively exploring formal participation in AIM. As a result of the analysis of severe maternal morbidity in the state using a combination of de-identified discharge and birth data, along with strong support from NNEPQIN, NH has been invited to join AIM. State participation in AIM expands opportunities for birth hospitals interested in implementing maternal safety bundles for the reduction of conditions such as obstetric hemorrhage, severe hypertension in pregnancy, safe reduction of primary cesarean birth, and maternal venous thromboembolism. In addition, state health department participation introduces significant efficiencies by centralizing the processing and submission of de-identified data to the AIM data portal. The time-savings is significant when compared with each participating hospital submitting data separately. Discussions are ongoing with the appropriate DHHS staff regarding necessary data use agreements. Hospitals which choose to participate would be able to view their own data in comparison with a group of de-identified hospitals with similar characteristics (e.g. volume). They would also be able to enter additional quality improvement data not available in state data sets when necessary for implementing the safety bundles of their choice.

* * * * * * * * *

National Performance Measure #14.1: Percent of women who smoke during pregnancy

Evidence Based or Informed Strategy Measure: Number of calls received by the New Hampshire Quitline in the past year

Objectives:

- By July 1, 2020, decrease the percentage of women who smoke during pregnancy to less than 28% among deliveries paid by NH Medicaid.

- By July 1, 2020, decrease the percentage of women who smoke during pregnancy to less than 4.5% among deliveries not paid by NH Medicaid

- 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 through education of health care providers and citizens
- Facilitate enrollment into tobacco treatment programs by making referrals for both providers and clients easier (e.g. electronic two-way system)
- Professional education on best practices in tobacco treatment through e-learning modules
- Collaborate with neighboring state to offer pregnant women an option to assist them in quitting by using a smartphone assistive program.

MCH Specific Activities

MCH will continue to collaborate with the Tobacco Prevention and Cessation Program (TPCP) and the Community Health Institute (CHI) in the development and marketing of a web-based professional learning module on tobacco cessation. Module five (5) focuses on the prenatal population. This module is now available to all state health care providers and features a staff member from one of the Community Health Centers. The module will assist prenatal providers in using motivational interviewing to discuss smoking and teach providers how best to refer, follow, and assist the patient through quitting. The following table demonstrates the potential for improvement in this area for New Hampshire. As shown in the table, 43% of women who responded to the Pregnancy Risk Assessment Monitoring (PRAMS) survey from 2015 births, and self- report that they were smokers, reported that they had spent time discussing how to quit smoking with the doctor, nurse or other healthcare worker. Two other notable percentages are 19% of the women responding to the survey stated yes to being referred for help with quitting and 14% stated yes to being referred to a national or state quit line. These numbers all have potential to improve as providers and other healthcare workers learn about and participate in the viewing of the smoking cessation module that was created specifically for providers who are working with the pregnant population.

Among NH women who had a live birth in 2015 and smoked in the 3 months prior to pregnancy (NH PRAMS)	
Q: During any of your prenatal care visits did a doctor, nurse or other health care worker...	**%Yes**
Spend time discussing how to quit smoking	43%
Refer you to counselling for help with quitting	19%
Refer you to a national or state quit line	14%
Recommend using a nicotine patch	16%
Provide booklets, videos, or other materials to help you quit smoking on your own	25%

Mothers who participate in PRAMS surveys are randomly chosen from birth records. Women who delivered a low birth weight infant are selected at a higher rate to ensure that adequate data are available in this smaller but higher risk population.

The intended benefit of Module 5 is to offer ways for obstetric providers to motivate patients to quit smoking and also how to refer patients to QuitNow-NH. By assisting providers in techniques for encouraging patients to be smoke-free, the number of women offered counseling and assistance through the quit-line should improve. The module can be found at http://quitworksnh.org/education-training/tobacco-treatment-professional-development/. The modules can be started and stopped, giving flexibility to accommodate hectic clinic schedules. Each module has an evaluation at the end and staff who complete the evaluation are eligible for free continuing education credits. The modules will be shared with providers throughout New Hampshire beginning this year.

Social Media

MCH's Perinatal Nurse Coordinator will continue to participate in the use of the Department of Public Health's Facebook, Twitter and Instagram pages as a way to reach out to the public and share information. The goal is to share information with the public through this social media outlet at least three times monthly. However, this social media connection is not limited to three times per month. Colleagues who post for many departments will post as often as a program requires. They are also able to schedule posts at times that the intended demographic is most likely to see the post. This is one way to directly reach the public to increase knowledge of QuitNow-NH as well as overall tobacco cessation.

UVM Smoking Cessation Smartphone Program

There is an ongoing project at the University of Vermont that involves incentive-based rewards for women who are pregnant and succeed in quitting smoking and remain abstinent from smoking postpartum. Most recently this UVM group obtained funding to widen the area of the project geographically and to add the use of a smartphone application. By using the smartphone the women do not need to make a trip to the clinic as was the case in the original program. In the next year the program will be offered in WIC offices as well as to those in our home visiting program. The UVM project does have a relationship with National Jewish Health as does the New Hampshire Tobacco Prevention Cessation Program (TPCP). Women who decide to use the smartphone incentive program are also encouraged to use the quitline as needed.

Health Resources for Providers/Patients

The Perinatal Nurse Coordinator regularly collaborates with the TPCP and did so in early 2018 to create a large mailing to all obstetric providers' offices. In this mailing packet were a number of links to assist providers working with pregnant women. Many public health programs participated by sending materials to share with the providers. The mailing included posters to place in offices

for 1-800-QUIT-NOW, breastfeeding information and lead poisoning fact sheets. The links contain information on SBIRT for screening women for drug and alcohol use, PRAMS information, postpartum depression and a number of other resources. A notable resource supplied in the mailing was for the Alliance for Innovation of Maternal Health (AIM). AIM has on its website information to assist providers with recognizing and treating potential barriers to having a healthy birth outcome.

The TPCP included in the packet a QuitWorks-NH factsheet and flyer, QuitNow-NH poster and rack card, and the You Can Quit Tobacco booklet. The email and phone number for questions or to order additional copies of the items in the packet were provided as well as the email and phone number to reach the Perinatal Nurse Coordinator. Future mailings will follow, as materials are replenished and new materials are designed or collected.

* * * * * * * * *

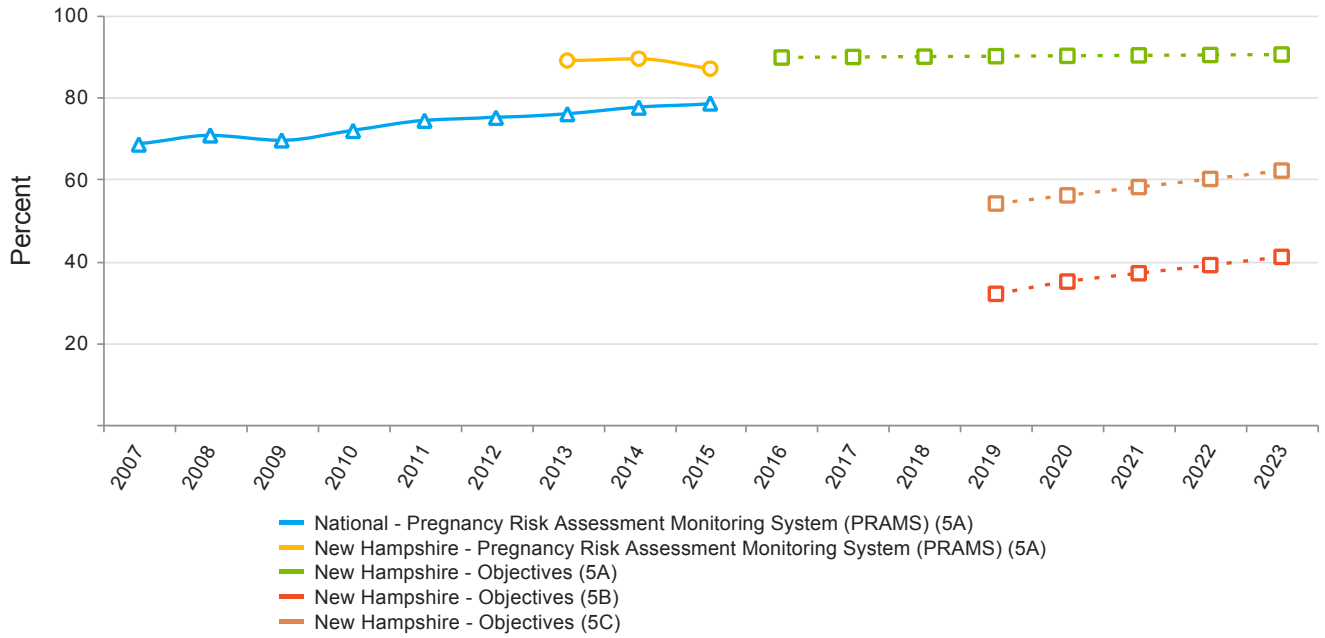
Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2015	4.1	NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2015	1.3	NPM 5
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2015	80.4	NPM 5

National Performance Measures

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding
Baseline Indicators and Annual Objectives



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

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2016	**2017**
Annual Objective	89.6	89.7
Annual Indicator	89.4	87.0
Numerator	10,407	10,258
Denominator	11,645	11,798
Data Source	PRAMS	PRAMS
Data Source Year	2014	2015

State Provided Data		
	2016	2017
Annual Objective	89.6	89.7
Annual Indicator		86.3
Numerator		10,315
Denominator		11,954
Data Source		NH PRAMS
Data Source Year		2016
Provisional or Final ?		Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	89.8	89.9	90.0	90.1	90.2	90.3

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

FAD for this measure is not available for the State.

State Provided Data	
	2017
Annual Objective	
Annual Indicator	29.7
Numerator	3,541
Denominator	11,921
Data Source	NH PRAMS
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	32.0	35.0	37.0	39.0	41.0

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

FAD for this measure is not available for the State.

State Provided Data	
	2017
Annual Objective	
Annual Indicator	51.3
Numerator	5,992
Denominator	11,676
Data Source	NH PRAMS
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	54.0	56.0	58.0	60.0	62.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		60
Annual Indicator	68.4	73.7
Numerator	13	14
Denominator	19	19
Data Source	Birth hospital survey via SurveyMonkey	Birth hospital survey
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	94.0	94.0	100.0	100.0	100.0	100.0

State Action Plan Table

State Action Plan Table (New Hampshire) - Perinatal/Infant Health - Entry 1

Priority Need

Decrease unintentional injury.

NPM

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Objectives

By January 1, 2023, 100% of New Hampshire's birth hospitals will have a safe sleep policy in writing.

Strategies

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

Utilize the Pregnancy Risk Assessment Monitoring System (PRAMS) data to inform key stakeholders about safe sleep education needed

Promote safe sleep policy development and change within birthing facilities

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

Promote public education on safe sleep

Collaborate with birth hospitals in their use of Safe Plan of Care for neonates

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

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

National Performance Measure #5:
(A) Percent of infants placed to sleep on their backs
(B) Percent of infants placed to sleep on a separate approved sleep surface
(C) Percent of infants placed to sleep without soft objects or loose bedding

Evidence Based or Informed Strategy Measure: The percentage of birth hospitals with a written safe sleep policy, including placing all infants to sleep on their back

Objectives: By January 1, 2023, 100% of New Hampshire's birthing hospitals will have a safe sleep policy in writing

Strategies:

- Utilize SUID case registry to describe the distribution of risk factors and identify possible points of intervention
- Utilize PRAMS data to inform key stakeholders about safe sleep education needed
- Promote safe sleep policy development and change within birthing facilities
- Train providers working with infants (e.g. labor and delivery nurses, child care providers)
- Promote public education on safe sleep
- Collaborate with birth hospitals in their use of Safe Plan of Care for neonates

Data Analysis

National Outcome Measure 8 – Perinatal mortality rate per 1,000 live births plus fetal deaths
National Outcome Measure 9.1 – Infant mortality rate per 1,000 live births
National Outcome Measure 9.2 – Neonatal mortality rate per 1,000 live births
National Outcome Measure 9.3 – Postneonatal mortality rate per 1,000 live births
National Outcome Measure 9.5 – Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

NH data from the National Vital Statistics System (NVSS), as provided in Form 10a, indicate that the state is essentially holding steady in its infant mortality-related rates. As shown in Form 10a, perinatal mortality went from 4.9 per 1,000 live births in 2014 to 4.5 in 2015; infant mortality went from 4.4 per 1,000 live births in 2014 to 4.1 in 2015; neonatal mortality went from 2.7 per 1,000 live births in 2014 to 2.8 in 2015; post neonatal mortality went from 1.7 per 1,000 live births in 2014 to 1.3 in 2015; and sleep-related sudden unexpected infant deaths (SUID) went from 89.4 per 100,000 live births in 2014 to 80.4 in 2015.

Deaths due to prematurity make up approximately 39% of its infant deaths (see graphic below, showing 2011 – 2016 NH infant deaths). Statewide effort is made to decrease births due to prematurity by addressing early access to prenatal care and decreasing prenatal tobacco use, and use of targeted funds from the Centers for Disease Control and Prevention (CDC) to address infant deaths from SUID (sudden unexpected infant death).

According to the CDC, in 2015 there were about 3,700 sudden unexpected infant deaths (SUID) in the United States.[1] Data from NVSS for NH show that the rate for NOM9.5 on sleep-related SUID deaths was 80.4 per 100,000 in 2015, an improvement over the previous two years of 89.4 per 100,000 in 2014 and 96.8 per 100,000 in 2013 (infant deaths are weighted to account for deaths that were unable to be linked to a birth certificate).

These deaths in infants less than one (1) year old, with no immediately obvious cause, include those with a final diagnosis of Sudden

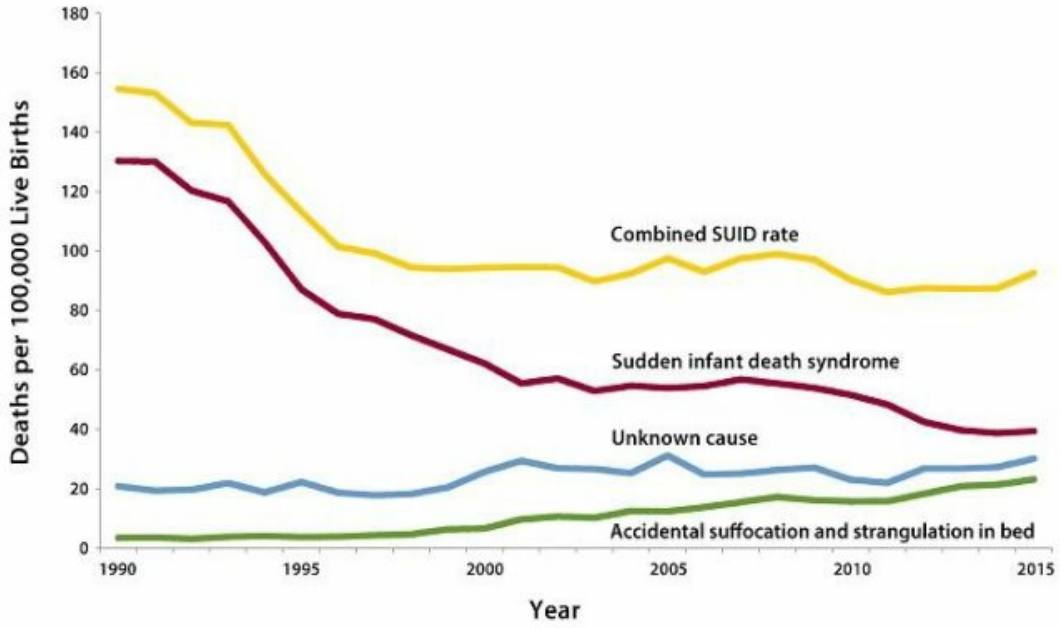
Infant Death Syndrome (SIDS), unknown or undetermined cause, and accidental suffocation or strangulation in a sleep setting. NH's SUID rate has not varied much in the past few years in looking at multi-year combined averages, due to the small number of cases per year (see below). NH's SUID rate per 1,000 live births in 2016 was 0.6, compared to a national rate of 0.9 in 2015.[2]

NH SUID rate per 1,000 Live Births
(source: NH SUID Case Registry confirmed cases)

Year	SUID	Live Births	Rate per 1,000	LCI	UCI
2011	7	12800	0.5	0.2	1.1
2012	8	12282	0.7	0.3	1.3
2013	11	12290	0.9	0.4	1.6
2014	11	12239	0.9	0.4	1.6
2015	9	12376	0.7	0.3	1.4
2016	7	12221	0.6	0.2	1.2
2011-2013	26	37372	0.7	0.5	1.0
2014-2016	27	36836	0.7	0.5	1.1
2011-2016	53	74208	0.7	0.5	0.9

Nationally, in 2015 there were approximately 1,600 deaths due to SIDS, 1,200 due to Unknown/Undetermined, and approximately 900 due to accidental suffocation or strangulation in a sleep setting.[3] NH has been consistent with national data in ranking SIDS as one of the leading causes of infant deaths. SIDS is defined as the death of an infant less than one (1) 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 since the early 1990s. In the past ten to fifteen years, in addition to the SIDS rate declining nationally and in NH, the overall SUID rate seems to be leveling off.

Trends in Sudden Unexpected Infant Death by Cause, 1990-2015



In New Hampshire, SIDS rates have decreased, but there is no statistically significant difference between year groups.

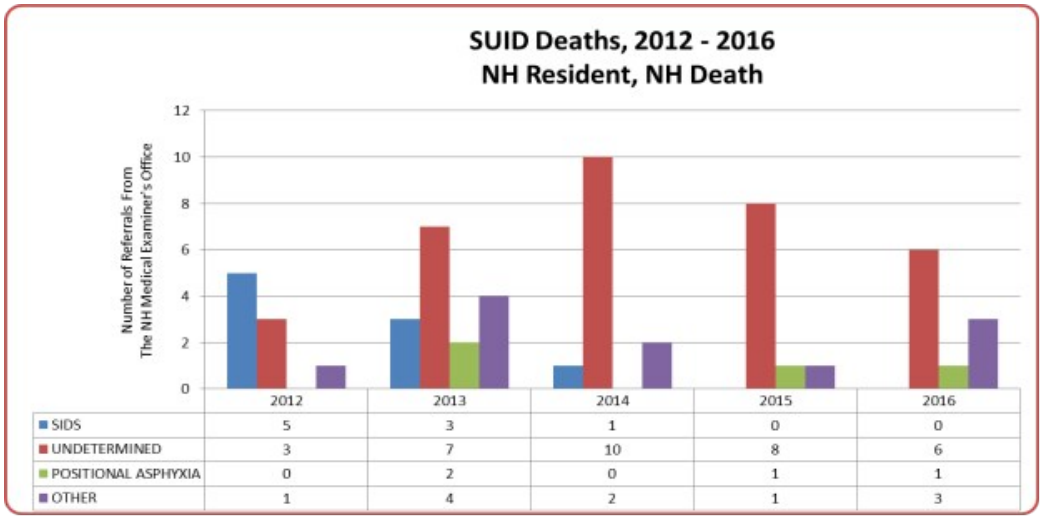
Top Ten Leading Causes of Natural Death in 2015, Infants (under age 1 year)[4]

Leading Causes of Natural Infant Death	2005-2015	2015
Newborn affected by maternal factors and by complications of pregnancy, labor and delivery	273	19
Congenital malformations, deformations and chromosomal abnormalities	90	6
SUID-Undetermined R99	51	8
SUID-Sudden infant death syndrome (SIDS) R95	47	0
Diseases of the nervous system	13	2
Certain infectious and parasitic diseases	11	0
Diseases of the respiratory system	11	1
SUID-Accidental suffocation and strangulation in bed W75	11	1
Endocrine, nutritional and metabolic diseases	10	2
Diseases of the circulatory system	8	2
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	8	0

New Hampshire Residents, Deaths from SIDS, 3-year Groups [5]

Year Group	SIDS	Births	Rate per 10,000 births	Lower 95% CI	Upper 95% CI
2007-2009	14	41,245	3.4	1.9	5.7
2010-2012	10	38,083	2.6	1.3	4.8
2013-2015	3	37,087	0.8	0.2	2.4

NH also continues to be consistent with past and most recent national statistics for all races/ethnicities of observed peak SUID incidence at ages one to two months, with 33% of NH SUID deaths occurring then. It is also consistent with national trends of having approximately 90% of SUID deaths occurring in the first four months of age,[6] with NH at 92%.[7]

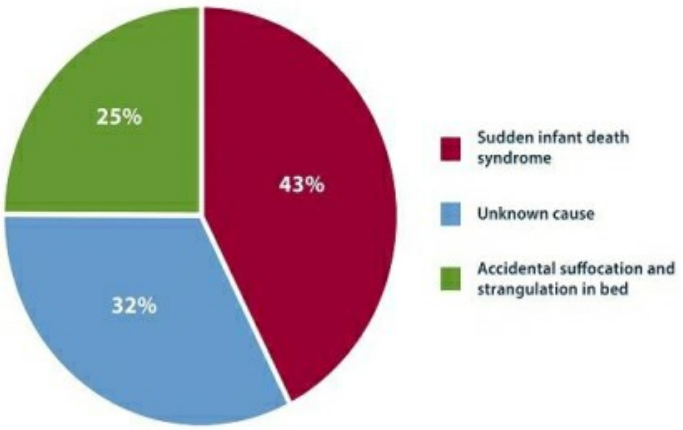


	2012	2013	2014	2015	2016
SIDS	5	3	1	0	0
UNDETERMINED	3	7	10	8	6
POSITIONAL ASPHYXIA	0	2	0	1	1
OTHER	1	4	2	1	3

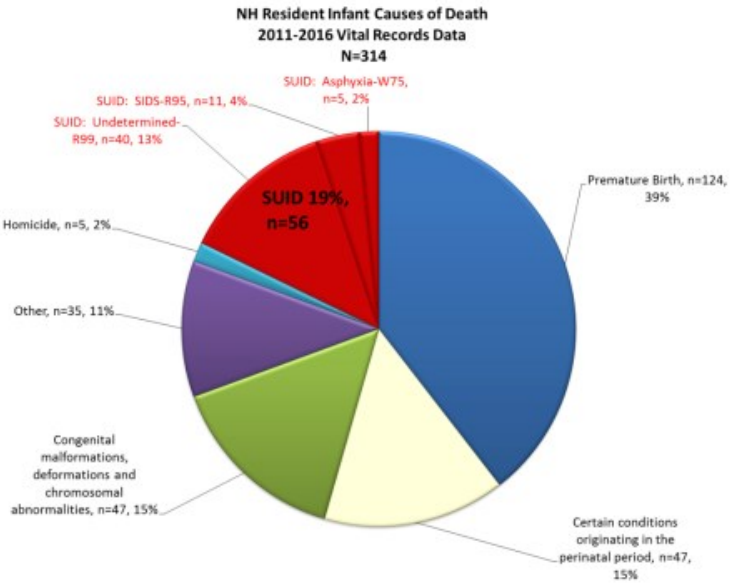
Source: NH Division of Public Health Services/Maternal and Child Health Section
and NH Office of the Chief Medical Examiner

In breaking down the specific causes of SUID deaths, as shown in the pie charts below, NH deaths from Undetermined or Unknown make up a larger portion of the SUID deaths than nationally, where the SIDS proportion is higher. Fewer NH deaths are also finalized as Accidental Asphyxia or Suffocation than nationally. This may be due to the strict adherence by the NH Office of Chief Medical Examiner (OCME) to the national guidelines pertaining to diagnoses of sudden unexpected infant death.

United States 2015 National SUID Deaths



Source: CDC/NCHS, National Vital Statistics System



Source: NH Office of Chief Medical Examiner

Deaths from several ICD10 codes (R95, R99 and W75) that include SIDS, Undetermined cause, 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 SUID as not all R99 (Undetermined) deaths were connected to unsafe sleep.

Compared to all natural manner of death cases, death due to complications of pregnancy and delivery is the leading cause of natural death and SUID is the second leading cause of infant death.

New Hampshire Residents, Causes of Death Counts, Infants (under 1 yr) 2013-2015[8]

Cause of Death	Manner of Death	2014		2015		Total	
		Count	%	Count	%	Count	%
Newborn affected by maternal factors and by complications of pregnancy, labor and delivery	Natural	14	33%	19	45%	33	39%
Congenital malformations, deformations and chromosomal abnormalities	Natural	7	16%	6	14%	13	15%
SUID-Undetermined	Undetermined	9	21%	6	14%	15	18%
Diseases of the nervous system	Natural	3	7%	2	5%	5	6%
Diseases of the circulatory system	Natural	1	2%	2	5%	3	4%
Diseases of the respiratory system	Natural	0	0%	1	2%	1	1%
Endocrine, nutritional and metabolic diseases	Natural	0	0%	2	5%	2	2%
Assault	Homicide	1	2%	2	5%	3	4%
SUID-Accidental suffocation and strangulation in bed	Accidental	0	0%	1	2%	1	1%
SUID-Sudden infant death syndrome (SIDS)	Natural	1	2%	0	0%	1	1%
Unknown Unspecified	Natural	3	7%	0	0%	3	4%
Neoplasms	Natural	1	2%	1	2%	2	2%
Cerebrovascular diseases	Natural	1	2%	0	0%	1	1%
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	Natural	1	2%	0	0%	1	1%
	Pending	0	0%	0	0%	0	0%
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	Natural	1	2%	0	0%	1	1%
	Total	**43**	100%	**42**	100%	**85**	100%

[9]

As shown in the PRAMS data below, and in Form 10a, National Performance Measure #8 results, NH did not show much change in 2016 compared to its previous years' results for infants placed on their backs. These slight yearly variations are not significantly different from year to year.

NH PRAMS[9]	2013	2014	2015	2016
Baby most often placed to sleep on back	88.8%	89.4%	86.9%	86.3%

Based on the 2013-2015 NH birth cohort demographic data (below), all sub-groups were similar in their degree of compliance with the supine sleep position recommendation, indicating a need to continue to target the whole population of pregnant and postpartum mothers.

New Hampshire 3-year prevalence (2013-2015) of placing infants to sleep on their back, by socio-demographic characteristics[10]

1,595 placed their infants to sleep on their back	Percent Yes	95% CI Lower	95% CI Upper	Responses	Population Estimate
Maternal race/ethnicity (n=1784)					
White non-Hispanic	89.1	87.1	90.8	1,406	27,571
Black non-Hispanic	81.8	54.1	94.5	20	337
Asian non-Hispanic	86.0	73.2	93.3	66	1,062
American Indian/Alaska Native	(-)	(-)	(-)	(-)	(-)
Native Hawaiian/Other Pacific Islander	0	0	0	0	0
Other or more than one race	84.3	63.9	94.2	24	542
Hispanic	79.1	66.4	87.8	59	1,191
Maternal nativity (n=1804)					
US-born	89.1	87.2	90.8	1,449	28,655
Not US-born	80.8	72.7	86.9	146	2,507
Maternal age (n=1804)					
Under 20 years of age	86.1	73.3	93.3	64	1,321
20-29 years of age	86.8	83.8	89.4	693	14,485
30-39 years of age	89.4	86.7	91.6	771	14,097
40+ years of age	99.4	98.0	99.8	67	1,260
Marital status (n=1803)					
Married	89.1	86.9	91.0	1,089	20,539
Other	86.9	83.2	89.9	505	10,576
Parity (n=1790)					
No previous live birth	88.8	85.9	91.2	763	14,009
Had a previous live birth	88.1	85.5	90.3	821	16,924
Urban/Rural (n=1804)					
Urban	88.0	85.6	90.1	981	19,585
Rural	89.0	85.9	91.5	614	11,578
Maternal education (n=1795)					
Less than 12 years	81.5	71.4	88.5	99	1,877
12 years	85.9	81.2	89.6	303	6,597
More than 12 years	90.0	87.9	91.7	1,186	22,518
Household poverty level (n=1724)					
0 - 100% of FPL	83.8	78.8	87.8	330	6,411
>100% - 185% of FPL	83.1	77.5	87.6	248	5,073
>185% of FPL	91.3	89.0	93.1	943	18,128

(-) numbers too small and unreliable to report

Data from the state's just released PRAMS 2016 birth cohort, with new questions on room sharing, bed sharing, and the sleep environment showed that NH is doing fairly well in adhering to the American Academy of Pediatrics recommendations. These are new questions in the PRAMS survey and there is as yet no other state data available for comparison.

Question from 2016 NH PRAMS survey	**Percent Yes**
Q 50: Percent of women who most often put their baby to sleep on his/her back	86.3%
Q 51: In past 2 weeks, how often has baby slept alone in his or her bed	Always: 60.2% Often: 17.9% Sometimes: 6.7% Rarely: 5.2% Never: 10.1%
Q 52: When baby sleeps alone, crib or bed is in same room with mother	74.2%
Q 53: In past 2 weeks baby usually slept:	
a. In crib, bassinet, or pack and play	89%
b. On twin or larger mattress or bed	26.9%
c. On a couch, sofa, or armchair	8.1%
d. In an infant car seat or swing	56.6%
e. In a sleeping sack or wearable blanket	51.4%
f. With a blanket	42.4%
g. With toys, cushions or pillows	6.2%
h. With crib bumper pads (mesh or non-mesh	13.7%
Q 54: A doctor, nurse or other health care worker told mom :	
a. To place baby to sleep on back	98.7%
b. To place baby to sleep in crib, bassinet, or pack and play	91.8%
c. To place baby's crib or bed in mom's room	52.7%
d. What things should and should not go in bed with baby	90.6%

Systems Building

Since 2011, MCH has been one of the CDC grantees for the SUID Registry. Currently, CDC supports SUID monitoring programs in 16 states and two (2) jurisdictions, covering 30% of all SUID cases in the United States. States and jurisdictions participating in the SUID Case Registry use data about SUID trends and characteristics to inform strategies to reduce future deaths. The SUID Case Registry builds on the National Center for Fatality Review and Prevention's System and brings together information about the circumstances associated with SUID cases, as well as information about investigations into these deaths.[11]Through a Memorandum of Agreement, MCH collaborates closely and successfully with the NH 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 participants on the SUID Review Group are also members. The SUID Review Group also numerous perinatal-related representatives, such as a home birth provider, a certified nurse midwife, an OB-GYN, a neonatologist, the State WIC Program Administrator, a Northern New England Perinatal Quality Improvement Network (NNEPQIN) representative and state and local agency home visiting agency representatives.

At each meeting, the direct care staff that was involved with the deceased infant is invited to attend, to contribute case information,

and participate in the development of recommendations following the case discussion. This includes the infant's home visitor, first responder, local law enforcement, 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 are 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.

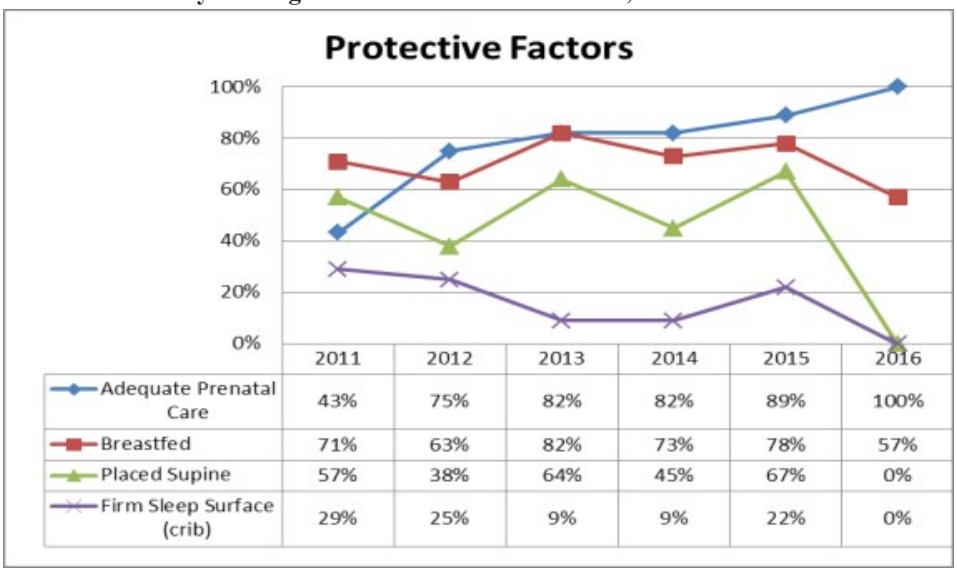
Data from cases reviewed of 2011-2016 deaths from SUID by the SUID Review Group help the state focus its strategies on targeted groups. Key findings about the caregivers of these infants show that:

- 62% were WIC participants
- 79% had adequate prenatal care
- 55% were Medicaid participants
- 36% of Caregiver 1 and 20% of Caregiver 2 had documentation of a history of substance abuse
- 13% of cases, both Caregivers had documentation of a history of substance abuse

This indicates that prenatal providers, WIC clinics, and substance use programs continue to be important touch points to educate and reinforce safe sleep information in addition to the birth hospitals.

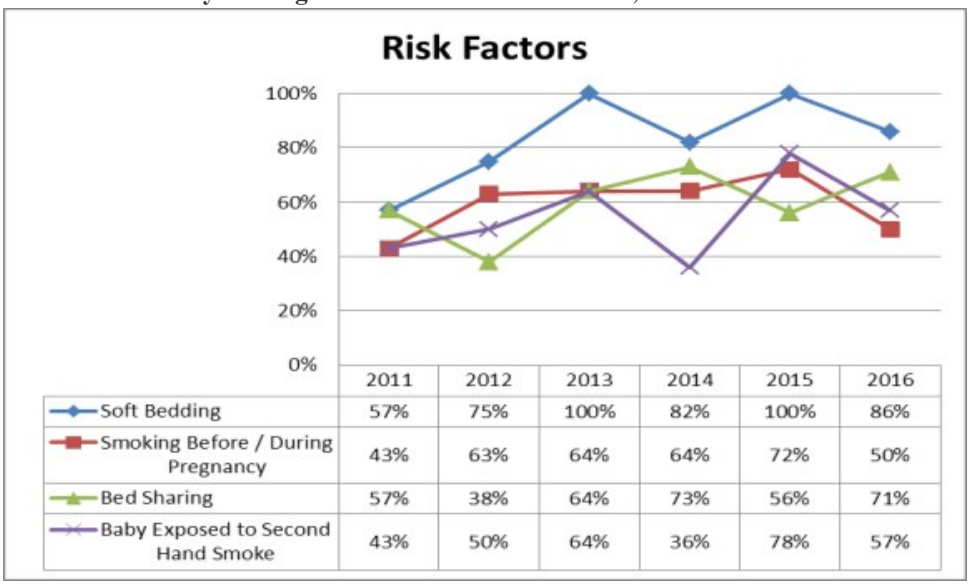
Although safe sleep education is being carried out in the prenatal and postpartum health care settings, data on the state's SUID cases (i.e. 7 confirmed SUID cases in 2016) indicate that these parents are not necessarily following the safe sleep instructions.

American Academy of Pediatrics Protective Factors
Key Findings from 53 SUID deaths in NH, 2011-2016[12]



	2011	2012	2013	2014	2015	2016
Adequate Prenatal Care	43%	75%	82%	82%	89%	100%
Breastfed	71%	63%	82%	73%	78%	57%
Placed Supine	57%	38%	64%	45%	67%	0%
Firm Sleep Surface (crib)	29%	25%	9%	9%	22%	0%

American Academy of Pediatrics Risk Factors
Key Findings from 53 SUID deaths in NH, 2011-2016[13]



	2011	2012	2013	2014	2015	2016
Soft Bedding	57%	75%	100%	82%	100%	86%
Smoking Before / During Pregnancy	43%	63%	64%	64%	72%	50%
Bed Sharing	57%	38%	64%	73%	56%	71%
Baby Exposed to Second Hand Smoke	43%	50%	64%	36%	78%	57%

Through the case reviews, the SUID Review Group learned in 2015 and earlier, 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 summer 2015 adapting a tool from the Massachusetts Department of Health, developed by the Harvard School of Public Health. The survey had a 100% response rate and a surprising result in that only 42% (8 of 19) of the birth hospitals indicated that they had a written safe sleep policy or guideline. This provided the baseline for the ESM for this performance measure.

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 in the 2015 survey. Results from this informal email 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."

A shorter, follow-up survey was sent in December 2016 to the 19 birth hospitals. One hundred percent of the birth hospitals completed the survey. The hospitals were asked: "In the 2015 survey, results showed that 42% of the respondents had a safe sleep policy or guideline on how to place a healthy infant for sleep while they were cared for at their facility. We later learned from feedback that for many, the policy was not a stand-alone policy, but was part of a larger overall policy that included "safe sleep." Does your maternity department have a written "safe sleep" policy or guideline on how to place healthy infants for sleep while they're cared for at your facility, either as an individual policy or part of a larger policy?" Sixty-eight percent (68%) (13 of 19) answered yes; 6% (1 of 19) answered no; and 26% (5 of 19) indicated that their department is in the process of or is planning to develop one. In both the 2015 survey and its follow up, patients' beliefs were cited as the strongest barrier to improving safe sleep practices.

In January, 2017, a modified version of the survey was disseminated to the 20 home birth/birth center providers by a certified lay midwife who is a member of the NH SUID Review group and the NH Safe Sleep Workgroup. There were only four (4) respondents despite several reminders from the distributing home birth provider. One of four indicated they had a written "safe sleep" policy or guideline on how to place healthy infants for sleep while under their care; three of four indicated their practice educated its staff about the AAP sleep recommendations; three of four indicated that staff, in general, supported safe sleep practice, and three of four indicated their staff modeled the behavior. Regarding patient education, all indicated that they review an educational document, such

as a discharge checklist with each new mother verbally prior to discharge and three of the four indicated that safe sleep practice recommendations were included. Three of the four indicated they distributed safe sleep-specific parent education material. The fourth indicated it was only communicated verbally.

In spring 2018, the 19 birth hospitals once again all completed a brief email survey and indicated that the percent having a safe sleep policy/procedure had increased to 74% (14 of 19). Of the other five (5), two (2) indicated they followed an unwritten safe sleep policy on their unit. Eighty six percent (86%) of those with a written policy (12 of 14) indicated that it is a stand-alone document, with the other two indicating it is part of a more comprehensive policy. In response to questions on whether safe sleep behavior is monitored on the unit by audit, 32% (6 of 19) responded yes, with the monitoring frequency ranging from monthly to quarterly and was supplemented by "periodically as needed."

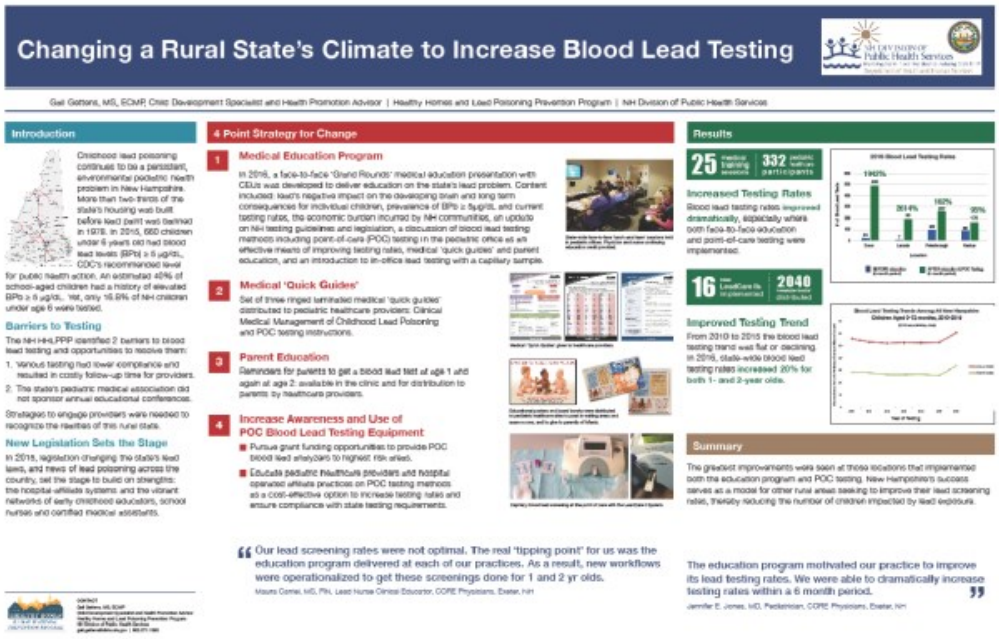
In response to how education is done, 68% (13 of 19) give safe sleep information in their discharge summary; 37% (7 of 19) give an organizational brochure containing safe sleep information; and 11 of the 19 hospitals (58%) indicated that they give other material, such as sleep sacks, the Sleep Baby Safe and Snug book, a DVD, resources, safe sleep handouts, etc. Other activities by the hospitals include having parents sign a Safety Agreement upon admission that includes safe sleep information, having a mock nursery display set up in a waiting area, having laminated safe sleep posters in each room, etc. Four of 19 hospitals (21%) have achieved the Cribs for Kids Hospital Safe Sleep Certification. Three of 19 (16%) hospitals provide the Baby Box as an alternative to promote safe sleep despite the NH Division of Public Health adhering to the position of the American Academy of Pediatrics that there is insufficient data on the role cardboard boxes may play in reducing infant mortality.

MCH Specific Activities

MCH staff has continued to be involved in the efforts by DHHS' Division of Children, Youth and Families (DCYF) to come into compliance with the requirements of the federal Comprehensive Addiction and Recovery Act (CARA) signed July 2016. This requires that a Safe Plan of Care be put into place prior to discharge from the birth hospital/health care provider's care, if an infant has been born and identified as being affected by substance use or withdrawal from prenatal drug or alcohol exposure. One (1) component of this is discussing safe sleep practices with the mother and family. NH is currently piloting this Safe Plan of Care with five (5) birthing hospitals.

MCH continues to have a successful collaboration with DPHS Healthy Homes and Lead Poisoning Prevention Section in getting the message out on two (2) public health initiatives at the same time – healthy homes and safe sleep. Their Health Promotion Advisor/Child Development Specialist continues to conduct in-office education programs for pediatric and family health providers, focusing on childhood lead poisoning in NH, distributing the board book *Sleep Baby, Safe and Snug*, in English and Spanish. The program has printed up stickers in English and Spanish with the lead screening schedule that are adhered to the back cover. It also promotes the books with the safe sleep message at conferences and displays, as shown in the photo below from the May 3, 2018 Healthy Homes display at the Northeast Nurse Practitioner Annual Conference in Nashua, NH.

Additionally, the Health Promotion Advisor/Child Development Specialist, did a research poster presentation (see below) on "Changing a Rural State's Climate to Increase Blood Lead Testing" which included the distribution of the board book to reinforce both the safe sleep and lead screening messages at the December 2017 CDC Healthy Homes Lead Poisoning Prevention Program Project Managers Meeting in Atlanta. A manuscript was submitted based on the research poster which has been accepted for publication by CDC and the Journal of Public Health Management and Policy for January 2019 special edition focusing on childhood lead poisoning.



State WIC staff participate in the SUID Review Group meetings, sharing client information at the case reviews, and participate in the Safe Sleep Workgroup. WIC local agency nutritionists give the Sleep Baby board books to their pregnant women clients at their last visit before delivery, or if missed, at the Post-Partum WIC visit. The NH SUID Program Coordinator presented an update of NH SUID statistics, risk factors and prevention information at the November, 2017 WIC Directors' meeting, distributing the new national safe to sleep campaign material, and raffling off several sleep sacks.

In November 2017, the NH Child Care Licensing Revised Rules were released. Requirements were added that child care staff who will be responsible for the care of infants age 12 months and younger must first complete trainings on prevention of SIDS and use of safe sleep practices. Safe Sleep is one of the 11 topics federally required for child care providers in states that receive federal child care development block grant funding. The SUID Project Coordinator provided input to the on-line safe sleep module for child care providers developed by a national company contracted by the state's Child Development Unit. Staff must be supervised by another qualified staff member until the trainings have been completed. Rules were also added or clarified relative to safe sleep environments and sleep position for infants; specifically, He-C 4002.19 (h)-(m):

> (h) To reduce the risk of Sudden Infant Death Syndrome (SIDS), infants up to 12 months shall be placed on their backs to sleep in a crib or playpen, unless there are written medical orders from the infant's primary health practitioner requiring alternate positioning.
>
> (i) Infants up to 12 months shall not nap or sleep in a car safety seat, bean bag chair, bouncy seat, infant seat, swing, jumping chair, highchair, chair, futon, or any other type of furniture or equipment that is not a play pen or crib that meets the requirements of He-C 4002.22(x) and (y).
>
> (j) If an infant up to 12 months falls asleep in any place that is not a safe sleep environment, including entering the program asleep in a car safety seat, staff shall immediately move the infant and place him or her in the supine position in the crib or play pen.
>
> (k) Cribs or play pens used by infants up to 12 months shall not have bumper pads, blankets, flat sheets, pillows, quilts, comforters, sleep positioners, or any soft items or toys.
>
> (l) When child care personnel place infants in their crib or play pen for sleep, they shall check to ensure that the temperature in the room is comfortable for a lightly clothed adult, check the infants to ensure that they are comfortably clothed and not overheated or sweaty, and that bibs and garments with ties or hoods are removed.
>
> (m) Children older than 3 months shall not be swaddled or placed in restrictive or weighted sleep suits or devices unless there are written medical orders from the child's primary health practitioner.

SUID-related collaboration with the Community Mental Health system and Alcohol and Substance use treatment community occurs several times a year with the dissemination of educational messages, new handouts, articles and emails from the national Safe to Sleep campaign disseminated by the MCH SUID/SDY Project Coordinator to the behavioral health and the drug and alcohol state program representatives on the SUID Review Group.

Integration with the DPHS Tobacco Prevention and Cessation Program continues with its staff participation in the Safe Sleep Workgroup, and assistance in developing new safe sleep handouts from the workgroup based on photographs submitted by workgroup members to educate through visual images, and few words, on safe and unsafe sleep. These handouts will ultimately be laminated and used as teaching tools for those with limited English, as well.

Collaboration with the home birth provider community continues through the participation of one of its members on both the SUID Review Group, and the Safe Sleep Workgroup. In August 2017, the home birth provider/community midwife distributed a copy of the Sleep Baby board book, a sleep sack, and a sampling of safe sleep handouts from the NH SUID Program to the NH certified midwives to increase their awareness of safe sleep resources.

MCH works closely with the MCH-funded Injury Prevention Program (IPC) at Children's Hospital at Dartmouth-Hitchcock (CHaD) in continuing to blend the messages of safe sleep and Period of PURPLE Crying at display table opportunities, presentations, and handouts. During the month of October, Safe Sleep Awareness Month, Dartmouth-Hitchcock Medical Center had safe sleep information on its on-hold message. Through its Kohl-funded home safety grant, it continues to provide free Pack'n Plays along with window guards and safety gates to high risk families upon request from the DCYF District Offices, and the state-funded home visiting programs.

In SFY18, in addition to the above safe sleep activities, a broad variety of other activities were carried out by the MCH staff, the Safe Sleep Workgroup members and members of the SUID Review Group.

A total of thirteen (13) presentations or workshops related to SUID or safe sleep were given by the MCH Child Health Program Manager/Nurse Consultant, who is the NH SUID Project Coordinator; the MCH Injury Prevention Surveillance Analyst; the MCH PRAMS Project Coordinator, the Chief Forensic Investigator for the Chief Medical Examiner's Office, or by the IPC at CHaD's Program Manager on SUID, Safe Sleep, or sudden unexpected infant death scene investigations. Audiences included forensic nursing students, child care providers, early childhood education students, perinatal addiction programs, home visitors, nurses, social service providers, state-funded community health center staff, and the SUID Review Group members.

In SFY18, safe sleep material was showcased by MCH, the IPC at CHaD, or Lead Poison Prevention Program staff at a display table, or distributed at a conference or community event such as a community safety night, or a community baby shower sponsored by NH Healthy Families, one of the two Medicaid Managed Care organizations, at a minimum of seven (7) dates. These included the state Healthy Homes conference, the Foster Parents Annual Conference, the NH DHHS lobby, the annual state Immunization conference, and the NH Children's Trust's annual Strengthening Children conference, to name a few.

MCH has increased the use of social media in getting out the safe sleep message. Tweets and facebook postings in July 2017 focused on safe sleep when traveling. August featured information from a national consumer safety email received to share information about not using air mattresses for infant sleep, and about August being the National Child Safety Awareness Month. September's focus was several safe sleep messages targeting grandparents, for September as National Grandparents Month. October's focus was National Safe Sleep Awareness Month. January 2018 focused on avoiding overheating infants with over bundling. And April's postings were on encouraging sleep sacks as gifts for a new baby. The DHHS webpage had its October 2017 slider focus on Safe Sleep Awareness Month; it received 46 hits in September and 115 in October.

NH's MCH staff efforts are shared not only in-state but with other states as well. Each year, at the two- day New England Child Fatality Review meeting, the NH SUID Project Coordinator presents a summary of its activities to the other New England states and Nova Scotia, none of which have a CDC SUID Case Registry grant. This year's meeting will be held on June 7-8, in Lowell, Massachusetts. The NH SUID Project's latest Data Brief (see below) will be shared with all.

NEW HAMPSHIRE PUBLIC HEALTH ISSUE BRIEF: SLEEP-RELATED INFANT DEATHS, 2011-2016

INTRODUCTION

The National Centers for Disease Control and Prevention (CDC) support Sudden Unexpected Infant Death (SUID) Monitoring programs in 16 states and 2 jurisdictions that participate in a SUID Case Registry. The data about SUID trends and characteristics inform strategies to reduce future deaths. SUID deaths include infants who died in a sleep-setting from: Sudden Infant Death Syndrome (SIDS), asphyxiation, suffocation, or those classified as "Undetermined". Between 2011 and 2016, there were 53 sleep-related infant deaths in New Hampshire to New Hampshire residents, several of which might have been prevented. Eleven of these 53 deaths were due to SIDS and 38 were "Undetermined", and 4 were due to Asphyxia. This data brief is meant to provide information on the circumstances surrounding these deaths to learn more about preventing them in the future. *Caution is recommended in generalizing these results as they are from a small number of cases.*

ABOUT THE BABIES

Of the 53 2011-2016 SUID deaths:

- 87% of the infants were white
- 57% of the infants were male
- 55% of the infants were on Medicaid
- 40% of the infants were premature
- 23% of the infants had low birth weight
- Infants' age: 13 (25%) were less than 1 month, 18 (34%) were 1-2 months, 13 (25%) were 3-4 months, and 9 (17%) were 5 months or older

ABOUT THE BABIES' CAREGIVERS

Among the 53 sleep-related infant deaths:

- 79% of mothers had a high school or less than high school education
- 78% of mothers were in a low income bracket
- 79% of mothers received regular prenatal care
- 60% of the infants' mothers smoked during or after pregnancy
- 28% of mothers used alcohol during or after pregnancy
- 72% of mothers breastfed their infant
- 36% of mothers had a history of substance misuse.

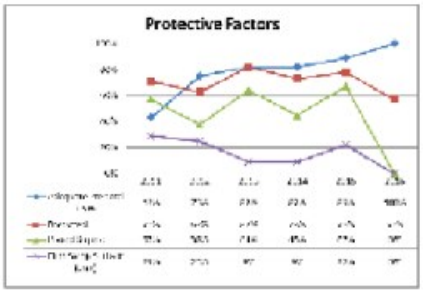
ABOUT THE SLEEP ENVIRONMENTS

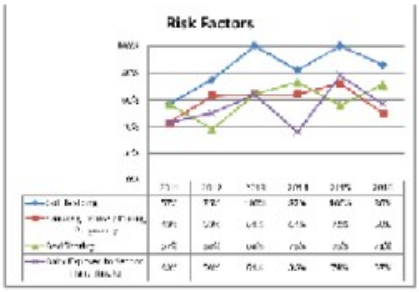
- 85% of cases had soft or loose bedding in the sleep setting
- 60% of cases involved sharing a sleep surface with an adult (bed, chair, or couch)
- Despite the recommendation that all healthy infants be placed on their backs to sleep, the New Hampshire SUID Review Group found that only 47% of cases reviewed had been placed on their backs.
- 85% of sleep-related infant deaths occurred among infants found sleeping in a place other than a crib.

PREVENTING SLEEP-RELATED DEATHS

The American Academy of Pediatrics, supported by strong and consistent scientific evidence, recommends that infants are safest room-sharing without bed-sharing. Infants should sleep ALONE, on their BACKS, in a safety-approved crib, bassinette, or portable play area. Put baby on a firm flat mattress without any soft objects or loose bedding, and avoid overheating. Best practices for mothers include avoiding smoke exposure during pregnancy and after birth, getting early and routine prenatal care, and breastfeeding. The New Hampshire Department of Public Health promotes these recommendations to parents, caregivers, and health care professionals.

American Academy of Pediatrics Recommendations Key Findings





New Hampshire Department of Health and Human Services
Division of Public Health Services
Maternal and Child Health Section
29 Hazen Drive, Concord, NH 03301
Phone: 603-271-9766
http://www.dhhs.nh.gov/dphs/bchs/mch

Released January 2018

In the May 2018 CDC e-newsletter to its SUID and SDY grantees, the achievements of the NH SUID Project were highlighted in the congratulations to the NH SUID/SDY Project Coordinator upon her upcoming retirement. Also featured was a new step instituted by the NH SDY Project in closing the loop on unsuccessful attempts to get parental consent for a SUID/SDY bio-specimen to be sent to one of the CDC research biorepositories (see below).

Best Wishes to Audrey Knight in New Hampshire!

At the end of this month, one of our original awardees will be retiring. Audrey Knight has been part of the Registry since 2010. Her work on the SUID Case Registry has been amazing. Although New Hampshire is a small state, she is mighty. Through Audrey's leadership, New Hampshire has completed 6 death year cohorts and has been able to better understand the circumstances of infant and child deaths in the state. An example of Audrey's Registry data dissemination to drive prevention are the data briefs she instituted. See attached Data Brief as an example of Audrey's work.

Audrey has never been shy of asking questions and her keen mind has enabled us to make mid-course changes to our program, and better understand the barriers our state and jurisdictional awardees face. The SUID and SDY Case Registry is only one of many hats Audrey wears in the New Hampshire State Health Office, yet she has always given 100% to our project and has made us feel like it is the only job she has. Our guess is that the other programs she runs are the same way. Audrey's creativity and drive for prevention in her state has been incredible. Thank you Audrey for everything you have done to improve the State of New Hampshire, and also to improve the Registry as a whole. You will be greatly missed. On behalf of the entire SUID and SDY Case Registry, we wish you all the best in retirement!

Closing the Loop After Multiple SDY Consent Attempts

Have you considered documenting your final attempt to reach a family for SDY consent? The New Hampshire Team led by Audrey Knight and Kim Fallon recently addressed this process. We are attaching a template of their letter for use in your work. This letter can be used for families where multiple attempts at consent using various modes of communication have been tried. This letter can be modified for your team and sent either by snail mail, email or both. This process is best practice when doing this type of research with families.

Hospital Discharge Data

The hospital discharge data was updated in 2017 to include 2014 and 2015 events, and the 2016 data has just become available in late August 2018 (originally scheduled to become available in early fall of 2017). The planned quarterly updates of discharge data as reported last year are no longer expected on this schedule; data acquisition challenges and staffing changes external to the MCH section have contributed to delays. This lack of timeliness limits the effective use of this dataset for quality improvement efforts at the intersection of public health and clinical medicine.

The NH hospital discharge dataset includes occurrent (i.e. in-state) births only. The out-of-state discharges for NH residents have not yet been integrated into the dataset (including 2014 and 2015). However, these records are all in-house as of early May 2018, and through collaboration with colleagues in the Health Statistics and Data Management Section it is hoped to gain early access (pre-

integration) to these data for MCH analyses. With nearly one in 10 births to NH residents occurring out-of-state, these records are critical to include in population analyses. In their absence, the in-state discharges are utilized to examine topics from a systems perspective within NH. Examples include analyses for Severe Maternal Morbidity (SMM) and Neonatal Abstinence Syndrome (NAS).

The updating of the linkage of maternal delivery discharges to births was completed in August 2018. Changes to the dataset necessitated a re-evaluation of available linkage fields and a custom dataset with fields not available in the public or limited use files was obtained in May 2018. A new linkage algorithm will be developed as part of this process since the fields available for linkage have changed significantly.

Neonatal Abstinence Syndrome

NH continues to monitor Neonatal Abstinence Syndrome (NAS) and related data points. The table below shows NAS information from the 19 NH birth hospitals, for the aggregated period of 2013-2015 using the NH discharge data.

Neonatal Abstinence Syndrome Inpatient Discharges
Occurring in New Hampshire Birth Hospitals 2013-2015

Hospital Name	NAS Discharges	Births	NAS Rate per 1,000 Births	Percent
Alice Peck Day Memorial Hospital	1	859	1.2	0.1%
Androscoggin Valley Hospital	21	321	65.4	6.5%
Catholic Medical Center	10	3115	3.2	0.3%
Cheshire Medical Center	9	1303	6.9	0.7%
Concord Hospital	78	3777	20.7	2.1%
Dartmouth Hitchcock Medical Center	266	3494	76.1	7.6%
Elliot Hospital	153	5754	26.6	2.7%
Exeter Hospital	15	1924	7.8	0.8%
Frisbie Memorial Hospital	16	1074	14.9	1.5%
Lakes Region General Healthcare	67	1041	64.4	6.4%
Littleton Regional Hospital	5	982	5.1	0.5%
Memorial Hospital	17	711	23.9	2.4%
Monadnock Community Hospital	3	890	3.4	0.3%
Parkland Medical Center	6	510	11.8	1.2%
Portsmouth Regional Hospital	13	1472	8.8	0.9%
Southern New Hampshire Medical Center	71	3793	18.7	1.9%
Speare Memorial Hospital	2	517	3.9	0.4%
St. Joseph Hospital	7	1533	4.6	0.5%
Wentworth Douglass Hospital	69	3324	20.8	2.1%

NOTES:

Data Source: NH Vital Records, Births 2013-2015
19 NH Birth Hospitals
Occurrent Births, *regardless of residence* (includes non-residents)

Data Source: NH Inpatient Discharges 2013-2015 (v12, 11, 11)
(NAS) ICD-9 Code 779.5 or ICD-10 P96.1 Admitting, Principle or Secondary Diagnosis
Occurrent discharges, *regardless of residence* (includes non-residents)

Excludes NH resident births and discharges occurring out-of-state (~9% of births)
Excludes cases in hospitals not categorized as birth hospitals for entire 3yr period

Evidence suggests NAS is underreported in discharges in some hospitals

The number of delivery discharges is sometimes used as the denominator for NAS rates (but not here, because vital records likely is the best source)

Infants are not always delivered in the nearest hospital (e.g. delivery may occur at a hospital providing an advanced level of care)

Statistics presented here may differ from other published rates using different methods and/or sources and populations (e.g. residence-based rates)

Analysis: NH Division of Public Health Services, Maternal & Child Health Section, November 2017

Statewide hospital discharge data have often been used to assess neonatal abstinence syndrome in NH and across the country. While this approach has been useful in calling attention to the issue, it has several important limitations, notably, hospital-based differences in diagnostic code use, and the lag time associated with processing data, both of which impact data quality attributes such as standardization of case definition and timeliness. Analysis of discharge data has clearly identified these shortcomings. Further complicating the assessment challenge are factors such as the timing of diagnosis in relation to delivery discharge and the relationship between prenatal opioid exposure and withdrawal symptoms (symptoms do not appear in all exposed).

An April 2018 report by the NH Community Health Institute, NNEPQIN, and the UNH Institute for Health Policy and Practice examined data from 32 perinatal practices and found the following estimated prevalences of substance use related complications among newborns in the state:

- 10% were observed for NAS
- 7% met the criteria for NAS

- 3% required medication treatment for NAS

It was further found that in 0.5% of cases there was a presumption of Fetal Alcohol Syndrome and 1.5% of cases had complications from exposure to maternal substance use other than opioids or alcohol.

Federally available data for NOM10, the percent of infants in NH born with fetal alcohol exposure in the last three months of pregnancy, obtained from the national PRAMS survey, was 9.7% in 2015, 11.0% in 2014, and 13.0% in 2013. Per CDC PRAMS policy, only states/jurisdictions that met the response rate threshold are included (≥55% from 2015 to 2016, ≥60% from 2012 to 2014).

And federally available data for NOM11, the rate of infants born with neonatal abstinence syndrome per 1,000 hospital births, obtained from HCUP–State Inpatient Databases, was 7.1 in 2009 and 6.4 in 2008 (the data is old due to unavailability of NH hospital discharge data).

Levels of Care Assessment Tool (LOCATe)

The American Academy of Pediatrics (AAP), the American College of Obstetricians and Gynecologists (ACOG), and the Society for Maternal-Fetal Medicine (SMFM) have published guidelines for classifying neonatal and maternal levels of care by hospital capabilities and ability to care for high-risk patients.

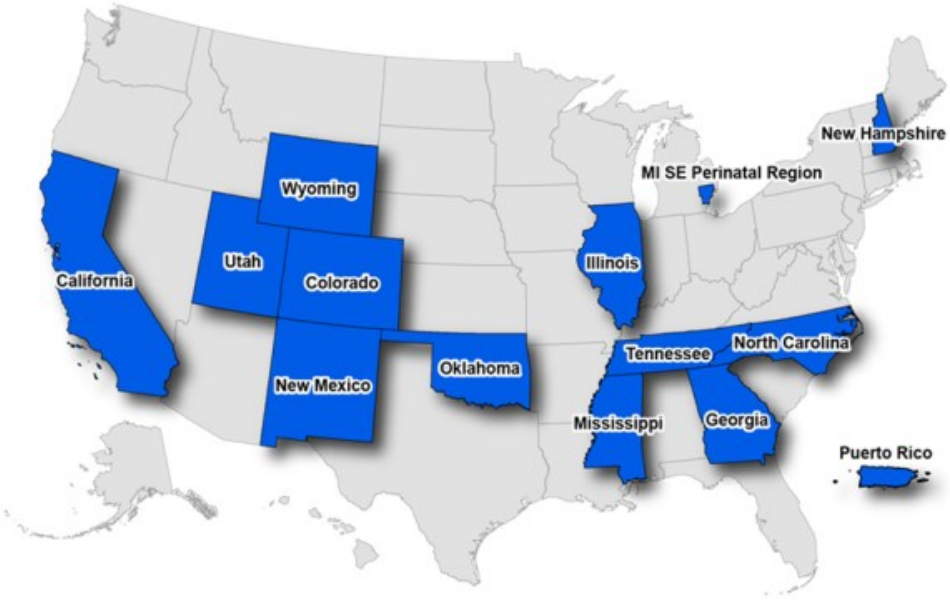
The "Levels of Care Assessment Tool" (LOCATe)[14] was developed by CDC based on the 2012 AAP Policy Statement on Levels of Neonatal Care, and the 2015 ACOG/SMFM publication on Maternal Levels of Care. The MCH Epidemiologist, with support from the CDC, implemented an assessment of birth hospitals to better understand the statewide system of healthcare services for NH's mothers and infants. Formal endorsement of this assessment by the NH state chapters of AAP and ACOG, the NH Hospital Association and NNEPQIN (Northern New England Perinatal Quality Improvement Network) were sought and obtained. New Hampshire is the first state in New England to use LOCATe, and neighboring states are considering implementation.

A personalized letter from the NH MCH Section Administrator was emailed to a contact person in each NH birth hospital on May 3, 2018. The letter included a description of LOCATe, noted the endorsements, and provided a link to the online assessment tool. A request was made for the designation of one person at each hospital to collect and enter the information needed for LOCATe by May 31, 2018.

Nearly 10% of NH resident births occurred in approximately 60 out-of-state hospitals in 2017. An analysis was conducted that identified a group of 13 hospitals that accounted for about 87% of out-of-state NH resident births. This group includes birth hospitals in Massachusetts (9), Maine (2), and Vermont (2). The MCH Epidemiologist is communicating with colleagues in neighboring states and NNEPQIN to determine the best approach for possibly requesting LOCATe information from these hospitals.

The standardized LOCATe results, when combined with public health surveillance data, allow more detailed analyses to promote understanding of maternal and infant health outcomes by level of care, as well as of the relationship between the volume of services provided by a facility and maternal and infant health outcomes. LOCATe results are expected to inform discussions between DHHS, stakeholders and providers.

As of May 2018, a total of 13 states as shown below (California, Colorado, Georgia, Illinois, the southeast perinatal region of Michigan, Mississippi, New Hampshire, New Mexico, North Carolina, Oklahoma, Tennessee, Utah, and Wyoming) and Puerto Rico are participating in CDC LOCATe.



* * * * * * * * *

Zika/Birth Conditions Program

The Zika Surveillance project was implemented on 8/1/2016 through grant number NH50DD000009 from the Centers for Disease Control and Prevention. The project became active in May 2017, with the hiring of its personnel, one FTE Public Health Nurse. It will terminate on 9/30/2018 and evolve into a birth conditions program.

Background

Birth defects are a leading cause of infant mortality in the United States and contribute substantially to health care costs and life-long disabilities. In NH, infant deaths due to birth defects were 3.96 per 1,000 live births. During 2014, there were 12,283 births in NH; of those 11,158 were births to NH residents. In 2014, there were approximately 300 birth defects identified by the NH Birth Conditions Program (NHBCP), or a prevalence rate of 2.5%.

The Zika virus is spread to people primarily through the bite of an infected *Aedes* species of mosquito, as well as through sexual transmission. The illness is usually mild with symptoms lasting for several days to a week after being bitten by an infected mosquito. However, many infected individuals are asymptomatic. The Zika virus can also be spread from a pregnant woman to her fetus. Zika virus infection has been linked to microcephaly and potentially other central nervous system (CNS) defects in babies of mothers who had Zika virus while pregnant. The full spectrum of outcomes of children exposed or potentially exposed to the Zika virus is not yet known.

In late 2015 there were reported cases of birth defects associated with the Zika virus occurring in South America, with a potential for increased numbers of birth defects cases with the spread of the virus to Central and North America and travelers coming from Zika-endemic countries. In January 2016, the Centers for Disease Control and Prevention (CDC) activated the Emergency Operations

Center to address national and international public health concerns regarding the spread of the Zika virus and related adverse health outcomes in pregnant women. On February 1, 2016, the World Health Organization declared Zika virus infection a public health emergency of international concern.

An urgent public health response was implemented to understand the impact of adverse birth outcomes related to the Zika virus during pregnancy, by establishing a population-based surveillance system to identify cases of microcephaly and other defects potentially linked to Zika virus from all pregnancy outcomes, to better assess the impact on communities. However, given the routine lag time in surveillance systems to capture timely case information (from several months up to one to two years), 'real-time' reporting and data collection are needed to monitor the impact of Zika virus on pregnancy and infant outcomes as events unfold. These include using a standard case definition across surveillance systems, expanding data sources to include non-traditional sources such as specialty clinics and State Laboratory reports of any pregnancy with positive or inconclusive Zika virus test results, employing innovative and timely approaches to data collection, and participating in CDC centralized pooled clinical and surveillance data projects including the U.S. Zika Pregnancy Registry.

Since January of 2016, the NH Bureau of Infectious Disease Control (BIDC) has been facilitating Zika virus testing of travelers returning from Zika affected areas. In August 2017, there were fourteen reported cases of Zika virus infection in NH residents (3 of 7 females were pregnant, 6 males, 1 congenital), with sexual transmission and travel risk factors present within the group. With many countries still affected by the virus, Zika virus disease is still a concern among travelers returning to NH, including possible cases detected in pregnant women, where exposure can be from both travel and sexual transmission. Zika continues to be one of the State of NH's Reportable Infectious Diseases, requiring any suspected Zika infection to be reported to the BIDC within 24 hours of diagnosis or suspicion of diagnosis.

Approach

The NH MCH section received funding to establish a rapid active case ascertainment surveillance system for microcephaly and select CNS defects possibly linked to maternal Zika virus infection in NH. Since the original NH Birth Conditions Program concluded in early 2016 when CDC funding ended, the Zika grant funds were used to hire a full-time Birth Conditions Public Health Nurse Program Coordinator (PHN) who has been carrying out the activities and strategies in accordance with CDC standards for birth conditions surveillance, including Zika-related birth conditions. By hiring an experienced registered nurse, NH DPHS ensured clinical support for case review. The PHN has-collaborated with the U.S. Zika Pregnancy Registry effort through cooperative work and communication on the Zika Incident Management Team.

1. Assuring Legal Authority for Surveillance Activities

NH-specific activities and strategies included aligning work with the CDC and the National Birth Defects Prevention Network (NBDPN) guidelines, utilizing the standard case definition as defined by both entities.

NH RSA 141-J and Rule He-P3012 authorize the NH DHHS to determine prevalence and trends of birth conditions among New Hampshire residents. However, RSA 141-J defined birth conditions specifically as those conditions listed in the "***Guidelines for Conducting Birth Defects Surveillance***" established by the NBDPN. Since microcephaly was removed from the NBDPN list in 2014, NH lost the authorization to collect microcephaly data through the NH Birth Conditions Program. This change to the NBDPN list necessitated introducing legislation to re-authorize collecting this data. Senate Bill 222 was introduced in January 2017, which amends RSA 141-J to replace "listed" by the NBDPN, with, "recommended by the National Birth Defects Prevention Network and/or the Centers for Disease Control and Prevention." DPHS staff, including legislative liaisons, the Population Health and Community Services Bureau Chief, the Director of Public Health Services, and others worked with policy makers to provide information and testimony to ensure that the NH DHHS was able to update the legal authority for rapid active case ascertainment surveillance. See the NH law authorizing the program: http://www.gencourt.state.nh.us/rsa/html/x/141-j/141-j-mrg.htm).

Full legislative authority with the updated law and working rules is required to implement surveillance activities. In the early months of 2017, with a new incoming administration and Governor, the administrative rules, under which the program operates, expired during a hold on personnel and a rule-making moratorium, leaving the program without full authority to conduct surveillance activities.

The NHBCP PHN worked with the Legislative Rules Unit to create an interim set of rules for the program. The New Hampshire Joint Legislative Committee on Administrative Rules (JLCAR) reviewed and adopted the interim rule for the NHBCP in July 2017. With the interim rule in place, regular rule-making for the NHBCP ensued.

Bringing together both the public and stakeholders for comment and addressing those comments to satisfy concerns is essential for stakeholder buy-in and program operation. The NHBCP identified and contacted stakeholders to address the current rules as well as the Opt-Out procedure. Meetings were held with stakeholders as part of the NHBCP advisory committee function in September and November of 2017. These meetings were geared toward the administrative rule-making process, to glean input on the proposed rule and to establish authority for the program. Written responses were solicited for those not able to attend committee meetings. A hearing seeking public comment was also held November 27, 2017, regarding the proposed rule.

Meetings were held with stakeholders for rule comment and input. Rules were amended to accommodate requests and scheduled for review by JLCAR at their December 23, 2017 meeting, when they were approved. The new rules were adopted January 9, 2018. These will be effective until January 2028.
(see Maternal Child Health Chapter, He-P 3000, Part He-P 3012, Birth Conditions Program, http://www.gencourt.state.nh.us/rules/state_agencies/he-p3000.html.)

2. Collaborative Partnerships

Develop relationships among professional partner organizations and providers, to educate the public on prevention of Zika infection among adults desiring pregnancy

A tabletop exercise held in May 2017, focused on refining the NH Zika Response plan. Facilitated by the BIDC Bureau Chief, the meeting consisted of situational exercises with the purpose of supporting stakeholders in assessment of their current policies and procedures, as well as identifying any necessary programmatic support needed to operationalize the response to the Zika virus in NH. The meeting was well attended by contractors and providers of vector-control services, members of many bureaus and sections within the DPHS, including the BIDC, the Bureau of Population Health and Community Services, and the Bureau of Public Health Protections, as well as the State Epidemiologist and the Public Information Officer. This meeting was useful in assisting the PHN in evaluating the NHBCP rules and law parameters for use in a situational response to an emerging public health threat related to birth outcomes, and to identify potential partnerships and resources to build capacity for current and future responses.

The PHN met with stakeholders in the MCH section to determine the most effective avenue to reach the target population of providers, to educate them on prevention of Zika infection in adults desiring pregnancy, and for disseminating important Zika information to others providing services to women of child bearing age on the importance of preventing Zika infection prior to conception and during pregnancy. The PHN presented information at the Family Planning Directors Meeting June 2017, regarding the status of Zika locally and globally, and reviewed the Guidelines for Prevention of Zika virus infection prior to conception and during pregnancy. The Family Planning Directors represent a group of providers that manage Community Health Centers offering family planning services, which are located throughout the State of NH.

The NHBCP also collaborated with MCH Family Planning Program to facilitate distribution of free intrauterine devices (IUDs) to the Family Planning Clinics in New Hampshire. To encourage prevention of pregnancies in the setting of maternal exposure to the Zika

virus, sixty-two (62) free IUDs were supplied to the eight (8) Family Planning Clinics. As of May 2017, twenty-one (21) IUDs were utilized to support these efforts.

The NHBCP and BIDC, along with the State of Vermont, presented Zika information at the NNEPQIN winter meeting, January 25, 2018. The presentation consisted of information on awareness and prevention information related to Zika, and statistical information that was released as part of the January 2018 MMWR on Zika. The Morbidity and Mortality Weekly Report (MMWR) Series is prepared by the CDC. This presentation also highlighted a case of a hurricane-impacted family from Puerto Rico/US Virgin Islands that relocated to Vermont, and relocated again to Maine, emphasizing that interstate collaboration is crucial to Zika surveillance, as families with affected infants may not be permanent residents of the state. This emphasized the value of having representatives from NNEPQIN as active members of the NHBCP stakeholder/advisory committee.

A Resource Guide is in the final stages of development for families and individuals in NH affected by the Zika virus, and their providers. This Resource Guide is funded through the NH Zika Pregnancy Registry (ZPR)/BIDC (the Public Health Preparedness and Response (PHPR) Cooperative Agreement for All-Hazards Public Health Emergencies). The NHBCP and BIDC have been working cooperatively to develop and provide content for this guide.

Develop relationships among NH State Programs to build cooperation and understanding of roles in the effort to prevent the spread of Zika infection among adults desiring pregnancy

Initially, regular bi-monthly meetings were held between MCH staff, the staff of the Infectious Disease Surveillance Section and the Infectious Disease Investigation, Prevention and Care Services Section, in the BIDC. BIDC manages the grant for the Zika Pregnancy Registry (the Public Health Preparedness and Response (PHPR) Cooperative Agreement for All-Hazards Public Health Emergencies; grant number NU90TP921870). The purpose of these meetings was to establish a working relationship between the BIDC Pregnancy Registry staff and the MCH Zika Birth Conditions Surveillance Program. Potential use of the NH Electronic Disease Surveillance System (NHEDSS) for the BCP PHN to acquire information concerning Zika-related pregnancies was discussed; however with the relatively low number of expected cases, it was decided that regular contact with the department in person or by phone would be the soundest avenue for exchange of information. The BCP PHN is working with the BIDC Epidemiologist and the BIDC Vectorborne Disease Surveillance Coordinator (VBDSC) to follow Zika-related cases. Larger, monthly meetings included MCH and BIDC as well as staff from the state laboratory and the State Epidemiologist. These larger meetings focused on updates on the national and international Zika situation, laboratory, and surveillance updates for NH as well as partner and public communication efforts.

The ongoing partnerships cultivated with the BIDC have led to a cooperative relationship where, during the time the NHBCP rules were being developed, the BIDC had statutory authority to execute follow up of infants of infected mothers. Collaboration between MCH and BIDC for referral to services has occurred for the one (1) identified congenital Zika case.

There is ongoing development of relationships within the MCH section to work in partnership for Zika case identification and services available to impacted infants. Relationships have been developed with the Early Hearing Detection and Intervention Program (EHDI) and Newborn Screening (NBS) to identify possible Zika-impacted infants. Both programs have been in contact with their providers statewide asking them to watch for any possible Zika-impacted infants. If there is a possible exposure mentioned to one of the Program Coordinators, the Coordinator will in turn contact the NHBCP who will investigate the occurrence further.

3. Capacity Development

Infrastructure Improvements to allow for rapid, active surveillance

The NH Hospital Discharges, All-Payer Claims, and Fetal Death databases are not currently timely enough to serve as supplemental data sources for active reporting and notification. Therefore, other sources have been explored.

A request for proposals is being drafted for a database that will serve the needs of the EHDI program, the Critical Congenital Heart Defect (CCHD) component of the NBS Program, and the Birth Conditions Program. The database will allow EDHI, NBS and the NHBCP data to be housed together and have the potential for regular uploads from the NH Division of Vital Records Administration (DVRA) data. Currently, referral from EHDI or NBS of any potentially Zika-related cases comes from Zika-specific communication between the coordinators of each program, rather than from ongoing systems communication. A single working database for the three programs will allow for another avenue of case ascertainment for the BCP in more real-time.

The NH DVRA is situated in the NH Department of State and maintains a secure web-based vital records data system known as the New Hampshire Vital Records Information Network (NHVRIN).

MCH has worked with the DVRA in planning the addition of three fields to the NH birth certificate worksheets, both paper and electronic. The fields are: head circumference, length, and microcephaly. The Vital Records data is used as a supplemental case ascertainment source, to complement the active case-finding which takes place on site at birth hospitals. Both the paper and electronic versions of the birth worksheets were updated. The BCP and the MCH Epidemiologist have verified the use of the data extracted from the Vital Records birth file. Data quality of the three (3) new variables added to the birth certificate has been examined. It has been found that rates of missing data are low (~5% for the anthropometric data) and initial descriptive analysis suggests minimal problems with reporting of incorrect units (e.g. reporting head circumference in inches instead of centimeters). Currently, the BCP is able to request data regarding head circumference, length and microcephaly. In addition, the MCH Epidemiologist pulls microcephaly data from the birth record and reports this monthly to the BCP. Any anomalies are checked against the ZPR and then abstracted at the hospital sites.

Approval of the MOA and a contract with DVRA at the April 11, 2018 Governor and Executive Council meeting will allow work to begin on the next phase of development of the situational surveillance enhancement to the birth worksheet, and it may have applications beyond the surveillance of birth conditions.

Zika birth defect surveillance and clinical case project

The primary source of case ascertainment is from active surveillance of birth information at the hospital level. Hospitals are asked to supply information based on the case inclusion criteria for Zika-related birth defects referencing NBDPN and CDC guidelines, which include microcephaly and select central nervous system defects possibly related to the Zika virus.

Due to the interruption of operations of the original NH BCP subsequent to loss of program funding, and the constraints on hiring of personnel for program operations, it was necessary to revive relationships with hospital stakeholder Health Information Management Departments to request access to records for chart abstraction.

Hospital stakeholder responses to requests for record review have been sluggish. Many have undergone changes in staff and in electronic health records systems, creating difficulties in responding quickly to requests for access to health information. Infrastructure challenges between hospital Health Information Management and Information Technology have made slow work of creating the ICD-10 code reports that will allow record draw for review. Once the BCP established full legislative authority in January 2018, the PHN made requests to all hospitals for access to health information for review. NH has nineteen (19) birth hospitals. Thus far, two (2) hospitals have processed the request for the required January 2016 to June 2017 review. Two (2) other hospitals have processed only January 2017 to June 2017 records. Fifteen (15) hospitals are still working on requests.

4. Referral to Services

Identify resources to develop a plan for engagement of services for impacted infants and families

The NHBCP has engaged with Special Medical Services (SMS), who provide services to children with special health care needs for the age group birth to twenty-one (21) years, who have, or are at risk for a chronic medical condition disability or special health care need, and NH Family Voices (NHFV), who provide parent-to-parent interaction for families who have children with special needs.

These partners are available to answer questions and help navigate through the many services which impacted children and families may need. Both groups are active participants in the BCP stakeholders/ advisory committee. Currently, if the BCP has knowledge of an affected family needing services, a call is placed to the program coordinator at SMS and in turn SMS will contact NHFV if referral applies. The BCP will confirm with BIDC/ZPR if the mother is on the pregnancy registry and the infant is known to the ZPR prior to follow up with SMS. Currently, in order to connect a family to any services, legislation requires the BCP wait until the Opt-Out period ends (60 days from when the Opt-Out packet is mailed and the Opt-Out form has not been returned to the program. If the packet is returned undeliverable twice, the family is considered automatically opted out). If the parent has not opted out of the BCP Registry, they can be referred by the BCP to SMS and/or NHFV. In some cases, the infant or family is known to BIDC/ZPR and a referral to services has already been made.

Work group creation for identification of hurricane-affected families from Puerto Rico and the US Virgin Islands to identify and assist individuals and families who have Zika-affected children.
The BIDC/ZPR, NBS, EHDI and SMS are part of a workgroup led by the BCP and are also in communication with the Office of Health Equity to identify any hurricane-impacted family who may have a Zika-affected infant or pregnancy. An infant was identified by SMS as Zika-impacted and possibly coming from a hurricane-affected area. SMS contacted both the BCP and the ZPR and it was determined this was not a hurricane-impacted family, but was a Zika-affected infant already known to both the BCP and the ZPR. The BIDC/ZPR, EHDI, NBS, Office of Health Equity, and SMS are all working together with the BCP to watch for individuals/families that may have Zika coming from hurricane-impacted areas. EDHI, NBS, BIDC/ZPR, and the Office of Health Equity will contact either the BCP or SMS if an individual or family is identified.

5. Health and Developmental Outcomes

The PHN will work cooperatively with SMS and the BIDC on following all infants impacted by the Zika virus to determine health impacts and potential developmental delays in these children. While the BCP does not have authority to follow infants who do not have a diagnosed birth defect, the program will work jointly with BIDC to follow infants without evidence of Zika syndrome of mothers who had positive or inconclusive Zika testing.

* * * * * * * * *

---

[1] Centers for Disease Control and Prevention, Sudden Unexpected Infant Death and Sudden Infant Death Syndrome, Data and Statistics. Retrieved on 04/24/18) from https://www.cdc.gov/sids/aboutsuidandsids.htm.
[2] Ibid.
[3] Ibid.
[4] New Hampshire Child Fatality Review *Committee Report October2017*
[5] Ibid
[6] Parks WE, Erck Lambert AB, Shapiro-Mendoza CK. Racial and Ethnic Trends in Sudden Unexpected Infant Deaths: United States: 1995-2013 (Parks WE, Erck Lambert AB, Shapiro-Mendoza CK. Racial and Ethnic Trends in Sudden Unexpected Infant Deaths: United States: 1995-2013 (2017). *Pediatrics*:139 (6) e20163844
[7] New Hampshire Child Fatality Review Committee, *Committee Report October2017*
[8] New Hampshire Child Fatality Review *Committee Report October 2017*
[9]NH DHHS PRAMS Project

[10] Ibid.

[11] Centers for Disease Control and Prevention (2017). Sudden Unexpected Infant Death. Retrieved on 05/07/16/18 from https://www.cdc.gov/sids/pdf/sudden-unexpected-infant-death.pdf.

[12] NH DHHS SUID Project Data Brief released January 2018.

[13] Ibid.

[14] URL: https://cdc.gov/reproductivehealth/maternalinfanthealth/LOCATe.html

National Performance Measure #5:
(A) Percent of infants placed to sleep on their backs
(B) Percent of infants placed to sleep on a separate approved sleep surface
(C) Percent of infants placed to sleep without soft objects or loose bedding

Evidence Based or Informed Strategy Measure: The percentage of birth hospitals with a written safe sleep policy, including placing all infants to sleep on their back

Objectives: By January 1, 2023, 100% of New Hampshire's birthing hospitals will have a safe sleep policy in writing

Strategies:

- Utilize SUID case registry to describe the distribution of risk factors and identify possible points of intervention
- Utilize PRAMS data to inform key stakeholders about safe sleep education needed
- Promote safe sleep policy development and change within birthing facilities
- Train providers working with infants (e.g. labor and delivery nurses, child care providers)
- Promote public education on safe sleep
- Collaborate with birth hospitals in their use of Safe Plan of Care for neonates

Systems Building

The multidisciplinary SUID Review Group will continue to meet on alternate months.
The Safe Sleep Workgroup, a subcommittee of the SUID Review Group and chaired by MCH, will continue to provide technical assistance to the birthing hospitals so that the few who do not now have definitive policies on safe sleep will have them by the end of the SFY19.

Feedback from home visiting agencies was that a more graphic handout with pictures of unsafe sleep items or equipment such as Rock'n Plays, car seats, pillows to assist breastfeeding, etc. would be helpful, as would one showing the anatomical differences in trachea and esophagus positions between prone and supine. These would be especially helpful for non-English speaking and/or low literacy families. The Safe Sleep Workgroup will target the completion and dissemination of this teaching tool as a priority for the 2018 fall/winter period.

The Safe Sleep Workgroup will also continue to work with home birth providers to encourage safe sleep policy and practice through communication with the home birth provider representative on the SUID Review Group and Safe Sleep Workgroup.

MCH Specific Activities

MCH plans to further improve infants' safe sleep include continuing to work with providers and the general public in sharing the safe sleep message and the latest AAP recommendations, especially with perinatal and infant health providers. The 2015 NVSS data for New Hampshire shows a SUID rate of 80.4 per 100,000 (NOM9.5); this is consistent with the state's serious substance use problem, and the data showing that 36% of the 2011-2016 SUID deaths are known to have a primary caretaker with a history of substance abuse. Outreach will continue to be implemented to educate inpatient and outpatient substance treatment facility staff and their clients about the importance of safe sleep.

MCH will continue to work with the DPHS' Healthy Homes and Lead Poisoning Prevention Section in supporting two (2) public health initiatives at the same education outreach visit, getting out the safe sleep message.

In addition, MCH will disseminate its latest information on case risk factors and demographics, the 2018 birth hospital policy and practice survey results, and its latest PRAMS data on safe sleep behaviors and sleep environment to key stakeholders to better inform education and outreach efforts.

Safe Plan of Care and Neonatal Abstinence Syndrome

MCH staff will continue to be involved in the efforts by DHHS's Division of Children, Youth and Families (DCYF) to come into compliance with the requirements of the federal Comprehensive Addiction and Recovery Act (CARA) signed in July 2016. The five (5) birthing hospital sites continue to be pilots for the Safe Plan of Care (see a full description in last year's annual report for NPM5) for those infants born and identified as being affected by substance use or withdrawal from prenatal drug or alcohol exposure. Senate Bill 549, relative to plans of safe care for infants affected by substance abuse or withdrawal symptoms from prenatal drug exposure or fetal alcohol spectrum disorder, was passed during the 2018 legislative session. This bill codifies that health care providers shall develop a plan of safe care, in cooperation with the infant's parents or guardians and the NH DHHS to ensure the safety and well-being of the infant, to address the health and substance use treatment needs of the infant and affected family members or caregivers, and to ensure that appropriate referrals are made and services are delivered to the infant and affected family members or caregivers. Additional language in the bill states that the plan shall take into account whether the infant's prenatal drug exposure occurred as the result of medication assisted treatment, or medication prescribed for the mother by a health care provider, and whether the infant's mother is or will be actively engaged in ongoing substance use disorder treatment following discharge that would mitigate the future risk of harm to the infant. As of July 1, 2018 all hospitals will be required to develop these plans of safe care and notify DHHS of infants born with substance abuse or withdrawal symptoms resulting from prenatal drug exposure or fetal alcohol spectrum disorder.

Situational Surveillance and Neonatal Abstinence syndrome

In the next phase of development of the birth worksheet (following the addition of fields to capture infant outcomes potentially related to Zika virus exposure in the mother), the MCH Epidemiologist and DVRA will develop an innovative, first-of-its-kind "situational surveillance" enhancement to NHVRIN. This enhancement will allow exceptional agility in responding to data collection needs related to vital records. The enhancement to NHVRIN will provide for up to two questions to be added to birth records and presented at the time of birth data entry. These will be presented in pop-up windows and will require a response before continuing. The especially innovative feature is that these questions will be customizable without requiring a technical system coding change and can be rapidly deployed. The State Registrar will have access to a Graphical User Interface (GUI) that allows setting the question text and time frame of data collection. Through conversations with national and state colleagues it has been learned that this may be the first vital records system in the country with the capability to implement customizable data collection at a moment's notice at no additional expense.

As of July 1, 2018, this situational surveillance feature will be used to assess prenatal opioid exposure (licit or illicit) and infant withdrawal risk. Two questions will be added to the NH birth certificate for a period of three (3) months. A question directly addressing whether an infant has neonatal abstinence syndrome is not appropriate for the birth certificate due to varying definitions in use by providers and timing of symptom onset. Some providers will consider any infant with known exposure and any symptoms to have NAS while other providers may use numerical standards based on NAS assessment tools (e.g. Finnegan or Eat-Sleep-Console), or whether the infant required pharmacologic treatment of NAS symptoms as diagnostic criteria. Additionally, many hospitals complete birth certificate forms within the first two days after birth. Most infants will not display NAS symptoms due to

opioid exposure prior to 48 hours after birth and symptoms may not appear until day four (4) or five (5). Earlier symptoms may be due to other substances such as nicotine or SSRIs (selective serotonin reuptake inhibitors).

The three-month assessment period is scheduled for July-September 2018. A paper-based (not online) pilot study was conducted in early 2018 by a Dartmouth Leadership in Preventive Medicine Resident, in collaboration with the MCH epidemiologist. Explanatory correspondence with the hospitals and supporting documents have been prepared. While this new surveillance effort will not result in an improved NAS rate, it will provide a snapshot of useful NAS-related information. The table below shows the two questions that will constitute the initial assessment. The situation surveillance system currently restricts response options to Yes/No/Unknown.

Q1: Was there opioid exposure at any time during the pregnancy?	**Q2: Was the infant monitored for signs of opioid withdrawal or neonatal abstinence syndrome (NAS)?**
o Yes o No o Unknown	o Yes o No o Unknown
Aim: Determine the number of infants exposed to opioids in utero.	*Aim:* Determine the number of infants considered to be at risk for withdrawal by the medical team.

Levels of Care Assessment Tool (LOCATe)

The information gleaned from LOCATe (Levels of Care Assessment Tool) will inform about state capacity to provide perinatal care, particularly among high-risk populations. LOCATe will be used for public health and quality improvement purposes only, not for regulation or designation. LOCATe is a tool to inform our work as NH joins the national effort to improve the health system and quality of care for mothers and infants.

Only aggregate statistics from the statewide analysis will be shared publicly. Facility-level results will be shared by DPHS only with each facility and with NNEPQIN to facilitate quality improvement work. NH DPHS will send de-identified data to CDC to apply a standardized algorithm to assess each hospital's maternal and neonatal level of care. De-identified results may be used to conduct national and regional analyses, which would provide hospitals with a valid comparison group of similar hospitals to examine differences in health outcomes and facility capabilities.

A possible August 2018 visit from CDC partners to discuss the results of the NH LOCATe assessment is being discussed. Topics would include a review of the results, discordant hospitals (self-assessed vs. LOCATe-assessed differences and why), gaps in care based on specialist/equipment availability, future analysis options, transport and consult plans, and education and outreach.

New Hampshire does not currently regulate or designate neonatal or maternal levels of care, which are self-designated. Self-designation allows for differing assessment methods, including consideration of factors such as marketing value. While self-designated levels may be useful in some circumstances, the LOCATe results will provide a more robust and standardized determination of maternal and neonatal levels of care that can be used in a variety of analyses.

* * * * * * * * *

Zika/Birth Conditions Program

With Zika surveillance and reporting to the CDC coming to an end in the early fall of 2018, the Birth Conditions Program will expand operations to include all birth defects recommended by the NBDPN and the CDC for surveillance. With stakeholder relationships formed between the BCP program, hospital IT and HIM (health information management) staff, requests for access to information will be more straightforward for stakeholders to accommodate. Requests for health information for case ascertainment will be monthly, reducing the burden of reporting large amounts of information all at once for hospitals, and the amount of cases for abstraction at one time should decrease. With more real time surveillance information, referral to services can be accomplished in a timelier manner. Additionally, in the near future plans are to implement a means of transferring data using the Secure File Transfer Protocol (SFTP) system, whereby hospitals transfer their data securely and the BCP houses the data in an encrypted file and secure location allowing for easier request and review of information.

Collaborative efforts for birth defect case identification will increase between the EHDI, NBS, and Birth Conditions programs with the completion of the database to be utilized by the three programs. The database will help in identifying infants with birth conditions sooner, at a time around the birth, as information will be input at the hospital level at the time of discharge.

The BCP is working together with national partners at the NBDPN regarding awareness surrounding use of folic acid to aid in prevention of neural tube defects, and education and outreach using the National Birth Defects Prevention Month as a platform to disseminate information to providers and the public, notably through the use of social media. These national partnerships will assist the BCP in accomplishing public education goals.

* * * * * * * * *

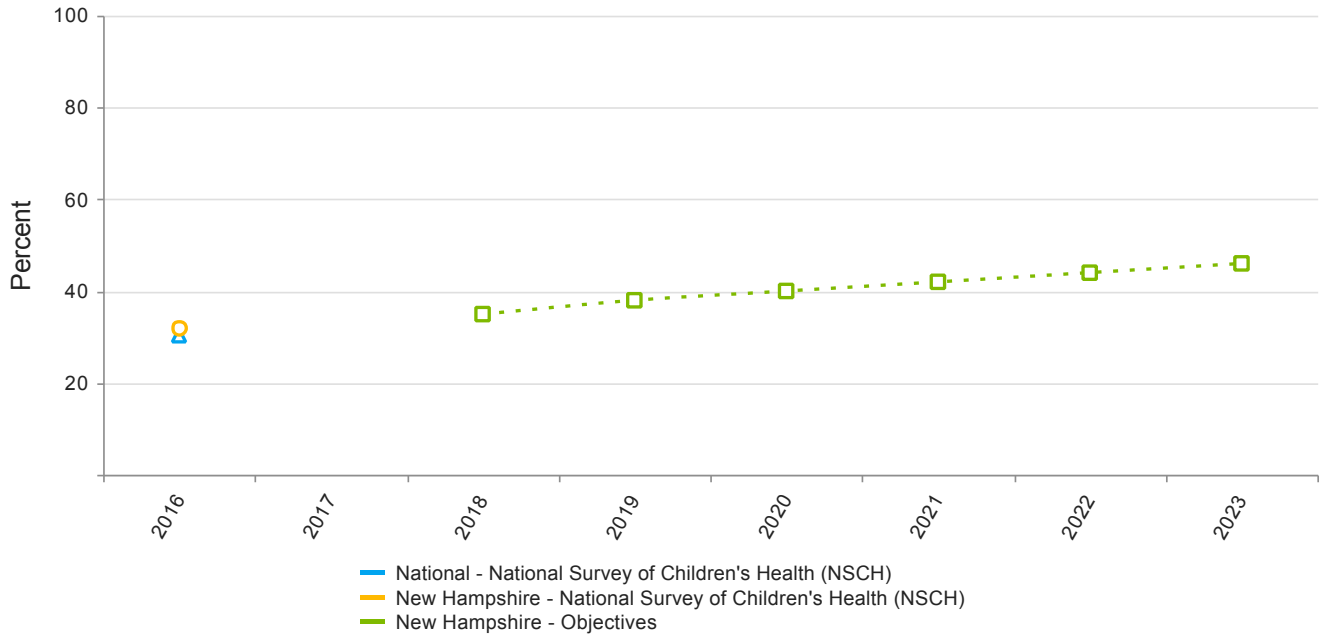
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available	NPM 6
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	92.0 %	NPM 6 NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2016	8.5 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2014	15.1 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2015	12.2 %	NPM 8.1

National Performance Measures

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
Baseline Indicators and Annual Objectives



Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	**2017**
Annual Objective		
Annual Indicator		32.0
Numerator		8,656
Denominator		27,043
Data Source		NSCH
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	35.0	38.0	40.0	42.0	44.0	46.0

Evidence-Based or –Informed Strategy Measures

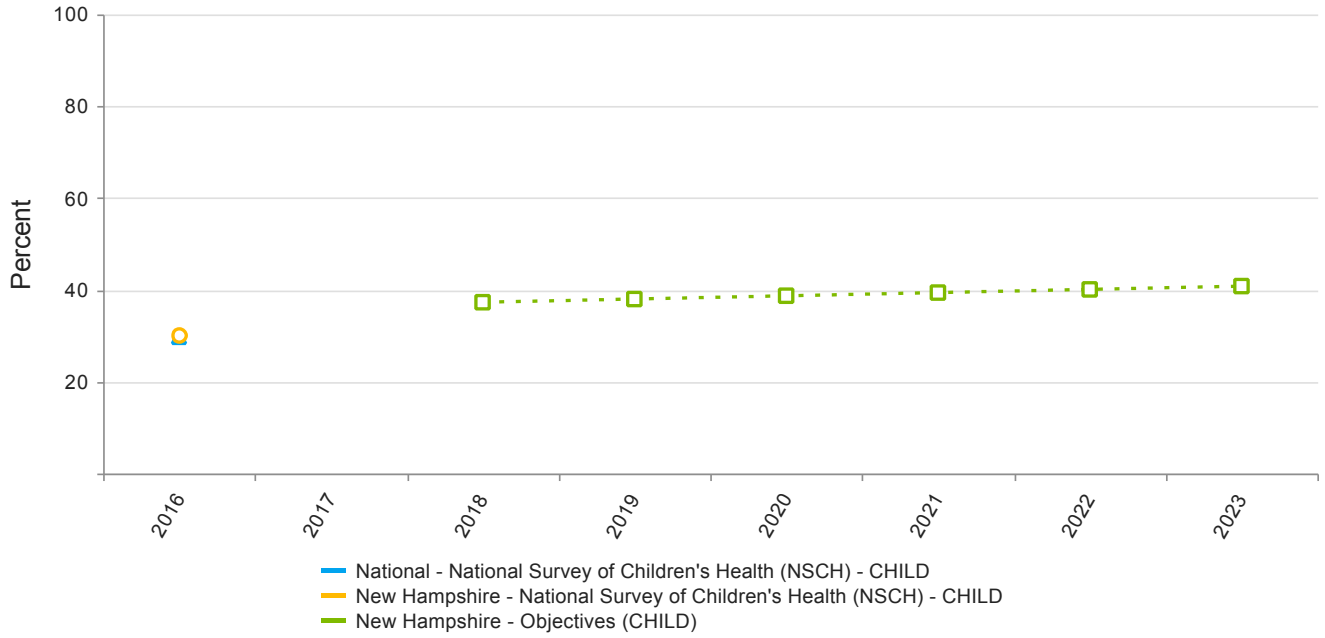
ESM 6.1 - The number of sites using ASQ/ASQ-SE screening tools and participating in the Watch Me Grow (WMG) System.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		90
Annual Indicator	43	69
Numerator		
Denominator		
Data Source	WMG Welligent Database	WMG Welligent Data
Data Source Year	2015	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	70.0	75.0	80.0	85.0	90.0	100.0

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day
Baseline Indicators and Annual Objectives



Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CHILD		
	2016	**2017**
Annual Objective		
Annual Indicator		30.1
Numerator		28,200
Denominator		93,602
Data Source		NSCH-CHILD
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	37.3	38.0	38.7	39.4	40.1	40.8

Evidence-Based or –Informed Strategy Measures

ESM 8.1.1 - 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.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		75
Annual Indicator	71.6	78.4
Numerator	48	185
Denominator	67	236
Data Source	DCYF data base, submitted by CFSS agencies	DCYF data base
Data Source Year	2017	2018
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	76.0	77.0	78.0	79.0	80.0	81.0

State Action Plan Table

State Action Plan Table (New Hampshire) - Child Health - Entry 1

Priority Need

Decrease pediatric overweight and obesity.

NPM

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Objectives

By July 1st of 2019, 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 19 (ends June 30th 2019).

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

Encouragement of clientele by health and social service providers for children and families to increase physical activity through fun, family-centered, local community-based opportunities

ESMs	Status
ESM 8.1.1 - 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.	Active

NOMs

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

State Action Plan Table (New Hampshire) - Child Health - Entry 2

Priority Need

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

NPM

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Objectives

To increase from 32% (2016 FAD baseline) to 46.0% the percent of children, ages 9 months to 35 months, who receive a developmental screening using a parent-completed screening tool, by 2023.

Strategies

- Promote the training of professionals to utilize the ASQ and ASQ-SE screening tools
- Provide leadership and group facilitation to Watch Me Grow and the NH Act Early team
- Review and identify gaps based on environmental scan and data analysis completed in SFY 18
- Promote developmental screening, participation in Watch Me Grow, and use of the online ASQ screening tool (as soon as the data bridges have been completed).
- Educate the public through dissemination of LTSAE materials, NH specific 'fact sheets' and updated web based information.
- Support the activities of the Learn the Signs Act Early Ambassador
- Collaborate with the NH Pediatric Improvement Partnership (NH PIP) and any efforts related to developmental screening

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

NOMs

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

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

National Performance Measure # 6:
Percent of children, ages 9 to 35 months, receiving a developmental screening using a parent-completed screening tool

Evidence Based or Informed Strategy Measure # 6.1:
The number of sites using the Ages & Stages Questionnaire (ASQ) and the ASQ-Social Emotional (ASQ-SE) screening tools and participating in the Watch Me Grow (WMG) system

Objective: To increase from 32% (2016 FAD baseline) to 46% the percent of children, ages 9 months to 35 months, who receive a developmental screening using a parent-completed screening tool, by 2023.

Strategies:

- Promote the training of professionals to utilize the ASQ and ASQ-SE screening tools.
- Provide leadership and group facilitation to WMG and the NH Act Early Team.
- Review and identify gaps based on environmental scan and data analysis completed in SFY18
- Promote developmental screening, participation in WMG, and use of the online ASQ screening tool (as soon as the data bridges have been completed).
- Educate the public through dissemination of Learn the Signs Act Early (LTSAE) materials, NH specific 'fact sheets' and updated web based information.
- Support the activities of the Learn the Signs Act Early Ambassador.
- Collaborate with the NH Pediatric Improvement Partnership (NH PIP) and any efforts related to developmental screening.

Data Analysis

The data for this indicator comes from the most recent National Survey of Children's Health (NSCH). The NSCH was a telephone survey led by the National Center for Health Statistics at the CDC under the direction and sponsorship of the federal Maternal and Child Health Bureau (MCHB). NH's percent of parents who self-report that they completed a standardized, validated developmental screening tool at 32% is comparable/slightly higher to the national response of 30.4%.[1] However, NH continues to fall below the cumulative average (37.9%) for developmental screening in Region 1 (New England states).

NH has its own data collection site for developmental screening results called *Watch Me Grow* (http://watchmegrownh.org/). In 2017, NH's Watch Me Grow (WMG) data indicated that 4,644 children were screened throughout the state. While this number appears to be far below the estimated 64,594 NH children, in the 0 to 4 year old age, in reality it is a companion data point to the percentage reported in the NSCH. This is because the NSCH asks parents to report on screening within a primary care/clinical environment and the WMG data only reflects screening that takes place in community settings. WMG efforts focus on the training and tracking of ASQ and ASQ-SE screenings by community providers including:

- Family Resource Centers (FRCs)
- Head Start
- Childcare providers
- Project LAUNCH
- MIECHV home visitors

From the NSCH - 2016

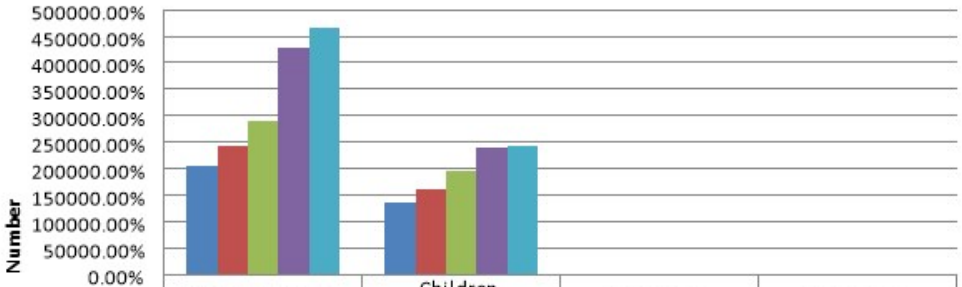
National Performance Measure 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (details)

		Parent completed developmental screening	Parent did not complete developmental screening	Total %
Nationwide	%	30.4	69.6	100.0
	C.I.	(28.0 - 33.0)	(67.0 - 72.0)	
	Sample Count	1,963	3,529	
	Pop. Est.	2,636,434	6,025,919	
New Hampshire	%	32.0	68.0	100.0
	C.I.	(21.4 - 44.9)	(55.1 - 78.6)	
	Sample Count	33	54	
	Pop. Est.	8,656	18,387	
HRSA Region I	%	37.9	62.1	100.0
	C.I.	(31.8 - 44.5)	(55.5 - 68.2)	
	Sample Count	251	365	
	Pop. Est.	127,762	209,038	

C.I. = 95% Confidence Interval.
Percentages and population estimates (Pop.Est.) are weighted to represent child population in US.
Please interpret with caution: estimate has a 95% confidence interval width exceeding 20 percentage points or 1.2 times the estimate and may not be reliable.

Currently our WMG data system collects information on screening for children from birth through age 5. This will provide some different results than the NSCH measure, which is focused on children from nine to 35 months old. The current WMG system does not have the ability to collect and/or merge the data from primary care providers' (PCP) electronic health records due to capacity issues (funding and process). Having PCPs partner with WMG to relay the data has been a challenge. Efforts have been focused on expanding the NH WMG system to provide Ages & Stages Questionnaire (ASQ) screening locally through FRCs and their community partners. Collaboration with Child Care Aware NH has allowed training to be allocated for continuing education credit to child care providers throughout the state. While the table here demonstrates an increase in developmental screenings over time, it only reflects the screenings reported by community providers in the WMG system. As noted above, the lack of capacity to capture the data regarding PCP screenings is a contributing factor to the difference in numbers between the estimated number of children in the state under the age of six (6) and those who have been screened.

From NH's WMG data system:



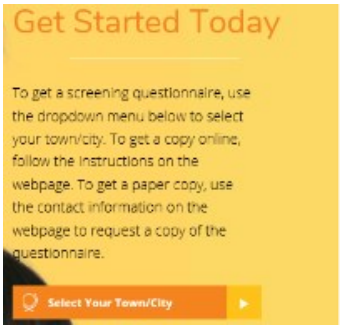
	Total Screenings	Children (unduplicated)	Referred*	Recheck**
2013	2,044	1,362	8%	13%
2014	2,428	1,615	10%	12%
2015	2888	1962	10.53%	11.25%
2016	4293	2388	7.87%	12.30%
2017	4644	2434	8.55%	13.18%

The WMG data system is Welligent software used by participating sites as well as other partner agencies to record and utilize Developmental Screening data. From July 1, 2016 to June 30, 2017 the Welligent data site shows that 2435 screenings occurred at FRC's and 4644 screenings occurred at WMG partner sites across the state. With funding from SAMHSA, Project LAUNCH paid one staff person to focus on this activity and held the highest reporting rate at 702 screenings. Three hundred and ninety seven (397) screenings indicated a needed referral. These children were referred to school districts, Family Centered Early Supports & Services, community mental health, and Head Start/ Early Head Start. Additionally, 612 screenings resulted in scheduled rechecks. The largest population of children screened was three and four year olds.

Systems Building

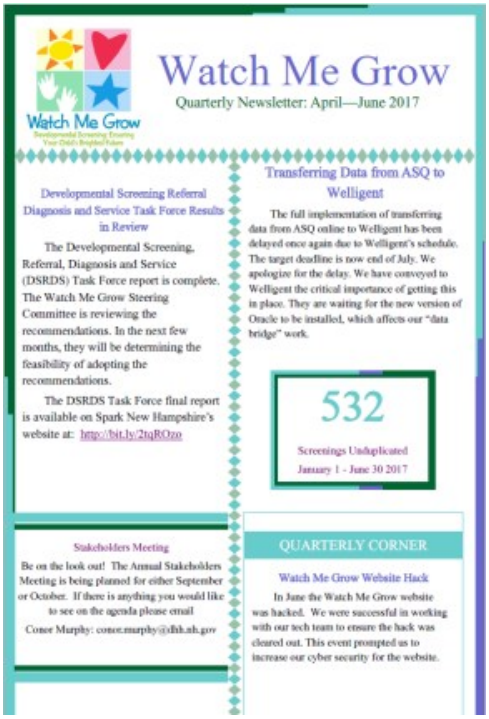
Since 2013, NH's State Health Improvement Plan (SHIP) has identified developmental screening for autism as one of its priorities and promoted screening within comprehensive pediatric care in community health centers as well as within the WMG developmental screening system to ensure high quality, accessible and coordinated screening, information and referral services and supports to NH families. WMG is the system supported by DHHS to provide high quality, accessible and coordinated developmental screening, information and referral services and supports to NH families of young children (birth to 6 years), ensuring that children have opportunities to reach their maximum potential. Leadership for WMG has been a partnership across MCH, SMS (Part C - Family Centered Early Supports and Services and Title V) and the Head Start State Collaboration Office (HSSCO). Additionally, the FRCs have been a key component of the effort and played a critical role in regard to educating families, screening children and data collection within their communities.

A major focus of WMG's activities has been to promote the ASQ and ASQ-SE since 2011.



In 2016-2017, WMG held monthly meetings coordinated by an AmeriCorps VISTA who assisted in the daily operations to help support the program. Attendance at meetings varied from 6-12 participants from various agencies including, but not limited to Title V, preschool special education, Project LAUNCH, WIC, DCYF; Bureau of Special Medical Services, Family Centered Early Supports & Services, NH Family Voices, and the UNH Institute on Disability . The goals for the year were to continue to increase the number of partners, provide technical assistance to programs that were in need, explore funding opportunities for infrastructure, and support early childhood providers. Participants in a Developmental Screening, Referral, Diagnosis and Services (DSRDS) workgroup planned and made recommendations to WMG and Act Early to help advance the developmental screening system across the state. The WMG AmeriCorps VISTA updated the website to make it more user-friendly for families so that they could click on the town they live in and find the local FRC where they could receive the developmental screen. www.watchmegrownh.org.

The FRCs were required by contract to submit quarterly reports that provided information on what activities around developmental screening they were doing in their area, as well as the number of materials they were sharing with families. This data does not reflect the whole system as there was a change in leadership at the state level and oversight of this reporting was not consistent. However, the information that was provided to the AmeriCorps VISTA volunteer was put into a quarterly newsletter that reported any new changes to the system and an overview of statewide numbers pulled from the Welligent system.



Watch Me Grow

Quarterly Newsletter: April—June 2017

Developmental Screening Referral Diagnosis and Service Task Force Results in Review

The Developmental Screening, Referral, Diagnosis and Service (DSRDS) Task Force report is complete. The Watch Me Grow Steering Committee is reviewing the recommendations. In the next few months, they will be determining the feasibility of adopting the recommendations.

The DSRDS Task Force final report is available on Spark New Hampshire's website at: http://bit.ly/2tqR0zo

Transferring Data from ASQ to Welligent

The full implementation of transferring data from ASQ online to Welligent has been delayed once again due to Welligent's schedule. The target deadline is now end of July. We apologize for the delay. We have conveyed to Welligent the critical importance of getting this in place. They are waiting for the new version of Oracle to be installed, which affects our "data bridge" work.

532

Screenings Unduplicated

January 1 - June 30 2017

Stakeholders Meeting

Be on the look out! The Annual Stakeholders Meeting is being planned for either September or October. If there is anything you would like to see on the agenda please email

Conor Murphy: conor.murphy@dhh.nh.gov

QUARTERLY CORNER

Watch Me Grow Website Hack

In June the Watch Me Grow website was hacked. We were successful in working with our tech team to ensure the hack was cleared out. This event prompted us to increase our cyber security for the website.

An ongoing and primary enhancement to the system was to incorporate online screening through the 14 comprehensive FRCs to families. The FRCs were asked to provide a link on their agency webpages that would connect to the ASQs. In an effort to make a smooth transition, a "bridge" was needed to link the Brookes Publishing online ASQ to the Welligent WMG system, so the information would transfer over without the staff having to input the data manually. One of the biggest concerns was cost, as approved screenings cost $.50 each and there has been very limited funding in the budget and it has been difficult to predict the potential number of screenings that would be done. Work was done on policy and implementation and technical assistance was provided to sites as they prepared for this next step.

In 2016-17 SMS' CYSHCN Systems Specialist, designed and tested a survey with assistance from the UNH Institute on Disabilities, NH PIP, and the Office of Health Equity. The purpose of the survey, which was completed in SFY 18 and whose results will inform the plan for SFY 19, was to:

- Assess what developmental screenings are being used in NH and by whom
- Identify what data is being collected about developmental screenings, who is collecting it, where are they storing the information and what is accessible for aggregation purposes
- Identify gaps between what currently exists and what is needed to achieve a coordinated statewide system for collecting and reporting standardized developmental screening data

A Developmental Screening, Referral, Diagnosis and Services System (DSRDS) Task Force was convened to:

1) *Determine the gaps in identifying and serving NH's young children* (birth to five years) who may have or be at risk for developmental delays or other concerns requiring timely supports and services for the child and/or family; and
2) *Generate recommendations* to (a) address the gaps and (b) expand the WMG system to include evaluation, diagnosis and services for young children and their families when a concern has been identified through developmental screening or another mechanism.

The Task Force, funded by Spark NH (NH's Governor Appointed Early Childhood Advisory Council), included representatives from the Act Early Team / Screening & Diagnosis Work Group of the NH Council on ASD, WMG Steering Committee, Spark NH, and other participants involved in working with young children and their families in NH. The initial focus identified resources and gaps in services relative to early identification, referral, diagnosis and services for young children. The themes identified by the group were sorted into three broad categories:

- Public Awareness/Training
- Screening/Referral/Data/Quality Assurance
- Interagency/System

The Task Force generated recommendations for a comprehensive early identification, referral, and services system. A survey was created that asked for members' intuitive responses to the feasibility of implementation on a five-point scale. The recommendations were sorted and presented to the Task Force in April 2017. Three final categories for implementation were used - Short term, Midterm and Long-term based on clustering of responses.[2]

Title V agencies coordinated with partners across systems to ensure that families had access to developmental screening for their children and assisted parents with the completion of the newest versions of the tools (i.e. ASQ-3 and ASQ:SE-2). MIECHV programs, Comprehensive Family Support Services, WMG partners (54 subgroups and 14 FRC's), some Early Supports and Service Programs, Head Start and Early Head Start, and SAMSHA funded preschools have developmental screening embedded into their requirements.

Child Care Aware of New Hampshire provided funding for thirty child care providers to learn about WMG and the ASQ and ASQ-SE. Many of these sites were not participating WMG partners therefore the number of developmental screenings conducted was not captured in Welligent.

Title V staff from MCH and SMS worked with partners to promote and support connections between professional organizations and service providers to embed Developmental Screening into their programs. A few examples of the work are:

Home Visiting New Hampshire and Healthy Families America (HFA) programs are required to:

- Monitor the development of participating infants and children with the ASQ-3 and ASQ:SE-2 at specific intervals (90% of target children at least 2 x per year under age 3, annually for 3-5 year olds) , unless developmentally inappropriate, and is administered according to the developers' instructions to ensure valid results
- Have policy and procedures for administration of the ASQ-3 and ASQ:SE-2 including the frequency of administration (twice per year for those under three and annually for 3-5 year olds) and specify that these tools are to be used with all target children participating in services, unless developmentally inappropriate.
- Assure all staff (working and hired in the last five years), this includes supervisors, who administer the tool are trained prior to the use.
- Establish policy and procedures to track children, suspected of having a developmental delay, follow through with referrals, and provide follow up as needed.

Project LAUNCH piloted an initiative in the Manchester Area (NH's largest city) with the following goal to address Developmental Screening:

- Provide screening and assessment in a range of child-serving settings, connecting children and families to services as needed. Major indicators are the number of children screened using ASQ-3 and ASQ:SE-2, who are also referred or rechecked as needed. In 2017, 307 children were screened through this process.
- Project LAUNCH funded a .5 FTE staff person to coordinate the screening results, to increase the number of screenings, improve the referral and follow up process, and coordinate activities among service providers.

New Hampshire Family Voices maintained a lending library supported through a contract with SMS and they agreed to be the hub for distribution of WMG materials. They distributed the following materials by direct mail, conference displays, and in workshop

resource packets.

- Milestone Moment Handbooks – 557
- Milestone Brochures - 400
- Watch Me Grow brochures - 175

Title V Specific Activities

- Participation in the Spark NH funded Task force (DSRDS) which made recommendations to expand the current developmental screening system under the NH Act Early Team led by the CYSHCN System Specialist.
- Developmental Screening Survey was created and disseminated statewide to any provider performing Developmental Screening.
- Learn the Signs Act Early materials were embedded into trainings as well as provided to WMG partner sites, family resource centers and others to disseminate to parents of young children to track milestones.
- Collaborated with NH PIP in their efforts related to developmental screening
- Collaborated on a process to implement the online version of the ASQ-3 and ASQ:SE-2 by WMG
- The Act Early team, chaired by SMS staff, convened routine meetings to address issues and efforts related to Developmental Screening.

* * * * * * * * *

National Performance Measure #8.1: Percent of children ages 6 through 11 who are physically active at least 60 minutes per day.

Evidence Based or Informed Strategy Measure: 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.

Objectives: By July 1 of 2019, 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 19 (ends June 30th, 2019).

Strategies:

- Screening and intervention on physical activity among MCH funded contract agencies (e.g. home visiting agencies and community health centers)
- Professional training on increasing physical activity
- Encouragement of clientele by health and social service providers for children and families to increase physical activity through fun, family-centered, local, community-based opportunities

Data Analysis

Childhood overweight and obesity continue to be a problem among children of all ages in the state of NH, According to the State of Obesity report, some 15.2% of 2-to-4 year old WIC participants are overweight or obese (https://stateofobesity.org/states/nh, accessed May 22, 2018), and the Kaiser Family Foundation reports that 23.8 % of children of age 10 through 17 years are overweight or obese, giving NH a ranking of fifth best in the US, where the average rate is 31.2%.[3]

Data from the National Survey of Children's Health in 2016 for this NPM#8 shows a rate of 30.1% of children ages 6 through11 in NH who are physically active at least 60 minutes per day. Due to significant changes in the mode of data collection and sampling

frame, 2016 NSCH data cannot be compared to prior NSCH data; 2016 data serve as a new baseline. In addition, the wording of the survey item capturing physical activity changed from 20 minutes of exercise involving sweating and breathing hard to 60 minutes of exercise. The estimates, numerators, and denominators presented are weighted to account for the probability of selection and non-response, and adjusted to represent the non-institutionalized population of children who live in housing units.

MCH provides Title V funding leveraged with that from the DCYF under CFSS program to 11 agencies that offer a Family Resource Center (FRC) for center-based activities and resources, and for doing home visiting with low income families with children in 13 different communities
statewide. This program provides education, coordination of care, and support for safe and healthy families to aid in the prevention of child abuse. In an effort to expand the focus of a healthy family, this performance measure has focused on working to improve the physical health of enrolled children and their families by increasing physical activity, to promote a healthy lifestyle. In SFY17, a total of 1,004 families were served by these funded services, which included 1,692 children[4]. Services were provided primarily at the agencies' CFSS FRCs, but also at home visits, some of which were reimbursable by Medicaid. The strategy being used is that of the "5-2-1-0 Healthy NH,"[5] 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.

Upon enrollment into the CFSS program, if there is a child of age six (6) through 11 in the family, the parent was asked if the child currently participates in at least one hour of moderate to vigorous physical activity every day. A data element was added to the DCYF electronic data collection form to capture the information. At discharge, the parent of the child was asked again about having at least one hour of physical activity per day, and again, data entry was made into DCYF's electronic data collection form.

As of April 2018, FY18 results showed that 85% of the parents with a child enrolling in CFSS services indicated that the child had at least one hour per day of physical exercise. At the time of discharge, 80% of parents indicated their child had at least an hour, which was an increase from the 71% initially reported, then 78% reported last year. The children were not necessarily the same from enrollment to discharge in FY18, as some had been enrolled the previous year. However, at the time of discharge, nine (9) had improved since enrollment from no exercise to yes, exercise. Two hundred fifty-nine (259) indicated no change. Two hundred thirty-two (232) continued to respond yes; thirty-six (36) continued to respond no. None indicated a negative change in initially responding yes, but by discharge, admitting to no. This reporting continues for FY19.

FY18 CFSS Physical Activity documentation at enrollment and discharge (Data Source: Kim Aubertin, DCYF 2/23/18)	Entry				Discharge			
	Children (6-11) Enter	Y	N	No Data	Children Discharge	Y	N	No Data
Berlin	56	54	2	0	20	20	0	0
Claremont	31	31	0	0	18	16	0	2
Concord	33	19	9	5	16	10	6	0
Conway	21	19	0	2	7	5	0	2
Keene	104	92	11	1	48	40	7	1
Laconia	98	87	11	0	57	50	6	1
Littleton	16	15	1	0	8	8	0	0
Manchester	41	36	5	0	25	20	5	0
Nashua	36	12	24	0	19	5	14	0
Portsmouth	20	16	4	0	14	10	4	0
Rochester	69	66	3	0	46	40	3	3
Salem	15	11	4	0	9	5	1	3
CAP Sub	8	8	0	0	4	3	1	0
CFS Sub	0	0	0	0	0	0	0	0
count	**548**	**466**	**74**	**8**	**291**	**232**	**47**	**12**
percent		85%	14%	1%		80%	16%	4%

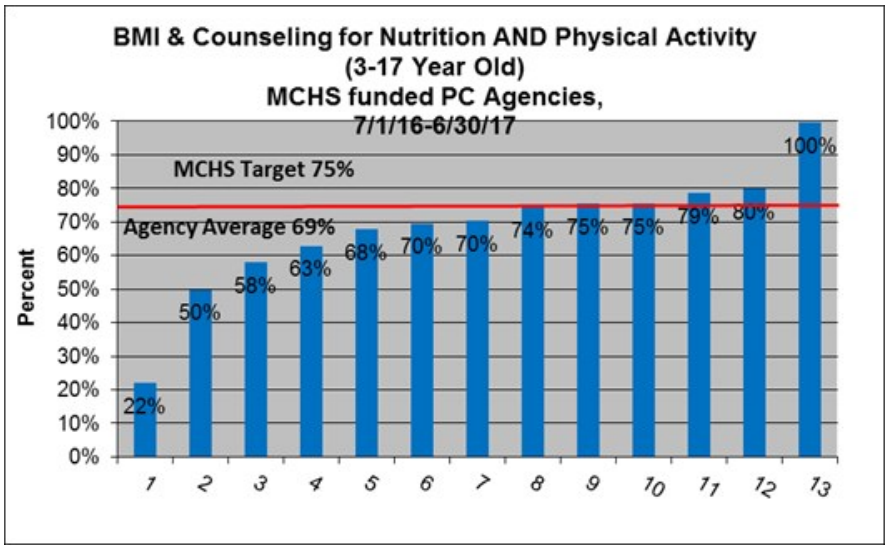
MCH continues to require its Title V-funded community health centers to report on BMI and counseling related to the 5-2-1-0 campaign. In SFY17, the MCH primary care contract agencies were required to report on the following performance measure, derived from HEDIS:

> Percentage of patients aged 3 to 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.

The numerator for this is the number of patients in the denominator who had their BMI percentile (not just BMI or height and weight) documented during the measurement year and who had documentation of counseling for nutrition and who had documentation of counseling for physical activity during the measurement year. This is based on one of the current UDS Primary Care Clinical Performance Measures.

The denominator for this is the number of patients who were one year past their second birthday (i.e., were 3 years of age) through adolescents up to one year past their 16th birthday (i.e., up until they were 17) at some point during the measurement year, who had at least one medical visit during the measurement year, and were seen by the health center for the first time prior to their 17th birthday.

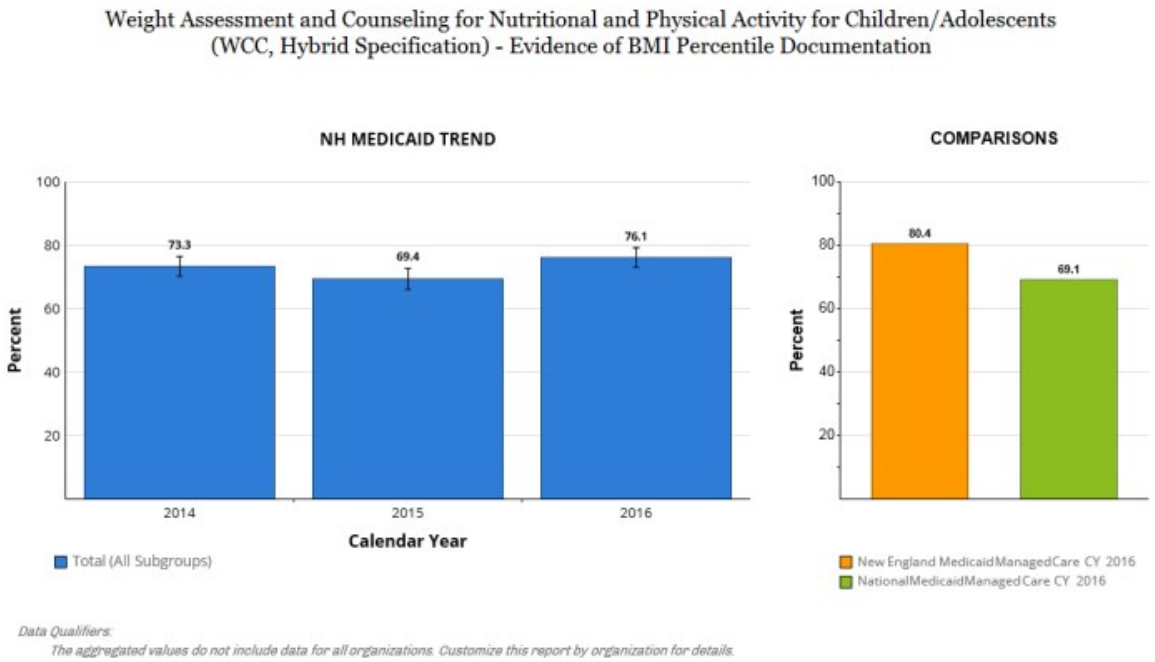
Update: The SFY17 results indicated that the agencies' results ranged from 22% to 100% with an average of 69%. Five of the 13 CHCs reached or exceeded the MCH-set target of 75% (red line on the graphic below). This is similar to the FY16 results of a range of 36% to 96%, with an average of 67%.



Source: MCH Performance Measure Data

The performance measure continued for SFY18.

The two (2) Medicaid Managed Care (MCO) agencies also report on a similar measure. The latest Medicaid report shows the following:



Source: NH Medicaid (https://medicaidquality.nh.gov/reports/weight-assessment-and-counseling-for-nutrition-and-physical-activity-for-children-adolescents-wcc-hybrid-specification-evidence-of-bmi-percentile-documentation-1, 4/5/18)

Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value. Measure Identifier: HEDIS_WCC.01.H

It is noteworthy that the New England Medicaid Managed Care clients did better than the National Managed Care patient load.

National Outcome Measure 19
Percent of children, ages 0 through 17, in excellent or very good health
National Outcome Measure 20
Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

NH data on the overall health of its children ages 0 through 17 being excellent to very good, provided in Form 10a from the NSCH indicates that 92.0%, of its children are doing very well. However, state data from Form 10a, from WIC and the NSCH (14.8 % in 2012 to 15.1% in 2014), and the Youth Risk Behavior Surveillance System (YRBS) (11.2% in 2013 to 12.2% in 2015) all indicate slight increases in children who are obese. This indicates that childhood obesity is an issue that the state continues to struggle with. Healthy food is expensive. Time and exercise resources are limited for schools to add in physical activity time. And many parents themselves are obese and don't exercise, providing a negative role model.

The good news is that NH is doing better in overweight and obesity than the national average. According to the Henry J. Kaiser Family Foundation report of the latest state data (2016) on percentage of children ages 10 – 17 who are overweight or obese, NH was at 23.8%, compared to the national figure of 31.2%, making NH the fifth in the state rankings of least obese.[6]

The latest Pediatric Nutrition Surveillance System (PedNSS) data shows that NH was perhaps showing some slight improvement (reductions) up to 2013, but rates have not continued a downward trend.

PedNSS data from 2011-2017

Agency	Attribute	2011	2012	2013	2014	2015	2016	2017
New Hampshire	Obese 5 &Over (count)	17740	15632	16009	15197	12858	12378	11904
New Hampshire	Obese 5 & over (%)	12.3	11.9	11.7	11.9	12.2	13.7	13.7
New Hampshire	Obese 2 & Over (count)	8278	6477	7312	6980	5603	5493	5399
New Hampshire	Obese 2 & Over (%)	14.7	14.3	14.2	14.6	14.8	16	15.2
New Hampshire	Overweight 2 & over (count)	8261	6465	7293	6961	5602	5493	5398
New Hampshire	Overweight 2 & over (%)	17	17.2	16.2	17.3	17.8	17	17.9

Systems building

The DPHS Chronic Disease Program (CDP) has worked closely with schools and child care throughout the state to implement environmental strategies that reinforce healthful behaviors and expand access to healthy choices. In the past year, it has continued its activities in working with licensed child care program to improve nutrition and/or physical activity policies and practices; has provided health and wellness trainings as part of the annual regional Caring for Our Children Health, Safety and Nutrition conferences offered throughout the state which are organized by Child Care Aware of New Hampshire; and, through a contract with Keene State College, has worked with NH School Administrative Units (SAUs) to assist school food directors in assessing and improving school nutrition environments and local wellness policies.

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. There are several initiatives throughout the state involving integration of community-based nutrition, physical activity, built environment and transportation system projects.

The CATCH Kids Club, originally managed by the NH Foundation for Health Communities, and currently by the Across NH Project, is an evidence-based physical activity and nutrition education curriculum for children from kindergarten to age eight (8) years, for use in after-school and summer program settings.[7] It is currently offered in numerous locations throughout the state. Across NH[8] is a project funded by the NH DHHS Child Development Bureau which provides consultation and training to afterschool professionals. Additionally**,** the Child Care Licensing Unit just adopted new regulations requiring that full-day programs provide at least one hour of physical activity each day.

Many of the community agencies, both the MCH-funded home visiting programs, and the CHCs, continued to be involved with Healthy Eating Active Living NH (HEAL NH) (http://www.healnh.org/index.php), chaired by the Foundation for Healthy Communities, with funding from the HNH Foundation, Anthem Blue Cross & Blue Shield Foundation, Endowment for Health, NH Charitable Foundation, and the Harvard Pilgrim Health Care Foundation. HEAL NH works with communities to develop strategies, tools and resources that can create healthy environments which help individuals and families make good choices where they live, learn, work and play. Activities include improving walking trails, sponsoring state-wide conferences, getting healthy food into local stores, etc.

The Healthy NH Foundation continues to support physical activity. In its 2014-2019 Healthy People Healthy Places Plan, NH's Statewide Plan for Healthy Eating and Active Living[9], themes include "Make Access to Healthy Environments More Equitable." Strategies are prioritized to address populations and geographic areas with higher chronic disease burdens through providing increased access to healthy foods and physical activity in high-need communities and "Expand Beyond Obesity Prevention." The state's obesity epidemic provided the impetus for the 2008 HEAL Action Plan. While lowering obesity rates continues to be a desired long-term outcome, stakeholders determined that the next phase of HEAL NH must be defined in a broader context with a focus on implementing strategies that address the underlying social and physical conditions that contribute to overall health and quality of life. One of its goals is "Active Transportation and Recreation;" i.e. that NH residents have equitable access to options for getting around, and safe, high-quality places to play and be active. One objective is "All New Hampshire communities are built to support walking, biking and other transportation options." A second objective is "All New Hampshire communities have access to indoor and outdoor recreation facilities within a reasonable distance."

The MCH-contracted Primary Care agencies and the Home Visiting agencies continue to work with their local WIC agencies in getting eligible pregnant women and children enrolled in WIC. Although the state WIC Program does not have statewide initiatives related to obesity and physical exercise (however, a few agencies, such as Belknap-Merrimack CAP's WIC Program continue to offer FITWIC), the state WIC Program continues to emphasize breastfeeding, and encourages enrollment for its food package with fruits and vegetables, which is all focused on obesity prevention. Much of the WIC Program's recent energy has been on rolling out eWIC. The program just finished participating in a rebranding campaign for retention and outreach which featured posters such as the one below. A 2017-2019 Outreach Plan included network meetings and ongoing public mailings for distribution at Primary Care Centers, Family Planning agencies, Child Health programs, Home Visiting agencies, and Prenatal Programs.

MCH specific activities

MCH has continued to co-facilitate the monitoring of the CFSS agencies with staff from DCYF, through site visits, monthly calls and analysis of performance measure outcomes. As stated previously, funded agency staff work with families with children of ages six (6) through 11 on strategies to sustain or increase daily physical activity. Materials from the 5-2-1-0 campaign are reviewed and

distributed.

In addition to assessing if the child gets at least one hour of physical activity per day, and integrating education on how to include exercise into the day, the CFSS-funded agencies carry out a variety of other healthy lifestyle/exercise promotion activities that impact many of the children enrolled in their program. Examples from the 11 agencies are as follows:

Child and Family Services (4 Regions: Concord, Manchester, Southern and Seacoast)

- Arranging visits at a local park and encouraging physical play (climbing, jungle gym, games)
- Sharing handouts with families that emphasize the importance of physical activity every day
- Using flexible funding through private grants to support children's involvement in activities like Karate, Kick Boxing, and memberships at the Boys and Girls Club.
- Connecting families to sports scholarships to allow them to join local baseball, soccer and basketball teams

Families First (Seacoast Region)

Parent Groups

- In every playgroup and session of childcare, provide an opportunity for gross motor play.
- Access to two outdoor playgrounds and an indoor playroom and gym; areas provide structures, bikes, mats, swings, bridges, slides, forts and sand for individual and group play.

Home Visiting

- Weather permitting, home visitors meet their clients at local playgrounds so children can get exercise. Home visitors talk to their clients about how to encourage their children to be active indoors, i.e. exercise videos, building forts and jumping rope. Home visitors have handouts from the Parents as Teachers curriculum that show parents how to be creative in planning indoor activities using gross motor skills.
- In summer, home visitors find funding for children to go to camp where they learn that exercise is fun. Our Partners in Health program provides camperships to children with physical disabilities who might not otherwise have an opportunity to exercise to their potential.

Children Unlimited (Conway region)

- Staff occasionally walk with a parent and child, conducting home visit discussion during the walk; this has positively impacted families who now walk with their children on their own, in the evening.
- Preschool staff and children walk together twice weekly and make healthy snacks together after.

TLC (Teaching Loving Connections) Family Resource Center (Sullivan County)

- Discuss importance of exercise and healthy eating on ongoing basis; have visits in community at local parks; participate in activities with families at local community center; go for walks with families during visits.
- Encourage activities such as Karate, gymnastics and swimming at the community center; assist families with scholarships for yearly family memberships at community center.
- AmeriCorps is working on new initiative for families in our coverage area to get moving, to be launched April 2. (See http://www.tlcfamilyrc.org/on-the-move.html) Flyer to be created on easy ways for families to be On the Move.

Lakes Region Family Resource Center (Laconia/Lakes Region)

- Encourage families to participate in community activities for increased physical activity and for socialization.
- Collaborate with SAMOSA-funded Project Extra (an after school support program located in the three Laconia elementary schools that highly encourages physical activity by having CFSS staff f at each location one day a week to bridge gap between the FRC and the families.

- Utilize the WOW trail (a walking trail along Lake Winnepesaukee, Opechee Bay, and Lake Winnisquam) with families (https://www.wowtrail.org/) when they are meeting at the office and collaborate with the local bike exchange to get families bicycles.

VNA at HCS (Keene area)

- Talk about physical activity at intake and provide education and resources.

Community Action Partnership of Strafford County (Rochester area)

- Encourage the following with families: -school sports/extracurricular activities, -camps, -afterschool programs, supervised outdoor play (playgrounds), having kids help with chores/cleaning around the house; -limiting screen time each day - attending family events in the community, especially those that involve physical activity (children's day, family fun night, etc.)

Family Resource Center at Gorham

- Partner with other providers, such as Appalachian Mountain Club, to promote their physical activity offerings and provide our family assistance with filling out applications and advocating for scholarships when costs are associated so they can benefit from their offerings.
- Incorporate a physical activity and offer healthy food options at "Family Nights."
- Implemented a "Healthy Me" initiative for staff, where staff have an individualized healthy activity each week, provide educational and inspirational type materials, and share the tips with the families they support.
- Staff are trained in "Growing Great Kids" and "Growing Great Families" which incorporate physical activities.
- Provide linkage and often tuition-free scholarships to our after-school programs which feature 5-2-1-0 and provide lots of education and activities to support that initiative.
- Carry out home visits at local parks, etc. to encourage physical activities.

Challenges continue in encouraging families to make lifestyle changes that will impact not only their child's level of activity, but the entire family's approach to decreasing screen time, making healthier food preparation and eating choices, and engaging the whole family in physical activity to contribute to improved physical and mental health. Local communities are increasing opportunities for families to engage in the environment as examples above demonstrate. Re-introducing recess, time outside, or time for physical activity in the schools is difficult with the increased scholastic demands and limited school budgets for equipment. MCH will continue its identified strategies to promote healthy lifestyles and will continue to monitor progress through its current performance measure and objective.

Lyme Disease

Lyme disease is of concern in NH, with an incidence rate of 51.8 per 100,000 population in 2016. Initial signs and symptoms of infection can be mild, but later signs and symptoms can be debilitating. [10]And children aged two (2) to 13 are particularly at risk for Lyme disease since much physical activity takes place outside, in yards, sports fields, parks, and other natural areas.

The organization Tick Free New Hampshire works in partnership with many other public health programs, community health promoters, as well as clinical care providers to raise awareness about the risk of tick encounters and educate about how to avoid ticks and prevent being bitten by a tick. Their Tick Free NH Schools component enlisted nearly 100 schools in 2017 to participate in the tick-control and disease prevention effort, through the distribution of wallet cards to identify the tick vectors and explain how to remove them when out on the trail; shower cards to remind everyone in the family to do a tick check every day; slap bracelets for kids to keep an eye out for ticks and be a "Tick Detective;" and Tick Detective Workbooks for Kids, designed for 1st through 4th graders, with education and activities to identify and protect themselves from tick encounters.[11]

* * * * * * * * *

[1] Child and Adolescent Health Measurement Initiative. Data Resource Center for Child and Adolescent Health. 2016 National Survey of Children's Health (NSCH) data query. Retrieved 06/18/18 from www.childhealthdata.org.

[2] Developmental Screening, Referral, Diagnosis, and Services System Task Force (DSRDS) Final Report, Tessa McDonnell -Task Force Facilitator

[3] https://www.kff.org/other/state-indicator/overweightobese-children/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22all%22:%7B%7D%7D,%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Percent%20of%20Overweight%20or%20Obese%20Children%22,%22sort%22:%22a accessed May 22, 2018

[4] email communication 4/4/18 between Audrey Knight, MCH, and Kim Aubertin, DCYF

[5] http://www.healthynh.com/5-2-1-0-healthy-nh.html

[6] https://www.kff.org/other/state-indicator/overweightobese-children/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22new-hampshire%22:%7B%7D%7D,%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22desc%22%7D accessed 5/22/18

[7] http://healthynh.com/ckc-home.html

[8] http://www.acrossnh.org/

[9] http://www.hnhfoundation.org/images/HEAL_HPHP_Summary_for_web.pdf, accessed 4/6/18

[10] https://www.cdc.gov/lyme/index.html, accessed May 24, 2018

[11] https://tickfreenh.org/, accessed May 24, 2018

Child Health - Application Year

National Performance Measure # 6:
Percent of children, ages 9 to 35 months, receiving a developmental screening using a parent-completed screening tool

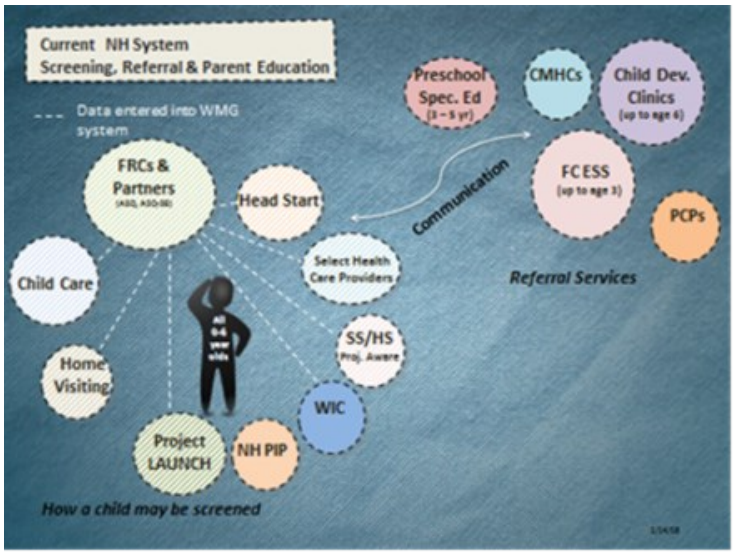
Evidence Based or Informed Strategy Measure # 6.1:
The number of sites using the Ages and Stages Questionnaire (ASQ) and the ASQ - Social Emotional (ASQ- SE) screening tools and participating in the Watch Me Grow (WMG) system

Objective: To increase from 32% (2016 FAD baseline) to 46% the percent of children, ages 9 months to 35 months, who receive a developmental screening using a parent-completed screening tool, by 2023.

Strategies:

- Promote the training of professionals to utilize the ASQ and ASQ-SE screening tools.
- Provide leadership and group facilitation to WMG and the NH Act Early Team.
- Review and identify gaps based on environmental scan and data analysis completed in SFY 18.
- Promote developmental screening, participation in WMG, and use of the online ASQ screening tool (as soon as the data bridges have been completed).
- Educate the public through dissemination of the CDC's Learn the Signs Act Early (LTSAE) materials, NH specific 'fact sheets' and updated web based information.
- Support the activities of the Learn the Signs Act Early Ambassador.
- Collaborate with the NH Pediatric Improvement Partnership (NH PIP) on any efforts related to developmental screening.

Systems Building



NH has a system that incorporates multiple entry points for access to screening, evaluation and services for children at risk for developmental delays, including the WMG system. WMG is the system supported by DHHS to provide high quality, accessible and coordinated developmental screening through community based agencies such as FRCs, Head Start/Early Head Start, and child care. Therefore screening in NH 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 or community based provider suspects a child is developmentally delayed, the provider may refer the family to any/all of the following:

- Part C Early Intervention (Family Centered Early Supports and Services -FCESS) to be evaluated for appropriate services
- An autism clinic for diagnostic evaluation

- One of the Title V funded multidisciplinary child development clinics (Title V funded) for diagnostic evaluation.

MCH, SMS/Family Centered Early Supports and Services (ESS), and Head Start State Collaboration Office (HSSCO) have provided joint leadership for the WMG system, which promotes the use of the ASQ and ASQ-SE. WMG data (2010 to 2017) demonstrates an increase in the WMG Comprehensive Family Resource Center sites from 5 to 14. The number of sub-locations (that provided data to WMG sites) grew from three to 54 during the same time. Recruitment this past year has been challenging as there has been limited oversight of the FRC's due to staff changes and program reorganization. This year SMS has stepped up to oversee WMG and it is anticipated that SMS will be identified, by fall 2018, as the new lead for WMG collaboration and planning. The goal will be to bring the Act Early Team and WMG team together to form one cohesive group. We will create a plan to merge the two groups and create one blueprint with assigned roles/ workgroups. Additionally, the plan focus on making progress with the online ASQ screening module so that the online version can be promoted and effectively utilized across the state. There will also need to be some targeted education/ public relation efforts to families. We will solicit feedback in real time to assist us in providing specific technical assistance to practices and sites as we continue to expand the system and increase the number of screenings occurring.

It would be ideal if PCPs could partner with WMG to relay the data into the WMG Welligent data system. However this has been a challenge and efforts will continue to work on educating providers about developmental screening, encouraging a dialogue on gathering the data from the sites for reporting purposes, providing educational materials from Learn the Signs. Act Early (LTSAE) campaign and sharing information sharing on best practices.

In addition, Title V agencies will continue to coordinate with partners across systems to ensure that families have access to developmental screening for their children, parents will be assisted with the completion of ASQ and ASQ: SE through MIECHV home visiting programs and CFSS. MCH and SMS and work with partners to promote and support connections between professional organizations and service providers. In 2019, it is anticipated that Child Care Aware of New Hampshire will fund 6 trainings for Child Care providers to learn about WMG and how to implement the ASQ and ASQ-SE. These trainings are supportive of our ESM efforts to increase the number of community based sites that participant in using and reporting data on the ASQ. Participants are not required to be WMG partners but they are required to provide screening if they would like to be recognized as a "highly qualified" child care program or "quality rating" system program. We will emphasize the benefits of participating in the WMG system. If they are not WMG partners, they would not report numbers of screenings into the Welligent system.

NH leaders and the Act Early Team will continue to engage in cross system planning and coordination of activities, while working to expand the system based on recommendations that have been made by the DSRDS Task Force (the Task Force, funded by Spark NH included representatives from the Act Early Team / Screening & Diagnosis Work Group of the NH Council on ASD, WMG Steering Committee, Spark NH, and other participants involved in working with young children and their families in NH. The Task Force's final report concluded that in order to build a sustainable comprehensive system in NH there is a need to develop an overarching policy to support the infrastructure that is needed. Funding is a significant gap. Data are not available to accurately report on the needs for screening and follow-up services. Eventually, requests to the legislature and other potential funders will be critical to support the work. It was recommended that Spark NH reach out to policy leaders and develop a plan of action to obtain funding for policy development and an analysis of the finances needed to address long-term recommendations.

Task Force Recommendations
System Building/Interagency Coordination

Short term
1. Develop MOU templates for interagency collaboration and data sharing.
2. Replicate/adapt the NJ Act Early resource that maps the "Next Steps for Developmental Services."
3. Create and maintain a master list of partners and their affiliates involved in screening.
4. Share strategic plans of organizations, agencies, and departments involved in developmental screening.
5. Document how many agreements sites have, when they are updated, and ensure they are correctly posted on the Watch Me Grow website. Assure MOU transparency and accountability.
6. Create a single point of contact in regions by position (not individual).
Mid Term
7. Re-examine the business plan of CT's Help Me Grow system with an analysis of the resources needed to implement the model with fidelity in NH.
8. Develop a one-page "Summary Report" form that would record screening, referrals and follow-up and a process to document collaboration, referral agency, and outcome; share with community partners.
9. Conduct an analysis of the benefits and barriers of other evidenced-based developmental screening tools and weigh them as additional pieces of the broader system in NH.
10. Assure that annual and federal reports from agencies accountable for screening contain shared information and are consistent and comprehensive.
11. Connect agencies so that they can better coordinate to provide resources to families and help them navigate the system.
Long Term
12. Request that the Office of Medicaid Insurance and Policy consider a review of network adequacy for pediatric specialty care services.
13. Establish an executive-level infrastructure to support a unified early childhood system.
14. Develop a policy for measuring child and system-level outcomes related to DSRDS.

Funding

Short Term
1. Promote communication across health and education teams in local communities with sufficient funding to support them (model communities of practice).
Mid Term
2. Fund a PR Consultant to develop and create a campaign for WMG, with the goal to reach all families and providers from early care, medical and other sectors.
3. Incentivize providers through private insurers.
4. Explore alternative funding sources for providers who fall outside the eligible health provider network (Early learning, family resource centers, school districts via DOE).
Long Term
5. Increase funding to expand child development clinics and other specialty providers to increase capacity.
6. Fund the Early Childhood Quality Rating System that includes implementation of standards for child screening in child care programs.
7. Review and consider applications for funding streams that would allow NH to engage in unified data collection with a single point of entry/collection and/or links across data systems.
8. Increase reimbursement rates for screening through Medicaid and private insurers.

Data

Short Term
1. Use the Child Care Aware NH Professional Registry and the CDC Watch Me Grow for data on trainings to monitor how many NH people have taken training.
2. Encourage the development and use of a data dictionary for data collection across systems to facilitate future linkages.
Mid Term
3. Ensure programs report all data collected on the ASQ and ASQ-SE in a timely manner (define).
Long Term
4. Develop mechanism for data to be collected, shared, and accessible so that gaps are identified, adequate resources are allocated, services needed are provided and work is accomplished across service sectors (ESS, DOE, community agencies including children born, children screened, related services, etc.) Create a Qualitative data dashboard.
5. Include developmental screening data from systems other than Watch Me Grow with a clear methodology for obtaining data and a mechanism for importing to Welligent or another system as needed. (Ex. Electronic Medical Record, EDHI (hearing and vision screenings), and Welligent systems used by other Home Visiting programs.)
6. Explore the feasibility of implementing a single unique identifier assigned at birth to longitudinally track children. (ex. Start with EDHI newborn screening).
7. Establish an integrated, cross-agency statewide Early Childhood Data System to improve program effectiveness and child and family outcomes.

Quality Assurance

Short Term
1. Provide frequent, consistent, and comprehensive overviews to the FRC's and WMG partners – collect data, compile, and distribute as summary reports on a quarterly basis.
2. Ensure the WMG Quality Assurance Standards are being followed for measuring quality, including scope and reach, fidelity to tool, monitoring, culturally responsive system and the "closing of the circle" (screening, referral, and response).
3. Create standard reporting on referrals and eligibility to ESS and other services as listed in the database including enrollment data, follow-up, and outcome.
Mid Term
4. Build fidelity across screeners.
5. Create and implement a process to eliminate duplicative records for children (ex. data is entered within a specified time, birth date checked.)
6. Create a process to collect family input regarding what quality is for them.
Long Term
7. Create an "easy" way to have a snapshot of the system and impact on stakeholders – develop a mechanism to identify trends, emerging issues. – dashboard of metrics and outcomes (long term impact with longitudinal data) how well are we doing with the process, what are the outcomes for children and families, use the data to look at the gaps in service.

Public Awareness, Outreach, and Communication

Short Term
1. Share best practices (in and out-of-state) and success stories to build mentoring and role modeling across the system.
2. Create and implement a public relations campaign for WMG, with the goal to reach all families and providers from early care, medical and other sectors. (PowerPoint to introduce the system to families and professionals or create a podcast, funding, and expertise to deliver an app and support website. roll out to focus on the online version, including social media messaging, ads for radio, television, newspaper)
3. Identify entity to coordinate sending out a message every month.
4. Use successful family stories with the focus on engaging and promoting the growth and development of children and benefits to the families.
5. Review where and how WMG information is displayed and distributed.
6. Increase parent communication. Leverage existing resources (Text for Babies, VROOM).
Mid Term
7. Coordinate the WMG system with all partners and agencies who provide information about developmental screening. Embed and simplify message with other organizations with similar initiatives.
8. Explore using the United Way 211 Resource line or Community Health Centers as the central place to get information on screening.
9. Ensure sustainability in local work plans to keep screening in the forefront.

Screening

Short Term
1. Finalize and distribute the WMG Implementation Guide.
2. Conduct an environmental scan or survey of the tools healthcare providers are using including how data is collected and stored.
3. Explore opportunities to increase access to programs and services, such as online screening, telehealth, and others.
4. Engage families as partners including families that have a culturally diverse background to assist with increasing screening by peers.
Mid Term
5. Inventory what other tools the Family Resource Centers use to collect data and where the data is stored.
Long Term
6. Create a network of screeners fluent in multi languages.

Referral to Resources, Services, and Support

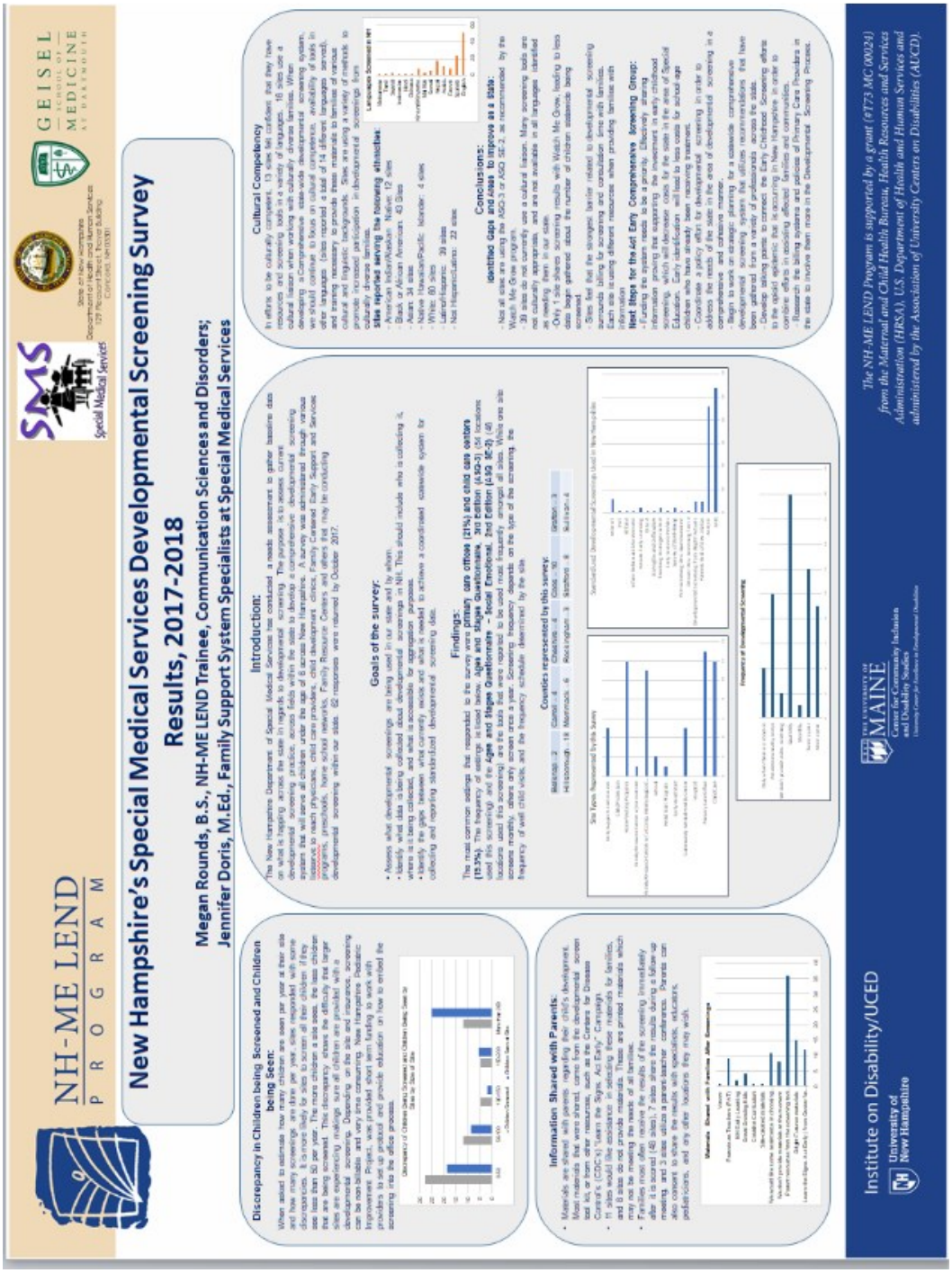
Short Term
1. Identify and implement best practices in communicating road maps to resources for parents, including follow-up and support groups.
2. Include WMG status on the agenda of quarterly meetings for Comprehensive Family Support Services programs.
3. Provide support to programs and partners with quarterly face-to-face regional meetings (such as those happening in Monadnock), and post summaries and reports on the WMG website.
4. Use family and partner testimonies to normalize process.
5. Ensure partner sites know what resources are available, where to find the resources, and how to make referrals. Ex. mentor or role model site assigned to help.
Mid Term
6. Ensure care coordinators connect and follow-up with families.
7. Support resources for Family Resource Centers to enter follow-up information, create incentives for entering data in Welligent.
8. Support sites to be culturally and linguistically competent so that referrals accommodate and meet the family's needs.
Long Term
9. Support child care programs, who seek an advanced quality rating in the new QRIS system, with full implementation of the WMG model.

Training and Technical Assistance

Short Term
1. Provide training on having difficult conversations with families. Embed the Strengthening Family approach in conversations with families (different languages).
2. Increase training on data input – including monitoring and access.
3. Share best practices – this is how we do it successfully.
4. Provide training for navigators/care coordinators to help families maneuver the system (SMS, ESS, area agencies, partners in health).
5. Promote the value of being a WMG site and the process to enter a MOA, encourage childcare sites to sign up for WMG before staff are trained.
Mid Term
6. Incorporate healthy homes, other home visiting programs with United Way 211.
7. Provide trainings to child care and schools on the ASQ and SE, why use it, what the results mean, how and when to refer, and how to share the information with families.
8. Provide "on demand" training on Ages and Stages ASQ, Question 3, and Social Emotional tool
9. Create Train the Trainer model.
Long Term
10. Explore training modalities to build capacity of the system (online, face-to-face, webinars).
11. Create tiered training models for implementation in programs, agencies, child care centers etc. with administration and staff.
12. Embed developmental screening and Watch Me Grow into college programs and internships to build professional capacity for those entering the field.
13. Update information for providers on the process for billing and provide training statewide. (Medical code 96110 for billing.)
14. Train people in the culturally diverse population to provide the screeners to their families and other diverse community members.

In September 2017, SMS conducted an environmental scan to gather baseline data on what is happening across the state in regards to developmental screening in order to inform the development of a comprehensive system that will serve all children under the age of 6 across NH. The purpose was to assess current developmental screening practices, across fields-- to help us to see what tools are being utilized, where data is stored, and to analyze the challenges that practices/ sites are experiencing. The survey was administered through various listservs to reach physicians, child care providers, child development clinics, FCESS programs, preschools, home school networks, FRCs and others that may be conducting developmental screening within our state.

By October 2017, 62 respondents submitted answers to the environmental scan. SMS had the assistance of a NH Leadership in Neurodevelopmental Disabilities (NH-LEND) trainee to evaluate, analyze and summarize the results. In 2019, we will be utilizing this information, as the lead for the Act Early Team with the ultimate goal of designing a comprehensive system that expands beyond the ASQ tools, and addresses the needs and gaps that are occurring throughout the state.



Title V Specific Activities

2019

- Create a new blueprint for change with the Act Early Team.
- Develop policy and funding recommendations to embed funding into various programs for sustainability.
- Promote the training of professionals to utilize the ASQ and SE screening tools with parents. Child Care Aware will fund 6 trainings.
- Provide leadership and group facilitation to WMG and NH Act Early Team, blending into one group with some smaller

workgroups for specific targeted areas.

- Utilize the information and results from the 2017 Developmental Screening Environmental Scan to establish goals and objectives for the Blueprint for change.
- Promote the ASQ and SE online versions for families to use, once the data bridges have been complete
- Increase the number of WMG partner sites that provide ASQ/ SE screenings. The focus will be to increase the number of partnerships with child care providers adding information to Welligent.
- Educate the public through use of Learn the Signs Act Early Materials, NH specific Developmental Screening Fact Sheets and updated web based information.
- Conduct one training in collaboration with NHPIP and IOD, for pediatric and primary care practices and their medical staff to cover:
    - What is developmental screening
    - What tools are available for use
    - Training related to the ASQ/ SE, if indicated
    - Discussion about process and implementation
    - Resources for families on milestones and development
    - Referrals
    - Follow up on referrals

* * * * * * * * *

National Performance Measure #8.1: Percent of children ages 6 through 11 who are physically active at least 60 minutes per day.

Evidence Based or Informed Strategy Measure: 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.

Objectives: By July 1 of 2019, 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 SFY19 (ends June 30th, 2019).

Strategies:

- Screening and intervention on physical activity among MCH-funded contract agencies (e.g. home visiting-MIECHV and CFSS and community health centers)
- Professional training on increasing physical activity
- Encouragement of clientele by health and social service providers for children and families to increase physical activity through fun, family-centered, local, community-based opportunities

Systems Building

MCH staff will continue its work with DPHS colleagues in the WIC Program and the Diabetes, Heart Disease, Obesity and School Health Program to share the latest research, recommendations, educational offerings, and health promotion opportunities to promote parent education, health systems interventions, and community and clinical interventions.

MCH Specific Activities

By fall 2018, the community agencies funded for Comprehensive Family Support Services (CFSS) will receive a written report on their five (5) SFY18 required performance measures. The report will also comment on their agency documentation of the physical activity measures, and the number of charts missing in that documentation, to improve the reporting numbers for SFY19. The CFSS agencies will continue to be encouraged to work with local community resources to increase healthy lifestyle activities to decrease childhood obesity. In SFY19, MCH staff will be working with DCYF staff on the new RFP that will start in FY20. Addressing physical activity as one means of reducing childhood obesity will continue to be a required component of MCH funding.

With the CHCs, MCH staff will continue to monitor the contractual performance measures, including its obesity-related one, which will remain unchanged for SFY19. Site visit discussions will include comments on performance measure results with particular attention on the poor performers and suggestions for improvement. By July 31, 2018, CHCs will be submitting their SFY18 data results and written feedback will be provided by MCH staff, led by the QI/QA Nurse Consultant.

MCH will continue to share obesity-related information, including that related to increasing physical activity, with its funded community health centers and with the Comprehensive Family Support Service agencies, partially funded by MCH, through DCYF contracts, such as webinars, articles, and in-state educational opportunities via email from the MCH QI/QA Nurse Consultant.

* * * * * * * * *

Adolescent Health

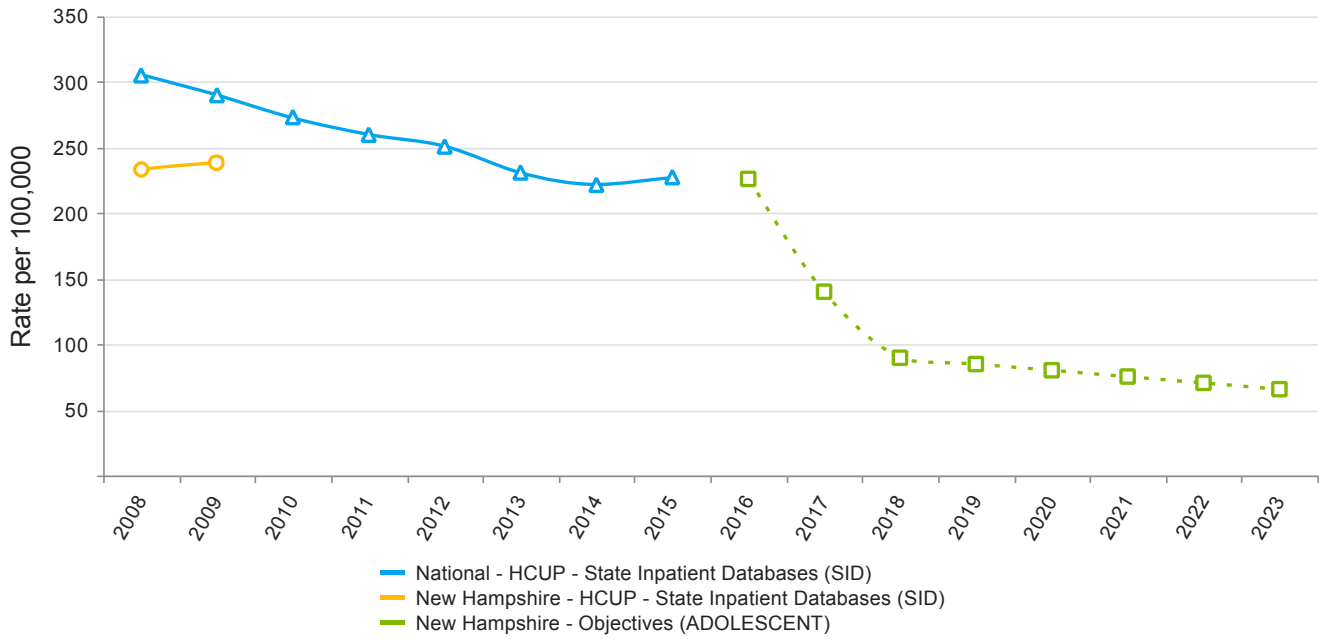
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	NVSS-2016	13.2	NPM 7.2
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2016	30.0	NPM 7.2 NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2014_2016	9.5	NPM 7.2 NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2014_2016	10.6	NPM 7.2 NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2016	63.0 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	92.0 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2016	8.5 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2014	15.1 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2015	12.2 %	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2016_2017	66.2 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISF-2016	70.7 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISM-2016	69.3 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2016	95.3 %	NPM 10

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2016	88.0 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2016	9.3	NPM 10

National Performance Measures

NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19
Baseline Indicators and Annual Objectives



Federally Available Data		
Data Source: HCUP - State Inpatient Databases (SID)		
	2016	**2017**
Annual Objective	225.8	140
Annual Indicator	226.6	238.7
Numerator	411	433
Denominator	181,369	181,369
Data Source	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2009	2009

State Provided Data		
	2016	2017
Annual Objective	225.8	140
Annual Indicator	98.4	94.7
Numerator	166	158
Denominator	168,680	166,811
Data Source	NH Inpatient Hospital Discharge data	NH Inpatient Hospital Discharge data
Data Source Year	2015	2015
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	89.9	85.1	80.3	75.5	70.7	65.9

Evidence-Based or –Informed Strategy Measures

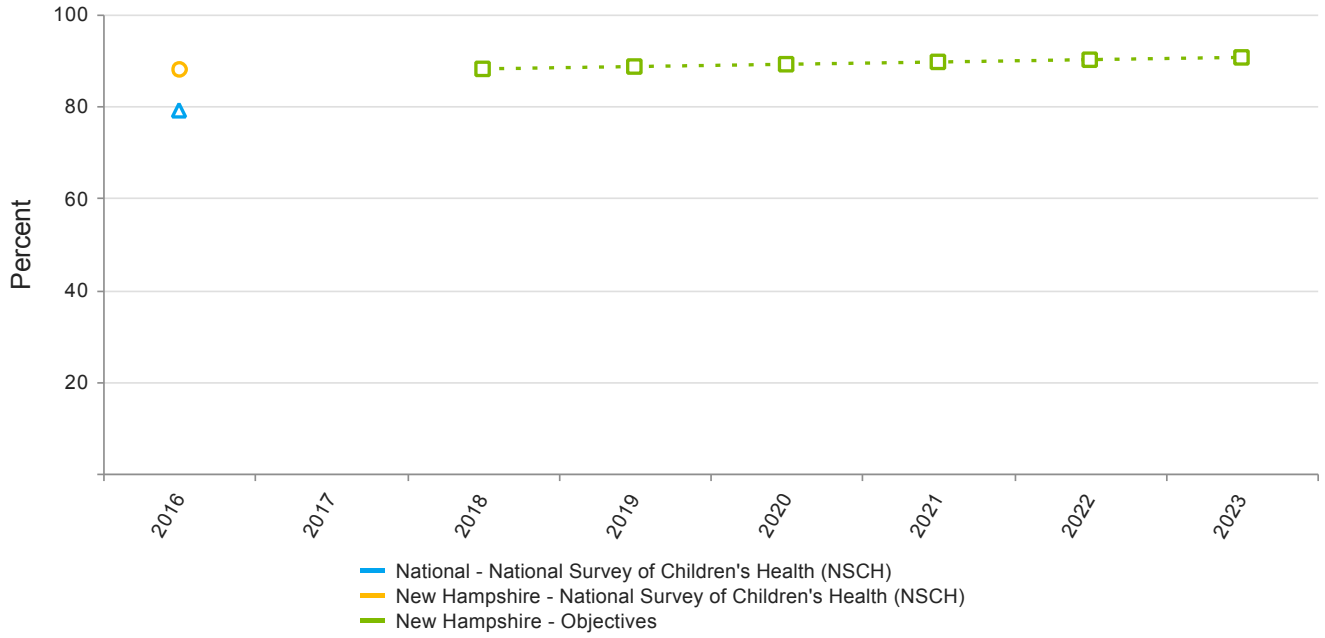
ESM 7.2.1 - Percentage of high school students who wear seatbelts

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		93.4
Annual Indicator	91.8	93.1
Numerator	13,027	50,699
Denominator	14,191	54,465
Data Source	YRBS	YRBS
Data Source Year	2015	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	94.0	94.8	95.7	96.5	97.4	98.2

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
Baseline Indicators and Annual Objectives



Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	**2017**
Annual Objective		
Annual Indicator		87.8
Numerator		82,975
Denominator		94,526
Data Source		NSCH
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	88.0	88.5	89.0	89.5	90.0	90.5

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		64
Annual Indicator	61.4	57.9
Numerator	6,630	6,178
Denominator	10,805	10,671
Data Source	NH DHHS, MCH section	NH DHHS, MCHS
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	60.0	62.0	64.0	66.0	68.0	70.0

State Action Plan Table

State Action Plan Table (New Hampshire) - Adolescent Health - Entry 1

Priority Need

Decrease unintentional injury.

NPM

NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Objectives

By June of 2019, increase seatbelt usage in the 15 high schools participating in the Teen Driving Project by 14% over the baseline of 70% to 80% in the observational study

By June of 2019, schools in the state will have implemented the NH Concussion Law and/or will have written policies, with at least 95% having a return to play policy and at least 50% having a return to learn policy

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	Status
ESM 7.2.1 - Percentage of high school students who wear seatbelts	Active

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 (New Hampshire) - Adolescent Health - Entry 2

Priority Need

Improve access to needed healthcare services for all populations.

NPM

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

Objectives

Increase the percentage of adolescents who have had a preventative medical visit at the MCH-funded community health centers from a baseline of 61% in SFY16 to 64% by the end of SFY17 and to 66% by the end of SFY20.

Strategies

Engage stakeholders and build partnerships to support collaborative efforts by: (1) collaborating with a variety of public and private partners through the NH Pediatric Improvement Partnership; (2) participating as a key member of the NH state team for the Adolescent and Young Adult Health Collaborative Improvement and Innovation Network AYAH CoIIN Cohort 2; (3) promoting Title V activities via mechanism of statewide contracting and provision of oversight of MCHS contracted Primary Care Services; (4) establishing mechanisms to inform and educate the public about adolescent and young adult health and preventive services via mechanisms such as social media

Ehance capacity of MCH-funded CHCs to improve access and quality of adolescent/young adult preventive services and well-care visits by: (1) establishing Primary Care Services Performance Measures which align with National Guidelines and promote Right Futures recommendations; (2) requiring contracted CHCs to develop an adolescent/young adult well-care Quality Improvement (QI) initiative to ensure CHCs maintain a focus on adolescent/young adult health and preventive services; (3) collecting, monitoring and analyzing Performance Measure Outcome data from contracted CHCs; (4) providing feedback and data results to contracted CHCs for comparison among contracted CHCs; (5) providing education, resources, QI support and technical assistance to contracted CHCs

Create an Adolescent Health Coordinator position under MCHS to expand adolescent health initiatives.

ESMs	Status
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	Active

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, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

National Performance Measure #7.2: 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

Objectives:

- By June of 2019, increase seatbelt usage in the 15 high schools participating in the Teen Driving Project by 10 percentage points over the baseline of 70% to 80% on the observational study

- By June of 2019, schools in the state will have implemented the NH Concussion Law and/or will have written policies with at least 95% having a return to play policy and at least 50% having a return to learn policy

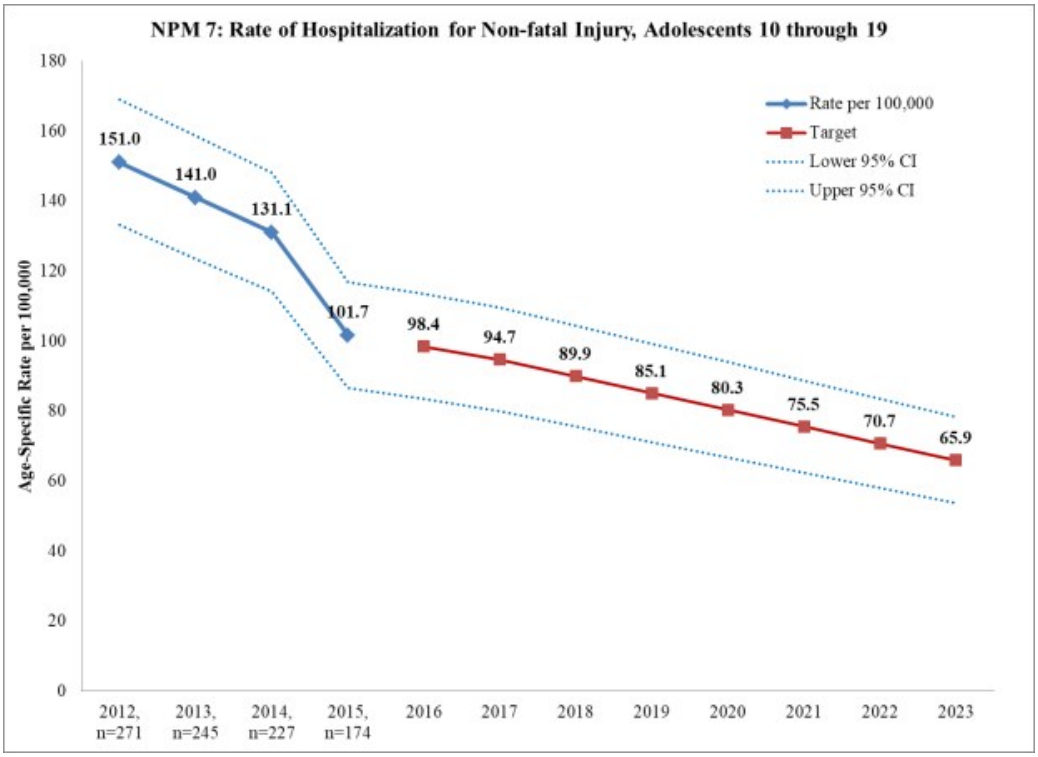
Strategies:

- 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 andmake recommendations for potential change.

Although adolescence is in general a healthy period of life, this time is marked by major physical, psychological and social development. As adolescents transition toward adulthood, they frequently initiate risky behaviors that negatively impact their health including unsafe sexual activity, unsafe driving, and use of substances (tobacco, alcohol, and illegal drugs). Under the New Hampshire's Department of Health & Human Services, the NH Maternal and Child Health section (MCH) strives to improve the health, safety and well-being of NH's adolescents and young adults by administering programs including the IPP, Family Planning Program, Home Visiting Program and Comprehensive Family Support Program.

Non-fatal injuries present a significant burden to the health care system, particularly to urgent care facilities and emergency departments (ED). Unintentional injuries accounted for the majority of all injury-related visits. Emergency department visits for unintentional injuries are often seen among both children and young adults; one of the age groups with the highest hospitalization rate is the 10 to 14 age group.

The rate of non-fatal injury inpatient (IP) hospital discharges in NH residents aged 10 to 19 years has shown a decreasing trend. Although there appears to be a steep decrease between 2014 and 2015, the decreasing trend between 2012 and 2015 is not statistically significant. By 2023, if the current change trend is maintained, the rate will be significantly lower than it was in 2012. The target on the graph represents approximately a 56% decrease, or 5% change per year between 2012 and 2023.



Data Source: NH Hospital Discharge Data, NH DHHS

The hospital discharge data used to create this projection is limited. The 2012 to 2014 data were collected using a different methodology, and only in-state discharges are available. It is not comparable to previous years, and 2010 and 2011 data are not available. Also, with the adoption of ICD10 codes in 2015, older data collected using ICD9 codes may not be directly comparable. This may account at least in part for the sharp drop between 2014 and 2015. A new baseline will be selected when 2016 data are available, since this will be the first full year of ICD-10 code utilization. Work has been done to further clean the 2012 to 2014 data set, so the rates in the graph above may differ from the rates presented in the 2017 report.

Several focus areas have been selected to decrease hospitalizations for non-fatal injury in New Hampshire's adolescent population, ages 10-19. The primary focus is Adolescent Driver Safety, which intersects with the second focus area, concussion prevention and response. The third focus area is teen suicide prevention.

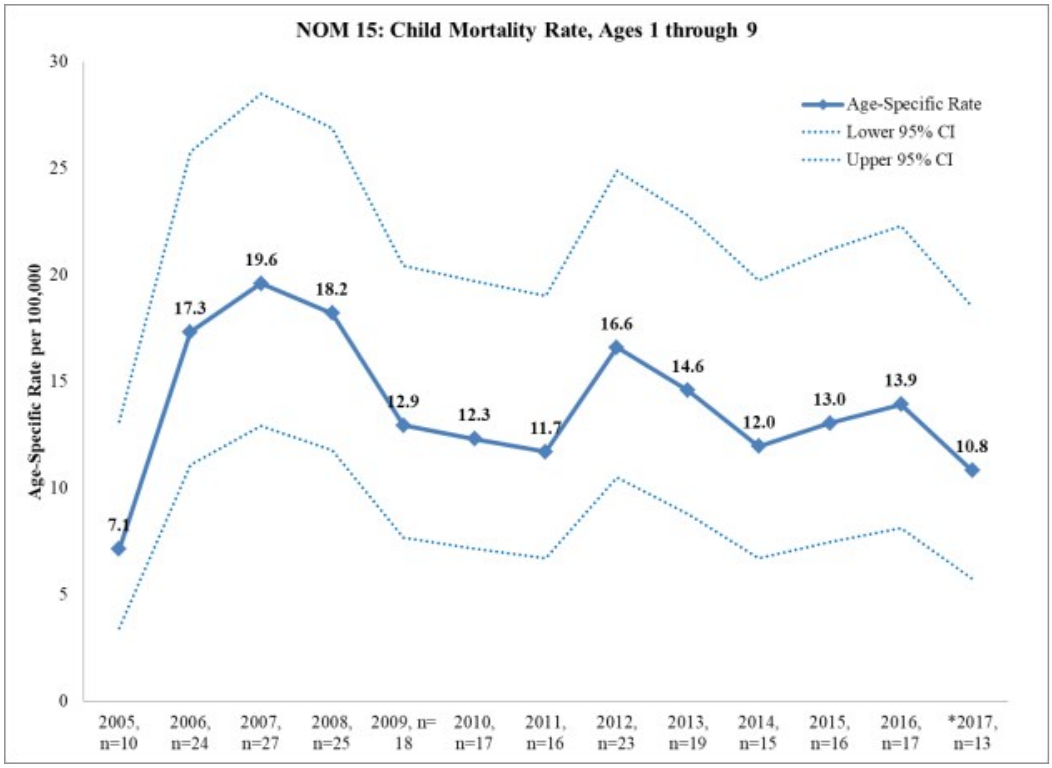
The following graphs and analysis address National Outcome Measures (NOM) 15, 16.2, 16.2, and 16.3 and how they intersect with National Performance Measure (NPM) #7.

NOM15 Child Mortality

The child mortality rate for NH residents aged 1 through 9 years old has not had a statistically significant change between 2006 and 2017. According to the Center for Disease Control and Prevention (CDC) WISQARS (Web-based Injury Statistics Query and Reporting System) data, unintentional injury is the leading cause of death in this age group, and the top cause of death in motor vehicle traffic related fatalities. The MCH section works closely with the Injury Prevention Center at Dartmouth (IPC) regarding child passenger safety. In 2014 RSA 265:107a was passed to strengthen child passenger safety by more clearly defining the age and size requirements for car seat use, booster seat year and seatbelts for children age 18 years and younger.

The second and third leading causes of death are cancer and congenital anomalies, followed by homicide at number four. Homicide in

the age group is rare and addressed in the Child Fatality Review Committee (CFRC). This committee meets every other month and develops recommendations toward the prevention of such deaths through policy, program, systems and educational changes. These recommendations are found in the biennial Child Fatality Review Report (https://www.doj.nh.gov/criminal/victim-assistance/documents/fifteenth-report.pdf).[1] There is a delay of several years before a homicide case can be reviewed because access to case records is not allowed until after it is fully adjudicated and closed. A new challenge is that DCYF has been advised not to share case information in unsubstantiated cases. This impacts the CFRC and other child death review committees such as the SUID (sudden unexpected infant death) and the SDY (sudden death in youth)review committees. The DCYF and DPHS legal consultants are discussing this issue with administrators to consider future legislation to clarify what can be shared.



Data Source: NH Vital Records

* Data year 2017 in the Death Certificate data is provisional, as it may be incomplete for NH residents who died out of state.

10 Leading Causes of Death, New Hampshire
2006 - 2016, All Races, Both Sexes

Rank	Age Groups 1-9
1	Unintentional Injury 39
2	Malignant Neoplasms 37
3	Congenital Anomalies 23
4	Homicide 13
5	Heart Disease ---
6	Benign Neoplasms ---
7	Influenza & Pneumonia ---
8	Septicemia ---
9	Cerebro-vascular ---
10	Five Tied ---

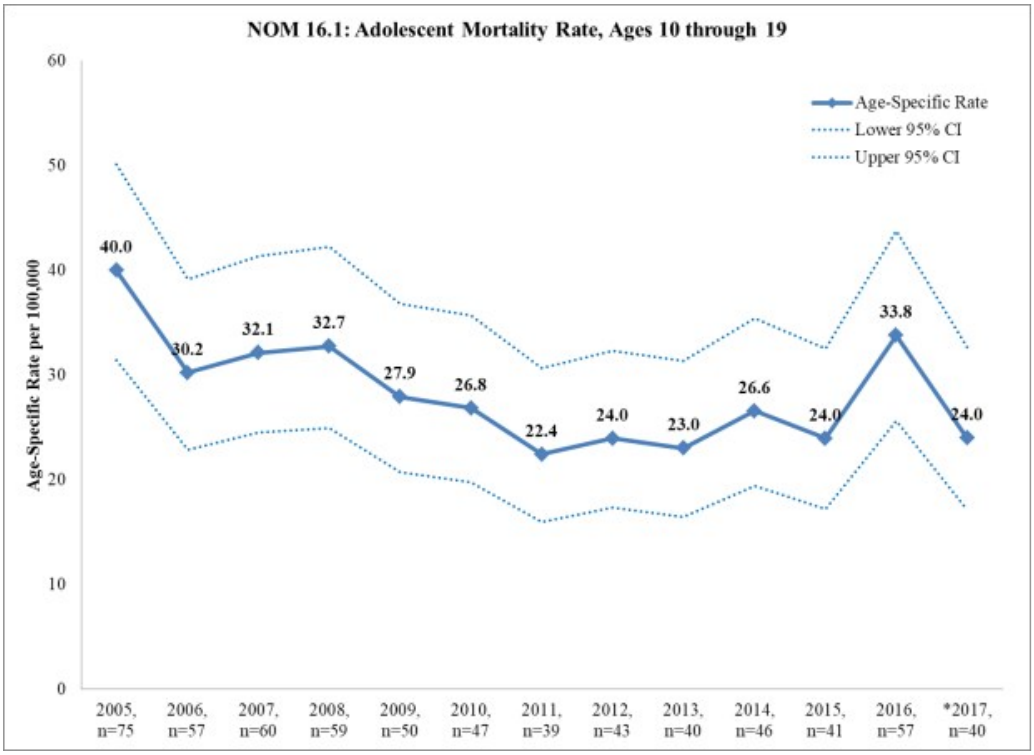
10 Leading Causes of Unintentional Injury Deaths, New Hampshire
2006 - 2016, All Races, Both Sexes

Rank	Age Groups 1-9
1	Unintentional MV Traffic 13
2	Unintentional Drowning 10
3	Unintentional Fire/burn ---
4	Unintentional Suffocation ---
5	Unintentional Fall ---
6	Unintentional Machinery ---
7	Unintentional Other Land Transport ---
8	Unintentional Pedal cyclist, Other ---
9	Unintentional Pedestrian, Other ---
10	---

Data Source: WISQARS, National Center for Health Statistics (NCHS), National Vital Statistics System, accessed 5/18/2018. (red highlighting is inserted by WISQARS .

NOM16.1 Adolescent Mortality

Adolescent mortality has shown a consistent, although not statistically significant decrease between 2005 and 2017, except for a spike in 2016. Annual counts of adolescent deaths range for 39 to 75 per year. According the CDC WISQARS, the 10 to 19 year old age group's leading overall cause of death is also unintentional injuries, with motor vehicle traffic being the number one specific cause. This is why MCH selected Adolescent Driver Safety as primary focus area for programmatic activities.



Data Source: NH Vital Records

* Data year 2017 in the Death Certificate data is provisional, as it may be incomplete for NH residents who died out of state.

10 Leading Causes of Death, New Hampshire
2006 - 2016, All Races, Both Sexes

	Age Groups
Rank	10-19
1	Unintentional Injury 200
2	Suicide 92
3	Malignant Neoplasms 49
4	Heart Disease 17
5	Congenital Anomalies 12
6	Homicide ---
7	Benign Neoplasms ---
8	Cerebro-vascular ---
9	Influenza & Pneumonia ---
10	Four Tied ---

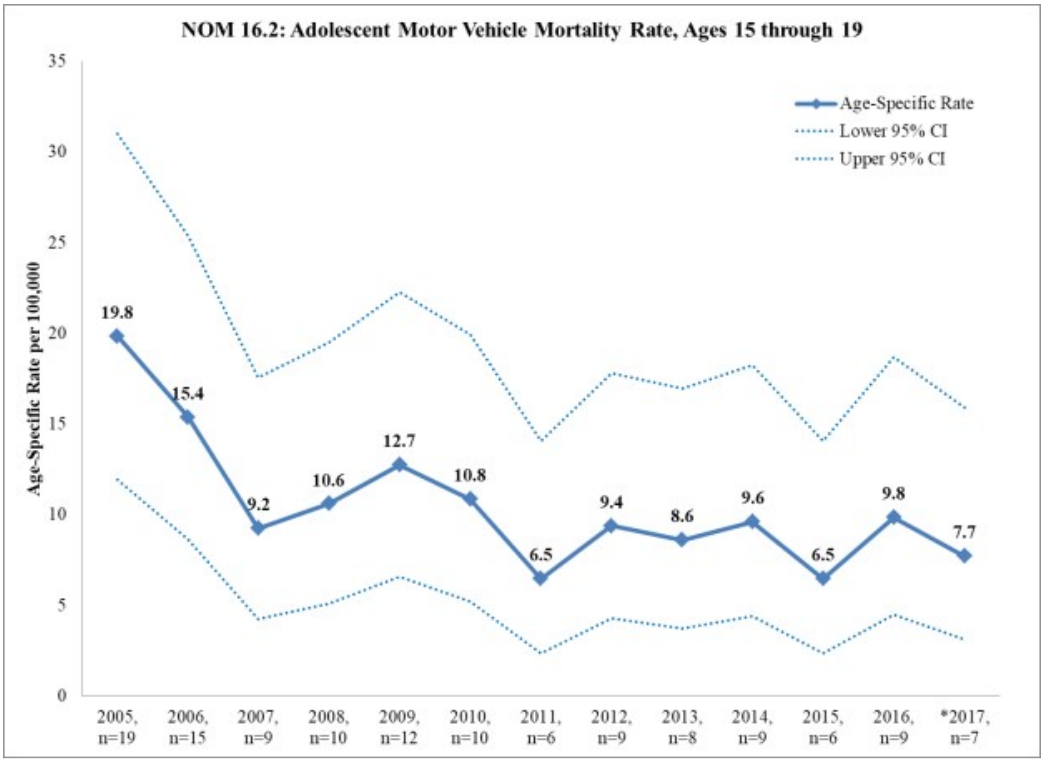
10 Leading Causes of Unintentional Injury Deaths, New Hampshire
2006 - 2016, All Races, Both Sexes

	Age Groups
Rank	10-19
1	Unintentional MV Traffic 115
2	Unintentional Poisoning 42
3	Unintentional Drowning 13
4	Unintentional Struck by or Against ---
5	Unintentional Suffocation ---
6	Unintentional Fall ---
7	Unintentional Other Land Transport ---
8	Unintentional Pedestrian, Other ---
9	Three Tied ---
10	Three Tied ---

Data Source: WISQARS, National Center for Health Statistics (NCHS), National Vital Statistics System accessed 5/18/2018. (red highlighting is inserted by WISQARS)

NOM16.2 Adolescent motor vehicle death

Motor vehicle crashes continue to be the number one cause of deaths for adolescents and new drivers. Speed and the inexperience of novice drivers are the major causes of fatal crashes among adolescents in NH. Adolescent motor vehicle death rates for NH residents, 15 through 19 years old has not changed significantly between 2006 and 2017. The annual counts per year are small; they may be unreliable and should be used with caution. Per the instructions for querying this data, the graph below includes all motor vehicle (MV) crash deaths: MV Occupants, Motorcyclists, Pedestrians or Pedal Cyclists injured in MV Crash. On average, between 2005 and 2017, approximately four adolescents age 15 to 19 who died per year in MV crashes were occupants of a motor vehicle. Of those four, about two per year were drivers at the time of the crash.

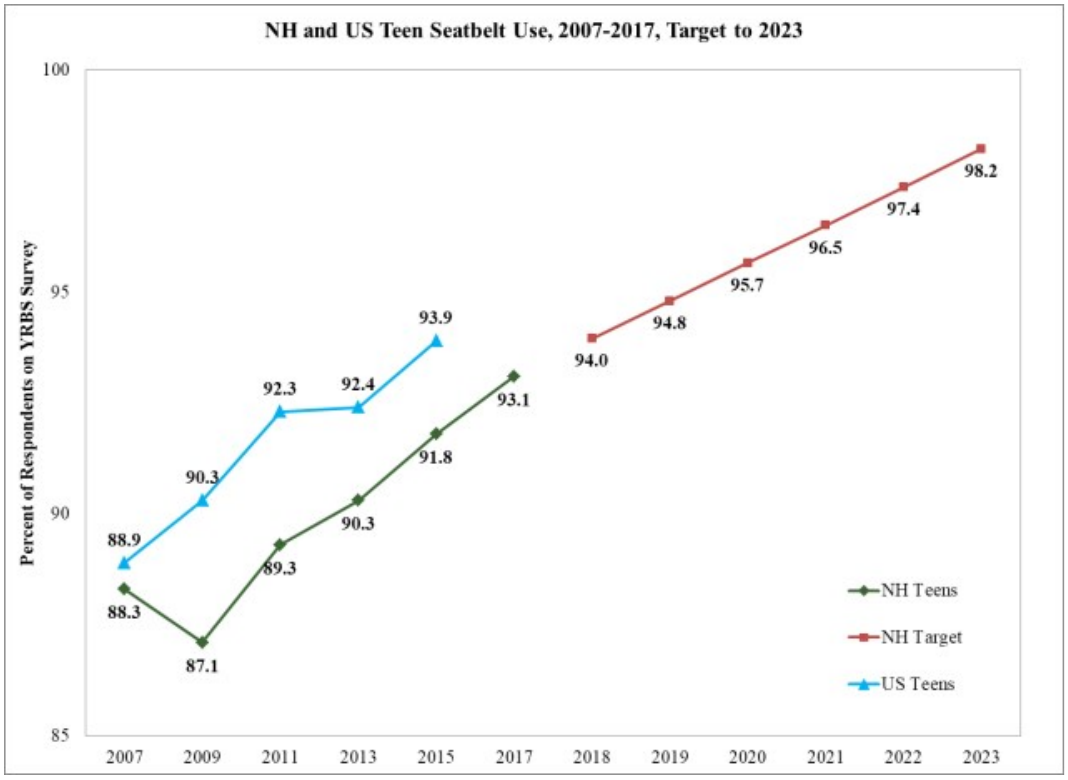


Data Source: NH Vital Records

* Data year 2017 in the Death Certificate data is provisional, as it may be incomplete for NH residents who died out of state.

ESM7.2.1 Seatbelt Use: Percent of high school students who wear seatbelts

The 2017 NH Youth Risk Behavior Survey (YRBS) indicates that of the respondents, 93.1% “Sometimes, most of the time, or always wore a seat belt (when riding in a car driven by someone else).” This number has gone up significantly from72.4% when it was first asked in 1993. If the current trend continues, by 2023 some 98.2% of students may report using their seatbelts. The number of students reporting that they are texting and driving has decreased from 48% when the question was first asked in 2013, to 42% in 2017. A "Hands Free" law was passed in 2015 in NH that forbids hand-held device use in drivers under age 18, except in the case of an emergency.



Source: US and NH YRBS

Adolescent Driver Safety Programmatic Activities

Objective: 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%, to 75.6%, based on observational studies.

The seatbelt observational study conducted in the spring of 2017 shows 75% of teen drivers, and 78% of teen passengers were actually wearing seatbelts.

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 andmake recommendations for potential change

Systems Building

MCH staff, particularly in the Injury Prevention Program (IPP), is continuing to support efforts regarding novice adolescent driving. MCH contracts with the Injury Prevention Center at Dartmouth (IPC) to fund (through state and CDC Preventive Health and Health Services Block Grant funds) a one day per week Highway Safety Specialist. This position is jointly funded by the Division of Highway Safety. The Highway Safety Specialist facilitates, with a MCH co-chair, the NH Teen Driving Committee, which was combined with the Statewide Buckle Up Coalition to serve all ages. Part of this work includes the NH Teen Driving Project (NHTDP).

The NHTDP's primary goals include assisting participating adolescents in understanding the true risks associated with their driving experience and educating parents and participating community members in understanding these same risks. The program also attempts to change the "driving culture" for NH's adolescents 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. Observational surveys of seat belt and electronic device use are collected at participating high schools at the start of the program implementation year(s) and periodically as interventions (educational programs, school seat belt challenges, etc.) are facilitated. YRBS school specific survey data is reviewed every other year and schools with low seat belt usage are targeted.

Of the 15 schools participating in the NHTDP peer-to-peer program, three schools provided observational studies in both the fall 2016 and spring 2017. These data are collected by counting the number of cars leaving the school's parking lot. The results are the following:

Beginning of the school year averages (Fall 2016):

- Electronic Device Usage: 3% (Range 2%-5%)
- Driver Belt Usage: 77% (Range 66%-87%)
- Passenger Belt Usage: 73% (Range 57%-87%)

End of the school year averages (Spring 2017):

- Electronic Device Usage: 3% (Range 1%-8%)
- Driver Belt Usage: 75% (Range 70%-86%)
- Passenger Belt Usage: 78% (Range 65%-95%)

Driver seatbelt usage decreased a bit, and passenger usage increased. Hand held device use was unchanged. With only three out of the 15 schools providing both spring and fall data, there is not enough information to show significant changes during this school year.

The MCH section and the IPC continue to look for ways to enhance parental awareness and involvement in highway safety issues. Some examples include: speaking at the DHHS sponsored Children and Family Conference in May of 2017, and the Ford Driving Skills for Life event conducted at the Loudon Speedway in July 2017, at which over 200 parents actively participated in the training that their teen drivers received.

Another major resource developed for parents is the parent toolbox online www.nhparentsofteendrivers.com. This web site is visited by thousands of people each year and contains vetted information designed to allow parents to be more involved as their teens become new drivers. This web resource is the only non-governmental teen driving resource to be listed in the Children's Safety Network 2017 edition Teen Driving Guide.

Teen Driver Safety and Buckle Up NH informational displays were shared at community events such as the Safe Kids 500 Bike Rally that was also held at the speedway with hundreds of parents attending, and the Derry Fest with an attendance of over 2,000 people including parents and teens. The Seat Belt Convincer, which simulates a low-impact crash, was set up at the Derry Fest. The Highway Safety Specialist attended the Boy Scout Jamboree on May 5 at the Loudon Speedway along with the AT&T "It Can Wait" distracted driving simulator. About 5,000 scouts attended this event. AT&T brought the Seat Belt Convincer to the Traffic Safety Conference on May 7 and to Windham High School on May 8.

MHC and IPC staff continued to look for ways to provide more and better educational experiences for teen drivers and for members

of the community. To assist with this, MCH and IPC staff participated in teen driving collaborative efforts hosted by the Children's Safety Network for the past three years.

In March 2017, the IPC received a grant from the Governor's Highway Safety Association (GHSA) and was one of only five states chosen to receive $15,000 to conduct a multi-school teen driver event. This event was conducted on October 23, 2017 in Concord with over 100 students from 10 high schools in attendance. The primary message for this event was "You can be the change." Guest speakers included secret service agent Garrett Fitzgerald who was paralyzed in a crash caused by a man impaired by heroin, NASCAR race car driver Melissa Fifield and Wakefield Police Chief Fifield. The funding for this event came from the Ford Motor Company, routed through GHSA. The success with Ford's Driving Skills for Life was a primary reason that NH was chosen to receive their grant funds.

The program's successes also resulted in IPC staff being asked to speak at this year's Lifesaver's Conference about New Hampshire's Teen Driving Program. This opportunity provided a platform to inform other states, enabling them to promote their teen driver programs, and also facilitated a mutual exchange of information that will enable NH to further enhance Teen Driver Safety efforts.

Occupant Protection and Teen Driving priorities are included in the revised DOT Strategic Highway Safety Plan. The Highway Safety Specialist and his assistant worked with approximately 15 high schools. Information and programing was provided to as many as 21 schools over the past year. Examples of upcoming programs include a half day "Healthy Choices Event" at Belmont High, three different programs at John Stark High (Safe Passenger Education for Freshmen, Room to Live seat belt education for Sophomores and a presentation by Grace Wight for Juniors and Seniors). Grace fell asleep behind the wheel and killed a pedestrian in her small town of Lyndeborough. The pedestrian was her neighbor and friend. Grace was 17 years of age when this crash happened three years ago. Windham High will have the AT&T It Can Wait event. Pinkerton Academy hosted IPC staff for their pre-prom event for juniors.

NH's HB1259 for an adult seat belt law was unsuccessful this year. Therefore, a primary focus at the May 7 conference was occupant protection and included guest speaker Tara Gill, Director of State Programs, Advocates for Highway and Auto Safety, Washington, DC. The second focus area has been impaired driving with Erin Holmes, Director of Traffic Safety, and Foundation for Advancing Alcohol Responsibility, Washington, DC. The teen driver program also had a representative there.

After 24 years of conducting the Seat Belt Challenge the same way, IPC staff are completely redesigning it. The redesign will be implemented in the fall of 2018. The new program will be more educational and less physical, and will allow more schools to participate. This new program is in the development stages and a method of evaluation has yet to be designed. Program evaluation in NH schools is a challenge because of the law that prohibits non-academic surveys in schools such as pre and post event knowledge checks. The YRBS survey is allowed, so seatbelt use by students can be estimated from YRBS data.

MCH Specific Activities

MCH's IPP continues working with the NH Driving Towards Zero Coalition (the Coalition). The Coalition is comprised of multiple State agencies and organizations and is now working towards the implementation of the *New Hampshire Strategic Highway Safety Plan, 2017-2021*, which has a component focusing on adolescents. The Coalition is working towards both strengthening and understanding the State's Graduated Drivers Licensing (GDL) laws, which involve stepped licensing of novice drivers; GDL has been proven effective in reducing the number of crashes and fatalities. All 50 States have some GDL components in place. Toward this end, the MCH IPP Manager, and the IPC Highway Safety Specialist both sit on the Governor's Highway Safety Council.

Concussion

Concussion in adolescents can be a result of a non-fatal motor vehicle crash, sports injury, or fall. The effects of concussion can be long lasting and vary in severity. New Hampshire has a law regarding return to playing sports after a concussion. The MCH section is working with the Brain Injury Association of NH (BAINH) to amend this law to include "return to learn." Cognitive abilities are affected after a concussion, and the brain needs time to rest and heal.

Objective: 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.

Strategy: Analyze concussion policies within school systems and make recommendations for potential change.

Data Analysis

In NH, the annual death count for traumatic brain injury (TBI) in ages 10 to 19 was low. Years 2006 to 2017 were aggregated in the table below which shows the selected causes of TBI deaths in NH adolescents. Motor vehicle crash is clearly the top cause of TBI deaths.

NH Adolescent TBI Death Counts 2006-2017

SELECTED CAUSE DESCRIPTION	Total
Motor Vehicle Crash-unspecified	17
Motor Vehicle Crash- MV Occupant	11
Motor Vehicle Crash- MV Driver	7
Pedal Cyclist or Pedestrian- Motor Vehicle Crash	7
Struck by or Against	3
ATV Driver Crash	2
Agricultural Vehicle Crash	1
Drowning	1
Fall	1
Other Accident	1
Pedal Cyclist or Pedestrian- Non-Traffic	1
Grand Total	**52**

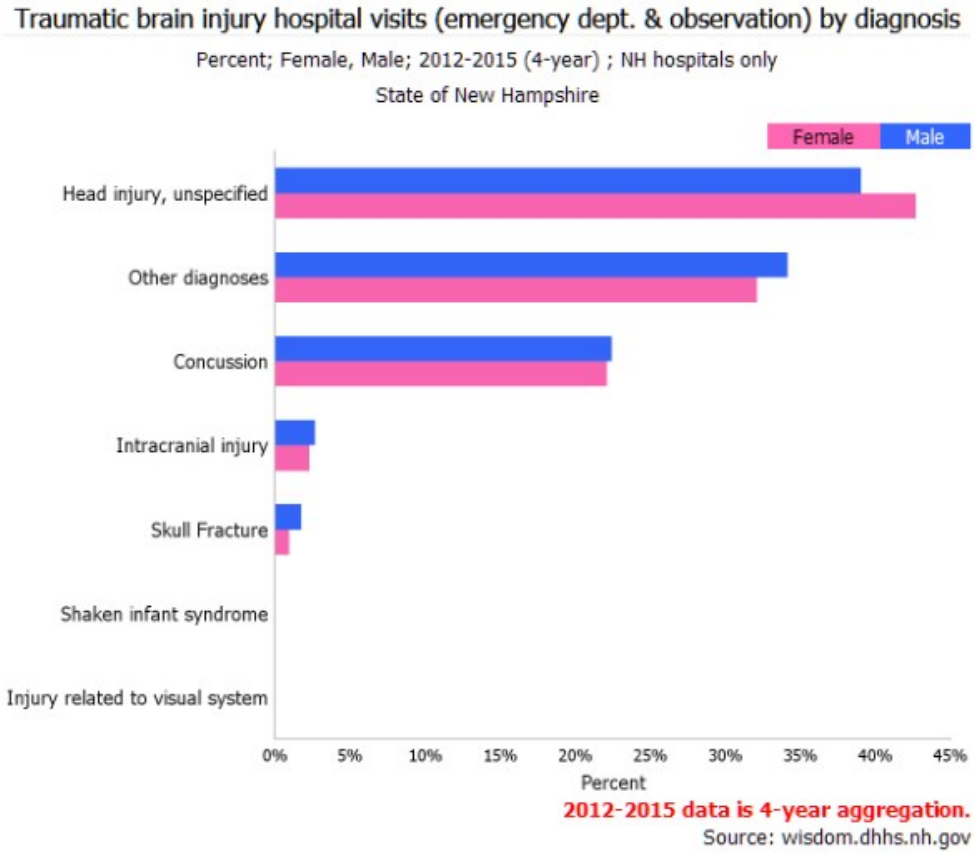
Data Source: NH Vital Records

IP discharge rates for adolescents ages 10 to 19 are lower than the overall NH rate. There were 164 adolescent IP cases between 2012 and 2015.

Emergency Department (ED) visit rates for this age group are higher than the overall NH rate. There were 9,331 adolescent ED visits between 2012 and 2015.

The number of cases seen in the hospital is not a complete count; some children are seen in urgent care facilities or a doctor's office, and some minimize their injuries and do not receive medical attention at all.

Concussion is the second most common cause of TBI seen in the ED; the Other Diagnoses as shown below are a compilation of several smaller categories of TBI.



Data Source: NH Health WISDOM, https://wisdom.dhhs.nh.gov/wisdom/#main, accessed 5/10/2018.

There has been increased education regarding the seriousness of concussion in response to the "Return to Play" law (RSA 200:49-52). This law, enacted in 2012 and revised in 2014, calls for the immediate removal of any student-athlete from play if a concussion is suspected. The law requires medical clearance and written authorization from a health care provider trained in the evaluation and management of concussions as well as parental written permission for return to play (https://www.accesssportsmed.com/news/governor-lynch-signs-nh-concussion-bill-into-law/)."

The most common causes of non-fatal TBI in children ages 10-19 years in NH are falls, sports injuries, and motor vehicle crashes. Comparing this to the deaths where MV crash is the most common cause of TBI deaths in youth shows the importance of Adolscent Driver Safety programming. Similarly, the most common causes for non-fatal concussions are sports injuries, falls, and motor vehicle crashes.

Over the last 10 years there have been no deaths due to concussion in this age group.

In 2015, there were 1,293 ED discharges for NH residents, age 10 to 19, with concussion, with an average cost per patient of $2,173. This information does not include students who may have had a concussion and sought care in a doctor's office without going to the hospital. IP care for more serious cases of concussion, most likely including additional injuries or complications, numbered 20 in 2015 at an average cost per patient of $41,194. In 2015, among ages 10 to 19, there were 2,669 children discharged from the emergency department with TBI (including concussion and other head injuries) at an average cost per patient of $2,130. TBI IP care in 2015 for this age group had 42 discharges at an average cost per patient of $49,426.

Type of Injury/Year	Count	Total Cost	Average Cost Per Patient
Emergency Department			
Concussion			
2014	1404	$3,224,058	$2,296
2015	1293	$2,809,957	$2,173
TBI			
2014	2570	$5,764,062	$2,243
2015	2669	$5,684,891	$2,130

Type of Injury/Year	Count	Total Cost	Average Cost Per Patient
Inpatient			
Concussion			
2014	17	$903,167	$53,127
2015	20	$823,889	$41,194
TBI			
2014	38	$1,746,824	$45,969
2015	42	$2,075,899	$49,426

Data Source: NH Hospital Discharge Data, NH DHHS

Systems Building/MCH Specific Activities

Many of the causes of TBI are predictable and preventable. Prevention geared towards adolescents may include:

- Creating a culture of safety awareness in schools through:
  - Wearing a seat belt every time you drive or ride in a motor vehicle.
  - Never driving while under the influence of alcohol or drugs or riding in a vehicle with an intoxicated driver.
  - Raising awareness of the seriousness of concussion and the importance of seeking medical help, and adhering to school policies on return to learn and return to play.
- Wearing a helmet while riding a bicycle, skateboard, motorcycle, snowmobile or all-terrain vehicle; also wearing head protection when batting or running bases, skiing, skate boarding, riding a horse, or playing a contact sport.
- Installing safety features in your home, such as non-slip mats in the bathtub, window guards, and safety gates on the top and

bottom of stairs (especially when young children are around) to limit falls.

MCH's IPP has been working with BIANH to assess the implementation and effectiveness of NH's school concussion law, RSA 200:49-52 (see http://www.gencourt.state.nh.us/rsa/html/XV/200/200-49.htm). The primary objective continues to be the determination of which specific elements of the law have been implemented. This includes the establishment of a concussion policy with regards to return to play and the distribution of information to both students and parents. Another objective was to determine what parts of the law are difficult to implement, and if MCH and the BIANH could assist in decreasing barriers.

A survey, sent to all New Hampshire high schools, was facilitated in early 2016 (the survey has not been repeated). There were 122 respondents, a 13% response rate. Respondents included school nurses (74%), athletic directors/trainers (22%), and school principals (4%). Key findings were:

- 96% of athletic directors/trainers report having a school policy versus 73% of all others (66% of school nurses)
- Only 64% of respondents reported having a "return to learn policy" (57% of school nurses)
- A majority of respondents have a baseline concussion testing program.
- 33% of all respondents say the policy is followed with absolutely no exceptions compared to 76% of athletic directors/trainers and 21% of nurses
- The top two (2) reasons concussion policies are not being followed consistently are that students do not truly describe how they are feeling and a lack of communication between parents, students, teachers and coaches
- The top two (2) sources for all respondents for information on concussions are "professional conferences" (78%) and "subject matter expert organizations" (42%); the "CDC" is cited more frequently (21%) than the "Brain Injury Association of NH" (5%)
- Only slightly more than one fifth of all respondents (22%) say they have ever contacted the BIANH to get information on concussions; of those, the top two (2) most frequently cited behaviors by all respondents are "visit the website/download information about concussions" (35%) or "attend a workshop sponsored" (24%)
- Seventy-two percent (72%) of respondents were aware of the law and 66% of those said they would be likely to strengthen it
- Only 5% of all respondents said they are not likely to support strengthening the law and pointed 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"

Recommendations were written up and brought to the Injury Prevention Advisory Council's Policy Subcommittee in the fall of 2016 to discuss any potential additional actions. At that time, legislative elections were being held and it was decided to postpone any legislative policy action.

However, further work was done to determine how the law was being implemented. MCH staff and the BIANH met with lead stakeholder organizations such as the NH Athletic Directors Association, the NH Pediatric Society, the NH Athletic Trainers Association and the NH School Nurses Association to learn what those organizations were doing to promote the law and discuss ways to strengthen education and outreach. BIANH is currently re-administering the 2016 survey cited above with high school nurses to assess any increase in return to play and return to learn policies in schools.

BIANH also hired an intern to identify all of the Return to Play (RTP) laws in other states and identify states with strong RTP laws.

Schools in a few states were contacted, and it was discovered that application of their state's RTP laws in inconsistent. Most schools were using the law as a guideline.

In 2016, DHHS's Bureau of Development Services, the Acquired Brain Disorder Program, received HRSA funding (with the help of a committee that included MCH staff) to facilitate a return to learn program in NH schools entitled *Concussion Chalk-Talk*. Funding was subcontracted with the Brain Injury Association of NH under the guidance of an advisory committee including MCH staff. Title V funding to the Brain Injury Association of NH is now being braided with this funding to include policy assessment and development as referenced above.

Concussion Chalk Talk is a program that assists schools with their concussion management policies and procedures. As with return to play, a concussed student needs a stepwise progression to go back to the classroom. *Concussion Chalk Talk* assists participating schools with understanding the necessary academic accommodations for a concussed student. The program includes the formation of a Concussion Management Team (CMT), consisting of key personnel both inside and outside the school. A highlight of the program is the presence of a neuropsychologist on the CMT, who visits the school to consult on challenging cases and answer questions.

The NH return to learn methodology is as follows:

- Enhanced behavioral management in the acute phase of concussion by designing a structured schedule within the school setting
- Enhanced communication between all parties, both inside and outside the school, to provide consistency and avoid conflicting sources of information
- Ongoing consultation with sports neuropsychology team at Geisel School of Medicine/Dartmouth Hitchcock Medical Center, including in-person visits to school to consult on challenging cases and perform additional neuropsychological testing if necessary
- Daily education and monitoring for students regarding behaviors and symptoms
- Feedback from teachers and parents on a daily basis to understand level of recovery across environments
- Assurance of a graduated return to academics and classroom functioning based on readiness and tolerance of cognitive activities
- Provision of a supervised space within the school for symptomatic students to engage in academic replacement activities while they recover

When students become concussed, parents should contact school personnel (nursing staff, attendance office, school counselor, etc.). The initial contact person will inform the CMT Leader, who will in turn make contact with parents to provide an overview of the program. The return to learn schedule is as follows:

1. Student rests at home for approximately the first 48 hours post-injury
2. Student returns to school as soon as they meet attendance criteria
3. Student checks in with Assistant CMT Leader to perform a symptom checklist and optimally a Behavioral Assessment (BA)
4. Results of the BA and symptoms determine next steps and creation of the day's schedule
5. Student attends class if able to do so - if symptoms arise, they return to the Chalk Talk Room where they can first rest and then engage in activities that are less cognitively taxing

6. Periodic check-ins throughout the day with the CMT Assistant if symptoms arise. These check ins will quickly reduce during a 2-5 day window
7. Plan for the evening
8. If student has not met expected progress in terms of symptom reduction, neuropsychologist advises CMT regarding referrals to specialists

An electronic survey followed up by phone interviews on *Chalk-Talk* was facilitated in February and March of 2017 and presented to the Injury Prevention Advisory Council in May of 2017. Special education staff at schools was also included as were school nurses, athletic directors/trainers and principals.

Respondents overall were pleased with the program:

> "I would absolutely recommend the Chalk Talk program. Having a program forces everyone to be more sensitive to concussions. All schools should have a Chalk Talk Return to Learn policy so kids can be appropriately rested as they recover"
>
> "We have done training with faculty. Many times faculty say, 'the kid seems fine' because they look fine…it's not as obvious as a broken leg. Even those not in sports that have experienced a concussion will get referred to the trainer and we put them in the protocol. The trainer works with the guidance counselor and makes sure there is communication with the teachers. Now with Chalk Talk, we will have a protocol for returning to the classroom."[2]

Respondents reported that are still some barriers to overcome, including:

- Staff concern about being responsible for the "diagnosis" of the student (in reality, they only report Better or Worse observations)
- Handling the non-compliant student/family
- Handling "abusers of the system"
- Communicating with parents who don't have email/computer access
- Parents who "opt out" of Chalk Talk because they and their athletes want the athletes to return to the playing field sooner

Results on following policies interestingly mirrored that of non-*Concussion Chalk Talk* school staff members surveyed in the beginning of 2016.

A majority (86%) of all respondents say they would support a "return to learn" policy as a way to strengthen NH's concussion law. Similarly, almost three-fourths (71%) of special education teachers say they would support revised legislation that would address "return to learn."

"After experiencing a concussion, the brain needs time to heal. Computer time and reading activities should be minimized during the healing process. Students' memory may also be impacted as a result of the concussion. Teachers need to be made aware of these issues and ensure that precautions are taken during the healing process"[3]

NOM16.3 Adolescent suicide

Adolescent suicide death rates for NH residents 15 through 19 years old have not changed significantly between 2007 and 2017.

The counts have doubled from 6 in 2015 to 11 in 2016 and 12 in 2017, which is concerning—while these low numbers may not be statistically significant, the death of any child is significant and the underlying causes need to be addressed. . According the CDC WISQARS, suicide is the second leading cause of death in the 10 to 19 year old age group. The most common lethal means of suicide are firearms, suffocation, and poisoning.

The MCH section hosts a Suicide Prevention Council. The mission of the State Suicide Prevention Council (SPC) is to reduce the incidence of suicide in NH by accomplishing the goals of the NH Suicide Prevention Plan, which are to:

- Raise public and professional awareness of suicide prevention;
- Address the mental health and substance abuse needs of all residents;
- Address the needs of those affected by suicide; and
- Promote policy change.[4]

"A major accomplishment of the council in 2016 was the revision of the NH Suicide Prevention Plan (2017-2020). A copy of the updated Plan is available from https://www.dhhs.nh.gov/dphs/bchs/spc. A key addition to the revised Plan is the concept of a Zero Suicide approach to prevention in the state. This concept was built into the overall goals of the Plan, as well as the goals of the individual SPC subcommittees. More information about Zero Suicide is available from http://zerosuicide.sprc.org/. The State Suicide Prevention Plan is not a static document and will continue to evolve over time to incorporate promising concepts and initiatives, such as Zero Suicide, that may help prevent suicides in the state."[5]

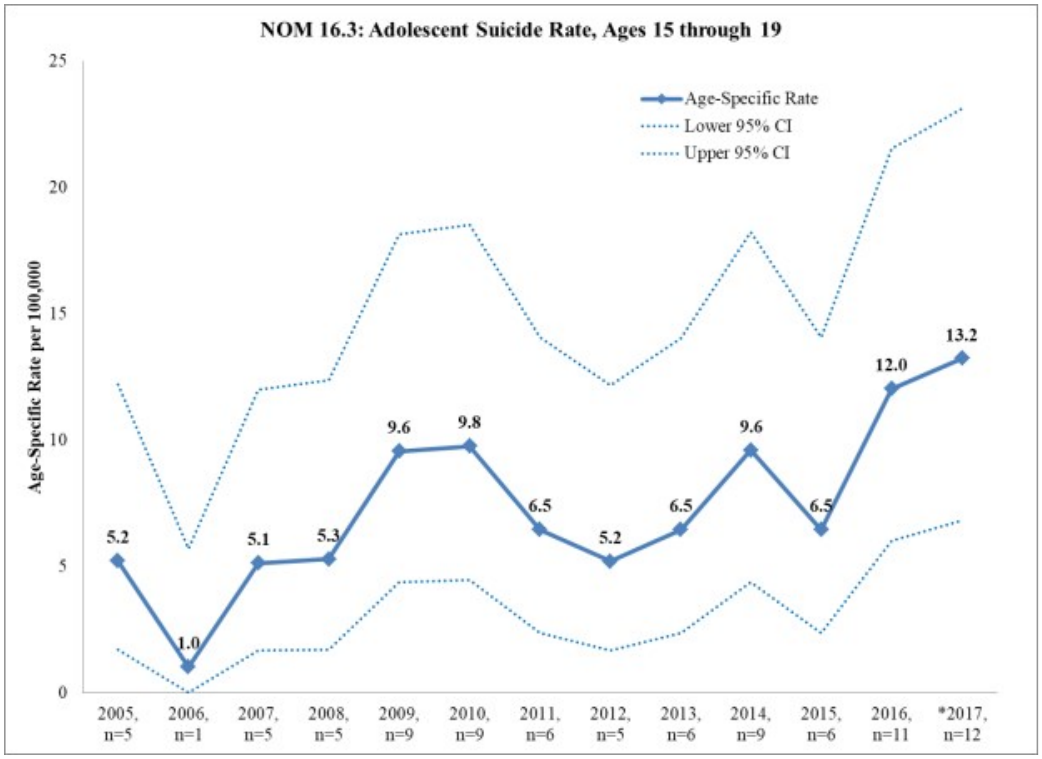
MCH in cooperation with National Alliance on Mental Health in NH (NAMI NH) produces an annual Suicide Prevention Report (http://theconnectprogram.org/sites/default/files/site-content/2016_annual_suicide_report_-_final_-_10-31-17.pdf) and the State Suicide Prevention Plan, which is regularly updated.

The goals of NH's Suicide Prevention Plan 2017-2020 are the following:

1. Promote awareness that suicide in NH is a public health problem that is generally preventable
2. Reduce the stigma associated with obtaining mental health, substance misuse and suicide prevention services
3. Improve and expand suicide surveillance systems
4. Collaborate with partners and implement training for recognition of at-risk behavior among the law enforcement community.
5. Educate the public to improve recognition of at-risk behaviors and the use of effective interventions. Promote training to personnel that are directly involved with veterans, service members and/or their families who exhibit high risk, concerning behaviors.
6. Coordinate delivery of informational material to the community and treatment sites or resources on potentially suicidal veterans, service members and/or their families.
7. Provide subject matter expertise to the NH Legislature regarding the public health impact of suicide.
8. Support survivors of suicide loss through the implementation of support and education programs for family, friends, and associates of people who died by suicide.
9. Promote Zero Suicide in collaboration with all other subcommittees of the State Suicide Prevention Council.[6]

"The Youth Suicide Prevention Assembly (YSPA) is dedicated to reducing the occurrence of suicide and suicidal behaviors among NH's youth and young adults up to 24 years old. This is accomplished through a coordinated approach to providing communities with

current information regarding best practices in prevention, intervention, and post-event strategies and by promoting hope and safety in our communities and organizations. YSPA is an *ad hoc* committee of individuals and organizations that meet monthly to review the most recent youth suicide deaths and attempts in order to develop strategies for preventing them. Over the years, YSPA and its partners have been involved with a wide range of suicide prevention efforts in the state – including: collecting and analyzing timely data on suicide deaths and attempts, collaborating on an annual educational conference, creating the original NH Suicide Prevention Plan and identifying the need for statewide protocols and training, which were developed through NAMI NH into the Connect Program."[7]



Data Source: NH Vital Records

* Data year 2017 in the Death Certificate data is provisional, as it may be missing NH residents who died out of state.

** Counts less than 20 should be used with caution.

10 Leading Causes of Death, New Hampshire
2006 - 2016, All Races, Both Sexes

	Age Groups
Rank	10-19
1	Unintentional Injury 200
2	Suicide 92
3	Malignant Neoplasms 49
4	Heart Disease 17
5	Congenital Anomalies 12
6	Homicide ---
7	Benign Neoplasms ---
8	Cerebro-vascular ---
9	Influenza & Pneumonia ---
10	Four Tied ---

10 Leading Causes of Violence-Related Injury Deaths, New Hampshire
2006 - 2016, All Races, Both Sexes

	Age Groups
Rank	15-19
1	Suicide Firearm 38
2	Suicide Suffocation 29
3	Suicide Poisoning ---
4	Homicide Cut/pierce ---
5	Homicide Firearm ---
6	Homicide Other Spec.. NEC[N] ---
7	Suicide Cut/pierce ---
8	Suicide Drowning ---
9	---
10	---

Data Source: WISQARS, National Center for Health Statistics (NCHS), National Vital Statistics System, accessed 5/30/2018. (red highlighting is inserted by WISQARS)

The MCH IPP has been awarded the National Violent Death Reporting System (NVDRS) grant from CDC since 2014. This grant's purpose is to collect more than demographic data around homicides, suicides, and firearm deaths. The data abstractor also reviews police reports, medical examiner records, and toxicology reports to develop a narrative on the circumstances that lead to violent deaths. MCH IPP partners with the Department of Justice, Office of Chief Medical Examiner on the grant. The first full year of clean data is for 2015. This data set will be released by CDC back to the state in the summer of 2018 so in-depth analysis can begin on the violent death circumstances. Preliminary NH-NVDRS data was provided for the 2016 Annual Suicide Report (link noted above).

* * * * * * * * *

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: 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

Objectives: Increase the percentage of adolescents who have had a preventative medical visit at the MCH funded CHCs from a baseline of 61% in SFY 16 to 64% by 2020.

Strategies:

1. Build partnerships by:

- collaborating with public and private partners through NH Pediatric Improvement Partnership
- participating in the Adolescent and Young Adult Health (AYAH) CoIIN Cohort 2
- statewide contracting with CHCs and provision of oversight on Primary Care Services
- establishing mechanisms to inform the public about adolescent preventive services via social media

2. Enhance capacity of CHCs to improve access and quality of adolescent services by:

- establishing performance measures that align with national guidelines and promote Bright Futures recommendations

- requiring contracted CHCs to develop an adolescent care Quality Improvement (QI) initiative
- collecting and analyzing Performance Measure outcome data from CHCs
- providing data results and feedback to CHCs for comparison
- providing education, resources, QI support and technical assistance

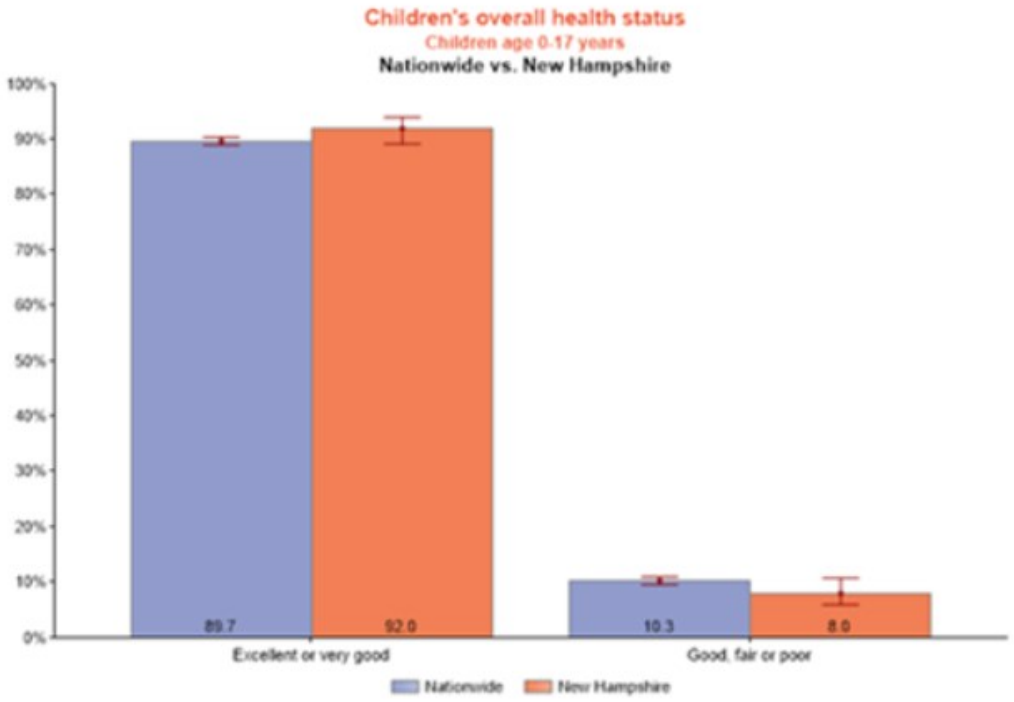
3. Create an Adolescent Health Coordinator position to expand adolescent health initiatives

The MCH section understands the issues impacting adolescent health and is well positioned to utilize staff expertise to maintain collaborations with state and local partners for the purposes of promoting adolescent health. MCH remains committed to ensure adolescent access to health care and preventive services which supports adolescents' ability to adopt or maintain healthy habits and behaviors and avoid health-damaging behaviors by implementing following:

- Engaging stakeholders and building partnerships to leverage collaborative efforts to support adolescent health
- Participating as a key member of the NH state team for the Adolescent and Young Adult Health Collaborative Improvement and Innovation Network AYAH CoIIN Cohort
- Promoting Title V priorities and adolescent well-visits via contracted mechanisms for services for health care and family support services
- Enhancing the capacity of MCH funded Community Health Centers (CHCs) to improve access and quality of adolescent/young adult services
- Providing positive adolescent health messages to the public

NH Adolescent Health

According to the 2016 National Survey of Children's Health (NSCH), 92% of NH's children, ages 0-17, are in excellent or very good health.[8] The health of NH's adolescents and young adults has been positively influenced by a high immunization rate and low teen birth rate and negatively influenced by tobacco, alcohol, drug use and unsafe behaviors.

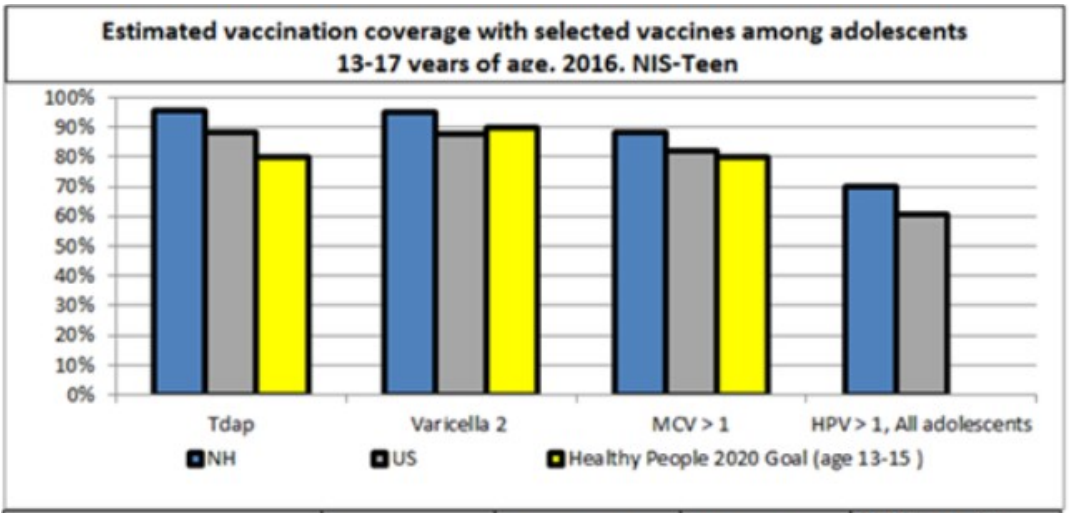


Source: 2016 National Survey of Children's Health

Vaccination Coverage

In New Hampshire, all children through the age of 18 years can receive all recommended immunizations at no cost. As a result NH has a strong history of attaining high vaccination rates for children and adolescents.

The state recently received five (5) awards at the National Immunization Conference including: "outstanding progress toward the Healthy People 2020 targets for each of the four vaccines among adolescents aged 13-17" and "outstanding progress toward the HP 2020 target of 70% for influenza vaccination coverage among children 6 months-17 years during the 2016-17 season."

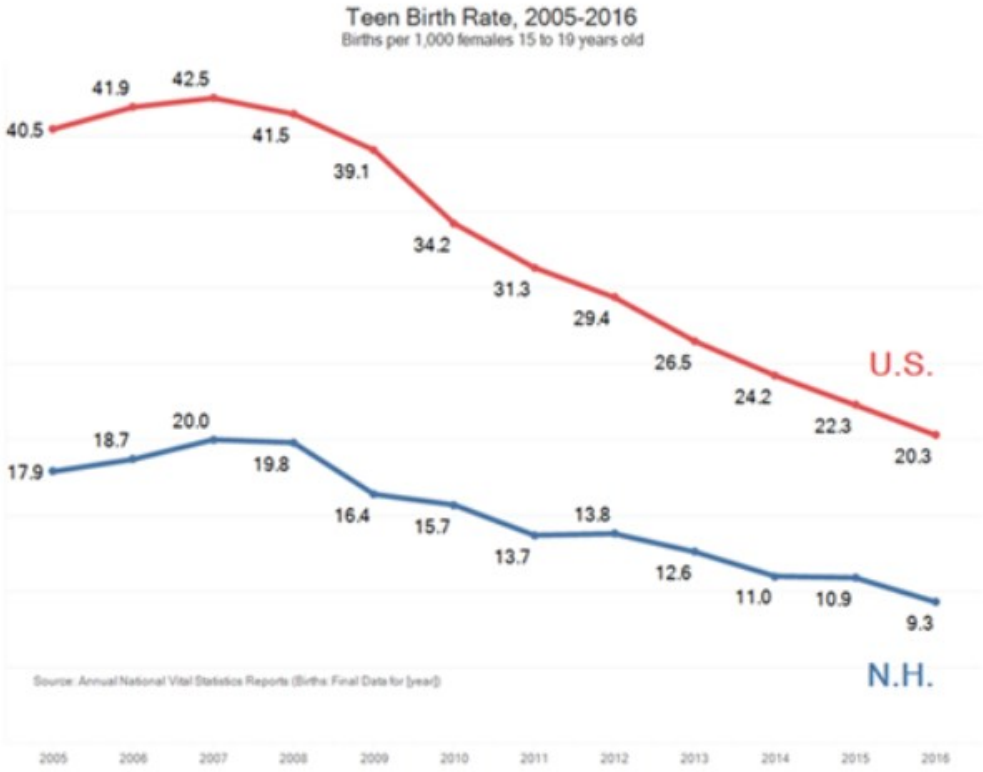


	Tdap	Varicella 2	MCV ≥ 1	HPV ≥ 1, All adolescents
NH *	95.3 (±2.8)	95.2 (±3.0)	88.0 (±4.2)	69.9 (±5.9)
US*	88.0 (±0.9)	87.8 (±0.9)	82.2 (±1.0)	60.4 (±1.2)
Healthy People 2020 Goal (age 13-15)	80%	90%	80%	---

National Immunization Survey-Teens, 2016: https://www.cdc.gov/mmwr/volumes/66/wr/mm6633a2.htm

Teen Birth

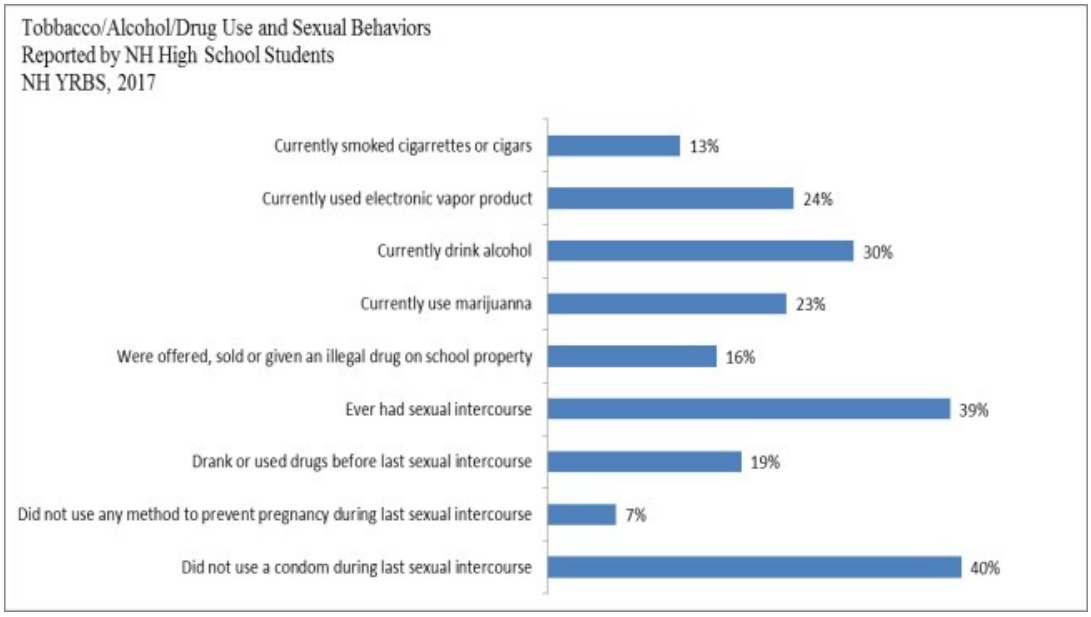
NH has attained one of the lowest teen birth rates in the nation. Currently, this rate is 9.3 per 1000 females 15-19 years old.[9] NH MCH contributes to this success by overseeing two adolescent pregnancy prevention projects (funded by the Administration of Children & Families) which operate in areas of the state that have the highest teen birth rate, ensuring access to primary care and family planning services.



Source: Annual National Vital Statistics Reports, 2017

NH Adolescent Health Risk

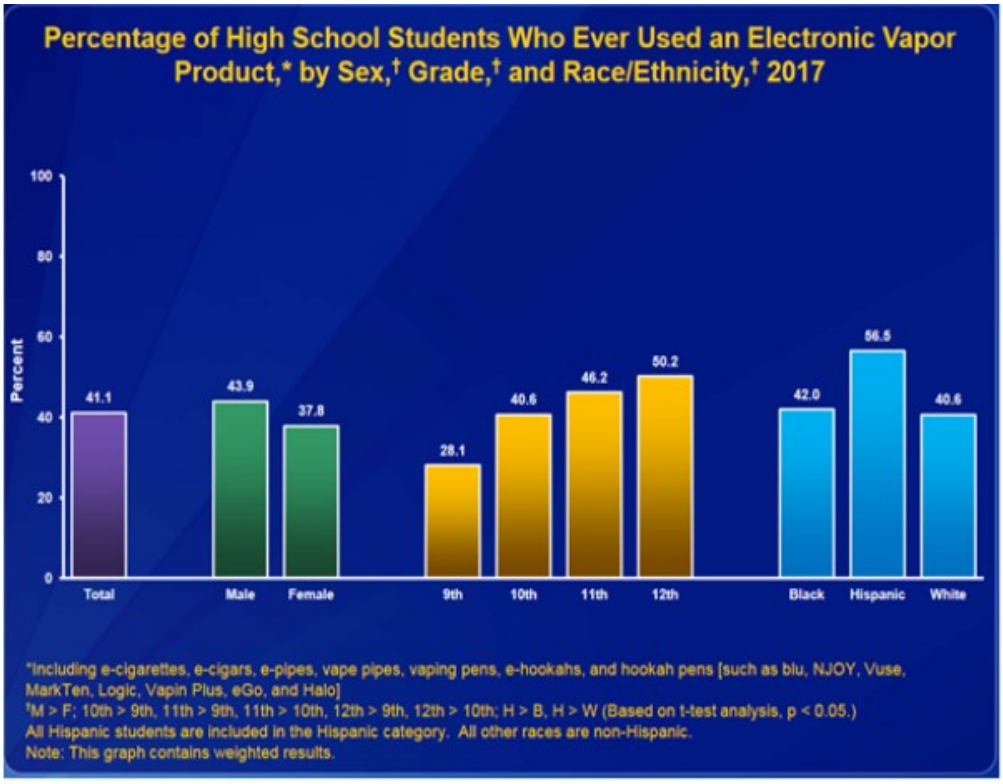
NH adolescent health continues to be at risk due to the use of tobacco, alcohol and drugs as well as unsafe driving and sexual behaviors. The graphic below illustrates a snapshot of tobacco/alcohol/drug and sexual behaviors among NH high school students from the 2017 NH Youth Risk Behavior Survey (YRBS).[10] (Please refer to the NPM7 narrative in this report for more discussion of adolescent safety risks).



Source: NH YRBS, 2017

Tobacco Use

According to the NH YRBS 2017, 24% of high school youth report having used tobacco products in the 30 days prior to taking the survey. The survey also shows electronic vapor product use among youth becoming more common, with 41% reporting ever use and 23% reporting current use. Electronic vaping (ever use) was highest among Hispanic students (57%).[11]

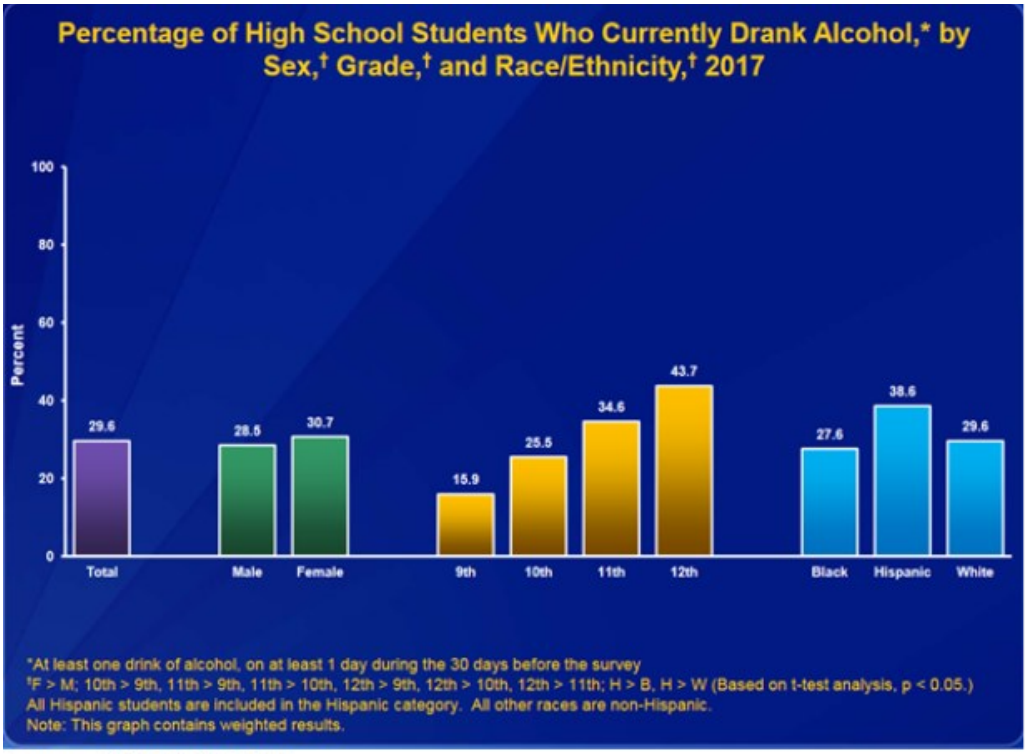


Source: NH YRBS, 2017

Alcohol Consumption

Alcohol use is prevalent across NH. In 2016, NH's total alcohol consumption of ethanol was >2.31 gallons per person, which puts NH in the top 30 states for alcohol consumption.[12]

The 2017 NH YRBS indicates that 30% of high school students currently drink alcohol (31% of females and 29% of males). Eleven percent (11%) of students reported having their first drink of alcohol before the age of 13. Alcohol consumption by Hispanic students is higher than the overall percentage at 39%, while Black students reported slightly less than the overall percentage (28%).



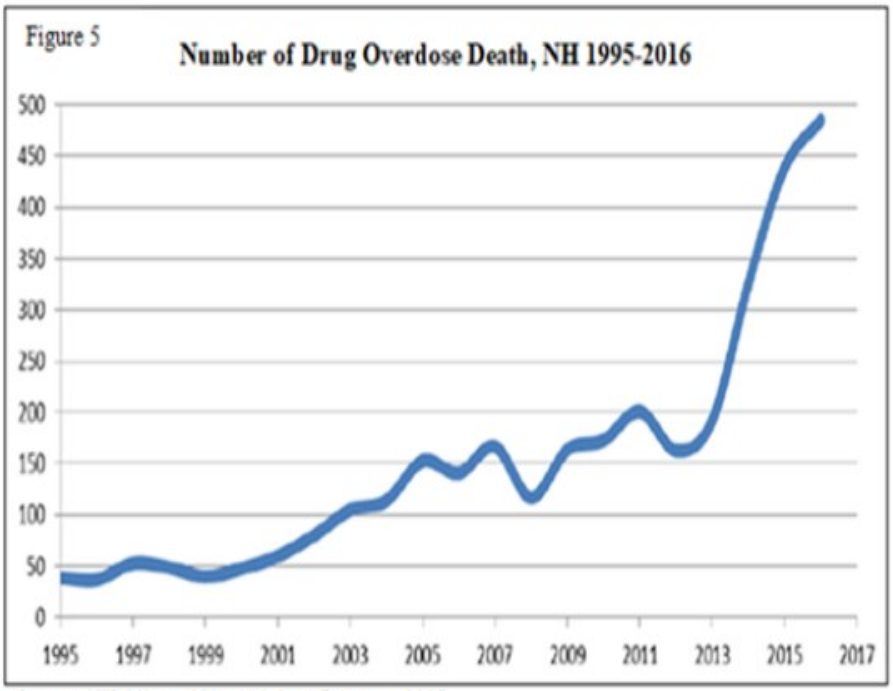
Source: NH YRBS, 2017

Sexual Risk

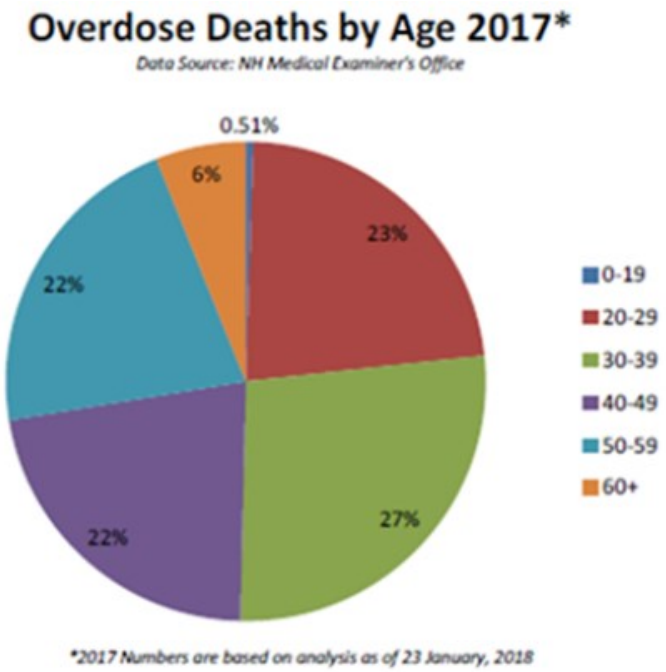
NH YRBS 2017 data indicate that 39% of NH high school students have ever had sexual intercourse. Although the majority of NH high school students receive some basic sexual health education (87%), some students were at risk for STI and/or pregnancy as 21% reported using alcohol and/or drugs before the last sexual intercourse, 40% did not use a condom and 7% did not use contraception at last intercourse.[13]

Drug Use

Drug use, especially use of opioids, has become a serious national crisis that affects social and economic welfare. According to the National Survey on Drug Use and Health, NH ranks among the highest in the country for illicit drug use among 18 to 25 year olds.[14] According to the CDC, in 2016 NH was ranked third in the nation for the number of opioid-related deaths relative to its population and more than 450 of NH's people died as result of a drug overdose in 2017. According to the NH Medical Examiner's office 87% of these deaths resulted from opioids and 23% of victims were 20-29 years of age.[15]



Source: NH Office of Chief Medical Examiner 2017



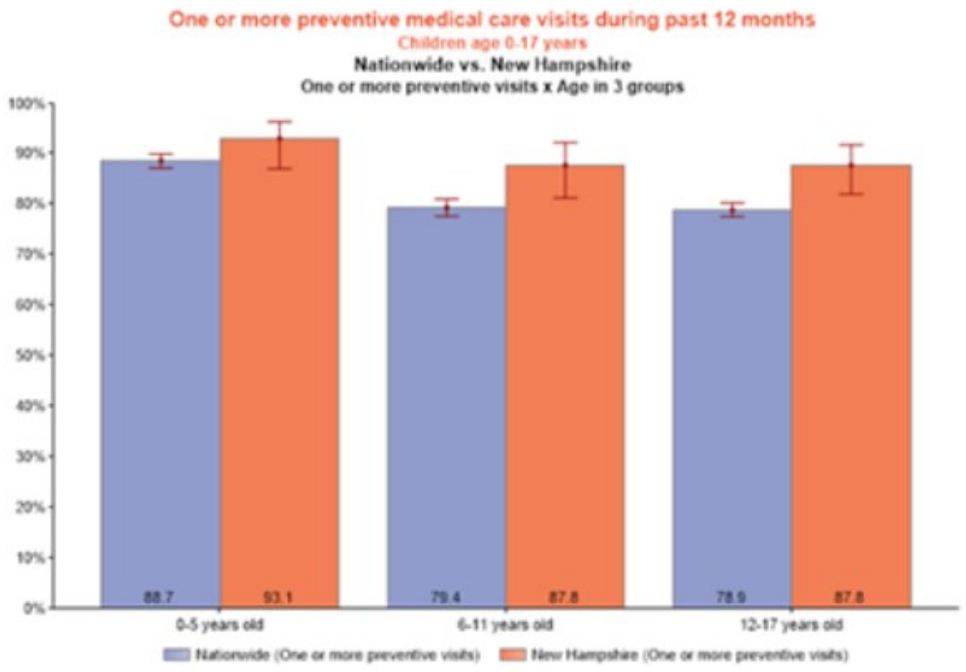
NH is dealing with the drug crisis by implementing a comprehensive response that includes prevention, treatment, and recovery services in every region of state. The strategies to combat this epidemic have started with expanding resources for treatment and recovery, support for law enforcement, and enhancing prevention efforts. New Hampshire has implemented provider trainings and updated rules for prescribers, which include assessing the need for opioids, the risk for abuse, and providing education to patients. As a result of this drug epidemic, all MCH contracted CHCs are expected to screen for drug and alcohol abuse as part of primary care

services. Although mechanisms are in place for CHCs to refer individuals with substance use disorder (SUD) for treatment, outpatient and residential substance abuse treatment for adolescents remains limited in NH.

In 2016, the Bureau of Children's Behavioral Health was established within the DHHS Division of Behavioral Health. This Bureau works alongside the Bureau of Mental Health Services, the Bureau of Drug and Alcohol Services, and the State's behavioral health facilities to unify the delivery of mental health and substance use disorder services.

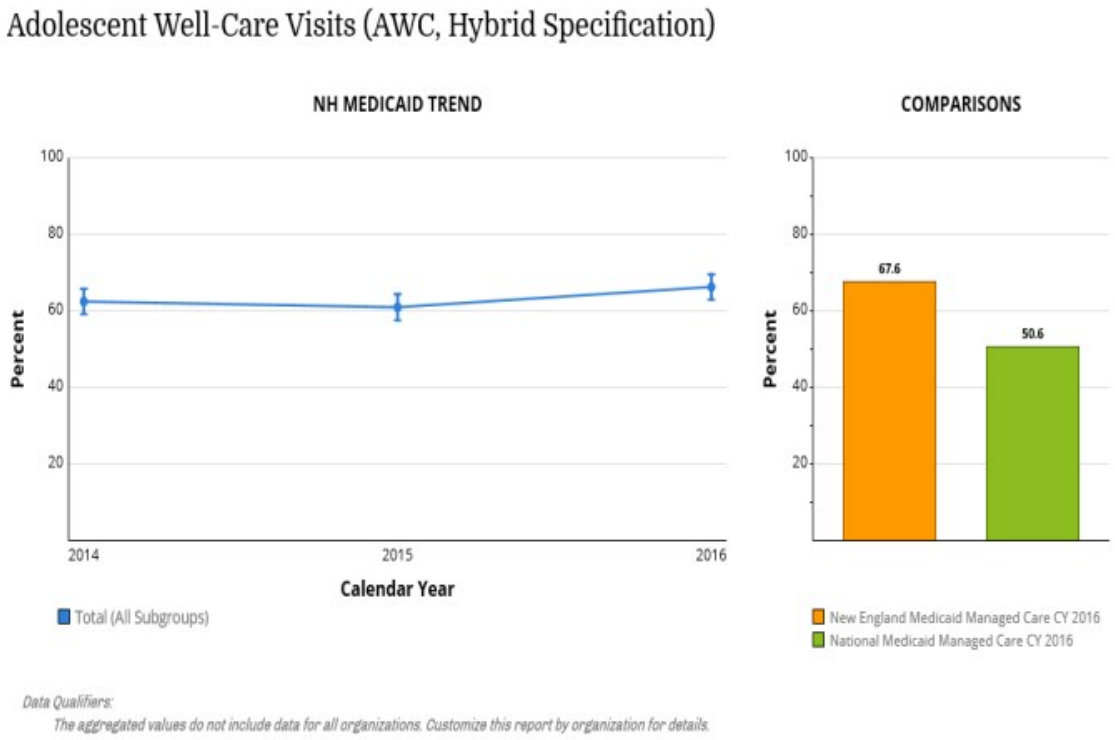
Adolescent Well-Visits

According to the 2016 data from the National Survey of Children's Health (NSCH), the state of New Hampshire has a higher percentage of adolescents aged 12-17 who have had a preventive medical visit than the national average, at 87.8% vs 78.9%.[16]



Source: National Survey of Children's Health, 2016

However, data from NH Medicaid suggests that well-care visits are less likely to occur after age 17 as the percentage of individuals having well-care visits decreases to 66% when this age group is expanded to include young adults up to age 21.[17]



As adolescents (12-17 year olds) and young adults (18-21 years of age) are less likely to have annual visits during the stage of their life in which they are developing health habits and more likely to engage in high risk behavior, MCH has selected the percentage of adolescents aged 12-17 (NPM) and the percentage of adolescents aged 12-21 (ESM) having an annual well-care visit as a priority area for this five-year reporting cycle.

MCH contracts with family planning and primary care health centers to ensure state-wide access to well-care visits as these provide an opportunity for youth to receive recommended preventive services. MCH primary care agencies are expected to follow National Standards of Care, such as Bright Futures/American Academy of Pediatrics; as such, adolescents receive age-appropriate anticipatory guidance and are routinely screened for nutrition, physical activity, depression, substance use (tobacco, alcohol and drug), sexual behavior, violence, and safety. For family planning services, contracted agencies are expected to obtain health history and screen for substance use (tobacco, alcohol and drug), sexual behavior, violence, and safety (coercion, intimate partner violence). Family planning providers also offer preconception counseling (regardless of pregnancy intention) to promote overall health and to refer adolescents to other services such as primary care, SUD treatment and behavioral health services as indicated. MCH provides contract monitoring and oversight of all contracted vendors.

National Outcome Measures (NOMS) influenced by Adolescent well visit

- NOM16.1 adolescent mortality: During well-care visits, health care providers deliver preventive services, assess health and safety behaviors, and provide age-appropriate anticipatory guidance (such as helmet use, protection against violence, firearm safety, and use of protective gear during sports) to encourage safe and healthy lifestyles. These activities seek to reduce adolescent mortality by supporting the adolescent to adopt healthy habits, prevent disease, manage chronic conditions and reduce unsafe behaviors.

- NOM16.2 adolescent motor vehicle mortality: During well-care visits, health care providers screen for alcohol and drug use (using validated tools such as Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) and provide age appropriate anticipatory guidance to encourage safe driving habits (following speed limits, seat belt use). These activities seek to reduce adolescent motor vehicle mortality by supporting the adolescent to reduce unsafe driving behaviors.

- NOM16.3 adolescent suicide: During well-care visits, health providers screen for depression and suicide risk using validated tools such as the Patient Health Questionnaire (PHQ) 2 and PHQ-9. If adolescents screen positive, clinicians then provide treatment of depression and referral to mental health providers. These activities seek to reduce suicide by identifying at risk adolescents and establishing protective interventions as needed.

- NOM18 mental health treatment: During well-care visits, health providers screen for mental health conditions such as depression, anxiety and if positive, provide appropriate treatment/follow up/referral for mental health services. These activities ensure that adolescents with mental health conditions receive appropriate treatment or counseling.

- NOM19 health status: During well-care visits, health care providers identify/address social determinants of health, deliver preventive services, assess health and safety, and provide age appropriate anticipatory guidance. These activities seek to improve the overall health status of adolescents by connecting adolescents with tangible resources (transportation, health insurance, WIC, food pantry, fuel assistance, etc.) to address social determinants of health and support adolescent wellbeing.

- NOM20 obesity: During well-care visits, health care providers assess BMI, nutrition/ physical activity, provide anticipatory guidance to promote healthy eating and active living. For obese adolescents, providers ensure follow-up or referral for further counseling of nutrition/physical activity. These activities seek to reduce obesity among adolescents.

- NOM22.2 Influenza vaccination, NOM22.3 HPV vaccination, NOM22.4 Tdap vaccination, NOM22.5 Meningococcal vaccination: During well-care visits, health care providers provide preventive services which include immunization and education about vaccine preventable diseases. These activities seek to improve rates of all CDC recommended vaccinations including, those for influenza, HPV, Tdap and meningitis.

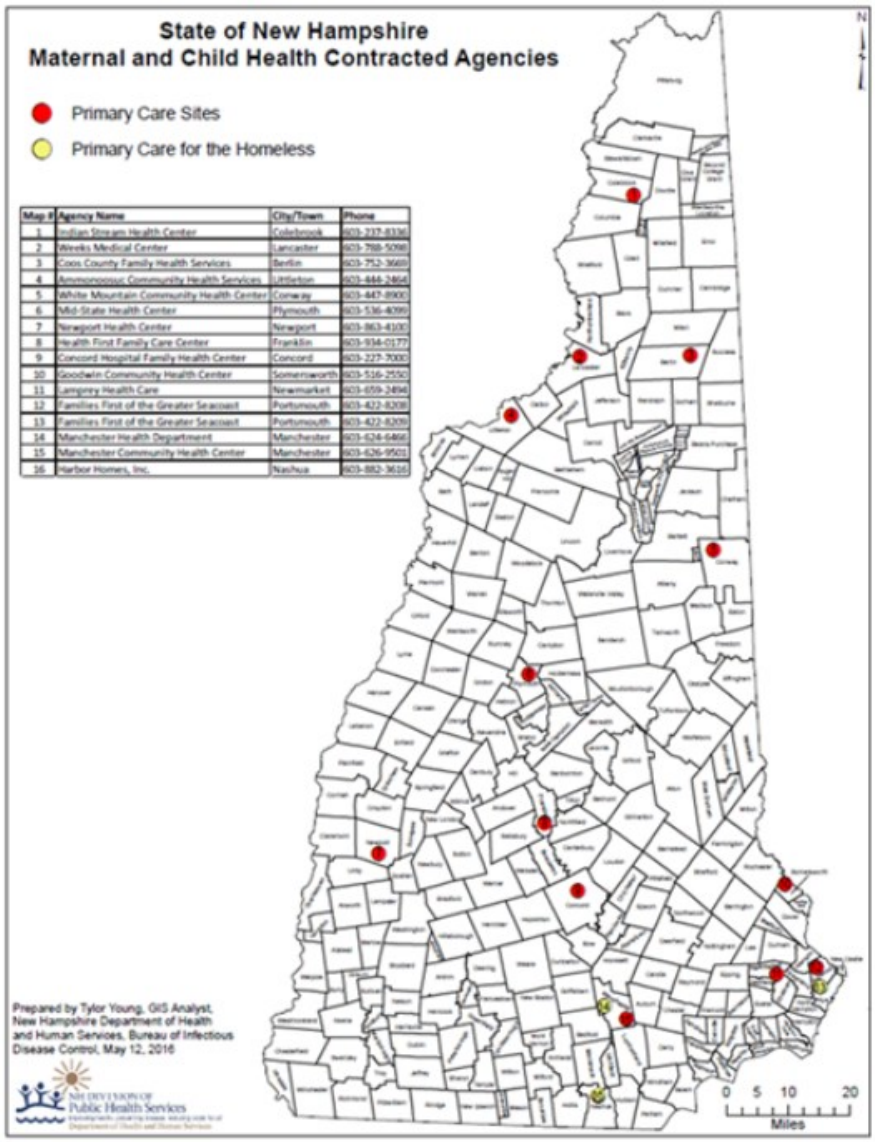
- NOM23 teen birth: During well-care visits, health care providers assess sexual health and behaviors, provide anticipatory guidance and discuss family planning methods. Confidential contraceptive services are made available at no cost through NH Title X family planning clinics. These activities seek to prevent teen pregnancy.

MCH Current Activities

MCH strategy to increase adolescent well-care visits is to focus on increased promotion by MCH-contracted partners, participation in the second cohort of the Adolescent and Young Adult (AYA) Collaborative Improvement and Innovation Network (CoIIN), and developing opportunities for public promotion.

Contracted Community Health Centers (CHCs)

For over 25 years MCH has utilized Title V funding to contract agencies to support primary care and primary care for the homeless services. Through this contracting, MCH has successfully engaged with CHCs across the state to ensure access and quality of primary care, including integration of behavioral health services. MCH provides agency oversight and ensures accountability by specifying reporting requirements and conducting site visits. Primary care contracted agencies are expected to provide services consistent with Bright Futures/National Guidelines and are required to submit performance outcome data to MCH.

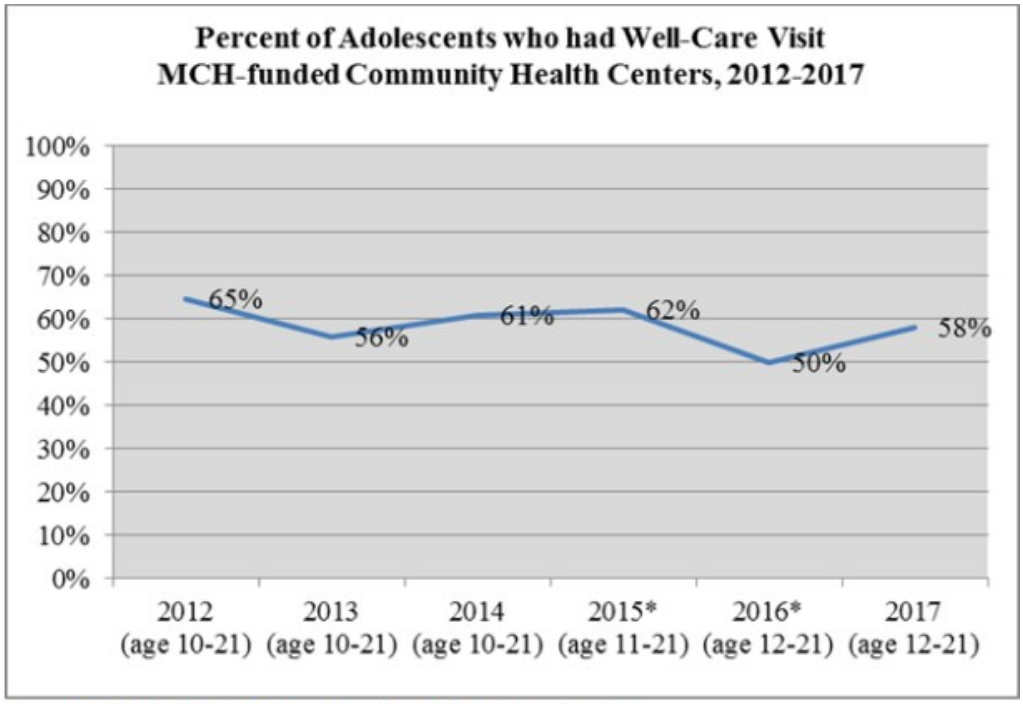


Map #	Agency Name	City/Town	Phone
1	Indian Stream Health Center	Colebrook	603-237-8336
2	Weeks Medical Center	Lancaster	603-788-5098
3	Coos County Family Health Services	Berlin	603-752-3660
4	Ammonoosuc Community Health Services	Littleton	603-444-2464
5	White Mountain Community Health Center	Conway	603-447-8900
6	Mid-State Health Center	Plymouth	603-536-8099
7	Newport Health Center	Newport	603-863-8100
8	Health First Family Care Center	Franklin	603-934-0177
9	Concord Hospital Family Health Center	Concord	603-227-7000
10	Goodwin Community Health Center	Somersworth	603-516-2550
11	Langstaff Health Care	Newmarket	603-659-2494
12	Families First of the Greater Seacoast	Portsmouth	603-422-8208
13	Families First of the Greater Seacoast	Portsmouth	603-422-8209
14	Manchester Health Department	Manchester	603-624-6466
15	Manchester Community Health Center	Manchester	603-626-9501
16	Harbor Homes, Inc.	Nashua	603-882-3616

Source: NH MCHS

MCH collects CHC data on 13 primary care services performance measures. Six (6) of these measures center on preventive care for adolescents including: Body Mass Index (BMI) documentation and education related to nutrition and physical activity for children 3-17 years; Body Mass Index (BMI) documentation and follow up for patients if their BMI is out of range (18 years and over); depression screening (12 years and over); tobacco screening and cessation for tobacco users (12 years and over); Screening Brief Intervention and Referral to Treatment (SBIRT) for substance misuse (18 years and over); and having a comprehensive well-care visit in the past year (ages 12-21 years).

MCH's historical data (see graph below) demonstrate a decrease in adolescent visit performance outcome from 62% in 2015 to 58% in 2017. However, the decrease may be due to a change in the performance measure specification which dropped younger children (age 10-11) from the denominator. As adolescent preventive services are often not performed outside of the well-care visit and MCH has not seen an increase in the percentage of adolescents receiving well-care visits, MCH has directed efforts to support this measure.



Source: NH DHHS, Maternal and Child Section, 2018

Over the last several years NH MCH has been shifting focus from quality assurance (QA) toward quality improvement (QI). As such NH MCH is revising the work that is being done with contracted CHCs to provide greater QI support and to require greater accountability for performance outcomes including:

- Collecting performance measure data twice per year rather than annually
- Requiring all contract agencies to develop an adolescent visit QI project
- Providing education, support and resources to further promote adolescent care

Data collection

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 (at least quarterly) and in 2015 MCH revised Primary Care contracts to require CHCs to submit MCH performance measure data to the state twice per year starting in SFY16. MCH staff (QI/QA nurse consultant) collects and analyzes CHC performance measure data. Following data analysis the 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 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.

Site Visits

Each contracted CHC receives a site visit every two-year contract period to provide support and monitor adherence to contract requirements. Over this past contract cycle the MCH team has changed the format of site visits to allow greater opportunity to understand agency services (especially services that address social determinants of health, i.e. enabling services), as well as performance and quality improvement efforts.

Chart audits are being conducted for adolescents aged 11-21 to promote Bright Futures Guidelines. The site visit and audit findings have prompted discussions about the significance of an annual well-care visits for the AYAH population and how to reduce missed opportunities 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

Coordinators' Meetings

Twice per year MCH staff holds Primary Care Coordinators' meetings for an opportunity to meet face to face with all contracted CHCs to provide them with information, resources, and technical support. Agency representatives for these meetings include agency directors/clinical managers and quality improvement staff members.

For the spring meeting in May 2017, the MCH QA/QI Nurse distributed a survey to assess each agency's adolescent-to-adult care transition policy to determine if the agency has a policy and if so: 1) are staff educated about the policy; 2) is the policy posted for patients/families to view; and 3) is the policy discussed with youth and families as part of an adolescent visit. The results from this survey indicate that few agencies have a transition policy (3 out of 10 agencies responding), and two agencies with a transition policy educated their staff and discussed the policy with youth and families. There were no agencies that post a policy for consumers to view. During the meeting, the "Six Core Elements of Health Care Transitions 2.0" from Got Transitions was made available as a resource.[18] As a result of finding few agencies with a transition policy, the MCH QA/QI Nurse has inserted the below element into the SFY19 administrative review tool for site visits to promote the use of transition policies.

> B. Youth and young adults are supported in the process of changing from a pediatric to an adult model of health in order to 1) improve the ability of youth and young adults to manage their own health care 2) effectively use health services and 3) ensure an organized clinical process in pediatric and adult practices to facilitate transition preparation, transfer of care, and integration into adult-centered care. (Resource: Got Transitions http://gottransition.org/about/index.cfm)

During the fall meeting in November 2017, the MCH QA/QI Nurse disseminated individualized reports to provide historical data for each agency to compare their own agency's performance vs. the performance of all contracted agencies. The focus of this meeting was behavioral health and substance use. The QA/QI Nurse specifically reviewed outcomes for tobacco use screening and intervention, depression screening and follow-up and SBIRT. During the meeting four (4) presentations were made, by the Tobacco Prevention and Cessation Program: "Electronic referral to NH Quitworks;" by the Division for Behavioral Health "Child Behavioral Health Services;" by the Bureau of Drug and Alcohol Services "SUD Treatment/MAT Implementation for Primary Care;" and by the Goodwin Community Health Center "Implementing MAT, an Agency Perspective."

MCH also requires MCH-contracted CHCs to submit annual Quality Improvement (QI) Work Plans to describe agency QI project activities. Prior to SFY18 all MCH-contracted CHCs were required to submit QI work plans, but MCH allowed each agency to self-select their QI project topic as long as it related to the Primary Care contract scope of services. As only two-(2) out of the 13

contracted CHCs self-selected the adolescent visit, MCH revised contract language to require an adolescent health QI workplan as a mechanism to ensure local effort for the SFY18-19 contract period. As of September 1, 2017, 100% of contracted CHCs had an Adolescent Visit QI Work Plan on file with MCH (see below QI Work Plan for example). At the end of each fiscal year CHCs will be requested to update their agency QI work plans to report the outcomes and improvement strategies for the next period.

SFY18-19 Quality Improvement Workplan, Adolescent Well Care

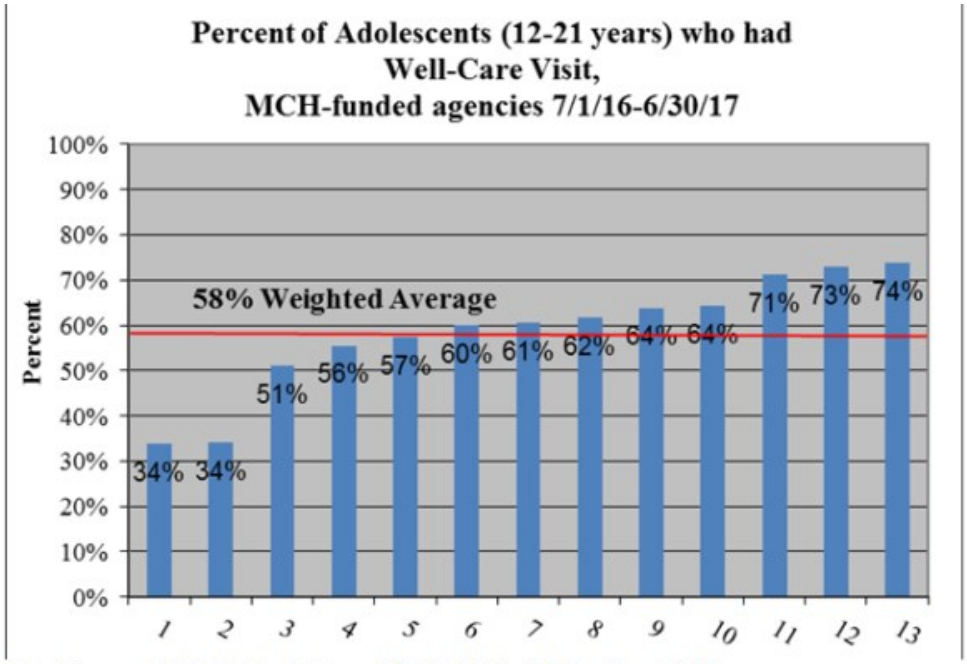
MCH Performance Measure: Adolescent Well-Care: Percentage of Adolescents 12-21, who had at least one comprehensive well-care visit with a PCP or an OBGYN practitioner during the measurement year.	
Project Objective #1: Increase provider capacity for adolescent well-care appointments by designating at least 4 appointment slots per scheduled provider per day, with one additional appointment available during Saturday extended hours.	
INPUT/RESOURCES	**PLANNED ACTIVITIES**
• **Patient Services staff** • **Clinical Support staff** • **Electronic Health Record Scheduling module and Point-of-Visit Reminders** • **Provider staff [addition of one new pediatrician hire in April 2017 and (2) APRN (Family) hires in July 2017]** • **Population Health/Registry software (i2i Tracks) and associated reports** • **Outreach letters, phone calls, Patient Portal Messages/Reminders**	• Outreach (via i2i Tracks population health software/Registries management for "coming due" and "overdue" well-care visit population in this age group) and scheduling of well-care visits by Patient Services staff and Clinical Support Staff (Medical Assistants) • Monitor provider future appointments available against standard
	EVALUATION ACTIVITIES
	• Director of Patient Services monitors biannually Schedule and appointment availability with EHR Audit reports • Director of Quality monitors quarterly Adolescent Well-Care Visit percentage using i2i Tracks and Crystal Reports • Daily schedule volume and appointment availability can be used as a more frequent Audit/Evaluation tool.
Project Objective #2: (For FY '19) Increase access to adolescent well-care appointments by developing an "Adolescent Well-Care Health Fair" to be offered twice per year at Mid-State Health Center that includes the elements of a comprehensive adolescent well care visit.	
INPUT/RESOURCES	**PLANNED ACTIVITIES**
• Chief Operations Officer/ Chief Financial Officer • Director of Advancement and Communication • MSHC providers and clinical support staff • School administrative staff, including school nurses, • Parental education and notification methods and materials • MSHC Billing and Accounting staff • Electronic health record reports • Participation incentives • Bright Futures • Clinicians/Support staff	• Use an integrated tem approach to providing a convenient and informative format for completing an adolescent well visit (schedule most likely to be during extended hours or on wee4kends, to make attendance convenient for families (include clinicians, behavioral health, dental staff, prescription services, and other staff as appropriate to address teen issues in a health Fair format) • Develop workflows for project execution • Develop marketing to parents and teens (and include community partners as appropriate) to promote participation. • Develop materials and notifications for parents/patients and school personnel, promoting convenience, ease of access, and benefits of a complete well-care visit than a "sports physical" – include some "raffle"-type incentives for participating teens and complete "sports clearance" forms, if needed, during the comprehensive well care visit as an additional incentive for students participating in seasonal school sports.
	EVALUATION ACTIVITIES
	• Initial evaluation will involve completed project development and implementation. • After implementation, evaluation methods will include numbers of adolescent students completing a well-care appointment in this format, as determined by appointment and completion audit reports. • Director of Quality will monitor overall Adolescent Well-Care percentage on a quarterly basis to determine potential positive effect of offering well-care appointments in this format. • Increases in the number of students participating in preventive care appointments overall may be used as an evaluation tool for determining project success.
Project Objective #3: 75% of Clinical Support Staff (Medical Assistants) consistently perform regular population health and care gaps management using electronic health record tools and population health management (pre-visit planning, Huddle Reports, point-of-visit Reminders).	
INPUT/RESOURCES	**PLANNED ACTIVITIES**
• Clinical Support staff • Patient Services staff • Electronic health record • i2i Tracks population health software • Resource Nurses	• Train all new Clinical Support staff in population health and care gaps processes and procedures. • Perform pre-visit planning activities to include chart prep, Huddle prep, and daily Huddles • Note care gaps and need for appointment scheduling of adolescent well-care visit. • Refer patient/parent to Patient Services staff and/or resource Nurse, if needed, for appointment scheduling.
	EVALUATION ACTIVITIES
	• Medical Assistant Supervisor holds MAs accountable to these activities and monitors adherence to daily process and procedures for pre-visit planning/Huddles to address care gaps for adolescent by observation and chart audit/reports. MA use of Huddle reports, Huddles, point-of-visit Reminders, and reporting tools is included in MA Annual Performance Review competencies evaluation. Denominator = number of Medical Assistants with an annual review during the reporting period, Numerator = number of Medical Assistants in the Denominator who have had documented success on this performance measure by their supervisor.

Source: NH DHHS, Maternal and Child Health Section, 2018

MCH continues to encourage CHCs to monitor their performance measure data at least quarterly and to implement improvement

activities throughout the year.

As SFY17 performance measure outcome data for the adolescent well-care visit demonstrate, outcomes are variable among contracted CHCs (range of 34% to 74%) and MCH continues to offer additional QI support (by phone, email and/or in person) to lower performing agencies and any agency requesting assistance.



Data Source: NH DHHS, Maternal & Child Health Section, 2017

AYAH CoIIN

MCH staff also promote Title V and adolescent health activities by participation in the NH Pediatric Improvement Partnership (NH PIP). NH PIP 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 NH PIP steering committee. In 2017, NH MCH began collaborating with NH PIP to participate in the second cohort of the Adolescent and Young Adult Health, Collaborative Improvement and Innovation Network (AYAH CoIIN), sponsored by the Adolescent and Young Adult Health National Resource Center (AYA-NRC). The objective of MCH participation in this 18-month CoIIN is to leverage existing relationships with the NH PIP to further advance evidence-informed strategies for improving access to preventive care services for both adolescents and young adults and the quality of visits for preventive health services statewide.

AYAH CoIIN Project Overview

The NH AYAH CoIIN team is currently implementing the following strategies to improve access to and quality of AYAH preventive care visits in NH.

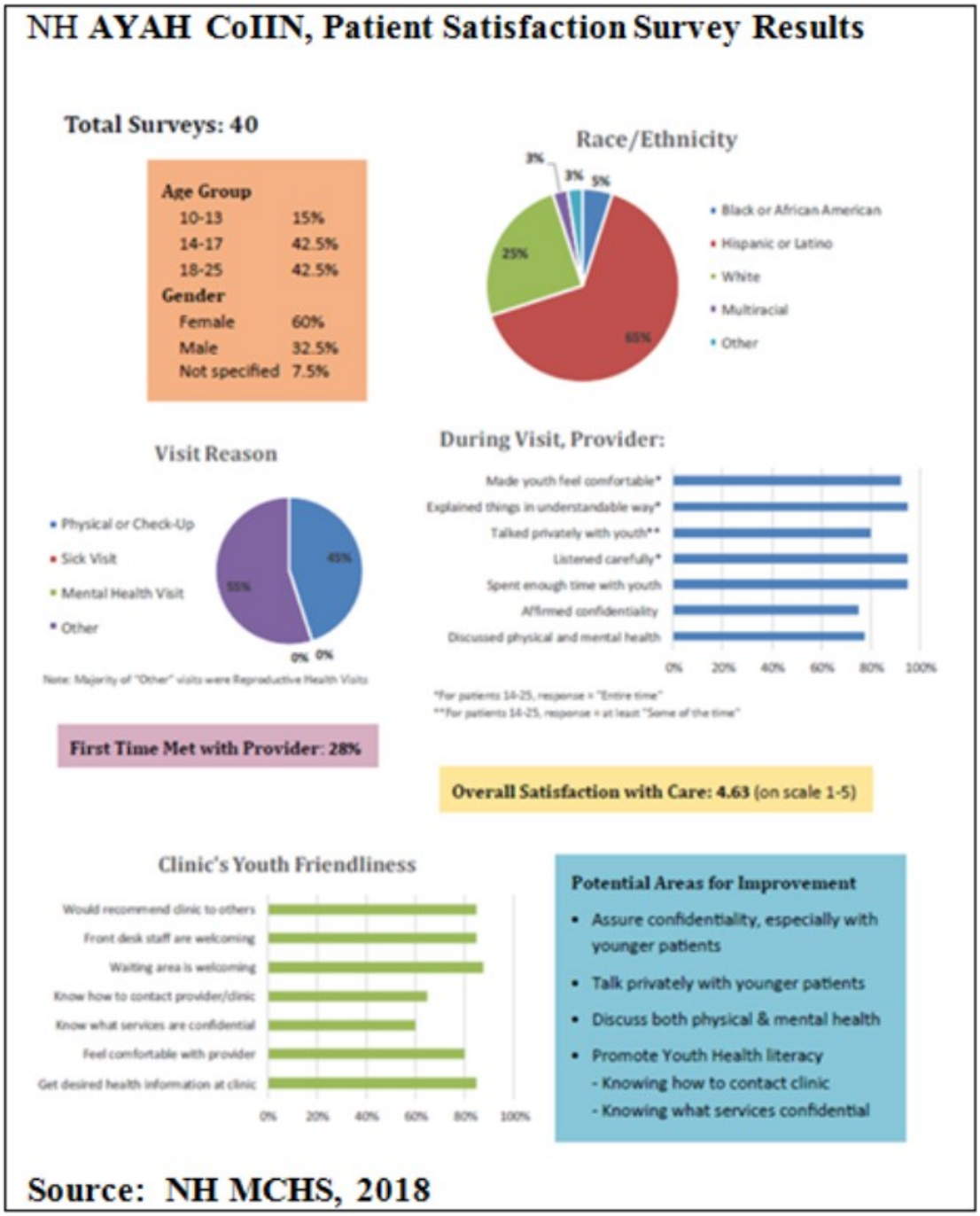
- Review of two (2) school administrative unit (SAU) policies on adolescent comprehensive exams (including sports physicals)

for students. This proposed project stems from local provider concerns over the challenges associated with current policies, and the belief that there is potential to make positive change in adolescent well-care through evolution of such policies. Through this review and in consultation with AYAH learning collaborative colleagues, the team would like to develop model language geared to SAU superintendents to encourage annual preventive care visits within the youth's medical home.

- Engage two MCH-contracted CHCs to participate in the AYAH CoIIN. At this time, the AYAH team youth representatives have completed clinic tours of each CHC and CHCs have submitted data and patient satisfaction surveys.

- Based on assessment findings, participating CHCs and the CoIIN team have identified confidentiality as a topic area for follow-up training and technical assistance. In-person confidentiality training has been scheduled to be provided to the CHCs by a board-certified adolescent medicine physician starting in August 2018.

- Selected NH AYAH team members have participated in one of three monthly AYAH CoIIN National Strategy Team (NST) calls which seek to improve: 1) access and utilization of preventive services; 2) quality of preventive services (MCH QA/QI Nurse); and 3) state and system level policies and practices.



During AYAH CoIIN activities, a secondary topic of interest related to care of LGTB youth was identified by one CHC. As training on this topic is not feasible to be provided within the AYAH CoIIN 18-month timeframe (ending fall 2018) the NH AYAH CoIIN team intends to develop a resource list for both providers and LGTB Youth & Families. MCH has also forwarded to the CHC a recorded four-part webinar from the American Academy of Pediatrics, Section on Lesbian Gay Bisexual Transgender (LGBT) Health and Wellness designed to educate health care providers on caring for transgender youth.[19]

Social Messaging

In 2017, the use of social media was made available to MCH through the NH Division of Public Health (DPHS) to promote healthy lifestyles, preventive screenings and overall health awareness. As adolescents are spending more and more time using online media, reaching youth through online avenues has become a priority. On average, adolescents aged 13-18 years old spend nearly nine hours a day using online media (video, music, gaming, and social media). Those aged 10-12 years old are spending 6 hours a day using online media.[20]

In April 2018, DPHS launched its Instagram account. In addition to promoting health awareness and health education, the goal of using Instagram is to reach youth, as 76% of American teens (13-17 years old) use Instagram (source: https://www.sciencedaily.com/releases/2017/04/170421113306.htm). This platform will be essential in increasing adolescent awareness of the importance of adolescent wellness visits and for the promotion of healthy behaviors. Social media platforms have provided MCH an opportunity to place health messages where youth gather and share information. Currently, MCH is creating and posting adolescent health awareness messages (examples below) on three social media accounts (Facebook, Instagram, and Twitter).

* * * * * * * * *

---

[1] NH Department of Health and Human Services, Child Fatality Review Report, https://www.doj.nh.gov/criminal/victim-assistance/documents/fifteenth-report.pdf

[2] Schnell, R. (2017). Presentation to the Injury Prevention Advisory Council on *Concussion Chalk Talk*.

[3] Ibid.

[4] NH NAMI, NH Suicide Prevention 2016 Annual Report, http://theconnectprogram.org/sites/default/files/site-content/2016_annual_suicide_report_-_final_-_10-31-17.pdf accessed 5/18/2018

[5] Ibid.

[6] NH Suicide Prevention Council, NH Suicide Prevention Plan, 2017-2020 https://www.dhhs.nh.gov/dphs/bchs/spc, assessed on 6-18-2018

[7] NH NAMI, NH Suicide Prevention 2016 Annual Report, http://theconnectprogram.org/sites/default/files/site-content/2016_annual_suicide_report_-_final_-_10-31-17.pdf accessed 5/18/2018

[8] Child and Adolescent Health Measurement Initiative. Data Resource Center for Child and Adolescent Health. 2016 National Survey of Children's Health (NSCH) data query. Retrieved [06/06/18] from www.childhealthdata.org. CAHMI: www.cahmi.org.

[9] Centers for Disease Control and Prevention (CDC), National Center for Health Statistics website. Retrieved [05/30/18] from https://www.cdc.gov/nchs/pressroom/sosmap/teen-births/teenbirths.htm.

[10] New Hampshire Department of Education website. Retrieved [05/30/18] from https://www.education.nh.gov/instruction/school_health/hiv_data.htm

[11] ibid

[12] National Institute on Alcohol Abuse and Alcoholism (NIAAA). Surveillance Report #110. Apparent per capita alcohol consumption: national, state, and regional trends, 1977-2016. Retrieved [05/14/18] from https://pubs.niaaa.nih.gov/publications/surveillance110/CONS16.htm.

[13] Ibid.

[14] Anyone, Anytime. Facts about NH's heroin, fentanyl, & other opioid crisis. Retrieved [05/14/18] from https://www.nhshp.org/resources/Documents/Opioid%20Crisis%20FACTSheet_FINAL.pdf.

[15] NH Medical Examiner's Office, 2017. Drug Death Data. Retrieved [05/14/18] from https://www.dhhs.nh.gov/dcbcs/bdas/documents/dmi-december-2017.pdf.

[16] Child and Adolescent Health Measurement Initiative. Data Resource Center for Child and Adolescent Health. 2016 National Survey of Children's Health (NSCH) data query. Retrieved [05/30/18] from www.childhealthdata.org. CAHMI: www.cahmi.org.

[17] NH Department of Health and Human Services. Office of Quality Assurance and Improvement. Report generated on Jun 06 2018 at 17:23. Retrieved [05/30/18] from http://medicaidquality.nh.gov.

[18] The National Alliance to Advance Adolescent Health. Retrieved [03/30/17] from http://gottransition.org/providers/index.cfm.

[19] American Academy of Pediatrics, Section on Lesbian Gay Bisexual Transgender (LGBT) Health and Wellness website. Retrieved [05/29/18] from https://www.aap.org/en-us/about-the-aap/Sections/Section-on-LGBT-Health-and-Wellness/Pages/Education.aspx.
[20] USATODAY Published 10:54 a.m. ET Nov. 3, 2015. Retrieved [5/09/18] from https://www.usatoday.com/story/news/nation/2015/11/03/teens-spend-more-time-media-each-day-than-sleeping-survey-finds/75088256).

Adolescent Health - Application Year

National Performance Measure #7.2: 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

Objectives:

- By June of 2019, increase seatbelt usage in the 15 high schools participating in the Teen Driving Project by 10 percentage points over the baseline of 70% to 80% on the observational study

- By June of 2019, schools in the state will have implemented the NH Concussion Law and/or will have written policies with at least 95% having a return to play policy and at least 50% having a return to learn policy

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 andmake recommendations for potential change.

The current New Hampshire State Injury Prevention Plan 2014 – 2018 (https://www.dhhs.nh.gov/dphs/bchs/mch/documents/nh-injury-prevention-plan-2014-2018.pdf), released in November 2013, is in the initial stages of being updated. The MCH Injury Prevention Program (IPP) in conjunction with the Injury Prevention Center at Dartmouth (IPC) and the Injury Prevention Advisory Committee (IPAC) has engaged the services of a program evaluator who is currently doing an environmental scan of injury prevention partners and stakeholders. The IPP has also made arrangements for two summer interns to work on data collection and other information to support the topic areas the IPP will focus on for the 2019-2023 plan.

Injury prevention topic areas in the state plan that are pertinent to the MCH Title V Block Grant currently include:

- Child maltreatment prevention for ages 0 to 1
- Providing safety equipment in the home for children under 5
- Concussion prevention for those involved in physical activity up, to age 24
- Promoting teen driver safety in high school students ages 15 to 19

Between June and September 2018, the IPP staff at MCH, IPC, IPAC, evaluator and interns will review inputs from stakeholders and data resources to decide if the best course of action will be to continue focusing on these topics, or if there are emerging issues of more severity that require addressing.

MCH IPP will align the Title V MCH block grant Five-Year State Action Plan with the NH State Injury Prevention Plan, focusing efforts on Teen Driver Safety, ages 15 to 19, and Concussion Prevention and Response for ages 10 to 19. These two topic areas have data to support the need to continue addressing them, and the momentum of programmatic activities that are underway. Some activities in the Title V MCH block grant also align with work funding by the Public Health and Human Services Block Grant (PHHS BG). Aligning all of these programs will help keep them on track and promote efficiency and effectiveness by reducing duplication of effort.

Also, in the HRSA crosswalk table showing linkages between NPMs and NOMs, it is noted that NPM9 – Bullying, intersects

NOM16.1 Adolescent Mortality and NOM16.3 Adolescent Suicide, both of which are also linked to NPM 7, which is one of the NH-selected measures. The emerging issue of violence in schools needs to be addressed. IPP's collaboration with the New Hampshire Coalition Against Domestic and Sexual Violence under the Rape Prevention and Education Grant can work to reduce bullying through the programs offered about healthy relationships and bystander intervention in high schools.

MCH will work with the Brain Injury Association of NH (BAINH) to collect data from all NH high schools regarding Return to Play and Return to Learn policies. For the 2018-2019 school year, the target for establishing Return to Play policies is to increase from 85% to 95%, and Return to Learn policies from 10% to 50%. The BAINH will continue to provide information and education to NH schools and guidance for Return to Play and Return to Learn policy development.

Five-Year State Action Plan Table
Adolescent Health—Decreasing Unintentional Injury

Strategies	Objectives	National and State Performance Measures	Evidence–Based or –Informed Strategy Measures	National and State Outcome Measures
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	By June of 2019, increase seatbelt usage in the 15 high schools participating in the Teen Driving Project from the baseline of 70% to 80% on the observational study	National Performance Measure #7 Rate of hospitalization for non-fatal Injury per 100,000 adolescents ages 10 through 19	Percentage of high school students who wear seatbelts. (YRBS)	16.1 Adolescent mortality rate, ages 10 through 19, per 100,000 16.2 Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Analyze concussion policies within school systems and make recommendations for potential change	By June of 2019, at least 95% of the schools in the state will have implemented the NH Concussion Law and/or will have written policies regarding return to play, and 50% will have policies regarding return to learn	National Performance Measure #7 Rate of hospitalization for non-fatal Injury per 100,000 adolescents ages 10 through 19	Had a concussion from playing a sport or being physically active one or more times during the past 12 months (YRBS)	16.1 Adolescent mortality rate, ages 10 through 19, per 100,000 16.2 Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000
Promote Bystander Intervention Training in High Schools	By June of 2019, at least 8 out the 13 Rape Prevention Educators will be trained in the Bystander Intervention curriculum and present it in schools in their catchment area	National Performance Measure #7 Rate of hospitalization for non-fatal Injury per 100,000 adolescents ages 10 through 19.	Were bullied on school property ever during the past 12 months (YRBS) Seriously considered attempting suicide ever during the past 12 months (YRBS)	16.1 Adolescent mortality rate, ages 10 through 19, per 100,000 16.3 Adolescent suicide rate, ages 15 through 19, per 100,000

* * * * * * * * *

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: 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

Objectives: Increase the percentage of adolescents who have had a preventative medical visit at the MCH-funded CHCs from a baseline of 61% in SFY16 to 64% by 2020.

Strategies:

1. Build partnerships by:

- collaborating with public and private partners through NH Pediatric Improvement Partnership
- participating in the Adolescent and Young Adult Health (AYAH) CoIIN Cohort 2
- statewide contracting with CHCs and provision of oversight on Primary Care Services
- establishing mechanisms to inform the public about adolescent preventive services via social media
-

2. Enhance capacity of CHCs to improve access and quality of adolescent services by:

- establishing performance measures that align with national guidelines and promote Bright Futures recommendations
- requiring contracted CHCs to develop an adolescent care Quality Improvement (QI) initiative
- collecting and analyzing Performance Measure outcome data from CHCs
- providing data results and feedback to CHCs for comparison
- providing education, resources, QI support and technical assistance
-

3. Create an Adolescent Health Coordinator position to expand adolescent health initiatives

In the upcoming year, MCH will be wrapping up the 18-month Adolescent and Young Adult Health (AYAH) Collaborative Improvement and Innovation Network (CoIIN). By the fall of 2018 MCH anticipates the following from this project:

- TA and training related to confidentiality will be provided to the two (2) participating MCH-contracted Community Health Centers (CHCs). The goal of this training (provided by a board-certified adolescent medicine physician) is to increase CHC staff knowledge and communicate skills needed when caring for youth and young adults.
- Two (2) LGTB resource guides (one for providers and one for LGTB Youth & Families) will be developed and provided to the two (2) participating CHCs.
- A school policy on adolescent well-care visits will be developed and provided to NH SAU superintendents as a strategy to promote the health and wellbeing of students.

MCH anticipates advancing the work completed through the AYAH CoIIN by disseminating information, education and resources to the network of contracted health centers. The two (2) participating CHCs will be encouraged to share lessons learned with other non-participating CHCs. MCH will additionally continue partnering with NH PIP and will seek opportunities to participate in collaborations that support adolescent health.

MCH will additionally continue to:

- Contract with health centers for the provision of family planning and primary care services. MCH will continue to provide contract monitoring which includes performing site visits, reviewing agency data and work plans and providing feedback to agencies to ensure access to care and improve quality of adolescent services.
- Collaborate with NH PIP, health centers and other community partners to promote access to quality adolescent care which include ways to leverage resources to reduce missed opportunities and increase reimbursement for services.
- Promote AAP Bright futures guidelines by disseminating information and resources for health professionals about adolescent health and preventive services.
- Develop social media campaigns to disseminate information and resources to the general public about adolescent health and preventive services.

* * * * * * * * *

Children with Special Health Care Needs

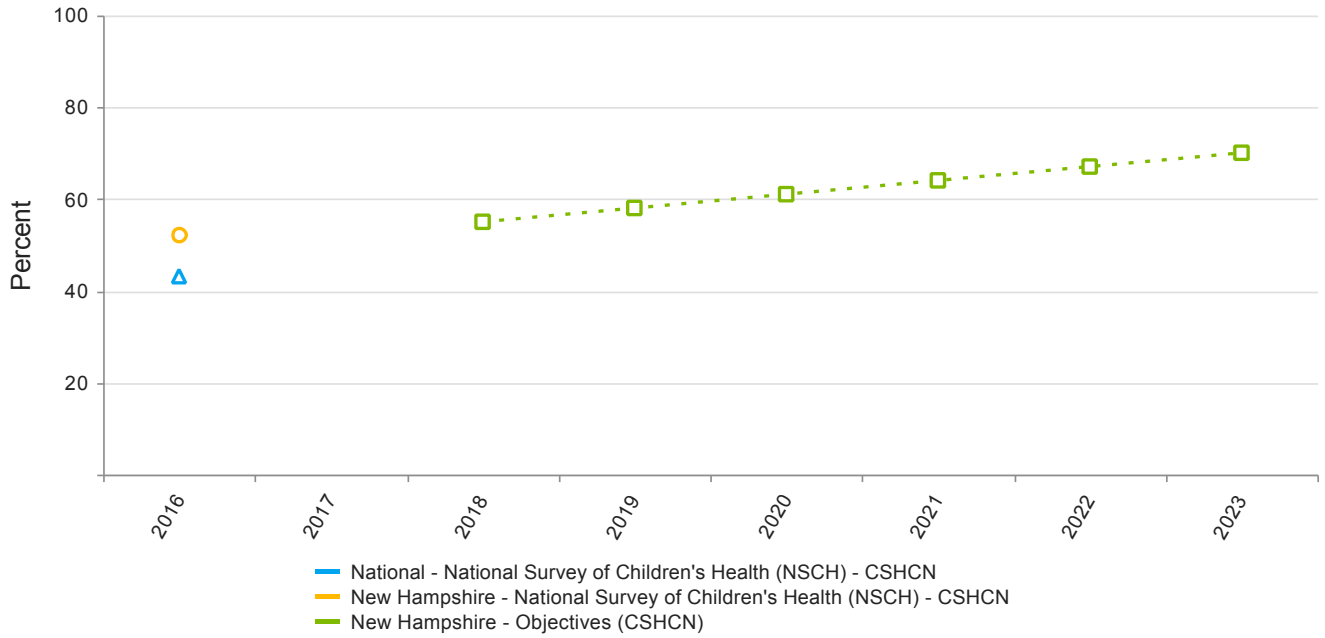
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2016	21.5 %	NPM 11
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2016	63.0 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	92.0 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year	NSCH-2016	1.8 %	NPM 11

National Performance Measures

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Baseline Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	**2017**
Annual Objective		
Annual Indicator		52.3
Numerator		27,289
Denominator		52,224
Data Source		NSCH-CSHCN
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	48.2	
Numerator	27,555	
Denominator	57,176	
Data Source	NSCH-CSHCN	
Data Source Year	2011_2012	
Provisional or Final ?	Final	

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	55.0	58.0	61.0	64.0	67.0	70.0

Evidence-Based or –Informed Strategy Measures

ESM 11.1 - The number of Primary Care Provider practices who have adopted a Transition Policy

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		1
Annual Indicator	0	6
Numerator		
Denominator		
Data Source	Medical Home Project Tracking	Medical Home Project Tracking
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	12.0	12.0	14.0	16.0	18.0	20.0

State Performance Measures

SPM 2 - Percentage of families enrolled in SMS who report access to respite

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		62.3
Annual Indicator	62.3	62.3
Numerator	264	264
Denominator	424	424
Data Source	SMS Biennial Survey	SMS Biennial Survey
Data Source Year	2016	2016
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	63.0	63.0	66.0	66.0	71.0	75.0

State Action Plan Table

State Action Plan Table (New Hampshire) - Children with Special Health Care Needs - Entry 1

Priority Need

Increase access to comprehensive Medical Homes.

NPM

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Objectives

To increase from 52.3% (2016 FAD baseline) to 70.0% the percentage of children with special health care needs having a medical home by 2023

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 families, public agencies, and providers to improve Medical Home awareness and understanding

Support for integrated care coordination 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

Facilitate the involvement of youth with special health care needs, through a selected vendor, to improve health care transition to adult medical services.

Facilitate a Medical Home Advisory Committee through a selected vendor.

ESMs	Status
ESM 11.1 - The number of Primary Care Provider practices who have adopted a Transition Policy	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

State Action Plan Table (New Hampshire) - Children with Special Health Care Needs - Entry 2

Priority Need

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

SPM

SPM 2 - 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 62% to 75%, on the SMS Satisfaction Survey, by 2022

Strategies

Exploration of options for increasing public awareness of access to and availability of respite providers

Analysis of available data to support policy development and support for respite

Support competency-based respite provider training modules.

Maximize the opportunity for intra-agency collaboration as a result of the creation of a new Division of Long Term Supports and Services that has agencies who serve families in need of respite across the lifespan.

Identify shared activities that can be implemented with the Bureau of Community Based Military Services to support families' respite needs.

Facilitate availability of respite tools for families through NH ServiceLink/NH Care Path

National Performance Measure # 11:
Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.

Evidence Based or Informed Strategy Measure # 11.1: The number of primary care provider practices who have adopted a transition policy

Objective: To increase from 52.3% (2016 FAD baseline) to 70.0% the percent of children with special health care needs having a medical home by 2023.

Strategies:

- Improvement of Family Partnerships with primary care providers (PCPs).
- Collaboration with the NH Pediatric Improvement Partnership (NH PIP).
- Support and advocacy of embedding medical home components into Medicaid managed care organization (MCO) contracts/quality indicators.
- Outreach and education to families, public agencies and providers to improve medical home awareness and understanding.
- Support for integrated care coordination 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.
- Facilitate the involvement of youth with special health care needs, through a selected vendor, to improve health care transition to adult medical services.
- Facilitate a Medical Home Advisory Committee through a selected vendor

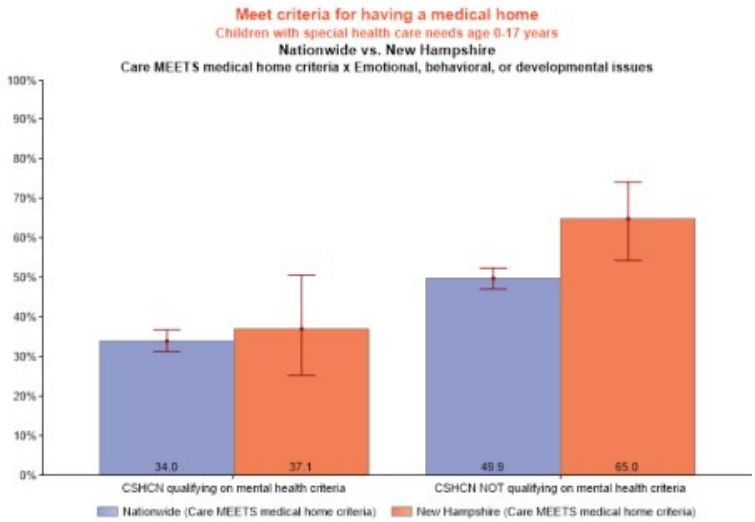
Data Analysis

The primary data for this indicator comes from the 2016 National Survey of Children's Health (NSCH), which was available in the fall of 2017. In previous years there was also a separate survey for Children with Special Health Care Needs however the 2016 NSCH integrated the two surveys: the original NSCH and the National Survey of Children with Special Health Care Needs (NS-CSHCN)[1]. As the survey method and questions were substantially changed in the 2016 NSCH, comparison of estimates or trends to previous data sets is not reliable.

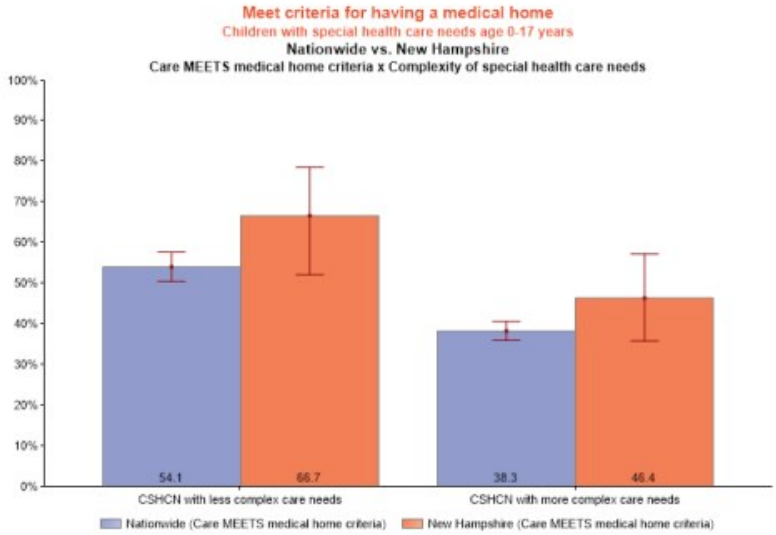
NH continued to perform well and had significantly higher performance than the national rate for children with special health care needs (CSHCN) and children without special health care needs. According to the 2016 NSCH, 52.3% of NH parents of CSHCN and 59.4% of parents of children without special health care needs identified that care provided for their children met medical home criteria. These exceed the nationwide reported rates of 43.2% for CSHCN, and 50% for those without special health care needs.[2]

However, NH families of children who qualify based on mental health criteria and those with more complex needs continue to report receiving care that meets medical home criteria at lower rates than CSHCN as a whole.

CSHCN who qualify based on mental health criteria receive care meeting medical home at a rate of 37.1%.[3]



CSHCN who have more complex needs receive care meeting medical home criteria at a rate of46.4% versus those with less complex needs at 67.7%.[4]



Additional data that is related to the Medical Home indicators is the Consumer Assessment of Healthcare Providers and Systems (CAHPS) data compiled by the Agency for Healthcare Research and Quality (AHRQ). NH data from the 2015-2016 CAHPS demonstrated that children covered by Medicaid-who utilized more than one service-experienced decreased access to health plan, provider, clinic based care coordination (60.2%-55.3%), As the population of children and youth with special health care needs (CYSHCN) often use more than one service this may be worth noting as a measure to monitor. There was also a decrease in “how often was it easy to get special medical equipment or devices for your child?” (81.6%-67.3%).[5]

When reviewing the NPM for transition (NH has incorporated a transition related ESM into NPM#11) while NH performs well—compared to the national average, NH had higher performance, but not statistically significant, for CYSHCN; and for children without special health care needs it had statistically significant higher performance—the rates themselves have much room for improvement. This opportunity for improvement is related to the survey results that only 22.8% of CYSHCN, age 12-17 years, indicated that their doctors usually/always encouraged increased responsibility for self-care, and (when needed) discussed transition to adult health care, changing health needs, and maintenance of insurance coverage.[6]

Systems Building

SMS has supported medical home improvement through a competitively bid contract for over a decade. Medical home improvement efforts during the reporting period were led by NH Family Voices (NHFV) as the contracted vendor. The contracted efforts have been multi-pronged, including collaboration with stakeholders, marketing, in-person and web-based training offerings, and practice-based technical assistance.

To guide project goals, NHFV initially utilized a core planning group, comprised of representatives from SMS, a pediatric primary care physician champion, and a family member. With the new focus on health care transition, members of the NH Healthcare Transition Coalition, which had additional parent members, and an adult primary care physician champion, were invited to work jointly with the Medical Home core planning group as opposed to being a separate group. This unified transition efforts and resulted in the creation of the Medical Home Project Advisory Committee (MHPAC).

To support practices seeking to improve their capacity for patient and family engagement, NHFV worked with practice-based teams, developing marketing tools, such as poster campaigns and brochures, and offering mentorship to family members. NHFV used previous experience mentoring parent partners within the Epilepsy Improvement Grant to encourage practices to engage families of various experience and skill sets, demonstrating that all families have the capacity to participate in quality improvement efforts with orientation and support.

To facilitate information distribution, NHFV established a requested resource for providers; an email distribution list, via google groups, "the NH Medical Home Resource Exchange". This resource was developed as the result of an initial request, and verification via survey of additional provider interest. Despite reported interest, only twenty providers joined the group. While all have remained active, none have actively participated. A comprehensive needs assessment is planned as part of the next phase of Medical Home Project funding, and will ascertain optimal methods of information needs and provision for all stakeholder groups, to include the future of this resource.

Is being a pediatric family advisor right for you?

Being a pediatric family advisor may be a good match with your skills and experiences if you can:

- Be comfortable speaking in a group setting, share suggestions and ideas to help improve care for others.
- Talk about your experiences as a patient, family or community member, but also think beyond them.
- Talk about both positive and negative care experiences and share your thoughts on what went well and how things could have been done differently.
- Work with people who may be different than you.
- Listen to and think about what others say, even when you disagree.
- Bring a positive attitude to discussions.
- Keep any information you may hear as an advisor private and confidential.

For more information about being a pediatric family advisor:

To get more information about becoming an advisor at Dartmouth-Hitchcock Keene Pediatrics or to find out how to apply:

Call: Gail Dubriske
(603) 354-6666
Email: Gail Dubriske
GDubriske@Cheshire-Med.com

05.2015

The Family Advisory Council of D-H Keene Pediatrics works in partnership with CHaD leadership to promote and enhance family centered pediatric care and services.

Council Goals:

- Educate the community about medical home and family centered care.
- Bridge the gap between families and their medical home.
- Improve the health of children by participating in the development of policies, programs and practices.
- Improve the delivery of pediatric care and services in a family centered environment.
- Increase awareness of children with chronic conditions or disabilities.
- Promote an effective medical home for children with special healthcare needs.
- Foster relationships within the community and surrounding areas.
- Be strong advocates for children and families.
- Promote effective communication between families, their medical team and community.
- Educate and empower families to be active partners in their children's healthcare.

SMS
New Hampshire FAMILY VOICES
This program has been developed in collaboration with New Hampshire Family Voices with funding from Special Medical Services and MAEDNH.

Dartmouth-Hitchcock Keene Pediatrics Family Advisory Council

Sharing ideas to enhance family centered pediatric care

CHaD Dartmouth-Hitchcock CHILDREN'S HOSPITAL AT DARTMOUTH

To broaden general awareness of medical home, NHFV created a podcast, and provided trainings, with efforts focused on reaching audiences outside of practices. NHFV leveraged opportunities to infuse medical home and transition elements into workshops at transition focused fairs, a Head Start Parent Advocacy Day and the Children and Families Collaboration Conference, a NH DHHS effort. The planned needs assessment will help the Medical Home Project to target future efforts.

To address health care transition, NHFV worked with a care coordinator within the Dartmouth-Hitchcock system to incorporate Got Transition elements into their transition processes. A draft policy was crafted, target patients were identified, and a family focus group was convened. Participants at the focus group identified key elements for practice consideration, including the importance of an established policy, the inception of planning no later than age 14, transition planning to include the recommendation of a provider, transfer to include communication of key health information to receiving provider, ongoing access to care coordination, and capacity for provision of appropriate care. (One family shared that her young adult uses a wheelchair, and could not be weighed in adult primary care, or examined outside of her chair.) The Coordinators site-based efforts were stalled, as leadership determined a system-wide, singular approach would be undertaken in the near future.

A number of statewide partnerships and collaborations help to spread Medical Home and transition efforts across stakeholder groups and systems. These include:

- The NH PIP 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. A steering committee, of which NHFV, SMS, and MCH are a part, serves in an advisory capacity to NH PIP staff, providing insight about implementation of strategic priorities, as well as emerging needs and/or opportunities.

- The YEAH Council is a youth driven, and youth directed group of individuals with special health care needs and/or disabilities. A member of the YEAH Council participates on the Medical Home Project Advisory Committee. In addition, the Medical Home Project will seek the input of YEAH regarding the needs of youth, and any development of materials for

use with youth.

- SMS continues to be an active member of the NH Transition Community of Practice. This group was initially comprised of stakeholders within the field of education, but has now engaged members of community and related service agencies. This participation has allowed for increased opportunities to integrate health into transition planning across systems.

- Members of SMS also participate on the MHPAC, and have co-presented with NHFV staff on health care transition at transition fairs and workshops across the state.

SMS has been actively engaged with the DHHS oversight and monitoring of Medicaid MCO contracts and quality indicators, as they relate to CYSHCN. As a part of this work DHHS, included children with disabilities as a key consumer group in their mandated External Quality Review (EQRO) of Medicaid beneficiaries regarding their experience with the Medicaid Care Management Program. For this review Horn Research engaged a standard qualitative data gathering process. A random sample of 75 beneficiaries was selected from each of the dually eligible and children with disabilities populations. A total of 28 individuals participated in a telephone interview. As a result suggested improvements centered on the following areas:

- *Increased Numbers of Specialist Providers*
  Participants noted a need for more specialists, particularly for mental health and dental care needs.
- *More Comprehensive Information about Providers*
  Participants requested expanded information about providers including providers' experience working with special needs children, current availability for new patients, and the age population the provider serves.
- *Expanded Coverage*
  Participants suggested that more providers should be included in their network or that there should be the opportunity to receive care out-of-network and still receive reimbursement.
- *Clearer Information Provided in a Variety of Formats*
  Participants suggested that information on benefits and coverage be provided more frequently and in more formats including easy-to-read, one-sheet summaries, videos, and group trainings.

Additionally, the CYSHCN Director has worked collaboratively with Medicaid on several projects related to MCO oversight and evaluation including;

- Establishing a list of pediatric subspecialists that will be used to monitor for MCO network adequacy.
- Review of MCO Provider Handbooks.
- Review of MCO candidate's for Special Needs Coordinator position to confirm that they meet position requirements as outlined in the contract.
- To create a Special Needs Enrollment Summary Report that provides DHHS with a monthly summary of members with special needs and what 'special needs status' is applicable.

Title V Specific Activities

SMS introduced a new project (February 2017) of having Health Care Coordinators and Family Support Coordinators implement new processes for the support and evaluation of transition readiness of youth ages 14 and up. To address this process, NHFV was asked to identify health readiness assessment tools and to develop a process for use by Health Care Coordinators and Family Support Coordinators.

The Transition Readiness Assessment Questionnaire (TRAQ) was chosen as the youth readiness assessment. A readiness assessment

developed by Got Transition was identified for parents. The process initiates was to ask parents/youth to fill out the appropriate readiness assessment at the same time that they are expected to complete their annual SMS application updates. All youth (age 14+) and family members began to be asked to complete the assessments.

Patient Name: _____ Date of Birth: __/__/__ Today's Date __/__/__ (MRN# _____)

Transition Readiness Assessment Questionnaire (TRAQ)

Directions to Youth and Young Adults: Please check the box that best describes your skill level in the following areas that are important for transition to adult health care. There is no right or wrong answer and your answers will remain confidential and private.

Directions to Caregivers/Parents: If your youth or young adult is unable to complete the tasks below on their own, please check the box that best describes your skill level. Check here if you are a parent/caregiver completing this form. ☐

	No, I do not know how	No, but I want to learn	No, but I am learning to do this	Yes, I have started doing this	Yes, I always do this when I need to
Managing Medications					
1. Do you fill a prescription if you need to?					
2. Do you know what to do if you are having a bad reaction to your medications?					
3. Do you take medications correctly and on your own?					
4. Do you reorder medications before they run out?					
Appointment Keeping					
5. Do you call the doctor's office to make an appointment?					
6. Do you follow-up on any referral for tests, check-ups or labs?					
7. Do you arrange for your ride to medical appointments?					
8. Do you call the doctor about unusual changes in your health (For example: Allergic reactions)?					
9. Do you apply for health insurance if you lose your current coverage?					
10. Do you know what your health insurance covers?					
11. Do you manage your money & budget household expenses (For example: use checking/debit card)?					
Tracking Health Issues					
12. Do you fill out the medical history form, including a list of your allergies?					
13. Do you keep a calendar or list of medical and other appointments?					
14. Do you make a list of questions before the doctor's visit?					
15. Do you get financial help with school or work?					
Talking with Providers					
16. Do you tell the doctor or nurse what you are feeling?					
17. Do you answer questions that are asked by the doctor, nurse, or clinic staff?					
Managing Daily Activities					
18. Do you help plan or prepare meals/food?					
19. Do you keep homeroom clean or clean-up after meals?					
20. Do you use neighborhood stores and services (For example: Grocery stores and pharmacy stores)?					

© Wood, Sawicki, Reiss, Livingood & Kraemer, 2014

As the questionnaires have been returned the assigned Health Care Coordinators/Family Support Coordinators are expected to conduct follow up activities and provide resources (such as those created by NHFV for youth) to support needed skills for health care transition.

The first five months of initial data (2/1-6/30/17) were reviewed, demonstrating that SMS care coordinators had attempted assessments for 82% of age appropriate youth, and successfully collected 59%. Family support coordinators attempted for 25% of youth, and successfully collected for 18%. Review of this data identified some data reporting challenges, as well as a need for some additional technical assistance for coordinators.

Community Health Center Activities: The majority of MCH's contracted CHCs are NCQA certified Patient Centered Medical Homes. In June of 2017, the Community Health Access Network)CHAN) presented at DPHS on NCQA certification changes.

As a result of the joint MCH / SMS State Action Plan Retreat in October of 2016, MCH added language on transition and transition policies to two of its CHCs site visit tools. Site visits are facilitated every other year. Additionally, transition policy language was added to the administrative tool, which the CHC fills out prior to a site visit. The incorporation of these changes provides an additional source of data, especially related to Medical Home/Transition for all children not just CYSHCN, as well as opportunities for both improved uptake in transition policies, and education regarding the importance of such processes. In addition to the data regarding the existence of transition policies available as a result of CHC site visits, efforts to establish baseline practice-based data are planned for the 2017-2018 project year.

Health Care Coordination: SMS continues to prioritize efforts regarding Health Care Coordination. This will continue to include contracted community based Health Care Coordinators, state based Health Care Coordinators and collaboration with MCOs, PCP offices, and School Nurses. In December 2016, materials were distributed and training occurred for SMS Health Care Coordinators

and Partners in Health Family Support coordinators to provide youth, age 14 and up and their parents with a Transition Readiness Assessment, as previously described. Preliminary use of the assessments and data collection began in February 2017. The approach used incorporates both written and direct education to families and planned individualized follow up upon the return of the assessment tools. In FY17 additional troubleshooting and process development was a focus for full scale implementation in FY18.

As a part of the work on increasing access to Medical Homes, SMS has included in its electronic database a mechanism to track whether or not CYSHCN have a usual and customary source of primary care. This has allowed SMS to assure that all children that received SMS services including Child Development Clinic, Nutrition, Feeding and Swallowing Consultation, Neuromotor Clinic, Health Care Coordination, and Family Support Coordination had a primary care physician. SMS continues to identify and support enabling, and some direct services to assure that CYSHCN have access to needed specialty care. These primarily contracted services include Child Development Diagnostic Clinics, Neuromotor Interdisciplinary Clinics, Nutrition and Feeding & Swallowing Consultation, Psychiatry Consultation, Family Support Coordination, Health Care Coordination, and Family to Family Health Information. In FY16, it became clear that NH's Program for Neuromotor Clinics was untenable as designed, primarily due to orthopedic clinician capacity. Stakeholders engaged in planning meetings and proposed a new model that maintained Neuromotor Clinics (fewer) but added a tiered program for children with Complex Needs that includes generic provider training and consultation, client based consultation, and an interdisciplinary clinic team. In FY17, this program was piloted and the decision was made to add it to the SMS array of contracted services in FY18. The RFP was created and put out for competitive bid in FY18 for a Neuromotor and Complex Care Network.

Collaboration with the NH Pediatric Improvement Partnership: The New Hampshire Pediatric Improvement Partnership (NH PIP) 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.

* * * * * * * * *

State Performance Measure #2:
Percent of children enrolled in SMS who report access to respite

Objectives: To increase the number of families reporting access to respite care, when needed, from 62% to 75% on the SMS Satisfaction Survey by 2023.

Strategies:

- Exploration of options for increasing public awareness of access to and availability of respite providers.
- Analysis of available data to support policy development and support for respite.
- Support competency-based respite provider training modules.
- Maximize the opportunity for intra-agency collaboration as a result of the creation of a new Division of Long Term Supports and Services that has agencies who serve families in need of respite across the lifespan.
- Identify shared activities that can be implemented with the Bureau of Community Based Military Services to support families' respite needs.
- Facilitate availability of respite tools for families through NH ServiceLink/NH Care Path.

Data Analysis

The 2010 Title V Needs Assessment indicated that respite was one of the top ten priorities for families caring for CYSHCN in NH. Despite a concerted statewide effort to improve access to and availability of respite services, it has continued to be one of the least available services and has been identified frequently and consistently as an unmet need across SMS programs and services.

The data for this indicator comes from the Effectiveness of SMS for NH's Children & Youth with Special Health Care Needs Bi-Annual Survey and Needs Assessment Report. In 2016, results indicated that only 62.3% of the 424 individuals who responded to the survey and identified respite as a need, were able to access care when needed. Comparison data will be available from the 2018 Survey/Needs Assessment Report. The data will be reveiwed and compiled in SFY19.

Systems Building

In 2009, SMS was the first Children's agency to be the recipient of a Lifespan Respite grant. Several state and community 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). These partners became the NH Lifespan Respite Coalition (LRC) along with other stakeholders who meet, monitor and guide respite efforts.

In 2017, NH applied to ACL for the Lifespan Respite Care Program: Advancing State Lifespan Respite Systems Grant. The proposal was prepared in partnership with the LRC and key stakeholders to expand and maintain a statewide coordinated lifespan respite system that builds on the infrastructure currently in place. The goal of proposed project was to improve the delivery and quality of respite services available to caregivers of individuals with disabilities by expanding and coordinating existing respite systems across the state. In addition to applying for the grant, core members of the LRC advocated for funding of a dedicated state-level staff to promote the provider training and use of the registry.

Unfortunately, NH was not selected to receive the award. Membership in the LRC continued to decrease and the remaining members indicated that NH Provider Link and the website were difficult to maintain and manage without dedicated staff. Furthermore, the core members were discouraged by the inability to secure funding for a coordinator and the discontinuation of support for the NH Provider Link from its host agency. Unfortunately, the LRC co-chairs announced that the LRC was being disbanded as of January 2018

NH LIFESPAN RESPITE COALITION

Concord, NH 03301

Dear Coalition Member,

During the past two years the NH LifeSpan Respite Coalition has worked diligently in moving forward to acquiring financial sustainability for the NHProviderLink program. Our Vision and Mission remained the same, for all caregivers in NH to be able to access high quality, affordable and culturally appropriate respite that would be delivered according to the caregivers' and families' needs, timelines and special circumstances ultimately enhancing the quality of life for individuals of all ages.

After the expiration of the grant monies procured by Bureau of Developmental Services/Special Medical Services and Gateways Community Services, our partnership to provide guidance and support continued with Gateways Community Services' program - NHProviderLink. As you are aware NHProviderLink is a website that individuals could look for providers available in their area or individuals could advertise that they were available to provide care. When the grant monies for NHProviderLink ended and the inability to procure a VISTA volunteer to help with marketing, education and the website, the LifeSpan Respite Coalition and Gateways began researching other permanent sustainable funding options.

The NH LifeSpan Respite Coalition has consistently brainstormed and researched different options, but each possible solution comes back to the need for monies to continue offering NHProviderLink or any other program. With all our efforts, we have been unable to procure these monies. The cost is around $20,000 per year to maintain NHProviderLink and $70-80,000 to hire an individual to develop, maintain and educate other organizations throughout NH.

Gateways did provide a formal proposal to the State and our Co-Chair Ken Jones spoke with several legislators. The proposal was reviewed and due to limited resources, the State could not support it. We also provided our support to Special Medical Services (Deirdre Dunn & Jennifer Davis) who submitted a proposal for a Federal grant related to respite services and our State was not chosen. Even though Gateways, Special Medical Services and Ken's diligence was exemplary, there was no substantial interest in funding NHProviderLink or an individual to maintain and develop this much needed program.

Since July 1st, Rewarding Work, who provides the software and website for NHProviderLink (renamed NHCareDirectory), has donated their time and the cost to run the program for six months at no cost to us. We are so grateful for their continuing support of providing a program such as NHProviderLink to New Hampshire. However, with our Coalition not being able to obtain the monies needed to maintain the program, the NHCareDirectory will end on January 1st.

Our Coalition does not have a fiduciary budget and is no longer supported by a 501(c)3 organization. This limits our ability to be able to submit for grants or to be a larger voice within the State of NH. There has also been a very limited community interest in membership since the initial development of NHProviderLink and the end of the grants.

Through discussions held over the past few months, it has become clear that we are at a standstill. With the current financial limitations, lack of membership interest and the inability to go forward, we as Co-Chairs have decided to dissolve the NH LifeSpan Respite Coalition.

We want to thank those that have participated in being a part of our Vision and Mission and value the dedication that you have shown. And in the future, when a coalition such as ours is needed, your support and guidance would be greatly appreciated.

Sincerely,

Ken Jones, Co-Chair

Vicki Pepper, Co-Chair

Valerie Kidder, Co-Chair

SMS continued to work toward System Standards for Respite Care, using the Standards for Systems of Care for CYSHCN, such that respite, both planned and emergency is available to all families and caregivers of CYSHCN. Despite NH's respite work having been at a systems level under the earlier Lifespan Respite grant, lack of resources and capacity resulted in a deterioration of this infrastructure and there are still unmet needs reported by families across the Family Support System for CYSHCN.

Title V Specific Activities

Lifespan Respite Activities

Respite continued to be an agenda item at Service Coordinator and Family Support Coordinator meetings, to promote the importance of respite and provide updates and guidance on how to share information with families about available respite services and help them to access them. Families receiving services through SMS programs were screened for respite care needs as part of the application and intake process. Some agencies provided a list of potential providers and helped families locate someone and others left the search up to the family.

SMS continued to support the training needs and opportunities for respite care providers throughout 2017 through the web-based training application accessible on the http://www.nh providerlink.org/. NH Lifespan Respite Provider Certification training consists of online courses through Relias™ Learning. This is a self-guided learning tool, which contains up to five courses for each competency. Courses range from the basic knowledge of being an in-home provider to diagnosis-specific courses for all age groups. The course work includes, but is not limited to patient rights and responsibilities, cultural diversity, infection control, HIPAA Regulations and documentation, and a variety of training on specific health conditions.

The ongoing use of the Respite Locator was possible due to a more formal partnership with one of the Area Agencies. The goal had been 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. However, the inability for the LRC to locate a new VISTA to continue to provide outreach and coordination has negatively affected these activities.

Coordination of Family Support and Respite Activities

The CYSHCN Systems Specialist, who was hired in July 2016, was instrumental in refining the Family Support systems work especially in addressing the work on Respite. In addition to conducting a Respite Survey, to assess the degree to which individuals are engaged in the work of the Coalition, she began to coordinate the LRC meetings and continued to do so until they were disbanded. SMS provided information from the ARCH National Respite Network and Resource Center and explored options for increasing the NH provider registry to better meet the needs of families. SMS determined that the registry provided a much-needed resource for families and organizations throughout New Hampshire. Therefore the news that the host agency would no longer be supporting the site resulted in contingency planning with Rewarding Work, the database owner. They agreed to keep the information currently on the platform which allowed for access by families but without funding/staffing to update and maintain the information the site's usefulness is limited.

Organizational placement in the state's Bureau of Developmental Services (BDS) has continued to support the coordination and improvement of statewide respite services. The BDS network of Area Agencies, in addition to SMS' Partners in Health program, is responsible for Family Support services including respite. The Family Support Administrator continued to provide administrative oversight for Family Support, which lent itself to additional coordination and integration of statewide respite services under BDS.

* * * * * * * * *

[1] Child and Adolescent Health Measurement Initiative. Data Resource Center for Child and Adolescent Health. 2016 National Survey of Children's Health (NSCH). Retrieved 6/15/18 from www.childhealthdata.org.
[2] Child and Adolescent Health Measurement Initiative. Data Resource Center for Child and Adolescent Health. 2016 National Survey of Children's Health (NSCH). Retrieved 7/9/18 from www.childhealthdata.org.
[3] Ibid
[4] Ibid
[5] https://cahpsdatabase.ahrq.gov/CAHPSIDB/Public/Chartbook.aspx
[6] Ibid

Children with Special Health Care Needs - Application Year

National Performance Measure # 11:
Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.

Evidence Based or Informed Strategy Measure # 11.1: The number of Primary Care Provider practices who have adopted a Transition Policy

Objective: To increase from 52.3% (2016 FAD baseline) to 70.0% the percentage of children with special health care needs having a medical home by 2023.

Strategies:

- Improvement of Family Partnerships with primary care providers.
- Collaboration with the NH PIP.
- Support and advocacy of embedding Medical Home components into Medicaid Care Management contracts/quality indicators.
- Outreach and education to families, public agencies, and providers to improve Medical Home awareness and understanding.
- Support for integrated care coordination 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.
- Facilitate the involvement of youth with special health care needs, through a selected vendor, to improve health care transition to adult medical services.
- Facilitate a Medical Home Advisory Committee through a selected vendor.

Systems Building

SMS will continue to support medical home improvement efforts through a contract awarded to NH Family Voices (NHFV) through FY 19 with an option for a two year extension. Broadly, the Medical Home Project is charged with fostering statewide medical home planning for CYSHCN, providing technical assistance and improving awareness and adoption efforts.

The efforts of NHFV's Medical Home Project will continue to be guided by an advisory group of diverse stakeholders, with youth and family participants, as well as representation from NH Medicaid (including both Medicaid Managed Care Organizations), SMS, NHFV, and primary care practices. Efforts to further enhance membership with a commercial insurance representative and an additional primary care champion is a goal for this coming year.

A major undertaking in this application year will be a comprehensive needs assessment regarding medical home in NH. In addition to a review of all available state data, information will be collected from a variety of stakeholder groups to identify current activities, informational needs, and optimal means of distribution and provision of training and / or materials. Data, such as that available from the 2016 NSCH, tells part of the story. Additional input is required to help to determine which improvement efforts might be most successful. These findings will allow the Medical Home Project to guide future efforts in a manner most likely to meet the needs of various stakeholder groups and maximize Project impact. It is anticipated that additional stakeholders, engaged in this process, will form a broader "Medical Home Network" in NH, allowing for more integration and collaboration regarding improvement efforts. We anticipate that this effort will expand current partnerships, such as those that exist with the NH Pediatric Improvement Partnership (NH PIP) and the NH Pediatric Society. We also anticipate that this information will provide much needed guidance to the development of a communications plan, informing the development of an awareness campaign as well as materials to meet the needs

of target audiences.

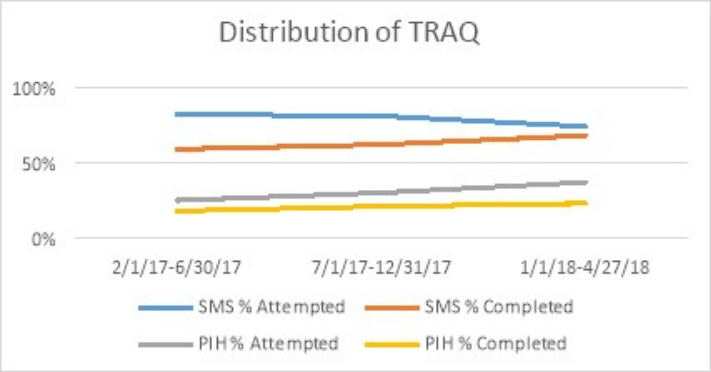
In order to address the issue of health care transition, the Medical Home Project will continue to support practices in the development of transition policies and processes, in accordance with recommendations from Got Transition™. The Medical Home Project has guided Concord Pediatrics, an independently owned practice, through this process, resulting in the adoption of a transition policy, the identification of age-specific "touch points" at which transition readiness is assessed and information provided. A resource toolkit has been developed and is being actively tested; the results of which will inform toolkit provision for programs within Special Medical Services. The Medical Home Project is also currently supporting Dartmouth-Hitchcock in its efforts to develop a uniform policy and process system-wide. Dartmouth-Hitchcock is adapting tools created by the Medical Home Project for Concord Pediatrics, choosing a similar approach of age-specific "touch points" for intervention.

The Medical Home Project will continue to track transition policy adoption within practices, utilizing baseline data procured through the support of a LEND intern during the 2017-2018 school year. Targeted outreach to practices to encourage uptake and offer technical assistance, such as that provided to both Concord Pediatrics and Dartmouth-Hitchcock, will be offered in order to further advance the adoption of processes that support successful transitions to adult primary care medical homes for all youth.

Title V Specific Activities

Due to staffing changes, the development of care coordination competencies has been on hold but in the coming year SMS will resume this work and address transition as a component of increased collaboration across service providers to assure an effective system of care. SMS will also continue to implement processes related to assessment of transition readiness. In the coming year there will be an emphasis on educating staff how to effectively evaluate completed and returned surveys in order to identify resources and education needed by youth and families. The Health Care Coordinator who has been identified as the Transition representative for the community of practice will continue in that role and as the expert available for community based trainings/panels and transition fairs.

As noted efforts to improve health care transitions for youth served by Special Medical Services programs will continue. At the time that update SMS application are due, all youth, age 14+ years of age, and their caregiver, will be assessed for transition readiness. Appropriate support and anticipatory guidance will then be provided, either by their Health Care Coordinator or Family Support Coordinator, to enhance needed skills to insure more seamless transitions. Medical Home Project staff will continue to provide technical assistance regarding the implementation of this project, with the goal of improving distribution and collection rates, as well as the provision of resources and educational materials. Below is an example of the data that can now be collected from the SMS database, which identifies SMS' attempts to solicit transition readiness assessments as well as return rates.



Reporting on this effort is now also a component of the required Annual Reports for all Health Care and Family Support Coordinators, with an additional measure (the identification of an adult primary care provider) upon program discharge (at age 21 years).

MCH site reviews of contracted Community Health Centers in 2019 will also provide additional data regarding health care transition and transition policies, as a result of questions placed following the MCH/SMS State Action Plan Retreat in October of 2016.

* * * * * * * * *

State Performance Measure #2:
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 62% to 75%, on the SMS Satisfaction Survey, by 2023.

Strategies:

- Exploration of options for increasing public awareness of access to and availability of respite providers.

- Analysis of available data to support policy development and support for respite.
- Support competency-based respite provider training modules.
- Maximize the opportunity for intra-agency collaboration as a result of the creation of a new Division of Long Term Supports and Services that has agencies who serve families in need of respite across the lifespan.
- Identify shared activities that can be implemented with the Bureau of Community Based Military Services to support families' respite needs.
- Facilitate availability of respite tools for families through NH ServiceLink/NH Care Path.

Systems Building

SMS will convene a Respite Workgroup in 2019 with representatives from the Division of Long Term Supports & Services including the Bureaus of Developmental Services, Special Medical Services, Elderly & Adult Services, and Military & Veterans Programs. Additional representatives will be invited from the Divisions for Children, Youth & Families and Behavioral Health. NHFV has expressed an interest and willingness to partner with this workgroup as well. The goals of this workgroup will include development of a State Plan for Respite that includes strategies for systems advancement and partnership development & stakeholder engagement using the framework of the AMCHP Standards for Systems of Care for CYSHCN.

Title V Specific Activities

SMS services will continue to address the areas identified as "unmet needs" for respite through flexible funding options, designated campership/respite funds, and the exploration of family strengths and community supports. The lack of a trained and well-compensated workforce is a significant problem for families seeking respite from the day-to-day requirements of caring for a child with special health care needs. SMS will continue to seek ways to provide training to potential providers and caregivers and to promote options for respite.

A new training mechanism was recently introduced when the Department identified Moodle as the preferred Learning Management Platform. Moodle will be available to registered users, which will include staff, contractors and families. Moodle will provide an opportunity to create effective online courses based on sound principles and best adult learning practices. The SMS CYSHCN Systems Specialist will continue the training she began in 2018 and make recommendations for designing Moodle courses. With this platform and designated staff, SMS will have the potential to expand training modules for respite providers without the added expense of an external platform. Until Moodle is operational, SMS will continue to support the NH Lifespan Respite Provider Certification training through Relias™ Learning.

In the coming year, SMS will engage families and family organizations in the planning process and use the 2018 survey data, local agency annual reports, and 2019 audit findings to gather information, analyze data, and make recommendations to the DLTSS Respite Workgroup. The development of a State Plan for Respite will include:

- Exploration of options for increasing public awareness of access to and availability of respite providers
- Analysis of available data to support policy development and support for respite
- Support competency-based respite provider training modules.
- Maximize the opportunity for intra-agency collaboration as a result of the creation of a new Division of Long Term Supports and Services that has agencies who serve families in need of respite across the lifespan.
- Identify shared activities that can be implemented with the Bureau of Community Based Military Services to support families' respite needs.
- Facilitate availability of respite tools for families through NH ServiceLink/NH Care Path.

* * * * * * * * *

Cross-Cutting/Systems Building

State Performance Measures

SPM 1 - Percentage of MCH-contracted Community Health Centers with Enabling Services workplan on file with DHHS/MCH.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		60
Annual Indicator	64.3	100
Numerator	9	14
Denominator	14	14
Data Source	NH DHHS, MCH section	NH DHHS, MCHS
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

SPM 3 - Percentage of behavioral health professionals recruited

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		40
Annual Indicator	38.9	21.1
Numerator	7	34
Denominator	18	161
Data Source	Bi-State Primary Care Recruitment Center	Bi-State Primary Care Association/Recruitment Ctr.
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	22.0	24.0	26.0	28.0	30.0	32.0

State Action Plan Table

State Action Plan Table (New Hampshire) - Cross-Cutting/Systems Building - Entry 1

Priority Need

Improve access to needed healthcare services for all populations.

SPM

SPM 1 - 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 90% by October 2018.

Strategies

Require MCH-contracted CHCs to submit an ES work plan as a contract deliverable.

Review completed ES work plans and provide feedback/technical assistance as needed to ensure activities are within the scope of services.

State Action Plan Table (New Hampshire) - Cross-Cutting/Systems Building - Entry 2

Priority Need

Improve access to mental health services.

SPM

SPM 3 - Percentage of behavioral health professionals recruited

Objectives

Increase the recruitment of behavioral health professionals by five percentage points over five years, from 21% (in 2017) to 26% (in 2021).

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

Policy: Support the State Loan Repayment Program for behavioral health professionals and change credentialing requirements

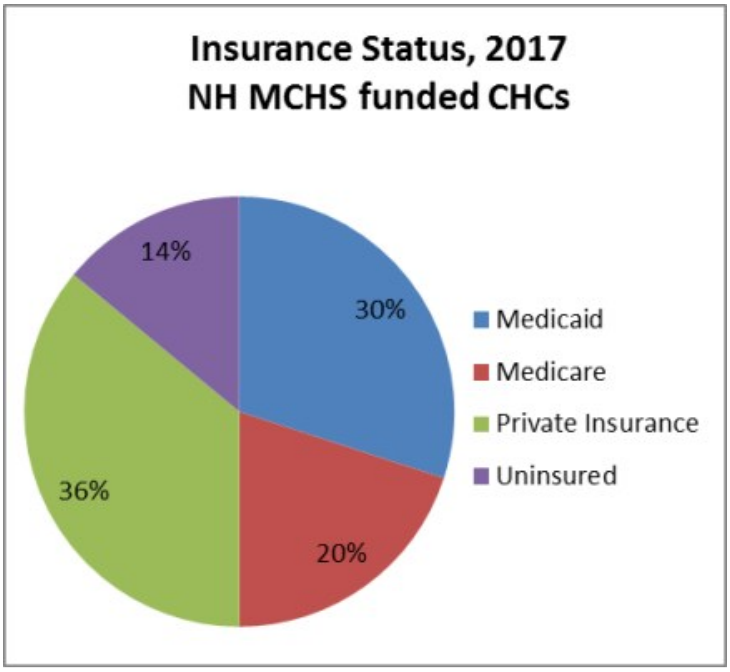
State Performance Measure #1: Percentage of MCH-contracted Community Health Centers (CHCs) with Enabling Services (ES) work plan on file with DHHS/MCH

Objectives: Increase the percentage of MCH contracted CHCs with an ES workplan on file with DHHS from 2015 baseline of 60% (9 of 15) to 90% by October 2018.

Strategies:

- MCH will require CHCs to submit an ES work plan as a contract deliverable
- MCH will review completed ES work plans and provide feedback/technical assistance as needed to ensure activities are within the scope of services

Background: For more than 25 years, MCH has used Title V funding and State General Funds to support a network of safety-net CHCs to provide primary care (PC), primary care for the homeless (PC-Homeless) and prenatal services for low -income and uninsured individuals and families. Historically, Title V funding had been used to provide direct care for uninsured individuals. In 2017, 14% of the 126,350 individuals served by the NH CHCs were uninsured. This number has trended downwards with the advent of the Affordable Care Act (ACA) and NH's expanded Medicaid initiatives, but there is still great variability among the health centers. Over the past few years, MCH has prompted the CHCs to re-direct funding away from individual care toward funding staff positions to offset agency cost associated with caring for the uninsured and underinsured populations[1] towards the support of ES and Quality Improvement (QI) activities. In June 2018, MCH received Governor and Council approval to retro-actively authorize contracts with 11 CHCs for Primary Care Services and three (3) CHCs for PC-Homeless Services effective April 1, 2018-March 31, 2020. Accountability for services has been maintained by MCH through monitoring performance via site visits and reporting requirements.



Source: NH MCH UDS Table, 2017

Enabling Services

ES are non-clinical services that support the delivery of basic primary care and preventive services by addressing geographic, linguistic, cultural and socioeconomic barriers. ES are not currently reimbursed by any health payer and are therefore supported by MCH funding to enhance CHCs capacity to "do the work" needed to care for their patient population. ES positively impacts care by improving the quality of services, supporting health equity and reducing health care costs. The following are examples of the type of enabling services currently being provided by CHCs:

- Case management
- Benefit counseling
- Insurance eligibility and enrollment assistance
- Health education and supportive counseling
- Interpretation
- Outreach
- Transportation
- Education of patients and the community regarding the availability and appropriate use of health services

MCH allows each CHC the flexibility to self-select the type of ES to be provided based on the unique needs of their own community. The following story is an example of ES that were performed by a Patient Navigator whose position is funded by MCH.

> "During this past year, one of our providers requested for our Patient Navigator to reach out to a family that was having financial difficulties. The Navigator utilized the Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE) tool to assess and respond to the needs of this family (a mother with five children). The Navigator assisted the family to access medical and dental care including transportation services to appointments (reimbursable by Medicaid) and identified unmet needs. The Navigator assisted the family with obtaining health insurance Medicaid (NHHPP and children's Medicaid), food stamps. The Navigator also connected the family to community services including Habitat for Humanity for housing, Tri County CAP fuel assistance for emergency fuel and financial assistance with replacing the aging oil tank, Holiday Caring Tree and local food pantries. In addition, the Navigator determined that one of the children had a chronic medical condition that potentially qualified her for family support services through the NH Partners in Health (PIH) Program. Working with the child's provider and the mother, the navigator completed the PIH application and provided follow up on application status until the child has been enrolled in PIH. The Navigator has regular contact with the family to provide follow-up calls relating to services, discuss challenges, and address any new needs as they arise."[2]

Systems Building

MCH monitors contract deliverables to ensure services are being provided in accordance with PC and PC-H Services, Scope of Services, Exhibit A as follows:

Budget/Budget Narrative: On an annual basis, MCH reviews and approves individual agency budgets and budget narratives which are electronically submitted by CHCs. This activity provides MCH an opportunity to understand how CHCs anticipate they will expend their funds and is one mechanism MCH uses to ensure fiscal accountability. Agency budgets and budget justifications were recently reviewed (Spring 2018) and revisions were requested as needed.

ES Work plans: On an annual basis, MCH reviews and approves individual agency ES work plans which are electronically submitted by CHCs. From the MCH perspective, the ES work plans are a key mechanism for CHCs to communicate with MCH about the

work that is being done. The ES work plan describes each individual agency's project goals, objectives, inputs/resources, planned activities and evaluation methods. This allows an opportunity for staff to provide the CHC feedback and request revision when needed. At the end of each state fiscal year (SFY), CHCs are then required to report annual outcomes by completing the "Work Plan Performance Outcome Section" (see below). This section prompts CHCs to: 1) revisit their work plans, 2) indicate if their agency targets/objectives were met or not, 3) evaluate the effectiveness of their activities and 4) to communicate any revisions to their work plan (improvement plan, required if targets are not met) as indicated. Once completed outcomes have been submitted to MCH, the MCH staff (QA/QI Nurse Consultant, Title V Program Administrator and Child Health Nurse Consultant) will review and then provide feedback to as part of continuous QI (August-Sept 2018).

SFY 18 Outcome: *Insert your agency's data/outcome results here for July 1, 2017- June 30, 2018*

_____ 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 SFY19*

_____ **Revised Work Plan Attached** (Please check if work plan has been revised)

Source: Enabling Service work plan, NH MCH, 2017

The ES work plan is of critical importance to MCH' understanding of how funds are being spent. Hence, starting in SFY18, MCH revised CHC contract language which no longer allowed agencies the "option" of submitting an ES work plan. As a result of "requiring" ES work plans as a contract deliverable, MCH has increased the percentage of contracted CHCs that have an ES work plan on file with MCH from 60% in 2016 to 100% by the fall of 2017.

In 2017, MCH received and reviewed ES work plans from all 11 PC contracted agencies and all three (3) PC-Homeless contracted agencies. One PC and one PC- Homeless ES work plans have been included below as examples of current ES work plans:

Primary Care Services, Enabling Services work plan

Project Goal: To increase access to healthcare.	
Objective #1: Reduce barriers to care by assisting 100 patients without health insurance to obtain health insurance through enrollment in expanded Medicaid or Marketplace policies.	
INPUT/RESOURCES	**PLANNED ACTIVITIES**
• Patient Navigator • Benefits counselors • Eligibility assistance coordinators • Outreach worker • Community navigator • Clinical staff • Social workers • QI staff • Front Desk staff	• Provide education about health insurance and how to use it. • Coordinate community health events and clinics to discuss the availability of expanded Medicaid and Marketplace policies. • Front desk staff will schedule an appointment with the Patient Navigator for all uninsured patients. • Determine which patients are qualified for expanded Medicaid or Marketplace policies. • Inter-office staff to sit with patients to review disabilities, work history, insurance plans, and benefits. • Staff will help sign patients up for expanded Medicaid, ACA, SSDI, APDD, or Veteran's benefits. • Referrals for SNAP and WIC will be provided to those patients that are eligible.
	EVALUATION ACTIVITIES
	• Determine if staff assessed health insurance needs of patients. • Determine if health insurance needs are being documented. • Determine if staff provided health insurance information and education as appropriate to those patients who have a documented need. • Track number of community events and activities being offered to patients. • Track the number of patients being spoken to about health insurance opportunities.
Objective #2: Reduce barriers to care by increasing health insurance literacy for 100 patients by providing education about health insurance policies and helping patients learn the benefits of their new health insurance plan.	
INPUT/RESOURCES	**PLANNED ACTIVITIES**
• Patient Navigator • Benefits counselors • Eligibility assistance coordinators • Outreach worker • Community navigator • Clinical staff • Social workers • QI staff	• Increase health literacy of 100 patients regarding health insurance policies. • Coordinate community health events and clinics to provide education about various health insurance policies. • Determine which patients are in need of increased health literacy regarding health insurance policies. • Work jointly with LRGH, Service Link, and other agencies in the Public Health Region. • Develop and distribute health insurance literacy materials to those patients in need.
	EVALUATION ACTIVITIES
	• Determine if staff assessed health insurance literacy needs of patients. • Determine if health insurance literacy needs are being documented. • Determine if staff provided health insurance information and education as appropriate to those patients who have a documented need. • Track number of community events and activities being offered to patients. • Track the number of health insurance literacy materials that are being developed and distributed. • Track the number of patients being spoken to about health insurance literacy and educational needs. • Track the number of trainings of employees regarding health insurance.

Source: Primary Care, Enabling Service work plan, NH MCH, 2017

Project Goal: Expand access to care for homeless individuals within our service area.	
Objective #1: Identify areas in the community where individuals may not know of FF HCH services, and provide face-to face outreach.	
INPUT/RESOURCES	**PLANNED ACTIVITIES**
HCH team, Clinical Director, Care Coordinators, community programs, key community contact persons	• HCH nurse and care coordinator to attend weekly community lunch at St. Raphael's church-Kittery
	EVALUATION ACTIVITIES
	• Number of encounters with potential and current patients via community lunch at St. Raphael's church
Objective #2: Make HCH services know to youth in the Seabrook area	
INPUT/RESOURCES	**PLANNED ACTIVITIES**
• HCH team, outreach staff, Seacoast Youth Services	• Scheduled time for HCH staff to make face to face contact with Seabrook youth.
	EVALUATION ACTIVITIES
	• Number of encounters with potential and current patients.
Project Objective #3: Identify homeless in the community who access ER services, but are not connected with primary care.	
INPUT/RESOURCES	**PLANNED ACTIVITIES**
• FF RN, Care Coordinators, ER staff	• FF RN to make scheduled round in ER to identify individuals in need of primary care, make face to face contact when feasible
	EVALUATION ACTIVITIES
	• Number of encounters with potential and current patients.

Source: Primary Care for the Homeless, Enabling Service work plan, NH MCH, 2017

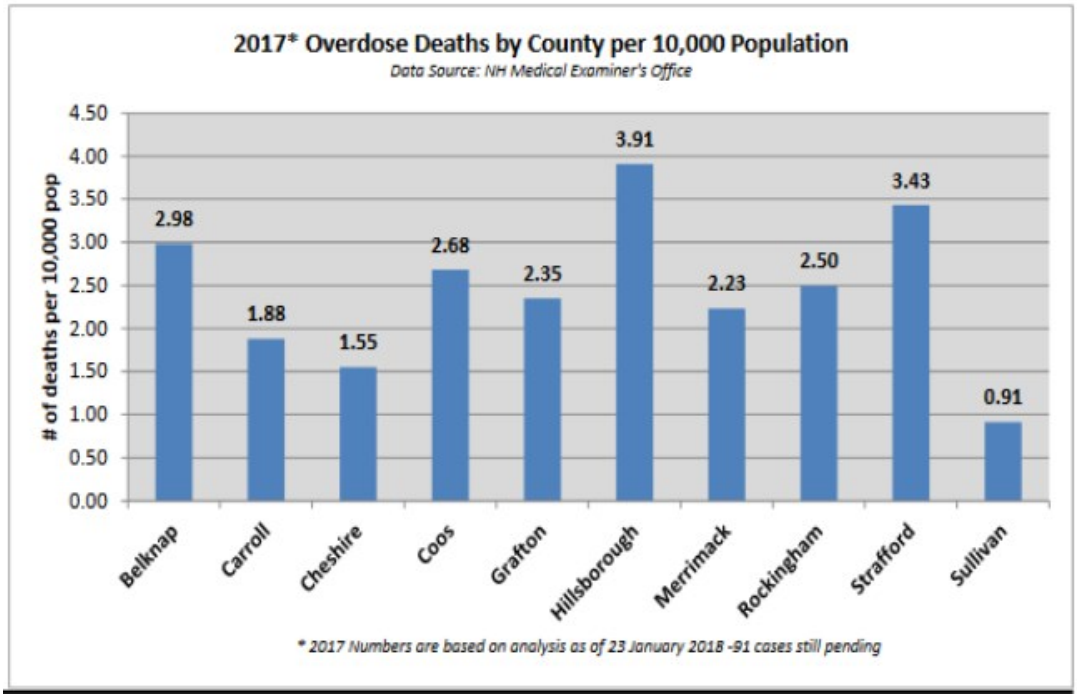
Site Visits: Once per each contract cycle, MCH conducts a site visit to allow an opportunity to meet face-to-face with each individual CHC to exchange information (hear about services and provide feedback). During site visits MCH conducts chart audits and reviews ES work plans and budgets in person with CHC staff. The site visit processes serve as further opportunity for agency accountability through in-person exploration to determine how ES are being implemented and how funds are utilized.

The following section is an example of how MCH utilizes contract deliverables (budget narratives, ES work plans) and site visits to provide oversight of ES as implemented by one (1) of MCH's contracted CHCs, Goodwin Community Health Center.

Goodwin Community Health Center

Goodwin Community Health Center is located in Strafford County and provided services for 10,125 patients with 47,418 encounters (2017 UDS).[3] Strafford County's ethnic characteristics mirror the state, with 92.1% White, non-Hispanic or Latino living in the County. The median income in Strafford County is $59,290 compared to the State's $64,064, and the percentage of people living below the federal poverty level is 10.5% compared to the state's 8.7%.

The county is ranked eight out of ten (ten being worst) in both health behaviors and health outcomes measures due to a high percentage of people: using tobacco and alcohol, being overweight or obese and being physically inactive[4]. Residents in this county are also negatively impacted by substance misuse. In 2017, Strafford County had an estimated per capita rate of 3.43 overdose deaths per 10,000 population, Strafford County and was ranked second highest of all NH counties for overdose deaths.[5]



Source: NH Medical Examiner's Office, 2018

According to Goodwin's budget narrative the agency anticipates using MCH funding to support the following staff positions:

- 0.43 FTE Physicians - provide primary care services to Greater Seacoast Community Health (GSCH) patients within the agency's Health Centers and in the agency's mobile health program
- 0.55 FTE Nurse Practitioner - provides primary care services to GSCH patients with the agency's Health Centers and in the mobile health program
- 0.79 FTE Nurse Coordinator - responsible for coordination of staff nurse assignments for GSCH mobile health care program
- 1.33 FTE Nurses - support providers in assessing patients health needs and in delivering primary care services to patients.
- 2.0 FTE Care Coordinators - assist in the coordination of care of GSCH patients by assessing needs for social services; make appropriate referrals to health, home care, and other social supports and/or service agencies; provide (limited) benefit counseling, outreach, assistance with transportation and any other barrier to care.
- 0.45 FTE Substance Abuse Counselor - provides substance abuse services to GSCH patients.
- 0.50 FTE Enrollment Coordinator – coordinates enrollment activities and oversees enrollment staff.
- 0.25 FTE Outreach/Enrollment Staff - conduct outreach to people experiencing homelessness and assist patients in navigating the health care system by removing barriers and helping to enroll in health insurance and other benefits.
- 0.50 FTE Van Driver - responsible for driving the mobile health care van.
- 0.03 FTE Quality Improvement Coordinator – directs support of the work plans established for each enabling service. Establishes needed policies and procedures as well as data tracking.
- 0.26 FTE Clinical Director – responsible for the overall operations that includes: staff scheduling; updating clinical policies and procedures; and supervising primary health nurses, medical assistants, and patient coordinators.
- 0.03 FTE Finance Director - responsible for providing program and operational fiscal oversight.

- 0.10 FTE Operations Director - responsible for oversight of health center and dental center front office staff and oversight of the mobile health and dental programs operations.
- 0.03 FTE Medical Home Manager - responsible for facilitating care coordination services for patients in need of enhanced care coordination services.

According to Goodwin's SFY18-19 ES work plan (submitted fall of 2017) the CHC communicated a project goal of ensuring that infants born to enrolled pregnant moms have the best access to prenatal care by implementing the following:

Project Goal: To ensure that infants born to enrolled pregnant moms have the best access to prenatal care.	
Objective #1: To ensure that infants born to enrolled pregnant moms have the best access to prenatal care. Goal is for 85% of pregnant women who are enrolled in the agency's prenatal program will begin prenatal care during the first trimester of pregnancy by June 30, 2018 and June 30, 2019.	
INPUT/RESOURCES	**PLANNED ACTIVITIES**
Social Work Staff Prenatal Nurse Electronic Medical Record Front Office Staff Call Center Staff	• Patients will be preliminarily screened during initial phone call for approximate due date. Social work staff will be contacted if patient appears to be more than 10 weeks gestation (at best guess) before next available prenatal intake. Patient will then be scheduled at earliest available slot for intake (usually within one week). • Goodwin Community Health staff will work together to continue to educate existing patients on the importance of early prenatal care and that patient does ***not*** need to be insured to seek care. • Goodwin Community Health staff will work together to continue to educate the general public on available prenatal services and the importance of early care i.e. social media, outreach activities and agency to agency education. • Staff education surrounding the importance of early prenatal care and flexibility with staff in adjusting schedules as needed to allow early access to care.
	EVALUATION ACTIVITIES
	• Staff training on how to "prescreen" patients when making initial prenatal intake appointments. • Create follow up flow for staff to refer patients that may need earlier appointment. • OB provider will pick up an additional ½ day to see new patients if needed every other week (opening up an additional 5 new OB slots).
Objective #2: Test all female SUD patients receiving MAT for pregnancy and if pregnant schedule for an intake, if appropriate.	
INPUT/RESOURCES	**PLANNED ACTIVITIES**
• Social Work Staff • SUD team (MAT/IOP staff) • Nurses • Providers	• Continue outreach and education with local practices, treatment facilities and physicians regarding substance misuse and the importance of early care. • Continue to work closely with the social workers and other staff at local EDs so that they are referring to us patients they see in the ED who are in need of prenatal care. • Follow protocol for pregnancy tests for SUD patients. • Social work staff will be contacted if patient appears to be more than 10 weeks gestation (at best guess) before next available prenatal intake. Patient will then be scheduled at earliest available slot for intake (usually within one week). • Follow MAT/IOP protocols • Review on a monthly basis if patient referred for intake has kept their appointment. If they have not, outreach to patient.
	EVALUATION ACTIVITIES
	• Review on a monthly basis if patients referred for intake have kept their appointment.

In July 2018, the SFY17 work plan performance outcome section will be completed to provide MCH a sense of the activities that were performed during the year.

In addition to the budget, budget narrative and ES work plan, MCH staff (QA/QI Nurse Consultant, Child Health Nurse Consultant and Perinatal Nurse Coordinator) conducted a site visit to Goodwin in May 2018. During the site visit, discussions ensued related to agency challenges, ways MCH funds are utilized, clinical services, quality improvement and enabling services.

Since 2015, Goodwin initiated Screening, Brief Intervention and Referral to Treatment (SBIRT) for alcohol and drug use. In the past three years, the agency has expanded its behavioral health programs and has initiated a Medication Assisted Therapy (MAT) program and the Intensive Outpatient Program (IOP) in order to provide services to patients who would not have been previously identified. Currently, an estimated 49% of Goodwin's patients are screening positive for substance misuse and both the MAT and the IOP are at full capacity. *Note:* Goodwin also makes MAT available through their mobile health clinics. Staff resources are additionally strained by supporting patients with substance misuse who are not ready to enroll in MAT and/or IOP. Goodwin's staff discussed the issue of rising substance misuse in the community and the large amount of resources that have been dedicated to deliver their MAT program and IOP. Staff has expressed feeling unsafe due to outbursts and threats from patients seeking medication. Goodwin has responded by providing safety training and developing policies (i.e. limiting hours of appointments for MAT to times of the day when full staffing is available so no staff member is providing services alone).

Ongoing MCH Specific Activities

MCH intends to monitor program accountability and quality through the following activities:

- 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 Evaluation Specialist, QI/QA Nurse Consultant, Child Health Nurse Consultant) prior to each two (2) year contract cycle to clearly communicate (in writing) Primary Care contracted services and reporting requirements (Work plans, 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: MCS and the DHHS Audit Team monitor all sub-recipient activities and financial management in accordance per OMB Circular A-13. MCH staff ensures fiscal responsibility by reviewing contracted agency budget, budget justification, sources of revenue and program staff list annually. MCH staff ensures that work plan inputs/resources are accounted for in agency's financial documents. MCH staff communicates budget discrepancies to contracted agencies for reconciliation.
- Performance Measures: MCH staff works 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 (2) Primary Care contract cycle. As the majority of Primary Care contracted agencies continue to receive funding, MCH elicits input from contracted agencies by reviewing proposed Performance Measures and Definitions prior to implementing the measures for the next contract cycle. 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 implemented the below Primary Care Performance Measures for SFY18-19.

NH Maternal & Child Health Section
Primary Care Performance Measures SFY18-19

1. Percent of infants who are ever breastfed (Title V PM #4)
2. Percent of children 3 years of age who had two or more capillary or venous lead blood tests for lead poisoning by their third birthday (NH MCH)
3. 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)
4. 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)
5. Percentage of women who are screened for clinical depression during any visit up to 12 weeks following delivery using an appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen (NH MCH)
6. Percent 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 (NQF 0421, UDS)

7. Percent of patients aged 3 until 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 (UDS)
8. 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 (UDS)
9. 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 (NH MCH)
10. Percent of patients aged 18 through 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHG) during the measurement year (NQF 0018)
11. Percent of patients aged 65 years and older who were screened for fall risk at least once within 12 months (NH MCH)
12. 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, received a brief intervention or referral to services (NH MCH)
13. Percent of patients aged 18 years and older who were screened for substance use, using a formal valid screening tool, during any medical visit AND if positive, received a brief intervention or referral to services (NH MCH)
14. Percent of pregnant women who were screened, using a formal valid screening tool, for substance use, during every trimester they are enrolled in the prenatal program AND if positive, received a brief intervention or referral to services (NH MCH)

Key:
HEDIS – Healthcare Effectiveness Data and Information Set
NQF – National Quality Forum
NH MCH – New Hampshire Maternal & Child Health section
Title V – Federal Maternal and Child Health Services Block Grant
UDS – Uniform Data System

Source: NH DHHS, Maternal & Child Health section, 2017

- Data Collection & Analysis: At the beginning of each state fiscal year the MCH QA/QI Nurse Consultant requests contracted agencies to set and submit their individual agency's target for each performance measure. Performance Measure Outcome data is reported to MCH twice per year (January and July) via spreadsheets known as "Data Trend Tables" (DTT). DTTs are updated and forwarded with instructions for completion by the QA/QI Nurse Consultant to contracted agencies (30 days prior to due date). Completed DTTs are then reviewed and analyzed by the 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 the MCH QA/QI Nurse Consultant is provided as needed.
- Site Visits: MCH staff conduct site visits at each Primary Care contracted agency at least once per each two (2) year contract

cycle to: maintain relationships with CHC staff, explore how MCH funds are utilized, review and discuss agency specific data, work plan(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 Assistance (TA) and Support: MCH staff provides technical support via conference calls, site visits, and PC Coordinators meeting. For example, in order to support the promotion of ES and the new requirement for all CHCs to submit an ES Work plan MCH provided technical assistance during the May 2016 Primary Care Coordinators meeting via an ES presentation. During this ES presentation CHCs were provided: an overview of ES (what they are, why they are important), discussion of one agency's experience with ES to demonstrate the value of ES to the agency and their population served, information about the new reporting requirements, and instructions for completing key elements of the ES work plan which reinforced QI concepts (such as use of SMART objectives, measuring/monitoring performance at least quarterly and conducting PDSA cycles to improve performance)
- Education: MCH staff disseminates information, resources and provides 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 provide assistance to the 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 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 is determined by the degree of agency QI capacity.

Overall, the CHCs funded by MCH have moderately high to high QI capacity. Most agencies have embedded QI into their organizations culture and support QI activities by incorporating the following:

- Designating a "QI team" led by a full time "Quality Assurance Manager"
- Setting an expectation that all staff members will participate in one (1) to two (2) QI projects each year and allocating hours (limited) for staff members (of any discipline) to participate in "QI projects".
- Including QI participation on staff annual performance review
- Allocating IT support to automatically generate data reports which allow the QI team to analyze data monthly/quarterly. At this time nine (9) out of 15 MCH Primary Care contracted agencies 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 (EMR), practice management and accounting systems. As CHAN is responsible for writing these agencies' 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.

While all CHCs have shown a commitment to QI, proficiency and capacity varies among the health centers. Some health centers find that QA/QI has been assigned to a current staff member who has limited QI education/experience and 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. Often, health center IT systems do not easily capture data from the EMR. Health centers may also struggle to generate data reports and are surprised when their data shows poor performance. They may disregard their performance outcome data as they "know" they do a good job. In these situations, the health centers receive additional support and technical assistance

from the MCH QA/QI Nurse Consultant by email, phone and/or in person, as needed, to build staff QA/QI knowledge and skills allowing them to improve their QI initiatives and successfully complete reporting requirements.

* * * * * * * * *

State Performance Measure #3: Percent of behavioral health professionals recruited (number of sourced contacts that became "active"/number of reached or "sourced" contacts)

Objectives: Increase the recruitment of behavioral health professionals by five percentage points over five years, from a baseline of 21% (in 2017) to 26% (in 2021).

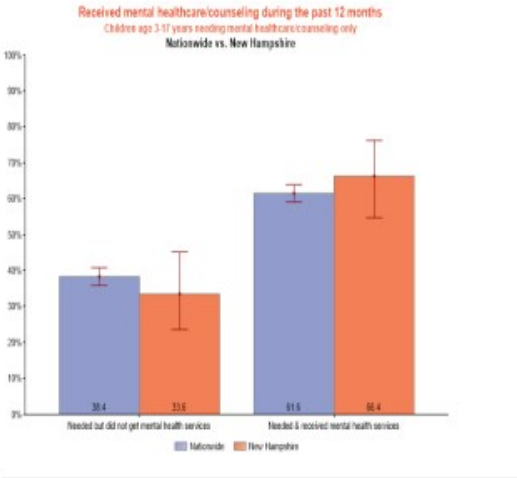
Strategies:

- 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
- Policy: Supporting the State Loan Repayment Program for behavioral health professionals and changing credentialing requirements

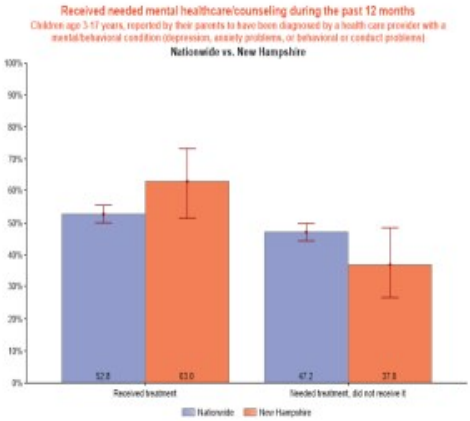
Background

Since 2017, those covered by NH Medicaid have access to substance use disorder benefits as well as general mental health services. Recently, the State also applied for an 1115(a) waiver from CMS enabling Medicaid to reimburse "Institutions of Mental Disease" for in-patient substance use disorder treatment. In the 2017 NH Legislative Session, HB 517 gave narrative direction and limited funding for the following: designated receiving beds, crisis intervention services, transitional/supportive housing, children's wraparound services and a children's residential substance use treatment center. A ten (10) year mental health plan is being written, efforts of which will be discussed later in this section. Nevertheless, significant challenges still remain in serving the State's citizens with behavioral health needs. The new benefits and efforts taking place in NH have increased demands on already overtaxed behavioral (mental health and substance use disorder) health care providers, underscoring the need for continuing reform and change.

Wait times for psychiatry services for new and old patients of all coverage status are often over 30 days.[6] Data from the recent 2016 National Survey of Children's Health, shows a small decrease in the percentage of children ages 3-17 needing mental health counseling and receiving it from 66.4% in 2011/2012 to 63.0% in 2016.



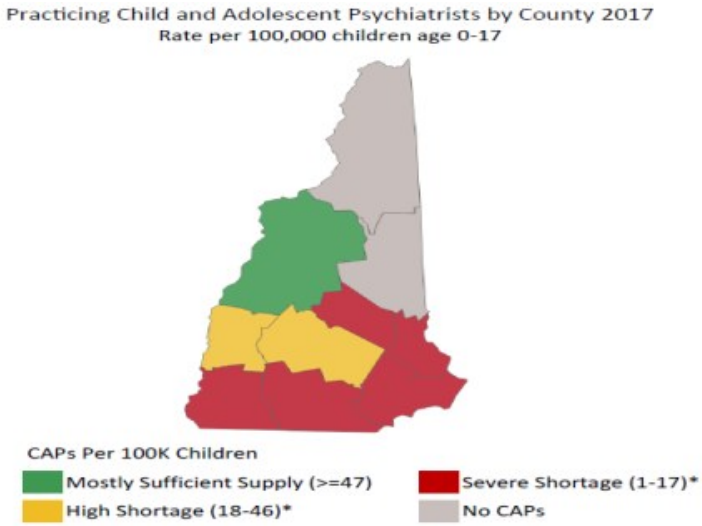
2011/2012



[7]

2016

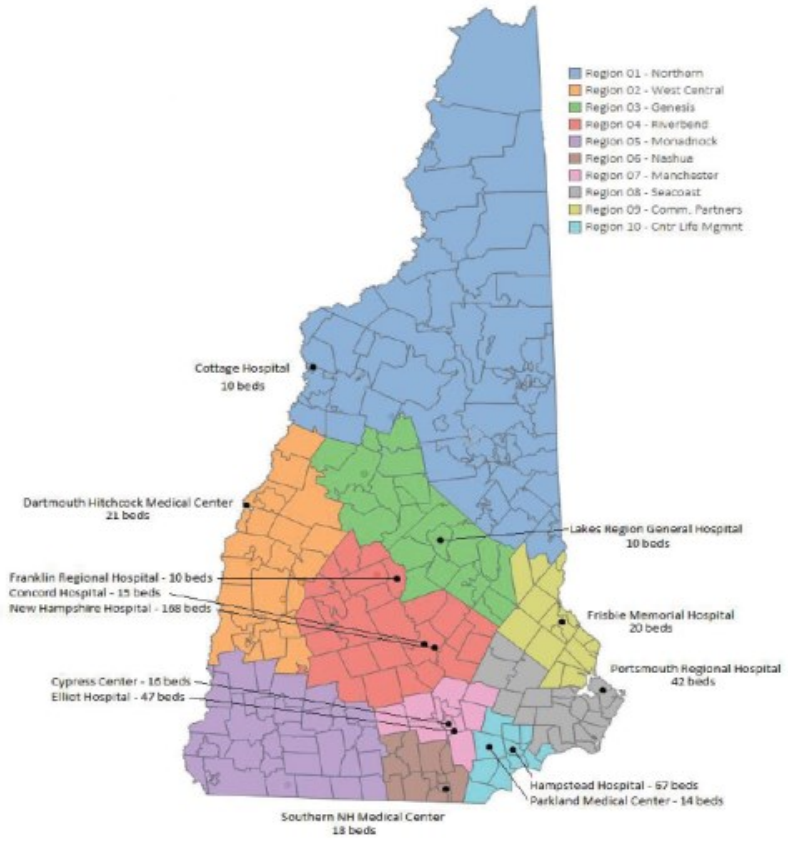
In October of 2017, NH had a mental health professional shortage area (MHPSA) designation for about one third of the state.[8] Most of the geographic area of the state was deemed insufficient for child and adolescent psychiatrists according to the American Academy of Child and Adolescent Psychiatrists.[9]



[10]

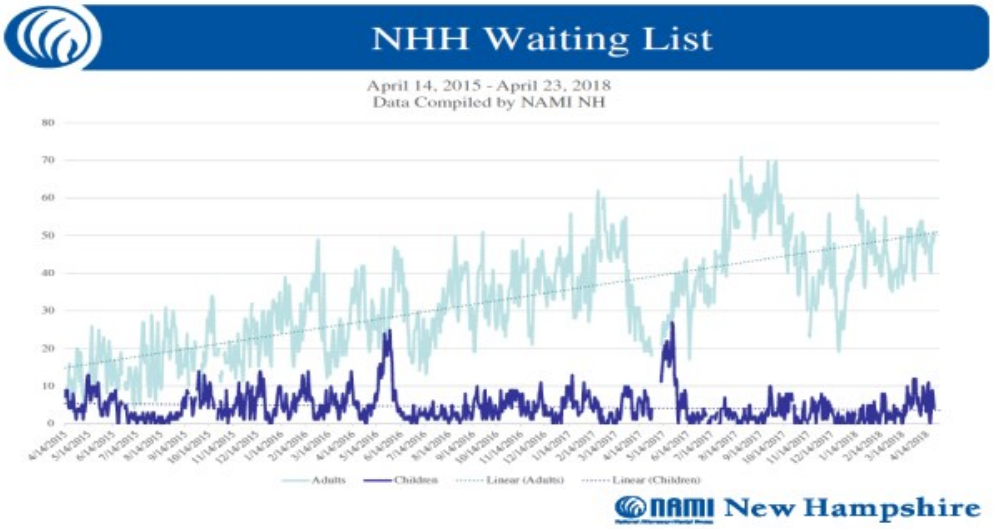
Community mobile crisis teams and assertive community treatment teams have increased in the state; as have the number of in-patient beds.

Exhibit 4. Inpatient Psychiatric Bed Capacity by CMHC Region



December 2017[11]

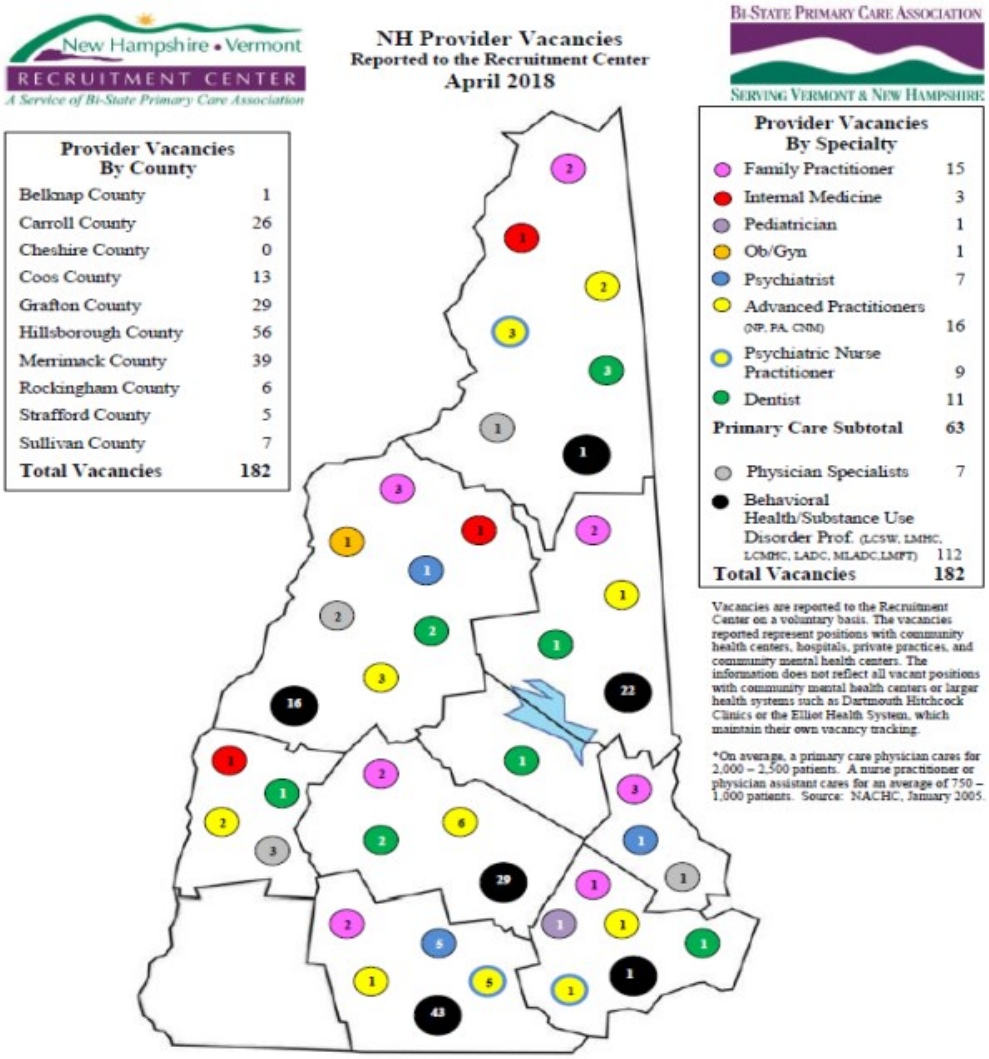
Yet the number of patients needing in-patient behavioral health care waiting in hospital emergency departments is not waning and has even increased over the last several years.[12]



[13]

The number of people waiting for inpatient admissions in emergency departments is usually indicative of a need for enhanced community supports and crisis response. The evaluation done in 2017 of the State's behavioral health system found just that, a lack of sufficient alternatives to emergency departments and readily accessible community care.[14] Several reports from NH's behavioral health community in the last two (2) years[15], [16] have pointed to severe workforce shortages and high staff turnover, as extreme as one (1) in five (5) per year for children's providers.[17] Lack of adequate reimbursement making salaries for positions not financially feasible, stringent requirements and lack of reciprocity of the State's licensing boards round out the difficulties.[18], [19] Suggested interventions have included both financial (state loan repayment, higher insurance payments) and management (peer and mentor support, generous professional training) state.[20], [21]

These needs match with Title V's priority area of increasing access to mental health services and as such MCH continues to leverage Title V funding with additional funds from DHHS' Division of Behavioral Health for a behavioral health expansion of the contract with the New Hampshire Vermont Recruitment Center, a service of Bi-State Primary Association (Recruitment Center). The Recruitment Center is the regions' only non-profit state focused recruitment resource. For many years, 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 to identify and match primary care doctors, dentists, nurse practitioners, physician assistants and nurse midwives with practices and communities throughout NH that met their personal and professional needs. MCH's piece of the Recruitment Center's contract focuses on recruiting behavioral health providers for its Title V funded agencies (including home visiting). Behavioral health providers are defined as psychiatrists; clinical or counseling psychologists; nurse practitioners; masters prepared social workers, mental health counselors, and family therapists; licensed alcohol and drug counselors; and masters prepared licensed alcohol and drug counselors. As of May 1, 2018, provider vacancies reported to the Recruitment Center were as follows (including primary care and dental):



[22]

In the recently released *The State of Mental Health in America 2018,*[23] NH ranks 29th in an overall prevalence ranking of mental illness compared to rate of access to care. A higher overall ranking indicates lower prevalence of mental illness and higher rates of access to care. The overall ranking includes a combination of the following 15 measures:

1. Adults with any mental illness
2. Adults with alcohol dependence and illicit drugs (marijuana, heroin and cocaine)
3. Adults with serious thoughts of suicide
4. Youth with at least one major depressive episode in the past year
5. Youth with alcohol dependence and illicit drugs use
6. Youth with severe major depressive episode
7. Adults with any mental illness who did not receive treatment
8. Adults with any mental illness reporting unmet need

9. Adults with any mental illness who are uninsured
10. Adults with disability who could not see a doctor due to costs
11. Youth with a major depressive episode who did not receive mental health services
12. Youth with severe major depressive episode who received some consistent treatment
13. Children with private insurance that did not cover mental or emotional problems
14. Students identified with emotional disturbance for an individualized education program (IEP)
15. Mental health workforce availability [24]

Current situation

There are currently 112 vacancies for behavioral health providers (as of May 1, 2018). The state performance measure is the percent of behavioral health professionals recruited which is defined as the number of "active" contacts divided by the number of reached or sourced contacts. A reached or sourced contact is someone who the Recruitment Center has communicated with (electronically, in-person, etc.) who has expressed an interest in working in the state of New Hampshire. A contact is considered "active" if that person has actually followed-up and sent a resume and additional personalized information in seeking a position. To address these vacancies, since July of 2017, the Recruitment Center has reached or sourced 161 candidates, which included:

- Addiction Counselors: eight (8) sourced and one (1) became active
- Mental Health Counselors/Therapists; 54 sourced and three (3) became active
- Social Workers: 23 sourced and nine (9) became active
- Psychiatric Nurse Practitioners: 17 sourced and seven (7) became active
- Psychiatrists: 57 sourced and 13 became active
- Psychologists: two (2) sourced and one (1) became active

Twenty-one percent (34) of the 161 sourced contacts became "active" with the Recruitment Center since July of 2017. This is down from last year's 39% that became active contacts. However, the numbers from last year were primarily psychiatrists and psychiatric nurse practitioners. The Recruitment Center has many years of working to recruit physicians and nurse practitioners with outreach tactics that have been tried over time. The percentage of psychiatrists, psychologists and psychiatric nurse practitioners from sourced to active is 28%, more aligned with last year's percentage. Combining the first three categories (addiction counselors, mental health counselors/therapists and social workers), the percentage from sourced to active is only 15%. Recruitment for Masters level clinicians is new for the Recruitment Center and they are trying different options, discussed later in the report, to see which will be the most effective. They may also learn that there may be a lower conversion curve putting the doctorate and masters candidates together. Annual objectives were adjusted based on this theory and this year's actual percentage.

From an active status, an individual is then referred for matching to the recruiting agency for potential interviews, etc. The 34 active contacts became matched with 43 job opportunities (some matched to multiple opportunities). Six (6) interviews took place and one job offer to a psychiatrist was made. Although the psychiatrist declined the position, he did take another job within New Hampshire. [25]

Systems Building

The Recruitment Center assessed the behavioral health workforce needs of the agencies and the State by meeting with Chief Executive Officers and Human Resource Directors from the majority of the State's Community Mental Health Centers (CMHCs) and FQHCs, behavioral health professional associations and private behavioral health agencies. Recruitment Center staff also met with key staff of three (3) training programs including the University of New Hampshire's Psychiatric Nurse Practitioner Program, the Dartmouth Psychiatric Residency Program and Plymouth State University's Addiction Treatment Certificate Program. These discussions often focused on the facilitators and barriers to behavioral health workforce development and recruitment. Staff found that some of the barriers include:[26]

- Lack of qualified candidates: Overall, there's a shortage of qualified candidates to fill all the positions throughout the state.
- Geography: It's hard to recruit across the state, but it is extremely difficult to recruit to rural areas.
- Burn Out: oversize caseloads, lack of continuity, difficult job working with highly complex patients and heavy administrative burdens contribute to burnout.
- Low and varied salaries across the board: CMHCs struggle the most with their ability to pay a competitive salary. Another challenge for them is their high staff turnover. One (1) reason for this is that they are often a training ground for new graduates and once trained and licensed the clinician moves on to a higher paying job. This causes a lot of movement in the industry.
- Billable credentials and inconsistent reimbursement: This impacts an agency's decision around recruitment. This can vary based on three factors. First, the type of credential that the provider holds. Some licenses are not billable, such as Licensed Clinical Mental Health Counselors (LICMHC); however, this depends on a second factor which is the type of facility. For example, CMHCs have the ability to submit a waiver, which allows them to be reimbursed for services provided even by an unlicensed clinician. And, lastly, what can be billed varies according to payer source.
- Student debt: Social worker and mental health professionals may graduate owing $50,000 or more and the salaries they receive make it very difficult to pay down their loans.
- Stigma: Stereotypes, prejudices and discrimination about mental illness and addiction are not only a deterrent for people seeking services, but they can also be a barrier for people looking to enter the profession.
- Integrated services: There is a movement towards integrating behavioral health and substance use services into primary care. This creates a unique challenge to health centers for finding staff that are specifically trained in integrated care.
- Lack of pipeline and training programs: There are limited sources within our state for filling psychiatrists and psychiatric nurse practitioners positions, which are in great demand. There are more options for master's level positions but the graduates aren't keeping up with the demand.
- Licensure: There are several areas within licensure that are causing hardships. First, it is difficult to hire licensed clinicians and the process of obtaining licensure includes many hours of supervision by a licensed clinician. In addition, lack of reciprocity can be difficult.

And on the other hand, the Recruitment Center discovered that some facilitators to behavioral health recruitment are:[27]

- Sign-on bonuses
- Covering relocation expenses
- Loan repayment and/or forgiveness programs
- Tuition reimbursement
- Assistance with obtaining licensure, especially for new graduates

- Opportunities for leadership development
- Career development and compensation increases
- Flexible and/or part time hours
- Reduced and flexible hours for employees close to retirement
- Paid time-off policies
- Careful vetting of candidates and transparency about job responsibilities and expectations
- Hosting residents and internships as a way to build a pipeline for recruitment
- Maintaining a positive work culture with solid supervision and support
- Licensure reciprocity for specific disciplines
- Use of telemedicine to extend workforce

Understanding the factors that contribute to the workforce shortages informed the development of subsequent strategies that are outlined in the document *Workforce Development Plan: Developing a Pipeline and Recruiting and Retaining Behavioral Health and Substance Use Disorder Treatment Providers for New Hampshire 2017-2018*.[28] The Recruitment Center then held two (2) stakeholders meetings, one (1) with the NH Primary Care Workforce Commission one (1) with many of the same staff and agencies interviewed, to present the document and obtain feedback on particularly the marketing and outreach strategies.

The Recruitment Center uses a mixture of the following strategies in its recruitment efforts.

- Hosting a current vacancy map on the Recruitment Center's website (http://bistaterecruitmentcenter.org/)
- Participating in recruitment events such as fairs, virtual events, exhibits, meetings and conferences.
- Subscriptions to web based job hosting sites such as 3RNet and other clinician job search engines and databases.
- Presentations to students enrolled in educational and training programs related to behavioral health.
- Posting of on-line and print advertisements that appear in professional journals and online concurrently.

The Recruitment Center uses a Kontact Intelligence database to create employer profiles, track vacancies including the production of a visual depiction and record candidate information. The Recruitment Center promotes all vacancies at their outreach efforts but also provides a premium promotional plan which enables member agencies to post their openings on the national 3RNet job board. 3RNet is a national nonprofit committed to matching healthcare professionals with rural and underserved jobs. There is one 3RNet member per state and the Recruitment Center is NH's. Promotional plan members have their information passed out at every recruitment event. MCH funded agencies get a discounted rate.

Demand for behavioral health providers is so great that NH practices not only compete against themselves, but also with colleagues across the country. The Recruitment Center is increasing the visibility of NH by using a centralized marketing and outreach campaign informed by research with job seekers as well as individuals who are already successfully practicing in the state. An example of a print advertisement put on social media is the following:

The Recruitment Center is particularly focused on 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.[29] Data from the most recent physician survey from the Rural Health and Primary Care Section show that the top five (5) residencies where the most recently graduated practicing physician trained were almost all New England/New York.[30] This data is a key resource in recruitment initiatives.
Some highlights of the past year's marketing efforts, including work with training programs, are:

- Presentation to the only psychiatric residency program in NH at Dartmouth Hitchcock Medical Center. Four (4) residents became sourced and two (2) became active.
- Exhibits and presentations at several behavioral health association conferences (both in NH and nationally) and graduate school career fairs.
- Presentation to Southern New Hampshire University's Clinical Mental Health Counseling graduate students. Thirty-four of the students became sourced and out of that, 20 became active.

The Recruitment Center also held a "Health Recruitment and Retention" conference in December 2017. This educational conference attracted more than 100 human resource staff, administrators and leaders directly involved in the recruitment and retention of

physicians, dentists, nurse practitioners, physician assistants, and behavioral health professionals.

The Governor proclaimed the day as "Healthcare Workforce Recruitment Day" and a proclamation was read. The day's agenda included a national keynote address on combating clinician burnout from Dr. Corey Martin, founder of the *Bounce Back Project*. His talk focused on the benefits of gratitude, and its association to resiliency and happiness and its application in the workplace. Other sessions included updates on employment law, retention and boarding strategies and job posting best practices. Attendees were provided time to network with colleagues and vendors, and given a Resource Guide with information on leading sponsors and organizations that pertain to the health care workforce, recruitment and retention industry.

- Conference evaluation forms indicated a solid overall conference rating with 79% rating it "very good" or "excellent" and the remaining rating it "good".
- 98% of respondents found the topics to be pertinent to their recruitment needs.

A significant factor for individuals early in their career in behavioral health is the debt that is incurred in pursuit of the necessary education. Recruitment staff heard and continues to hear that the cost of education is limiting, both in the terms of the jobs people feel they can afford to accept and in advancing their education once in the field. There are three primary programs in NH that address provider loan repayment and forgiveness, the National Health Service Corp, the State Loan Repayment Program (SLRP) and the Public Service Loan Forgiveness Program. The first is based on the Health Professional Shortage Area (HPSA) need score. There are a limited number of HPSAs in NH that have scores high enough for providers to receive an award. The last applies to individuals working for a certain employer who made a significant amount of pay loan repayments who may be forgiven the balance. This program is not an attractive recruitment incentive. SLRP however is a program that is a great recruitment tool. Located in MCH's colleague the Rural Health and Primary Care Section, SLRP provides loan repayments to those working in areas of NH that are federally designated as medically underserved. Because of the great number of disciplines able to apply (including all of the behavioral health providers being recruited) and the limited amount of funding, there is always a waitlist. The Recruitment Center is supporting policy change through 2018 state legislation that would add between additional general funding annually to SLRP beginning in the 2020/2021 biennium budget.

Another policy strategy the Recruitment Center is undertaking is working with the five (5) different boards in the state who license

those who provide behavioral health services. Licensing requirements are complex and potential rule changes may make it easier for certification to take place.

MCH Specific Activities

MCH continues to work with its CHCs on the integration of behavioral health and primary care. In fact, MCH is considered a "pioneer" in the State with over a decade of funding support for for integrated care. Research shows that 25 to 30% of visits for primary medical care either originate from or have a significant related behavioral health component.[31], [32], [33] A study done over a four (4) year period determined that collaborative or integrated care had a cost savings of $3,363 per patient per year.[34] More recent studies have backed up that research finding, albeit with lesser cost savings.[35], [36], [37] In June of 2018, 100% of the CHCs surveyed replied that they either had enhanced co-location or were fully integrated by the definitions below:

> Enhanced co-location: 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.
>
> Fully Integrated: Agency has a specialty skilled behaviorist embedded full-time or part-time on primary care team that serves the primary care population through brief interviews and longer traditional care.

This percentage has increased from last year when 14% of the CHCs still had a preferred referral mechanism in place. Several of the CHCs 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.

CHCs continue to utilize MCH funding for enabling services such as care coordination and quality improvement. Some agencies utilized a portion of their funding to provide otherwise non-billable mental health such as the following:

- A subcontract with a local community mental health agency for direct service or consultation.
- Case management time from existing personnel-social services, nurse coordinator, etc.
- Direct service for uncompensated time from existing integrated behavioral health practitioners.

For example, a CHC that was newly designated as a "Look-Alike" FQHC braids Title V funds with other sources of income for a monthly in-person consultation with a psychiatrist. This has enabled clinical competency particularly with respect to prescribing of medications for behavioral health issues. Another CHC weaves funds, including Title V/MCH, providing a full-time psychiatric nurse practitioner on-site. This has enabled clients with acute psychiatric symptoms to be seen on a same day basis as necessary. In addition, the psychiatric nurse practitioner acts an internal consultant for the primary care providers who feel a client is not being successfully managed and is looking for a more comprehensive evaluation and treatment plan.

Although the integration of behavioral health into primary care seems to be moving forward, on-the-ground issues such as billing, coding, payment, privacy concerns, continuity between providers, credentialing and workforce shortages are slowing progress.[38] MCH is working with the Citizens Health Initiative, a program of the Institute for Health Policy and Practice at the University of New Hampshire, on their Behavioral Health Integration Learning Collaborative (BHILC). Starting its fourth year, 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.

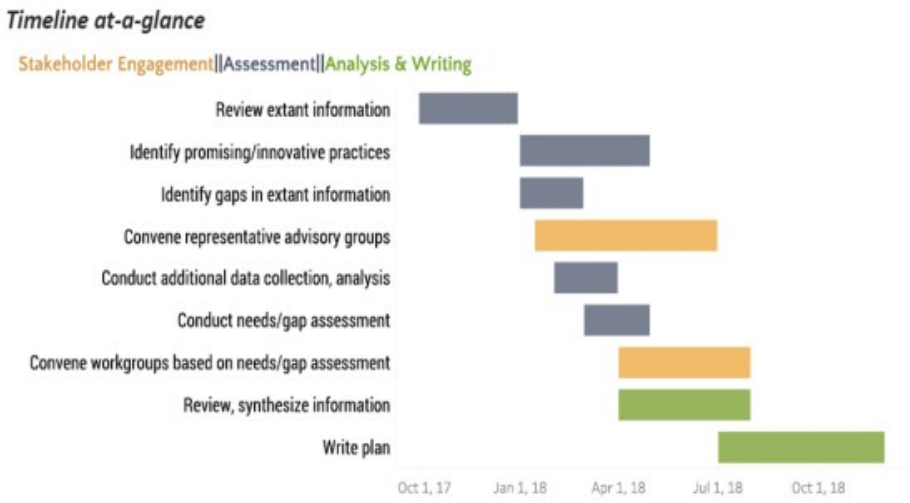
- Demonstrating improvement on key quality and cost measures, using EMR reporting tools and claims-based analytic reports.

The BHILC is assisting the state in moving forward and sustaining evidence-based models of integrated behavioral health into primary care. Health care providers (including some MCH funded CHCs) have been working on multi-year QI projects designed to improve their level of integration and have been submitting clinical process and outcomes data to track performance on selected measures. A final aggregated report should be coming out in late 2018. A coach from the BHILC staff meets monthly with each individual participating provider group. MCH staff will continue to be a part of the BHILC until its end and will continue to encourage its funded CHCs to take advantage of learning opportunities such as the BHILC.

Another statewide endeavor around behavioral health integration into primary care is the previously described Medicaid 1115 DSRIP waiver. All seven (7) IDNs, which include all of the MCH funded CHCs, are working towards this goal as well as an overall goal of increasing the behavioral health and primary care workforce. The Recruitment Center as well as the Rural Health and Primary Care Section participate. This enables MCH staff to also have routine IDN related updates at their (MCH/Bi-State/Rural Health and Primary Care) monthly meetings.

DPHS and MCH leadership are actively participating in all aspects of behavioral health planning for both children and adults. The MCH Administrator has continued working with the Executive Committee of the Workforce Development Network of 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.*" Recently updating its work plan, the mission of the CHBC's Workforce Development Network is to ensure a "highly effective, stable, diverse workforce by building responsive and effective cross sector development opportunities that are infused with the core competencies and system of care values and guiding principles."[39] 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. The Deputy Director of DPHS has recently joined the CHBC statewide advisory committee.

The CHBC is updating its overall state plan to coincide with the release of the DHHS's Division of Behavioral Health's ten (10) year state mental health plan, legislated under HB 400 in 2017. The timeline for the plan is as follows:



[40]

* * * * * * * * *

[1] NH DHHS, Maternal & Child Health Section: Uniform Data Set Table, 2017

[2] Ammonoosuc Community Health Center, Personal communication with staff, 2018.

[3] NH DHHS, Maternal & Child Health Section, 2017 UDS data

[4] Strafford County Public Health Network, "2015-2017 Strafford County Public Health Network Community Health Improvement Plan". Retrieved [06/19/18] from https://www.scphn.org/wp-content/uploads/community-health-improvement-plan-final-strafford-phn.pdf

[5] Medical Examiner's Office, NH Drug Monitoring Initiative. Retrieved [06/19/18] from https://www.dhhs.nh.gov/dcbcs/bdas/documents/dmi-2017-overview.pdf

[6] NH Health Professions Data Center (2015). 2015 Physician Survey Results. Presentation to Legislative Commission on Primary Care Workforce Issues, March 23, 2017.

[7] Child and Adolescent Health Measurement Initiative. Data Resource Center for Child and Adolescent Health. 2016 National Survey of Children's Health (NSCH) data query. Retrieved 05/01/2018 from www.childhealthdata.org.

[8] Alisa Druzba, Administrator of the Rural Health and Primary Care Section, New Hampshire Department of Health and Human Services, Division of Public Health Services , Personal Communication, May 2, 2018.

[9] American Academy of Child and Adolescent Psychiatrists. New Hampshire Child and Adolescent Psychiatry Workforce Distribution Map 2017. Retrieved from http://www.aacap.org/app_themes/aacap/docs/Advocacy/federal_and_state_initiatives/workforce/individual_state_maps/New%20Hampshire%20work on 05/06/2018.

[10] Ibid.

[11] Human Services Research Institute. *Final Report: Evaluation of the Capacity of the New Hampshire Behavioral Health System, December 22, 2017*. Retrieved on 05/06/2018 from https://www.dhhs.nh.gov/dcbcs/bbh/documents/nh-final-report-12222017.pdf.

[12] NH Department of Health and Human Services. *Behavioral Health Initiatives*. Presentation to the Governor and Executive Council on 12/05/2017. Retrieved on 05/02/18 from https://www.dhhs.nh.gov/documents/gandc-presentation-12052017.pdf

[13] Patrick Roberts, Coordinator of Program Evaluation and Improvement, National Alliance on Mental Illness New Hampshire Chapter, Personal Communication, May 2, 2018.

[14] Human Services Research Institute. *Final Report: Evaluation of the Capacity of the New Hampshire Behavioral Health System, December 22, 2017*. Retrieved on 05/06/2018 from https://www.dhhs.nh.gov/dcbcs/bbh/documents/nh-final-report-12222017.pdf.

[15] Ibid.

[16] Children's Behavioral Health Collaborative. *Improving Child and Community Health: Addressing Workforce Challenges in Our Community Mental Health Centers*. Retrieved on 05/06/2018 from http://www.endowmentforhealth.org/uploads/resources/id107/CMHC_Workforce_Full_Report_2016.pdf

[17] Ibid.

[18] Ibid.

[19] Human Services Research Institute. *Final Report: Evaluation of the Capacity of the New Hampshire Behavioral Health System, December 22, 2017*. Retrieved on 05/06/2018 from https://www.dhhs.nh.gov/dcbcs/bbh/documents/nh-final-report-12222017.pdf

[20] Ibid.

[21] Children's Behavioral Health Collaborative. *Improving Child and Community Health: Addressing Workforce Challenges in Our Community Mental Health Centers*. Retrieved on 05/06/2018 from http://www.endowmentforhealth.org/uploads/resources/id107/CMHC_Workforce_Full_Report_2016.pdf

[22] Bi-State Primary Care Recruitment Center (2018). Personal communication with Director on 05/01/2018.

[23] Mental Health America. *The State of Mental Health in America 2018*. Retrieved 05/04/2018 from http://www.mentalhealthamerica.net/sites/default/files/2018%20The%20State%20of%20MH%20in%20America%20-%20FINAL.pdf.

[24] Ibid.

[25] Pagliuca, Stephanie and Peterson, Michelle, NH/VT Recruitment Center, Bi-State Primary Care Association. *Workforce Development Plan: Developing a Pipeline and Recruiting and Retaining Behavioral Health and Substance Use Disorder Treatment Providers for New Hampshire 2017-2018*. Electronic communication from Ms. Pagluica on 05/09/2018.

[26] Ibid.

[27] Ibid.

[28] Ibid.
[29] NH Health Professions Data Center (2015). 2015 Physician Survey Results. Presentation to Legislative Commission on Primary Care Workforce Issues, March 23, 2017.
[30] Ibid.
[31] Gunn, W, Blount A (2009). Primary care mental health: A new frontier for psychology. *Journal of Clinical Psychology*; 65(3):235-252.
[32] Ansseau, et al. (2004). High prevalence of mental disorders in primary care *Journal of Affective Disorders*; 78(1): 49-55.
[33] Peterson, S., et al. (2014). Mental health treatment in the primary care setting: patterns and pathways. *Families, Systems & Health: The Journal of Collaborative Family HealthCare*. 32(2): 157-166
[34] Unutzer J, et al. (2008). Long-term cost effects of collaborative care for late-life depression. *American Journal of Managed Care*; 14(2):95.
[35] Ross, K. et al. (2018).The cost effectiveness of embedding a behavioral health clinician into an existing primary care practice to facilitate the integration of care: A prospective, case-control program evaluation. *Journal of Clinical Psychology in Medical Settings*; doi: 1007/s10880-018-9564-9.
[36] Looman,W. et al. (2018). The cost effectiveness of preventive, integrated care for community-dwelling frail older people: A systematic review. *Health and Social Care in the Community*; doi: 10.1111/hsc.12571.
[37] Basu, S. et al. (2017). Behavioral health integration into primary care: a microsimulation of financial implications for practices. *Journal of General Internal Medicine*; 32(12):1330-1341.
[38] NH Citizens Health Initiative (2017). *Integrating Behavioral Health and Primary Care in New Hampshire: A Path Forward to Sustainable Practice and Payment Transformation*. Retrieved on 05/14/2018 from http://www.citizenshealthinitiative.org/sites/default/files/media/NH%20Citizens%20Health%20Initiative%20Whitepaper%20-%20Dec%202016.pdf.
[39] New Hampshire Children's Behavioral Health Collaborative, Workforce Development Network (2018). *New Hampshire Children's Behavioral Health Workforce Development Network Plan, 2018-2023*.
Retrieved on 05/14/2018 from http://nh4youth.org/collaborative/workgroups/workforce-development-network
[40] Personal communication from the Chief of the DHHS Bureau of Children's Behavioral Health on 05/14/2018.

Cross-Cutting/Systems Building - Application Year

State Performance Measure #1: Percentage of MCH-contracted Community Health Centers (CHCs)with Enabling Services (ES) work plan on file with DHHS/MCH

Objectives: Increase the percentage of MCH contracted CHCs with an ES workplan on file with DHHS from 2015 baseline of 60% (9 of 15) to 90% by October 2018.

Strategies:

- MCHS will require CHCs to submit an ES work plan as a contract deliverable
- MCHS will review completed ES work plans and provide feedback/technical assistance as needed to ensure activities are within the scope of services

Systems Building

MCH recognizes both the public health value of ES and the importance of maintaining accountability provided by contracted agencies. Therefore, MCH proposes to continue to impose a requirement for the inclusion of ES in the contract period April 1, 2018- March 31, 2020.

In order to attain this objective:

- Contract deliverables were included within the Primary Care Services Scope of Services, Exhibit A and have been electronically shared with agencies as part of the contract procurement process (Spring 2018).
- Upon final contract approval by Governor & Council, the MCH QI/QA Nurse Consultant forwarded ES templates along with written instructions for developing an Enabling Service Workplan to newly contracted agencies for submission within 30 days of Governor & Council approval (June 2018).
- MCH staff will provide technical support and assistance to agencies to ensure all agencies are successful in developing Enabling Service Workplan.
- MCH will review submitted SFY18-19 ES Work plans (outcome sections) and provide feedback to agencies if revisions are needed (Sept/Oct 2018)

* * * * * * * * * *

State Performance Measure #3: Percent of behavioral health professionals recruited (number of sourced contacts that became "active"/number of reached or "sourced" contacts)

Objectives: Increase the recruitment of behavioral health professionals by five percentage points over five years, from a baseline of 21% (in 2017) to 26% (in 2021).

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
- Policy: Supporting the State Loan Repayment Program for behavioral health professionals and changing credentialing requirements

Systems Building

MCH will continue with its third year of funding with a new contract with the Recruitment Center to support agencies that provide behavioral health (mental health and substance use disorder treatment) referrals for MCH contractors, including home visiting agencies, community health centers, etc., in the recruitment of behavioral health providers. Behavioral health providers are defined as psychiatrists; clinical or counseling psychologists; nurse practitioners; masters prepared social workers, mental health counselors, and family therapists; licensed alcohol and drug counselors; and masters prepared licensed alcohol and drug counselors. Some of the anticipated activities include, but are not limited to:

- The engagement and encouragement of agencies to post behavioral health provider/clinician vacancies through the Recruitment Center. These vacancies will be tracked as a means to identify vacancy, recruitment and turnover trends and determine effective tactics for successful outreach, recruitment and retention. These trends will be shared with MCH and other key stakeholders as appropriate.
- The carrying out of efforts to promote the vacancies with the target audience of behavioral health providers using targeted marketing and outreach such as: advertisements in publications and journals, use of on-line posting platforms, mailing/emailing to targeted groups, exhibiting at events and conferences, subscriptions to candidate databases and sourcing services, direct recruitment with schools/training programs and direct contact with practicing providers or students.
- The participation with colleges, universities and training programs as a means to develop a pool of candidates that can fill identified workforce needs. This may include information sessions, on-site exhibits and assistance in development of internship sites, student job searches and internship placements.
- The provision of technical assistance to organizations and agencies with recruitment needs for behavioral health providers on the techniques of recruitment and retention and the measures critical for securing candidates.

The Recruitment Center is going to provide MCH with quarterly statistics on the recruitment of behavioral health providers as tracked by its electronic vacancy tracking system and measured by:

- The number of contacts with behavioral health professionals broken out by provider type. This includes the number sourced, the number who have become active and then the number of professionals who then match with interviews.
- The number of behavioral health professionals recruited to and who obtained employment within NH again broken out by

agency and provider type.

- The number and type of behavioral health provider who declined placement and the reason(s) for declining.

The types of technical assistance will be recorded as well.
The Recruitment Center is supporting policy change through SB 590 in 2018 state legislation that would add up to $400,000 in general funds to the state loan repayment program until the end of State Fiscal Year 19 (June 30, 2018). The funding would be spent against an excess appropriation allocation account made up of enhanced children's Medicaid federal funding if that were to occur. The bill has been passed in both the House and Senate, but has yet to be signed by the Governor. The Recruitment Center will continue support of an additional general fund allocation to the state loan repayment program through the State Fiscal Years 20 and 21 biennium budget process beginning now and continuing through the end of State Fiscal Year 19.

The Recruitment Center is also supporting SB 487 in 2018, which is still in Committee, and would amend the licensure statutes for licensed clinical social workers and licensed clinical mental health counselors to be able to provide supervision for one another. This is currently not in place and is a barrier to professional training and recruitment.

MCH Specific Activities
MCH will continue to work with its contracted CHCs on the integration of behavioral health and primary care. As part of this, it will maintain its involvement with the Behavioral Health Integration Learning Collaborative (BHILC). MCH and SMS staff will also continue to monitor and participate in as appropriate the integration and workforce activities spearheaded by the Medicaid 1115 DSRIP waiver.

MCH and SMS staff will also participate in the creation of the ten (10) year mental health plan out of DHHS.

* * * * * * * * *

III.F. Public Input

Public Input

Maternal and Child Health Section

Input on the Title V MCH Block Grant is gathered routinely from stakeholders who are not members of the MCH staff, through task force or advisory committee meetings attended or led by MCH staff, through multidisciplinary work group meetings, or through sub-grantee meetings with staff of Title V MCH-funded Community Health Centers.

Broader input is also sought from all members of the general public, but this is more difficult to acquire. Focus groups can be organized if resources are available, but this is frequently not the case. Ad hoc or scripted conversations with clients of health facilities can be arranged, but these must be made non-disruptive of the facility's services. Public meetings can be held, but these are usually attended by no one but the facilitators. Public hearings were discontinued in New Hampshire several years ago due to poor attendance; likewise for public notices, which were costly and generated little to no response. Many programmatic meetings, particularly those that are legislated, such as the Newborn Screening Advisory Committee, are also open to the public. Legislated committee meetings are noted the month prior to their occurrence on the DHHS website, where agendas and previous meeting minutes are also available.

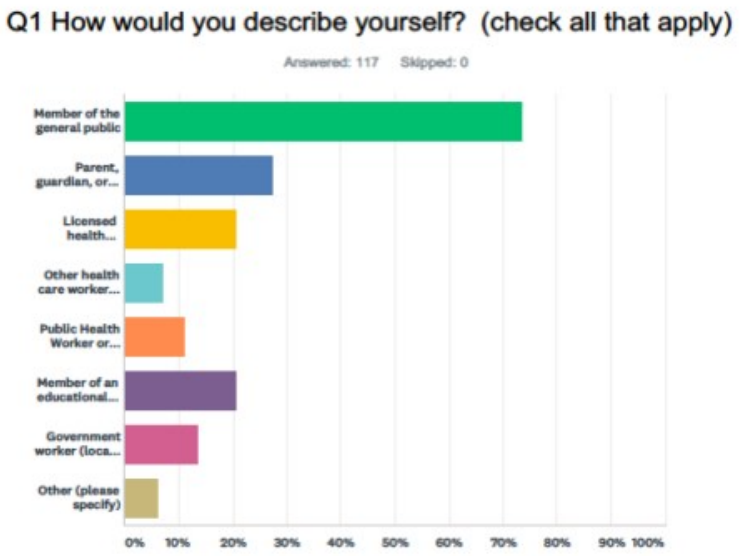
Public participation regarding Title V activities is best achieved by an active web-based presence. Surveys can be implemented, and these can have the greatest reach and be the least costly in resources, as well as the least burdensome on respondents, and written surveys (especially online) can be done at a time of the respondents choosing. However, surveys often have the drawback of being non-representative of the general population if the respondents self-select, and many persons may not be inclined to spend any time or effort to complete a survey that is not required to obtain services or benefits. So while results cannot be generalized to the entire MCH population, an online survey was the main non-routine approach that was utilized to garner public input. A survey instrument was created to query the public's opinions and attitudes on the current Title V MCH Block Grant priority needs, and the importance or effectiveness of the strategies identified to address these needs.

Social media is utilized regularly by the Division of Public Health Services (DPHS) to air health messages, and a social media campaign was launched to solicit participation on the block grant survey; see an example below of the ad as it appeared on Facebook. The DHPS Facebook page can be found at www.facebook.com/NHPubHealth, and the DPHS twitter handle is @NHPubHealth. Each of MCH's programs provides at least two (2) social media posts monthly. The media posts consist of the latest health updates, health reminders, health factoids, public service announcements, and/or program information.

The social media campaign consisted of paid social media ads on Facebook and Instagram that were run for 12 consecutive days, targeting men and women between the ages of 18-44. Ad metrics showed that 10,236 people were reached, resulting in 173 clicks on the survey link embedded in the ad. The demographics of the survey respondents revealed that 88% were female and 84% between the ages of 25-44 years of age. Organic (unpaid) posts were also run during this time on Twitter, Facebook, and Instagram. The Facebook post was pinned to the top of the NH Public Health Services page for the same duration of time as the ad (12 days). Organic posts expanded the survey reach by an additional 338 people.

An invitation/request to complete the survey was also placed on the MCH homepage. As part of the greater NH DHHS website, the MCH homepage provides an excellent opportunity to capture interest in Title V activities and illicit feedback on MCH priorities and strategies. The homepage was revised to include a brief description of the Title V Block Grant, a link to the HRSA New Hampshire State Snapshot (https://mchb.tvisdata.hrsa.gov/uploadedfiles/StateSubmittedFiles/2018/stateSnapshots/NH_StateSnapshot.pdf), a link to the New Hampshire Block Grant brochure (https://www.dhhs.nh.gov/dphs/bchs/mch/documents/title5mchplan.pdf) as well as a link to the survey itself (https://www.surveymonkey.com/r/mchblockgrant2018).

The survey contained a total of 17 questions, which was quite lengthy and probably contributed to many respondents' dropping out before reaching the end of the questionnaire. Future versions of this survey tool will be shorter, and hopefully garner a better completion rate. As of this writing there have been 117 respondents, of which 73% were members of the general public, and 27% were the parent, guardian or caregiver of a child with special health care needs. So this was an effective means of getting input from these two groups. Health workers and educators comprised most of the other respondents (see graphic and table below).

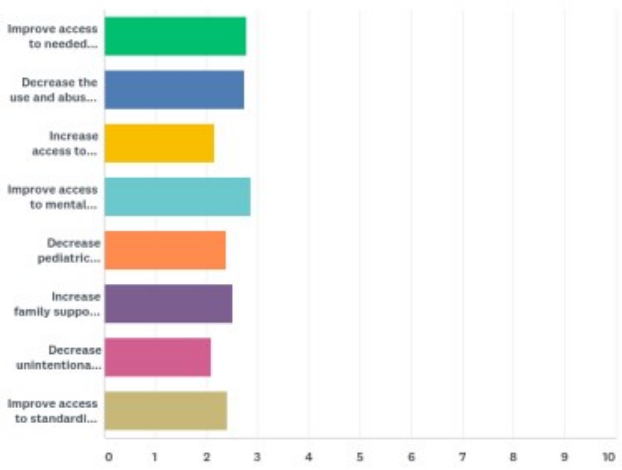


Answer choices	Responses	
Member of the general public	73.50%	32
Parent, guardian, or caregiver of a child with special health care needs	27.35%	32
Licensed health professional (Physician, registered nurse, etc.)	20.51%	24
Other health care worker (hospital, physician's office, etc.)	6.84%	8
Public Health Worker or Community Health Worker	11.11%	13
Member of an educational institution or school	20.51%	24
Government worker (local, state, federal)	13.68%	16
Other	5.98%	7

The survey results showed that of the identified priority needs, the most salient ones (determined by a combined rating of Highly Important or Important) for the most respondents were to improve access to mental health services (100%), followed by decreasing the use and abuse of alcohol, tobacco, and other substances (99%), and improving access to needed health care services for all populations (98%).

At the other end of the spectrum, the two needs that were least often considered Highly Important or Important were decreasing unintentional injury (81%) and increasing access to comprehensive medical homes (86%). While they were the least often deemed to be the most important, these needs nonetheless garnered high ratings, which demonstrates that the selection of these eight priorities at the last five-year needs assessment process was very much on-point.

Q2 How would you rate the importance of the following health needs? (check one box for each need)



Priority Needs	Highly Important	Important	Minimally Important	Not Important	Weighted Average
Improve access to needed health care services for all populations	81.05% 77	16.84% 16	2.11% 2	0% 0	2.79
Decrease the use and abuse of alcohol, tobacco and other substances among youth, pregnant women, and families	75.9% 72	23.16% 22	1.05% 1	0% 0	2.75
Increase access to comprehensive medical homes	30.77% 28	54.95% 50	14.29% 13	0% 0	2.16
Improve access to mental health services	86.32% 82	13.68%	13	0% 0	2.86
Decrease pediatric overweight and obesity	48.42% 46	43.16% 41	7.37% 7	1.05% 1	2.39
Increase family supports and access to trained respite and childcare providers	54.74% 52	41.05% 39	4.21% 4	0% 0	2.51
Decrease unintentional injury	29.47% 28	51.58% 49	17.89% 17	1.05% 1	2.09
Improve access to standardized developmental/social emotional screening, assessment, and follow-up	51.61% 48	38.71% 36	8.60% 8	1.08% 1	2.41

Outreach to specific stakeholders

MCH continues to make targeted presentations on the MCH Block Grant and the State Action Plan across the state to stakeholder meetings.

The discussions are 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: The NH Governor's Early Childhood Advisory Committee
- Northern New England Perinatal Quality Improvement Network
- New England Rural Health Roundtable
- New England Regional Genetics Network

Input has been generally favorable and has 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. Information about the MCH Block Grant and State Action Plan is also provided.

Shorter presentations are delivered at annual site visits to the 15 community health centers funded through the MCH Block Grant. Site visits are structured 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 (2) 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 centers serve priority MCH populations and receive a proportionately large share of MCH Block Grant funding. Community Health Center staff provides feedback on performance measure strategies and progress.

Special Medical Services

Special Medical Services (SMS) has been actively involved in a variety of public input activities with an emphasis on identifying unmet needs in the system of care. These activities have included feedback from clients, community members, and providers alike regarding the variety of programs that have been integrated under SMS due to their shared commonality of serving children with special health care needs including Title V, State Improvement Grants, Partners in Health and Part C Early Intervention.

SMS has been the grantee for two HRSA grants focused on system of care improvement, the "Awareness and Access to Care for Children and Youth with Epilepsy" and the "State Planning Grants for Improving Services for Children and Youth with Autism Spectrum Disorder (ASD) and Other Developmental Disabilities." The work of each grant has incorporated a process for soliciting public perspective on the current systems of care. The University of New Hampshire Survey Center conducted surveys of non-specialist primary care providers, school nurses and parents and caregivers. Survey results provided information regarding workforce demographics and expertise, Medical Home feedback, and parent perspective on barriers and needs. Additionally, the Autism grant

has incorporated parent focus groups, regional stakeholder gatherings, and key informant interviews.

Special Medical Services conducts a biannual survey of parents/caregivers of CYSHCN enrolled in SMS programs, which include Health Care Coordination, PIH Family Support, Nutrition/Feeding and Swallowing Consultation, Neuromotor Specialty Clinic, and Child Development Clinic. In February 2016, SMS surveyed 3480 unduplicated enrolled families by mail with a 19.8% response rate (n=648). The survey was repeated in 2018 but the report is not yet complete.

The survey questions incorporate questions consistent with those used in the National Survey of Children with Special Health Care Needs (NS-CSHCN) and incorporate topic areas relevant national initiatives, including Family Centered Care, Strengthening Families, Medical Home Improvement, and Medicaid Case Management. Qualitative Data was obtained by included open ended questions including:

- *"Please identify any unmet needs in the last year related to the condition of your child."*
- *"Please share what would you identify as the most important needs that are NOT being met for children and youth with special health care needs, in New Hampshire."*

The SMS survey in 2016, consistent with previous surveys, indicated a major difference from the results of the NS-CSHCN in a variety of areas and reinforces the benefit of seeking input specific to children enrolled in SMS programs. One of these areas is related to caregiving burden. When NH families were asked about the extent of clinical nursing they were providing for their child in the home, the SMS survey revealed a four-fold increase over the data in the NS-CSHCN and for children enrolled in Health Care Coordination there was a ten-fold increase. This is consistent with limited capacity in NH to meet the need for Home Nursing services, which is also identified in the Emerging Issues section of the Block Grant. Additionally, the requirements of caregiving had a more detrimental effect on caregiver employment in the SMS survey than what was reflected in the NS-CSHCN. It is likely that there is link between the difficulty in accessing Home Nursing services and this caregiving burden. SMS will continue to edit the biannual survey to solicit pertinent input consistent with the National Survey of Children's Health.

III.G. Technical Assistance

In the Title V Block Grant, family partnership, and by extension family engagement, is defined as "patients, families, their representatives and health professionals working in active partnership at various levels across the health care system-direct care, organizational design and governance, and policy making-to improve health and health care. This partnership is accomplished through the intentional practice of working with families for the ultimate goal of positive outcomes in all areas through the life course.[1] This happens with MCH's contract agencies such as the community health centers and the home visiting agencies that are mandated by their federal and state funding with specific guidance and regulations. This takes place consistently in terms of family and constituent participation in Boards of Directors, Advisory Councils and the like. However, on the state level, MCH programs are inconsistent in terms of family engagement, occasionally inviting a family to be part of a bi-annual advisory committee or be involved in a special time limited project. With the revision of the Title V Block Grant this funding year, additional emphasis has been put on family partnerships and engagement beyond the scope of children and youth with special health care needs, looking at the entire maternal and child health population.

Thus, the first request for MCH staff specifically is the provision of an environmental scan of family engagement and partnership within all of its programming, facilitated by colleagues from NH Family Voices. NH Family Voices is uniquely positioned for this type of technical assistance because of its many years working with the state's Title V programs. Staff of NH Family Voices is familiar and have worked with MCH programs, some more in depth than others such as newborn screening. Historically, as in many other states, New Hampshire's state affiliate of Family Voices has been contracted with Title V funds for programs focusing on CYSHCN. This is the case in New Hampshire with Family Voices led projects on medical home, transition, autism and other developmental disabilities. NH Family Voices also has expertise in working to support the development of patient family advisory councils, in particular a local site of Dartmouth Hitchcock, the largest medical provider in the state. Family Voices will meet with individual program staff from the entirety of MCH. This technical assistance can take place through the use or development of an engagement tool, discussions with individual MCH program staff and resulting presentations to MCH management.

In accompaniment to the written environmental scan will be a draft plan specific to each MCH program at the state level suggestive of how exactly to increase both family partnerships and engagement. Part of this plan will include any identified professional training necessary. Also included will be a review of how to utilize family partnerships at the contractor level for state purposes, such as reviewing the Title V Block Grant on an annual basis, not just at every five year needs assessment.

The second technical assistance request specific to MCH is the provision of approximately 36 hours of evaluation expertise provided to MCH's Injury Prevention Program (IPP) by the Center for Program Design and Evaluation (CPDE) at Dartmouth. The CPDE has assisted the IPP with an evaluation and logic model design previously but not on the interventions specifically related to meeting NPM #7, the rate of hospitalization for non-fatal injury per 100,000 adolescents ages 10 through 19. It is essential to have additional tutoring in refining the objective and tracking methodology currently in place and identifying any new measurable objectives as necessary. This technical assistance could lead to the identification of ways to streamline program activities, strengthen partnerships and document processes.

The technical assistance requests specific for SMS staff are focused on supporting integration and collaboration across the system of care for CYSHCN. The first is a request that will focus on the need for data sharing, amongst the collaborative work taking place with Title V staff and their colleagues' in-state (e.g. developmental screening, Part C, Medical Homes). Data informed decision making is a goal in SMS' Strategic Plan and is a key component of care coordination and shared plans of care across the entirety of the medical home neighborhood. In order to gain traction with any data efforts all partners involved must have a mutually consistent understanding of data governance and management. Data governance establishes responsibility for data, and the framework for program staff to collaboratively and continuously improve data. Data management is the systematic development, implementation, and

enforcement of procedures to operationalize quality and security policies. An understanding of both the Health Insurance Portability and Accountability Act (HIPPA) and the Family Educational Rights and Privacy Act (FERPA) is critical to Title V programs. Thus, SMS is requesting a one-day workshop and follow-up consultation from DaSy, the Center for IDEA Early Childhood Data Systems for Title V staff and partners. Consultation would support development of 'boilerplate' language for all to utilize in their individual development of policies and working agreements, such as an MOU.

The second request has a similar goal of facilitating collaboration with a focus on maximizing resources and avoiding duplication of effort. A variety of programs serving CYSHCN offer case management/coordination services and many are able to leverage funding through Medicaid Billing for Targeted Case Management (TCM). While there have been some informal discussions across these programs to limit any duplication of services a more formal approach to consistency of effort is needed. The efforts within the NH Department of Health and Human Services to better integrate services for CYSHCN, under SMS administration, has resulted in a valuable opportunity to request technical assistance to develop formal guidance for TCM billing that will facilitate training, education, appropriate billing and monitoring. SMS would like to work with the Catalyst Center, the National Center for Health Insurance and Financing for Children and Youth with Special Health Care Needs to develop this guidance and initiate a training/dissemination plan.

And for its final program specific request, SMS would like to pursue technical assistance to assist in the development of a standardized formula for establishing caseload limits for CYSHCN being served under its Health Care Coordination program. SMS has developed and implemented rating systems for the Level of Care and Level of Complexity with the intent of utilizing this information to work on setting caseload standards. However, SMS does not have the internal expertise to bridge from implementing the rating systems to developing a reliable formula/process for setting caseload standards. The technical assistance request would be for expert consultation and training from national experts for the SMS Administrator and Clinical Coordinator to support this initiative. MCH and SMS staff, both part of the state's Title V program, are physically separated in two distinct locations. The distance between the two entities is only 2.5 miles, but can sometimes feel like much more when working together routinely and on a daily basis is necessitated. Within the past year, MCH has rebuilt the state's Birth Conditions Program as well as is in the preliminary stages of bringing its follow-up coordination for newborn hearing screening out of a contractor's purview and back with state staff. Both of these programmatic activities now require a more consistent interaction between certain MCH and SMS staff members. Therefore, SMS and MCH together request a half-day facilitated discussion on follow-up coordination between the two pieces of the state's Title V Program. This could benefit all Title V staff, increasing familiarity not only with the process of follow-up coordination, but the individual programmatic efforts taking place in each section. Having this facilitated would take the burden off both section's administrators and enable them to be part of the discussion. A suggested facilitator could be the Community Health Institute or CHI out of the John Snow Institute (JSI). Long-term CHI staff have facilitated the day long Title V State Action Plan training as well as conducted part of the last needs assessment and led the MCH/SMS CAST V process. Thus, they have current insight into the Title V Block Grant and New Hampshire's program.

---

[1] Carman, et al. "Patient and Family Engagement: A framework for understanding the elements and developing interventions and policies." *Health Affairs*. 2013; 32:223-231.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Title_V_Medicaid_IAA-MOU.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - TitleV blurb ver2018.pdf

Supporting Document #02 - Glossary of Acronyms Utilized in the Title V Block Grant.pdf

Supporting Document #03 - SMS SFY 17 - SERVICE UTILIZATION SUMMARY.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - orgchart2_uploaded.pdf

VII. Appendix

This page is intentionally left blank.

Form 2
MCH Budget/Expenditure Details

State: New Hampshire

	FY19 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 1,989,264	
A. Preventive and Primary Care for Children	$ 760,961	(38.2%)
B. Children with Special Health Care Needs	$ 798,201	(40.1%)
C. Title V Administrative Costs	$ 176,448	(8.9%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,735,610	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 5,743,753	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 966,336	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 6,710,089	
A. Your State's FY 1989 Maintenance of Effort Amount $ 2,872,257		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 8,699,353	
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)	$ 9,559,396	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 18,258,749	

OTHER FEDERAL FUNDS	FY19 Application Budgeted
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 2,247,675
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 813,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 195,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 2,970,751
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Adult Medicaid Quality: Improving Maternal and Infant Health Outcomes in Medicaid and CHIP	$ 345,297
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Death in the Young (SDY) Registry	$ 59,900
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 491,490
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 318,028
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 158,600
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Violent Death Registry	$ 153,282
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Enhanced State Opioid Overdose Surveillance	$ 356,373
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 150,000
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) > Administration for Children & Families (ACF) > Social Services Block Grant (SSBG)	$ 950,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000

	FY17 Annual Report Budgeted		FY17 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 1,986,075		$ 1,989,264	
A. Preventive and Primary Care for Children	$ 767,328	(38.6%)	$ 716,270	(36%)
B. Children with Special Health Care Needs	$ 804,879	(40.5%)	$ 862,998	(43.3%)
C. Title V Administrative Costs	$ 158,092	(8%)	$ 198,920	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,730,299		$ 1,778,188	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 5,751,467		$ 4,561,373	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 993,154		$ 1,052,350	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 6,744,621		$ 5,613,723	
A. Your State's FY 1989 Maintenance of Effort Amount $ 2,872,257				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 8,730,696		$ 7,602,987	
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		$ 7,905,731	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 15,815,424		$ 15,508,718	

OTHER FEDERAL FUNDS	FY17 Annual Report Budgeted	FY17 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 250,000	$ 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	$ 100,308
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Violent Death Registry	$ 144,606	$ 117,761
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 164,584	$ 89,518
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 251,700	$ 266,534
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Unexpected Infant Death (SUID) Case Registry Program	$ 26,774	$ 15,167
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	$ 2,198,527
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	$ 140,000	$ 132,782
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 98,796
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 175,000	$ 136,834
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 829,000	$ 761,746
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project LAUNCH	$ 839,650	$ 748,890

OTHER FEDERAL FUNDS	FY17 Annual Report Budgeted	FY17 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Title XIX -- Grants to States for Medical Assistance Programs	$ 319,065	$ 208,630
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Social Services Block Grant (SSBG)		$ 833,474
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)		$ 1,848,762
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant		$ 54,575
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Enhanced State Opioid Overdose Surveillance		$ 8,073
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Zika Surveillance Systems Grant Program		$ 20,862
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Death in the Youth (SDY) Reistry	$ 25,000	$ 14,492

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:	**Annual Report Expended**
	Field Note: This line includes both Infants <1 and Children 1 - 22.	
2.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: Actual expenditure	
3.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: Actual expended	

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	FY19 Application Budgeted	FY17 Annual Report Expended
1. Pregnant Women	$ 63,414	$ 57,871
2. Infants < 1 year	$ 228,288	$ 230,157
3. Children 1 through 21 Years	$ 532,673	$ 486,113
4. CSHCN	$ 798,201	$ 862,998
5. All Others	$ 190,240	$ 153,205
Federal Total of Individuals Served	$ 1,812,816	$ 1,790,344

IB. Non-Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Pregnant Women	$ 159,109	$ 161,796
2. Infants < 1 year	$ 1,539,130	$ 1,634,816
3. Children 1 through 21 Years	$ 1,336,519	$ 1,359,088
4. CSHCN	$ 2,602,818	$ 1,126,266
5. All Others	$ 477,328	$ 485,389
Non-Federal Total of Individuals Served	$ 6,114,904	$ 4,767,355
Federal State MCH Block Grant Partnership Total	$ 7,927,720	$ 6,557,699

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2019**
	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 1-21 yrs. We are reflecting budget and expended calculations accordingly.	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2017**
	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 1-21 yrs. We are reflecting budget and expended calculations accordingly.	

Data Alerts:

- Children 1 through 21 Years, Application Budgeted does not equal Form 2, Line 1A, Preventive and Primary Care for Children Application Budgeted. A field-level note indicating the reason for the discrepancy was provided.
- Children 1 through 21 Years, Annual Report Expended does not equal Form 2, Line 1A, Preventive and Primary Care for Children, Annual Report Expended. A field - level note indicating the reason for the discrepancy was provided.

Form 3b
Budget and Expenditure Details by Types of Services

State: New Hampshire

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Direct Services	$ 429,780	$ 422,767
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 83,374	$ 78,839
B. Preventive and Primary Care Services for Children	$ 154,838	$ 146,415
C. Services for CSHCN	$ 191,568	$ 197,513
2. Enabling Services	$ 835,616	$ 810,765
3. Public Health Services and Systems	$ 723,868	$ 755,732
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		$ 4,471
Physician/Office Services		$ 225,359
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 10,934
Laboratory Services		$ 0
Other		
Nutrition and Feeding & Swallowing Consultation		$ 64,199
Child Development Clinic (Clinical Consultation)		$ 85,392
Neuromotor Clinic (MD Consultation)		$ 17,319
Family Support (home modfctn, hospital visits, etc		$ 13,731
Health Care Support		$ 1,362
Direct Services Line 4 Expended Total		$ 422,767
Federal Total	$ 1,989,264	$ 1,989,264

IIB. Non-Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Direct Services	$ 2,111,355	$ 1,975,788
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 1,069,588	$ 1,142,702
B. Preventive and Primary Care Services for Children	$ 417,091	$ 406,870
C. Services for CSHCN	$ 624,676	$ 426,216
2. Enabling Services	$ 2,454,624	$ 1,630,881
3. Public Health Services and Systems	$ 2,090,230	$ 1,572,987
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 9,649
Physician/Office Services		$ 626,183
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 23,594
Laboratory Services		$ 923,618
Other		
Nutrition and Feeding & Swallowing Consultation		$ 136,419
Child Development Clinic (Clinical Consultation)		$ 181,459
Neuromotor Clinic (MD Consultation)		$ 36,804
Family Support (home modfctn, hospital visits, etc		$ 35,124
Health Care Support		$ 2,938
Direct Services Line 4 Expended Total		$ 1,975,788
Non-Federal Total	$ 6,656,209	$ 5,179,656

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: New Hampshire

Total Births by Occurrence: 12,051 **Data Source Year: 2017**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Screen	(B) Aggregate Total Number Presumptive Positive Screens	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	12,010 (99.7%)	14	14	14 (100.0%)

Program Name(s)				
3-Hydroxy-3-methyglutaric aciduria	3-Methylcrotonyl-CoA carboxylase deficiency	Argininosuccinic aciduria	Biotinidase deficiency	Carnitine uptake defect/carnitine transport defect
Citrullinemia, type I	Classic galactosemia	Classic phenylketonuria	Congenital adrenal hyperplasia	Cystic fibrosis
Glutaric acidemia type I	Glycogen Storage Disease Type II (Pompe)	Hearing loss	Homocystinuria	Isovaleric acidemia
Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	Maple syrup urine disease	Medium-chain acyl-CoA dehydrogenase deficiency	Methylmalonic acidemia (cobalamin disorders)	Primary congenital hypothyroidism
Propionic acidemia	S, ßeta-Thalassemia	S,C disease	S,S disease (Sickle cell anemia)	Severe combined immunodeficiences
ß-Ketothiolase deficiency	Trifunctional protein deficiency	Tyrosinemia, type I	Very long-chain acyl-CoA dehydrogenase deficiency	

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	11,704 (97.1%)	396	20	19 (95.0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

We do not serve older children and women and do not perform long term follow up. Our surveillance of a diagnosed child ends when they have been connected to care. The long term follow up is the responsibility of the specialist and the PCP.

Form Notes for Form 4:

There is one infant for whom both diagnostics and referral is still process for the early intervention, from 2017 births. The full process for an infant to be diagnosed and referred for treatment can be up to 6 months.

We do not serve older women and children nor perform long term follow up. Our surveillance of a diagnosed child ends when they have been connected to care. The long term follow up is the responsibility of the specialist and the PCP.

Field Level Notes for Form 4:

1.	**Field Name:**	**Early Hearing - Referred For Treatment**
	Fiscal Year:	**2017**
	Column Name:	**Other Newborn**

Field Note:
There is one infant for whom both diagnostics and referral is still process for the early intervention, from 2017 births. The full process for an infant to be diagnosed and referred for treatment can be up to 6 months.

We do not serve older women and children nor perform long term follow up. Our surveillance of a diagnosed child ends when they have been connected to care. The long term follow up is the responsibility of the specialist and the PCP.

Data Alerts: None

Form 5a
Count of Individuals Served by Title V

State: New Hampshire

Annual Report Year 2017

		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	1,990	24.6	0.0	73.4	2.0	0.0
2. Infants < 1 Year of Age	3,638	24.6	0.0	73.4	2.0	0.0
3. Children 1 through 21 Years of Age	34,588	25.7	0.0	69.7	4.6	0.0
3a. Children with Special Health Care Needs	5,577	56.0	0.0	36.0	3.0	5.0
4. Others	85,975	9.9	0.0	83.0	7.1	0.0
Total	126,191					

Form Notes for Form 5a:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2017**
	Field Note: Fiscal year: 2017 These 1990 pregnant women were provided direct and enabling services by the Comprehensive Family Support Services (CFSS) contract agencies (that provide home visiting) and the Community Health Center contracted agencies (utilizing UDS figures). The percentages for primary source of coverage were taken from the proxy data provided by the CDC.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2017**
	Field Note: Infants Less Than One Year Total Served: Fiscal year: 2017 There were 3,638 infants that were provided direct and enabling services by the Comprehensive Family Support Services (CFSS) contracted agencies (that provide home visiting, the Community Health Center contracted agencies (utilizing UDS numbers) and newborn screening program referrals. The percentages for primary source of coverage were taken from the proxy data provided by the CDC. This count does not include the population-based count of 12,010 infants serviced by the Newborn Hearing Program, which canvasses nearly all NH infants born, excluding only a small percent (.04%) wherein the parents refused, the infant died, or hearing test was missed for some other reason.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2017**
	Field Note: Children 1 to 21 Years of Age Served: Fiscal year: 2017 These 34,588 children 1 to 21 years of age were provided direct and enabling services by the Comprehensive Family Support Services (CFSS) contract agencies and the Community Health Center contracted agencies (utilizing UDS figures). The percentages for primary source of coverage were taken from the proxy data provided by the CDC.	
4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2017**

Field Note:
Children with Special Health Care Needs Served:
Fiscal year: 2017
Children with Special Health Care Needs = 5,577
The number is calculated as follows:
1. Unduplicated count (Form5a) of the children enrolled directly in SMS' CSHCN program: 2,568
2. Unduplicated count served by New Hampshire Family Voices (NHFV): 1,180
3. NHFV HC-CSD Outreach: 243
4. NHFV Information and Referral (Lending Library): 412
5. SMS' SSI Outreach: 413
6. SMS' HC-CSD Outreach: 375
7. SMS' Information and Referral: 386
Additionally, NHFV has a very active website and while it is not possible to link these contacts directly to NHCSN, it is significant and should be reported.
NHFV Web Hits (unique) = 942,876 and Unique Visitors = 69,932

On From 5b, for line 3a: These percentages for primary source of coverage were taken from NH Bureau of Special Medical Services data, not from the proxy data supplied by the CDC, and the percentages supplied pertain only to this subset.

5.	**Field Name:**	**Others**
	Fiscal Year:	**2017**

Field Note:
Others Served:
Fiscal Year 2017
These 85,975 non-pregnant females and males over the age of 21 were provided direct and enabling services by the Comprehensive Family Support Services contracted agencies and the Community Health Center contracted agencies (with the utilization of UDS figures).

The percentages for primary source of coverage were taken from the proxy data provided by the CDC.

6.	**Field Name:**	**Total_TotalServed**
	Fiscal Year:	**2017**

Field Note:
Total Number of Individuals Served:
Fiscal Year 2017
This number of 126,191 is the total number of those who were provided direct and enabling services by the Comprehensive Family Support Services contract agencies, the 17 Community Health Center contracted agencies, Newborn screening referrals post-hearing testing, and Home Visiting.

Data Alerts: None

Form 5b
Total Percentage of Populations Served by Title V

State: New Hampshire

Annual Report Year 2017

Populations Served by Title V	Total % Served
1. Pregnant Women	100
2. Infants < 1 Year of Age	100
3. Children 1 through 21 Years of Age	100
3a. Children with Special Health Care Needs	9
4. Others	100

Form Notes for Form 5b:

None

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2017**
	Field Note: This figure is the best estimate of the population served by Title V program across all levels of the MCH pyramid including direct services, enabling services and public health services and systems. This includes safe sleep public health campaigns as well as work done on quality improvement in the birthing hospitals.	
2.	**Field Name:**	**Infants Less Than One Year**
	Fiscal Year:	**2017**
	Field Note: This figure is the best estimate of the population served by Title V program across all levels of the MCH pyramid including direct services, enabling services and public health services and systems. This includes all live births because they are reached with newborn screening and newborn hearing screening.	
3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2017**
	Field Note: This figure is the best estimate of the population served by Title V program across all levels of the MCH pyramid including direct services, enabling services and public health services and systems. This includes all injury prevention programming specific to children and adolescents as well as quality improvement projects within the primary care setting done with colleagues such as the Pediatric Improvement Partnership.	
4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2017**
	Field Note: The denominator for this percentage is 61,013 and was determined by using the 2016 American Community Survey estimate of children under 20 (306,653) and multiplying that by 19.9% which is the percentage of Children With Special Health Care Needs Services Program (CSHCN) reported in the 2016 National Survey of Children's Health.* *For line 3a, These percentages were taken from NH Bureau of Special Medical Services data, not from the proxy data supplied by the CDC.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2017**
	Field Note: This figure is the best estimate of the population served by Title V program across all levels of the MCH pyramid including direct services, enabling services and public health services and systems. This includes the injury prevention programming done with adults (motor vehicles) and older adults (falls and motor vehicles).	

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: New Hampshire

Annual Report Year 2017

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	12,064	10,512	219	642	12	409	6	116	148
Title V Served	2,468	2,119	45	151	3	84	2	33	31
Eligible for Title XIX	3,335	2,788	109	286	7	47	1	37	60
2. Total Infants in State	12,064	10,512	219	642	12	409	6	116	148
Title V Served	2,468	2,119	45	151	3	84	2	33	31
Eligible for Title XIX	3,335	2,788	109	286	7	47	1	37	60

Form Notes for Form 6:

Most of the population of Title V is included in the figure for those eligible for Title XiX, due to crossover. The prenatal and infant count is UDS / PCDF total, and includes the figure from NH Child and Family Services.

The "13 count difference" between Form 4's count being 12,051 "Total Births by Occurrence" to Form 6's "Total Deliveries in State" being 12,064 is that Form 4 represents Total Births in New Hampshire and Form 6 reports Infant Births to New Hampshire residents.

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	2019 Application Year	2017 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(603) 271-4517 x4517	(603) 271-4517 x4517
2. State MCH Toll-Free "Hotline" Name	Maternal and Child Health	Maternal and Child Health Section
3. Name of Contact Person for State MCH "Hotline"	Sarah Pigsley	Sarah Pigsley
4. Contact Person's Telephone Number	(603) 271-0064 x64	(603) 271-0064 x64
5. Number of Calls Received on the State MCH "Hotline"		52

B. Other Appropriate Methods	2019 Application Year	2017 Annual Report Year
1. Other Toll-Free "Hotline" Names	SMS (800) 852-3345 x4488	SMS - (800) 852-3345 x 4488
2. Number of Calls on Other Toll-Free "Hotlines"		4,485
3. State Title V Program Website Address	www.dhhs.nh.gov/dphs/bchs/mch/index.htm & www.dhhs.nh.gov/dcbcs/bds/sms	https://www.dhhs.nh.gov/dcbcs/bds/sms/ and https://www.dhhs.nh.gov/dphs/bchs/mch/index.htm
4. Number of Hits to the State Title V Program Website		11,672
5. State Title V Social Media Websites	www.facebook.com/NHPubHealth	www.facebook.com/NHPubHealth
6. Number of Hits to the State Title V Program Social Media Websites		63,993

Form Notes for Form 7:

A.1. MCH does not have a "Hotline" The 800 number is the main number into MCH.
A.5. Number of calls are those to the MCH main line.
B.1. SMS has its own toll free "Hotline".
B.2. The number of calls are those received on the SMS line.
B.4. MCH had 2982 website hits. SMS website hits 8,690
B.6. MCH number of hits to Social Medial Websites includes Facebook (41686) reached, number of post 242, likes 971) and Twitter (22307)

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	Administrator Maternal and Child Health Section/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	CYSHCN Director / Special Medical Services, Bureau Administrator
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	New Hampshire Family Voices 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 2019

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.

None

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
2016	85.3 %	0.3 %	10,411	12,210
2015	85.2 %	0.3 %	10,543	12,369
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: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009	75.5	7.7	97	12,856
2008	89.9	8.3	118	13,122

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
2012_2016	NR	NR	NR	NR
2011_2015	NR	NR	NR	NR
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 - 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
2016	6.4 %	0.2 %	789	12,252
2015	6.9 %	0.2 %	852	12,382
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 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	7.8 %	0.2 %	954	12,252
2015	7.9 %	0.2 %	981	12,416
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 - 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
2016	21.1 %	0.4 %	2,585	12,252
2015	20.6 %	0.4 %	2,559	12,416
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
2016/Q2-2017/Q1	2.0 %			
2015/Q2-2016/Q1	1.0 %			
2015/Q1-2015/Q4	1.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	3.0 %			
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
2015	4.5	0.6	56	12,461
2014	4.9	0.6	60	12,336
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
2015	4.1	0.6	51	12,433
2014	4.4	0.6	54	12,302
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
2015	2.8	0.5	35	12,433
2014	2.7	0.5	33	12,302
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
2015	1.3 ϟ	0.3 ϟ	16 ϟ	12,433 ϟ
2014	1.7	0.4	21	12,302
2013	1.6	0.4	20	12,396
2012	1.0 ϟ	0.3 ϟ	12 ϟ	12,352 ϟ
2011	1.3 ϟ	0.3 ϟ	17 ϟ	12,851 ϟ
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

ϟ 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
2015	112.6 ϟ	30.1 ϟ	14 ϟ	12,433 ϟ
2014	121.9 ϟ	31.5 ϟ	15 ϟ	12,302 ϟ
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 ϟ	31.1 ϟ	16 ϟ	12,874 ϟ
2009	231.7	41.7	31	13,377

Legends:

Indicator has a numerator <10 and is not reportable

ϟ 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
2015	80.4	25.4	10	12,433
2014	89.4	27.0	11	12,302
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
2015	9.7 %	1.4 %	1,161	11,983
2014	11.0 %	1.5 %	1,311	11,959
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 hospital births

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009	7.1	0.7	93	13,080
2008	6.4	0.7	86	13,374

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 year

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	9.3 %	1.3 %	22,805	244,608

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable 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
2016	13.2	3.3	16	121,647
2015	12.2	3.2	15	122,586
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
2016	30.0	4.3	49	163,287
2015	21.6	3.6	36	166,384
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
2014_2016	9.5	1.9	25	263,615
2013_2015	9.0	1.8	24	268,243
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
2014_2016	10.6	2.0	28	263,615
2013_2015	8.6	1.8	23	268,243
2012_2014	8.1	1.7	22	272,708
2011_2013	6.5 ϟ	1.5 ϟ	18 ϟ	276,615 ϟ
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 ϟ	1.5 ϟ	19 ϟ	289,465 ϟ

Legends:

Indicator has a numerator <10 and is not reportable

ϟ 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 (CSHCN), ages 0 through 17

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	19.9 %	1.6 %	52,224	262,485

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable 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), ages 0 through 17, who receive care in a well-functioning system

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	21.5 %	4.0 %	11,203	52,224

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, 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
2016	2.7 %	0.8 %	6,110	223,714

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, 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
2016	10.5 %	1.4 %	23,265	221,599

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, 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
2016	63.0 %	5.7 %	22,819	36,205

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, 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
2016	92.0 %	1.2 %	240,207	261,214

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	15.1 %	0.5 %	838	5,551
2012	14.8 %	0.5 %	931	6,294
2010	15.0 %	0.4 %	1,086	7,263
2008	17.2 %	0.5 %	1,063	6,173

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
2015	12.2 %	0.4 %		
2013	11.2 %	0.8 %		
2011	12.1 %	0.9 %		
2009	11.9 %	1.3 %		
2007	11.5 %	1.0 %		
2005	11.3 %	1.1 %		

Legends:

Indicator has an unweighted denominator <100 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)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	8.5 %	1.6 %	10,029	117,963

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	3.1 %	0.5 %	7,967	260,834
2015	3.2 %	0.5 %	8,406	262,940
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
2016	78.0 %	3.1 %	14,471	18,550
2015	74.1 %	3.6 %	14,156	19,116
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, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	66.2 %	2.0 %	162,153	245,018
2015_2016	66.4 %	2.1 %	170,753	257,274
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) - Teen (Female)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	70.7 %	4.1 %	27,689	39,195
2015	74.2 %	4.5 %	29,640	39,971
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) - Teen (Male)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	69.3 %	4.4 %	28,561	41,237
2015	69.8 %	4.0 %	29,488	42,221
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) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	95.3 %	1.4 %	76,673	80,431
2015	92.4 %	2.0 %	75,951	82,192
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) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	88.0 %	2.2 %	70,796	80,431
2015	87.7 %	2.3 %	72,044	82,192
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

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	9.3	0.5	392	42,093
2015	11.0	0.5	468	42,705
2014	11.1	0.5	484	43,624
2013	12.6	0.5	560	44,434
2012	13.9	0.6	629	45,384
2011	13.7	0.5	629	46,092
2010	15.7	0.6	722	45,985
2009	16.4	0.6	765	46,557

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	12.9 %	1.6 %	1,560	12,126
2014	9.3 %	1.4 %	1,114	11,995
2013	12.1 %	1.6 %	1,470	12,123

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

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	1.8 %	0.4 %	4,671	261,738

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10a
National Performance Measures (NPMs)

State: New Hampshire

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Federally Available Data		
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)		
	2016	**2017**
Annual Objective	65.7	67
Annual Indicator	68.6	65.3
Numerator	147,910	140,723
Denominator	215,479	215,631
Data Source	BRFSS	BRFSS
Data Source Year	2015	2016

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	68.3	69.5	70.8	72.0	73.0	74.0

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2016	2017
Annual Objective	89.6	89.7
Annual Indicator	89.4	87.0
Numerator	10,407	10,258
Denominator	11,645	11,798
Data Source	PRAMS	PRAMS
Data Source Year	2014	2015

State Provided Data		
	2016	2017
Annual Objective	89.6	89.7
Annual Indicator		86.3
Numerator		10,315
Denominator		11,954
Data Source		NH PRAMS
Data Source Year		2016
Provisional or Final ?		Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	89.8	89.9	90.0	90.1	90.2	90.3

Field Level Notes for Form 10a NPMs:

None

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

FAD for this measure is not available for the State.

State Provided Data	
	2017
Annual Objective	
Annual Indicator	29.7
Numerator	3,541
Denominator	11,921
Data Source	NH PRAMS
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	32.0	35.0	37.0	39.0	41.0

Field Level Notes for Form 10a NPMs:

None

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

FAD for this measure is not available for the State.

State Provided Data	
	2017
Annual Objective	
Annual Indicator	51.3
Numerator	5,992
Denominator	11,676
Data Source	NH PRAMS
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	54.0	56.0	58.0	60.0	62.0

Field Level Notes for Form 10a NPMs:

None

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	**2017**
Annual Objective		
Annual Indicator		32.0
Numerator		8,656
Denominator		27,043
Data Source		NSCH
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	35.0	38.0	40.0	42.0	44.0	46.0

Field Level Notes for Form 10a NPMs:

None

NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Federally Available Data		
Data Source: HCUP - State Inpatient Databases (SID)		
	2016	**2017**
Annual Objective	225.8	140
Annual Indicator	226.6	238.7
Numerator	411	433
Denominator	181,369	181,369
Data Source	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2009	2009

State Provided Data		
	2016	**2017**
Annual Objective	225.8	140
Annual Indicator	98.4	94.7
Numerator	166	158
Denominator	168,680	166,811
Data Source	NH Inpatient Hospital Discharge data	NH Inpatient Hospital Discharge data
Data Source Year	2015	2015
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	89.9	85.1	80.3	75.5	70.7	65.9

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**Annual Objective**

Field Note:
New baseline started from 2012:
271/179442=151.0 in 2012;
245/173784=141.0 in 2013;
227/173205=131.1 in 2014;
174/171118=101.7 in 2015.
Objectives for 2016-2023 are projection estimates based on 2012-2015 data.

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CHILD		
	2016	**2017**
Annual Objective		
Annual Indicator		30.1
Numerator		28,200
Denominator		93,602
Data Source		NSCH-CHILD
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	37.3	38.0	38.7	39.4	40.1	40.8

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.

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	**2017**
Annual Objective		
Annual Indicator		87.8
Numerator		82,975
Denominator		94,526
Data Source		NSCH
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	88.0	88.5	89.0	89.5	90.0	90.5

Field Level Notes for Form 10a NPMs:

None

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	**2017**
Annual Objective		
Annual Indicator		52.3
Numerator		27,289
Denominator		52,224
Data Source		NSCH-CSHCN
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

State Provided Data		
	2016	**2017**
Annual Objective		
Annual Indicator	48.2	
Numerator	27,555	
Denominator	57,176	
Data Source	NSCH-CSHCN	
Data Source Year	2011_2012	
Provisional or Final ?	Final	

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	55.0	58.0	61.0	64.0	67.0	70.0

Field Level Notes for Form 10a NPMs:

None

NPM 14.1 - Percent of women who smoke during pregnancy

Federally Available Data		
Data Source: National Vital Statistics System (NVSS)		
	2016	**2017**
Annual Objective	15	14.9
Annual Indicator	12.6	11.1
Numerator	1,530	1,342
Denominator	12,194	12,052
Data Source	NVSS	NVSS
Data Source Year	2015	2016

State Provided Data		
	2016	**2017**
Annual Objective	15	14.9
Annual Indicator	10.8	11.1
Numerator	1,321	1,343
Denominator	12,204	12,076
Data Source	NH Division of Vital Records birth table	NH Division of vital records birth table
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	11.0	10.8	10.7	10.6	10.5	10.4

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
in the denominator, 45 records are missing

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.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		60
Annual Indicator	64.3	100
Numerator	9	14
Denominator	14	14
Data Source	NH DHHS, MCH section	NH DHHS, MCHS
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	100.0	100.0	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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		62.3
Annual Indicator	62.3	62.3
Numerator	264	264
Denominator	424	424
Data Source	SMS Biennial Survey	SMS Biennial Survey
Data Source Year	2016	2016
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	63.0	63.0	66.0	66.0	71.0	75.0

Field Level Notes for Form 10a SPMs:

1. **Field Name:** **2016**

   Column Name: **State Provided Data**

   Field Note:
   A survey questions will be added to the SMS Survey in 2017. The first year in which new data will be available is 2018.
   Data reported for 2016 is baseline.

2. **Field Name:** **2017**

   Column Name: **State Provided Data**

   Field Note:
   The SMS biennial survey administration date was changed to January 2018 and results are not yet available. Additional questions were added to the SMS Survey in to better identify barriers that families experience related to respite care.

SPM 3 - Percentage of behavioral health professionals recruited

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		40
Annual Indicator	38.9	21.1
Numerator	7	34
Denominator	18	161
Data Source	Bi-State Primary Care Recruitment Center	Bi-State Primary Care Association/Recruitment Ctr.
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	22.0	24.0	26.0	28.0	30.0	32.0

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)

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		20
Annual Indicator	25.6	35.5
Numerator	500	1,980
Denominator	1,955	5,572
Data Source	JSI database	JSI database
Data Source Year	2017	2017
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	40.0	45.0	50.0	55.0	60.0	65.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: 2016 data is not available; this measure was added to the JSI database after a Directors' meeting in November 2016. 25.6% is provisional data from 1st quarter of 2017.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: 1/1/2017 - 12/31/2017	

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		60
Annual Indicator	68.4	73.7
Numerator	13	14
Denominator	19	19
Data Source	Birth hospital survey via SurveyMonkey	Birth hospital survey
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	94.0	94.0	100.0	100.0	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.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		90
Annual Indicator	43	69
Numerator		
Denominator		
Data Source	WMG Welligent Database	WMG Welligent Data
Data Source Year	2015	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	70.0	75.0	80.0	85.0	90.0	100.0

Field Level Notes for Form 10a ESMs:

1. **Field Name:** **2017**

   Column Name: **State Provided Data**

   Field Note:
   In SFY 2017 the Watch Me Grow program experienced several challenges including changes in the Leadership Team when NH's ECCS grant ended and planned support from a VISTA volunteer 'fell through'. These issues impacted the programs ability to focus on recruitment and training of new sites.

2. **Field Name:** **2018**

   Column Name: **Annual Objective**

   Field Note:
   WMG is currently under re-organization. Due to changes in its leadership structure, promotional efforts have been minimal over the past nine months. NH has subsequently reduced annual objectives during this period of transition.

ESM 7.2.1 - Percentage of high school students who wear seatbelts

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		93.4
Annual Indicator	91.8	93.1
Numerator	13,027	50,699
Denominator	14,191	54,465
Data Source	YRBS	YRBS
Data Source Year	2015	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	94.0	94.8	95.7	96.5	97.4	98.2

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
This is 2015 YRBS data; there is no data for 2016; next data will be for 2017.

ESM 8.1.1 - 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.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		75
Annual Indicator	71.6	78.4
Numerator	48	185
Denominator	67	236
Data Source	DCYF data base, submitted by CFSS agencies	DCYF data base
Data Source Year	2017	2018
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	76.0	77.0	78.0	79.0	80.0	81.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
This is provisional data, covering 9 months, July 1, 2016 - March 30, 2017

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		64
Annual Indicator	61.4	57.9
Numerator	6,630	6,178
Denominator	10,805	10,671
Data Source	NH DHHS, MCH section	NH DHHS, MCHS
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	60.0	62.0	64.0	66.0	68.0	70.0

Field Level Notes for Form 10a ESMs:

None

ESM 11.1 - The number of Primary Care Provider practices who have adopted a Transition Policy

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		1
Annual Indicator	0	6
Numerator		
Denominator		
Data Source	Medical Home Project Tracking	Medical Home Project Tracking
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	12.0	12.0	14.0	16.0	18.0	20.0

Field Level Notes for Form 10a ESMs:

1. **Field Name:** **2016**

   Column Name: **State Provided Data**

   Field Note:
   There is currently no registry for Medical Homes to indicate they have a Transition Policy unless they are accredited by National Committee for Quality Assurance. NH will contract with a vendor agency to obtain this information in 2018.

2. **Field Name:** **2017**

   Column Name: **State Provided Data**

   Field Note:
   In SFY 17 the Medical Home Contractor had begun a pilot process for tracking Primary Care Providers who had indicated that they have a Transition Policy . NH's contract with the vendor agency has identified this registry as a performance measure for SFY 2018.

ESM 14.1.1 - Number of calls received by the New Hampshire Quitline in the past year

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	13	18
Numerator		
Denominator		
Data Source	QuitNow NH, the state tobacco treatment quitline	QuitNow NH, the state tobacco treatment quitline
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	20.0	23.0	26.0	31.0	36.0	38.0

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/Systems Building

Measure Status:	Active
Goal:	To increase the percentage of MCHS contracted Community Health Centers who address social determinants of health through the provision of Enabling Services- non-clinical services such as transportation, interpretation, outreach, and health education.
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:	NH DHHS/MCHS, 2017
Significance:	Enabling services are an essential element of health care as these services: 1) ensure health equity for all populations 2) improve health outcomes and 3) reduce health care costs. Enabling services ensure health equity by increasing access and utilization of primary care for some of NH's most vulnerable populations, especially for racial and ethnic minorities and people living in poverty. By addressing social and economic conditions that present barriers to care, enabling services promote the use of community health centers as medical home. As a usual source of care, medical homes, not only improve health outcomes, but also reduce inappropriate use of Emergency Departments which are both associated with reducing health care costs.

SPM 2 - Percentage of families enrolled in SMS who report access to respite
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
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' report of access to a break or respite; NH added new 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/Systems Building

Measure Status:	Active
Goal:	To increase the Behavioral Health professional workforce in the State of NH
Definition:	**Numerator:** # of active Behavioral Health professionals sourced that became active **Denominator:** # of Behavioral Health professionals sourced **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:	Recruitment and retention of behavioral health care providers are two of the most important issues affecting patient access. NH MCH works with the Bi-State Primary Care Recruitment Center to recruit and retain behavioral health professionals into local positions. 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. Sourced professionals express interest in the state of New Hampshire through a variety of modalities including an in-person meeting, online through a job site, etc. Active professionals are those who have been sourced and then go on to submit a resume and potentially have job interviews.

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 Measures (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, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
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 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
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 every two years
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 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	To increase from 43 (WMG, 2015) to 100 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 7.2.1 - Percentage of high school students who wear seatbelts
NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Measure Status:	Active
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 8.1.1 - 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 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
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 DCYF from CFSS-funded agencies at time of child's discharge from the program
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.

Measure Status:	Active
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:	

Numerator:	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
Denominator:	total number of adolescent patients ages 12-21 years of age at the MCH-contracted health centers by the end of the measurement year
Unit Type:	Percentage
Unit Number:	100

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, ages 0 through 17, who have a medical home

Measure Status:	Active
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 14.1.1 - Number of calls received by the New Hampshire Quitline in the past year
NPM 14.1 – Percent of women who smoke during pregnancy

Measure Status:	Active
Goal:	Promote increased use of the state-funded quitline
Definition:	**Numerator:** number of calls received by New Hampshire Quitline **Denominator:** N/A **Unit Type:** Count **Unit Number:** 12,076
Data Sources and Data Issues:	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 in 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.
Significance:	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.

Form 11
Other State Data

State: New Hampshire

The Form 11 data are available for review via the link below.

Form 11 Data