



**Maternal and Child Health Services
Title V Block Grant**

**State Narrative for
New Hampshire**

**Application for 2009
Annual Report for 2007**



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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

An attachment is included in this section.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

Assurances and certifications are maintained on file in the New Hampshire Title V program's central office at:

Maternal and Child Health Section
NH DHHS
29 Hazen Drive
Concord, NH 03301

Assurances and certifications are available on request by contacting the New Hampshire Maternal and Child Health Section, Division of Public Health Services, Department of Health and Human Services at the above address, or by phone at 603-271-4517, by email at dlcampbell@dhhs.state.nh.us, or via the NH MCH website at: <http://www.dhhs.state.nh.us/DHHS/BMCH/CONTACT+INFO/default.htm>

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

E. Public Input

In the Title V Quinquennial Needs Assessment year, emphasis was placed on the inclusion of public and stakeholder input. The NH Title V Program, Maternal and Child Health Section (MCH) and Special Medical Services Section (SMS), through MCHB technical assistance, completed a CAST-5 process that included over 50 stakeholders.

As part of the needs assessment, SMS completed a Delphi process. Over 100 professionals and family members representing over 40 different constituent groups participated as key informants, as members of focus groups, or as survey respondents. Findings were reported in a widely distributed 2004 executive summary.

Additionally, a survey of families of CSHCN receiving SSI for their own disability was conducted in 2004.

MCH and SMS presented findings at a public input meeting to over 100 stakeholders and parents from around the state. Participants were given the opportunity to express their opinions regarding priorities and needs. This presentation is attached to this section.

/2007/

Because the Title V program is continuing the mandate to focus on priorities discussed in 2005, no further public forums were held in 2006. Feedback on priorities was generated by advisories, including the Youth Health Care Transition Group and an ad hoc workgroup for workforce development for respite/childcare and early childhood stakeholders. Partners have indicated that we are continuing to address priority needs.

This application is available at: www.dhhs.state.nh.us/DHHS/BMCH/CONTACT+INFO or by calling 603-271-4526. //2007//

/2008/

NH continues to look to the 2005 Needs Assessment as the guide for Title V priorities and activities. To ensure that our priorities were still relevant to our partners, Title V sent out an electronic survey to over 150 stakeholders and families. Results from that survey (51% response rate) indicated that the priorities identified in the 2005 Needs Assessment are still "important" or "more important now than ever".

Access to mental health supports and services for children and youth, including those with special health care needs was identified as the most important of the ten priorities. Prevalence of childhood overweight and obesity; safe and healthy environments for families, including those with special health care needs; and development of a trained workforce available to provide respite and child care for medically and behaviorally complex children with special health care needs were considered to be of primary importance.

Title V gathers feedback from many advisory groups and collaborative activities to leverage resources to meet needs. For example, as a direct result of this feedback Title V developed an application for the State Agency Partnerships for Promoting Child and Adolescent Mental Health. //2008//

/2009/ As stated previously, this application is placed on the NH DHHS website. The public was also invited to provide feedback on the priorities and activities of Title V through an electronic, web-based survey on the DHHS website next to the block grant link. To date, there have been almost 400 respondents, many leaving detailed comments. Access to health insurance and health care is the pre-eminent concern among NH residents. The survey is attached.//2009/
An attachment is included in this section.

II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

New Hampshire's 2005 needs assessment process was based on recommendations in Promising Practices in MCH Needs Assessment. Process changes since last year's block grant included extensive analyses of available MCH population data, including birth, death, hospital discharge (UHDDS) data, and surveys of families and health care providers of CSHCN, as well as a more formal approach for gathering input from internal and external stakeholders. This assessment identified disparities and gaps in health services and capacity, leading to the targeting of priority concerns. Assessment of Title V capacity was conducted using CAST-5. With completion of these analyses, areas for intervention became apparent.

Title V continues to address priorities developed in the 2005 Needs Assessment. To ensure our priorities were still relevant, an e-survey was sent in January 2007 to over 150 partners and families, many of whom had attended the town hall-style public input meeting for the 2005 Needs Assessment. Results (51% response) indicated that all priorities are still "important" or "more important now than ever".

//2009/

In order to continue to invite feedback on Title V priorities and activities, as well as gauge what NH families are most concerned about, a web based survey was placed on the NH DHHS web site and sent electronically to numerous family, health and education listserves. Almost 400 surveys were completed. NH families are most concerned about affordable health care and insurance for all families, access to mental health care, and having a safe, healthy and affordable place to live. There is also increasing concern about autism. This feedback is in alignment with priorities below.//2009//

1. Data collection and analysis, identifying disparities, examining barriers to care, and researching and implementing best practice models. NH continues to struggle with data capacity. Poor access to vital records has been a historical barrier to analysis and data linkage. Title V created an action plan to address data needs. Working with community agencies and the NH Office of Information Technology, Title V is developing an integrated system of linked data sets to help fulfill critical MCH functions. Completion of the Perinatal Client Data Form (PCDF) Project to link clinic records and birth data was a significant achievement this year and will increase MCH capacity in future years.

2. Safe and healthy pregnancies

Adolescents and young women in NH, as well as those dependant on Medicaid as a payer source, continue to experience disproportionate levels of prenatal care and less favorable birth outcomes than other women.

To enhance assessment capacity, the MCH Epidemiologist has worked with the University of Alabama and the Alliance for Families and Children to analyze NH hospital discharge data using the Prenatal Health Care Index. Initial findings indicate that the index is useful in providing information beyond the more traditional measures of LBW and prematurity.

3. Safe and healthy environments

The most frequent causes of hospitalization in young children in NH are respiratory diseases, including asthma. Young children are also vulnerable to the effects of lead poisoning. Pending

legislation, developed with MCH lead program data , will reduce the blood lead level at which the state can order property owners to remove lead hazards from rental properties.

Further promoting safe environments, in the fall of 2006, Title V collaborated with UNH and the NH Coalition Against Domestic and Sexual Violence to conduct a survey of violence against women in NH. The survey found that 22.7% of women 18 and over have been the victim of a sexual assault with 19.5% having been the victim of sexual assault with penetration in their lifetime. Intimate partner violence has been experienced by at least 33.4% of NH women. A press conference was held at the NH Attorney General's office and the research findings were featured on the front page of every major newspaper in the state.

4. Dental disease

Dental care access has been a problem in NH, especially for the poor, under and uninsured. While recent advances have improved NH's oral health capacity, continued effort is needed to sustain this fledgling system. This priority continues to be ranked among the highest needs in the state.

5. Unintentional injuries

Unintentional injuries rank as the leading cause of death for all children and adolescents in NH. Most unintentional injury deaths are due to motor vehicle crashes; other causes vary by age and include poisonings, falls and drowning. Many are preventable.

6. Healthy behaviors and access to health care services for adolescents

SMS completed a follow-up SSI survey in 2006, to obtain more information about care coordination, the adequacy of insurance and the impact of "out-of-pocket" costs for these families. This data will be utilized in planning for future service development. In particular issues for 16-21 year olds will be highlighted. Also a satisfaction survey was done for the Neuromotor Clinics to determine quality of services provided.

7. Effective public health programming

Title V is on the frontlines of ensuring that all residents have access to high quality health care by working with state leaders to improve the infrastructure of the public health system and by advocating for fair funding strategies for MCH providers. Based upon input from providers and needs assessments, MCH will be developing a new funding strategy for all community health centers.

8. Mental health

Public mental health services for children in NH are often fragmented, duplicative and categorically-based relative to funding streams. Worse, estimates show that many children don't receive services at all. This continues to be ranked as one of the highest shared priorities.

9. Childhood obesity

Obesity is an increasing problem nationally, but one for which little NH data is available. Available NH data reveal that the percentage of overweight and obese NH school-aged children and adolescents is significantly above the national recommended standard. MCH has surveyed contract agencies on their use of the BMI and has developed a BMI-related performance measure for the MCH-funded primary care agencies.

10. Respite and child care for CSHCN

The National Survey of CSHCN and NH state data indicate a lack of adequate respite and childcare services available to this population, including the need for workforce development.

III. State Overview

A. Overview

GEOGRAPHY: New Hampshire shares boundaries with Canada to the north, Maine and the Atlantic Ocean to the east, Vermont to the west and Massachusetts to the south. It ranks 44th in area among the states and 19th in population density. NH's population is nearly equal to Maine and twice that of Vermont, but only 1/6 that of Massachusetts. (1) The population is estimated at 1.3 million in 2004, with 49% residing in rural areas and 51% in urban areas. (2) Seventy-seven percent of NH municipalities are considered non-urban or rural. Urban and near urban areas are located in the southeast and south central regions of the state, with primarily rural areas in the western, central and northern sections. The three most populous cities are Manchester, Nashua and Concord, all located in the southern third of the state. Manchester, the only city with a population over 100,000, is the largest city in northern New England. Hillsborough County includes the two largest cities of Manchester and Nashua and is the most densely populated area with 396,778 residents or 30.7% of the total population. (3)

/2009/

New Hampshire's scenic rivers, mountain ranges, lakes and agricultural lands define the state's culture and geography but also create boundaries and barriers to the resources that improve health. Many New Hampshire residents depend on family and friends to get to and from food shopping, work and community events. Access to oral, mental, primary, specialty and/or reproductive health care can be a significant challenge, whether it's a few blocks or several hours away.*/2009/*The White Mountain Nation Forest separates the northernmost rural section of the state, which consists of Coos County. Coos County, known as the North Country, has the largest landmass of any county but the smallest population.(4)

DEMOGRAPHICS: While NH's population growth rate exceeds that of all the New England states, it has slowed since 2000, and NH, along with Massachusetts, are the only New England states experiencing this decline. (5) The state's population is expected to increase by 12.1% between 2000 and 2010 and by 23.4% between 2000 and 2020. Population declines are expected only in Coos County between 2000 and 2010, followed by a return to 2000 levels by 2020. (6)

POPULATION BY AGE: NH's population, like that of the nation, is aging; with increases of 66% expected in the 55-64 year age group by 2010, and 121% in the 60-69 year age group by 2020. In 2004, the median age was 38.8, with an estimated 269,194 women of childbearing age (15-44 years) comprising 22% of the population. By 2020, women of this age group are expected to comprise 19% of the population. The total female population is expected to increase 12% by 2010 and 33% by 2020. (7) Today, children under 18 comprise 25% of the population, but it is estimated that by 2020 they will constitute just over 21%. (8)***/2009/ In New Hampshire, there are 177,872 families, with 298,998 children. Twenty-one percent (61,464) of the children live in low-income families (National: 39%), defined as income below 200% of the federal poverty level. There are significant demographic differences throughout the state. For example, in 2006, Coos County, the poorest and most northern county, had 33,007 residents, 16% fewer than in 1940. Much of the loss of population in Coos has been due to the on-going out-migration of young adults. Between 1990 and 2000, the county lost nearly 40% of its 20-29 year olds.****(79)/2009/*

RACE & ETHNICITY: NH's population was 95.1% White and non-Hispanic in the 2000 US Census, but is steadily becoming more racially and ethnically diverse. Since 1990, the Asian population, the state's largest racial minority, increased from 0.8% of the state's population to an estimated 1.7% in 2003, and the African-American population increased from 0.6% to an estimated 0.9%. Residents self-identifying as Hispanic or Latino comprised 1.8% of the population in 2003, compared to 1.0% in 1990. (9) Children with special health care needs comprise 15.2% of NH children under age 18 (n=47059) and reside in 23.4% of the state's

households. (10) NH is one of 30 states to have a dedicated Office of Minority Health. NH REACH 2010 Initiative data indicates that minority populations in the state have increased by 26% (Blacks/African American), 39% (American Indian), 71% (Asian) and 81% (Latinos) from 1990 to 2000. The White population increased by 8% during this period. African Descendents and Latinos differed substantially from Non-Hispanic Whites on most of the assessed health indicators. Of note, only 58% of African Descendents and 38% of Latinos reporting having health insurance. Disparities were also evidenced in body mass index and prevalence of diabetes. (11)

While 96% of NH children are White, the non-White population is expected to grow significantly in the coming years. Projections are that the Black and Hispanic child populations will each have grown by 21%, and the Asian and Pacific Islander child populations will have grown by 30% between the years of 2000 and 2005. (12) The 2001 National Survey of CSHCN data for NH indicates that 91% of the children are White, 3% are Hispanic, 2% are multi-racial, 2% are Black, and 1% report as "other". Seventy-eight percent of the state's minority populations reside in the three southern counties of Hillsborough, Rockingham and Strafford, 22% in Manchester and 19.5% in Nashua. (13) Community health agencies in these counties are increasingly aware of the linguistic and cultural needs of minority populations. Achieving cultural competence is more difficult for agencies in rural and nonurban areas where the numbers of minorities are smaller. NH is also home to more than 6,500 refugees; 80% reside in the state's southern tier. NH refugees come from over 30 nations. Of those settling in the state from 2000 to 2004, 45% were from Eastern Europe, 46% from Africa and 8% from the Middle East. (14) /2007/ In 2004, 88% of refugees were from Africa. In 2006, 49% were from Africa with the remaining mostly originating from Europe including Uzbekistan and Meskhetian Turks. (63)

As ethnicity of new refugees changes from year to year, increased pressure is placed upon health care and social service providers to become increasingly proficient in adapting services to meet the needs of these diverse and vulnerable communities. //2007// Among Manchester residents ages five and older, 19.6% spoke a language other than English at home, compared to 8.3% statewide. (15) While many of these new residents experience a range of health issues such as nutritional deficits, parasitic infestations, and communicable diseases, maternal and child health issues predominate. Case management, outreach and interpretation services are all in high demand for this population.

BIRTHS: NH's resident births peaked in 1989 at 17,801 and declined by 19.2% to 14,383 in 2003. /2007/ Although year to year variance makes it difficult to predict lasting trends, it should be noted that birth rates are beginning to increase. In 2004 there were 14,573 births. (64) //2007// The birth rate decreased from 12.2 in 1997 to 11.2 in 2003. /2007/ By 2004, it had risen to 12.1. //2007// In 2003, NH had the 3rd lowest birth rate in the nation behind Maine and Vermont, 5.1% lower than the US non-Hispanic white rate of 11.8. (16) Given population projections and birth trends, it is clear that the state's demographics are changing.

TEEN & NONMARITAL BIRTHS: Similar to national rates, NH's teen birth rate has steadily decreased since 1990, when it was over 30 births/1000 females ages 15-19. In 2003, NH's teen birth rate had declined to 18.1, compared with the US white rate of 27.5. (17) In 2003, 5.7% of all births were to teens, a decreasing trend since 1997. A decrease in non-marital births occurred across all age groups and was highest among adolescents less than age 20, where 88.1% of births were to single mothers. (18) Health risks for teen mothers and their infants and the long-term negative socioeconomic implications are well known./2008/ NH continues to compare favorably in non marital and teen birth rates, but the implications for those families remain profound. Children living in single mother households account for only 21% of all children in the state, but those children account for 68% of the total rate of children in poverty. (74)//2008//

MATERNAL SMOKING: Maternal smoking, a significant risk factor affecting infant health, is a concern in NH. NH has experienced a decrease in maternal smoking, from 17.4% in 1997 to 14.2% in 2003. Smoking among teen mothers decreased as well, from 37.9% in 1997 to 34.4% in 2003, but remains more than double that of all mothers combined. (19)

PRENATAL CARE & INFANT HEALTH: Contrary to the decline in teen births and maternal smoking, NH has experienced a steady increase in LBW and premature births, highest among adolescent mothers. The 1997 state infant mortality rate (IMR) of 4.4 was the lowest ever and the lowest overall white IMR nationally. The state ranked 3rd for low birth weight (LBW) rates in 1997, with a rate of 5.9 compared to the U.S. white rate of 6.5. New Hampshire was also among the top three states in adequacy of prenatal care measures. In 1997, late or no prenatal care comprised 1.5% of all births compared with the national white rate of 3.2%. (20) Provisional vital statistics indicate the IMR for NH in the 12-month period ending November 2004 was 5.6 (N=83), an increase from the 2003 rate of 3.8 (N=55) during the comparable period (21). The 2002 rate for this period was 5.3 (N=77) (22). The U.S. rate was higher and ranged from 6.9 in 2002 to 6.6 in 2003.

Infant Mortality Rate Nov. '03-Nov. '04 Nov. '02-Nov. '03 Nov. '01-Nov. '02 NH 5.6 (N=83) 3.8 (N=55) 5.3 (N=77) US 6.6 (N=27,100) 6.7 (N=27,500) 6.9 (N=27,700). The 2003 LBW rate, at 6.2%, remained lower than the US non-Hispanic white rate of 7.0%. LBW remains higher for the Medicaid population, at 7.2%, than for the privately insured (6.0%). The percent of women receiving late or no prenatal care in 2003 was 1.1% compared to the US non-Hispanic white rate of 2.1%. However, the percent of women on Medicaid receiving adequate prenatal care (> 80% observed to expected prenatal care ratio on the Kotelchuck Index) remains below that of non-Medicaid women (86.8% versus 91.7%) and may explain, in part, disparities in LBW and infant mortality. (23)

SOCIOECONOMIC INDICATORS INDUSTRY & INCOME: NH's economic profile is largely one of prosperity as we follow the national trend of shifting from a goods producing economy toward a service providing one. For example, NH's Gross State Product grew 2nd fastest in the region and 16th fastest in the nation and the average weekly wage increased at the same rate as inflation from 2000 to 2003. In 2003, NH's average weekly wage was \$718, slightly lower than the national figure of \$726, and our median household income ranked first in the nation, along with New Jersey, Maryland, Alaska, Connecticut, and Minnesota. (24)

UNEMPLOYMENT & POVERTY: NH continues its recovery from the 2001 recession with yielding a fifth-lowest-in-the-nation average unemployment rate of 4.3%. However, NH ranked 40th in the nation for unemployment duration during the same year, with an average unemployment duration of 17.8 weeks. In addition, bankruptcy filings increased to a record high of 4,357 in 2003, up 8.4% from 2002. (25) NH's preliminary seasonally adjusted unemployment rate for 2005 is 3.7% and continues to be lower than the US rate of 5.2%. (26) Many NH families and children live below the federal poverty level. Between 1990 and 2000, the proportion of NH children in poverty increased from 7.4% to 7.8%, while the nationwide proportion decreased from 18.3% to 16.6%. (27) Poverty rates for NH indicate that in 2003, 8% of people were in poverty. Eight percent of related children under 18 were below the poverty level, compared with 9 percent of people 65 years old and over. Five percent of all families and 19% of families with a female householder and no husband present had incomes below the poverty level. (28) In 2003, an estimated 5.1% of NH families had incomes below the federal poverty level compared to the US average of 9.8%. However, this percentage has increased significantly from the 2000 figure of 3.5%. (29)/2007/ Between 2003 and 2004 there was a 33% increase in children living in poverty, from 8% to 10%. (65) //2007// This signifies a disquieting trend for our state's children, as the negative impact of poverty on the health and well being of children is well documented.

/2007/ In general, even though NH's total employment has been growing, it has been growing at a slower rate when compared to previous years. Current Employment Statistics for April 2006 show a 1.08 % gain in NH's total employment since April 2005. This is well below the state's average growth rate of 2.50 %. (66) 2004 data show that 29% of children live in homes where no parent has full time, year round work(67) Another critical component to family poverty is that NH is the only New England state with a minimum wage not greater than the federal standard. //2007//

/2009/Wage growth in NH has not kept pace with national productivity, nor has it kept pace with rising cost of living in the state. Since 2000, working families have seen median monthly rental payments increase by 19 percent and median mortgage payments increase by 21 percent. This means that, even for high-wage workers, growth in housing costs outpaced personal wage growth between 2000 and 2006. (80) //2009//

SSI RECIPIENTS: NH is a SS209 (b) state where eligibility for SSI does not automatically qualify a child for Medicaid benefits. As of December 2003, the number of NH children receiving SSI cash benefits for their own disability was 1710, a 5% increase over the 1,630 reported in December of 2000. (30) These children constitute 13.4% of all SSI recipients in the state, which is congruent with the 2003 national rate of 13.8% for children under age 18. (31) Based on a recent NH survey, 67% of NH children receiving SSI for their own disability were enrolled in Medicaid in 2004. (32)

SOCIOECONOMIC HEALTH CONCERNS: While many of NH's health and economic indicators are impressive, there are tremendous disparities within the state. Kids Count New Hampshire 2003 reports data related to children and families, grouping towns into five economic clusters ranging from poor to wealthy, and exploring how child health varies by residence. Dramatic differences exist among communities, even for indicators where the state as a whole excels. For example, inadequate prenatal care rates are 2 to 3 times higher in the poorest communities than the wealthiest. Teen birth rates are 3.5 times greater in the poorest communities than the wealthiest. In the wealthiest towns, 1 in 9 births are to single mothers versus 1 in 3 births to single mothers in the poorest towns. (33)

/2007/ NH continues to be ranked among the top states in the country for children's well being in part due to data that show that NH has the lowest child death rate, teen death rate, and teen birth rate in the nation. (68) However, it is important to note that over the last four years there has been a 67 percent increase in the NH child poverty rates, from 6 to 10 percent. Current census data shows that 23 percent of NH children live in low-income families and nearly three-quarters of those families struggle under the burden of housing expenses that consume more than 30% of their income. //2007//

HOUSING: In 2003, median monthly housing costs were \$1,420 for mortgage owners, \$493 for nonmortgage owners, and \$780 for renters. Twenty-eight percent of owners with mortgages, 19% of owners without mortgages, and 45% of renters spent 30% or more of household income on housing. (34) From 1999 to 2004, median gross rental costs increased from 19%, in the most northern, rural areas, to over 35%, in the central part of the state. For 2004, the two bedroom median gross rent including utilities was \$978 per month. (35) /2007/ In 2006 the median priced two-bedroom unit, including utilities, statewide rose from \$989 in 2005 to \$1,003. Rural Carroll County had the highest increase for the median priced two-bedroom unit at 11%. Quality rental housing remains unaffordable for many families. For example, a family in Rockingham County in the southeastern part of NH needs an income of \$43,000 to afford the median priced two-bedroom apartment. (69) //2007//

HEALTH INSURANCE STATUS: The US Census Bureau estimates that about 131,000 people in NH were uninsured in 2003. (36) According to National Survey of CSHCN data for NH, 6% of CSHCN were uninsured at the time of interview. Of those insured, 22% were enrolled in public insurance and 6% in a combination of public/private. (37) In 2001, the NH Insurance Family Survey estimated the number of uninsured and explore reasons for uninsurance. The random telephone survey interviewed 5,177 adult (age 18-64) family health care decision makers. The percent of uninsured children was estimated to be 5.1 (16,000 children), compared with the 8.3% (26,000 children) in a 1999 survey. (38) In the New Hampshire state profile from the Data Research Center for Children and Youth Special Health Care Needs (CYSHCN) (Indicator 3), 14.5% of CYSHCN were reported to be without insurance at some point during the past year (pre-survey), while 94.1% were insured at the time of the interview (Indicator 4). (39) Almost 9%

of NH youth with special health care needs between ages 12-17 were without insurance at the time of the survey and 17% of this age group was uninsured at some point during the preceding 12 months. (Indicator 4) The highest uninsurance rates in NH are among young adults ages 18 through 29 (14%) followed by those 30-44 years of age (10%). It is estimated that nearly 75% of uninsured women in the state are of childbearing age. An estimated 30% of all uninsured women were ages 18-29 and 43% were ages 30-44. Half of these uninsured women ages 18-44 are not Medicaid eligible. Thus, large numbers of women may have difficulty accessing reproductive or perinatal care due to lack of health insurance. (40) / 2007/ It is disturbing to note that the rate of the uninsured population continues to increase in NH. In 2004 the uninsured rate was 10.3% and it has risen to 11.7% in 2005. (70). //2007// /2008/ NH's uninsurance rate continues to hold steady without significant change.(75)//2008//

MEDICAID & SCHIP: NH's CHIP is a unique partnership between the NH DHHS and the NH Healthy Kids Corporation (NHHK). NHHK administers CHIP health insurance programs, outreach and coordination. Healthy Kids Gold (HKG -Medicaid) expands coverage for infants up to 300% of federal poverty level (FPL). Children ages 1 - 18 at 185-400% FPL qualify for Healthy Kids Silver (HKS) with premiums based on income. In NH, pregnant teens to age 19 are eligible for Healthy Kids Gold (<185% FPL) or Silver (186-300% FPL). Pregnant women age 19 and over with incomes up to 185% of FPL are eligible for HKG. In 2003, Medicaid was the payment source for 20.3% of all births in the state. (HSDM) Of women obtaining prenatal care through Title V funded agencies, 69% were enrolled in Medicaid in 2003 and 12% were uninsured, 13% were between 15 and 19 years of age, and 43.5% were between 20 and 24 years of age. (MCH) These women are eligible for enhanced prenatal services including social services, nutrition, care coordination and client education provided during a home or clinic visit. NHHK estimates that, in its first 15 months of operation, CHIP reduced the number of uninsured children by one-third. (41) The 2001 Insurance Family Survey estimated that the 32,928 children enrolled in NHHK represent 68.5% of eligible children targeted for the program, leaving 31.5% of those eligible uninsured. Healthy Kids Gold reported 60,909 enrollees as of March 2005. Healthy Kids Silver had 8,209 children enrolled, including those in the self-pay program. (42) A recent survey of Healthy Kids participants revealed that families are disenrolling at rates lower than other states. Those surveyed believed the application was easy to understand and reported satisfaction with health access and care. Some differences were found between those with Healthy Kids Silver and Healthy Kids Gold relative to ease of access to care and compliance with preventive visits, with the former reporting higher percentages. Efforts continue to ascertain why eligible children are not enrolled. Some reasons include: inability to pay premiums; lack of understanding of eligibility; belief that insurance is unnecessary as basic medical services can be accessed through safety net providers; and difficulties associated with eligibility determination and enrollment procedures. Efforts are underway to streamline eligibility determination and continue outreach, exploring creative options to encourage enrollment. (43) /2007/ 2003 data indicate little change among children with no health insurance. Overall, 6% of children under 17 have no health insurance. Those most at risk for no health insurance are those children within families that live under 100% poverty (16%); 150 to 174% poverty (16%); and 175 to 199% poverty (12%). (71) //2007//

/2008/ NH continues to be among the most successful states in achieving low uninsurance rates for children. Multiple factors lead to this success including high rates of employer-sponsored insurance, general consensus that children should have coverage and the public-private partnerships that make Healthy Kids NH a successful safety net for low and moderate income families. (76) However, like all states, NH is anxiously awaiting the federal reauthorization of SCHIP programs. Advocates strongly support congressional funding levels that would provide increased funding for this valuable program. Advocates are troubled by a presidential proposal to limit eligibility to children whose family incomes are twice the FPP or less. If enacted, it is estimated that over 10,000 children would be in jeopardy of losing coverage.(77) NH currently covers kids at three times the poverty level due to the high cost of living in New Hampshire. Without the enhanced federal match on those children, NH would lose an estimated \$2 million a year, and \$10 million over the 5-year reauthorization period.(78)//2008//

/2009/Healthy Kids Silver (SCHIP) is close to meeting its 2008 enrollment targets. It is unclear if or how new federal rules that require parents to provide more identification for their children than just a birth certificate may effect future enrollment.//2009//

STATE ISSUES IMPACTING WOMEN & CHILDREN: MEDICAID MODERNIZATION: Like other states, NH is grappling with Medicaid costs, and working to devise a more efficient and effective system of health coverage for eligible populations. This initiative, known as Granite Care, promises to bring significant changes to eligibility and covered services over the next years. While still in the planning stages, proposed reforms have included expanded eligibility for pregnant women and reproductive health services, institution of health services accounts for pregnant women and children, and the development of systems to improve community-based care for senior citizens. /2007/ As part of Medicaid Modernization, DHHS is developing plans for enhanced care coordination that will include efforts to provide care coordination for women with high risk pregnancies and children with special health care needs. MCH and SMS participated in initial planning and proposal reviews. This program is anticipated to begin in 2007. //2007//

//2008// NH has recently entered into a contract with Schaller Anderson Healthcare to provide enhanced care coordination for NH's Medicaid program. Schaller Anderson will provide prior authorization services and a nurse helpline for the entire Medicaid population and specialized care coordination services for those most at risk in their health care needs, including high risk pregnant women. It will be a patient centered model incorporating clinical best practices, comprehensive case tracking and case management based upon risk stratification and inpatient and outpatient management. There will be a primary focus on establishment and maintenance of a medical home and coordination of mental health and primary care services, including pharmacy and disease management. The program is currently in the Phase 1- Design and Development Phase examining data and developing relationships with providers and clients. Phase 2- Operations Maintenance and Monitoring is anticipated to begin in July 2007. //2008//

TANF REAUTHORIZATION & CHILD CARE: Two issues impacting the health of women and children in New Hampshire are welfare reform and child care. The annual average number of Temporary Assistance to Needy Families (TANF) cases open on the last day of the month has declined 34% from 1994 to 2004 from 9,071 to 5,932. (44) As of August 2004, 771 people had reached their 60-month time limit on TANF. (45) An estimated average of 21 individuals will reach this limit each month during the coming year. (46) MCH is aware of the importance of reaching out to this population to assure access to health care. The number and percent of children receiving TANF assistance has also declined, with marked differences among the town economic clusters described earlier. Wealthier communities saw a decline of 45% during 1995-1999, while poorer ones saw a decline of only 33%. (43) The number of children in poorer cluster of towns receiving food stamps and Medicaid benefits is 4 to 5 times that of the wealthiest cluster. (47) If TANF is to be successful in moving women into the workforce, then available quality child care with an adequate capacity to serve all children in need is paramount. A 1997 report estimated that 56% of preschoolers requiring out of home care were in regulated childcare settings, leaving the remainder in unregulated settings or without care at all. (48) As of September 2002, an average of 14.3 licensed childcare opportunities existed per 100 children age 0-17. (49) In 2003, 64.9% of NH women participated in the labor force, seventh in the nation for this indicator. (50) This figure is likely to increase as TANF rolls decline. New work requirements will result in a burgeoning demand for quality childcare and an increased need to support child care providers in the areas of health and safety and early childhood development. MCH's Healthy Child Care NH initiative is working to improve a key component of quality childcare; health and safety in child care environments.

/2007/ Responding to federal changes to the TANF program, in June 2006 Gov. John Lynch issued an Executive Order requiring DHHS to increase child care, transportation, education and other support services, as well as creating a system for monitoring the implementation TANF program changes, and the impact of those changes on clients, and the state's efforts to meet

federal requirements. The increased requirements for adults, including mothers with young children, to participate in work activities instead of training or education are likely to stress systems currently in place that support MCH populations. //2007//

//2009//

In order to ensure that families have access to high quality child care programs, the DHHS Child Development Bureau developed Licensed Plus, a quality rating system that recognizes child care programs for efforts to improve the quality of care for young children and rewards programs that strive to improve their practices and staff qualifications. It also allows families to identify programs with higher quality. Levels build from a foundation of minimum standards for licensing to full national accreditation. Health and safety standards were developed in consultation with MCH and child care providers. //2009//

Parents of CSHCN receiving TANF, Medicaid, and/or SSI for a disabled child are among the hardest to assist through many traditional mechanisms. Sustaining employment and accessing appropriate, adequate child care for children with special needs are often impossible conditions for these parents to meet. A 2002 government report on welfare reform found that 15% of TANF recipients were adults who reported having at least one physical or mental impairment and a child who also had impairment, or were parents caring for a child with a disability. (51) It is estimated that up to 40% of women with welfare experience has children with special health care needs. (52) Welfare parents with children with special needs are 33% more likely to lose a job involuntarily, due to the effects of the child's chronic illness. (53) A 2002 Manpower Demonstration Research Corporation study found that 25% of non-employed mothers receiving TANF had a child with an illness or disability that limited her ability to work or attend school. (54)

HOMELESSNESS: One in ten poor children, over 1 million children in the US, experience homelessness every year; the risk is higher for younger children. Homelessness greatly impacts the health and well being of children and youth. Compared to children with homes, homeless children are more likely to have health problems, developmental delays, mental health problems such as anxiety and depression, behavioral problems and lower academic achievement. As much as 12% of the homeless population is estimated to consist of youth between the ages of 16 and 24 years old who are not living in families. Homelessness creates enormous negative health and social costs for young people, These youth have high poverty rates and are often runaways or throwaways who have experienced physical and/or sexual abuse, childhood homelessness, parental substance abuse, foster care and/or juvenile detention. It is estimated that 25% of foster children have experienced homelessness within 2 to 4 years of leaving foster care. Homeless youth have an increased risk of physical and sexual abuse on the streets and in adult homeless shelters, with sexual assault rates of homeless youth estimated at 15 to 20 percent and physical assault at 50%. Obtaining accurate data on homelessness is challenging; these data often undercount the true population. A one-day count of students in homeless situations in January 2005 identified 976 homeless students in New Hampshire, 0.5% of students attending NH public schools in 2002-2003(most recent available data). (55) Homeless NH families often live in seasonal rentals, moving several times per year between campgrounds in the summer and motels and apartments in the winter. Children in these settings are often forced to leave school in the spring when they are must leave a winter rental before the school year ends, disrupting their education and social networks.

CURRENT STATE HEALTH AGENCY PRIORITIES & THE IMPACT ON TITLE V NEWBORN SCREENING: Scientific advances have resulted in the ability to screen newborns for a multitude of heritable disorders. In 2002, NH formed a Newborn Screening Advisory Committee (NSAC) to consider this issue and make recommendations for screening, focusing on the then-current March of Dimes recommendation to screen for 10 disorders. The NSPAC recommended in late 2003 to increase New Hampshire's panel to 10 disorders. In response, the DHHS examined the current funding mechanism of the program and determined that an amendment to the statute was needed to add the recommended screenings and keep abreast of the rapidly changing science in

this field. Senate Bill 108, introduced in the fall of 2004, would accomplish both of these goals. While this bill sailed smoothly through the Senate approval process, media attention nearly resulted in retention in the House. /2007/ SB108, enacted in 2005, clarified the criteria by which additional disorders are added to the newborn screening panel; established a newborn screening fund; and codified the Newborn Screening Advisory. The NSAC continues to meet and in May 2006 has advised DHHS to work towards adding another 15 conditions to the panel. //2007//

REFUGEE HEALTH: Refugee health became a noteworthy issue and important DHHS priority this year, as a cluster of refugee children with elevated lead levels occurred during the summer and fall of 2004 in Manchester. Since the death of a refugee child from lead poisoning in 2002, New Hampshire has obtained baseline and follow up lead levels on refugee children resettled in the state. MCH's CLPPP worked with the CDC's Lead Program, the state's EIS Officer, the Manchester Health Department and the Refugee Resettlement Agencies to develop a coordinated response to this issue. The completion of a descriptive case series investigation of this cluster, published in the MMWR in October 2004, concluded that lead poisoning occurred after resettlement in New Hampshire and therefore a follow up lead screen of refugees three to six months after the initial screen on arrival is useful. A cohort study, described in Section IVB, is currently underway to examine potential risk factors among refugee and non-refugee children living in comparable housing in Manchester. This investigation resulted in new recommendations from CDC on lead screening in refugee populations, and emphasized the need for New Hampshire to proactively consider the health needs of its refugee population. /2008/ Title V continues to build its relationship with the Office of Energy and Planning where the state's Refugee Program is located. The Refugee Program has received authorization to plan for and hire a new Refugee Health Coordinator position. The Refugee Program Coordinator has begun discussion with DPHS and MCH to see how this new position could best coordinate with existing health efforts that include the refugee population. It has been tentatively decided that this new Refugee Health Coordinator position will physically reside with MCH while maintaining accountabilities to the Office of Energy and Planning. Through this co-location, the two programs will be able to maximize efforts, avoid duplication and reach the intended population of refugees and their health care providers in a more efficient manner. //2008//**//2009/Unfortunately, due to administrative barriers, the Refugee Health Coordinator position has not yet been filled and if and when that occurs the position will be placed in the Office of Energy and Planning.//2009//**

PERFORMANCE MANAGEMENT: Performance management is a key DHHS strategy for improving state and local capacity to deliver core public health services and increase service quality. Our vision is to promote evidence-based practice by defining and measuring quality; establishing quantitative performance expectations; and holding state and local health systems, community agencies, and other service providers accountable through performance-based contracting. DHHS reorganization in 2004 created a new Bureau of Policy and Performance Management (BPPM) within the public health agency to work toward this goal for both internal and external processes. Trainings held in February 2003 and April 2005 taught performance measure development to program managers throughout the Division of Public Health Services (DPHS). Performance measure targets for community agencies are monitored over time and used in specialized Performance Management site visits to assist agencies in improving processes and outcomes. A DPHS Public Health Improvement Team (PHIT) will form this year, co-chaired by the BPPM and BCHS Bureau Chiefs. /2007/ PHIT met monthly in 2005 and 2006 with many MCH participants. //2007// SMS is in the process of updating and revising policy and procedure for quality assurance and improvement, and has increased the requirements for contractors to meet specified performance measures, congruent with the national measures for CSHCN. The Neuromotor Programs are focusing on evidence-based practices, e.g. regarding pain management and spasticity control. Special attention will be given to patient and family satisfaction measures during the next fiscal year./2008/SMS completed a follow-up survey of enrolled CYSHCN receiving SSI. The results of that survey clearly identify and address what families see as issues with the adequacy of their insurance coverage. A satisfaction survey for the statewide Neuromotor Clinic Program was also administered and that data is being sorted

and analyzed and will be available for use in SFY 2008.//2008//

HEALTHY PEOPLE 2010: DHHS used the Healthy People 2010 process to establish the state's prevention agenda. MCH staff was actively involved in and remains committed to aligning MCH program goals with leading health status indicators as articulated in Healthy NH 2010. MCH staff led Healthy NH 2010 work groups for Maternal, Infant and Child, Reproductive and Sexual Health, and Injury Prevention focus areas to select indicators for New Hampshire and create action plans for these objectives. These objectives are included in the attachment to this section. MCH and SMS use the Healthy NH 2010 objectives, along with Title V Performance Measures and other national and state objectives, to guide and measure their efforts. For example, pertinent Healthy NH 2010 objectives are integrated throughout the NH Adolescent Health Strategic Plan released this year. In addition, Healthy NH 2010 objectives and Title V performance measures are used where applicable with contracted community agencies providing MCH services. These performance measures are the basis of DPHS' work toward the implementation of performance management into public health practice. See Section IVB for MCH activities in this area.

STRENGTHENING THE SAFETY NET: Another top DHHS priority is to preserve and strengthen our infrastructure of community agencies serving low income and uninsured populations. Like all states, we have evolved a patchwork of health centers and other local agencies providing direct and enabling services. These agencies successfully integrate public health and prevention into clinical practice, providing true population-based care and leveraging far more in services than what is paid for by public funds. Their survival is critical to the continuing health of our communities. A 2000 report affirmed that the Community Health Centers (CHCs) are essential health care system components that serve individuals who may otherwise not be able to access health care and called for a renewed public and private commitment to CHCs. The report clearly described the deteriorating financial status of these agencies. Recommendations included: Medicaid and CHIP enrollment for all eligible patients; continued efforts to expand private health insurance; maximizing federal funding by expanding the number of 330 centers; examining DHHS resource allocations and reimbursement for certain services; expanding partnerships with hospitals, businesses and foundations; and securing access to long-term funding and short-term credit. (56)

The state's CHCs saw 24,055 uninsured patients in 2004, over 18% of all the uninsured in the state. (57) While 11% of the state's residents were uninsured in 2003, 32% of CHC patients were uninsured. Similarly, 21% of CHC clients were enrolled in Medicaid while about 6% of the state's residents were Medicaid eligible. (58) State CHCs are funded in part through Title V. The FY2006 State budget preserves current CHC funding, including a 2004 increase of \$1.1 million that provided a much-needed influx of funding to help sustain these safety net providers.

/2008/ CHC's continue to demonstrate success in meeting the health care needs of the uninsured and under-insured citizens of the state. The NH Legislature has acknowledged these contributions and has proposed a significant increase in state funding for CHC's in SFY08 and 09. With this proposed increase, DHHS leadership has asked MCH to develop a new needs based funding strategy. It will be informed by state data and input from providers.//2008//

/2009/

With increased funds dedicated to CHCs in SFFY08, NH was able to implement a new funding strategy for existing CHCs and use that same formula to support 3 additional CHCs and 2 new primary care for the homeless programs. To further ensure that safety net providers are accessible to all NH residents, MCH will work with CHCs to develop a defined, equitable, useable policy for sliding fee scales for uninsured and underinsured adults that addresses agencies' need to maintain fiscal stability while assuring access to care for low income populations in NH.//2009//

ENHANCED PUBLIC HEALTH BENEFITS FOR MEDICAID RECIPIENTS: Title V partners with

Medicaid to expand MCH services such as home visiting, enhanced prenatal care, substance abuse treatment and oral health care. For example, in 2004, a local Medicaid code was developed that allows reimbursement to MCH contract agencies for family support and coordination services. MCH and Medicaid coordinate in the quality assurance and training activities for this code. Pharmacy Benefits Management was implemented in November 2001 for individuals receiving prescription medications through Medicaid. This program should reduce Medicaid drug expenditures while improving quality control and data reporting capabilities and claims. Medicaid is currently implementing a comprehensive disease management program for recipients with respiratory, heart and kidney disease, and diabetes mellitus. This program will promote adherence to health care treatment plans and evidence based guidelines through individualized counseling with trained specialty care nurses, with the goals of: enhancing health status and quality of life; reducing barriers to care; improving communication with health care providers; improving symptom identification and control; increasing medication compliance; and increasing understanding of the use of medical homes.

THE POLITICAL CLIMATE: NH operates under a unique Governor & Council (G&C) form of government. Five Executive Councilors, each representing 1/5 of the population, are elected separately from the Governor, though for the same two-year term. The Councilors participate in the active management of the business of the state. Together, the G&C has the authority and responsibility over the administration of the affairs of the state as defined in the NH Constitution, its' statutes and the advisory opinions of the NH Supreme Court and the Attorney General. All state departments and agencies must seek approval of both receipt and expenditures of state and federal funds, budgetary transfers within the department and all contracts with a value of \$5,000 or more. New Hampshire also has the third largest legislative body in the English-speaking world, consisting of 24 senators and 400 representatives. The structure and size of NH's executive and legislative branches, respectively, ensure that citizens are well represented in matters of the state. In January 2005, democratic Governor John Lynch took office, while a republican majority remained in the legislature. Governor Lynch is working to make progress on the issues important to NH families -- education, health care costs, the environment, and employment. Commissioner John Stephen, former Assistant Commissioner of Safety, was appointed in the fall of 2003. Under Commissioner Stephen, DHHS is completing extensive restructuring, to bring programs into alignment and promote efficiencies within the department. /2007/ NH politics will remain in flux, as residents will vote for a new governor in Fall 2006. //2007//

//2009// As with many states, NH is experiencing significant budget challenges. A new DHHS Commissioner, Nicholas Toumpas and a new Director of DPHS, Dr. Jose Montero, are leading efforts for increased efficiencies in a resource challenged environment.//2009//

THE STATE BUDGET & SCHOOL FUNDING: The biennium budget process for SFY06/07 has brought continued fiscal challenges to both the state and DHHS, as New Hampshire strives to achieve a balanced budget. A significant issue impacting New Hampshire's budget considerations for the past decade has been funding for public education. Developing an equitable school funding methodology, and finding state funds to pay for an adequate public education for every child has impacted the state's ability to address some other issues. At this point, the budget maintains funding for most essential MCH services. A mechanism to fund additional screening for heritable disorders in newborns are included.

ADVOCACY FOR CHILDREN: The Children's Alliance of New Hampshire (CANH), the child advocacy group that annually produces Kids Count NH, also publishes an annual plan to focus attention on and build support for children's needs, the Children's Agenda. Both Kids Count and the Children's Agenda set forth priorities for public policy and identify gaps in available data that are needed to adequately describe and monitor the status of children and families in the state. These efforts place a high priority on children and families, promoting a climate ripe for collaboration among many stakeholders to work towards improving the health of children in NH. Both MCH and SMS are members of CANH and participate in setting the annual Agenda. /2007/

CANH's 2006 focus is on the following areas: a long term and sustainable funding system for public education; support of early intervention through legislation to require private insurers to fund its services; preservation of the "best interests of the child" standard in divorce settlements; studying the adequacy of NH consumer protection laws to prevent vulnerable families from predatory lending practices; support for school breakfast programs; promotion of the "Watch Your Mouth" campaign to improve children's oral health; and strategies to reduce underage alcohol problems. //2007//

STATEWIDE HEALTH CARE DELIVERY SYSTEMS: NH's health care delivery system consists of an array of public and private health service providers. This system, which varies regionally, presents special obstacles to the attainment of a seamless system of health care services for all citizens that is the NH Department of Health and Human Services' (DHHS) vision. Much of the state is designated as medically underserved. While NH's two largest cities have public health departments, there is no statewide network of local health departments providing direct or population based health care services. Instead, the DHHS contracts with community-based, non-profit, safety net providers such as community health centers, prenatal, family planning, and child health agencies. These agencies provide direct health care and enabling services, such as case management, care coordination, nutrition, social services, home visiting, transportation, and translation to low income, uninsured and underinsured populations including those with special health care needs. Their locations assure that most services are available throughout the state. This patchwork of agencies, along with private providers and specialty clinics for those with special health care needs, comprises the State's primary care health care service system. Maps of health shortage areas and a list of MCH and SMS contract agencies are attached to this section.

PUBLIC HEALTH INFRASTRUCTURE: The bastion of NH's public health infrastructure is the DHHS. The Division of Public Health Services (DPHS), as the public health arm of DHHS, promotes the development of public health infrastructure and capacity in various ways, including funding community agencies to provide direct health care services, developing community and state level health programs, and imparting leadership and direction through health policy and planning activities. The Community Public Health Development Program is dedicated to building New Hampshire's local public health systems. This program promotes regional collaborations to ensure that the ten essential public health services are provided and that local public health systems are fully integrated with local emergency preparedness and response systems and the state public health system. Grantees are responsible for developing strategic linkages with businesses, schools, hospitals, and human service providers to assess and plan for improvement of overall health status and to participate, when necessary, in local public health related emergency response. As emergency preparedness capacity is achieved, the PHNs will also provide an umbrella for convening and coordinating other local public health-focused coalitions and networks.

/2009/ MCH is continuing to work with DPHS in developing plans for increased regionalization of public health services. Financial feasibility studies and pilot programs are anticipated to begin in July 2008.//2009//

/2008/ MCH participated in NH's Assessment of the National Public Health Performance Standards with over 100 health and human service professionals, from both public and private sectors, to assess the capacity and performance of the state's public health system. Participants used the State Public Health Assessment Instrument to rate the state public health system's ability to carry out the Ten Essential Services of public health. The assessment identified that the strength of NH lies in the commitment of many individuals and the small and manageable size of the public health community and general population. Weaknesses included fragmentation of services and a lack of coordination. Work continues through the Public Health Improvement Action Plan Advisory Committee to maintain an ongoing performance improvement planning process.//2008//

/2007/ EMERGENCY PREPAREDNESS: Two main mosquito borne viruses present in NH that can cause human disease are West Nile Virus and Eastern Equine Encephalitis (EEE). West Nile Virus appeared for the third year in the summer of 2005. The first human case of EEE arrived in 2004. In 2005, six human cases were detected resulting in two deaths from the infection. The DPHS response has been to increase surveillance and promote prevention through public education. In November 2005, NH DHHS participated in an avian pandemic flu drill. DPHS was at the center of the drill and partnered with state agencies, local municipalities, schools and community-based organizations. Title V staff volunteered in many capacities as three all-day clinics were established to deliver real flu shots in a drill setting. As a result, over 2000 NH residents received flu shots and state planners learned many lessons in preparation and logistics that have refined current emergency planning. (72, 73) There is still work to be done, and Title V is providing technical assistance in planning for the unique needs of the MCH and CYSHCN populations. *//2007//*

HIGH RISK NEWBORN FACILITIES: NH has 24 birthing hospitals, a decrease from 26 birthing hospitals in 2003. Dartmouth Hitchcock Medical Center (DHMC) in the western central part of the state provides tertiary care in most specialties for much of the state. This and the Elliot Hospital in southern NH are the in-state alternatives for high-risk newborn care. In some areas, patients may seek specialty or tertiary care in Massachusetts or Maine, but most high-risk births are delivered at DMHC. DHMC administers a regional perinatal outreach program and conducts transport conferences with state birthing hospitals to monitor the appropriateness of transfers of high-risk mothers and infants to the facility. The perinatal program also provides continuing education to hospital perinatal nurse managers.

MENTAL HEALTH SERVICES: A continuing gap in NH's health care infrastructure is access to mental health services. Although Medicaid covers mental health services, services are difficult to access. While community mental health centers are available in some regions, they cannot meet the demand for services. In addition, in selected areas of the state it is proposed that services for the developmentally disabled (Area Agencies) be combined with community mental health centers. All centers have waiting lists at some point during each year. In some cases, fees are beyond the reach of low-income families. A primary issue is workforce recruitment and retention for mental health care providers, especially those specializing in care for very young children. According to the Data Research Center for CYSHCN, in 2001 32.7% of NH children with special healthcare needs needed mental health or counseling services at some time during the year preceding the survey. Of children needing these services, 15.3% of families reported not receiving the service. (59) The 2004 NH survey of CSHCN receiving SSI for their own disability indicated that 51% of that group needed mental health care, but 28% of those needing mental health care did not receive the services. See the NH CSHCN SSI report in the Needs Assessment. The Division of Behavioral Health (DBH)*/2007/* now Bureau of Behavioral Health (BBH) *//2007//* and the NH Infant Mental Health Association are addressing these issues. The community mental health system for children has been developing a more complete service array in each region to better meet local need, but resources remain inadequate. The BBH has undertaken a comprehensive examination of financing and is committed to shifting resources to the children's mental health system. In collaboration with DHHS and DOE, BBH is working to increase access to mental health services for children birth through six and their families. SMS is planning an initiative for the workforce development of respite and childcare providers for the families of behaviorally and medically complex CSHCN. */2007/* Through NH's HRSA Strategic Partnership Review, Title V and other HRSA grantees have dedicated action steps for addressing mental health integration into primary care. *//2007//* */2008/* Continuing this partnership, Title V is exploring new funding opportunities for integrating care. *//2008//* ***/2009/Related to Autism Spectrum Disorders, NH has legislatively convened an Autism Commission, created an Autism Registry and a Statewide Autism Council in the last year. //2009//***

/2009/

The NH Office of Medicaid Business and Policy profiled Medicaid members' health care experience during CY 2005 to better understand the scope and costs associated with

depression among NH Medicaid members. The study found that depression is common among all members of NH Medicaid and is not limited to individuals with a mental health disability or individuals traditionally served by behavioral health programs. Twenty percent of NH Medicaid members had symptoms of depression- 10% identified by diagnosis and another 10% identified by antidepressant use. Medicaid members with evidence of depression have substantially higher costs than those without depression. While some of this difference might be expected based on the treatment for the disease (i.e., medication and therapy costs), members with evidence of depression averaged 3.8 times higher payments than members with no evidence. Hospitalization rates were 4.7 times higher for members with depression, than those without depression. (81)

To address the burden of disease, in SFY08 MCH encouraged and provided funding for all contracted primary care agencies to integrate behavioral health within their primary care practice. Each community health center developed plans and formal agreements to increase access and integration of care.

//2009//

ORAL HEALTH SERVICES: Improving access to oral health services for vulnerable populations continues to be a high priority for DHHS, but barriers to realizing this goal persist. The distribution of dentists throughout the state is erratic and few treat uninsured and underinsured clients. For example, there are only 21 pediatric dentists in the state, located primarily in central and southern regions; the rural North Country has no pediatric dentists. In the North Country, the overall dentist to patient ratio is 1:4,338, 30% of the population fall under 200% FPL, and only 12% benefit from optimal water fluoridation. (60) One urban and four rural NH areas are designated as Dental Health Professional Shortage areas; together, these areas contain 20% of the state's population. In addition, the dental work force is aging. Of the 675 dentists practicing in the state, 44% are over age 50. The number of new dentists moving to NH will be insufficient to replace those retiring in coming years; without a state dental school, there is no local supply of newly trained dentists to fill the need. Data from NH's 2003 oral health statewide survey of third grade students revealed that 22% had untreated decay, 52% had caries experience and 46% had sealants on at least one permanent molar. Among those same children 25% needed early dental care, and 5% required urgent dental treatment. (61) Similarly, the 2001 National Survey of CSHCN indicated that, while 83.5% of NH's CSHCN needed dental care, including check-ups, in the 12 months preceding the survey, approximately 9% did not receive all the dental care needed. (62) Since 2001, numerous improvements in the Medicaid oral health system have been realized, including increased reimbursements, streamlined claims processing, and the elimination of prior authorization, improved provider relations and utilization review. Through the PHHS Block Grant, the DHHS funds school-based preventive programs and community dental centers, some in community health centers or mobile clinics. /2007/ However, these services are threatened by proposed federal elimination of this funding stream. //2007//

EVALUATING HEALTH SYSTEMS FACTORS & DEVELOPING TITLE V PRIORITIES:

Determining Title V priorities is a complex process that requires weighing multiple factors, including known data, capacity and service gaps, state priorities, and emerging issues. Emerging issues for CSHCN have been identified, validated and assessed, via an extensive Delphi process, and the results have been incorporated into the State priorities. CSHCN priorities are based on the SMS needs assessment, focus group data, parent advisory input, and the National Survey of Children with Special Health Care Needs 2001 results for New Hampshire. One new priority need, respite and childcare workforce development has been selected to be addressed in FY06. SMS and MCH are also jointly addressing the identified priorities of mental health services for children and adolescents, and the issue of child and adolescent overweight/obesity. Key Title V managers annually evaluate these factors as they relate to the Title V mission, needs assessment findings and Health Systems Capacity Indicators data to arrive at consensus on state priority needs. A detailed description of this process is discussed in Section II; the list of Title V priorities for this year can be found in Section IVB. /2007/ There is no new data to suggest that the Title V priorities identified in the 2005 Needs Assessment should change in 2006. It was

through thoughtful consideration that Title V continues to proceed into FY07 with the same set of priorities. Focus will be maintained on these issues by continually collecting and analyzing the data and creating action steps that mobilize our MCH and SMS programs, and state and community partners. //2007//

/2009/ NH has had a long history of family involvement and the benefit of a contractual relationship with New Hampshire Family Voices (NHFV). The value of family participation and involvement has become a mainstay in new and ongoing projects related to CSHCN. NHFV has been a participant in the MCH/SMS Block Grant planning meetings and the yearlong Needs Assessment meetings (to review current needs as well as to plan for the upcoming 5-year needs assessment). //2009//

Endnotes are attached to this section
An attachment is included in this section.

B. Agency Capacity

STATEWIDE SYSTEM FOR CSHCN

For children with special health care needs (CSHCN) an interdependent relationship exists between the private medical system and the Title V CSHCN Program. Private practice pediatricians and family practitioners provide primary care for the large majority of New Hampshire's CSHCN and are the foundation of the state's primary care infrastructure. However, physician distribution is uneven across the state. Of concern is the availability of pediatricians to care for this population of children.

Dartmouth Hitchcock Medical Center (DHMC) in Lebanon provides tertiary care for CSHCN through "ChaD", the Children's Hospital at Dartmouth. Inpatient units include the Intensive Care Nursery, Pediatric Intensive Care Unit and Pediatric and Adolescent Inpatient Unit. Specialty clinics for cystic fibrosis, spina bifida, cardiac anomalies, cleft lip and palate, epilepsy and child development are held at ChaD. The DHMC Child Development Clinic is supported by SMS contract with outreach to Laconia and Lancaster. In addition SMS provides a multidisciplinary neuromotor clinic at ChaD, as part of our statewide Neuromotor Program.

An important addition to services at DHMC is the ChaD Family Center that provides health information, access to financial assistance and a quiet place to relax between visits. A unique support and educational program offered at the medical center is the Steps Toward Adult Responsibility (STAR) Program for teenagers living with chronic, physical health conditions.

In addition to Lebanon, pediatric sub-specialty services are offered in Manchester, a more central location, and Child Development, cardiology and neurology services are available statewide at other locations.

Ninety-seven percent of NH respondents to the National CSHCN survey said they received the specialty care that their child needed. However, information received from the Board of Medicine, supported by clinician reports, indicates that NH continues to experience a serious shortage of pediatric ophthalmologists, allergists, and physiatrists.

For CSHCN, dental access issues are compounded. Like all children, CSHCN need routine dental care; however access to care is an even larger issue due to the lack of providers who have the skill level necessary to manage this group of children. According to the NSCSHCN, 2001, 42% of NH families said there was a problem with their health plan regarding dental care; 6% said dental care cost too much and 6% said the dentist did not know how to treat CSHCN. /2007/ New Hampshire Family Voices recently facilitated three focus groups on dental care with parents of CSHCN. This activity was done with technical assistance from Health Systems Research, Inc. (Washington, D.C.) Meetings were held in Keene, Manchester, and Laconia. The intent was to gain information regarding participants' experiences obtaining and using dental services for their

children with special needs. After the analysis is completed, the goal is to a) use the findings as rationale for future funding and b) to increase capacity by educating NH dentists regarding the needs of this population. //2007//

Facilitating and supporting the primary care provider role is an important responsibility of SMS. New Hampshire initiatives related to spreading the concept of the Medical Home are crucial to supporting private practitioners. To date eight pediatric practices have participated in MCHB funded activities associated with the Rural Medical Home, nine practices have participated in the Partners in Chronic Care Project and five practices are currently participating in Beyond the Medical Home activities. SMS supports a 0.5 FTE Public Health Nurse coordinator to work with the Center for Medical Home Improvement. Consultation is provided to care coordinators and office personnel associated with all the sites. A new SMS initiative, the NH Health Transition Project, is providing intensive collaboration to three pairs of pediatric-adult care providers, to explore the process and strategies involved with moving YSHCN to adult systems of care. /2007/ SMS consultation regarding health care transition of young adults is a component of the MCHB funded Integrated Services For NH CSHCN Grant Initiative. //2007///2008/ SMS consultation regarding inclusion of CSHCN in child care has occurred through support of workshops for child care providers and health professionals consulting to child care facilities.//2008//

Another gap in the infrastructure for CSHCN in NH is access to mental health services. Available providers are overburdened. Expertise in treating children and adolescents, in particular CSHCN, is limited in the publicly funded mental health system and few other mental health resources are available. /2007/ To compensate for limited Mental Health services (and to initiate best practices) SMS and MCH sections are participating in the HRSA sponsored Strategic Partnership action plan to integrate behavioral health services in primary care. //2007//

The NH Behavioral Health Bureau is completing a \$5 million, 5 year grant (SAMSHA/New Hampshire Cares) to implement systems of care for children with serious emotional disturbances in three communities. The Title V CSHCN Program has joined with four other State programs to support 14 regional Infant Mental Health teams. These teams are charged with developing community-based, wrap-around services for the 0-5 year population and their families.

Historically and at the current time, it is difficult for parents to obtain independent school consultations from private mental health practitioners or community mental health centers. These consultations are necessary to deal with diagnostic issues and development of an IEP. While SMS-funded Child Development Programs and the SMS Consulting Psychologist provide some support for school consultations, these services remain extremely under-funded.

The diversity in conditions and unique needs of CSHCN present an enormous challenge to developing systematic approaches for providing care. The State service delivery system is a patchwork of different systems, including health, education, social/welfare and juvenile justice. Leadership and administration varies across systems and a variety of disease- and issue-specific advisory boards exist at state, regional and local levels. Federal and state mandates defining authority and responsibilities for certain groups of CSHCN are broad and often overlap.

Federal funding received by State agencies further defines programs and services, most often categorically. For example, the New Hampshire Area Agency system consists of 11 designated non-profit and specialized service agencies, which represent specific geographic regions, that have the responsibility of providing information, supports and services for NH consumers with developmental disabilities and acquired brain disorders.

NH Partners In Health (PIH) is another important component of the statewide system for CSHCN. This community-based program addresses the needs of families of children with chronic health conditions, birth to age 21, utilizing a family-centered approach and works within the community to facilitate and enhance the care and services that families need. The goal is to create opportunities for families, health professionals and relevant agencies and institutions to work

together in order to design innovative solutions that will meet the needs of families within their communities. Flexible funds are available to families participating in the program. SMS coordinators frequently partner with PIH to deliver services to families of CSHCN. ***//2009/ Related to the new alignment of SMS into the Bureau of Developmental Services a statewide summit was held in October 2007 to clarify the roles and eligibility criteria of 4 agencies that provide services in BDS to CSHCN, in order to improve communication and identify any risks for duplication of services. These agencies include Area Agency Family Support, Early Supports & Services, Partners in Health and Special Medical Services.//2009//***

The complexity of the community-level system increases proportionately with the number of agencies, providers and funding sources that are involved. The task of integrating services is a complex undertaking. To ensure integration, facilitate this process, and promote family-centered, community-based care, a major portion of SMS resources are used to support professional care coordination services. To maintain this program SMS supports a centralized staff of care coordinators for specific geographic areas and contracts with community agencies serving high density urban populations.

NH REVISED STATUTES ANNOTATED (RSA) RELEVANT TO TITLE V

RSA 125, General Provisions, describes the responsibilities of the Department of Health and Human Services' (DHHS) Commissioner to "take cognizance of the interests of health and life among the people". RSA 126 establishes the DHHS to "provide a comprehensive and coordinated system of health and human services as needed to promote and protect the health, safety, and well being" of New Hampshire citizens and mandates that services "shall be directed at supporting families, strengthening communities, and developing the independence and self-sufficiency of New Hampshire citizens".

RSA 132, Protection for Maternity and Infancy, provides broad authority for MCH and CSHCN services "to protect and promote the physical health of women in their childbearing years and their infants and children". It authorizes the Commissioner to: accept federal funds; employ staff; cooperate with federal, state and local agencies to plan and provide services; supervise contracts with local agencies; make rules and to conduct studies as necessary to carry out the provisions of the law. CSHCN services are defined in the law as diagnoses, hospitalization, medical, surgical corrective and other services and care of such children. This law also allows for administration of the WIC program.

RSA 132-A creates an exemption to child abandonment laws if the child is delivered to a "safe haven".

RSA 132:10A mandates newborn screening, requiring health care providers attending newborns to test for metabolic disorders. *//2007/ Revised 12/05. //2007//*

RSA 132:24 requires parental notification before abortions may be performed on unemancipated minors.

RSA 611, Medical Examiners, requires the medical examiner to file a record with MCH of any death determined to be the result of Sudden Infant Death Syndrome.

RSA 137G, Catastrophic Illness Program, defines catastrophic illness to include cancer, hemophilia, end-stage renal disease, spinal cord injury, cystic fibrosis *//2007/* and multiple sclerosis. *//2007//* which require extensive treatment such as hospitalization, medication, surgery, therapy or other medical expenses such as transportation. Eligible individuals may have services paid for by DHHS; eligibility and services to be covered are set forth in rules. *//2008/Revised 3/07.//2008//*

RSA 126 contains provisions establishing a division of juvenile justice services; allowing for

DHHS quality assurance activities; establishing an Advisory Council on Child Care to plan for improved child care services, report to the Legislature and Governor, and to act as a forum to receive child care related information; the development of primary preventive health services for low-income and uninsured populations; establishing an emergency shelter program, a council for children and adolescents with chronic health conditions and their families, and the Tobacco Use Prevention Funds; and restricts sale of tobacco products to minors. RSA 126-M:1 recognizes the importance of prevention and early intervention programs and creates a formal network of family resource centers.

/2008/ RSA 254:144:X, Riding on Bicycles, No person less than 16 years of age may operate or ride upon a bicycle on a public way unless he or she wears protective headgear of a type approved by the commissioner of health and human services.//2008//

RSA 130-A, Lead Poisoning Prevention and Control, provides for public education, comprehensive case management services, an investigation and enforcement program and the establishment of a database on lead poisoning in children.

RSA 135-C allows DHHS to establish, maintain, and coordinate a comprehensive system of mental health services.

RSA 141-C, Immunization, and Reporting Communicable Diseases, prohibits enrollment in school or child care unless immunization standards are met, requires reporting of specified communicable diseases to the State Department of Public Health, prohibits mandatory genetic testing and requires informed consent, except for establishment of paternity and for newborn metabolic screening.

RSA 169-C mandates reporting of suspected child abuse.

/2009/RSA 318B:12A allows substance abuse treatment without parental consent at age 12.

RSA 141-C:18 allows adolescents to receive testing and treatment for sexually transmitted diseases without parental consent at age 14.//2009//

RSA 263:14 outlines a system of graduated licensing for youthful operators.

RSA 265:82 prohibits driving while under the influence of alcohol or drugs and requires the use of infant booster seats and seat belts up to age 18.

RSA5-C:2 establishes the Division of Vital Records within the Department of State.

/2009/RSA 270:30-a, mandates personal flotation devices on children 12 and under while in a boat.//2009//

The full, unofficial text of these statutes may be accessed on the State's website at: www.state.nh.us. Information on Title V program activities related to these statutes can be found in Sections IIIC, IIIE, and IV of this application.

Listed below are bills of particular interest to Title V passed by the New Hampshire Legislature during the most recent Legislative Session.

SB30 establishes the Collaborative Practice for Emergency Contraception Act, allowing a pharmacist to initiate emergency contraception. SB108 addresses adding to the panel of newborn screening tests and creates a restricted revenue fund to cover the cost of the screening laboratory's contract. HB118 requires bicycle helmet use by persons 16 years of age or less when riding on public ways. HB383 requires the secretary of state and the commissioner of the

department of health and human services to enter into a memorandum of understanding relative to the state's vital record system. All of these bills were passed during the 2005 session. **//2009/Emergency contraception is able to purchased over the counter.//**

//2007/

Bills passed in 2006 of interest of Title V: SB 250, clarified lead paint poisoning prevention; HB 1201 realtive to child passenger restraints.//2007//

//2008/

Bills of interest to Title V in the 2007 General Court of New Hampshire include:

HB 184 repeals RSA 132:24-28, requiring notification of a parent 48 hours before a minor has an abortion. This law has been ruled unconstitutional by the Federal District Court, the 1st Circuit Court of Appeals, and the US Supreme Court because it has no health exception clause. Both the House and Senate have voted to repeal this law.

HB 802 would have required seat belt use by all motor vehicle drivers and passengers. This bill was defeated in the Senate. NH remains the only state to not require adults to use passenger restraints in motor vehicles.

HB362: Amends RSA 126:24, by clarifying the reporting requirement for the advisory committee on quality of vital records information. Requires the committee to produce an annual report on the quality of the prior year's vital records data, including the completeness of data on events that occurred out of state. This bill has been passed by both the House and Senate.

SB 176 was passed to lower the blood lead level that determines when a child is lead poisoned, from the current level of 20 to 10. The bill also allows the DHHS to inspect other units of a multi-unit dwelling when a child has been found to be lead poisoned in one of the units; extends the period of time that interim controls be used as an alternative to lead hazard abatement under certain circumstances; and establishes a commission to study the current childhood lead poisoning prevention policies.//2008//

//2009/

Bills of interest to Title V in the 2008 General Court of New Hampshire include:

HB 1496 would establish learner's permits for drivers' licensing, extend the graduated drivers licensing requirement to 40 hours of supervised driving, and puts limitation on driving hours for youth operators under the age of 18. The bill passed the House, but was voted Intermim Study by the Senate Transportation Committee.

HB1505, signed by the Governor in June 2007, authorizes the DHHS MCH program to establish and maintain a statewide, population-based public health surveillance program on birth conditions. //2009//

PREVENTIVE & PRIMARY CARE SERVICES FOR WOMEN, MOTHERS & INFANTS

Aside from population based activities, and as outlined in Section IIIA, MCH contracts with community agencies to provide prenatal, reproductive health care, and home visiting services for low income and underserved populations. Thirteen **//2007/** Twelve **//2007//** agencies statewide provide prenatal care and enabling services such as case management, nutrition counseling, tobacco cessation interventions, and individual social services. Of these, ten **//2007/** nine **//2007//** are primary care community health centers (CHC), offering the full spectrum of health care services to all ages; the others are 'categorical', offering access to reproductive health, prenatal care, and enabling services through various models that meet their community's needs. Eleven agencies provide contracted reproductive health services through Title X funds, and 15 **//2007/** 14

//2007// agencies provide home visiting services for pregnant women, and mothers and their infants through age one. ***/2009/ At the time of submission of the 2009 application, 14 agencies contract with MCHS to provide prenatal care. Twelve of these agencies are primary care, community health centers. //2009//***

Of the ten CHCs, seven have Federally Qualified Health Center status. /2007/ As of 2006, eight of the eleven have Federally Qualified Health Center status. //2007// These agencies generally utilize family practice physicians and advanced practice nurses for care provision, and offer full-time service with evening and weekend hours for easy access. Two CHC locations are health centers affiliated with hospitals; one center applied for 330 status in 2005, but was not funded. The three categorical prenatal agencies offer care directly or through subcontract with local physicians. By contract, social services, nutritional counseling, and referral for high-risk care must be provided.

In 2003, these 13 agencies served 2107 (14%) of New Hampshire's pregnant women at 17 separate clinic locations. Of pregnant women served by MCH agencies, 69% were enrolled in Medicaid for the pregnancy, 12% were uninsured, 13% were between 15 and 19 years of age, and 43.5% were between 20 and 24 years of age. /2007/ In 2004, the 12 prenatal agencies served 2098 (14%) of New Hampshire's pregnant women at 16 separate clinic locations. Of pregnant women served by MCH agencies, 71% were enrolled in Medicaid for the pregnancy, 11% were uninsured. No significant changes were noted in age from 2003. //2007//

/2009/ With additional state funding in the 2008 budget, MCH now contracts with a total of 13 community health centers (CHCs), 10 of which are FQHCs, and two healthcare for the homeless programs. CHCs provide primary care across the lifespan for low income families. In 2006, 2119 women were served at the prenatal agencies. Of these, 69% were enrolled in Medicaid, and 12% were uninsured. //2009//

MCH also contracts with 15 community-based agencies in 18 sites across the state to provide home visiting services for Medicaid eligible pregnant and parenting women. Home Visiting New Hampshire (HVNH) is a preventive program that provides health, education, support and linkages to other community services. Each family has a team of home visitors that includes a nurse and a parent educator. Parent educators can be highly trained paraprofessionals, or professionals with expertise in social work, family support or early childhood studies. Families are supported in their roles as their child's first and best teacher and learn ways to enhance their child's learning and development.

HVNH served over 700 pregnant women and their infants in SFY04. /2007/ In SFY05, HVNH served over 900 pregnant women and their infants.//2007// By funding almost two thirds of program sites in counties with a higher than the state average poverty rates, the program is able reach vulnerable populations. Additionally, HVNH sites are located in a variety of community-based agencies from traditional VNA programs to hospitals, family resource centers to mental health centers. By utilizing a variety of platforms, HVNH can reach families using supports embedded within each unique community.

Recent evaluations have shown that 34% of participants come into the home visiting program with a history of depression. During pregnancy, 22% of participants demonstrated symptoms of depression. That rate dropped by half to 11% after the baby was born. Participating women also have high rates of smoking, but during program participation, they reduced the numbers of cigarettes smoked. Specifically, although 63% of women smoked prior to pregnancy, by the time they gave birth that number dropped to 33%. Another compelling result of HVNH evaluations was that over 90% of participants initiated prenatal care at the recommended time and over 95% received the recommended number of prenatal visits, higher than state averages.

Prenatal Disparities: Section IIIA of this application presents data clearly delineating disparities in prenatal care access and health outcomes for privately insured women versus those uninsured or

on Medicaid. The 2005 needs assessment provides much information about those groups more likely to obtain less than adequate prenatal care or experience poor pregnancy outcomes. While MCH knows little about where these women obtain prenatal care, other than at its' contract agencies, or whether care meets acceptable OB standards, we recognize the need to further explore these disparities, including examining the private prenatal care system to assure capacity for addressing this population's complex needs. MCH will work with its epidemiologist, Medicaid, WIC, and other stakeholders to develop a plan to address these disparities and any service system gaps.

/2007/

A recent initiative of the MCH Prenatal Program has been the formation of an intra-departmental Birth Outcomes Workgroup to coordinate policy efforts and provide broad consultation to develop strategies for improvement of birth outcomes.

MCH completed analyses using low birth weight and fetio-infant mortality as key indicators. A Perinatal Periods Of Risk (PPOR) and a Population Attributable Risk (PAR) analyses were conducted using NH birth records. The preliminary data were presented to the Birth Outcomes Workgroup and invited representatives from health care organizations. The final results of this assessment along with birth statistics on various sub-populations will be used to target interventions to improve maternal and infant health.

The Prenatal Data Linkage Project was formed to link prenatal clinic records and NH birth data to assure that MCH is able to monitor and evaluate MCH prenatal program data. This project will greatly assist in program management, policy development, and evaluation of health services to pregnant women and newborns.//2007//

/2008/ MCH is completing development of the Perinatal Client Data Form (PCDF) Data Linkage Project that will link clinic records from the perinatal periods with NH birth data. Data collection from all prenatal agencies is expected to begin July 1, 2007. MCH completed extensive internal testing of the Auris PCDF system and will pilot the manual web-based data entry component with 2 community-based prenatal agencies.

/2009/ The PCDF became operational for all clients whose first prenatal visit with an MCH-funded prenatal agency occurred on or after July 1, 2007; agencies submit data through a web-based system. A comprehensive user's manual was distributed to PN agency staff as part of an effort to assist agencies to use the system and to obtain agency input on enhancements to the system.//2009//

The MCH Epidemiologist collaborates with colleagues at the University of Alabama and the Alliance for Families and Children to analyze NH hospital discharge data using the Prenatal Health Care Index (PHCI). The PHCI is a measure of preventable hospitalizations similar to Ambulatory Care Sensitive Conditions, but specific to pregnant women and neonates. Initial findings indicate that the index is useful in providing information not given by the more traditional measures of low birth weight and prematurity. The next step will be to link the NH hospital discharge data with the birth certificate file to allow a more thorough analysis.//2008//

PREVENTIVE & PRIMARY CARE SERVICES FOR CHILDREN /2009/AND ADOLESCENTS//2009//

Title V's capacity for children's preventive and primary care services consists primarily of its network of child health agencies. MCH contracts with 11 /2009/14//2009//community agencies throughout the state to provide direct child health care services to low-income, underserved children from birth through age 19. Ten of these are the CHCs described above; /2009/As noted above, three new community health centers were added this year.//2009//one is a 'categorical' pediatric clinic utilizing a multidisciplinary care model. Services at child health direct care agencies include the full spectrum of family practice, such as well-child visits, immunizations,

acute care visits and, in some cases, mental and oral health services. In 2003, MCH-funded child health direct care agencies saw 12,783 children ages 12 and under, with 19% of their total caseloads enrolled in Medicaid and 57% living at less than 185% of FPL.

//2009/In 2006, these MCH- funded CHCs which provide child health direct care, saw 14,174 children ages 12 and under. Adolescent health care is also contracted through the CHCs through out the state and one additional 'categorical' adolescent health clinic. Together primary care was provided to over 10,000 adolescents aged 10-24 years old in 2007. The adolescent health clinic reported annual exams for 85% of clients with no other PCP in 2007, an increase of 6% from 2006.//2009//

In the period from 1996 to 2000 the overall number of clients at MCH categorical agencies, including prenatal, child health and family planning agencies, decreased by 7%, while the number of clients at CHCs increased by 38%. In the case of some categorical child health agencies, enrollment decreased by as much as 68% over this period, presumably due to increasing enrollments in NH Healthy Kids, the state's SCHIP, as well as the growth of the CHCs.

This decline in service utilization led MCH, in 2001, to pilot a model for alternative use of Title V funds for child health services. Recognizing the continued need for low income, often multi-problem families to access support, counseling, and assistance services to effectively access and utilize medical care, local agencies could apply for "Child and Family Health Support" funding in lieu of providing direct care services. Unlike traditional direct care models, Child Health Support funding allowed the use of MCH funds to provide vital enabling services that many families need. A 2003 analysis from CompCare described the need for MCH to continue its' support of community child health agencies. Findings included the perceived benefit of Title V funding at the community level, and the need in some communities to have greater flexibility in the use of funds to meet Title V priorities.

MCH continues to assess its child health resource allocation to assure that the priority needs of low-income children and families are met. Each agency applying for enabling service funding is required to demonstrate that direct care services are accessible to vulnerable families in their region. By contract, direct care services such as well child visits and immunizations must be provided by Child Health Support agencies should the need arise during the contract period. For SFY 2006, MCH is piloting grants that allow agencies more flexibility to meet local needs. In addition to providing direct child health services where the need exists, agencies may choose from a menu of additional services, including child and family support services and child care health consultation. In the future, other options for MCH services provided at the local level may be built into local grants. The 2005 Title V needs assessment process will assist MCH in developing additional options for funding local child health services and reassessing resource use and distribution. //2007/ In SFY05, 952 children were seen by the four agencies providing "Child and Family Health Support" services. They assisted 282 families in enrolling on Healthy Kids, the SCHIP Program. In SFY06, four agencies that previously provided a "well child clinic" model of direct care services, began providing support services, as well. The flexibility in use of funding allows these agencies to better meet their communities' unique MCH needs including the need for: outreach; education; support; assessment and referral for health and social services to families. //2007// ***//2009/In SFY07, eight Child and Family Health Support-funded community agencies enrolled over 1,400 children, providing approximately 7,000 home visits and arranging over 1,700 referrals to needed services for the family.//2009//***

All child health agencies providing direct care and all CHCs screen children for developmental delay and refer them to specialty services as appropriate, though the screening tools used vary widely. In 2005, MCH and SMS collaborated with Easter Seals New Hampshire and the New Hampshire Pediatric Society, to apply for a Vermont Child Health Improvement Program grant to expand New Hampshire's successful "Baby Steps" developmental screening project into a 6th Title V funded CHC and a Title V funded community-based support agency. This grant would have developed an "Improvement Partnership" with public and private providers, including the

state Medicaid Program, and also revived previous efforts of a NH Pediatric Society workgroup to make recommendations on the use of up-to-date developmental screening tools and trained private medical providers in the new communities where the Baby Steps project will be offered. Though unfunded, Title V will continue to work with these partners to improve developmental screening efforts in the state.

//2009/With the release of the revised Bright Futures Guidelines, MCH is changing its clinical pediatric and adolescent site visit tool, and is working with the Title V funded agencies to assess the impact of the recommendations, such as any subsequent training needed. The changes in developmental screening and surveillance, including universal autism screening at the 18 and 24 month visits, align with recommendations from a legislative autism commission report issued May 2008. The report of the Commission, of which MCH, representing DPHS, was a member, urges the Department of Health and Human Services to take the lead in providing technical assistance and other supports to ensure that all pediatric primary care settings screen for Autism Spectrum Disorders. //2009//

Maps are attached to this Section.

SERVICES FOR CSHCN [Section 505(a)(1)]

CAPACITY TO PROVIDE REHABILITATION SERVICES FOR BLIND AND DISABLED INDIVIDUALS LESS THAN 16 YEARS OF AGE: NH children under age 18 receiving SSI for their own disability totaled 1710, per SSA 2003 data. Those children under age 16 receiving SSI numbered 1422, per the National Healthy and Ready to Work 2004 data. Children receiving SSI who are clients of SMS number 186, per SMS SFY 05 data, or 13.1% of those under age 16. //2007/ Children receiving SSI who are clients of SMS number 193, per SMS FY '06 data, or 12.7% of those under age 16.//2007// //2008/ SMS clients receiving SSI numbered 340 or 10% of those actively enrolled in SFY 2006. //2008// Special Medical Services assigns a designated care coordinator to follow-up on all children applying for SSI who are not receiving Medicaid and are not included in the SMS client database. See NPM 4 for more detail on SSI follow-up. SMS disseminates periodic, family-friendly, material about SSI and SSI updates applicable to CSHCN and their families. Based on the results of the NH CSHCN SSI survey (see Needs Assessment) SMS is planning to evaluate further the care coordination needs of CSHCN receiving SSI and Medicaid.

The MICE (Multi-Sensory Intervention through Consultation and Education) program is administered by the Parent Information Center in cooperation with the Bureau of Developmental Services to serve children (0-3) for whom there is a concern relative to vision and/or hearing. Children may be referred to the Area Agencies for intake and developmental evaluation, in conjunction with Early Supports and Services (ESS) staff. The emphasis is on the impact of a diagnosed visual/hearing impairment on learning and development. Consultation and technical assistance are provided to ESS teams, and direct services to children and families.

CAPACITY TO PROVIDE FAMILY-CENTERED COMMUNITY-BASED, COORDINATED CARE: SMS capacity regarding this element is highlighted throughout most of the SMS-specific service and system descriptions, as well as the Needs Assessment. The Title V CSHCN Program provides a care coordinator for each enrolled child. 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 medical services with other community providers and schools, to ensure continuity of care, and family support. SMS is currently focusing on developing care coordination in the medical home. //2008/ This effort is being supported with the availability of an SMS Nurse Coordinator identified specifically for practices as well as the identification and production of community resource information for the practices.//2008//

CULTURAL COMPETENCE & THE TITLE V PROGRAM

The rising importance of racial and minority health in New Hampshire is demonstrated by the near doubling of NH minority births between 1997 and 2002. The 2001 Title V needs assessment illustrated that the state's minorities are a heterogeneous group with diverse prenatal health and health care utilization patterns, as traditional associations between marital status, age, education, and LBW were not consistently supported by minority birth data. For example, the highest LBW was found in black college graduates and beyond (11.8%) and the best infant outcomes in American Indians with less than a high school education (2.9%). While the analysis did not explain the cultural and social dimensions of these groups in NH, it confirmed the need to further examine minority issues and proactively plan for addressing their needs.

Title V undertook several activities to garner information on minority populations. Through the SSDI grant, the Manchester Health Department studied health disparities and barriers to access among racial, ethnic and socioeconomic minorities. Focus groups were held with minority women to learn about their experiences in accessing prenatal care. Completed in 2002, focus groups revealed that, while most were satisfied with the prenatal care received, many minority women voiced problems encountered in receiving care. Barriers to prenatal care included lack of insurance, language difficulties, work conflicts, lack of child care, and transportation difficulties.

With the NH Immunization Program, focus groups on child health access issues were held in Manchester and Nashua. The 2005 report revealed that minority participants believed childhood immunizations to be effective and necessary but identified several barriers to accessing health care in these two cities. Barriers included lack of insurance, difficulty navigating the Medicaid system, lack of awareness about available community services, and fear of deportation on the part of undocumented participants. The top challenges in accessing health care by participants were medical interpretation, lack of a central location to access information on available public services, and access to transportation services.

A 2004 study indicated that since 1990 there has been a 22% increase in the population of residents with limited English proficiency (LEP) in NH, most of which reside in Hillsborough County. From 14% to 32% of patients in the county's two largest cities have LEP. Interpreter resources employed by providers include externally paid interpreters, bilingual clinical and non-clinical staff, telephone Language Line use, signage and other written materials, videos, and community-based volunteer resources. Nearly half of LEP discussion group participants incorrectly believed that it was their responsibility to provide or pay for an interpreter. Specific strategies to address such problems are recommended in the report. (Source: Assessing Language Interpretation Capacity Among New Hampshire Health Care Providers, 2004, The Access Project and The Cultural Imperative, funded by the Endowment for Health)

Medicaid Client Services provides telephone access in the three languages most spoken by non-native Medicaid consumers, Spanish, Arabic and Bosnian, and all District Offices have mechanisms to facilitate language barrier reduction for their consumers. SMS continues to allocate funds for interpreter services for the CHS Child Development, Community Care Coordination and Neuromotor programs. Applications have been translated into Spanish, to better serve the state's Latino population.

Title V has become more aware of the challenges facing minorities in NH and current activities to address these issues. The 2004 cluster of elevated lead levels in refugee children provided another reminder that minority concerns are mounting. Over the coming year, MCH hopes to further address minority concerns by working with Refugee Resettlement Agencies on environmental issues, and by exploring mechanisms to address the identified barriers and challenges for minority populations in accessing health care services. //2007/ In 2006, MCH participated in the "Girls Speak Up" project, identifying unique needs of immigrant and refugee girls. //2007// One activity will be to bring together the NH Minority Health Coalition, Title V, and other interested parties to plan for assessing and promoting cultural competence in local

agencies using available national standards.

In addition to race/ethnicity and language 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. One issue affecting service availability, accessibility and timely provision, is the lack of comprehensive planning, resource sharing and funding mechanisms, among the state, community-based non-profits, and the private sector. Until recently, health data specific to NH residents was minimal. The MCH and SMS Sections are assessing the new data, to improve health care service and quality, and reduce disparities in health care.

An attachment is included in this section.

C. Organizational Structure

NH's Title V Program is located within the DHHS. The New Hampshire Department of Health and Human Services (DHHS) is headed by a Commissioner reporting directly to the State's Governor. DHHS is currently completing an extensive restructuring. Two major divisions within DHHS are the Division of Public Health Services (DPHS) within the Division of Program Operations and the Office of Medicaid Business and Policy(OMBP).John Lynch was re-elected governor in 2006 and the DHHS Commissioner resigned in August 2007.

//2009/Nicholas Toumpas has been appointed Commissioner of DHHS and Dr Jose Montero has been selected as the new Director of DPHS.//2009//

Administration of the Block Grant is assigned jointly to the Maternal and Child Health Section (MCH) for services to women, infants and children and the Special Medical Services Section (SMS) for children with special health care needs (CSHCN). MCH resides in the DPHS Bureau of Community Health Services (BCHS), along with the Alcohol, Tobacco and Other Drug Treatment Services, HIV/STD Prevention, Rural Health & Primary Care, and Community Health Development.

SMS resides in the OMBP Bureau of Medical Services. This alignment with Medicaid allows SMS to focus on the shared goals of ensuring the adequacy of health insurance for CSHCN, including medical homes, program design, and applied research. The integration within Medicaid operations enhances policy development, disease case management, quality assurance, leadership opportunities for SMS staff, increased access and improved care for CSHCN in New Hampshire, and better access to data systems. Organizational charts are included as an attachment to this section. /2007/ As a result of reorganization SMS now sits in the Division of Community Based Care Services, Medical Services Bureau. This alignment is appropriate since all the Bureaus now within this Division share common goals and philosophies related to special populations. Organization charts reflecting this change are attached. //2007//***//2009/ In 2007 SMS was realigned into the Bureau of Developmental Services. This maintains SMS' affiliation with the Division of Community Based Care Services. In addition the Catastrophic Illness Program, which only serves adults 18 years of age or older, was transferred to the Home and Community Based Care Operations Agency in the Bureau of Elderly & Adult Services. to formalize the relationship between SMS and MCH, a new MOU was developed to document responsibilities and commitments to shared goals. It is attached. //2009//***

Organizational Charts are attached to visually describe the structure of each program.

Each Title V Program Director (MCH and SMS) is responsible for her own staff, budget, and assuring that activities proposed under the MCH Block Grant are carried out. The MCH Director assumes coordinating responsibilities for the Block Grant submission.

While each program is distinct administratively, they coordinate frequently at the programmatic

level. For example, MCH oversees operations of the Newborn Screening Program. If, however, a child is found to have a heritable disorder, MCH staff works with the SMS staff that will provide care coordination services for the child and family. Further, MCH and SMS staff members sit on one another's respective advisory boards as appropriate, such as the Newborn Screening Program Advisory Committee and Preschool Vision and Hearing Program Advisory Committee. Finally, MCH and SMS staff continue to work together with the NH Child Health Month Coalition to develop the packet of health and safety materials mailed to over 5,000 health care providers, child care staff and schools in observance of October as Child Health Month. Such activities assure that the needs of both MCH and CSHCN populations are considered in program planning. A primary example of joint endeavors and coordinated activities is the recent participation in CAST-V activities to examine overall agency capacity.

THE FEDERAL-STATE BLOCK GRANT PARTNERSHIP: MCH PROGRAMS

PRIMARY CARE PROGRAM: MCH supports ten community health centers in providing comprehensive primary care services, including prenatal and pediatric care, for over 60,000 /2007/ 70,000 //2007// individuals/year. Many sites offer support and enabling services such as nutrition counseling, case management, transportation and interpretation services. ***/2009/MCH-contracted primary care services began in FY08 in three additional FQHCs in the northern third of the state: Mid-State Health Center, Indian Stream Health Center, and Weeks Medical Center./2009//***

ORAL HEALTH PROGRAM: The Oral Health Program is located within the Rural Health and Primary Care Section (RHPC) in the Division of Public Health Services. In 1999 the Oral Health Program's move to RHPC supported the philosophy that oral health is important to total health and should be integral to the delivery of primary care services. ***/2009/The Oral Health Program collaborated with MCH and RHPC to amend primary care contracts for community health centers to integrate oral health services into the delivery of primary care./2009//***

PRENATAL PROGRAM: Thirteen local MCH-funded agencies provide prenatal care to over 2,100 women/year. Services include: medical care, nutrition, social services, nursing care, case management, home visiting and referral to specialty care. /2008/ Eleven local MCH-funded agencies provide prenatal care to over 2,100 women/year. //2008// ***/2009/In 2008, this increased to 14 MCH-funded prenatal agencies. //2009//***

CHILD HEALTH PROGRAM: Nineteen community health agencies receive funding to provide child health services. Of these, eleven offer direct care to low-income children through clinics and home visits; eight provide health and social support services to children and their families. All agencies provide case management, outreach, and SCHIP enrollment assistance, and may use funds to provide child care health consultation. /2008/ Ten agencies will be funded in SFY 2008 for Child and Family Health Support Services and one will be funded for Pediatric Primary Care Services. The ten agencies will provide case management, outreach, SCHIP enrollment assistance, education and support to low income children in their community. The one Pediatric Primary Care Service grant will support an agency in Manchester which offers primary care to a pediatric-only population. //2008// ***/2009/Nine community agency sites will receive Child and Family Health Support Services funds in FY09, and an agency in Manchester will continue to provide Pediatric Primary Care Services. //2009//***

SIDS PROGRAM: The SIDS program offers information, support and resources to families and care providers of infants suspected to have died of SIDS. Title V staff work with trained SIDS Counselors to provide home visits. Information and training are provided upon request. /2008/ The SIDS Program Coordinator has become increasingly involved in the state's Child Fatality Review Committee activities, and, since attending the CDC Train the Trainer Sudden Unexplained Infant Death Scene Investigation Academy, will be providing workshops to key stakeholders on the CDC information.

//2008//2009/In the fall and winter of FY08, several workshops on improving infant death scene investigations were presented to police, juvenile justice workers, child protection agency workers, and deputy medical examiners in follow up to the CDC training. //2009//

NEWBORN SCREENING PROGRAM (NSP): The NSP coordinates the screening and short-term follow up of all infants born in New Hampshire for heritable disorders ascertained through dried blood spot testing. NH currently screens for six disorders, and plans to add four additional disorders in the coming year. /2007/ As of May 2006, NH screens for 15 conditions. The NSP Advisory Committee is considering further expansion of the panel in the future. To date, the incidence of positive screening and confirmation of Cystic Fibrosis, one of the four new conditions, has been double of what was predicted. In May 2006, the NSP Advisory Committee recommended further expansion of the panel to include 16 additional disorders. The program is in the process of obtaining the services of a medical consultant to advise the medical community on follow-up for infants with abnormal screening results. //2007///2008/ A Medical Consultant has been available, by contract, since January 2007, to support community providers managing clinically significant screening results. The current screening panel will increase to 32 conditions as of July 1,2007. //2008//

//2009/ BIRTH CONDITIONS PROGRAM: In a collaborative effort between Dartmouth Medical School (DMS) and DHHS, NH has maintained a birth conditions surveillance program. It's purpose, in part, is to detect trends in the occurrence of birth conditions. In June 2008, the program was established in law to be under the authority and direction of DHHS. While it will continue to be housed at DMS, a new advisory structure will monitor and oversee the program. MCH will also have new roles in oversight of the "opt out" process for inclusion in the program.//2009//

PRESCHOOL VISION & HEARING PROGRAM (PSVH): PSVH works with trained community volunteers to provide hearing and vision screening and follow-up for approximately 1,700 preschool children/year, targeting low-income families. This program is currently transitioning, from a direct care model to an infrastructure-building model and will offer technical assistance to communities./2008/The PSVHSP clinics have ceased, and the program now provides technical assistance to community organizations and providers upon request. Program audiometers are loaned out, as needed, to the MCH contract community health centers and to Head Start Programs.//2008// **//2009/ NH physicians were notified that PSVHSP clinics have ceased and technical assistance was available for their staff. Technical assistance is offered upon request for community providers. By Fall 2008, the loan of the program audiometers will cease. //2009//**

EARLY HEARING DETECTION & INTERVENTION (EHDI): EHDI promotes screening all newborns for hearing loss, and helps assure appropriate follow-up and intervention. In 2003, 91% of all newborns born in NH hospitals were screened for hearing loss. 2009/Corrected data for past years is as follows: 2003-91% of newborns born in NH hospitals were screened for hearing loss; 2004-93%; 2005-95%; 2006-97%; and 2007-98%. Increase due to tracking and quality assurance activities.

ADOLESCENT HEALTH PROGRAM: The Adolescent Health Program promotes adolescent-friendly health care through one Teen Clinic and ten CHCs/**2009/ all MCH primary care sites //2009//**. MCH provides technical assistance regarding adolescent health; participates in population-based activities; and coordinates forums for networking around adolescent issues.

ABSTINENCE EDUCATION PROGRAM: This program seeks to reduce unintended pregnancies among children ages 10-14 years through community agreements to implement abstinence-only curricula./ 2007/ Plans are in place to administer this program through a contracted entity. //2007// /2008/ MCH has awarded Catholic Medical Center (CMC) the Leadership in Abstinence Education Program. In turn, it supports community agencies statewide to provide abstinence

education. //2008//**2009/ CMC continues to facilitate abstinence education and will do so through the end of SFY08 when federal funding is anticipated to end.**//2009//

HOME VISITING NEW HAMPSHIRE (HVNH): HVNH promotes healthy pregnancies and birth outcomes, safe and nurturing environments for young children, and enhances families' life course and development for pregnant women and families with children up to age one. Eighteen projects currently serve in excess of 650 families/year. /2007/ By SFY05 the HVNH program had grown to serve over 900 women and their infants per year. HVNH agencies were very involved with Title V's ECCS efforts. //2007// Title V staff are involved in training, data collection and evaluation activities.

HEALTHY CHILD CARE NEW HAMPSHIRE (HCCNH): HCCNH focuses on improving the quality of health and safety in child care environments by increasing the number and expertise of child care health consultants and by incorporating content expertise and collaboration of other state and community programs with the child care industry in NH.

INJURY PREVENTION PROGRAM (IPP): The IPP seeks to reduce morbidity and mortality due to intentional and unintentional injuries. The IPP is also responsible for violence prevention, including sexual assault & domestic violence, funds the State Injury Prevention Center, and is the liaison/2007/ to the poison control educator associated //2007// with the state's Poison Control Center contractor, /2007/ Northern New England Poison Center of the Maine Medical Center. //2007//

STATE SYSTEMS DEVELOPMENT INITIATIVE (SSDI): SSDI is improving data capacity through linking data sets with infant birth and death registries. A major goal is to link birth certificate and NSP data to assure all babies are screened.

FAMILY PLANNING PROGRAM (FPP): The FPP provides confidential reproductive health care for low-income women and teens to over 30,000 individuals/year.

CHILDHOOD LEAD POISONING PREVENTION PROGRAM (CLPPP): As proscribed in RSA 130-A, the CLPPP provides for public education, comprehensive case management services for children with elevated lead levels, an investigation and enforcement program and the establishment of a database on lead poisoning.

SMS PROGRAMS

Federal funding supports a portion of all sixteen SMS contracts. More specifically, these contracts for direct services are supported 68% with New Hampshire general funds and 32% with Federal Block Grant funds. This Federal-State Partnership includes the following programs:

CHILD DEVELOPMENT PROGRAM: The Child Development Services Network is comprised of five Child Development Programs contracted through DHMC and local community health agencies to provide a community-based approach to state-of-the-art diagnostic evaluation services, to children (0-6) suspected of or at risk for altered developmental progress.

PEDIATRIC SPECIALTY CLINICS: SMS operates 6 Pediatric Specialty Clinics for Neuromotor Disabilities. These family-centered, community-based, multidisciplinary clinics utilize treatment approaches that encourage parents/children 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 and psychology services.

NUTRITION, FEEDING AND SWALLOWING PROGRAM: The SMS Nutrition, Feeding and Swallowing Program offers community-based consultation and intervention services statewide.

These contractors have developed networks of regional nutritionists, and feeding and swallowing specialists. SMS offers specialized training for all network providers and monitors their quality of care to assure a coordinated, outcome-oriented approach that is family-centered and community-based.

FAMILY SUPPORT SERVICES: Funding received from NH Title V CSHCN supports New Hampshire Family Voices (NHFV) in its mission to assist families with CSHCN. NHFV provides information, support and referral to families with the 800 line provided by SMS. NHFV maintains a comprehensive lending library, specializing in children's books for families and publishes a quarterly newsletter, "Pass It On". NHFV publishes an annual listing of support group/organizations, and operates a comprehensive website. The staff are parents of CSHCN who can personally relate to the issues and concerns raised by individuals seeking their assistance. Upper Valley Parent to Parent Support Program offers a service matching families of newly diagnosed children with parent mentors, an interactive ***An attachment is included in this section.***

D. Other MCH Capacity

STAFFING

The Maternal and Child Health Section (MCH) is headed by an Administrator, who is the MCH Title V Director and responsible for all MCH activities. MCH employs 27.9 FTEs (fulltime staff equivalents); 12 positions are paid in some part through Title V funds. The three main programmatic units within MCH include: Child Health (Child Health, SIDS, EHDI, NSP, PSVH, HVNH, HCCNH, and ECCS programs -- 6 FTEs); Women's Health (Family Planning, Prenatal, Adolescent Health, Abstinence Education, Injury Prevention and SSDI programs -- 7.6 FTEs); and the Childhood Lead Poisoning Prevention Program (CLPPP) (7.8 FTEs) ***/2009/ Due to 2008 legislative changes for the CLPPP, staffing has increased to 11.5 FTEs./2009//***

The MCH Data Team consists of those staff with an interest or expertise in data collection, analysis and dissemination; the SSDI Program Planner, Program Evaluation Specialist, Quality Assurance Nurse Consultant, Adolescent Health Coordinator and contractual MCH Epidemiologist all participate in this team. MCH also employs administrative support staff (6.5 FTEs). All MCH staff are centrally located at the DPHS building in Concord, NH.

MCH manages four */2008/* five *//2008//* contracts to provide specific consulting capacity to MCH. These include: */2008/Metabolic, //2008//* OB-GYN and pediatric medical consultants; a consulting audiologist; and an MCH epidemiologist. The audiologist, Mary Jane Sullivan, MA, CCC-A, consults to the EHDI program, bringing experience in pediatric audiology and hospital-based newborn hearing screening programs. MCH epidemiologic support is provided by David LaFlamme, through a contract with the University of New Hampshire's Institute of Health Policy and Practice. Mr. LaFlamme has a PhD from Johns Hopkins University School of Public Health. He devotes three days per week to MCH issues, providing expertise in data analysis and health policy. In addition, MCH houses Melissa Heinen, New Hampshire's health education liaison from the New England Poison Control Center. */2008/* Dr. Harvey Levy, pediatric metabolic specialist, provides support to medical providers managing clinically significant newborn screening results.*//2008/ /2009/The EHDI Program established a contract with the M.I.C.E. (Multisensory Intervention through Consultation and Education) Program to provide parent support and education to families of infants who were referred for diagnostic testing or confirmed with a hearing loss./2009//*

SENIOR LEVEL MANAGEMENT BIOGRAPHIES: MCH

Lisa L. Bujno, MSN, ARNP, Administrator

Ms. Bujno received both BS and MS degrees in nursing from the University of Pennsylvania. She has over 13 years experience in public health, including positions in two community health centers and as a civilian community health nurse for the Department of the Army in Germany.

She was a 1997 Fellow of the National Association of Community Health Centers, and has been employed in MCH since 1999. Her particular areas of expertise are prenatal and adolescent health issues, primary care in community health center settings, and systems for quality improvement. /2007/ In 2005, Ms. Bujno accepted the position of Bureau Chief of the Bureau of Community Health Services (BCHS), DPHS. The BCHS is responsible for many HRSA funded programs including MCH, Rural Health and Primary Care, and HIV/STD programs. //2007//

/2007/ Patricia M. Tilley, MS Ed, Administrator

Ms. Tilley holds a Master of Science in Education from the University of Pennsylvania. She has over 5 years experience in public health in New Hampshire and 10 years experience in education and social services. Previous to becoming Administrator of MCH, she was the Early Childhood Special Projects Director in MCH managing home visiting, Early Childhood Comprehensive Systems, Healthy Child Care NH and other early childhood projects. Prior to state service, she was the Director of a family resource center in rural, western Pennsylvania.//2007//

Audrey Knight, MSN, RN, Child Health Nurse Consultant

Ms. Knight has a Masters degree in nursing from Yale University and has held the position of MCH Child Health Nurse Consultant since 1986. She is the SIDS program coordinator and manages the Child Health, SIDS, PSVHSP, NSP and EHDI programs. Ms. Knight has expertise in preventive and primary care for children.

Anita Coll, M.Ed, Prenatal and Adolescent Program Manager

Ms. Coll has over 20 years of experience in women's health, including 15 years in public health settings. She has a Masters degree in education from Cambridge College and has recently completed her requirements for her Juris Doctorate from Massachusetts School of Law at Andover. Ms. Coll manages the Prenatal, Injury Prevention, Adolescent Health, and Abstinence programs./2008/ Ms. Coll is no longer employed with MCH. At present, Title V does not have a Prenatal Coordinator. The Adolescent Health and Injury Prevention Program manager is providing programmatic coverage for this position until Title V can hire a dedicated Prenatal Coordinator.//2008//

Rhonda Siegel, MS Ed, /2008/ manages the Prenatal, Injury Prevention, Adolescent Health, and Abstinence programs.//2008//**/2009/She has close to twenty five years experience in the public health field. With both her undergraduate and graduate degrees from the University of Pennsylvania, Ms. Siegel has worked in the state system for the last ten years and prior to that was the health educator/community outreach coordinator/clinic coordinator for a primary care health center and large metropolitan medical center.//2009//**

Kathy Desilets, BS, Family Planning Program Manager

Ms. Desilets has over ten years of experience in public health, with an emphasis on reproductive health, HIV and STDs./2008/ Ms. Desilets is no longer employed with MCH. Carol Mandigo is the current Family Planning Program Manager.//2008//

Carol Mandigo, LICSW, Family Planning Program Manager

Ms. Mandigo has a master's degree in social work from the State University of New York at Albany. Ms. Mandigo has over 26 years experience in management and program development and has worked in mental health and child welfare agencies throughout her career. Ms. Mandigo has expertise in management, program development, quality assurance, and supervision. //2008//**/2009/ Ms Mandigo resigned in July 2008. The position is now vacant.//2009//**

Marie Kiely, MS, SSDI Program Planner

Ms. Kiely manages the MCH Data Team and has a Masters degree in Public Health from Tufts University. Ms. Kiely has nearly 20 years of experience in public health programs, including previous management of the New Hampshire Injury Prevention Program and Cancer Registry.

Michelle Dembiec, MEd, CHES, /2007/Early Childhood Special Projects Manager

Ms. Dembiec manages the Home Visiting New Hampshire program and oversees Healthy Child Care NH and ECCS activities. She is a Certified Health Education Specialist with a Masters degree in health education and over ten years of experience in health education and public health programs. ***/2009/ Ms Dembiec is no longer employed with MCH. Title V has been unable to post and fill this position. ECCS and home visiting activities are still coordinated by the Title V Director in collaboration with the Healthy Child Care NH Coordinator.//2009//***

/2007/

Laura Vincent Ford, Childhood Lead Poisoning Prevention Program (CLPPP) Manager
Ms. Ford manages the CLPPP and has a Masters degree in Criminal Justice from Rutgers University's School of Criminal Justice. Ms. Ford has 6 years of public health experience in managing the NH WIC Program.//2007//

Beverly McGuire, MS, BSN, Quality Assurance Nurse Consultant
Ms. McGuire has a Masters degree in Health Administration and a Juris Doctorate degree. She was hired in 2004 to measure the quality assurance efforts of the funded local agencies. She has 25 years of experience in community health as the CEO of a VNA.

SENIOR LEVEL MANAGEMENT BIOGRAPHIES: SMS

Judith A. Bumbalo, RN, PhD, Administrator, CSHCN Director
Dr. Bumbalo received her M.S. from Boston University and her Ph.D. from Wayne State University, and has over 25 years of experience working with CSHCN and families. As a faculty member for academic nursing programs at the University of Washington and the University of Wisconsin (Milwaukee), she worked closely with state Title V programs. Dr. Bumbalo is the former Director of a Title V training program for graduate education in nursing at the University of Washington. Prior to joining SMS, she was the Training Director for the MCHB funded LEND program at the University of New Hampshire/Dartmouth Medical Center (1995-1999)./2008/ Retired//2008//

/2008/ Elizabeth Collins, RN-BC,MS,BSN,BA, Administrator, CSHCN Director
Ms. Collins was hired in June 2007. See bio. below.//2008//

Kathy Higgins Cahill, MS, ARNP, Title V CSHCN Program Specialist.
Ms. Cahill was hired for this position in Dec. 2002. The position focus is on the needs assessment process and special projects. One such special project is Youth Health Care Transition. Ms. Cahill has 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. Currently, Ms. Cahill is the Project Coordinator for the Youth Health Care Transition Project and consults to several work groups that have youth transition initiatives./2008/ She became SMS Program Manager in December 2006.//2008//

Lee Ustinich, M.S., Title V CSHCN Health Care Financing Specialist
Ms. Ustinich received her M.S. in Allied Health/Rehabilitation Counseling from Virginia Commonwealth University (Medical College of Virginia). She was hired in 2002 to focus on the CSHCN Health Care Financing initiative, infrastructure-building services, and the performance measures. Ms. Ustinich is also the SSI State Liaison. She came to SMS from the Virginia Community Services Board system, where she has over ten years experience in the multi-program management of community-based disability services, primarily the development of specialized, family-centered, substance abuse treatment and HIV/AIDS programs. /2007/ In 2006 Ms. Ustinich accepted a position at the Bureau of Behavioral Health. //2007//

/2008/ Sharon Kaiser, RN, BS, Early Childhood Systems Program Specialist.
Ms. Kaiser was hired in Dec. 2006. She has a BS from Keene State College. She was the Director of a non-profit, residential facility for CSHCN for 26 years and a MCH nurse in the community for 7 years.//2008//

PARENTS OF CHILDREN WITH SPECIAL NEEDS

Three parents of children with special health care needs staff New Hampshire Family Voices are supported by Title V funds. Martha-Jean Madison and Terry Ohlson-Martin are Co-Directors of the project and Sylvia Pelletier is the Outreach Coordinator. Martha-Jean is the parent of eight children with disabilities and special health care needs, Terry has a son with disabilities and Sylvia is the parent of two children who are cancer survivors.

STAFFING CHANGES

A statewide hiring freeze continued to hamper agency capacity, but waivers were approved for some MCH vacancies. As mentioned above, Beverly McGuire was hired for the QA Nurse position in June 2004. Ms. McGuire, former CEO of a Rhode Island VNA and community health center, brings a wealth of expertise to this position. She focuses on clinical quality assurance activities and performance management relating to MCH contract agencies. Chantal Kayitesi, MPH, was hired in 2005 to fill the Adolescent Health Coordinator position. Ms. Kayitesi graduated from the Boston University School of Public Health with a concentration in Health Services. She has over six years of experience in public health, working mostly in women's health and communicable disease programs. In April 2005, MCH was able to fill a critical vacancy. The Executive Secretary position, which had been vacant for 18 months, was filled by Cheryl Storey. Joanne Cudmore was hired in May 2005 to fill the secretarial position left vacant by Ms. Storey's promotion, yielding nearly a full complement of support staff in MCH for the first time in two years. ***/2009/Ms. Kayitesi no longer works as the Adolescent Health Coordinator./2009//***

Elizabeth Collins, BA, RN, was hired in March 2004 as a Public Health Nurse Consultant. She has a BA from Wells College and BSN from the University of Southern Maine. She has experience working in an Intermediate Care Facility for the Mentally Retarded, is ANCC certified in Psychiatric Mental Health Nursing, and participated in the UNH LEND program during 2004-2005./2008/ She received a Masters degree in Nursing from UNH./2008//

Kathy Hoerbinger, BS, RN, was hired in November 2004 as a part-time Public Health Nurse Coordinator with responsibilities as the Title V liaison between SMS and the Medical Home Initiative.

The position of SMS Program Manager, which oversees the health coordinators, remains vacant and 'frozen' due to state budget cuts. One currently vacant FTE Public Health Nurse Coordinator position is in recruitment at the interview stage. The remaining 0.5 FTE of the coordinator position (filled half-time by Ms. Hoerbinger) also remains vacant, and in recruitment. /2007/ The vacant FTE Public Health Coordinator position was filled by Maria Butler, BS, RN. Ms. Butler was previously employed by SMS (2001-2003) and her most recent employment was as a school nurse. She has experience as an office nurse and in hospital-based pediatrics. She completed the LEND program at the University of New Hampshire in 2002./2008/ A FTE Public Health Nurse Coordinator, Cheryl Randolph LeBrun RN was hired. She worked with NH Foster Care./2008// ***/2009/ Two FTE Program Specialist positions were filled. The first was for a Needs Assessment/Data Management specialist, which was filled by Margaret Bernard. The second was for a HC-CSD nurse coordinator who is outreaching to all children newly approved for Medicaid through HC-CSD criterion. This position was filled by Elizabeth Allen, RN./2009//***

The SMS Program Manager and Program Specialist positions remain vacant at this time due to budget management constraints. Request for waivers and permission to recruit are pending. //2007// /2008/Positions filled./2008//

/2007/ Patricia Tilley, MS Ed was hired in November 2005 as the MCH Administrator after Lisa Bujno accepted the position as Bureau Chief of the Bureau of Community Health Services in DPHS. Previously, Ms Tilley was the Early Childhood Special Projects Coordinator for MCH. Michelle Dembiec switched positions in MCH from the CLPPP Program Manager to fill the Early

Childhood Special Projects Coordinator. Ms Dembiec has used her experience from developing the childhood lead poisoning elimination plan to finalize the ECCS Implementation Plan. Laura Vincent Ford is now the CLPPP Program Manager. Ms Ford brings extensive budgeting and management skills from her experience in the WIC Program.//2007//

/2008/ This past fiscal year has brought many changes to MCH. We have been unable to fill two critical positions, the Prenatal Program Manager and Early Childhood Special Projects coordinator. These vacancies have challenged existing staff to maintain the programmatic gains in the area of birth outcomes and ECCS plan implementation. //2008//

/2009/

The Family Planning Health Promotion Advisor was vacated in June 2007. There was an attempt to reclassify this position and make it available for re-hire, but due to budget constraints, it is not anticipated that this will happen until SFY09.

In 2008 an Adolescent Health Coordinator and a Prenatal Coordinator were hired. Alicia M. L'Esperance, BS/BA, PHC is the Adolescent Health Coordinator. Her experience includes program planning, development and quality assurance, as well as training, case management, and epidemiology.

Kimberly Flynn, MS, RD is the new prenatal coordinator. Ms. Flynn has many years experience working in an urban community health center as a nutritionist for WIC.//2009//

E. State Agency Coordination

NH's Title V Program has a long history of maximizing limited financial and human resources through the development of partnerships and coalitions. By establishing common goals and objectives in a multitude of collaborative relationships, Title V has greatly expanded its "reach" in both the state family and the community. Because of our limited capacity, Title V utilizes its many partners to help us accomplish our priorities.

Title V staff participate in numerous state-level committees and legislative workgroups, such as: the Governor's Commission on Domestic and Sexual Violence, the Governor's Domestic Violence Fatality Review Committee, the Child Fatality Review Committee, and the Perinatal Alcohol, Tobacco, and Other Drug Use Legislative Task Force /2008/, the Brain and Spinal Cord Injury Advisory Council, the Suicide Prevention Council, and the Governor's Task Force on Childhood Lead Poisoning Prevention //2008// ***/2009/ the Teen Driving Group, the Youth Suicide Prevention Assembly, the NH Transition Coalition, and the Coordinated School Health Council, the NH Childhood Obesity Expert Panel, the HB396 Autism Commission, the Advisory Committee for the Healthy Tomorrow's Pediatric Obesity Project and the Legislative Study Commission on Lead Poisoning.//2009//*** An extensive table of Title V membership on and involvement with various task forces, commissions, committees, and work groups is available by request from MCH.

In the interest of conveying the essence of how Title V coordinates and collaborates with other organizations in New Hampshire, the following activities are highlighted:

RELATIONSHIPS AMONG STATE HUMAN SERVICES AGENCIES

Coordination of program activities takes place through joint efforts by Title V and other DHHS agencies on topics of mutual interest and concern. Community and national health issues and available data drive the investigation, analysis and development of strategies to respond to these concerns.

/2009/ Child Development Bureau, Department of Environmental Services (DES): The

Healthy Child Care New Hampshire (HCCNH) coordinator is a member of the legislative Child Care Advisory Council. HCCNH coordinates with DES to incorporate environmental health content in the 2008 revision of child care licensing rules, and include environmental health standards into the emerging child care Quality Rating Improvement System. //2009//

Infertility Prevention Project: The Family Planning Program (FPP) coordinates with STD/ HIV Prevention and the State Public Health Laboratory (PHL) to implement annual chlamydia screening and treatment for female FPP clients between ages 15-26. Federal monies for this screening project are for women in the targeted category who would not otherwise be able to afford this screening. Funds are provided to the PHL for testing and to STD/ HIV for treatment.

TANF & Family Planning: This initiative coordinates FPP and Temporary Assistance for Needy Families (TANF) program efforts. Programming focuses on expanding outreach to target Medicaid-eligible women and teens at risk for pregnancy. Program design was purposefully community-based, developed by family planning and primary care agencies aware of ongoing community efforts and unmet needs. Program expansion in 2002 occurred with the Teen Pregnancy Prevention Curriculum Project. TANF provided funds to promote implementation of teen pregnancy prevention curricula, with the FPP administering the effort and reimbursing local agencies, such as schools and Teen Clinics, to implement evidence-based curricula. To document effectiveness, a comprehensive evaluation of the project's implementation over the past three years has been completed.

Medicaid, TANF & Home Visiting New Hampshire (HVNH): This project supports 18 home visiting programs statewide with TANF and Title V funds. HVNH provides health, education, support and linkages to other community services to Medicaid-eligible pregnant women and their families in their homes. Expansion from 3 pilot programs was achieved through collaboration with Medicaid and TANF, with MCH as the lead agency and backing from the then-active Governor's Kids Cabinet.

Medicaid & MCH: MCH has worked with Medicaid to develop and implement local Medicaid codes that pay for MCH-related services, such as child and family support and expanded prenatal services. MCH and Medicaid staff provide training to agencies in the use of the codes; Medicaid QA auditors inform MCH of identified needs for additional training. In 2005, MCH staff participated in Medicaid's initiative to develop a new IT solution for Medicaid billing. /2008/ Title V staff participated in the grant review for the new Medicaid care coordination contract with Schaller-Anderson to begin in Spring.//2008//.

SCHIP & Title V: MCH collaborates with NH SCHIP and Healthy Kids to disseminate program information and policy changes to local MCH contract agencies, obtain feedback from local agencies to state level programs, and encourage local agencies to enroll all eligible children in SCHIP and Healthy Kids. The MCH Child Health Nurse Consultant is a member of the SCHIP quality assurance workgroup (QCHIP) and the workgroup overseeing three RWJ-funded ("Covering Kids and Families") pilot projects. /2008/MCH staff participated in the proposal review for the SCHIP contract with the Healthy Kids Corporation. //2008//

SMS care coordinators inform uninsured families about the NH Healthy Kids (Medicaid) programs and send applications. A designated care coordinator (Butler) provides follow-up for families who have applied for SSI but are not receiving Medicaid or enrolled with SMS. This follow-up includes information and applications for SMS and/or Healthy Kids, as requested. The Healthy Kids program coordinator is available for consultation with SMS staff, and refers families as appropriate to NH Family Voices as well as to SMS.

State Department of Education (DOE): Coordination with the DOE occurs through several MCH programs. The Adolescent Health Program (AHP) collaborates with the DOE manager of the YRBS to select questions for inclusion and to assure a representative sample. MCH staff participate in a DHHS/DOE initiative to develop a Coordinated School Health Plan and other

activities to improve the health of school age children. ***/2009/ Although not funded in SFY08, the Coordinated School Health Council now has a formal designation./2009/*** The School Nurse Consultant maintains a listserv for school nurses and MCH staff post items and conduct surveys through this venue. *//2007//*. The FPP collaborates with the HIV Prevention Coordinator on teen pregnancy and STD prevention training and education programs for teachers. ***/2009/ The Injury Prevention Program works with the Safe and Drug Free Schools Program./2009/***

*/2007/*State Suicide Prevention Plan Committee: MCH provides leadership in coordinating this effort among the Injury Prevention Program (IPP), Adolescent Health, DCYF, Behavioral Health, and the Commissioner's Office. The IPP and the Adolescent Program collaborate with the DHHS Commissioner's Office, DCYF, and Behavioral Health on the implementation of the State Suicide Prevention Plan. A state level advisory committee exists which oversees this effort.*//2007//*

/2009/The Suicide Prevention Council (SPC) coordinates the state suicide prevention plan and its structure and membership was codified into law in 2008. The IPP facilitates the communications subcommittee. The Chief of the BCHS co-chairs the Garrett Lee Smith Advisory Committee, another subcommittee./2009//

Division of Behavioral Health (DBH): Collaboration with the DBH, DOE, and the Division of Developmental Services (DDS)*/2007/* continues even as NH DHHS has undergone continuing re-organization. The DBH and DDS are now housed within the Division of Community Based Services (DCBCS) and the respective programs are now known as the Bureau of Behavioral Health and the Bureau of Developmental Services. The Special Medical Services Unit is also now housed within the DCBS, within the Bureau of Medical Services.***/2009/ The Bureau of Medical Services was dissolved in 2007 and SMS was moved to fall within the Bureau of Developmental Services. This has facilitated improved collaboration between SMS and Early Supports & Services/ Part C, Family Support Coordinators at the Area Agencies and Partners in Health Program funded through the Social Security Block Grant./2009//***

Title V continues to work with the same partners and an excellent example of one collaborative system to do this *//2007//* is illustrated by the Children's Care Management Collaborative (CCMC). This group models state level collaboration to ensure that our collective resources provide access to a full array of community-based services and supports for families with children and adolescents who have or are at risk of serious emotional disturbance, developmental or educational disabilities, substance abuse issues, or special health care needs. A product of the CCMC is the development Regional Infant Title V staff are active members of the CCMC. */2008/* The MCH Injury Prevention Program with the DBH on the Brain and Spinal Cord Injury Advisory Committee. The Injury Prevention Program Manager is an associate member of the National Association of State Head Injury Administrators, along with the state representative, the Manager of the Acquired Brain Disorder Service, under DBH. SMS now has a representative (Collins) who is a member of the NH State Mental Health Planning and Advisory Council.*//2008//* ***/2009/SMS facilitates the NH Youth Health Care Transition Coalition, which has started a Youth Advisory Group. MCH works with the Division of Behavioral Health on suicide prevention issues and the IPP is writing the script for the TBI/SCI data report, due in late 2008./2009//***

Division of Children, Youth and Families (DCYF): MCH collaborates with DCYF on several projects and committees. A representative from DCYF is a member of the NH Child Health Month Coalition discussed later in this section. The DCYF Division Director, MCH Child Health Nurse Consultant and SMS Medical Consultant are members of the NH Child Fatality Review Committee, and a representative of DCYF and the MCH Child Health Nurse Consultant are Board members of the NH Children's Trust Fund. The DCYF Division Director is also a member of the statewide suicide prevention plan implementation team facilitated by the Adolescent Health and Injury Prevention Programs.***/2009/Title V participates in the "Watch Me Grow" Initiative. Started as part of MCH ECCS planning, it is now coordinated as part of DYCF and Early Supports and Services to meet new CAPTA standards to increase access to developmental screening for young children, especially for those involved with child***

protection.

Additionally, the SMS senior state physician is now available for monthly consultation to DCYF. //2009//

DPHS Bureau of Prevention Services (BPS): MCH collaborates with the BPS to produce a brochure on Fetal Alcohol Syndrome. The BPS and MCH distribute brochures to their respective contract agencies and other stakeholders. /2007/ In 2006, the state rules requiring FAS brochures was repealed. Therefore, MCH no longer distributes these brochures, but supports health care providers in providing education on this topic. //2007//MCH collaborates with the BPS on a statewide poison prevention committee and a BPS representative is a member of the NH Child Health Month Coalition discussed later in this section.***//2009/MCH works with the Alcohol, Tobacco, and Other Drug Section staff on many issues and workgroups including the Teen Driving Committee. //2009//***

DPHS' Health Statistics Section (HSS): A CDC core injury surveillance grant was awarded to the HSS in 2002, enabling the hiring of an injury surveillance manager and expansion of injury surveillance activities. This collaborative effort with MCH produced a state Injury Data Report and a draft statewide injury prevention plan, along with continued work by the Injury Advisory Committee and many data-driven programmatic efforts. /2007/ Although this grant is no longer funded, the MCH IPP continues to collaborate with the Injury Surveillance Program in HSS through activities with the MCH Data Team and DPHS Data Users Group. //2007//

DHHS Health Data Users' Workgroup: The Health Data Users' Workgroup was formed in 2005 to maximize the quality and efficiency of data related activities that support the functions of DHHS and promote the health of New Hampshire citizens. The group provides members with cross-training, collaborative problem solving, guidance, and access to appropriate resources related to: dataset information; analysis methods and interpretation; confidentiality and privacy; dataset and survey development and infrastructure; and future dataset contents and quality. MCH staff participate in this group.

Women's Health Week Coalition: This collaborative group, chaired by the FPP Manager, was begun in 2002 as an initiative to promote women's health week activities and has evolved into an ongoing concern. Representatives from MCH, WIC, Health Promotion and Tobacco Prevention and Control meet regularly to address women's health activities. The group provides an epicenter from which to coordinate a more comprehensive approach to Women's Health within DHHS.
//2009/The MCH Prenatal Coordinator now chairs the Women's Health Week Coalition.//2009//

HIV Community Planning Group: The FPP Manager sits on this group that develops priorities for HIV prevention work. In part because of this collaboration, the FPP was awarded a competitive grant to increase the integration of HIV prevention counseling and testing at family planning sites in the most highly impacted state communities.

MEDICAID and CSHCN: Since 2003 NH Medicaid's initiative to increase access to dental care has resulted in most reimbursement rates being raised, a strong partnership with the New Hampshire Dental Society, reduced administrative burden of claims processing, ongoing parent and PCP education programs, and improved coordination of oral health programs across the DHHS. The Medicaid initiative focuses on improving access to dental care for underserved populations, such as CSHCN who continue to have limited access to dental care, through provider outreach and education efforts. /2007/ A process for review and negotiation of Durable Medical Equipment requests for children served by both SMS and Medicaid was initiated. In addition SMS assisted Medicaid Client Services in responding to a backlog of consumer placed calls that needed a timely response. The reorganization placing both units under the Bureau of Medical Services facilitated this collaboration.//2007///2008/ The SMS Administrator participated in

the grant review for the Medicaid care coordination contract with Schaller-Anderson.//2008//.

/2009/A new position created within SMS for an HC-CSD coordinator who will represent an ongoing link between Medicaid and Title V. This position has been integral to new rule development for Medicaid related to utilization of services for children qualified under HC-CSD criterion. This individual will continue to interface with Medicaid in an ongoing process of identifying children, who are at risk of becoming disqualified for Medicaid under this new rule, and working with their families to develop a modified service utilization plan. //2009//

//2008//The MCH Epidemiologist represents the NH DHHS on the Vital Records Improvement Fund Advisory Committee. Committee members include town clerks, data users, vital records staff, etc. In addition, the MCH Epidemiologist works closely with staff from the Health Statistics and Data Management Section to address access and data quality issues pertaining to vital records. The changeover to the 2003 revision of the birth certificate in July 2004 has resulted in many data quality issues requiring significant attention.//2008//

RELATIONSHIPS WITH OTHER HEALTH AGENCIES

Local Public Health Agencies: MCH works with the 2 existing local health departments, in Manchester and Nashua, on issues of mutual concern. For example, the MCH provided funding to both health departments to conduct focus groups with minority populations through the SSDI grant in 2001. On an ongoing basis, the CLPPP funds both health departments to do follow up and nursing case management for children in those areas with elevated blood lead levels.

Public Health Networks (PHN): MCH and the PHNs are beginning to collaborate more as the PHNs progress from fledgling public health programs to active forces within their local communities. The MCH Director participated in grant review for PHN applications in the last competitive bidding cycle, and presented on MCH programs at a 2004 PHN coordinators' meeting. One PHN was selected as the pilot site for the Frameworks implementation discussed below. MCH staff have participated in the application review for the continuing education services for the PHNs and Local Lead Action Committees and Healthy Homes Committees, coordinated by the MCH CLPPP are linked with PHNs when the service areas overlap.

Federally Qualified Health Centers (FQHCs): Seven FQHCs in New Hampshire provide direct care and enabling services to MCH populations, in part through Title V funds. MCH coordinates closely with the Rural Health and Primary Care Section to assess service needs, ensure appropriate scopes of services, and provide quality assurance monitoring for the FQHCs. MCH staff review proposals for these contracts, reviews agency workplans and performance measures, and administer QA activities through site visits and development of review tools. MCH contract agency directors attend quarterly meetings chaired and conducted by MCH. Sections IIIA, B, and D, and Sections IVB, C, and D contain additional information about the relationship with these safety net providers.

Primary Care Association: The Bi-State Primary Care Association serves community health centers in New Hampshire and Vermont, providing advocacy and support for these agencies. MCH representatives attend Bi-State presentations /2007/ and regular meetings //2007// when appropriate and some members of the Bi-State PCA Board of Directors are directors of MCH contract agencies that attend MCH quarterly Directors' meetings. /2007/ The Bi-State Policy Director has participated in HRSA facilitated partnership planning meetings and has briefed MCH staff on the state of community health centers and FQHC funding in NH.//2007//

Tertiary Care Facilities: MCH and SMS collaborate with the state's two tertiary care facilities, Dartmouth Hitchcock Medical Center (DHMC) and the Elliot Hospital, as needed. For example, MCH staff regularly present at the DHMC Perinatal Program's nurse manager meetings to update

the community nurses on MCH issues and activities. Several DHMC physicians are members of the Newborn Screening Advisory Committee. SMS supports Child Development and Neuromotor Programs at DHMC.

RELATIONSHIPS WITH TECHNICAL RESOURCES

Educational Programs & Universities: Title V frequently coordinates with educational programs and universities. For example, the IPP funds the Injury Prevention Center at Dartmouth College to provide statewide population-based injury services and works with them on many injury initiatives. MCH and SMS collaborate with Dartmouth's Birth Conditions Program, NH's birth defect surveillance system, to assure access to hospital records for case finding and provide care coordination for children with these conditions. /2008/ MCH CLPPP works in partnership with Dartmouth's Toxic Metals Research Program on various lead poisoning prevention initiatives //2008// **2009/ MCH applied for a grant through SAMSHA and NIDA in collaboration with Dartmouth Center on Addiction, Recovery and Education (DCARE) that will, if funded, provide for drug and alcohol screening, brief intervention, and referral to treatment (SBIRT) in the MCH primary care agencies.//2009//**

MCH contracts with the University of New Hampshire (UNH) Institute of Health Policy and Practice to fund an MCH epidemiologist, as discussed in Section IVB. /2007/ The Epidemiologist continues to play an essential role in MCH, contributing to the completion of the first comprehensive MCH statewide needs assessment in 2005. //2007// MCH AHP staff participated in the creation of the UNH Center on Adolescence, a clearinghouse of best practices and information for researchers and communities on adolescent concerns. The AHP Coordinator is working with the Center to implement the statewide Adolescent Health Strategic Plan.

The MCH Director is a member of the Boston University School of Public Health MCH Department's Advisory Committee. BU staff will work with MCH in 2005 to develop a plan addressing prenatal disparities in the state. /2007/ This project has continued throughout 2006 and Dr. Milton Kotelchuck continues to advise MCH as needed. //2007// In addition, the Adolescent Health Program Coordinator participates in activities provided by the Boston Children's Hospital Leadership Education in Adolescent Health program.

Efforts to increase collaboration with the Dartmouth Medical Center/UNH Leadership Education in Neurodevelopmental Disabilities (LEND) program have led to collaborative clinical and educational activities. The Child Development Program at Child Health Services (Manchester), and the Seacoast Child Development Program at UNH, under SMS contracts, are working on strategies to share professional expertise and increase the cultural competence of LEND trainees. SMS staff (Collins) recently participated in a 2-day regional LEND conference on cultural competence. The conference activities are related to initiatives of Kaiser-Permanente Hospital. Conference materials are being disseminated to community-based agencies. **/2009/ SMS trained LEND staff on Transition for Youth with Special Health Care Needs.//2009//**

Northern New England Poison Control Center (NNEPCC): The NNEPCC, affiliated with Maine Medical Center, is NH's contractor to provide poison control activities. Funded by the Bioterrorism grant, the Poison Educator sits within MCH. In addition, the IPP collaborates with the Poison Educator on many programmatic activities. As discussed in Section IIIB, MCH provides logistic support to the educator and oversight to activities within NH, including monitoring of the regular report on center calls.

Child Health Month Coalition: MCH continues to Chair the state's Child Health Month Coalition, a collaborative effort between MCH Child Health and IPP, SMS, the NH Pediatric Society, the Injury Prevention Center at Dartmouth, the Safe KIDS Coalition Children's Hospital at Dartmouth (CHaD), and DCYF. The coalition sponsors a yearly mailing to over 5,000 health and social services professionals, schools, hospitals, and agencies that work with children and families, and a web page hosted by the CHaD. Improved use of listserves and email lists in recent years has

increased the distribution of the materials. In primary care offices, these resources are used in providing anticipatory guidance and education at EPSDT visits. /2008/ Over the years, several handouts have been developed as a result of recommendations from the NH Child Fatality Review Committee, such as on the topics of "Space Monkey" a potentially fatal game involving temporary asphyxia, and safe sleep for infants.//2008//

New Hampshire Coalition Against Domestic and Sexual Violence (NHCADSV): MCH is represented on workgroups including the education subcommittee. MCH has hosted joint education sessions on domestic violence and pregnancy with community health center staff. /2007/ Together NHCADSV and MCH collaborate to implement a CDC funded Rape Prevention and Education Grant. //2007//

Dartmouth-Hitchcock Medical Center: The MCH Prenatal Program collaborated with Dartmouth to create a Perinatal task force that is establishing updated clinical procedures and will host best practice seminars on topics such as helping patients quit alcohol, tobacco, and drug use during pregnancy; psychotropic medication use in pregnancy; genetic screening; and prenatal nutrition and weight management.

Other State Agencies & the IPP: The IPP works with the NH Highway Safety Agency, and Departments of Safety, Transportation, and Education on all restraint issues. As a member of the Suicide Prevention Council, MCH is involved with oversight of the SAMSHA Garrett Lee Smith funds which go to the National Alliance on Mental Illness, NH to carryout the Frameworks Project. See Section IVC for additional information.

//2008//The MCH Child Health Nurse Consultant has played a key role in the NH Child Fatality Committee, working closely with representatives from the Medical Examiner's Office, DCYF, the state police, and the Attorney General's Office. //2008//**/2009/ With information from an MCHB webcast on child death review teams, the Nurse Consultant revised the process by which committee recommendations are developed and tracked. In 2007, she participated in a state team that attended the CDC Regional Child Death Scene Investigation Academy, and subsequently presented several trainings in fall and winter 2007 on the material.//2009//**

/2007/ The New England Lead Coordinating Committee (NELCC): NELCC, sponsored by the EPA, is a consortium of New England state agencies, tribal partners, and non-profit organizations that are working to eliminate lead poisoning. NELCC develops regional projects and promotes the exchange of information, ideas, materials, and programs among its member agencies, federal agencies, and other organizations working to eliminate lead poisoning throughout New England. The NH CLPPP has two appointed seats on its coordinating committee.//2007//

TITLE V & EPSDT The EPSDT Program works with MCH to provide data upon request, clarify program coverage issues, and work with the MCH Child Health Nurse Consultant on committees and workgroups such as the state's Child Fatality Review Committee and SCHIP quality assurance committee. Diana Dorsey, MD, shares a staffing position between the SMS Section and Medicaid. Dr. Dorsey provides pediatric consultation on EPSDT issues, with a particular focus on issues of medical necessity.

TITLE V & OTHER FEDERAL GRANT PROGRAMS

WIC:Title V works with WIC through a mutual knowledge of community agencies and a joint vision of services for women and children. Coordination of immunization, nutrition, breastfeeding promotion, injury prevention **/2009/ and lead screening //2009//** strategies are shared across programs in both state office and in communities. Lacking an MCH nutritionist, consultation from WIC nutrition staff on key nutrition issues impacting women and children is critical. For example, MCH staff collaborated with WIC and the NH March of Dimes to develop a folic acid public education campaign in 2000. WIC shares educational material with MCH contract agencies either directly or through MCH sponsored mailings and meetings. WIC staff present on nutrition-focused

topics at MCH meetings and the Child Health Nurse Consultant provides updates on MCH programs at WIC meetings.

Title X Family Planning Program (FPP): The NH Title X program is a major unit within MCH and is administered by the MCH Director, ensuring a seamless coordination between MCH and reproductive health services. MCH staff meetings, the yearly retreat and other planning activities include both MCH and FPP staff. The FPP Manager participates in the MCH Management Team. Adolescent Health, IPP, and FPP personnel meet regularly to coordinate activities related to teens. **//2009/ The FPP Manager position is currently vacant.//2009//**

Childhood Lead Poisoning Prevention Program (CLPPP): The CLPPP resides within MCH and provides surveillance, education, comprehensive case management, investigation and enforcement on lead poisoning in children

F. Health Systems Capacity Indicators

Introduction

Health System Capacity Indicators (HSCIs) are helpful in tracking trends in the population and measuring progress toward our health system goals. The HSCIs are also helpful in benchmarking with other states.

The availability of information based on valid, reliable data is an important requirement for the analysis and objective evaluation of the health situation, evidence based decision-making and the development of strategies to promote health among our population. Because of our mandate to collect data regarding these HSCIs, Title V has improved its relationships with other data providers as well as played a key role in improving data quality throughout the state.

Critical to many of the data improvement activities has been the State System Development Initiative (SSDI) grant. SSDI has enhanced the data capacity of New Hampshire's Title V programs by improving existing and establishing new data linkages and surveillance systems. Current linkages between the birth files, perinatal care data files, and newborn screening data will enable in depth analyses, which will identify priority needs for programs and interventions. It has also provided the infrastructure for the MCH Data Team to interface and develop relationships with other data stewards to ensure that MCH has timely access and accurate analysis of other data sources.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	12.9	12.9	14.7	17.2	17.1
Numerator	98	98	107	125	126
Denominator	75685	75685	72789	72789	73500
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007

Data is from the NH Asthma Control Program and is from New Hampshire Inpatient Hospital Discharge Data for 2005.

It does capture the number of NH residents hospitalized in border states.

Notes - 2006

Data is from the NH Asthma Control Program and is based on the cleaned and final data from Calendar Year 2004. The Census data is from the U.S. Census 2004 estimates (which are based on adjusted 2000 Census numbers).

It is different from last year's numbers as it does capture the number of NH residents hospitalized in border states. In addition the NH Asthma Control Program reports this rate to 16.8. The difference is that they utilize age adjusted rates. This allows for a more meaningful analysis when comparing data between state or when looking at trends within a single state.

Notes - 2005

Data is from the NH Asthma Control Program and is based on the cleaned and final data from Calendar Year 2004. The Census data is from the U.S. Census 2004 estimates (which are based on adjusted 2000 Census numbers).

It is important to note that this Annual Indicator might be an underestimate, as it only represents NH residents hospitalized in NH and does not capture the number of NH residents hospitalized in border states.

An attachment is included in this section.

Narrative:

/2008/

The data reported this year continues to represent more specificity to the data from calendar year 2004. It does reflect an increase in the rate of children hospitalized for asthma per 10,000 children who are less than five years of age. This can be attributed to the fact that the number of hospitalizations does include NH residents who were hospitalized in the border states of MA, VT and ME. The numbers also reflect the fact that nationally the prevalence of asthma has increased. However, NH rates have consistently been lower than the national rates. In addition, NH continues to surpass the US Healthy People 2010 objective for reducing the number of hospitalization for this population to 25 per 10,000.

STRATEGIES:

Because, Title V does not have the needed resources to address asthma issues alone, Title V works with the Bureau of Health Promotion to plan and develop activities that the Asthma Program Coordinator in Bureau of Health Promotion implements in accordance with Asthma Control Program strategic plans.

MCH staff has met with the Asthma Program Coordinator in Bureau of Health Promotion to discuss ways to educate MCH contract agencies about how to keep children with asthma healthy and how to prevent acute episodes resulting in office, emergency room, and in-patient visits. Regional one-day trainings on "Healthy Homes" are planned to include the MCH-funded primary care, child health and home visiting funded agencies, as well as Community Action and Headstart Programs.

/2009/ SMS has partnered with NH Asthma Control Program in several ways. The Administrator of SMS was a presenter in their annual conference: Asthma 2008 Putting the Pieces Together: A Community Challenge. Over 100 people attended this conference. SMS also has a representative (Butler) who participates in the NH Asthma Control Program. The NH Asthma Control Program consists of working groups on Healthy Homes, Schools, Workplaces, Surveillance and Clinical outcomes. Butler sits on the Asthma Health Improvement subcommittee and the Healthy Homes subcommittee. She also participated in a Healthy Homes training this past year.

Housing conditions can significantly affect public health. Nationally, childhood lead poisoning, injuries, and respiratory diseases such as asthma have been linked substandard housing units. The New Hampshire MCH Section, Childhood Lead Poisoning

Prevention Program (CLPPP), in partnership with the National Center for Healthy Housing (NCCH) has begun the planning process for a comprehensive, statewide Healthy Housing Program in New Hampshire. A "healthy home" is defined as a home designed, constructed, maintained, or rehabilitated in a manner that supports the health of residents. The focus of the initiative is to identify health, safety, and quality-of-life issues in the home environment and to act systematically to eliminate or mitigate problems. In partnership with multiple state agencies and community based organizations and through a contract with NCHH, approved in March 2008, NCCH will write and disseminate a final implementation strategic plan through collection of current healthy homes best practices and data, and investigation of New Hampshire's current structure. This final document is scheduled to be complete in December 2008.//2009//

INTERPRETATION OF DATA:

Hospital discharge data indicates that one of the most frequent cause of hospitalization among NH children is asthma (approximately 11.5%). Nationally and in NH children aged 1-4 have the highest hospitalization rate for asthma among all age groups of children. The NH DHHS Asthma Control Program continues to suggest that access to care is an increasingly important factor in the effective treatment of asthma. In addition to issues with access to insurance there are gaps in the data set that could illustrate significant issues. The missing knowledge includes trends that may be related to racial/ethnic diversity, work-related asthma and insurance claims. //2008//

//2009/ The formal report is not yet available on this data presented from 2005. However it appears somewhat promising that the rates of hospitalization for this population have stabilized. Since these numbers already include those hospitalized in border states the expectation is that the final cleaned data will not have significant changes. This is the first step toward reversing the trend of increased hospitalization and getting closer to the goals of Healthy People 2010. //2009//

Health Systems Capacity Indicator 02: The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	81.1	83.7	83.4	84.9	86.1
Numerator	3715	4415	4430	4776	4929
Denominator	4582	5272	5312	5628	5722
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007

Data is from the 2007 416 report, via Maria Pliakos (ext. 7194) and Jackie Leone (ext 8169) in the Office of Medicaid Administration.

Part of NH SCHIP development was Medicaid expansion for infants (0-1), from 185% to 300% of poverty. Therefore the numbers for HSCI # 2 and HSCI # 3 are the same.

Notes - 2006

Data is from the FY2006 416 report, via Denise Towle (ext 7194) and Jackie Leone (ext 8169) in the Office of Medicaid Administration. This report was slightly revised for FY2006, and - retroactively - for 2004 and 2005. The revision made the numerator and denominator for this indicator much more clear and explicit (and therefore the data we used for the FY08 application is much more accurate than what we have used in the past). We have used this more accurate data for the FY06 indicator, and have also revised the indicators for FY04 and FY05 - i.e., using the new and more accurate data.

Part of NH SCHIP development was Medicaid expansion for infants (0-1), from 185% to 300% of poverty. Therefore the numbers for HSCI #2 and #3 are the same.

Notes - 2005

Data is from FY2005 416 report, via Denise Towle (ext. 7194) and Jackie Leone. The 416 report has been revised, with rows that make explicit the numbers for initial periodic screens (i.e., not simply "expected and received" screens OF ANY KIND); therefore this data for 2005 has been revised with the submission of the FY08 application (i.e., revised in the spring of 2007).

Part of NH SCHIP development was Medicaid expansion for infants (0-1), from 185% to 300% of poverty. Therefore the numbers for HSCI #2 and #3 are the same.

Narrative:

/2008/

DATA SOURCE AND CURRENT FINDINGS

This information has been available through the Medicaid program data files in the past and, with the implementation of the new Medicaid Decision Support System, MCH is hopeful it will eventually have direct access to Medicaid data.

As described in the notes, all infants up to 300% of poverty receive the same SCHIP/Medicaid benefits. Therefore the numerator and denominators for HSCI #2 and #3 are the same.

STRATEGIES:

MCH continues to review charts at its funded primary care agency site visits for adherence to the American Academy of Pediatrics (AAP) Periodicity schedule for preventive visits and key health screenings. In SFY06, 7 of the 10 primary care agencies were visited; all showing appropriate adherence to the schedule, given the high risk nature of their clientele. By the end of SFY07, all 10 agencies will be on, or in the process of transitioning to, an electronic medical record system which will enhance the agency's ability to assure that children receive the necessary periodic visits on schedule. Staff of MCH-funded Child and Family Health Care Support and Home Visiting NH agencies work with parents of infants to educate them on the importance of getting preventive care on schedule, and assist with transportation and other issues that may pose obstacles.

Currently eight of the ten MCH-funded community health centers have an EMR system. Community agencies funded for MCH's Child and Family Health Support Services grant are required by their contract's Scope of Services to assure that children referred to their program for services have a primary health care provider/medical home, and they must monitor adherence to the AAP schedule.

Agencies use a variety of other techniques such as reminder calls and postcards prior to a visit to enhance compliance, and follow up with phone and letters when a visit is missed. The increase of an electronic medical record system (EMR) that can generate postcards has also helped facilitate the process. Infants, with the high number of required immunizations and more frequent acute care visits, tend to have a better show rate than children over one year of age.

Title V recognizes that New Hampshire's investment in its Healthy Kids Program is critical to ensuring that all children have access to preventive health care. MCH and SMS both participate

in numerous workgroups, including the NH SCHIP quality assurance workgroup, to provide leadership and technical assistance for policy makers and program specialists. Title V also participates in the New Hampshire Children's Alliance that creates an annual list of priorities for children. Access to health insurance is always a priority and a critical part of any action steps leading to improved child health and safety.

//2009/ MCH is continuing similar strategies for SFY09. With three new MCH-funded community health centers and nine community agencies receiving Child and Family Health Support Services, community-based organizations will continue their focus on helping families enroll in SCHIP and maintain their eligibility. //2009//

INTERPRETATION:

In December 2005, the NH Healthy Kids Program released the "Evaluation of the Quality of Care in the Children's Health Insurance Program". It found that 71% of children aged 1-2 enrolled in either the Healthy Kids Gold/Medicaid or Fee for Service and Managed Care programs received the appropriate amount of preventive visits. That number rose to nearly 90%, in the fee for service, Healthy Kids Silver population.

The 2006 data reported for this indicator suggests that nearly 85% of enrolled children under age one are receiving the appropriate amount of preventive visits. Through anecdotal evidence, there is a suggestion that perhaps EPSDT visits are under-reported as health care providers may be billing under codes that reflect more complex preventive care.

It also must be noted that this data has been slightly revised for FY2006, and retroactively for 2004 and 2005. The revision is due to changes in the descriptors in rows and columns in the Medicaid data set. The numerator and denominator for this indicator is now much more explicit and therefore the data we used for the FY08 application is much more accurate than what we have used in the past. The revised numerators and denominators are represented above in the FY06 indicator and FY04 and FY05. //2008//

//2009/NH has exceeded the federal benchmark of 80% for the percent of Medicaid enrollees whose age is less than one year during the reporting year who received at least one periodic screen. At 86.1%, the data suggests that there is a small, but upward trend in ensuring that all infants receive these services. It can be hypothesized that part of this trend is due to outreach efforts, continued access to primary care services within a medical home, more accurate coding and billing, and the use of presumptive eligibility.//2009//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	81.1	83.7	83.4	84.9	86.1
Numerator	3715	4415	4430	4776	4929
Denominator	4582	5272	5312	5628	5722
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007

Part of NH SCHIP development was Medicaid expansion for infants (0-1), from 185% to 300% of poverty. Therefore the numbers for HSCI # 2 and HSCI # 3 are the same.

Notes - 2006

Part of NH SCHIP development was Medicaid expansion for infants (0-1), from 185% to 300% of poverty. Therefore the numbers for HSCI #2 and #3 are the same.

Notes - 2005

Part of NH SCHIP development was Medicaid expansion for infants (0-1), from 185% to 300% of poverty. Therefore the numbers for HSCI #2 and #3 are the same.

See the notes for HSCI # 2 for further information regarding these numbers.

Narrative:

/2008/

DATA SOURCES and CURRENT FINDINGS:

This information has been available in the past from the Medicaid Program. In addition, as a participant on the state's QCHIP (NH SCHIP quality assurance workgroup), MCH has been granted access to a draft report of the "Evaluation of the Quality of Care in the Children's Health Insurance Program" from the Healthy Kids Program, which contains data on average number of primary care visits by continuously enrolled children under age one year on Healthy Kids Gold/Medicaid for both Fee for Service and Managed Care participants.

As described in the notes, all infants up to 300% of the federal poverty level receive the same SCHIP/Medicaid benefits. Therefore the numerator and denominators for HSCI #2 and #3 are the same.

STRATEGIES:

MCH continues to review charts at its funded primary care agency site visits for adherence to the American Academy of Pediatrics (AAP) Periodicity schedule for preventive visits and key health screenings. In FY06, 7 of the 10 primary care agencies were visited; all showing appropriate adherence to the schedule, given the high risk nature of their clientele. By the end of FY07, all 10 agencies will be on, or in the process of transitioning to, an electronic medical record system which will enhance the agency's ability to assure that children receive the necessary periodic visits on schedule. Staff of MCH-funded Child and Family Health Care Support and Home Visiting NH agencies work with parents of infants to educate them on the importance of getting preventive care on schedule, and assist with transportation and other issues that may pose obstacles.

Currently eight of the ten MCH-funded community health centers have an EMR system. Community agencies funded for MCH's Child and Family Health Support Services grant are required by their contract's Scope of Services to assure that children referred to their program for services have a primary health care provider/medical home, and they must monitor adherence to the AAP schedule.

Agencies use a variety of other techniques such as reminder calls and postcards prior to a visit to enhance compliance, and follow up with phone and letters when a visit is missed. The increase of an electronic medical record system (EMR) that can generate postcards has also helped facilitate the process. Infants, with the high number of required immunizations and more frequent acute care visits, tend to have a better show rate than children over one year of age.

/2009/ MCH is continuing similar strategies for SFY09. With three new MCH-funded community health centers and nine community agency sites providing Child and Family Health Support Services, community-based organizations will continue their focus on helping families enroll in SCHIP and maintain their eligibility.

//2009//

INTERPRETATION:

In December 2005, the New Hampshire Healthy Kids Program released the "Evaluation of the Quality of Care in the Children's Health Insurance Program". It found that 71% of children aged one to two years enrolled in either the Healthy Kids Gold/Medicaid or Fee for Service and Managed Care programs received the appropriate amount of preventive visits. That number rose to nearly 90%, in the fee for service, Healthy Kids Silver population.

The 2006 data reported for this indicator suggests that nearly 85% of enrolled children under age one are receiving the appropriate amount of preventive visits. Through anecdotal evidence, there is a suggestion that perhaps EPSDT visits are under-reported as health care providers may be billing under codes that reflect more complex preventive care.

It also must be noted that this data has been slightly revised for FY2006, and retroactively for 2004 and 2005. The revision is due to changes in the descriptors in rows and columns in the Medicaid data set. The numerator and denominator for this indicator is now much more explicit and therefore the data we used for the FY08 application is much more accurate than what we have used in the past. The revised numerators and denominators are represented above in the FY06 indicator and FY04 and FY05.

//2008//

/2009/NH has exceeded the federal benchmark of 80% for the percent of Medicaid enrollees whose age is less than one year during the reporting year who received at least one periodic screen. At 86.1%, the data suggests that there is a small, but upward trend in ensuring that all infants receive these services. It can be hypothesized that part of this trend is due to outreach efforts, continued access to primary care services within a medical home, more accurate coding and billing, and the use of presumptive eligibility.//2009//

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	90.7	90.7	81.7	84.0	85.8
Numerator	12642		8841	9087	9509
Denominator	13934		10819	10823	11079
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2007

1574 birth records did not have information needed to do the necessary computations. These records were therefore not included in the denominator.

Data does not include out-of-state births (unavailable), includes multiple births, and is only for women 15-44.

Data is not comparable to years prior to 2005, due to the fact that the month prenatal care began is not collected after 2004. Instead, we collect the date of the first prenatal care visit and calculate the month of pregnancy in which prenatal care began by subtracting the date of the last menses. Moreover, this indicator is likely skewed downward for 2005-2007, for the following reason: out-of-state births to NH residents typically have an appropriately high score on the Kotelchuck Index. This is because complicated pregnancies, resulting in high prenatal care usage (i.e. many visits) tend to go to specialty centers outside of NH. In other words, it is reasonable to assume that, if the the out-of-state births were included in the data, the indicator for Kotelchuck would be higher.

Notes - 2006

1,933 birth records did not have information needed to do the necessary computations. These records were therefore not included in the denominator.

Data does not include out-of-state births (unavailable), includes multiple births, and is only for women 15-44.

Data is not comparable to years prior to 2005, due to the fact that the month prenatal care began is not collected after 2004. Instead, we collect the date of the first prenatal care visit and calculate the month of pregnancy in which prenatal care began by subtracting the date of the last menses. Moreover, this indicator is likely skewed downward for 2005 and 2006, for the following reason: out-of-state births to NH residents typically have an appropriately high score on the Kotelchuck Index. This is because complicated pregnancies, resulting in high prenatal care usage (i.e. many visits) tend to go to specialty centers outside of NH. In other words, it is reasonable to assume that, if the the out-of-state births were included in the data, the indicator for Kotelchuck would be higher.

Notes - 2005

In 2005, 1,954 birth records did not have information needed to do the necessary computations.

NH moved to the 2003 National Birth Certificate Specifications in July, 2004. Neighboring states were not using the new national specifications in 2004, making it particularly difficult to calculate certain measures when including out-of-state births to NH residents. In addition, since the change was implemented by NH Vital Records (Department of State) in the middle of 2004, seamless statistics for the entire year (2004) is difficult or impossible to produce for many measures. As such, we have decided to provide 2005 birth data for this application. Although these data come with the significant limitation of only including resident occurrent births (i.e. no NH resident out-of-state births yet), we feel it is the best possible choice at this time. We recognize the critical importance of vital records and are actively working on multiple approaches to improve the accuracy and timeliness of vital records in New Hampshire.

In addition: data is not comparable to previous years due to the fact that the month prenatal care began is no longer explicitly collected. Instead, we collect the date of the first prenatal care visit and calculate the month of pregnancy in which prenatal care began by subtracting the date of the last menses. Moreover, this indicator is likely skewed downward for 2005, for the following reason: out-of-state births to NH residents typically have an appropriately high score on the Kotelchuck Index. This is because complicated pregnancies, resulting in high prenatal care usage (i.e. many visits) tend to go to specialty centers outside of NH. In other words, it is reasonable to assume that, if the the out-of-state births were included in the data, the annual indicator for Kotelchuck would be higher.

Narrative:

/2008/

DATA SOURCES and CURRENT FINDINGS:

As described in the Notes, this data is available through the DPHS Health Statistics and Data Management Section (HSDM) and is obtained on a yearly basis. However, it must be noted that in 2004, New Hampshire moved to the 2003 National Birth Certificate Specifications. Since many fields have changed, this makes it particularly difficult to calculate certain measures. For example, the Kotelchuck Index relies in part on the "Month Prenatal Care Began". This is no longer explicitly collected. Instead, NH collects the date of the first prenatal care visit. Combining this with the Date of Last Menses allows calculation of the estimated month of pregnancy in which prenatal care began - though this difference in methodology calls into question the comparability of the statistic across NH Vital Records data systems in 2004, and across multiple years using different data systems.

In 2005, 1,954 birth records did not have information needed to do the necessary computations for the Kotelchuck Index.

STRATEGIES

MCH-funded agencies provide comprehensive prenatal care to low income, uninsured and underinsured women.

Data on initiation of prenatal care and number of visits is collected by and reported to the MCH funded prenatal providers. Entry to care is a performance measure and allows for analysis of adequacy using entry and visits.

MCH is completing development of the Perinatal Client Data Form (PCDF) Data Linkage Project that will link clinic records from the prenatal and post-partum periods with NH birth data (data collection from all prenatal agencies is expected to begin July 1, 2007). MCH completed extensive internal testing of the Auris PCDF system and is preparing to pilot test the manual web-based data entry component with 2 community-based prenatal agencies.

MCHS is able to fully understand and respond to the needs of, and threats to, pregnant women and newborns. Additionally, this project will greatly assist in program management, policy development, and evaluation of health services to pregnant women and newborns.

/2009/

MCH-funded agencies continue to provide comprehensive prenatal care to low income, uninsured and underinsured women.

MCH hired a new Prenatal Program Coordinator in 2008. The Coordinator has been visiting all MCH-funded prenatal agencies to provide feedback and troubleshoot any problem areas that each specific agency may encounter. As a nutritionist, she brings a valued perspective to this role and complements other MCH skills and capacities.

The Prenatal Program Coordinator has reconvened the Birth Outcome Work Group. The first order of business was to change the name to Pregnancy Outcome Work Group to recognize that a healthy pregnancy is the key to a healthy baby. Over the next year the work group will be prioritizing its goals and developing strategies to improve outcomes of New Hampshire's pregnant women.

MCH completed development of the Perinatal Client Data Form Project. Data collection started on July 1, 2008. It will take a year in order to collect enough data to analyze and interpret. MCH will use this data to guide the agencies in making positive improvements in the prenatal programs. MCH will also use this data to determine new directions or

initiatives that are needed through out the state. //2009//

INTERPRETATION:

The Adequacy of Prenatal Care Utilization (APCNU) Index in New Hampshire is often significantly better than in the US as a whole. New Hampshire does particularly well with Initiation of prenatal care, but does not do as well with Received Services. It is difficult to interpret the 2005 data that shows a decline in the percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index. This may be due to data quality issues, included the fact that a significant number of birth records did not contain the information needed to do the necessary computations.

Moreover, this indicator is likely skewed downward for 2005, for the following reason: out-of-state births to NH residents typically have an appropriately high score on the Kotelchuck Index. This is because complicated pregnancies, resulting in high prenatal care usage (i.e. many visits) tend to go to specialty centers outside of NH. In other words, it is reasonable to assume that, if the out-of-state births were included in the data, the annual indicator for Kotelchuck may have been higher.

In the coming year, with the Prenatal Data Linkage Project in place, MCH will be able to better analyze trends in utilization and entry to care. //2008//

/2009/ From a low point in 2005, NH is pleased that the data continue to improve for this measure. With increased numbers of MCH-funded community health centers, MCH is supporting increased access to care. //2009/

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	72.3	73.0	74.8	76.4	74.0
Numerator	68982	68129	71350	74571	72906
Denominator	95347	93337	95444	97655	98463
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007

The numerator was provided by Maria Pliakos (ext 7194) and Jackie Leone. Data for the denominator is the sum of two numbers: the number of 1-21 year olds enrolled/eligible for Medicaid plus 15,157, obtained by Christina Purdam of the DHHS Office of Planning and Research, from the 2001 DHHS Insurance Family Survey. The latter number reflects uninsured 0-18 year-olds that were eligible for Healthy Kids insurance. Although the age groups added for the denominator do not match exactly, this methodology results in the most accurate estimate available.

Notes - 2006

The numerator was provided by Denise Towle (ext 7194) and Jackie Leone. Data for the denominator is the sum of two numbers: the number of 1-21 year olds enrolled/eligible for

Medicaid plus 15,157, obtained by Christina Purdam of the DHHS Office of Planning and Research, from the 2001 DHHS Insurance Family Survey. The latter number reflects uninsured 0-18 year-olds that were eligible for Healthy Kids insurance. Although the age groups added for the denominator do not match exactly, this methodology results in the most accurate estimate available.

Notes - 2005

The numerator was provided by Denise Towle (ext 7194) and Jackie Leone. Data for the denominator is the sum of two numbers: the number of 1-21 year olds enrolled/eligible for Medicaid plus 15,157, obtained by Christina Purdam of the DHHS Office of Planning and Research, from the 2001 DHHS Insurance Family Survey. The latter number reflects uninsured 0-18 year-olds that were eligible for Healthy Kids insurance. Although the age groups added for the denominator do not match exactly, this methodology results in the most accurate estimate available.

Narrative:

/2008/

DATA SOURCES AND CURRENT FINDINGS:

The numerator, number of children who received a service paid by Medicaid, was provided by the NH Medicaid Administration. Data for the denominator is the sum of two numbers: the number of 1-21 year olds Enrolled/eligible for Medicaid plus 15,157, DHHS Office of Planning and Research, from the 2001 DHHS Insurance Family Survey. The latter number reflects uninsured 0-18 year-olds that were eligible for Healthy Kids insurance. Although the age groups added for the denominator do not match exactly, this methodology results in the most accurate estimate available.

Data trends look promising for this measure, with small annual increases from 2002-2006.

INTERPRETATION OF DATA:

NH often compares favorably to other states in many measures of health. NH has made a commitment to ensuring that children have access to health care. That commitment is reflected in strategic investments, like Medicaid and the Healthy Kids SCHIP program, that allow children up to 300% of poverty have access to health insurance.

The data also seem to indicate that a large percent of Medicaid eligible children have access to basic clinical care. However, as part of an ongoing needs assessment more surveillance and analysis is needed to determine if and where geographic or racial/ethnic disparities exist.

STRATEGIES TO MAINTAIN GAINS:

NH Healthy Kids states in their 2005 Evaluation and of Access and Utilization In the Children's Health Insurance Program that the following coordinated activities have contributed to continued increases in enrollment and utilization:

- Centralized enrollment processing and case management for children enrolled in all Healthy Kids programs.
- Revision of the community-facilitated application process and enhanced training of community partners who help families complete the application.

All MCH funded agencies are charged with providing outreach and education about NH Healthy Kids. Specifically, agencies funded to provide child health support activities, must actively work with uninsured families to ensure that eligible children have access to insurance. NH Healthy Kids

and MCH coordinates additional training for community health centers and other MCH-funded agencies to better understand the application process as well as technical tips that increase the timeliness of completed applications.

In FY06, the eight MCH-funded Child and Family Health Support agencies saw over 1,600 children 0 -- 18, over 60% of which were Medicaid-eligible at the time of their first contact with agency staff. As part of their MCH contract requirement, agencies complete an annual workplan with performance measures. Results of the performance measure pertaining to percent of Medicaid eligible children that were enrolled on Medicaid/Healthy Kids Gold by the end of the reporting period was 89% on average, with a range of 78 -- 100%. Data from the completed workplans of these same eight agencies showed that on average, 100% of enrolled children had a medical home by the end of the reporting year. FY07 marked the end of the three year Covering Kids Robert Wood Johnson-funded Covering Kids initiative to get hard to reach Medicaid eligible children enrolled in Healthy Kids. The MCH Nurse Consultant was a member of the Project Coordination workgroup which oversaw the activities in the three communities.

In FY08, following a competitive bid process, the number of MCH-funded Child and Family Support agencies will increase from eight to ten, further improving community efforts to get eligible children enrolled on Medicaid, connected to a medical home, and receiving preventive health care services according to the AAP recommended schedule.

//2008//

/2009/ MCH is working with the Title V-funded agencies to adapt to the recommendations of the newly revised Bright Futures Guidelines. In addition to an increased emphasis on developmental screening and surveillance, a major change for the agencies is the addition of a new visit at 30 months of age.

Beginning spring 2008, MCH is now funding three new community health centers, and two primary care for the homeless programs. These programs will have received an initial site visit by MCH staff by the end of SFY08.

In FY09, eight of the agencies funded in SFY08 will continue to provide Child and Family Health Support funding, with one, north country site receiving an additional contract to expand its catchment area. In SFY07, the eight agencies provided services to an unduplicated total of over 1,400 children and assisted in making over 1,700 referrals for additional services. Data from the completed workplans of these eight agencies showed that on average, 95% of enrolled children eligible were enrolled on Healthy Kids Gold by the end of the year, with a range of 89 -- 100%. And 100% of enrolled children had a medical home by the end of the reporting year, with a range of 98 -- 100%./2009//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	36.3	42.5	48.1	56.3	57.6
Numerator	4682	8690	10057	10230	10545
Denominator	12896	20426	20900	18170	18321
Check this box if you cannot report the numerator because					
1. There are fewer than 5 events over the last year,					

and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007

Data is from FY2007 416 report, obtained from Maria Pliakos (ext 7194) and Jackie Leone.

Notes - 2006

Data is from FY2006 416 report, obtained from Denise Towle (ext 7194) and Jackie Leone.

Notes - 2005

Data is FY2005 416 report, obtained from Denise Towle (ext 7194) and Jackie Leone.

Narrative:

/2008/

DATA SOURCE AND CURRENT FINDINGS:

This information is available through the EPSDT program within the NH Medicaid Administration.

//2009/ 2007 data indicate a continued increase in the number of eligible school-aged children receiving dental services.//2009//

STRATEGIES:

The Oral Health Program provided technical support to the following new oral health programs that served EPSDT eligible children aged 6 through 9 years:

- Sullivan County Oral Health Collaborative
- Monadnock Hospital HealthyTeeth School Dental Program
- Weeks Hospital/Mountain ViewDental Practice

The Oral Health Program collaborated on the following grant projects to improve the oral health of 6 through 9 year-old EPSDT eligible children:

- The New Hampshire Statewide Sealant Project used community dentists recruited by the New Hampshire Dental Society to provide on-site school dental exams prior to the application of dental sealants. School-based hygienists provided important care coordination to remove barriers to care and link identified students with local dentists for needed restorative treatment.
- The State Oral Health Collaborative Systems Grant trained medical providers to integrate oral screenings, parent education, preventive dental interventions, and referrals to dental offices for children into well-child medical visits. The oral health training curriculum was revised and piloted through three oral health trainings for child care providers in child care facilities.
- The Oral Health Program works closely with Head Start Oral Health Initiative that links identified high-risk pregnant women to oral health services through home visits. Children enrolled in Head Start and Early Head Start in Laconia, Concord, Manchester and Nashua are linked to community dentists through the care coordination provided by the dental hygienist hired through the Head Start Oral Health Initiative grant. In September 2007 the Oral Health Program will conduct a dental exam survey in 25 randomly selected Head Start sites using three volunteer pediatric dentists to collect data on the oral health status of enrolled children and link them to needed preventive and restorative treatment.
- The Oral Health Program has been involved in the planning of the Early Childhood Comprehensive Systems Grant to assure that children find dental and medical homes.

/2009/

In SFY08, the Oral Health Program applied for a HRSA Workforce grant to implement NH's Strategic Oral Health Workforce Plan to ensure a qualified oral health workforce to care for all people living in the New Hampshire with emphasis on three population groups: 1) residents of rural and designated dental health professional shortage areas; 2) underserved populations; and 3) children.

The Oral Health Program also applied for a Cooperative Agreement with CDC to support expanded capacity of the Oral Health Program to address the full range of data collection, surveillance, strategic planning, prevention interventions, and program evaluation required for a robust program. If funded, support from CDC will revitalize plans for the next Third Grade Basic Screening Survey that, for the first time, will collect county level oral health data on children. This Cooperative Agreement would ensure resources necessary to assess the capacity of non-school sealant communities to implement sealant programs in their schools, evaluate short and long term outcomes, create efficiencies, and thereby increase the capacity of NH's school-based sealant programs to provide sealants to middle school students. Assistance from CDC would also enable the reconstitution of NH's Water Fluoridation Reporting System.//2009//

INTERPRETATION:

Strategies such as the State Oral Health Collaborative Systems Grant training for medical providers to integrate oral screenings, parent education, preventive dental interventions, and referrals to dental offices for children into well-child medical visits may have led to the continued increases in children receiving dental care. /2008/

/2009/

With increased access and an increase in integrated services as well as increased education and outreach, especially among school based clinics, NH is pleased to see this indicator continue to rise.//2009//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	11.1	13.1	12.7	8.9	9.5
Numerator	160	186	193	145	166
Denominator	1443	1422	1514	1636	1741
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007

The numerator is specifically those under the age of 16 as of 12/31/07 and the denominator is the number of recipients of SSI as reported from a SSA December 2007 report and a table titled "Number of children under age 16 receiving federally administered SSI payments"

Notes - 2006

The decrease in the percentage reported for this HSCI this year is related to the increased specificity of the data retrieval from the SMS database. In previous years the number has included those 16 years old. This year the numerator is specifically those under the age of 16 as of 12/31/06 and the denominator is the number of recipients of SSI as reported from a SSA December 2006 report and a table titled "Number of children under age 16 receiving federally administered SSI payments"

Notes - 2005

Data on state CSHCN program enrollees receiving SSI is an estimate derived from the SMS database and includes those 0-16 years of age.

Data for number of recipients of SSI is from a SSA December 2005 report and a table titled "Number of children under age 16 receiving federally administered SSI payments" .

Narrative:

/2008/

Data on state CSHCN program enrollees receiving SSI is derived from the SMS database. Data for the number of recipients of SSI is from a SSA December 2006 report and a table titled "Number of children under age 16 receiving federally administered SSI payments". This report states that 1,636 children under age 16 are receiving SSI, as of December 2006. Of these, 145 (8.9%) are enrolled in the NH CSHCN program (Special Medical Services). This does identify a decrease from last year's rate however, this can be attributed (at least in part) to the fact that the Data reported this year is more specific and more closely matches the SSA data.

STRATEGIES:

As previously noted the National Survey of Children with Special Health Care Needs, 2001 data for NH, indicated that only 2.26% of the NH CSHCN surveyed were receiving SSI for their own disability, indicating an under-representation of this population in the survey. SMS has surveyed the SSI child population in fall 2004 and then again in spring 2006. The most recent survey was undertaken to better determine the care coordination needs and adequacy of health care services (including out-of-pocket costs) of this population of NH CSHCN. The data has been analyzed and the full report to include implications and conclusions will inform future policy discussions regarding the provision of services to this group. Also Special Medical Services will be undertaking a review of current policy and practice that limits outreach to new SSI recipients that are not currently known to NH Medicaid.

/2009/ SMS has implemented a process of outreaching to the families of children (with chronic health conditions) newly accepted for SSI, who do not have Medicaid. This process incorporates written and telephone contact from a Nurse Care Coordinator to assess the needs of families and to connect them with the appropriate resources, including Special Medical Services. Currently the finishing touches are being put on the outreach letter for Spanish speaking families. At the start of FY 2009 SMS will begin to contact families of children who are enrolled in Medicaid to confirm that they are receiving the services necessary. In addition, there is a plan to pilot an outreach letter highlighting community based resources to those children and youth with a primary Mental Health or Autism Spectrum Disorder. //2009//

INTERPRETATION OF DATA:

From 1998 to 2003, New Hampshire had seen a steady decrease in the number of children under the age of 18 receiving SSI cash benefits. However, the next three years each saw an increase in this population. The increases seen were 4% in 2004 (from 1710 to 1780), 2% in 2005 (from 1780 to 1809) and 8% in 2006 (from 1809 to 1953). The decreasing trend had been associated

with changes in economic prosperity and it is possible that the new increasing trend is related to NH's increasing rate of child poverty.//2008//

//2009/ The rate of children, in NH, under the age of 16 receiving SSI benefits increased 6% this year. The rationale that this could be related to the increasing rate of child poverty still applies there is also a need to consider a correlation with the significant rate of children being diagnosed with Autism Spectrum Disorders as part of this increase. The percentage of those children being served by Special Medical Services also increased. It is possible that SMS' efforts at outreaching to community agencies to make better connections has been successful. In addition the significant efforts being made by SMS to outreach new SSI enrollees are likely to have played a role in this increased caseload. //2009//

Health Systems Capacity Indicator 05A: Percent of low birth weight (< 2,500 grams)

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2007	payment source from birth certificate	7.4	5.1	5.8

Narrative:

/2008/

DATA SOURCES AND CURRENT FINDINGS:

New Hampshire's limited (see notes) low birth weight data is taken from the payment source indicated on birth certificate reports collected by New Hampshire Vital Records.

STRATEGIES

Because women who are uninsured, under-insured and/or Medicaid eligible often experience disparities in birth outcomes, NH MCH programs focus most strategies to effect low birthweight on these populations. The most significant strategy is in the funding of community health centers and categorical prenatal programs. MCH-funded agencies provide comprehensive prenatal care to low income, uninsured and underinsured women.

Data on initiation of prenatal care and number of visits is collected by and reported to the MCH funded prenatal providers. Entry to care is a performance measure and allows for analysis of adequacy using entry and visits.

Unfortunately, Title V has been without a prenatal program manager for much of this fiscal year. This has impacted MCH's ability to focus on programmatic changes and stratified data analysis, including the development of a one time PRAMS-like survey described in last year's application. However, NH continues to work with the March of Dimes to promote educational opportunities for providers in understanding ways to prevent, treat and support low birth weight and premature babies.

As part of SSDI, the Prenatal Data Linkage Project has continued to move forward. It was formed in coordination with the NH SSDI program to link MCH-funded prenatal clinic records and NH birth data to assure MCH is able to fully understand and respond to the needs of, and threats to, pregnant women and newborns. Additionally, this project will greatly assist in program management, policy development, and evaluation of health services to pregnant women and newborns.

The PCDF web based data collection system has been developed and data will be collected through this system as of July 1, 2007.

Title V has also been involved with the selection of and the design process of a new contracted service for NH Medicaid to provide Care Coordination for those most at risk in their health care needs. Schaller Anderson Healthcare will provide prior authorization services and a nurse helpline for the entire Medicaid population and specialized care coordination services for a subset of Medicaid participants that includes high risk pregnant women.

It will be a patient centered model incorporating clinical best practices, comprehensive case tracking and case management based upon risk stratification and inpatient and outpatient management. There will be a primary focus on establishment and maintenance of a medical home and coordination of mental health and primary care services, including pharmacy and disease management. The program is currently in the Phase 1- Design and Development Phase examining data and developing relationships with providers and clients. Phase 2- Operations Maintenance and Monitoring is anticipated to begin in July 2007.

It is anticipated that Schaller Anderson will work with community based providers to ensure that high risk pregnant women receive appropriate assessments and ancillary services required to help prevent pre-term labor and low birthweight.

Most women enter prenatal care at 8 -- 12 weeks post conception and the period prior to this is the time when the greatest risks to fetal development occur. Promoting overall good health prior to pregnancy is an important way to reduce these risks. A lifecourse perspective may be a helpful framework to better understand practices at the provider and system level. To increase Title V understand of this perspective, NH will participate in Fall 2007 in a Region I meeting to address this topic.

//2009/With TA support, MCH brought policy leaders and legislators together for a day long conference, PRIORITIZING HEALTH DOLLARS NOW. . .AN INVESTMENT IN NH's FUTURE. Dr Milton Kotelchuck of Boston University School of Public Health was a keynote speaker discussing, Investing in Mothers and Children: A Life Course Perspective, highlighting how issues such as low birth weight have health and real dollar costs for generations.//2009//

INTERPRETATION OF DATA:

The conditions under which a baby is born can have profound and lifelong implications. As stated above, NH has generally favorable outcomes with respect to low birth weight. Among non-Medicaid populations, the 2006 rate was 6.1% and the Medicaid population was 7.2%. Even though a clear disparity exists among payer groups, it is encouraging to note that in 2003 the total US rate was 7.9%, slightly above the New Hampshire percentage for Medicaid populations alone.

With further analyses of disparities and more information through survey instruments, Title V is will focus future activities on interpreting LBW outcome data and developing evidence based activities to improve outcomes in every population.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL

Infant deaths per 1,000 live births	2005	payment source from birth certificate	7.4	3.6	4.5
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Notes - 2009

Numbers reported last year for 2004 were:

Medicaid: 5.7
 Non-Medicaid: 5.5
 All: 5.6

We believe the change seen in the difference between the Medicaid and non-Medicaid infant death rates for 2005 is an artifact of the calculation methodology, rather than a significant change in the actual rates. Preliminary analyses support this conclusion, and we will be doing further analysis to confirm our findings.

Applying the methodology used this year to the 2004 data results in the following numbers:

Medicaid: 10.7
 Non-Medicaid: 3.8
 All: 5.6

Narrative:

/2008/

DATA SOURCES AND CURRENT FINDINGS:

The data sources for this indicator come from 2004 New Hampshire Vital Records.

Statistics based on birth certificate data are subject to substantial data issues (completeness, consistency, and small numbers), and therefore, even though it appears that there are reversals in trends, Title V has determined that the data should not solely be used in decision-making until these issues can be resolved.

STRATEGIES:

Many strategies to reduce infant death are similar to strategies to reduce the incidence of low birth weight, including access and utilization of prenatal care, analyses of racial/ethnic disparities, geographic disparities and disparities among payer sources.

In addition to addressing improved birth outcomes, MCH is actively involved in injury prevention activities, SIDS education and education regarding family violence. The MCH SIDS Program Coordinator has provided many in-services to a variety of health and child care personnel on reducing the risk of SIDS, and on promoting safe sleep conditions to decrease deaths from accidental overlay or asphyxiation, including working with hospitals on bed sharing policies.

MCH participates in the state's Child Fatality Review Committee to further explore strategies to decrease unexpected deaths of infants and plays a key role in its Executive Committee. In follow up to an MCHB webcast, she has introduced a new format for formulating and following up on recommendations that arise from the Committee's case reviews. She recently attended CDC's regional Sudden Unexpected Infant Death Scene Investigation Train the Trainer Academy as one of the five New Hampshire team members. She has participated in presenting the information to the Attorney General's Task Force on Child Abuse and Neglect, and to the NH Child Fatality Review Committee, to date, and will be conducting further training sessions in the coming year to other key stakeholders. MCH staff are working with the state's Child Care Licensing staff to revise the current rules, which include assuring that infant sleep environments are safe.

/2009/ The MCH SIDS Program Coordinator conducted over 15 workshops and presentations on reducing the risk of SIDS and other sudden unexpected infant deaths to

a variety of professionals including child care providers, early childhood education students, public health nurses, perinatal hospital nurse managers, Head Start program staff, law enforcement, DCYF staff, and local WIC agency staff. With approximately half the referrals from the state Medical Examiner's Office to the SIDS Program, of infants dying suddenly and unexpectedly, involving bed sharing or co-sleeping, much emphasis has been placed on the AAP's recommendations to promote a safer sleep environment including having infants sleep close to but separate from their parent.

An informal assessment of perinatal nurse managers in November 2007 showed that "Back to Sleep" information was distributed to most new mothers in the hospital, but there were inconsistencies across the state in role modeling of putting infants to sleep on their backs, advising close but separate sleeping, and having safe sleep nursery policies. Efforts are underway for SFY09 to work with hospitals, home birth providers, and leaders of the breast-feeding community on these issues. //2009//

INTERPRETATION OF DATA:

Infant Mortality represents many factors surrounding birth, including but not limited to: the health of the mother, prenatal care, quality of the health services delivered to the mother and child and infant care.

It is interesting to note that NH's infant mortality rate has appeared to increase in the past year. According to Kids Count 2006 Data Book, New Hampshire had the nation's lowest infant mortality rate in 2003. At 3.4, New Hampshire, as a whole, was below the national health objective for 2010 rate of 4.5 infant deaths per 1,000 live births. Among the non-Medicaid populations, New Hampshire's 2003 rate was 2.9 deaths per 1000 live births, and among the Medicaid population the rate was 4.8 per 1000 live births.

However, the 2004 data seem to reveal that NH dropped to a 12th place ranking for infant mortality with an overall rate of 5.6, higher than the Healthy People 2010 goal of 4.5 infant deaths per 1,000 live births. A long term perspective reveals that the NH rate traditionally has a fair amount of variability in it. This is in all likelihood due to the small numbers. It is difficult to tell from one point if this is the beginning of a trend.

To further analyze this situation, MCH will need to utilize the 2005 and 2006 out-of-state birth and death records which are, at present, unavailable from NH Vital Records.

Like low birth weight and other birth outcomes, further analyses is needed to better understand disparity in care and outcomes among sub populations.

/2009/Please see notes for interpretation of data changes for 2005.//2009/

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in	2007	payment source from birth certificate	68.7	87.7	82

the first trimester					
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Narrative:

DATA SOURCES AND CURRENT FINDINGS:

New Hampshire's entry to care data is collected from the birth certificate reports collected by New Hampshire Vital Records.

STRATEGIES:

MCH-funded agencies provide comprehensive prenatal care to low income, uninsured and underinsured women. MCH requires all funded contract agencies to report performance measures related to early entry to care. Strategies that contract agencies use include:

- A social marketing campaign with a focused message on where to find prenatal health services in Manchester was launched in response to a patient survey on delayed care.
- Patient surveys in the clinic setting to determine community or systems specific barriers to care distribution of materials on the importance of early entry to care.
- Coordination and collaboration between health care clinicians and community based support programs.
- Site visits to MCH funded agencies include chart audits and discussions on how to improve these strategies and ultimately how to improve outcomes.

The Prenatal Data Linkage Project was formed to link MCH-funded prenatal clinic records and NH birth data to assure MCHS is able to fully understand and respond to the needs of, and threats to, pregnant women and newborns. Additionally, this project will greatly assist in program management, policy development, and evaluation of health services to pregnant women and newborns. Because, most women enter prenatal care at 8 -- 12 weeks post conception and the period prior to this is the time when the greatest risks to fetal development occur. Promoting overall good health prior to pregnancy is an important way to reduce these risks.

MCH is working with partners such as the March of Dimes to promote preconception health. In addition, New Hampshire will work with all of Region I in planning a day long meeting with Dr Neal Halfon to better understand how a lifecourse perspective would lead to systems changes that would support positive health outcomes, including preconception health and birth outcomes.

In an associated strategy to address initiation of care, as well as adequacy of care, MCH has advocated for a waiver that would increase eligibility to make Medicaid-supported family planning services available to all individuals at or below 185% of FPL. Broad based coverage can prevent first pregnancies among individuals who do not wish to be pregnant, prevent more costs related to Medicaid-funded births and promote healthy decision making about childbearing among young women. In support of this concept, legislation was introduced in 2007 that states that the NH Department of Health and Human Services shall develop a Medicaid waiver to support the extension of Medicaid-allowable family planning services, as defined in the state's Medicaid plan, to Medicaid-eligible clients. If passed, DHHS will present the proposed waiver design, including proposed coverage groups and budget neutrality calculation, to the legislative fiscal committee prior to submission of a final concept paper to the Centers for Medicare and Medicaid Services (CMS) for federal approval.

//2009/

In 2008, MCH hired a new Prenatal Program Coordinator. The Coordinator has been visiting all of the agencies to provide feedback and troubleshoot any problem areas that each specific agency may encounter.

//2009//

INTERPRETATION OF DATA:

It is concerning that data indicate a continued decline in percent of infants born to pregnant women receiving prenatal care beginning in the first trimester among the Medicaid population. In

2005, 83.4 % of women received care in the first trimester. 2006 data indicate that this has gone down to 81.5%, with declines in both the Medicaid and non-Medicaid population. Anecdotal information from community agencies suggest that women are coming into care by early in the second trimester, but often miss the opportunity to start their care earlier. MCH-funded community health centers and prenatal care providers report that 75% of pregnant women received care in their first trimester. Those programs in large urban areas, and often those with a more culturally diverse population, report lower rates of first trimester care than those in more rural areas. In the future, with the Prenatal Data Linkage Project in place, MCH will be able to better analyze trends in utilization and entry to care.

/2009// Current data shows, for both Medicaid and Non-Medicaid, there has been slight increases in the number of women who obtain prenatal care beginning in the first trimester. MCH-funded CHCs and prenatal care providers report that 78% of their clients obtain care within the first trimester. It is encouraging that the MCH-funded agencies had a higher increase than state overall possible reflecting the positive efforts of the contract agencies in reaching at risk populations./2009//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2007	payment source from birth certificate	78.7	88.8	85.8

Narrative:

DATA SOURCES AND CURRENT FINDINGS:

As described throughout this application, this data is available through the DPHS Health Statistics and Data Management Section (HSDM) and is obtained on a yearly basis. However, it must be noted that in 2004, New Hampshire moved to the 2003 National Birth Certificate Specifications. Since many fields have changed, this makes it particularly difficult to calculate certain measures.

STRATEGIES:

MCH-funded agencies provide comprehensive prenatal care to low income, uninsured and underinsured women.

MCH stresses coordination and collaboration between MCH-funded health care clinicians and community based support programs. One example is the coordination between the Home Visiting New Hampshire (HVNH) program and prenatal providers. The HVNH nurses and home visitors, as part of their education for pregnant women, stress the importance of regular compliance with prenatal care and provide support to overcome potential barriers in accessing care.

The Prenatal Data Linkage Project was formed to link MCH-funded prenatal clinic records and NH birth data to assist MCH in responding to the needs of, and threats to, pregnant women and newborns. Additionally, this project will improve in program management, policy development,

and evaluation of health services to pregnant women and newborns.

In an associated strategy to address adequacy of care, as well as initiation of care, MCH has also advocated for a waiver that would increase eligibility to make Medicaid-supported family planning services available to all individuals at or below 185% of FPL (the same level at which pregnant women are entitled to Medicaid coverage.) Broad based coverage can prevent first pregnancies among individuals who do not wish to be pregnant, prevent more costs related to Medicaid-funded births and promote healthy decision making about childbearing among young women. In June 2007, the NH Legislature has passed a bill that requires NH to move forward in drafting a Medicaid waiver application. Work is set to begin in SFY08 and it is anticipated that MCH will be involved in the design and drafting.

Young women who have not had a first birth will be reached by this approach, but not by a post partum extension. Some of these low-income young women are among those who are most likely to have poor birth outcomes, as well as late entry to care.

Most women enter prenatal care at 8 -- 12 weeks post conception and the period prior to this is the time when the greatest risks to fetal development occur. Promoting overall good health prior to pregnancy is an important way to reduce these risks. As with the general population, a lifecourse perspective may be a helpful framework to better understand practices at the provider and system level.

//2009/

The PCDF Project was completed. Data collection started on July 1, 2008. It will take a year in order to collect enough data to analyze and interpret. MCH will use this data to determine new directions or initiatives that are needed through out the state. //2009//

INTERPRETATION OF DATA:

The Adequacy of Prenatal Care Utilization (APNCU) Index in New Hampshire is often significantly better than in the US as a whole. New Hampshire does particularly well with Initiation of prenatal care, but does not do as well with Received Services.

Among non-Medicaid births, 15-24 year olds tend to have lower APNCU scores. Medicaid births tend to have lower APNCU scores than Non-Medicaid births, regardless of age.

It is difficult to interpret the 2006 data that shows a continued decline in the percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 % on the Kotelchuck Index. This may be due to data quality issues, included the fact that a significant number of birth records did not contain the information needed to do the necessary computations.

Moreover, this indicator is likely skewed downward for 2006, for the following reason: out-of-state births to NH residents typically have an appropriately high score on the Kotelchuck Index. This is because complicated pregnancies, resulting in high prenatal care usage (i.e. many visits) tend to go to specialty centers outside of NH. It is reasonable to assume that, if the out-of-state births were included in the data, the annual indicator for Kotelchuck would be higher.

In the future, with the Prenatal Data Linkage Project in place, MCH will be able to better analyze trends in utilization and entry to care.//2008//

//2009/ The downward trend in the percent of women with a live birth whose observed to expected prenatal care visits are greater than or equal to 80 % of the Kotelchuck index has seemed to stabilize. Overall, there was a slight increase from 84 % from 2006 to 85.9% in 2007.

The APNCU for Medicaid births is still lower compared to non-Medicaid births, though the

gap is getting smaller.//2009//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Infants (0 to 1)	2007	300
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Infants (0 to 1)	2007	300

Narrative:

/2008/

DATA SOURCES:

This information is available from Medicaid and New Hampshire Healthy Kids.

STRATEGIES:

The MCH Child Health Nurse Consultant is a member of the SCHIP quality assurance workgroup ("QCHIP") and the workgroup overseeing the Robert Wood Johnson-funded "Covering Kids and Families" three pilot community projects.

Title V recognizes that New Hampshire's investment in its Healthy Kids Program is critical to ensuring that all children have access to preventive health care. Despite occasional threats of change due to the state's fiscal status, the poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1), children and pregnant women has been unchanged since it was first implemented in stages in 1998 and 1999. NH currently covers kids at three times the poverty level due to the high cost of living in this state. Advocacy groups have been successful in lobbying to prevent any lowering of the income eligibility criteria, but they are troubled by the current presidential proposal to limit eligibility to children whose family incomes are twice the FPP or less. It is unclear if additional state funds would be used to maintain the current level of 300%.

But as of Spring 2007, despite threats of possible budget cuts and Medicaid eligibility changes, NH's percent of poverty level for eligibility in its Medicaid and SCHIP programs remained unchanged. Advocacy groups continue to actively lobby policy makers to maintain status quo.

MCH and SMS both participate in numerous workgroups, including the NH SCHIP quality assurance workgroup, to provide leadership and technical assistance for policy makers and program specialists. Title V also participates in the New Hampshire Children's Alliance that creates an annual list of priorities for children. Access to health insurance is always a priority and a critical part of any action steps leading to improved child health and safety.

//2008//

/2009/

New Hampshire Healthy Kids operates the outreach and enrollment center for SCHIP. Healthy Kids is increasing outreach and enrollment activities through focus group initiatives in which the MCH participated. Focus group initiatives include form assistance, active outreach enrollment procedures, and communication strategies targeted at parents. New Hampshire Healthy Kids has also systemically addressed retention by working with the NH Division of Family Assistance (TANF) to institute a second renewals notice for families to reduce the numbers of families that lose coverage due to a failure to renew.

***In 2007, Enrollment in Healthy Kids Gold (Medicaid) was up 1.6% and enrollment in Healthy Kids Silver (SCHIP) was up 2.9%.
//2009//***

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2007	185
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2007	400

Narrative:

/2008/

DATA SOURCES:

This information is available from Medicaid and New Hampshire Healthy Kids.

STRATEGIES AND INTERPRETATION:

The MCH Child Health Nurse Consultant is a member of the SCHIP quality assurance workgroup ("QCHIP") and the workgroup overseeing the Robert Wood Johnson-funded "Covering Kids and Families" three pilot community projects.

Title V recognizes that New Hampshire's investment in its Healthy Kids Program is critical to ensuring that all children have access to preventive health care. Despite occasional threats of change due to the state's fiscal status, the poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1), children and pregnant women has been unchanged since it was first implemented in stages in 1998 and 1999. NH currently covers kids at three times the poverty level due to the high cost of living in this state. Advocacy groups have been successful in lobbying to prevent any lowering of the income eligibility criteria, but they are troubled by the current presidential proposal to limit eligibility to children whose family incomes are twice the FPP or less. It is unclear if additional state funds would be used to maintain the current level of 300%.

But as of Spring 2007, despite threats of possible budget cuts and Medicaid eligibility changes, NH's percent of poverty level for eligibility in its Medicaid and SCHIP programs remained unchanged. Advocacy groups continue to actively lobby policy makers to maintain status quo. In addition, efforts to encourage the expansion of the Healthy Kids insurance program to the adult population have started at the grassroots level.

MCH and SMS both participate in numerous workgroups, including the NH SCHIP quality assurance workgroup, to provide leadership and technical assistance for policy makers and

program specialists. Title V also participates in the New Hampshire Children's Alliance that creates an annual list of priorities for children. Access to health insurance is always a priority and a critical part of any action steps leading to improved child health and safety.

//2008//

/2009/New Hampshire Healthy Kids operates the outreach and enrollment center for SCHIP. Healthy Kids is increasing outreach and enrollment activities through focus group initiatives in which the MCH participated. Focus group initiatives include form assistance, active outreach enrollment procedures, and communication strategies targeted at parents. New Hampshire Healthy Kids has also systemically addressed retention by working with the NH Division of Family Assistance (TANF) to institute a second renewals notice for families to reduce the numbers of families that lose coverage due to a failure to renew.

In 2007, Enrollment in Healthy Kids Gold (Medicaid) was up 1.6%./2009//

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Pregnant Women	2007	185
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Pregnant Women	2007	400

Narrative:

/2008/

DATA SOURCES:

This information is available from Medicaid and New Hampshire Healthy Kids.

STRATEGIES AND INTERPRETATION:

The MCH Child Health Nurse Consultant is a member of the SCHIP quality assurance workgroup ("QCHIP") and the workgroup overseeing the Robert Wood Johnson-funded "Covering Kids and Families" three pilot community projects.

Title V recognizes that New Hampshire's investment in its Healthy Kids Program is critical to ensuring that all children have access to preventive health care. Despite occasional threats of change due to the state's fiscal status, the poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1), children and pregnant women has been unchanged since it was first implemented in stages in 1998 and 1999. NH currently covers kids at three times the poverty level due to the high cost of living in this state. Advocacy groups have been successful in lobbying to prevent any lowering of the income eligibility criteria, but they are troubled by the current presidential proposal to limit eligibility to children whose family incomes are twice the FPP or less. It is unclear if additional state funds would be used to maintain the current level of 300%.

But as of Spring 2007, despite threats of possible budget cuts and Medicaid eligibility changes, NH's percent of poverty level for eligibility in its Medicaid and SCHIP programs remained unchanged. Advocacy groups continue to actively lobby policy makers to maintain status quo. In addition, efforts to encourage the expansion of the Healthy Kids insurance program to the adult population have started at the grassroots level.

MCH and SMS both participate in numerous workgroups, including the NH SCHIP quality assurance workgroup, to provide leadership and technical assistance for policy makers and program specialists. Title V also participates in the New Hampshire Children's Alliance that creates an annual list of priorities for children. Access to health insurance is always a priority and a critical part of any action steps leading to improved child health and safety.

//2008//

/2009/

New Hampshire continues to maintain these eligibility levels for access to Medicaid for pregnant women. Legislation would not be needed to increase the eligibility levels, it would simply require an amendment to the state Medicaid plan, changes to state rules, and more importantly, increased appropriation from the state budget. Although, many policy makers are sympathetic to the needs of low income women, it is not anticipated that there will be the political will to make the increases needed in appropriation in the upcoming biennium budget.

As an additional strategy for ensuring that families receive access to care for which they are eligible, the New Hampshire Office of Medicaid and Business Policy has begun work with Schaller Anderson to introduce Enhanced Managed Care for high cost patients. The initiative aims to provide comprehensive, patient-centered medical management and care coordination while optimizing health outcomes and improving quality of care. The program works with Medicaid recipients in the Temporary Assistance to Needy Families (TANF) and Aid to the Permanently and Totally Disabled (APTD) eligible populations as well as Medicaid members enrolled in prenatal care. In addition to ensuring coordinated medical and behavioral health services and individualized health care plans focused on prevention for Medicaid recipients with complex health care needs, the program components also include: fostering the concept of a medical home, establishing a 24/7 nurse advice line, implementation of standardized, evidence-based clinical guidelines for decision making, provider outreach and support, client incentive programs, and quality improvement via benchmarking, establishing performance standards and outcomes measurement.

//2009//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	2	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	1	No
Annual linkage of birth certificates and WIC eligibility files	1	No

Annual linkage of birth certificates and newborn screening files	3	Yes
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	1	No

Notes - 2009

We have electronic access to the Uniform Hospital Discharge Data Set (UHDDS).

Narrative:

/2008/

The NH Division of Vital Records (VR) moved from the Department of Health and Human Services (DHHS) to the Department of State (DOS) in 2003. Since then, although the Title V capacity for data analysis has increased, the program has encountered challenges in accessing complete and validated data sets. For example, the structure of the VR datasets has changed drastically for certain fields, most notably race and ethnicity due to allowing multiple responses. These data are now more difficult to use and its comparability across past years and across states is called into question. While NH law protects public health access to the data, the quality and timeliness is not adequately addressed.

Through the SSDI grant, the MCH is continuing to develop the collaborative relationships to enable access to data from DHHS and other agencies, as well as facilitate linkages between MCH program data and other data sets (e.g. Vital Records). The Section continues to improve linkages between birth certificate and Newborn Hearing Screening Program and Newborn Screening Program data to assure that all newborns are screened for hearing loss and metabolic and other disorders at birth. The system to link birth and Prenatal data is completed and data collection is scheduled to begin on July 1, 2007. The Data Mart, which will eventually house all linked MCH data, continues to mature as progress is made in carrying out the linkage plan. Planned expansions of data linkages include adding Childhood Lead Prevention Program (CLPPP), as well as linking Medicaid and WIC data with MCH program data. These linkages will assist the Section in assessing the MCH population and evaluating MCH programs.

DATA SOURCES AND CURRENT FINDINGS

The MCH State Performance Measure related to this priority is percent of data linkage projects completed. Planned data linkage projects are: infant births/deaths/fetal deaths; prenatal program/birth data; EHDI Program/birth data; NSP Program/birth data; and Medicaid/birth data/prenatal program data. Three of the five data linkages are completed: EHDI, NSP and Prenatal (July 2007).

Several factors have influenced the MCHS' ability to maintain and/or improve this measure, including:

Hiring of a full time SSDI coordinator as well as an MCHS Epidemiologist (.6FTE) with Title V funding, has helped improve this measure. These staff coordinate data capacity improvement efforts, analyze data and prepare reports.

Reorganization of NH Division of Vital Records (DVR) out of DHHS resulted in discontinuation of the VR data feed to DHHS and several quality improvement issues including lack of data documentation. Lack of VR data impacted implementation of the EHDI and NSP data linkages (Data feed was restored in FY 06)

Assignment of 2 highly skilled Office of Information Technology analysts to the data linkages project has moved the project forward over the past 2 years. MCH Data Mart developed in FY 06; NSP linkage deployed September 2006; Prenatal data linkage scheduled for deployment in July 2007.

NH's 2007 PRAMS application received a high priority ranking, but was not funded due to the state's high birth outcomes rankings.

/2009/The new prenatal program/birth data linkage will provide timely and accurate data and reports on prenatal clients to the MCH, while reducing the reporting burden on the MCH-funded agencies./2009//

STRATEGIES:

The MCHS submitted its SSDI grant application, outlining a 5-year plan for increasing MCH data capacity in FY06. In FY07, project staff completed construction of the MCH Data Mart, which will eventually house all of the linked databases and facilitate analysis by project staff. The goal over the next 5 years is for all MCH-related data including the CLPPP data and NH Birth Defects Surveillance, WIC and Medicaid data to reside in the MCH Data Mart, where it will be available to public health analysts and policy makers with pre-established linkages. Expansion of the MCH Data Mart will take place concurrently with other data system improvements.

SSDI funding will enable MCHS to continue to improve access to timely and accurate data for both internal (DHHS) and external users (e.g., MCHS-funded community health centers). Additionally, initial discussions are underway to increase access to and analysis of the annual birth defects surveillance system. Through collaborative efforts with all data stewards and users, MCHS will increase its ability to obtain vital records and Medicaid data for reporting on Title V performance measures and ongoing needs assessment, and increase the ability and skills of project staff to analyze these data routinely.//2008//

/2009/Data linkages have improved NH's public health efforts. For example, since the linkage between Vital Records and the Newborn Screening Program began in September 2006, the NSP has identified 28 infants from Vital Records without newborn screening results. //2009//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes
NH Youth Tobacco Survey	3	No
Behavioral Risk Factor Surveillance Survey	3	Yes

Notes - 2009

Narrative:

/2008/

Strategies:

Youth tobacco use is a significant issue in New Hampshire. The Tobacco Prevention and Control Program (TCPC), within DPHS, is funded by the Centers for Disease Control and Prevention, and is dedicated to the implementation of a comprehensive program designed to reduce the prevalence and consumption of tobacco use in New Hampshire.

The Program's primary goals are to: prevent NH youth from beginning to use tobacco; eliminate exposure to secondhand smoke; and promote quitting tobacco among users.

The TPCP promotes the use of free, personalized and confidential help through a Quit Line, 1-800-Try-To-STOP. The NH Smokers' Helpline & Tobacco Resource Center uses evidence-based interventions to assist those willing to quit. They have worked with primary care providers to promote routine evidence based screening and office systems interventions to promote follow up.

The MCH Adolescent Health Program includes tobacco education and cessation activities among the items reviewed on primary health care site visits and chart audits.

The NH Youth Risk Behavior Survey (YRBS) also collects information on adolescent smoking and for the second time NH was able to obtain a representative sample. Collaboration between the Department of Education (DOE), which administers the survey, and DHHS, which has epidemiological resources to contribute, has successfully overcome previous barriers.

It is important to note that children are the most disparate group of all in New Hampshire when it comes to exposure to second hand smoke. Efforts aimed at adult smoking cessation directly impact the health of many children. TCPC will be emphasizing the Ask, Advise, Refer & Prescribe Protocol as a standard of care over the next few years. That means that all physicians and clinician's should be using this protocol at all patient visits - especially pediatric MD/ARNP's. TCPC will be working in collaboration with MCH to ensure that all community health centers have access to training and resources to support this effort. **//2009/ The MCH contracts requires agencies use the 5As, and the TCPC offers 5As specific training. The TCPC will offer technical assistance training on the 5As at an up-coming MCH agency meeting.//2009//** The data from YRBS, NH Youth Tobacco Survey and the Behavioral Risk Factor Surveillance Survey will continue to inform TCPC and MCH activities. **//2008//**

/2009/

The Adolescent Health Program participates on the Coordinated School Health Council (CHS) with the Department of Education and the Department of Environmental Services. CSH focuses on physical activity, nutrition, and tobacco (PANT) activities. One of these activities is the School Health Index (SHI) training and creating school health teams for implementation. The SHI assists schools in rating themselves in relation to policies and programs including those addressing tobacco.

SCREENING BRIEF INTERVENTION AND REFERRAL TO TREATMENT (SBIRT): The Adolescent Health Program coordinated an effort for SBIRT for an alcohol and drug abuse early intervention initiative. If successful, the initiative will include uniform screening and intervention tools for six MCH primary care agencies encompassing tobacco activities. The MCH-led Bright Futures and APP recommendations committee is pursuing other means to implement this recommendation. //2009//

IV. Priorities, Performance and Program Activities

A. Background and Overview

New Hampshire's priorities are selected based on many factors, such as the political and socioeconomic climate of the state, needs assessment findings, and emerging health issues. Sections II and IIIA address the process for choosing priorities based on needs assessment findings and statewide capacity, determining the importance of competing factors that impact health services delivery, and prioritizing identified needs. This section describes current considerations in developing state priorities./2007/ At present, in 2006, Title V has committed to continuing to address the priorities developed through the 2005 Needs Assessment process and CAST V capacity assessment. Many partners delivered the same message in that they want Title V to continue focus on these critical areas for a significant amount of time. Progress in programming and policy development is often slow. State systems are not nimble. With concentrated focus over several years, partnerships can be arranged and progress can be made. Several updates can be found within this Section, as throughout the application. NH Title V continues to move forward with these priorities as a guide. //2007//

The complete list of Title V priorities is located in Section IVB.

The 2005 Title V needs assessment, in Section II, provides an overview of maternal and child health in NH, describes health status indicators, identifies disparities and gaps in health services, and led to the targeting of priority concerns. Findings point to potential areas of intervention, such as:

- Creating a comprehensive, multi-program plan to intervene with at-risk pregnant women in order to reduce LBW.
- Developing policies to promote Medicaid enrollment and care utilization.
- Assessing cultural competence in local and state MCH programs and creating supports to enhance services.
- Improving prenatal care access in southern counties to reduce birth disparities in minorities.
- Expanding YRBS use to improve the understanding of vulnerable adolescent populations.
- Improving understanding of the primary care workforce distribution and its' effect on access to care.
- Addressing the impact of pediatric mental health and dental provider shortages.
- Creating strategies to protect children at higher risk for lead poisoning, such as malnourished refugee populations, from NH's aging housing stock, while avoiding stigmatization.
- Examining funding distributions for MCH programs, addressing barriers to care, improving access, and whether efforts to improve enrollment in SCHIP and Medicaid impact health outcomes.
- Implementing best practices to reduce teen injury from motor vehicle crashes.
- Strengthening the state infrastructure to promote the integration of mental health services for children, youth and their families into primary care practices.
- Enhancing systems development to reduce fragmentation among multiple entities that provide resources to intervene on the prevalence of obesity among children.

- Confronting the shortage of trained respite and childcare providers to serve families of the most medically and behaviorally complex CSHCN.

/2007/ NH has moved forward with activities and strategies to address all of the intervention areas above. The following are of specific note:

- Convening the Birth Outcomes Workgroup
- Partnerships to address behavioral health integration into primary care
- Data capacity and linkage enhancements

//2007//

/2008/ Title V and its partners continues to focus on the priorities identified in the 2005 Needs Assessment. Notable highlights from the current year include:

- 2007 legislation that promotes increased primary prevention of lead poisoning
- Further improvements in data capacity, linkages and statewide data policy
- Strengthened partnerships to address childhood overweight
- Continued development of competency based training curriculum for respite for medically and behaviorally complex children.

//2008//

At present, economic factors affecting NH's population are fluctuating. Rising unemployment in some regions, a soaring housing market, and Medicaid modernization are issues that may influence the health of New Hampshire's families over the next years. In addition, scarce state resources and federal funding reductions threaten the existence of some state programs in SFY06. The full effect of this economic climate is difficult to predict, but the potential continues for decreasing access to care and worsening health indicators among women and children, including CYSHCN.

New Hampshire continues to struggle with data capacity issues; data capacity was a top priority identified in NH's CAST-V process. Some Title V program data is of very limited use. Lack of access to birth files and other vital records data has presented a barrier to basic analysis and data linkage efforts in recent months. The MCH Data Team has assessed data and information needs for MCH programs and created an action plan to address these needs.

Program development for CSHCN, based on identified priorities, has become easier with the availability of data from the National Survey of CSHCN 2001. Additionally, stakeholder input from the needs assessment and the associated data have been crucial to the capacity evaluation process. Title V's ability to develop interdependent collaborative relationships with stakeholders who share concerns for CSHCN has improved in the past few years and the result is a heightened interest, statewide, in determining and strengthening the infrastructure for community-based, family-centered, care coordination, as an overarching priority. New State Performance Measures #8, 9, and 10 are one outcome of this heightened stakeholder interest.

Population-based needs for care coordination remains a consistent theme across all MCH pyramid levels for CSHCN. The needs assessment data evidences what we already know: that families need, value, and request assistance with care coordination for their children. Additionally, needs assessment results for CSHCN indicate that further evaluation is warranted for the specific issues of mental/behavioral health, respite and child care workforce development, and care coordination for CSHCN who receive Medicaid and SSI benefits.

Title V continues to recognize the importance of identifying broadly focused priority needs. The needs of each MCH population have been evaluated, including CSHCN, and the critical areas of mental health, oral health, injury prevention, and childhood obesity are acknowledged. Concerns about maintaining current service levels and improving Title V capacity were integrated. A priority

addressing the foundation of MCH practice will further Title V's focus on infrastructure and population-based services, while a priority addressing the preservation of effective public health programming will remind us of our core mission and the vulnerable populations we serve. Priorities are systems-focused and likely to respond to evidence-based interventions. Directing limited MCH resources to these areas is critical to maintain the health of New Hampshire's families.

/2009/

NH's Title V programs continue to be guided by the needs and priorities suggested in the 2005 Needs Assessment; activities impact both national and state performance measures, spanning all levels of the MCH pyramid. Public input continues to demand that state agencies remain focused on core priorities such as maintaining affordable access to health care for all families, increasing access to mental health and oral health care services and ensuring high quality services for all populations including CYSHCN. Other examples include:

Direct Care Services: Maintaining support for safety net providers and clinics for CYSHCN

Enabling Services: Development of new models of integrated care.

Population-based Activities: Engaging new partners in SIDS education.

Infrastructure: Early childhood systems building. //2009//

B. State Priorities

RELATIONSHIP OF STATE PRIORITY NEEDS & PERFORMANCE MEASURES

New Hampshire priority needs, as described in Section II, are as follows:

1. To improve the Title V program's ability to impact the health of MCH populations through data collection and analysis, identifying disparities, examining barriers to care, and researching and implementing best practice models (All NPM & SPM)
2. To assure safe and healthy pregnancies for all women, especially vulnerable populations (NPM #8, 15, 17, 18 & SPM #2)
3. To assure safe and healthy environments for MCH populations, including those with special health care needs (NPM #13, 14 & SPM #3)
4. To decrease dental disease in MCH populations (NPM #9 & SPM #4)
5. To decrease unintentional injuries among children and adolescents, including those with special health care needs (NPM #10 & SPM #5)
6. To promote healthy behaviors and access to health care services for adolescents, including those with special health care needs (NPM #2-6, 8, 13, 14, 16 & SPM #6)
7. To preserve effective public health programming, including an infrastructure of safety net providers, to address the needs of MCH populations (All NPM & SPM)
8. To improve access to mental health supports and services for children and youth, including those with special health care needs. (NPM #2, 3, and 5; SPM #8)
9. To decrease the prevalence of childhood overweight and obesity. (SPM #9)
10. To increase the trained workforce available to provide respite and child care for medically and behaviorally complex children with special health care needs. (NPM #2, 5; SPM #10)

ACTIVITIES RELATING TO PRIORITY NEEDS

MCH and SMS strive to provide a state Title V program addressing all state priority needs. Many priorities related to performance measures; those discussions are included in Sections IVC and D. Some activities clearly relate to priority needs, but are not integral to the performance measurement system and are included here.

//2009/Highlights from the current year are included to serve as sample updates. //2009//

PRIORITY #1

SSDI GRANT: MCH will improve data capacity through linkages, such as linking EHDl data with birth certificate data to assure that all infants are screened. Data linkages were on hold this past year pending an MOU between DHHS and the Secretary of State regarding public health access to vital records data. MCH issued an RFP to create a web-based module for prenatal program data, to be implemented this year. The MOU is now completed and MCH's IT liaison is proceeding with data linkage activities.

/2007/

MCH recently submitted its SSDI grant application, outlining a 5-year plan for increasing MCH data capacity. In FY06, project staff further developed the concept of a data linkage model, centered on the establishment of an MCH Data Mart, which will house all of the linked databases and facilitate analysis by project staff. Significant accomplishments include the final development of EHDl data linkage; Phase I of newborn screening data linkage; and the initiation of a web-based prenatal data collection tool that for MCH funded agencies that will be linked with vital records.

The goal over the next 5 years is for all MCH-related data and NH Birth Defects Surveillance, WIC and Medicaid data to reside in the MCH Data Mart, where it will be available to public health analysts and policy makers with pre-established linkages.

//2007//

MCH HEALTH POLICY CAPACITY: MCH has formed a Data Team, consisting of the MCH epidemiologist, SSDI Coordinator, QA Nurse, Program Evaluation Specialist and MCH Director, to improve MCH evaluative capacity. This past year, work focused on the needs assessment and improving data collection from local programs. In the coming year priorities will be implementing the Data Action Plan from CAST-5 and creating a systematic approach to data through business planning.

/2007/ The MCH Data Team continues to meet. Through this group goals and objectives were developed for SSDI activities as well as other cross cutting data work. The group works closely with a Data Users workgroup facilitated by the DPHS Health Statistics Section. *//2007//*

/2008/

Title V continues to grow its capacity to gather and analyze data. This priority is linked to all performance measures in as much as our ability to understand and effect change is linked to our ability to gather correct information. The MCH Epidemiologist has been working closely with other state data users on the Vital Records Advisory Board to increase the quality of that data. *//2008//*

HOME VISITING NEW HAMPSHIRE (HVNH) BEST PRACTICES: The HVNH Best Practices project sought to identify best practices in home visiting by quantifying the costs of providing services, incorporating staff and client satisfaction and clinical outcomes. The project, completed in 2005, provided information on six HVNH agencies, showing that participants and staff are very satisfied with HVNH services. Clinical outcomes and costs varied widely. Adjusted cost for a care episode ranged from \$3,170 to \$10,710; cost reduction opportunities varied from 4 to 35%. Significant cost drivers included the % of non-direct clinical time; time spent on visits and associated functions; and the staff mix of home visitors and nurses. HealthMETRICS, the project contractor, developed 22 detailed recommendations for participating agencies; some recommendations are transferable to other HVNH programs. The project's Executive Summary is included as an attachment to this Section. ***//2009/ No longer attached, but available for review.//2009//***

SIDS NATIONAL DATA BASE: The NH SIDS Program will be participating in the data collection of the national "SIDS in Child Care Setting" study through the Children's National Medical Center in 2005.

PRIORITY #2

BIRTH OUTCOMES WORKGROUP: MCH will address disparities between Medicaid and non-Medicaid populations in IMR, LBW, and prenatal care and explore other areas where intervention may improve prenatal outcomes. A plan will be developed to address these issues based on best practices. Meetings have been held with Medicaid, WIC and NH Tobacco Prevention and Control to discuss a collaborative effort to address poor prenatal outcomes. MCH requested TA from Boston University's Dr. Milton Kotelchuck in planning this initiative.

/2007/

Title V convened the Birth Outcomes Workgroup (BOW) with technical assistance from Dr. Milton Kotelchuck. Title V staff and members of the BOW also participated in the Region I event, "The Impact of Inequality on Birth Outcomes: From Analysis to Action". Central to this work is the need to collect more specific data on disparities in birth outcomes in racial/ethnic minority groups, and disparities based upon age, insurance status and geographic region. Although a PRAMS application was not funded by the CDC, Title V is seeking other options to obtain the type of data available from such a survey. The BOW and Prenatal program of MCH is also committed to web-based prenatal data collection tool for MCH funded agencies that will be linked with vital records. This will provide much needed information about the specific outcomes of women enrolled in MCH-funded prenatal care.

//2007//

/2008/

MCH has continued work with both Region I and the March of Dimes. Most importantly, the Perinatal Client Data Forms, web based data collection tool for MCH-funded prenatal providers has been completed and will begin collecting data in July 2007. This tool will be instrumental as we look to interpret state measures such as the percent of women statewide who smoked during pregnancy as well as data linkages.

//2008//

PRIORITY #3

HVNH: HVNH provides health, education, support and linkages to other community services to Medicaid-eligible pregnant women and their families in their homes. Begun as an MCHB CISS grant in 1996, the program is now in 18 areas of the state. HVNH teams, including a nurse and parent educator, use the nationally recognized Parents as Teachers curriculum and a resource developed in New Hampshire, HVNH Prenatal and Infant Cue Sheets, to guide visit content. The focus areas are prenatal smoking cessation, family planning, and maternal depression. The project is funded through TANF and Title V funds, and Medicaid reimbursable home visits as discussed in Section III E. Plans for 2005 include a planning grant for an urban area of the state previously unable to support an HVNH program.

HEALTHY CHILD CARE NEW HAMPSHIRE (HCCNH): MCH administers HCCNH, entwining its goals of health and safety in child care settings with those of the ECCS initiative. MCH works with the state's Child Development Bureau (CDB) to provide trainings to child care providers with curriculum developed by this project. With blended funding from SMS, CLPPP, and the NH Immunization program, MCH plans a CCHC pilot for 2005 to support the role in local communities by funding CCHCs housed in regional Child Care Resource and Referral centers. This will ensure that such topics as caring for CSHCN, lead poisoning prevention, and accurate immunization documentation will be of highest priority.

EARLY CHILDHOOD COMPREHENSIVE SYSTEMS (ECCS): This MCHB-funded planning

process will continue through the upcoming year with implementation of a comprehensive plan beginning in July 2006. HCCNH objectives are complexly integrated within this project. SMS (Bumbalo) collaborates with MCH colleagues on grant activities related to integrating Medical Home and Infant Mental Health programs.

/2007/ An implementation plan for NH ECCS was submitted in June 2006. In it, plans are detailed for continued support of programs such as HVNH and HCCNH, as well as initiatives such as the Family Resource Connection at the NH State Library and Regional Infant Mental Health Teams. The plan supports efforts of HCCNH to contract with a community based agency in the southeastern part of the state to provide child care health consultation to child care providers. This contract was financed by using ECCS funds and funds from the NH Immunization Program and Childhood Lead Poisoning Program. This initiative is also the basis for NH to adopt a New England Region-wide State Performance Measure regarding child care health consultation.
//2007//

SAFE SLEEPING EDUCATIONAL EFFORTS: The MCH Child Health Nurse Consultant/SIDS Program Coordinator includes SIDS risk reduction and safe sleeping information in all presentations, as a result of the increasing infant deaths in NH involving bed sharing. In follow up to a 2004 Child Fatality Review Committee recommendation, a handout on educating parents about the dangers of bed sharing has been developed for the Fall 2005 Child Health Month Coalition packet mailing.

REFUGEE LEAD STUDY: In 2004, a cluster of refugee children with elevated blood lead levels was identified in Manchester, NH. A descriptive case series investigation of this cluster concluded that lead poisoning occurred after resettlement in NH and that follow up lead screens for refugees is useful, especially where malnutrition is a complicating factor. A cohort study is now underway to examine potential risk factors among refugee and non-refugee children living in comparable housing in Manchester. A questionnaire has been administered to the refugee families in the cohort in addition to estimated risk appraisals of the housing. The final results will be made available locally and nationally and a manuscript will be written and submitted to a peer-reviewed journal.

/2009/In partnership with the National Center for Healthy Housing, MCH has begun the planning process for a integrated Healthy Housing Program in New Hampshire. This is the first statewide effort to develop a multi-disciplinary plan that includes lead, asthma and other housing related issues.//2009//

PRIORITY #4

ORAL HEALTH & HOME VISITING: In light of evidence that pregnant women with dental disease are at higher risk for premature and low birth weight infants, an oral health module for HVNH was developed. Oral Health funds supported HVNH activities to promote collaboration between the dental community and HVNH programs in the 18 sites. HVNH programs were successful in developing educational strategies and leveraging resources to provide pregnant women and infant's access to care. An oral health curriculum for grades K - 3 was implemented in all schools.

/2007/

The oral health component of HVNH continues with positive feedback from participants. The Oral Health Program has also worked with Area Health Education Centers and the NH Minority Health Coalition to promote a reference library of NH "branded" materials and provide trainings for prenatal and pediatric medical and dental providers that educates them about the transmission of oral disease between mothers and infants and the importance of good oral health for their high-risk patients.

//2007//

MANCHESTER ORAL HEALTH INITIATIVE: This year, MCH will provide additional financial support to the state's largest school dental program in an urban center experiencing a dramatic increase among immigrant and refugee students at risk for dental disease.

PRIORITY #5

INJURY PREVENTION PROGRAM (IPP): The IPP addresses injury more broadly than the performance measurement system. For example, the IPP leads a 50 member advisory group to address injury prevention needs statewide. The program manager is active in the national State and Territorial Injury Prevention Directors Association (STIPDA), the national advisory committee of the Children's Safety Network, and participates on a STIPDA assessment team. Intentional injury is addressed by funding 13 local domestic violence agencies for prevention, largely in school settings; developing a state plan to address violence against women; and participating in the NH Firearms Safety Coalition. Unintentional injury priorities include chairing the NH Falls Risk Reduction Task Force and participating in the NH SafeKids Coalition advisory committee.

/2007/ The IPP continues its work in all the areas highlighted above and is preparing for final publication of a NH State Plan for Injury Prevention. MCH is also planning for a re-organization of programs within the section to better align IPP with adolescent health. //2007//

PRIORITY #6

ADOLESCENT HEALTH STRATEGIC PLAN: MCH released its statewide Adolescent Health Strategic Plan in 2004 and will disseminate findings and continue working with community partners this year. One focus area will be teen access to preventive health care. MCH will develop a youth development focused performance measure for its contract agencies and implement the new measure in 2006.

COMMUNITY YOUTH MAPPING (CYM) PROJECT: MCH funded a first training on CYM for those interested in community-level youth development. The CYM collects data on assets useful to youth; the main focus is to build a positive information infrastructure. CYM creates a complete picture and map on available services and support for youth and families and allows easy access to the information. MCH will continue to work with UNH Cooperative Extension to support implementation of this project in local communities.

/2007/

MCH has helped fund day-long trainings for CYM. This project has led to increased interest within the Adolescent Health Program in the broader social and health needs of refugee and immigrant adolescents.

//2007//

/2009/

BEHAVIORAL HEALTH SCREENING: A medical resident at one of the MCH-funded CHCs administered a survey, Adolescent Depression Screening: Current Knowledge, Attitudes and Practices among NH Community Health Centers on behalf of MCH to determine barriers to behavioral health screening. The survey found that most CHCs are supportive of the concept of screening but have not found ways to universally implement best practices. MCH will work with CHCs to develop strategies to overcome identified barriers to screening including: time limitations; identifying the best screening methods; inefficiencies within the EMR and lack of counseling and treatment options.//2009//

PRIORITY #7

PERFORMANCE MANAGEMENT (PM) INITIATIVE: As discussed in IIIA, MCH continues to move toward a comprehensive PM system. Contract agency performance measures were refined this year and new site visit tools implemented, including self-assessment tools for contract

agencies. MCH staff continue to provide training on performance measurement as part of a DPHS-wide initiative. The MCH Administrator, along with the DPHS Bureau of Policy and Performance Management Chief, will chair the DPHS Performance Improvement Committee.

/2007/

This initiative has grown to into the Public Health Improvement Team (PHIT) and is co-chaired by the DPHS Bureau of Community Health Services Chief. Title V has participated by utilizing a Plan-Do-Study-Act (PDSA) model to document tests of change in individual programs. This emphasis on performance management enabled the HRSA Strategic Partnership Review to move smoothly as multiple HRSA-funded programs decided upon a mutual performance measure that seeks to improve the integration of behavioral health into primary care. (This also relates to Priority #8)

//2007//

FUNDERS' COLLABORATIVE: The ECCS Coordinator worked with the United Way of the Greater Seacoast (UWGS) to explore common goals in building community-based agencies' capacity to better understand, document, and disseminate outcomes of the community programs they fund. Both public and private funders have received similar messages from community-based partner agencies; multiple funding sources are asking agencies to develop data collection and evaluation plans, but these requests are not aligned. Surveys of both funded agencies and public and private funders were conducted. Results were then brought to grant makers through a meeting in March 2005. Eighteen individuals, representing the NH DHHS, NH DOE, numerous charitable foundations, United Ways, the NH Children's Trust Fund and the NH Women's Fund, attended. Discussions centered on how funders could align funding streams to maximize community impact and how systems could be improved. Although many stakeholders are involved in other ECCS efforts, this meeting was a unique opportunity to focus on funding. Funders will continue to convene quarterly.

PRIORITIES #8-10:

These priorities were related to new State Performance Measure in 2005.

/2008/

PRIORITY #9:

SMS piloted a program intended to encourage Healthy, Independent Participation in Fitness (HIPFit) for children and youth with mobility issues. The program helps children/adolescents, who have mobility issues, to get more comfortable with being active and making healthy food choices. The program includes data collection in order to measure each child's level of fitness. A physical therapist shows the kids (and their parents) how to safely use everyday activities and gym equipment, and what changes need to be made individually. Overall the focus will be on encouraging safe activities best suited to each child. A nutritionist guides kids and families on how to add healthy and simple-to-prepare foods to meal and snacktimes. The focus is on helping kids to eat healthier and be more active every day.

//2008//

/2009/ The MCH Child Health Consultant was a member of a panel that produced "Recommendations from the New Hampshire Childhood Obesity Expert Panel: Preventing Childhood Obesity-Promoting Physical Activity and Healthy Eating". She also participated as an adviser to an American Academy of Pediatrics/MCHB-funded Healthy Tomorrows grant, "Get In Shape", a pediatric obesity program at Weeks Medical Center in the northern-most county of NH.

SMS has a representative (Butler) on the New Hampshire Healthy Schools Coalition-Action for healthy kids, a national organization working on childhood obesity. She is helping to represent the needs of CSHCN and concomitant or related weight issues. //2009//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	85	85	90	95	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	13	11	16	14	23
Denominator	13	11	16	14	23
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100

Notes - 2005

The objectives are reduced for 2006 and 2007, as new conditions have been added to the newborn screening panel, and state systems and health providers may not have refined follow-up procedures on all of the new conditions.

a. Last Year's Accomplishments

Newborn screening is a preventive, public health program that screens newborns to identify medical disorders for which early detection, diagnosis, and treatment can prevent death and disability. Greater than 99% of the 14,000 infants born annually in New Hampshire are screened. More than just a laboratory procedure, newborn screening is a complex integrated system that involves screening, follow-up, diagnosis, treatment and management, and evaluation. Education for parents and health care professionals is integrated throughout each component of the program. The following highlight accomplishments of the past year:

DAILY TASKS:

Managed the essential daily tasks of the program, which remained the first priority. This included providing technical assistance to birth hospitals, daily reporting out of results back to birth hospitals and tracking and follow-up of infants needing repeat screenings. (PB)

Trained co-worker as back up for program coverage. (IB)

Drafted the program's Internal Operations Manual. (IB)

Prepared and reviewed the Request for Proposals (RFP) to provide laboratory services for newborn screening for the entire state of New Hampshire to re-bid that service. A new contract is in place with the University of Massachusetts, effective July 1, 2007 through June 30, 2009 (IB)

SYSTEMS BUILDING:

Supported the work of the Newborn Screening Advisory Committee, including implementation of the recommendation to expand the state-screening panel by adding 19 conditions. (Target date July 1, 2007) (IB, PB)

Assisted with revision of Administrative Rules for the program to reflect additional expansion. Changes included expansion of state screening panel to 32 conditions and increase in fee to \$50. (Approved JLCAR 4-25-07) (IB)

Conducted broad state- wide notification regarding expansion of state screening panel. This included development of a poster advertising this expansion, letters of notification to all hospitals, midwives and physician providers (Pediatricians, Family Practice Physicians and Obstetricians), Press Release and articles in professional newsletters. (PB)

Conducted site visits to select birth hospitals regarding recent changes to the Newborn Screening Program and released a Quality Assurance (QA) Tool to birth hospitals regarding process of newborn screening in their individual institutions. (Initial release February 2007) (IB)

Secured and utilized the services of the Medical Consultant for the program via Service Delivery Agreement, approved December 2006. (IB)

Expanded educational efforts through mailing of newborn screening brochures to both birth hospitals and to obstetrician's offices. (IB)

Drafted Annual Report on status of State Newborn Screening Program for Legislative Oversight Committee as required by Administrative Rules. (IB)

Supported the work of the Data Linkage Project, (Initiated September 21, 2006) (IB)

REGIONAL AND NATIONAL EFFORTS:

Participated on CLSI workgroup convened to revise the standard "Blood Collection on Filter Paper for Newborn Screening Programs". This involved one face to face meeting and a number of conference calls. (IB)

Participated in regional genetics and newborn screening activities including NERGG, New England Metabolic Consortium Annual Meeting and New England Regional grant opportunity (Initial grant award). (IB)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to manage the daily process of reporting out and follow-up.			X	
2. Continue to support the ongoing work of the Newborn Screening Advisory Committee.				X
3. Report back to New Hampshire birth hospitals via the QA Report every six months with statistics on various aspects of the newborn screening process specific to their facility.				X
4. Complete the Internal Operations Manual to guide day-to-day program operations.				X
5. Perform the Data Linkage Process daily and monitor findings (refusals and misses) of this process.				X
6. Participate in regional efforts including NERGG, New England Metabolic Consortium, New England Regional Collaborative (NERC) grant effort and Long Term Follow-up Workgroup activities.				X
7. Utilize the services of the Medical Consultant via the Service Delivery Agreement and evaluate the benefits and need for this				X

continued arrangement.				
8. Support educational efforts regarding newborn screening through periodic presentations and the dissemination of newborn screening brochures.				X
9. Continue collaboration with genetics counselor regarding a system for managing recommendations for care for infants with hemoglobinopathy findings.				X
10. Renew contract with screening laboratory which will be up June 30, 2009.				X

b. Current Activities

Managing the essential daily tasks of the program remains the first priority, including: daily reporting out of results back to birth hospitals; daily data linkage with vital records; providing technical assistance to birth hospitals and providers; and tracking and follow-up of infants needing repeat screenings. PB

The NSP is drafting an Internal Operations manual and guide for data linkage. (IB)

Implemented contract with the screening laboratory July 2007 to include monitoring of two performance measures. (IB)

Utilize and evaluate the services of the Medical Consultant via the Service Delivery Agreement. (IB)

Continue to support the Newborn Screening Advisory Committee. (IB)

Work with genetics counselors to develop system in state to manage follow-up of hemoglobinopathy results. (IB)

Provide feedback to the birth hospitals regarding the process of newborn screening in their institution via the QA Tool every six months. (IB)

Support educational efforts regarding newborn screening by disseminating brochures to hospitals and providers. (IB)

Purchased and distributed CLSI Standard LA4 A5 "Blood Collection on Filter Paper for Newborn Screening Programs" for all New Hampshire birth hospitals and midwives. (IB)

Participate in regional activities representing NH. (IB)

Presented APHL/CLSI teleconference on the newly revised standard "Blood Collection on Filter Paper", March 2008 and presented a "Newborn Screening Update" at Annual Meeting of New Hampshire Medical Assistants, April 2008. (E)

c. Plan for the Coming Year

DAILY TASKS:

Continue to manage the essential daily tasks of the program, including: daily reporting out of results back to birth hospitals; daily data linkage with vital records; providing technical assistance to birth hospitals and providers; and tracking and follow-up of infants who missed screening or need repeat screenings. (PB)

Monitor numbers of both refusals and misses in order to target educational efforts. (IB)

Upgrade a Secretary II position to a Program Assistant position to re-direct some of the routine

daily tasks, allowing the coordinator to focus on special projects and enhancements. (IB)

Complete the program Internal Operations Manual. (IB)

Respond to requests for educational presentations on the current status of newborn screening in New Hampshire and provide educational brochures to New Hampshire birth hospitals on newborn screening. (PB) (E)

SYSTEMS BUILDING:

Continue to support the work of the Newborn Screening Advisory Committee, which is required by Administrative Rules to meet at least annually. (IB)

Issue QA Report to New Hampshire birth hospitals every six months with statistics on their performance regarding newborn screening and make site visits to as indicated. (IB)

In accordance with the new Memorandum of Understanding between the Title V Special Medical Services Program and MCH, the NSP will develop a plan for further integration of activities between the Title V programs in relation to the needs of newborns and their families. (IB)

Utilize the services of the Medical Consultant via the Service Delivery agreement and assess the benefits of this service for state medical providers. This agreement requires yearly evaluation and renewal. (IB)

Evaluate and assess the process of reporting out of the newborn screening results to assure that the reports are reaching the physicians in need of them. (IB)

Continue to collaborate with the Cystic Fibrosis workgroup regarding newborn screening for CF. Update and revise current Fact Sheets. (IB)

Continue to collaborate with state genetics counselor(s) regarding a system of follow-up for infants with hemoglobinopathy findings. (IB)

Integrate the new oversight operations associated with the New Hampshire Birth Conditions Program with the Newborn Screening Program, as appropriate.

REGIONAL AND NATIONAL EFFORTS:

Participate in regional activities including NERGG, New England Metabolic Consortium Annual Meeting and New England Regional Collaborative (NERC) grant opportunity including the Long Term Follow-up Workgroup effort. (IB)

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	54.9	54.9	54.9	55.9	55.9
Annual Indicator	54.9	54.9	54.9	54.9	60
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is					

fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	61	61	61	61	65

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

Through contract arrangements, SMS continues to support NH Family Voices (\$137,348) and Upper Valley Parent-to-Parent (\$16,662). Special Medical Services has had Family Leaders in paid consultant positions for over 15 years and this is ongoing. In addition, parents continue to participate in the MCH block grant review process with federal partners.

SMS focuses on providing support to medical home sites in their endeavors to increase parent participation and family-centered care. Staff (Hoerbinger), works with practice teams in Hillsborough, Concord, Exeter and Dover. She has completed brochures and wall posters that detail what patients and families can expect from medical home staff and is now working on an easy to use pocket guide for community resources. The cost for design and printing of these materials is covered by SMS. Parent partners are active participants in these initiatives and are clearly identified on all materials.

Through activities associated with NPM#6 and the Integrated Care for NH CSHCN grant, particular efforts are being made to recognize youth as experts in their own care by expanding on the development of the Health Care Transition Coalition. Four parents and three youth are participating on this advisory group this year. Plans are to increase the number of participating families and to continue a separate youth initiative. It is expected that these activities will have a direct influence on increasing family participation in decision-making.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to contract with NH Family Voices		X	X	X
2. Continue contract with Parent to Parent		X	X	X
3. Collaborate with parent partners working on State Implementation Grants (administered through the Hood Center)			X	X
4. Require annual parent satisfaction surveys from all clinical programs				X
5. Recruit and involve parents and YSHCN on all planning and groups				X
6. Recruit members of diverse cultures for all decision-making activities				X
7.				
8.				

9.				
10.				

b. Current Activities

SMS continued contract arrangements to support NH Family Voices (\$162,842) and Upper Valley Parent to Parent (\$16,662). This represented the 16th year that Family Leaders will be in paid consultant positions to SMS. Parents will continue to participate in the MCH block grant preparation and the review process with federal partners. All SMS supported programs (contract and state supported) were required to conduct and submit parent satisfaction surveys focusing on quality of care indicators. SMS continued to focus on providing support to Beyond the Medical Home Improvement in their endeavors to increase parent participation and family-centered care. Staff (Hoerbinger), continued to work with practices in Hillsborough, Dover, Exeter and Concord. Parent partners are active participants in these initiatives and are clearly identified on all materials. Through activities associated with NPM #6 and the Integrated Care for NH CSHCN grant, particular efforts will be made to continue to recognize youth as experts in their own care by expanding on development of the Health Care Transition Coalition. The Coalition partially separated the youth from the advisory and parent group and then used this groundwork to start a separate Youth Advisory Board in NH. With significant support from NH Family Voices this has been successful. There a part-time paid facilitator and 6-9 active youth participants.

c. Plan for the Coming Year

Special Medical Services remains committed to supporting Family partnership and involvement. For the 17th year SMS will have a contractual arrangement with NH Family Voices (increased to \$167,467). There is a goal to continue the process, started in the current year, of improved communication and cooperation with statewide efforts. NH Family Voices (NHFV) will continue to be invited to have a role in the Title V Block Grant Needs Assessment planning meetings and Block Grant reporting. SMS has invited NHFV to participate in the rewriting of it's rules and this is expected to be successfully completed in SFY 2009. SMS also has a working relationship with the parent partners participating in two separate State Implementation Grants (administered by the Hood Center). This will continue in the coming year and will be critical to sustainability planning as the SIG funding ends and SMS is responsible to maintain and spread these efforts.

In addition the contractual relationship with Parent-to-Parent in NH with continue (\$16,656). It is especially important that SMS activities in the next fiscal year continue to focus on recruiting families from diverse cultures to participate in the decision making process that impacts the system of care for CSHCN. Although the percentage of European American / White children in New Hampshire continues to be over 93%, but the city of Manchester is now home to an increasing number of families who are recent immigrants from African countries. Historically, it has been difficult to recruit families from diverse ethnic and socioeconomic groups to participate in educational and advisory activities; however, a major goal of the Integrated Care for NH CSHCN grant is to develop a collaborative infrastructure to support and sustain a culturally competent system of providing care coordination within medical homes. SMS has previously had a Spanish language application for services and in the coming year the plan is to augment the number of materials available in Spanish. In addition, in SFY 2009 all agency contracts with SMS have a funded line item for cultural and linguistic supports in order to make services more accessible and responsive to families.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	55.9	55.9	55.9	56.9	56.9

Annual Indicator	55.5	55.5	55.5	55.5	49.6
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	50	50	50	50	54

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

The contract "Every NH Child Deserves a Medical Home" awarded to CMHI (Center for Medical Home Improvement) continued. This ensured continued State of NH funding for further development and support of the Medical Home Model. The following activities occurred: focusing on statewide Medical Home planning; developing a Medical Home network; creating policy regarding Medical Home development; and providing technical assistance to medical practices working to develop medical homes.

SMS Coordinator Staff (Hoerbinger) facilitated twice monthly meetings for three (3) medical practices (two pediatric and one primary care), created agendas, ensured follow through, and provided experienced consultation to these Medical Home teams. In addition, she acted as a resource for practice based care coordinators, providing case consultation and modeling care coordination activities for complex children and families.

SMS Coordinator Staff (Hoerbinger) collaborated with staff from the Center for Medical Home Improvement to formalize "spread" of Medical Home Model throughout NH. This included but is not limited to meeting formally six (6) times annually, communicating via telephone or e-mail on an as needed basis, working together on Medical Home related documents, forms, and presentations. Contact was typically weekly or more often.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. SMS coordinator acts as liaison to the Center for Medical Home Improvement.				X

2. SMS coordinator facilitates Medical Home Practice meetings for medical teams and acts as a resource to practice-based coordinators (providing support and technical assistance).		X	X	
3. Participates in Medical Home Learning Collaboratives and Learning Sessions.			X	X
4. Planning and development of a state contracted program that will offer financial sustainability to Medical Homes in NH.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activities funded by SMS through the contract "Every NH Child Deserves a Medical Home" continue as described above. The focus is the creation of a Medical Home network / database. Awareness building among health care providers as well as the public is a priority.

SMS Coordinator Staff (Hoerbinger) maintains her schedule of meeting facilitation for active Medical Home practices. She continues in her role of consultant to Medical Home Improvement Team members, particularly practice based care coordinators. She has organized, with NH Family Voices and the Parent Information Center, evening in-services (series of 3) addressing CSHCNs' topics including "Paying the Bills", "Special Education" and "Maneuvering the Maze of Services". This is to meet an expressed need expressed by providers, ancillary health care staff and families of CSHCNs.

SMS collaborates on an ongoing basis with CMHI staff in order to help make the Medical Home concept a reality for NH CSHCNs and their families. Particular attention is paid to assisting teams plan for the continuation of their improvement activities after their CMHI facilitated federal grant ends on 7/1/08.

SMS Coordinator staff (Hoerbinger) continues to attend CMHI organized NH Council on the Future of the Primary Care Medical Home meetings. This Advisory and other efforts have been supported with a contractual arrangement between SMS and the CMHI (\$75,206).

c. Plan for the Coming Year

The CMHI facilitated "Beyond the Medical Home" federal grant ends on June 30, 2008. SMS' "in-kind" assistance of Coordinator staff (Hoerbinger) will end at that point. She will, however, remain available to offer care coordination support and modeling to the Medical Home practice based coordinators on an "as requested" basis. During the past 3.5 years, relationships have been established between the Medical Home practice teams and the SMS coordinator. They routinely telephone or e-mail looking for guidance and resources. It is anticipated that this will continue. One pediatric practice in particular has asked that any patient referrals they make to SMS be referred to SMS coordinator (Hoerbinger) for continuity of this relationship and to enhance utilization of community resources.

SMS also will query medical practices involved with previous CMHI / Medical Home grants to determine if they are still practicing the medical home philosophy, what SMS may be able to assist them with in order to do so and, how SMS can best serve them in their management of CSHCNs.

In the course of updating our SMS website, we plan to include information about "Medical Home

in New Hampshire", links to AAP, CMHI and others. SMS will also more widely publicize our availability to help practices either create in-office Care Coordination positions and, or assist them technically to make Medical Home a reality in their provision of care.

SMS will continue its contractual relationship with the CMHI to support the evolution of Medical Home in New Hampshire Primary Care, particularly for CSHCN. This contract will increase in the coming year to \$89,957. The focus continues to be on influencing macrosystem change (increasing political and public understanding and will) but continued support to practices will be factored in as will continued efforts at reimbursement for care plan oversight from private health insurance. SMS has been asked to be a member of the Medical Home workgroup of the NE Regional Consortium on Genetics and Newborn Screening. Also there is a meeting scheduled in summer 2008 to discuss with the State Council for Children and Adolescents with Chronic Health Conditions the possibility of creating a workgroup to consider recommending the definition of Medical Home in state statute.

Finally, NH Medicaid has been chosen to be involved in the Federal Medical Home Summit and efforts will be made to link SMS' efforts with those supported by Medicaid.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	61.9	61.9	61.9	62.9	62.9
Annual Indicator	61.9	61.9	61.9	61.9	67.3
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	68	68	68	68	70

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

Last year SMS received over 600 SSI transmittals this year and staff (Butler) followed-up on 97 transmittals, of those children without Medicaid coverage, with phone calls/letters to ascertain needs or eligibility for SMS.

The Survey of Families of Children receiving SSI (see attachment), was completed (2006) and analyzed (2007). A major component of the assessment was to determine the adequacy of current health coverage for these families. Significant out of pocket costs were identified by families despite Medicaid or private health insurance coverage. The inadequacy of insurance of CYSHCN in New Hampshire has become increasingly evident. In addition, the status of health coverage for YSHCN is often problematic.

State legislation was passed in March 07 that will allow for insurance coverage for children's early intervention therapy services. The effort to make parental insurance available to all dependents ages 19 to 25 years of age was successful but it is not required for self insured companies, such as the State of NH. This coverage also applies to those enrolled in college. SMS staff (Collins) sought consultation from the Catalyst Center, and there are plans to obtain data from a more representative sample, regarding adequacy and health insurance coverage. The project has been initiated in collaboration with the NH Council of Children and Adolescents with Chronic Health Conditions whose mandate is to advise the legislature regarding policy/program development and to increase awareness of the unique needs of CSHCN and their families.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Follow-up of SSI referral transmittals has been reviewed and changes have begun in outreach and information and referral.	X	X		
2. Web-based library of materials for and about CSHCN was expanded		X	X	
3. Exploration of strategies for insurance re-imburement for nutrition services continue			X	X
4. Revision of SMS policy/procedure and data collection methods continue		X		X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A new Data Specialist (Bernard) is assisting with the next five-year needs assessment. She is the primary contact for the SMS Data Integrity Enhancement Initiative for data clean up and system enhancements to streamline the SMS database, to insure more efficient analysis and reporting in the future.

SMS received more than 344 transmittals from SSI for potential outreach. Of these, 50 are already served by our agency and outreach was provided to the 68 families who had no Medicaid. The HC-CSD Coordinator (Allen) started in January 2008 and is working with Medicaid (Disability Determination and Prior Authorization departments) and Family Voices to provide intake services, care coordination and service utilization for children newly accepted for HC-CSD Medicaid.

Significant mental health needs of the population of children on SSI and SMS continue and Child Health Services (a contractor) collaborated with the Community Mental Health Center to co-locate a mental health professional in order to integrate services. In addition SMS has provided funding for the cost of mental health visits for uninsured homeless/impoverished teens (18-21 years old) identified by the Teen Health Center in Manchester.

Statewide nutrition and feeding & swallowing services for CYSHCN are contractual and have begun to initiate third party re-imburement.

c. Plan for the Coming Year

SMS will continue to participate in statewide and programmatic planning to improve the percentage of children with adequate insurance. These efforts will not only be related to those CSHCN who are 0-18 years old but will also include the needs of young adults 18-21 year old.

SMS sponsored/contracted services (i.e.: clinics, nutrition, feeding & swallowing) will continue to explore and expand third party reimbursement. This will allow for increased capacity to serve those children without insurance. Care coordinators will continue to familiarize themselves with options for insurance and other financial resources (local, state, regional and national) for families to access. Care planning will illustrate planning for supporting families in efforts to attain and maintain consistent insurance and financial resources for health related costs.

Despite the fact that the State of NH is focusing on limiting costs and cutting budgets SMS anticipates being able to continue to support the costs of some health related needs for children and youth who meet financial eligibility criteria (>185% of FPL). In the coming SFY SMS has \$173,000 budgeted to support these needs (ex: DME, medications, specialty services/providers and transportation). SMS' new alignment with the Bureau of Developmental Services allows us to more collaboratively work with other programs that offer support to families (Area Agencies, Early Intervention and Partners in Health). This effort will continue to improve the process of family centered services that lead the discussion about which agency is the lead and ideal source of support as well as when it is appropriate to collaborate and "braid" funding to meet the needs of CSHCN. In addition, SMS will continue to maintain its Equipment Bank, which allows children to access DME that has been used but refurbished by a Certified Equipment Vendor.

Outreach to children and youth newly enrolled in SSI will be expanded. SMS will be piloting outreach to any child or youth with a medical diagnosis even if they have Medicaid. In addition the SSI activities will begin to send written information about local resources to those families with children with developmental and mental health/emotional/behavioral diagnoses. This effort had been piloted in our HC-CSD project and will continue with that population.

Finally, New Hampshire has a new legislatively mandated Autism Council and SMS has been asked to participate on this council. One of the major initiatives that this Council is charged with is the need to improve public and private insurance coverage for recommended services for those children and youth diagnosed with Autism Spectrum Disorder.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	78.4	78.4	78.4	79.4	79.4
Annual Indicator	78.4	78.4	78.4	78.4	85.8
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	86	86	86	86	89

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

All care coordination caseloads were reviewed, the levels of complexity were documented, using a standard scale, and an Intake Unit was established. SMS' comprehensive care coordination staff continued to be active in new initiatives within NH's systems of care, including participating in the state Council for Children and Adolescents with Chronic Health Conditions (CCACHC) (Butler) and the Asthma Prevention Program (Butler).

Staff attended education programs on cultural sensitivity (Cahill, Collins). Acceptance letters were available in Spanish and interpreter services are actively used.

SMS contracted for Nutrition, Feeding and Swallowing services for a pilot program for an interdisciplinary feeding assessment/intervention team. Another pilot program was the HIPFit program -- see SPM #9.

SMS provided the gap filling services of statewide Neuromotor Disabilities Clinics (seven sites) and Child Development Clinics (four sites).

SMS collaborated with the Hood Center at DHMC for the Integrated Care for NH CSHCN initiative. This project developed practice based care coordination models to 3 practices. SMS staff (Collins, Cahill) participated at the planning level project with two SMS contracted coordinators providing the outreach (Moore, Gassek).

In addition, SMS supported care coordination and mental health assessments for clients in the Manchester Teen Clinic who have mental health diagnoses.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Orientation for two new care coordinators for regional and statewide positions				X
2. Continuous improvement activities for care coordination		X		X
3. Nutrition, Feeding and Swallowing program focuses on reimbursement issues, alternative service models and develops program presentation.				X
4. Development of the outreach program, known as HC-CSD, for children with severe conditions in cooperation with Medicaid		X		X
5. SSI care coordination outreach is expanded		X		
6. Expanded outreach and information sessions including SMS program presentation "road show"			X	X
7.				
8.				
9.				
10.				

b. Current Activities

Work continues with the SIG and Medical Home models that assist primary care practices to develop capacity to meet care coordination needs of CSHCN. Our SMS coordinators are in positions to continue to offer care coordination resources when these grants end. Our SSI outreach is expanding to reach all CSHCN with medical conditions.

SMS outreach to the HC-CSD Medicaid population of children with severe medical disabilities began in January 2008. One hundred and five referrals were received in the three-month pilot with 50% being our target medical group. The other 50%, children with developmental and mental health diagnoses, receive personal mailings about relevant resources.

Reorganization of the SMS unit within the NH DHHS has occurred. We are now part of the Bureau of Developmental Services. This gives us an outstanding opportunity to work more directly with three child-focused programs operated out of this Bureau. They are the Early Supports and Services program (early intervention) and the family support coordinators for children with developmental disabilities (located in the ten DD agencies) and those with chronic illness. The latter program is called NH Partners in Health.

All agency contracts for FY 2009 include an outcome measure that cultural competence training will be provided for personnel.

The Nutrition, Feeding & Swallowing Program continues its services statewide. It has developed an educational power point that will be used statewide

c. Plan for the Coming Year

The SMS care coordination program that includes both the community based and the Neuromotor clinic coordinators will continue to address three goals. The first will be to improve communication with physicians and other agencies and is addressed through increased outreach using care coordination fact sheets and a power point presentation about SMS services. A second goal is to clarify how the various agencies serving CSHCN could provide non-duplicative services and how SMS care coordination model could best be utilized. This process was begun at a statewide forum held in the fall of 2007. An ongoing goal is to continually improve our quality with this year's focus on care planning and case presentations. Additionally SMS will focus on health care transition education for enrolled families and youth and work with their primary care providers to

assure that they have transition medical summaries and assistance with referral to adult providers.

SMS will examine coordinator caseloads based on complexity and review standards for follow up needed. Continued efforts will be made at increased regional and statewide information and education sessions to improve interagency collaboration with other agencies serving CSHCN.

SMS will continue to outreach to newly identified CSHCN. This will include increasing information and referral services to CSHCN identified by SSI enrollment as well as those identified by HC-CSD Medicaid enrollment.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective		5.8	5.8	5.9	5.9
Annual Indicator	5.8	5.8	5.8	5.8	51.6
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	52	52	52	52	55

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

We continued many of the activities of the Youth Health Care Transition Project, including the Health Care Transition Coalition. A presentation by Toni Wall CSHCN Director of Maine occurred and highlighted the actual process of starting and maintaining a Youth Advisory Group.

The Health Care Transition Coalition expanded to include a high school nurse, the state Adolescent coordinator, a new parent and a new youth as well as the coordinator of the Integrated Services Grant. Parent participation was consistent and active. This group formalized

a statewide plan to address family and professional education about health care transition. The Project Coordinator (Cahill) presented the NH Health Care Transition Project's tools and model to the March 2007 AMCHP conference. In addition, we discussed with the NH Pediatric Society growth of the transition effort. We participated in the third statewide collaborative transition education effort for families by presenting a health care transition workshop at the Dreams into Action conference.

An ad hoc work group of private and public stakeholders concerned about the transition needs of individuals over the age of 16 with complex medical and developmental needs continued to explore capacity issues related to caring for these young adults. This group was chaired by SMS staff (Bumbalo) and the CEO of a community partner (Cedarcrest) and provided a report with strategies that will be carried forth by Cedarcrest.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote and coordinate health care transition activities				X
2. Consult to medical practices as requested		X		X
3. Meet quarterly with the Health Care Transition Coalition to advise on HCT activities and plan to promote improved transition practices statewide.				X
4. Survey Adult primary care providers about needs with YSHCN.			X	X
5. Participate in collaborative educational programs with community partners to describe health care transition.		X		X
6. Improve transition services to youth enrolled in Special Medical Services through ongoing staff training.		X		X
7. Support the development of the Youth Advisory Council with NH FV.			X	X
8. Increase awareness of health care transition through distribution of the revised "Growing Up" brochure and other materials, including CD with tools for providers.				X
9. Promote increased physician knowledge about transition by providing joint conference with NH Pediatric Society.			X	X
10.				

b. Current Activities

Health Care Transition activities continued through quarterly Health Care Transition Coalition (a joint effort of SMS and NH Family Voices) meetings, care coordination work and other statewide efforts. One of the initiatives this year was on youth and the formation of Youth Advisory Council. Funding to hire a facilitator for the group was secured by Family Voices and an experienced group leader was hired. The group met 5 times in this FY.

At the health care provider level we have several specific projects. We surveyed family physicians, internists and nurse practitioners to learn about their needs and experiences with transition aged YSHCN and how we might help (See attachment). In order to provide another avenue for provider education we jointly planned a transition conference with the NH Pediatric Society. SMS coordinated a keynote physician speaker from Healthy and Ready to Work, supported by the Integrated Services Grant. SMS made transition materials available through a CD entitled Tools for Health Care Transition that was distributed at the conference. We shared the results of the adult provider survey to encourage increased communications with adult providers, especially promoting the use of a Transition Medical Summary.

In addition SMS is a member of the Transition to Adult Health Care workgroup of the NE Regional Consortium on Genetics and Newborn Screening. SMS is also a member of the IDEA Partnership Community of Practice on Transition.

An attachment is included in this section.

c. Plan for the Coming Year

The Health Care Transition Coalition will continue to meet. NH Family Voices has received an MCHB Family to Family Health Information grant and will be taking a lead in family education activities around transition by hiring a designated transition educator. The Coalition will act in an advisory capacity to these efforts. The Coalition will continue to address family issues and the priorities and progress of the Youth Advisory Council. NH Family Voices will maintain fiscal management of the Youth Advisory Council. The first focus of this Youth Advisory Council (as determined by its members) was the development of educational materials targeted to their needs and based on the Rhode Island pamphlet series "Ready, Set Go". It is expected that these materials will be ready for distribution in SFY 2009. SMS care coordinators will be encouraged to use the transition tools to assist youth and families in all SMS programs and to support families to work with their pediatricians and specialists to accomplish successful transitions.

Continued outreach to health care providers will be a priority. This will be accomplished through continued distribution of the Adult Provider Survey results and of a CD on Tools for Health Care Transition that was created in Spring 2008. Adding website access to the NH tools will be explored.

Possible initiatives for this coming year include: Legislative efforts to improve reimbursement to practices to allow joint transition meetings and/or family interview meetings in primary care practices will be explored; formal outreach to area agencies and to schools to include health care management topics in the transition planning services they provide to YSHCN will be considered; and the collation and data analysis of youth transition surveys that have been completed by participants of the Neuromotor clinics.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	80	80	80	87	87
Annual Indicator	80.9	83.9	86.3	82.5	80.7
Numerator	12177	12628	12990	12418	11485
Denominator	15052	15052	15052	15052	14233
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

	2008	2009	2010	2011	2012
Annual Performance Objective	82	83	84	85	86

Notes - 2007

The numerator was obtained by using the most recent CDC National Immunization Survey rate for NH (revised February, 2008 estimates), available from the NH Immunization Program, and applying it to the denominator. The denominator is two year olds in NH in 2007, from the US Bureau of the Census Estimates Branch.

Notes - 2006

The numerator was obtained by using the most recent CDC National Immunization Survey rate for NH, available from the NH Immunization Program, and applying it to the denominator. The denominator is two year olds in NH from the 2000 census.

Notes - 2005

Data is from calendar 2004. This is the most recent data available.

a. Last Year's Accomplishments

The NH Immunization Program (NHIP) within the NHDHHS, DPHS, continued to combine state funds, federal funds and contributions from health insurance companies that do business in NH, to purchase enough vaccine to provide every NH child with all recommended vaccinations. Health plans have been assisting with funding for many years. (PB, IB)

The NHIP developed a simplified immunization schedule for New Hampshire healthcare providers. The purpose of a simplified immunization schedule is to consistently administer vaccines at the earliest possible time so that children are protected against vaccine-preventable diseases. This schedule includes all of the routinely recommended vaccines for young children and adolescents. In addition, minimum age and minimum intervals have been incorporated into this schedule. (PB)

MCH ACTIVITIES:

Continued to collaborate with the NH Immunization Program on obtaining CASA results for agency quality improvement efforts, including use at MCH site visits, and for agency workplans. (IB)

Continued to work with NHIP staff to disseminate information to the MCH direct care and home visiting agencies, as well as to Healthy Child Care New Hampshire child care health consultants on any changes or updates regarding vaccines to children and adolescents, including the new HPV vaccine. (PB)

The new HCCNH community-based child care health consultant provided a workshop to 25 child care facilities on immunization and infectious disease, and followed it up with a one-hour site visit to each facility addressing those specific topics. (IB)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with the NH Immunization Program on any state or local activities.				X
2. Communicate immunization policy changes and immunization updates to Title V-funded agencies.				X
3. Collaborate with the NH Immunization Program in using CASA results from Title V-funded agencies for quality assurance				X

activities including site visits and performance measures.				
4. Continue to include immunizations in the information updates to the MCH Home Visiting contract agencies, and to Healthy Child Care New Hampshire child care health consultants.				X
5. Work with the 3 newly funded community health agencies on their immunization efforts.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCH ACTIVITIES:

MCH continues to collaborate with the NH Immunization Program using the MCH contract agencies' CASA results as part of its quality improvement activities for site visits and agency workplans. The most recent data, SFY06, show that 91% of children enrolled in MCH-contracted child health agencies and community health centers have received the appropriate schedule of immunizations at 24-35 months. (IB)

MCH continues to work with Immunization Program staff to disseminate information to the MCH contract agencies, MCH Home Visiting contract agencies, and to Healthy Child Care New Hampshire child care health consultants on any changes or updates regarding vaccines to children and adolescents through mailings and presenting at the fall '07 MCH Coordinators' meeting. MCH shares the simplified immunization schedule for New Hampshire healthcare providers as requested and as part of QA activities. (IB)

The HCCNH community-based child care health consultant continues to provide consultation and workshops to child care facilities on immunization and infectious diseases. (IB)

MCH staff will be working with staff from three newly funded community health centers, in addition to the 10 current MCH-funded community health centers, on improving their immunization rates spring '08 through site visits and achieving the identified performance measure through workplan activities. MCH has requested CASA visits to the new centers from the Immunization Program to get baselines. (IB)

An attachment is included in this section.

c. Plan for the Coming Year

MCH ACTIVITIES:

MCH will continue to collaborate with the NH Immunization Program using the MCH contract agencies' CASA results as part of its quality improvement activities for site visits and agency workplans. (IB)

MCH will continue to work with Immunization Program staff to disseminate information to the MCH contract agencies, MCH Home Visiting contract agencies, and to Healthy Child Care New Hampshire child care health consultants on any changes or updates regarding vaccines to children and adolescents through mailings and meetings. A mini workshop on adult immunizations is planned for the Fall 2008 MCH Coordinators' meeting by Immunization Program staff. (IB)

The HCCNH community-based child care health consultant will continue to provide consultation and workshops to child care facilities on immunization and infectious diseases. (IB)

MCH staff will be working with staff from the 13 community health centers, with special attention to the 3 new agencies, to improving their immunization rates through site visits and achieving the identified performance measure through workplan activities. (IB)

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	12	12	10	6.9	6.9
Annual Indicator	7.4	7.4	6.9	7.2	7.4
Numerator	199		195	205	203
Denominator	26864		28128	28653	27473
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	7.3	7.2	7.1	7	6.9

Notes - 2007

Birth data is resident occurrent births only, i.e. out-of-state data is not available.

Notes - 2006

Birth data is resident occurrent births only, i.e. out-of-state data is not available.

Notes - 2005

NH moved to the 2003 National Birth Certificate Specifications in July, 2004. Neighboring states were not using the new national specifications in 2004, making it particularly difficult to calculate certain measures when including out-of-state births to NH residents. In addition, since the change was implemented by NH Vital Records (Department of State) in the middle of 2004, seamless statistics for the entire year (2004) is difficult or impossible to produce for many measures. As such, we have decided to provide 2005 birth data for this application. Although these data come with the significant limitation of only including resident occurrent births (i.e. no NH resident out-of-state births yet), we feel it is the best possible choice at this time. We recognize the critical importance of vital records and are actively working on multiple approaches to improve the accuracy and timeliness of vital records in New Hampshire.

a. Last Year's Accomplishments

BACKGROUND:

In 2005, The National Campaign to End Teen Pregnancy described key findings for New Hampshire. Between 1991 and 2002, the teen birth rate for girls aged 15-19 declined 40 percent in New Hampshire. If the teen birth rate had not improved in the state:

- Over 4,200 additional children (under age 18) in the state would have been born to teen mothers between 1991 and 2002, and
- Fully 75 percent of these children would have been under age six in 2002.

Focusing specifically on children under age six in 2002:

- 10 percent more children in the state would have been living in poverty, and

- 16 percent more children would have been living in single mother households.

Since 2003, teen birth rates have remained relatively stable. Reducing the rate of birth (per 1,000) for teenagers aged 15 through 17 years requires a multi-factorial approach. Multiple programs in the NH DHHS have this as a stated or implied goal and work in partnership with community based organizations and individuals to ensure supportive services are available to engage youth in making healthy choices.

MCH ACTIVITIES:

The Adolescent Health Program continued to implement the Adolescent Health Strategic Plan through technical assistance in adolescent medicine. (IB, PB)

In collaboration with the MCH quality assurance program, site visits and performance measures continued to assess the adequacy of adolescent health preventive services at community health centers and one specific adolescent health clinic, Child Health Services. (PBS, IB)

The Adolescent Health Program continued to strengthen a partnership with the Department of Education to develop the Coordinated School Health Plan. (IB)

The Family Planning Program (FPP) provided confidential reproductive health care to over 30,000 low-income women and teens through contracts with family planning and teen clinics. Eight clinics offer "teen only" services incorporating teen peer educators. FPP are supported with a combination of Federal Title X funds, state funds and TANF discretionary funding. (DHC)

The FPP promoted and supported community education activities and the use of evidence-based programs. Community educators provided education to adolescents and their parents on topics such as abstinence, contraception, healthy relationships and any other relevant topics through contacts with schools and youth serving agencies. (IB, PB, ES)

The FPP continued to promote the three evidence-based targeted teen pregnancy prevention curricula in middle and high schools. The Adolescent Health Program continued to strengthen a partnership with the Department of Education to develop the Coordinated School Health Plan. (IB, PB)

MCH contracted with Catholic Medical Center to provide the community based Leadership in Abstinence Education Program (LAEP). Through this contract, funds were used to administer a statewide abstinence education initiative through the distribution of small community grants, development of abstinence education networks, establishment of technical assistance and training programs and evaluation of abstinence education programs. The State Abstinence Advisory Committee discussed ongoing activities related to abstinence education and made recommendations for improvement, as needed. (PB, IB)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Providing confidential reproductive services.	X			
2. Providing community education activities.			X	
3. Supporting three evidence-based high school curricula.		X	X	
4. Participating on the Coordinated School Health Council.				X
5. Providing the Leadership in Abstinence Education Program (LAEP).		X	X	X
6. Utilizing the State Abstinence Advisory Committee.				X

7. Coordinating the Adolescent Health Strategic Plan implementation.				X
8. Providing adolescent focused community health centers and an adolescent clinic.	X	X		
9.				
10.				

b. Current Activities

MCH ACTIVITIES:

The Adolescent Health Program is meeting with community and agency partners on specific issues addressed in the strategic plan to identify who, what, and when of current activities related to adolescence. (IB)

In collaboration with MCH, social networking site web pages are being developed to increase access to health and health services information for adolescents and families. (ES)

The FPP continues to offer confidential reproductive health services to adolescents statewide as required by Title X. Education and reproductive health services also are continuing to be offered through teen clinics. (DHC)

The FPP continues to promote and support community education activities and the use of evidence-based programs. FPP continues to target adolescents and young people through contacts with schools and youth serving agencies and through targeted teen pregnancy prevention provided by community educators.

The FPP continues to promote the implementation of evidence-based curricula in schools and youth serving agencies. The Adolescent Health Program continues to strengthen a partnership with the Department of Education to develop the Coordinated School Health Plan. (IB, PB)

The administration of abstinence education funds continues through the same contract with Catholic Medical Center. The state advisory committee continues to meet and provide guidance and oversight to the abstinence education program. (PB, IB)

c. Plan for the Coming Year

MCH ACTIVITIES:

The Adolescent Health Program is planning a summit to build energy around adolescence, revisit the strategic plan implementation, and move current activities into action statewide. The aim is to progress toward the attainment of the NH 2010 objectives. The plan will include quarterly meetings to re-address and revise these action steps. (IB)

In collaboration with the MCH quality assurance program, The Adolescent Health Program will also continue to monitor practices through site visits to all of the community health centers and adolescent clinic. (IB, PB)

In collaboration with MCH, social networking site web pages will be utilized to increase access to health and health services information for adolescents and families. (ES)

The FPP will continue to promote and support community education activities and the use of evidence-based programs. FPP will continue to target adolescents and young people through contacts with schools and youth serving agencies and through targeted teen pregnancy prevention provided by the Family Planning Program's community educators. (PB, ES)

The FPP will work to continue to advocate for multiple funding sources including Federal Title X

funds, state funds and TANF discretionary funding to support FPP activities designed for teens.

The FPP will continue to offer confidential reproductive health services to adolescents statewide as required by Title X. Education and reproductive health services also are continuing to be offered through teen clinics. Services offered include counseling on abstinence and encouraging teens to involve their parents in their reproductive and sexual health decisions. (IB, DHC)

The FPP will continue to promote the implementation of evidence-based curricula in schools and youth serving agencies. (PB) The Adolescent Health Program will continue to partner with the Department of Education to develop the Coordinated School Health Plan. (IB)

Dependent on funding, the administration of abstinence education funds will continue through the same contract with Catholic Medical Center. The state advisory committee will continue to meet and provide guidance and oversight to the abstinence education program. (PB, IB)

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	46	46	42.4	42.4	42.4
Annual Indicator	45.9	42.4	42.4	42.4	42.4
Numerator	188	249	249	249	249
Denominator	410	587	587	587	587
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	42.4	44	44	44	44

Notes - 2007

Statewide oral health data for NPM #9 and SPM #4 is generally collected every five years through the Oral Health Survey of Third Grade Children. The next data from the survey will not be available until the spring of 2010.

Notes - 2006

Statewide oral health data for NPM #9 and SPM #4 is generally collected every three years through the Oral Health Survey of Third Grade Children. The next data from the survey will not be available until the spring of 2009.

Notes - 2005

Statewide oral health data for NPM #9 and SPM #4 is collected every three years through The Oral Health Survey of Third Grade Children. The survey was conducted for the second time in the spring of 2004 and will be repeated again in the spring of 2007.

a. Last Year's Accomplishments

Although the Oral Health Program (OHP) is not housed within the NH MCH program, it has a long history of collaborative work with MCH; MCH populations; and our mutual partners. Accomplishments of last year have led directly to current activities and plans for the coming year.

DATA ANALYSES:

The OHP and chronic disease epidemiologist collected, analyzed, and added new data to the statewide oral health surveillance system that uses national performance indicators to measure programmatic improvement. (IB, PBS, ES)

The OHP and chronic disease epidemiologist presented oral health programmatic trend data to 22 school-based hygienists at the annual Calibration Clinic indicating programmatic improvement over time and areas still needing improvement. (IB, PBS, ES)

The OHP and chronic disease epidemiologist published and distributed to 100 NH oral health stakeholders, New Hampshire Oral Health Data, 2006 reporting on all 8 national oral health indicators, including an indicator on dental sealants. (IB, PBS, ES)

SYSTEMS BUILDING:

The OHP worked with the Dental Director to inform dental professionals on Medicaid rate increases and program improvements to increase the number of enrolled dental providers and improve access to oral health care for low-income families. (IB, ES, PBS, DS)

The OHP collaborated with EFH and NH Dental Society to sustain school sealant programs. (IB, PBS, ES, DS).

The OHP worked with AHEC, the NH Minority Health Coalition, Home Visiting New Hampshire and Healthy Child Care New Hampshire through the SOHCS grant that promoted NH "branded" materials and provided trainings for child care providers on the transmission of oral disease, the importance of good oral health for high-risk children, and preventive interventions that interfere with the dental disease process. (IB, ES, PBS)

The OHP collaborated with the NH Oral Health Coalition and physicians to incorporate oral health screenings, parent education, risk assessment and preventive services into medical well-child visits to address declining numbers of dentist providers by incorporating oral health into children's total health care. (IB, PBS, ES)

The OHP collaborated with Head Start programs on a HRSA grant to support a dental hygienist to provide oral health education for pregnant women, staff and families; on-site preventive services for children; and link children with "dental homes" in four NH communities. (IB, ES, PBS, DS)

The OHP planned a statewide oral health Head Start Survey to examine the oral health and BMI of enrolled children.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue collaboration with Medicaid to find oral health care for clients.		X	X	X
2. Continue collaboration with Medicaid to ensure the success of new dental programs in Sullivan, Grafton and Coos counties.	X	X	X	X
3. Work with 21 established school-based dental programs and the Concord School Dental Sealant Coalition to ensure the sustainability of school-based sealant activities for students in NH elementary schools.	X	X	X	X
4. Continue collaborating with NH Head Start (HS) and Early Head Start programs to provide oral health screenings,	X	X	X	X

education, preventive interventions, and links to a “dental home” for enrolled children and pregnant women.				
5. Present the results of the NH Head Start Healthy Smiles-Healthy Growth Survey at the National Oral Health Conference. Calibrated volunteer pediatric dentists and HS staff collected data from 27 HS sites. NH DHHS Oral Health Program analyzed survey re	X	X	X	X
6. Continue collaborating with MCH partners to incorporate oral health activities into state-funded contracts to deliver primary care services.	X	X	X	X
7. Continue collaborating with the chronic disease epidemiologist and Health Promotion Program to secure financial support and technical assistance to conduct the 2009 Third Grade Oral Health/BMI Survey to collect, analyze and report on county level	X	X	X	X
8.				
9.				
10.				

b. Current Activities

DATA ANALYSES:

The Oral Health Program (OHP) collaborates with the chronic disease epidemiologist and 20 state-funded programs to collect, analyze, and disseminate data in the statewide oral health surveillance system. (IB, PBS, ES)

The OHP collaborates with the Health Promotion Program and chronic disease epidemiologist to secure support and technical assistance for NH's Third Grade Oral Health Survey. (PBS, IBS)

SYSTEMS BUILDING:

The OHP works with the Medicaid Dental Director to increase the number of enrolled dental providers (IB, ES, PBS, DS)

The OHP collaborates with the NH Dental Society and key community stakeholders to promote the sustainability of school sealant programs that also link identified children with a "dental home." (IB, PBS, ES, DS)

The OHP is collaborating with 27 Head Start programs to survey enrolled 3-5 year olds using 3 volunteer pediatric dentists and Department staff to assess their oral health, BMI and link them to a "dental home." (IB, ES, PBS, DS)

The OHP is developing "Head Start Healthy Smiles-Healthy Growth Survey in NH -A Collaborative Approach" for acceptance as a Contributed Paper for the National Oral Health Conference, April 30, 2008. (PBS, IBS)

The OHP continues collaborating with key stakeholders to support the opening of new dental center in Sullivan County. (IBS, PBS, ES, DS)

c. Plan for the Coming Year

DATA ANALYSES:

The OHP will collaborate with the chronic disease epidemiologist to collect, analyze, disseminate and add new data from 20 state-funded oral health programs to the statewide oral health surveillance system. (IB, PBS, ES)

The OHP will collaborate with NH Head Start programs to disseminate the Head Start Healthy

Smiles-Healthy Growth Survey results describing the prevalence of ECC, untreated decay, history of decay, treatment urgency and BMI findings among 3-5 year old children enrolled in 27 NH Head Start programs to report the need for preventive and restorative oral health interventions focused on the high-risk Head Start population. (IB, ES, PBS, DS).

The OHP will collaborate with the chronic disease epidemiologist and Health Promotion Program to secure financial support and technical assistance to conduct the state-wide Oral Health Third Grade Survey.(ES, PBS, IBS)

SYSTEMS BUILDING:

The OHP will work with the Dental Director and Medicaid Program to inform and educate the dental professional community with the goal of increasing the number of enrolled dental providers and improve access to oral health care. (IB, ES, PBS, DS)

The OHP will collaborate with the Dental Director and Medicaid Program, the NH Dental Society and key stakeholders in Concord and other communities with school-based dental sealant programs to promote the ongoing sustainability and effectiveness of school sealant programs that also link identified children with restorative care and a "dental home." (IB, PBS, ES, DS)

The OHP will continue collaborating with the Medicaid program and EFH to support the opening of new dental centers in the city of Manchester and Sullivan County. (IB, PBS, ES, DS)

The OHP will continue collaborating with the Area Health Education Centers (AHEC), the NH Oral Health Coalition, MCH programs, and Healthy Child Care New Hampshire to offer oral health trainings for providers of pregnant women's and children's health services that educate providers about the transmission of oral disease between mothers or caregivers and infants and the importance of good oral health for their high-risk clients. (IB, ES, PBS)

The OHP will collaborate with Dr. David Blaney, CDC EIS Officer in NH to develop a scientific manuscript for publication on the results of the Head Start Healthy Smiles-Healthy Growth Survey describing the prevalence of ECC, untreated decay, history of decay, treatment urgency and BMI findings among children enrolled in 27 randomly selected NH Head Start programs to report the need for preventive and restorative oral health interventions focused on the high-risk Head Start population. (IB, ES, PBS, DS).

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	36	36	36	60	60
Annual Indicator	51.7	60.7	0	0	89.3
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Provisional	Provisional

	2008	2009	2010	2011	2012
Annual Performance Objective	80	80	80	80	80

Notes - 2007

Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Calendar year 2007 vital records death data is provisional, due to the fact that out-of-state data is incomplete.

Raw data is as follows:

NH numerator: 3
 NH denominator: 241,716
 US Rate per 100,000; 2005: 1.39

US data source: http://webappa.cdc.gov/sasweb/ncipc/mortrate10_sy.html

The Standard Ratio methodology as described in the block grant guidance is used to calculate the indicator. Essentially, 89.3 means that 3 events in NH is 89.3% of what one would expect, given the US rate per 100,000. Please note that this calculation is based on the 2005 US rate, because it was the most recent year available.

Notes - 2006

Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Calendar year 2006 vital records death data is provisional, due to the fact that out-of-state data is incomplete. As of the time of the 2009 grant submission, there were no deaths.

Notes - 2005

Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Finalized data for 2005 became available during preparation of the 2009 application, so this data has been entered, superceding the 2004 data that was provided for 2005 in the 2008 application. There were no deaths in 2005.

a. Last Year's Accomplishments

BACKGROUND:

New Hampshire has seen a relatively level number of fatal crashes (all ages) over the last 10 years with the number varying between 120 to 140 per year. The number of fatalities climbed to 171 in 2004 and 166 in 2005. Fortunately, relatively fewer young children die in motor vehicle crashes as compared to other age cohorts.

The MCH Injury Prevention Program leads efforts to decrease the number and rate of deaths to children aged 14 years and younger caused by motor vehicle crashes. In collaboration with many

partners, positive outcomes are accomplished through participation in strategic planning; outreach and education; and policy development.

Certified car seat technician workforce:

Recertification by Safe Kids Worldwide changed to include the necessity of obtaining six continuing education credits within the two- year certification time frame (IB).

The Injury Prevention Program Manager obtained recertification as a car seat technician for an additional two years (IB). A train the trainer session took place, which provided currently certified car seat technicians with the tools to provide educational programs in the community, especially in child care centers, on child passenger safety issues (IB). Special needs training, on the use and availability of special needs seats, took place in several hospitals (IB). Two new car seat technician trainings, certifying 40 participants, were also facilitated (IB).

Inspection stations and check up events:

The analysis of the Safe Kids Worldwide project was incorporated into how checkup events and inspection stations function (IB).

Best practice teen seatbelt project:

Through MCHB technical assistance, the Children's Safety Network facilitated a symposium training both professionals and members of two community teams on best practices in increasing adolescent seat belt use (IB). The teams committed to instituting an adolescent seat belt program for at least one year post training (PB).

Traffic safety conference:

The traffic safety conference took place in late spring, once again including child passenger safety issues (PB, IB).

Policy:

Seat belt legislation for adults was introduced into last year's legislative session, but failed to pass the Senate (IB).

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Train and certify child passenger safety technicians and instructors.				X
2. Continue to promote and distribute booster, convertible, and infant seats.			X	
3. Facilitate car seat checks.			X	
4. Plan and facilitate the statewide Traffic Safety Conference.			X	X
5. Work with the Children's Safety Network on their technical assistance with the best practice teen seatbelt project.				X
6. Develop and facilitate several "tween" traffic safety programs.			X	
7. Participate in the Department of Transportation's Safe Routes To School proposal review.				X
8.				
9.				
10.				

b. Current Activities

Certified car seat technician workforce:

Two car seat technician trainings, in opposite ends of the state, are being facilitated (IB). A

refresher course for currently certified car seat technicians is being held, which will focus on the LATCH system (IB).

Inspection stations and check up events:

There is community targeted outreach to Coos County, the northernmost county in the state and the most rural, with mobile car seat checks utilizing the Safe Kids New Hampshire van and certified technicians (PB). The Injury Prevention Program Manager is participating in four check-up events around the state (PB).

Best practice adolescent seatbelt project:

The two teams that received training are instituting projects in their communities for one-year post seminar (PB). Mentoring and technical assistance is being provided to these communities through the Teen Driving Committee and the Children's Safety Network (PB).

Traffic Safety Conference:

A traffic safety conference is being held in April of 2008 (PB, IB).

"Tween" (eight to twelve year old) traffic safety projects:

The Safe Kids curriculum, which teaches older kids to "spot the tot" in and around the car, is being implemented in several communities across the state (PB). A new cub scout patch was developed on traffic safety in conjunction with Chevrolet dealers across the state (PB). The Injury Prevention Program is participating in the proposal review for the Department of Transportation's Safe Routes to School Program (IB).

c. Plan for the Coming Year

The MCH Injury Prevention Program will continue to lead efforts to decrease the number and rate of deaths to children aged 14 years and younger caused by motor vehicle crashes. In collaboration with many partners, positive outcomes will continue to be accomplished through participation in strategic planning; outreach and education; and policy development.

Strategic Highway Safety Plan for New Hampshire

The Injury Prevention Program Manager will continue to chair sub-committees for the Strategic Highway Safety Plan for New Hampshire. As a committee chair, the Injury Prevention Program Manager will continue to encourage the use of additional data including emergency department visits as a result of motor vehicle crashes to aid in strategic planning. (IB)

Certified car seat technician workforce:

Two car seat technician trainings will be facilitated. There will be stipends for child care providers to pay for substitute teachers so they can let staff go to the trainings (IB).

Best Practice Adolescent Seat Belt Project:

The Teen Driving Committee will compile the results of this project and share them at the aforementioned traffic safety conference. They will also help to sustain the two community based programs dependent on funding (PB, IB).

"Tween" (eight to twelve year old) traffic safety projects:

A pilot project with Safe Kids New Hampshire will be developed on traffic safety for 11 and 12 year olds incorporating safety stations. One school and community will be chosen to receive a stipend to facilitate the project (PB). Cub scouts across the state will continue to participate in activities in order to get the traffic safety patch previously developed with Chevrolet dealers (PB). The Injury Prevention Program will continue to participate in the proposal review for the Department of Transportation's Safe Routes to School Program (IB).

Data:

Will hold statewide observational surveys of car seat use during Child Passenger Safety Week

(IB).

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				45	45
Annual Indicator			45.9	43.8	48.7
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	50	51	52	53	54

Notes - 2007

Data is from the CDC Breast Feeding Report Card, 2007: Outcome Indicators (www.cdc.gov). A numerator and denominator are not available.

Notes - 2006

Data is from the CDC National Immunization Survey, 2005 (www.cdc.gov). A numerator and denominator are not available.

Notes - 2005

Data is from the National Immunization Survey, 2004 (www.cdc.gov). A numerator and denominator are not available. Data was reviewed and provided by Maureen Thibault. This is statewide data, and is thus used instead of WIC specific data from the PEDNSS (Pediatric Nutrition Surveillance System).

a. Last Year's Accomplishments

For the children of New Hampshire to be healthy and strong, they must receive the best possible nutrition when they are infants. MCH works in collaboration with many partners, including pediatricians, community health centers, hospitals, WIC, the NH Breastfeeding Task Force, and others to encourage breastfeeding. To this end, MCH has supported the following strategies of the NH Breastfeeding Task Force:

Inform expectant parents of the advantages of breastfeeding to both mother and infant.

Provide expectant mothers with information on how to prepare for, initiate, and maintain lactation.

Encourage practices that support breastfeeding in all sectors of the health care system.

Institute policies in worksites that create an environment fostering success in breastfeeding.

Increase public awareness of the benefits of breastfeeding.

Increase community services that support breastfeeding.

Keep health professionals informed of available breastfeeding services and information in the state.

MCH ACTIVITIES:

MCH co-sponsored the 2007 annual spring conference by the NH Breastfeeding Task Force and encouraged the MCH contract agencies to attend. (PB)

The MCH Child Health Nurse Consultant continued to collaborate with WIC and the NH Breastfeeding Task Force on activities that support breastfeeding among the women enrolled in the Title V-funded MCH agencies including the home visiting programs and the Healthy Child Care New Hampshire child care health consultants. This included sharing educational offerings and electronic informational updates with agency staff. (IB)

The MCH SIDS Program Coordinator continued to promote breastfeeding in public and professional information activities focused on SIDS risk reduction and safe sleep practices. (PB)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with WIC and the NH Breastfeeding Task Force on activities to enhance breastfeeding in MCH Title V-funded agencies.			X	X
2. Promote breastfeeding in public and professional information activities focused on SIDS risk reduction and safe sleep practices.			X	
3. Work with MCH contract agencies to explore activities to promote breastfeeding among clients of MCH contract agencies.			X	X
4. Explore adding a performance measure related to breastfeeding to the MCH-funded agencies' prenatal program workplans.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCH ACTIVITIES:

MCH has hired a new Prenatal Program Coordinator who is a Registered Dietician and Certified Lactation Consultant. She is visiting all the MCH funded prenatal programs and community health centers and their respective coordinators to gain a more thorough understanding of both their daily functioning and potential needs. (IB)

The MCH Child Health Nurse Consultant continues to collaborate with WIC and the NH Breastfeeding Task Force on activities that enhance breastfeeding among the women enrolled in the Title V-funded MCH agencies. This includes the home visiting programs and the Healthy Child Care New Hampshire nurse consultants, and consists of sharing educational offerings and electronic informational updates with agency staff. (IB)

The MCH SIDS Program Coordinator promotes breastfeeding in public and professional information activities focused on SIDS risk reduction and safe sleep practices. (PB)

MCH had a public health doctoral student explored why the data on breastfeeding from the birth certificates appeared to differ significantly from the breastfeeding data obtained from the information section of the Newborn Screening Program's filter papers. Although the analysis was not completed, some preliminary results are available which could be shared with the hospitals and used as the foundation for further investigation. (PB, IB)

c. Plan for the Coming Year

Research has shown that what happens in the hospital or birth center plays a crucial role in establishing breastfeeding and helping mothers to continue breastfeeding after leaving the birth facility. Although NH scored favorably in the CDC sponsored Breastfeeding-Related Maternity Practices at Hospitals and Birth Centers --- United States, 2007, tying with Vermont for the highest scores of pro-breastfeeding practices, there are still significant efforts needed to ensure that families receive support and education to maintain breastfeeding by six months post-partum.

MCH's new Prenatal Program Coordinator will be the MCH representative on the NH Breastfeeding Task Force. She will take a more active role in promoting its efforts and in working with WIC to enhance breastfeeding among the women enrolled in the Title V-funded MCH agencies including the home visiting programs and the Healthy Child Care New Hampshire nurse consultants. The Prenatal Coordinator will participate in task force activities related to the following task force strategies:

Inform expectant parents of the advantages of breastfeeding to both mother and infant.

Provide expectant mothers with information on how to prepare for, initiate, and maintain lactation.

Encourage practices that support breastfeeding in all sectors of the health care system.

Institute policies in worksites that create an environment fostering success in breastfeeding.

Increase public awareness of the benefits of breastfeeding.

Increase community services that support breastfeeding.

MCH SPECIFIC ACTIVITIES:

MCH will continue to work with WIC to share educational offerings, electronic informational updates, and promote August as Breast Feeding Awareness Month. (IB, PB)

MCH will keep health professionals informed of available breastfeeding services and information in the state.
(IB, PB)

The MCH SIDS Program Coordinator will continue to promote breastfeeding in public and professional information activities focused on SIDS risk reduction and safe sleep practices. (PB)

MCH will provide feedback to hospitals based on breast feeding rates at the time of discharge based on the work of last summer's public health doctoral student. (PB, IB)

MCH will explore adding a breastfeeding performance measure to the MCH contract agency Prenatal Program workplans for FY10. (IB)

When it becomes available, MCH will utilize the MCHB The Business Case for Breastfeeding and companion train-the-trainer curricula to increase awareness among employers of the economic

benefits of breastfeeding.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	85	85	96	97	98
Annual Indicator	91.2	96.0	96.1	97.2	98.2
Numerator	12655	13500	13422	13673	13683
Denominator	13875	14062	13968	14069	13937
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	99	99	99	100	100

Notes - 2007

Numerator is actual number of infants screened. Denominator is number of occurrent births.

Notes - 2006

Numerator is actual number of infants screened. Denominator is number of occurrent births.

Notes - 2005

Numerator is actual number of infants screened. Denominator is number of occurrent births.

a. Last Year's Accomplishments

The Early Hearing Detection and Intervention Program is integrated into the newborn screening and child health activities of the NH MCH program. Greater than 98% of the 14,000 infants born annually in New Hampshire receive a hearing screening before discharge from the hospital. For those children who screen positive for a potential hearing loss, families receive support as they navigate a system that involves screening, follow-up, diagnosis, treatment and management, and evaluation. Education for parents and health care professionals is integrated throughout each component of the program. The following highlight accomplishments of the past year:

DAILY TASKS:

As expected, managing the essential, programmatic daily tasks remains the priority of the Early Hearing Detection and Intervention Program (EHDI). This included providing technical assistance to birth hospitals, daily data linkage and tracking and follow-up of infants needing repeat screenings. (PB)

The hospital screening staff and the audiologists in Pediatric Audiology Diagnostic Centers reported results through the Auris tracking system. The EHDI staff monitored all entries into the tracking system, and compliance with performance measures and national standards of care. (IB)

Nurse managers of each hospital birth unit used hospital based performance measures to monitor their newborn screening programs. Performance measures include: Initial Screen by 1 Month of Age; Percent of those with an Initial Screen Who Are Referred; Of Initial Refers,

Percent Receiving Re-Screen (ABR); Of Initial Refers, Percent Receiving Re-Screen(OAE); Of Initial Refers, Percent Who Referred on their Re-Screen; Of Total Screened, Percent Who Referred; Of Re-Screen Refers, Percent To Receive Diagnostic Evaluation. (PB)

SYSTEMS BUILDING:

EHDI Advisory Committee members met on a regular basis. Priority topics included: completion of a state specific resources; development of family advocate role; strategic planning regarding dearth of diagnostic centers. (IB)

A comprehensive, state specific resource book for families of infants and young children identified as deaf or hard of hearing was completed and disseminated. (IB)

Two Diagnostic Centers were removed from the list of qualified centers, after the audiologists resigned, resulting only two available diagnostic centers, one of which is restricting new referrals. The EHDI staff offered educational opportunities for audiologists through individual, group and regional offerings in order to support the remaining providers. (E)

In April 2007, the EHDI program established the Education, Advocacy and Referral System (EARS Program) through a contract with the MICE Program, the statewide educational program for children from birth to three years with hearing (or other sensory) impairments, to hire, train and supervise a family advocate to provide support, guidance and education to families who are informed that their infant or young child may have a hearing loss. (E)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support and monitor the quality of the activities of the newborn hearing screening programs in all New Hampshire hospitals with birth facilities.			X	
2. Support and monitor the quality of the activities of the pediatric audiology diagnostic centers in New Hampshire.		X		
3. Continue the activities of the EHDI Advisory Committee.				X
4. Monitor and analyze all newborn hearing screening data entered by participating birth hospitals into the Auris tracking system funded by the CDC Early Hearing Detection and Intervention Program.				X
5. Maintain a contract with a community-based agency to establish a family advocate position and supervise the activities of the family advocate to assist and educate families of infants and young children with a suspected or newly confirmed hearing loss		X		
6. Include in chart audit of MCH-funded primary care center, documentation of newborn hearing screening results in charts of children under age three.				X
7. Convene meetings of representatives of hospital newborn hearing screening programs to discuss, develop and implement strategies to reduce the percentage of infants lost to follow-up.				X
8.				
9.				
10.				

b. Current Activities

Managing the essential, programmatic daily tasks including providing technical assistance to birth hospitals, daily data linkage and tracking and follow-up of infants needing repeat screenings. The EHDI staff continuously monitors entries into the tracking system, and monitors compliance with performance measures and national standards of care. (PB)

Hospital screening staff and the audiologists in Pediatric Audiology Diagnostic Centers continue to report results through the Auris tracking system. Nurse managers of each hospital birth unit continue to use the performance measures to monitor their newborn screening programs. (PB, IB)

EHDI Advisory Committee members continue to meet on a regular basis. (IB)

Audiologists at two Pediatric Audiology Diagnostic Centers resigned. Audiologists at 3 diagnostic centers decided not to offer audiologist testing for infants and young children. One diagnostic center restricted the referrals to hospital newborn hearing screening programs in the northern area of New Hampshire. (E)

The EHDI staff continues to offer educational opportunities for audiologists through individual, group and regional offerings. (E)

Audiologists at the Pediatric Audiology Diagnostic Centers distribute resource books to families of infants when they are identified as deaf or hard of hearing. The EHDI program staff also distributes resource books to any family that requests one. (IB)

EHDI purchased an OAE screener and trained midwives to use them in home births. (E)

c. Plan for the Coming Year

DAILY TASKS:

The EHDI program will continue managing the essential, programmatic daily tasks remains the priority of the Early Hearing Detection and Intervention Program (EHDI). This will continue to include providing technical assistance to birth hospitals, daily data linkage and tracking and follow-up of infants needing repeat screenings. (PB)

The EHDI staff will encourage use of performance measures to monitor hospital newborn hearing screening programs. (IB)

The hospital screening staff and the audiologists in Pediatric Audiology Diagnostic Centers will continue to report results through the Auris tracking system. The EHDI staff will continuously monitor entries into the tracking system, and monitor compliance with performance measures and national standards of care. (IB)

Managers of hospital newborn hearing screening programs will be asked to submit screening protocols and documentation of screening results. (IB)

SYSTEMS BUILDING:

EHDI Advisory Committee members will continue to meet on a regular basis. (IB)

EHDI staff, with the MCH epidemiologist, will develop reports to perform trend analyses for EHDI activities for different client groups with the MCH data mart for use in future planning of parent materials and presentations. (IB)

The EHDI staff will assist any interested sites to develop qualified Pediatric Audiology Diagnostic Centers. (E)

The EHDI staff will continue to offer educational opportunities for audiologists through individual,

group and regional offerings and ensure that all audiologists at diagnostic centers follow the 2007 Joint Committee on Infant Hearing (JCIH) Guidelines for audiologic evaluations. (E,IB)

Audiologists at the Pediatric Audiology Diagnostic Centers will continue to distribute resource books to families of infants and young children when they are identified as deaf or hard of hearing. The EHDI program staff will continue to distribute resource books to anyone who requests one. (IB)

LOSS TO FOLLOW-UP:

In addition to ensuring that newborns are screened for hearing before hospital discharge, EHDI will staff will concurrently work on initiatives to prevent loss to follow-up for infants that screen positive for potential hearing loss in the hospital. Related activities will include:

Convene meeting of hospital newborn hearing screening managers to discuss strategies to reduce the percentage of infants lost to follow-up. (E, PB, IB)

Establish a working group to develop the script for the message to parents when an infant does not pass the initial screening and develop surveys for feedback from families and providers. (E)

Continue to work with the EARS Program to support families through the screening and diagnostic process.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	6.5	6.5	6.5	5.5	5.5
Annual Indicator	5.1	5.1	6.0	6.0	6.0
Numerator	15891	15891	18667	19402	19402
Denominator	309496	309496	311117	323309	323309
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	5.5	5	4.5	4	3.5

Notes - 2007

Data was obtained from the March, 2007 report, "Whose Kids are Covered, A State-by-State Look at Uninsured Children" prepared for the Robert Wood Johnson Foundation. The data comes from page 4, table 3 of the report, "Number and Percent of Children (0-18) With and Without Health Insurance Coverage in the United States, by State: Three-Year Average 2003-2005". According to the "Kids Count New Hampshire Data Book, 2008", the uninsured rate continues to be 6% (data obtained from Census estimates). Kids Count New Hampshire is based at the Children's Alliance of NH.

The Kaiser Family Foundation Website (statehealthfacts.org) show 7% for NH. Their uninsured estimates are based on the Census Bureau's March 2006 and 2007 Current Population Survey (CPS: Annual Social and Economic Supplements).

The Behavioral Risk Factor Surveillance Survey conducted in NH in 2005-2006 may be releasing information they have gathered in the near future, regarding the percentage of children uninsured in NH. When this data is released, it will be reviewed to see how it compares with the census estimates.

Notes - 2006

Data was obtained from the March, 2007 report, "Whose Kids are Covered, A State-by-State Look at Uninsured Children" prepared for the Robert Wood Johnson Foundation. The data comes from page 4, table 3 of the report, "Number and Percent of Children (0-18) With and Without Health Insurance Coverage in the United States, by State: Three-Year Average 2003-2005".

Notes - 2005

Data was obtained from Tricia Brooks, Executive Director of the Healthy Kids Corporation, and "is a three-year average of the 2004 census data". This data is now deemed by Healthy Kids to be more reliable than the previously used Insurance Family Survey from 2001.

a. Last Year's Accomplishments

BACKGROUND:

NH Healthy Kids provides free or low-cost health insurance to uninsured New Hampshire children. Children can qualify for Healthy Kids if they are under the age of 19, have no other health insurance coverage and household income is no higher than 300% of the federal poverty income limits. Healthy Kids Gold is a Medicaid service for children at 185% or below the federal poverty limits. Healthy Kids Silver is the state SCHIP program for children up to 300% of poverty.

New Hampshire Healthy Kids (NHHK) is a non-profit organization providing access to low-cost and free health coverage options for New Hampshire's uninsured children and teens. NHHK works in partnership with the New Hampshire Department of Health and Human Services, Anthem Blue Cross Blue Shield, Northeast Delta Dental, hospitals, community health centers, healthcare providers, schools and social service agencies across New Hampshire to connect uninsured children with the healthcare services they need to stay healthy and go to school ready to learn.

In addition to financial qualifications, children may also qualify for Medicaid if they meet the following:

Children with Severe Disability (CSD): requires a severe disability but does not require institutional level of care. Family income and resources are considered for financial eligibility.

Home Care for Children with Severe Disability (HC-CSD), commonly referred to as Katie Beckett: requires children to meet an institutional (nursing facility) level of care requirement and only considers a child's income and resources for financial eligibility.

MCH ACTIVITIES:

NH DHHS performs financial audits of MCH-contract agencies, including community health centers and other categorical health providers to assure adequate documentation of assessing and referring children eligible for Medicaid to the NH Healthy Kids Gold program. (IB)

The MCH Child Health Nurse Consultant served as a technical consultant on the RFP proposal review committee for the state's SCHIP competitive bid contract process, and participated in the revision process of the current NH Healthy Kids application. (IB)

MCH continued to monitor Title V contract agencies' percentage of children without health insurance, percent of eligible children enrolled on NH Healthy Kids, and activities to enhance health insurance enrollment through review of statistics and annual workplans. (IB)

The MCH Child Health Nurse Consultant participated in the final year of the workplan oversight committee for the communities funded by the Robert Wood Johnson-funded "Covering Kids and Families" (CKF) grant. The CKF initiative is designed to engage statewide and local coalitions to increase the number of eligible children enrolled in publicly supported health coverage programs. In New Hampshire, the focus is on hard-to-reach families in minority and rural populations.(IB)

With input from community agencies, MCH revamped its child health grant for the competitive bid process to offer community agencies state-wide the opportunity to apply for funds for "Child and Family Health Support Services" which includes outreach to families with children eligible for Healthy Kids Gold (Medicaid) or Silver (SCHIP program), assisting families with completing the Healthy Kids application, and connecting children with a medical home. (IB)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with NH Healthy Kids and the NH SCHIP coordinator.				X
2. Monitor documentation of clients' financial status and efforts to enroll on Medicaid at site visits.				X
3. Monitor performance measure on contract agencies' workplans on percent of eligible children enrolled on Healthy Kids Gold/Medicaid.				X
4. Monitor agency data on uninsured children.				X
5. Provide technical assistance and oversight to Child and Family Health Support funded agencies in getting eligible children enrolled on Healthy Kids Gold/Medicaid.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCH ACTIVITIES:

DHHS continues to do financial audits to contract agencies to assure documentation of assessing and referring eligible children to the Medicaid/NH Healthy Kids Gold program. (IB)

MCH monitors Title V contract agencies' percentage of children without health insurance, percent of eligible children enrolled on NH Healthy Kids and activities to enhance Medicaid/NH Healthy Kids Gold enrollment through review of statistics and annual workplans. (IB)

MCH staff continues to collaborate with the NH Healthy Kids Program and the NH SCHIP Coordinator to share information, policy changes and discussions about possible barriers to work on to increase enrollment of uninsured eligible children on Medicaid/Healthy Kids Gold through meetings, presentations, and sessions with the MCH contract agencies. (IB)

MCH works closely with 10 community agencies funded for "Child and Family Health Support Services" which includes outreach to families, schools and childcare providers, with children eligible for Healthy Kids Gold (Medicaid) or Silver (SCHIP program), assisting families with completing the Healthy Kids application, and connecting children with a medical home, through meetings, mentoring, and administrative oversight. (IB)

MCH is conducting site visits to three new community health centers to learn about their efforts to

enroll eligible children in Medicaid/Healthy Kids Gold. (IB)

c. Plan for the Coming Year

MCH ACTIVITIES:

DHHS will continue its financial audits to contract agencies, with a special focus on the three new community health centers, to assure documentation of assessing and referring eligible children to the Medicaid/NH Healthy Kids Gold program. (IB)

MCH will monitor Title V contract agencies' percentage of children without health insurance, percent of eligible children enrolled on NH Healthy Kids and activities to enhance Medicaid/NH Healthy Kids Gold enrollment through review of statistics and annual workplans, with a special focus on the 3 new community health centers. (IB)

MCH staff will continue to collaborate with the NH Healthy Kids Program and the NH SCHIP Coordinator to share information, policy changes and discussions about possible barriers to work on to increase enrollment of uninsured eligible children on Medicaid/Healthy Kids Gold through meetings, presentations, and sessions with the MCH contract agencies. (IB)

MCH will continue to work closely with nine community agencies funded for "Child and Family Health Support Services" which includes outreach to families, schools and childcare providers, with children eligible for Healthy Kids Gold (Medicaid) or Silver (SCHIP program), assisting families with completing the Healthy Kids application, and connecting children with a medical home, through meetings, mentoring, and administrative oversight. (IB)

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				35	35
Annual Indicator			35.0	34.0	33.6
Numerator			2274	2381	2437
Denominator			6496	7003	7254
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	33	32	31	30	29

Notes - 2007

Data is from Lisa Richards, NH WIC program, from CDC Pediatric Nutrition Surveillance System.

Notes - 2006

2006 data was not available for the 2008 application, and was provided during preparation of the 2009 application.

Notes - 2005

Data is CDC CY05 Pediatric Nutrition Surveillance System, via the state WIC program (Lisa Richards). Rates are increasing: 18% in 1984 and 27% in 1994.

a. Last Year's Accomplishments

BACKGROUND:

New Hampshire has the 38th highest rate of adult obesity at 22.4 % and the 33rd highest rate of overweight youths (ages 10-17) at 12.9 % in the nation, according to a 2007 report by Trust for America's Health. Although NH received a grade of "B" for childhood obesity-related activities, there is significant room to strengthen policies and improve outcomes.

NH WIC has developed several strategies to address the growing problem of overweight in New Hampshire WIC preschoolers. The first strategy is to offer culturally and linguistically appropriate physical activity education to Hispanic families enrolled in the New Hampshire WIC Program. The second strategy is to improve collaborations among community health and education programs that serve 3 and 4 year old WIC children in an effort to promote consistent age appropriate physical activity messages. The third and final strategy is to address New Hampshire WIC staff's ability to deliver effective and high quality nutrition services to WIC families. (PB, DS)

NH WIC has also obtained federal funding to expand their "Fit WIC" to include a Head Start program, evaluate both the Fit WIC kit and Parent's activity book for cultural appropriateness, and translate the material into Spanish. (PB)

MCH ACTIVITIES:

MCH monitored BMI use at site visits to the state-funded community health centers. (IB)

In follow up to last year's survey, staff from the Nutrition and Health Promotion Section presented an in-service at the October 2006 Child Health Program Coordinators' Meeting on "Using the BMI As A Tool For Health Promotion". (IB)

The Child Health Month Coalition, chaired by the MCH Child Health Nurse Consultant, developed 2 handouts for its Fall 2007 mailing focusing on obesity-prevention: one on healthy alternatives for observing holidays, and one on "What is a BMI?". (PB)

MCH introduced a new required performance measure for its FY08 primary care grantees on documenting at least yearly an age and gender-appropriate BMI percentile for enrolled children age two to nineteen years, to be monitored by MCH staff through agency workplans. (IB)

POLICY:

The Child Health Nurse Consultant, representing NH DHHS, participated in a NH childhood obesity expert panel, chaired by the Foundation for Healthy Communities, to develop recommendations for pediatric clinician practices to improve screening for and management of pediatric obesity. The recommendations were shared with all the MCH-funded agencies.

The panel adopted a statewide public education campaign, "5-2-1-0 Healthy NH" to bring awareness to the daily guidelines for nutrition and physical activity. Its message is simple and clear and represents some of the most important steps families can take to prevent childhood obesity:

- 5 Fruits and vegetables...more matters! Eat at least 5 servings a day. Limit 100% fruit juice.
- 2 Cut screen time to 2 hours or less a day.
- 1 Participate in at least one hour of moderate to vigorous physical activity every day.
- 0 Restrict soda and sugar-sweetened sports and fruit drinks. Instead, drink water and 3-4 servings/day of fat-free/skim or 1% milk.

(PB)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to monitor the documentation and graphing of BMI results in paper and electronic charts as part of the MCH quality assurance site visit and monitoring of agency workplans.				X
2. Continue to collaborate with WIC in sharing any educational information on preventing and reducing childhood obesity with MCH contract agencies.			X	X
3. Continue to participate in any statewide obesity prevention and control activities representing the NH DHHS.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCH continues to monitor and discuss progress with documenting and graphing of BMI, and age and gender-appropriate BMI percentiles as part of its quality assurance site visits to the state-funded community health centers. (IB)

The MCH Child Health Nurse Consultant represents NH DHHS on an Advisory Board to the federally and MCH-funded northern area community health centers that received a three year Healthy Tomorrows AAP/MCHB grant focusing on pediatric obesity. (IB)

MCH shares information electronically or at the twice yearly meetings with MCH-funded agencies on new initiatives, research, educational material, or suggestions for working with families to prevent or reduce pediatric obesity. (IB, PB)

MCH is coordinating a workgroup of community health center representatives to review changes in the AAP's newly revised Bright Futures, including the new BMI requirements, implications for the agencies, and how MCH can assist agencies to comply with them. (IB)

MCH and WIC staff met to share program updates that might impact mutual clients. (IB, PB)

POLICY:

The NH Child Advocacy Network, of which MCH is a technical advisor, placed the issue of childhood obesity on the 2008 Priorities for New Hampshire's Children. The Call to Action included promoting the 5 -2 -1 -0 message and to support a legislative commission to study and make recommendations for public policies that support active living and healthy food choices. (IB)
An attachment is included in this section.

c. Plan for the Coming Year

MCH ACTIVITIES:

MCH will continue to monitor and discuss progress with documenting and graphing of BMI, and age and gender-appropriate BMI percentiles as part of its quality assurance site visits to the state-funded community health centers, with a special focus on the three new community health

centers. (IB)

MCH will assess the FY08 agency results of the new BMI-related performance measure by discussing workplan activities with staff at site visits and through written feedback to the agencies. (IB)

The MCH Child Health Nurse Consultant will continue to represent NH DHHS on an Advisory Board to one of the northern community health centers that received a Healthy Tomorrows AAP/MCHB grant focusing on pediatric obesity. (IB)

MCH will continue to coordinate the workgroup of community health center representatives reviewing changes in the AAP's newly revised Bright Futures, including the new BMI requirements, implications for the agencies, and how MCH can assist agencies to comply with them. Findings of the workgroup will be presented at the fall 08 MCH Coordinators' Meeting. (IB)

MCH and WIC staff will continue to meet to share program updates that might impact mutual clients, and information that can be shared with each other's contract agencies. (IB, PB)

The Oral Health Program will disseminate the information gathered from a surveying 3-5 year olds in 27 Head Start programs using 3 volunteer pediatric dentists and Oral Health Program staff to assess their oral health, BMI and link them to a "dental home." (IB, ES, PBS, DS)

POLICY:

The Child Health Nurse Consultant will participate in any statewide obesity prevention and control activities representing the NH DHHS. (IB)

MCH will participate in action steps, as appropriate, from the New Hampshire HEAL (Healthy Eating Active Living) Action Plan, a blueprint for statewide efforts to assist residents in adopting and maintaining a healthy weight.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				12	12
Annual Indicator			12.3	12.7	13.3
Numerator			1511	1599	1681
Denominator			12246	12605	12621
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	13	12	11	10	9

Notes - 2007

Data does not include out-of-state births, as they are not available.

Notes - 2006

Resident occurrent births, as data for out-of-state births are not available.

In preparation for the 2009 application, the denominator was changed from 12788 to 12605, thus changing the indicator from 12.5 to 12.7. This was done to correct the mistaken inclusion of 183 "unknowns".

Notes - 2005

556 birth records are missing information for this measure.

NH moved to the 2003 National Birth Certificate Specifications in July, 2004. Neighboring states were not using the new national specifications in 2004, making it particularly difficult to calculate certain measures when including out-of-state births to NH residents. In addition, since the change was implemented by NH Vital Records (Department of State) in the middle of 2004, seamless statistics for the entire year (2004) is difficult or impossible to produce for many measures. As such, we have decided to provide 2005 birth data for this block grant. Although these data come with the significant limitation of only including resident occurrent births (i.e. no NH resident out-of-state births yet), we feel it is the best possible choice at this time. We recognize the critical importance of vital records and are actively working on multiple approaches to improve the accuracy and timeliness of vital records in New Hampshire.

a. Last Year's Accomplishments**BACKGROUND:**

Although NH has many favorable birth and maternal health outcomes, significant work must be done to continue to address the unacceptably high percentage of women who smoke in the last three months of pregnancy.

The NH Tobacco Prevention and Control Program's primary goals are to: prevent NH youth from beginning to use tobacco; eliminate exposure to secondhand smoke; promote quitting tobacco among users; and prioritize efforts to reach those most affected by tobacco. MCH works in partnership with the Tobacco Prevention and Control Program to develop strategies to help support pregnant women to quit smoking.

QUALITY ASSURANCE

MCH uses the following performance measure to monitor clinical interventions for smoking cessation throughout pregnancy: "Percent of pregnant women identified as tobacco users who received a provider intervention based on the 5 A's best practice model."

This measure is included in all MCH-funded prenatal and primary care contracts. Contract agencies submitted workplans on the strategies, action plans, evaluation, and outcomes. Outcomes were reported back to the agencies as trend data.

MCH completed distribution of the 5 A's smoking cessation intervention to all New Hampshire birthing facilities and prenatal providers. (ES) (IB)

MCH marketed the New Hampshire Smokers Help line to clinical providers throughout the state. (IB, ES, PB)

MCH continued to evaluate performance and outcomes of Home Visiting New Hampshire programs' effect on smoking cessation among high-risk pregnant women. (IB)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue coordination of tobacco cessation programming among NH DHHS programs and New Hampshire Ob/GYN and Neonatology practices.			X	X
2. Identify and disseminate best practice information among prenatal care providers throughout the state.			X	X
3. If pending legislation is successful, develop funding strategy and performance measures for increased smoking cessation activities in primary and prenatal care.				X
4. Collaborate with New Hampshire March of Dimes on Prematurity Summit focused on strategies for smoking cessation.			X	X
5. Collaborate with Alcohol, Tobacco and other Drug Prevention, Alcohol, Tobacco and other Drug Treatment, and Strategic Prevention Framework State Incentive Grant on the issue of marijuana use among pregnant women.		X	X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

New Hampshire lawmakers passed the NH Indoor Smoking Act in June 2007 to protect the public by reducing exposure to secondhand smoke. The amendment mandates that smoking is prohibited in restaurants, cocktail lounges, and enclosed places owned and operated by social, fraternal, or religious organizations when open to the general public. State policies such as this may indirectly lead to reduced smoking in all populations, including pregnant women. (PB)

MCH continues to market the New Hampshire Smokers Help line to clinical providers throughout the state. (IB, ES, PB)

MCH monitors clinical interventions for smoking cessation throughout pregnancy through community health center and prenatal agencies performance measures. (IB)

MCH continues to evaluate performance and outcomes of Home Visiting New Hampshire programs' effect on smoking cessation among high-risk pregnant women. (IB)

MCH is collaborating with New Hampshire Tobacco Control Program to plan for increased funding for community health centers to further integrate smoking cessation into primary care and prenatal care. (IB)

The Prenatal Program Coordinator assisted the Program Planning Committee of the NH March of Dimes for the Annual Prematurity Summit. The summit focused on strategies to help pregnant women quit smoking. The topics include implementing the 5As, motivational interviewing and pharmacology of smoking cessation. The MCH Epidemiologist presented "Trends in Smoking Among Pregnant Women". (ES, PB)

c. Plan for the Coming Year

QUALITY ASSURANCE:

MCH will continue to monitor clinical interventions for smoking cessation throughout pregnancy through community health center and prenatal agencies performance measures and evaluate performance and outcomes of Home Visiting New Hampshire programs' effect on smoking

cessation among high-risk pregnant women. (IB)

MCH will continue to market smoking cessation resources to clinical providers throughout the state. (IB, ES, PB)

COLLABORATION AND SYSTEMS BUILDING:

MCH will continue to work with New Hampshire Tobacco Control Program to plan for further integration of smoking cessation and the new Public Health Service Guidelines into primary and prenatal care. (PB, ES, IB)

The Prenatal Program Coordinator plans to reinstate the Birth Outcome Work group to begin establishing priorities for the coming year; specifically identifying birth outcomes that are related to maternal smoking. (IB, PB)

The Prenatal Program plans to work with Alcohol, Tobacco and other Drug Prevention to gather written information for the providers to utilize at the MCH funded health centers. (PB)

The Prenatal Program plans to work with Alcohol, Tobacco and other Drug Treatment to allow pregnant women priority at drug treatment facilities if they choose. (ES)

The Prenatal Program is planning to collaborate with those involved in the Strategic Prevention Framework State (IB)

The MCH Epidemiologist will continue analysis of birth outcomes by using the Prenatal Health Care Index (PHCI). The PHCI is an outcome index based on preventable maternal and neonatal hospitalizations. Because smoking among pregnant women is relatively high in NH, it is anticipated that analyses will help identify opportunities for intervention. (IB)

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	138	138	138	130	102
Annual Indicator	130.6	103	63.7	12.6	37.2
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.				Yes	Yes
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	30	30	30	30	30

Notes - 2007

Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Raw 2007 *provisional* (incomplete) data is as follows:

NH numerator: 3
NH denominator: 98207
US Rate per 100,000 in *2005*: 8.2

US data source: http://webappa.cdc.gov/sasweb/ncipc/mortrate10_sy.html

The Standard Ratio methodology as described in the block grant guidance is used to calculate the indicator. Essentially, 37.2 means that 3 events in NH is 37.2% of what one would expect, given the US rate per 100,000. Please note that the US Rate for *2005* was used in this calculation, as it was the most recent available.

Notes - 2006

Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Raw 2006 *provisional* (incomplete) data is as follows:

NH numerator: 1
NH denominator: 96995
US Rate per 100,000 in *2005*: 8.2

US data source: http://webappa.cdc.gov/sasweb/ncipc/mortrate10_sy.html

The Standard Ratio methodology as described in the block grant guidance is used to calculate the indicator. Essentially, 12.6 means that 1 event in NH is 12.6% of what one would expect, given the US rate per 100,000. Please note that the US Rate for *2005* was used in this calculation, as it was the most recent available.

Notes - 2005

Finalized data for 2005 became available during preparation of the 2009 application, so this data has been entered, superceding the 2004 data that was provided for 2005 in the 2008 application.

Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Raw 2005 data is as follows:

NH numerator: 5
NH denominator: 95761
US Rate per 100,000 in 2005: 8.2

US data source: http://webappa.cdc.gov/sasweb/ncipc/mortrate10_sy.html

The Standard Ratio methodology as described in the block grant guidance is used to calculate the indicator. Essentially, 63.7 means that 5 events in NH is 63.7% of what one would expect, given the US rate per 100,000.

a. Last Year's Accomplishments

BACKGROUND:

Suicide is the second leading cause of death for young people between 15 and 24 years old in New Hampshire. Many more youth attempt suicide each year. Guided by the New Hampshire State Plan for Suicide Prevention, MCH is dedicated to reducing the rate of suicide deaths through strategic partnerships with community based practitioners, advocacy, education, and policy development.

Youth Suicide Prevention Assembly (YSPA):

The Youth Suicide Prevention Assembly is dedicated to reducing the occurrence of suicide and suicidal behaviors among New Hampshire's youth between 10 and 24 years old. They accomplish this by providing communities with current information regarding best practices in prevention, intervention, and postvention strategies and by promoting youth safety in our communities and organizations. The Maternal and Child Health Section (MCH) continued to participate in YSPA's monthly meetings (IB).

Statewide Suicide Prevention Plan:

MCH continued to promote the implementation of the Statewide Suicide Prevention Plan through its active participation on the State Suicide Prevention Council (SPC). The SPC oversees the implementation of the plan. It is made up of organizations and individuals from across the state. Each subcommittee under the SPC was assigned specific goals for follow-up. The MCH Injury Prevention Manager co-chaired the communication subcommittee (IB).

Frameworks Project:

MCH continued its advisory role for the Framework project, implemented by the National Alliance on Mental Illness, NH Chapter (NAMI) through Garrett Lee Smith SAMSHA funds. The Bureau Chief of Community Health Services, a senior manager overseeing MCH, continued her role as the Co-Chair of the Garrett Lee Smith Advisory Committee. MCH staff worked closely with NAMI and YSPA to provide public health expertise for the implementation of the GLS activities. MCH also used Title V funds to provide Frameworks training with clergy for State Fiscal Years 07 and 08 (IB, PB).

Counseling on Restricting Access to Lethal Means:

The project continued with additional funding (PB). The Harvard Injury Control Research Center finished their evaluation with positive results (IB).

Firearm Safety Coalition:

The Coalition increased its dissemination of, "Staying Safe Around Guns: High School Edition". It also supported ten additional community forums on firearm safety utilizing the video and requiring the use of an evaluation tool (PB).

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to represent MCH on YSPA.				X
2. Work with state partners, the Suicide Prevention Council, and the various subcommittees to implement the Statewide Suicide Prevention Plan.			X	X
3. Work on the various projects of the communications subcommittee of the SPC.			X	X
4. Provide oversight to the implementation of the GLS grant.				X
5. Secure funding for ongoing planning and implementation of				X

suicide prevention training and education activities.				
6. Convene and chair the Firearm Safety Coalition.			X	X
7. Continue to facilitate the trainings on restricting access to lethal means.			X	X
8.				
9.				
10.				

b. Current Activities

An Adolescent Health Coordinator was hired, increasing staffing dedicated to this performance measure (IB).

A MD resident administered a survey on Adolescent Depression Screening: Knowledge, Attitudes and Practices among NH Community Health Centers. (IB)

Youth Suicide Prevention Assembly (YSPA):

The Adolescent Health Coordinator will continue active involvement on YSPA by participating in monthly meetings. YSPA data committee and SPC data committee are going to combine. The Medical Examiner's Office is redefining the categories on the death certificate to provide additional information on suicide (IB).

Suicide Prevention Council:

The Injury Prevention Manager continues to co-chair the communication subcommittee (IB). Two public service announcements on suicide prevention were created and aired on the largest television station in the state (PB). Work continues on linking them with calls to the statewide suicide prevention hotline (IB). A presentation and discussion on the media guidelines for reporting on suicides is being planned with journalism students at two state colleges (PP, IB).

Frameworks Project:

MCH continues to monitor the implementation of activities funded under the GLS grant as well as its own contract with NAMI to train clergy members in the Suicide Prevention/Postvention Frameworks Protocols during State Fiscal Year 08 (IB, PB).

Counseling on Restricting Access to Lethal Means & Firearm Safety Coalition:

These projects continued with additional funding. (PB IB)

c. Plan for the Coming Year

Guided by the New Hampshire State Plan for Suicide Prevention, MCH will continue efforts in reducing the rate of suicide deaths through strategic partnerships with community based practitioners, advocacy, education, and policy development.

Adolescent Health:

The Adolescent Health Coordinator will continue to promote integrated universal behavioral health and substance abuse screening as part of preventive health visits in MCH-funded adolescent health programs and community health centers. During quality assurance site visits and technical assistance, the Adolescent Health Coordinator will audit medical charts of adolescents in adolescent health programs and community health centers to ensure that this is routine practice. (IB)

Using the information gathered in the 2008, Adolescent Depression Screening: Current Knowledge, Attitudes and Practices among New Hampshire Community Health Centers, the Adolescent Health Coordinator will work with CHCs to develop strategies to overcome their identified barriers to screening including: time limitations; uncertainty about the best screening methods; inefficiencies within the EMR and lack of resources to manage the results of screening especially in terms of counseling and treatment. CHCs would appreciate more support to provide

screening services in the setting of a busy practice struggling with competing pressures. The Adolescent Health Coordinator will work in partnership with community providers to increase community and family support for adolescent depression screening. (IB)

Youth Suicide Prevention Assembly (YSPA):

The Adolescent Health Coordinator will continue active involvement on YSPA by participating in monthly meetings. YSPA will continue to: convene annual events to build awareness of suicide prevention; generate, distribute regularly, and centralize on a web site press releases, presentations, and fact sheets that include data, risk and protective factors, warning signs, and helping resources; promote and support effective community-based training activities of groups such as Samaritans and Community Mental Health Centers (IB).

Suicide Prevention Council:

The Injury Prevention Manager will continue to co-chair the Communication committee. A special project on teen drama related to suicide prevention is being discussed (PB, IB).

The Adolescent Health Coordinator will serve as department liaison for the professional training subcommittee (IB).

Frameworks Project:

MCH will continue to monitor the implementation of activities funded under the GLS grant (IB). MCH will continue to work with NAMI NH and the SPC to develop a sustainability plan (IB).

Counseling on Restricting Access to Lethal Means:

The project will continue with additional funding (PB).

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	86	86	80	80	86
Annual Indicator	80.0	80	78.7	85.3	78.0
Numerator	96		107	110	92
Denominator	120		136	129	118
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	79	80	81	82	83

Notes - 2007

Data is for resident occurrent births. Out-of-state data is not available for 2007.

Notes - 2006

Data is for resident occurrent births. Out-of-state data is not available for 2006.

Notes - 2005

NH moved to the 2003 National Birth Certificate Specifications in July, 2004. Neighboring states were not using the new national specifications in 2004, making it particularly difficult to calculate certain measures when including out-of-state births to NH residents. In addition, since the change was implemented by NH Vital Records (Department of State) in the middle of 2004, seamless statistics for the entire year (2004) is difficult or impossible to produce for many measures. As such, we have decided to provide 2005 birth data for this application. Although these data come with the significant limitation of only including resident occurrent births (i.e. no NH resident out-of-state births yet), we feel it is the best possible choice at this time. We recognize the critical importance of vital records and are actively working on multiple approaches to improve the accuracy and timeliness of vital records in New Hampshire.

a. Last Year's Accomplishments

SYSTEMS DEVELOPMENT:

MCH developed a data sharing and training opportunity among prenatal and neonatal nursing staff in order to facilitate regional coordination and clinical updates. (IB)

MCH facilitated the implementation and evaluation efforts of the Birth Outcomes Workgroup. (IB, PB, ES)

MCH sponsored a daylong conference on best practices/ research updates for nursing staff from birthing facilities, prenatal practices, and NICU facilities. (IB)

MCH implemented action steps developed at "The Impact of Inequality on Birth Outcomes: From Analysis to Action", hosted by Boston University. As part of the Birth Outcomes Workgroup, there is an ongoing task force to address racial, ethnic, and language barriers and their impacts on birth outcomes (IB, PB).

Representatives from MCH participated in training about "Life Course Health Development" hosted by Boston University. (IB, PB)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Sponsor annual conference with Neonatal and Perinatal Nurse Managers to provide research updates and best practice models.		X	X	
2. Continue to meet with the Performance Management Team to coordinate provider site reviews.				X
3. Communicating with Perinatal Outreach Nurse at Dartmouth-Hitchcock on ways to refer women to appropriate level prenatal care.		X	X	
4. Continue to disseminate best practice interventions and updated guidelines among prenatal care providers within the publicly funded community health centers.				X
5. Sponsor "Policy day for Legislators" concerning the need to address healthy behaviors through the lifespan.				X
6.				
7.				
8.				

9.				
10.				

b. Current Activities

MCH is sponsoring a daylong conference on best practices/ research updates for nursing staff from birthing facilities, prenatal practices, and NICU facilities. (IB)

The Prenatal Program Coordinator is communicating with the Perinatal Outreach Nurse at Dartmouth Hitchcock Regional Program for Women and Children's Health on ways to better refer high-risk patients to appropriate high-level care based on annual meetings with hospitals around the state conducted by Dartmouth-Hitchcock. (IB, PB, ES)

MCH is implementing action steps developed at "The Impact of Inequality on Birth Outcomes: From Analysis to Action", hosted by Boston University. (IB, PB)

MCH is sponsoring a legislative policy conference, PRIORITIZING HEALTH DOLLARS NOW . . . AN INVESTMENT IN NEW HAMPSHIRE'S FUTURE that highlighted the need to address healthy behaviors through the lifespan beginning in early childhood. Dr Milton Kotelchuck provided one of the keynote presentations entitled Investing in Mothers and Children:a Life Course Perspective. Part of the presentation focused on the need to invest in high quality perinatal care. (IB, PB)

c. Plan for the Coming Year

SYSTEMS DEVELOPMENT:

Prenatal Program Coordinator plans to include the topic of very low birth weight infants delivered at facilities for high-risk deliveries and neonates in Birth Outcomes Work Group strategic planning to identify and make recommendations. (IB, PB)

MCH plans to continue to sponsor meeting for perinatal nursing staff from birthing facilities, prenatal practices and NICU Facilities. (IB, PB)

Prenatal Program Coordinator plans to work with the March of Dimes to identify ways to reduce or prevent prematurity. (IB, PB)

The Prenatal Program Coordinator plans to develop better communication with Perinatal Outreach Nurse at Dartmouth-Hitchcock on ways to refer women to appropriate level of prenatal care to increase the number of women who deliver at a tierary birthing facility. (IB, PB)

The MCH Epidemiologist will continue analysis of birth outcomes by using the Prenatal Health Care Index (PHCI). The PHCI is an outcome index based on preventable maternal and neonatal hospitalizations. Additionally, the MCH Epidemiologist will investigate trends among very low birth weight infants delivered at facilities for high-risk deliveries and neonates including further exploration of birth data for the 11-12% of New Hampshire infants delivered at out of state hospitals. In one county of the state, approximately 29% of all births are out of state deliveries. (IB)

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	88	88	90	85	82
Annual Indicator	91.0	91	83.4	81.5	82.0
Numerator	13090		9251	8980	9233
Denominator	14383		11095	11015	11263
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	83	84	85	86	87

Notes - 2007

1425 birth records did not have information for this measure, and were not included in the denominator.

Out-of-state birth data is not available.

Data is not comparable to years prior to 2005, due to the fact that the month prenatal care began is no longer explicitly collected after 2004. Instead, we collect the date of the first prenatal care visit and calculate the month of pregnancy in which prenatal care began, by subtracting the date of the last menses.

Notes - 2006

1773 birth records did not have information for this measure, and were not included in the denominator.

Out-of-state birth data is not available.

Data is not comparable to years prior to 2005, due to the fact that the month prenatal care began is no longer explicitly collected after 2004. Instead, we collect the date of the first prenatal care visit and calculate the month of pregnancy in which prenatal care began, by subtracting the date of the last menses.

Notes - 2005

1707 birth records did not have information for this measure.

NH moved to the 2003 National Birth Certificate Specifications in July, 2004. Neighboring states were not using the new national specifications in 2004, making it particularly difficult to calculate certain measures when including out-of-state births to NH residents. In addition, since the change was implemented by NH Vital Records (Department of State) in the middle of 2004, seamless statistics for the entire year (2004) is difficult or impossible to produce for many measures. As such, we have decided to provide 2005 birth data for this application. Although these data come with the significant limitation of only including resident occurrent births (i.e. no NH resident out-of-state births yet), we feel it is the best possible choice at this time. We recognize the critical importance of vital records and are actively working on multiple approaches to improve the accuracy and timeliness of vital records in New Hampshire.

In addition, for this measure: data is not comparable to previous years due to the fact that the month prenatal care began is no longer explicitly collected. Instead, we collect the date of the

first prenatal care visit and calculate the month of pregnancy in which prenatal care began by subtracting the date of the last menses.

a. Last Year's Accomplishments

Disparities in primary and perinatal care may contribute to disparities in birth outcomes. MCH is dedicated to addressing these disparities in health outcomes by ensuring access to comprehensive health care services, including prenatal care, through community health centers and categorical prenatal agencies.

MCH ACTIVITIES:

Hired and trained new Prenatal Program Coordinator. (IB)

MCH-funded Prenatal Program Coordinators' meetings were continued on a biannual basis. Topics that were covered at the FY 2007 meetings included recruitment and retention of prenatal patients. (IB)

The MCH Prenatal Program explored funding alternatives to develop a PRAMS-like survey in New Hampshire. (PB, IB)

Initiated planning with the Office of Medicaid and Management with the goal of designing and implementing policies supporting prenatal case management services covered under the public insurance programs of New Hampshire. (PB, IB)

The Data Team began planning the implementation of contract agency data reporting with New Hampshire birth records. The linkage project will provide more comprehensive and timely surveillance of prenatal and birth outcome data to the MCH program. (IB)

MCH invited internal and external partners to a Region I funded state planning process, "the Impact or Inequality on Birth Outcomes: From Analysis to Action", hosted by Boston University. (PB, IB)

As a progression of the previous training "The Impact on Inequality on Birth Outcomes", MCH participated in another training about "Life Course Health Development" hosted by Boston University. (PB, IB)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to meet with the Performance Management team to coordinate provider site reviews.				X
2. Continue to facilitate Prenatal Program Coordinators' meeting on biannual basis.		X	X	
3. Reinstating Birth outcomes Work group and begin establishing priorities for the coming year.			X	X
4. Participate in the Program Planning Committee of the New Hampshire March of Dimes to ensure efforts are linked		X	X	
5. Gathering data form prenatal data collection tool and start to interpret, analyze and make recommendation based on data.			X	X
6. Establishing quality improvement tool for prenatal data lineage project.				X
7. Working with the Office of Medicaid and Management on pilot project "Enhanced Care Coordination" to endure high-risk pregnant women receive adequate and appropriate services.		X		X

8.				
9.				
10.				

b. Current Activities

MCH ACTIVITIES:

MCH uses Title V and state general funds to support the infrastructure of 13 community health centers and 2 stand-alone prenatal agencies to provide comprehensive prenatal care for all women without regard to ability to pay. MCH will continue to monitor and provide technical assistance to promote quality assurance. (IB)

MCH funded Prenatal Program Coordinators' meetings to continue on a biannual basis. FY08 topics include ways to reduce Fetal Alcohol Syndrome and premature births. (IB, ES, PB)

The MCH data linkage project ensures that contract agency prenatal and birth data are analyzed and reported back to providers for quality improvement purposes as well as to inform public health policy in maternal and child health. Early entry to care is monitored and reported. (IB)

Prenatal Coordinator and Title V Director continue to serve on the Program Planning Committee of the New Hampshire March of Dimes to ensure that efforts for improving birth outcomes are linked. (IB)

MCH is sponsoring a "Policy Day for Legislators" about the need to address healthy behaviors through the lifespan beginning in early childhood. (IB, PB)

MCH is currently working with the Office of Medicaid and Management on a pilot project titled "Enhanced Care Coordination". This pilot project works with high risk/high cost prenatal women. Their goals are to increase utilization of medical services, increase quality and satisfaction of services, and to improve birth outcomes. (ES, PB)

c. Plan for the Coming Year

QUALITY ASSURANCE:

MCH will continue to monitor and provide technical assistance to MCH-funded prenatal and primary care agencies that provide comprehensive prenatal care to low income, uninsured and underinsured women. (DS, ES)

MCH-funded Prenatal Program Coordinators' meetings to continue on a biannual basis. (IB)

The linkage project will ensure that contract agency prenatal and birth data are going to be analyzed and reported back to providers for quality improvement purposes as well as to inform public health policy in maternal and child health. Further develop a quality improvement plan for the prenatal data linkage project including collection, analysis, and reporting measures. (IB)

SYSTEMS DEVELOPMENT:

MCH will facilitate implementation of the Birth Outcomes Action Plan. (IB, PB, ES)

Title V Director and Prenatal Coordinator will continue to serve on the Program Planning Committee of the New Hampshire March of Dimes to ensure that efforts for improving birth outcomes are linked. (IB)

The Prenatal Coordinator will facilitate a strategic planning process for the newly energized Birth Outcome work group and start establishing priorities for future recommendations for prevention and intervention. (PB, ES)

Analyze, interpret, report back and make recommendations based on data from prenatal data

collection tool (IB)

Based on results of "Policy Day for Legislators", will start to gather information in establishing Life Course Health Development policy. (IB, PB)

Continue to work with the Office of Medicaid and Management and the "Enhanced Care Coordination" project to increase utilization of services, increase quality and satisfaction of services and to improve birth outcomes. (PB, ES)

D. State Performance Measures

State Performance Measure 1: *Percent of data linkage projects completed*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				40	60
Annual Indicator				60.0	80.0
Numerator				3	4
Denominator				5	5
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	80	100	100	100	100

Notes - 2007

The infant birth, and Maternal and Child Health Section prenatal care link was achieved in CY 2007.

Notes - 2006

Early hearing detection, infant birth and death, and newborn screening were completed.

Notes - 2005

This was a new measure for FY06.

a. Last Year's Accomplishments

OVERALL DATA LINKAGE PLAN:

In FY07, MCH continued development of an integrated system of linked data sets that will assist in fulfilling several critical public health functions: identification of infants not screened for hearing and metabolic disorders, identification of disparities among the prenatal population receiving MCHS-funded community-based services and among other MCH populations in the state, and evaluation of the effectiveness and accessibility of health services provided by the MCH. MCH intends to virtually consolidate existing and potential future data silos that were often developed in response to specific funding streams. Linking these datasets creates a more complete picture of services across data silos and, in some cases, reduces reporting burden.

SSDI funding from HRSA is supporting development of this data linkages project, which involves linking birth data with infant death, Newborn Screening, Early Hearing Detection and Intervention (EHDI), Prenatal clinic, Medicaid, WIC and other MCH-related data. Elements of these linked data sets will eventually reside in the MCH Data Mart. The goal is for the Data Mart to house linked MCH-related databases currently not residing elsewhere, linkage information, and derived fields, in a place that will be available to public health analysts and policy makers.

MCH DATA MART:

Preliminary planning for the Data Mart between MCH staff and the Office of Information Technology (OIT) began in FY07. See Attachment for a schematic of the MCH Data Mart.

Began discussion with the NH Childhood Lead Poisoning Prevention Program (CLPPP) regarding the addition of CLPPP data to the MCH Data Mart.(IB)

PERINATAL CLIENT DATA FORM LINKAGES:

Completed development of the Auris Perinatal Client Data Form (PCDF) web-based system. The new PCDF will provide timely, accurate data regarding Prenatal clients of MCH-funded Prenatal agencies and community health centers (CHCs) and will reduce the reporting burden on the agencies by allowing an electronic medical record (EMR) file extract upload, and by linking with the birth certificate to greatly reduce the number of data items collected (since additional items may be obtained through the birth certificate). (IB)

Completed extensive internal testing of the Auris PCDF coding and edit checks for both the manual data entry and file upload components. (IB)

Held ongoing meetings between MCH, the NH Office of Information Technology (OIT) and Welligent LLC (PCDF vendor) to develop and refine the PCDF. Completed and distributed to PCDF users a data dictionary, data collection instructions and data entry form. Convened a meeting with all Prenatal agencies and CHCs to demonstrate the PCDF.

Began testing of the manual data entry component with Prenatal agencies and CHCs. Prepared a one-year contract to provide TA to PN agencies in adapting their EMR's to Auris PCDF requirements.(IB)

OTHER LINKAGES:

Completed EHDI, infant birth/death, NSP and Prenatal-birth data linkages(IB).

The Newborn Screening Program (NSP)/birth data linkage became operational in September 2006 and is now utilized to identify infants who missed screening. Since September 2006, fifteen true misses requiring case follow-up have been identified. The Program Coordinator reports satisfaction with the current system's effectiveness and efficiency. Several Phase II enhancements to the NSP/birth data linkage to improve manual matching, reporting, querying and research and make the system more user-friendly were completed during FY07. (IB)

The MCHS Epidemiologist assisted with user acceptance testing for NH birth and death data.(IB)

The MCH Epidemiologist completed work on the redevelopment of a Perinatal Health Index to be used for small area analysis in New Hampshire. The index is based on preventable maternal and neonatal conditions as found in the hospital discharge dataset. (IB)

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to make enhancements to the PCDF including the development of reporting capabilities for both the PN agencies and the MCHS.				X
2. Continue to improve access to timely and accurate data for both internal (DHHS) and external users (e.g. MCHS funded community health agencies).				X
3. Develop policies and procedures for the NSP, PCDF, and EHDI linkages and for access to the MCH Data Mart.				X
4. Expand the MCH Data Mart to include linked data from Auris				X

(EHDI, PCDF, Birth Conditions Program), linked NSP data, NSP and EHDI test results and finally WIC and Medicaid data. Add birth data as necessary in support of MCH reporting needs.				
5. Provide predefined reports and limited query capabilities.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Even with setbacks, MCH is ahead of target for achieving planned data linkages. Activities include:

OVERALL DATA LINKAGE PLAN:

Developing policies and procedures for the NSP, PCDF, and EHDI linkages to improve access to timely and accurate data for both internal (DHHS) and external users (e.g. MCHS funded community health agencies) (IB)

MCH DATA MART:

Planning and early development work on the Data Mart was begun in SFY08 with the assistance of OIT staff. However, reassignment of OIT staff resulted in a delay in the timeline to complete this project. Data Mart development is now expected to begin in May 2008 and be completed by October 2008 as part of Bureau of Public Health Informatics IT plan.(IB)

PERINATAL CLIENT DATA FORM LINKAGES

Implemented the Auris PCDF data system in all Prenatal Program agencies statewide; data collection from all prenatal (PN) agencies began July 1, 2007. (IB)

Prepared and distributed a comprehensive PCDF Users Manual to all PCDF users in Prenatal agencies and CHCs. (IB)

Continuing to make corrections and enhancements to the PCDF for issues discovered during the testing phase, including the development of reporting capabilities for both the PN agencies and the MCH. (IB)

Convened a meeting of all PN agencies April 2008 to demonstrate Auris reporting capacity and obtain input on their data reporting needs. (IB)

Providing training and technical assistance, through a contract, for Prenatal agencies and CHCs as they implement the new reporting system.(IB)

An attachment is included in this section.

c. Plan for the Coming Year

MCH will continue the development of an integrated system of linked data sets fulfilling several critical public health functions: identification of infants not screened for hearing and metabolic disorders, identification of disparities among the prenatal population receiving MCHS-funded community-based services and among other MCH populations in the state, and evaluation of the effectiveness and accessibility of health services provided by the MCH.

Phase I included linkages with Newborn Screening Program (NSP), Early Hearing Detection and Intervention(EHDI), and Perinatal Client Data Form (PCDF). With continued support from HRSA SSDI, MCH will continue development of data linkages in Phase II and Phase III focusing on Death data, Medicaid data and WIC data in years 2008-2010. Please see attachment for complete timeline.

OVERALL DATA LINKAGE PLAN:

Develop policies and procedures for the NSP, PCDF, and EHDl linkages and for access to the MCH Data Mart (IB)

Continue to improve access to timely and accurate data for both internal (DHHS) and external users (e.g. MCHS funded community health agencies) (IB)

MCH DATA MART:

MCH is dependant on OIT to develop the MCH Data Mart; development is now expected to begin in May 2008 and be completed by October 2008. Plans include efforts to expand the MCH Data Mart to include linked data from Auris.(IB)

As part of MCH Data Mart activities, MCH will develop an Memorandum of Understanding (MOU) between Title V and NH Medicaid. As part of this MOU, there will be detailed plans and commitments for data sharing. (IB)

PERINATAL CLIENT DATA FORM LINKAGES:

MCH will continue to make enhancements to the PCDF including the development of reporting capabilities for both the PN agencies and the MCH and continue to provide training and technical assistance to Prenatal agencies and CHCs, as needed, as they implement the new reporting system.(IB)

An attachment is included in this section.

State Performance Measure 3: *Percent of children age two (24-35 months) on Medicaid who have been tested for lead.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	30	30	27	27	28
Annual Indicator	23.3	27.2	31.7	27.4	33.8
Numerator	1252	1263	1507	1316	1618
Denominator	5365	4646	4751	4801	4780
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	34	35	36	37	38

Notes - 2007

Calendar year 2007 data from Megan Tehan, CLPPP.

Notes - 2006

Data came from Medicaid enrollment records matched to blood lead screening/testing data for the calendar year. Reports from Medicaid, including all children under 6 enrolled in Medicaid, are run quarterly for the state lead program. The quarterly reports are combined, and duplicates are eliminated.

a. Last Year's Accomplishments

MCH monitored lead screening activities in its MCH direct care and primary care agencies by chart audits at site visits, and oversight of agency annual workplans which included performance measures on screening one and two year olds. (IB)

The CLPPP worked with the Manchester Health Department and Dartmouth Medical School to develop a web based series of "Grand Rounds" regarding best practices in lead screening

targeted to physicians in Manchester and statewide. (PB, IB)

Child Health Services in Manchester continued to receive CDC funding from the CLPPP as part of its MCH contract to do lead case management on all enrolled children identified with an elevated lead level. (IB)

CLPPP facilitated and provided technical assistance to Local Lead Action Committees (LLAC). The CLPPP secured CDC funding for lead case management in another high risk area (city of Rochester) and a LLAC was formed there. (IB, PB)

The CLPPP continued to provide training as needed on preventing lead poisoning to MCH Home Visiting agencies and HCCNH child care health consultants, and provided an update at the spring '07 MCH Coordinators' Meeting. (IB)

The CLPPP continued to promote screening by providing materials for the Medicaid enrollment packets. (PB)

The CLPPP continued surveillance on testing of refugee children and alerts providers when refugee children are overdue for testing. (IB)

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The CLPPP staff will continue to attend MCH Coordinators' Meetings to share with Title V funded Child Health and Primary Care information updates.				X
2. MCH will continue to monitor lead screening activities in its MCH direct care, primary care agencies, and Child Health Services, by chart audits at site visits, and oversight of agency annual workplans which include a performance measures on screenin				X
3. The CLPPP will continue to facilitate and provide technical assistance (TA) to Local Lead Action Committees (LLAC) in high risk areas.			X	X
4. The CLPPP will continue to provide training as needed on preventing lead poisoning to MCH Home Visiting agencies and HCCNH child care health consultants.				X
5. The CLPPP will continue to promote screening by providing materials for the Medicaid enrollment packets.			X	
6. The CLPPP will continue surveillance on testing of refugee children and alerts providers when refugee children are overdue for testing.				X
7.				
8.				
9.				
10.				

b. Current Activities

The CLPPP staff continues to attend MCH Coordinators' Meetings to share with Title V funded Child Health and Primary Care information updates. (IB)

Child Health Services in Manchester received the FY08 MCH "Pediatric Primary Care" grant, won

through a competitive bid, which includes CDC funded lead case management dollars. (IB)

MCH staff continues to monitor the lead screening activities of the primary care grantees, and Child Health Services. Lead screening of two year olds continues to be a required performance measure for FY08, although the parallel measure of screening one year olds was discontinued due to identical action and evaluation plan activities. (IB)

Lead case management services began in Avis Goodwin Community Health Center, another MCH contract agency serving children living in an area at high risk for lead poisoning (Rochester). (IB)

The CLPPP staff continues to provide training as needed on preventing lead poisoning to MCH Home Visiting agencies and HCCNH child care health consultants. (IB)

The CLPPP staff continues to promote screening by offering materials to be included in Medicaid enrollment packets. (PB)

The CLPPP epidemiologist continues surveillance on testing of refugee children and alerts providers when refugee children are overdue for testing. (IB)

The CLPPP continues to facilitate and provide technical assistance (TA) to Local Lead Action Committees (LLAC) in high risk areas. (IB, PB)

An attachment is included in this section.

c. Plan for the Coming Year

SCREENING:

The Childhood Lead Poisoning Prevention Program's (CLPPP) collaboration with Manchester Health Department and Dartmouth Medical School to develop a web based series of "Grand Rounds" regarding best practices in lead screening targeted to physicians in Manchester and statewide will be completed and implement changes required by Senate Bill 176 (effective January 2008). (PB, IB)

The CLPPP will monitor performance of a grant to The Way Home, Inc. in the amount of \$5,000 to provide lead poisoning prevention and management workshops for childcare providers, healthcare providers and other professionals, focusing on screening guidelines, and provide guidelines to homeowners and families. (PB, IB)

The CLPPP will begin collaboration with Medicaid to implement the 2008 Healthcare Effectiveness Data and Information Set (HEDIS). (IB)

The CLPPP will coordinate with stakeholders to implement office systems interventions in pediatric practices in two communities other than Manchester to increase screening rates. (PB, IB)

The CLPPP will invite Dr. Michael Shannon, chair of Pediatrics at Harvard Medical School, to speak at an educational session for health care professionals regarding screening and management of blood lead levels in children. (PB, IB)

The CLPPP will research the update of its data management system to better meet program needs and improve efficient and accurate collection, analysis and reporting of screening data. (IB)

The CLPPP will implement, as appropriate, the recommendations documented by the Legislative

Childhood Lead Poisoning Prevention Study Commission in its November 2008 final report. (PB, IB)

HEALTHY HOMES:

Although NH will continue to prioritize efforts related to screening for lead poisoning, especially among high risk populations, the MCH CLPPP program is planning for a program shift to introduce the importance of including more environmental and health risk factors affecting MCH populations.

The MCH CLPPP, in partnership with the National Center for Healthy Housing, Inc. (NCHH), has begun the planning process for a Healthy Housing Program in New Hampshire. A "healthy home" is defined as a home designed, constructed, maintained, or rehabilitated in a manner that supports the health of residents. The focus of the initiative is to identify health, safety, and quality-of-life issues in the home environment and to act systematically to eliminate or mitigate problems. A strategic plan that will include the collection of current healthy homes best practices and data, and investigation of New Hampshire's current structure will be complete in December 2008. CLPPP will then implement the recommendations, as feasible, within the next five years.

State Performance Measure 4: *Percent of third grade children screened who had untreated dental decay.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	21.7	22	24.2	22	24
Annual Indicator	21.7	24.2	24.2	24.2	24.2
Numerator	89	142	142	142	142
Denominator	410	587	587	587	587
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	24.2	22	22	22	22

Notes - 2007

Statewide oral health data for NPM #9 and SPM #4 is generally collected every five years through the Oral Health Survey of Third Grade Children. The next data from the survey will not be available until the spring of 2010.

Notes - 2006

Statewide oral health data for NPM #9 and SPM #4 is generally collected every three years through the Oral Health Survey of Third Grade Children. The next data from the survey will not be available until the spring of 2009.

Notes - 2005

Statewide oral health data for NPM #9 and SPM #4 is collected every three years through The Oral Health Survey of Third Grade Children. The survey was conducted for the second time in the spring of 2004 and will be repeated again in the spring of 2007.

a. Last Year's Accomplishments

Although the Oral Health Program is not housed within the NH MCH program, it has a long history of collaborative work with MCH; MCH populations; and our mutual partners. Accomplishments of last year have lead directly to current activities and plans for the coming year.

TRAINING:

The Oral Health Program (OHP) worked with the Dental Director to inform and educate dental professionals about Medicaid program improvements and increases in Medicaid reimbursement rates to enroll more dental providers and improve access to oral health care for low-income families. (IB, ES, PBS, DS)

The OHP collaborated with physicians to incorporate oral health screening into medical visits as described on the New Hampshire Prevention Guidelines poster distributed to physicians offices statewide. (IB, PBS, ES)

DATA ANALYSIS:

The OHP and chronic disease epidemiologist collected, analyzed, and added new data to the NH oral health surveillance system that uses national performance indicators to measure programmatic improvement. (IB, PBS, ES)

The OHP and chronic disease epidemiologist presented oral health programmatic trend data to 22 school-based hygienists at the annual Calibration Clinic indicating programmatic improvement over time and areas still needing improvement. (IB, PBS, ES)

The OHP and Health Promotion Programs planned an oral health Head Start Survey to examine enrolled children and link them with a "dental home." (IB)

SYSTEMS BUILDING:

The OHP collaborated with the Endowment for Health (EFH) and NH Dental Society on the NH Statewide Sealant Project to sustain the statewide school sealant program that links children with untreated decay to a "dental home." (IB, PBS, ES, DS)

The OHP collaborated with Medicaid and EFH providing technical assistance needed to open the first dental center in Sullivan County, a second dental center in Manchester and recruit a fulltime dentist for "The Molar Express," in the state's northern-most county. (IB, ES, PBS, DS)

The OHP collaborated with Area Health Education Centers (AHEC), the Minority Health Coalition, and Healthy Child Care New Hampshire through the SOHCS grant that promoted NH "branded" materials and provided trainings for child care providers on the transmission of oral disease, the importance of good oral health for high-risk children, and preventive interventions that interfere with the disease process. (IB, ES, PBS)

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue collaboration with Medicaid to find oral health care for clients.		X	X	X
2. Continue collaboration with Medicaid to ensure the success of new dental programs in Sullivan, Grafton and Coos counties.	X	X	X	X
3. Work with 21 established school-based dental programs and the Concord School Dental Sealant Coalition to ensure the sustainability of school-based sealant activities for students in NH elementary schools.	X	X	X	X
4. Continue collaborating with NH Head Start (HS) and Early Head Start programs to provide oral health screenings, education, preventive interventions, and links to a "dental home" for enrolled children and pregnant women.	X	X	X	X
5. Present the results of the NH Head Start Healthy Smiles-Healthy Growth Survey at the National Oral Health Conference.	X	X	X	X

Calibrated volunteer pediatric dentists and HS staff collected data from 27 HS sites. NH DHHS Oral Health Program analyzed survey re				
6. Continue collaborating with MCH partners to integrate oral health activities into state-funded contracts to deliver primary care services.	X	X	X	X
7. Continue collaborating with the chronic disease epidemiologist and Health Promotion Program to secure financial support and technical assistance to conduct the 2009 Third Grade Oral Health/ BMI Survey to collect, analyze and report on county level d	X	X	X	X
8.				
9.				
10.				

b. Current Activities

DATA ANALYSIS:

The OHP and chronic disease epidemiologist are collecting, adding and analyzing data from 20 state-funded oral health programs to the statewide oral health surveillance system. (IB, PBS, ES)

The OHP is collaborating with Head Start programs to conduct the Healthy Smiles- Healthy Growth Survey in 27 sites to examine enrolled children and link underserved children with a dental home. (DHC, ES, PBS, IB)

SYSTEMS BUILDING:

The OHP works with the Dental Director and Medicaid Program to inform and educate dental professionals about programmatic improvements and increases in Medicaid reimbursement rates so that more dentists will enroll as dental providers. (IB, ES, PBS, DS)

The OHP collaborates with the NH Dental Society to assure sustainability of the NH Statewide Sealant Project in Concord and Nashua, and refer those with untreated decay to local dentists and/or the dental center for treatment.(IB, PBS, ES, DS)

The OHP collaborates with the AHEC, the NH Oral Health Coalition and pediatricians to provide training and technical assistance for medical practices interested in the application of fluoride varnish on children at risk for dental disease. (IB, ES, PBS)

The OHP, NH Medicaid and the EFH are providing technical assistance to support the opening of a dental center in Sullivan County; a second dental center in Manchester; and recruitment of a fulltime dentist for "The Molar Express," a mobile dental program in the state's northern-most region. (IB, ES, PBS, DS)

An attachment is included in this section.

c. Plan for the Coming Year

DATA ANALYSIS:

The OHP will collaborate with the chronic disease epidemiologist to collect, analyze, disseminate and add new data from 20 state-funded oral health programs to the statewide oral health surveillance system. (IB, PBS, ES)

The OHP will collaborate with the chronic disease epidemiologist and Health Promotion Program to secure financial support and technical assistance to conduct the statewide 2009 Third Grade Oral Health/BMI Survey.(ES, PBS, IBS)

The OHP will collaborate with NH Head Start programs to disseminate the Head Start Healthy Smiles-Healthy Growth Survey results describing the prevalence of ECC, untreated decay,

history of decay, treatment urgency and BMI findings among 3-5 year old children enrolled in 27 NH Head Start programs in an effort to quantify the need for preventive and restorative oral health interventions focused on the high-risk Head Start population. (IB, ES, PBS, DS).

The OHP will collaborate with Dr. David Blaney, CDC EIS Officer in NH to develop a scientific manuscript for publication on the results of the Head Start Healthy Smiles-Healthy Growth Survey describing the prevalence of ECC, untreated decay, history of decay, treatment urgency and BMI findings among 3-5 year old children enrolled in 27 randomly selected NH Head Start programs to report the need for preventive and restorative oral health interventions focused on the high-risk Head Start population. (IB, ES, PBS, DS).

SYSTEMS BUILDING:

The OHP will work with the Dental Director and Medicaid Program to inform and educate the dental professional community with the goal of increasing the number of enrolled dental providers and improving access to oral health care for NH children. (IB, ES, PBS, DS)

The OHP will collaborate with the Dental Director, the Medicaid Program, the NH Dental Society, key Concord stakeholders and other New Hampshire communities with school-based dental programs to promote the effectiveness and ongoing sustainability of school sealant programs that also link identified children with restorative care and a "dental home." (IB, PBS, ES, DS).

The OHP will continue collaborating with the Medicaid program and EFH to support the opening of new dental centers in the city of Manchester and Sullivan County. (IB, PBS, ES, DS)

The OHP will continue collaborating with the Area Health Education Centers (AHEC), the NH Oral Health Coalition, MCH programs, and Healthy Child Care New Hampshire to offer oral health trainings that educate providers of pregnant women's and children's health services about the transmission of oral disease between caregivers and infants and the importance of good oral health for their high-risk clients. (IB, ES, PBS)

The OHP will continue collaborating with AHEC, the NH Oral Health Coalition and physicians to augment declining numbers of dental providers in the workforce by adding oral health risk assessment, screening, parent education, and the application of fluoride varnish to well-child visits. (IB, PBS, ES)

State Performance Measure 5: *The rate (per 100,000) of emergency department visits among youths aged 15-19 resulting from being an occupant in a motor vehicle crash*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	2300	2500	2500	2300	2300
Annual Indicator	2,305.6	2,705.5	2,207.6	1,807.3	2207.6
Numerator	2113	2549	2114	1753	
Denominator	91645	94214	95761	96995	
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	2200	2100	2000	1900	1800

Notes - 2007

Provisional data for 2007 is not available. Therefore, the last finalized data from 2005 is used as the indicator for 2007.

Notes - 2006

2006 data is provisional due to the incompleteness of out-of-state data.

Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Notes - 2005

Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Finalized data for 2005 became available during preparation of the 2009 application, so this data has been entered, superceding the 2004 data that was used for 2005 in the 2008 application.

a. Last Year's Accomplishments

The MCH Injury Prevention Program leads efforts to decrease the number and rate of emergency department visits among youths aged 15-19 resulting from being an occupant in a motor vehicle crash. In collaboration with many partners, positive outcomes are accomplished through participation in strategic planning; outreach and education; and policy development.

New Hampshire Highway Strategic Plan and Injury Data:

Hospitalization and emergency room data on motor vehicle crashes involving adolescents was incorporated into the NH Department of Transportation's Strategic Highway Safety Plan. This was due to a new collaboration between the Health Statistics Section of the New Hampshire Department of Health and Human Services and the Transportation Data Section of the New Hampshire Department of Transportation. In the past, only fatalities were reported (IB). The Injury Prevention Program Manager acted as the chair of the Adolescent and Elderly Driver Subcommittee of this Plan (incorporated with the Teen Driving Committee) (IB). The Subcommittee drafted and finalized the Plan's recommendations, including sections on increased enforcement of the primary seat belt law for adolescents 17 and under; increasing community engagement in enforcement and education on adolescent seat belt use; strengthening the graduated drivers licensing law; increasing parental involvement in graduated drivers licensing and training; and making advanced skills training and drivers' attitudinal courses accessible to all adolescents (IB).

Teen Driving Committee:

The Committee met on a monthly basis, using the recommendations of the New Hampshire Highway Strategic Plan as their guide (IB). The Committee also worked with a group of health policy graduate students at Dartmouth's Center for the Clinical and Evaluative Sciences. This focused on a model plan for modifying the state's graduated drivers licensing system for new drivers. The students recommended gradually strengthening the graduated drivers licensing system over several years. This would include instituting stricter passenger restrictions, limiting nighttime driving, and developing a learner's permit (IB).

Best practice adolescent seatbelt project:

Through MCHB technical assistance, the Children's Safety Network presented findings from a literature search on best practices in increasing adolescent seat belt usage. This was done in an interactive seminar to two community teams and state professionals. Both communities had low seatbelt usage as determined by their Youth Risk Behavior Survey Results and the Highway Safety Agency's annual seatbelt survey. The Teen Driving Committee hosted this seminar at a

high school in the northern part of the state in April of 2007 (PB, IB). It also acted as mentors to both teams throughout the year (PB).

Traffic safety conference: A traffic safety conference was held in April of 2007. The conference included presentations on best practices in increasing adolescent seatbelt use and graduated drivers licensing. The session on adolescent seatbelt use was a collaborative one between the Children's Safety Network and the Injury Prevention Program (PB, IB).

Policy:

A primary seatbelt law for adults was introduced into the 2007 legislative session, but failed to pass the State Senate. The Seat Belts for All Coalition introduced the legislation. Although the bill failed, a study commission was put together with recommendations due the summer of 2008. The commission is led by the Injury Prevention Center's Director and consists of organizations both for and against a primary restraint bill (IB).

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor data trends in adolescent motor vehicle injuries.				X
2. Monitor progress of graduated drivers' licensing legislation.				X
3. Dependent upon legislation passing and being signed into law, develop media and educational campaign for parents on the contents and implications of new law.			X	
4. Provide technical assistance with the best practice adolescent seatbelt project to community teams.			X	X
5. Prepare for implementation related to adolescent drivers on the state's Highway Strategic Plan.				X
6. Facilitate monthly meetings of the Teen Driving Committee.				X
7. Gain funding, plan, and facilitate a Teen Driver Conference, only for teens.			X	
8. Help to plan and facilitate the statewide Traffic Safety Conference.			X	X
9. Work to help increase enforcement of the seat belt law for teenagers through training and best practice measures.			X	X
10. Seek out additional funding to accomplish this performance measure.				X

b. Current Activities

Workforce:

An Adolescent Health Coordinator was hired, increasing staffing dedicated to this performance measure (IB).

Teen Driving Committee: The Teen Driving Committee is acting as the primary advocate for the implementation of the recommendations listed in the state's Highway Strategic Plan under adolescent drivers. It continues to meet on a monthly basis (PB, IB).

Best practice adolescent seatbelt project:

Two teams that received training are instituting projects in their communities for one-year post seminar (PB). Mentoring and technical assistance is being provided to these communities through the Teen Driving Committee and the Children's Safety Network.(PB, IB)

Traffic Safety Conference: A traffic safety conference is being held in April of 2008. Three sessions will be held on issues related to teen driving; the first on traumatic brain injuries, the second introducing AAA's web based program "Start Smart" which encompasses parent-teen

driving contracts, and the third facilitating a discussion on advanced driving schools.

Policy: A primary seatbelt law for adults was introduced into the 2007 legislative session, but failed to pass the State Senate. The Seat Belts for All Coalition introduced the legislation. Although the bill failed, a study commission was put together with recommendations due the summer of 2008. The commission is led by the Injury Prevention Center's Director and consists of organizations both for and against a primary restraint bill. (PB)

c. Plan for the Coming Year

The MCH Injury Prevention Program will continue to lead efforts to decrease the number and rate of emergency department visits among youths aged 15-19 resulting from being an occupant in a motor vehicle crash through its collaboration with many partners. Using the NH Department of Transportation's Strategic Highway Safety Plan, along with other related strategic plans, the MCH Injury Prevention Program will continue to enhance current partnerships and develop new relationships to implement evidence-based education and policy development.

Teen Driving Committee:

The Teen Driving Committee will continue acting as the primary advocate for the implementation of the recommendations listed in the state's Highway Strategic Plan under adolescent drivers. The Department of Transportation has asked the Committee to develop a funding proposal for possible initiatives. The Teen Driving Committee will also continue meeting on a monthly basis (PB, IB). The Committee will work on the development of a media and educational campaign for parents of novice drivers on state's graduated drivers' law (PB). Funding will be sought after for a conference for teens on safe driving issues (PB). In collaboration with the Highway Safety Agency, the Teen Driving Committee plans on increasing enforcement of the primary seat belt law (up through age 17) through various training and best practice measures (PB, IB).

Traffic Safety Conference:

A traffic safety conference will be held in April of 2009. It will include a track on adolescent driving. The traffic safety conference is organized by a statewide collaboration of organizations, including the Injury Prevention Program, who are committed to reducing fatalities and injuries due to motor vehicle crashes (PB, IB).

Best Practice Adolescent Seat Belt Project:

The Teen Driving Committee will compile the results of this project and share them at the aforementioned traffic safety conference. They will also help to sustain the two community based programs dependent on funding (PB, IB).

Policy: As a result of legislative efforts in 2008, a study commission convened and tasked with developing a set of legislative and policy recommendations regarding teen driving and licensure. The MCH IPP is anticipated to take a lead role in implementing those recommendations, where appropriate.

State Performance Measure 6: Percent of adolescents (ages 10-20) eligible for an EPSDT service who received an EPSDT service during the past year

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	39	35	35	40	42
Annual Indicator	35.1	40.6	41.5	41.4	43.5
Numerator	9451	11474	12127	12976	13739
Denominator	26930	28246	29205	31352	31579
Is the Data Provisional or Final?				Final	Final

	2008	2009	2010	2011	2012
Annual Performance Objective	45	46	47	48	49

Notes - 2007

From FY2007 416 report via Maria Pliakos (ext 7194) and Jackie Leone.

Notes - 2006

From FY2006 416 report via Denise Towle (ext 7194) and Jackie Leone.

Notes - 2005

From FY2005 416 report via Denise Towle (ext 7194) and Jackie Leone.

a. Last Year's Accomplishments

BACKGROUND:

The New Hampshire (NH) Adolescent Health Strategic Plan, created in conjunction by the Maternal and Child Health (MCH) Section of the Department of Health and Human Services (DHHS), the Center on Adolescence at the University of New Hampshire (UNH), NH youth serving providers, and young people from across the state, aims to improve the overall health and wellbeing of adolescents ages 10-24 in accordance with Healthy New Hampshire 2010, Healthy People 2010 and its 21 critical adolescent health objectives.

This strategic plan addresses seven major health areas that need improvement in order to better the overall health and wellbeing of young people in the state. These health areas are: physical activity and diet, mental health, injury, reproductive health, alcohol, tobacco and other drugs, the environment and school achievement.

Recommendations in the plan support activities to increase the percent of adolescents eligible for an EPSDT service who received an EPSDT service during the past year and provided guidance for the accomplishments below.

SYSTEMS DEVELOPMENT:

The Adolescent Health Program issued a Request For Proposals (RFP) to provide adolescent-focused clinical preventive services to adolescents 12 to 19 years old. The Adolescent Health Program continued to promote the use of evidence based practices whenever possible when providing clinical preventives services to children and adolescents. This was through the use of guidelines from experts and professional organizations such as the American Medical Association and the American Pediatrics Society. (DHC, IB, PB)

In collaboration with the MCH quality assurance program, MCH continued to assess the adequacy of MCH-funded adolescent health preventive services through site visits and performance measures. The Adolescent Health Program implemented an annual screening site performance measure for the adolescent-focused clinical site. MCH updated the primary care center chart audit review tool for adolescents based on the third edition of Bright Futures and American Academy of Pediatrics recommendations. Site reviews conducted with the new tool uncovered implementation of system integration and communication interventions around disconnect in the adolescent medical home. The adolescent services disconnect spanned a vast array of varied school based health centers, sports physicals, clinics, and limited social services that pushed annual exams to an average of 2 years apart. Recommendations also focused on increasing the formal behavioral screening, and medication and services follow-up at sites. (IB)

The Adolescent Health Program continued to work with LEAH (Leadership Education in Adolescent Health) and the Konopka Institute for Best Practices in Adolescent Health to provide resources and information to MCH funded agencies, other youth serving organizations and community partners in NH. The Adolescent Health program continued to build stronger collaborations with other state programs targeting youth in order to provide regular and updated

information and resources. (IB)

MCH continued to work on implementing the adolescent health strategic plan. Recommendation 2, Focal Areas, were approached by the various program partners, such as Health Promotion, MCH behavioral health integration, Family Planning, and the Injury Prevention Center. Recommendations 4 & 8, Collaboration and Support, were approached through meeting in collaboration with the UNH Center on Adolescence including target community members. Working groups were formed from this meeting around Recommendations 1 & 5, Access and System Responsiveness, for ages 18-24 years. Training needs of Recommendation 3, were approached through various community conferences. Recommendation 5, Families, was approached by a new initiative of the UNH Cooperative Extension. The Coordinated School Health Council approached Recommendation 7, Educational Environment. (IB, PBS)

The Adolescent Health Program continued to strengthen a partnership with the Department of Education to develop the Coordinated School Health Plan. (IB)

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Providing adolescent clinical contract, oversight, and technical assistance.	X			X
2. Providing primary care contract adolescent-specific technical assistance.	X			X
3. Providing statewide specialized clinical care referrals.	X			X
4. Implementing an adolescent annual exam clinical performance measure for all patients at MCH-funded agencies.				X
5. Participating on the NH Coordinated School Health Council.				X
6. Participating on the NH Transition Coalition.				X
7.				
8.				
9.				
10.				

b. Current Activities

SYSTEMS DEVELOPMENT:

The Maternal and Child Health Section (MCH) and the Adolescent Health Program in particular continue to promote best practices in adolescent health in NH. They also encourage MCH-funded agencies and other local providers to build a strong focus on adolescent health. MCH distributed copies of the Bright Futures clinical guidelines to MCH funded agencies. (IB)

The Adolescent Health Program is contracting with one agency for SFY08 to provide adolescent-focused clinical preventive services. (DHC) The program is also connecting this agency with clinical and management partners, including the LEAH Boston, the UNH Center on Adolescence, and internal and external primary care clinical contacts, to ensure evidence based practice. (IB)

A medical resident at one of the MCH-funded community health centers developed and administered a survey, Adolescent Depression Screening: Current Knowledge, Attitudes and Practices among NH Community Health Centers on behalf of MCH to determine barriers to behavioral health screening. (IB, PB)

In collaboration with MCH, social networking site web pages are being developed to increase

access to health and health services information for adolescents and families. (ES)

The Adolescent Health Program is meeting with community and agency partners on specific issues addressed in the strategic plan to identify who, what, and when of current activities related to adolescence. (IB)

An attachment is included in this section.

c. Plan for the Coming Year

Although the MCH Adolescent Health Program is pleased that progress is continuing to be made in the percent of adolescents eligible for an EPSDT service who received an EPSDT service during the past year, there are many more activities needed to reach the federal benchmark of 80%. Using the NH Adolescent Health Strategic Plan as a guide, and in partnership with colleagues and community based programs, the following highlight plans for next year.

SYSTEMS DEVELOPMENT:

The Adolescent Health Program is planning a summit to build energy around adolescence, revisit the strategic plan implementation, and move current activities into action statewide. The aim is to progress toward the attainment of the NH 2010 objectives. The plan will include quarterly meetings to re-address and revise these action steps. (IB)

The Adolescent Health Program will continue to work with the LEAH (Leadership Education in Adolescent Health) and the Konopka Institute for Best Practices in Adolescent Health to provide resources and information to MCH funded agencies, other youth serving organizations and community partners in NH. The Adolescent Health program will continue to build stronger collaboration with other state programs targeting youth to provide regular and updated information and resources. The program plans to develop a state adolescent health status data overview factsheet to disseminate annually. (IB)

The Adolescent Health Program will continue to contract with one agency to provide adolescent-focused clinical preventive services. (DHC) The program will provide adolescent-specific oversight to the MCH-funded primary care agencies, and will continue to provide technical assistance to ensure evidence-based practice. (IB)

In collaboration with the MCH quality assurance program, site visits and performance measures will continue to assess the adequacy of adolescent health preventive services by MCH funded agencies. The Adolescent Health Program will utilize pilot data to implement an annual screening site performance measure for all of the MCH Primary Care centers, based on the results of the new site visit tool. (IB)

The Adolescent Health Program will continue to strengthen a partnership with the Department of Education to develop and implement the Coordinated School Health Plan and build a relationship with the school nurses. (IB)

The Adolescent Health Program will develop social networking site pages to provide preventive health information and resources to adolescents where easily accessible for the population. The initiative will aim to provide accurate information, increase access to resources and services, and create an interactive community face and space for MCH teen activities. (PBS)

The Adolescent Health Program, in collaboration with MCH and Dartmouth Hitchcock Medical School, is pursuing training and intervention services in adolescent medicine focusing on prevalent adolescent health issues. The training would be for MCH-funded agencies. (ES, PBS)

State Performance Measure 7: *Percent of center-based child care facilities in the MCH catchment area and serving children under age 2, that are visited at least once a month by a child care health consultant*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				5	5
Annual Indicator				0.0	1.8
Numerator				0	1
Denominator				43	55
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	4	8	16	25	35

Notes - 2007

Although most centers did not have a monthly on-site visit by a child care health consultant, many child care centers did have at least one on-site visit in the year 2007.

Number of centers surveyed: 55

Number of on-site visits by a child care health consultant to centers: 67

Number of children in attendance at the centers on an average day: 813

The survey was conducted by telephone. In addition to the collection of more accurate data by phone, this had the advantage of personalized marketing of the child care health consultation network. Follow-up thank you letters will be sent to the providers, with specific health and safety information that they requested during the survey; they will also be sent contact information for their child health care health consultant.

Notes - 2006

NH's performance measure is consistent with Caring for Our Children, The National Health and Safety Performance Standards Guidelines for Out of Home Child Care Programs. Although 5 of the cohort of 43 child care centers had received at least one on site CCHC consultation, none had received a visit in each month of 2006.

Notes - 2005

This is a new measure for FY07. In FY06 it was a "placeholder measure".

a. Last Year's Accomplishments

TECHNICAL ASSISTANCE:

HCCNH, a member of the state's legislatively mandated Child Care Advisory Council, provided technical assistance and data on all matters related to health and safety. (IB)

HCCNH provided technical assistance and information to the Bureau of Child Care Licensing for its revision of the Child Care rules and regulations. This is mandated for completion in 2008. (IB)

HCCNH provided technical assistance to the New Hampshire Oral Health Program manager and Southern NH Area Health Education Center in its development of a pilot project inclusive of on-site oral health training for child care facilities. (PB)

CHILD CARE HEALTH CONSULTATION TRAINING:

HCCNH provided oversight and assistance to Easter Seals New Hampshire as part of its contract

to provide child care health consultation services and health and safety trainings for child care providers.

HCCNH and Healthy Child Care Vermont trained CCHC's and Head Start Health Managers, in a four-day curriculum adapted from the National Training Institute for Child Care Health Consultants. (PB)

HCCNH provided support of CCHC's by telephone and face-to-face meetings. (PB)

HCCNH coordinated with the NH Child Care Resource and Referral Network to provide health and safety workshops throughout the state. Emphasis was placed on mentoring local health professionals as the workshop presenters. (PB, IB)

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue supervising contracted CCHC's.		X		
2. Continue facilitating the incorporation of information from other state programs into practical applications for usage by NH's child care providers.			X	X
3. Continue advocating for the inclusion of health and safety training workshops through the NH Child Care Resource and Referral Network, Early Learning NH and NH NAEYC.			X	
4. Continue collaborative efforts with Region 1 Healthy Child Care America.				X
5. Continue linking state and community resources to child care specifically through workshop delivery and onsite consultation.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

HCCNH is participating in meetings with the public advocacy organization Early Learning New Hampshire on health and safety issues in child care. (PB)

HCCNH is coordinating with New Hampshire's American Academy of Pediatrics Chapter Child Care Contact to raise awareness of pediatricians about their role supporting quality child care through their practice activities. (PB)

HCCNH is continuing to provide trainings and technical support to CCHC. (PB)

HCCNH is continuing to provide oversight and assistance to Easter Seals New Hampshire as part of their contract to provide child care health consultation services and health and safety trainings for child care providers. As part of this oversight, HCCNH is evaluating the outcomes of this project and determine if further funding is necessary to continue implementation. (IB)

c. Plan for the Coming Year

HCCNH, a member of the state's legislatively mandated Child Care Advisory Council, will

continue to provide technical assistance and data on all matters related to health and safety.

HCCNH will continue to provide oversight and assistance to Easter Seals New Hampshire as part of their contract to provide child care health consultation services and health and safety trainings for child care providers.(IB)

HCCNH will develop an internal system to ensure timely reporting of data to meet the requirements of this state performance measure. (IB)

HCCNH will examine if this performance measure with its current definition reflects the scope and nature of child care health consultation in the catchment area. (IB)

HCCNH will provide assista in the development of a business plan for a statewide system of CCHC activities. (IB)

HCCNH has received permission to use North Carolina's child care health consultation data program. HCCNH will operationalize that program with NH's CCHC encounter data. (IB)

State Performance Measure 9: [REVISED]:The percent of CSHCN who are at risk for/are overweight or obese

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				25	25
Annual Indicator					
Numerator				14	13
Denominator				164	143
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	8	8	8	8	8

Notes - 2006

This reflects those children with a BMI of 95% or greater. If the population of children with a BMI of 85-95% (identified by the CDC as "at risk for overweight") is included, the percentage more than doubles from 8.54% to 18.9%. This is the first year of data collection for this measure. The numbers represent solely a select population of children who are being served by the Neuromotor Clinic Program. Next year's data is expected to include a larger population of children with Neuromotor conditions and those with a diagnosis of Spina Bifida.

Notes - 2005

This is a new performance measure and as of the end of this fiscal year there is no data available to submit.

a. Last Year's Accomplishments

Activities this year focused on the implementation of the pilot program initially titled: Youths with Special Needs: Food and Fitness Program. Once the decision was made to move forward with this pilot program, with contract funding, further development and design meetings were held to facilitate initiation. The program name was changed to Healthy and Independent Participation in Fitness (HIPFit) and goals and objectives were refined. The design included identification of provider roles, facilities to be used, participant features and objective and subjective measures to be utilized. The group design focused on both group and individual education, which was best suited to a small participant group. There have been two sessions of the HIPFit, which have involved 4-5 students (and parents/support persons) in each session. Data collection

(anthropometric, nutrition knowledge) took place at the start and end of each of two pilot sessions and a satisfaction survey was done at the completion of each session. This data will be available for discussion and planning of future sessions in the next fiscal year.

SMS staff (Butler) was a member of the Steering Committee of the NH Healthy Schools Coalition, it is the NH affiliate for the National Action for Healthy Kids (AFHK). AFHK was formed specifically to address the epidemic of overweight, undernourished and sedentary youth by focusing on changes at school. Butler will represent the special considerations associated with CSHCN.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued multidisciplinary program design to include: nursing, physical therapy, and nutrition for children with mobility impairment, who are at risk for/are overweight or obese.		X		X
2. Continued to use data collection tool (BMI, Ht. & wt, age of child) and review process used across SMS neuromotor clinic populations		X		X
3. SMS participation in the NH affiliate of the National Action for Healthy Kids				X
4. SMS representation at the national meeting of the National Action for Healthy Kids				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The data for the outcome-based measure was expected to include a larger population, in this reporting year. SMS staff (Cahill) had reviewed this measure with the clinical coordinator of Dartmouth-Hitchcock Medical Center Spina Bifida clinic. However, this year the data was not obtained from DHMC due to their staffing limitations. Therefore the data this year continues to capture the population of participants in the SMS' neuromotor clinics .

The HIPFit program was continued (see attachment). However, when the coordinator attempted to schedule the HIPFit sessions it became evident that without the capacity to relocate the program, families who were interested found it a hardship to travel to the program 3 times a week. 3 sessions were held 2 previous participants who wanted to continue with the program. Goals of the program included: fitness education, family education, reinforcement of health eating habits, identification and encouragement of appropriate home exercise and demonstration of non-typical forms of fitness such as yoga. One of these participants (non-ambulatory) demonstrated the program's effectiveness with a 19 pound weight loss.

SMS staff (Butler) continued to participate in the NH Healthy Schools Coalition, and in other statewide efforts to develop an obesity plan. She also was invited and attended the national meeting in Chicago, IL of the National Action for Healthy Kids initiative.

An attachment is included in this section.

c. Plan for the Coming Year

SMS will continue to focus on obtaining data for the outcome-based measure from a larger population, in the next reporting year. The data collection tool will be utilized to capture the joint populations of participants in both the neuromotor clinics and the spina bifida clinics. This data continues to be significant in relation to trends in the spina bifida population that attribute a rate of overweight/obesity (particularly in youth and young adults) of up to 50%. If necessary SMS will offer administrative staff support to collect this data. Trends in this data will be an important addition to statewide data for "typical" children and will help to guide additional services.

The plan is to not continue the HIPFit program. At this point in time the resources needed to continue it are not justified by the limited participation. However, family and youth responsiveness to the program indicate continued needs in addressing physical activity and nutrition education for this population. The clinical providers of the HIPFit program will be reviewing individual components in order to identify aspects that might be able to be shared with other groups/providers. The goal of this effort will be to attempt to facilitate the spread of tools/techniques that might be beneficial to CSHCN, who are not candidates due to their lack of proximity to the facilities utilized. This information will be used to create fact sheets and/or informational packets on Healthy activity and Healthy Eating for children with balance and mobility issues. It will be provided to participants in the Neuromotor and Spina Bifida clinics and will be available to Physical Education instructors and community recreation providers.

SMS staff (Butler) will continue to participate in the NH Healthy Schools Coalition in other statewide efforts to help to represent the unique needs of CSHCN.

State Performance Measure 10: *[REVISED]: The percent of respite/childcare providers, serving medically and behaviorally complex children, who have participated in competence-based training.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				0	20
Annual Indicator					
Numerator				0	0
Denominator				1	1
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	20	40	60	80	100

Notes - 2006

The indicator for this measure is zero based on the fact that the competency based training program is still in active development.

Notes - 2005

This is a new performance measure and as of the end of this fiscal year there is no data to submit.

a. Last Year's Accomplishments

An application for a three-year planning grant, from the NH Endowment for Health (EFH), was submitted. This initiative involved the state Title V staff, a parent consultant, Bureau of Behavioral Health staff, Director/parent of Council for Children and Adolescents with Chronic Health Conditions and a partner knowledgeable in medically fragile children from the private sector. The funding was not obtained, but the formal project commenced in July of 2007 utilizing the work plan (logic model) developed for the EFH. Early Childhood Systems Program Specialist (Kaiser) informally and formally investigated the various respite programs in NH and has participated in-

group meetings with individuals from area agency, community mental health, visiting nursing and parent organizations to identify their differences in respite programs.

Additional meetings with State Agency personnel in Children and Adolescent Behavioral Health, Developmental Services (Area Agencies and Early Supports and Services), Child Care Bureau, Maternal Child Health including the ECCS and Healthy Child Care Coordinators, have been attended to foster support and collaboration for this project. Ms. Kaiser participated in the identification of core competencies in Vermont for their Early Childhood Childcare and Children's Mental Health. Ms. Kaiser has participated in a Seacoast Autism Advisory Respite Planning group and is a consultant to a "respite drop-in" facility for children with developmental disabilities. The Bureau of Behavioral Health Child and Adolescent Services staff position has been vacant since November 2007. This position is important to oversee all the State of NH Child and Adolescent Behavioral Health Services as well as an integral part of the partnership in this respite/childcare initiative. This initiative has been slowly moving forward with only the one staff at SMS (Kaiser).

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Informally and formally gathered information about current respite curricula available in NH.				X
2. Coordination of a subgroup of collaborators representing families, state agencies and private not-for-profits to continue to work within the logic model work plan that was submitted on September 30, 2006 to the NH Endowment for Health.				X
3. Meeting with individuals and groups in state agencies and communities regarding respite/childcare needs for medically and behaviorally complex children and fostering collaboration among the individuals and groups.				X
4. Continue to investigate other states respite/childcare programs and curricula with competencies.				X
5. Participating in State and local activities that are associated with respite/childcare to help build collaboration and infrastructure.				X
6. Increase the Advisory Planning Respite Group to include representatives from agencies representing Foster Care and Developmental Service				X
7. Advisory Planning Respite Group will identify from curricula and competencies available the best to meet the basic needs of the families with CSHCN respite/child care in NH				X
8.				
9.				
10.				

b. Current Activities

The Administrator in the Bureau of Behavioral Health Child and Adolescent retired and this staff position has been vacant since November 2007, due to staff hiring freeze in the State of NH. This position is an important conduit to all the directors and programs in the State of NH Child and Adolescent Behavioral Health Services as well as an integral part of the partnership in this respite/childcare initiative. This initiative has been slowly moving forward with only the one staff at SMS (Kaiser). Inventory and review of training outlines, via web search, with the identification of the core elements critical to a basic respite curriculum was completed. The advisory group reviewed the outlines and core elements on April 16, 2008. The respite/childcare initiative

advisory group identified the core competencies necessary to provide quality respite/childcare services to CSHCN. They identified questions for a formal survey of current curricula and training outlines by NH service providers and training programs. This survey was completed June 2, 2008. Over thirty representatives from various agencies and programs in NH responded to the survey. There is no consistent basic competency based curriculum in NH for Respite/Child Care providers, and most of the curriculums are disability specific, and are not shared geographically among similar agencies serving similar clientele.

c. Plan for the Coming Year

The current advisory group (Title V staff, parent consultant, State Children and Adolescent Behavioral Health staff, Parent/Director Council for Children and Adolescents with Chronic Health Conditions (CCACHC) and a partner knowledgeable in medically fragile children from the private sector) will be expanded to include Bureau of Developmental Services (BDS) and Division of Children Youth and Family (DCYF) Foster Care. The advisory group will consider the survey results and identify the training mechanisms that will meet the wide diversity of provider workforce needs; and initiate curriculum development that will be shared with identified partners across the State of NH. This group will identify the core elements and competencies necessary to address each core element and is reflective of diverse geographic, cultural and disability concerns as well as to identify potential qualified training partners and their constituents. Core elements and competencies will be integrated into a curriculum in a series of modules and an evaluation tool will be developed to be utilized at the conclusion of each training. State of the art technologies will be identified that may be applicable to the training of providers that will increase efficiency and access and minimize costs. Planning will also involve an investigation of mechanisms to maintain sustainability and to tie funding for respite services to quality training initiatives.

E. Health Status Indicators

The NH Title V program faces several challenges in utilizing these health status indicators to direct public health efforts, provide surveillance and monitoring, and evaluate the effectiveness of programs. The primary limitation is the scope to which Title V can affect population-based indicators. Through our partnerships with community health centers, community based organizations and other state agencies, Title V provides assistance and leadership in developing promising practices and strategies to address the needs that these indicators illustrate. The limitation occurs in the amount of resources Title V can provide to support these efforts.

Title V has also encountered infrastructure challenges in accessing and using the most current data that MCHB requests as health status indicators. The NH Division of Vital Records (VR) moved from the Department of Health and Human Services (DHHS) to the Department of State (DOS) in 2003. This move has reduced the influence of the Division of Public Health Services (DPHS) on the quality and timeliness of Vital Records data in New Hampshire. While NH law protects public health access to the data, the quality and timeliness is not adequately addressed.

DPHS senior management, MCH and Health Statistics epidemiological staff recognize the critical need for timely and accurate vital records in public health. As a result, efforts are underway to address these issues within New Hampshire.

//2008/ The MCH Epidemiologist participates on the Vital Records Advisory Committee (DVRA). Recently passed legislation has clarified the reporting requirement for the advisory committee on the quality of vital records information. The committee is now mandated to produce an annual report on the quality of the prior year's vital records data, including the completeness of data on events that occurred out of state. It is anticipated that this will lead to higher quality and more timely data.//2008//

/2009/ In 2008, the DVRA completed work on a software application to facilitate entry of out-of-state NH resident births into the NH system. Out-of-state births to NH residents are currently being entered for 2005 and are expected to be complete by summer 2008. Subsequent years will follow. The phased implementation of the national revised certificate of live birth presents significant challenges to this process since surrounding states were not using the new version in 2005 and 2006 and several items are not comparable across years. Among states in New England Region I, NH has the highest proportion of resident births occurring out-of-state, with a rate of 11-12% annually. //2009//

HEALTH STATUS INDICATORS

LOW BIRTH WEIGHT:

Health Status Indicator #01A

The percent of live births weighing less than 2,500 grams.

Health Status Indicator #01B

The percent of live singleton births weighing less than 2,500 grams.

Health Status Indicator # 02A

The percent of live births weighing less than 1,500 grams.

Health Status Indicator # 02B

The percent of live singleton births weighing less than 1,500 grams.

Low birth weight (LBW) is a strong predictor of infant health and survival. LBW babies may face serious health and development complications such as respiratory disorders, intestinal complications and developmental delays. Infants born below 5.5 pounds (2,500 grams) are low birth weight. Very low birth weight (VLBW) infants are those born at less than 1,500 grams. Normal birth weight ranges from 2,500 to 3,999 grams, and high birth weight is defined as 4,000 grams or greater.

/2008/

In 2006, 6.4%, or 817 New Hampshire infants, were born weighing less than 2,500 grams. The number of VLBW babies, weighing less than 1500 grams, is very small. Only 1% of all births in NH were very low birth weight (0.6 % of singletons). The 2006 LBW rate among singleton births is 4.3%. Although this data has not significantly changed in the past few years and continues to compare favorably with the rest of the United States, it does not negate the emotional, medical, and economic costs of low birth weight babies. This data creates a powerful incentive to address prevention efforts throughout NH communities.

//2008//

In 2005, MCH completed a statewide Perinatal Periods Of Risk (PPOR) and Population Attributable Risk (PAR) analysis using 1999 through 2003 data from New Hampshire birth records. The preliminary data were presented to the MCH Birth Outcomes Workgroup (BOW) and invited representatives from health care organizations. The final results of the PPOR and PAR along with a SWOT assessment will form the basis of MCHS recommendations to the BOW.

In coordination with SSDI activities, the Prenatal Data Linkage Project was formed to link MCH-funded prenatal clinic records and NH birth data to assure MCHS is able to fully understand and respond to the needs of, and threats to, pregnant women and newborns. Additionally, this project will greatly assist in program management, policy development, and evaluation of health services to pregnant women and newborns. This data from this linkage will be used in comparison with the indicators listed above to more accurately describe the health of the vulnerable populations that receive care in MCH funded health agencies. ***/2009/ The PCDF is now operational; data on all clients entering care at MCHS-funded prenatal clinics on or after July 1, 2007 is being entered into the system. //2009//***

MCH has used the indicators above to advocate for a waiver that would increase eligibility to make Medicaid-supported family planning services available to all individuals at or below 185% of FPL (the same level at which pregnant women are entitled to Medicaid coverage.) This would ensure that women who deliver a baby while covered by Medicaid would continue to be covered for family planning services.

It would also provide coverage to women who have never been pregnant and potentially their partners and families. Broad based coverage can prevent first pregnancies among individuals who do not wish to be pregnant, prevent more costs related to Medicaid-funded births and promote healthy decision making about childbearing among young women. Some of these low-income young women are among those who are most likely to have poor (and costly) birth outcomes

MCH is hopeful that the DHHS will move forward on its waiver application in FY2007. Preliminary discussions have begun and MCH anticipates that continued surveillance of data will provide continued evidence to move forward on this promising practice.

/2008/

MCH is pleased to update information on a proposed Medicaid waiver for family planning services. Legislation in support of this concept was introduced in 2007 that states that the NH Department of Health and Human Services shall develop a Medicaid waiver to support the extension of Medicaid-allowable family planning services, as defined in the state's Medicaid plan, to Medicaid-eligible clients. As passed, the Department of Health and Human Services will present the proposed waiver design, including proposed coverage groups and budget neutrality calculation, to the legislative fiscal committee prior to submission of a final concept paper to the Centers for Medicare and Medicaid Services (CMS) for federal approval.//2008//

/2009/ With consent from the legislative committee in support of development of the waiver, work on the family planning waiver has been delayed until 2009 when it is anticipated that federal partners will have better guidance for states in what elements should be included for a successful application. //2009//

Most women enter prenatal care at 8-12 weeks post conception and the period prior to this is the time when the greatest risks to fetal development occur. Promoting good health prior to pregnancy is an important way to reduce these risks./2008/ MCH is working with partners such as the March of Dimes to promote preconception health. In addition, New Hampshire will work with all of Region I in planning a meeting with Dr Neal Halfon to better understand how a lifecourse perspective would lead to systems changes that would support positive health outcomes. The team from NH will utilize the data from these Health Status Indicators as part of that day-long strategic planning session. //2008//

Overall, the Health Status Indicators referenced above provide a means to monitor long-term progress in developing interventions to address low birth weight. Because New Hampshire's data describes a state that on the whole, has favorable outcomes, additional analysis that describes disparities based upon race/ethnicity and to a greater extent on age and payer source, will provide greater insight as to where to focus narrowly tailored programs.

UNINTENTIONAL INJURIES

Health Status Indicator # 03A

The death rate due to unintentional injuries among children aged 14 years and younger.

Health Status Indicator # 03B

The death rate for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

Health Status Indicator # 03C

The death rate for unintentional injuries for youth aged 15 through 24 years old due to motor vehicle crashes.

Health Status Indicator # 04A

The rate of all non-fatal injuries among children aged 14 years and younger.

Health Status Indicator # 04B

The rate of non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger.

Health Status Indicator # 04C

The rate of non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

The Injury Prevention Program (IPP) seeks to reduce morbidity and mortality from intentional and unintentional injuries in New Hampshire. The program focuses its efforts on those high incidence injuries that are most amenable to public health interventions.

//2008//

A crucial first step in any of this work entails the collection and analysis of the data, including the MCH health status indicators. The IPP works with the Injury Surveillance Manager out of the Health Statistics and Data Management Section of DPHS, as well as other colleagues in the state, to gather and analyze injury data on the State's residents and then use this to guide prevention efforts. //2008// **2009/Unfortunately, the Injury Surveillance Manager position is now vacant and due to a state hiring freeze, it is unclear if or when it will be filled.**

MCH invited a State Technical Assessment Team (STAT) visit in June 2008. This process brings a team of injury prevention professionals into the state to assess the status of the injury and violence prevention program focusing on five core components of successful state health department injury and violence prevention programs including: 1) Infrastructure; 2) Data Collection, Analysis, and Dissemination; 3) Intervention: Design, Implementation and Evaluation; 4) Technical Support and Training; and 5) Public Policy. The IPP is hoping that the recommendations include a strong advocacy for injury surveillance. //2009//

Much of the IPP's prevention work regarding injuries among children and families is done in collaboration with the Injury Prevention Center (IPC) at Dartmouth Hitchcock Medical Center. As partners, these programs collaborate with other organizations throughout the state looking at the data to: provide training and technical assistance to professionals and the public; promote and implement effective prevention programs; and evaluate the impact of these activities. //2008// The health status indicators serve as a monitoring tool and overall outcome goal for the prevention efforts. //2008// The overall program design focuses on integrating injury prevention and control activities into existing health care and other community based services.

Preventable injuries rank as the leading cause of injury death for all New Hampshire children and young adults age 1-24. The types of injuries are somewhat different among age groups with injuries such as drowning and fire related injuries among 1-4 year olds and motor vehicle related deaths among 5-9 year olds. The rate of non-fatal motor vehicle injuries for children 14 and younger is 10.1 per 100,000. That rate significantly increases as children move into adolescence. The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years in 2004 was 96.

Motor vehicle crashes are the leading cause of injury and death in New Hampshire. This data, in addition to other data sets, provides the rationale for the IPP's focus on motor vehicle crashes and the Injury Prevention Program 2005 State Plan recommends several focus areas for public

policy review and program activity.

- Enhance educational programs for the law enforcement community, the media, employers, insurers, driver educators, legislators, and judges about best practice prevention strategies in reducing fatalities and severity of injuries in an automobile crash.
- Develop public private partnerships to support best practice prevention strategies in reducing fatalities and severity of injuries in an automobile crash for all walks of life, professional and personal. This includes activities related to the concept of Graduated Licensing and the promotion of the reduction of distracted/ exhausted drivers behind the wheel.
- Promote programs that address the physiologic effects of alcoholic and other impairing substances on driving.
- Regularly convene representatives from the NH Traffic Safety Commission, the Departments of Safety, Education, Transportation, Health and Human Services, NH Highway Safety Agency as well as other injury prevention and health education organizations to review current data and to recommend changes in policy or procedure as necessary, specifically focused on restraint use among different populations and law enforcement and protocols regarding driving under the influence.

In part, the Health Status Indicators above provided a rationale for the MCH IPP to receive technical assistance in 2006 regarding best practices in increasing adolescent seat belt use. The IPP with the Children's Safety Network (CSN) will develop a literature and key informant review and a one-day information sharing symposium.

//2008// The CSN will present findings in an interactive seminar to two community teams and state professionals. The Teen Driving Committee is hosting this seminar at a high school in the northern part of the state. One of the projects of the Teen Driving Committee has been acting as the chair of the adolescent and elderly driver subcommittee of the New Hampshire Highway Strategic Plan (spearheaded by the Department of Transportation). This has resulted in draft recommendations on adolescent drivers coming out within the next year. The motor vehicle health indicator and additional data helped guide the development of these recommendations.//2008//

/2009/In 2004, 30% of the total number of EMS runs were due to adolescent injuries in motor vehicle crashes. Emergency Department (ED) visits for NH youth 15-19 years old decreased from 2000 to 2001 and have since remained stable. In 2004, the rate for male adolescents 10 to 14 years was 212.6 ED visits per 100,000 people. For females, the rate was 307.7 ED visits per 100,000 people. For male adolescents age 15-19, the rate predictably increases to 1,927.5 visits per 100,000 people. For females in the same age category, it is 2,765.8. ED visits for adolescents due to motor vehicle crashes cost the state approximately two and a half million dollars in 2004.

Adolescents hold 7% of the licenses in the state of New Hampshire. Strategies in the Strategic Highway Safety Plan include: Increase Enforcement of Existing Seat Belt Laws; Increase Community Engaging in Enforcement and Education on Adolescent Seat Belt Use; Strengthen Graduated Licensing Law and Add Advanced Skill Training to Driver Education.//2009//

Alcohol plays a large part in motor vehicle fatalities in New Hampshire as elsewhere. In 2004 among all ages, 35% of fatalities involved a .08 or higher blood alcohol content. In 2000, alcohol was a factor in 21% of New Hampshire's crash costs. Alcohol-related crashes in New Hampshire cost the public an estimated four hundred million dollars including monetary and quality of life costs.

CHLAMYDIA
Health Status Indicator #05A

The rate per 1000 women aged 15 through 19 years with a reported case of chlamydia.
2006: 11.5
Health Status Indicator #05B
The rate per 1000 women aged 20 through 44 years with a reported case of chlamydia.
2006: 21.1

New Hampshire sees its highest rates of chlamydia among women less than 25 years of age. The state monitors chlamydia through the STD MIS System and reports age specific rates for various age groups.

/2009/

Historically, the highest rates have been among 20-24 year olds with 15-19 year olds having the next highest rates, but this is changing. Data is provided to state residents and providers through educational programs and reports offered by the STD Program and by the Family Planning Program (FPP). Because of the high rates of chlamydia among adolescents, the STD program prioritizes this age group for follow-up education, assurance that treatment was completed and partner tracking. The Program follows the 2006 CDC STD Treatment Guidelines. The FPP, supported by the Infertility Prevention Project, urges all contract agencies to test all female clients under 25 at least annually for chlamydia. This is monitored as a performance measure for family planning agencies and is evaluated annually. In NH SFY07, family planning agencies tested 46% of all female clients less than 25 years of age, a significant increase from the rate of 26% tested in FY01 when formal evaluation began.

In spite of the efforts describe above, New Hampshire is continuing to see an increase in cases of chlamydia but the rate may be leveling or decreasing. The 2007 rate per 1000 women aged 15-19 years with a reported case of chlamydia was 9.4. In 2003 that rate rose to 11.6 and 2007 data indicates the rate was 12.0.

The STD Program and the FPP are taking several steps to assure that all publicly funded programs are adhering to STD Treatment Guidelines and accordingly using practices that will ultimately reduce infection carriage. They are investigating the proportion of positive cases who either don't get timely treatment (within 30 days of diagnosis) or who are not retested within 3-4 months of a positive test result. With this information, they are identifying barriers to implementing these recommended treatment standards and training sites on ways to overcome them.

The STD program is also evaluating the use of expedited partner therapy (EPT) to increase the number of partners to diagnosed cases of chlamydia who are treated. In EPT if the partner of an individual who is diagnosed cannot be persuaded to come to the clinic for treatment, the original patient can be given medication for her/his partners along with information on the infection, instructions for using the medication and advice to notify other who may be infected. In other states, this system has increased success in treating the partners of infected individuals.

//2009//

DEMOGRAPHICS

Health Status Indicator #06A -
Infants and children aged 0 through 24 years by age group and race.

Health Status Indicator #06B -
Infants and children aged 0 through 24 years .

Health Status Indicator #07A -
Live births to women (of all ages) enumerated by maternal age and race by age group and ethnicity.

Health Status Indicator #07B

Live births to women (of all ages) by maternal age and ethnicity.

Health Status Indicator #08A -

Deaths of Infants and children aged 0 through 24 years by age and race.

Health Status Indicator #08B -

Deaths of Infants and children aged 0 through 24 years by age and ethnicity.

POPULATION GROWTH

While population growth in New Hampshire does exceed expectations for natural growth alone, i.e. when the number of births exceeds the number of deaths, the growth rate has slowed since 2000. NH's growth rate exceeds that of all other New England states. This is partly attributable to an inflow of people moving in from other states, most specifically Massachusetts, as well as the consistent inflow of immigrants and refugees (NH Office of Energy and Planning, Vital Signs, 2006). The state's population is expected to increase by 12.1% between 2000 and 2010 and by 23.4% between 2000 and 2020. All areas of the state are expected to experience population increases except for Coos County in the north, which is expected to experience population declines between 2000 and 2010, followed by a return to 2000 levels by 2020 (NH OEP Population Projections website, 2006).

POPULATION BY AGE GROUP

New Hampshire's population is aging; the age group with the largest expected increase by 2010 is the 55 to 64 year age group (66%); by 2020, the largest expected increase occurs in the 60 to 69 year age group (121%). The female population (all ages) is expected to increase by 12% by 2010 and 33% by 2020. (US Census Bureau, Population Division, 2005). There were an estimated 269,194 women of childbearing age (15-44 years) in NH in 2000, comprising 22% of the population. Population projections predict that women of this age group will comprise 19% of the population by 2020. (Calculated from NH OEP Population Estimates, 2005).

In 2005, 78% of all births were to white women, less than 1% each to women of other racial backgrounds, and 19% did not have race noted on the birth certificate. Five percent of women were of Hispanic ethnicity and the remaining either were non-Hispanic or ethnicity was not noted on the birth certificate.

/2008/

Fewer children live in NH than just four years ago, and those children are increasing in their ethnic and racial diversity.//2008// There were less than one half million children and youth, 0-24 years, in NH in 2005. Over 94% of those 0-24 years are White. Less than 2% of children were reported as Asian, and less than 1% of children were represented in each other racial group, Black/African American, American Indian, Pacific Islander, or with either more than one race represented or no race noted. Two percent of children and youth, 0-24 years reported Hispanic ethnicity.

New Hampshire is fortunate to have a low teen birth rate. In 2005, there were 817 births to teens. Although the state-level data is important, it is even more important to break that relatively small number down by geographic region and by payer source for the birth. Additional analyses are needed to understand if a disproportionate number of teen births are to Hispanic young women. Eleven percent of births to 15-19 year olds were to Hispanic women, compared to the fact that Hispanic young women only make up less than 2% of the total population of 15-19 year old females in 2005. By drilling down state level data, the Title V and its partners can better target and tailor programs to address teen pregnancy prevention and access to health care. For example, Family Planning Teen Clinics are strategically placed in communities with higher rates and actual numbers of teen pregnancy./2008/ These indicators are used in planning programming such as Abstinence Education and Family Planning Outreach activities.//2008//

DEATHS

In 2003, the infant mortality rate in New Hampshire (deaths per 1,000 live births) was ranked first in the nation with a rate of 3.9 compared to a national rate of 6.9. In 2003, HCSI indicator for NH was 3.4 per 1,000 overall and 4.8 per 1,000 in the Medicaid population. Threatening this favorable outcome is the recent New Hampshire trend of an upward climb in the rate of low birth weight infants. This trend is found in both singleton and multiple births. /2008/ The 2004 data seem to reveal, however, that NH dropped to a 12th place ranking for infant mortality with an overall rate of 5.6, higher than the Healthy People 2010 goal of 4.5 infant deaths per 1,000 live births. A long term perspective reveals that the NH rate traditionally has a fair amount of variability in it. This is in all likelihood due to the small numbers. It is difficult to tell from one point if this is the beginning of a trend.

To further analyze this situation, MCH will need to utilize the 2005 and 2006 out-of-state birth and death records which are, at present, unavailable from NH Vital Records. //2008//

Non-normal birth weight, either low or high birth weight, is associated with maternal age; older mothers are most likely to have non-normal birth weight infants. Younger women, however, are more at risk for having very low birth weight or moderately low birth weight infants. Disparities may also exist based upon race/ethnicity and to a greater extent on age and payer source. Improvement in birth outcomes, and the ultimate goal of reducing infant mortality for these particular subpopulations of pregnant women will require narrowly tailored and targeted interventions.

MCH has dedicated significant effort to better educate health care and social service providers about deaths in infancy caused by unsafe sleep conditions. The MCH SIDS Program Coordinator has provided many in-services to a variety of health and child care personnel on reducing the risk of SIDS, and on promoting safe sleeping to decrease deaths from accidental overlay or asphyxiation, including working with hospitals on bed sharing policies. **/2009/The SIDS Program Coordinator was part of a 5 member NH team to attend the CDC Sudden Unexplained Infant Death Investigation National Training Academy in 2007. In the following months, she shared the information at a variety of state and local conferences and trainings to improve death scene investigations to ultimately improve data collection that can be used to develop infant and child mortality prevention strategies.//2009//**

/2008/Health Status Indicators have also been used to help provide a rationale for the expansion of Newborn Screening in NH. While most newborns appear healthy at birth, they may be affected by disorders that are not clinically apparent and need to be identified before clinical symptoms present in order to improve outcomes and possibly prevent death. In May 2006, the NH newborn screening panel expanded from a panel of six conditions to a panel of 13 conditions, including Cystic Fibrosis. In July 2007, once again the panel will expand to a total of 32 conditions ensuring that more infants will receive timely clinical care. //2008//

Deaths among older children **/2009/Deaths among children older than one are often attributable to injury. Populations that require attention include adolescents aged 15-19 years and young adults aged 20-24 years. Motor vehicle deaths are common in these data sets. /2009/ NH mirrors the national trend of Unintentional Injury and specifically Motor Vehicle related injuries being the leading cause of death among adolescents in these age groups. However, poisonings are trending up as the second leading cause, especially with unintentional poisonings with prescription drugs. //2009//** This data is the basis for promoting activities aimed at improving seat belt usage among adolescents.

Suicide is another unfortunate factor in these age groups. **/2009/ Attempted suicides in high school students in the 2005 NH YRBS were reported by 10.8% of female students and 2.8% of male students.//2009//** Title V has focused increased attention to suicide prevention activities in partnership with mental health agencies and community-based partners.

The Health Status Indicators referenced above provide a means to better understand the needs of our state. By monitoring the changes in populations, MCH can better target programs and assistance for providing culturally competent care in various regions throughout the state. Population data also allows us to track growing populations. This information is critical as potentially new funding allocations are developed for community health centers, safety net providers and other MCH funded agencies.

Clearly, New Hampshire is in the fortunate position of having few child deaths. The Child Fatality Review, in which MCH participates, is able to investigate deaths that appear troublesome or from which state systems can learn lessons and develop strategies to prevent further injury or death. There are so few child deaths in the state annually (190 deaths in children age 0-24 in 2005) that any analyses on the data require the use of multi-year trends, especially in regard to differences among ethnic or racial groups. As noted earlier in this section, the IPP in MCH actively monitors and utilizes death data on unintentional injury and motor vehicle crashes. From sentinel events and trends, the IPP has mobilized partners in state agencies and community-based organizations to promote education and policy to prevent further injury or death.

DATA LIMITATIONS

After the move of the NH Division Vital Records (VR) from the Department of Health and Human Services (DHHS) to the Department of State (DOS) in 2003, DPHS has had a smaller influence on the quality and timeliness of Vital Records data in NH.

This move has greatly affected the quality of the data that can be reported by DPHS and the Title V program. A significant challenge has been the timeliness with which out-of-state birth and death records for NH residents are obtained and entered into the database. Additionally, the structure of the VR datasets has changed drastically for certain fields, most notably race and ethnicity allowing for multiple responses. These data are now much more difficult to use. The MCH epidemiologist has developed new methods to deal with the new structure.

STATE PROGRAMS

HSI #09A - Demographics (Miscellaneous Data)

Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race.

HSI #09B - Demographics (Miscellaneous Data)

Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by ethnicity.

These data are complex and tell many stories. By looking at the numbers of children in certain programs such as WIC and Food Stamps, it is apparent that poverty is affecting the lives of NH residents; the percentage of children receiving food stamps is at its highest point in a decade. But this connection is a critical component of the activities that MCH seeks to fund and support in community health centers and other MCH-funded social service programs such as home visiting. Title V programs understand that with limited resources, health care providers must leverage all possible supports for the families that they serve.

When the data is broken down by race and ethnicity, it is clear that minorities are disproportionately represented. As stated throughout this section and this application, further disparities would be noted if the data were analyzed by geographic region. Not only is the population of children greater in the southern and eastern section of the state, the populations of racial and ethnic minorities are more represented in these areas.

However, in the more rural areas of the state, the effects of poverty are often magnified as access to services, such as WIC, is compromised by geographic isolation. Across Northern New England as a whole, the child poverty rate is 40% higher than in non-rural areas. Rural families are more

likely to be under-, self-employed or unemployed. They often lack access to work sponsored health insurance and other benefits. /2008/ In the poorest towns of NH and often the most rural, children are five times more likely to be born to a mother without a high school degree. //2008//

Although only 2.5% of children are enrolled in TANF, new federal requirements that increase requirements for adults, including mothers with young children, to participate in work activities instead of training or education will likely to stress systems currently in place that support MCH populations. MCH is prepared to monitor these changes and respond with increased attention with programs such as Healthy Child Care NH, to ensure that families have access to quality child care alternatives.

The Health Status Indicators provide a means to better understand both the connectedness of families to services, and monitor trends in data such as school drop out and juvenile arrests. By monitoring these indicators, MCH can better target programs and assistance for providing culturally competent care in various regions throughout the state.

GEOGRAPHIC LIVING AREA

HSI #10 - Demographics (Geographic Living Area)

Geographic living area for all resident children aged 0 through 19 years old.

New Hampshire's total population is just over 1.2 million, with 49% residing in rural areas and 51% in urban areas (NH OEP, 2000). Seventy-seven percent of New Hampshire towns are considered non-urban or rural, with urban and near urban areas located in the south east and south central regions and primarily rural areas in the western, central and northern sections. The three most urban areas are Manchester, Nashua and Concord, all located in the state's southern third. Manchester, the only New Hampshire city with a population over 100,000, is the largest city in the tri-state area of Maine, New Hampshire, and Vermont.

Hillsborough County includes the two largest cities of Manchester and Nashua and is the most densely populated area with 380,841 residents (30% of the total population). The White Mountain National Forest separates the south from the northernmost rural section of the state, which consists of Coos County. New Hampshire citizens in rural communities face geographic barriers to health care such as lack of transportation and increased travel time to health care providers and hospitals.

Interestingly, although NH has no metropolitan areas, as defined by the US Census, 60% of children 19 years and younger live in urban areas and 40% of children live in rural areas. This indicates, once again, that the rural areas of the state are aging while the more urban areas of the state are experiencing population growth, including families with children./2008/ Nine percent of children in rural areas live in poverty. //2008//

This information confirms what is anecdotally known throughout the state. The needs of the state vary by geography. Population and services are concentrated in the southern and eastern areas of the state. The northern areas of the state are aging and services for children are located farther apart. Health care providers are in short supply in these areas, especially in the fields of oral health and mental health services. As for all populations in northern areas, transportation needs compound these challenges. Population data drives innovative strategies such as telehealth services. Title V continues to monitor these changes to support safety net providers in developing service delivery methods to meet the needs of their specific communities.

POVERTY LEVEL

HSI #11 - Demographics (Poverty Levels)

Percent of population at various levels of the federal poverty level.

HSI #12 - Demographics (Poverty Levels)

Percent of population aged 0 through 19 at various levels of the federal poverty level.

According to the 2006 Kids Count Data Book, New Hampshire experienced a 67 percent increase in child poverty from 2000 to 2004, rising from 6% to 10% of the state's children living in poverty. For children under age six, 13 % live below the federal poverty level. Despite this dramatic increase, New Hampshire is tied with Connecticut for the lowest child poverty rate in the nation. ***/2009/Yet, our numbers in poverty continue to trend upwards parallel to national figures. //2009//***

The Health Status Indicators above provide a means to better understand the needs of our state. Although 2000 Census data used in this Health Status Indicator represents the overall population, and is not presented separately for children, it is commonly accepted that often children, especially the youngest children, are disproportionately affected by poverty. By monitoring the changes in levels of poverty, MCH can better anticipate the needs of community-based safety net providers that provide care low income and vulnerable families. re-allocation of resources for community health centers and safety net providers

F. Other Program Activities

PRESCHOOL VISION AND HEARING SCREENING PROGRAM (PSVH): Program staff and trained community volunteers have provided hearing and vision screening and follow-up for preschool children since the 1960s, targeting low-income families without access to affordable health care services. Declining enrollments in screening clinics and staffing constraints prompted MCH to re-evaluate this program in 2005. ***/2007/S***creening clinics were gradually phased out in 2006 with encouragement to refer uninsured children and/or those without a medical home to Title V-funded programs for assistance with Healthy Kids enrollment and health care services at the community health centers. The PSVHSP Coordinator surveyed the Title V MCH funded agencies and headstart Programs on their technical assistance needs and will be providing on-site training as requested. ***//2007//2009/ The PSVHSP Coordinator provided several on-site trainings to Headstart Programs, CHCs, and private physician offices in addition to loaning out the PSVHSP equipment. With the revised Bright Futures, MCH will be surveying its contract agencies on training needs in June 2008 to better carry out screening services, including vision and hearing screening of children.//2009//***

NEW HAMPSHIRE BIRTH CONDITIONS PROGRAM: Dartmouth Medical School (DMS), SMS, MCH, WIC, and Early Intervention continue to collaborate on the implementation of a birth defect surveillance system for NH. Funded through a CDC cooperative agreement, the project is: establishing a high quality, statewide, comprehensive birth defect surveillance system; expanding NH folic acid education and birth defect prevention activities; and improving access to health care and early intervention services for infants with birth defects. The MCH and SMS Directors are active members of the project's Advisory Council. MCH provides support as appropriate, such as development of the MOU between DHHS and Dartmouth, and a letter outlining the project to encourage hospital participation. ***/2009/ In June 2008, the program was established in law to be under the authority and direction of DHHS. While it will continue to be housed at DMS, a new advisory board structure will monitor and oversee the program. MCH will also have new roles in oversight of the "opt out" process for inclusion in the program.//2009//***

ELDERLY FALLS: Taking it Back to Your Community and Making it Work". The project concluded with a June 2006 conference that highlighted each teams' efforts and nationally recognized speakers that presented new interventions, such as vitamin D supplementation. ***//2007///2009/ A paper based upon community efforts in, "Evidence Based Falls Risk Reduction in the Elderly: Taking It Back To Your Community And Making It Work" was drafted with the Harvard Injury Prevention and Control Research Center. Community-based organizations implemented exercise programs and falls risk screenings, referred adults to therapists, and facilitated home safety surveys and follow-up. They tracked participants' functional status using***

standard assessment tools, monitored 9-1-1 calls and Emergency Department visits for falls. By contrast, teams in clinical and residential settings instituted environmental changes (e.g., improved lighting), improved risk assessments and developed protocols for alerting staff to those at high-risk for falls. They tracked falls and falls-risk within their settings. Among all teams, the falls and fall injury rates trended downward.

Falls screening among older adults was added as a clinical assessment in the scope of services for all MCH funded community health centers. As a response, the New Hampshire Falls Risk Reduction Task Force was contracted to provide geriatrician lead trainings on facilitating these screenings in practices. //2009//

/2009/

STATE TECHNICAL ASSISTANCE TEAM (STAT) VISIT: The Injury Prevention Program is hosting a STAT visit during June 2008. This process brings a team of injury prevention professionals into the state to assess the status of the injury and violence prevention program focusing on five core components of successful state injury and violence prevention programs including: 1) Infrastructure; 2) Data Collection, Analysis, and Dissemination; 3) Intervention: Design, Implementation and Evaluation; 4) Technical Support and Training; and 5) Public Policy.//2009//

/2007/ POISON PREVENTION: The IPP coordinates the Northern New England Poison Center's NH Educator in the following: poison prevention information designed specifically for the non-English speaking population an inhalant abuse prevention campaign; and a carbon monoxide awareness effort coordinated with the IPP and the CPSC. //2007//2009/The Northern New England Poison Center continues to be New Hampshire's contracted poison center with the regional educator sitting in MCH's Injury Prevention Program. This year focused on the growing issue of deaths from methadone poisonings and unintentional medication use. The regional educator also designed a social marketing campaign on medication misuse in the older adult population with input from the state's Council on Aging. //2009//

/2008/HEALTHY CHILDCARE NH is working with Child Care Licensing to implement a new requirement for medication administration training for child care providers.//2008// /2009/ Pending legislative approval of a mandated medication administration training for child care providers, Healthy Child Care NH will work with the NH Child Development Bureau and Child Care Licensing on implementation of an on-line course.//2009//

/2009/

TEEN DRIVING: The teen driving group is coordinated by the Adolescent Health/Injury Prevention Program and includes region-wide professional groups. The group is pursuing a seatbelt initiative in schools and collaborating on law revisions for extended graduated driver's licensing (GDL).

NH SIDS Program -- The Program continues to provide training on reducing the risk of SIDS and promoting safe sleep to child care providers, early childhood education students, hospital staff, child protection workers, foster parents, juvenile justice staff, community health staff, and local WIC and Community Action Program staff. Over fifteen workshops were presented in FY08.

WATCH ME GROW PROJECT -- MCH & SMS staff have been participating in an initiative spearheaded by MCH's ECCS funding, DCYF and Early Supports and Services in response to CAPTA and IDEA mandates, to improve the system of universal access to developmental screening. An RFP for a community pilot site may be available in the next few months.

AUTSIM LEGISLATIVE COMMISSION- MCH staff have been participating in a commission

mandated by NH House Bill 236, to develop a report and recommendations, released spring 2008, on improving awareness, services, training, and reimbursement related to serving the needs of children and young adults with Autism Spectrum Disorders. Among the recommendations is that a council be formed to continue the work of the commission. A variety of grants are being written, including one from MCH to provide funds for recommended activities.

BRIGHT FUTURES WORKGROUP -- MCH purchased and distributed to all its contract agencies copies of the revised Bright Futures and its Pocket Guide. MCH staff met with representatives from the state-funded community health centers in April 2008, to discuss implications on the changes. MCH will be surveying the agencies for training needs in June 2008.

NH HEALTHY HOMES PLANNING PROJECT -- MCH is spearheading a planning process to move the childhood Lead Poisoning Prevention Program (CLPPP) to a Healthy Homes Program by 2010. This initiative is on the forefront of the CDC, EPA and the HUD moving forward with tri-agency healthy housing collaboration. A final implementation plan is scheduled for December 2008.

//2009//

G. Technical Assistance

/2007/

In tandem with the 2005 Title V Needs Assessment, MCH developed and participated in an extensive process to identify the health needs of MCH populations in New Hampshire and capacity needs to address health concerns. Because it is widely accepted that successful, efficient and effective organizations operate under the umbrella of a cohesive, shared vision, MCH recognized the need to re-define its vision, especially in the context of public health as a whole in New Hampshire.

In the previous Title V Block Grant, MCH indicated the need to develop a vision for MCH that is aligned with a DPHS vision that also serves the following purposes:

1. Assures that MCH strategies are integral to the overall DPHS vision
2. Assists key Title V managers in developing a shared understanding of their basic purpose, strategies and values; and
3. Enhances MCH's visibility both within and external to DPHS.

With TA support through HRSA, a visioning process is scheduled to begin in July 2006. Activities scheduled include: telephone interviews with key members of the Executive Group; a one-day retreat, "Stakes in the Ground"; follow-up one-day retreat; a final endorsed vision statement; an implementation and communication plan; and follow up activities.

/2008/ In July 2006, an executive group comprised of senior staff from the Division of Public Health Services (DPHS) and key public health stakeholders was convened to assist the DPHS to develop a vision. Voussoir Consulting was hired to lead the group through a visioning process. The group met for a day and a half retreat working with Voussoir's framework for visioning, which includes a series of questions relative to an agency's raison d'etre, values and strategies. Following these two days, Voussoir drafted a vision narrative based on the key points they extracted from the discussion. DPHS staff then rewrote the vision, giving it a DPHS voice. Subsequently, focus groups of DPHS staff had an opportunity to react to the vision narrative and to suggest to DPHS leadership how to make the vision real for staff and to infuse it throughout the organization. A subsequent rewrite has been crafted and the vision will be rolled out to DPHS in the fall 2007.**//2008//**

INJURY PREVENTION:

Increasing adolescent seat belt use: In addition, technical assistance was also obtained through HRSA in 2006 to look at best practices with respect to increasing adolescent seat belt use. The Injury Prevention Program is coordinating along with the contractor, the Children's Safety Network (CSN), a best practice project which consists of the following two phases:

A literature and key informant review: A thorough literature review on increasing adolescent seat belt use is being conducted by CSN. This is including, at a minimum, academic papers and interviews with key informants of best practice. Copies of the review will be provided to the MCH Section and colleagues in the field.

Information symposium: The second phase will be a one-day symposium, facilitated by the Children's Safety Network (and based on the review previously conducted) to approximately 30 people. This is taking place at the end of the fiscal year and is going to include colleagues in the Maternal and Child Health Section, identified professionals in the traffic safety field throughout the state and two community-based teams of five persons each. Each team is currently being selected through an application process (done by the Injury Prevention Program in tandem with the Injury Prevention Center), which is being based on seat belt usage data and past and existing community restraint programs in their area. Teams will agree to institute an adolescent restraint program, for at least one-year post workshop, in their community based on what they learn. Facilitation will also include appropriate data measures used in collecting information on seat belt usage and team effectiveness.

//2008/ The Children's Safety Network (CSN) has also provided technical assistance in several areas other than on motor vehicle issues. The first issue concerns evaluation of programs and coalitions. The Injury Prevention Program was a participant in both webinars on evaluation facilitated by Dr. Rhonda Zakocs of Boston University, CSN's evaluation consultant. In addition, Dr. Zakocs will be coming to New Hampshire to provide individualized technical assistance and consultation to the Injury Prevention Program and its contractors in evaluating the effectiveness of their coalition efforts. Since much of the work done by the Injury Prevention Program is through its coalitions, this will be very valuable.

CSN has also developed a resource on ways to integrate injury prevention into various MCH programs, which will be looked at as a guide. //2008//

//2009/The New Hampshire Injury Prevention Program prepared an application to request a State Technical Assessment Team (STAT) visit from The State and Territorial Injury Prevention Directors Association (STIPDA). The program is designed to assist state health department injury prevention programs in building their capacity to prevent injuries and violence.

The IPP program, with the help of the Health Statistics and Data Management Section put together a 1,000 page-briefing book with a description of the core components of the programs including infrastructure, interventions, data, and policy. The STAT process brought a team of injury prevention experts into a state for a five-day site visit in mid June of 2008. During the visit, the team interviewed MCH staff and 41 partners of the state's injury prevention program. The STAT team assessed the capacity of the injury prevention program to conduct primary prevention. The team also produced a report on-site, which described the status of the program and made recommendations for its advancement.

//2009//

RESOURCE ALLOCATION:

New Hampshire Title V has supported community health centers and safety net providers to serve Medicaid eligible, uninsured and under-insured residents of the state with affordable and accessible health care. The current funding methodology used to distribute resources is based upon historical assumptions of need. As the demographics of the state change and newer community health centers open their doors, New Hampshire must re-organize the methods used

to distribute limited resources. A workgroup of state level decision makers has begun this task, but it is anticipated that further assistance will be needed to provide consultation on best practices in resource allocation.//2007//

/2008/ Title V continues to support community health centers and safety net providers. In SFY07, Title V developed and released new competitive Requests for Proposals for almost all contracted services, including those for primary care. NH DHHS leadership suggested that funding strategies remain similar to past years for this competitive bid in anticipation that additional state funds may be made available for SFY08 and 09. Feedback was generated from safety net providers and stakeholders, and a team of DHHS leaders has begun the task of analyzing options, but until potential future appropriations are known, it will be impractical to make significant changes. //2008//

/2009/MCH implemented a new funding strategy in 2008 for all MCH-funded community health centers. Previously, safety net providers were funded based upon historically evolved dollar amounts that were not science-based; services were not provided statewide, nor did they have defined service areas; funding had no relation to performance and quality of services; and it ignored factors that may influence service system needs including population in need, and other resources of the area. With stakeholder input, a formula was developed that was defined, equitable, and had a useable method for distributing state resources to help assure access to health care for low income, uninsured and underserved populations in New Hampshire while minimizing/eliminating disproportionate share funding.

In 2009, a similar task force that developed the funding strategy will be working on updating MCH policies on sliding fee scales. The goal will be to have a defined, equitable, useable policy that addresses agencies' need to maintain fiscal stability while assuring access to care for low income, uninsured and underserved populations in New Hampshire. It is anticipated that TA will be required to ensure that NH understands and perhaps utilizes best practices from other regions of the country.
//2009//

/2009/

EARLY CHILDHOOD:

With support TA from Boston University's MCH program, MCH was instrumental in bringing policy leaders and legislators together for a day long conference, PRIORITIZING HEALTH DOLLARS NOW. . . .AN INVESTMENT IN NEW HAMPSHIRE'S FUTURE to discuss: the real costs associated with health care; the benefits of developing state policies to promote healthy behaviors throughout the lifespan; and the financial solutions needed to develop sound health policies during times of tight budgets. Dr Milton Kotelchuck of Boston University School of Public Health was a keynote speaker discussing, Investing in Mothers and Children: a Life Course Perspective.

NH also received TA support in 2008 to help bring Helene Stebbins, from the National Center for Children in Poverty to a symposium on early childhood policy that featured an interactive, day-long discussion and brainstorming with high level policy makers and others in the fields of early education, family support, and health. It is anticipated that there will be further needs for technical assistance as MCH participates in the planning for unified early childhood systems. //2009//

INTEGRATING BEHAVIORAL HEALTH INTO SYSTEMS OF CARE:

New Hampshire HRSA grantees have identified a mutual priority of integrating behavioral health into primary care. Through HRSA Strategic Partnership Meetings, state and community partners have asked to come together again to share the products of work assignments arranged at the Strategic Partnership Meeting and to create a plan for distribution of those products across the state while broadening participation amongst the various integration efforts across the state. It is

anticipated that New Hampshire will continue to need some technical assistance in bringing speakers to the state who can share their experience in developing integrated systems of care. In particular, New Hampshire will need assistance in researching the how to best support those systems within community health centers that receive limited support from Title V.

/2008/This continues to be a need. To address some of the issues, a team of DHHS leaders from mental health, child protection, rural health and primary care, developed a proposal for integrating adolescent mental health and primary care. Upon notice of this grant award, Title V will have a better sense of the direction and TA that will be needed to support integration of mental health services into primary care across the lifespan.//2008//

/2009/ New Hampshire partners continued to address this need. MCH TA was sought and granted to the Bi-State Primary Care Association's Primary Care Conference to bring in speakers to describe innovative ways integrating mental health in primary care.//2009//

BIRTH OUTCOMES:

Although NH's birth outcomes are among the best in the nation, disparities persist based on race/ethnicity and to a greater extent on age and payor source. Improvement in birth outcomes for these particular subpopulations of pregnant women will require narrowly tailored and targeted interventions. In addition a broad-based shift to an emphasis on preconceptional care will require the management of a change process throughout multiple practice areas as well as in public policy.

In 2005, the MCH completed statewide Perinatal Periods Of Risk (PPOR) and Population Attributable Risk (PAR) analyses using 1999 through 2003 data from New Hampshire birth records. The preliminary data were presented to the Birth Outcomes workgroup and invited representatives from health care organization. The final results of the PPOR and PAR along with a SWOT assessment will form the basis of MCHS recommendations to the Birth Outcomes Workgroup (BOW).

MCH is requesting technical assistance to design and facilitate an implementation plan among the BOW representatives and MCH funded prenatal providers. The implementation process will have an evaluation plan included. The technical assistance would provide the design and facilitation of the process as well as expertise in content and programming areas.

Additionally, outside expertise in developing targeted interventions based on stratified population data would assist the MCH to match analysis of data to the most appropriate intervention strategies. //2007//

/2008/ For 2008, NH Title V will be requesting technical assistance for the on-going needs listed above, as well as: assistance in utilizing and tracking financial data and performance measures of MCH-funded community health centers; development of a strategies to address workforce issues affecting the EHDI program; and assistance for community based agencies to increase their capacity to communicate their understanding of cultural needs and their ability to describe the services they have in place to meet those needs.//2008//

TECHNICAL ASSISTANCE FOR SPECIAL MEDICAL SERVICES (CSHCN Program)

I. Strategic Planning for Care Coordination

Special Medical Services (SMS) is requesting technical assistance, consultation, and facilitation to conduct a formal Section-level strategic planning process regarding care coordination services. This request is in accord with all identified priorities for NH CSHCN, all National and State Performance Measures for CSHCN, and Health Systems Capacity Indicator #08. /2007/ No formal technical assistance was received during 2006. SMS collaboration with the Integrated

Care for NH CSHCN makes this need even more essential for maintaining sustainability. //2007//

Assistance is needed to help guide the SMS staff in the identification of the technology, policies, and funding strategies necessary to achieve the goals of SMS. Special Medical Services offers infrastructure-building expertise to develop the NH systems of health care for CSHCN, in balance with the direct provision of community-based care coordination.

To fully actualize the principles of family-centered, community-based care, both the direct provision of service by state coordinators, and the provision of consultation to other public and private providers, is crucial. Facilitated planning will encompass the priorities and needs of NH CSHCN, their families, and the provider community. The core issue is the defining of future applications of the SMS care coordination model and determining the nature and extent of direct care coordination services provided by SMS staff and contractors, within the overall CSHCN health care system. Defining exactly which CSHCN subpopulations, which geographic areas of the state, what family impact factors, eligibility criteria, and other such specifics, is necessary in order to target the limited resources to the identified priority needs in the most effective manner.

/2008/ Special Medical Services is intending to pursue strategic planning for care coordination in conjunction with a review and planning for future program design of our clinic services. Issues that will need particular focus will be addressing program wide cultural & linguistic competency and public awareness of our Program. //2008// **/2009/ In FY 2008 this goal was put on hold while SMS acclimated into it's new organizational and physical location. The goal is to pursue this technical assistance in FY 2009. //2009//**

/2007/ II. Insurance coverage for 18-21 year old YSHCN

According to the American Academy of Pediatrics, the goal of transition in health care for young adults with special health care needs is to maximize lifelong functioning and potential through the provision of high quality and developmentally appropriate health care services that continue uninterrupted as the individual moves from adolescence to adulthood; however, this standard is very difficult to attain because of issues related to the cost of care. Typically, both private and public insurance programs discontinue coverage for children as they reach the ages of 18-21. Youth must then find private coverage (through their parent/school/work) or apply for public coverage (e.g., SSI/SSDI/Medicare, Medicaid, Title V). In addition to having to investigate and maneuver through this process, these youth frequently must meet a higher standard to qualify for coverage. It is not unusual for this standard to require that they be able to work or attend school full-time or be completely disabled and unable to do so. These are opposite ends of a continuum of physical ability and there are many degrees in between. There is great difficulty in finding coverage for those YSHCN who have significant health conditions but are able to work or attend school with modifications and considerations for their individual needs. There is a non-insurance rate of 4.7% for CSHCN while the rate increases five times to 25% for YSHCN.

Youth with special health care needs experience this lack of insurance in the form of substantial negative impacts, both physiologic and economic. In comparison to youth in general, YSHCN have poorer health status, use more services (outpatient, inpatient, specialty and ancillary), have more prescription medication, experience additional days of restricted activity, and report more unmet needs (related to financial barriers) and greater personal expense.

During FY'05-06 Special Medical Services has become acutely aware of insurance and cost of care issues for young adults within the 18-21 year old age group. Health care expenditures for youth in this group enrolled in SMS and eligible for financial assistance totaled \$50,293. This figure represents approximately one third of the dollars budgeted for overall SMS patient care services. Even more significant is the fact that six YSHCN accounted for over \$41,000 of this amount (i.e., 2 boys with cystic fibrosis, 1 boy with diabetes, 1 girl with spina bifida, 1 girl with cystic fibrosis, 1 boy with cystic fibrosis and diabetes).

SMS is requesting technical assistance to increase the skill set of nurse coordinators who are working to assist youth like these to maneuver the complex maze of state, federal and private insurance plans and their associated qualifications for coverage. In addition, it will be important to analyze future demands on the program vis-a-vis the Title V role as "insurer of last resort" for this population. Because the Catalyst Center at Boston University, School of Public Health has identified its mission as focusing on the scope, causes and consequences of medical debt and related financial hardship among families of CSHCN, it can be surmised that an essential component of this charge will be to incorporate the dilemmas related to the transition to adulthood for this population. The staff of the Catalyst Center appear to be the most appropriate professionals to assist SMS to meet the challenge posed by the insurance needs of YSHCN.//2007//

/2008/ SMS did outreach to the Catalyst Center to explore further the areas of support and consultation that might be available for addressing the areas of need that were highlighted in our 2006 survey of children who receive SSI for their own conditions. The results of that survey point to significant health care access issues. However, in order to inform statewide policy and influence future program design it is necessary to undertake a wide scale survey/data collection process that will capture a broader range of the NH population of CSHCN. //2008//

V. Budget Narrative

A. Expenditures

SIGNIFICANT EXPENDITURE VARIATIONS APPEARING ON FORMS 3-5

For the purpose of this application, "significant expenditure variation" is defined as an expended amount in any line item that is greater than 10% above or below the budgeted amount for that year. The following lines on Forms 3-5 adhere to this criterion:

Form 3:

The expended amount on Line 8, Other Federal Funds, shown for FY 2004 was less than 10% of the budgeted amount, due to delays in accepting those federal grants into the state budget as well as delays in staffing projects during a state hiring freeze.

Form 4:

Line Id: The expended amount for CSHCN was greater than budgeted amount by 17%, due to one anticipated SMS contract that was not approved, and reductions in other SMS contracts during that SFY.

Line If: The increase in the expended amount for Administration is due to a change in the formula used to calculate this line using the job code system.

Form 5:

Expended amounts in Line III differs more than 10% from the budgeted amount for FY 2004 as a result of inclusion of the Injury Prevention Program budget being added to the MCH appropriation after the program transitioned, and due to certain cost allocation expenses not being included in the original budgeting process.

New Hampshire implemented a job code system in 2000. Assignment of job codes permits calculation of expenditures in a more detailed fashion than was previously feasible. All expenditures, including personnel, supplies, equipment, and contractual, use job codes reflecting classification as expenditures related to specific grants or programs, in order to draw the correct percentage of Federal vs. General funds. This allows for accuracy in reporting expenditures for Financial Status Reports and Award Histories.

Unfortunately, limited job codes are permitted under the NH system, prohibiting the creation of enough codes to also classify expenditures by types of individuals served and by pyramid levels. These expenditures will continue to be calculated by formula applied to expenditure reports according to line item.

/2007/

As with previous applications, "significant expenditure variation" is defined as an expended amount in any line item that is greater than 10% above or below the budgeted amount for that year. The following lines on Forms 3-5 adhere to this criterion:

Form 3:

The expended amount on Line 3, State Funds, was less than budgeted due to State budget reductions and a hiring freeze.

Form 4:

Line Ia, b, Differences between budgeted amounts and expended amounts occur for several reasons. Because the budget is amount is calculated 2 years in advance, it is difficult to predict future policy and fiscal restraints. These lines were reduced in 2005 due to State budget reductions and a hiring freeze.

Line Id: As above, the expended amount is less than budgeted. Two years ago NH DPHS reviewed how Administration costs were calculated when reporting budgets and expenditures. Using the revised job code system, it is anticipated that Title V can provide a more accurate accounting of Administrative costs.

Form 5:

Line IV: Again, it is difficult to predict future policy and fiscal restraints. This line was reduced in 2005 due to State budget reductions and a hiring freeze. //2007//

/2008/

As with previous applications, "significant expenditure variation" is defined as an expended amount in any line item that is greater than 10% above or below the budgeted amount for that year. The following lines on Forms 3-5 adhere to this criterion:

Form 3:

The expended amount on Line 3, State Funds, was approximately 11% less than budgeted due to State budget reductions and a hiring freeze.

All other spending was within the 10% variance allowed.

Form 4:

Lines Ia-e, Differences between budgeted amounts and expended amounts occur for several reasons. Because the budget is calculated 2 years in advance, it is difficult to predict future policy and fiscal restraints. In general, there have been reductions in state dollars budgeted for Title V programs. These lines were reduced in future budgeting cycles to reflect these reductions and to bring our projected expenditures in line with fiscal constraints.

Line If: 2005 expenditures begin to reflect an upward swing in administrative costs, with a \$477,445 increase in administration. Three years ago NH DPHS reviewed how Administration costs were calculated when reporting budgets and expenditures. Using the revised job code system, it is anticipated that Title V can provide a more accurate accounting of Administrative costs and cost allocation.

Form 5:

In order to move towards the MCH pyramid, funds have slowly moved "down" the pyramid of services to support increased infrastructure, population based, and enabling services.

Both arms of Title V, MCH and SMS have made efforts to fund less direct services and provide more support for the foundation of the pyramid.

Line I marks a small decrease in Direct Services. Fewer clinical services were provided directly by MCH and SMS staff. For example, the MCH Preschool Vision and Hearing Program began in this fiscal year to transition to providing more technical assistance to community based health care providers and organization such as Head Start in lieu of providing direct screening for children. This trend will continue to be noted in future budget reports.

Line II shows an 11% reduction in enabling services. This is due to reduced staff time devoted to providing direct enabling services for families.

Line III shows a 10% increase in population-based activities. Increased attention has been placed in Birth Outcomes, Newborn Screening, Childhood Lead Poisoning Prevention and Injury Prevention activities.

Line IV shows a 10% increase in Infrastructure Activities. This includes funding for evaluation of programs such as Home Visiting New Hampshire and activities to support the Title V Needs assessment.

//2008//

/2009/

As with previous applications, "significant expenditure variation" is defined as an expended amount in any line item that is greater than 10% above or below the budgeted amount for that year. The following lines on Forms 3-5 adhere to this criterion:

Form 3:

In FY 2007 there was a significant increase of \$199,588 in Line 5, Other Funds expended due to the preparation for an expanded newborn screening panel. These other funds include the fees collected from hospitals for newborn screening filter papers. These funds are then used to support the contract with the University of Massachusetts Newborn Screening Laboratory.

The expended amount on Line 8, Other Federal Funds, was approximately 16% less than budgeted due to decreases in grants such as Abstinence Education and Rape Prevention and Education as well as some administrative challenges in drawing down the correct federal funds for MCH staff. Although, the federal programs have continued to function with the lower federal share, the administrative issues with drawing down salaries has been corrected.

All other spending was within the 10% variance allowed.

Form 4:

Lines 1a-e, Differences between budgeted amounts and expended amounts occur for several reasons. Because the budget is calculated 2 years in advance, it is difficult to predict future policy and fiscal restraints. In general, there have been reductions in state dollars budgeted for Title V programs.

In general, expenditures were increased for pregnant women, infants and children due to increased state general funds for primary care, prenatal services and infant screening programs.

Administration had a significant decrease (50%) in expenditures in FY2007 due to normal budget variances due to freezes on equipment, supplies travel and new hires that utilize state general funds. However, a greater portion of the decrease in administration expenditures resulted from the fact that SMS had initially budgeted \$275,089 in administration for FY07 and with a new methodology in their new organizational setting, they did not expend any of those funds.

All other lines were within a 10% variance.

Form 5:

Expended amounts in Line III, Population-Based Activities were 10% increased from the budgeted amount for FY 2007 due to changes in determination of pyramid level activities for Special Medical Services. A planned review of the distribution of funding related to services being provided was undertaken. When evaluated against the definitions of the pyramid of services it was apparent that Population Based activities were being provided but had been calculated into Infrastructure building and Enabling services. The expenditures more accurately reflect the nature of services provided in FY 2007.

All other expenditures by pyramid level were within the 10% variance allowed. //2009//

B. Budget

HOW FEDERAL SUPPORT COMPLEMENTS THE STATE'S TOTAL 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. 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 MCH activities.

Aside from State funds, other monies are also leveraged by these Federal dollars for MCH services at both the state and community levels. For example, Title V dollars help fund the New Hampshire Family Resource Connection, a clearinghouse and library service, administered by the State Library on issues related to maternal and child health. For this initiative, \$5,000 MCH dollars are combined with additional funds from the Child Care Development Fund, Department of Education, Division of Behavioral Health, Division of Developmental Services, and Division of Children, Youth, and Families to fund the project. Another example of the leveraging power of Title V funds is the proposed plan for Child Care Health Consultant services. MCH funds for this project (\$50,000) are leveraging additional monies from New Hampshire's Immunization Program (\$15,000), CLPPP (\$10,000) and SMS (\$5,000) and will likely result in additional funding once the pilot project is complete. /2007/ Title V has continued all of these funding partnerships and has increased its commitment to Regional Infant Mental Health Teams by contributing \$9,000 for SFY07 to the match efforts of the Department of Education and the DHHS Bureau of Behavior Health. //2007//

/2008/ Title V continues to support the combined efforts addressed above. In fact, this strategy of combining funds with other state agencies for mutually beneficial programs was the cornerstone of the Early Childhood Comprehensive Systems Implementation Plan. //2008//

At the community level, Title V dollars help fund numerous local agencies and projects that provide a wide variety of services to MCH populations. In these communities, Title V dollars also help leverage funds from municipalities, businesses, and private foundations to serve the Title V mission. Often, simply the fact that an agency contracts with MCH gives them increased credibility with other funders and an increased ability to leverage funds from small, community foundations, the United Way, or other fundraising efforts.

/2008/ With a substantial new increase in state general funds for community health centers for SFY08 and 09, Title V is at the forefront in planning the distribution of those funds and developing the scope of services and performance measures associated with this funding. By doing this, not only will NH strengthen the safety net of health care providers serving low income and un- and underinsured families, but Title V will also have the opportunity to ensure that services are consistent with the needs outlined in the Title V Needs assessment and the Title V mission. //2008//

/2009/ With increased state general funds in SFY08, MCH was able to contract with three additional community health centers to provide comprehensive primary care for pregnant women, children and their families. Additionally, MCH was able to contract the two organizations to provide primary care for the homeless.//2009//

AMOUNTS UTILIZED IN COMPLIANCE WITH THE 30%-30% REQUIREMENTS

As shown on Form 2, New Hampshire complies with Federal 30%-30% requirements. Services for CSHCN are provided through the SMS; \$925,000, or 44.79% of New Hampshire's Title V allocation, is appropriated to the SMS budget for FY 2006. Preventive and primary care services for children are provided through the MCHS; costs include direct care and support services through contracts with community agencies, population based program costs, and infrastructure costs for all MCHS children's services. The total of \$816,442, the amount projected for FY 2006, is 39.54% of the Title V allocation. /2007/ In this application, Title V increased its commitment to Services for CSHCN by allocating \$837,750, a total of 42% of Title V funding. //2007// /2008/ Title V has continued to maintain its commitment to CSHCN with an \$837,410 investment, 42% of Title V funding.

With new administration in both MCH and SMS, and organizational changes to the placement of SMS within NH DHHS, it is anticipated that continued dialogue will occur throughout SFY08 regarding MCH and SMS use of Title V funding. A memorandum of understanding has been drafted between the two sister programs that clearly delineates the roles, responsibilities and commitments between the two programs. The goal of this dialogue will be to continue efforts to move budget expenditures more closely to the proportions suggested by the MCH pyramid and to better understand how the two programs can work collaboratively to meet mutual goals. //2008//

HOW ADMINISTRATION & MAINTENANCE OF EFFORT ARE MAINTAINED

Administration: This amount is projected using calculations from prior years' cost allocation reports on a specific job code that identifies administrative expenses required to carry out this grant. /2007/ Two years ago DPHS reviewed how Administrative Services were being calculated when reporting the Title V budget and expenditures. The increase of 7.31% detailed on Form 2 is reflective of that change in methodology, and a continued evaluation of expenses based upon job codes. //2007//

/2008/ Budget projections for FY2008 reflect a decrease in the percentage of administrative costs, 6%. This is due to a new budgeted increase in state general funds to be used for community health center support that will not require a substantial or equal increase in administration. //2008//

/2009/ Cost allocation continues to trend upward within the NH DHHS. In FY2009, NH DHHS will use 6.09% for cost allocation, a total of \$121,662. This figure is now taken from the total New Hampshire allocation of \$1,997,739.

The remaining \$1,876,076 of program funds is then divided between SMS and MCH, at 41.5% and 58.5%, respectively. Because of this methodology, increased cost allocation and reduced federal share, funds for SMS have been decreased from previous years.
//2009//

Maintenance of Effort: The Title V Block Grant Maintenance of Effort requirement is one factor considered when planning the MCH and SMS budgets. The budget development process includes incorporation of the Title V Maintenance of Effort amount in calculating appropriation requests.

SOURCES OF OTHER FEDERAL MCH DOLLARS, STATE MATCHING FUNDS & OTHER STATE FUNDS USED TO PROVIDE THE TITLE V PROGRAM

Sources of other Federal dollars, as indicated on Form 2, include grants from the Maternal and Child Health Bureau (MCHB) and other Federal agencies. Only MCHB grants are discussed below /2007/ (Please assume continued funding for SFY07 ***/2009/ and FY09 //2009//***, if not noted differently)//2007//:

SSDI Grant: \$100,000

These funds are used to address New Hampshire's capacity to improve performance on Health Systems Capacity Indicator #09A and to develop linkages between MCH program datasets and New Hampshire birth files.

/2009/ It is disappointing that SSDI support has decreased in the past fiscal year. At \$94,000, MCH is struggling to maintain salary and benefit costs associated with the SSDI Coordinator and state cost allocation. To maintain even minor support for contracted services, DPHS reduced the amount of cost allocation from its current formula. Without support from programs such as EHDI and now Title V, it would be impossible to maintain programmatic growth in data linkages.//2009//

Abstinence Education Grant: \$94,901

These funds are being used for community grants to implement abstinence-only curricula.

/2008/ Title V has just received notice that State Abstinence funds will not be available from the Federal ACYF in FY2008. NH DHHS is committed to using state general funds to support this program for SFY08. //2008//

/2009/ For the past two years, the majority of 510 abstinence funds have been contracted to Catholic Medical Center, Manchester NH, to implement a community-based, statewide effort in abstinence education and teacher training. This model of local leadership has produced the greatest outcomes and increased community engagement for abstinence when compared to previous efforts. Although it appeared that this support would have ended in 2008, federal support was maintained throughout the state fiscal year. However, federal support anticipated to end as of June 30, 2008. This will be a loss to the communities that have utilized those services. It is not anticipated that general funds will be used to support the project if and when federal support ends.//2009//

Universal Newborn Hearing Screening Grant: \$120,000

These funds are used to establish New Hampshire's universal newborn hearing screening program, including implementation of quality assurance standards and a data-tracking initiative.

ECCS Grant, CISS Program: \$100,000

This grant is used to fund a strategic planning project for early childhood comprehensive systems. This planning project is in its final year, and will address strategies to strengthen the five focus areas highlighted in the MCHB Strategic Plan for Early Childhood.

/2007/

In SFY07, /2008/ as well as in SFY08, //2008// MCH anticipates increased funding of \$140,000 for ECCS Implementation. The Implementation project will support the efforts of Healthy Child Care NH, programs such as the Family Resource Connection at the NH State Library, and other activities related to five focus areas highlighted in the MCHB Strategic Plan for Early Childhood. //2007//

/2009/ ECCS continues to support the efforts of the Healthy Childcare NH Coordinator and a community-based contract to provide child care health consultation in two counties of the state. The ECCS plan continues to provide a foundation for all early childhood systems building efforts in the state. It is currently funded at \$140,000. //2009//

/2008/

CDC funds include support for the Rape Prevention and Education Grant (RPEG), \$172,998 and Early Hearing Detection and Intervention (EHDI) program, \$150,000.

//2008//

//2009/ The CDC recently confirmed FY08 budget cuts to New Hampshire RPEG funding resulted in a \$3,036 loss, or a total of \$169,962. In the recently submitted 09 Rape Prevention Education application, the contract amount went down further to \$167,568. This cut will ultimately affect MCH's contract with the New Hampshire Coalition Against Domestic and Sexual Violence. //2009//

NH does not receive funding for PRAMS.

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.

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" or "Other State" funds included in the MCH or SMS appropriations, as indicated on Form 2.

SIGNIFICANT BUDGET VARIATIONS FROM FORMS 3-5

For the purpose of this application, "significant budget variation" is defined as an increase or decrease in any budgeted line item that is greater than 10% from the budgeted item in the previous year. The following lines on Forms 3- 5 adhere to this criterion:

Form 3:

No budgeted amounts FY 2006 differ more than 10% from amounts for FY 2005.

//2009/

No budgeted amounts for FY 2009 differ more than 10% from amounts for FY 2008. //2009//

//2008/ No budgeted amounts for FY 2007 differ more than 10% from amounts for FY 2006 with the exception of Line F, Other Funds. Other Funds increase from \$152,000 to \$870,000. This is due to an increase in Newborn Screening Filter Paper Fees paid by birth hospitals to the NH DHHS to support an expanded Newborn Screening Panel. In 2005 the Newborn Screening Program only screened for 6 disorders. In May 2006, that expanded to 13 disorders and in July 2007 there will be an additional expansion to 32 disorders. These funds support the contract for laboratory analysis with the University of Massachusetts, Newborn Screening Lab.

//2008//

//2007/

FY 2007 has the following budget variations:

Line 5: \$152,000 is budgeted in Other Funds. These reflect Newborn Screening Filter Paper Fees paid by birth hospitals to the NH DHHS that, by New Hampshire Administrative Rules, must be used to support the contract for laboratory services for Newborn Screening.

//2007//

Form 4:

//2009/

No budgeted amounts for FY 2009 differ more than 10% from amounts for FY 2008. //2009//

Lines 1a, b, e, and f: The decrease in budgeted amounts for "Pregnant Women" and "Infants < 1 year old" in FY2006 by 12% and 11% respectively are due to the increase in "Administration" of 465%, resulting from the use of a new methodology for calculating this amount, as discussed in Section VA. The increase in the budgeted amount for "Others" is in part due to the increase in the proportion of men and elderly clients seen in MCH-funded community health centers, and estimated amounts in the State's Catastrophic Illness fund.

/2007/

Line If: The continued increase of Administration in FY2007 is reflective of the use of a new methodology for calculating this amount, as discussed in Section VA.

//2007//

Line Ilk: The decrease in budgeted HCCA funds is due to the completion of this grant.

/2008/

Lines I a-c all show a substantial increase in funds directed to services for pregnant women and children in SFY08. This is reflective of increased state general funds directed toward community health centers. Funds for services for pregnant women increase by 27%; funds for services for infants increase by 28%; and funds for children increase by 30%.

Line I d reflects a decrease of 11% for funds for CYSHCN.

Line If: Administration is decreased by 24% from FY2007 to FY2008. This is reflective of the continued refinement of a new methodology for calculating this amount.

//2008//

Form 5:

/2009/

No budgeted amounts for FY 2009 differ more than 10% from amounts for FY 2008. //2009//

No budgeted amounts for FY 2006 differ more than 10% from amounts for FY 2005.

/2007/

No budgeted amounts for FY 2007 differ more than 10% from amounts for FY 2006.

//2007//

/2008/

Line III represents a significant increase from FY2007 \$463,995 to FY 2008 \$897,243. This is due to the increased Newborn Screening Panel for all New Hampshire infants that was launched July 2007.

No other budgeted amounts for FY 2008 differ more than 10% from amounts for FY 2007

//2008//.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.