

The New Hampshire Maternal and Child Health
Section

5 Year Needs Assessment

July 2005

Department Health and Human Services
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Bureau of Community Health Services
Maternal and Child Health Section

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The New Hampshire Maternal and Child Health Section **5 Year Needs Assessment**

I. Organization of the report

The report is organized according to the recommendations contained in the Promising Practices in MCH Needs Assessment: A Guide Based on a National Study document published by the Health Resources and Services Administration (HRSA) in December 2004 (USDHHS, 2004). The report begins with an overview of the State of New Hampshire: geography, demographics and health status of the population. The assessment of the Maternal and Child Health population follows the overview and presents the available data on the health of this population. This section is organized by the population subgroups served by Title V funding: pregnant women, mothers and infants; children (and adolescents) and children with special health care needs. For each population sub-group, an introductory paragraph summarizes the findings and describes the major issues, followed by presentation of the available data describing the health status and risks to that population. Leading causes of mortality and inpatient hospital discharges are described for each population subgroup. New Hampshire birth certificate data is used to describe the health of the maternal and infant population. A summary of local needs assessments from various geographic areas in the state is presented last in this section. The next section of the report describes MCH capacity in the state, organized by the levels of the pyramid: direct and enabling services; population-based services; infrastructure building (CAST-5); and individual and organizational assets. The final two sections match needs to capacity and describe the process of priority setting used by the Title V Needs Assessment Team.

II. Needs Assessment Process

The needs assessment process has been ongoing since the previous quinquennial Title V needs assessment, gaining greater momentum during the final (5th) year. New Hampshire's 2000 needs assessment was actually completed in 2001, due to delays in obtaining epidemiological expertise at that time. Two epidemiologists eventually shared the work: one prepared an analysis of maternal indicators, and one focused on children's health indicators. Findings were intriguing, but not directive. For example, the maternal health assessment highlighted the diversity of New Hampshire's minority populations, but did not address disparate birth outcomes between the Medicaid and non-Medicaid populations.

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 since 2001. 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, these 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. In response, MCH leadership met with the NH Minority Health Coalition and the Director of the NH Office of Minority Health. MCH now funds a home visiting contract directed toward services for minority families.

For the 2005 needs assessment, the 2001 report was revisited. This analysis picked up where the 2001 report left off, by increasing both the breadth and depth of analysis for maternal indicators in order to identify the most striking disparities as well as provide an indication of where interventions could be made.

While the needs assessment process was initially based on prior experiences and existing practices identified in the needs assessment and evaluation literature, the process was strengthened by adoption of the recommendations contained in *Promising Practices in MCH Needs Assessment: A Guide Based on a National Study*. A diagrammatic representation of this process was developed (Appendix B). The five core components are briefly described below.

Assessment of Population MCH Needs

Health status information was collected and analyzed from a wide variety of sources, including vital records birth death and hospital discharge data. Data were stratified by appropriate factors such as age, payor source, race/ethnicity, and geography. Distributions and trends were examined to identify patterns of interest. Both quantitative and qualitative data were included.

Analysis of the Capacity of Systems to Meet These MCH Population Needs

Staff examined capacity in each of the following areas: direct and enabling services, population-based services, infrastructure-building capacity within the NH MCH Section (using the Capacity Assessment for State Title V (CAST-V) tool) and individual and organizational assets available to support and improve the New Hampshire MCH system (using the tool provided in the Promising Practices document). The examination included assessing accessibility, quality, and affordability of services (except for population-based services).

The following three components are described after the Capacity Assessment section:

Matching Needs to Capacity

Setting Priorities

Using the Needs Assessment

III. Assessment of the MCH population

A. Methodology

MCH staff developed an analysis plan as part of the needs assessment process. Staff analyzed data from birth and death certificates, as well as inpatient hospital discharge data from the NH Department of Health and Human Services (DHHS) Health Statistics and Data Management Section. Other DHHS sources of data that are included in this report are Family Planning, Childhood Lead Poisoning Prevention, Immunization and the HIV and Sexually Transmitted Diseases (STD) Programs. Survey data from the Behavioral Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Survey (YRBS) are presented, along with homelessness and school dropout data from the NH Department of Education (DOE). In order to identify needs in specific geographic areas, while obtaining input from a wide range of stakeholders, local community needs assessments were reviewed and summarized in this report. Documents considered included: the NH Critical Access Hospital State Plan (NHDHHS, 2003); Community Benefit Reports from seven hospitals across the state and Critical Access Hospital Market Analyses from twelve additional local hospitals in various parts of the state. The following hospital reports were considered:

- (1) Community Benefit Reports:
 - (a) Cheshire Medical (Keene)
 - (b) Riverbend Community Mental Health (Concord)
 - (c) Concord Regional VNA (Concord)
 - (d) Huggins Hospital (Wolfeboro)
 - (e) Catholic Medical Center (Manchester)
 - (f) Dartmouth Hitchcock Manchester
 - (g) Elliot Health System (Manchester)

- (2) Critical Access Hospital Market Analysis:
 - (a) Lakes Region (New London)
 - (b) Memorial Hospital (Conway)
 - (c) Androscoggin Valley Hospital (Berlin)
 - (d) Franklin Regional Hospital (Franklin)
 - (e) Valley Regional Hospital (Claremont)
 - (f) Spere Memorial Hospital (Plymouth)
 - (g) Huggins Hospital (Wolfeboro)
 - (h) Monadnock Community Hospital (Peterborough)
 - (i) Littleton Regional Hospital (Littleton)
 - (j) Cottage Hospital (Woodsville)
 - (k) Weeks Medical Center (Lancaster)
 - (l) Upper Connecticut Valley Hospital (Colebrook)

Sources of data about New Hampshire Children with Special Health Care Needs (CSHCN) include a Delphi process used to assess needs and resources for CSHCN in New Hampshire, conducted by the NH Title V Program (NHDHHS, Bureau of Special Medical Services (SMS), 2001-2004); a survey of parents of CSHCN receiving Supplemental Security Income for their

own disability (also conducted by the NH Title V Program) (NHDHHS, SMS, 2004); information from the Family-Centered Early Supports and Services Program (FCESS) of the NH Bureau of Developmental Disabilities, which is the New Hampshire early intervention program for the birth to three populations of children with special need (Part C); the 2003 School Health Services Report from the New Hampshire Department of Education, which provides a listing of the diagnoses of children from public pre-school programs through 12th grade; and the Special Education Data Information System (SPEDIS) Statewide Census by Disability, also from the New Hampshire Department of Education. Additional data related to selected chronic illnesses and disabilities of childhood (e.g., congenital anomalies, asthma, and diabetes) are included in descriptions of the overall child and adolescent populations.

B. Overview of the NH Maternal and Child Health Population Status

1. 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. New Hampshire is one of the 3 northern New England states, which along with Maine and Vermont, are more rural than the southern tier: Massachusetts, Connecticut and Rhode Island. New Hampshire's population is approximately equal to Maine's, approximately twice Vermont's, but only 1/6 that of Massachusetts (US Census Bureau, 2000).

The state's population numbers 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 NH city with a population over 100,000, is the largest city in the tri-state area of Maine, NH, and VT. 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 (NH DHHS Rural Health and Primary Care section, 2004)

2. Demographics

Population growth

While New Hampshire's population growth rate exceeds that of all other New England states, the growth rate has slowed since 2000, and New Hampshire, along with Massachusetts, are the only New England states experiencing this decline (NH Office of Energy and Planning (OEP), *Vital Signs 2005*). 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, 2005).

Population by age group

NH'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 New Hampshire 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). There are an estimated 309,562 children under 18 years of age.

Figure AP-1

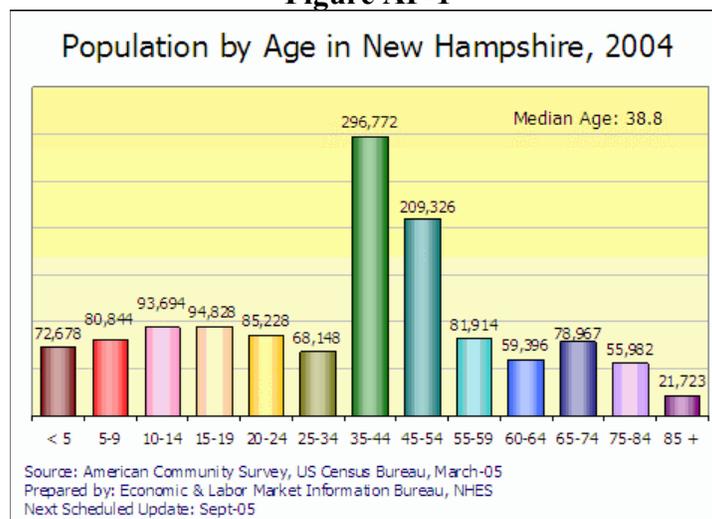
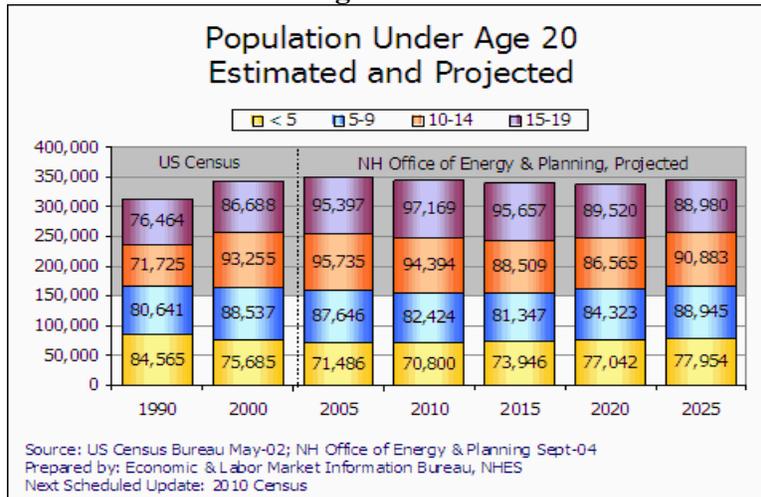


Figure AP-2



Figures AP-3, AP-4
Population Pyramids of New Hampshire
 Percent of Total Population

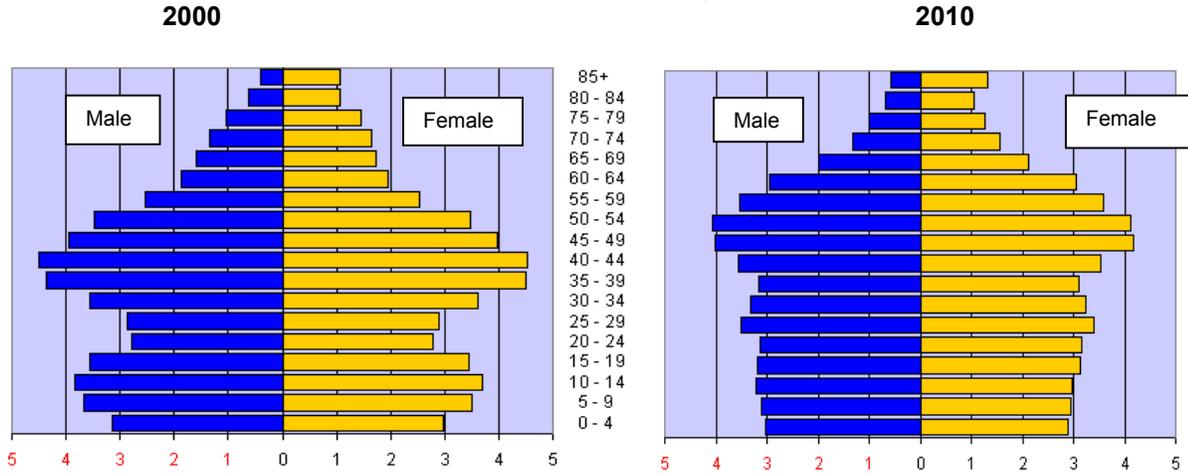
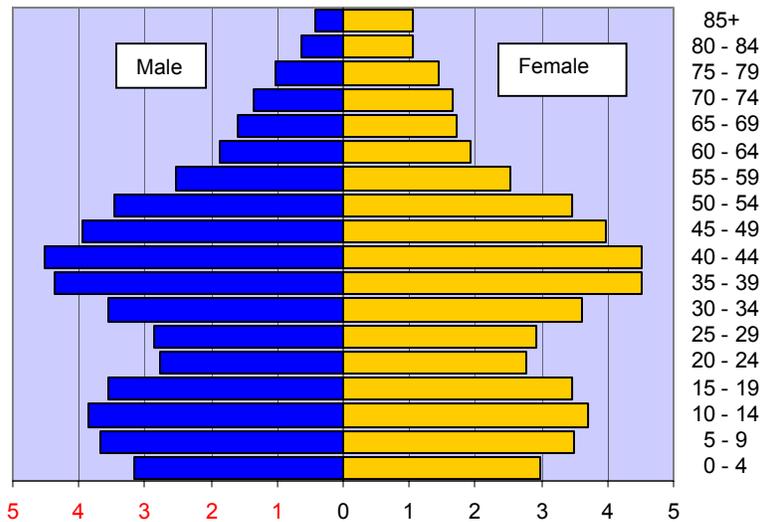


Figure AP-5

Population Pyramids of New Hampshire
 Percent of Total Population
2020



Source: US Census Bureau, Population Division, Interim State Population Projections, 2005. Internet Release Date: April 21, 2005

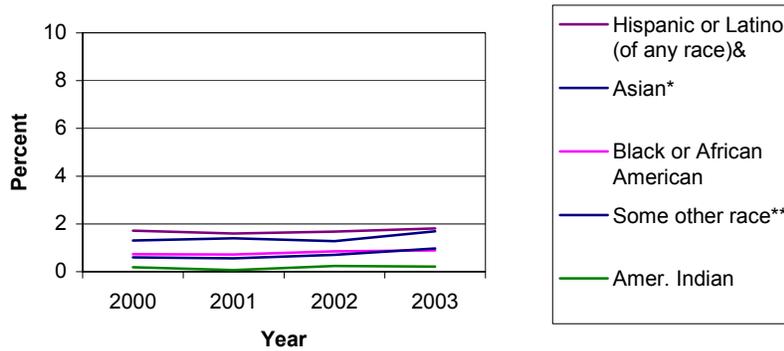
Racial and ethnic minorities

New Hampshire's population was 95.1% white, not of Hispanic origin, in the 2000 U.S. census (compared to the U.S. 75.1%), but is steadily becoming more racially and ethnically diverse.

Over the 10-year period, 1990 to 2000, the Asian population increased from 9,343 (0.8% of the population) to 16,302 (1.3%) and remains the largest racial minority population in the state. In 2003, the Asian population is estimated at 1.7% of the population. The African American population increased from 7,198 (0.6%) in 1990 to 9,035 (0.7%) in 2000 and to an estimated 0.9% in 2003. An estimated 1% of the population identified themselves as “some other race” in 2003, compared to 0.6% in 2000. Only the white, Asian and “some other race” population increases from 2000 to 2003 were statistically significant. (US Census Bureau, 2003 American Community Survey). Seventy eight percent of the state’s minority populations reside in three counties in the southernmost part of the state: Hillsborough, Rockingham and Strafford counties, 52% in Hillsborough County alone. Hillsborough County contains the state’s two largest cities: Manchester (population 107,006 in 2000) and Nashua (population 86,605 in 2000); most of the minority populations reside in these two cities (22. 5% and 19.5% respectively). In the 2000 Census, Nashua’s population was 9.3% racial minorities; Manchester’s was 6.5%, more diverse than the state as a whole. (US Census Bureau, Census 2000 Redistricting Data (Public Law 94-171) Summary File, Matrices PL1 and PL2) Over 9% of Manchester residents were foreign born in 2000, compared to 4.4% in the state overall. Among Manchester residents ages five and older, 19.6% spoke a language other than English at home, compared to 8.3% statewide (US Census Bureau NH Quick Facts <http://quickfacts.census.gov/qfd/states/33/3345140.html>). Residents of New Hampshire who identified themselves as Hispanic or Latino (of any race) comprised 1.8% of the population in 2003 and 1.7% in 2000, compared to 1% in 1990 (US Census Bureau, 2003 American Community Survey). The Hispanic or Latino populations are also concentrated in the southern part of the state and in the state’s largest cities, Manchester and Nashua, located in Hillsborough County, similar to racial minority groups. (U.S. Census Bureau, Census 2000 Summary File 1)

New Hampshire is home to more than 6,500 refugees with 80% residing in the state's southern tier. New Hampshire refugees come from over 30 nations. Of those settling in the state between 2000 and 2004, 45 % were from Eastern Europe, 46% from Africa and 8% from the Middle East (personal communication, NH OEP Refugee Program, May 2005). While these new residents experience a range of health issues including poor nutrition, parasitic infestations, communicable diseases and lead poisoning, maternal and child health issues predominate. Case management, outreach and interpretation services are all in high demand for this population. (15) The National Survey of Children with Special Health Care Needs 2001 indicates that 90.8% of New Hampshire CSHCN are white, 3.1% are Hispanic, 2.3% are multi-racial, 2.2% are black and 1.2% report as 'other'.

Figure AP-6: Race/Ethnicity Trends, NH 2000-2003



Source: U.S. Census Bureau, 2003 American Community Survey

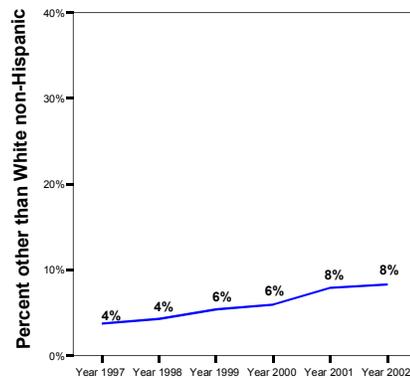
*Indicates that the data for earlier years are statistically significantly different from the most current year

**2000 & 2001 data were significantly different from most current year.

& 2001 data was significantly different from most current year.

Figure AP-7: Racial and Ethnic Diversity

Resident Births



Note: Y-axis range is 0-40% to show detail

New Hampshire is becoming more ethnically and racially diverse. The proportion of births to non-white mothers in NH approximately doubled in this 6 year period. This suggests a need to assure culturally and linguistically appropriate services.

3. Births

Births in New Hampshire declined 19.8% from the peak number of resident births of 17,801 in 1989 to 14,275 in 1997. The birth rate declined from 12.2 per 1000 population in 1997 to 11.3 per 1000 in 2002, 16.3% lower than the US white rate of 13.5 (NCHS 1997, 2002). The State continues to have the 4th lowest birth rate in the nation (USDHHS NCHS, 2002).

Given birth trends and population projections, it is clear that the State's demographics are changing. Today, children under 18 comprise 25% of the population, but it is estimated that by 2020 they will constitute just over 21%. (US Census Bureau, Population Division, 2005).

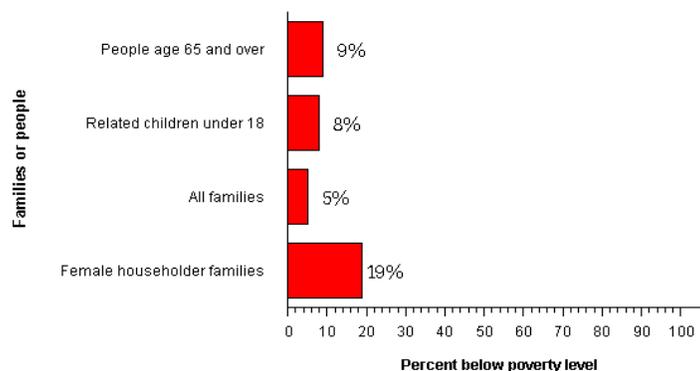
4. Economic

New Hampshire has an overall median household income significantly above the national average. The median household income in NH (in 2003 inflation adjusted dollars) was \$53,910 compared to \$43,564 nationally. (U.S. Census Bureau, 2003 American Community Survey). In addition, the state's poverty rate was the lowest of the New England states in 1999 (US Census Bureau HHES/PHSB, 2000). New Hampshire's poverty rate has been approximately half that of the U.S. since 2000 and is one of the lowest in the nation (NHES Vital Signs, 2005). In 2003, an estimated 5.1% of New Hampshire families had incomes below the federal poverty level (\$18,660 for a family of 4) compared to the U.S. average of 9.8% of families (US Census Bureau, 2003 American Community Survey). Although the percent of families below the poverty level in New Hampshire continues to be lower than the U.S. average, it is of significance to note that in 2000, only 3.5% of families in New Hampshire had incomes below the federal poverty level (FPL) compared to the estimated rate of 5.1% in 2003.

Certain demographic and geographic subpopulations in the state experience much higher poverty rates. Nearly 20% of New Hampshire families headed by a woman with no husband present had incomes below the poverty level (U.S. Census Bureau, 2003 American Community Survey). This percentage has increased since 2000, when 17.6% of female householder families lived below the poverty level (U.S. Census Bureau, Census 2000 Summary File 3-Sample Data). In 2003, an estimated 19.4% of NH family households were headed by a woman with no husband present. Children and adolescents are also more likely to live below the poverty level; in 2003, 8% of New Hampshire families with children under age 18 lived below the federal poverty level in the previous 12 months, compared to 5% of individuals overall in the state. (US Census Bureau, 2003 American Community Survey Summary Tables)

Figure AP-8

Poverty Rates in New Hampshire in 2003



Source: American Community Survey, 2003

Table AP-1: NH Families, 2003 vs. 2000

Income below Federal Poverty Level (FPL) in past 12 months	2000		2003*	
	Number	Percent below FPL	Estimated number	Percent below FPL
Number families below FPL past 12 months [^]	11,356	3.5%	17,316	5.1%
With related children under 18 years	8,909	6.5%	12,562	8%
Female householder families	7,357	17.6%	9,191	19%

Source: US Census Bureau, American Community Survey Office: Census 2000 Summary File 3 –sample data

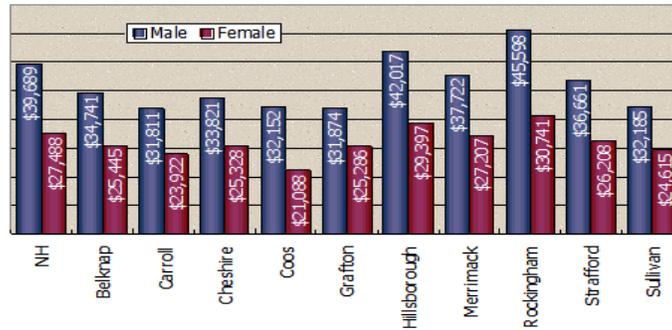
*Source: US Census Bureau, Census 2000 Summary File 1 – Sample data

[^]Difference is statistically significant

In New Hampshire’s largest city: Manchester, 10.6% of residents had incomes below the FPL in 2000, compared to 6.5% of individuals statewide and 6.8% of Nashua residents (2000 Census, 1999 data). Manchester’s median household income in 2000 was \$40,774, significantly below the state average of \$49,467. (2000 Census, 1999 data). Several counties had poverty rates above the state average in 2000, including Sullivan (8.5%), Strafford (9.2%) and Coos (10%). (Source: US Census Bureau: State and County Quick Facts, 2005.)

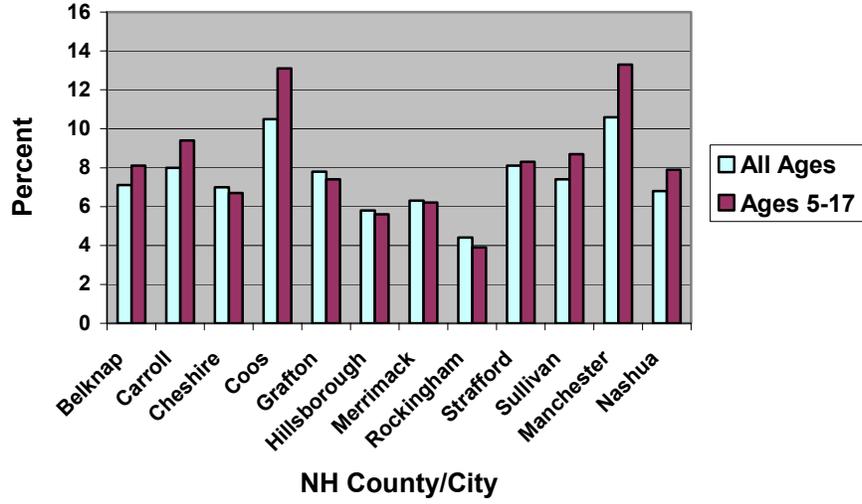
Figure AP-9

Median Earnings, Full Time Workers, 1999



Source: US Census Bureau May-02
 Prepared by: Economic & Labor Market Information Bureau, NHES
 Next Scheduled Update: 2010 Census

Figure AP-10: Percent of NH Residents with Incomes below Federal Poverty Level, by Age Group, 2002



Source: US Census Bureau, Housing and Household Economic Statistics Division, Small Area Estimates Branch
 For US Census Bureau purposes, the Federal Poverty Level is defined as \$18,660 for a family of four

5. Health status

New Hampshire has been ranked one of the top two healthiest states 11 times in the past 15 years (United Health Foundation, 2004). Rankings are based on a combination of indicators, including health outcomes (infant mortality, cancer rates, etc.), community, environment and health policies. NH had the lowest infant mortality rate and teen birth rate in 2003. (United Health Foundation, 2004). The most recent National Healthcare Quality Report (2005) from the Agency for Health Care Quality Research ranked NH second in the nation for the percent of women receiving prenatal care in the first 3 months of pregnancy (90.6% vs. 83.6 U.S. average in 2001). NH was also superior to the average in the rankings for the percent of live born infants with low or very low birth weight, infant deaths per 1,000 live births, and the percent of children ages 19-35 months who received all recommended vaccines.

However, closer analysis reveals differences among subpopulations in New Hampshire and among specific indicators. The National Healthcare Quality Report mentioned above rated NH as inferior to the average for suicide deaths per 100,000 population, and for several indicators of elderly health. Analysis of NH birth data for the years 1997-2001 revealed differences in tobacco use among pregnant women, adequacy of prenatal care and incidence of low birth weight infants among certain populations, including young women and women on Medicaid.

C. Maternal Health (pregnant women and mothers) and the Health of Women in their Reproductive Years

This section reviews a number of health outcomes that impact women, looking first at the ability of women to receive care when they are pregnant (adequacy of prenatal care) and at other issues that impact women in their roles as mothers (smoking in pregnancy, interval between pregnancies, method of delivery). In addition, indicators of sexual health and access to health care are considered including access to contraceptive care and rates of sexually transmitted infections (including HIV/AIDS). Broader issues in women's health and well-being are addressed by considering hospitalizations and leading causes of death among women in the childbearing years. Particular attention is focused on domestic violence and assault and finally disparities among areas of the state of New Hampshire with regard to teen births; adequacy of prenatal care and other factors are examined.

The analysis exposes variations within the overall positive picture of health for women in New Hampshire and finds that women in the adolescent and young adult years, as well as those dependant on Medicaid as a payer for their health care, experience disproportionate levels of inadequate prenatal care and less favorable birth outcomes than women in other age groups. Young women also have the greatest proportion of chlamydial infections, with rates increasing despite interventions to increase screening and are most likely to have emergency room visits due to assault. Other key findings are:

- An increasing proportion of births are by Cesarean section
- Family Planning services are widely available and focus on women under 25

- Complications of pregnancy, childbirth and the puerperium are the most frequent cause of hospitalization among women 15-34, followed by mental disorders and the most common cause of death is unintentional injuries, primarily motor vehicle crashes.

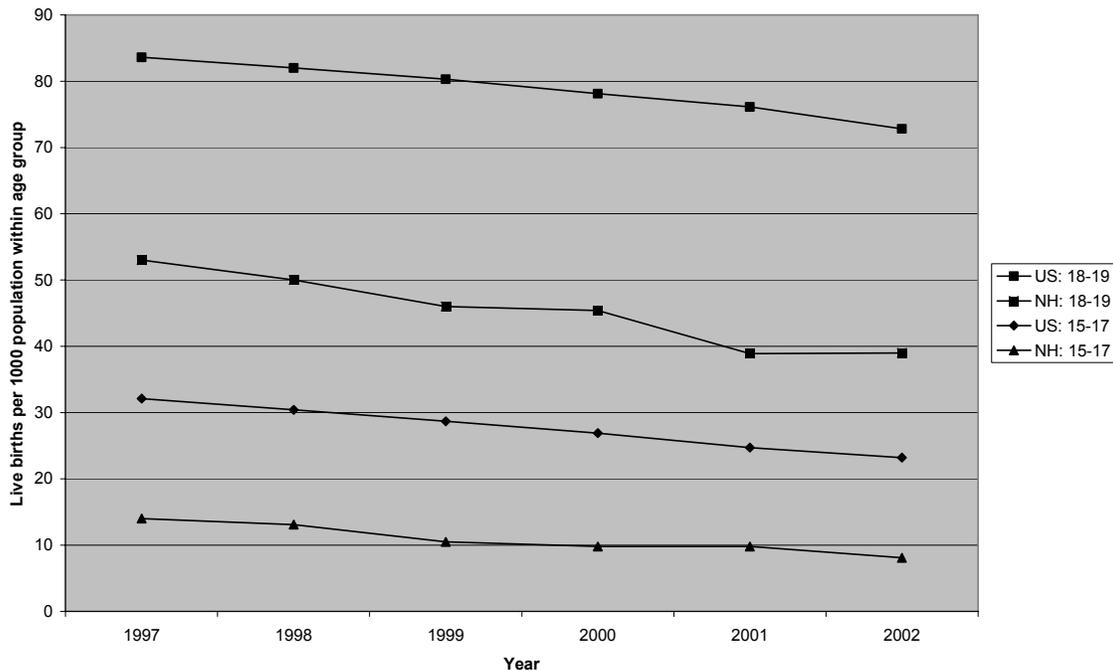
1. Birth Rates and Pregnancy Intention

The ability of women to maintain a positive health status for themselves and their young children is profoundly impacted by the circumstances under which a woman gives birth. In New Hampshire, no comprehensive resource is available on pregnancy intention. We can, however, make some educated guesses about the degree to which women are ready for motherhood by looking at their age and circumstances when they give birth. When motherhood happens too early, when the mother has not completed her education or when the family faces significant economic challenges, the health of both the woman and the child are at risk.

Teen pregnancy has long been recognized as presenting many risks to mother and child, and this is particularly true with births to women under 17 years of age. These mothers have typically not completed high school, they are the least likely of all mothers to be married or in a stable partnership with the father of the child, and they are most likely to have poor pregnancy outcomes. In New Hampshire, the overall rate of births to teens has generally been decreasing, along with the national rate since the 1970's. The following graphics (Figure AP-11, Table AP-2 and Figure AP-12) show the overall trend in this decrease. Generally, women are giving birth at a later age.

Figure AP-11

Teen Birth Rate: 1997-2002



Data source: NHDHHS, DPHS, Health Statistics Section, 2004

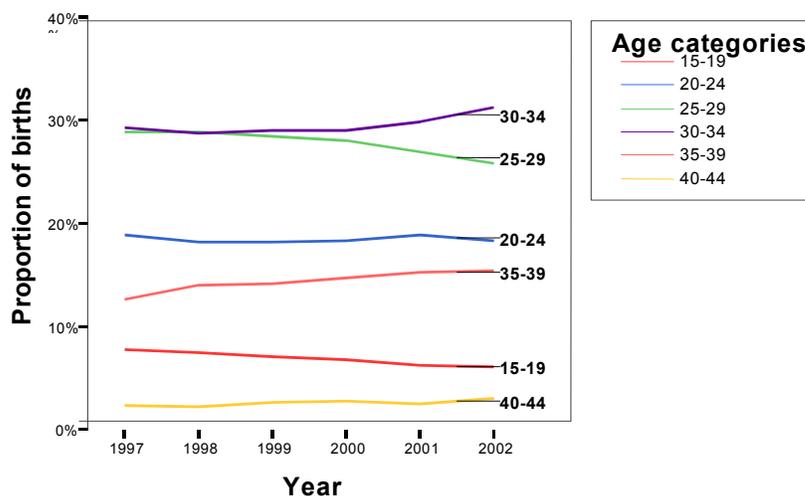
Age Group		Year						Total
		1997	1998	1999	2000	2001	2002	
15-19	Count	1110	1089	995	994	913	881	5982
	% within Year	7.8%	7.5%	7.1%	6.8%	6.2%	6.1%	6.9%
20-24	Count	2702	2632	2559	2676	2767	2636	15972
	% within Year	18.9%	18.2%	18.2%	18.3%	18.9%	18.3%	18.5%
25-29	Count	4126	4178	4008	4107	3951	3734	24104
	% within Year	28.9%	28.9%	28.5%	28.1%	27.0%	25.9%	27.9%
30-34	Count	4184	4163	4093	4239	4384	4501	25564
	% within Year	29.3%	28.8%	29.1%	29.1%	29.9%	31.2%	29.6%
35-39	Count	1808	2024	1996	2145	2239	2220	12432
	% within Year	12.7%	14.0%	14.2%	14.7%	15.3%	15.4%	14.4%
40-44	Count	329	320	374	402	372	427	2224
	% within Year	2.3%	2.2%	2.7%	2.8%	2.5%	3.0%	2.6%
Total	Count	14275	14432	14046	14590	14648	14427	86418
	% within Year	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

^aStatistics for <15 years and >45 years are suppressed for reasons of confidentiality due to small cell sizes. Total counts are correct.

Data source: NH DHHS, DPHS, Health Statistics Section, 2004

Figure AP-12

Proportion of births by age and year
NH Resident Births: 1997-2002



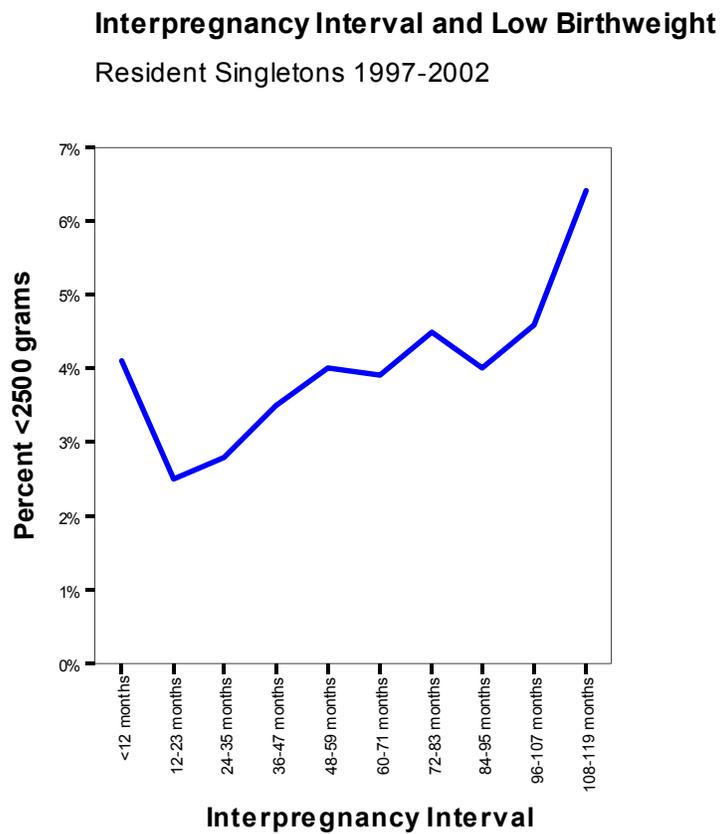
Data source: NHDHHS, DPHS, Health Statistics Section, 2004

D

2. Interpregnancy Interval

The Interpregnancy Interval (IPI) is a measure of birth spacing and is defined as the time between the end of one pregnancy (birth) and the beginning of the next (estimated date of conception based on the birth date minus the gestational age). Figure AP-13 shows the association of IPI with low birth weight. While the proportion of low birth weight infants is lower in New Hampshire than in the U.S. as a whole, the J-shape of the curve matches that found in national studies. Overall, the IPI most likely to be associated with a desirable birth weight appears to be 12-23 months.

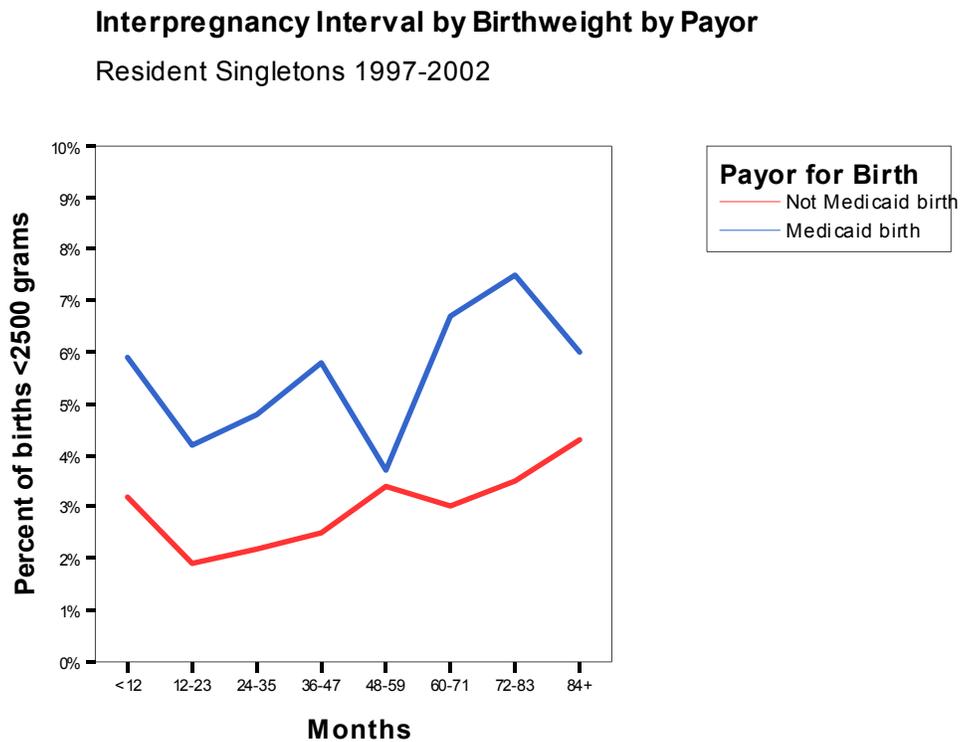
Figure AP-13



Data source: NHDHHS, DPHS, Health Statistics Section, 2004

An examination of the interpregnancy interval using payer source as a proxy for socioeconomic status reveals a disparity between Medicaid and non-Medicaid births (Figure AP-14). The last 3 IPI categories in Figure AP-13 above were consolidated in Figure AP-14 below due to the small number of Medicaid births within this category. Age is positively associated with IPI and Medicaid births tend to be to younger women. The dip in the LBW Medicaid births at the 48-59 month IPI category is likely an anomaly due to the small sample size within this category (n=22).

Figure AP-14



Data source: NHDHHS, DPHS, Health Statistics Section, 2004

3. Adequacy of Prenatal care

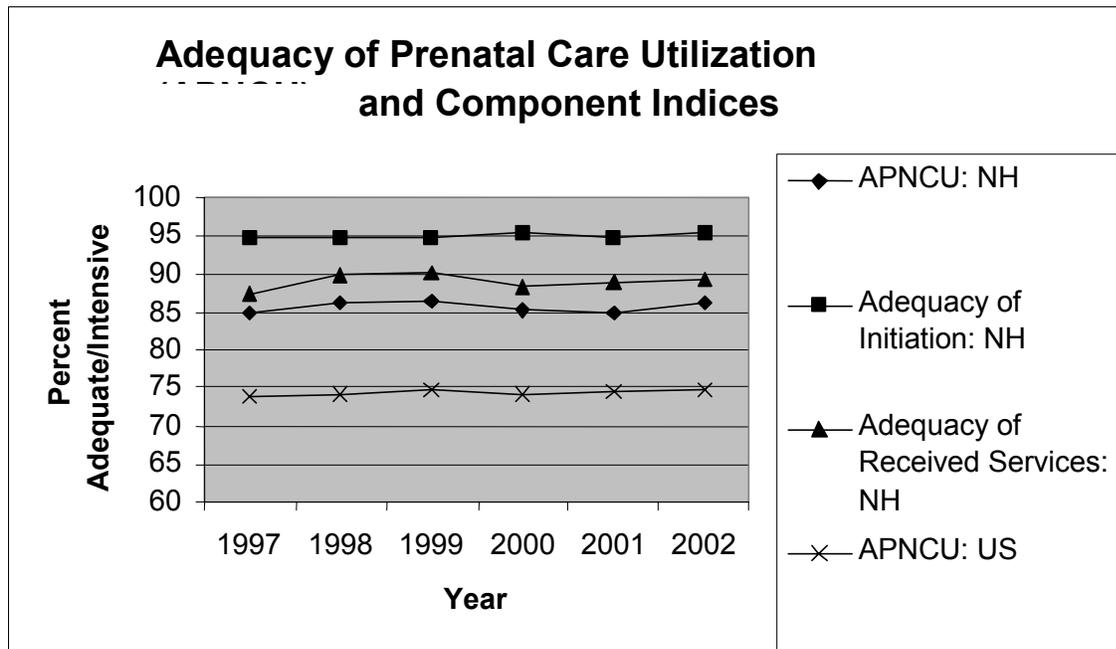
Once a woman becomes pregnant and decides to carry her pregnancy to term, she will be most able to assure the best health for herself and her child if she gets good and complete prenatal care. The Adequacy of Prenatal Care Utilization Index (APNCU or Kotelchuck Index) is a measure of the timeliness and dosage of prenatal care (PNC) visits. The index is made up of two sub-indices, the Adequacy of Initiation of Prenatal Care index and the Adequacy of Received Services index. Each index uses the categories outlined in the table below to describe the adequacy of prenatal care.

Table AP-3: Adequacy of Prenatal Care Utilization Index			
Index →	Adequacy of Initiation of Prenatal Care	Adequacy of Received Services	Adequacy of Prenatal Care Utilization Index
<i>Adequate Plus</i>	1 st or 2 nd month	≥110% of recommended visits	PNC by 4 th month and ≥110% visits
<i>Adequate</i>	3 rd or 4 th month	80-110%	By 4 th month and 80-109% visits
<i>Intermediate</i>	5 th or 6 th month	50-79%	By 4 th month and 50-79% visits
<i>Inadequate</i>	7 th month or later	<50%	After 4 th month or <50% visits

Source: Kotelchuck, M. (1994). An evaluation of the Kessner Adequacy of Prenatal Care Index and a proposed Adequacy of Prenatal Care Utilization Index. *Am. J. Public Health*, 84, 1414-1420.

The APNCU Index in NH is significantly better than in the US as a whole. NH does particularly well with *Initiation* of PNC, but does not do as well with *Received Services*. The *Adequacy of Received Services Index* does adjust for the initiation of care. The NH data in the graph below shows resident live singleton births only. It is unknown if the US data, taken from the National Vital Statistics Reports annual final birth reports, include only singleton births. Since the Adequacy of Received Services Index does not adjust for multiple births, it is likely that the gap seen between the NH and US APNCU trend lines is greater than shown if the US APNCU statistics do indeed include multiple births.

Figure AP-15

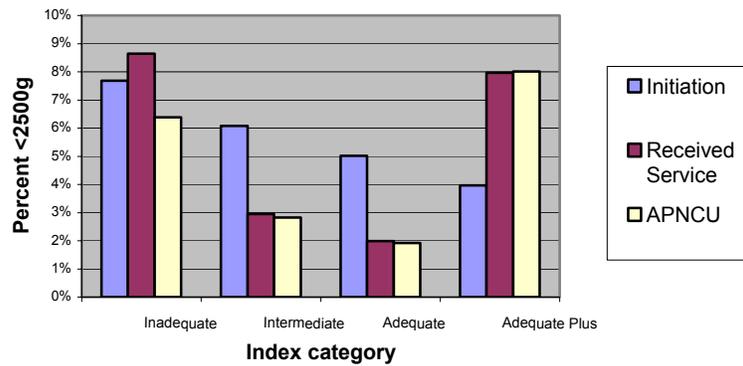


Data source: NHDHHS, DPHS, Health Statistics Section, 2004

When stratified by category and crossed with the proportion of low birth weight infants (graph below), the pattern that emerges is consistent with previously published national data (Kotelchuck, 1994). The better the APNCU, the lower the proportion of low birth weight infants. An exception to this relationship is found in the Adequate Plus category, which is likely due to identified high-risk pregnancies appropriately receiving more than the expected number of visits. The number of expected births is based on uncomplicated pregnancies and the index does not adjust for this factor.

Figure AP-16

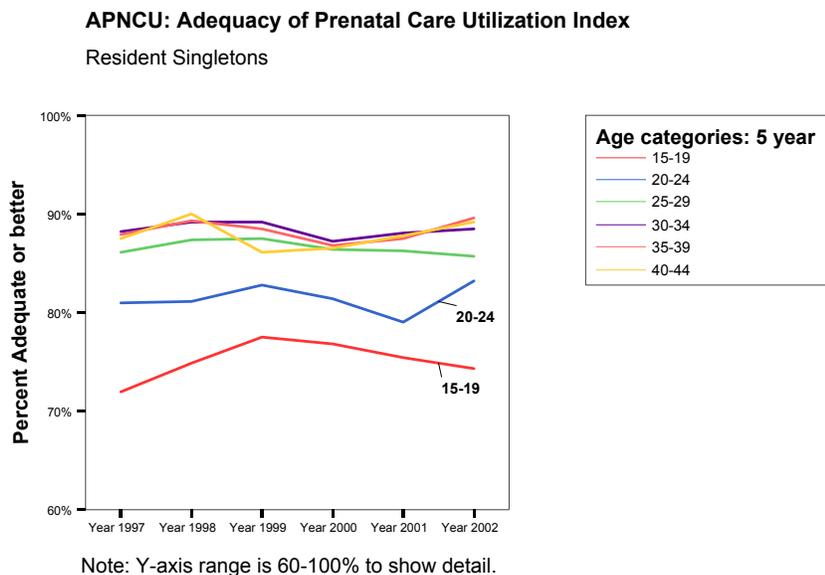
APNCU and Components



Data source: NHDHHS, DPHS, Health Statistics Section, 2004

The 15-19 and 20-24 year age groups tend to initiate prenatal care later and receive less than the recommended number of visits (adjusted for initiation) than other age groups (see figure AP-17 below). The 15 to 24 year old age group accounted for about 24% (N=3517) of all births in 2002.

Figure AP-17



Data source: NHDHHS, DPHS, Health Statistics Section, 2004

Similarly, 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. See graphics below. This suggests that target population identifying factors include age 15-24 years (any payer) and payer source (any age).

Figure AP-18

NON-MEDICAID: APNCU by Age
Resident Singletons

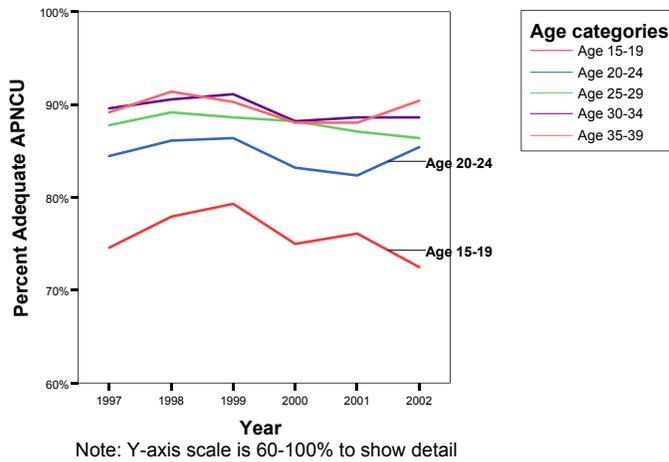
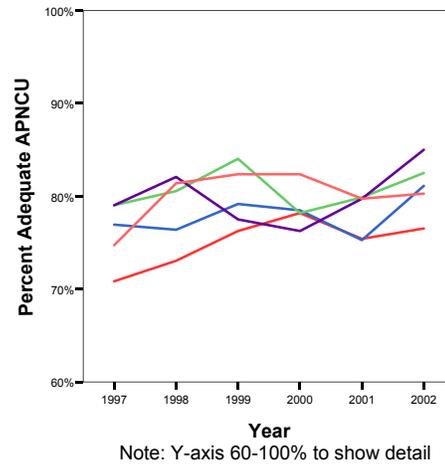


Figure AP-19

MEDICAID: APNCU by Age
Resident Singletons



Data source: NHDHHS, DPHS, Health Statistics Section, 2004

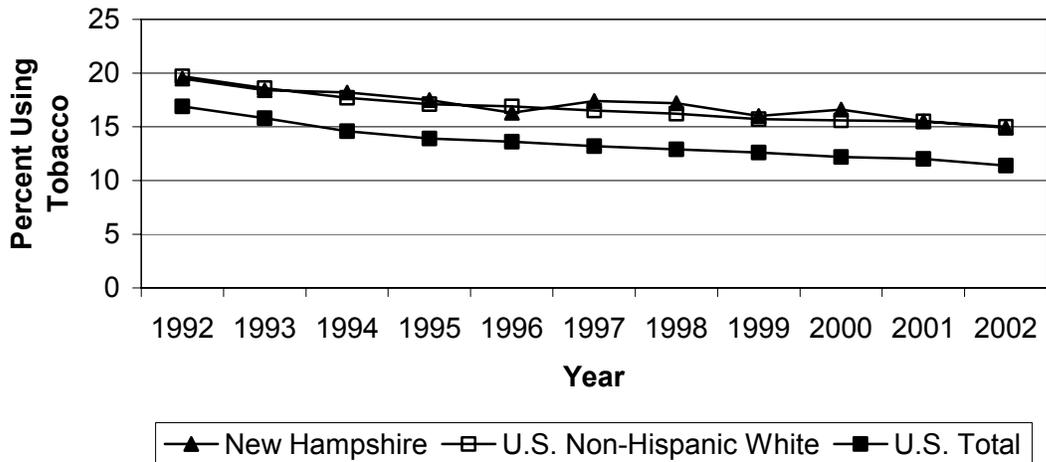
4. Tobacco Use in Pregnancy

Smoking during pregnancy nearly doubles a woman’s risk of having a low-birthweight baby. Studies also suggest that smoking increases the risk of preterm delivery. Premature and low-birthweight babies face an increased risk of serious health problems during the newborn period, and chronic lifelong disabilities (such as cerebral palsy and mental retardation). Smoking has been associated with a number of pregnancy complications. In addition, during pregnancy, a woman is more likely to consider stopping smoking. This has the potential to have a significant long term impact on the women’s health. Interventions to reduce smoking during pregnancy range from warnings printed on cigarette packages about the risks of smoking to clinic-based programs.

Nationally and in New Hampshire, the proportion of pregnant women who report tobacco use during pregnancy has been steadily declining over the last decade. Still, a higher proportion of pregnant women in NH smoke than in the US overall. Since the NH population is largely non-Hispanic white, this population provides a better US comparison group than the US overall. The graph below shows the overall smoking rates for each of these groups, as well as the downward trend.

Figure AP-20

Mothers Who Reported Tobacco Use During Pregnancy

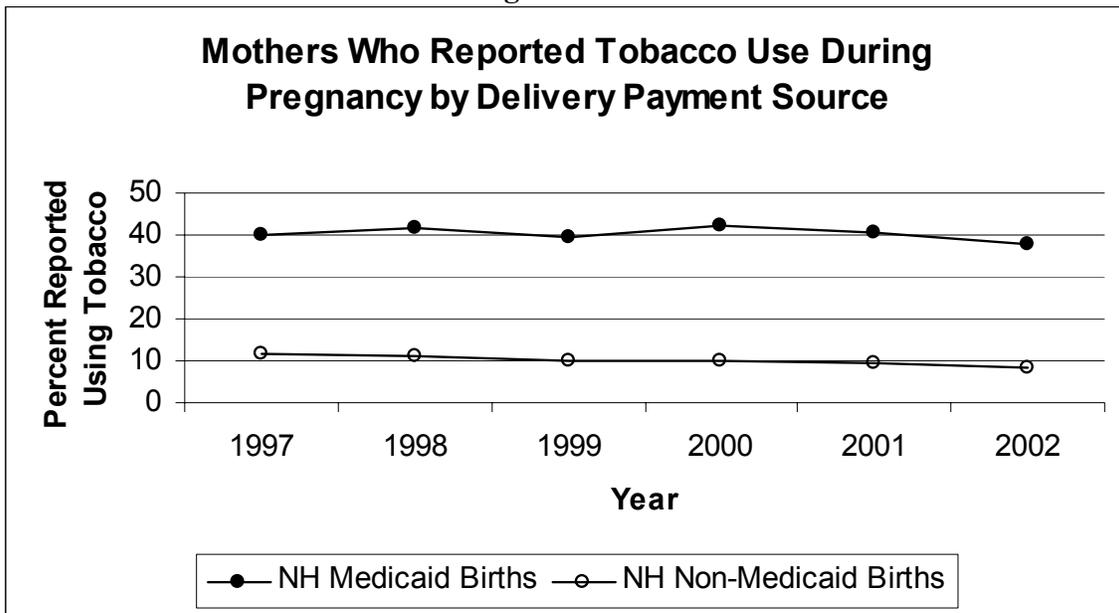


Data source: NHDHHS, DPHS, Health Statistics Section, 2004

When the smoking data is stratified by the payment source for delivery, it becomes clear that women of low socioeconomic status (SES) (using Medicaid payer status as a proxy for SES) are significantly more likely to smoke while pregnant than more financially comfortable women. See graph below.

Figure AP-21

Mothers Who Reported Tobacco Use During Pregnancy by Delivery Payment Source



Data source: NHDHHS, DPHS, Health Statistics Section, 2004

This trend is further supported by the fact that 15-24 year olds (regardless of payer) and those whose births are paid for by Medicaid (regardless of age) are the most likely to report smoking. See graphs below. This trend of more problematic indicators for low income and young women is similar to that observed with regard to adequacy of prenatal care. These socio-demographic characteristics suggest ways of identifying at-risk populations for smoking cessation interventions.

Figure AP-22

Tobacco use * Age: Non-Medicaid
Resident births

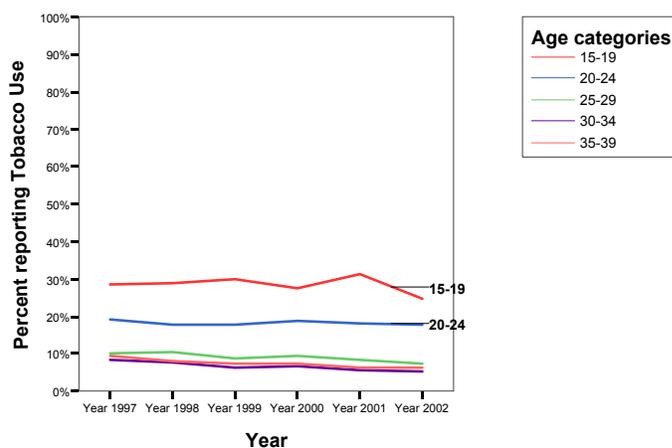
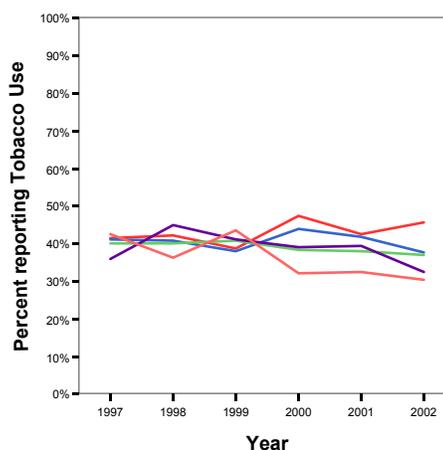


Figure AP-23

Tobacco use * Age: Medicaid
Resident births



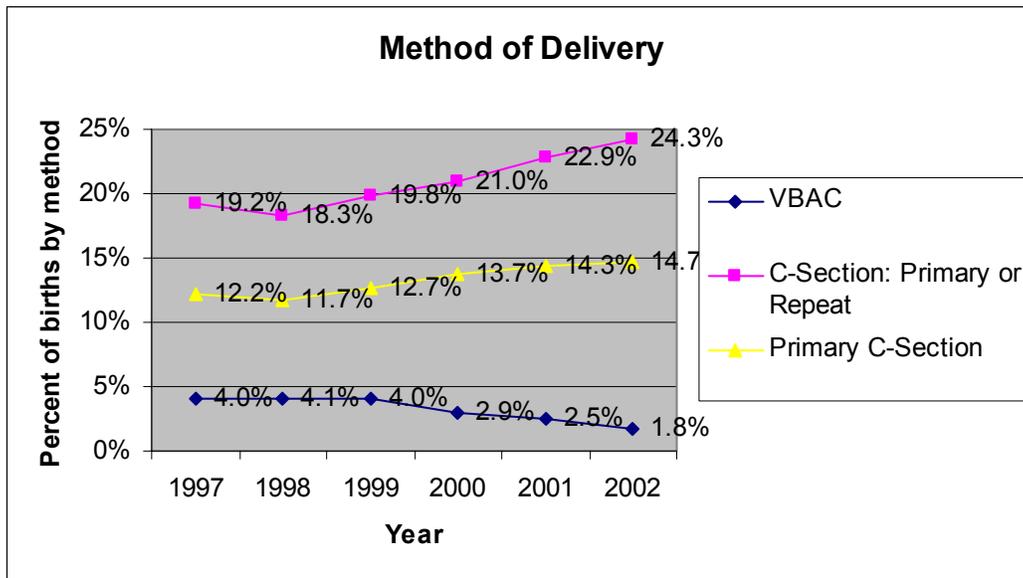
Data source: NHDHHS, DPHS, Health Statistics Section, 2004

5. Method of Delivery: C-Section Rates, Primary and Repeat

Preliminary data for 2003 indicated that 27.6% of all births in the United States resulted from cesarean deliveries, an increase of 6% from 2002 and the highest percentage ever reported in the United States. After declines during 1989 to 1996, the total cesarean rate and the primary cesarean rate (i.e., percentage of cesareans among women with no previous cesarean delivery; 19.1% in 2003) have increased each year. In addition, the rate of vaginal birth after cesarean delivery (VBAC), which had increased during 1989—1996, decreased by 63% to 10.6% in 2003. Among women with previous cesarean deliveries, the likelihood that subsequent deliveries would be cesarean was approximately 90% in 2003. (NCHS, 2004)

In New Hampshire, the proportion of births by cesarean delivery (Figure AP-24) has been increasing as the proportion of vaginal births after previous cesarean delivery has been decreasing over the last several years. According to the national 2002 birth report, “the escalation in the total cesarean rate is fueled by both the rise in the primary cesarean rate and the steep decline in the rate of VBAC delivery (NCHS 2002). Controversy continues to stimulate research and discussion on the risks, benefits, and long-term consequences of cesarean (medically indicated or elective) delivery and VBAC delivery.”

Figure AP-24



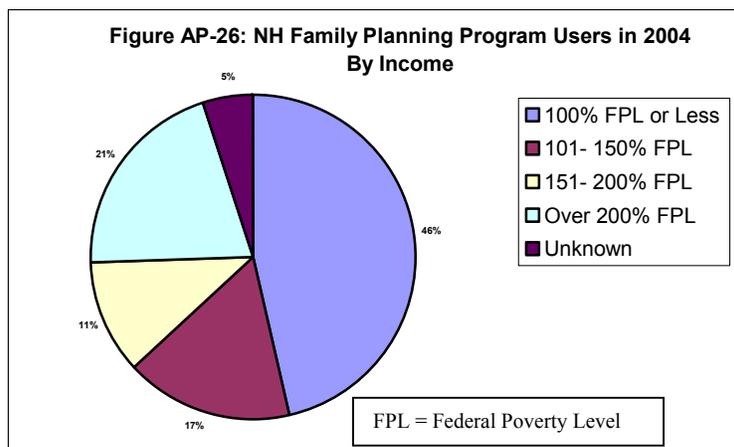
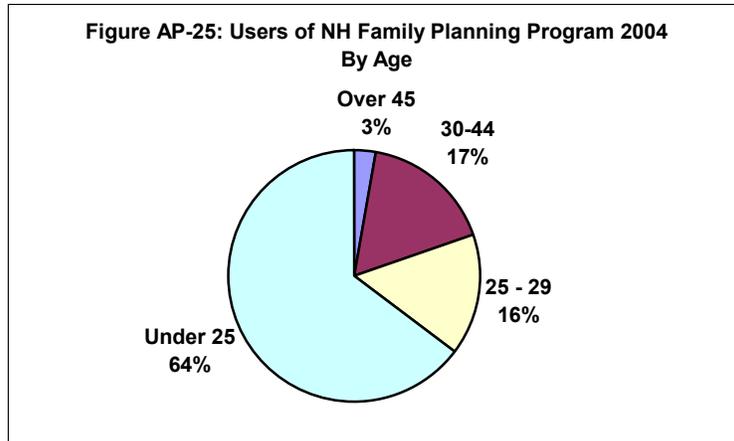
Data source: NHDHHS, DPHS, Health Statistics Section, 2004

6. Family Planning and Contraception

For sexually active women of reproductive age, the consistent use of contraception is the major method for the prevention of unintended pregnancy. In New Hampshire, as elsewhere, family planning methods are available over the counter (condoms, spermicide), through private physicians and at publicly funded primary care and family planning clinics. Data are generally not available for contraceptive provision by private providers or for drugstore purchases.

The New Hampshire Family Planning Program uses Title X funds, state funds and a limited amount of funding from the state's Temporary Assistance to Needy Families (TANF) program to provide services statewide. Thirty clinics are located in such a way as to make subsidized family planning services available to all residents of the state within an hour's drive of their homes. The clinics serve individuals in all age and income groups, providing a sliding fee scale to those with incomes under 250% of the federal poverty level.

In 2004, 30,817 individuals used services provided by the NH Family Planning Program. Of these, 29,521 (95%) were female. As shown in the following charts, users of the program are mainly young (64% under 25 years of age) and poor (with 74% below 200% of the federal poverty level).



Data Source: NH Family Planning Annual Report, 2004

Family Planning clients are generally white (29,180 – 95%) and about 3% report being of Hispanic origin.

A major objective of the family planning program is to provide highly effective contraceptive methods to low-income women who need and want them. James Trussell, PHD, a health economist, is a leading authority on contraceptive failure rates. According to his most recent estimates, the IUD, Depo-Provera and birth control pills all have effectiveness rates in actual use of over 90% with theoretical perfect effectiveness rates of 99% or over. This compares to much lower effectiveness rates of over the counter methods – condoms 85% use effectiveness and 98% perfect effectiveness, spermicides 75% use effectiveness and 92% perfect effectiveness. These figures suggest that the use of the IUD, Depo Provera and birth control pills, methods that can only be accessed via prescription, is most likely to decrease the risk of unintended pregnancy.

Data on family planning clients shows significant proportions of them to be using the most effective methods. Use of Depo Provera, oral contraceptives or IUD is reported by 51% of female clients at their last visit of the year compared to 41% at their first visit.

In recent years, the availability of Emergency Contraception provided another option to reduce unintended pregnancies. For example, Emergency Contraception can be used after an act of unprotected intercourse caused by either a method failure such as condom breakage or the failure

of a couple to use contraception, it can prevent pregnancies that would have been averted by regular contraceptive use.

In New Hampshire, publicly funded family planning services are broadly available. These services support the voluntary use of contraceptive methods most likely to prevent unintended pregnancy and serve the young and low-income women likely to be most in need. Despite this, figures compiled by the Alan Guttmacher Institute demonstrate that publicly funded clinics currently meet only 47% of the estimated need for these services. (Alan Guttmacher Institute, 2005)

7. Sexually Transmitted Infections (STI's):

Sexually transmitted infections, and in particular, Chlamydia can negatively impact fertility by damaging the fallopian tubes. CDC estimates that this happens in up to 40% of women with untreated infection. In pregnant women there is some evidence that untreated Chlamydia can cause premature birth and in addition, untreated maternal chlamydia can cause early infant pneumonia and conjunctivitis in newborns.

As shown below, chlamydia is most common among women under 25 and rates of chlamydia in New Hampshire are showing a slow but steady increase perhaps in part due to significant screening efforts at family planning clinics.

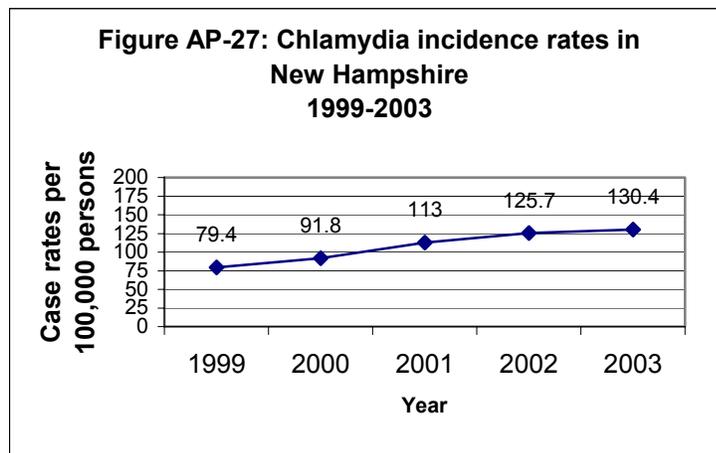
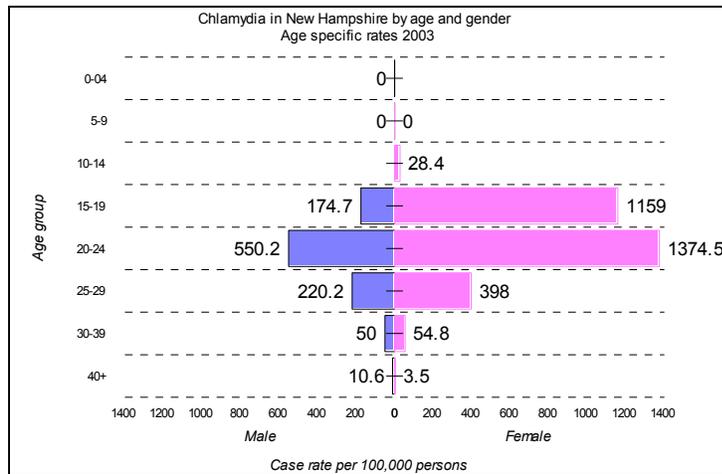


Figure AP-28



Source: NH STD/HIV Program, 2005

8. HIV:

In NH, females represent 18% (178 reported cases since 1983) of current AIDS cases and 28% (128 reported cases since 1991) of current HIV (non-AIDS) cases. Ten percent of AIDS cases and 14% of HIV cases were transmitted through heterosexual contact. An additional 20% of AIDS cases and 23% of HIV cases were transmitted by injecting drug use (IDU). While between 2002 and 2004, men having sex with men (MSM) continued to be the identified group most frequently infected with HIV and AIDS, the next largest group of cases had no identified risk (NIR). Due to the system used by CDC to classify cases, heterosexual transmission where no partner risk is identified is reported as NIR. In 2004, 70% of female HIV cases and 40% of female AIDS cases were reported as NIR.

In NH since 1991, 10 cases of pediatric HIV infection have been reported in NH. Eleven cases of pediatric AIDS have been reported in NH since 1983.

9. Domestic violence

Violence against women is a serious public health problem in New Hampshire and nationally, affecting infants and children as well as the women that the violence is directed toward. From 1990-2003, 48% of NH homicides were related to domestic violence. Women represented 82% of all victims of domestic violence homicides in NH during this period. During the 4-year period, 1999-2002, 3,956 women ages 18 and over were treated at NH emergency departments for injuries resulting from an assault. Approximately 25% of these visits were for injuries caused by battering by a spouse or partner, abuse by a family member or rape. This is likely to be an underestimate, since hospital data often lack the coding that would identify the nature of the assault. Women in the 15-24 and 25-34 year old age groups had the highest rate of assault injury related emergency department visits during 1999-2002: 500 and 400 visits per 100,000 females, respectively, significantly higher than the rates in other age groups. The number of homicides and inpatient hospitalizations for violence against women are too few to allow stratification by age groups (NHDHHS unpublished data, 2005).

Violence against women also carries substantial financial costs to public funding sources: in NH during the 4 year period 1999-2002, 33% of inpatient hospitalizations for assault injuries to women were paid by Medicare and 28% were paid by Medicaid (Figure AP-30 below).

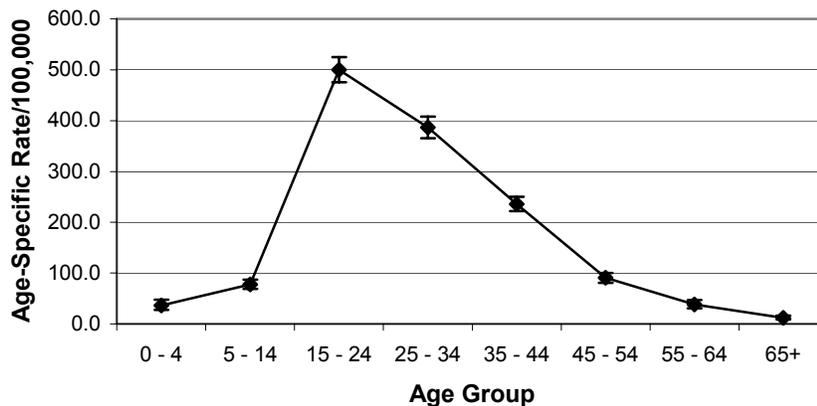
Pregnancy may increase the risk of violent injury and death from a woman's partner, but few states are collecting data on the pregnancy status of domestic violence murder victims.

In 2002, the NH Coalition Against Domestic and Sexual Violence (NHCADSV) provided assistance to 6,531 primary victims of DV and over 1,000 primary victims of sexual assault. (NHCADSV, 2003)

Data that would adequately describe the VAW problem is lacking. Problems such as incomplete and inaccurate hospital coding, insurance reimbursement practices, reluctance of victims to disclose information and other factors impede data collection.

Young women ages 15-24 and women ages 25-34 have the highest rate of emergency department visits for assault:

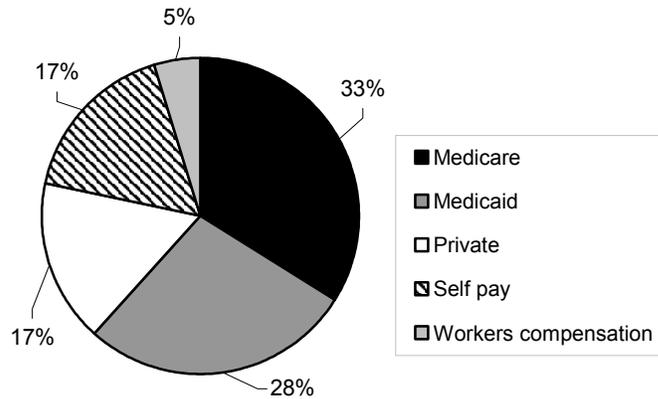
Figure AP-29: Emergency Department Visits for Assault Injuries Among Females by Age Group, NH 1999-2002



Source: NH DHHS DPHS UHDDS, 2004

Medicare (33%) and Medicaid (28%) are the most frequent payers of inpatient hospitalizations for assault on women:

**Figure AP-30: Primary Payer for Inpatient Hospitalizations due to Assault Injuries
NH Females, 1999-2002 (N=65)**



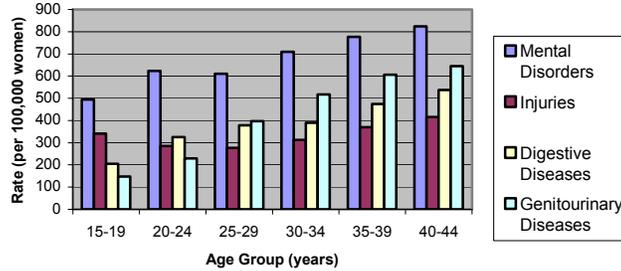
Source: NH DHHS DPHS UHDDS, 2004

10. Hospitalizations among NH women in the childbearing years: ages 15 through 44 years

Finding overall data to understand the overall health of women in New Hampshire is somewhat challenging. One way to identify major health problems among women of childbearing age is to examine hospitalization data. The leading cause of inpatient hospital discharges for New Hampshire women in each age group between 15 and 39 years is the category, “Complications of Pregnancy, Childbirth and the Puerperium” (with rates of 9194, 30935, 41166, 33948, and 13539 discharges per 100,000 women in each age group: 15-19, 20-24, 25-29, 30-34, and 35-39, respectively). “Mental disorders” (depression, anxiety and other disorders), are the second leading cause for each 5-year age group through age 39 (with rates of 1980, 2493, 2444, 2839 and 3109 discharges per 100,000 women in each age group: 15-19, 20-24, 25-29, 30-34, and 35-39, respectively). Mental disorders is the leading cause of discharges for women ages 40-44. Injuries (intentional and unintentional) are also a leading cause of inpatient hospitalizations among women of childbearing age. The discharge rates for many diagnoses follow the expected pattern of increasing with age. Injury discharge rates vary from this pattern, similar to national data.

The MCH Section plans to conduct further analysis of these data in the future to identify specific diagnoses and injuries that may be amenable to intervention.

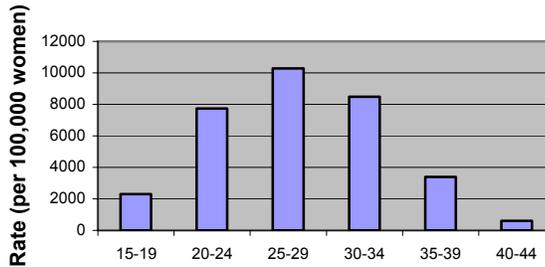
Figure AP-31: Leading Causes* of Inpatient Hospital Discharges by Age Group, NH Females Ages 15-44 years, 1999-2002



Source: NHDHHS, Health Statistics Section, 2005

*Complications of Pregnancy, Childbirth, & the Puerperium is the leading cause of inpatient hospital discharges for ages 15-39. This category is excluded from the graph in order to show detail.

Figure AP-32: Inpatient Hospital Discharge Rates for Complications of Pregnancy, Childbirth, and the Puerperium, NH Females Ages 15-44 by Age Group, 1999-2002



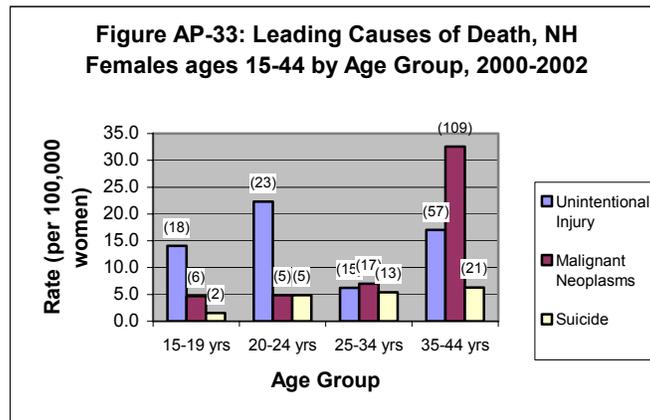
Source: NHDHHS, Health Statistics Section, 2005

*Note scale differences in comparison to figure above; inpatient hospital discharge rates due to Complications of Pregnancy, Childbirth, and the Puerperium occur at a much greater rate than discharges from other causes.

11. Leading causes of death among NH women in the childbearing years: ages 15 through 44 years

Another way of looking at major health problems is to consider causes of death. Unintentional injuries are the leading cause of death among adolescent females up to age 24 years and the second leading cause of death among women ages 25 to 44. The majority of these deaths are due to motor vehicle crash-related injuries. Nationally, injuries are the leading cause of death among women ages 1 through 34 years. Malignant neoplasms are the second leading cause of death for New Hampshire’s adolescent females and the leading cause for women ages 25 to 44. Suicide is the third leading cause of death among women 20 to 34. Small numbers of deaths in many age and cause categories limit analysis of these data.

The MCH Section plans to conduct further analysis of these data in the future to identify specific causes of death that may be amenable to prevention.



Source: CDC, NCIPC WISQARS (on-line), 2005
 Number of deaths in parentheses
 Rates based on fewer than 20 deaths are unstable and should be viewed with caution.

D. Infants – Age less than 1 year

In 2001, the infant mortality rate in New Hampshire (deaths per 1,000 live births) was ranked first in the nation with a rate of 3.8 compared to a national rate of 6.8 (NCHS, 2002). Recent New Hampshire data, however, indicate an upward climb in the rate of low birth weight infants. This trend is found in both singleton and multiple births. 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.

1. Infant Birth Weight

Low birth weight (LBW) is a strong predictor of infant health and survival. Low birth weight is a public health problem in the United States. LBW babies may face serious health and development complications such as respiratory disorders, malformations, intestinal complications and developmental delays. Infants born below 5.5 pounds (2,500 grams) are low birth weight. Very low birthweight infants are those born at less than 1,500 grams. Normal birthweight ranges from 2,500 to 3,999 grams, and high birthweight is defined as 4,000 grams or greater. In 2002, 541 New Hampshire infants (3.9% of singleton births) were moderately low birth weight and an additional 98 (.7% of singleton births) were very low birth weight (Table AP-5). The emotional, medical, and economic costs of low birth weight babies creates a powerful incentive to address prevention efforts throughout New Hampshire communities.

The distribution of birth weight by year can be found in Table AP-4 (all births). Overall, the proportion of very low birth weight (VLBW) births was steady at about 1% over the 1997-2002 time period. During the same period, the proportion of moderately low birth weight (MLBW) births has risen significantly (17.4%) from a low of 4.6% in 1998 to a high of 5.4% in 2001. The proportion of normal birth weight (NBW) births has remained steady at about 80%. High birth weight (HBW) births have decreased significantly (-11%) from a high of 14.1% in 1997 to a low of 12.7% in 2001.

Table AP-4										
Birth weight - NH Resident Births										
Year		Major birth weight categories								
		VLBW <1500 grams		MLBW 1500-2499 grams		NBW 2500-3999 grams		HBW At least 4000 grams		Total
1997	Count	168		667		11398		2003		14236
	% within Year	1.2%		4.7%		80.1%		14.1%		100.0%
	95% CI	1.0%	1.4%	4.4%	5.0%	79.4%	80.8%	13.5%	14.7%	
1998	Count	161		660		11536		2005		14362
	% within Year	1.1%		4.6%		80.3%		14.0%		100.0%
	95% CI	0.9%	1.3%	4.3%	4.9%	79.6%	81.0%	13.4%	14.6%	
1999	Count	164		706		11215		1919		14004
	% within Year	1.2%		5.0%		80.1%		13.7%		100.0%
	95% CI	1.0%	1.4%	4.6%	5.4%	79.4%	80.8%	13.1%	14.3%	
2000	Count	194		721		11628		2019		14562
	% within Year	1.3%		5.0%		79.9%		13.9%		100.0%
	95% CI	1.1%	1.5%	4.6%	5.4%	79.2%	80.6%	13.3%	14.5%	
2001	Count	159		797		11810		1863		14629
	% within Year	1.1%		5.4%		80.7%		12.7%		100.0%
	95% CI	0.9%	1.3%	5.0%	5.8%	80.1%	81.3%	12.2%	13.2%	
2002	Count	157		756		11605		1899		14417
	% within Year	1.1%		5.2%		80.5%		13.2%		100.0%
	95% CI	0.9%	1.3%	4.8%	5.6%	79.9%	81.1%	12.6%	13.8%	

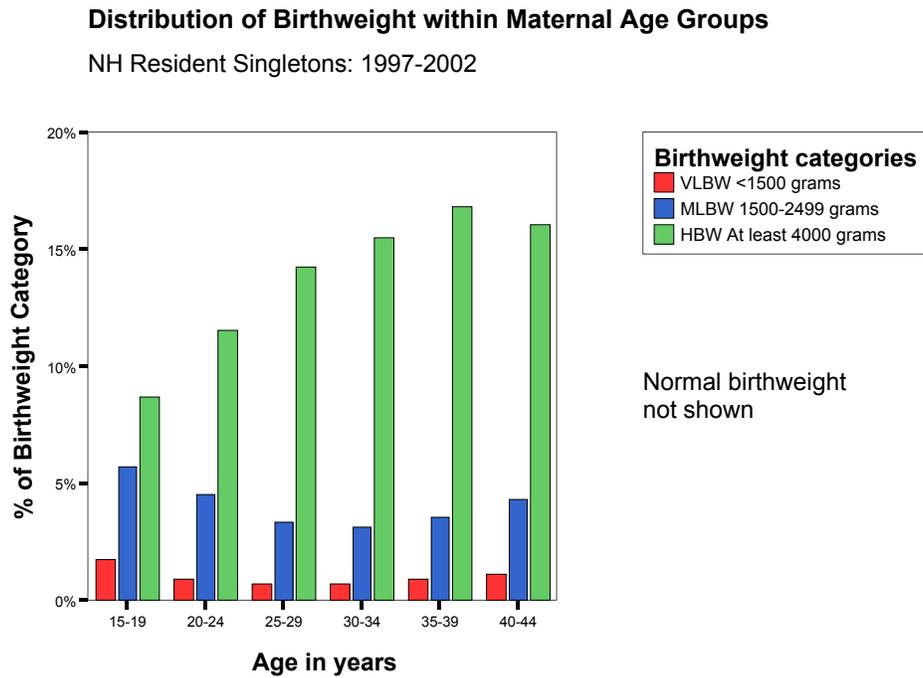
Note: Total births are slightly lower than actual due to a very small number of births missing birth weight data.

The distribution of *singleton* birth weight by year can be found in Table AP-5. The proportion of VLBW singleton births was steady at about 0.8% over the 1997-2002 time period. During the same period, the proportion of MLBW singleton births has risen significantly (14.7%) from a low of 3.4% in 1998 to a high of 3.9% in 2001-02. The proportion of NBW singleton births has remained steady at about 81%. High birth weight singleton births have decreased significantly (-8.3%) from a high of 14.5% in 1997 to a low of 13.3% in 2001.

Table AP-5							
Birth weight							
NH Resident Singleton Births							
		Major birth weight categories					
<i>Year</i>		<i>VLBW <1500 grams</i>	<i>MLBW 1500-2499 grams</i>	<i>NBW 2500-3999 grams</i>	<i>HBW At least 4000 grams</i>	<i>Total</i>	
1997	Count	127	478	11165	2003	13773	
	% within Year	.9%	3.5%	81.1%	14.5%	100.0%	
		0.7% 1.1%	3.2% 3.8%	80.4% 81.8%	13.9% 15.1%		
1998	Count	116	471	11295	2003	13885	
	% within Year	.8%	3.4%	81.3%	14.4%	100.0%	
		0.7% 0.9%	3.1% 3.7%	80.7% 81.9%	13.8% 15.0%		
1999	Count	105	509	10971	1919	13504	
	% within Year	.8%	3.8%	81.2%	14.2%	100.0%	
		0.6% 1.0%	3.5% 4.1%	80.5% 81.9%	13.6% 14.8%		
2000	Count	124	533	11377	2018	14052	
	% within Year	.9%	3.8%	81.0%	14.4%	100.0%	
		0.7% 1.1%	3.5% 4.1%	80.4% 81.6%	13.8% 15.0%		
2001	Count	115	542	11513	1862	14032	
	% within Year	.8%	3.9%	82.0%	13.3%	100.0%	
		0.7% 0.9%	3.6% 4.2%	81.4% 82.6%	12.7% 13.9%		
2002	Count	98	541	11359	1896	13894	
	% within Year	.7%	3.9%	81.8%	13.6%	100.0%	
		0.6% 0.8%	3.6% 4.2%	81.2% 82.4%	13.0% 14.2%		

The distribution of birth weight within maternal age groups is shown in Figure AP-34. Women in the 15-24 year age group are more likely to have VLBW infants than the women in the 25-34 age group. Women 35 and over are less likely than the 15-24 year old women, but more likely than the 25-34 years old women, to have a VLBW infant. A similar U-shaped pattern holds true for MLBW as well. However, the HBW pattern looks quite different. The prevalence of HBW increases noticeably with maternal age. Summing the 3 birth weight proportions represented by the category bars within each age group shown in Figure AP-34 reveals the percentage of non-normal birth weight births. The proportion of non-normal birth weight births is positively associated with age (older women are most likely to have non-normal birth weight infants).

Figure AP-34



The distribution of maternal age within birth weight categories can be seen in Figure AP-35. The 40-44 year old mothers represent the smallest proportion of births within any category. While younger women are more likely to have VLBW infants, they account for the *smallest* proportion of the number of births within this birth weight category. The 30-34 year old mothers account for the largest proportion of VLBW and HBW births, and the second largest proportion of MLBW births.

Figure AP-35

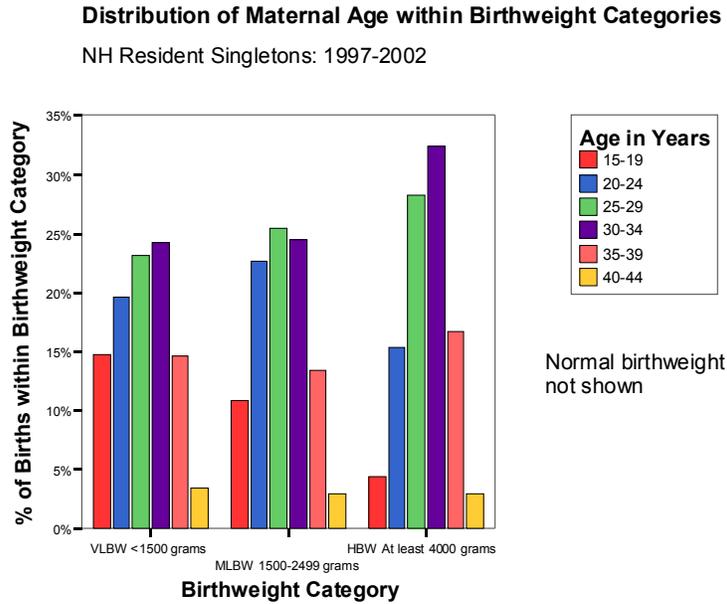
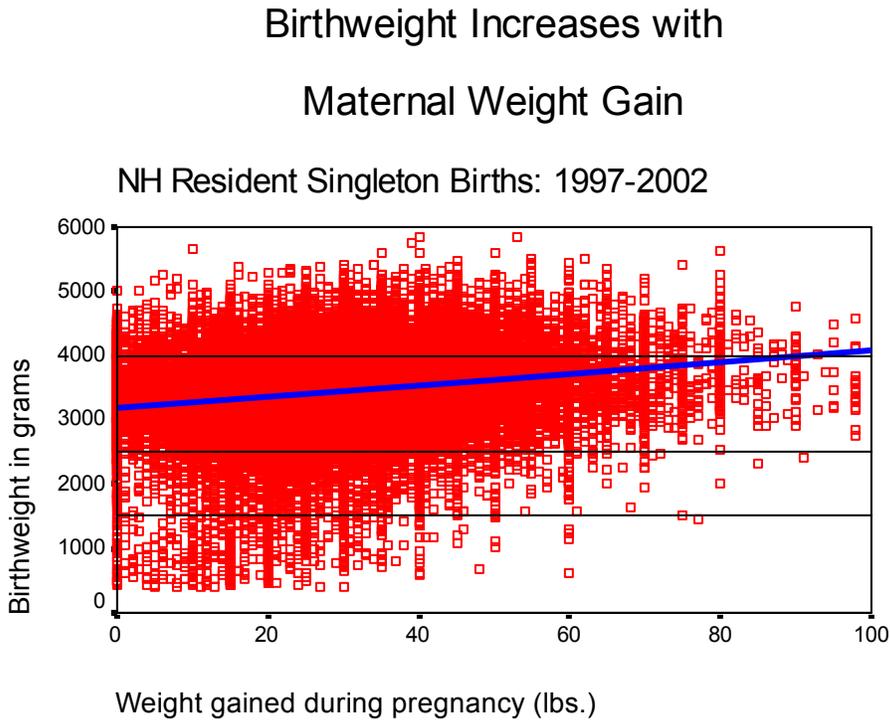


Figure AP-36 shows that birth weight is positively associated with maternal age, reinforcing the association seen in Figure AP-34.

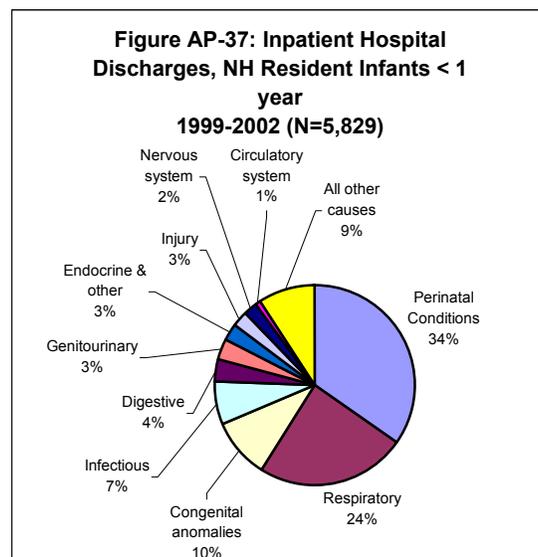
Figure AP-36



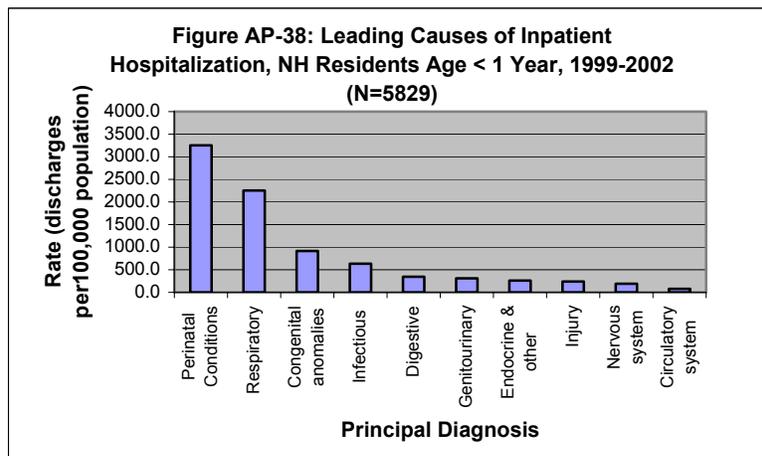
While younger women are at higher risk for having VLBW and MLBW infants, older women are at higher risk of having HBW infants. Although age can be used to identify higher risk women and target the most intensive interventions, the large numbers of non-high risk women having non-normal birth weight infants suggests a corresponding need to maintain and improve interventions for women of all ages.

2. Hospital Discharges (1999-2002)

The leading cause of inpatient hospital discharges for New Hampshire infants <1 year old is the category, “Certain conditions originating in the perinatal period” at a rate of 3623/100,000. The second leading cause is “Diseases of the respiratory system (including asthma)” at a rate of 2320/100,000.



Data source: NHDHHS, DPHS, HSDM Section, 2005
Includes NH residents discharged from both in- and out-of-state hospitals



Data source: NHDHHS, DPHS, HSDM Section, 2005

3. Leading causes of death (1999-2001)

During the 3-year period, 1999-2001, there were 222 deaths to NH residents under 1 year old; 158 (71%) of the deaths were neonatal (occurring less than 28 days after birth), 64 (29%) were postneonatal (occurring between 28 days and 11 months after birth). Causes of death vary greatly between these two infant age groups. The leading cause of neonatal death was congenital anomalies, responsible for 34 (22%) of these deaths. Other leading causes among neonates were disorders related to short gestation and low birth weight (22 or 14%), complications of placenta, cord and membranes (19 or 12%) and maternal complications of pregnancy that affected the newborn (13 or 8%). The leading cause of postneonatal death was SIDS, responsible for 17 deaths (27%) in this older infant age group, congenital anomalies (8 deaths - 13%) and injuries (unintentional and intentional combined), responsible for 7 deaths (11%). Four of these infant deaths were homicides, 2 deaths were due to unintentional strangulation in bed and 1 death was due to a house fire. (NHDHHS, DPHS, Health Statistics Section, 2005).

Table AP-6: Leading Causes of Neonatal Death, NH, years 1999-2001

Cause of Death	Number
Congenital Abnormalities	34
Short Gestation	22
Placenta Complications	19
Maternal Complications	13
Intrauterine Hypoxia	10
Interstitial Emphysema	6
Atelectasis	5
Respiratory Distress	4
Complications of Labor	4
Neonatal Hemorrhage	4
SIDS	4
Circulatory System	2
Bacterial Sepsis	2
Other	29
Total	158

Table AP-7: Leading Causes of Postneonatal Death, NH, years 1999-2001

Cause of Death	Number
SIDS	17
Congenital Abnormalities	8
Homicide	4
Accidents	3
Chronic Resp. Disease	3
Atelectasis	2
Circulatory System	2
Flu & Pneumonia	2
Intrauterine Hypoxia	2
Other	21
Total	64

4. Kernicterus

Following a national conference presentation indicating a reemergence of Kernicterus as a cause of infant death, the MCH Section examined mortality and hospital data to determine whether there was an increase in NH. Kernicterus is a preventable condition affecting newborns, resulting from untreated hyperbilirubinemia. Kernicterus is preventable through screening and treatment of hyperbilirubinemia. If left untreated, kernicterus results in severely disabling brain damage or death. Cases of Kernicterus declined dramatically since the 1960's with the introduction of various methods of treating and/or preventing hyperbilirubinemia. However, shorter hospital stays since the early 1990's, resulting in reduced monitoring of newborns, may be contributing to its reemergence nationally (CDC, 2001).

New Hampshire data did not show the increase noted nationally. There were 2 deaths over the period 1990 to 2001, both occurring in 1996. During the period 1990 through 2001, inpatient hospital discharges due to kernicterus and hyperbilirubinemia-related diagnoses declined. (See attached data and graphs)

5. Breastfeeding rates

Breastfeeding is one of the most important contributors to infant health, and provides a range of benefits for the infant's growth, immunity, and development. The American Academy of Pediatrics specifically references the role of breastfeeding in decreasing the incidence and severity of diarrhea, lower respiratory infections, and otitis media, as well as possible protective effects against sudden infant death syndrome, diabetes, and some chronic digestive diseases. Breastfeeding has also been related to possible enhancement of cognitive development in children. (AAP, 1997) (USDHHS Office of Women's Health, 2000).

Breastfeeding is considered a promising approach for preventing obesity. Children who are ever breastfed are 15%-25% less likely to become overweight, and those who are breastfed for 6 months or more are 20%-40% less likely. (USDHHS Office of Women's Health, 2000).

Data for the WIC-specific population in New Hampshire from the CDC Pediatric Nutrition Surveillance System show lower rates than the national goal of 75% women breastfeeding in the early postpartum period. The average rate of breastfeeding at the time of hospital discharge for this population for the years 2000-2002 is 54.3%. Although this rate is slightly higher than the US WIC population rate of 51.1%, New Hampshire has work to do to achieve the national goal for 2010. The New Hampshire rates continue to increase each year, which is a positive trend among the low-income population enrolled in WIC. Low-income populations generally have lower breastfeeding rates than the general population (USDHHS Office of Women's Health, 2000).

Data from the National Immunization Survey, comparing New Hampshire breastfeeding rates to other New England states and to the Healthy People 2010 goal, are presented in the table below.

Table AP-8: Comparison of New Hampshire Breastfeeding Rates to New England States and Healthy People 2010

State	Ever breastfeeding (%)	Breastfeeding at 6 mos. (%)	Breastfeeding at 12 mos. (%)	Exclusive breastfeeding at 3 mos. (%)	Exclusive breastfeeding at 6 mos. (%)
CT	72.9 +/- 5.3	36.8 +/- 5.5	18.1 +/- 4.2	40.1 +/- 5.7	14.8 +/- 4.1
ME	71.3 +/- 5.3	39.6 +/- 5.4	20.6 +/- 4.2	44.6 +/- 5.6	18.9 +/- 4.2
MA	70.6 +/- 5.0	38.6 +/- 5.1	16.1 +/- 3.6	39.8 +/- 5.0	14.3 +/- 3.5
NH	72.0 +/- 5.3	43.4 +/- 5.5	23.0 +/- 4.4	50.1 +/- 5.6	17.3 +/- 3.9
RI	66.7 +/- 5.4	35.2 +/- 5.6	16.5 +/- 4.4	39.3 +/- 5.9	12.9 +/- 3.9
VT*	77.0 +/- 5.5	50.1 +/- 5.9	30.0 +/- 5.1	52.9 +/- 6.1	24.4 +/- 4.7
HP 2010	75	50	25		25% (AAP)

*VT (and 5 other states: HI, ID, OR, UT, WA) has achieved all of the HP 2010 objectives on breastfeeding. Only OR has achieved an exclusive breastfeeding rate above 25% at 6 months.

Data source: National Immunization Survey, CDC

website: <http://www.cdc.gov/nip/coverage/default.htm> - NIS

http://www.cdc.gov/breastfeeding/NIS_data/

E. Children - Ages 1 through 9 years

New Hampshire consistently ranks among the top states in the nation for many indicators or predictors of child well-being. Data from New Hampshire often paint a picture of a state where children, for the most part, begin life with many advantages, are healthy, have access to health care and economic security, and are able to avoid many consequences associated with less favorable statistics. Yet, New Hampshire still has opportunities through public policy to create safety nets and coordinated services for its youngest children. This summary of children's needs describes the areas in which the state has opportunities to direct its efforts to address the leading causes of morbidity and mortality.

Preventable injuries rank as the leading cause of death for all New Hampshire children and young adults age 1-24 (See Table AP-16). 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.

Hospital discharge data indicate that most frequent cause of hospitalization among children are diseases related to the respiratory system, including asthma. Children aged 1-4 have the highest hospitalization rate for asthma among all age groups of children.

Young children are also vulnerable to the effects of lead poisoning. The Childhood Lead Poisoning Prevention Program is using multi disciplinary population based and targeted efforts to eliminate childhood lead poisoning across the state. In 2003, among children screened, 2% of children <72 months had confirmed elevated blood lead levels. However, there are significant geographic differences across the state. In Franklin 10% of the children screened had elevated blood levels and in Claremont 4.6% of children screened had elevated levels.

New Hampshire has consistently led the nation in childhood vaccination rates. The New Hampshire Immunization Program is using very targeted approaches to continually improve these rates. By targeting the state's largest volume providers to move from the state average rate

of 85% of children receiving appropriate vaccination to over 95%, it is anticipated that approach would yield an overall state increase of 10%. Other initiatives target child care providers and pockets of urban, minority populations that are under vaccinated.

1. Childhood Lead Poisoning

Childhood lead poisoning continues to be a major, preventable environmental health problem for the children of New Hampshire. Despite significant progress toward the elimination of elevated blood lead levels (EBLL), children, who are most vulnerable continue to be exposed to this toxic metal at an unacceptable rate.

In 2000, a New Hampshire Sudanese refugee child died from lead poisoning, the first death in the U.S. in 10 years. Follow up studies found that the lead exposure had likely occurred in New Hampshire and identified a pattern of elevated blood lead levels (BLL) among refugee children, leading to the release of new guidelines for screening and monitoring of refugee children (CDC, 2000, 2005). The studies found that BLL's became elevated after resettlement for nearly 30% of refugee children. Risk factors for lead poisoning identified among these children were behaviors that could increase the chance of ingesting lead, lack of awareness of the dangers of lead and evidence of chronic and acute malnutrition.

Risk factors for elevated lead levels are age between 1 and 2 years (national data show that levels peak at 18-24 months of age (CDC, 1997)); children enrolled in Medicaid or other income-based assistance programs; and children living in housing built before 1950 (unrelated to socioeconomic indicators) Statewide, 28% of housing was built before 1950, but in some areas of the state, 45-70% of housing was pre-1950.

NH Lead screening recommendations

For children living in high-risk communities: In New Hampshire, communities with 27 percent or more of the housing stock built before 1950 are considered high-risk by the NH Lead Program (CDC recommendations). In these high-risk communities, universal screening recommendations should be followed: screen all children at one and two years of age (i.e. at the well child visits around the child's first and second birthday), and screen all children ages 36-72 months who have not been screened previously.

For children living in low risk communities: A targeted approach is suggested in communities designated as low-risk. This approach recommends that providers use a brief questionnaire and screen children only if they meet specific criteria. All children who are enrolled in Medicaid, receiving WIC benefits or who are enrolled in Head Start should be tested regardless of the risk designation of their town of residence.

For refugee children: Refugee children ages 6 months through 15 years of age will have a blood lead test performed at the time of their initial health screening (with TB testing, which must occur within 90 days of arrival).

The NH Childhood Lead Poisoning Prevention Program (CLPPP) recommends that follow up testing be done between three and six months after the initial blood lead screening to identify children who are being exposed to lead after they are resettled in New Hampshire.

NH children with elevated lead levels

In 2003, 273 children < 72 months old (2% of those screened) had confirmed elevated lead levels. Over the period 1999-2003, the percentage of confirmed elevations varied little.

**Table AP-9: Confirmed Elevated Blood Lead Levels
(≥ 10 ug/dL)**

<u>Year</u>	<u>Age Range (months)</u>	<u>Lead Level (ug/dL)</u>			<u>Total</u>	<u>Confirmed Elevation</u>
		<u>10-14</u>	<u>15-19</u>	<u>20+</u>		
1999	0-11	- *	-	-	33	8.1%
	12-23	97	35	34	166	2.2%
	24-35	53	21	9	83	2.4%
	36-71	-	-	-	58	2.3%
	Total	179	61	44	284	2.1%
2000	0-11	-	-	-	20	5.0%
	12-23	79	36	19	134	1.9%
	24-35	55	16	17	88	2.6%
	36-71	-	-	-	42	1.6%
	Total	146	49	32	227	1.7%
2001	0-11	-	-	-	21	4.6%
	12-23	76	32	14	122	1.8%
	24-35	44	7	9	60	1.8%
	36-71	-	-	-	24	1.0%
	Total	174	49	32	227	1.7%
2002	0-11	-	-	-	23	5.2%
	12-23	87	23	18	128	1.8%
	24-35	56	19	11	86	2.2%
	36-71	-	-	-	28	1.1%
	Total	174	52	39	265	1.9%
2003	0-11	-	-	-	14	3.9%
	12-23	87	34	18	139	2.0%
	24-35	51	13	12	76	2.0%
	36-71	-	-	-	44	1.7%
	Total	179	53	41	273	2.0%

*numbers in cell too small to report

Data source: NH Childhood Lead Poisoning Prevention Program (CLPPP), 2005

Geographic differences:

Franklin had a higher percentage of children (0-72 months) with confirmed elevated lead levels, compared to other areas of the state and the state as a whole (10.0% of children screened vs. 1.9% NH). In Claremont, 4.6% of children screened had elevated lead levels.

2. Vaccine Preventable Diseases

NH has consistently high childhood vaccination rates, significantly higher than the US average for many vaccines. NH has consistently been one of the top five states in national rankings for immunization levels. Therefore, well-targeted interventions are called for to reach the non- or under- vaccinated children. The NHIP plans to add epidemiological resources and immunization record assessment resources to the Program. The immunization record review is a proven strategy for increasing immunization levels, and NHIP has a solid track record using this approach. The state's 35 largest volume providers are responsible for 80% of the children being vaccinated. Increasing this group's rates from the average 85% to over 95% would yield a 10% increase in the overall state rate. The New Hampshire Immunization Program (NHIP) also plans to target pockets of need within urban populations, where ethnic diversity and population growth challenge existing systems, and within rural populations. With these added resources NHIP could determine best use of resources and then provide targeted immunization records review in more venues (such as child care). The end result will be to provide interventions to increase immunizations where it is most needed and will have the most impact.

The most recent data available for all currently reportable vaccine preventable diseases in NH are provided in the following table:

**Table AP-10: Reported Cases and Rates of Vaccine Preventable Diseases in New Hampshire
2002 - 2004**

Disease	Reported Cases 2002	2002 Rate*	Reported Cases 2003	2003 Rate*	Reported Cases 2004, YTD	2004 Rate*
Haemophilus influenzae	14	1.1	20	1.6	13	1.0
Hepatitis A	12	0.9	19	1.5	12	0.9
Hepatitis B	25	1.9	24	1.9	24	1.9
Measles	0	-	1	0.1	0	-
Mumps	5	0.4	2	0.2	1	0.1
Pertussis	78	6.1	119	9.2	28	2.2
Rubella	0	-	0	-	0	-
Tetanus	0	-	0	-	0	-

* Reported cases per 100,000 persons
NH Population 1,288,000 (2003 estimate NH Office of State Planning)

All data are based upon information provided to the New Hampshire Department of Health and Human Services. The numbers reported may represent an underestimate of the true absolute number and incidence rate of cases in the state. All population calculations and rates are based on the 2003 estimates by the NH Office of State Planning.

The increase in 2003 disease rates for pertussis is considered to be within the normal range of historical fluctuation. The waning of immunity due to vaccination only being available until age six, is one reason that this disease persists. Future options (based on vaccines in development) for pertussis "booster" vaccination of adolescents and adults should reduce the prevalence of this disease. For 2004, year-to-date, the rate of pertussis cases reported has declined, and will continue to be monitored.

Areas for improvement/Problem areas:

To better define under-immunized segments of the population, a follow-up Government Performance and Results Act (GPRA) Medicaid assessment was carried out in 2003/2004. The initial Medicaid assessment indicated the immunization rate for enrolled two-year old children was 67%, about 12% lower than the overall statewide average as reported in the National Immunization Survey for 2001.

Preliminary data found a difference in up-to-date rates between counties, with a low of 47% in Merrimack County and a high of 92% in Carroll County. The relatively small sample size for some counties will be enhanced by the second half of the study by including an expanded number of record reviews.

The NHIP continues to review strategies to impact varicella vaccination rates at the provider level. The latest NIS data (2003) for NH for this vaccine is 83.3% for children ages 19-35 months. This compares to a 73.9% rates for 2002. This indicates a significant impact of the NHIP outreach efforts, combined with the new requirements for this vaccine for school and child-care attendance.

Another objective is to increase by 15% school immunization record documentation of 11-18 year-olds immunized with 3 doses of hepatitis-B vaccine in CY 2004 (baseline 50% of students had documentation of having received 3 doses of hepatitis B – data source; annual program review of school records).

3. Obesity/Physical activity

The primary results from a study of school aged children (n=20,328), grades K through 12 in New Hampshire reveal that New Hampshire children are significantly more overweight than the national standard. The study showed that more than 17 percent of girls and more than 22 percent of boys are classified as overweight ($p < 0.0001$) compared to the national recommended standard of 5 percent (Figures AP-39 and AP-40).

BMI is calculated utilizing height, weight, age and gender. Thus, it is important when studying a group of aging children to analyze for both height and weight to determine if higher BMIs are due to decreased height or increased weight. These separate analyses show that New Hampshire children are taller than the national standard, while significantly heavier than the national standard.

Analysis of the fitness levels, utilizing the Physical Best protocol, show that 88 percent of school children upon entering school at the age of 5 are able to pass all four fitness components to the minimum healthy fitness zone. Only 47 percent of children a year older are able to reach the minimum healthy fitness zone for the same four tests. These fitness levels stay consistent until the age of 10 when the aerobic capacity test is also introduced. Only 22 percent of children at the age of 10 are able to reach the healthy fitness zone for all five tests. Less than 40 percent of these children are able to reach the healthy fitness zone for the original four fitness tests. By the age of fifteen only 4 percent of children were able to meet the healthy fitness zone for all five

tests and less than 10 percent could reach the healthy fitness zone for the original four tests. (UNH, 2005)

Figure AP-39: Girls BMI Percentiles

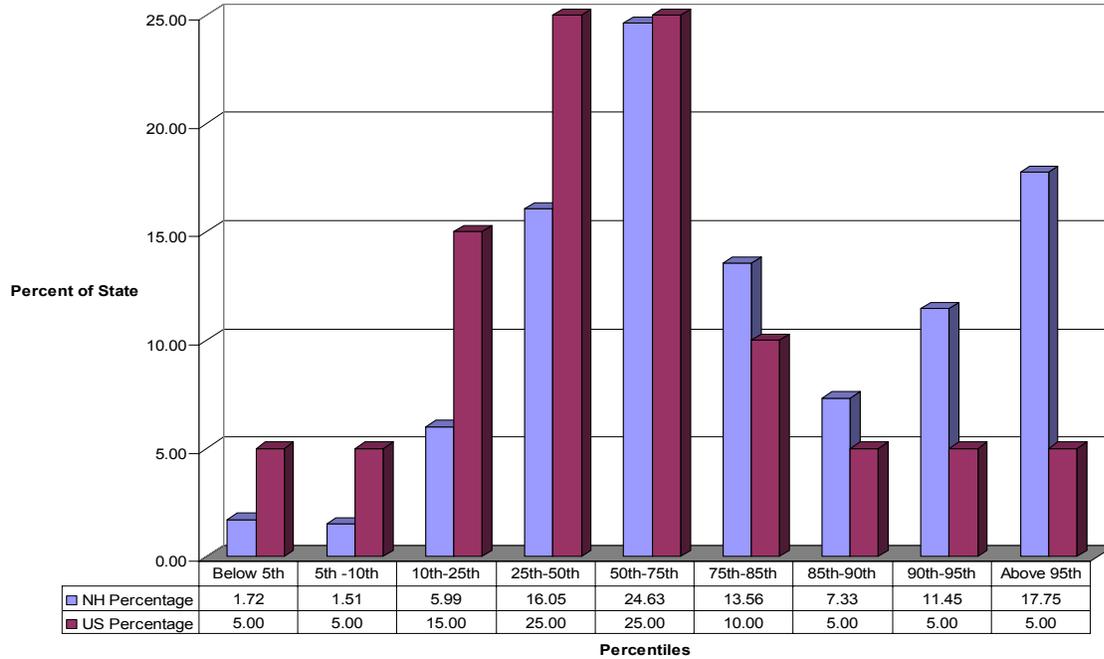
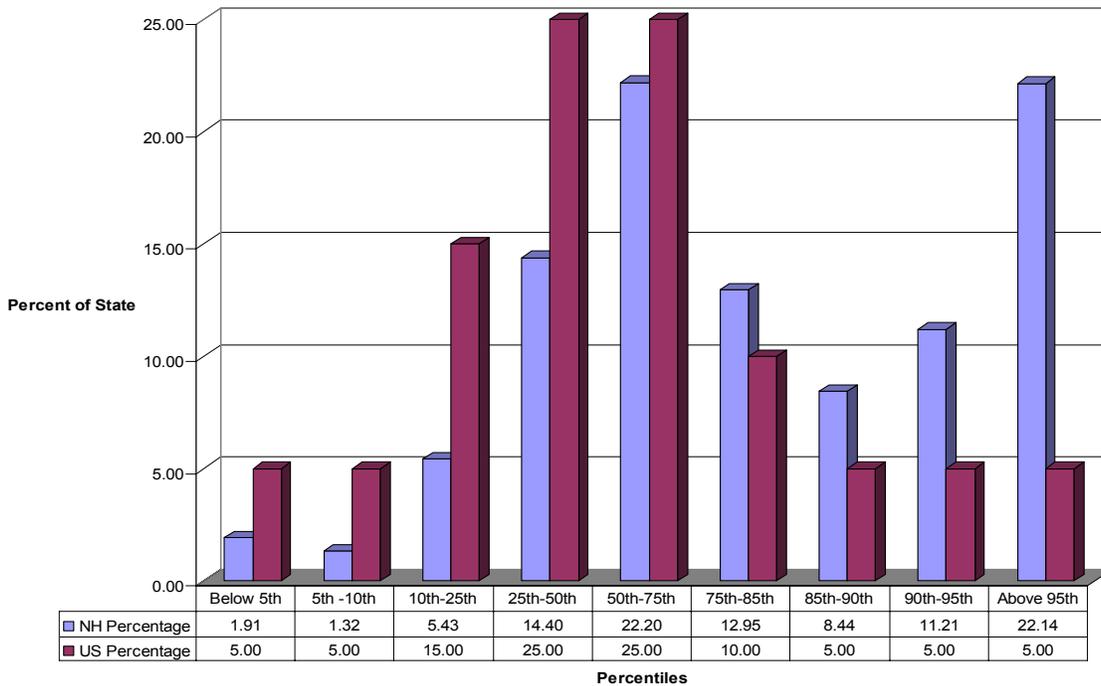


Figure AP-40: Boys BMI Percentiles



Not unlike what is happening in the rest of the United States, overweight in children is emerging as a public health crisis for New Hampshire’s children. Data from the NH WIC program, the University of NH Healthy Schools Project, the YRBS data, and selected school districts illustrates the significance of the problem (Figure AP-39, Figure 40, Table AP-11). The data that focus on Manchester first graders is of particular concern because it illustrates a significant increase in overweight and/or obesity over a five-year time span.

Table AP-11
Manchester First Graders
Overweight or Obese Based on BMI†

	School Year 1997-98*	School Year 2001-02*	School Year 2002-03**
Overweight	29%	37%	39%
Obese	13%	20%	20%

*Sample of 1/3 of all first graders

** Measurement of all first graders; Healthy Schools Project, UNH

† Body Mass Index (BMI) is a measure of weight for height and correlates with body fat and the risk for certain diseases.

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Unfortunately, it also appears that one of the sequelae of pediatric obesity (i.e., Type II diabetes) is having an impact on NH children and young adults (Table #). Recent discharge data shows 156 hospitalizations for Type II diabetes to persons 24 years and under between 1999-2002.

Table AP-12

Diabetes as Principal Diagnosis, Inpatient Hospital Discharges, 1999-2002, Age 24 Years and Under

	Age <1	Ages 1-4	Ages 5-9	Ages 10-14	Ages 15-19	Ages 20-24	Total All ages
Type I	4	70	143	188	233	280	918
Type II	3	1	6	13	30	103	156

Type II diabetes is typically an Adult Onset condition. Type II rates of diabetes in children are rising. Obesity is a leading risk factor for Type II diabetes.

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4. Oral Health

Among New Hampshire’s children, dental disease is the most prevalent chronic childhood disease, five times more common than asthma. Over 51% of New Hampshire students have had dental caries in their teeth by third grade, (*NH Third Grade Oral Health Survey, 2004.*) Eighty percent of adolescents have had dental caries by age 17. (NIH, U.S Department of Health and Human Services, 1987.) Like the adult population, many of New Hampshire’s children from low-income, uninsured families do not have access to regular oral health care and education. Even for those covered under the NH Healthy Kids Gold (Medicaid) program, families have difficulty accessing dental care for their children as many dentists are not taking new Medicaid patients. Among very young children, the cost to treat early childhood caries is \$1000-\$2000 per child. If hospitalization is necessary, treatment costs double (*The IHS Primary Care Provider 23(3): 37-39*).

The causes of oral health problems are multifaceted: The state population is growing rapidly and becoming more diverse especially as refugees resettle in the urban centers of Manchester and Nashua. Few dentists treat low-income families, even in cities where more dentists are available. In Manchester for instance, the ratio of dentists treating low-income people is 23,889:1 (Manchester Dental HPSA application 2000). Close to 35% of Manchester inner city children live in poverty. Students screened in the first through third grades exhibit twice the prevalence of untreated obvious decay as compared to all other Manchester neighborhoods. (Manchester Health Department School Dental Program Performance Work Plan/Reporting Form, 2004).

Cost effective interventions that prevent dental disease like community water fluoridation and protective dental sealants are underutilized in New Hampshire. Only 43% of residents served by

a community water system benefit from fluoridated public water supplies even though the average per capita cost of water fluoridation is \$0.51 per year. Over a lifetime this can be less than the cost of placing one filling. In 1999 the average cost of placing a dental sealant was \$27.09 compared to the average cost of \$73.77 for a one-surface dental filling (American Dental Association, *Survey of Dental Fees*, 2000). Since many children are not on a public water supply, the percent of children receiving fluoride would not reach 100% even if all the public water supplies were fluoridated. Naturally occurring fluoride varies in wells throughout the state. To help low income families assess their need for age-appropriate supplemental fluoride, the Maternal and Child Health Section pays for well water testing for fluoride at the State Laboratory for children enrolled in the state-funded community health centers, so that an appropriate fluoride supplement can be prescribed if needed.

5. Homeless Children

It is estimated that approximately 39% of the homeless in the U.S. are children; 65% of these are 8 years old or under. Homelessness has a devastating impact on the health of children and youth. Studies have found higher rates of illness, emergency department and inpatient hospital admissions, previous suicide attempts, elevated lead levels, delayed immunizations, developmental delays and learning disabilities. Homeless children often lack routine preventive health care. Measuring homelessness is difficult; it is estimated that more than 40% of homeless children and youth are not in school. (Wong J, Salomon A, Thistle-Elliott L; Tallarita L and Reed S, 2004).

The NH Department of Education conducted a one-day count of students in homeless situations in January 2005. This count identified a total of 976 homeless students in New Hampshire, .5% of students attending NH public schools in 2002-2003 (most recent available data) (DOE 2005). Data were reported by local homeless education liaisons using an electronic survey. Ninety-five percent of School Administrative Units (SAUs) and 78% of public school districts in NH responded to the survey. Table AP-13 shows the breakdown by grade level. Table AP-14 shows the breakdown by type of temporary residence.

Table AP-13

Breakdown by Grade Level		
K- grade 5	526	54%
6 –grade 8	211	22%
9 –grade 12	239	24%
Total	976	100%

Table AP-14

Temporary Residence		
Shelters	125	13%
Doubled Up*	640	66%
Motel/Hotel	96	10%
Unknown/other	97	10%
Total	958	99%

Source: NHDOE Homeless Education Program, 2005.

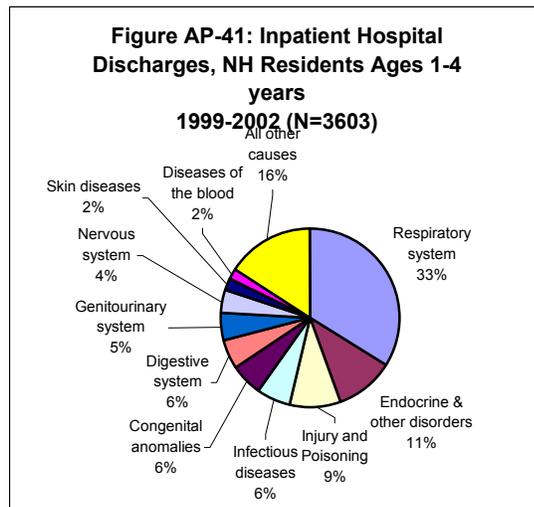
*"Doubled up" is temporarily living with other people due to lack of housing; many families begin by "doubling up" on the spiral to shelter care or the street.

6. Children ages 1 through 4 years
Hospital Discharges (1999-2002)

Diseases of the respiratory system (including asthma) were the most frequent cause of inpatient hospital discharges for New Hampshire 1-4 year olds during the 4 year period 1999-2002, with a rate of 542 discharges per 100,000 population (Figure___), followed by the categories: endocrine disorders, injury and poisoning, congenital anomalies, and digestive disorders.

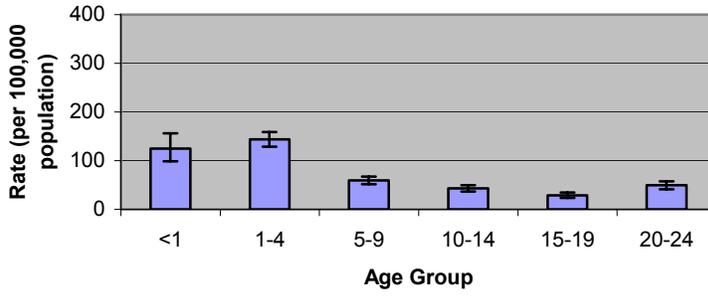
Asthma was the principal diagnosis for 350 discharges (27%) discharges in this category for this age group. Figure ___ shows that New Hampshire's asthma hospital discharge rates are highest among the 1 to 4 year olds, following the national pattern, at a rate of 125 discharges per 100,000 population. Most emergency department visits and hospitalizations for asthma can be prevented by managing the condition according to established guidelines.

Primary payor is the expected source of payment at the time of discharge from the hospital. For the 4-year period 1999 to 2002, Medicaid paid for 23% of asthma discharges among 1 to 4 year olds, at a total cost of \$256,857 for this age group alone. An additional \$62,708 was attributed to the "self-pay" category, which often represents the uninsured. These costs may ultimately be borne by Medicaid or absorbed by the hospital. (NH DHHS, 2003)



Source: NHDHHS, DPHS, Health Statistics Section, 2005

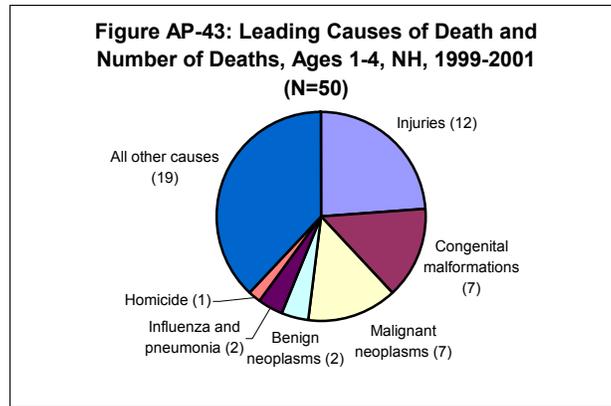
Figure AP-42: Inpatient Hospital Discharge Rates for Asthma, NH Residents Ages 24 and under, by Age Group, 1999-2002



Source: NH UHDDS, DHHS, DPHS, HSDM Section, 2005

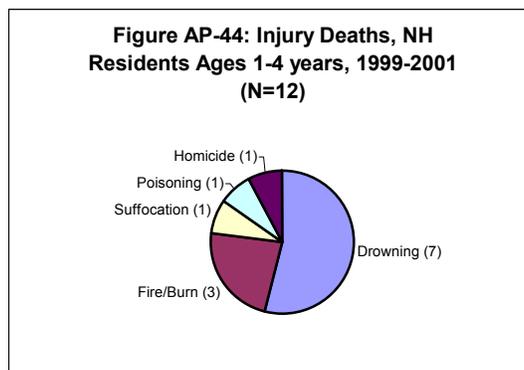
7. Children ages 1 to 4 years
Leading Causes of Death (1999-2001)

Among children ages 1 to 4 years, unintentional injuries were responsible for 12 out of 50 deaths (24%) during the 3-year period 1999-2001. Seven of these injury deaths were due to drowning, 3 were due to fires, and one each was due to suffocation and poisoning. Invasive cancer and congenital anomalies were each responsible for 7 deaths during this period. See detailed list below figure ___ for other causes of death in this age group.



“All other causes” category includes other ill-defined and unspecified causes (4), hepatic failure (2), cerebral palsy (2), pleural effusion (1), viral intestinal infection (1), respiratory arrest (1), stomach disease (1), nervous system disease (1), cytomegaloviral disease (1), combined immunodeficiency (1), urinary tract infection (1), chronic lower respiratory disease (1), heart disease (1), kidney infection (1)

Source: NHDHHS, DPHS, Health Statistics Section, 2005

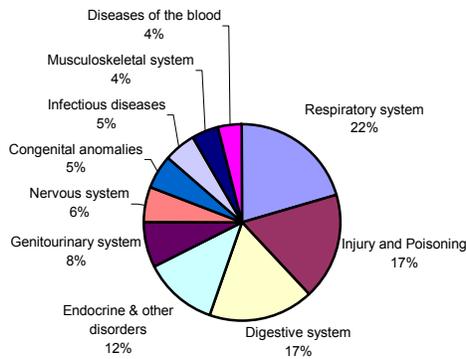


Source: NHDHHS, DPHS, Health Statistics Section, 2005

8. Children ages 5 to 9 years
Leading Causes of Hospital Discharges (1999-2002)

Diseases of the respiratory system (including asthma) were the most frequent cause of hospitalization for New Hampshire 5-9 year olds during the 4 year period 1999-2002, at a rate of 214 per 100,000 population (Figure AP-45), followed by the category digestive disorders (126/100,000) and unintentional injuries (125/100,000).

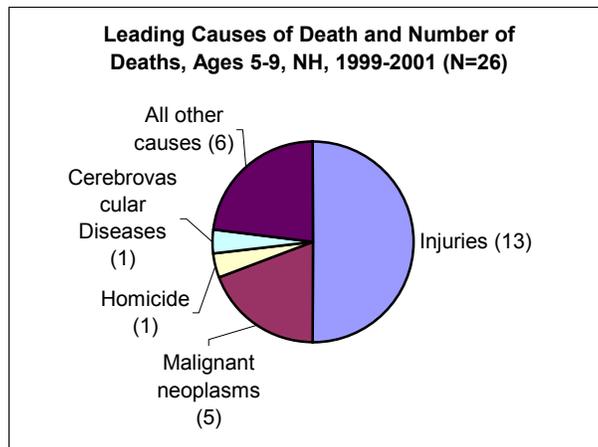
**AP-45: Inpatient Hospital Discharges, NH
Residents Ages 5-9 years
1999-2002 (N=2726)**



9. Children ages 5 to 9 years
Leading Causes of Death (1999-2001)

Preventable injuries were the leading cause of death to children ages 5-9 during the period 1999-2001, responsible for 13 deaths (50%) in this age group. There were 5 deaths from invasive cancer and 1 death from homicide during this period. See detail below figure for other causes of death in this age group. (DHHS, DPHS, HSDM Section, 2005)

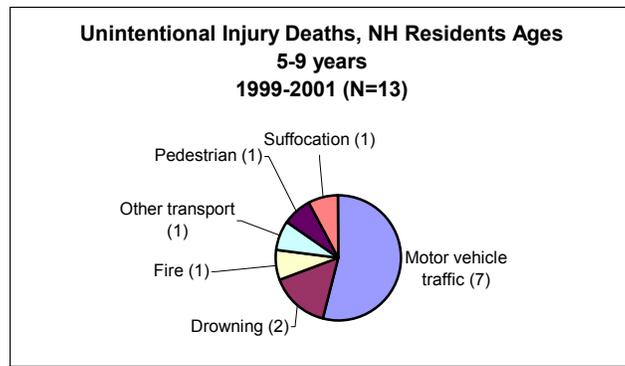
Figure AP-46



“All other causes” category includes shock (1), anoxic brain damage (1), cerebral edema (1), infantile cerebral palsy (1), sphingolipidosis (1), infectious/parasitic disease (1)

Source: NHDHHS, DPHS, Health Statistics Section, 2005

Figure AP-47



Source: NHDHHS, DPHS, Health Statistics Section, 2005

F. Adolescents - Ages 10 through 24 years

New Hampshire earned one of the highest rankings by the Annie E. Casey Foundation for indicators of overall child well being for 1996-2000. Compared with the national average, fewer New Hampshire youth drop out of school or live in extreme poverty (Annie E. Casey

Foundation, 2003). While New Hampshire generally ranks favorably on many adolescent health indicators, some adolescents are more vulnerable and have poor health outcomes compared to the rest of their peers.

The Annie E. Casey Foundation's 2004 Kids Count report refers to America's "Most Disconnected Youth": a group of adolescents lacking the skills, supports and experience to successfully make the transition to adulthood and the most "at-risk" kids in the country. The report defines this group as teens in foster care; youth involved in the juvenile justice system; teen parents and youth who did not finish high school. Many of these youth come from low income and minority families. As a group, they are more likely to remain in low wage jobs, be incarcerated, be victims of crime, and generally face a greater chance of negative outcomes than their peers (Annie E. Casey Foundation, 2004).

1. Foster care/homelessness

As of September 2001, there were 745 New Hampshire youth ages 10-17 in placement outside of their homes, with 66% living in foster homes, 31% in group homes, 3% in residential institutions, and 1% in supervised independent living (NH DHHS, Division of Family Support Services, 2003). However, youth ages 18 to 21 are not eligible for services in the foster care system and are not covered by child protection statutes, making them especially vulnerable to homelessness.

The one-day count of students in homeless situations in January 2005, described in Section E. Children, above, identified a total of 976 homeless students in New Hampshire, .5% of students attending NH public schools in 2002-2003 (most recent available data) (DOE 2005). Twenty-four percent of these students were in grades 9 through 12 (See Tables AP-13 and AP-14 in Children section E. above) (NHDOE, Homeless Education Program, 2005).

2. School dropout rates

The NH Department of Education is required to collect and report on dropout data. NH has an overall estimated cumulative dropout rate, as of the 2003-2004 school year, of 14.4%. This rate varies by district. The highest dropout rates (of those districts with greater than 20 dropouts) were as follows: Manchester Central HS (32.0%), Somersworth (28.4%), Woodsville (23.6%), Rochester and Claremont (both 23.2%), Raymond (22.3%), Manchester Memorial HS (21.9%), Winnacunnet HS (Hampton) (21.3%) and Berlin and Conway (both 20.6%). The following districts had the lowest dropout rates (of those districts with greater than 20 dropouts): Salem (6.2%), Portsmouth (7.8%), Goffstown (8.1%), Kingswood Regional HS (9.3%), Exeter and Milford (both 9.6%). (Note: The Estimated Cumulative Rate represents an estimate of the percentage of current students who will drop out before reaching graduation. The annual rate is applied to a progressively declining base population to arrive at the cumulative rate.)

3. Juvenile justice system involved youth

At any given time in New Hampshire, 2,500-3,000 adolescents under age 17 are involved with community juvenile justice services (Division of Family Support Services [DFSS], NH DHHS, personal communication, 8/4/03). At New Hampshire's Youth Detention Services Unit, where detained youth are held before arraignment and if they are not released to home before trial and

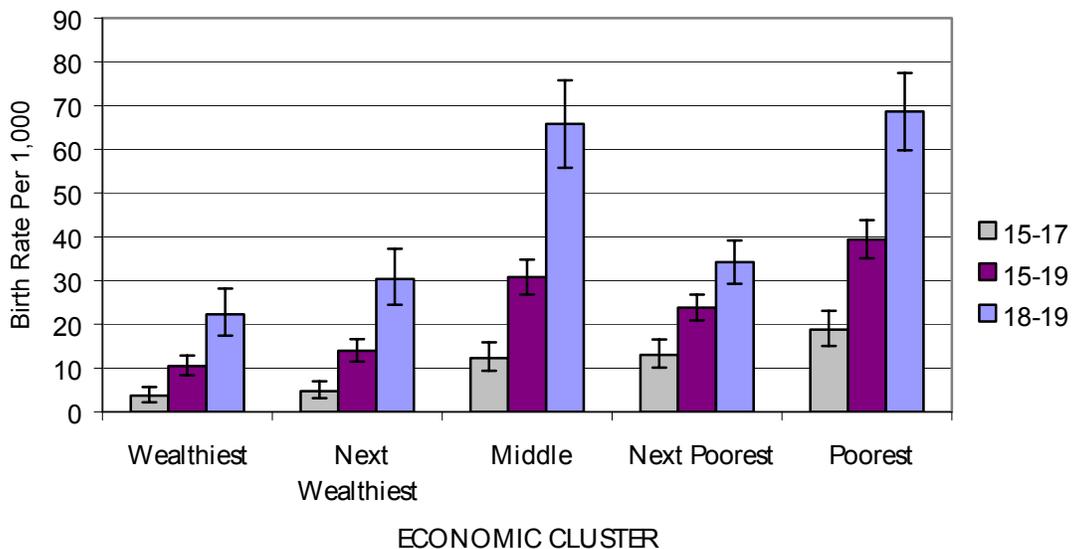
sentencing, the average yearly census is 450 adolescents (DFSS, NH DHHS, personal communication, 1/28/03). The average yearly census at the Youth Detention Center, where sentenced juveniles are held, is approximately 100, with an average stay of about nine months. It is important to note that a recent report to the Division of Juvenile Justice (2004) found that 37% of this population had a history of emotional disturbance, 24% had a history of learning disability, and 22% were identified with Other Health Impairment (including ADHD). (Children with Disabilities in the New Hampshire Juvenile Justice System, 2004). Although there are no youth under 17 years of age in the New Hampshire State Prison, 194 inmates were ages 17-21 years, and 367 inmates were ages 22 through 25 in November 2003, accounting for 23% of the total prison population (New Hampshire Department of Corrections, 2003).

4. Socioeconomic status (SES)

SES is strongly associated with the health of adolescents (National Center for Health Statistics, 2000). Low family income decreases the ability to afford safe housing, healthy food, and appropriate health care. In New Hampshire, more than one out of every 14 children under age 18 (7.3%) are living below the Federal Poverty Level (US Census Bureau, 2000).

Using a methodology similar to that developed for the Children’s Alliance of New Hampshire’s Kids Count 2000 data book, SES was investigated for its impact on various adolescent health outcomes in New Hampshire. New Hampshire towns were segregated into one of five economic clusters, equal in population size, based on 2000 Census data. Although teen births was the only statistically significant indicator found in this analysis, there is a pattern suggesting that residence in poorer New Hampshire towns places youth at increased risk for poor outcomes. Adolescent suicide, unintentional injury, and hospitalizations for asthma are areas of most concern (NH DHHS, DPHS, MCH 2005).

Figure AP-48: Teen Birth Rates by Age and Economic Cluster, NH, 1996-2000



Data source: 2000 U.S. Census

5. Mental Health Services

The National Institute for Mental Health [NIMH] (2004) reports that, “in the US today, one in ten children suffers from a mental disorder severe enough to cause some level of impairment”. Less than one in five of these children obtain needed treatment (NIMH, 2004). The need for both prevention and treatment services is clear.

Access to mental health services is an identified need in New Hampshire. While Medicaid provides coverage for children’s mental health services, a diagnosis of severe emotional disturbance is required to receive services. Mental health safety net systems are overtaxed, with long waiting lists. Limited community-wide coordination exists for the early identification of mental disorders. For example, in 1995, public mental health centers in New Hampshire served 6,409 children and youth. Although the number served increased by approximately 75%, to 11,165 served in 2001 (New Hampshire Child Fatality Review Committee, 2002), waiting lists are still prohibitively long. In both private and public sectors the picture is equally bleak, with few New Hampshire psychiatric providers statewide trained in caring for children.

6. Physical Activity & Diet

Obesity is an increasing problem nationally, but one for which little NH data is available at this time. The two most predictive factors in the development of obesity are physical activity and diet. According to the 2003 New Hampshire Youth Risk Behavior Survey (NH YRBS), more than a third of surveyed young people in grades 9–12 did not regularly engage in vigorous physical activity and 26% reported watching three or more hours of television on the average school day. Of the 18-24 year olds responding to the 2002 NH BRFSS survey, 83% engaged in some physical activity, while 17% reported no physical activity.

7. Injuries

Unintentional injuries are the leading cause of death to adolescents in New Hampshire and nationally. Many of these deaths are preventable. The majority of unintentional injury deaths are due to motor vehicle crashes. Other causes of unintentional are poisonings, falls and drowning. Intentional injuries – suicide and homicide are leading causes of death to adolescents as well. While adolescent homicide rates in New Hampshire are low compared to other states, suicide and physical violence are areas of concern. In New Hampshire, suicide is the second leading cause of injury-related death among adolescents ages 15-24 and those ages 10 to 14 while nationally suicide is the third cause of death among the same age groups. Death rates are higher among males than females, due to their greater use of more lethal means. Hospital discharge rates for self-inflicted injuries are higher among females, who tend to use less lethal means.

Suicide and self-injurious behaviors are critical issues for adolescent health and well-being:

- During the three year period, 1999 to 2001, there were 69 suicides of New Hampshire adolescents 10 to 24 years of age, a rate of 8.77 deaths per 100,000, slightly higher than the U.S. rate of 7.46 deaths per 100,000 (USDHHS, CDC, WISQARS, 2003).
- Adolescents ages 15 to 24 experienced the highest rate of inpatient hospitalizations for self-inflicted injuries among all age groups at 105.4 hospitalizations per 100,000 population during 1997 to 2001.

There were an average of 159 inpatient hospitalizations per year to adolescents during that period (Burns & Twitchell, 2003)

- The highest rate of emergency department visits for self-inflicted injuries, at 333.4 visits per 100,000 population, also occurred among those ages 15 to 24. There were over 500 emergency department visits per year during the three-year period of 1999 to 2001. Two thirds of these visits occurred among females (Burns & Twitchell, 2003).

8. Oral Health

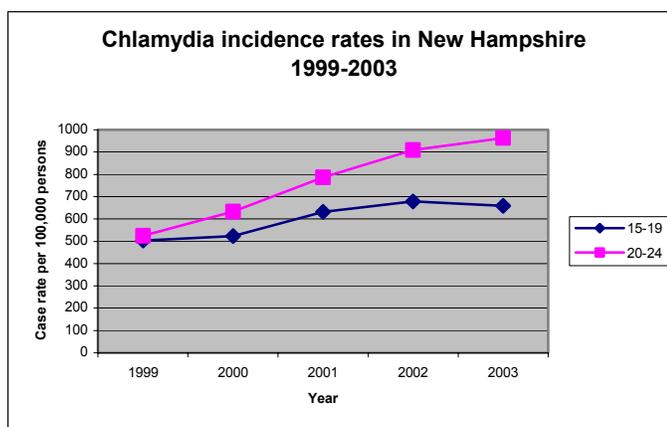
The American Academy of Periodontology (2003) reports an increased risk of periodontal disease in early adolescents, at least partly due to fluctuations in hormonal levels. While no data exists on the oral health of New Hampshire's adolescents, access to dental services can be surmised to affect oral health.

Access to dental care is a problem for many in New Hampshire, specifically the poor, under and uninsured in rural communities and large population areas. The five New Hampshire areas designated as Dental Health Professional Shortage areas contain 249,150 people, or 20% of the state's population. Nationally, only 18% of adolescent Medicaid beneficiaries receive dental screenings (Olson, Perkins, and Pate, 1998). During 2002, only 49% of New Hampshire children and adolescents ages one to 20 enrolled in Medicaid were seen by a dentist (Office of Medicaid Policy and Business, NH DHHS, 2004).

9. Sexually Transmitted Infection (STI) among NH adolescents

Chlamydia is the most common reportable sexually transmitted infection in the US and in New Hampshire. In women, and possibly in men, this infection, if untreated can lead to infertility. Chlamydia is most common in young women and since 1999 the rate of this infection has increased steadily in 20-24 year olds. For 15-19 year olds, there was an increase between 2000 and 2002. In 2003, infections among young adolescents stabilized and fell slightly, but it is too early to determine if this represents a trend toward decreasing infection.

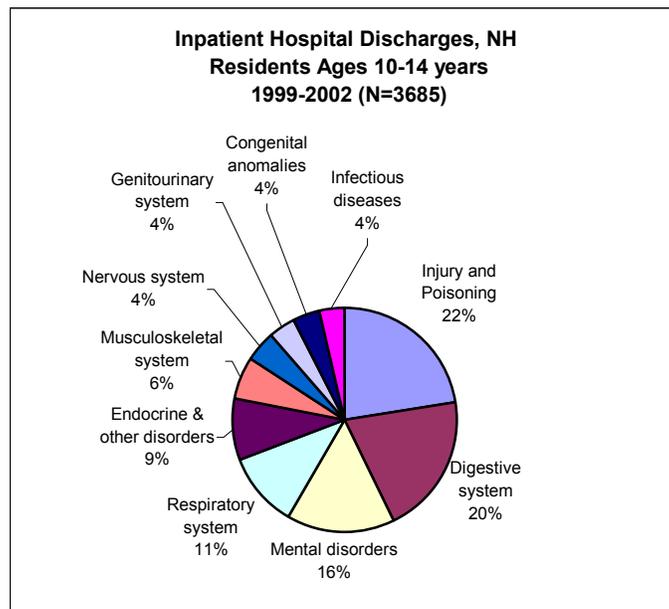
Figure AP-49



10. Inpatient Hospital Discharges (1999-2002)

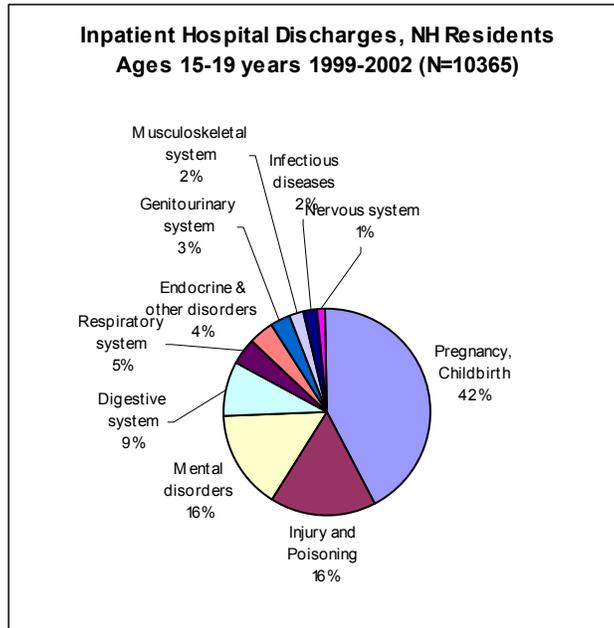
Injuries and poisonings were the leading cause of inpatient hospital discharges in NH residents aged 10-14 years, at a rate of 225/100,000. Second to injuries and poisonings were discharges due to digestive disorders, at a rate of 196/100,000. These categories were followed by mental disorders, respiratory disorders, and endocrine and other disorders.

Figure AP-50



The category “pregnancy and childbirth” was the leading cause of inpatient hospital discharges in NH residents aged 15-19 years, at a rate of 1072/100,000. The second leading cause of inpatient discharges was injuries and poisonings, at a rate of 473/100,000. These categories were followed by mental disorders, digestive disorders, respiratory disorders, and endocrine and other disorders.

Figure AP-51



The category, “pregnancy and childbirth” was the leading cause of inpatient hospital discharges in NH residents aged 20-24 years, at a rate of 3171/100,000. The second leading cause of inpatient discharges was mental disorders, at a rate of 580/100,000. Mental disorders was followed by the categories, injuries and poisoning, digestive disorders, respiratory disorders, genitourinary disorders, and endocrine and other disorders.

Figure AP-52

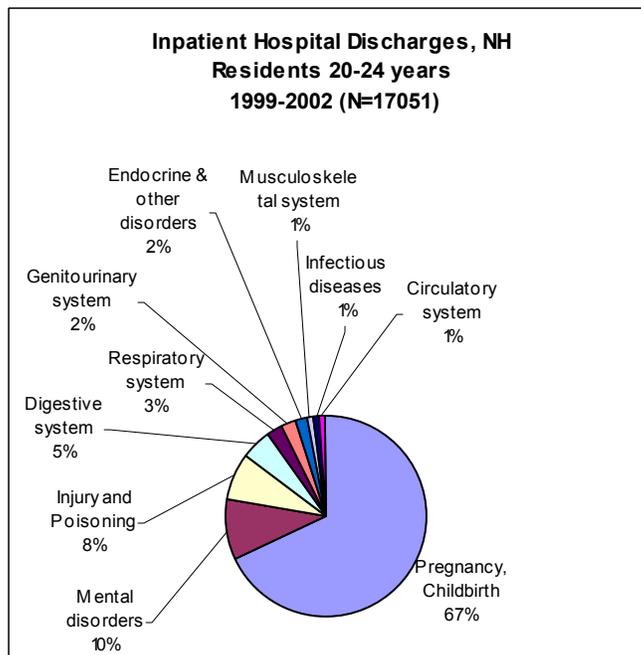
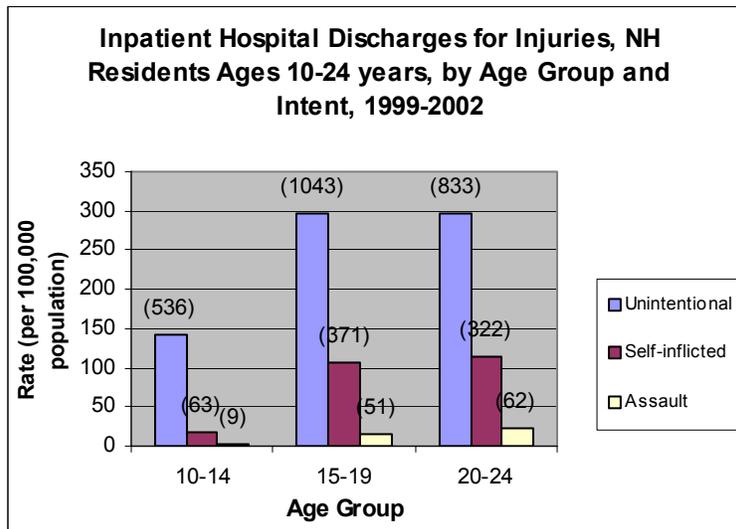
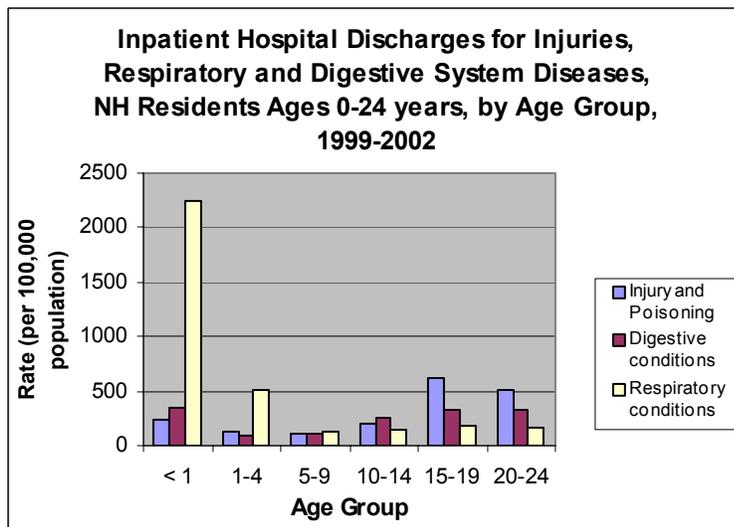


Figure AP-53



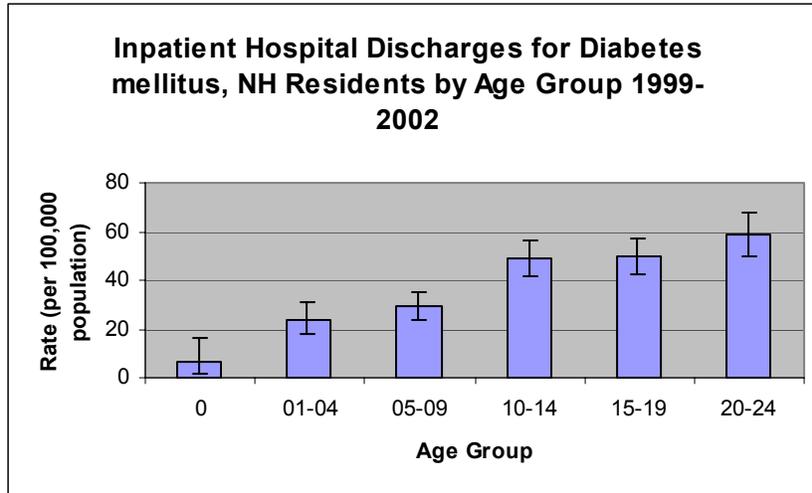
Source: NH UHDDS, DHHS, DPHS, HS, 2005

Figure AP-54



The rate of hospital inpatient discharges for diabetes increases with age, with 20-24 year olds having the highest rate (59/100,000) among those ages 0 to 24 years.

Figure AP-55

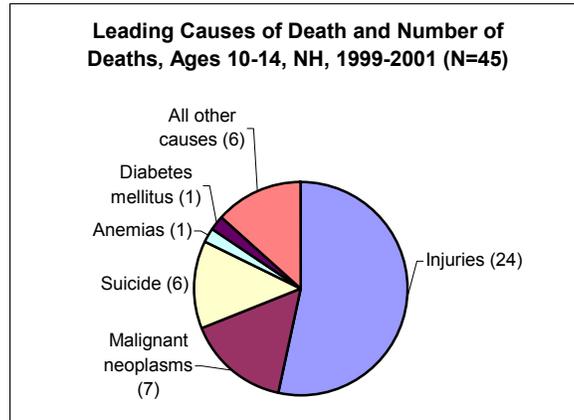


11. Leading Causes of Death (1999-2001)

Mortality rates for New Hampshire adolescents are also significantly lower than national rates for many causes of death. New Hampshire's teen suicide rates, however, are higher than the U.S. average. Reasons for this are not known. There are also noteworthy differences among age groups in New Hampshire: mortality rates for youth ages 15-19 are more than three times higher and mortality rates for youth ages 20 – 24 are more than four times higher than for those ages 10 – 14 [US Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Compressed Mortality File].

A total of 335 adolescents, ages 10-24 years old, died from all causes during the 3-year period 1999-2001. Many of these deaths were preventable. Unintentional injuries were responsible for 173 deaths (52% of all deaths in this age group), and were the leading cause of death to adolescents during this period. An additional 69 adolescents died as a result of suicide and 6 from homicide. Non-injury causes of death included malignant neoplasms (22 deaths) and heart disease (9 deaths). See detail under figures below for other less frequent causes of adolescent deaths.

Figure AP-56

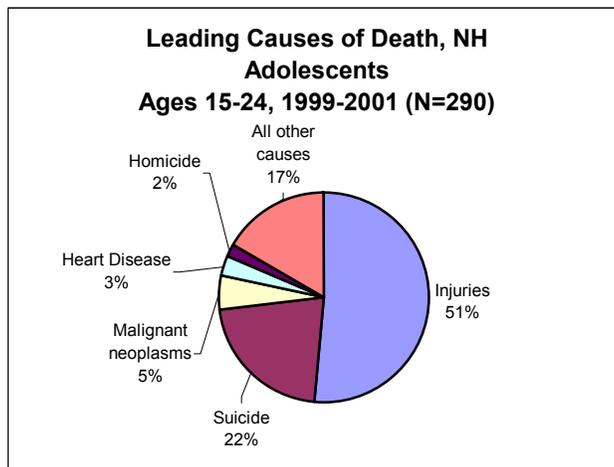


Source: NH UHDDS, DHHS, DPHS, HS, 2005

Injuries=unintentional injuries

“All other causes” category includes Muscular dystrophy (1), infantile cerebral palsy (2), Meningococcal infection (1), Septicemia (1), benign neoplasms (1),

Figure AP-57



Source: NHDHHS, DPHS, Health Statistics Section, 2005

Injuries=unintentional injuries

“All other causes” category includes Respiratory disease (4), Congenital malformations (4), benign neoplasms (3), Cerebrovascular diseases (2), Infantile cerebral palsy (2), Muscular dystrophy (2), Cystic fibrosis (3), Viral meningitis (1), Meningococcal infection (1), Diabetes (1), Flu/pneumonia (1), Conditions originating in perinatal period (1), Septicemia (1), Legal intervention (1), Pregnancy, childbirth and the puerperium (1), Pneumonitis (1), HIV (1), Hypertensive renal disease (1), Complications of medical and surgical care (1), Aortic aneurysm (1), Mental and behavioral disorders due to alcohol dependence syndrome, and other, unspecified and ill defined conditions.

Preventable unintentional injuries were the leading cause of death for all children and youth, ages 1 to 24 years, during the years 2000-2002.

12. Youth Risk Behaviors

Table AP-15: Responses to Selected Risk Behaviors, NH 9th - 12th graders, 2003

Behavior	Percent of Youth
<i>Alcohol, tobacco, other drugs</i>	
Smoked cigarettes on 20 or more of the past 30 days	10%
Binge drinking - 5 or more drinks in couple of hours on one or more of past 30 days	31%
Used Marijuana one or more times in lifetime	50%
<i>Reproductive health</i>	
Use Condoms*	56%
<i>Injury and violence</i>	
Rode with drinking driver on one or more of past 30 days	25%
Never or Rarely wear seat belt when riding in a car driven by someone else	13%
Felt so sad and hopeless for 2 weeks that they stopped some usual activities	28%
One or more prior suicide attempts in past 12 months	8%
Physical fight one or more times in past 12 months	31%
<i>Overweight</i>	
Overweight (\geq 95th percentile for BMI)	10%

Source: NH DOE, Youth Risk Behavior Survey (YRBS) 2004

Several risk behaviors, as reported on the Youth Risk Behavior Survey (YRBS), have decreased since 1995 (the last year that valid data was available). See italics for those that have decreased. Underlined risk behaviors have increased.

Injury and violence related

- 12.6% (15.9% males; 9.2% females) of high school students surveyed reported that they never or rarely wear a seat belt when riding in a car driven by someone else. *In 1995, this figure was 23.8%.*
- 24.7% (25.3% males; 24.0% females) reported riding one or more times in a vehicle driven by someone who had been drinking alcohol in the past 30 days. *In 1995, this figure was 31.5%.*

Tobacco, alcohol and other drugs

- 19.1% (18.2% males; 19.8% females) of students reported smoking cigarettes on one or more of the past 30 days, and 9.6% (10.0% males; 9.1% females) reported smoking cigarettes on 20 or more of the past 30 days. *In 1995, these figures were 36.0% and 19.3% respectively.*

- 30.6% (32.9% males; 28.2% females) of students reported using marijuana one or more times during the past 30 days. In 1993, this figure was 20.9% and in 1995, 27.7%.
- 10.2% (10.3% males; 10.0% females) reported using any form of cocaine, including powder, crack or freebase one or more times during their life
- 13.1% (13.2% males; 12.9% females) reported sniffing glue, breathing aerosol spray cans or inhaling any paints or sprays to get high one or more times during their life

Sexual activity

- 41.5% (41.7% males; 41.4% females) of students reported having ever had sexual intercourse (Grade 9: 24.0%; Grade 10: 37.9%; Grade 11: 47.9%; Grade 12: 62.5%)
- Of students who had had sexual intercourse within the past 3 months, 33.3% (26.4% males; 39.9% females) used, or their partner used, birth control pills during the last sexual intercourse
- Of students who had had sexual intercourse within the past 3 months, 21.6% (22.7% males; 20.3% females) drank alcohol or used drugs before the last sexual intercourse

Obesity/Physical activity

- 30.5% of students described themselves as slightly or very overweight, and 44.5% reported that they were trying to lose weight
- 64.1% of students reported exercising or participating in aerobic physical activities for at least 20 minutes on three or more of the past seven days

Source: NH DOE, Youth Risk Behavior Survey (YRBS), 2003

Summary of Leading Causes of Death for NH Children and Adolescents

Table AP-16: Leading Causes of Death and number of deaths, by Age Group, NH, 2000-2002

Source: Prepared by CDC, NCIPC
Data Source: CDC, NCHS Vital Statistics System

Rank	Age Group					
	<1	1-4	5-9	10-14	15-19	20-24
1	Congenital Anomalies 41	Unintentional Injury 10	Unintentional Injury 14	Unintentional Injury 22	Unintentional Injury 56	Unintentional Injury 82
2	Short Gestation 26	Cancer 7	Cancer 8	Suicide 8	Suicide 27	Suicide 32
3	SIDS 21	Congenital Anomalies 5	Diabetes 1	Cancer 5	Cancer 13	Cancer 13
4	Placenta Cord Membranes 17	Influenza & Pneumonia 2	Influenza & Pneumonia 1	Anemias 1	Heart Disease 6	Heart Disease 5
5	Intrauterine Hypoxia 13	Kidney Infections 1		Benign Neoplasms 1	Chronic Low. Respiratory Disease 3	Cerebrovascular 2

G. Health status of populations in selected geographic areas of the state

As part of this statewide needs assessment, a small study was conducted to identify specific areas of the state that are significantly below the state and/or national average statistics. In sharp contrast to the overall state statistics, there are areas of high need in certain categories. These areas deserve consideration in any needs assessment and planning for services. The following state and local documents were reviewed and selected findings are presented below: The State of New Hampshire Critical Access Hospital Plan, June 2003, Community Benefit Reports and Critical Access Hospital Market Analysis.

The local community needs assessments identified indicators related to maternal and women's health, infants, children and adolescents, for which their area exceeded the state average. See Appendix A for additional regional information.

The Androscoggin Valley Hospital in Berlin, covering 13 towns in the northernmost section of the state identified the following problem areas in their community: a higher percentage of teen births (11.2%) compared to the State average (7.1%); higher infant mortality rate (6.9/1000 births) compared to the state rate (4.8/1000 births). Berlin also identified a greater percentage of their population that was low income compared to the state as a whole: 30.4% of residents were low income (200% of the federal poverty level or below) compared to 19% statewide, 13% are uninsured, compared to the state average 7.8%; and 19.3% are enrolled in Medicaid, compared to 10.6% statewide.

Franklin Regional Hospital, covering 13 towns in the middle of the state, reported that 13.7% of births were to teens, almost twice the state average, and a higher percentage of pregnant women (of all ages) receiving inadequate prenatal care (15.8%) compared to the state average (12.9%). Twenty-five percent of their population is low income and 16.8% are enrolled in Medicaid.

Cottage Hospital in northern New Hampshire (Woodsville), covering 12 towns, reported 11.4% of infants born to 18 to 24 year old mothers were low birthweight.

Speare Memorial Hospital in northern New Hampshire (Plymouth), covering 17 towns, has an uninsured population approximately twice the state rate (13.8% vs.7.8%), a low-income population of 28.7% compared to 19% statewide and a teen birth rate of 10.8% (NH 7.1%).

Valley Regional Hospital, covering 11 towns in the western part of the state (Claremont) reported 25.9% of their population is low income (<200% FPL) and 11% of births are to teen mothers. The infant mortality rate was 9.9 per 1000 births compared to the state average of 4.8 and their rate of low birth weight infants was 81.6 per 1000 births, compared to the state rate of 61.2.

The MCH section will be conducting further analysis of birth certificate and other data to identify needs in specific geographic areas of the state.

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I. Children with Special Health Care Needs (CSHCN)

(Note: Because the CSHCN section contains two independently published reports pasted into the needs assessment, the formatting, style of references, and table/figure numbering for this section were retained. The table numbering, etc. is different from other sections of the NA)

In the National Survey of *Children with Special Health Care Needs* (CSHCN), 23% of New Hampshire households include at least one child (0-18) with special health care needs and an estimated 15% of New Hampshire children are considered to have special needs. This translates to 47,814 children and youth, and ranks New Hampshire as the 9th highest nationally for the prevalence of CSHCN (van Dyck et al., 2002). Other circumstances impacting the health of adolescents are described below.

1. Data from External Sources

The New Hampshire Department of Education **Special Education Data Information System** (SPEDIS) provides a Statewide Census by Disability. As of December 2004, there were 31,675 students ages 3 –21 with individual educational plans (IEP's) based on their disability code. This number represents 15.2% of the pre-school through 12th grade population (the same percentage as NH SLAITS data). Of these, 13,382 or 42% have the primary educational code of specific learning disability, which may not represent any special health care need. The remaining primary educational codes include the numbers of students in following categories:

- Mental Retardation – 955
- Speech/language impairment –6,136
- Developmental delay – 1,966 (all under 10 years of age)
- Multiple disabilities – 392
- Autism – 799
- Emotional disturbance - 2,672
- Other Health Impaired – 4,767 (this category probably includes many children with chronic diseases. Alternatively, there are 504 Plans for some of this population)
- Hearing impairment –212
- Deafness – 69
- Vision impairment – 139
- Orthopedic Impairment – 120
- Deaf-blind – 6
- TBI - 60

The New Hampshire State Department of Education 2003 **School Health Services Report** provides a listing of the diagnoses of children from public pre-school programs through 12th grade. Schools reporting represent 117,210 students or about 55% of the 207,417 enrolled in NH public schools as of 9/9/2004. Of these 117,210 students, there are 14,804 students or 12.6 % of the population identified with any special health care needs. These students may not have IEPs. The report does not provide data on the 23,470 students enrolled in non-public schools or the 3,621 home-schooled children and youth.

Selected diagnostic groupings and specific sub categories are listed below as an indicator of the scope of various conditions occurring among NH children and adolescents (and managed by

school health nurses). Note that this report represents only 55% of the school-aged population. The following categories are not inclusive of all diagnoses in the report:

- Development/Behavioral - 5,865 students are identified with ADHD.
- Endocrine - 347 students are identified with diabetes Type 1.
- Psychiatric/Behavioral - 441 are identified with autism and 299 with pervasive developmental disorder (PDD). Equally significant are the 1,482 identified with emotional disorders and the 1,041 identified with other psychiatric/behavioral conditions.
- Neurologic/Nervous System – 197 children are listed with cerebral palsy (Special Medical Services Neuromotor Disabilities Program serves 339 children, many with this type of condition). 765 children have epilepsy while 43 are identified with spina bifida.
- Pulmonary – Asthma is the diagnosis for 8,645 children. Cystic Fibrosis affects 110 children in these public schools.
- Sensory – 591 children have hearing impairments and 1,091 are vision impaired.
- Other Conditions includes 1,730 children with a potential for anaphylaxis. Also included in this category are 290 children with Nutrition/Metabolic conditions and 439 with GI/GU system conditions.

The Family-Centered Early Supports and Services Program (FCESS) of the New Hampshire Bureau of Developmental Disabilities is the New Hampshire early intervention program for the birth to three populations of children with special needs. Eligibility for the program is based on three criteria: a) 33% delay in any one area of development (adaptive/self-help, cognition, communication, physical, social/emotional); b) established condition; c) at risk. For the purposes of early intervention programming, the state is divided into 12 regions with a single point of entry. After referral an evaluation and initial IFSP must be completed and approved by the parent within 45 days. Based on data from 2004, eleven regions were in 100% compliance with this requirement and one region was at 96% compliance.

For 2003 New Hampshire served 1,146 children aged birth to three years of the 43,959 children in New Hampshire of the same age (2.6%). During this time period, children served by the program were categorized as follows:

Developmental delay – 829

Established condition- 300

At risk (5 criteria out of a list of 16 child/family factors) – 4

It is interesting to note that there has been a 20% increase in the number of children served from 1999 (n=979) to 2003 (n=1146).

For the period of January 2004 to December 2004, a total of 3,372 children were referred for early intervention services. Of these, 613 were found ineligible (18%) and IFSP's were developed for 2,759 children.

2. Special Medical Services Data

Between 2001-2004, New Hampshire Special Medical Services undertook two major projects to assess the needs of New Hampshire children with special healthcare needs and their families:

1. A broad-based Delphi process involving several qualitative methodologies (key informant interviews, focus groups) and a two-phase written survey, and
2. A written survey based on the National Survey of Children with Special Health Care Needs, targeted at families whose children receive SSI for their own disabilities.

The final product of the Delphi process is titled “Assessing Needs and Resources for Children with Special Health Care Needs in New Hampshire, October, 2004.” The targeted survey is titled “New Hampshire 2004 Survey of Parents of Children Receiving Supplemental Security Income for Their Own Disability”. Both reports, including summaries and conclusions, are included as essential components of the overall needs assessment document. Copies of the survey instruments are included as appendices. Based on data from both external sources and data generated from research conducted by Special Medical Services, new State Performance Measures which focus on priorities related to mental health services for children and adolescents, and respite/childcare workforce development, were developed for inclusion in the 2006 block grant application.

3. Assessing Needs and Resources for Children with Special Health Care Needs in New Hampshire, Executive Summary, October 2004

Introduction

This report highlights the qualitative and quantitative methods and findings of a study undertaken by the New Hampshire Department of Health and Human Services, Special Medical Services Bureau. Specific attention is given to the implementation of a Delphi survey conducted during the winter and spring of 2004. The Delphi method is used for future forecasting and is an intense, iterative process by which stakeholders participate in survey completion and consensus building. It is expected that engagement and connection with the Delphi process will result in the priority ranking of issues, commitment of the participants, and continued engagement in working on identified priorities.

Background and Qualitative Process

Beginning in April 2001, the Special Projects Coordinator for Special Medical Services Bureau, New Hampshire Department of Health and Human Services, began a process to assess the concerns and opinions of NH stakeholders relative to children with special health care needs (CSHCN) and their families. Key informant interviews (n = 23) and focus group discussions (n = 14) were used to elicit responses to the following questions:

1. What trends do you think will continue to impact care/needed services for children with special health care needs and their families in the future?
2. What new knowledge will change and/or redefine the needs of children with special health care needs and their families in the future?
3. What current and projected societal trends (family, community issues) do you think will impact the needs of children with special health care needs and their families?
4. What do you see as the strengths and/or gaps/ deficiencies in current programs/services for this population of children/families?

A total of 110 professionals and family members representing over 40 different constituent groups participated in this process (Appendix A). Extensive written notes were recorded at the time of the interactions and transcribed immediately thereafter based on the discussion points. Initial data collection was completed in September 2001.

Based on preliminary analysis of the qualitative data, 88 emerging issues and 111 discrete concerns were identified. Further analysis of patterns and concepts produced nineteen (19) different themes that encompassed the issues identified by the participants.

Instrument Development

Beginning in January 2002 an extensive process began to translate the qualitative data into a written instrument in order to conduct a Delphi survey. Literature review was used to determine the criteria to construct Likert – type scales. Discrete items were grouped based on the identified themes. Initially, respondents were asked to make judgments for 123 items based on four criteria and a seven-point scale from least important to most important.

Pilot testing of the initial instrument was conducted during early 2003 with 25 professional and family member volunteers. Based on feedback from respondents, the wording of individual items was further refined. The original 19 themes were grouped into 21 content areas. Finally, it was decided to reduce the complexity of the instrument by changing the Likert scale to five points and using only two criteria for judgment (i.e., potential of a program to impact the lives of CSHCN and their families; potential of a program for community and/or interagency collaboration to address issues). The final survey instrument was then developed (Appendix B).

Quantitative Process

Survey Instrument

Phase 1 Survey

During the first phase of the Delphi survey, the questionnaire developed from informant interviews and focus group discussion(s) was mailed to stakeholders who had participated in the initial qualitative stage. This instrument included 113 items within twenty-one topic areas. For each item, respondents were asked to rate their perception of the *potential degree of impact on families* and *potential for collaboration* on a scale of 1 (low) to 5 (high). Surveys were mailed to 135 stakeholders and the response rate was 65%.

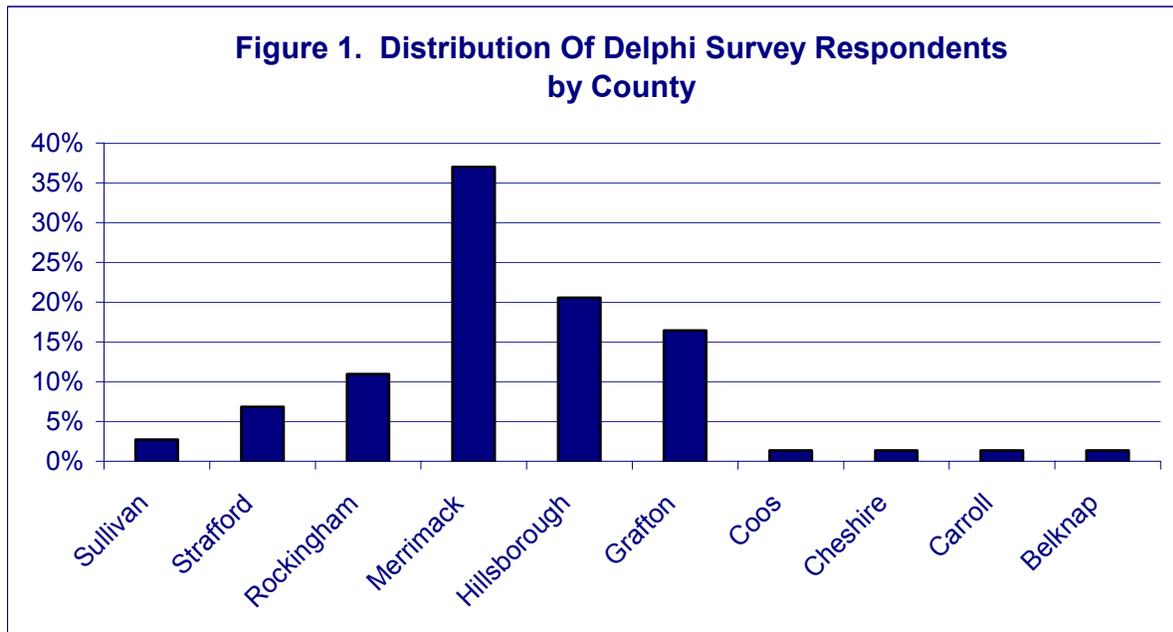
Phase 2 Survey

The second phase of the Delphi process was also a mailed survey that involved re-surveying first-round respondents (n = 88) using a modified *Phase 1* survey instrument. The most supported first-round survey items comprised the second-round survey instrument. Items not receiving the greatest support were excluded. Second phase respondents were provided not only their original score, but also the group mean score for each item. Respondents were asked to reconsider their original score and then to again rate their perception of the *potential degree of impact on families* and *collaboration potential* on a scale of 1 (low) to 5 (high). Eighty- three

percent of surveys were returned. An additional three surveys were returned after data entry was complete and were not included in the final analysis.

Table 1. Data at a Glance		
Instrument and Sample	PHASE 1	PHASE 2
Survey Instrument		
Number of Topic Areas	21	20
Number of Items	113	78
Sample		
Number of Mailed Surveys	135	88
Number of Returned Surveys	88	74
Response Rate	65%	83%
Affiliation	Professional – 77 Family – 11	Professional - 61 Family – 11 Did not answer- 2

Figure 1 shows the distribution of survey respondents by county. Counties with high survey participation rates are consistent with provider and population concentrations.



Analysis

Phase 1

Each Item received an aggregate mean and standard deviation score. An aggregate mean score of 3.9 or higher with a standard deviation less than or equal to 1 was selected to demark the score at

which Items were deemed as receiving the greatest support. Items falling outside of these rules were viewed as least supported and excluded from the next survey phase.

Phase 2

Analysis for the second survey phase used aggregate means, mirroring the first phase. The broad topic areas and individual items for degree of impact on families and collaboration potential were rank ordered. Next the combined mean score (*impact on families + potential for collaboration*) was determined and ranked based on the top quartile to represent the items receiving the greatest support overall. Finally, the *impact on family* items were analyzed separately using stakeholder affiliation (professional versus family) and ranked based on the top items as reported by families.

Results

Table 2. shows that, in general, respondents rated the topic area of *Health Care Coordination* as having the greatest potential impact on the family, followed by the areas of *Mental Health Issues, Child Care and Respite Care, Increased School Intervention, and Transition Services*.

N.B. Color coding in all tables reflects topic areas.

Table 2. Topic Areas with the Greatest Potential for Impact on Families	
RANK	TOPIC AREA
1	HEALTH CARE COORDINATION
2	MENTAL HEALTH
3	CHILD CARE and RESPITE
4	SCHOOLS
5	TRANSITION

Respondents also indicated that *Health Care Coordination* has the greatest potential for collaboration, followed by the area of *Educational Needs of Parents, Home-Based Services, Special Needs Diagnosis and Diagnostic Options* (Table 3.)

Table 3. Topic Areas with the Greatest Potential for Collaboration	
RANK	TOPIC AREA
1	HEALTH CARE COORDINATION
2	EDUCATIONAL NEEDS OF PARENTS
3	HOME-BASED SERVICES
4	SPECIAL NEEDS DIAGNOSES
5	DIAGNOSTIC OPTIONS for CSHCN

Table 4 shows the top 10 items deemed as having potential for the greatest degree of impact on families. These items are associated with five different topic areas. Items related to Child Care and Respite and Health Care Coordination each represent one – third of the ten highest rankings.

Table 4. Top 10 Items Having the Greatest Potential for Impact on Families	
RANK	DEGREE OF IMPACT ON FAMILIES
1	Respite care for behaviorally and medically complex children
2	Lack of mental health services / professionals skilled in pediatric / family-based treatment
3	Home-based services for children with medical/behavioral needs
4	Coordination at all points of transition (e.g., preschool, middle to HS, youth to adult)
5	Increasing demand for child care options for families with young children with behavioral problems
6	Adequate Medicaid reimbursement for providers
7	Need for intra-agency cooperation/collaboration
8	Funding of schools to meet the needs of CSHCN to avoid rationing of special education and related services
9	Case coordination for the most involved, medically complex children
10	Need for SSI and other funding after 18 years of age

Table 5 illustrates the top 10 items deemed as having the greatest potential for collaboration. Of these, fifty percent fall under the *Health Care Coordination* topic area. The remaining items are derived from the *Lack of Capacity*, *Educational Needs of Parents*, and *Transition Services* topic areas.

Table 5. Top 10 Items with the Greatest Potential for Collaboration	
RANK	POTENTIAL FOR COLLABORATION
1	Need for intra-agency cooperation/collaboration
2	Case coordination for the most involved, medically complex children
3	Continuing education/technical assistance for providers
4	The health/medical needs of adolescents and CSHCN in transition (age 14-21)
5	Training for all staff in family-centered principles of care
6	Coordination at all points of transition (e.g., preschool, middle to HS, youth to adult)
7	Parent skill training in behavior and health
8	Educational materials for parents that are clear and pragmatic
9	Support for care coordinators in the community
10	Care coordination in primary care offices

In order to narrow the focus to specific issues for further discussion and future priorities, the next analysis combined the mean scores for degree of impact on families and potential for

collaboration to indicate most overall support. Table 6. shows the first quartile, in rank order, of the 18 items with the greatest combined score, hence, the most overall support.

Table 6. Top 25% Most Supported Items Using the Combined Impact and Collaboration Scores		
RANK	COMBINED IMPACT AND COLLABORATION ITEMS	TOPIC AREA
1	Need for interagency cooperation/collaboration	Health Care Coordination
2	Respite care for behaviorally and medically complex children	Child Care and Respite
3	Case coordination for the most involved, medically complex children	Health Care Coordination
4	Coordination at all points of transition (e.g., preschool, middle to HS, youth to adult)	Health Care Coordination
5	The health/medical needs of adolescents and CSHCN in transition (age 14-21)	Transition
6	Home-based services for children with medical and behavioral needs	Child Care and Respite
7	Increasing demand for child care options for families with young children with behavioral problems	Child Care and Respite
8	Care coordination in primary care offices	Health Care Coordination
9	Funding of schools to meet the needs of CSHCN to avoid rationing of special education and related services	Schools
10	Need for family support and counseling	Mental Health
11	Lack of mental health services / professionals skilled in pediatric / family-based treatment	Mental Health
12	Need for interagency partnerships / collaboration between health and educational communities	Schools
13	Specific training for professionals/paraprofessionals to provide care in home settings	Home-Based Services
14	Need for prepared/expert professionals	Lack of Capacity
15	Provision of adult health care for the special needs population	Transition
16	Increasing number of children with significant medical problems who live at home	Home-Based Services
17	Early diagnosis and treatment of mental health problems	Mental Health
18	Need for home – school collaboration and coordination	Schools

Because family members of CSHCN were under represented in the final survey, it was not appropriate to categorize respondents for statistical comparison. Nonetheless, it is critically important to have an idea of family members’ perceptions regarding programs they view as having the most potential impact on their lives. Table 7 illustrates the top 10 items that received the highest mean scores from family – member respondents. Items one through eight reflect the overall survey results; however, items nine and ten (related to public funding and health care cost) are unique to the priority issues identified by the family – member respondents.

1	Respite care for behaviorally and medically complex children	Child Care and Respite
2	Provision of adult health care for the special needs population	Transition
3	Need for interagency cooperation/collaboration	Health Care Coordination
4	Need for SSI and other funding after 18 years of age	Transition
5	Lack of mental health services / professionals skilled in pediatric / family-based treatment	Mental Health
6	Increasing demand for child care options for families with young children with behavioral problems	Child Care and Respite
7	Home-based services for children with medical and behavioral needs	Child Care and Respite
8	Need for family support and counseling	Mental Health
9	Demand for blending / coordination of funding sources / funding flexibility	Public Funding
10	Demand for coverage for durable medical equipment and non-pharmaceutical products	Health Care Cost

Study Limitations

Several limitations of this work have been identified:

- Although identified as being very important and valuable stakeholders, and included in the original survey mailings, family members are under represented in the Delphi survey. An additional needs assessment will be specifically targeted at families.
- In the attempt to be all-inclusive and sensitive to stakeholder input, and reflecting the desire to have the final survey instrument mirror the breadth and complexity of the original qualitative process, survey completion time was labor intensive for respondents. This may have influenced participation and reliability.
- Although not strictly a limitation, it should be acknowledged that the Delphi survey asked respondents to rate the perceived impact of a single item, not rank its importance relative to other items.
- Although a strict ranking process may have provided additional insights, the methods used here provide the relative importance or value of an item ranked by aggregate means.

It should be noted that all items used in the survey were identified as important by participating stakeholders.

Summary and Conclusions

Using an extensive qualitative and quantitative process, stakeholders in New Hampshire have identified 18 priority issues of concern in relation to CSHCN. If programs addressing these issues were developed and/or further refined, survey participants believe that there is potential to significantly impact the lives of CSHCN and their families. Furthermore, respondents have indicated that programs related to these concerns have significant potential for community and/or interagency collaboration.

In conclusion:

- The mandate to improve interagency collaboration is clear.
- The expressed need to address mental health services for this population is consistent with many previous findings and a specific priority for family members.
- Programs addressing care coordination in a variety of settings are also viewed as having priority.
- The finding that over five of the items ranked in the first quartile are related to home-based services and respite or childcare needs speaks loudly to perceived gaps in our current service delivery system.
- There is consensus that health care transition for adolescents must receive attention.
- Three of the most highly ranked items call for renewed efforts to coordinate services between home, school and the medical community.
- The results of the survey indicate that we must seriously consider the concerns of families regarding public funding and specific health care costs for CSHCN.
- The ongoing need for expert professionals in the field must be addressed.

The challenges facing professionals, families and communities in the next decade are clear. It is time to get on with the work of assuring the health and quality of life for every child with special needs in New Hampshire.

4. New Hampshire 2004 Survey of Parents of Children Receiving Supplemental Security Income for Their Own Disability

Background

New Hampshire Special Medical Services (SMS)¹ is responsible for assuring statewide services to children with special health care needs (CSHCN)² and their families, and for providing data

¹ New Hampshire Department of Health and Human Services, Office of Medicaid Business and Policy, under authority of RSA 132 (NH Revised Statutes Annotated).

² The federal Maternal and Child Health SMS defines CSHCN as those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. McPherson M, Arango P, Fox H, et al. A new definition of children with special health care needs. *Pediatrics*. 1998; 102:137-140.

and technical expertise to agencies, medical and service providers, legislators, and parent groups. New Hampshire's state-supported programs for children with special health care needs are guided by the requirements of the Maternal and Child Health Title V Block Grant, which includes National Performance Measures (NPM's) for CSHCN that set forth the standards for the states' efforts. (Figure 1)

Figure 1

The National Performance Measures (NPM'S)

Performance Measure #01: The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State. **Not measured by the National Survey**

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)

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)

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)

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)

Performance Measure #06: The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)

A major national survey was designed by our federal partners to provide baseline outcome data for these selected National Performance Measures of the Title V Block Grant. In 2001, the National Survey of Children with Special Health Care Needs³ (hereafter referred to as 'the national survey') was conducted "...to assess the prevalence and impact of special health care needs among children in all 50 States and the District of Columbia." This telephone survey explores the extent to which children with special health care needs have medical homes, adequate health insurance, access to needed services, care coordination, satisfaction with care and impact on the family.

³ van Dyck PC, McPherson M, Strickland BB, Nessler K, Blumberg SJ, Cyamon ML, Newacheck PW. The National Survey of Children with Special Health Care Needs. *Ambulatory Pediatrics* 2:29-37. 2002.

In New Hampshire more than 3,000 households with children were screened in order to identify a sufficient pool of children with special needs. (See Appendix 1 for Survey Screener Criteria) A similar process was used in every state. Each state was guaranteed a sufficient pool of 750 completed interviews. Interviews were conducted with the parents of identified CSHCN.⁴ The national data collection method, referred to as SLAITS (State and Local Area Integrated Telephone Survey), was developed for the Centers for Disease Control and Prevention by the National Center for Health Statistics⁵. The national survey results for New Hampshire will hereafter be referred to as the NH CSHCN survey results.

The national survey estimates the population of CSHCN in the state as 47,059 or 15.1% of children between birth to age 18. This estimate is consistent with the number of children known to meet these criteria in the state. The results from the NH CSHCN survey are meaningful; however, there is a subpopulation of SSI-receiving CSHCN that the national survey was not specifically designed to capture. For instance, in New Hampshire, the national survey revealed that of those surveyed, only seventeen (unweighted number) CSHCN receiving **Supplemental Security Income (SSI)**⁶ for their own disability were identified.

The New Hampshire Survey of CSHCN Receiving SSI

Because the national survey was not designed to estimate the New Hampshire population of CSHCN receiving SSI, in order to determine how SSI-receiving CSHCN score on the national outcome criteria, New Hampshire's Special Medical Services in 2004 conducted its own survey, the New Hampshire Survey of Parents of Children of Special Health Care Needs Receiving SSI for Their Own Disability, hereafter referred to as 'the NH SSI CSHCN survey'. (See Appendix 2 for the NH SSI CSHCN survey instrument) Because eligibility for SSI requires both means testing and meeting specific diagnostic criteria, it is important to have an accurate picture of the needs of this population

to guide strategic planning for the Title V program.

The New Hampshire SSI CSHCN survey employed an instrument that mirrored the national survey questions used to determine the success rate of the five core outcomes that are correlated with five National Performance Measures in the Title V Maternal and Child Health Block Grant requirements.

Survey Response

In October 2004, 1141 surveys were mailed to the addresses of the known population of SSI-receiving children with special health care needs, birth to age 18, who were residing in the state

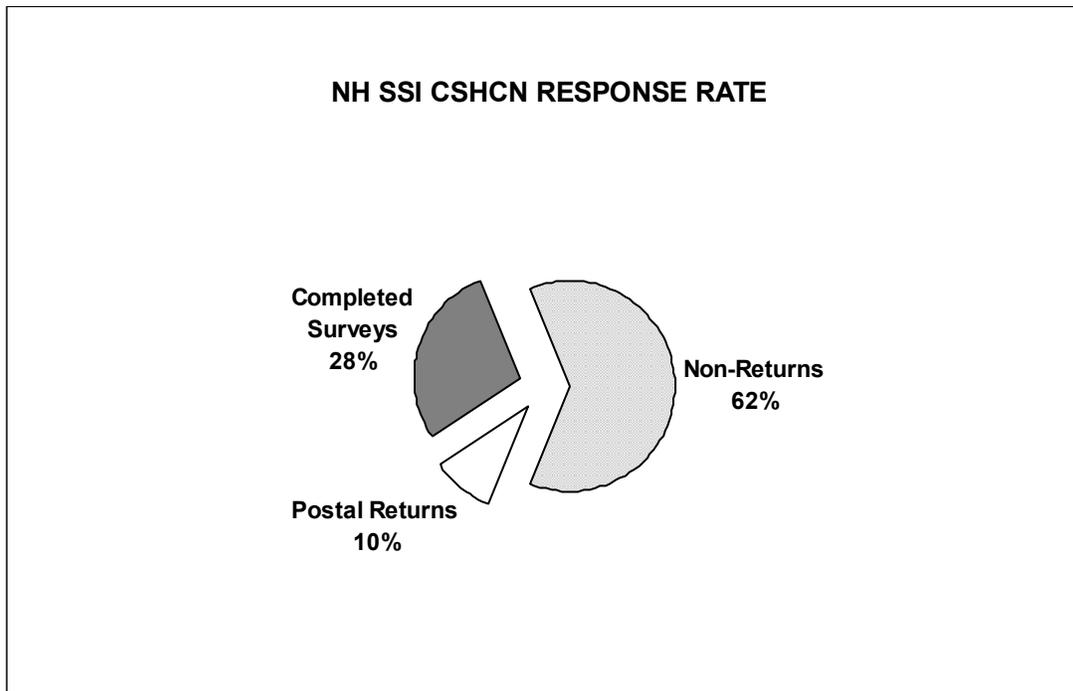
⁴ <http://www.cdc.gov/nchs/about/major/slaits/cshcn.htm>

⁵ Data source: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001. Version: Revised sampling weights, version 2. Analysis Date: April 28, 2003.

⁶ Supplemental Security Income (SSI) is a Federal income supplement program funded by general tax revenues (not Social Security taxes). It is designed to help aged, blind, and disabled people, who have little or no income, and it provides cash to meet basic needs for food, clothing, and shelter. <http://www.ssa.gov/notices/supplemental-security-income/>

during the preceding twelve months. Of the 1141 mailed surveys, 108 (9%) were returned as non-deliverable, while 291 (26%) were returned and completed. There was no response from 742 (72%) delivered addresses. After removing the non-deliverable surveys, a final response rate of 28% was achieved. (Figure 2) With such a low response rate, it is understood that the survey findings are influenced by nonresponse *bias* and the reader should keep this in mind.⁷

Figure 2



It must be emphasized that the NH Survey is not intended to be a scientific research effort; rather, the intent is to inform program planning. The rigorous criteria necessary to assure research-level results were not feasible for this project. Given the difficulty in reaching this population, the ‘best practices’ commonly utilized to maximize the potential for a high survey response rate were also outside the scope and budget of the project. No claims are made from the results regarding the characteristics of the nonresponders and/or the general population of SSI-receiving CSHCN. However, the findings from this survey do offer greater insight into the needs of the respondents and serve as the most reliable and available information regarding this group of NH CSHCN.

Methodological Differences Between the National Survey and the New Hampshire Survey

One of the obvious differences between the NH SSI CSHCN survey and national NH CSHCN survey is that the national survey is a population-based telephone survey that allows the findings to be generalized to the entire population of CSHCN, while New Hampshire’s survey can only

⁷ Hager, Mark A., et al. (2003). Response Rates for Mail Surveys of Nonprofit Organizations: A Review and Empirical Test. *Nonprofit and Voluntary Sector Quarterly*, vol.32, no. 2, 252-267.

speak to those who chose to respond to the survey, which was mailed to a known group. Additionally, the SLAITS sampling method was designed to estimate NH children known to have special health care needs, while the NH SSI survey was designed to survey all known families with CSHCN who receive SSI for their own disability.

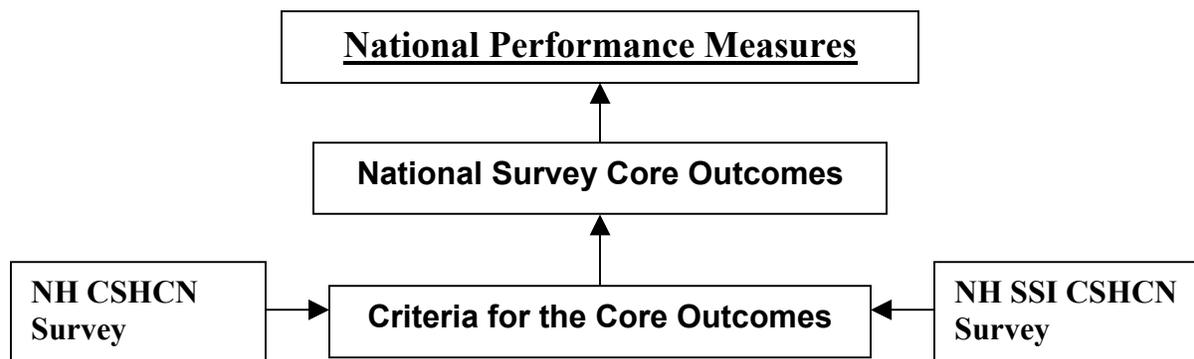
Core Outcomes

Both the NH CSHCN and the NH SSI CSHCN surveys will be used to address the success rate that supports the national performance measures. Two primary resources were used in the development of this report, which utilizes the data to bring into closer focus the health care status of the SSI-receiving group of CSHCN. Data from the national survey is drawn from SLAITS files⁸ and from the Data Resource Center for CSHCN⁹. The NH SSI CSHCN survey was analyzed by the NH Department of Health and Human Services¹⁰. If the complexity of the process rendered slight variations in a figure, the figure from the Data Resource Center was used.

Figure 3 illustrates how the NH SSI CSHCN survey results contribute to the current outcome data for New Hampshire children with special health care needs. Progress on the NPM’s is measured by Core Outcomes, which require multiple criteria to meet the threshold for “success”. Only those responses that meet the success criteria are incorporated in the results for the core outcomes. The five core outcomes and the results from the national survey for the United States, the national survey for New Hampshire CSHCN, and the NH SSI CSHCN survey are included in Table 1.

Figure 3

Title V Maternal and Child Health: CSHCN Measures and Outcomes



⁸ Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001. Version: Revised sampling weights, version 2. Analysis Date: April 28, 2003.

⁹ U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. *The National Survey of Children with Special Health Care Needs Chartbook 2001*. Rockville, Maryland: U.S. Department of Health and Human Services, 2004.

¹⁰ Office of Medicaid Business and Policy, Bureau of Healthcare Research.

Table 1

<u>Core Outcomes for National Performance Measures for CSHCN</u>	NATIONAL Survey Success Rate	NH CSHCN Survey Success Rate	NH SSI Survey Success Rate
Families of CSHCN will partner in decision-making and will be satisfied with the services they receive.	58% CI (56.5 – 59.5)	55% CI (47.6 – 62.4)	49% CI (43.2 – 54.7)
CSHCN will receive coordinated ongoing comprehensive care within a medical home.	53% CI (52.0 – 53.9)	56% CI (51.3 – 60.7)	14% CI (10.0-17.9)
Families of CSHCN will have adequate private and/or public insurance to pay for the services they need.	60% CI (59.0 – 60.9)	62% CI (57.3 – 66.7)	33% CI (27.5 – 38.43)
Community-based service systems will be organized so families can use them easily.	74% CI (72.7 – 75.3)	78% CI (72.0 – 84.0)	53% CI (47.2 – 58.7)
Youth with special health care needs will receive the services necessary to make transitions to adult life, including adult health care, work, and independence.	6% CI (5.7 – 6.3)	3% ¹¹ CI (0.02 – 6.4)	4% ¹² CI (0.6 – 7.3)

CI: There is a 95 percent chance that the true value falls within these boundaries.

The Core Outcomes for the above NPM's are calculated based on the number of respondents who consistently answered favorably to **all items** needed to constitute the outcome. The findings of the NH SSI CSHCN survey reflect New Hampshire's success rate in addressing the needs of CSHCN that are receiving SSI for their own disability. There are clear disparities between the overall NH CSHCN population and the SSI population.

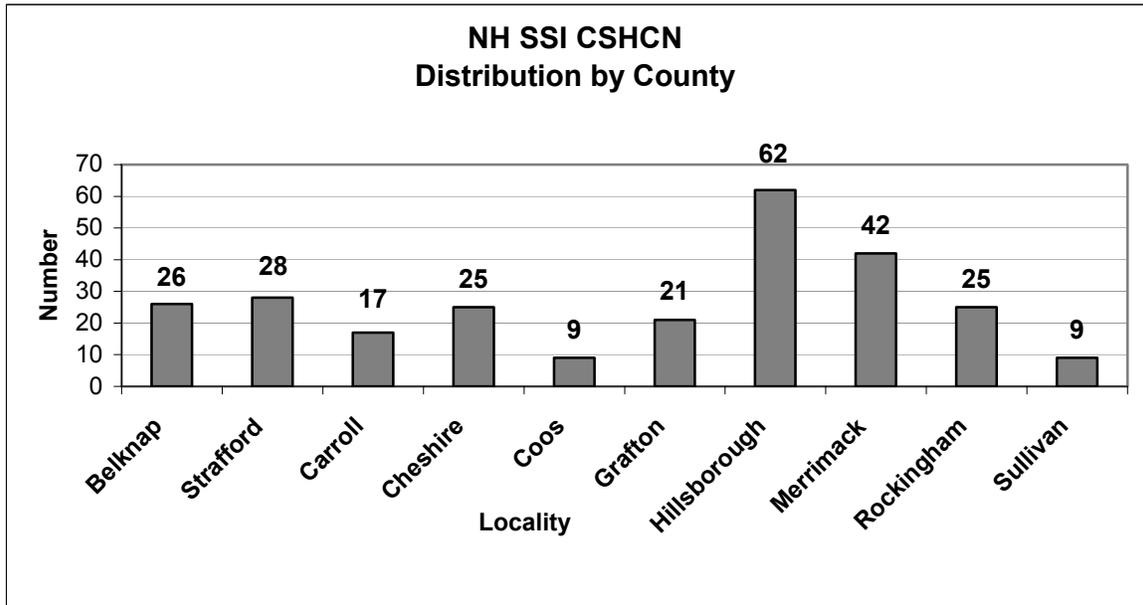
Demographics

All ten New Hampshire counties were represented in the NH SSI CSHCN 2004 survey. The most populous, Hillsborough County, accounted for 24% (n=62) of the respondents, followed by Merrimack at 16% (n=42), Strafford at 11% (n=28) and Belknap at 10% (n=26). The remaining counties were Rockingham (10%), Cheshire (10%), Grafton (8%), Carroll (6%), Sullivan (3%), and Coos (3%). (Figure 4)

¹¹ Estimates do not meet the National Center for Health Statistics standard for reliability or precision. The relative standard error is greater than 30%.

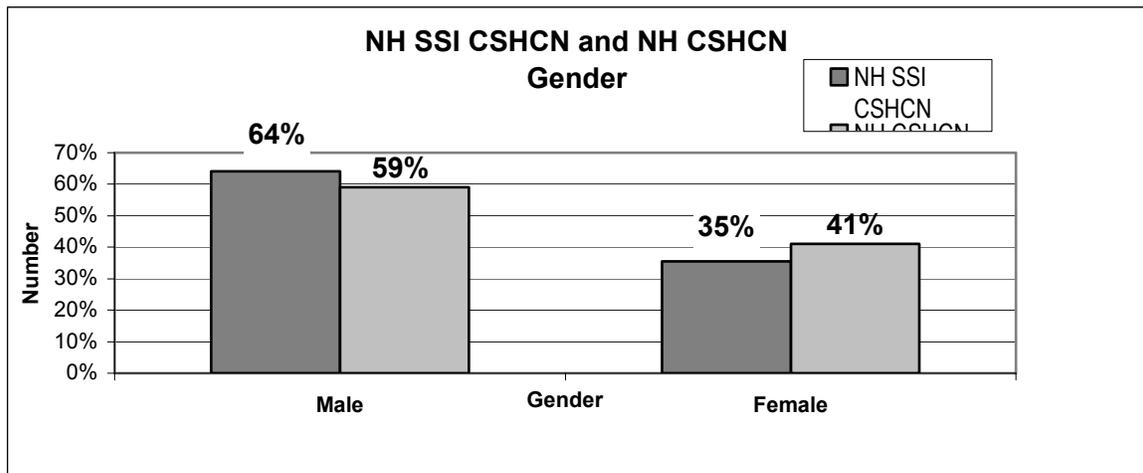
¹² Estimates do not meet the National Center for Health Statistics standard for reliability or precision. The relative standard error is greater than 30%.

Figure 4



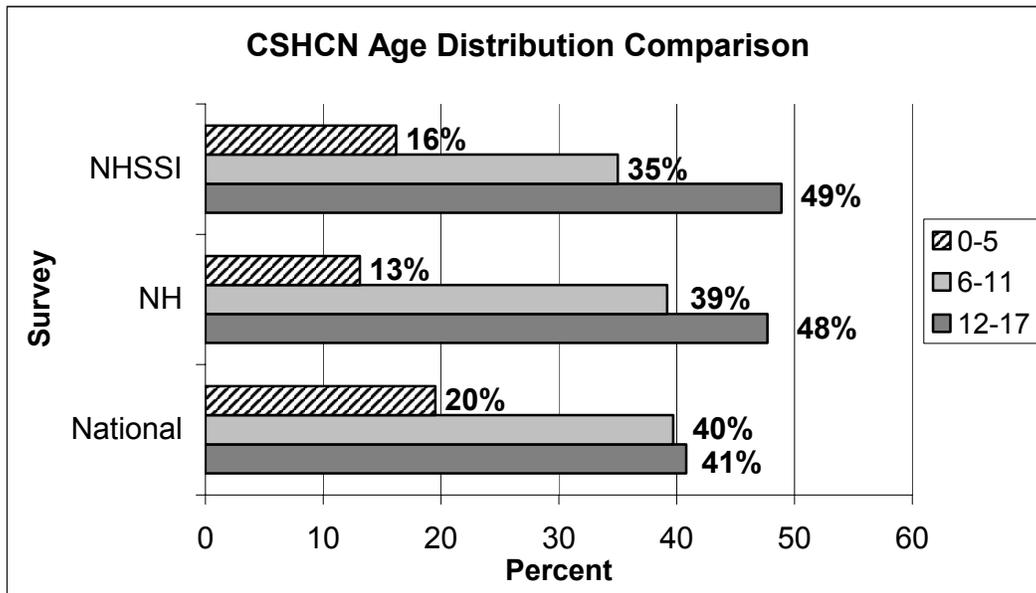
Of the 253 reports of gender in the NH SSI survey, 64% are male and 35% are female. The National survey sample for New Hampshire estimates a distribution of 59% male and 41% female. (Figure 5)

Figure 5



The age distribution of the children represented by the NH CSHCN-SSI survey, the national survey data for NH CSHCN, and the national survey for U.S. CSHCN, is illustrated in Figure 6.

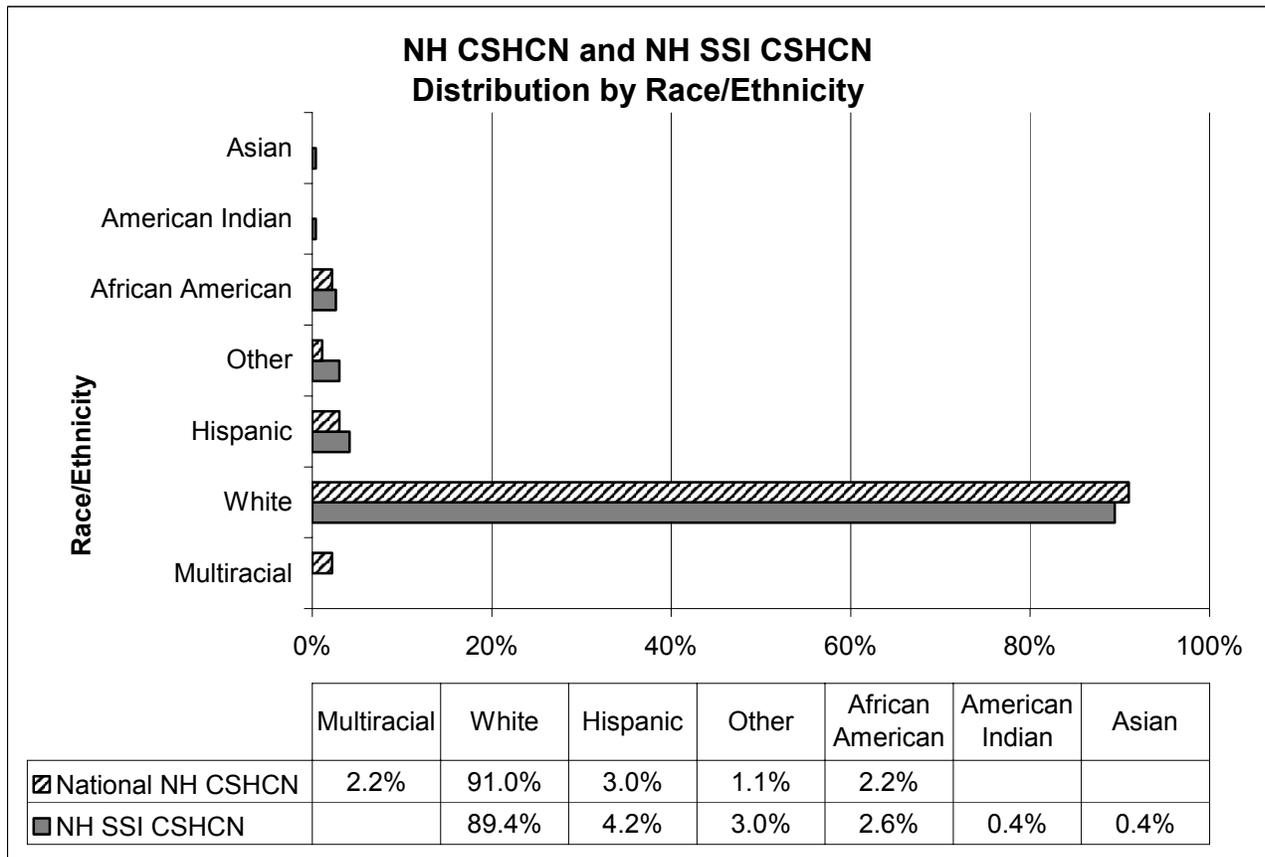
Figure 6



The population of New Hampshire children under age 18 is primarily White (95%¹³). The NH CSHCN SSI survey population is 89% White, which is somewhat more diverse than the national survey for NH CSHCN indicates. (Figure 7)

¹³ US Census 2000

Figure 7

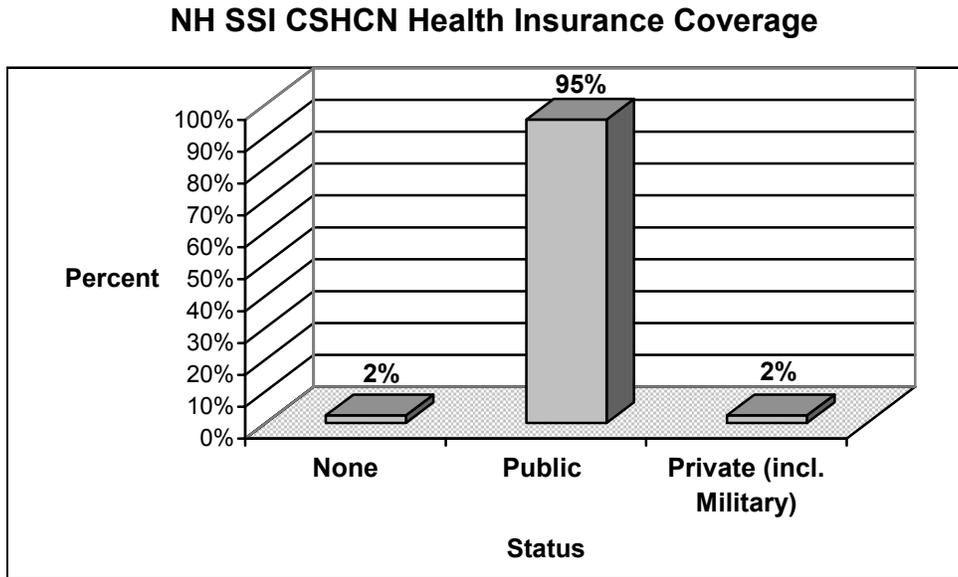


Note: Use caution in interpreting Race/Ethnicity when cell size is less than 5%.

New Hampshire is significantly less racially/ethnically diverse than most other states in the nation; however, minority and immigrant populations are now increasing in the southern-most area of the state. As the minority and refugee populations increase in New Hampshire, service providers for children with special health care needs are proactively integrating culturally sensitive and culturally competent methods into their practice sites. For example, Special Medical Services allocates designated funds to support foreign language interpreters for the Child Development Clinic site. The Department of Health and Human Services provides and facilitates interpreter services for the public seeking services or information. The NH Hospital Association members utilize the AT&T Language Line, and there are initiatives in place with the Endowment for Health and the NH Minority Health Coalition.

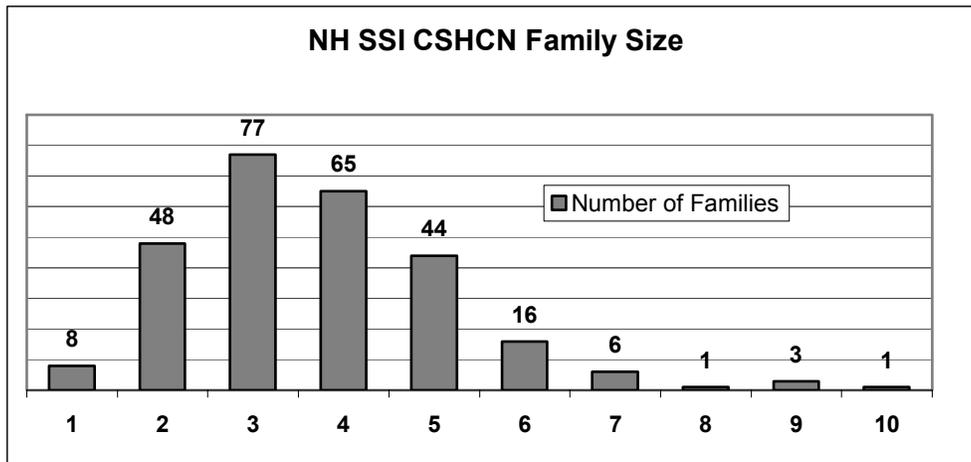
The health insurance coverage rate for all NH CSHCN, per the national survey, is 95%. According to the national survey results for New Hampshire, however, 28% of currently insured CSHCN have insurance that is not adequate to their needs. Of 249 NH SSI CSHCN survey respondents that indicated insurance status, 95% were currently covered by insurance, and 81% had insurance that met the child’s needs. (Figure 8) Medicaid accounts for 84% of the insurance by type for the SSI CSHCN population.

Figure 8



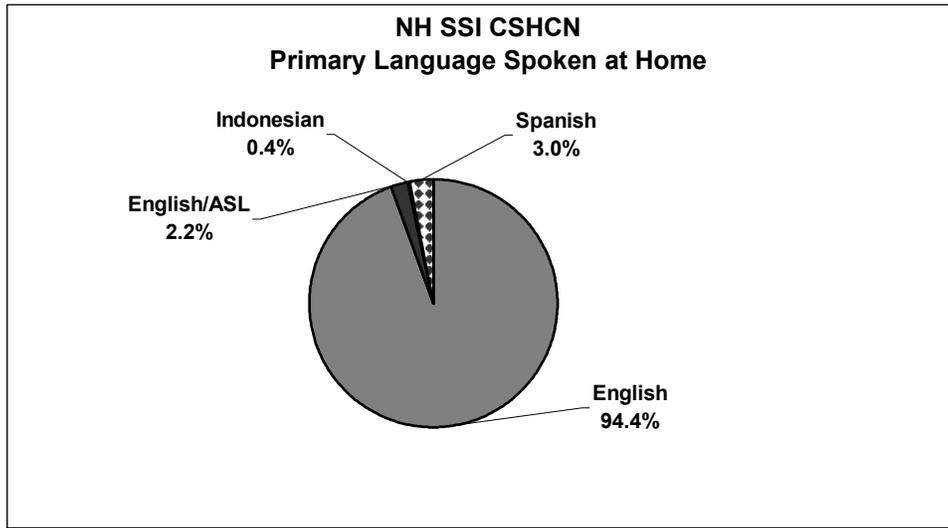
The majority of families of CSHCN receiving SSI for their own disability averaged three members per family, followed by four members and two members per family, respectively. (Figure 9)

Figure 9



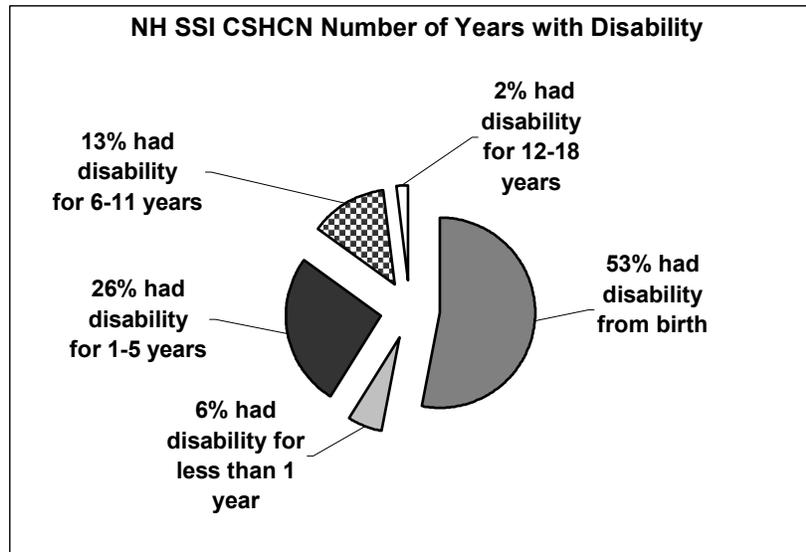
English is reported as the primary language spoken in the homes of the majority of survey respondents, followed by Spanish and American Sign Language. (Figure 10)

Figure 10



Over 50% of children referenced in the survey had the disability from birth. The next longest duration, between one and six years, was reported by over 25% of respondents. (Figure 11)

Figure 11¹⁴



¹⁴ Number of Years with Disability = Age – How long child had primary condition

Access and Impact

The NH SSI CSHCN survey addressed the same key domains as the national survey: medical homes, adequate health insurance, access to needed services, care coordination, satisfaction with care and impact on the family.

The NH CSHCN survey and the NH SSI CSHCN survey report data specific to the federally selected sub-questions that make up the five core outcomes. To meet the threshold for ‘success’ as a core outcome, the respondent had to answer “always” or “usually” to all the sub-questions comprising the core outcome. Table 2 below shows the results for both New Hampshire surveys.

Table 2

New Hampshire Core Outcomes (NH CSHCN and NH SSI CSHCN)

Survey Criteria ¹⁵	NH CSHCN		NH SSI CSHCN	
	Valid Number (or *Weighted Number)	% Yes ¹⁶	Valid Number	% Yes
1. Families of CSHCN will partner in decision-making and will be satisfied with the services they receive.	296	55%	142	49%
1.1 Doctors usually or always made the family feel like a partner	272	86%	242	83%
1.2 Family was very satisfied with services received	279	58%	149	51%
2. CSHCN will receive coordinated ongoing comprehensive care within a medical home.	718	56%	40	14%
2.1 The child had a usual source of care	43*	92%	260	89%
2.1a The child had a usual source for sick care	43*	92%	267	92%
2.1b The child had a usual source for preventive care	47*	100%	276	96%
2.2 The child had a personal doctor or nurse	43*	93%	265	92%
2.3 The child had no problems obtaining referrals when needed	19*	77%	208	73%
2.4 Effective care coordination was received when needed	3*	37%	55	18.9%

¹⁵ Criteria are MCH-defined Core Outcomes for National Performance Measures for CSHCN; data source for the Core Outcomes is “Progress Toward Implementing Community-Based Systems of Services for Children with Special Health Care Needs: Summary Tables from the National Survey of Children with Special Health Care Needs, 2001”; data release April 28, 2003, Tables 1 through 10.

¹⁶ In order to be counted as a “yes (success)” in the Core Outcome row (the overall percentage) ALL of the components must have been answered “always or usually” by the individual respondents. Because the same respondents do not answer the same way for each item, the final percentage for all respondents is almost always lower than any given item, and can never be higher than the lowest item.

Survey Criteria ¹⁵	NH CSHCN		NH SSI CSHCN	
	Valid Number (or *Weighted Number)	% Yes ¹⁶	Valid Number	% Yes
2.4a The child had professional care coordination when needed	5*	78%	166	58%
2.4b Doctors communicated well with each other (excellent/very good)	4*	62%	144	51%
2.4c Doctors communicated well with other programs (excellent/very good)	3*	49%	120	42%
2.5 The child received family-centered care	31*	71%	167	57.4%
2.5a Doctors usually or always spent enough time	39*	88%	222	78%
2.5b Doctors usually or always listened carefully	41*	91%	242	85%
2.5c Doctors were usually or always sensitive to values and customs	40*	90%	227	81%
2.5d Doctors usually or always provided needed information	37*	84%	222	78%
2.5e Doctors usually or always made family feel like a partner	39*	88%	242	84%
3. Families of CSHCN will have adequate private and/or public insurance to pay for the services they need.	727	62%	97	33%
3.1 Child had public or private insurance at time of interview	44*	94%	282	98%
3.2 Child had no gaps in coverage during year prior to the interview	40*	85%	233	84%
3.3 Insurance usually or always met child's needs	39*	89%	228	81%
3.4 Costs not covered by insurance were usually or always reasonable	32*	76%	123	45%
3.5 Insurance usually or always permitted child to see needed providers	41*	93%	241	86%
4. Community-based service systems will be organized so families can use them easily.	274	78%	153	53%
4.1 Services were usually or always organized for easy use	271	78%	153	53%
5. Youth with special health care needs will receive the services necessary to make transitions to adult life, including adult health care, work, and independence.¹⁷	108¹⁸	3%	5¹⁹	4%

¹⁷ Estimates do not meet the NCHS standard for reliability or precision.

¹⁸ Estimates are based on data from National Survey of CSHCN interviews conducted after July 5, 2001 (less than the full survey period).

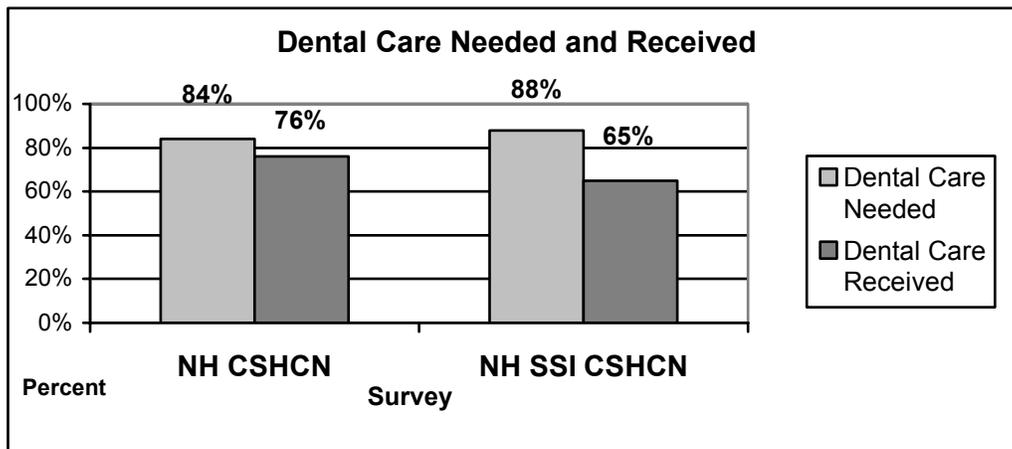
¹⁹ Small total response decreases reliability

Survey Criteria ¹⁵	NH CSHCN		NH SSI CSHCN	
	Valid Number (or *Weighted Number)	% Yes ¹⁶	Valid Number	% Yes
5.1 Child has received guidance and support in transition to adulthood	108	13%	14	4.8%
5.1a Doctors have talked about changing needs as child becomes an adult	110	52%	55	44%
5.1b Child has plan for addressing changing needs	57	67%	35	29%
5.1c Doctors discussed shift to adult provider	57	41%	21	18%
5.2 Child has received vocational or career training	113	17%	26	22%

An extensive number of additional questions relating to the need for, and receiving of, specialty services were asked in the national survey. These items are associated with Core Outcome 2 (comprehensive care in a medical home), under Question 2.3, regarding the difficulty obtaining referrals when needed. For the purpose of the abbreviated NH SSI CSHCN survey, inquiries were made regarding two specialty areas; i.e. dental care and mental health needs.

NH children receiving Medicaid, which includes the majority of the SSI CSHCN group, receive dental services solely through providers that accept Medicaid. The Medicaid payments for many dental procedures were increased two years ago; however, there is both a shortage of dentists in the state, generally, and a shortage of those that accept Medicaid. (Figure 12)

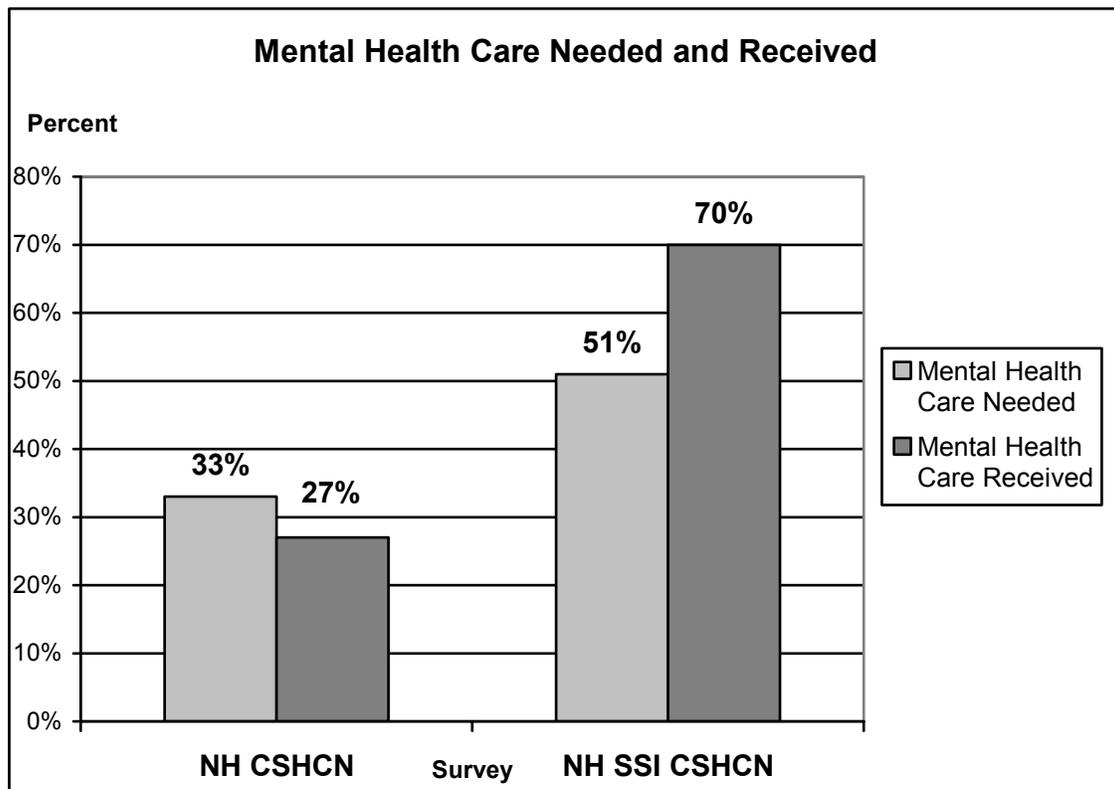
Figure 12



While one third of the NH CSHCN reported needing mental health services, and half of the SSI group reported that need, only 27% of the NH CSHCN reported receiving the mental health care needed, while 70% of the SSI group reported receiving the needed services. (Figure 13) One question that emerges from this data is whether the SSI group reporting the need for mental health care is receiving this specialty care in a greater proportion than non-SSI CSHCN, due to

the prevalence of the diagnosis of Serious Emotional Disturbance (SED) in the SSI population. A lesser degree of severity of mental health issues, which does not meet the restrictive diagnostic criteria for SSI eligibility, is more likely to be the case among the non-SSI group. Physicians are often reluctant to ‘label’ a child SED, and many serious behavioral and mental health conditions do not meet the threshold for SSI eligibility. The need for mental health services for CSHCN and the difficulty locating and/or accessing such services, especially for those without an SED-related diagnosis, has emerged as a priority in the New Hampshire “Assessing Needs and Resources for Children with Special Health Care Needs” (Delphi survey) which is also included as part of the Five Year Needs Assessment.

Figure 13

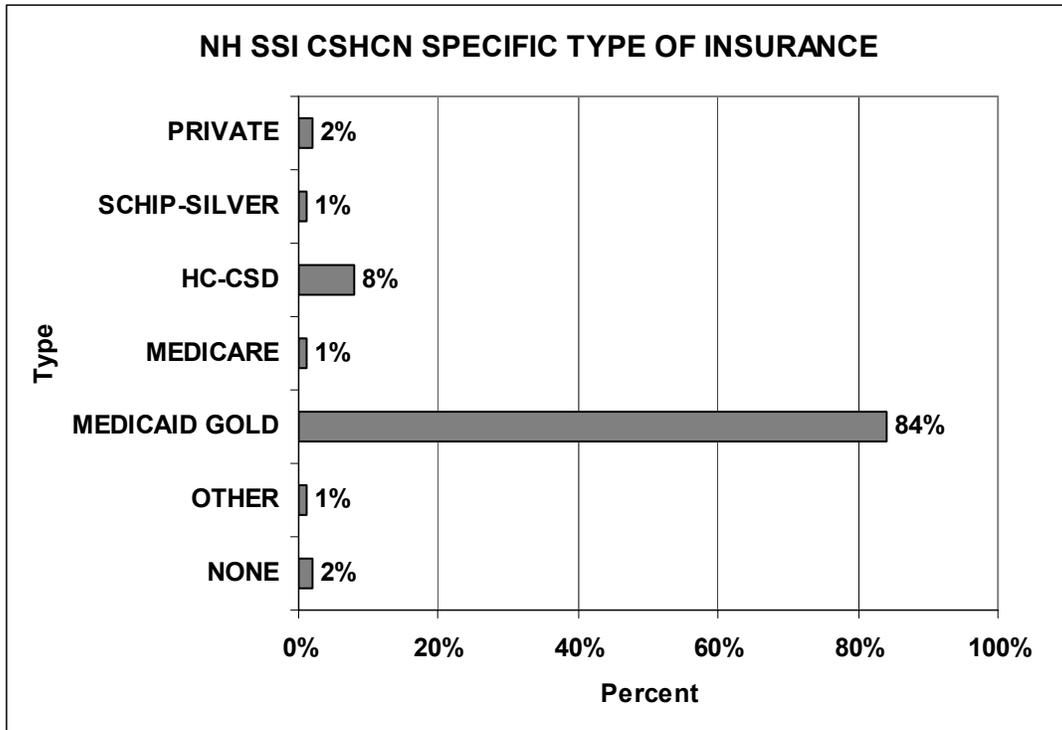


As reported previously, 95% of the 249 families that responded to the questions about health insurance coverage reported having coverage for their child at the time of interview/survey. Figure 14 details the type of insurance held, with the majority being covered by some form of public insurance, such as Medicaid. New Hampshire is one of 19 states that do not use Federal SSI eligibility for automatic Medicaid eligibility, and one of 11 states (“§209(b) states”) that use at least one Medicaid criterion that is more restrictive than the SSI program.²⁰ Despite the requirement that disabled children must file separate applications for SSI and Medicaid, approximately 70% of New Hampshire children receiving SSI for their own disability also are

²⁰ Benefits Planning Query Handbook, Social Security Administration, September 2004

insured through Medicaid.²¹ Of those whose parents responded to the survey, 95% are covered by some form of Medicaid or Medicare for their health care needs. Federal and state discussions regarding Medicaid reform, or modernization, primarily propose measures for cost sharing utilizing a combination of reduced benefits and increased out-of-pocket expenses. This is of heightened concern for the youth with special health care needs (YSHCN) receiving SSI and Medicaid, who are aging out of pediatric services and transitioning to adult status.

Figure 14



In addition to insurance status, the NH SSI CSHCN survey asked parents about their out of pocket expenses related to medical care for their child, the amount of time family members spent on providing health care for their child at home, the amount of time the family spent coordinating care and services for their child, and the affect of the child’s condition and needs on income and working status. Out of pocket expenses for the child’s medical care were reported in both the national and NH SSI CSHCN surveys. Many families sustained costs exceeding \$500, up to over \$1000 per year. (Figure 15 and Figure 16) A recent study finds that health care cost-sharing has more impact on low-income people, as Medicaid beneficiaries pay a proportionately larger share of their income for out-of-pocket medical expenses; in 2002, poor disabled SSI beneficiaries covered by Medicaid, including YSHCN over age 18, spent an average of 6% of

²¹ Special Medical Services, Bureau of Medical Services, Office of Medicaid Business and Policy, NH Department of Health and Human Services, 2004.

their income, more than eight times the percentage of income paid by non-low-income adults with private insurance.²²

Figure 15

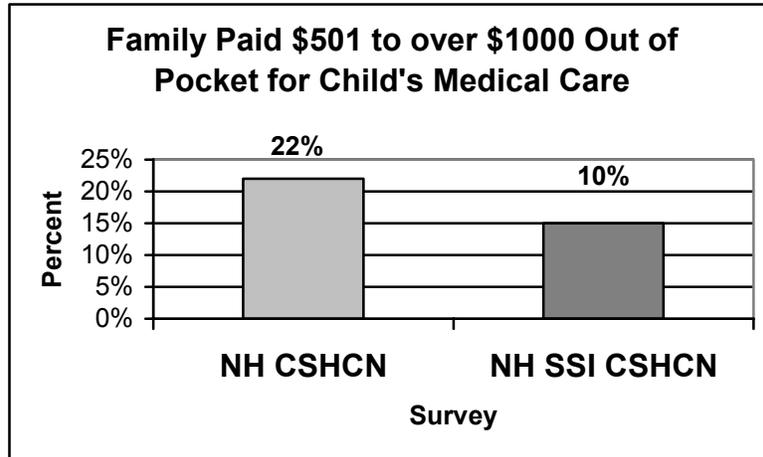
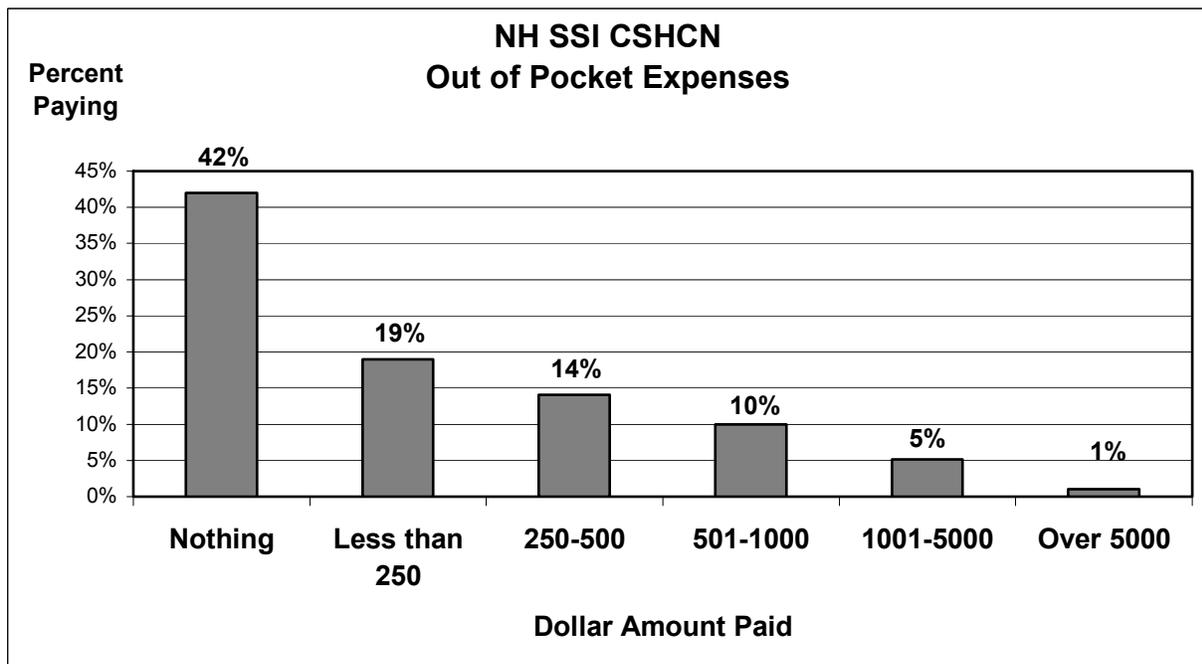


Figure 16



Over two-thirds of the families of NH SSI CSHCN surveyed reported that they provide health care for their child at home. (Figure 17 and Figure 18) These families experience the impacts of both a financial affect as well as the affect of often ‘around-the-clock’ health care for a disabled

²² Out-of-Pocket Medical Expenses for Medicaid Beneficiaries are Substantial and Growing, Leighton Ku and Matthew Broaddus, Center on Budget and Policy Priorities, May 2005.

child. Children who qualify for SSI for their own disability are by definition experiencing debilitating, and often medically severe problems as a result of their condition. In an article authored by SMS staff, currently in press for the Journal of Maternal and Child Health²³, an analysis of selected national survey NH data indicated that the severity of the child's condition had a more profound affect on the family than simply the presence or lack of financial resources.

Figure 17

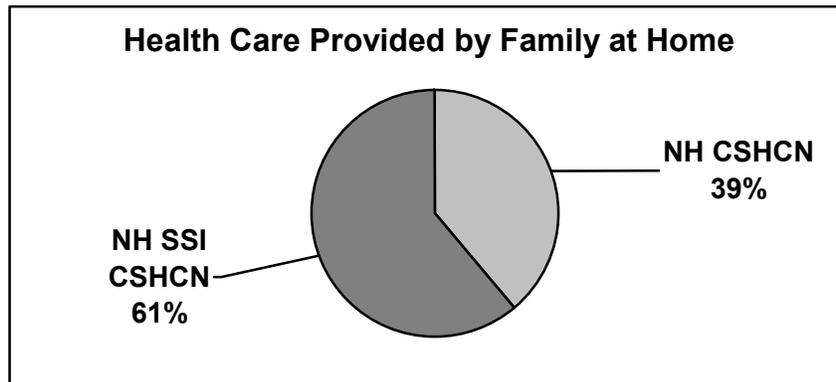
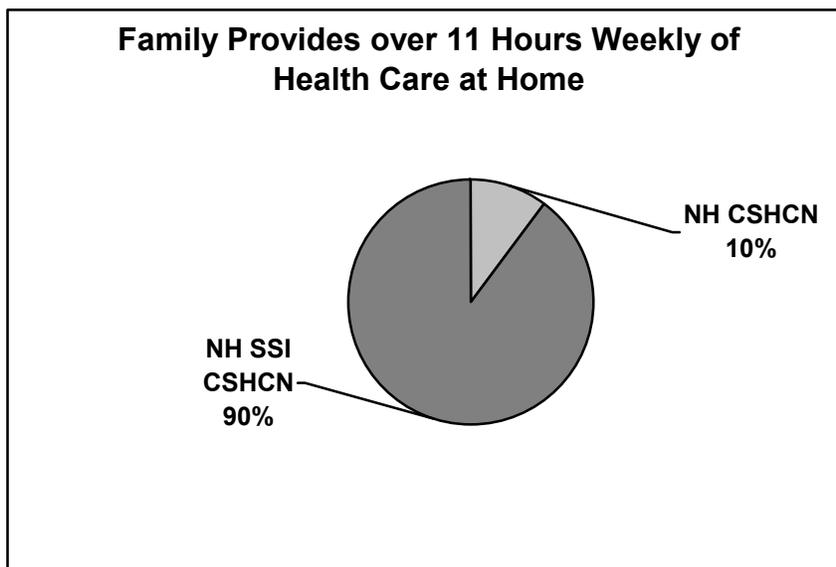


Figure 18



In addition to families often providing direct health care for their child, the various components of arranging for coordination of care among providers, programs and services is also a task that is undertaken by almost half of families of children with special health care needs, including the families of the NH SSI CSHCN surveyed. (Figure 19) The data also indicate that parents of

²³ Economic Impact on Families Caring for Children with Special Health Care Needs in New Hampshire: The Effect of Socioeconomic and Health-Related Factors. Bumbalo, J., Ustinich, L. Ramcharran, D., and Schwalberg, R., Maternal and Child Health Journal Vol. 9S, No. 2, June 2005 DOI: 10:1007/s10995-005-4350-3

CSHCN receiving SSI must provide a significantly higher percentage of their own care coordination than other NH families with CSHCN. (Figure 20) Only 18.9% reported that they received effective care coordination when needed (Table 2).

Figure 19

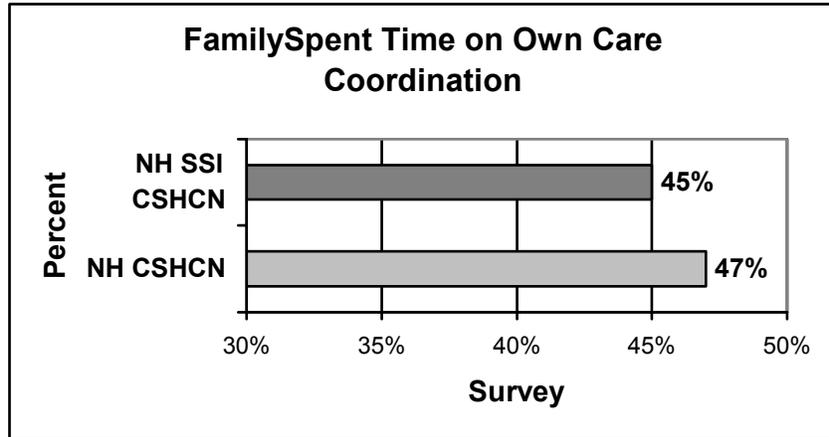
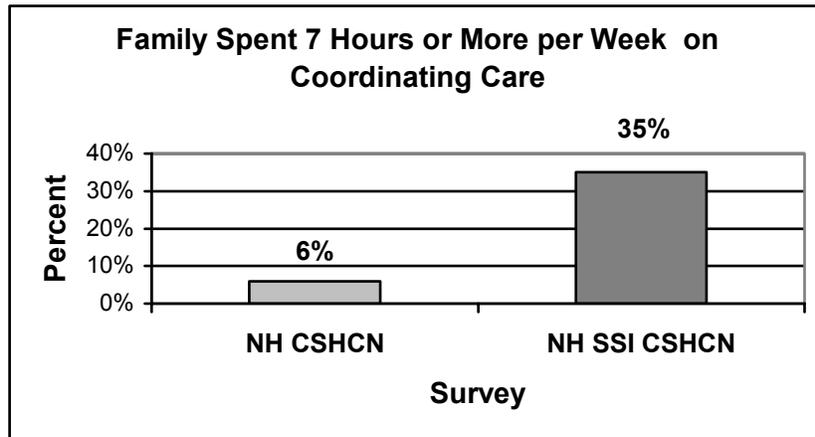
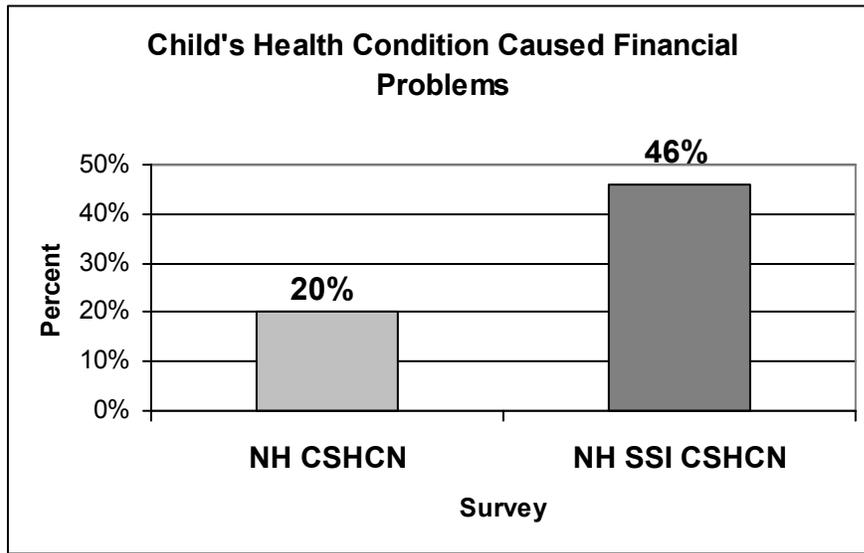


Figure 20



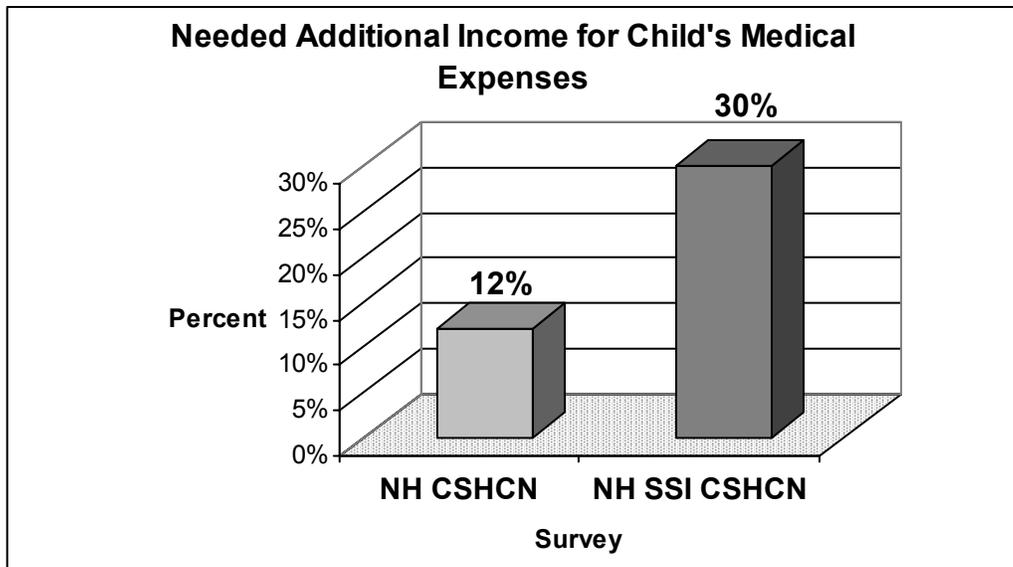
Over 45% of families of SSI-receiving CSHCN report sustaining financial problems because of the child's health condition, which is more than double the percentage reported in the national survey by families of CSHCN in New Hampshire. (Figure 21)

Figure 21



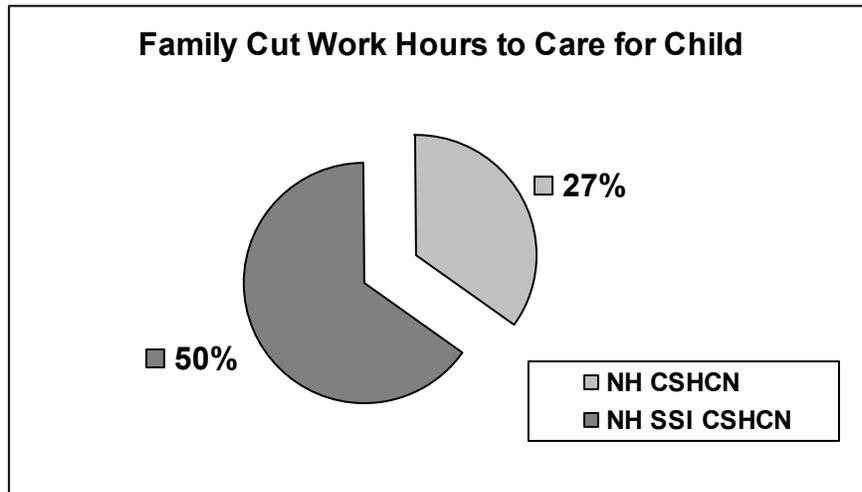
Parents of children receiving SSI for their own disability report a significantly higher need for additional income to pay for health care/medical expenses not covered by insurance. (Figure 22)

Figure 22



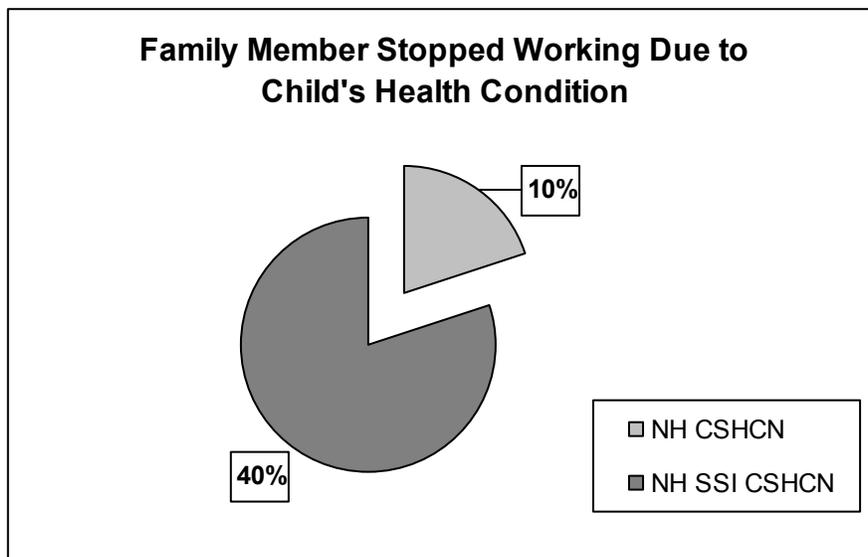
In addition, half of the families of the CSHCN SSI group reported having to cut work hours to care for their child. Slightly less than 30% of the NH CSHCN group reported having to decrease work hours. (Figure 23)

Figure 23



The data analyzed for the Maternal and Child Health Journal article indicate that it is the severity of the child's condition that most impacts the family with regard to situations such as having to reduce hours worked in order to provide care in the home, or the need to stop working altogether to care for the child, due to the child's condition.²⁴

Figure 24

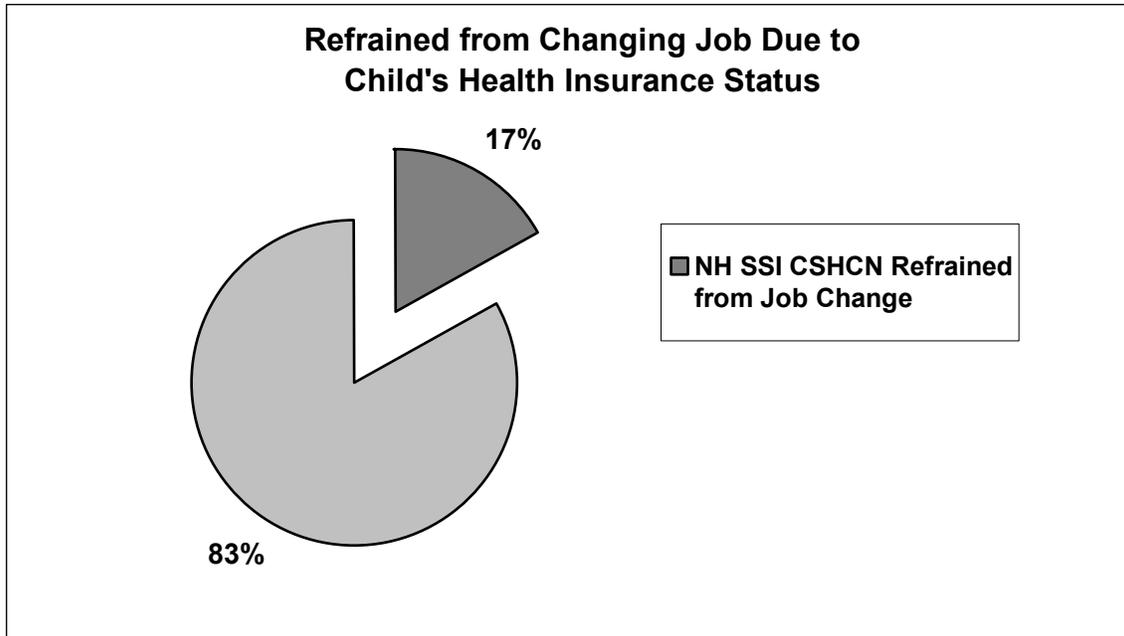


The NH SSI CSHCN survey asked families to respond to one question that was not asked on the national SLAITS survey: "Have you or other family members refrained from changing jobs because of your child's health insurance status?" (Figure 25) Based on response to this inquiry,

²⁴ Ibid. Bumbalo et.al. (2005).

New Hampshire Special Medical Services has suggested that this item be included in the next iteration of the national survey, scheduled to be conducted in 2006.

Figure 25



Transition to Adult Life

Questions regarding the transition to adult life and adult services were added to the national SLAITS survey after the survey was initially begun. For this reason, the NH data is limited and is not intended to represent the current, largely unknown, status of transition efforts and measured outcomes in the state. When the national survey is repeated next calendar year, the transition questions will be included from the beginning, and will be asked of all interviewees representing CSHCN age 12 or older. The NH SSI CSHCN survey asked the transition questions of all families with SSI-receiving CSHCN, age 12 to 18. (Table 3) The numbers of people responding to the transition questions ranged from 124 to 127, or approximately 43% of all respondents.

Two items of significance have emerged from the NH SSI survey data: 1) this group of children are much less likely to have plans to address their changing needs developed with their physicians, and 2) the physicians and nurses treating the SSI group of CSHCN are less likely to discuss transition to an adult medical practitioner. (Table 3)

Table 3

TRANSITION PLANNING (Percent of 'yes' responses)	
NH CSHCN Survey	NH SSI CSHCN Survey
1. If child is 12 years or older, has the child's doctor talked with family or child about how health care needs might change when he/she becomes an adult.	
51%	44%
2. Has a plan for addressing these changing needs been developed with the doctor or other health care providers?	
66%	29%
3. Has the child's doctor or other health care provider discussed having the child eventually see a doctor who treats adults?	
40%	18%
4. Has the child received any vocational or career training to help him/her prepare for a job when he/she becomes an adult?	
17%	22%

Conclusions

The analysis of the survey data regarding this subpopulation of CSHCN in New Hampshire indicates several issues for consideration in future policy and program planning. These findings include the following:

- NH CSHCN receiving SSI for their own disability demonstrate a greater need for care coordination than NH CSHCN in general.
- The SSI CSHCN population evidences a greater need for better-organized community-based systems.
- Respondents express a desire for increased access to public/private funding, perhaps because of a concern regarding costs that are not covered by insurance.
- Although almost 98% of the sample are insured and an almost equally high percent are insured through Medicaid, respondents perceive that this coverage alone is not sufficient to meet the dental and mental health care needs of children receiving SSI. It is unknown from the survey data what the perceived insufficiencies might be.
- The adequacy of Medicaid appears to be an issue for families that must pay out-of-pocket for non-covered medical and health care-related items and services, perhaps for durable medical equipment or psychotropic medications not included in the state formulary.

- The well-documented shortage of dental providers in New Hampshire, and the further shortage of those who will accept Medicaid, reflects the need for the State to support initiatives to increase the number of providers who will accept Medicaid clients, including CSHCN.
- Survey results related to the need to curtail employment and the intensity of at-home care indicate a need for increased respite care at home, and child care services, for these medically and/or behaviorally complex children.
- Youth with special health care needs age 12 and older are much less likely to have plans to address their changing needs developed with their physicians; professionals treating the SSI group of CSHCN are less likely to discuss the transition to a medical practitioner who treats adults. Both of these issues need to be addressed.

In summary, the overall results of the NH SSI CSHCN survey indicate that this group of children and their families experience an array of health-related difficulties, which may have a more severe impact on the family than the impact of difficulties experienced by families of NH CSHCN in general. The medical and financial eligibility requirements for SSI benefits are sufficiently restrictive to assure that the children receiving Supplemental Security Income for their own disability are, by definition, in a heightened state of need for this assistance.

The survey also indicates that the provision of SSI does not close the gap between what Medicaid will cover and what families must pay for out-of-pocket. Meeting the actual expenses of the child's care is often accomplished by working multiple jobs and/or providing a high degree of health-related care in the home. It appears that the cost-of-care burden is greater for these families than for the families of NH CSHCN in general. Furthermore, respondents indicate concerns regarding adequacy of insurance coverage. The survey was not designed to capture further details about the issues that elicited respondent concerns. SMS plans a second mailing to the families of CSHCN receiving SSI, to request additional feedback on the issues raised. This process will be confidential and anonymous, used only to extract data for planning purposes, as was the original survey.

The NH survey also indicates that these children are evidencing a greater need for comprehensive, community-based, care coordination and well-organized service systems. Details for this initiative are outlined under National Performance #3 in the 2006 Title V Block Grant narrative. Specific deficits are indicated in the areas of mental health services and the transition to adult services. Special Medical Services is currently working on a special grant-funded project²⁵ to meet the needs related to transition to adult care for CSHCN.

Given that the majority of children receiving SSI for their own disability will continue to meet the financial and medical criteria for this assistance, it appears imperative that New Hampshire's programs for CSHCN specifically and pro-actively address the unique needs of this subpopulation, as they age into adulthood.

²⁵ New Hampshire Youth Health Care Transition Project, funded by the Champions for Progress Incentive Award, Champions for Progress Center, Early Intervention Research Institute, Utah State University.

IV. Capacity Assessment

(Note: The tables and figures in this section are labeled “CA” for “capacity assessment”.)

A. Direct and Enabling Services

New Hampshire'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 New Hampshire Department of Health and Human Services' (DHHS) vision. Much of the state is designated as medically underserved or health professional shortage areas. While New Hampshire's two largest cities have public health departments, there is no statewide network of local health departments providing direct 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, nutrition, social services, home visiting, transportation, and translation to low income, uninsured and underinsured populations. 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. See maps of medically underserved areas and health professional shortage areas and MCH program service areas in Appendix D.

1. Accessibility

Preventive & Primary Care Services for Women

Thirteen agencies throughout the state provide prenatal care and enabling services such as case management, nutrition counseling, tobacco cessation interventions, and patient-specific social services. Of these, ten are considered primary care agencies, offering the full spectrum of health care services to all ages; the other three are 'categorical' agencies, 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; six of these are primary care agencies.

In 2003, the thirteen prenatal agencies served 2107 (14%) of New Hampshire's pregnant women. Of pregnant women served by Maternal and Child Health Section (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. (NH DHHS, MCH Section (CDF data, 2003))

Of the ten primary care agencies, seven have Federally Qualified Health Center (FQHC) status. 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 primary care 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.

The state's CHCs saw 24,055 uninsured patients in 2004, over 18% of all the uninsured in the state. (Bi-State PCA, 2004) 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. (NH DHHS, MCH Section (UDS data), 2003) 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 needed influx of funding to help sustain these safety net providers.

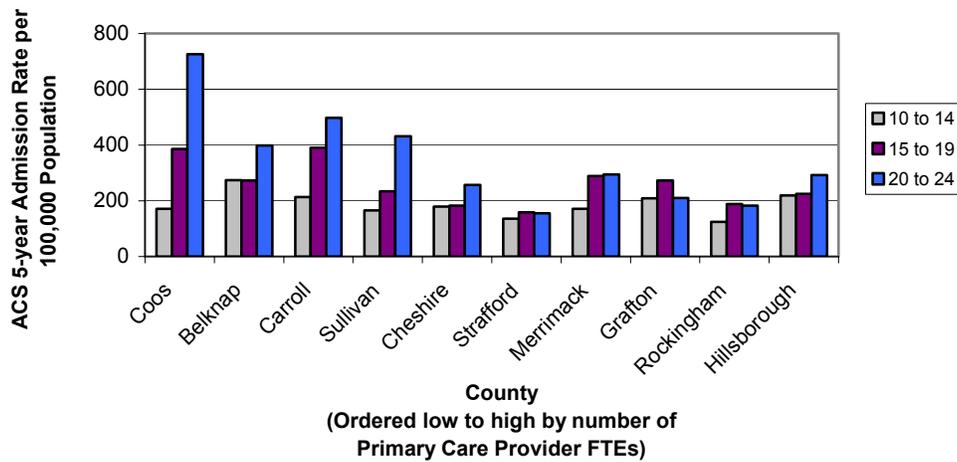
Preventive & Primary Care Services for Children

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 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 primary care agencies described above; one is a 'categorical' pediatric clinic utilizing a multi-disciplinary care model. Services at the 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. (NH DHHS, MCH Section (UDS data), 2003)

Health Care Access - Ambulatory Care Sensitive Conditions

One way to measure health care access is to examine hospital discharge data for Ambulatory Care Sensitive Conditions (ACSC). Ambulatory Care Sensitive Conditions are health problems such as asthma, diabetes and epilepsy, where receiving appropriate primary care services can prevent inpatient hospitalizations (Billings et al., 1993). High ACSC admission rates may indicate poor access to or impaired quality of health care services. It can be seen in Figure CA-1 that the rate of ACSC admissions for adolescents tends to be higher in New Hampshire counties with the fewest Full Time Equivalent (FTE) primary healthcare providers. Indeed, two counties (Belknap and Coos) are federally designated health provider shortage areas, and portions of many other counties have also been identified as shortage areas. The 20-24 year age group, particularly in counties with the greatest shortage of primary healthcare providers, experiences higher rates of preventable admissions. As individuals in this age group transition from their parents' or guardians' health insurance, they may have difficulty accessing primary care services due to the lack of health benefits often associated with introductory level jobs. While further analysis is necessary to account for the ratio of primary care providers to county population, and for the geographic distribution of primary care providers within counties, these data do suggest a measurable consequence (higher ACSC hospital admissions) of the primary healthcare provider shortages in several counties.

Figure CA-1: Ambulatory Care Sensitive (ACS) Conditions by County and Age Group, NH Adolescents Ages 10 to 24, 1996-2000



Data source: Data from the Health Statistics and Data Management Section (HSDM), BDCLS, NH DHHS; Analysis by BMCH; ¹Readers should be cautioned not to compare different age groups within or across counties, but rather to compare the same age group across counties.

Rural Health

A 2004 New Hampshire Rural Health Report explored differences in the health of rural and non-rural areas of the state, finding that there are real, significant, and observable differences in the health profiles of the state’s rural and non-rural communities. Some of the most notable differences were in the demographic characteristics of rural residents. For example, rural residents are significantly older, poorer, and less educated than non-rural residents. They are far more likely to be unemployed or out of the labor force and more likely to be self-employed or employed in industries where health insurance benefits are less available.

The study looked at a variety of health service indicators with rural implications. EMS records for the state were analyzed and showed dramatic differences in overall response times and percentage of calls arriving within an 8-minute standard in rural areas. The total number of primary care providers in rural areas increased faster than in non-rural areas in the past few years, and total provider ratios appeared favorable, although access to specialty physicians, such as pediatricians and obstetricians, was more limited in rural areas.

Health insurance was one of the greatest disparities in rural areas, where residents were significantly less likely to have private health insurance and more likely to be on Medicaid. Rural residents were also less likely to be insured for dental services.

The overall mortality rate of rural residents was comparable to that of non-rural residents once age-adjusted, but was significantly higher in absolute terms due to the higher elderly population. Rural residents showed dramatically higher rates of accidental and injury-related deaths. Birth statistics showed much higher rates of perinatal risk factors in rural areas by access to prenatal care was favorable, which may explain comparable outcomes in terms of LBW and infant

mortality. In addition, there was a significant difference in the rate of psychiatric hospitalizations for rural residents. (NH DHHS Rural Health and Primary Care Section. (2004)).

Services for Children with Special Health Care Needs (CSHCN) [Section 505(A)(1)]

Table CA-1 provides a summary of the capacity of New Hampshire private and public programs to provide direct and enabling services to children with special health care needs. Overall, unmet need for services is minimal; however, approximately one quarter of families report problems obtaining referrals for specialty care. It is of concern that pediatric therapists are primarily located in the southern, non-rural areas of the state. The state has one private facility with 26 ICFMR beds, one special rehabilitation hospital with 62 beds for individuals up to age 30, and two residential skilled nursing facilities that can accommodate 10 transition-age youth. According to the national Survey of CSHCN 2001 data, a little more than half of NH CSHCN receive care in an identified medical home; however, over 90% have a usual source of care. Based on the national Survey data, over three-quarters of families report receiving family-centered care. Moreover, quality of care reported by families enrolled in SMS programs is consistently rated well over the 90th percentile.

Table CA-1: New Hampshire Capacity Indicators for CSHCN: 2005

ACCESSIBILITY	AFFORDABILITY	QUALITY
<p>Percentage of newborns who are screened and confirmed with metabolic conditions who receive appropriate follow-up (MCHB NPM #1)</p> <p>NH screens for 6 conditions (approx. 15,000 live births yearly)</p> <p>2004 cases identified/confirmed: 12</p> <ul style="list-style-type: none"> • 1 Galactosemia (Classical) • 1 PKU (Classical) • 1 HYPEN PHW • 9 Congenital Hypothyroidism <p>100% of cases entered into follow-up and treatment</p>	<p>Percentage of CSHCN whose families have adequate private and/or public insurance to pay for the services they need (MCHB NPM #4)</p> <p>62% (National Survey of CSHCN: NH)</p> <p>National Survey of CSHCN indicators:</p> <ol style="list-style-type: none"> 1) Adequacy of benefits and covered services: 89%, 2) Out-of-pocket costs \$500 or over 24% 3) Choice permitted for child to see provider he/she needs to see: 93% 	<p>Percentage of CSHCN who receive coordinated, ongoing, comprehensive care within a medical home (MCHB NPM#3)</p> <p>56% (National Survey of CSHCN: NH)</p> <p>National Survey of CSHCN indicator:</p> <ol style="list-style-type: none"> 1) Child has unmet need for care coordination: 22% 2) Child has a personal doctor or nurse: 93% 3) Child has a usual source of sick care: 92%
<p>Percentage of families of CSHCN reporting unmet need for health services</p> <p>14% (National Survey of CSHCN: NH)</p>	<p>Percentage of State SSI beneficiaries under age 16 receiving rehab. services from the State CSHCN program (MCHB HSCI #8)</p> <p>83% (National Survey of CSHCN: NH)</p> <p>Degree to which the State CSHCN Program provides or finances specialty and subspecialty care, not otherwise accessible or affordable to its clients.</p> <ol style="list-style-type: none"> 1) SFY 04: \$379,144 expenditure (total per eligible client [186% of FPL] by program) 2) SFY 04: 14 contracts supporting direct care; total expended \$1,283,334; 5 individual providers and 9 interdisciplinary clinic services 	<p>Percentage of families of CSHCN reporting receiving family-centered care</p> <p>71% (National Survey of CSHCN: NH)</p> <p>National Survey of CSHCN indicators:</p> <ol style="list-style-type: none"> 1) Provider spends enough time with family: 88% 2) Provider listens carefully to parents: 91% 3) Provider makes parent feel like a partner in child's care: 88% 4) Provider is sensitive to family's values and customs: 90% 5) Provider gives the specific information that family needs: 84%
<p>Percentage of families of CSHCN reporting problems obtaining referrals for needed specialty care</p> <p>23% (National Survey of CSHCN: NH)</p>		

Table CA-1: New Hampshire Capacity Indicators for CSHCN: 2005

ACCESSIBILITY	AFFORDABILITY	QUALITY
<p>Number of pediatric specialists and sub specialists and their geographic distribution in a State</p> <p>275 pediatric specialists 11 sub-specialties 33 pediatric sub-specialists</p> <p>In NH, Pediatricians (and Obstetricians) comprise 14% of the providers in the most rural tier, compared to 33% in the non-rural tier; there is less access to pediatric specialists that may be necessary for more complicated medical conditions. (Source: NH Rural Health Report, 2004)</p>	<p>3) SMS supports 10 child development and neuromotor clinics</p> <p>4) Other resources:</p> <ul style="list-style-type: none"> • Crotched Mountain Rehabilitation Center and School, Greenfield, NH • Cedarcrest, Inc., Keene, NH • The NH Department of Juvenile Justice Services • Easter Seal Society of NH • NH Area Agencies (developmental disabilities) • CHaD (Children's Hospital at Dartmouth, Lebanon, NH); 30 specialties; 8 specialty programs; 12 regional specialty sites • Private providers (# unknown) 	<p>Percentage of families of CSHCN who are satisfied with the services they receive</p> <ul style="list-style-type: none"> • 58% are satisfied with services received <p>Source: National Survey of CSHCN: NH</p> <ul style="list-style-type: none"> • 98% report satisfaction with staff courtesy and compassion • 80% reported that wait time was reasonable • Other: 95% Very satisfied and satisfied <p>Source: 2001 Program for Children with Neuro-motor Disabilities (Parent Survey):</p> <ul style="list-style-type: none"> • 81% always/usually thought provider was sensitive to values and customs • 78% report provider spent enough time <p>Source: 2004 NH Survey of Parents of CSHCN Receiving SSI</p>
<p>Number and geographic distribution of rehabilitative service providers for children.</p> <p>Varies widely per organization/geography</p> <p>Estimated all-not just children's providers (NH Employment Security 2003): Occupational Therapists: 570 Physical Therapists: 850</p> <p>Pediatric Physical Therapists: 30</p> <p>Primarily located in Concord, with several in the seacoast and southern areas; 1 or none located in the north or west</p>		

Table CA-1: New Hampshire Capacity Indicators for CSHCN: 2005

ACCESSIBILITY	AFFORDABILITY	QUALITY
<p>Percentage of children screened and determined eligible for publicly financed Early Intervention services who receive them; or number and geographic distribution of children on waiting list for Early Intervention follow-up services</p> <p>Number screened: 3372 (FESS Report, 2004)</p> <p>Percentage deemed eligible and received service: 82%</p> <p>No waiting list for follow-up services.</p>		<p>Cultural competency of providers serving CSCHN in new immigrant communities and other racial/ethnic minority groups</p> <p>For FY 04 and FY 05, over \$4,000 in SMS funding was available to Child Health Services, Manchester (through contracts) to provide: foreign language interpreters available for community-based care coordination, Child Development Program Network, and Neuromotor Disabilities Clinical Program (30% of funds were utilized)</p> <p>Other foreign language assistance:</p> <ul style="list-style-type: none"> • DHHS dedicated language phone service • DHHS reception phone lists to obtain interpreters quickly • DOE translators for 15 languages <p>Key organizations providing training and resources relevant to providers & families</p> <ul style="list-style-type: none"> • NH Minority Health Coalition • Manchester Cultural Diversity Task Force • Parent Information Center • Haitian Community Center of NH; other group-specific organizations • Immigration and Refugee Services, Manchester • NH LEND seminars/symposia

Capacity to provide family-centered community-based, coordinated care

SMS provides (through either state-based or contracted services) the following services for CSHCN and their families:

Child Development Services Network is a community-based approach to the provision of state-of-the-art diagnostic evaluation services to children from birth to 6 years of age suspected or at risk for altered developmental progress. The network is comprised of five Child Development Clinics contracted through local health agencies. The Dartmouth-Hitchcock Medical Center serves as both a local program and a tertiary referral center for children that are more complex. Although the University Center for Excellence in Disabilities at Durham does not receive supplemental Title V funding in addition to its federal MCHB LEND grant, it does participate as a Network provider serving the Seacoast region and submits service utilization data to SMS.

Pediatric Specialty Clinics (Neuromotor Disabilities) are supported to assist families to access community-based interdisciplinary services to evaluate children with complex medical needs. Neuromotor Clinics are supported in six sites in New Hampshire. Each clinic has a Medical Director and a Nurse Coordinator. Additional professional staff, appropriate to the condition, is specified for each clinic site. Consultant staff includes physical therapy, nutrition, psychology and developmental pediatrics.

The SMS **Nutrition, Feeding and Swallowing Program** offers community-based consultation and intervention services for families with CSHCN throughout the State. The program has developed statewide networks of contracted pediatric dietitians, and feeding and swallowing specialists to serve children who have nutritional or oral motor feeding issues. There are currently 14 Registered Dietitians and 5 Occupational/Speech/Language Therapists providing school and home-based services.

Each child and family enrolled in the Title V CSHCN program is provided an individual **Care Coordinator** who assists with management and follow-up of prescribed medical treatment and family support services. Care coordinators operate through the central office and two community sites. SMS Care Coordinators collaborate with other State systems and community agencies (e.g., Partners in Health, Beyond the Medical Home sites, Enhanced Care Coordination for Chronic Care, HMO coordinators) by sharing clinical expertise and information about available resources.

SMS contracts with two **Parent Organizations** that provide Level I Care Coordination (i.e., information and referral) and act as a resource to inform health professionals, policy makers and the broader community regarding the needs of CSHCN and their families. New Hampshire Family Voices works within community systems to promote family-centered policies and supports the needs of families through a comprehensive Website, lending library and newsletter. Upper Valley Parent-to-Parent Support Program offers a service matching families of newly diagnosed children with parent mentors, an interactive Website, and educational materials suitable for parents and professionals.

Psychology Consultation services (one contractor) are supported by SMS to facilitate community-based behavioral and emotional health services for CSHCN and their families. Services are provided via a triage model to families and schools. Assessment and referral is based on individual evaluations and observations of children at home and in school setting, and consultation with parents and involved professional providers. Treatment consultation may focus on coping with chronic illness and other behavioral and educational issues.

Financial support for direct care and enabling services provided by Special Medical Services is a significant component of the service system for CSHCN in New Hampshire. Table CA-2 summarizes expenditures remitted to vendors on behalf of SMS enrolled CSHCN from July 1, 2004 to June 30, 2005.

Table CA-2
SMS Expenditures for Direct and Enabling Services*
June 30, 2004 to July 1, 2005

<u>Provider/Vendor</u>	Notation	Amount Remitted
Dental Care		\$5,785
Pediatric Specialty Care		\$26,312
Pediatric Primary Care		\$2,456
Pharmacy	Including infusions and supplements	\$101,846
Hospital Costs		\$21,372
Laboratory Costs	Including radiology and anesthesia	\$9,114
Ambulance Services		\$1,338
Durable Medical Equipment	Including orthotics	\$118,363
Nutrition, Feeding and Swallowing Services	In addition SMS supported three nutritionists for infrastructure development (\$177,099-two contracts)	\$125,162
Psychologist/Behavioral Specialist	In addition SMS supported one psychologist for consultation services (\$52,125-one contract)	\$1,260
Physical Therapist	In addition SMS supported two therapists for specialty clinics (\$24,350-two contracts)	\$1,085
Visiting Nurse/Home Health Agency		\$8,867
Community Support Agencies	N.H. Partners in Health; Area Agencies	\$3,736
Parents	Direct payments to parents of CSHCN for health-related expenses	\$34,063
TOTAL		\$460,579

*Not inclusive of contracted services for specialty clinics and providers.

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. 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. Extensive efforts are made to contact these families and to assess their current needs, including application to SMS services. Referral is made to NH Healthy Kids (Medicaid/SCHIP) as appropriate, and information about the SSI denial appeals process is offered as indicated. Additionally, the Title V Health Care Financing Specialist (Ustinich) serves as the State SSI Liaison and is an active participant on the SMS/NHFV Health Care Financing Advisory Group. SMS disseminates periodic, family-friendly, material about SSI. Upcoming SMS informational material will include SSI updates applicable to CSHCN and their families. Based on the results of the NH CSHCN SSI survey SMS is planning to evaluate further the care coordination needs of CSHCN receiving SSI and Medicaid.

Family Support & Enabling Services

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 primary care centers increased by 38%. In the case of some categorical child health agencies, enrollment decreased by as much as 68% over the five year period, presumably due to increasing enrollments in NH Healthy Kids, the state's SCHIP, as well as the growth of the primary care centers. (DHHS, Maternal and Child Health Section (2005).

The decline in service utilization led MCH, in 2001, to pilot an alternative model for the use of Title V funds for child health services. Recognizing the continuing 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 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 provided through MCHB technical assistance 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 reassess 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 some 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 2006 Title V needs assessment will assist MCH in developing additional options for funding child health services at the local level and reassessing resource use and distribution.

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) 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 taught strategies to enhance their child's learning and development, and are supported as the first and best teacher for their child.

HVNH served over 700 pregnant women and their infants in SFY04 (NH DHHS MCH Section, 2005). As two thirds of the program sites are located in counties with higher than the state average poverty rates, the program is able to 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 that are embedded within each unique community.

Early Supports and Services

As a result of formal screening and clinical judgment, Title V contracted agencies refer families to local Early Supports and Services (ESS) providers. Each agency develops mechanisms to ensure speedy and accurate referrals. At the state level, Title V works closely with the Early Supports and Services administrator located within the DHHS, Division of Developmental Services. MCH and SMS staff participate in collaborative councils with Early Supports and Services, such as the Children's Care Management Collaborative, Early Childhood Comprehensive Systems Advisory, and the Developmental Disabilities Council. Additionally, efforts have been made to coordinate training opportunities for ESS and MCH home visiting front line staff at the state and local level.

Developmental Screening

All direct care child health and primary care agencies screen children for developmental delay and refer to specialty services as appropriate, though the screening tools used vary widely. MCH is collaborating with Easter Seals New Hampshire, SMS, and the New Hampshire Pediatric Society to apply for a one-year grant from the Vermont Child Health Improvement Program, funded by the Commonwealth Fund. This grant would expand New Hampshire's successful "Baby Steps" developmental screening project into a sixth Title V funded primary care agency and a Title V funded community-based support agency. This grant would not only develop an "Improvement Partnership" with public and private providers, including the state Medicaid Program, but also revive the previous efforts of the NH Pediatric Society to make recommendations on the use of up-to-date screening tools and train private medical providers in the new communities where the Baby Steps project will be offered.

Mental Health Services

A continuing gap in New Hampshire's health care infrastructure is access to mental health services. While community mental health centers are available in some regions, they cannot meet the demand for services. 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 health care 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. (CDC, National Survey of CSHCN, 2001).

The Division of Behavioral Health (DBH) 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 DBH has undertaken a comprehensive examination of financing and is committed to shifting resources to the children's mental health system and, in collaboration with DHHS and DOE, 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 child care providers for the families of behaviorally and medically complex CSHCN.

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. (NH DHHS, 1999) One urban and four rural New Hampshire 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 New Hampshire 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. (NH DHHS, Oral Health Survey, 2003) Similarly, the 2001 National Survey of CSHCN indicated that, while 83.5% of New Hampshire'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. (CDC, National Survey of CSHCN, 2001)

Since 2001, numerous improvements in the Medicaid oral health system have been realized, including increased reimbursements, streamlined claims processing, 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. In addition, five agencies across the state have DHHS contracts to provide dental operatories on behalf of children receiving Medicaid.

Accessibility for Special Populations

New Hampshire's population was 95.1% white and non-Hispanic in the 2000 US Census, but is steadily becoming more racially and ethnically diverse, with 78% of the state's minority populations residing in the three southernmost counties, 22% in the city of Manchester and 19.5% in the city of Nashua. (US Census Bureau, Census 2000 Summary File 1) Community health agencies in these counties are increasingly aware of the linguistic and cultural needs of minority populations. As mentioned in the overview, New Hampshire is home to more than 6,500 refugees with 80 % residing in the state's southern tier. New Hampshire 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. (Personal communication, NH Office of Energy and Planning, Refugee Section, May 2005) Among Manchester residents ages five and older, 19.6% spoke a language other than English at home, compared to 8.3% statewide. (US Census Bureau, Census 2000 Summary File 1) While these new residents experience a range of health issues such as nutritional deficits, parasitic infestations, and communicable diseases, maternal and child health issues predominate.

Achieving cultural competence is more difficult for agencies in rural and non-urban areas where numbers of minorities are smaller. Community-based health agencies are aware of the need for case management, outreach and interpretation services for this population and are working to develop capacity in this area. For example, at the Greater Nashua Health Center, where there is a large Hispanic population, efforts are made to recruit bilingual staff, trained in medical interpretation, in order to provide integrated, seamless services for minority clients.

Physical Barriers to Accessibility

New Hampshire, as a largely rural state has little infrastructure in public transportation. No municipality has a subway system, and only three municipalities have local public bus routes. AMTRAK runs through the southeastern part of the state, from Boston, MA, to Portland, ME, with only three stops in New Hampshire, in Exeter, Durham and Dover. In the northern areas of the state, there are no public transportation options. In response, several of New Hampshire CHCs have developed transportation assistance programs to aid their clientele in accessing medical care.

2. Affordability

The Uninsured

The US Census Bureau estimates that about 131,000 people in New Hampshire were uninsured in 2003. (US CENSUS, 2004) A 1999 New Hampshire Health Insurance Coverage and Access Survey estimated that 74% of uninsured children were eligible for, but not participating in, publicly sponsored programs such as Medicaid and SCHIP. Regional disparities were also found, with higher rates of uninsured in the northern and central eastern parts of the state. Yet, the four largest urban areas accounted for 70 % of uninsured individuals.

In 2001, the New Hampshire 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. (NH DHHS OPR, 2001) The New Hampshire state profile from the Data Research Center for CYSHCN (Indicator 3) reports that 14.5% of CYSHCN were without insurance at some point during the past year (pre survey), while 94.1% were insured at the time of the interview (Indicator 4). (CDC, National Survey of CSHCN, 2001, Version 2. Analysis Date: 2003)

The highest uninsurance rates in New Hampshire 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. (NH DHHS OPR, 2001)

Medicaid & SCHIP

New Hampshire's CHIP is a unique partnership between the NH DHHS and the New Hampshire 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 New Hampshire, 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. (NH DHHS, personal correspondence, May 2005) Of women obtaining prenatal care through Medicaid in 2003, 47.6% were enrolled in Title V funded prenatal programs (NHDHHS, DPHS, MCH CDF, 2003). These women are eligible for enhanced prenatal services including social services, nutrition, care coordination and client education provided during a home or clinic visit.

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.

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.

There is no complete information about the percent of private providers accepting Medicaid and SCHIP in New Hampshire. Information on provider availability is gleaned from licensing records and professional associations, which do not include information about practice policies, full-time or part-time status, or caseload. A survey of practicing physicians, nurse practitioners and physician assistants would narrow this informational gap, but such a study has never been undertaken in New Hampshire.

Uncovered Services & Barriers to Enrollment

NHHK estimates that, in its first 15 months of operation, CHIP reduced the number of uninsured children by one-third. (NH Healthy Kids Progress Report, Winter 2001) 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. (NH Healthy Kids <http://www.nhhealthykids.org/Reportspub.htm>, accessed June 16, 2005)

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, with few reporting unmet health care needs. 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.

3. Quality

Performance Management & Title V Funded Agencies

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. Performance measures are required for contracted community agencies. Agency performance is monitored over time and used in specialized Performance Management site visits to assist agencies in improving processes and outcomes.

MCH developed performance measures for local agencies in 2000; performance measures were selected using national and state standard measures from such sources as Healthy People 2010, Healthy New Hampshire 2010, HEDIS, and various federal funding agencies. Contract agencies are provided with performance measures and baseline data relative to the measure, and are asked to set targets, describe activities used to reach the targets, and outline evaluation plans. These workplans are submitted to MCH in advance of the upcoming contract year, with outcomes reported once the grant year is completed.

Local program data have now been collected for four years and are proving useful in monitoring agency performance and highlighting areas where program support is needed. See Appendix E: MCH agency performance measures, state and agency average, and agency ranges for SFY01 – SFY04. MCH will continue to work with community partners over the next several years to progress from performance measurement to performance management.

Community Health Center Customer Satisfaction

The Community Health Access Network (CHAN) is a regional collaboration of community health care organizations in New Hampshire, whose goal is to enable member health centers to serve vulnerable populations and maintain comprehensive range of health care services. As an integrated provider network, CHAN members collectively established common standards for the network in clinical protocols, operational policy, financial and information systems. Conditions of network participation focus on measured consistency in clinical quality, cost, patient satisfaction, and other delivery system components. Five of the ten MCH-funded community health centers are CHAN members.

CHAN member agencies participate in yearly customer satisfaction surveys using the ‘Opinionmeter’, surveying all patients seen at a site during a predetermined period. Survey questions include items on timeliness of visit scheduling, wait times, privacy, comfort, comprehension of information given, staff courtesy, overall satisfaction, and whether patients know how to reach a provider when the center is closed. The 2004 CHAN Opinionmeter survey found high markings for the five participating CHCs on almost all variables. Only in-office wait times, at 87%, and knowledge of how to reach providers when the center was closed, at 69%, fell below 90% levels. (CHAN, personal communication, June 2005)

Home Visiting New Hampshire Evaluations

Recent HVNH evaluations have shown that 34% of participants enter the 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's birth. At program entry, pregnant women were more likely to smoke than the state average, at 63%, but by delivery, the proportion had decreased to 33%. One compelling result of this evaluation was that over 90% of participants initiated prenatal care at the recommended time and over 95% received the recommended number of prenatal visits, significantly higher than state averages. (NH DHHS, MCH Section, unpublished HVNH Program evaluation data, 2005)

The goal of the HVNH Best Practices project was to determine the best practice in home visiting by quantifying the costs of providing these services, incorporating staff and client satisfaction and clinical outcomes. This project, completed in January 2005, provided extremely useful information on six home visiting agencies' programs. The results indicate that participants and staff are very satisfied with HVNH services. Clinical outcomes and costs varied dramatically. Adjusted costs for an episode of care from enrollment during pregnancy to the child's first birthday ranged from \$3,170 to \$10,710. Opportunities for cost reduction varied from 4% to 35%. The most significant drivers of cost included the percentage of non-direct clinical time, the time spent on the visit and associated functions, and the staff mix of home visitors and nurses. HealthMETRICS, the project contractor, developed twenty-two detailed recommendations for HVNH program sites that can improve the overall cost, quality and satisfaction of participants and staff. Some recommendations, such as determining the optimal time for visits and follow up, are transferable to other home visiting programs as well. (HealthMETRICS, 2004)

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, these 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. This 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. (The Access Project and The Cultural Imperative, funded by the Endowment for Health, 2004)

The OMBP 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. In SFY03/04, SMS allocated approximately \$5000 for interpreter services in contracts with the Child Health Services (CHS) Child Development Program Network, CHS Community Care Coordination of Hillsborough, Rockingham and Strafford Counties Special Needs Children, and the CHS Neuromotor Disabilities Clinical Program. SMS continues to fund interpreters for Child Development and Neuromotor clinics as needed. SMS has also translated its application for services 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. 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 for some groups, Title V programs are addressing other issues of cultural competence among MCH populations. These include homelessness, mental health/mental disorders, and substance abuse (addictive disease). One issue affecting overall 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 strengthen

the interdependence among cultural competence, improving health care service and quality, and eliminating racial/ethnic/disparities in health care.

4. Emerging Issues

Medicaid Modernization

New Hampshire, like other states, 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.

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. (NH DHHS, personal communication, June 14, 2005) As of August, 2004, 771 people had reached their 60-month time limit on TANF (NH Employment Security, 2005). An estimated average of 21 individuals will reach this limit each month during the coming year. (NH DHHS, personal communication, June 14, 2005) 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%. 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. (Annie E. Casey Foundation, 2003)

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 child care settings, leaving the remainder in unregulated settings or without care at all. As of September 2002, an average of 14.3 licenses child care opportunities existed per 100 children age 0-17. (Annie E. Casey Foundation, 2003)

In 2003, 64.9% of NH women participated in the labor force, seventh in the nation for this indicator. (NH Employment Security, 2002) This figure is likely to increase as TANF rolls decline. New work requirements will result in a burgeoning demand for quality child care and an increased need to support child care providers in the areas of health and safety and early childhood development. The MCH Healthy Child Care NH initiative is working to improve a key component of quality child care, health and safety in child care environments.

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. (GAO, 2002) It is estimated that up to 40% of women with welfare experience have children with special health care needs (Kaiser Family Foundation, 2003). Welfare parents with children with special needs are 33% more likely to lose a job involuntarily, due to the affects of the child's chronic illness. (AMCHP, 2003) 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. (National Council on Disability, 2003)

Federal Health & Social Services Funding Cuts

The proposed elimination of the Centers for Disease Control and Prevention's Preventive Health and Health Services Block Grant in Federal Fiscal Year 2006 is a matter of concern in New Hampshire, as a number of public health programs important to MCH populations are funded from this grant. The proposed cut to the Title V Block Grant threatens services as well. DHHS is currently examining whether there are other funding sources able to contribute resources to preserve at-risk programs, but the potential is slim. Oral health, injury prevention, and health promotion programs are all threatened by this possible loss of funding.

Newborn Screening

Scientific advances have resulted in the ability to screen newborns for a multitude of heritable disorders. In 2002, New Hampshire formed a Newborn Screening Program Advisory Committee (NSPAC) 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. At this point, it is expected that the bill will pass. The NSPAC continues to meet, next considering recommendations contained in the recently released ACMG report.

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 2000, 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 further 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.

The State Budget

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 some essential MCH services. A substantial increase to fund additional screening for heritable disorders in newborns is included.

B. Population-Based Services

1. Accessibility & Quality

Population-based programs are an essential element in improving the health of MCH populations. In New Hampshire, Title V staff work extensively with other state-level agencies and organizations to plan and implement population-based programming to address needs. Most pertinent to this review are the following core MCH programs: the Newborn Screening Program; the Early Hearing Detection and Intervention Program; the Childhood Lead Poisoning Prevention Program; and the Injury Prevention Program.

All of these programs strive to achieve cultural competence in serving their populations. The Early Hearing Detection and Intervention (EHDI) Program provides sign language interpreters for Advisory Committee meetings and other meetings when requested. They plan to have brochures and a resource book (when completed) translated into Spanish. The program utilizes EHDI materials available in Spanish through CDC, and materials developed by other states in additional languages. The Childhood Lead Poisoning Prevention Program (CLPPP) had most of their materials translated into Spanish and Bosnian (they were in the process of translating other languages but the funding was cut). Program staff had training in Cultural Competency provided by the Minority Health Coalition several years ago and have requested that Southern NH AHEC hold a training on cultural competency in Concord in the fall. In Manchester and Nashua, CLPPP nurse case managers work with interpreters (and help staff find interpreters) for home visits and inspections. The Injury Prevention Program provides bilingual staff, when available, at events such as child safety seat checks and hearing aids of some events for seniors.

Newborn Screening Program (NSP)

Newborn screening in New Hampshire is required by law, unless the parent or guardian objects. Fees for this screening are incorporated into global fees for delivery. Hospitals, birthing centers and home birth attendants all have the responsibility of assuring that each infant is screened. In 2004, 14,114 infants were screened for six conditions: PKU; hypothyroidism; toxoplasmosis; galactosemia; MSUD; and homocystinuria. In addition, targeted hemoglobinopathies screening for was performed on 5,464 infants. Presumptive positive screens for each condition were as follows: PKU – 14; hypothyroidism – 192; galactosemia – 5; MSUD – 15; homocystinuria – 21; and toxoplasmosis – 3. Thirteen disorders were confirmed; all received appropriate follow up. Based on calculations using 2003 Vital Records birth data and newborn screening data for that year, 99.7% of the newborns in NH (occurrent births) were screened for congenital anomalies (2003 is the latest birth data available).

Early Hearing Detection and Intervention Program (EHDI)

Newborn hearing screening in New Hampshire is performed in 23 of the 24 birthing hospitals in the state. Fees for this screening are included in global delivery charges and reimbursed by health insurance companies and Medicaid. In 2003, 91% of infants born in the state were screened. Initial hospital pass rates ranged from 76% to 100% in 2004. Of 645 infants who failed the initial screening, 42 infants received diagnostic evaluation. Time from screening to diagnosis of a permanent childhood hearing loss (PCHL) has improved; the average age of diagnosis with a PCHL in 2002 was 2.7 months, compared to 5.2 months in 2001 (2003 data not available).

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. Screening for elevated lead levels in children in New Hampshire is accomplished largely through health care providers in the course of health maintenance visits, and accessibility is therefore dependent on the availability of preventive care for children across the state. Two exceptions are in Manchester and Nashua, where the CLPPP has contracts with local health departments to provide outreach, case management, and health education for children at risk, including minorities and children with LEP. MCH promotes adherence to the national standards of screening children at age one and age two with its contracted agencies.

In 2004, the statewide initial screening rate for 12 – 23 month old children was 47.4%, while the rate for 24-35 month olds was 22.4%. All children with an elevated blood lead level living in rental housing receive an environmental screen for lead hazard, per statute. For those living in their own homes, the environmental screening is offered. All children receive case management services and health education.

Recognizing that the risk of lead poisoning is dependent on housing stock, and therefore varies geographically, the CLPPP has developed a plan to eliminate lead poisoning in New Hampshire

by 2010. This plan integrates the use of local workgroups in areas where higher levels of low income and pre-1950 housing elevate the risk of lead poisoning for children. Table CA-3 illustrates the relationship between screening rates for 1 and 2 year olds in high-risk geographical areas, as well as the state overall.

**Table CA-3: New Hampshire Childhood Lead Poisoning Prevention Program
2002/2003 Blood Lead Screens**

Town	Family Income <= 200% FPL (%) **	Pre-1950 Housing (%) *	Age Group	2002 Screens		2003 Screens	
				Initial Screening Rate***	Confirmed Elevations/Total Children Screened	Initial Screening Rate***	Confirmed Elevations/Total Children Screened
Berlin	33.2%	69.0%	12-23 mos	94.8%		80.9%	
			24-35 mos	77.5%		71.6%	
			0-72 mos		1.2%		1.7%
Claremont	27.9%	49.7%	12-23 mos	66.8%		58.7%	
			24-35 mos	52.9%		61.9%	
			0-72 mos		4.6%		1.8%
Newport	31.8%	41.6%	12-23 mos	100.0%		80.3%	
			24-35 mos	59.1%		63.6%	
			0-72 mos		3.5%		0.8%
Franklin	35.6%	50.9%	12-23 mos	49.6%		41.1%	
			24-35 mos	23.4%		25.0%	
			0-72 mos		10.0%		6.7%
Laconia	27.8%	44.8%	12-23 mos	42.7%		38.8%	
			24-35 mos	18.7%		10.5%	
			0-72 mos		3.1%		11.7%
Manchester	25.9%	43.8%	12-23 mos	61.0%		67.6%	
			24-35 mos	41.7%		39.2%	
			0-72 mos		3.3%		3.9%
Nashua	18.8%	25.8%	12-23 mos	44.0%		50.3%	
			24-35 mos	23.5%		24.3%	
			0-72 mos		0.6%		1.2%
All Other Towns	17.6%	11.6%	12-23 mos	48.1%		46.1%	
			24-35 mos	35.8%		35.2%	
			0-72 mos		1.5%		1.5%
NH Total	19.0%	14.4%	12-23 mos	48.7%		47.9%	
			24-35 mos	25.8%		25.3%	
			0-72 mos		1.9%		2.0%

†Berlin, Claremont, Franklin, Newport, Laconia, Manchester, and Nashua are communities with local coalitions.

* US Census, 2000

** Federal poverty level =\$13,290 for 3 person household, source:US Census 2000

200%FPL = \$26,580 for 3 person household,

MCH uses <=200% FPL as eligibility criteria for many programs

*** Screening rate includes one test per child per year

NOTE:The screening numbers include all screens, capillary and venous

The percentage of children screened for lead in NH (Table CA-3) decreased slightly from 2002 to 2003. The decrease in screening percentages over this period that occurred in several NH towns may be due to the following:

- CLPPP analysis used U.S. Census denominator data from 2000, which is getting less and less accurate.

- The difference in percentages might also reflect the small population and therefore, small numbers of children screened in some towns. In a town the size of Newport, for example, having two more one year olds screened could have a large effect on the percentage.

The NH CLPPP has changed the parameters of the age categories in its surveillance data to more closely match CDC surveillance data. Instead of using 6-17 months to group "one year olds", they are now using 12-23 months to classify one year olds; instead of using 18-29 months for "two-year olds", they are now using 24-35 months.

Injury Prevention Program (IPP)

The New Hampshire Injury Prevention Program (IPP) is located within the Maternal and Child Health Section within the New Hampshire Department of Health and Human Services. The IPP aims 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 statewide Injury Prevention Center at Dartmouth, and is the liaison with the state's Poison Control Center contractor. The 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. Major activities of the Injury Prevention Program include:

- Educating the public and others about the scope and major causes of death and disability from intentional and unintentional injuries;
- Identifying and implementing effective prevention programs and strategies
- Collaborating with private and public sector stakeholders to increase the effectiveness of Injury Prevention Program work;
- Enhancing effective public policies to reduce injuries

Much IPP work is done in collaboration with the Injury Prevention Center (IPC) at Dartmouth Hitchcock Medical Center and the New Hampshire Coalition against Domestic and Sexual Violence (CADSV). These three entities collaborate with partners throughout the state to: provide training and technical assistance to professionals and the public; advocate for policies based on the best available science and data; promote and implement effective prevention programs; and evaluate the impact of these activities. The overall program design focuses on integrating injury prevention and control activities into existing health care and other community based services.

The bulk of the IPP and its partner agencies' effort is the identification of prevention strategies with demonstrated effectiveness. These then become strategies that can be recommended to local or regional initiatives. Providing "train the trainer" programs is also essential in building statewide injury prevention infrastructure and facilitating program replication at the local level.

As a program with limited resources, the IPP and its partners seek to create and lead collaborations among agencies and individuals interested in specific injury topics. Programmatic

and fiscal synergy is often an outcome of these collaborations, as interested parties complement one another's resources and expertise. Currently, the IPP, IPC, and/or the CADSV convene the following groups: the NH Falls Risk Reduction Task Force; NH SAFE KIDS; the Injury Prevention Program Advisory Committee; the Statewide Child Passenger Safety Program; the NH Firearm Safety Coalition; the Youth Suicide Prevention Assembly; the Teen Motor Vehicle Legislative Workgroup; the Booster Seat Advisory Committee; the Governor's Commission on Domestic and Sexual Violence, Survey and Prevention Committees; the Domestic Violence Health Leadership Initiative; Buckle UP NH; and the NH Media Violence Coalition. All three agencies are also working members of additional coalitions with injury prevention related missions.

The Northern New England Poison Center serves New Hampshire, Maine and Vermont, and is operated through a contract. The coordinator position is located in the MCH Section and the Injury Prevention Program provides the link to public health. During the period July 1 through December 31, 2004, the center received 32,694 calls, an average of 180 calls per day.

C. Infrastructure-Building

The bastion of New Hampshire'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 Office of Medicaid and Business Policy, the health planning and reporting and medical assistance arm of DHHS, is dedicated to the identification of NH's health care and social service needs through assessment of health care and social services delivery systems. In order to methodically evaluate New Hampshire's infrastructure – building capacity, Title V staff selected the Capacity Assessment for State Title V (Cast – 5) model developed through MCHB.

1. CAST- 5

Background

Plans to use CAST-5 were initiated jointly by Title V leadership – MCH in the DPHS and the Children with Special Health Care Needs (CSHCN) program, Special Medical Services (SMS), in the OMBP. The primary impetus for using CAST-5 was the comprehensive needs assessment. The fact that New Hampshire's Title V program had never undergone a structured capacity assessment, coupled with a recent reorganization within DHHS created an opportunity to come together across programs to review capacities and develop strategies to maintain and strengthen essential services. Through federal MCHB technical assistance, a health policy consultant (Catherine Hess) assisted New Hampshire in this process.

Given the purpose and goal of the CAST-5 process, New Hampshire decided to implement all of its components to get a comprehensive picture of essential services performance and capacity needs. New Hampshire leaders worked with the consultant to complete CAST 5 in 3 total days, with one two day meeting in November and a second one day meeting in December, 2004.

Approximately 40 individuals participated in CAST-5 over the course of the meetings, including staff from multiple programs within MCH, representative SMS staff, several senior leaders and representatives of higher levels within DHHS, several representatives of community based agencies, and parents.

Context for Capacity Assessment

CAST-5 participants brainstormed collective responses to a set of core questions about New Hampshire's vision, mission, goals and strategies, as well as priority health issues for women, children and youth and the environmental factors influencing issues and strategies. Each major MCH/SMS program area is in some stage of answering these questions, but CAST-5 represented an opportunity for participants to share more overarching views on these important questions. The status or results of these processes were shared briefly with CAST-5 participants in discussion and in handouts included in meeting packets. With these program frameworks in mind, the entire group of participants brainstormed and shared answers to four of CAST-5's core questions.

While MCH has been meeting to discuss vision and goals, the Childhood Lead Poisoning Prevention Program recently developed a plan with goals, and SMS has identified five priority goals and is developing related policies and procedures, no comprehensive, broad vision exists for Title V programming in New Hampshire. CAST-5 participants discussed themes fundamental to such a vision. The basic goals of a better quality of life and improved health for all women and children were identified, as well as the need to be ethics-based and good stewards of public funds. Strategies to achieve these goals included: being data and evidence based; using best practices and family centered approaches; promoting access to health care; connecting people with resources; capacity building to fill gaps; and assuring quality of services. Strong and broad partnerships with communities, developing public health capacity in communities, and integrating children and youth with special needs into health systems were identified as well.

Priority health issues and desired population health outcomes were discussed. In addition to those emerging issues outlined earlier in this section, the following areas were noted:

- Community knowledge of MCH issues and poverty
- Family health
- Health services systems
- Health promotion and prevention
- Women's health
- Screening and early identification
- Environment for addressing priority health issues

Numerous environmental factors were discussed as they relate to the Title V goals. New Hampshire, a state with a culture of emphasizing personal responsibility, is the third wealthiest state, but rates 49th in philanthropic giving. New Hampshire lacks a broad-based tax and the state deficit is currently estimated at \$330 million. The state's longstanding educational funding crisis makes it difficult to focus on other issues facing the state. The changing demographics of the state, with the population in the southern part of state growing; increasing diversity; aging population; and the increased survival of CYSHCN and individuals with chronic conditions will affect Title V needs in the years to come. Internal barriers or areas needing improvement

included communication among program “silos”. Reorganization was seen as a cause of stress, but also as creating opportunities for inter-departmental partnerships. Certain priorities (such as education, Medicaid) dominate, which can leave Title V in crisis mode.

The group outlined several overarching themes as critical macro-level strategic directions for the Title V program:

- Identify Title V’s specific/unique role
- Be proactive with the media
- Enhance community partnerships (information loop)
- Better use data to make decisions for funding and policies/programs
- Understand/use social marketing
- Inform/educate state legislators to promote a public health partnership approach
- Have a consistent/deliberate approach to Quality Improvement
- Support partners in building infrastructure to collect and use data
- Identify strategic alliances, such as with health insurance companies, foundations
- Streamline and improve systems of care
- Strategically use resources and have realistic expectations

The CAST 5 group did not address the last core question regarding programmatic organizational strategies to implement strategic directions, as MCH and SMS specific program plans will be reviewed and developed in the context of the comprehensive Title V needs assessment. Some component programs, including lead poisoning prevention and injury prevention, have recently developed plans and/or logic models.

Indicator Ratings & SWOT Analysis Themes

Results from rating indicators for each of the ten MCH essential services provided a detailed picture of levels of adequacy in performing these core public health functions relative to New Hampshire’s desired level of performance. The CAST-5 tools ask participants to rate performance of a set of indicators for each essential service on a scale that ranges from minimally, to partially, to substantially, to fully adequate. Participants are asked to rate performance relative to where they want their state MCH/SMS system to be. For New Hampshire, the ratings were to reflect the overall performance of the MCH/CSHCN system, so that both strengths and weaknesses of specific programs and activities had to be considered in coming up with a consensus on an overall rating for that essential service. The detailed indicator ratings for each Essential Service are presented in Appendix F.

Although participants were instructed not to reserve the rating “Fully Adequate” for near perfect performance, New Hampshire participants were reluctant to rate themselves this highly against what they want to achieve for the women, children and youth in their state. Therefore, the ratings were almost entirely in the Minimally, Partially or Substantially Adequate Categories. New Hampshire’s overall Title V system seemed to be strongest in the following Essential Services:

- #5: Provide leadership for priority setting, planning, and policy development to support community efforts to assure the health of women, children, youth, and their families.
- #6: Promote and enforce legal requirements that protect the health and safety of women, children and youth, and ensure public accountability for their well-being.

- #2: Diagnose and investigate health problems and health hazards affecting women, children, and youth.
- #8: Assure the capacity and competency of the public health and personal health workforce to effectively and efficiently address maternal and child health needs.

In the mid-range were Essential Services:

- #7: Link women, children and youth to health and other community and family services, and assure access to comprehensive, quality systems of care.
- #4: Mobilize community partnerships between policymakers, health care providers, families, the general public, and others to identify and solve maternal and child health problems.

In the lower tier were Essential Services:

- #1: Assess and monitor maternal and child health status to identify and address problems.
- #3: Inform and educate the public and families about maternal and child health issues.
- #9: Evaluate the effectiveness, accessibility, and quality of personal health and population-based maternal and child health services.
- #10: Support research and demonstrations to gain new insights and innovative solutions to maternal and child health-related problems.

Specific issues and ideas related to performance of each essential service were identified as strengths, weaknesses, opportunities or threats (SWOT). Additionally, significant themes in this detailed SWOT were identified. Strengths identified included evolving capacity for data analysis, collaborative relationships, strong contract mechanisms, and diverse strengths and expertise in staff across programs. Weaknesses included limited and strained staffing, inefficient agency level processes, data access issues, and uneven and limited local infrastructure and capacity. Threats identified by CAST-5 participants included aspects of the culture that conflict with some public health approaches, budget limitations and cuts, and major policy changes in Medicaid. Many opportunities to build on strengths and improve areas of weakness were identified in areas including data analysis, contracting, information dissemination, and community capacity and relationship building.

Capacity Needs & Action Plans

The CAST-5 Capacity Needs tool identifies 28 capacity needs in four areas: structural resources; data and information systems; organizational relationships; and competencies. The participants in the December CAST-5 meeting discussed each of the 28 needs, and agreed on whether New Hampshire generally does or does not have significant needs for each area. Participants also specified topics related to each particular need. The results of this process for all 28 Capacity Need areas are in Appendix G. Just over half of the areas, 15 of the 28, were assessed to be needs in New Hampshire.

In order to narrow down the list of identified capacity needs, participants identified criteria to utilize in setting priority areas for developing action plans. The criteria for priority setting identified by the group were:

- Amenable/possible to change in the context of changing demographics and the political environment
- Possible to address in a five year time frame
- Magnitude of need
- Potential impact on desired outcomes
- Potential to have impact on other capacities/needs (secondary effects)

Using the dot method, participants initially cast 5 votes each for one or more of their top priorities. This initial prioritization yielded the following results:

- #1. Sufficient Authority & Funding (13 votes)
- #5. Workforce capacity (institutionalized, including job descriptions, contract language, performance assessment, etc.) (13 votes)
- #10. Adequate data infrastructure (13 votes)
- #23. Ability to influence policymaking process (12 votes)
- #25. Management/organizational development skills (11 votes)
- #21. Communication/data translation skills (7 votes)
- #27. Data and analytic skills (7 votes)
- #8. Access to timely data (6 votes)
- #2. Routine, two-way communication channels or mechanisms with constituencies (6 votes)
- #12. Relationships with other state agencies (5 votes)
- #14. Relationships with local providers of health & other services (5 votes)
- #9. Supportive environment for data sharing (3 votes)
- #6. Mechanisms for accountability & quality improvement (3 votes)
- #13. Relationships with insurers/insurance oversight stakeholders (1 vote)
- #20. Relationships with businesses (0 votes)

In reviewing these results and preparing for a second vote to determine the top three priorities, the group decided to combine capacity needs related to data. A participant suggested and the group agreed that the needs in this grouping shared a common focus that could be addressed with similar strategies, and that keeping them separate might dilute their importance. Participants were then given another 3 dots and asked to vote for one or more of the top 7 priorities (with #s, 8, 9, 10 and 27 related to data combined as one). The results of this vote were as follows:

1. Data access, environment, infrastructure and competencies (17 votes)
2. Ability to influence the policymaking process (14 votes)
3. Workforce capacity (institutionalized, including job descriptions, contract language, performance assessment, etc.) (10 votes)
4. Management/organizational development skills (8 votes)
5. Routine, two-way communication channels or mechanisms with constituencies (4 votes)
6. Relationships with other state agencies (1 vote)
7. Communication/data translation skills (1 vote)

In preparation for developing initial action plans for the top priorities, the group decided to address management and organization skills as part of efforts to improve workforce capacity.

The three top priority areas were selected for developing action plans: (1) data access, infrastructure, environment and competencies; (2) ability to influence the policy making process;

and (3) institutionalize workforce capacity through policies and programs (including management and organizational development skills). Initial action steps were identified and assigned lead staff and timelines.

Follow-up and Accountability

MCH and SMS leadership committed to working together to support and follow up on action steps. Staff at all levels, across programs, will be leading or participating in further development of strategies, and in implementing action steps such as a review of all position responsibilities.

MCH and SMS management agreed to be accountable for overall leadership and monitoring to assure follow-up on the results of CAST-5. Specifically:

- MCH and SMS management will monitor and assure support for initiation and completion of agreed upon action steps.
- MCH and SMS management will meet together prior to submission of the Title V block grant application to examine jointly budget and workforce needs in the context of CAST-5 and needs assessment results.
- MCH and SMS management will follow-up on possible joint actions such as shared staffing and joint recommendations for departmental action.

Finally, MCH and SMS management agreed to reconvene staff across programs in the fall of 2005, and annually thereafter. Following the federal review and feedback on the Title V MCH block grant application, this meeting will be an opportunity to review progress and make any necessary adjustments in plans to build capacities needed in New Hampshire to assure the health of women, children, youth and families.

2. Individual & Organizational Assets

The MCH and SMS Sections worked closely together and with stakeholders during this needs assessment. MCH and SMS staff were part of the Title V Needs Assessment Team that met regularly throughout 2004-2005 to plan and produce the report and the meetings to obtain public input. Stakeholders were involved throughout the process. As described in other sections of this report, information was obtained from local community hospitals on perceived needs, as well as through surveys of families of CSHCN and health care providers. Preliminary findings were presented to stakeholders at several public meetings over the past year.

New Hampshire'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.

Title V staff participate in numerous state-level committees and Legislative workgroups, such as: the Governor's Commission on Sexual and Domestic Violence, the Governor's Domestic Violence and Child Fatality Review Committees, the Governor's Traffic Safety Commission and the Perinatal Alcohol, Tobacco, and Other Drug Use Legislative Task Force. Title V staff are also participants in or leaders of an extensive array of advisory committees, Boards, workgroups,

and coalitions. (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.) For the purposes of this assessment, Title V gathered information on these assets from various sources, including previous grant applications and the environmental scan for early childhood, combining these to make a master list of assets. This worksheet was reviewed by each Title V program area to ensure that all partners and potential collaborators were included. See Table CA-4: the completed Worksheet 1: Organizational Assets, below. For more extensive descriptions of Title V partnerships, please refer to Section III E of the Block Grant application and annual report.

MCH staff will edit the needs assessment report and prepare it for public release, making it available to stakeholders through the DHHS website, the State library, and DHHS District offices. MCH will notify stakeholders who attended the March 2005 meeting, as well as contracted health care agency directors and others, of the report release, major findings, and its availability on the DHHS website.

State Systems Development Initiative (SSDI)

The State Systems Development Initiative (SSDI), housed in the MCH Section, is improving data capacity through linking data sets with infant birth and death registries. A major goal is to link birth certificate and Newborn Screening Program data to assure 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. The linked data systems will dramatically increase MCH capacity to plan and evaluate programs and will greatly contribute to future needs assessments.

The SSDI Program Manager coordinates the recently formed Data Team, which also includes the MCH epidemiologist, QA Nurse, Program Evaluation Specialist and MCH Director. The Data Team was formed to improve MCH evaluative capacity. This past year, work focused on the needs assessment and improving data collection from local programs. Priorities for the coming year include implementing the Data Action Plan developed through the CAST-5 process and creating a systematic approach to data through business planning.

Table CA-4: WORKSHEET 1. ASSESSMENT OF CURRENT AND POTENTIAL ASSETS FOR MCH SYSTEMS BUILDING

POPULATION						
Categories of Assets	Names	Current or Potential Asset	Strength of Current working relationship? (high, medium, low)	Perceived strength of interest in MCH issues? (high, medium, low)	How can asset help build MCH systems?	What steps are needed to mobilize/further engage this asset?
A. Partnerships/ Collaborations	Preschool Technical Assistance Network (PTAN)	C	M	H	Support for all EC initiatives	Continue collaboration
	NH Institute for Health Policy and Practice	C	H	H	MCH Epidemiologist Contract	Continue to renew contract
	Kids Sight	C	L	M	Provides local community services as MCH program decentralizes	Participates on MCH Preschool Vision Screening Program Advisory Committee
	Regional Infant Mental Health Teams (IMH)	C	M	H	Continued resource for disseminating information about early childhood development and parent child attachments.	Continued participation in braided funding IMH Teams are participating in Early Childhood Comprehensive Systems (ECCS) planning
	Breastfeeding Task Force	C	L	H	Helps support Title V efforts to increase breastfeeding rates	Link Task Force activities more with Title V funded programs
	Family Support NH	L	L	M	Networking organization of family resource centers	Increased participation of Title V staff in planning and networking.
	Early Education & Intervention Network	C	H	H	Provides information and support for best practices for professionals in early intervention and EC	Continue collaboration

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POPULATION						
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	Early Learning NH (ELNH)		H	H	Independent organization of family and center based child care providers that promote public awareness of child care and early learning issues.	Continued participation of the Healthy Child Care NH coordinator on the ELNH Advisory Board.
	NH Childcare Resource & Referral Network	C	H	H	Disseminate information to child care providers through workshops, newsletter, Bridge relationships with child care providers and DPHS	More resources, both hard dollars and personnel time to focus on health and safety issues
	Adolescent Health Coordinators Network	C	M	H	Learn from other state Adolescent Health Programs	Participate regularly in conference calls and other activities organized by the network
	Safe Kids	C	H	H	Support for all unintentional injury issues related to children	Continue collaboration
	Manchester Child Care Committee	C	H	H	Are a connection with child care providers and grass root community for dissemination of information	The Healthy Child Care Consultant used to sit on this committee but stepped down due to program resources allocation, that is the program does not have enough personnel time to be on each city's child care council and thus can not justify being on just Manchester's committee.

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	Youth Suicide Prevention Advisory Assembly (YSPA)	C	H	H	YSPA coordinates prevention and intervention training, collaborations, and implementation of the state plan.	YSPA is fully engaged and MCHS staff attends meetings and actively participate in project work groups.
	Rural Health Care Consortium	P	L	L	Employs a number of Physicians and other providers. Data and infrastructure to help more people.	Identifying common needs and goals
	Firearms Safety Coalition	C	H	H	Support for injury prevention initiatives	Continue collaboration
	New England Regional Genetics Group	C	M	M	Utilize NERGG's resources in program expansion	Continue participation in NERGG activities
	New England Injury Prevention Network	C	H	H	Support for injury prevention initiatives	Continue collaboration
	Buckle Up	C	H	H	Support for injury prevention initiatives	Continue collaboration
B. Advisory Committees/Task Forces						
	Newborn Screening Program Advisory Committee	C	M	H	Utilize committee in program expansion efforts	Continue to engage committee members in issues related to program
	Early Hearing Detection and Intervention Program Advisory Committee	C	H	H	Members provide input into improving delivery of EHDI program services	Continue to engage committee members in issues related to program
	Preschool Vision & Hearing Screening Advisory Committee	C	M	H	Utilize committee in developing and carrying out program changes	Continue to engage committee members in issues related to program

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	Residential Transition Task Force	C	H	M	Developing a system to transition CSHCN into community	Continued meetings
	510 Abstinence Advisory Committee	C	H	M	Advises the Program on activities and perceived educational needs of communities.	The committee is fully engaged and acts as a bridge to abstinence- only educators
B. Advisory Committees/Task Forces Con't	Injury Prevention Advisory Committee	C	H	H	Supports and advises on all injury prevention initiatives	Continued collaboration and facilitation
	ECCS Early Childhood Stakeholders (Advisory Group)	C	H	H	Advises and participates in the development of a Comprehensive Plan for Early Childhood Systems	Continued participation as a whole and as smaller groups organized around particular early childhood domains.
	Family Assistance Advisory Group	C	H	H	Reviews policy and implementation issues regarding the TANF program. Family Planning receives funds through TANF and participates in the group.	FP continue to participate in this Council and facilitate two way information interchange
	Child Care Advisory Council	C	M	H	Council advises how to spend federal monies on state child care issues	Continued participation of HCCNH Coordinator. Facilitate filling MD position on the council
	Governor's Commission on Sexual & Domestic Violence	C	M	H	Provides policy advice to the governor on issues related to sexual and domestic violence	Assure that information from the committee is appropriately shared

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B. Advisory Committees/Task Forces Con't	Governor's Domestic Violence Fatality Review Committee	C	L	M	The group addresses women's safety through recommendations to the appropriate state agency.	Have staff member appointed to the group by HHS Commissioner.
	Governor's Traffic Safety Commission	P	L	L	Could support mv work of injury prevention program	Get ourselves appointed
	Legislative Committee on Perinatal	<u>P</u>	M	H	The Legislative body has suspended the Committee.	Legislature must appoint members. There are no further steps MCHS can take at this time.
	Brain and Spinal Cord Injury Advisory Committee	C	H	H	Support for injury	Continued participation
See above	Childcare Advisory Council					
	Childhood Lead Poisoning Prevention Program Advisory Committee	C	H	H	Support for healthy environments for young children	Continued participation
	Council on Children and Adolescents with Chronic Conditions	C	H	H	Legislature appointed family support organization	Continue collaboration on issues for CSHCN
	Covering Kids Coalition	C	M	H	Provide funding to support local communities' infrastructure	Continue to participate on this coalition and share activities and findings with other Title V funded agencies
	Family Planning Advisory Committee	C	M	H	Build community visibility and value for Family Planning services	Continue to engage members
	Family Planning Community Educators workgroup	C	H	H	Professional development of educators as the community spokespersons for Family Planning	Continue to identify and support community linkages for community educators

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POPULATION						
Categories of Assets	Names	Current or Potential Asset	Strength of Current working relationship? (high, medium, low)	Perceived strength of interest in MCH issues? (high, medium, low)	How can asset help build MCH systems?	What steps are needed to mobilize/further engage this asset?
C. Other Public Agencies and Interagency Groups	Family Resource Connection	C	M	M	Connects families and professionals throughout NH with literature, resources and materials regarding early care and learning	Continued Title V financial support as part of the braided funding stream that supports the FRC.
	Health Data Users Group	C	M	M	Data capacity and collaboration	Regularly attend and participate in meetings and subgroups
	Healthy NH 2010	C	L	M	Share data with participants and participate in HP workgroups	Continue activities in NH HP2010 workgroups
	Health Statistics Section	C	H	H	Data capacity – provide vital records data and TA	Continue collaboration
	STD/HIV Prevention Program	C	H	H	Integration of STD/HIV services within Primary Care or Family Planning	Continue collaboration
	Infertility Prevention Project (Chlamydia Prevention)	C	H	H	Early public health intervention to prevent STD within Family Planning	Collaboration with private providers
	Tobacco Prevention Program	C	M	M	Provides expertise in tobacco use prevention and cessation. We can build on their coalitions to advance other adolescent or MCH activities such as positive youth development.	Continue and strengthen our existing partnership
	WIC Nutrition Services	C	M	H	Utilize WIC data and activities with Title V funded programs	Schedule routine meetings with WIC to facilitate relationship and improve communication

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C. Other Public Agencies and Interagency Groups Con't						
	Oral Health Program	H	H	H	By bringing dental providers into MCH activities	Incorporation of Oral Health in all MCH discussions
	Child Health Month Coalition	C	H	H	Develops/distributes annual health and safety information packet	Continue to chair and participate in the coalition
	Children's Care Management Collaborative	c	H	H	A collaborative with representation across DHHS and DOE created to build a system of care for children's mental health needs	Continue to have MCH and SMS representation on the CCMC. Continued collaboration with ECCS activities.
	State Child Health Insurance Program (SCHIP) and NH Healthy Kids Program	C	M	H	MCH works with Title V funded agencies to get low income children enrolled on SCHIP	Continue to work with NH Healthy Kids and SCHIP staff to facilitate local agencies enrolling children
	Dental Program (Medicaid)	M	M	L	By bringing dental providers into MCH activities	All non-dental providers to perform prevention OH interventions for high risk children

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	Region I Women's Health Workgroup	C	H	H	Acts as policy forum on issues impacting women's health in general as well as special populations. Provides education on emerging issues in women's health.	Continue participation and share information gathered with MCH partners and agencies as appropriate. Continue to follow up on initiatives such as Women's Health Week.
	Association of MCH Programs (AMCHP)	C	M	H	National level advocacy and technical assistance	Faster engagement With other NH MCH staff and continue current level of collaboration.
	Healthy Child Care NH (HCCNH)	C	H	H	Promotes health and safety in out-of-home child care settings by linking health professionals, community and state agencies, child care providers and families.	Continue to support HCCNH activities through NH ECCS efforts
	Birth Data Quality Group	C	L	H	Address quality issues in Birth Data	More regular participation and build relationships
D. Higher Education Institutions	Leadership Education in Adolescence (LEAH)	C	M	H	TA assistance MCH staff & providers' training	Continue to attend LEAH trainings, plan a training in Adolescent Health for NH providers

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	UNH School of Health and Human Services (Nursing, Health Management and Policy, MPH Program)	C	M	M	Interns	Build relationship with internship coordinators
	University of NH School of Nursing	This is listed above under SHHS				
D. Higher Education Institutions Con't						
	Education Development Center, Inc.	C	H	H	Support for injury prevention initiatives	Continued collaboration
	Cooperative Extension Service	C	M	H	Science based education on topics of interest to target population. Potential for shared programs	Maintain current relationships (e.g. through family planning advisory group). New relationships and potential for shared programs can be explored
	University of Massachusetts Medical School/ New England Newborn Screening Program	C	H	H	Contracts to provide lab services for newborn screening	Continue to attend meetings and utilize staff in program expansion plans
	Harvard School of Public Health Injury Prevention Research Center	H	H	H	.	Continue to work with them and possibly retain an intern.
	Center on Adolescence (UNH)	C	M	M	Health the implementation of the Adolescent Health Strategic Plan	Continue partnership with UNH Center on Adolescence/ identify and mobilize resources for the implementation of the Strategic Plan

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Categories of Assets	Names	Current or Potential Asset	Strength of Current working relationship? (high, medium, low)	Perceived strength of interest in MCH issues? (high, medium, low)	How can asset help build MCH systems?	What steps are needed to mobilize/further engage this asset?
D. Higher Education Institutions (CONT.)						
	NHTI Dental Hygiene Program	C	M	M	By training/allowing dental auxiliaries to provide preventive OH services to MCH population while augmenting dwindling dental workforce	Continue to provide public health education at NHTI defining need for OH services by the MCH population that has only limited access to dental services and encourage students to enter public health
	Child Find Initiative	C	L	M	Provides local community services as MCH program de-centralizes	Participates on MCH Preschool Vision Screening Program Advisory Committee
	Leadership Education in Neurodevelopmental Disabilities (Dartmouth/UNH)	C	H	H	Provides advanced training to health care professionals	Continue support and collaboration
E. Individuals						
	Karen Carpenter- NH Children's Trust Fund	P	L	M	By recognizing rampant dental disease left untreated as a form of child neglect	Continue to remind NHCTF that this is an issue of neglect that affects many children
	Endowment for Health	P	H	H	By focusing public interest and funds on MCH issues	Invite reps from EFH to MCH workshops to educate them about what we are doing for the MCH pop.

Table CA-4: WORKSHEET 1. ASSESSMENT OF CURRENT AND POTENTIAL ASSETS FOR MCH SYSTEMS BUILDING

POPULATION						
Categories of Assets	Names	Current or Potential Asset	Strength of Current working relationship? (high, medium, low)	Perceived strength of interest in MCH issues? (high, medium, low)	How can asset help build MCH systems?	What steps are needed to mobilize/further engage this asset?
F. Voluntary Associations/CBO's						
	Public Health Information Network (PHIN)	P	L	H	Integrating MCH concerns into local public health infrastructure	Work toward increasing communication with network partners
	Easter Seals –Baby Steps	C	M	H	Provides screening to dome Title V funded health centers; assists in early identification/screening/referrals	Apply for funding to expand to other community health center sites
	NH Opthamological Assoc	C	L	M	Participates in Preschool vision & Hearing Screening Advisory Committee	Engage in Advisory Committee activities
	NH Optometrist Assoc	C	L	M	Participates in Preschool vision & Hearing Screening Advisory Committee	Engage in Advisory Committee activities
	Dept. of Education	C	M	H	Shares MCH activities and info. as appropriate, with school nurses Bring MCH perspective in the Coordinated School Health Plan (to be developed)	-Continue sharing information and collaborate on projects as appropriate -Strengthen existing relationship with DOE -Build an active new partnership with the SBHC*
	Head Start	C	M	H	Participates in Preschool vision & Hearing Screening Advisory Committee	Engage in Advisory Committee activities
	Community Health Access Network	C	M	H	Data Collection	Money, increase collaboration with communities and MCH

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F. Voluntary Associations/CBO's Con't						
	Nurse Practitioner Association	P	L	L	Share information with and engage support of mid-level providers in carrying out Title V MCH activities and public health efforts	Cultivate relationship with the Association and better utilize its list serve to communicate
	Dental Hygienists Association	P	M	M	Increase provider numbers	Make sure they have a representative at state wide meetings
	American Academy of Family Practitioners	P	L	L	Share information with and engage support of members in carrying out Title V MCH activities and public health efforts	Cultivate relationship with the organization
	Encare (Emergency Nurses)	C	L	L	Support for injury prevention initiatives	Increase collaboration
	ASEP Association of Emergency Docs	C	L	L	Support for injury prevention initiatives	Increase collaboration
	NHPHERD	C	L	L	Support for injury prevention initiatives	Increase collaboration
	OTA	C	L	L	Support for injury prevention initiatives	Increase Collaboration
	PTA	C	L	L	Support for injury prevention initiatives	Increase Collaboration
	NH Celebrates Wellness	P	L	L	Engage the partner in initial dialogue on mutual interests.	Provide information on mission aligned initiatives of MCHS

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F. Voluntary Associations/CBO's Con't						
	National Alliance for Mentally III (NAMI)	C	M	L	Collaborate on projects related to Suicide and Family Health or Wellness Issues	Provide information to members. Continue attendance at meetings and project sessions.
	John Snow Inc. Research and Training Institute	C	H	H	Training Resources	Continue collaborations
	Partners In Health/Hood Center	C	H	H	Direct support to families with CSHCN in each county	Continue partnership on individual cases and special projects collaboration
	NH Coalition Against Domestic and Sexual Violence	C	H	H	Direct services, support, training, education and policy advocacy on prevention and intervention for domestic and sexual violence.	Maintain strong partnership Continue to pass along CDC rape prevention funds and other funds to support projects
	Behavioral Health/ Developmental Services	C	H	H	NH CARES –project to improve children's mental health services	Coordinate on individual cases and collaborate state level
	Area Health Education Centers	C	M	H	Training and technical assistance for health care providers on key health issues – special interest in culturally sensitive care	Continue relationships to support activities and help with publicizing
	Guttmacher Foundation	C	H	H	Supports adolescent suicide prevention efforts	Continue collaboration
	Brain Injury Assoc.	C	H	H	Support for injury prevention initiatives	Continue collaboration

Table CA-4: WORKSHEET 1. ASSESSMENT OF CURRENT AND POTENTIAL ASSETS FOR MCH SYSTEMS BUILDING

POPULATION						
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F. Voluntary Associations/CBO's Con't						
	Bi-State Primary Care Association	C	H	H	Support, technical assistance, training, advocacy and policy support for primary health care providers.	Continue collaborative work and strengthen Section-wide communication
	Association of SIDS and Infants Death Professionals	C	L	H	Share resources with appropriate colleagues	Utilize as a resource
	STIPDA	C	H	H	Support for injury prevention initiatives	Continue collaboration
	NH Minority Health Coalition	P	L	M	Develop better access to reproductive health services for minority populations	HIV Integration grant focuses on minority women
	Community Health Institute	C	H	H	Training resource	Continue collaboration
	NH Association for the Education of Young Children	M	H	M	Through conference venues for MCHS to highlight H&S in child care as a quality issue.	
	NH Children's Trust Fund	C	H	H	Share resources	Collaborate on projects of mutual interest as appropriate
	March of Dimes	C	L	H	Share data; Has initiatives impacting MCH Title V population	Collaborate on projects of mutual interest; Continue participation on MCH advisory committees
	NH Pediatric Society	C	L	H	Assist MCH in carrying out pediatric Public health initiatives and share information with the private sector	Engage members in more MCH committees; Improve communication with key leaders

Table CA-4: WORKSHEET 1. ASSESSMENT OF CURRENT AND POTENTIAL ASSETS FOR MCH SYSTEMS BUILDING

POPULATION						
Categories of Assets	Names	Current or Potential Asset	Strength of Current working relationship? (high, medium, low)	Perceived strength of interest in MCH issues? (high, medium, low)	How can asset help build MCH systems?	What steps are needed to mobilize/further engage this asset?
F. Voluntary Associations/CBO's Con't	NH Public Health Association	C	L	M	Share information	Collaborate when appropriate opportunities arise
	School Nurses Association	C	L	M	Networking, share information, help build visibility of Family Planning services for teens	Maintain linkages
	Association of the Deaf	C	M	M	Participate in Newborn Hearing Advisory Committee; Share information with and engage support of members in carrying out Title V MCH activities and public health efforts	Cultivate relationship with the organization
	NH Audio logy Association	C	M	M	Participate in Newborn Hearing Advisory Committee; Share information with and engage support of members in carrying out Title V MCH activities and public health efforts	Cultivate relationship with the organization
	NH Children's Alliance (NH CAN)	C	H	H	Advocacy organization that promotes an annual "Children's Agenda" for lawmakers. Agenda items often include issues effecting MCH population. NH CAN also publishes annual "Kid's Count" data reports	Continue to participate in NH CAN advisory councils and continue their participation with ECCS.
	Safety and Health Council	C	H	H	Support for injury prevention initiatives	Continue collaboration

Table CA-4: WORKSHEET 1. ASSESSMENT OF CURRENT AND POTENTIAL ASSETS FOR MCH SYSTEMS BUILDING

POPULATION						
Categories of Assets	Names	Current or Potential Asset	Strength of Current working relationship? (high, medium, low)	Perceived strength of interest in MCH issues? (high, medium, low)	How can asset help build MCH systems?	What steps are needed to mobilize/further engage this asset?
G. Other						
	Healthy NH Foundation	P	L	M	Collaboration on issues of mutual interest/projects	Contact when projects arise
	Croched Mountain Rehabilitation Center/ Harry Allen Gregg Foundation	C	L	M	Residential and outpatient services for CSHCN /family grants	Continue individual coordination
	NH Family Voices	C				
	Public Health Informatics Institute	P	L	H	White papers and other pubs	Remain on mailing list, seek out conference/training opportunities
	Children's Hospital at Dartmouth	C	L	M	Funds/helps disseminate Child Health Month Coalition mailing	Continue to engage in Child Health Month Coalition activities
	Maine Poison	C	H	H	Support for injury prevention initiatives	Continue collaboration
	Foundation for Blood Research					
	STAR-Steps toward Adult Responsibility/Hood Center	C	M	H	Collaboration on health care transition	Participate in fall conference, invite to transition coalition
	Child Dev and Genetics (Dartmouth)	C	H	H	Contracts to provide diagnosis and treatment for developmental issues/delays through statewide child development clinics	Continue contracts; promote program collaboration with other contracted agencies
	New Hampshire Technical Institute Dental Hygiene Program	C	M	M	Educate more providers	Have a representative at State Wide meetings

Table CA-4: WORKSHEET 1. ASSESSMENT OF CURRENT AND POTENTIAL ASSETS FOR MCH SYSTEMS BUILDING

POPULATION						
Categories of Assets	Names	Current or Potential Asset	Strength of Current working relationship? (high, medium, low)	Perceived strength of interest in MCH issues? (high, medium, low)	How can asset help build MCH systems?	What steps are needed to mobilize/further engage this asset?
	Delta Dental	C	H	H	Financial and educational support	Ongoing collaboration
	Center for Medical Home Improvement	C	H	H	Improving care for CSHCN in pediatric practices	Continue partnership
	Hood Center for Children and Families	C	H	H	Provides supports for services for CSHCN	Continue collaboration
	Department of Audio logy Dartmouth Hitchcock Medical Center	C	M	M	Participate in Newborn Hearing Advisory Committee; Share information with and engage support of members in carrying out Title V MCH activities and public health efforts	Cultivate relationship with the organization
	Injury Prevention Center	C	H	H	Contract agency and Support for injury prevention initiatives	Continue contract and collaboration
	Maine Medical Center NNE Region 1 Poison Center	C	H	H	Continue to support the work of Poison Center by supplying space for the poison educator and advocating for money	

V Matching Needs to Capacity

Upon completion of data analysis and initial meetings to garner input on Title V needs, an internal meeting of Title V managers was held to match needs to capacity. Needs and capacity were matched using the tools provided in the Promising Practices document (See Table CA-5: Worksheet 2 below). High needs that matched with high capacity were identified as prime candidates for intervention, while low needs matched with low capacity were identified as low priority. A mismatch of needs and capacity provided information that will be used to reallocate resources accordingly. A master list of priority needs was created.

Table CA-5: Worksheet 2: Analysis of MCH System Capacity to Address MCH Needs			
Needs	Pyramid Level	Capacity	Weaknesses/Gaps
Mental Health Improved quantity and quality of mental health services Population: - Children - Special Health Care Needs (CSHCN) - Children - Adolescents	Direct Health Care Services	-Community Mental Health Centers with children's services -SMS psychology services -SMS Child Development programs state network -Links to Early Learning Program –Early Childhood Comprehensive Systems (ECCS) grant -Anna Phibrock Ctr. (acute inpatient child psych) Low	-Discrepancy & lack of consistency in children's services -Critical staff shortages of qualified professionals
	Enabling Services	CARE NH supports and wrap around	-Private and public funding is insufficient -Lack of insurance parity for Mental Health services -Systematic care coordination services lacking N/A
	Population-Based Services		N/A
	Infrastructure Building Services		-CARE NH Program -Potential new Substance Abuse and Mental Health Services Administration \$ -Reimbursement barriers -Scarce resources

Table CA-5: Worksheet 2: Analysis of MCH System Capacity to Address MCH Needs

<u>Needs</u>	<u>Pyramid Level</u>	<u>Capacity</u>	<u>Strengths</u>	<u>Weaknesses/Gaps</u>
	Systems-Building/Collaboration		<ul style="list-style-type: none"> -DHMC child development psychiatry and psychology collaboration, including Comprehensive Office Rounds (COR) -Collaborative work with NAMI & Granite State Federation for Families -Pediatric Society initiatives (5/25 meeting, sponsoring Infant MH conference) -Title V support of 14 Regional Infant Mental Health Teams -Youth Suicide Prevention Assembly/Injury Prevention Committee (YSPA/IPC) -Child Fatality Review Committee 	"Silo Effect" inhibits true collaboration
<i>Respite</i>	Direct Health Care Services		<ul style="list-style-type: none"> -VNA in-home services -Area Agencies have financial support -Cedarcrest and Crotched Mt. have center-based respite for medically complex 	<ul style="list-style-type: none"> -Lack of trained staff (number of and skill level) to provide respite -Insufficient programs willing to provide childcare to CSHCN
Population: - Children Special Health Care Needs	Enabling Services	Low	<ul style="list-style-type: none"> -Area Agencies -Community-based funding -Medicaid waivers (HC-CSD) 	<ul style="list-style-type: none"> -Limited and fragmented funding targeted to developmentally disabled adults and medically complex only
	Population-Based Services		<ul style="list-style-type: none"> -Healthy Child Care NH childcare health consultants providing training support for childcare providers to serve CSHCN 	<ul style="list-style-type: none"> -Limited funding, serving limited regions of the State

Table CA-5: Worksheet 2: Analysis of MCH System Capacity to Address MCH Needs

<u>Needs</u>	<u>Pyramid Level</u>	<u>Capacity</u>	<u>Strengths</u>	<u>Weaknesses/Gaps</u>
	Infrastructure Building Services		<ul style="list-style-type: none"> -Cedarcrest provides model for training/education for C N A 's - Preschool Technical Assistance Network (PTAN) provides consultants to preschools and child care centers - Preschool Technical Assistance Network 	<ul style="list-style-type: none"> -No model for work force development -No financial support for health care consultants
	Systems-Building/Collaboration			<ul style="list-style-type: none"> -No unified system for respite for work force development or provision of care (like Oregon model) -Question of 'silo effect' as barrier to obtaining collaboration
<p>Obesity</p> <p>Impact the growing overweight/obesity rate in NH children</p> <p>Population:</p> <ul style="list-style-type: none"> -Children - Children Special Health Care Needs 	Direct Health Care Services		<ul style="list-style-type: none"> -WIC/Health Promotion unit -Selected SAU programs and DOE initiatives -NH Healthy Schools Coalition/Action for Healthy Kids (Tamara Martin) -Manchester program (DHMC and schools) -SMS regional pediatric nutritionists -School nurse initiatives 	<ul style="list-style-type: none"> -Fragmented State-wide approaches -Lack of interdisciplinary team models for intervention
	Enabling Services	<u>Low</u>	<ul style="list-style-type: none"> -Community based funding -Preventive Health and Health Services Block Grant - CDC 	<ul style="list-style-type: none"> -Lack of family education and support -Lack of funding and reimbursement
	Population-Based Services		<ul style="list-style-type: none"> -Media attention to the issue -Walk and Bike to School Initiative with Health Promotion -Safe Sports Initiatives with Health Promotion and Oral Health 	<ul style="list-style-type: none"> Lack of funding – no incentive for collaboration

Table CA-5: Worksheet 2: Analysis of MCH System Capacity to Address MCH Needs

<u>Needs</u>	<u>Pyramid Level</u>	<u>Capacity</u>	<u>Strengths</u>	<u>Weaknesses/Gaps</u>
Obesity can't	Infrastructure Building Services		<ul style="list-style-type: none"> -Several school nurse initiatives -Media attention -Title V-funded community health centers required to use Body Mass Index (BMI) -State MCH office providing Community Health Centers (CHC) with Bright Futures physical activity resources -Governor's wife is pediatrician with high interest in the issue -Issue identified as a priority for funding from healthy NH Foundation for community projects 	<ul style="list-style-type: none"> -Lack of buy in from professional organizations in community -Lack of consistent statewide data
	Systems-Building/Collaboration		N/A	<ul style="list-style-type: none"> -Lack of state support for regional initiatives
<u>Oral Health</u> Decrease the rates of dental disease among high risk children Population: -Children	Direct Health Care Services	High	<ul style="list-style-type: none"> -Community based & school based oral health programs -State Oral Health Program -State Oral Health plan -Increased Medicaid reimbursement rates -Established oral health surveillance system -Outreach to physicians to incorporate oral health into medical visits -Watch your Mouth campaign -Service delivery is community based through hospitals, CHC's schools, VNA's 	<ul style="list-style-type: none"> -Severely limited funding -Rapidly declining workforce -Insufficient number of providers to treat special populations -Insufficient number of Medicaid providers -Limited functions allowed by auxiliary professionals -Geographic disparities -Lack of fluoridated public water systems -No state support -Endangered PHHS Block Grant
	Enabling Services		<ul style="list-style-type: none"> -Community and program based. Some dental clinics have "3 strikes – You're out" -Care coordination occurs at local programmatic level 	<ul style="list-style-type: none"> -Parents do not value Oral Health and do not take kids to appointments -Care coordination is dependent on parental value of oral health. Children go untreated even when barriers are eliminated

Table CA-5: Worksheet 2: Analysis of MCH System Capacity to Address MCH Needs			
<u>Needs</u>	<u>Pyramid Level</u>	<u>Capacity</u>	<u>Strengths</u>
			<u>Weaknesses/Gaps</u>
<i>Oral Health Con't</i>	Population-Based Services		-Fluoridation of Manchester seen as a model -Statewide Sealant Project – Year 1
	Infrastructure Building Services		-Free well-water (Fluoride) analysis for community health centers -Collaboration with Dept. of Environmental Services to facilitate water tests and record keeping in CHC's -describe (in grant) the high capacity currently – for another year only) when endowment redirects funding focus away from NH
	Systems-Building/Collaboration		-Participation in Watch Your Mouth public awareness campaign with endowment for Health, NH Dental Society, AAP, et al -Collaboration with Medicaid Dental Program -Collaboration with NH Dental Society as fiscal agent and Medicaid provider -Collaboration with hospitals on “community benefits”
<i>Safe Environments</i>	Direct Health Care Services	High	-Severely limited state funds -Limited federal funds through endangered Preventive Health Block Grant (PHHS)
			N/A

Table CA-5: Worksheet 2: Analysis of MCH System Capacity to Address MCH Needs			
<u>Needs</u>	<u>Pyramid Level</u>	<u>Capacity</u>	<u>Strengths</u>
			<u>Weaknesses/Gaps</u>
	Enabling Services		N/A
	Population-Based Services		-Lead Program -IP Program and contractors ICP and NHCADSV IP Plan -DV efforts -HCCNH -HVN NH -CH Program -SIDS risk reduction -Adolescent health strategic plan -Child abuse prevention
	Infrastructure Building Services		Manchester Lead Hazard Control Program
	Systems-Building/Collaboration		Local Lead Action Committees
<i>Healthy Pregnancies</i>	Direct Health Care Services		-Home Visiting New Hampshire programs in 18 program sites across the State. One site is primarily focused on minority women and LEP -Medicaid expanded eligibility for pregnant women -Funding for prenatal care at 13 community agencies
Population: -Women -Adolescents -CSHCN	Enabling Services	<u>Low</u>	-No home visiting in Nashua as well as other communities
			N/A
			Limited funding for lead hazard control activities outside of Manchester
			N/A
			-Limited staff resources -Lengthy contract approval process

Table CA-5: Worksheet 2: Analysis of MCH System Capacity to Address MCH Needs			
<u>Needs</u>	<u>Pyramid Level</u>	<u>Capacity</u>	<u>Strengths</u>
			<u>Weaknesses/Gaps</u>
	Population-Based Services		-Ability to analyze data on disparities -Performance measures -Collaborative relationship with Dartmouth & UNH -New information on association of LBW and periodontal infection
	Infrastructure Building Services		N/A
	Systems-Building/Collaboration		N/A
	Direct Health Care Services		-Teen specific reproductive health services offered at 10 clinics. Primary care services at site
Adolescents	Enabling Services		N/A
Population: -Adolescents	Population-Based Services	High	-Medicaid reimbursable support/education services for MCH Title V funded agencies only
			-Good relationships with internal & external stakeholders -Link to CHCs for promoting adol health -Adol plan released -Adol health coordinator -YRBS representative sample; addition of protective factors
<i>Adolescents can't</i>	Infrastructure Building Services		N/A
	Systems-Building/Collaboration		N/A
			-No PRAMS -No current partners addressing disparities -Lack ability to track and respond to emerging communities -Current data collection system inadequate -No access to dental treatment for high risk pregnant women
			N/A
			N/A
			-No dental services for high risk adolescent population
			N/A
			-No dedicated funding -Limited staff resources -No statewide standards for adolescent medicine -Slow recognition (in medicine) of adol as special population -Lack of adol specialty providers
			N/A
			N/A

Table CA-5: Worksheet 2: Analysis of MCH System Capacity to Address MCH Needs			
<u>Needs</u>	<u>Pyramid Level</u>	<u>Capacity</u>	<u>Strengths</u>
	Direct Health Care Services		N/A
	Enabling Services		N/A
<i>Injury</i>	Population-Based Services	<u>High</u>	-Opportunity to add violence module to BRFFSS -YSPA -Statewide VAW plan -Statewide suicide prevention plan -Dartmouth IPC -UNH Center on Adolescence -MCH HVNH & CH support Programs -Frameworks project
Population: -Children	Infrastructure Building Services		N/A
	Systems-Building/Collaboration		N/A
<i>Data</i>	Direct Health Care Services	<u>Low</u>	N/A
Population: -All MCH populations	Enabling Services		N/A
	Population-Based Services		N/A
			Weaknesses/Gaps
			N/A
			N/A
			-Lack of data -Weak relationship with DCYF & DOE -Weak in addressing middle childhood issues -Threat to PHSBG -Limited staff resources
			N/A

Table CA-5: Worksheet 2: Analysis of MCH System Capacity to Address MCH Needs			
<u>Needs</u>	<u>Pyramid Level</u>	<u>Capacity</u>	<u>Strengths</u>
<i>Data Con't</i>	Infrastructure Building Services		-Data Team -HS staff -PCC staff -Analysis tools -Contract agency PMs used as Dept. model -Plan developed for data collection, use and linkages -FP data system is a model N/A
	Systems-Building/Collaboration		N/A
Safety Net	Direct Health Care Services		-Increasing support for networking of primary health care centers
Preserve safety net/infrastructure	Enabling Services	High	N/A
Population:	Population-Based Services		N/A
-All MCH populations	Infrastructure Building Services		-Adapting contracts to shifting community needs -Collaborative relationship with contract agencies -PH Network emerging as local conduit -Improved ability to validate and communicate effectiveness of contract agencies -Strong children's advocacy network
	Systems-Building/Collaboration		N/A
			Weaknesses/Gaps -Data entry capacity -Access to data -Ability to analyze limited by lack of data linkages and agency capacity -Lack of child health data -Time intensive start up limits efficiency -Dissemination: DHHS approval process is slow N/A
			Many CHC's without dental facility
			N/A
			N/A
			-No funding methodology -Reimbursement rates may not be adequate -No mechanism for mobilization of advocacy efforts on MCH issues
			N/A

Table CA-5: Worksheet 2: Analysis of MCH System Capacity to Address MCH Needs			
<u>Needs</u>	<u>Pyramid Level</u>	<u>Capacity</u>	<u>Strengths</u>
<i>Work Force</i> Population: -All MCH populations	Direct Health Care Services	<u>Low</u>	N/A -Declining number of dentists -Dental providers practice in Southern 1/3 of the State
	Enabling Services		N/A
	Population-Based Services		N/A
	Infrastructure Building Services		-Consistent staff -Training opportunities -Working to develop internal staff development -Ability to identify shortage areas
	Systems-Building/Collaboration		N/A
<i>Care Coordination</i> Increased availability of care coordination for vulnerable populations (e.g. families of children receiving SSI for their own	Direct Health Care Services	<u>Low</u>	-Lack of qualified professionals -Lack of payment mechanisms for care coordination
	Enabling Services		N/A -Lack of payment mechanisms for care coordination
	Population-Based Services		N/A

Table CA-5: Worksheet 2: Analysis of MCH System Capacity to Address MCH Needs			
<u>Needs</u>	<u>Pyramid Level</u>	<u>Capacity</u>	<u>Weaknesses/Gaps</u>
	Infrastructure Building Services		-Strong centralized care coordination through state Title V program
	Systems-Building/Collaboration		-Developing system of care coordination through Medical Homes -Developing models of care coordination for support through the NH ECCs Implementation Plan
			-Lack of qualified professionals -No systematic training/education -Need to define skills, competencies -Multiple definitions of "care coordination" between and within early childhood systems

VI. Setting Priorities

1. Process for Setting 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. New Hampshire's Title V planning and prioritization process has become stronger, more structured and much more deliberate in recent history. The importance of cultural competence in local and state MCH programs and the need to create supports and enhance services for minority populations seamlessly within the state service system is recognized as an underlying theme for New Hampshire's Title V program. Similarly, recognition of other socioeconomic factors influencing health outcomes – poverty, education, and availability of affordable housing, for example – are seen as guiding themes that are interwoven throughout all priorities and activities. Priorities have been developed that are purposefully broad and systems-focused, and likely to respond to evidence-based interventions.

This needs assessment provided an overview of the current state of maternal and child health in New Hampshire, and it identified disparities and gaps in health services and capacity, leading to the targeting of priority concerns. With completion of the data analysis and capacity assessment, areas where intervention is desirable became apparent:

- Data
- Prenatal disparities
- Injury prevention
- Oral health
- Mental health
- Children's environments
- Adolescent health
- Preserving infrastructure
- Obesity
- Respite care for families of CSHCN

In order to validate these early findings, garner public input, and progress to the next stage in setting priorities, over 100 invited stakeholders from around the state were invited to meet in March 2005. Participants included community agencies, service providers, family members, organizational partners and others whose work intersects with maternal and child health issues. Needs assessment findings were highlighted, and, in a town meeting format, participants were invited to offer their thoughts and perceptions about the MCH priorities for New Hampshire. Feedback could be given verbally during the meeting, or in writing on color-coded file cards given to each participant.

Participants confirmed that across maternal and child health systems, at the state and local levels, issues such as limited data capacity, disparities among populations and coordination of care, especially among mental health and primary care providers,

continue to be of the highest priority. The comments of the stakeholders reflected a general agreement that these issues were of primary importance in the state. No other areas of significant need were offered in addition to or as replacement for any of the issues presented.

Subsequently, Title V staff selected criteria by which to make final determinations on the top state priorities. These criteria were based on common public health principles:

1. The area is amenable to change, in the context of changing demographics and the political environment of the state.
2. The area is possible to address in a five-year timeframe.
3. There is a magnitude of need in this area.
4. The potential exists to make an impact on desired outcomes.
5. There is a potential for secondary effects on other capacities/needs.

With the matching of identified needs to capacity, using Worksheets 2 and 3 (from *Promising Practices in MCH Needs Assessment: A Guide Based on a National Study*), in the context of Title V's guiding principles, top priority needs crystallized and could be articulated, as described below.

New Hampshire continues to struggle with data capacity issues; data capacity was one of the three top priorities identified in NH's CAST-V process. Historically, some MCH program data has been of very limited use. For example, while NH's 2003 YRBS achieved representative data, trend analysis is prohibited by prior years' failure to do so. Lack of access to birth files and other vital records data has presented a formidable barrier to basic analysis and data linkage efforts over the past year.

MCH has recently formed a Data Team, consisting of the MCH Director, SSDI Program Planner, Program Evaluation Specialist, QA Nurse Consultant, Adolescent Health Coordinator, Lead Program Epidemiologist and contractual MCH Epidemiologist. The Data Team has assessed data and information needs for MCH programs and created an action plan to address these needs.

2. FFY 06 Priorities

A priority addressing the foundation of MCH practice through data collection and use, and implementing evidence-based interventions, was seen as likely to further Title V's focus on infrastructure and population-based services - for example, expanding YRBS use to improve the understanding of vulnerable adolescent populations; and improving understanding of the primary care workforce distribution, and its effect on access to care. These considerations led to priority #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)

The data analysis exposed variations within the overall positive picture of health for women in New Hampshire and found that women in the adolescent and young adult years, as well as those dependant on Medicaid as a payer for their health care, experience disproportionate levels of inadequate prenatal care and less favorable birth outcomes than women in other age groups. Other key findings are:

- While the Adequacy of Prenatal Care Utilization Index shows that NH does particularly well with *Initiation* of PNC, it does not do as well with *Received Services*.
- An increasing proportion of births are by Cesarean section
- Complications of pregnancy, childbirth and the puerperium are the most frequent cause of hospitalization among women 15 - 34, followed by mental disorders

These 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; implementing anti-smoking campaigns targeting specific prenatal age groups; developing policies to promote Medicaid enrollment and care utilization; and improving prenatal care access in the four southernmost counties to reduce disparities in minority birth outcomes. These considerations led to priority #2:

To assure safe and healthy pregnancies for all women, especially vulnerable populations (NPM #8, 15, 17, 18 & SPM #2)

Hospital discharge data indicate that the most frequent cause of hospitalization among children is diseases related to the respiratory system, including asthma. Children aged 1-4 years have the highest hospitalization rate for asthma among all age groups of children.

Young children are also vulnerable to the effects of lead poisoning. Refugee children have been identified as having an increased risk for elevated blood lead levels and efforts are being made to ensure that this population is screened. In 2003, among all children screened, 2% of those <72 months had confirmed elevated blood lead levels. However, there are significant geographic differences across the state. In Franklin 10% of the children screened had elevated blood levels and in Claremont 4.6% of children screened had elevated levels. These considerations resulted in priority #3:

To assure safe and healthy environments for MCH populations, including those with special health care needs (NPM #13, 14 & SPM #3)

Access to dental care is a problem for many in New Hampshire, specifically the poor, under and uninsured in rural communities and large population areas. New Hampshire has five designated Dental Health Professional Shortage Areas. Nationally, only 18% of adolescent Medicaid beneficiaries receive dental screenings. During 2002, only 49% of New Hampshire children and adolescents ages one to 20, enrolled in Medicaid, were seen by a dentist. While recent advances in New Hampshire have improved capacity for oral health services in several areas of the state, continuing effort is needed to sustain this

fledgling system. The NH SSI CSHCN survey found that only 65% of New Hampshire CSHCN receiving SSI who needed dental care, received the care. Thus, priority #4:

To decrease dental disease in MCH populations (NPM #9 & SPM #4)

Preventable injuries rank as the leading cause of death for all New Hampshire children. 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.

Similarly, unintentional injuries are the leading cause of death to adolescents in New Hampshire and nationally. Many of these deaths are preventable. The majority of unintentional injury deaths are due to motor vehicle crashes; other causes are poisonings, falls and drowning. Thus, priority #5:

To decrease unintentional injuries among children and adolescents, including those with special health care needs (NPM #10 & SPM #5)

In New Hampshire, more than one out of every 14 children under age 18 (7.3%) are living below the Federal Poverty Level. An investigation of the impact of socioeconomic status on adolescent health outcomes in New Hampshire found a pattern suggesting that residence in poorer New Hampshire towns places youth at increased risk for poor outcomes. Teen births, adolescent suicide, unintentional injury, and hospitalizations for asthma are areas of most concern.

Suicide and physical violence are areas of concern also. In New Hampshire, suicide is the second leading cause of injury-related death among adolescents ages 15-24 and those ages 10 to 14 while nationally suicide is the third cause of death among the same age groups.

- During the three year period, 1999 to 2001, there were 69 suicides to New Hampshire adolescents 10 to 24 years of age, a rate of 8.77 deaths per 100,000, slightly higher than the U.S. rate of 7.46 deaths per 100,000
- Adolescents ages 15 to 24 experienced the highest rate of inpatient hospitalizations for self-inflicted injuries among all age groups at 105.4 hospitalizations per 100,000 population during 1997 to 2001
- The highest rate of emergency department visits for self-inflicted injuries, at 333.4 visits per 100,000 population, also occurred among those ages 15 to 24.

These considerations led to priority #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)

At present, some economic factors affecting NH's population are fluctuating. Rising unemployment in some regions, soaring housing costs and Medicaid modernization are

just a few of the issues that may influence the health of New Hampshire's families over the next several years. In addition, scarce state resources and reductions in federal funding may threaten the existence of some state programs in SFY06. The full effect of this economic climate is difficult to predict, but the potential continues to exist for decreasing access to care and worsening health indicators among women and children, including children and youth with special health care needs. Given these factors, a core Title V value is to maintain current levels of effective services and improve Title V capacity. These considerations led to priority #7:

To preserve effective public health programming, including an infrastructure of safety net providers, to address the needs of MCH populations (All NPM & SPM)

Access to mental health services is an identified need in New Hampshire. In the Delphi process conducted by SMS, lack of mental health services and skilled professionals in family-based treatment emerged as a significant need. Data from the New Hampshire Department of Education and the Division of Juvenile Justice also indicated significant mental health problems in children and adolescents. While Medicaid provides coverage for children's mental health services, a diagnosis of severe emotional disturbance is required to receive services. Mental health safety net systems are overtaxed, with long waiting lists. Limited community-wide coordination exists for the early identification of mental disorders. For example, in 1995, public mental health centers in New Hampshire served 6,409 children and youth. Although the number served increased by approximately 75%, to 11,165 served in 2001, waiting lists are still prohibitively long. In both private and public sectors the picture is equally bleak, with few New Hampshire psychiatric providers statewide trained in caring for children. Hence, priority #8:

To improve access to mental health services for children, including those with special health care needs, and their families (NPM #3-5, 16 & SPM #8)

Obesity is an increasing problem nationally, but one for which little NH data is available at this time. The two most predictive factors in the development of obesity are physical activity and diet. According to the 2003 New Hampshire Youth Risk Behavior Survey (NH YRBS), more than a third of surveyed young people in grades 9–12 did not regularly engage in vigorous physical activity and 26% reported watching three or more hours of television on the average school day. Of the 18-24 year olds responding to the 2002 NH BRFSS survey, 83% engaged in some physical activity, while 17% reported no physical activity. Data from the UNH Healthy Schools Project and the Manchester Public School system also point to a significant problem with childhood obesity. Hence, priority #9:

To decrease the prevalence of childhood obesity (SPM #9)

Data from the National Survey of CSHCN and NH state data indicate a lack of adequate respite and childcare services available to this population, including need for workforce development. Per the National Survey of CSHCN 2001 data for New Hampshire, 3,754 (8%) of children needed respite services, and 2,358 (5%) received the needed care. This indicates that over 1,300 of New Hampshire children with special health care needs and

their families were without respite care services when such services were needed. In addition, the Delphi survey conducted by Special Medical Services identified respite care for behaviorally and medically complex children as the item having the most potential impact on families. The capacity of the system to address this need has been assessed to be weak or to have gaps in certain areas (i.e., the lack of trained staff both in terms of number and skill level; limited and fragmented funding; funding that is targeted to developmentally disabled adults and medically complex only; no model for workforce development; a silo effect creating a barrier to collaborative efforts across agencies). Other input from stakeholders indicated that while child care programs in New Hampshire receive some health care consultation, the staffs of these programs are not adequately trained to provide care for behaviorally/medically fragile children and often decline to enroll them. It is clear that a statewide effort is needed to promote and provide instrumental support for workforce development to serve this population of CSHCN. Thus, priority #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)

3. Changes in Priorities Since 2000

Changes in priorities since 2000 reflect the more formal needs assessment process utilized in 2005, based on the recommendations in *Promising Practices in MCH Needs Assessment: A Guide Based on a National Study*. This needs assessment included an extensive analysis of available data on the MCH population and a more formal process for gathering input from internal and external stakeholders. The assessment provided an overview of the current state of maternal and child health in NH and identified disparities and gaps in health services and capacity, leading to the targeting of priority concerns. With this information, the Title V team was better able to make decisions regarding priorities. The Team agreed on the criteria to be used in deciding priorities, based on accepted public health principles, including: the magnitude of the need, whether the area of need is amenable to change in the context of changing demographics and the political environment of the state, and whether the need is possible to address in a 5-year timeframe. With the matching of identified needs to capacity, in the context of Title V's guiding principles, top priority needs crystallized and could be articulated. Title V team also concurred on the need to focus the priorities broadly.

4. New State Performance Measures

Once consensus had been reached on state priorities, the relationship to National Performance Measures and existing State Performance Measures could be considered. The number of the associated National Performance Measure for each priority is acknowledged above. Existing State Performance Measures were reviewed, and a determination made as to whether these measures continued to have merit in measuring progress on the associated priority. While measures relating to prenatal access to care, oral health services, childhood lead poisoning, injury, and adolescent health remain pertinent, new measures were crafted for data, mental health, obesity, and respite care. In

addition, New Hampshire has participated in the Region I collaborative to develop an asset-based performance measure relative to early childhood comprehensive systems. What follows is a brief description of the rationale for new State Performance Measures.

Data

The performance measure developed from the data-related priority is “the percentage of data linkage projects completed”. The goal of this measure is to link MCH and vital records data to improve analytical opportunities.

The priority is relatively broad. We’ve chosen to focus on data linkages as the first step in improving data capacity. Completing these linkages will then allow us to move on to more sophisticated analyses, which in turn will inform our interventions. Linking MCH data will improve data quality and improve our ability to evaluate programs and identify needs. It will also decrease the reporting burden on MCH-funded agencies by reducing redundant data collection.

We identified five priority data linkages and set a goal to complete at least two of the five in the coming year (see detail sheet in Block Grant application).

Obesity

The performance measure developed from the obesity priority is “to convene a statewide Summit of all collaborators with initiatives in the area of childhood obesity”. The goal is to increase collaboration among stakeholders with current local initiatives and to determine current capacity in both the public and private systems to address overweight and obesity in New Hampshire children, including those with special health care needs.

This priority is focused on the Title V program assuming leadership in this arena by providing a forum for dialogue and supporting efforts that are currently underway in a variety of settings across the state. It is anticipated that identification by the State of the various New Hampshire initiatives available, the opportunity to share promising strategies, compare challenges, and determine the need for additional programs will assist families and professionals to combat the problem of pediatric obesity. MCH and SMS staff will assume the responsibility for planning and convening a Summit on Pediatric Obesity in New Hampshire and ensuring that infrastructure activities receive ongoing support. The overall intent is to maintain and/or increase accurate data collection regarding the problem, educate regarding evidence-based practices, optimize available resources and increase the diffusion of information regarding successful community-based efforts.

Planning for the summit meeting will begin in August 2005 and it is anticipated that the meeting will convene in late Spring 2006. In addition to Title V staff, the initial planning group will include representation from the SMS pediatric dietician network and the Health Promotion Program. A product of the summit meeting will be the publication and dissemination of an executive summary and recommendations for future initiatives.

Mental Health

New Hampshire will develop a State Plan to integrate mental health services into primary care settings, to support children, youth and their families. This State Performance Measure is designed to address the emergent priorities related to child and youth mental health needs articulated in the NH Needs Assessment. The ultimate goal of the measure is to improve access to existing and future mental health supports and services for the target population.

This is a joint measure of MCH and SMS, and will involve dedicated key staff from those Sections, as well as representatives from other state entities and external organizations, crucial to the development and implementation of the State Plan.

To begin to meet this measure, NH will make application for funding under the upcoming HRSA “Integration of Services for CSHCN” request for proposals, expected to be announced in August.

A work group has been assembled to plan and complete the proposal and conduct activities that will culminate in a statewide stakeholders conference on NH mental health services for children and youth in SFY 06.

The first-year purpose of this measure is to “inventory” and draw together the various, somewhat fragmented, existing initiatives related to improved access to mental health services. Once the current programs, resources and services are comprehensively known to the stakeholders, an outline for the proposed State Plan will be drafted.

It is anticipated that this measure will be viable for several years, and, as such, is being approached as a multi-stage development project with long-term implications for funding needs, state policy discussions, and further input from NH families and mental health providers.

This measure is in direct support of the developmental Objective # 18-7, for Health People 2110, “to increase the proportion of children with mental health problems who receive treatment”, and the recommendations of the President’s New Freedom Commission on Mental Health (2003).

Respite Care

The performance measure developed from the respite and childcare priority is “to develop a statewide initiative to facilitate workforce development of individuals to provide respite and child care for behaviorally and medically complex children”. The goal is to develop a curriculum to train Licensed Nurse Assistants, childcare workers, and respite care providers to work more effectively with this subset of CSHCN.

This priority is focused on a statewide collaborative effort to bring together interested policy makers and families of CSHCN to determine needed curriculum content, strategies to support an ongoing training initiative, means of building on existing training activities, and methods of identifying and recruiting potential trainees. Special Medical Services staff will assume the responsibility for convening and establishing a task force to work on a New Hampshire specific training program and a methodology for publicizing, marketing and supporting implementation of said program. The overall intent is to increase the availability of well qualified and motivated individuals to help care for children in both home and childcare settings thereby increasing options for families and reducing potential stress associated with the demands of care giving.

Initial activities for FYI 2006 will be to recruit task force membership, convene and host an initial planning meeting, and begin the process of identifying, reviewing and selecting a curriculum and training model/methodology.

Early Childhood Systems

New research in public health promotion is beginning to document how building a population's strengths and social capital can promote positive outcomes and avoid or mitigate negative ones.²⁶ In addition, asset-based community development activities throughout the country have also shown how empowerment, resiliency, and the ability of communities to build on their asset base can contribute to achieving desired changes.

The asset-based measurement approach can complement traditional measures of needs, morbidity, and remediation by highlighting capacity-building strategies to promote a population's strengths and minimize deficits. For instance, family resource centers (FRCs) can be effective multi-service delivery platforms with high degrees of family participation, trust and satisfaction. Measuring the prevalence of FRCs, identifying common elements of and services offered by an FRC, and gleaning best practices from the child and family outcomes related to use of an FRC can provide incentives and strategies to develop FRCs in new and existing service delivery models.

The state of New Hampshire worked with five other states in Region I and the National Center for Infant and Early Childhood Health Policy at the UCLA Center for Healthier Children, Families and Communities to develop an asset indicator framework. This framework embraces an ecologic model of factors that influence early childhood health and development. The framework includes indicators at the state policy level, the community level, the service provider level, as well as the parent/family and individual/child levels. This framework will help identify improvements in infrastructure development by pointing out how assets at one level (e.g. individual child or family) interact with assets at another level (e.g., provider or policy).

²⁶ Murphey, D., Lamonda, K., Carney, J., Duncan, P. Relationships of a brief measure of youth assets to health-promoting and risk behaviors. Journal of Adolescent Health. 2004, 34:184-191.

The measurement framework also allows for study of asset use. For instance, it will consider a prevalence measure (i.e., to what extent does the asset exist?), a performance measure (i.e., how well is the asset being utilized?), and a measure that examines how well an asset is integrated into a portfolio of other strengths, resiliencies, programs, and policies.

The Title V block grant and needs and strengths assessments are important means of conveying federal and state evidence-based priorities. The state Title V agencies in federal Region I have agreed to develop an indicator that reflects the collective assets of their early childhood health and development systems. The Region has chosen to focus on their collective assets regarding childcare health consultants (CCHC). CCHC's improve the general health and safety of children in childcare and promote the development of children in other domains—e.g., socio-emotional development, cognitive development, etc.

The state of New Hampshire will work with Title V agencies throughout the region to examine what measures can be developed to capture the use of CCHC's; their contributions to young children's health and development; continuous improvement in their ability to support children, families, and providers; and their role in the early childhood service system.

VII. Using the Needs Assessment

This needs assessment, particularly the state priorities, is intended to be a living document that will inform stakeholders and community partners and focus the direction of program design and resource allocation. It is the intention of Title V to reformat needs assessment findings for MCH stakeholders in New Hampshire and to publish and distribute these findings accordingly. Title V will make the document available to stakeholders through the DHHS website, the State library, and DHHS District offices. MCH will notify stakeholders who attended the March 2005 meeting, as well as contracted health care agency directors and others, of the report release, major findings, and its availability on the DHHS website.

NH Title V has and will continue to refer to this document while responding to MCH needs in New Hampshire. As further analysis and evaluation are undertaken, findings will be updated and the Title V program direction refined. Directing limited MCH resources to these areas will be critical to maintain the health of New Hampshire's families.

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Appendix A: New Hampshire Regional Needs Assessments
2005

Background

A small study of the assessment of needs was conducted to identify specific areas of the state that are significantly below the state and/or national average statistics. The state, as a whole, looks to be average or above average statistically in a number of areas. In sharp contrast, there are areas of high need in certain categories. These areas deserve consideration in any needs assessment and planning for services.

Documents considered included:

- (3) The State of New Hampshire Critical Access Hospital Plan, June 2003
- (4) Community Benefit Reports:
 - (a) Cheshire Medical (Keene)
 - (b) Riverbend Community Mental Health (Concord)
 - (c) Concord Regional VNA (Concord)
 - (d) Huggins Hospital (Wolfeboro)
 - (e) Catholic Medical Center (Manchester)
 - (f) Dartmouth Hitchcock Manchester
 - (g) Elliot Health System (Manchester)
- (5) Critical Access Hospital Market Analysis:
 - (a) Lakes Region (New London)
 - (b) Memorial Hospital (Conway)
 - (c) Androscoggin Valley Hospital (Berlin)
 - (d) Franklin Regional Hospital (Franklin)
 - (e) Valley Regional Hospital (Claremont)
 - (f) Speare Memorial Hospital (Plymouth)
 - (g) Huggins Hospital (Wolfeboro)
 - (h) Monadnock Community Hospital (Peterborough)
 - (i) Littleton Regional Hospital (Littleton)
 - (j) Cottage Hospital (Woodsville)
 - (k) Weeks Medical Center (Lancaster)
 - (l) Upper Connecticut Valley Hospital (Colebrook)

Summary of New Hampshire Regional Needs Assessments, 2005

Agency	Low income pop	Mortality	Perinatal	Demographics	Medicaid	Other
Androscoggin Valley Hospital (Berlin) 13 towns	*30.4% (NH: 19) * <100% FPL is 55% > weighted states * <200% FPL: 59% > weighted states	* >NH rate for malignant neoplasms, CV disease, DM, accidents & adverse effects * ranks much higher in 8/9 leading causes	* 11.2% teens births (NH 7.1) * 6.9 infant mortality rate (NH 4.8)	* 20% > 65 yo (67% > weighted states)	* 19.3% of population (NH 10.6%)	* 13% of population uninsured (69% > weighted states)

Consider:

- very high low income population
- high mortality rate for leading causes of death
- high teen birth and infant mortality rates
- high elderly population
- high uninsured population

Agency	Low income pop	Mortality	Perinatal	Demographics	Medicaid	Other
Valley Regional Hospital (Claremont) 11 towns	* 25.9% low income (wgt states 19.8%) * 9% <100% fpl * 25.9% <200% fpl	* >than state rates in 8/9 causes of death * DM rate significant	* 11% teen mos * 81.6 lbw (NH 61.2) * 9.9 inf mort rate (NH 4.8)	* 16.1% > 65		

Consider:

- significant low income pop
- Sullivan Cty mortality rate for DM: 50.1 (NH 22.4) plus Sullivan Cty as % of NH: 224%
- infant mortality rate almost 2x that of state
- significant lbw rate

Agency	Low income pop	Mortality	Perinatal	Demographics	Medicaid	Other
Franklin Regional Hospital (Franklin) 13 towns	*almost 1 in 4	*higher rates in 8/9 causes	*13.7% teen mos (NH 7.1%) *15.8% inadeq PN (NH 12.9) *64.6 lbw (NH 61) *5.4 inf mort (NH 4.8)	*large elderly pop	*16.8% (NH 10.6)	*need PCPs

Consider:

- 25% of population is low income; high % on Medicaid
- high mortality rates leading causes
- almost 2x state rate teen mothers
- high inadequate PN care
- higher than state lbw and inf mortality

Agency	Low income pop	Mortality	Perinatal	Demographics	Medicaid	Other
Memorial Hospital (Conway) 13 towns	*30.2% <200% fpl (NH 19)	*higher rates in all 9 causes	*8.5% teen mos (NH 7.1)	*15.8% > 65 (NH 12)	*16.3% (NH 10.6)	*13.5% uninsured (NH 7.8) *need for PCPs *need specialists *need MH professionals

Consider:

- high mortality rates, high elderly pop
- specific need for medical professionals

Agency	Low income	Mortality	Perinatal	Demographics	Medicaid	Other
Catholic Medical Ctr D-H Manchester Elliot Health System		*obesity huge issue *high lead levels *pedi asthma *heart disease 78% > NE rate *stroke 21% >NH rate				*dental need *55-76 languages *shortage of MH services for pedi/teens

Consider:

- obesity issue
- lead levels
- heart and stroke levels very high
- need for interpretation of many languages

(pg 3 of)

Agency	Low income	Mortality	Perinatal	Demographics	Medicaid	Other
Lakes Region VNA (New London) 13 towns	*34% < 200fpl	*higher rates for asthma, Ca, DM, CAD, smoking, obesity		*lack of MH providers, esp. for elderly		*poor dental access *family stability & parenting skills *domestic violence *shortage of PCPs

Consider:

- high rates for mortality causes
- need for MH workers
- dental access
- domestic violence/family stability

Agency	Low income	Mortality	Perinatal	Demographics	Medicaid	Other
Monadnock Community Hospital (Peterborough) 14 towns		*Cheshire: higher rates all causes	*8.8% teen mos in Cheshire (NH 7.1)			*need fo 25.8 PC FTEs

Consider:
 -high mortality
 -high teen mos
 -need for medical providers

Agency	Low income	Mortality	Perinatal	Demographics	Medicaid	Other
Speare Memorial Hospital (Plymouth) 17 towns	<i>Low income</i> *9.9% <100%FPL (NH 6.5) *28.7% <200% FPL (NH 19)	*exceeds state rate in 6/8 diseases	*teen mos 10.8% (NH7.1)		*13.8% uninsured (NH 7.8)	

Consider:
 -uninsured almost 2x state rate
 -higher %employed & living in poverty = less gainfully employed
 -higher % enrolled in Medicaid—difference in area rate/state rate should be higher= eligible people not enrolling?

Agency	Low Income	Mortality	Perinatal	Demographics	Medicaid	Other
Littleton Regional Hospital (Littleton) 7 towns			*teen mos 11.6% Coos, 8.1 Grafton Cty (NH 7.6)		*13.7% < 19yo on medicaid	*need for 10 add'l PCPs

Consider:
 -high # teen mothers
 -need for PCPs

Agency	Low income	Mortality	Perinatal	Demographics	Medicaid	Other
Cottage Hospital (Woodsville) 12 towns		*high lung Ca rate *death rate from DM 97 (NH 68.7)	*13% inadequate PN care *9.8% late or no PN care *23.6% smoke *10.5% teens *lbw 11.4% for mos 18-24 yrs (NH 5.7) *23.6% mos smoke (NH 17.6)	*16.8% >65 (NH 11.7%)	8.8% inpoverty (NH 6.9) *14% uninsured (NH 9.3)	*absence of dental care *substance abuse *domestic violence

Consider: (Data from 2000 report)
 -dental needs
 -high PN smoking rate
 -high lung Ca

Agency	Low income	Mortality	Perinatal	Demographics	Medicaid	Other
Weeks Medical Center (Lancaster) 9 towns		*higher infant death rate compared to state *higher death rates for all common causes	<i>Perinatal</i> *1.7% late PN care (NH.4) *teen mos 12% (NH 8)	*15.17% 65+ (NH 11.9)	*18.7% <19 (NH 9.1) *3.5% >19 (NH 2.1)	*7 % unemployed (NH 4) *high need ofr dental *high need for MH professionals

Consider:
 -high teen pregnancy rate
 -high elderly rate

Agency	Low income	Mortality	Perinatal	Demographics	Medicaid	Other
Upper Connecticut Valley Hospital (Colebrook) Hospital (Colebrook)		*highest rate in NH for smoking, COPD *high rate of obesity, drinking	*teen mos 47.1 (NH 32.4) *26% PN smokers		*16.6% <19 on Medicaid (NH 9.1) *4.5% >19 (NH 2.1)	

Consider:

- highest rate for smokers, COPD
- high rates teen moms
- high rates for Medicaid recipient

Appendix B

A. Assessment of Population MCH Needs

Health Status Information

1. Collection
2. Analysis
 - a. Stratification
 - b. Trends
 - c. Combine Quantitative & Qualitative

B. Analysis of the Capacity of Systems to Meet These MCH Population Needs

1. Direct & enabling (p.12, NPM)
2. Population-based services (p.19)
3. Infrastructure-building capacity within Title V agency (p.19, CAST-V)
4. Individual & organizational assets available to support & improve MCH system (p.21, Worksheet 1)

Within each of the 4 steps above, 3 major dimensions:

1. Accessibility
2. Quality
3. Affordability (excluding step 2)

D. Setting Priorities

1. Framing
2. Priority-setting process
 - a. Stakeholders
 - b. Consensus
 - c. Criteria
 - i. Impact
 - ii. Intervention
 - iii. Practical

E. Use the Needs Assessment

C. Matching Needs to Capacity

- Worksheets 2-3 (pp.23-24)

Capacity		Intervention	Need to reallocate resources to address these needs
+	-		
+	-	Excess capacity – Can move resources to other needs	Not a priority
-	+		

APPENDIX C for Special Medical Services

APPENDICES from the Delphi Survey, "Assessing Needs and Resources for Children with Special Health Care Needs in New Hampshire, Executive Summary, October 2004"

Appendix 1.

STAKEHOLDERS/INVITED PARTICIPANTS

Anthem Blue Cross/Blue Shield Care Managers

Capital Region Family Health Center

Child Health Services Manchester

Children's Alliance of New Hampshire

Community Health and Hospice Laconia

Concord Regional Visiting Nurse Association

Council on Children and Adolescents with Chronic Health Conditions

Crotched Mountain Rehabilitation Center

Dartmouth-Hitchcock Medical Center

Center for Medical Home Improvement

Child Development and Genetics

Department of Pediatrics

Hood Center for Families and Children

Partnerships for Enhanced Medical Care

STAR Program (Steps Toward Adult Responsibility)

Disability Rights Center

Easter Seals of New Hampshire

Exeter Pediatrics

Granite State Independent Living

Infant Mental Health Association

Institute on Disability

Project Connection

Project Jump Start

Interim HealthCare

Lamphrey Health Center

Monadnock Pediatrics
National Alliance for the Mentally Ill (NAMI) New Hampshire
New Hampshire Child Development Network
New Hampshire Department of Education
 Bureau of Special Education
New Hampshire Department of Health and Human Services
 Bureau of Maternal and Child Health
 Healthy Child Care New Hampshire
 Department of Children, Youth and Families
 Foster Care Programs
 Department of Medicaid Business and Policy
 Special Medical Services Bureau
 Special Medical Services Bureau Family Advisory Board
 Division of Behavioral Health
 Project Care New Hampshire
 Division of Developmental Services
 Area Agencies
 Early Supports and Services
 MICE (Multi-sensory Intervention through Consultation and Education)
 Traumatic Brain Injury Program: Project Response
New Hampshire Developmental Disabilities Council
New Hampshire Family Voices
New Hampshire Federation for Families
Parent Information Center
Pediatric Physical Therapy Inc.
Pediatric Society of New Hampshire
Preschool Technical Assistance Network (PTAN)
Richie McFarland Children's Center
SERESC (Southeastern Regional Educational Service Center)

Appendix 2. Delphi Survey Instrument

DEFINITION of Children with Special Health Care Needs

The federal Maternal and Child Health Bureau defines children with special health care needs (CSHCN) as those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.²⁷

DIRECTIONS

SURVEY QUESTIONS

1. If programs could be developed to address some of the issues affecting CSHCN and their families, what do you think the **degree of impact** would be, for each issue?
2. What might be the **potential for collaboration** among interested stakeholders?

COMPLETING THE SURVEY

1. Please rank the **degree of impact** for each item listed in the survey, on a scale of 1-to-5.

One (1) is the lowest degree of positive, significant impact and 5 is the highest degree of positive, significant impact.

2. Also rank the **potential for the development of community and/or interagency collaboration**, for each issue.

Use the same scale, with 1 being the lowest potential and 5 being the highest potential.

PLEASE

DO NOT LEAVE ANY ITEM BLANK
AND SELECT ONLY ONE WHOLE NUMBER FOR EACH ITEM.

This is important for the automated data analysis process.

²⁷ McPherson M, Arango P, Fox H, et al. A new definition of children with special health care needs. *Pediatrics*. 1998;102:137-140.

A. If programs could be developed to address any of the following **ACCESS TO CARE** issues, what degree of impact do you think each would have on the lives of children with special health care needs (CSHCN) and their families? What do you think the potential is for community and/or interagency collaboration to address these issues?

PROGRAMS TO ADDRESS		DEGREE OF IMPACT					COLLABORATION POTENTIAL				
A-1	Service and health status disparities based on geographic region (esp. rural NH)	1	2	3	4	5	1	2	3	4	5
A-2	Isolation of families leading to delay in treatment and increased self-treatment	1	2	3	4	5	1	2	3	4	5
A-3	Lack of access to adequate dental care	1	2	3	4	5	1	2	3	4	5
A-4	Lack of transportation options to access care; cost of transportation	1	2	3	4	5	1	2	3	4	5
A-5	Need for a directory of services	1	2	3	4	5	1	2	3	4	5
A-6	Limited access to technology and/or databases	1	2	3	4	5	1	2	3	4	5

B. Health services to CSHCN have been affected by the **LACK OF CAPACITY** in the current system, including a lack of professionals and a lack of education and expertise about special needs populations. Please rank the degree of impact upon CSHCN and their families if programs could be developed to address these issues. Also rank the potential for community and/or interagency collaboration to address these issues.

PROGRAMS TO ADDRESS		DEGREE OF IMPACT					COLLABORATION POTENTIAL				
B-1	Need for more Certified Nursing Assistants (CNA)	1	2	3	4	5	1	2	3	4	5
B-2	Need for prepared/expert professionals	1	2	3	4	5	1	2	3	4	5
B-3	Continuing education/technical assistance for providers	1	2	3	4	5	1	2	3	4	5
B-4	Training for all staff in family-centered principles of care	1	2	3	4	5	1	2	3	4	5
B-5	Need for experts in endocrinology, gastroenterology, metabolic disorders	1	2	3	4	5	1	2	3	4	5
B-6	Mechanisms to influence pediatric residency training	1	2	3	4	5	1	2	3	4	5

C. Changes in family demographics have created a new group of needs in NH. If initiatives could be developed to address the issues of **FAMILY DEMOGRAPHICS AND SUPPORT** listed below, what degree of impact do you think this would have on CSHCN and their families? What is the potential for community and/or interagency collaboration around each issue?

PROGRAMS TO ADDRESS		DEGREE OF IMPACT					COLLABORATION POTENTIAL				
C-1	Coordination of resources/capacity across geographic areas	1	2	3	4	5	1	2	3	4	5
C-2	Increasing number of children in poverty in NH	1	2	3	4	5	1	2	3	4	5
C-3	Lack of services for working poor	1	2	3	4	5	1	2	3	4	5
C-4	Need for outreach strategies to bring underserved into the system of care	1	2	3	4	5	1	2	3	4	5
C-5	Social support for families due to fewer nuclear and extended family constellations	1	2	3	4	5	1	2	3	4	5
C-6	Services for children being raised by grandparents	1	2	3	4	5	1	2	3	4	5
C-7	Services for homeless families	1	2	3	4	5	1	2	3	4	5
C-8	Increasing number of older parents in the caretaker role for CSHCN	1	2	3	4	5	1	2	3	4	5

D. Please rank the degree of impact programs to address the following **CHILD CARE and RESPITE** options would have on CSHCN and their families. What is the community and/or interagency collaboration potential to address these issues?

PROGRAMS TO ADDRESS		DEGREE OF IMPACT					COLLABORATION POTENTIAL				
D-1	Respite care for behaviorally and medically complex children	1	2	3	4	5	1	2	3	4	5
D-2	Home-based services for children with medical and behavioral needs	1	2	3	4	5	1	2	3	4	5
D-3	Need for group care/congregate care as long term living options	1	2	3	4	5	1	2	3	4	5
D-4	Increasing demand for child care options for families with young children with behavioral problems	1	2	3	4	5	1	2	3	4	5

E. If initiatives could be developed to address the following **NEW TREATMENT OPTIONS** what would be the degree of impact on CSHCN and their families? What is the potential for community and/or interagency collaborative programs for these issues?

PROGRAMS TO ADDRESS	DEGREE OF IMPACT	COLLABORATION POTENTIAL
E-1 Increased use of pharmacology and the need for individualized evaluation and management	1 2 3 4 5	1 2 3 4 5
E-2 Information regarding allergies (e.g., food, latex) and associated treatments (e.g., dietary)	1 2 3 4 5	1 2 3 4 5
E-3 Increasing knowledge of brain function/chemistry with associated new treatments/interventions	1 2 3 4 5	1 2 3 4 5
E-4 Use of biomechanical engineering to provide treatment (e.g. robotics, specialized mobility devices)	1 2 3 4 5	1 2 3 4 5
E-5 Increasing knowledge of metabolism and nutrition leading to new treatments/service needs	1 2 3 4 5	1 2 3 4 5
E-6 Increased use of cochlear implants requiring both individual and family treatment/education	1 2 3 4 5	1 2 3 4 5

F. HOME-BASED SERVICES are required by some CSHCN. Please rank the degree of impact on CSHCN and their families if the following issues were addressed through new initiatives. What is the potential for community and/or interagency collaboration?

PROGRAMS TO ADDRESS	DEGREE OF IMPACT	COLLABORATION POTENTIAL
F-1 Increasing number of children with significant medical problems who live at home	1 2 3 4 5	1 2 3 4 5
F-2 Educational services and care in the home setting	1 2 3 4 5	1 2 3 4 5
F-3 Specific training for professionals/paraprofessionals to provide care in home settings	1 2 3 4 5	1 2 3 4 5
F-4 Parents forced to leave employment to provide in-home care for CSHCN	1 2 3 4 5	1 2 3 4 5

G. What degree of impact would programs to address the **EDUCATIONAL NEEDS OF PARENTS** have on CSHCN and their families? What is the potential for community and/or interagency collaboration to develop such programs?

PROGRAMS TO ADDRESS		DEGREE OF IMPACT					COLLABORATION POTENTIAL				
G-1	Parent skill training in behavior and health	1	2	3	4	5	1	2	3	4	5
G-2	Preparation of parents for leadership roles	1	2	3	4	5	1	2	3	4	5
G-3	Assisting parents with technology used with CSHCN (e.g., hardware and software possibilities)	1	2	3	4	5	1	2	3	4	5
G-4	Parent-to-parent helping models that reimburse the “teacher”	1	2	3	4	5	1	2	3	4	5
G-5	Educational materials for parents that are clear and pragmatic	1	2	3	4	5	1	2	3	4	5

H. If initiatives could be developed for the following **HEALTH CARE COORDINATION** issues, what degree of impact would these have on CSHCN and their families? To what degree do you think there is a potential for interagency and/ or community collaboration in these areas?

PROGRAMS TO ADDRESS		DEGREE OF IMPACT					COLLABORATION POTENTIAL				
H-1	Support for care coordinators in the community	1	2	3	4	5	1	2	3	4	5
H-2	Care coordination in primary care offices	1	2	3	4	5	1	2	3	4	5
H-3	Case coordination for the most involved, medically complex children	1	2	3	4	5	1	2	3	4	5
H-4	Integration of care between primary and tertiary care settings	1	2	3	4	5	1	2	3	4	5
H-5	Coordination at all points of transition (e.g., preschool, middle to HS, youth to adult)	1	2	3	4	5	1	2	3	4	5
H-6	Need for intra-agency cooperation/collaboration	1	2	3	4	5	1	2	3	4	5

I. Children born with conditions such as cystic fibrosis and spina bifida are surviving into adulthood due to improvements in treatment, and chronic conditions such as asthma, diabetes and mental illness are increasing. What would be the degree of impact on Youth with Special Health Care Needs (YSHCN) and their families if services were developed to help them with the following **TRANSITION** issues? What is the potential for collaboration on these issues?

PROGRAMS TO ADDRESS		DEGREE OF IMPACT					COLLABORATION POTENTIAL				
I-1	The health/medical needs of adolescents and CSHCN in transition (age 14-21)	1	2	3	4	5	1	2	3	4	5
I-2	Provision of adult health care for the special needs population	1	2	3	4	5	1	2	3	4	5
I-3	Provider education regarding the developmental issues of youth and young adults with special health care needs	1	2	3	4	5	1	2	3	4	5
I-4	Self-advocacy skills for youths with special health care needs	1	2	3	4	5	1	2	3	4	5
I-5	Adequate funding for inclusion / self determination models of care	1	2	3	4	5	1	2	3	4	5
I-6	Need for SSI and other funding after 18 years of age	1	2	3	4	5	1	2	3	4	5

J. What degree of impact would initiatives to address the following **MULTICULTURAL ISSUES** have on CSHCN and their families? What is the potential for collaboration within the community and/or interagency to develop programs?

PROGRAMS TO ADDRESS		DEGREE OF IMPACT					COLLABORATION POTENTIAL				
J-1	Need for cultural competence among providers and health care organizations	1	2	3	4	5	1	2	3	4	5
J-2	Lack of training focusing on multicultural issues	1	2	3	4	5	1	2	3	4	5
J-3	Increasing need to serve immigrant populations	1	2	3	4	5	1	2	3	4	5
J-4	Need for interpreters in health care settings	1	2	3	4	5	1	2	3	4	5
J-5	Differing beliefs and values re: self sufficiency and using public services	1	2	3	4	5	1	2	3	4	5

K. Health and disease information is readily available from multiple resources, including the Internet. If initiatives were developed to address this **KNOWLEDGE EXPLOSION** what degree of impact might there be on CSHCN and their families? What is the potential for community and/or interagency collaboration on these issues?

PROGRAMS TO ADDRESS		DEGREE OF IMPACT					COLLABORATION POTENTIAL				
K-1	Increased need for parent - professional dialogue due to increasingly sophisticated consumers of care (educated via the Internet and other sources)	1	2	3	4	5	1	2	3	4	5
K-2	Need to assist families and professionals to evaluate and process new knowledge	1	2	3	4	5	1	2	3	4	5
K-3	Use of the Internet for diagnosis, counseling and consultation	1	2	3	4	5	1	2	3	4	5

L. SCHOOLS provide necessary treatment, care and related services to CSHCN. What degree of impact would initiatives to address the following issues have on CSHCN and their families? What is the potential for community and/or interagency collaboration?

PROGRAMS TO ADDRESS		DEGREE OF IMPACT					COLLABORATION POTENTIAL				
L-1	Demand for more complex nursing care in school settings	1	2	3	4	5	1	2	3	4	5
L-2	Support & education for school nurses	1	2	3	4	5	1	2	3	4	5
L-3	Funding of schools to meet the needs of CSHCN to avoid rationing of special education and related services	1	2	3	4	5	1	2	3	4	5
L-4	Need for after school and recreational activities for CSHCN	1	2	3	4	5	1	2	3	4	5
L-5	Need for interagency partnerships / collaboration between health and educational communities	1	2	3	4	5	1	2	3	4	5
L-6	Need for home – school collaboration and coordination	1	2	3	4	5	1	2	3	4	5

M. New knowledge has led to new **DIAGNOSTIC OPTIONS** for CSHCN. What would be the degree of impact on CSHCN and their families if services to address these issues were developed? What is the potential for community and/or interagency collaboration?

PROGRAMS TO ADDRESS		DEGREE OF IMPACT					COLLABORATION POTENTIAL				
M-1	Increased recognition of co-morbidity and dual diagnoses	1	2	3	4	5	1	2	3	4	5
M-2	Role of the environment in the etiology of health and developmental problems	1	2	3	4	5	1	2	3	4	5
M-3	Focus on prevention of chronic illness in children; (e.g., folic acid & spina bifida, asthma protocols)	1	2	3	4	5	1	2	3	4	5
M-4	Newborn hearing screening leading to earlier diagnosis and need for intervention (under 1 year)	1	2	3	4	5	1	2	3	4	5
M-5	Genetic counseling/treatment (new knowledge)	1	2	3	4	5	1	2	3	4	5

N. If initiatives could be developed to address the following needs of **VULNERABLE POPULATIONS**, what would be the degree of impact on CSHCN and their families? What is the potential for community and/or interagency collaboration?

PROGRAMS TO ADDRESS		DEGREE OF IMPACT					COLLABORATION POTENTIAL				
N-1	Increased number of CSHCN in foster care	1	2	3	4	5	1	2	3	4	5
N-2	Need for adoption/ permanency for CSHCN in out-of-home placement	1	2	3	4	5	1	2	3	4	5
N-3	Medical/health needs of emotionally disturbed children	1	2	3	4	5	1	2	3	4	5
N-4	Need for services for youth with special needs in the juvenile justice system (e.g., evaluation, medical services, mental health services)	1	2	3	4	5	1	2	3	4	5
N-5	Transitional support for teens leaving the foster care system or detention (e.g., mentors, housing, health care)	1	2	3	4	5	1	2	3	4	5

O. There is an increasing population of children with **SPECIAL NEEDS DIAGNOSES**. Please rank the degree of impact for CSHCN and their families if programs could be developed to address the following areas. What is the potential for community and/or interagency collaboration?

PROGRAMS TO ADDRESS	DEGREE OF IMPACT	COLLABORATION POTENTIAL
O-1 The increasing survival of low birth weight babies with associated biological, cognitive, developmental and behavioral problems	1 2 3 4 5	1 2 3 4 5
O-2 Growing population of children with complex medical needs	1 2 3 4 5	1 2 3 4 5
O-3 Increasing longevity of CSHCN population associated with improved treatment (e.g., cancer, cardiac)	1 2 3 4 5	1 2 3 4 5

P. If initiatives could be developed to address the following **MENTAL HEALTH** issues, what degree of impact do you think each would have on the lives of CSHCN and their families? What is the potential for community and/or interagency collaboration?

PROGRAMS TO ADDRESS	DEGREE OF IMPACT	COLLABORATION POTENTIAL
P-1 Early diagnosis and treatment of mental/emotional/behavioral disorders in children	1 2 3 4 5	1 2 3 4 5
P-2 Need for family support and counseling	1 2 3 4 5	1 2 3 4 5
P-3 Lack of mental health services / professionals skilled in pediatric / family-based treatment	1 2 3 4 5	1 2 3 4 5
P-4 Need for early identification of infants and families at risk (e.g., addiction / domestic abuse)	1 2 3 4 5	1 2 3 4 5
P-5 Need for support groups for families	1 2 3 4 5	1 2 3 4 5
P-6 Need for information on how to access mental health services	1 2 3 4 5	1 2 3 4 5

Q. The delivery of quality services is the outcome of good **SYSTEMS PLANNING**. What degree of impact would such planning have on the following areas, if initiatives could be developed to address them? What is the potential for community and/or interagency collaboration for these areas?

PROGRAMS TO ADDRESS		DEGREE OF IMPACT					COLLABORATION POTENTIAL				
Q-1	Emphasis on evidence – based practice	1	2	3	4	5	1	2	3	4	5
Q-2	Adequate data systems to support care for CSHCN and families	1	2	3	4	5	1	2	3	4	5
Q-3	Demand for outcomes and accountability in healthcare and other service arenas	1	2	3	4	5	1	2	3	4	5
Q4	Inconsistency / differences in quality across programs, services	1	2	3	4	5	1	2	3	4	5
Q-5	Incorporation of a Continuous Quality Improvement process into state-funded agencies	1	2	3	4	5	1	2	3	4	5

R. If initiatives were developed to address the following **ETHICAL ISSUES**, what degree of impact would each have on the lives of CSHCN and their families? What is the potential for community and/or interagency collaboration?

PROGRAMS TO ADDRESS		DEGREE OF IMPACT					COLLABORATION POTENTIAL				
R-1	Complex ethical dilemmas associated with priorities, cost of care, available resources, expanding scientific info	1	2	3	4	5	1	2	3	4	5
R2	Possibility for genetic discrimination associated with familial syndromes	1	2	3	4	5	1	2	3	4	5
R3	Reimbursement for services based on the predicted natural history of a “diagnosis” rather than that of an individual child	1	2	3	4	5	1	2	3	4	5
R-4	Different expectations regarding care/treatment from consumers, medical professionals, managed care organizations	1	2	3	4	5	1	2	3	4	5

S. If initiatives could be developed to address issues of **PUBLIC FUNDING**, what do you think would be the degree of impact for CSHCN and their families? What is the potential for community and/or interagency collaboration?

PROGRAMS TO ADDRESS		DEGREE OF IMPACT					COLLABORATION POTENTIAL				
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S-1	Increase in the demand for Medicaid	1	2	3	4	5	1	2	3	4	5
S-2	Need for Medicaid restructuring	1	2	3	4	5	1	2	3	4	5
S-3	Potential for the rationing of services	1	2	3	4	5	1	2	3	4	5
S-4	Need for follow-up with families who are denied SSI or HC-CSD (Katie Beckett)	1	2	3	4	5	1	2	3	4	5
S-5	Adequate Medicaid reimbursement for providers	1	2	3	4	5	1	2	3	4	5
S6	Demand for blending / coordination of funding sources / funding flexibility	1	2	3	4	5	1	2	3	4	5
S-7	Increasing focus on set-aside, "carve-out" programs	1	2	3	4	5	1	2	3	4	5
S-8	Teaching families how to navigate/negotiate a complex and difficult service system	1	2	3	4	5	1	2	3	4	5
S-9	Need for new coding systems associated with new diagnosis, to insure payment	1	2	3	4	5	1	2	3	4	5

T. If initiatives could be developed to address the following issues related to **VALUES**, what degree of impact might this have on CSHCN and their families? What is the potential for community and/or interagency collaboration?

PROGRAMS TO ADDRESS	DEGREE OF IMPACT					COLLABORATION POTENTIAL					
T-1	Increasing tension between inclusion versus exclusion of the child with disabilities in community settings.										
T-2	Responsibilities of the larger community for the needs of CSHCN										
T-3	Educating politicians about the changing needs of constituents/families of CSHCN										

U. HEALTH CARE COST remains a major barrier to access. Health insurance is not readily available to all segments of the NH population. If programs could be developed to address the following issues what degree of impact would there be for CSHCN and their families? What is the potential for community and/or interagency collaboration?

U-1	Increasing difficulty in obtaining adequate insurance coverage for CSHCN	1	2	3	4	5	1	2	3	4	5
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U-2	Demand for coverage for durable medical equipment and non-pharmaceutical products	1	2	3	4	5	1	2	3	4	5
U-3	Frequent changes in insurance (e.g., with uncertain job market)	1	2	3	4	5	1	2	3	4	5
U-4	Limits imposed by the use of “health accounts” and the potential for medical needs of CSHCN not being covered	1	2	3	4	5	1	2	3	4	5
U-5	Co-pays, items not covered by insurance, out of pocket expenses	1	2	3	4	5	1	2	3	4	5
U-6	Increasing number of working poor not eligible for services	1	2	3	4	5	1	2	3	4	5
U-7	Difficulties/ demands associated with specialty referrals; “out of network” referrals	1	2	3	4	5	1	2	3	4	5
U-8	Payment for alternative / complementary treatment, (e.g., medications, nutritional, acupuncture)	1	2	3	4	5	1	2	3	4	5

End of Survey

Please review to be sure that the survey was completed by responding to all items in both columns.

APPENDICES from the SSI CSHCN Survey

1. Survey Screener Criteria for CSHCN
2. The New Hampshire Survey of Parents of Children with Special Health Care Needs Receiving SSI for Their Own Disability, 2004.

Appendix 1: Survey Screener Criteria for CSHCN

The Children with Special Health Care Needs (CSHCN) Screener© was developed through the efforts of the Child and Adolescent Health Measurement Initiative (CAHMI), a national collaboration coordinated by FACCT—The Foundation for Accountability. The Screener is a set of five consequences-based questions used to identify children with chronic or special health care needs. The questions are designed to be self-administered or telephone administered as part of a parent/caretaker survey.

Screening Criteria

The theoretical framework used by the CSHCN Screener is based on the Questionnaire for Identifying Children with Chronic Conditions (QuICCC) (Stein, et al., 1997). Like the QuICCC, the criteria used by the CSHCN Screener to determine whether a child has a chronic or special health care need are independent of a specific diagnostic or a formally recorded etiology.

The CSHCN Screener uses health-related consequences to identify children with chronic or special health care needs. The following must all be present for a child to qualify:

- The child must currently experience a specific consequence.
- The consequence is due to a medical, behavioral, or other health condition.
- The duration or expected duration of the condition is 12 months or longer.

The first part of CSHCN Screener question asks whether a child experiences one of five different health consequences:

- Use or need of prescription medication
- Above average use or need of medical, mental health or educational services
- Functional limitations compared with others of same age
- Use or need of specialized therapies (OT, PT, speech, etc.)
- Treatment or counseling for emotional, behavioral or developmental problems

The second and third parts of each question ask those responding “yes” to Part 1 of the question whether the consequence is due to a specific health condition and if so, whether that condition has lasted or is expected to last for at least 12 months.

All three parts of at least one screener question (or in the case of question 5 there are two parts) must be answered “yes” for a child to meet the CSHCN Screener criteria for having a chronic condition.

The CSHCN Screener has three “definitional domains”. They are:

- Dependency on prescription medications
- Service use above that considered usual or routine
- Functional limitations

The definitional domains are not mutually exclusive categories. A child identified by the CSHCN Screener may qualify on one or more domains.



State of New Hampshire
Department of Health and Human Services
Office of Medicaid Business and Policy

Special Medical Services Bureau

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Insurance/Cost-of-Care Survey
for Children with Special Health Care Needs, 2004

INTRODUCTION

The Special Medical Services Bureau is conducting this survey to gather accurate information about the cost of health care and the impact on children and youth with special health care needs and their families. We are sending this survey to families whose child with special health care needs is receiving SSI (Supplemental Security Income) for his or her own condition.

This survey is anonymous and confidential. No names or individual identification are used. The survey will only compile data based on numbers and percentages that result from the survey.

We report the results to the federal Maternal and Child Health Bureau, which provides funding for state programs serving children with special health care needs, under Title V of the Social Security Act. More importantly, the results are used to help the Special Medical Services Bureau make policy and funding decisions that are designed to improve services statewide.

Please take a few moments to look over the survey. If you decide to participate, please fill out the entire survey. We will have a better understanding of the cost-of-care issues for families with children with special health care needs if people participate and complete the whole survey.

The survey is very simple and should not take a lot of time. All you have to do is put a check mark in the answer box you select, for each item, and mail the survey back in the postage-paid envelope provided. **Please mail it back to DHHS-SMSB, 29 Hazen Drive, Concord, NH 03301-6504, attn: Lee Ustinich, no later than a week after receipt.** You may also fax the completed survey to 603-271-4902, Attn: Lee Ustinich. Feel free to call or e-mail with any questions or comments, 603-271-4014. justinich@dhhs.state.nh.us

Thank you very much for your time.

Decision-Making Partner

We are interested in your role as a partner in the decision making process, along with your child's health care providers. Please choose the answer that best reflects your experience.

1. In the past 12 months, how often did your child's doctors or other health care providers help you feel like a partner in (his/her) care?

- Never (1)
- Sometimes (2)
- Usually (3)
- Always (4)
- Don't know (5)

2. Thinking about your child's health needs and the services (he/she) receives, how satisfied or dissatisfied are you with those services?

- Very satisfied (1)
- Somewhat satisfied (2)
- Somewhat dissatisfied (3)
- Very dissatisfied (4)
- Don't know (5)

Medical Home

We now would like to ask you about the coordination of services and health care for your child. Please choose the answer that best reflects your experience.

3. Is there a place that your child usually goes to when he/she is sick?

- Yes (1)
- There is not place (2)
- There is more than one place (3)
- Don't know (5)

4. Is there a place that your child usually goes to for routine or preventative care?

- Yes (1)
- There is not place (2)

- There is more than one place (3)
- Don't know (5)

5. Do you have one person who you think of as your child's personal doctor or nurse?

- Yes (1)
- No (2)
- Don't know (5)

6. In the past 12 months, how much of a problem, if any, was it to get a referral to a specialist who your child needed to see?

- A big problem (1)
- A small problem (2)
- Not a problem (3)
- Child did not need to see a specialist in the past 12 months (4)
- Don't need referrals (6)
- Don't know (5)

7. During the past 12 months, was there any time when your child needed coordination among different health care providers and services?

- Yes (1)
- No (skip to question 9.) (2)
- Don't know (skip to question 9) (5)

8. **If yes**, did your child receive all the professional care coordination that was needed?

- Yes (1)
- No (2)
- Don't know (5)

9. How well do you think your child's doctors and other health care providers communicate with each other about your child's care?

- Excellent (1) Very good (2)
- Good (3) Fair (4)
- Poor (6) Communication not needed (7)
- Don't know (5)

10. How well do you think your child's doctors and other health care providers communicate with his or her school, early prevention programs, childcare providers, or vocational rehabilitation program?

Appendix 2: Survey

_____ Excellent (1) _____ Very good (2) _____ Don't know (5)
 _____ Good (3) _____ Fair (4)
 _____ Poor (6) _____ Communication
 not needed (7)

<u>Check the box that most closely reflects your experience.</u>	Never (1)	Sometimes (2)	Usually (3)	Always (4)	Don't know (5)
11. In the past 12 months, how often did your child's doctor or other health care providers spend enough time with him/her?					
12. In the past 12 months, how often did your child's doctor or other health care provider listen carefully to you?					
13. In the past 12 months, how often were the doctors or other health care providers sensitive to your family's values and customs?					
14. Information about a child's health care can include things such as the causes of any health problems, how to care for the child now, and what changes to expect in the future. In the past 12 months, how often did you get the specific information you needed from your child's doctors and other health care providers?					

Adequate Health Insurance

We would like to ask you about health care coverage for your child.

Please choose the answer that best reflects your experience.

15. What kind of health insurance does your child currently have?
 _____ No coverage (skip to question 20) (1)
 _____ Medicaid (Healthy Kids Gold) (2)
 _____ Medicare (3)
 _____ HC-CSD (Home Care for Children with Severe Disabilities/"Katie Becket") (4)
 _____ SCHIP (Healthy Kids Silver) (5)
 _____ Medigap (6)
 _____ Military (7)

- _____ Private health insurance (8)
 _____ Single service plan (dental, vision, prescriptions) (9)
 Other: _____ (10)

16. **If your child has coverage now**, has there been any time in the past 12 months that your child was **not** covered by any health insurance?
 _____ Yes (1) _____ No (2)
 _____ Don't know (5)
17. Do you believe that your child's health insurance offers benefits or covers services that meet his or her needs?
 _____ Never (1)

Appendix 2: Survey

- _____ Sometimes (2)
- _____ Usually (3)
- _____ Always (4)
- _____ Don't know (5)

18. Are the costs not covered by your child's health insurance reasonable?

- _____ Never (1)
- _____ Sometimes (2)
- _____ Usually (3)
- _____ Always (4)
- _____ Don't know (5)

19. Does your child's health insurance allow him or her to see the health care providers he or she needs?

- _____ Never (1)
- _____ Sometimes (2)
- _____ Usually (3)
- _____ Always (4)
- _____ Don't know (5)

20. If your child has no public or private health insurance, what is the reason?

Please check all that apply.

- _____ Cost too much (1)
- _____ Not eligible for State insurance (Healthy Kids, Gold/Silver) (2)
- _____ Do not know about State insurance (Healthy Kids Gold/Silver) (3)
- _____ Insurance is not in effect yet, pending (4)
- _____ Don't know (5)

If you do not know about Healthy Kids Gold or Healthy Kids Silver, may we contact you about this State Insurance option?

- _____ Yes (1): Phone _____
- _____ No (2)

21. At this time, is your child enrolled in Special Medical Services, the NH Title V program?

- _____ Yes (1)
- _____ No (2)
- _____ Don't know (5)

Impact on the Family

We would like to ask you about the impact of your child's cost-of-care on your family.

Please choose the answer that best reflects your experience.

22. How much did your family pay out-of-pocket for your child's health care needs in the past 12 months? Important: do not count the cost of insurance itself or any reimbursement from insurance. Out-of-pocket payments for health-related needs include things such as co-pays, non-covered prescription medications, over-the-counter medicines, special foods, adaptive clothing, durable equipment, home modifications, any kind of non-covered therapy, and other items or services that are necessary for your child's health care that you must pay for yourself.

- _____ Nothing \$0 (1)
- _____ Less than \$250 (2)
- _____ \$250-\$500 (3)
- _____ \$501-\$1000 (4)
- _____ \$1001-\$5000 (6)
- _____ Over \$5000 (7)
- _____ Don't know (5)

23. Do you or other family members provide health care at home for your child, such as changing bandages, care of feeding or breathing equipment, giving medication and therapies, and providing transportation to appointments?

- _____ Yes (1)
- _____ No (skip to question 25) (2)
- _____ Don't know (skip to question 25) (5)

24. How many hours per week do you or other family members spend providing this kind of care?

- _____ Hours per week
- _____ Don't know (999)

Appendix 2: Survey

25. How many hours per week do you or other family members spend arranging or coordinating your child's care? This includes making appointments, making sure that care providers are exchanging information, and following up on your child's care needs.

_____ Hours Per Week
_____ Don't Know (5)

26. Has your child's health condition(s) caused financial problems for your family?

_____ Yes (1)
_____ No (2)
_____ Don't know (5)

27. Have you or other family members cut down on the hours you work to care for your child?

_____ Yes (1)
_____ No (2)
_____ Don't know (5)

28. Have you needed additional income to cover your child's medical expenses?

_____ Yes (1)
_____ No (2)
_____ Don't know (5)

29. Have you or other family members stopped working because of your child's health conditions?

_____ Yes (1)
_____ No (2)
_____ Don't know (5)

30. Have you or other family members refrained from changing jobs because of your child's health insurance status?

_____ Yes (1)
_____ No (2)
_____ Don't know (5)

Community-Based Service Systems

31. Thinking about the services your child needs, are those services organized in a way that makes them easy to use?

_____ Never (1)
_____ Sometimes (2)
_____ Usually (3)
_____ Always (4)
_____ Don't know (5)

Access to Selected Services

32. During the past 12 months, was there a time when your child needed dental care, including check-ups?

_____ Yes (1)
_____ No (skip to question 34) (2)
_____ Don't know (skip to question 34) (5)

33. Did your child receive all the dental care that he or she needed?

_____ Yes (skip to question 35) (1)
_____ No (2)
_____ Don't know (5)

34. **If no**, why did your child not get the dental care he or she needed? Check all that apply.

_____ Cost too much (1)
_____ Health plan problem (2)
_____ Not available in our area (3)
_____ Transportation problem (4)
_____ Other (6)

_____ Don't know (5)

35. During the past 12 months, was there a time when your child needed mental health services?

_____ Yes (1)
_____ No (skip to question 38) (2)
_____ Don't know (skip to question 38) (5)

36. Did your child receive all the mental health services that he or she needed?

_____ Yes (skip to question 38) (1)
_____ No (2)
_____ Don't know (5)

37. **If no**, why did your child not get the mental health service he or she needed? Check all that apply.

_____ Cost too much (1)

Appendix 2: Survey

- Health plan problem (2)
- Not available in our area (3)
- Transportation problem (4)
- Other (6)

Don't know (5)

38. During the past 12 months, was there a time when your child needed substance abuse services?

- Yes (1)
- No (skip to question 41) (2)
- Don't know (skip to question 41) (5)

39. Did your child receive all the substance abuse services that he or she needed?

- Yes (skip to question 41) (1)
- No (2)
- Don't know (skip to question 41) (5)

40. **If no**, why did your child not get the substance abuse service he or she needed? Check all that apply.

- Cost too much (1)
- Health plan problem (2)
- Not available in our area (3)
- Transportation problem (4)
- Other (6)

Don't Know (5)

Transition to Adult Life
(Respond only if your child is age 12 or older.)

Now we would like to ask about transition planning for adult life, adult health care, work, and independence. Please check the box that best reflects your experience.	Yes (1)	No (2)	Don't Know (5)
41. If your child is 12 years or older, has your child's doctor or other health care provider talked with you or your child about how his/her health care needs might change when he/she becomes an adult?			
42. Has a plan for addressing these changing needs been developed with the doctor or other health care provider(s)?			
43. Has your child's doctor or other health care provider discussed having your child eventually see a doctor who treats adults?			
44. Has your child received any vocational or career training to help him/her prepare for a job when he/she becomes an adult?			

Demographic Information for Statistical Purposes only

Again, this survey is anonymous and confidential. No names or individual identification is used. The survey will only compile data based on aggregate numbers and percentages that result from the survey. We would like to gather some demographic data reflecting the families surveyed. Please take an extra few moments to complete this final part of the survey. Thank you.

45. How old is your child with special health care needs? _____ Years _____ Months

46. Is your child male (1) or female (2)?

47. What is your county of residence?

- Belknap _____(1)
- Carroll _____(2)
- Cheshire _____(3)
- Coos _____(4)
- Grafton _____(5)
- Hillsborough _____(6)
- Merrimack _____(7)
- Rockingham _____(8)
- Sullivan _____(9)
- Strafford _____(10)

48. What is the race/ethnicity of your child? _____

49. What is the primary language spoken at home? _____

50. How long has your child had his or her primary condition? _____ Years
_____ Months

51. What is your household income: \$ _____

Do not know: _____(5)

Decline to answer: _____(9)

52. How many children *under* 18 are in your household? _____

53. How many adults *over* 18 are in your household? _____

END OF SURVEY

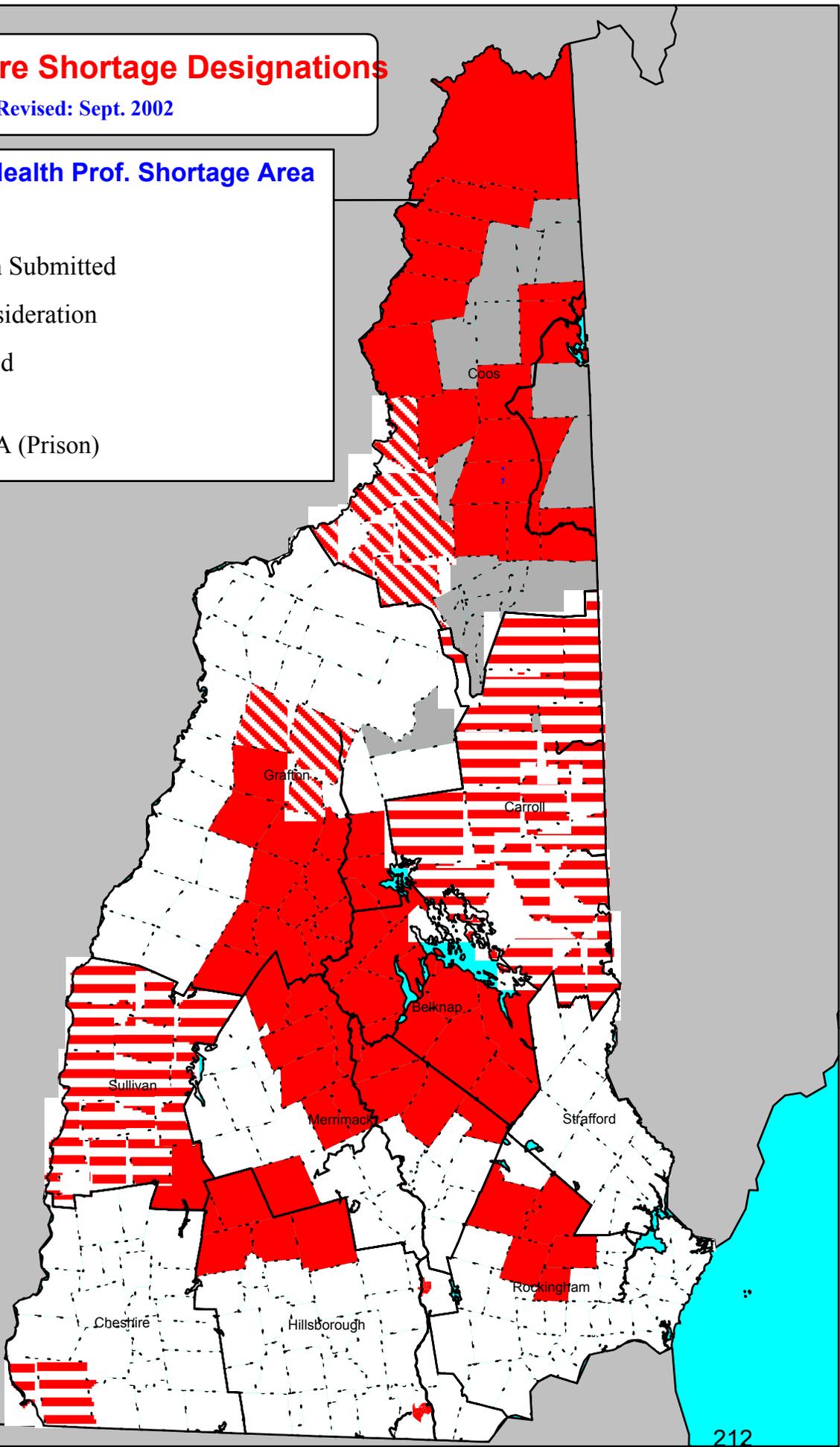
Please return completed survey as soon as possible in the envelope provided.

New Hampshire Shortage Designations

Revised: Sept. 2002

Primary Care Health Prof. Shortage Area

-  HPSA
-  Application Submitted
-  Under Consideration
-  Unpopulated
-  Non HPSA
-  Facility HPSA (Prison)

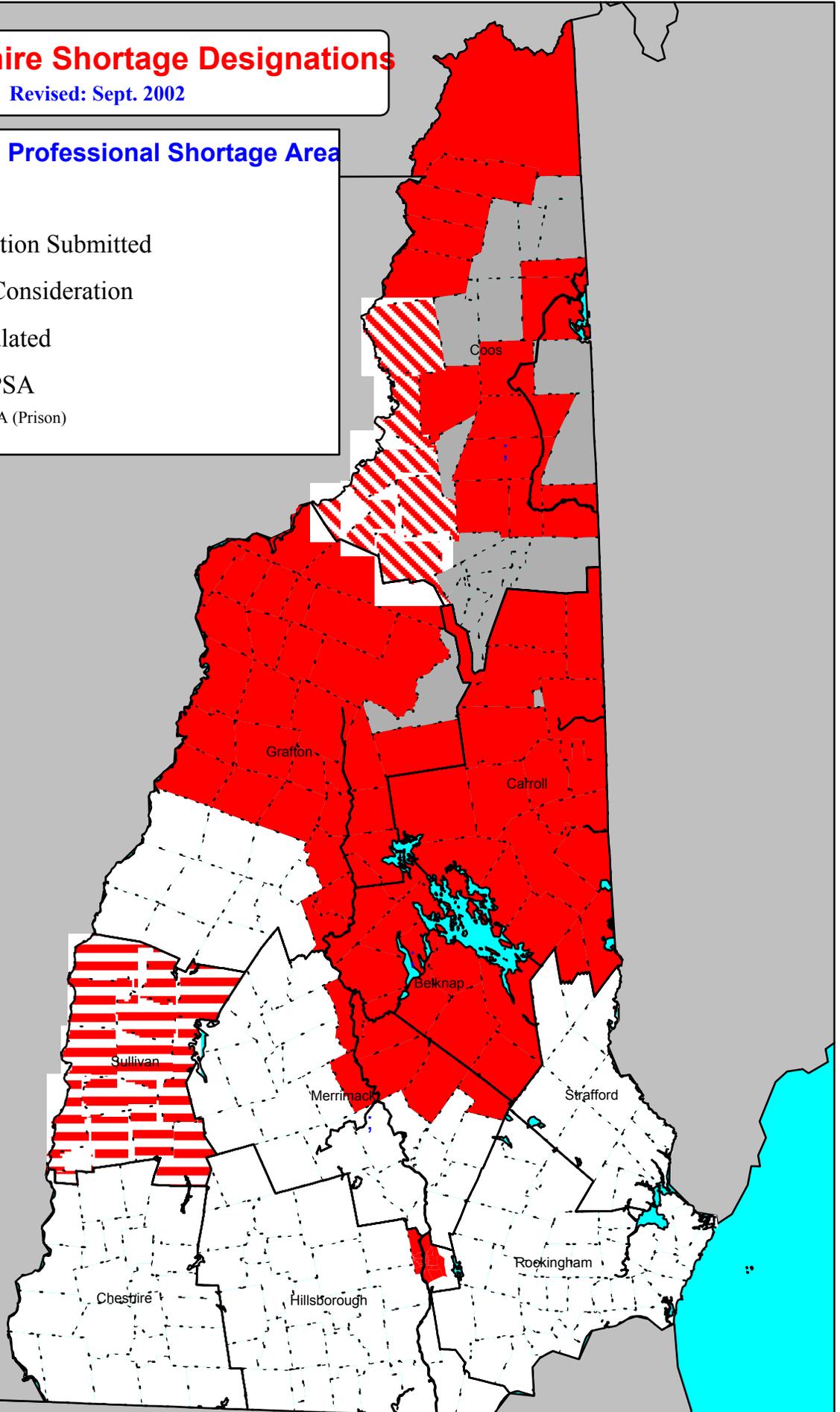


New Hampshire Shortage Designations

Revised: Sept. 2002

Dental Health Professional Shortage Area

-  HPSA
-  Application Submitted
-  Under Consideration
-  Unpopulated
-  Non HPSA
-  Facility DHPSA (Prison)

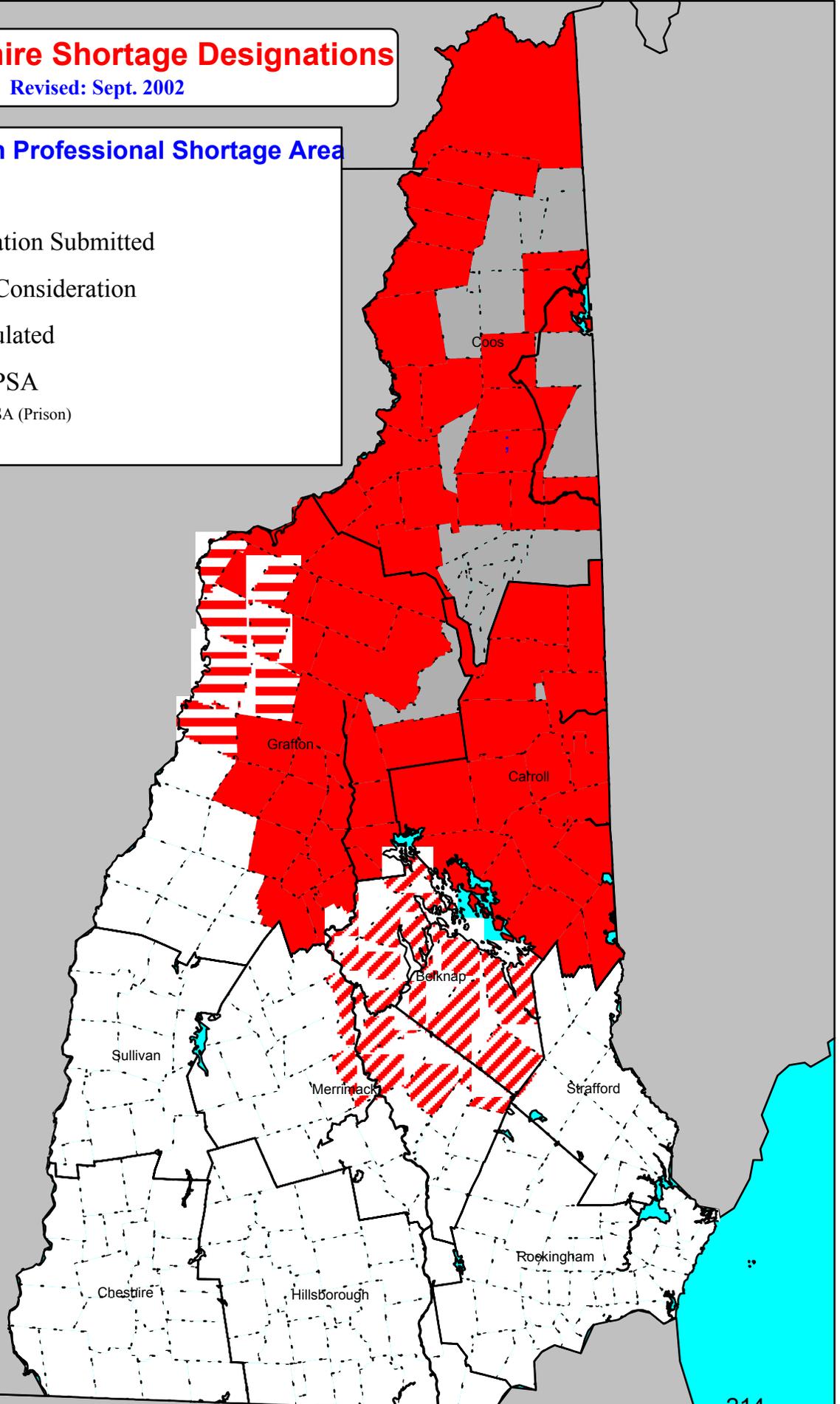


New Hampshire Shortage Designations

Revised: Sept. 2002

Mental Health Professional Shortage Area

-  HPSA
-  Application Submitted
-  Under Consideration
-  Unpopulated
-  Non HPSA
-  Facility MHPSA (Prison)



Appendix E MCH AGENCY PERFORMANCE MEASURE TRENDS

Child Health Support

Performance Measure	FY01	FY02	FY03	FY04	FY05
Percent of children not insured (measure was developmental in FY01)	NH Rate	5.1	5.1	5.1	
	CH-S Agencies' Rate/Avg	26	27	4	13
	CH-S Agencies' Range	8-44	6-60	0-7	2-20
Percent of children enrolled in Healthy Kids (HK) Gold (measure was developmental in FY01)	NH Rate			None	None
	CH-S Agencies' Rate/Avg	52	55	76	62
	CH-S Agencies' Range	19-85	30-74	39-99	13-100
Percent of children enrolled in Healthy Kids (HK) Silver (measure was developmental in FY01)	NH Rate			None	None
	CH-S Agencies' Rate/Avg	0.5	0.5	4	2
	CH-S Agencies' Range	0-1	.5-.78	0-10	0-4
Percent of children with a primary care provider/medical home (PCP)	NH Rate			None	None
	CH-S Agencies' Rate/Avg			100	98
	CH-S Agencies' Range			100	94-100
Percent of children whose parents received parenting support and education	NH Rate			None	None
	CH-S Agencies' Rate/Avg			100	96
	CH-S Agencies' Range			100	93-100
Percent of children whose family was linked with a needed resource such as a health/dental provider, WIC, mental health services, social services, fuel assistance, housing, etc.	NH Rate			None	None
	CH-S Agencies' Rate/Avg			98	54
	CH-S Agencies' Range			93-100	21-100

Appendix E MCH AGENCY PERFORMANCE MEASURE TRENDS

Child Health Direct		FY01	FY02	FY03	FY04	FY05	FY06
Performance Measure							
Percent of children 24-35 months who have received basic immunization series (measure was developmental in FY01)	NH Rate	77.6	83.5	86.5	84		
	CH-D Agencies' Rate/Avg	88.2	87	85	91		
	CH-D Agencies' Range	71-100	64-100	50-100	67-100		
Percent of children age 2 (18-29 months) screened for blood lead (Measure was developed in FY01, 02, and 03)	NH Rate	23	23	25	25		
	CH-D Agencies' Rate/Avg		74	76	76		
	CH-D Agencies' Range		7-100	25-100	0-100		
Percent of children age one (6-17 months) screened for blood lead	NH Rate		54	52	53	48	
	CH-D Agencies' Rate/Avg		75	83	84		
	CH-D Agencies' Range		33-100	50-100	25-100		
Percent of children not insured (discontinued in FY 06)	NH Rate	5.1	5.1	5.1	5.1		
	CH-D Agencies' Rate/Avg		22	25	15		
	CH-D Agencies' Range		7-60	9-77	2-92		
Percent children 2 mos – 6 yrs who adhered to periodicity schedule (measure was developmental in FY01, 02, and 03 - not used for 04 and 05)	NH Rate			None			
	CH-D Agencies' Rate/Avg			77			
	CH-D Agencies' Range			32-95			
Revised Measure 04 Percent of children who turned 15 months old during the fiscal year, who were continuously enrolled since 31 days of age, who adhered to the MCH/AAP periodicity schedule for well child visits (measure is developmental for 04 and 05)	NH Rate				None		
	CH-D Agencies' Rate/Avg				76		
	CH-D Agencies' Range				0-100		
Percent of eligible children enrolled in Medicaid/Healthy Kids Gold (new for FY '06)	NH Rate						
	CH-D Agencies' Rate/Avg						
	CH-D Agencies' Range						

Appendix E MCH AGENCY PERFORMANCE MEASURE TRENDS						
Prenatal Services Performance Measure	FY01	FY02	FY03	FY04	FY05	
Percent of infants born to women receiving prenatal care beginning in the first trimester	State Rate	88% / 75%	None	94% / 83%		
	State Agencies' Rate/Average	None		79%		
	Agency Range	54 - 81	33 - 90	56 - 96		
Percent of pregnant women who smoke received tobacco cessation counseling	State Rate	None	None	None		
	State Agencies' Rate/Average	None		93%		
	Agency Range		84 - 100	79 - 100		
Percent pregnant women screened for substance abuse each trimester	State Rate		None	None		
	State Agencies' Rate/Average			88%		
	State Agencies' Range		57 - 100	14 - 100		
Percent pregnant women receive prenatal screening for metabolic/genetic disorders	State Rate		None	None		
	State Agencies' Rate/Average			65%		
	Agency Range		25 - 85	16 - 100	0	

PM #1 State Rate Non-Medicaid /Medicaid Rates

**Appendix F: Indicator Ratings for 10 Essential Services
Summary Sheet: Essential Service #1**

Assess and monitor maternal and child health status to identify and address problems.

<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	1.DU.1 Use public health data sets to prepare basic descriptive analyses related to priority health issues (e.g., PRAMS; BRFSS; YRBS; live birth, fetal death, abortion, linked live birth/infant death data; community health surveys; census data; etc.)
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	1.DU.2 Conduct analyses of public health data sets that go beyond descriptive statistics
<input checked="" type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	1.DU.3 Generate and analyze primary data to address state- and local-specific knowledge base gaps
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	1.DU.4 Interpret and report on primary and secondary data analysis for use in policy and program development
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	1.TA.1 Establish framework/template/standards about core data expectations for local health agencies and other MCH providers/programs
<input checked="" type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	1.TA.2 Provide training/expertise about the collection and use of MCH data to local health agencies or other constituents for MCH populations
<input checked="" type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	1.TA.3 Assist local health agencies in data system development and coordination across geographic areas so that MCH data outputs can be compared

Summary Sheet: Essential Service #2

Diagnose and investigate health problems and health hazards affecting women, children, and youth.

<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	2.1 Use epidemiologic methods to respond to MCH issues and sentinel events as they arise
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate (Lead is Substantially)	2.2 Engage in collaborative investigation and monitoring of environmental hazards (e.g., physical surroundings and other issues of context) in schools, day care facilities, housing, and other domains affecting MCH populations, to identify threats to maternal and child health
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	2.3 Develop and enhance ongoing surveillance systems/population risk surveys and disseminate the results at the state and local levels
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	2.4 Serve as the state’s expert resource for interpretation of data related to MCH issues
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	2.5 Provide leadership in reviews of fetal, infant, child, and maternal deaths and provide direction and technical assistance for state and local systems improvements based on their findings
<input checked="" type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	2.6 Use epidemiologic methods to forecast emerging MCH threats that must be addressed in strategic planning

Summary Sheet: Essential Service #3

Inform and educate the public and families about maternal and child health issues.

<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	3.IB.1 Utilize a routine mechanism for identifying existing and emerging health education needs and appropriate target audiences
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	3.IB.2 Conduct and/or fund health education programs/services on MCH topics targeted to specific audiences to promote the health of MCH populations
<input checked="" type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	3.IB.3 Produce and disseminate evaluative reports on the effectiveness of health promotion and health education programs/campaigns
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	3.PB.1 Utilize a routine mechanism for identifying existing and emerging population-based health information needs
<input checked="" type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	3.PB.2 Design and implement public awareness campaigns on specific MCH issues to promote behavior change
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	3.PB.3 Develop, fund, and/or otherwise support the dissemination of MCH information and education resources
<input checked="" type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	3.PB.4 Produce and disseminate evaluative reports on the effectiveness of public awareness campaigns and other population-based health information services

Summary Sheet: Essential Service #4

Mobilize community partnerships between policymakers, health care providers, families, the general public, and others to identify and solve maternal and child health problems.

<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	4.1 Respond to community MCH concerns as they arise
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	4.2 Specify community geographic boundaries and/or stakeholders for use in targeting interventions and services
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	4.3 Provide trend information to targeted community audiences on state and local MCH status and needs
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	4.4 Actively solicit and use community input about MCH needs
<input checked="" type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	4.5 Provide funding and/or technical assistance for community-driven and –generated initiatives and partnerships among public and/or private community stakeholders (e.g., MCOs, hospital associations, parent groups)
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	4.6 Convene, stimulate, and/or provide resources (e.g., staffing, funding) for coalitions of agencies and/or constituent professional organizations to develop strategic plans to address health status and health systems issues

Summary Sheet: Essential Service #5

Provide leadership for priority setting, planning, and policy development to support community efforts to assure the health of women, children, youth, and their families.

<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input checked="" type="checkbox"/> Fully Adequate	5.DD.1 Actively promote the use of the scientific knowledge base in the development, evaluation, and allocation of resources for MCH policies, services, and programs
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	5.DD.2 Support the production and dissemination of an annual state report on MCH status, objectives, and programs, beyond the annual Block Grant submission
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	5.DD.3 Establish and routinely use formal mechanisms to gather stakeholders' guidance on MCH concerns
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	5.DD.4 Use diverse data and perspectives for data-driven planning and priority setting
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	5.PD.1 Participate in and provide consultation to ongoing state initiatives to address MCH issues and coordination needs
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate Formal IAs not viewed as important in NH	5.PD.2 Develop, review, and routinely update formal interagency agreements for collaborative roles in established public programs (e.g., WIC, family planning, Medicaid)
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	5.PD.3 Serve as a consultant to, and cultivate collaborative roles in, new state initiatives, through either informal mechanisms or formal interagency agreements
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	5.PD.4 Advocate for programs and policies necessary to promote the health of MCH populations based on the scientific knowledge base/data and community input

Summary Sheet: Essential Service #6

Promote and enforce legal requirements that protect the health and safety of women, children and youth, and ensure public accountability for their well-being.

<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate Thru partnerships with external orgs.	6.LA.1 Periodically review <i>existing</i> state MCH-related legislation to assess adequacy and any inconsistencies in legislative/regulatory mandates across programs serving MCH populations
<input checked="" type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	6.LA.2 Monitor <i>proposed</i> legislation that may impact MCH and participate in discussions about its appropriateness and effects
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	6.LA.3 Devise and promote a strategy (specific to state constraints/protocols) for informing elected officials about legislative/regulatory needs for MCH
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate SMS more limited than MCH	6.LA.4 Initiate legislative proposals and/or lead regulatory efforts (specific to state constraints and protocols) pertaining to MCH concerns when appropriate
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate Given limited licensure in NH	6.CS.1 Participate in processes led by professional organizations and other state agencies to provide MCH expertise in the development of licensure and certification processes
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	6.CS.2 Provide leadership to develop and promulgate harmonious and complementary standards that promote excellence in quality care for women, infants, and children, in collaboration with professional organizations and other state agencies with regulatory capacity as appropriate
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	6.CS.3 Integrate standards of quality care into third party contracts for Title V-funded services, other publicly-funded services (e.g., Medicaid, SCHIP, WIC, family planning), and/or privately-financed services
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	6.CS.4 Develop, enhance, and promote protocols, instruments, and methodologies for use by health plans, insurance agencies, and other relevant state and local agencies that promote MCH quality assurance
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	6.CS.5 Participate in or provide oversight for quality assurance efforts among regional health providers and systems and local health agencies and contribute resources for correcting identified problems

Summary Sheet: Essential Service #7

**Link women, children and youth to health and other community and family services,
and assure access to comprehensive, quality systems of care.**

<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	7.AA.1 Develop, publicize, and routinely update a toll-free line and other resources for public access to information about health services availability
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	7.AA.2 Provide resources and technical assistance for outreach, improved enrollment procedures, and service delivery methods for hard-to-reach populations
<input checked="" type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	7.AA.3 Develop and routinely evaluate tracking systems for universal, high risk, and underserved populations
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	7.AA.4 Provide or pay for direct services not otherwise available to CSHCN and other MCH populations (with Title V or other available funding)
<input checked="" type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	7.AA.5 Provide resources to strengthen the cultural and linguistic competence of providers and services to enhance their accessibility and effectiveness
<input checked="" type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	7.AA.6 Collaborate with other state agencies to identify and obtain resources to expand the capacity of the health and social services systems, and establish interagency agreements for the administration of capacity-expanding initiatives/protocols
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	7.AA.7 Actively participate in public insurers' oversight of health plan/provider enrollment procedures and development of plans for appropriate provision of services for new enrollees
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	7.CC.1 Provide leadership and resources for a system of case management and coordination of services
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate Meaning unclear	7.CC.2 Provide leadership and oversight for systems of risk-appropriate perinatal and children's care and care for CSHCN

Summary Sheet: Essential Service #8

Assure the capacity and competency of the public health and personal health workforce to effectively and efficiently address maternal and child health needs.

<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	8.CP.1 Develop and enhance formal and informal relationships with schools of public health and other professional schools to enhance state and local public agency analytic capacity
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate Federal HRSA doing; unnecessary to do at state level. NH obtains, reviews data.	8.CP.2 Monitor the numbers, types, and skills of the MCH labor force available to the state and localities
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	8.CP.3 Monitor facility/institutional provider and program distribution throughout the state
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	8.CP.4 Integrate information on workforce and facility/program availability or distribution with ongoing health status needs assessment in order to address identified gaps and areas of concern
<input checked="" type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	8.CP.5 Create financial and other incentives and program strategies to address identified clinical professional and/or public health workforce shortages
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	8.CM.1 Make available and/or support continuing education for targeted professional audiences in public and private provider sectors on clinical and public health skills, emerging MCH issues, and other topics pertaining to MCH populations (e.g., cultural competence, availability of ancillary services and community resources, the community development process)
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	8.CM.2 Play a leadership role in establishing professional competencies for Title V and other MCH programs

Summary Sheet: Essential Service #9

Evaluate the effectiveness, accessibility, and quality of personal health and population-based maternal and child health services.

<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	9.1 Support and/or assure routine monitoring and structured evaluations of state-funded services and programs
<input checked="" type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	9.2 Provide and/or assure technical assistance to local health agencies in conducting evaluations
<input checked="" type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	9.3 Provide resources for and/or collaborate with local health or other appropriate agencies in collecting and analyzing data on consumer satisfaction with services/programs and community perceptions of health needs, access issues, and quality of care
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	9.4 Perform comparative analyses of programs and services
<input checked="" type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	9.5 Disseminate information about the effectiveness, accessibility, and quality of personal health and population-based MCH services
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	9.6 Utilize data for quality improvement at the state and local levels
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate Not applicable/role not supported by agency	9.7 Assume a leadership role in generating and disseminating information on private sector MCH outcomes

Summary Sheet: Essential Service #10

Support research and demonstrations to gain new insights and innovative solutions to maternal and child health-related problems.

<input checked="" type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	10.1 Monitor the progress of state-specific and national MCH research and disseminate results of that research to providers, public health practitioners, and policy makers
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate Performed by Health Statistics & NH Kids Count Lead Prog. seen as expert consultant in its field	10.2 Serve as a source for expert consultation to MCH research endeavors in the state
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	10.3 Conduct and/or provide resources for state and local studies of MCH issues/priorities

Appendix G: Assessment of New Hampshire Capacity Needs

Structural Resources

<u>Capacity Need</u>	Have	Need	Specific Needs
1. Sufficient Authority & Funding		X	<ul style="list-style-type: none"> ○ Authority to spend grant funds as approved by funders ○ Identify specific priority needs & impact of inadequate funds ○ Newborn screening authority
2. 2-Way Communication Channels or Mechanism		X	<ul style="list-style-type: none"> ○ Formal mechanisms ○ Need way to make it a priority given turnover, etc. ○ Be more proactive with constituencies ○ Use social marketing
3. Access to up-to-date information	X		
4. Partnership Mechanisms	X		
5. Workforce capacity institutionalized (job descriptions, contract language, performance assessment, etc.)		X	<ul style="list-style-type: none"> ○ Adequate numbers of staff ○ Routine data collection & training ○ Assess what's needed (skills) & use in recruiting & hiring
6. Mechanisms for accountability & quality improvement		X	<ul style="list-style-type: none"> ○ Institutionalize, make regular what's been developed
7. Formal assessment/planning protocols	X		

Data/Information Systems

<u>Capacity Need</u>	Have	Need	Specific Needs
8. Access to timely data		X	○ Real time
9. Supportive environment for data sharing		X	
10. Adequate data infrastructure		X	○ Many aspects ○ Public/private system

Organizational Relationships

<u>Capacity Need</u>	<i>Have</i>	Need	Specific Needs
11. State Health Dept./Agencies/Programs	X		
12. Other state agencies		X	○ Juvenile Justice, Housing, Economic Development, Education ○ High level leadership/structure to support programs, such as Children's Cabinet
13. Insurers/insurance oversight stakeholders		X	○ Joint planning with Medicaid ○ Private insurers ○ Insurance Dept. ○ Employers
14. Local providers of health & other services		X	○ Private providers
15. Superstructure of local health operations/state-local linkages	X		
16. State/national entities enhancing analytical & programmatic capacity	X		
17. National governmental sources of data	X		

18. State/local policy makers			
19. Non-governmental advocates, funders, resources for state/local health activities	X		
20. Businesses		X	

Competencies

Capacity Need	Have	Need	Specific Needs
21. Communication/Data translation skills		X	<ul style="list-style-type: none"> ○ Need more staff ○ Could work more with marketing firms; need to be able to get what we need from them
22. Ability to work effectively with public/private organizations	X		<p>Need to maintain</p> <p>Also could be contracted out</p>
23. Ability to influence policymaking process		X	
24. Experience/expertise in working with & in communities	X		
25. Management/organizational development skills		X	<ul style="list-style-type: none"> ○ Maintain ○ New/promoted managers ○ Draw on what exists more formally & cross program ○ Utilize existing resources
26. Knowledge and understanding of the state context	X		
27. Data and analytic skills		X	<ul style="list-style-type: none"> ○ More staff with these skills needed
28. Knowledge of MCH and related content areas	X		

Appendix H: Action Plans for Capacity Building in Priority Areas

1. Data access, environment, infrastructure and competencies (#s 8, 9, 10 &27)*

<u>Issue & Action Steps</u>	<u>Responsible Staff</u>
Access to timely program and population data – Public/Private (real time) (#8)	
1) DPHS needs access to Birth Data, currently denied by Secretary of State	
➤ Schedule meeting with OIT liaison (Rich Regan)	Marie
➤ MOU with SOS is being developed	
2) Develop prenatal module in AURIS.	Marie
➤ Schedule meeting with OIT liaison (Rich Regan)	Marie
➤ Conference call with Welligent re: proposal, on 2/9/05 (LB, AC, DL, JZ, MK, invite OIT)	Ruth/Marie
➤ Amend Welligent Contract 1/05	
➤ Discuss contract with BA and Dave Perry	Lisa
3) SMS contractor data– Talk to Judy and Jane 1/24/05.	Lee U.
➤ Include specific data requirements in SMS contracts,	
➤ Assign support staff.	Judy/Jane
4) Access to other agency data:	
➤ Medicaid (MDSS) – find out when additional staff/programs will be trained.	Marie
➤ Dept of Education – contact Mary Bubnis and ask her to notify Lisa and Judy when YRBS available.	Anita
➤ Justice – crime data - Contact DOJ for available data.	John
➤ Compile list of all data that we collect, including DV. DCYF, Housing – determine if need formal MOU.	Shari
➤ NH health data inventory website compilation of data from various sources. David will talk to UNH about notification.	David
➤ UDS – continue to obtain yearly and analyze – talk with Bryan.	Lisa
➤ CH/HVP data - Discuss what’s collected now at Data Team meetings – any revisions – link w/birth data for program evaluation	Marie

Supportive Environment for Data Sharing (#9)

➤ Injury coding – After hiring injury epid., train hospital coders.	TBD
➤ MCH agency codebook – develop (performance indicators).	David
➤ WRQS – Find out status and ensure access.	David
➤ Document data requests - create central data file on T:drive, ○ include e-mail requests, Health Statistics request form, ○ provide detail of what is included in data, staff person ○ who completed the request.	Marie
➤ Participate in DHHS Health Data Committee.	John/Marie/ David

Adequate Data Infrastructure (#10)

- Software needs – Megan statistical software needed follow-up
 - with CDC for SAS. Megan
- Reports – Make a plan for report dissemination – meet with PIO –
 - Kathleen Desmaris. Invite Kathleen to MCH Management Team
 - Meeting along with Judy and Lee. Shari
- SMS Funding and Infrastructure Problems – Look for \$ for
 - Welligent module for care coordination. Medicaid might have \$. Lee

Data and Analytic Skills (#27)

- Continue Data Team. Marie
- Continue providing opportunity to attend MCH Leadership
 - training systems. Lisa
- See software training – SAS, SPSS and Access and \$ build into
 - SDI \$ (workforce development). Marie
 - SMS – train support staff. Lee
- UNH “Prove It” course – look into having course provided here. David
 - (Intro to using data)
- Data Team provide in-service to MCH staff. David
- Purchase audio recording equipment for focus groups, etc. Shari
 - (DL discussed options with LB)
- MCH Epi conference and others Marie/David/John
- Participate in committees Marie/David/John
 - statewide and DHHS NH data users

2. Ability to influence the policymaking process (#23)

- Share information/resources on advocacy (eg. NHCAN) **Sharon by Jan. 1, 2005**
- Conduct in-services for staff and contracted agencies on legislative processes and agenda (e.g. invite Kate Frey) **Lisa and Judy contact Kate by Jan. 15, 2005**
- Include on advisory groups Congressional staff (e.g. for Sen. Gregg), policymakers (eg. legislators with interests in specific issues) and policy influencers (e.g. Governor’s wife on obesity performance measures) **Audrey determine agency leads/plans on obesity as a first step by Jan. 30, 2005. Lorna identify key legislative staff people by Jan. 30, 2005**
- Share agency information on key state legislation introduced. **MCH send to SMS by Feb. ‘05**
- Share information/reports with policymakers; include study committees and target those with relevant interests. (Ties into identified weaknesses and capacity needs to increase reports/information dissemination/marketing) **Lead/steps TBD**

- Invite policymakers to conferences *All relevant; ongoing*
- Participate in NHCAN work groups planning for the fall summit to identify advocacy needs *Joanne & Sharon ongoing by Fall each year*

3. Workforce capacity (including management and organizational development competencies) (#s 5 and 25)

- Improve sharing of information across programs
 - *SMS will share manuals by January 2005*
 - *MCH will share its emails on training opportunities on an ongoing-basis, beginning January 2005*
- Review RFPs/contract language/requirements to address needed workforce capacities *Responsible Program Mgrs. for all RFPs over next 24 months*
- Develop proactive mechanisms for all staff at all levels to receive training/development in needed capabilities, mechanisms such as:
 - Staff orientation
 - Routine identification of needs and plans for training via performance evaluations
 - Formal leadership development process*Anita & Lee will form small work group (with different levels and types of staff) by Jan. 30, 2005 to recommend possible strategies*
- Review allocation of Title V budget for staffing patterns vs. capacity needs (& functional strategic priorities) *Judy and Lisa by March 2005*
- Review workforce needs across programs (MCH & SMS)
 - Judy and Lisa by March, 2005*
 - Possibly identify areas to share staff
- Assign staff leads for priority health issues (performance measures). [Responds to example in #5 in CAST-5 tool as method for promoting accountability for identified needs and plans]
 - Block Grant Team by July 15, 2005*
- Review/carefully look at job descriptions/supplemental job descriptions and actual job responsibilities (including representation commitments) for filled and open positions
 - All staff – Submit to SMS/MCH Management with annual reports by Sept. 1, 2005*
- Meet with HR to explain/discuss workforce needs, and make recommendations, including on recruitment
 - Judy and Lisa by Sept. 30, 2005*
 - Consider hiring a recruitment consultant

* Numbers refer to the capacity needs as listed in the CAST-5 tool

Summary of New Hampshire's 2005 Needs Assessment

List of the State's priority needs and any changes since last BG application

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

NH continues to struggle with data capacity; this was a top priority identified in NH's CAST-V process. Lack of access to birth files and other vital records has presented a barrier to analysis and data linkage efforts this past year. The MCH Data Team created an action plan to address data and information needs. This priority was seen as likely to further Title V's focus on infrastructure and population-based services.

2. To assure safe and healthy pregnancies for all women, especially vulnerable populations

NH women in the adolescent and young adult years, as well as those dependant on Medicaid as a payer source, experience disproportionate levels of inadequate prenatal care and less favorable birth outcomes than other women. These findings point to potential intervention areas, such as anti-smoking campaigns targeting certain prenatal age groups and policies to promote Medicaid enrollment and care utilization.

3. To assure safe and healthy environments for MCH populations, including those with special health care needs

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. Refugee children have been identified as having an increased risk for elevated blood lead levels and efforts have begun to ensure that this population is screened.

4. To decrease dental disease in MCH populations

Dental care access is a problem in NH, specifically for the poor, under and uninsured. In 2002, 49% of NH children enrolled in Medicaid were seen by a dentist. While recent advances have improved NH's oral health capacity, continued effort is needed to sustain this fledgling system.

5. To decrease unintentional injuries among children and adolescents, including those with special health care needs

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

6. To promote healthy behaviors and access to health care services for adolescents, including those with special health care needs

In NH, 7.3% of children < age 18 live in poverty. One investigation suggested that residence in poorer NH towns places youth at increased risk for poor outcomes. Teen births, adolescent suicide, unintentional injury, and hospitalizations for asthma are areas of most concern. In NH, suicide is the 2nd leading cause of injury-related death among adolescents ages 10-24. NH's teen suicide rates exceed the U.S. average.

7. To preserve effective public health programming, including an infrastructure of safety net providers, to address the needs of MCH populations

Rising unemployment in some regions, soaring housing costs and Medicaid modernization all may influence the health of NH's families in the near future. Scarce state resources and federal funding reductions in may threaten the existence of some state programs. The potential exists for decreasing access to care and worsening health indicators among women and children, including CYSHCN.

8. To improve access to mental health services for children, including those with special health care needs, and their families

Information from several sources indicated significant mental health problems in children and adolescents and a lack of mental health services and skilled professionals. Mental health safety net systems are overtaxed, with long waiting lists. Limited community-wide coordination exists for the early identification of mental disorders. In both private and public sectors, the picture is equally bleak.

9. To decrease the prevalence of childhood obesity

Obesity is an increasing problem nationally, but one for which little NH data is available at this time. Available NH data reveal that the percentage of NH school-aged children and adolescents is significantly above the national recommended standard. More than a third of surveyed young people in grades 9-12 did not regularly engage in vigorous physical activity.

10. To increase the availability of respite and child care for medically and behaviorally complex children with special health care needs. (NEW)

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. The capacity of the system to address this need has been assessed to be weak or to have gaps in certain areas. A statewide effort is needed to provide support for workforce development to serve this population of CSHCN.

Changes to priorities made since last year's application include a wording change in priority #5, and the replacement of a priority on self-care for YSHCN with priority #10 on respite for families of CSHCN.

Process used to determine the State's priority needs and any changes

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 provided an overview of current maternal and child health in NH, and 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.

Initial meetings with external stakeholders were held to garner input on Title V needs, followed by internal meetings of Title V managers to match needs to capacity and determine priorities. High needs that matched with high capacity were identified as prime candidates for intervention. A master list of needs was created. Title V staff selected criteria by which to choose top priorities. Criteria were based on public health principles, including magnitude of need, whether the need is amenable to change, and whether the need can be addressed in a 5-year timeframe. With matching of needs to capacity, in the context of Title V's guiding principles, top priorities crystallized and were articulated.

Partnership building and collaboration

Families of CSHCN and health care providers were surveyed to identify needs; findings were presented to stakeholders in October 2004. To validate these needs assessment early findings, garner public input, and progress to the next stage in setting priorities, over 100 invited stakeholders from around the state were invited to meet in March 2005. Participants included community agencies, service providers, family members, organizational partners and others whose work intersects with maternal and child health issues. Needs assessment findings were highlighted, and, in a town meeting format, participants were invited to offer their thoughts and perceptions about the MCH priorities for NH.

Participants confirmed that across MCH systems at the state and local levels, issues such as data capacity, disparities among populations, and coordination of care continue to be of the highest priority. Public comments reflected a general agreement that these issues are of primary importance in NH. No other areas of significant need were offered in addition to or as replacement for any of the issues presented.

Justification of how the State's analysis of need relates to the priority needs

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. The importance of cultural competence in local and state MCH programs and the need to create supports and enhance services for minority populations seamlessly within the state service system is recognized as an underlying theme for NH's Title V program. Similarly, recognition of other socioeconomic factors influencing health outcomes – poverty, education, and availability of affordable housing, for example – are seen as guiding themes that are interwoven throughout all priorities and activities. Priorities have been developed that are purposefully broad and systems-focused, and likely to respond to evidence-based interventions.