

# STATE TITLE V BLOCK GRANT NARRATIVE

STATE: **NH**

APPLICATION YEAR: **2005**

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## I. GENERAL REQUIREMENTS

### A. LETTER OF TRANSMITTAL

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

### B. FACE SHEET

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

### C. ASSURANCES AND CERTIFICATIONS

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

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

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

### D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

### E. PUBLIC INPUT

/2004/BUREAU OF MATERNAL AND CHILD HEALTH (BMCH) BMCH presents priorities and plans to contract agency Directors at quarterly meetings and to their community agency or consumer advisory Boards during application development, as part of the Title V public input process. Feedback is elicited and incorporated into the final application. This presentation is included as an attachment to this Section. Yearly public hearings were held previously, but attendance was poor (<5 people/year, all from MCH contract agencies) and this process was discontinued. Instead, BMCH will post the completed application on its website to solicit continuous feedback. The public is encouraged to contact BMCH to provide input. In addition, a copy of the Block Grant will be available to all residents via the State Library system.**/2005/This year, MCH staff presented its priorities to community Public Health Information Network grantees./2005//**

SPECIAL MEDICAL SERVICES BUREAU (SMSB) SMSB is responsible for the state population of Children with Special Health Care Needs. This application is available for public access through the SMSB office (Concord). SMSB priorities are identified and developed through public input mechanisms that include parent and teen focus groups, feedback from contracted consultants (paid parents), results from work sessions at state and regional conferences, direct communication with families served, parent **/2005/and staff//2005//** 'problem case' forms, NH data from the National Survey of Children With Special Health Care Needs 2001, ongoing needs assessment activities, and NH Family Voices advisory groups.**/2004/**



## **II. NEEDS ASSESSMENT**

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

### III. STATE OVERVIEW

#### A. OVERVIEW

##### GEOGRAPHY

New Hampshire shares boundaries with Canada to the north, Maine and the Atlantic Ocean to the east, Vermont to the west and Massachusetts to the south. It ranks 44th in area among the states and 19th in population density. New Hampshire is approximately twice as populated as Vermont, three times that of Maine, but only 1/6 that of Massachusetts.(1) The population numbers just over 1.2 million, with 49% residing in rural areas and 51% in urban areas (30.6% in urbanized areas and 20.3% outside urbanized areas).(2) 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 Nation Forest separates the south from the northernmost rural section of the state, which consists of Coos County. Coos County, known as 'the North Country', has the largest landmass of any county but the smallest population. 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.(3)

##### DEMOGRAPHICS

GENERAL: New Hampshire's estimated population has increased by nearly 1% annually in the past 5 years, exceeding growth in all New England states except Vermont. During this time, immigration from other states averaged 6,250 new residents/year, exceeding increases due to natural population growth.(4) The State's population grew 11.4 % in the last decade, still surpassing other New England states, with increases occurring in the south, as many people moved north from Massachusetts. Population declines occurred in the North Country, with Coos County reporting a 4.9% population decrease. All NH's largest communities reported increases except Portsmouth, which experienced a 19.8% decrease, likely due to an air base closing.(5)

BIRTHS: New Hampshire's birth rate declined 19.8% from the peak number of resident births of 17,801 in 1989 to 14,275 in 1997. /2002/The birth rate declined from 12.2 in 1997 to 11.7 in 1999. New Hampshire has the 4th lowest birth rate in the nation, 15.8% lower than the US white rate of 13.9.(6,7) /2003/The birth rate for 2000, at 12.0, was still lower than the US white rate of 14.1. The State continues to have the 4th lowest birth rate.(8) /2004/Resident births increased from 14,098 in 1999 to 14,647 in 2001. The birth rate, at 11.6, was stable, and lower than the US white rate of 13.9. (9)//2004//**2005/The 2002 birth rate remained stable at 11.3.//2005//**

POPULATION BY AGE: There are an estimated 262,799 women of childbearing age (15-44 years) in New Hampshire in 2000, comprising 21% of the population. Population projections predict that women of this age group will comprise 19% of the population by 2010.(10) 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 20%. Between 1995 and 2005, the number of children under 12 is expected to decrease while the number of children ages 12-14 remains stable.(11)

RACE & ETHNICITY: Minority populations are concentrated in the state's southern areas in Hillsborough and Rockingham counties. The county share of total minority populations for Hillsborough and Rockingham counties, respectively, is: white Hispanic (49.7%, 21.6%); black (43.3%, 30.8%); American Indian/Eskimo (29.3%, 19.4%); and, Asian/Pacific Islander (41.3%, 25.4%).(12) /2003/The county share of total minority populations for Hillsborough and Rockingham is, respectively: white Hispanic (59.4%, 16.2%); black (54.3%, 17.9%); American Indian/Eskimo (31.8%,

16.4%); and Asian/Pacific Islander (47.3%, 19.5%).(13) The State's population remains largely homogeneous with 96.0 % of the population white and non-Hispanic. The remaining population are Hispanic (1.7%), black (0.7%), American Indian/Eskimo (0.2%), and Asian/Pacific Islander (1.3 %). (14) Community health agencies in these two counties are increasingly aware of the linguistic and cultural needs of minority populations. Achieving cultural competence is more difficult for agencies in rural and non-urban areas where numbers of racial and ethnic minorities are smaller. New Hampshire is home to an estimated 5,000 refugees; 80 % reside in the state's southern tier. One third of these refugees are from Southeast Asia, 30% from the former Yugoslavia and the remainder from the former Soviet Union, Romania, and Africa. /2003/New Hampshire refugees come from over 30 nations, with 70.84 % from Europe, 16.29% from Africa and 12.09% from Asia. The greatest numbers are from Bosnia (1,155), Sudan (219), Croatia (143) and Vietnam (130). 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)***/2005/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'./2005//***

**PRENATAL CARE & INFANT HEALTH:** New Hampshire performs well in many health and socioeconomic indicators. The 1997 state infant mortality rate (IMR) of 4.4 is the lowest ever and the lowest overall white IMR nationally. The state ranks 3rd for low birth weight (LBW) rates, with a rate of 5.9 in 1997 compared to the U.S. white rate of 6.5. New Hampshire is also among the top three states in adequacy of prenatal care measures. In 1997, late or no prenatal care comprised 1.5% of all births compared with the national white rate of 3.2%.(16)

/2002/The 1999 state IMR was 5.4/1000 births. The rates for the US and other states are not currently available for comparison. It is unclear at this time why NH's IMR increased from 4.3 in 1998, but it is likely related to an increased LBW from 5.7 in 1998 to 6.3 in 1999. Nationally, the increasing LBW rate is partly attributed to an increase in multiple births; New Hampshire has also experienced an increase in multiple births. /2003/The 2000 IMR declined to 5.1 and is below the US rate of 7.0 for 1999. The LBW rate remained stable at 6.3 in 2000. While the total IMR for the state declined, the rate for women with Medicaid rose from 7.4 in 1999 to 8.7 in 2000. Further, the disparity in IMR between the Medicaid and non-Medicaid populations widened from 1.9 more infant deaths per 1,000 live births in the Medicaid population in 1999 to 4.4 more in 2000. Similarly, in 2000 the LBW rate declined among the non-Medicaid population from 5.9% to 5.8%, but grew for the Medicaid population from 7.9% to 8.3%.

The percent of women receiving late or no prenatal care during 1999 remained low at 1.5%, comparing favorably with the US white rate of 3.2%. New Hampshire ranks 2nd in the nation for this measure. /2003/The percent of women receiving late or no prenatal care declined to 1.3% during 2000, while the US white rate rose to 3.3%. However, the percent of women on Medicaid receiving adequate prenatal care remains below that of non-Medicaid women (80.4% versus 89.3%) and may explain, in part, disparities in LBW and infant mortality.(17)

/2004/The IMR declined to 3.8 in 2001, with a narrowing of the disparity between Medicaid (4.8 IMR) and non-Medicaid (3.2 IMR) populations -- a difference of 1.6 infant deaths. The LBW rate rose minimally to 6.5% in 2001, decreasing slightly for the Medicaid population (from 8.3% to 7.9%) while increasing for the non-Medicaid population (from 5.8% to 6.3%). The percent of women receiving late or no prenatal care during 2001 increased to 1.7% but remained below the US white rate of 3.2%. In 2001, 5.8% of NH women with Medicaid had late or no prenatal care, compared to 3.0% of other pregnant women.(18)***/2004// /2005/Death data for 2002 is unavailable from Vital Records at this time./2005//***

**TEEN & NONMARITAL BIRTHS:** The State's 1997 teen birth rate is second only to Vermont at 28.6/1000 females aged 15-19, 38.2% below the US white rate of 52. For 1999, New Hampshire's

teen birth rate is the lowest in the country at 24 compared with the US white rate of 44.6. (17) /2003/The teen birth rate decreased to 23.4 in 2000 (compared with the US white rate of 32.5) (19), /2004/and decreased again in 2001, to 21.(20)//2004//

Certain trends are less favorable and bear mention. In 1997, 7.8% of all births were to teens, an increase of 5.4% from 1996 and an increasing trend since 1992. An increase in non-marital births occurred across all age groups and was highest among adolescents less than 18, where 95.9% of births were to single mothers. Along with the rise in teen births, there was an increase in LBW and VLBW babies, highest among adolescent mothers. Health risks for teen mothers and their infants and the long-term negative socioeconomic implications are well known. /2002/Teen births declined from 7.8% in 1997 to 7.6 % in 1998 and 7.1% in 1999. Non-marital births remained stable in 1999 at 24.2%. Non-marital teen births increased from 95.9% in 1997 to 96.5% in 1998 and declined to 87.0% in 1999.(21) /2003/Teen births declined for the 3rd year to 6.8% in 2000. Non-marital teen births also declined to 86.6%. Non-marital births rose slightly, to 24.6% in 2000.(22) /2004/In 2001, teen births declined for the 4th year, to 6.3%. Non-marital births also declined slightly, to 24.1%. Non-marital teen births were stable at 86.6%.(23)//2004//**/2005/The percent of births to teens remained stable at 6.1%./2005//**

**MATERNAL SMOKING:** Maternal smoking, a major risk factor affecting infant health, is a concern in New Hampshire. Contrary to national declines, New Hampshire has experienced a slight increase in maternal smoking, from 16.3% in 1996 to 17.4% in 1997 and a slight decline in 1998 to 17.1%. This is influenced by an increase in smoking among teen mothers, from a 1992-1996 five-year average of 34.3% to 37.9% in 1997.(24) /2002/Maternal smoking decreased in 1999 to 16.0% from 17.1% in 1998. Smoking among teen mothers continues to be double the state average.(25) /2003/Maternal smoking increased slightly to 16.6% in 2000, with teen maternal smoking more than twice the state average, at 38.7%.(26) /2004/Maternal smoking decreased to its lowest point in the past five years, to 15.4% in 2001 with teen maternal smoking declining to 37.4%.(27)//2004//**/2005/Maternal smoking continued to decline in 2002, with 14.7% of all mothers, and 14.7% of teen mothers smoking during their pregnancy./2005//**

## SOCIOECONOMIC INDICATORS

**UNEMPLOYMENT:** New Hampshire's economic profile is one of prosperity. The unemployment rate of 2.5% in April 2000 is a near record low. On average, wages in 1997 rose more rapidly than the cost of living. However many families, and 10% of our children (30,000), live below the federal poverty level. Between 1985 and 1996, children in poverty increased by 25%, while the national percent decreased by 5 %. During that time, the percent of single parent families with children increased by 41%, to 24%, an increase three times that of the nation. While the percent of children living with parents lacking full-time, year round employment dropped by 11% nationally, in New Hampshire this indicator increased by 15%.(28) This signifies a disturbing trend for our state's children, as the negative impact of poverty on the health and well being of children is well documented. /2002/New Hampshire's preliminary seasonally adjusted unemployment rate remains low at 2.9% compared with the US rate of 4.5%.(29) /2003/The percent of children under 18 years in poverty has decreased to 6.8% and for children under age 5 the percent is 9.2. New Hampshire's preliminary seasonally adjusted unemployment rate increased to 4.0% but remains lower than the US rate of 6.0%.(30)

/2004/New Hampshire's preliminary seasonally adjusted unemployment rate remains stable at 4.1% and continues to be lower than the US rate of 5.8%.(31)//2004//

While many of New Hampshire's health and economic indicators are impressive, there are tremendous disparities within the state. Kids Count New Hampshire 2000 analyzes data related to children and families, grouping towns into five economic clusters ranging from poor to wealthy. The report explores how child health and well-being vary by residence. Dramatic differences exist among communities, even for indicators where the state as a whole excels. For example, inadequate prenatal care rates are 3 to 4 times higher in the poorest communities than the wealthiest. Teen birth rates are 4 times greater in the poorest communities than the wealthiest. In the wealthiest towns, 1 in

9 births are to single mothers versus 1 in 3 births to single mothers in the poorest towns. /2004/Kids Count NH 2003 notes that the gaps in teen birth rates and inadequate prenatal care have narrowed to 3.5 times greater and 2--3 times greater, respectively, in the poorest communities than the wealthiest.//2004//

SSI RECIPIENTS: The number of New Hampshire children receiving SSI cash benefits has decreased from 1,860 as of December 1998 to 1,630 as of December 1999, a 12.4% change.(32) The decrease is attributed to continuing economic prosperity in the state rather than welfare reform. New Hampshire is a 209(b) state where eligibility for SSI does not automatically qualify a child for Medicaid benefits. /2002/The number of New Hampshire children receiving SSI cash benefits as of December 2000 remains unchanged from the previous year at 1,630.(33)/2004/Child beneficiaries of SSI under age 18 receiving services from the Special Medical Services Bureau constitute slightly over 12% of all SSI recipients in the State (34), which is congruent with the 2001 national rate of 13% for children under age 18.(35) Reference section III.F. for additional text on SSI and CSHCN. //2004//**2005/Per the SSA report for December 2003, 1714 New Hampshire children under age 18 were receiving SSI, and 1443 children under the age of 16. As of May 2004, NH DHHS reports that 1748 children under age 18 are receiving SSI.//2005//**

HEALTH INSURANCE STATUS: In 1999, the DHHS sponsored the New Hampshire Health Insurance Coverage and Access Survey, a population-based, probability sample telephone survey, which revealed that 96,000 or 9% of state residents remain uninsured. An estimated 25,000 (26%) are children. The survey estimated that 74% of uninsured children (18,500) were eligible for, but not participating in, publicly sponsored programs such as Healthy Kids Gold and Silver. Data gathered since the survey by New Hampshire Healthy Kids (NHHK) suggests that some of these children may now be insured through CHIP.

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.

Regional disparities in uninsurance rates were also found, with higher rates in the northern and central eastern parts of the state. Yet, the urban areas of Manchester, Nashua, Concord and Portsmouth accounted for 70 % of uninsured individuals. A partnership between DHHS, the Legislature, New Hampshire health care providers and businesses and NHHK is focusing on strategies to reduce uninsurance rates for adults.

/2003/In 2001, the DHHS Office of Health Planning and Medicaid conducted the Insurance Family Survey to estimate the number of uninsured and explore reasons for uninsurance. The telephone survey sample was selected using random digit dial, and 5,177 adult (age 18-64) family health care decision makers were interviewed. The percent of uninsured children was estimated to be 5.1% (16,000 children) compared with 8.3% (26,000 children) in the 1999 survey.(36)/**2005/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).//2005//**

MEDICAID & SCHIP: New Hampshire CHIP is a unique partnership between the NH DHHS and the New Hampshire Healthy Kids Corporation. NHHK administers CHIP health insurance programs, outreach and coordination. Healthy Kids Gold (Medicaid) expands coverage for infants at 185-300% of federal poverty level (FPL). Children ages 1 - 18 at greater than 185-300% FPL qualify for Healthy Kids Silver with premiums based on income. NHHK estimates that, in its first 15 months of operation, CHIP reduced the number of uninsured children by one-third.(37) In 1999, 6,100 children obtained health insurance coverage through CHIP. Over 4,100 children were screened as income-eligible for Healthy Kids Gold coverage. Cumulative enrollment in Healthy Kids Silver, including the self-pay

program, hit a record high in the five-year history of NHHK with 2,346 children enrolled as of December 1999. Subsidized enrollees totaled 2,050. /2002/NHHK experienced an 82% overall growth during 2000. Healthy Kids Gold processed 7,993 applications in 2000, a 92% increase from 1999. (38) /2003/ The 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.

/2004/Healthy Kids Gold processed 4,055 applications in 2002, an 11.8% increase in the number applying compared to 2001. Healthy Kids Silver enrolled 1,491 children, including those in the self-pay program, accounting for increases of 31.9% and 18.8% respectively.//2004//

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.

/2003/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. This evaluation will inform NHHK to make necessary programmatic adjustments.

**MEDICAID & PRENATAL CARE:** 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 Medicaid. From 1998 through 2000, Medicaid was the payment source for about 21% of all births in the state. Of women obtaining prenatal care through Title V funded agencies, 80% were enrolled in Medicaid in 1998; this percentage declined to 76% in 1999 and to 71.3% in 2000. These women are eligible for enhanced prenatal services including social services, nutrition, care coordination and client education provided during a home or clinic visit.(39, 40)

/2004/Medicaid as the payment source of all state births declined in 2001 to 17.1%. Of women receiving prenatal care through Title V funded community agencies, 69% were enrolled in Medicaid and 10% were uninsured.(41)//2004// **/2005/Medicaid as the payment source of all state births remained stable at 18.8% in 2002.//2005//**

## STATE ISSUES IMPACTING WOMEN & CHILDREN

**WELFARE REFORM & 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 40 % from 1994-1998 from 9,071 to 6,123.(42) The number and percent of children receiving TANF assistance has also declined, with marked differences among the town economic clusters described earlier. Wealthier communities saw a decline of 45% during 1995-1999, while poorer ones saw a decline of only 33%.(43) The number of children in poorer cluster of towns receiving food stamps and Medicaid benefits is 4 to 5 times that of the wealthiest cluster. /2002/The annual average number of TANF cases open on the last day of the month declined 27.9 % from 1996-1999, from 7,745 to 5,581. As of July 1999, New Hampshire ranked lowest in the country for the number of TANF cases at 4.9. (44) /2003/As of July 2001, there were 5,452 families on TANF, a slight decrease from 2000. New Hampshire continues to rank lowest in the nation for TANF cases per population at 4.3 in 2000, a decline from the previous year. As of September 30, 2001, 101 people reached their 60-month time limit on TANF. An estimated 40-50 individuals will reach this limit each month. BMCH is aware of the importance of reaching out to this population to assure access to health care.(45) /2004/As of September 2002, 5,849 families received TANF, a 7.3% increase over July 2001. As of September

2002, 329 people reached their 60-month time limit on TANF.(46)//2004// **/2005/TANF caseload increased by 5.2% from 2001 to 2002, reaching nearly 6,000 cases./2005//**

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.(47) In New Hampshire, women's participation in the work force has always been higher than the national rate and in 1996 was 62.9%.(48) /2003/In 2000, 66.7% of NH women participated in the labor force, the highest rate since 1994, and seventh in the nation for this indicator.(49) These figures are likely to worsen as TANF rolls decline. The BMCH is working to improve one key component of quality child care, health and safety in child care environments, through its Healthy Child Care NH initiative. A main goal is to engage child care providers to assist families in Medicaid and CHIP enrollment. /2004/TANF reauthorization will bring significant changes to that program in coming years. 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.//2004//

**WELFARE REFORM & MEDICAID:** New Hampshire's Medicaid caseload dropped less than 1% between 1995 and 1997, perhaps because de-linking of TANF with Medicaid kept eligibility for Medicaid and TANF aligned.(50) As the results of current outreach efforts for NHHK programs are embedded in Medicaid numbers, however, any conclusions about caseload trends are tentative. TANF-supported outreach to Medicaid eligible individuals was initiated in 2000 through community-based Family Planning agencies working in 25 sites. Approximately \$300,000 in TANF funds per year fund direct outreach in district welfare offices, Employment Security, and other sites, such as workplaces employing large numbers of low-paid part-time workers. Outreach efforts target teen parents and teens at risk for pregnancy in school and community settings.

#### CURRENT STATE HEALTH AGENCY PRIORITIES & THE IMPACT ON TITLE V

**HEALTHY PEOPLE 2010:** DHHS is using the Healthy People 2010 process to establish the state's prevention agenda for the next decade. MCH staff has been actively involved in and will commit to aligning MCH program goals and resource allocation with leading child health status indicators as articulated in the Healthy NH 2010 report. /2002/DHHS released the Healthy NH 2010 report in March 2001. The Maternal, Infant and Child focus group, led by the Title V director, selected five MCH objectives to be included in Healthy NH 2010:

1. Reduce low birth weight and very low birth weight
  2. Increase the percentage of women who receive early and adequate prenatal care
  3. Reduce the percentage of pregnant women who report smoking cigarettes
  4. Reduce the percentage of pregnant women who report drinking alcohol in the past month
  5. Increase the proportion of newborns that are screened for hearing loss by age one month
- BMCH is using these objectives, along with Title V Performance Measures and other national and state objectives, to guide and measure their efforts. To do so, a matrix was created to ascertain commonalities among objectives, HEDIS measures and those of the New Hampshire Child Health Indicators Work Group. A copy of this matrix is included as an attachment to this Section. The matrix was also used to select performance measures for contracted community agencies providing MCH services. Performance measures are the basis of community agencies' work plans and a step toward performance based contracting. Community agency targets will be monitored over time. See Section IVD for BMCH activities in this area.

/2004/Workgroups are being formed to revisit Healthy NH 2010 objectives and create action plans to address goals. BMCH staff will lead workgroups on Maternal and Child Health, Injury Prevention and Reproductive and Sexual Health.//2004// **/2005/Action plans for Injury Prevention and Reproductive Health are finalized; MCH action plans are still in process, but slated to be complete by the fall of 2004./2005//**

**QUALITY IMPROVEMENT INITIATIVE:** DHHS sees performance management as a major strategy to

improve state and local level capacity to deliver core public health services and to improve 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, contracted community agencies, and other service providers accountable through performance-based contracting. The initiative is an integrated Medicaid and Public Health collaboration to create an effective system for clinical quality assessment and improvement, with a strong link to prevention and population-based services. A major activity has been the creation of a post-doctoral Clinical Quality Fellowship funded by DHHS with Dartmouth Medical School's Family Practice Residency, Dartmouth's Center for Evaluative Clinical Sciences, and Capital Region Family Health Center. Post-doctoral fellows will be assigned to support DHHS as it plans for, develops and implements clinical quality improvement programs and to support community health agencies and other providers to effectively partner with the state in implementing clinical quality improvement programs.

/2004/OCPH continues to work toward a comprehensive performance management system. BMCH staff was active in the planning committee for and presented at a Performance Management Summit, held in February 2003 for all OCPH Program Managers to learn about the subject and develop measures for contract agencies. Division-wide activities will refine these efforts and expand protocols for quality assurance.//2004// **/2005/DHHS reorganization this year will create a new Bureau of Policy and Performance Management within the public health agency. This Bureau will work toward quality improvement for both internal and external processes.//2005//**

**STRENGTHENING THE SAFETY NET:** Another top DHHS priority is to preserve and strengthen our infrastructure of community agencies serving low income and uninsured populations. Like all states, we have evolved a patchwork of health centers and other agencies providing direct and enabling services. These agencies provide health care access and are successful in integrating public health and prevention into clinical practice, providing true population-based care. These agencies leverage far more in services than what is paid for by public funds, and their survival is critical to the continuing health of our communities. DHHS activities include the financial assessment and market analysis of safety net providers, development of a Medicaid reimbursement strategy to offset the adverse impact of BBA 97, and development of a strategy to provide coverage for uninsured adults.

/2002/In October 2000, the NH Office of Planning and Research (OPR) released Strengthening the Safety Net: A Financial Analysis of New Hampshire's Community Health Centers. The report revealed that the Community Health Centers (CHCs) are essential components of the health care system and serve individuals who may otherwise not be able to access health care. While 9% of the State's residents are uninsured, 41% of CHC patients are uninsured. Similarly, 19% of CHC clients are enrolled in Medicaid while 6% of the State's residents are eligible for Medicaid. The report clearly describes the deteriorating financial status of the CHCs. In 1999, total margins, the ability of organizations to cover expenses with revenues, ranged from 2.0-4.0%. During the 1994-1999, the CHCs were unable to generate enough cash to meet capital investment needs for property, plant and equipment. The report called for a renewed public and private commitment to CHCs. Recommendations included:

1. Enrolling all eligible patients in Medicaid and CHIP;
2. Continued efforts to expand private health insurance to those who cannot afford coverage;
3. Maximizing federal funding by expanding the number of 330 centers;
4. Examining DHHS resource allocations and reimbursement for certain services;
5. Developing and expanding partnerships with hospitals, businesses and foundations; and
6. Securing access to long-term funding and short-term credit.

/2004/State CHCs are funded in part through Title V. The FY2004 State budget preserves current CHC funding and may include an expected increase of \$1.1 million for these agencies.//2004// **/2005/The expected \$1.1 million increase in state funding for CHCs was realized in the 2004/2005 biennium budget and provides a much needed influx of funding that will help sustain these safety net providers.//2005//**

ENHANCED PUBLIC HEALTH BENEFITS FOR MEDICAID RECIPIENTS: DHHS plans to use Medicaid to expand MCH services such as home visiting, enhanced prenatal care, substance abuse treatment and oral health care. DHHS also plans to contract with a Pharmacy Benefits manager for Medicaid to improve management of prescription drugs. /2003/Pharmacy Benefits Management (PBM) 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.

/2004/A local Medicaid code was developed that will allow reimbursement for family support and coordination services. Only BMCH contract agencies can use this code, which should foster the fiscal viability of these programs.//2004// ***/2005/MCH contract agencies increased their use of the new reimbursement code for family support and coordination this year. A Medicaid QA audit revealed some areas of confusion about the use of the code; training was provided through the venue of the MCH Directors' Meeting. //2005//***

MANAGED CARE, MEDICAID & PUBLIC HEALTH: With a changed political climate and health care market, the privatization of Blue Cross/Blue Shield, and the financial failure of two of New Hampshire's largest health plans, the state has re-evaluated its proposed transition to fully capitated Medicaid Managed Care. Instead, DHHS is pursuing a Primary Care Case Management model. New Hampshire's vision is to create a comprehensive integrated health care system for citizens lacking the resources to purchase private health care coverage. This system will integrate population-based, prevention oriented, public health into traditional medical care. To achieve this, DHHS must make the transition from payer of claims to value-based purchaser of services for its Medicaid beneficiaries. Like private sector payers, DHHS is attracted to outcomes and performance measurement, and the cost and utilization management that managed care offers. Thus, DHHS is actively pursuing the development of an improved capacity to support its role as a value-based purchaser. This includes improved analytic capabilities, as well as disease management.

DHHS is involved with two notable collaborations. First, DHHS partners with Medical Directors of all the State's Health Plans through participation in the Foundation for Healthy Communities. The Foundation has embraced several high priority MCH activities, including: the development of statewide child health indicators; asthma management protocols; advocacy for newborn hearing screening advocacy; c-section reduction; and improved birth outcomes projects. In addition, DHHS participates in the Region I Public Health and Managed Care Collaborative, chaired by the USPHS Regional Director. Priority areas are development and dissemination of joint Managed Care/Public Health guidelines to improve health care and health status.

## THE POLITICAL CLIMATE

The New Hampshire Child Health Indicators Project 2000 is a public-private partnership co-chaired by the DHHS and the Foundation for Healthy Communities with participation of community providers and child advocates. The mission is to develop a tool kit of community level health status indicators so communities can better use data to assess needs, advocate for resources, and evaluate efforts. The group has identified key indicators based on available data to improve communities' understanding of children's health needs at the local level.

The Children's Alliance of New Hampshire (CANH), a child advocacy group that annually produces Kids Count New Hampshire, reports on key child health indicators by economic cluster. CANH also recently published The Children's Agenda 2000, a plan to focus attention on children's needs and build support to meet needs. Both Kids Count and the Children's Agenda set forth priorities for public policy and identify gaps in available data that are needed to adequately describe and monitor the status of children and families in the state. These efforts place a high priority on children and families, promoting a climate ripe for collaboration among many stakeholders to work towards improving the health of children in New Hampshire.

/2004/This year has brought changes to New Hampshire's administration, as Cabletron founder and

former CEO Governor Craig Benson took office in January 2003. Nicholas Vailas was confirmed as the new DHHS Commissioner in February. Commissioner Vailas, a physical therapist and health care entrepreneur, successfully founded an outpatient surgical center. ***/2005/Commissioner Vailas resigned in the fall of 2003; John Stephen, former Assistant Commissioner of Safety, was appointed to take his place. Under Commissioner Stephen, DHHS is undergoing major restructuring, to bring programs into alignment and promote efficiencies within the Department./2005//***

The biennium budget process for SFY04/05 brought challenges to the State and to the OCPH. Divergence among the Governor's, Senate's and House's recommended budgets resulted in a Committee of Conference and Governor's veto of the resulting budget. A special Legislative session was held on June 30th in an unsuccessful attempt to override the veto. A 90-day continuing resolution was approved, however, allowing for a continuance of State operations until a budget agreement can be reached. It is unclear at this time what effect, if any, budget deliberations will have on MCH services. ***/2004// /2005/After a three month continuing resolution, the 2004/05 biennium budget was passed in September 2003. This budget maintained funding for essential MCH services. Budget reductions focused mainly on personnel through a statewide hiring freeze and reduced travel and equipment line items./2005//***

## STATEWIDE HEALTH CARE DELIVERY SYSTEMS

New Hampshire's health care delivery system consists of an array of public and private health service providers. This system, which varies widely throughout the state, presents special obstacles to the attainment of a seamless system of health care services for all citizens that is the vision of New Hampshire's Department of Health and Human Services (DHHS). Most of the state is designated as medically underserved. While New Hampshire's two largest cities have public health departments, there is no statewide network of local health departments. Instead, the DHHS, including the BMCH, contracts with community-based, non-profit safety net providers including prenatal, family planning, primary care and child health agencies targeting low-income, uninsured and underinsured pregnant women, children and men and women of all ages. These agencies provide comprehensive services including direct health care and enabling services, such as case management, nutrition, social services, home visiting, transportation, and translation. 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. ***/2004/Maps of health shortage areas, BMCH program service areas and a list of BMCH contract agencies are attached to this Section./2004//***

**PUBLIC HEALTH INFRASTRUCTURE:** The bastion of New Hampshire's public health infrastructure is its DHHS. The Office of Community and Public Health (OCPH), as the chief 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.

***/2004/The Community Public Health Development Program is a new initiative dedicated to building New Hampshire's local public health systems. This program is promoting regional collaborations to ensure that the ten essential public health services are provided and that local public health systems are fully integrated with local emergency preparedness and response systems and the State public health system./2004// /2005/Community Public Health Development grantees continue to be funded. Grantees are working on increasing public health infrastructure at the local level, and are currently developing community needs assessments. The MCH Director presented information on Title V services to these grantees in the spring of 2004, and MCH will network with local coordinators via email to keep them informed of Title V priorities./2005//***

**HIGH RISK NEWBORN FACILITIES:** New Hampshire is divided into 26 hospital service areas. Dartmouth Hitchcock Medical Center (DHMC) in the western central part of the state provides tertiary

care in most specialties for much of the state. This and the Elliot Hospital in southern New Hampshire are the in-state alternatives for high-risk newborn care. In some areas, patients may seek specialty or tertiary care in Massachusetts or Maine, but most high-risk births are delivered at DMHC. DHMC administers a regional perinatal outreach program and conducts transport conferences with state birthing hospitals to monitor the appropriateness of transfers of high-risk mothers and infants to the facility. The perinatal program also provides continuing education to hospital perinatal nurse managers.

**MENTAL HEALTH SERVICES:** One serious lack in New Hampshire's health care infrastructure is access to mental health services. While community mental health centers are available in some areas, they cannot meet the demand for services. In some cases, fees are beyond the reach of low-income families. While Medicaid covers children's mental health services, a diagnosis of severe emotional disturbance is required for services. Adults also must have severe mental illness for Medicaid to pay for services. The dearth of mental health providers specializing in very young children affects access as well. The Division of Behavioral Health (DBH) and the NH Infant Mental Health Association are addressing these issues. ***/2005/According to the Data Research Center for CYSHCN, state-level results from the National Survey of CSHCN 2001 indicate that 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./2005//***

*/2002/*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. A primary issue has been workforce recruitment and retention for mental health care providers. All centers have waiting lists at some point during each year. There is also geographic disparity in service access. 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.

**ORAL HEALTH SERVICES:** Improving access to oral health services for vulnerable populations is among the highest of DHHS priorities. There are many barriers to realizing this goal. There are only 21 pediatric dentists in the state, located primarily in central and southern regions. The rural North Country has no pediatric dentists. Only 43% of children enrolled in Medicaid have seen a dentist in the last year. */2002/*Access to dental care is a growing problem for many in New Hampshire, specifically the poor, under and uninsured in rural communities and large population areas. The distribution of dentists throughout the state is poor. One urban and four rural areas have been designated Dental Health Professional Shortage areas; together, these areas contain 20% of the state's population. Only 38% of children enrolled in Medicaid saw a dentist within the last year. Less than 20 dentists in the state see new Medicaid patients and few are willing to treat uninsured and underinsured clients. */2003/*In 2001, 60 dental providers treated 100 or more Medicaid patients each, 102 dental providers treated 50 or more Medicaid patients and 294 dental providers saw at least one Medicaid patient.

***/2005/Data from NH's first oral health statewide survey of third grade students revealed that 22% had untreated decay, 52% had caries experience (filled and decayed teeth) 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. Left untreated, children with obvious decay will only experience increasing pain and disease. The National Survey of CSHCN 2001 results for New Hampshire indicate that 83.5% of CSHCN needed dental care, including check-ups, in the 12 months preceding the survey. Approximately 9% did not receive all the dental care needed, representing a weighted estimate of 3,497 children. Five agencies across the state have contracted with the Office of Medicaid Business and Policy to provide dental operatories: Avis Goodwin Community Health Center; Greater Nashua Dental Connection; North Country Health Consortium (mobile services in 6 towns); Poisson Dental Clinic; and White Mountain Community Health Center (operatoriy and school-based screening clinic), on behalf of children receiving Medicaid. Most of these grantees are recipients of Endowment for***

***Health awards. Duplication was avoided and all funds are highly leveraged.//2005//***

With few dental providers in the North Country, there is too scarce a supply even to treat fee for service patients. The dentist to patient ratio in this region is 1:4,338. Thirty percent of the area's population fall under 200% FPL and only 12% benefit from optimal water fluoridation. Inadequate access to dental care in rural areas is compounded by a lack of public transportation. (51) 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 scheduled to retire in coming years; without a state dental school, there is no local supply of newly trained dentists to fill the need.

The DHHS Oral Health Program (OHP) has recruited a dentist to provide leadership across five key components of an initiative to address these challenges. Areas include: Public Health/Prevention; Medicaid; Community-Based Dental Programs; Workforce Development; and Enabling Services. /2002/Improvements in the Medicaid oral health system included increased reimbursements, streamlined claims processing and elimination of prior authorization. Managed Care Program improvements included prepaid benefits and increased coverage. Developing enhanced capacity improvements included improved provider relations and utilization review. /2003/Additional school-based preventive programs, Primary Care and Hospital Dental Clinics, and community dental collaboratives were funded by the OHP. The Donated Dental Services (DDS) Project continued, providing free dental services through local, volunteer dentists.

***/2005/ In July 2003 the voluntary managed care prepaid dental benefit was terminated. To compensate for a significant decrease in access to dental services for Medicaid enrolled children, dental reimbursement was increased significantly and the new Medicaid Dental Director made personal contact with dentists to enroll them as new Medicaid providers.//2005//***

#### EVALUATING HEALTH SYSTEMS FACTORS & DEVELOPING TITLE V PRIORITIES

MCH priorities were selected based on needs assessment findings and DHHS priorities. The Healthy NH 2010 plan is in development, with focus area workgroups determining priority objectives. The MCH workgroup chose five objectives; state priority needs # 2 and # 9 have corresponding Healthy NH 2010 objectives. /2002/The process for choosing priorities based on the needs assessment is discussed in Section II. There were no HP2010 objectives included in HNH 2010 for CSHCN due to measurement imprecision. Emerging issues for CSHCN are currently being validated via focus groups with stakeholders and will be incorporated into priorities on completion of the assessment process. Meanwhile, last year's CSHCN priorities will remain as stated. ***/2005/Qualitative data from focus groups and key informant interviews have been translated into a survey instrument. This Delphi survey forms the basis for needs assessment data to be presented in the FY06 application.//2005//***

/2004/Determining Title V priorities is a complex process that requires weighing multiple factors, including known data, service gaps, State priorities, and emerging issues. Key Title V managers annually evaluate these factors as they relate to the Title V mission, needs assessment findings and Health Systems Capacity Indicators data to arrive at consensus on State priority needs. This year, priorities were revised so that all have a comprehensive focus. For example, three prenatal priorities addressing first trimester care, substance use and birth spacing were combined into a new, comprehensive priority on "safe and healthy pregnancies". A list of Title V priorities can be found in Section IVB. CSHCN priorities are based on the SMSB needs assessment, focus group data, parent advisory input, and the National Survey of Children with Special Health Care Needs 2001 results for New Hampshire. One priority need has been selected to address in FY04. Endnotes are attached to this Section.//2004//

## **B. AGENCY CAPACITY**

## STATEWIDE SYSTEM FOR CSHCN

/2003/Particularly for children with special health care needs (CSHCN), a mutually interdependent relationship exists between the private medical system (reliance on pediatric specialists and primary care providers) and the Title V CSHCN Program (payer of last resort, gap filler, provider of wrap-around services). Private practice pediatricians and family practitioners provide primary care for the large majority of New Hampshire's CSHCN and are, therefore, the foundation of the state's primary care infrastructure. However, physician distribution is uneven across the state. Rural counties have significant shortages of primary care physicians. Of particular concern is the availability of pediatricians to care for this population of children.

With the exception of allergy and ophthalmology, New Hampshire appears to have an adequate number of pediatric subspecialty providers. There are pediatricians in the practice of cardiology, developmental medicine, endocrinology, gastroenterology, genetics, hematology and oncology, infectious disease, intensive care, neonatology, neurology, pulmonary medicine and rheumatology. In addition, there are several community-based pediatric orthopedists and a pediatric urologist. All the sub-specialists practice, with few exceptions (pediatric orthopedist and ophthalmologist) either at Dartmouth-Hitchcock Medical Center in Lebanon or in the greater Manchester area. A network of pediatric specialty outreach clinics, operated or supported by the Bureau, ensures availability of and access to community-based care. /2004/According to the NSCSHCN, 2001, data for NH, 97% of respondents said that they received the specialty care that their child needed.//2004//

One serious gap in the infrastructure for CSHCN in New Hampshire is access to mental health services. Available providers are overburdened. Expertise in treating children and adolescents, and in particular CSHCN, is limited in the publicly funded mental health system and few other mental health resources are available to low income and uninsured families. The need to address pediatric mental health issues, however, has been recognized. The Division of Developmental Services partially supports the salary of a child psychiatrist housed at DHMC whose specific expertise is management of children and adults with /2004/autism, mental retardation and severe emotional disturbance (SED).//2004//

/2003/As stated above, one serious gap in the infrastructure for CSHCN in NH is that of mental health services. Our current assessment is based on the experience of actual delivery of care through our contracted Consulting Psychologist. Specifically, there has been no difficulty in referring SMSB enrolled children to psychologists in the private sector, but not all offices are wheelchair accessible. It has been very hard, however, to find private sector child and adolescent psychiatrists in Manchester and Concord. With respect to publicly funded mental health services, expertise in treating children and adolescents and, in particular, CSHCN is limited. These practitioners lack experience working with children with chronic health care needs, especially children with neurological impairment, mental retardation, and autism, as well as infants and toddlers. Community Mental Health Centers do not follow a behavioral health model or attract staff knowledgeable about behavioral health or behavioral medicine. Services are not adequate because a psychiatrist's consultation cannot be accessed unless a child is already receiving mental health services through the Mental Health Center. This puts the Mental Health Center psychiatrists out of the reach of SMSB enrolled children with Medicaid or other insurance. Finally, it is difficult for parents to obtain independent school consultations from private practitioners or community mental health center staff because there is little or no funding from Medicaid or private insurance to support this service. These consultations are necessary to deal with diagnostic issues as well as programming (e.g., development of an IEP). While SMSB-funded Child Development Programs provide some support for school consultations, their services they remain extremely under-funded with respect to demand.

A directory of mental health specialists with expertise in managing CSHCN has been produced by the Hood Center for care giving families. The Division of Behavioral Health has been awarded a \$5 million, 5-year grant/2004/New Hampshire Cares//2004// to implement systems of care for children with SED in three communities with a plan to go statewide with this initiative after the demonstration is completed. To support infrastructure development, the CSHCN Program has joined with four other

State programs to support 14 regional Infant Mental Health teams. These teams are charged with developing community-based, wrap-around services for the 0-5 year population and their families. /2004/Based on the NH results from the NSCSHCN, 2001, 16% of families needed mental health care or counseling for their child and of these, 75% received this care.//2004// **/2005/State-level weighted estimates reported by the Data Center for CSHCN indicate that over 32.7% needed mental health services. Approximately 85% reported receiving the care that was needed.//2005//**

For CSHCN, dental access issues are compounded. Children with special health care needs, like all children, need ongoing, routine dental care, yet sometimes their complex medical or behavioral situations require a more skilled provider. Access to care for this population is an even larger issue due to the lack of adequate providers who have the skill level necessary to manage this group of children. /2004/According to the NSCSHCN, 2001, 42% of NH families said their was a problem with their health plan regarding dental care; 6% said dental care cost too much and 6% said the dentist did not know how to treat CSHCN.//2004// **/2005/The Data Research Center for CSHCN reports approximately 84% of CSHCN needed dental care and 91% received it, in the year preceeding the National Survey.//2005//**

/2002/CSHCN are a diverse group who depend upon the availability of a wide range of services for their health and ability to function. Not only the child's, but also the entire family's future can be impacted by the occurrence of a chronic illness or disabling condition. **/2005/The Data Center reports that 52% of New Hampshire's CSHCN needed care from a specialist in the preceding 12 months. Fourteen percent reported one or more unmet need for specific health care services (Indicator 6).//2005//**

The diversity in conditions and the needs of CSHCN present an enormous challenge to developing systematic approaches for providing care to these children and their families. Currently, the State service delivery system consists of a patchwork of different systems, including health, education, social/welfare and juvenile justice. Leadership and administration is varied across service systems and a variety of disease specific and issue specific advisory boards exist at state, regional and local levels. Federal and state mandates defining authority and responsibilities for certain groups of CSHCN (i.e., the developmentally disabled, the chronically ill) are broad and often overlapping. Additionally, federal funding received by State agencies further defines programs and services, most often categorically.

The complexity of the system at the community level seems to increase proportionately as the number of agencies, providers and funding sources. Services are provided through multiple agencies with multiple funding sources and accountability requirements. There are individual agency rules about eligibility, types of services provided and how expenditure of funds occurs. /2004/For example, Part C eligibility criteria have recently been revised such that an infant (0-3 years) referred for early supports and services must have a 33% delay in 1 or more of 5 developmental areas. This same child/family may or may not be eligible for Title V support based on income and/or specific medical needs.//2004// The task of integrating the service system for CSHCN is a complex undertaking. Program planning efforts in response to needs and gaps in resources for all CSHCN must reflect collaboration among local agencies and promote integration of community level services. As a start, the SMSB has initiated two community-based pilots tasked to integrate care coordination and family support at the local level for children with chronic illness and their families. Outcomes of these pilots will direct future planning and development of service models.

Facilitating and supporting the primary care provider role is an important responsibility of the SMSB. For CSHCN, a mutually interdependent relationship exists between the private medical system (reliance on pediatric specialists and primary care providers) and the Title V CSHCN Program (payer of last resort, gap filler, provider of wrap-around services). Pediatricians and family practitioners in private practice continue to provide primary care for the large majority of New Hampshire's children with special health care needs and remain the foundation of the state's primary care infrastructure. However, the distribution of physicians is uneven across the state. Rural counties have significant

shortages of primary care physicians. Of particular concern is availability of pediatricians and pediatric sub-specialists to care for this population of children. No assessment of current provider capacity has been undertaken to date. /2003/Recent assessment related to expanding the medical home capacity of pediatric and family practice has identified needs of these practitioners. Results will help prioritize SMSB activities for 2003. /2004/Consultation has been provided to care coordinators and office personnel associated with the Rural Medical Home and Partners in Chronic Care projects.//2004//

***/2005/Childhood Cancer Lifeline of New Hampshire serves families with children between birth and 18 who have a diagnosis of cancer. The coordinator for the program (Pellitier) is a parent contractor with SMSB. The program provides a wide array of enabling services (e.g., money for travel associated with treatment, food and hotel vouchers). A total of 27 families were served in 2002, and 48 families received help in 2003. To date for 2004, 16 new families have received assistance. The Lifeline has close working relationships with the social service departments at Dartmouth Hitchcock Medical Center, Massachusetts General Hospital, New England Medical Center, Boston Children's Hospital and Maine Medical Center.//2005//***

***/2005/New Hampshire Partners in Health (PIH) is a community-based program addressing the needs of families of children with chronic health conditions. PIH family support coordinators are located in 13 locations around the state, helping families to find the information, resources and support they need. These individuals work collaboratively with the Special Medical Services Bureau care coordinators.//2005//***

#### NH REVISED STATUTES ANNOTATED (RSA) RELEVANT TO THE TITLE V PROGRAM

/2004/RSA 125, General Provisions, describes the responsibilities of the Commissioner of the Department of Health and Human Services (DHHS) to "take cognizance of the interests of health and life among the people". RSA 126, Department of Health and Human Services, establishes the DHHS to "provide a comprehensive and coordinated system of health and human services as needed to promote and protect the health, safety, and well being" of New Hampshire citizens. This law mandates that services "shall be directed at supporting families, strengthening communities, and developing the independence and self-sufficiency of New Hampshire citizens".//2004//

/2003/RSA 132, Protection for Maternity and Infancy, provides broad authority for maternal and child health and CSHCN services "to protect and promote the physical health of women in their childbearing years and their infants and children". It authorizes the DHHS Commissioner to: accept federal funds; employ staff; cooperate with federal, state and local agencies to plan and provide services; supervise contracts with local agencies; make rules and to conduct studies as necessary to carry out the provisions of the law. Services for "crippled children" are defined in the law as diagnoses, hospitalization, medical, surgical corrective and other services and care of such children. This law also requires health care providers to treat newborns with silver nitrate solution or an alternative to prevent ophthalmia, and allows for administration of the WIC program.

***/2005/The Senate and House of Representatives enacted Senate Bill 472, at the request of the Department of Health and Human Services. It was approved and effective 7/04. The bill revised state statutes to replace the term "crippled children" with the term "children with special health care needs" and defines the term consistently with applicable federal law. The new language appears in RSA 132:1, 132:11, and 132:13. The request for this legislative change was initiated by the Special Medical Services Bureau.//2005//***

RSA 132:10A mandates newborn screening, requiring health care providers attending newborns to test for metabolic disorders including, but not limited to PKU, galactosemia, homocystinuria, MSUD, and hypothyroidism.

RSA 611, Medical Examiners, requires the medical examiner to file a record with the BMCH of any death determined to be the result of Sudden Infant Death Syndrome. The BMCH can inform the parents of the disposition of the case but not release the autopsy report.

RSA 137G, Catastrophic Illness Program, defines catastrophic illness to include cancer, hemophilia, end-stage renal disease, spinal cord injury or cystic fibrosis, which require extensive treatment such as hospitalization, medication, surgery, therapy or other medical expenses such as transportation. Eligible individuals may have services paid for by the Department. Eligibility and services to be covered are set forth in rules.

/2004/RSA 126 also contains a number of specific provisions pertinent to Title V. RSA 126-A4 establishes a division of juvenile justice services, and allows for DHHS quality assurance activities. RSA 126-A: 17 establishes an Advisory Council on Child Care to develop a state plan to improve child care services, report annually to the Legislature and Governor, and to act as a forum to receive child care related information. RSA 126-A: 18 addresses developing primary preventive health services for low-income and uninsured populations. RSA 126-A: 26 establishes an emergency shelter program. RSA 126-J: 1 establishes a council for children and adolescents with chronic health conditions and their families. RSA 126-K establishes the Tobacco Use Prevention Fund with tobacco settlement funds for tobacco use prevention and cessation programs, and restricts sale of tobacco products to minors. RSA 126-M: 1 recognizes the importance of prevention and early intervention programs and creates a formal network of family resource centers.

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

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

RSA 141-C, Immunization, and Reporting communicable diseases, prohibits enrollment in school or child care unless immunization standards are met and requires reporting of specified communicable diseases to the State Department of Public Health. RSA 141-H: 2 prohibits mandatory genetic testing and requires informed consent, excepting for establishment of paternity and for newborn metabolic screening.

RSA 169-C mandates reporting of suspected child abuse.

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

RSA 265:82 prohibits driving while under the influence of alcohol or drugs. RSA 265:107a requires the use of infant booster seats and seat belts up to age 18.

The full, unofficial text of these statutes may be accessed on the State's website at: [www.state.nh.us](http://www.state.nh.us). Information on Title V program activities related to these statutes can be found in Sections IIIC, IIIE, and IV of this application.//2004//

During the 1999-2000 legislative sessions, Senate Bill (SB) 456, An Act relative to testing newborns for deafness, was passed, requiring the Commissioner of DHHS to develop standards for testing newborns and produce a report with recommendations to the Legislature and Governor by November 2000. The BMCH has submitted recommendations and is currently developing program standards and protocols.

/2004/Listed below are bills passed by the New Hampshire Legislature during the 2002-2003 Legislative Session of particular interest to Title V.

HB104 creates an exemption of child abandonment laws if the child is delivered to a "safe haven". HB763 requires parental notification before abortions may be performed on unemancipated minors. SB128 transfers the bureau of vital records and health statistics from the Department of Health and Human Services to the Department of State. HCR3 calls on the President and the Congress to fully

fund the federal government's share of special education services in public elementary and secondary schools in the United States under the Individuals with Disabilities Education Act.

## PREVENTIVE & PRIMARY CARE SERVICES FOR WOMEN, MOTHERS & INFANTS

Aside from population based activities, and as outlined in Section IIIA, BMCH contracts with community agencies to provide prenatal care for low income and underserved populations. Twelve 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 now considered 'primary care agencies' that offer the full spectrum of health care services to all ages; two are still 'categorical', offering access to prenatal care and enabling services through various models that meet their community's needs.

Of the ten primary care agencies, six 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, and one center is currently applying for 330 status. The remaining categorical prenatal agencies offer prenatal care directly or through subcontract with local physicians. By contract, social services, nutritional counseling, and referral for high-risk care must be provided.

In 2002, these twelve agencies served 2045 pregnant women, or 12% of New Hampshire's pregnant women. Of these women, 69% were enrolled in Medicaid for the pregnancy or delivery, 10% were uninsured, and 289 were pregnant teens. A map of Prenatal Service Areas (PSA) is attached to this Section.

Section IIIA of this application presents data clearly delineating disparities in prenatal care access and health outcomes for privately insured women versus those uninsured or on Medicaid. The BMCH knows little at present about where women are obtaining prenatal care other than at its contract agencies, or whether the care meets acceptable OB standards, but recognizes the need to further explore these disparities, including examining the private prenatal care system to assure capacity for addressing this population's complex needs. BMCH will work with its epidemiologist and the UNH Survey Center to develop a plan to obtain information on the private service system for prenatal care and address potential service system gaps.

## 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. BMCH contracts with 14 community agencies throughout the state to provide direct child health care services to low income, underserved children from birth through age 11. Ten of these are the 'primary care' agencies described above; four are 'categorical' agencies. Services at the primary 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. Services at categorical child health direct care agencies are generally limited to well-child services, immunizations, and referrals to other agencies as needed.

All agencies screen children for developmental delay and refer children to specialty services, though the tools used vary widely. BMCH and SMSB are currently collaborating on a Developmental Screening Initiative to examine patterns of developmental screening at the agency level, make recommendations on the use of up-to-date screening tools, and provide technical assistance to agencies in billing Medicaid for these services. A map of Child Health Service Areas (CHSA) is included as an attachment to this Section.

In 2000, both types of BMCH-funded Child Health programs saw 14,756 children ages 12 and under, with 19% of their total caseloads enrolled in Medicaid and 57% living at less than 185% of the federal poverty level.

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. These declines in service utilization led the BMCH to pilot a model for the alternative use of Title V funds for child health services.//2004//

/2002/Alternative Use of Title V Funds for Child Health Services: Due to increasing enrollments in NH Healthy Kids, the state's SCHIP, some contracted BMCH agencies noted declines in their well child clinic enrollments. In response, BMCH offered communities an alternative use of the MCH grant for FY'02. Recognizing the continued need for low income, often multi-problem families to access support, counseling, and assistance services in order to effectively access and utilize medical care through NH Healthy Kids, local agencies could apply for either "Child Health Direct" or "Child and Family Health Support" contracts. Unlike traditional direct care models, Child and Family Health Support contracts allow the use of MCH funds to provide vital "wrap around" services that many families need. Although all areas could choose to apply for "Child Health Direct" or "Child and Family Health Support" contracts, each area applying for the enabling services was required to demonstrate that direct care services were not needed in their area. Four of 13 agencies applied for the Child and Family Health Support Services funding, and nine continued to apply for the direct care grant. BMCH needs to reassess its child health resource allocation to assure that priority needs of low-income children and families are met. Short-term, BMCH is funding several child health contract agencies to shift their focus from direct care to support services. Needs assessment data will assist BMCH to determine long-term child health services goals and reassess resource use and distribution.

/2003/The BMCH continues to fund four agencies to provide child health support services. MCHB technical assistance will allow exploration of Best Practices for these services. Use of resources for this purpose will be analyzed and re-evaluated during development of a child health services funding formula.

/2004/The MCHB technical assistance from CompCare is looking at this use of Title V funds to determine whether this shift is meeting the needs of New Hampshire's children. An initial report has been submitted. Focus groups with consumers will be held over the next few months with a final report due in Fall 2003. See Section IVB for additional information about this initiative.//2004//

***/2005/The final report from CompCare was completed in the fall of 2003. 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 is exploring a pilot grant for communities that will offer such flexibility.//2005//***

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

Capacity to provide rehabilitation services for blind and disabled individuals less than 16 years of age:

/2004/SMSB outreach to SSI applicants and beneficiaries includes having a designated care coordinator follow-up on all child applications for SSI that are not receiving Medicaid and are not known to SMSB. Extensive efforts are made to contact these families and to assess their current needs. 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 Family Voices/SMSB Health Care Financing Advisory Group, which is part of a joint Cost of Care initiative. The NH Family Voices newsletter "Pass it On" includes periodic, family-friendly, material about SSI. Upcoming SMSB Issue Briefs will include SSI as an aspect of health care financing issues. Activities related to NPM #6 (transition of YSHCN) will also include the SSI youth population in certain efforts. Reference sections III.A. and III.F. for additional text on SSI and CSHCN.//2004//

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

/2004/Special Medical Services Bureau 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 through 6 years of age suspected or at risk for altered developmental progress. The network is comprised of five (5) 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 more complex children. 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 SMSB.

Pediatric Specialty Clinics are supported to assist families to access community-based interdisciplinary services to evaluate children with complex medical needs. SMSB also helps to pay for medical and related services to treat these conditions. Each clinic has a Medical Director and a Nurse Coordinator. Additional professional staff, appropriate to the condition, are specified for each clinic type. Consultant staff include physical therapy, nutrition, psychology and developmental pediatrics. SMSB operated specialty clinics include Amputee/Limb Deficiency (one site) and Neuromotor Disabilities (five sites).

The SMSB Nutrition, Feeding & Swallowing Program offers community-based consultation and intervention services to families with children with special health care needs throughout the State. The program has developed statewide networks of contracted pediatric dieticians, and feeding and swallowing specialists to serve children who have nutritional or oral motor feeding issues. There are currently 18 Registered Dieticians and 4 Occupational/Speech/Language Therapists providing school and home-based services.

***/2005/There are 14 Registered Dieticians and 5 Occupational/Speech/Language Therapists providing school and home-based services./2005//***

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. Bureau Care Coordinators collaborate with other State systems and community agencies (e.g., Partners in Health, Rural Medical Home sites, Enhanced Chronic Care providers, HMO coordinators) by sharing expertise and information about available resources.

The SMSB offers income eligible families with children having a broad range of medical conditions financial assistance with payment for specialty care and family support needs. Families with income less than 200% of poverty are considered eligible. ***/2005/Families with income less than 186% of the federal poverty level are income-eligible for the Bureau's services./2005//***

SMSB contracts with three (3) parents to support the work of New Hampshire Family Voices. This program acts as a resource to inform health professionals, policy makers and the broader community regarding CSHCN. Family Voices works within community systems to promote family-centered policies and support the needs of families.

Psychology consultation services (one contractor) are supported by SMSB to facilitate community-based behavioral and emotional health services for CSHCN. 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 settings, and consultation with parents and involved professional providers. Treatment consultation may focus on coping with chronic illness, behavioral and educational issues, and problems with sleep, eating and soiling./2004//

CULTURAL COMPETENCE & THE TITLE V PROGRAM

Currently, little information is available regarding health disparities among state racial and ethnic populations. Through our State Systems Development Initiative (SSDI), we are optimistic that we will learn more in this area. Two grants are being awarded to the Nashua and Manchester health departments to study health disparities and barriers to access among racial, ethnic and socioeconomic minorities in MCH populations. This work will be done over the next year in partnership with the BMCH and with assistance from our newly hired MCH epidemiologists. /2002/The MCH Needs Assessment addresses health disparities among racial and ethnic populations in detail. Progress reports from SSDI grantees are due in January 2001. /2003/Reports from Nashua and Manchester will be completed in September 2002. Both cities are conducting focus groups with women of racial and ethnic minorities to learn about their experiences in accessing prenatal care.

/2004/Focus group reports were completed in the fall of 2002, revealing that, while most minority women were satisfied with the level of prenatal care received, many voiced problems encountered in the process of receiving care. Barriers to prenatal care included: lack of insurance; language difficulties; conflicts with work; inability to secure the provision of childcare; and transportation difficulties. These findings are available upon request from the BMCH. In partnership with the NH Immunization Program, additional focus groups relating to child health access issues are planned for 2003 in Manchester and Nashua.

The BMCH recognizes changing state demographics and the need to plan for increasing minority populations in coming years. BMCH staff met several times in 2002 with the Director of the DHHS Minority Health Office and leadership of the New Hampshire Minority Health Coalition (MHC) to discuss the needs of racial and ethnic minority populations.

The BMCH is becoming more aware of the challenging issues facing minorities in New Hampshire and activities that are currently underway to address these issues. A BMCH contract with the MHC in SFY 2004 will provide home visiting services for minority populations in Manchester and, hopefully, begin to address the State's minority issues.

The Special Medical Services Bureau continues to fund interpreters for the Child Development and Neuromotor clinics in Manchester, and has translated the SMSB application into Spanish, to better serve the state's Hispanic residents.//2004// ***/2005/The Special Medical Services informational poster is being translated into Spanish. It will be distributed in targeted areas of the state and posted on the Bureau's web page. The New Hampshire Minority Health Coalition presented a workshop on Cultural Competance in March 2004. Staff from SMSB participated. The workshop was sponsored by the New Hampshire LEND program, in collaboration with the Institute on Disability at the University of New Hampshire.//2005//***

## C. ORGANIZATIONAL STRUCTURE

/2004/The New Hampshire Department of Health and Human Services (DHHS) is headed by a Commissioner reporting directly to the State's Governor. Two major divisions within DHHS are the Office of Community and Public Health (OCPH) and the Office of Health Planning and Medicaid (OHPM). ***/2005/DHHS is currently undergoing a major restructuring. The former OHPM is now the Division of Medical Services, within the Division of Program Operations.//2005//***

The Title V Program is located within the DHHS, the Bureau of Maternal & Child Health (BMCH) in the OCPH Division of Family & Community Health (DFCH), /2003/and the Special Medical Services Bureau (SMSB) in the OHPM Medicaid Administration Bureau (MAB). Administration of the Block Grant is assigned jointly to the BMCH for services to women, infants and children (MCH) and the SMSB for children with special health care needs (CSHCN)./2004/Organizational charts are included as an attachment to this section.//2004// ***/2005/Updated organizational charts are attached.//2005//***

Each Title V Program Director (BMCH and SMSB) is responsible for their staffs, budgets, and assuring that activities proposed under the MCH Block Grant are carried out. The BMCH Director

assumes coordinating responsibilities for the Block Grant submission. While each program is administratively autonomous, they coordinate frequently at the programmatic level. For example, BMCH oversees operations of the Newborn Metabolic Screening Program. If, however, a child is found to have a metabolic disease, BMCH staff works with SMSB staff that will provide care coordination services for the child and family. Further, BMCH and SMSB staff members sit on one another's respective advisory boards as appropriate, such as the Newborn Hearing Screening Advisory Board.

/2003/In November 2001, the /2004/former//2004//Medicaid Assistance Bureau was removed from the Office of Community and Public Health, and reorganized as part of the new OHPM. Lori Real, MHA, is head of the new OHPM. This new alignment will allow SMSB to focus on the shared goals of ensuring the adequacy of health insurance for CSHCN, including medical homes, program design, and applied research. **/2005/Under the current reorganization, SMSB is still aligned as above./2005//** OCPH reorganized in the spring of 2002 to create a stronger infrastructure for deliberate public health planning and program coordination. As part of this reorganization, the Injury Prevention Program was moved back into the BMCH. The DFCH now includes the BMCH, the Immunization Program, HIV/STD, and Rural Health/Primary Care.

/2003/The SMSB Bureau Chief is part of the NH State Youth Collaborative, a BMCH initiative focusing on adolescent health issues. Another SMSB staff member actively worked with a BMCH colleague and other stakeholders to plan a two-day Adolescent Institute for June 2002. Finally, BMCH and SMSB staff worked together with the NH Child Health Month Coalition to plan joint activities for October 2002. /2004/and October 2003./2004// Such activities assure that the needs of the BMCH and CSHCN populations are considered in program planning.

/2004/Organizationally, SMSB is placed within the Office of Health Planning and Medicaid (OHPM), Health Management and Care Coordination Services. The integration within Medicaid operations enhances policy development, disease case management, quality assurance, leadership opportunities for SMSB staff, increased access and improved care for CSHCN in New Hampshire and better access to data systems./2004// **/2005/SMSB is now in the Division of Medical Services, within the Office of Program Operations./2005//**

/2003/OCPH reorganized in the Spring of 2002 to create a stronger infrastructure for deliberate public health planning and program coordination. As part of this change, the Injury Prevention Program moved back into the BMCH. The DFCH now includes BMCH, the Immunization Program, the HIV/STD Program, and the Rural Health & Primary Care Program.

**/2005/DHHS reorganized during SFY2004 to streamline services and create efficiencies. MCH remains within the Division of Public Health Services in the Bureau of Community Health Services, but is now called the Maternal and Child Health Section. The Childhood Lead Prevention Program will move back within MCH as of July 1, 2004./2005//**

/2004/FEDERAL-STATE BLOCK GRANT PARTNERSHIP: BMCH

**PRIMARY CARE PROGRAM:** The BMCH supports ten community health centers in providing comprehensive primary care services, including prenatal and pediatric care, for 65,000 individuals/year. Many sites offer support services such as nutrition counseling, case management, transportation and translation.

**PRENATAL PROGRAM:** The BMCH funds local agencies to provide prenatal care to over 1800 women yearly. Services include: medical care, nutrition, social services, nursing care, case management, home visiting and referral to specialty care.

**CHILD HEALTH PROGRAM:** Thirteen community health agencies receive funding to provide child health services. Nine offer direct care to low-income children through clinics and home visits; four provide health and social support services to children and their families. All agencies provide case

management, outreach, and SCHIP enrollment assistance, and may use funds to provide child care health consultation.

**SIDS PROGRAM:** The SIDS program offers information, support and resources to family and care providers of infants suspected to have died of SIDS. Title V staff work with trained SIDS Counselors to provide home visits. Information/training are provided upon request.

**NEWBORN SCREENING PROGRAM (NSP):** The NSP coordinates the screening and short-term follow up of all infants born in New Hampshire for six disorders.

**PRESCHOOL VISION & HEARING PROGRAM (PSVH):** PSVH works with trained community volunteers to provide hearing and vision screening and follow-up for approximately 2000 preschool children/year, targeting low-income families.

**EARLY HEARING DETECTION & INTERVENTION (EHDI):** EHDI seeks to screen all newborns for hearing loss, and to assure appropriate follow-up and intervention. By 2004, it is anticipated that 80% of all newborns born in NH hospitals will be screened.

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

**ABSTINENCE EDUCATION PROGRAM:** This program seeks to reduce unintended pregnancies among children ages 10-14 years through a targeted media campaign using an abstinence message and community grants to implement abstinence curricula.

**HOME VISITING NEW HAMPSHIRE (HVNH):** HVNH promotes healthy pregnancies and birth outcomes, safe and nurturing environments for young children, and enhances families' life course and development for pregnant women and families with children up to age one. Nineteen projects currently serve 350 families/year. Title V staff are involved in training, data collection and evaluation activities.

**HEALTHY CHILD CARE NEW HAMPSHIRE(HCCNH):** HCCNH, previously located at a contract agency, will reside within BMCH as of 2003. This program focuses on comparing state child care regulations with national standards, outreach to enroll children in SCHIP, and increasing the number and expertise of child care health consultants.

**INJURY PREVENTION PROGRAM (IPP):** The IPP seeks to reduce morbidity and mortality due to intentional unintentional injuries. The IPP is also responsible for violence prevention, including sexual assault & domestic violence, and funds the State Injury Prevention Center.

**ORAL HEALTH PROGRAM:** The Oral Health Program receives Title V funds to improve access to oral health services for all individuals. Strategies include establishing school-based programs and new dental clinics, assisting communities to organize to fluoridate water supplies, improving Medicaid reimbursement rates and policies, and increasing the number of dental providers.

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

**FAMILY PLANNING PROGRAM (FPP):** The FPP provides confidential reproductive health care for low-income women and teens to 29,000 individuals/year. Ten clinics offer "teen only" services incorporating teen peer educators.

***/2005/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 in children.//2005//***

PROGRAMS FUNDED BY THE FEDERAL-STATE BLOCK GRANT PARTNERSHIP -- SMSB

/2004/CHILD DEVELOPMENT PROGRAM: The Child Development Services Network is comprised of five Child Development Programs contracted through local community health agencies to provide a community-based approach to state-of-the-art diagnostic evaluation services, to children (0-6) suspected of or at risk for altered developmental progress.

PEDIATRIC SPECIALTY CLINICS: SMSB operates 5 Pediatric Specialty Clinics for Neuromotor Disabilities. These family-centered, community-based, multidisciplinary clinics utilize treatment approaches that encourage parents/children to fully participate in care planning. The clinic coordinator and consultant staff address issues of physical therapy, orthopedics, and developmental pediatrics, with access to SMSB nutrition and psychology services. An Amputee/Limb Deficiency Clinic is held quarterly.

NUTRITION, FEEDING AND SWALLOWING PROGRAM: The SMSB Nutrition, Feeding and Swallowing Program offers community-based consultation and intervention services statewide. The program has developed networks of contracted regional nutritionists, and feeding and swallowing specialists. SMSB offers specialized training for all network providers and monitors their quality of care to assure a coordinated, outcome-oriented approach that is family-centered and community-based. ***/2005/Four workshops for parents with children on the autism spectrum were supported by SMSB, presented in various locations in the state.//2005//***

CARE COORDINATION INITIATIVE: Each child/family enrolled in the Title V CSHCN Program has a care coordinator who provides an assessment in order to develop comprehensive health care plans that are responsive to the needs and priorities of the child/family. These staff provide coordination of medical services with other community providers and schools, to ensure continuity of care, and support that will empower families to assume the role of primary coordinator for their child.

FINANCIAL ASSISTANCE SERVICES: The SMSB offers children whose families meet the income guidelines financial assistance with payment for specialty medical care and services. All third-party resources must be exhausted before SMSB funding can be considered.

FAMILY SUPPORT SERVICES: Funding received from NH Title V CSHCN supports New Hampshire Family Voices (NHFV) in its mission to assist families with CSHCN. NHFV provides information, support and referral to families with the 800 line provided by SMSB. NHFV maintains a comprehensive lending library, specializing in children's books for families and publishes a quarterly newsletter, "Pass It On". NHFV publishes an annual listing of support group/organizations, and operates a comprehensive website. The staff are three parents of CSHCN who can personally relate to the issues and concerns raised by individuals seeking their assistance. NH Family Voices documented 716 inquiries between January and December 2002. Most of the inquiries were made by families (491 or 69%) with provider/professionals making 225 (31%) of the calls and consumers or those calling for their own needs made 17 (2%) of the calls. Although the majority of inquiries are made through the 800 number provided by Special Medical Services to Family Voices, with the creation of the NHFV web site, e-mail has allowed families to request assistance in this manner. Seventy-two such e-mails were received during this reporting period. Support services were the most frequently reported caller topic, followed by literature requests, information on health care financing and services, requests for financial assistance, and inquiries regarding special education issues.

PSYCHOLOGY CONSULTATION SERVICES: Psychology services are available to any family regardless of SMSB financial eligibility. ***/2005/The psychology consultant provides school, assessment, treatment, and staff consultations; confers with nurse coordinators, provides staff workshops/in-services, and helps problem-solve regarding gaps in pediatric mental***

## D. OTHER MCH CAPACITY

### STAFFING

*/2004/*The BMCH is headed by a Bureau Chief, who directs all MCH activities. The BMCH employs 19.2 FTEs (full-time staff equivalents); 10.6 FTE are paid in part or in full through Title V funds. The BMCH also contracts with an additional eight individuals to perform specific activities. There are five main programmatic divisions within BMCH: Child Health (4.0 FTE); Prenatal and Adolescent Health (2.0 FTE); Injury Prevention (1.6 FTE); Home Visiting/Healthy Child Care New Hampshire (1.0 FTE); and Family Planning (2.0 FTE). In addition, an Information & Quality Assurance unit consists of the SSDI Program Planner, a Program Evaluation Specialist, a 0.6 FTE Quality Assurance Nurse Consultant, and a 0.5 FTE Systems Development Specialist. The BMCH also employs administrative support staff (4.5 FTE). All BMCH staff are centrally located.

***/2005/With the DHHS reorganization, MCH consists of three main programmatic divisions: the CLPPP (Lead Program); Child Health, which includes Newborn Screening, EHDI, SIDS, ECCS, Healthy Child Care NH, and Home Visiting NH; and Women's Health, which includes the Prenatal, Family Planning, Adolescent Health, Injury Prevention, and SSDI.//2005//***

The Bureau Chief for the Special Medical Services Bureau (SMSB) is the director of the State CSHCN program. The SMSB employs 11 FTEs and employs administrative support staff (6 FTE); 4.6 FTE are paid in full or part by Title V funds. The SMSB contracts with 18 individuals to provide CSHCN expertise and services throughout New Hampshire.***/2005/The SMSB employs 12 individuals and/or agencies through contracts.//2005//***

### SENIOR LEVEL MANAGEMENT BIOGRAPHIES- Maternal and Child Health

Lisa L. Bujno, MSN, ARNP, Bureau Chief, BMCH:

Ms. Bujno received both BS and MS degrees in nursing from the University of Pennsylvania. She has over 11 years experience in public health and has been employed at the BMCH since 1999. Her particular areas of expertise are prenatal and adolescent health issues, primary care in the community health center setting, and systems for quality improvement.

Audrey Knight, MSN, ARNP, Child Health Nurse Consultant, BMCH:

Ms. Knight has a Masters degree in nursing from Yale University and has held the position of Child Health Nurse Consultant for the Bureau since 1986. She is the SIDS program coordinator and manages the Child Health Program, the Preschool Vision and Hearing Program, Newborn Metabolic Screening and Universal Newborn Hearing Screening Programs. Ms. Knight has expertise in preventive and primary care for children.

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

Ms. Coll has over 20 years of experience in women's health, including fifteen years in public health settings. She has a Masters degree in education from Cambridge College. Most recently, Ms. Coll was the Director of a BMCH-funded prenatal and child health program.

Patricia Tilley, MS, Home Visiting/HCCNH Program Specialist, BMCH:

Ms. Tilley manages the Home Visiting New Hampshire program and oversees Healthy Child Care New Hampshire activities. She has a Masters degree in education from the University of Pennsylvania and has worked in home visiting, and family support since 1995. Ms. Tilley will manage the upcoming Early Childhood Comprehensive Systems grant.

Kathy Desilets, BS, Family Planning Program Manager, BMCH:

Ms. Desilets has a Graduate Certificate in Public Health from the Rollins School of Public Health. She has over ten years of experience in public health, with an emphasis on reproductive health, HIV and STDs.

***//2005/Michelle Dembiec, CLPPP Program Manager, MCH:  
Ms. Dembiec has a Masters degree in Education and is a Certified Health Education Specialist.  
She has ten years of experience in health education and public health programs.//2005//***

#### SENIOR LEVEL MANAGEMENT BIOGRAPHIES - Special Medical Services Bureau

Judith A. Bumbalo, RN, PhD, Bureau Chief, CSHCN Director  
Dr. Bumbalo received her M.S. from Boston University and Her Ph.D. from Wayne State University, and has over 25 years of experience working with CSHCN and families. In academic nursing programs in Washington and Wisconsin, she worked closely with state Title V programs. Dr. Bumbalo is the former Director of a Title V training program for graduate education in nursing at the University of Washington. Most recently, she coordinated the MCHB funded LEND program at the University of New Hampshire/Dartmouth Medical Center (1995-1999).

Kathy Higgins Cahill, MS, ARNP, Title V CSHCN Program Specialist.  
Ms. Cahill was hired for this position in December 2002. The position focus is on the needs assessment process and special projects. One such special project is Adolescent Health Care Transition. Ms. Cahill also continues her work with the Spina Bifida population as a care coordinator, the position she held since June 1999. She has worked as a part-time staff to SMSB for many years, assisting with the formation of the Child Development clinics in the early 80's and then became a full-time public health nurse coordinator.

Diane M. McCann, RN, MSN, CSHCN Program Manager, Community-based Care Coordination Initiative  
Diane McCann received her BSN from Niagara University and MSN from Boston University She was employed in Medical - Surgical nursing of Adults and Children for several years after undergraduate studies and then worked in school health for about nine years .She has been with Special Medical Services since 1984 in a variety of coordination positions such as Neuromotor, Spina Bifida, and Newborn screen programs as well as administrative positions. Currently she is a Program Manager for the care coordination program and is filling in the gaps for Amputee clinic in the absence of staff in this clinical program and as other staff vacancies occur. ***//2005/Ms. McCann retired effective 6/04.//2005//***

Lee Ustinich, M.S., Title V CSHCN Health Care Financing Specialist  
Lee Ustinich received her M.S. in Allied Health/Rehabilitation Counseling from Virginia Commonwealth University. She was hired in the fall of 2002 as a program specialist for the Special Medical Services Bureau. The position focus is on the Bureau's CSHCN Health Care Financing initiative, performance measures and infrastructure-building services. Ms.Ustinich replaces Diana Dorsey, MD, in the role of SSI State Liaison. She comes to the Bureau from the Virginia Community Services Board system, where she has over tens years experience in program management of community-based disability services. She is also the parent of an adult child with special health care needs.//2004//

#### PARENTS OF CHILDREN WITH SPECIAL NEEDS

Three parents of children with special health care needs staff New Hampshire Family Voices, supported by Title V funds. Martha-Jean Madison and Terry Ohlson-Martin are Co-Directors of the project and Sylvia Pelletier is the Outreach Coordinator. Martha-Jean is the parent of eight children with disabilities and special health care needs, Terry has a son with disabilities and Sylvia is the parent of two children who are cancer survivors.//2004//

#### STAFFING CHANGES

/2003/In November 2001, Dr. Judith Bumbalo assumed the position of CSHCN Director. Dr. Bumbalo first joined the SMSB staff to focus on the CSHCN needs assessment. This activity formed a sound basis for assuming CSHCN Director responsibilities with her insight into the current issues and needs in New Hampshire.

/2004/The Public Nurse Coordinator position vacated by Ms. Cahill was subsequently eliminated due to staffing reductions. Kathy Marieb retired from her position as Public Health Nurse Coordinator in November 2002. This position is currently frozen. In late 2002, Kathy Higgins Cahill and Lee Ustinich (resumes attached) were hired as Program Specialists for the Special Medical Services Bureau, and Diana Dorsey, MD, was replaced by Ms. Ustinich as the State SSI Liaison.//2004//

In June 2002, Joan Ascheim transitioned from BMCH Bureau Chief to Director of Family and Community Health. Lisa Bujno, former Prenatal & Adolescent Program Chief, assumed the position in July 2002. Ms. Bujno is highly skilled in public health program administration and MCH has run smoothly under her interim leadership. /2004/The Prenatal Manager position was filled in October 2002 by Anita Coll.

Several new BMCH positions were created in 2002. First, an SSDI Program Planner position was created, funded by the SSDI grant. Marie Kiely, MPH, was hired for this position in May 2002. Ms. Kiely will coordinate SSDI activities and BMCH data analysis capacity. Ms. Kiely has an MPH from Tufts University and over 17 years of experience in public health, including 7 years as the NH Injury Program Manager.

Funded by the SSDI and EHDI grants, a 0.5 FTE Systems Development Specialist, Melvin Friese, was hired in May 2002, to develop data linkage solutions. Mr. Friese is experienced in computer programming, systems analysis, and database management. ***/2005/Mr. Friese has since been reassigned with the centralization of all IT staff.//2005//***

The second position is that of Adolescent Health Coordinator, directly resulting from New Hampshire's CISS grant, the Adolescent Health Strategic Planning Initiative. Benjamin Wood, MPH, was hired in August 2002. Mr. Wood graduated from the University of Michigan's School of Public Health with a concentration in health behavior and health education.

The third position is that of Quality Assurance Nurse Consultant, funded jointly with the Bureau of Rural Health and Primary Care and the Family Planning Program. This position will focus on quality assurance activities and performance management relating to BMCH contract agencies. Merle Taylor, RN, was hired for this position in January 2003. Ms. Taylor has been a consultant focusing on QA activities for 2 years, and has over 10 years of experience in case management and quality assurance programs.//2004//

The Newborn Metabolic Screening Program (NSP) has resided in the BMCH since 2000./2003/Marcia Lavochkin, RN, BSN was hired to coordinate the NSP in 2001. Ms. Lavochkin previously worked in the SMSB, providing CSHCN care coordination for several years.

Neil Twitchell, BS, is the new program manager for the Injury Prevention Program (IPP). Mr. Twitchell was most recently manager of the NH Childhood Lead Poisoning Prevention Program. He brings sound managerial skills and strong public health knowledge to the position.

/2004/In the wake of budget constraints and vacant position losses, the IPP Manager has been temporarily reassigned to lead the Bureau of Environmental & Occupational Health. The duration of this change is unknown. IPP activities have been reassigned to several BMCH staff, including the program's 0.6 FTE Health Promotion Advisor, Rhonda Siegel. Ms. Siegel, MSED, is Univ. of Pennsylvania graduate with 20 years experience in health education and public health.//2004//

During the summer of 2000, the Universal Newborn Hearing Screening Program (UNHSP)

Coordinator, Ruth Fox, RN, MS, was hired, launching this program. Ms. Fox has a long history of maternal and child health and Early Head Start experience. A contractual audiologist, Mary Jane Sullivan, MA, CCC-A, began working with the UNHSP in the fall, bringing experience in pediatric audiology and in establishing hospital based newborn hearing screening programs. John A. Bernard of JAB Computer Consulting Services, LLC came on board in February 2001 as the information systems contractor to direct UNHSP data tracking components and to provide expertise to the Adolescent Strategic Planning Initiative.

/2004/Other Title V-funded contractors include: OB-GYN and Pediatric Medical Consultants and an MCH Epidemiologist. The MCH Epidemiologist is funded through a contract with the University of New Hampshire's Institute of Health Policy and Practice. This individual will devote three days per week to MCH issues, providing expertise in data analysis and health policy. Interviews are currently underway to fill this position.//2004//

***/2005/Vacancies and a hiring freeze have hampered agency capacity this year. The IPP Manager, Adolescent Health Coordinator and QA Nurse Consultant resigned in 2004; none of these positions were filled. Aside from vacancies, 3 staff needed extended medical leave this FY. All have now resumed their duties. MCH obtained approval to fill its QA Nurse position, and a strong candidate has accepted. A Program Assistant position was created and filled. Epidemiologic support is now provided by David LaFlamme, through a contract with UNH. Mr. LaFlamme has a PhD from Johns Hopkins University School of Public Health.***

***SMSB: Diane McCann, CSHCN Program Manager and Coordinator of the Community-based Care Coordination services, retired from state service. Due to budget constraints, it is uncertain whether this position can be filled. Elizabeth Collins, BA, RN, was hired in March as a Public Health Nurse Consultant. She has a BA from Wells College and BSN from the Univ. of Southern Maine. She has experience working in an ICF-MR, is ANCC certified in Psychiatric Mental Health Nursing, and will participate in the UNH LEND program during 2004-2005.//2005//***

## **E. STATE AGENCY COORDINATION**

New Hampshire's Title V Program has a long history of maximizing limited financial and human resources through the development of partnerships and coalitions. Through the establishment of common goals and objectives, Title V has greatly expanded its "reach" in both the State family and the community.

/2004/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 Fatality Review Committee; the Governor's Child Fatality Review Committee; the Perinatal Alcohol, Tobacco, and Other Drug Use Legislative Task Force; and the Governor's Traffic Safety Commission. An extensive table of Title V membership on and involvement in various task forces, commissions, committees, and work groups is available by request from the BMCH.

In the interest of conveying the essence of how Title V coordinates and collaborates with other organizations in New Hampshire, the following activities are highlighted://2004//

### **RELATIONSHIPS AMONG STATE HUMAN SERVICES AGENCIES**

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

TANF & Family Planning: This initiative coordinates Family Planning Program efforts with the Division of Family Assistance, which administers Temporary Assistance for Needy Families (TANF) funds. Programming has focused on two areas: (1) Approximately \$300,000 in TANF funds/year will expand

outreach and community efforts targeting Medicaid-eligible women and teens at risk for pregnancy. Design of the activities addressing this task was purposefully community-based, developed by family planning and primary care agencies in close contact with ongoing community efforts and unmet needs. (2) A multidisciplinary planning committee is crafting a targeted intervention for preventing subsequent births to teen mothers. Preliminary strategies include using existing home visiting programs and family resource centers in combination with local family planning agencies and other categorical agencies such as WIC, prenatal programs, and Head Start.

/2004/Expansion of the TANF/FPP collaboration in 2002 occurred through the Teen Pregnancy Prevention Curriculum Project and feasibility study. TANF provided funds to promote youth development-based teen pregnancy prevention curricula and the Family Planning Program is administering this effort. Funds are being used to reimburse local agencies, such as schools and Teen Clinics, for implementation of evidence-based curricula and for a feasibility study to determine the likelihood of success for a comprehensive, community-based, youth development pregnancy prevention program, based on the model developed by Dr. Michael Carrera of the New York Children's Aid Society (CAS). This study will evaluate the potential of offering a similar program in Manchester or Nashua, where the large population would allow for the maximum impact on reducing the State's teen pregnancy rate. To document the effectiveness of these initiatives, a comprehensive evaluation of the curriculum project's implementation and feasibility of a CAS model is also underway.

Medicaid, TANF and Home Visiting: This project, detailed in Sections IIIA and IVB, funds 19 home visiting programs statewide. Expansion from three pilot programs was achieved through collaboration with Medicaid & TANF, with backing from the then-active Governor's Kids Cabinet. The BMCH, as lead agency, worked closely with the DHHS Commissioner's office on this initiative. /2004/BMCH worked with the Medicaid program to expand a local Medicaid code that will pay \$15 per 15 minutes for child and family support services to BMCH contract agencies, including home visiting and child health agencies. This code was available for use as of October 2002. All agencies were trained by BMCH and Medicaid in the appropriate use of the new code./2005/A Medicaid QA audit of several agencies identified the need for additional training in appropriate documentation to support billing the new code. This was provided through an MCH Directors' Meeting./2005//

SCHIP: BMCH collaborates with the NH SCHIP Coordinator and the NH Healthy Kids Program to disseminate state level program information and policy changes to local BMCH contract agencies, obtain feedback from local agencies to the state level programs, and encourage local agencies to enroll all eligible children in the SCHIP and Healthy Kids Programs. The BMCH Child Health Nurse Consultant is a member of the SCHIP quality assurance workgroup ("QCHIP") and the workgroup overseeing the Robert Wood Johnson-funded "Covering Kids and Families" three pilot community projects.

SMSB care coordinators inform families who lack insurance about the NH Healthy Kids programs (HK Gold, Silver and Silver Plus), and send applications. A designated care coordinator (Kaiser) provides follow-up for families who have applied for SSI but are not receiving Medicaid or are not enrolled with SMSB. This follow-up includes information and applications for Healthy Kids. The Healthy Kids program coordinator is readily available for consultation with SMSB staff, and will refer families as appropriate to NH Family Voices as well as to SMSB.

State Department of Education (DOE): Coordination with the DOE occurs through several BMCH programs. The Adolescent Health Program's State Youth Collaborative includes the DOE School Nurse Consultant and HIV Coordinator. The School Nurse Consultant maintains a listserv for school nurses and the Adolescent Health Coordinator has posted items and conducted a survey through this venue. The DOE HIV Coordinator, also manager of the Youth Risk Behavior Survey (YRBS), has provided information for the Adolescent Health Strategic Plan. The Home Visiting New Hampshire (HVNH) program has worked closely with the DOE, specifically regarding family literacy. The HVNH Manager has reviewed Even Start family literacy proposals and sits on the Statewide Family Literacy Initiative Committee.

***/2005/SMSB staff (McCann, Cahill) are active members of a task force associated with a federally funded grant to the New Hampshire Part C and Part B programs to integrate and promote quality assurance for special education services (QUILT). Major activities focused on establishing and monitoring cultural competence, family involvement, early literacy, data management and transition. Staff participated on the transition work group and were essential to making sure that health issues are taken into consideration when developing transition plans. In addition, Ms. McCann was appointed as the Health and Human Services representative to the School Advisory Committee for Special Education. This committee is charged with overseeing policy at a state level for the Department of Special Education and it convenes on a monthly basis./2005//***

Division of Behavioral Health (DBH): Collaboration with the DBH, DOE, and the Division of Developmental Services is illustrated through the Children's Care Management Collaborative. This group seeks to model collaboration at the State level to ensure that our collective resources provide access to a full array of effective and efficient community-based services and supports for families with children and adolescents who have or are at risk of serious emotional disturbance, developmental or educational disabilities, substance abuse issues, or special health care needs. ***/2005/Staff members from BMCH (Tilley) and SMSB (Bumbalo) are active members of the Children's Care Management Collaborative./2005//***

Division of Alcohol and Drug Abuse Prevention and Recovery (DADAPR): BMCH collaborates with DADAPR to produce a brochure on Fetal Alcohol Syndrome (FAS). Dissemination of this brochure is currently mandated for all persons applying for state marriage licenses, who must also sign a statement of understanding. DADAPR and BMCH distribute additional brochures to their respective contract agencies and stakeholders. A DADAPR representative is a member of the NH Child Health Month Coalition, a state-level group chaired by the BMCH Child Health Nurse Consultant, which develops and disseminates a packet of health and safety handouts to over 5,000 child care providers, pediatric and family health care providers, foster parents, and health and social service agencies statewide each fall. ***/2005/In the DHHS reorganization, DADAPR is merged with Public Health to create the Division of Public Health Services. DADAPR prevention and treatment programs will no be integrated throughout the agency, providing for a more streamlined approach to community public health services./2005//***

Division of Children, Youth and Families (DCYF): BMCH collaborates with DCYF on several projects and committees. A representative from DCYF is a member of the NH Child Health Month Coalition discussed in the preceding paragraph. The DCYF Division Director and the BMCH Child Health Nurse Consultant ***/2005/and the medical consultant for Special Medical Services Bureau //2005//*** are members of the NH Child Fatality Review Committee, and a representative of DCYF and the BMCH Child Health Nurse Consultant are Board members of the NH Children's Trust Fund.

Bureau of Health Statistics & Data Management (BHSDM): A CDC grant on core injury surveillance capacity was awarded to the BHSDM in 2002. This collaborative effort with BMCH Injury Prevention Program (IPP) personnel will produce a state Injury Data Report. IPP staff are involved with Injury Data Report activities through working with the State Advisory Committee and five subcommittees on a long-term injury prevention plan, and coordinating a conference focusing on injury data. Another collaboration with BHSDM is the WRQS project. BMCH is contributing funds and working with BHSDM and Enterprise Data Warehouse personnel to develop a web-based data resource and query system module on adolescent health. ***/2005/The Injury Data Report was released in the fall of 2003. MCH also collaborated with BHSDM in the creation of a protocol to determine whether an activity meets the definition of public health practice, in response to community agencies' concerns about providing program data to MCH due to HIPAA regulations. The protocol, and cover letter sent to agencies, is attached./2005//***

MEDICAID and CSHCN

The voluntary managed care contract with Anthem Blue Cross and Blue Shield was terminated 6/30-

03. The major impact was that families receiving Medicaid are no longer covered by the Delta Dental insurance plan. To lessen the impact of this decision, Medicaid has increased the fees paid for 27 dental procedures, with the expectation that this will increase the number of Medicaid providers. Senior leadership within the Office of Health Planning and Medicaid are currently engaged in extensive recruitment activities to ensure pediatric dental coverage in community-based health care settings. In the fall of 2003, a Request for Proposals (RFP) will be issued for work force development, to assure a public health safety net of dental care providers. ATPD and HC-CSD programs continue with extensive quality assurance and quality improvement process initiatives.

***/2005/The Medicaid Program will undergo "modernization" during SFY 05. There are numerous factors that require New Hampshire to evaluate the current Medicaid program, its principles and funding, and to consider substantial changes to the program. These factors include: a) short term federal revenue reductions of at least \$100 million for SFY 2006-2007 and b) the long term issue of a growing elderly population. The Department plans to initiate three major strategies: a) reorganization of units within DHHS to achieve improved communication and reduce administrative inefficiencies, b) convening public forums to solicit input about the challenges faced by constituents and potential solutions and c) submission of an 1115 waiver to recreate New Hampshire Medicaid. It is not clear how this process will impact CSCHN.//2005//***

## RELATIONSHIPS WITH OTHER HEALTH AGENCIES

Local Public Health Agencies: BMCH works with the two existing local health departments in Manchester and Nashua on issues of mutual concern. For example, the BMCH provided funding to both health departments to conduct focus groups with minority populations through the SSDI grant in 2001. BMCH and the Immunization Program are also developing a child health focus group initiative with health department input for 2004.

***/2005/BMCH staff continues to work with the NH Immunization Program to include questions about health care access for children in its focus groups on increasing immunization rates in children of racial and ethnic minorities in Manchester and Nashua.//2005//***

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

Primary Care Association: The Bi-State Primary Care Association serves Community Health Centers in both New Hampshire and Vermont, providing advocacy and support for these agencies. BMCH representatives attend Bi-State presentations when appropriate, and some members of the Bi-State PCA Board of Directors are also Directors of MCH contract agencies that attend MCH quarterly Directors' meetings.

Tertiary Care Facilities: BMCH and SMSB collaborate with the state's two tertiary care facilities, Dartmouth Hitchcock Medical Center (DHMC) and the Elliot Hospital, as needed. For example, BMCH staff regularly present at the DHMC Perinatal Program's nurse manager meetings to update the community nurses on state maternal and child health issues and activities. In addition, several DHMC physicians are members of the Newborn Screening Advisory Committee. ***/2005/SMSB supports Child Development and Neuromotor Programs at Dartmouth Hitchcock Medical Center. //2005//***

## RELATIONSHIPS WITH TECHNICAL RESOURCES

Educational Programs & Universities: Title V frequently coordinates with educational programs and

universities. For example, the Injury Prevention Program funds the Injury Prevention Center at Dartmouth Medical School to provide statewide population-based injury services and works with them on many injury initiatives. In addition, the BMCH has contracted with the University of New Hampshire's (UNH) Institute of Health Policy and Practice to fund an MCH epidemiologist, as discussed in Section IVB. BMCH Adolescent Health Program staff participated in the creation of the new UNH Adolescence Resource Center (ARC), a clearinghouse of best practices and information for researchers and communities on adolescent concerns. The Adolescent Health Coordinator is also working with the ARC in the final phases of the statewide Adolescent Health Strategic Plan. BMCH programs often collaborate with Area Health Education Centers on conferences and trainings. This year, BMCH will form a work group with nurse educators from each of the State's Schools of Nursing and the HCCNH Coordinator to develop a nursing curriculum and clinical rotation plan for Bachelor's level nursing students, focusing on the role of the child care health consultant. ***/2005/The Adolescent Strategic Plan is currently in the approval process and expected to be released this summer. MCH collaborated with the UNH Adolescence Resource Center to hold a Youth Summit in October 2003, which presented community stakeholders with the goals and focus areas of the plan, and assisted them in developing action steps for their own settings. Over 150 participants attended. MCH is collaborating with the UNH Survey Center and the NH Coalition Against Domestic and Sexual Violence (CADSV) to replicate a national survey sexual violence. This is slated for summer 2004./2005//***

***/2005/Efforts to increase collaboration with the Dartmouth Medical Center / University of New Hampshire Leadership Education in Neurodevelopmental Disabilities (LEND) program received particular emphasis. As a result of joint planning collaborative clinical and educational activities have occurred. Special Medical Services Bureau contracted the Child Development Program at Child Health Services (Manchester) and the Seacoast Child Development Program at UNH are working on strategies to share professional expertise and increase the cultural competence of LEND trainees. SMSB staff (Bumbalo, Landry) have provided didactic lectures on Title V programs to LEND trainees and a LEND graduate student completed a field study focused on SMSB needs assessment activities. Both agencies (SMSB and LEND) co-sponsored an in-service training activity for community-based providers (see NPM #5). /2005//***

Child Health Month Coalition: BMCH will continue to Chair the state's Child Health Month Coalition ***/2005/and an SMSB staff member participates./2005//*** The coalition is a collaborative effort between BMCH Child Health and Injury Prevention Programs, the NH Pediatric Society, the Injury Prevention Center at Dartmouth, the Safe KIDS Coalition, CHaD, and DCYF. The coalition sponsors a yearly mailing of seasonal information to over 5,000 health and social services professionals, schools, hospitals, and agencies who work with children and families, a yearly toll-free hot line for questions regarding children's health and parenting issues, and a web page hosted by the state Pediatric Society. ***/2005/Improved use of electronic listserves (i.e. Department of Ed.'s school nurses, Healthy Childcare NH nurse consultants, and NH CAN (Child Advocacy Network) and of email mailing lists are increasing the distribution of the material without additional expense. The website is changing to that of Children's Hospital at Dartmouth (CHaD). Increased media coverage is planned for the Fall '04 mailing to celebrate the coalition's 10th anniversary./2005//***

***/2005/The Injury Prevention Program works with the NH Highway Safety Agency, the NH Department of Safety, the NH Department of Transportation, and the NH Department of Education on all child and adolescent restraint issues. The IPP is also participating in the Frameworks project, an innovative adolescent suicide prevention program that has developed intra-disciplinary protocols for use at the community level in the event of suicidal attempts and threats, and for postvention. This initiative is being coordinated by the National Alliance for the Mentally Ill, New Hampshire chapter, with support from the Gutenberg Foundation. The initial planning process was MCH funded, and the MCH Director sits on the Frameworks Advisory Board. A community pilot is intended for the winter of 2004./2005//***

## TITLE V & EPSDT

The EPSDT Program works with BMCH in providing data upon request, clarifying program coverage issues from both state-level and local agency staff, and working with the MCH Child Health Nurse Consultant on committees and workgroups such as the state's Child Fatality Review Committee and the state's SCHIP quality assurance committee.

Diana Dorsey, MD, shares a staffing position between the Special Medical Services Bureau and Medicaid. Dr. Dorsey provides pediatric consultation on EPSDT issues, with a particular focus on issues of medical necessity.//2004//

## TITLE V & OTHER FEDERAL GRANT PROGRAMS

WIC: Title V works with the WIC program through a mutual knowledge of community agencies and a joint vision of services for women and children. Coordination of immunization, nutrition, breastfeeding promotion and injury prevention strategies are shared across programs both in the state office and in the communities we serve. Lacking a nutritionist within BMCH, consultation from WIC nutrition staff regarding key nutrition issues impacting women and children is critical. BMCH staff collaborated with WIC and the March of Dimes, New Hampshire Chapter, to develop a folic acid public education campaign and prevention of birth defects. /2004/Additionally, BMCH joined WIC in funding a printing order to obtain a supply of revised CDC growth charts that were distributed to the WIC and MCH Title V contract agencies. The WIC Program shares educational material with MCH contract agencies either directly or through MCH sponsored mailings and meetings. WIC staff present a nutrition-focused mini-inservice at the MCH Coordinators' Meeting, and the Child Health Nurse Consultant provides an update on MCH programs, including SIDS, at WIC Nutritionists Meetings.//2004//

/2004/Family Planning: The state Title X Family Planning program is a major division within BMCH and is thus administered by the Title V Director, ensuring a seamless coordination between MCH and reproductive health activities. BMCH staff meetings, the BMCH yearly retreat and other Bureau planning activities include both MCH and Family Planning staff. The Family Planning Program Manager is included in the BMCH Management Team. Adolescent Health, Injury Prevention, and Family Planning personnel meet regularly to coordinate activities related to adolescents. Projects, such as this year's Women's Health week activities, are frequently collaborative efforts between Title V and Title X.

Developmental Disabilities: Home Visiting New Hampshire has partnered with the NH DHHS Division of Developmental Services by developing a series of trainings for home visitors across professional disciplines regarding the Emotional Life of Infants and Toddlers. These trainings have been so well received that they are now proposed to be an annual event.//2004//

***/2005/Early Childhood Comprehensive Systems (ECCS): This MCHB-funded initiative is bringing together partners from a wide variety of fields to collaborate in the development of a statewide plan for early childhood systems. Preliminary planning sessions have been held; a list of participants is included as an attachment. Although the coordinator position created to support these activities is frozen, the Home Visiting NH Manager has taken the lead in coordinating grant activities, and a contract to fund a facilitator for the planning is in process. MCH and SMSB are also collaborating with the AAP, Easter Seals and MCH-funded community agencies to address developmental screening for young children.//2005//***

## F. HEALTH SYSTEMS CAPACITY INDICATORS

/2004/The following provides an overview of the Title V program's ability to monitor the health systems capacity indicators:

#01: The rate of children hospitalized for asthma (10,000 children > 5 years of age)

This information is currently available to the Title V program through the Hospital Uniform Discharge Data Set and Medicaid program data files.

The OCPH has a three-year planning grant from the CDC to establish an Asthma Control Program for New Hampshire. The objectives for the planning grant are to: a) develop an asthma surveillance system, b) convene an advisory council and statewide planning process, and c) develop a comprehensive Asthma Action plan for the state. The Bureau Chief for Special Medical Services (Bumbalo) is a member of the Advisory Council and participates on the subcommittee focusing on disease management. This collaboration will assure that issues related to pediatric asthma management are included in the action plan. At the current time focus groups are being held around the state in order to get input from families, school nurses, teachers, day care providers and a variety of health care providers. The work of the planning grant is being coordinated with the American Lung Assn of New Hampshire, the Asthma Regional Council, and the New England Public Health Managed Care Collaborative. On September 17, 2003 a provider conference for physicians, asthma educators, respiratory therapist and health plans will make recommendations regarding data collection and analysis, environmental action and disease management for consideration at a statewide Asthma Summit. It is anticipated that the Asthma Control Program will have a beneficial effect on the current pediatric hospitalization rate of 12.2 per 10,000 children > 5 years of age.

***//2005/The Asthma Control Program report "Asthma in New Hampshire, 1990-2002" reports that in 2002, 17.7% (95% CI: 15.7- 9.7) of adults had a child (17 or younger) in their household diagnosed with asthma. The 2001 inpatient hospital discharge rate for children age 0-4 was 12.8 (N=98) per 10,000 population, and is the highest in NH, following the rate for adults age 65 and older (9.7). The 2010 target for Healthy New Hampshire is 7.9 per 10,000 population age 0-17. The baseline for this group was 10.5 per 10,000 in 1998. The hospitalization rate was 8.8 per 10,000 population for this age group in 2001.//2005//***

#02: The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen

This information is available through the Medicaid program data files at present, and with the implementation of the new Medicaid Decision Support System, BMCH will have direct access to Medicaid data.

#03: The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one periodic screen

This information is available through the New Hampshire Healthy Kids program.

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

This data is readily available through the Bureau of Health Statistics and Data Management and obtained on a yearly basis.

#05: Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State

This information is available through the Bureau of Health Statistics and Data management and through Medicaid program data files.

#06: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1), children and pregnant women

This information is available from Medicaid and New Hampshire Healthy Kids. In addition, the BMCH Child Health Nurse Consultant is a member of the SCHIP quality assurance workgroup ("QCHIP") and the workgroup overseeing the Robert Wood Johnson-funded "Covering Kids and Families" three pilot community projects.

#07: The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year

This information is available through the EPSDT program.

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

New Hampshire reports that 1,470 children under age 16 are receiving SSI, as of December 2002, per the Social Security Administration, Office of Research, Evaluation and Statistics (SSA/ORES). Of these, 181 (12.3%) are enrolled in the State CSHCN program. The number of New Hampshire children receiving SSI cash benefits had decreased by 12.4% between 12/'98 (N=1,860) and 12/'99 (N=1630), with the decrease attributed to the continuing economic prosperity in the state, rather than welfare reform. For calendar year 2000, the number was unchanged from '99. For calendar 2001 and 2002, children receiving benefits numbered 1750 and 1740, respectively. This increase is congruent with the national rise in the children's share of the overall applications and awards, as noted in SSA/ORES's semi-annual report for December 2002, as well as the general decline in the nation's economy. The National Survey of Children with Special Health Care Needs, 2001, variables for NH report only 2.26% of the children surveyed were receiving SSI for their own disability, indicating an under-representation of this population in the survey. SMSB will be surveying the SSI child population in fall 2003, (reference NPM #4) which should yield a better 'picture' of this group. Reference sections III.A. and III.B. for additional text on SSI and CSHCN. ***/2005/Due to budget constraints and agency restructuring, the SSI child population was not surveyed in calendar 03, however is in the process of being surveyed currently (7/04). Of 1748 children receiving SSI for their own disability, 84% N=1443)are under age 16. The survey, titled "Insurance/Cost-of-Care Survey of Children with Special Health Care Needs, 2004" is being sent to 1200 of these families. The instrument was carefully constructed to utilize selected questions from the National Survey of CSHCN, in the major areas of insurance, impact, and access.(/2005//***

#09A: The ability of States to assure that the Maternal and Child Health Program and Title V agency have access to policy and program relevant information and data

Through the SSDI grant, the BMCH is developing collaborative relationships that will enable access to data from DHHS and other agencies, as well as facilitate linkages between MCH program data and other data sets (e.g. Vital Records). The Bureau is currently beginning linkage of birth certificate and Newborn Screening Program data to assure that all newborns are screened. Planned expansions of data linkages include birth data with Prenatal and Home Visiting Program data, as well as Medicaid and WIC data with MCH program data. These linkages will assist the Bureau in assessing the MCH population and evaluating MCH programs.

#09B: The ability of States to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the past month.

The New Hampshire Tobacco Prevention and Control Program administered the NH Youth Tobacco Survey in October and November of 2001. This survey provides representative data of public middle and high school students. The NH YTS will be administered again in 2004.

The NH Youth Risk Behavior Survey also collects information on adolescent smoking but for the past 3 administrations has not provided representative data. ***/2005/The 2003 administration of the NH YRBS provided representative data for the first time since 1995. Collaboration between the DOE, which administers the survey, and DHHS, which has epidemiologic resources to***

**contribute, have successfully overcome previous barriers. MCH, Health Statistics and Alcohol and Drug Abuse Prevention and Control are also seeking permission to fund local implementations of YRBS to obtain program specific information for the local level.//2005//**

#09C: The ability of States to determine the percent of children who are obese or overweight.

The NH Youth Risk Behavior Survey collects self-report information on obesity and overweight for the high school population but for the past 3 administrations has not provided representative data.

There are currently no ongoing efforts to collect information on obesity and overweight for all children. The last year statewide childhood obesity data was collected and released was 1991. School nurses in NH collect this information but there has not been an attempt to combine and analyze this data over the past decade. An initiative through the NH Healthy Schools project, in which the BMCH participates, has applied for funding to work with school nurses and health educators to collect, analyze and publish this data for the K-12 population.

According to the NH Nutrition Education Coalition, 9% of NH high school students are obese (BMI 95th percentile) and an additional 15% are at risk for obesity (BMI 85th-94th percentile). As a result of a pediatrician needs assessment, this organization has developed a Pediatric Weight Management Toolkit that includes the Recommended Pediatric Weight Screening Guidelines (decision-making trees), articles, fact-sheets, resource guides and patient handouts. Over 2000 toolkits have been distributed to NH pediatric health practitioners. An ongoing evaluation process will provide more data in the future.//2004//

**/2005/It is estimated that 25% of New Hampshire children and teens can be considered obese or at risk for obesity, a number which has more than doubled in the last few decades. A recent study commissioned by the Department of education shows that New Hampshire third-graders are significantly fatter than their peers across the country. (i.e., 36.6 percent of girls and 41.5 percent of boys were considered to be at risk or already in the category of being overweight.)**

**Funded through a federal Team Nutrition grant and analyzed by the University of New Hampshire's Department of Health Management and Policy, the New Hampshire health Assessment Project gathered information from 1,538 8-year-old third-graders in elementary schools in all 10 New Hampshire counties by measuring their Body Mass Index (BMI), a ratio of height to weight. The New Hampshire results show 126 girls, or 17.4 percent, are considered at risk for being overweight compared with 72 or 9.9 percent nationwide, and 139 New Hampshire girls or 19.2 percent are considered overweight compared with 36 girls or 4.9 percent nationally. Among New Hampshire boys, 148, or 18.2 percent are considered at risk to be overweight, compared to national figures of 81 or 9.9 percent, and 189 boys or 23.3 percent are considered overweight, compared to 41 or 5 percent nationally. A similar study done in city schools in Manchester, New Hampshire, found that two out of five first-graders were overweight (i.e., 40 percent).**

**These are baseline studies, which show that there is a problem of childhood obesity in New Hampshire despite our status as one of the healthiest states in the nation. Based on research done in other states, it is likely that childhood obesity is related to a combination of factors (e.g., lower income and education levels and a growing number of single-mother households). It is important to note that studies have shown that overweight adolescents have a 70 percent chance of becoming obese or overweight as adults. It is clear that a statewide initiative is needed to address the problem of childhood obesity in New Hampshire.//2005//**

## **IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES**

### **A. BACKGROUND AND OVERVIEW**

/2004/New Hampshire's priorities are selected based on many factors, including the political climate, needs assessment findings, and emerging issues. Sections II and IIIA address the processes for choosing priorities based on the needs assessment and determining the importance of competing factors impacting health services delivery. This section describes current considerations in developing state priorities. The complete list of Title V priorities is located in Section IVB.

The needs assessment provided an overview of maternal and child health in NH, described health status indicators, identified disparities and gaps in health services, and targeted priority concerns. Findings highlighted potential areas of focus, such as:

- ? Exploring barriers to early prenatal care entry for certain populations and implementing effective interventions
- ? Implementing anti-smoking campaigns targeting specific prenatal age groups.
- ? Developing policies to promote Medicaid enrollment and care utilization.
- ? Promoting midwifery care may improve infant outcomes and reduce care costs; policies to increase midwives practicing with minority women could be considered.
- ? Implementing culturally competent programs promoting Medicaid enrollment. Improving prenatal care access in the four southernmost counties could help reduce disparities in minority birth outcomes.
- ? Examining funding distributions for MCH programs, addressing barriers to care, improving access, and whether efforts to improve enrollment in SCHIP and Medicaid impact health outcomes.
- ? Systematically incorporate immunization with Prevnar into NH practices.
- ? Expand YRBS use to promote a focus on at risk adolescent populations.
- ? Better understanding of the primary care workforce would improve an understanding of access to care.
- ? Address pediatric mental health and dental provider shortages.
- ? /2004/With the data from the National Survey of CSHCN, the process of prioritizing program development will be easier. Lack of a common definition of CSHCN has been a major barrier towards estimating prevalence of conditions and collecting data about needs.
- ? Families value, and request, assistance with care coordination for their child. Determining the infrastructure for care coordination is a current priority.
- ? Concentrating on population-based needs for care coordination/case management remains a consistent theme across direct services and population-based needs assessments.
- ? Title V's ability to develop collaborative relationships with stakeholders who share concerns for CSHCN has been improved. One doctorally prepared staff person (Bumbalo) and one person with Master's preparation (Ustinich) have stabilized SMSB capacity and expertise.//2004//

The growing importance of racial and minority health in New Hampshire is demonstrated by the near doubling of NH minority births between 1995 and 1999. The needs assessment illustrated that the state's ethnic and racial minorities are a heterogeneous group with diverse prenatal health and health care utilization patterns. 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%). Conversely, Puerto-Rican mothers with less than 10 prenatal visits had the worst overall LBW rates, at 25.8%. This analysis falls short of explaining cultural and social dimensions of these groups in NH. However, these findings will assist Title V to identify further areas of investigation and geographical areas of focus, and in developing targeted approaches for minority MCH populations.

New Hampshire continues to struggle with data capacity issues. Some MCH program data is of very limited use. Linking birth files to agency reports would further Title V's understanding of MCH populations. The YRBS currently achieves participation of just over 2200 NH high school students, prohibiting weighting of data and representative results.

At present, economic factors affecting MCH populations are uncertain. Rising unemployment in some areas, a soaring housing market and the possibility of decreased Medicaid provider payments are just some examples of factors that may influence the health of New Hampshire's MCH populations. In addition, scarce resources may result in the elimination of programs such as early supports and services in SFY04. The full effect of this current economic climate is difficult to predict, but the potential exists for decreasing access to care and worsening health indicators among women and children, including children and youth with special health care needs.

In consideration of these factors, Title V recognizes the importance of identifying comprehensive priority needs. A priority for each MCH population exists, including CSHCN, and the distinctive areas of mental health, oral health, and injury prevention are included. A priority addressing the foundation of MCH practice through data collection and use, and implementing evidence-based interventions will continue to broaden Title V's focus on infrastructure and population-based services, while a priority addressing the preservation of effective public health programming will remind us of our core mission and the vulnerable populations we serve.

New Hampshire's Title V planning and prioritization process has become stronger, more sharply focused and much more deliberate in recent history. Priorities have been developed that are global in nature and systems-focused. Directing limited MCH resources to these areas will be critical to maintain the health of NH's women, infants and children.//2004//

***/2005/MCH has created a "Data Team", consisting of the contractual MCH Epidemiologist, Program Planner and Program Evaluation Specialist. Along with the MCH and SMSB Directors and other SMSB staff, the Data Team will spearhead the needs assessment effort over the next year. This will allow a more focused approach to the needs assessment so that priority needs can be revisited with a fresh outlook in the next year. In addition, this will assist Title V to institutionalize a basic needs assessment process for future years.//2005//***

## **B. STATE PRIORITIES**

### RELATIONSHIP OF STATE PRIORITY NEEDS & PERFORMANCE MEASURES

/2004/New Hampshire has revised priority needs, in response to multiple factors anticipated to affect the health care environment:

1. To improve the Title V program's ability to impact the health of MCH populations through data collection and analysis, identifying disparities, examining barriers to care, and researching and implementing best practice models (All NPM & SPM)
2. To assure safe and healthy pregnancies for all women, especially vulnerable populations (NPM #8, 15, 17, 18 & SPM #2, 12)
3. To assure safe and healthy environments for children, including those with special health care needs (NPM #13, 14 & SPM #8, 11, 13)
4. To decrease dental disease in MCH populations (NPM #9 & SPM #10)
5. To improve access to mental health services for children, including those with special health care needs, and their families (NPM #3-5, 16)
6. To decrease unintentional injuries among children under 18, including those with special health care needs (NPM #10 & SPM # 13)
7. To assure that youth with special health care needs, their families and providers learn the essentials of self-care and self-determination, to enhance their health status (SPM #13)
8. 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 #9, 15)
9. To preserve effective public health programming, including an infrastructure of safety net providers, to address the needs of MCH populations (All NPM & SPM)
10. To decrease the prevalence of childhood obesity (SPM 16)

## ACTIVITIES RELATING TO PRIORITY NEEDS

BMCH and SMSB strive to provide a cohesive state Title V program addressing all state priority needs. Many priorities relate to performance measures and those discussions are included in Sections IVC and D. Some activities clearly relate to priority needs, but are not integral to the performance measurement system and are included here.//2004//

### PRIORITY #1:

Integration with the State Systems Development Initiative (SSDI): SSDI funds enabled the BMCH to contract with two part-time MCH epidemiologists to address BMCH data analysis capacity, producing the needs assessment, the child health evaluation, refining a definition of medical home, and exploring the feasibility of linking maternal and child health data sets. Other funds will be contracted to the Manchester and Nashua health departments to assist them in analyzing health disparities among minorities.

/2002/SSDI staff will examine MCH needs and resource allocation. This may focus on geographic reallocation of funds, population-based services or particular populations, such as minority women. Focus groups will be conducted with women and families to learn more about barriers they face in accessing health care.

BMCH will work to improve data capacity through linkages, such as linking newborn metabolic screening data with birth certificate data to assure that all infants are screened. This will converge with efforts to establish a newborn hearing tracking system that also links with birth certificate files.

/2003/Work has focused on needs assessment findings and examining BMCH community funding. SSDI Data Linkages implementation was delayed several months due to the process of accepting funds into the State budget. As of May 2002, key staff was hired and the project was commencing.

/2004/The Data Linkage Advisory Committee met quarterly, providing input into BMCH data confidentiality and security policies. Technical documents describing linkages between NSP data, UNHSP data and birth certificate data were developed and pilots are ready to be implemented. Two barriers may delay implementation, however. First, hospitals providing UNHSP data are reluctant to submit protected health information (PHI) due to HIPAA regulations. Guidance has been provided to hospitals outlining the relationship between HIPAA and public health practice. Second, a bill introduced in this legislative session will move the Bureau of Vital Records from the OCPH to the Secretary of State's Office. Memorandums of Understanding are currently being developed to assure public health's access to this data set for purposes of public health practice. Plans to revise funding allocations are on hold pending technical assistance.

MCH Epidemiology & Health Policy Capacity: As discussed in Section IIID, BMCH has contracted with the Institute for Health Policy and Practice for a part-time, doctoral level, MCH epidemiologist to provide data analysis and health policy expertise to the program. This person will work with the SSDI Coordinator and Program Evaluation Specialist to improve BMCH evaluative capacity. Candidate interviews are currently in process. ***/2005/David LaFlamme accepted the position that provides 0.6 FTE MCH epi support to the program in October 2003. His work is focusing on the needs assessment, improving data collection from local programs, and creation of a systematic approach to data within the MCH program through business planning.//2005//***

CompCare Initiative: As discussed in Section IIIB, the CompCare project provided through MCHB will offer BMCH information on best practices in child and family support services and on our current child health program. This will assist us to determine whether the shift toward support services and away from direct care services will best serve both the Title V mission and New Hampshire's children and families. The initial phase is complete, with focus groups and additional site visits planned over the next months. A final report should be available in the fall of 2003. ***/2005/The final CompCare report was submitted, and MCH is addressing recommendations contained therein. Suggestions for***

***improved crossover with Medicaid are being addressed in the DHHS 'Medicaid Modernization' initiative, and MCH is considering a pilot contract for general MCH service delivery at the local level.//2005//***

***/2005/Birth Defects Surveillance System: MCH and SMSB continue to collaborate with Dartmouth Medical School on the implementation of a birth defects surveillance system for New Hampshire. A feasibility study was completed this year, and the State Medical Director provided a letter outlining the partnership for this project to encourage hospitals to cooperate with data sharing and reporting, given the lack of a New Hampshire statute requiring reporting.//2005//***

#### PRIORITY #2:

Previous prenatal priorities related to birth spacing, prenatal substance use and first trimester access to care for vulnerable populations are now combined into the above priority. This priority will support BMCH in addressing disparities between Medicaid and non-Medicaid populations in IMR, LBW, and PN care point as well as exploring other areas where intervention may improve our prenatal outcomes. New Hampshire's goal is to address the prenatal population in a more comprehensive manner. BMCH is actively collaborating with the March of Dimes on its Prematurity Campaign and our State Medical Director is serving as spokesperson for this initiative.//2004//

#### PRIORITY #3:

Home Visiting New Hampshire: This project, begun as an MCHB CISS grant in 1996, funds home visiting model programs in three diverse geographic areas of the state. A combination of nurse, social work and paraprofessional home visitors provide home-based services to women throughout their pregnancy until the child's second birthday. Services include education, support and linking families to other services to accomplish a broad range of health and developmental goals. The project is currently evaluating outcomes and obtaining client and stakeholder feedback in the pilot communities.

/2002/In May 2001, 10 new home visiting programs were launched, bringing the total number to thirteen. During May and June, training took place, including training key staff in the Parents as Teachers curriculum, which will be used by all programs. Additional training was provided on the three main home visiting focus areas of prenatal smoking cessation, family planning and maternal depression. Six new programs will be established early in 2002, thereby achieving statewide home visiting coverage. An evaluation plan is being developed.

/2003/Three new programs were funded in FY 2002, an additional six in FY2003 totaling nineteen programs. Training for new programs is slated for the fall. BMCH released an RFP this year for program evaluation. A contractor has been chosen, project should begin by fall.

/2004/Nineteen home visiting sites were funded in FY2003. The evaluation contract was approved in 2002, but initiation of the project has been delayed by local agencies' reluctance to share PHI with the contractor due to HIPAA concerns. BMCH has provided training and guidelines on HIPAA as it relates to public health practice, hoping to surmount this barrier. The evaluation will focus on health outcomes of clients enrolled in home visiting programs. However, the viability of the home visiting network is in question. Despite development of a local Medicaid code for family support services, budget constraints may result in home visiting agencies receiving less than half their current funding in SFY04/05.

Healthy Child Care New Hampshire (HCCNH): Until this year, HCCNH has been administered through a contract agency. In the new grant cycle, the BMCH will directly administer this program, entwining its goals with those of the Early Childhood Comprehensive Systems grant. The BMCH will work with the State's Child Development Bureau to provide training on health and safety to child care providers with our newly published curriculum. BMCH and CDB are also meeting with nurse educators statewide to develop a curriculum for basic nursing education that will highlight the role of

the child care health consultant. Other potential activities are developing a Warm Line for child care health and safety, and collaborating with CDB and TANF to study the availability of child care services compared to demand. The HCCNH Coordinator and an SMSB staff person (McCann) were on the advisory committee and task group that reviewed NH child care standards, as compared to Stepping Stones. The SMSB advised on strengthening specific state standards for the next revision.

Early Childhood Comprehensive Systems Initiative: Title V applied for the MCHB grant for statewide, collaborative Early Childhood Comprehensive Systems planning. If funded, this project will use a focused strategic thinking process to engage a wide variety of stakeholders in planning for early childhood services. HCCNH activities will also be enveloped into this project. SMSB (Bumbalo) collaborated with MCH colleagues to complete this grant application and will support all grant activities related to integrating Medical Home and Infant Mental Health programs.

#### PRIORITY #4:

The Oral Health Program and Home Visiting New Hampshire collaborated this year on an initiative to promote dental health during pregnancy. In light of evidence that pregnant women with dental disease are at higher risk for premature and low birth weight infants, an oral health module for the home visiting program was developed, trainings were held for home visitors, and 300 oral health kits for high risk pregnant women were distributed; also, dental resources for low-income women in home visiting service areas were recruited. An oral health curriculum for grades K - 3 was implemented in all schools.

#### PRIORITY #5:

Children's Care Management Collaborative: The BMCH provides funds and actively participates in this collaborative of state agencies and systems providing support for early childhood development. The vision of this group is the creation of an early childhood mental health system of care across New Hampshire offering an array of flexible and varied services delivered when needed in home and community settings.

Integral to this collaborative has been the implementation of 14 regional infant mental health teams across the state. Using braided funding from eight different state agencies, including BMCH, the CCMC supports these teams through the Southeastern Regional Education Network to help sustain and develop a cadre of professionals trained in the unique mental health needs of young children and their families.

In conjunction with the interagency Children's Care Management Collaborative, SMSB (Bumbalo) contributed to blended funding for 14 regional Infant Mental Health Teams. All IMH teams were surveyed to assess their need for ongoing training and technical assistance and began plans to respond to identified needs.

#### PRIORITY #6:

The Injury Prevention Program addresses intentional and unintentional injury in a broader scope than is measured in the performance measurement system. The program addresses intentional injury by: funding 13 local sexual assault/domestic violence agencies for prevention activities, largely in school settings; developing a state plan to address violence against women; and participating in the NH Firearms Safety Coalition. Unintentional injury priorities include: chairing the NH Falls Risk Reduction Coalition; chairing the NH Media Violence Coalition; and funding and participating in the NH SafeKids Coalition. Activities related to decreasing injury related to motor vehicles is discussed in Section IVC.

#### PRIORITY #7:

Preliminary needs assessment of the special health care needs population highlights a critical need to prepare CSHCN to become as self-sufficient as possible and to be responsible for managing their

health care needs (self-care and self-determination), so they can effectively transition into the adult health care system. Participants in a NH focus group for youth with special health care needs expressed the need to address their priority health concerns. (1) Transitioning to adult health care was an important issue, as most of the participants were not receiving counseling on this topic, despite good relationships with their providers. Research indicates that there is a discrepancy between the views of providers versus the views of parents, in relation to the providers' responsibility for assisting youth with special health care needs with transition issues. (2) However, summary data from the National Survey of Children with Special Health Care Needs, 2001, indicates that 48% of the doctors have not spoken with families of youth about their changing needs as they become adults, and almost 60% of survey respondents reported that doctors had not discussed the shift from pediatric care to an adult medical practice. (3) Transition activities must be supported by a collaborative process, with the goal of enhancing the quality of life and health status of the youth and young adults. (References attached)

PRIORITY #8:

The BMCH is currently completing an Adolescent Health Strategic Plan and will disseminate findings and create work groups to address known needs this year. One focus area will be teen access to preventive health care. BMCH will develop a youth development focused performance measure for its contract agencies and implement the new measure in FY 2004.

PRIORITY #9:

Performance Management Initiative: BMCH continues to move toward a comprehensive performance management system. Performance measures for contract agencies have been refined with the input of child health/prenatal workgroups and new site visit QA tools have been developed, including self-assessment tools for contract agencies.

Home Visiting Best Practices Project: A barrier to appropriate advocacy for funding a statewide home visiting network has been difficulty in quantifying the costs of providing these services. A contract currently in the approval process will fund a "Home Visiting Best Practices" project to identify the cost of providing these services, incorporating, staff and client satisfaction and clinical outcomes to determine "best" models of care in home visiting.//2004//

PRIORITY #10:

***/2005/An estimated 25% of NH children/teens are obese or at risk for obesity, a doubling over the last few decades. A recent study showed that 3rd-graders are significantly fatter than their peers nationally - 36.6% of girls and 41.5% of boys were at risk or already overweight. No consistent data currently exists to define obesity among school age children. A statewide initiative, including development of a consistent data source, is needed to further address the problem. See Section X for related SPM#16.//2005/***

## C. NATIONAL PERFORMANCE MEASURES

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.*

### a. Last Year's Accomplishments

The past year has been a very busy one for the Newborn Screening Program. In addition to the daily efforts required to manage the statewide process of screening all newborns and follow-up of those requiring it, there were a number of new initiatives. The Advisory Committee which was convened in November 2002 met 7 times and recommended that screening expand to

include 10 conditions. (Adding CAH, Biotinidase, MCAD and providing universal screening for Hemoglobinopathies). The process to implement these recommendations is now underway. Additionally the program hosted a Site Review by a team of specialists coordinated by Brad Therrell of the National Newborn Screening and Genetic Resource Center. The report from this visit has been received and is presently being reviewed. Plans to implement some of the recommendations in this report are underway. The Data Linkage Project remained ongoing, however the goal of being able to link our newborn screening data with vital records information has still not been attained. The program continues to provide educational materials in the way of a program brochure about newborn screening to all birth hospitals. Plans to expand this effort to obstetricians offices in an attempt to educate families earlier are still in the process of being developed. The RFP process for laboratory services for newborn screening was completed and a new contract with the New England Newborn Screening Program is in place. The coordinator of the program continues to participate in regional activities, specifically NERGG and the New England Consortium representing New Hampshire in these ongoing efforts to collaborate.

#### b. Current Activities

The first priority continues to be the daily task of managing the screening process. Additionally the report and recommendations of the Site Visit Review are being reviewed and a timeline for implementation of the recommendations is being developed. The first priority is the development of an Internal Operations Manual. Other items at the top of the list include development of a Refusal Form and a Fact Sheet regarding "Expanded Screening Information" for families who are interested in obtaining this for their child. The Administrative Rules are also being revised to incorporate the recommendations of the Advisory Committee. This is the first step in the implementation of these recommendations. The coordinator of the program has developed a Site Visit Tool and has plans to begin site visits to all birth hospitals shortly. In preparation for these visits, a copy of the NCCLS video series, "Newborn Screening: Blood Collection on Filter Paper" has been purchased for each birth hospital. Efforts to support the Advisory Committee and the Data Linkage work remain ongoing. The coordinator of the program continues to cultivate partnerships within our region through participation in NERGG Board activities and the New England Consortium activities.

#### c. Plan for the Coming Year

First priority will remain the daily management of the overall newborn screening process. Continuing efforts will also be made to support the work of the New Hampshire Advisory Committee and the Data Linkage Project. Both of these projects have encountered some barriers to be overcome. Efforts to develop an Internal Operations Manual for the program as well as a refusal form will hopefully be realized. One other project identified in the prior year is a fact sheet of information relative to "Expanded Screening" options for families who desire this for their infants. Efforts around quality assurance are underway. This includes the development of a QA tool relative to timing of specimen collection, which will be provided to birth hospitals twice yearly. This project is awaiting revision of the tool, which must be made by the screening laboratory. Additionally the coordinator is planning to continue with site visits to all the birth hospitals for the purpose of meeting those involved in the process and reviewing the process that occurs in each birth hospital. Once these initiatives are realized, an effort will be made to develop a practitioners manual for all birth hospitals and midwives on the process of newborn screening. Continued efforts will also be made to continue regional collaboration activities. This includes the development of more appropriate resources for individuals identified through hemoglobinopathy screening with trait or disease.

years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)

#### a. Last Year's Accomplishments

SMSB supported a contract with New Hampshire Family Voices (\$103,383) to provide paid parent consultants and to support a wide range of their activities. During this fiscal year NHFV maintained a comprehensive lending library, specializing in children's books for families; published a quarterly newsletter: published an annual listing of support groups/organizations; operated a comprehensive website. Parent staff has also been active in providing education to the professional community on family-centered care and in a policy advisory role for several State of NH government entities. (IB)

One paid parent consultant (Madison) assisted the professional staff of the Neuromotor Clinical Program in revising clinical protocols and screening instruments related to health care transition for all youth between the ages of 12--21 years of age who receive clinical services supported by SMSB. Parent participation in this activity resulted in improved services for this population and a renewed emphasis on family-centered care. (DHC)

In May 2003, SMSB staff (Bumbalo) participated in the annual New Hampshire Family Support Conference held in Bartlett, NH. Over 400 New Hampshire families of children with special health care needs attended keynote presentations and 23 workshops focused on parent education and support. Information on the Title V program was presented at a panel titled "Accessing Resources: Finding the Answers When You Don't Even know the Questions". (IB)

#### b. Current Activities

SMSB continues to support the NH Family Voices program and staff with a contract (\$115,374) for FY 04-05 (ES)

Professional staff continue to participate with NHFV and other parent and community volunteers on joint advisory committees that focus on improving services for children and families. The advisory group on insurance/funding issues is developing materials that address a) alternative approaches to care, b) communication with providers, c) insurance law, d) paying for medications, e) private funding resources, f) access to specialists, g) public programs, h) organizing records, i) quality of care issues, j) choosing vendors and paying for durable medical equipment. (See NPM 4). The advisory group on transition is developing educational materials for families and youth anticipating health care transitioning. (See NPM 6 and SPM 13). (IB)

SMSB staff have been working on two quality assurance projects to improve parent satisfaction with services. Both initiatives focused on direct care activities associated with the Neuromotor Clinical Program. The first project involved reducing the amount of time between the clinic visit and the completion of final interdisciplinary reports for distribution to families and community providers. The goal is to have reports completed and distributed to families and providers no longer than six weeks after the clinic visit. Changes have been made in the transcription service and a chart audit to measure progress will be completed in fall, 2004. (IB)

The second quality assurance initiative focuses on improving continuity of care for children undergoing major orthopedic surgery. In the past both families and professionals voiced concerns regarding lack of communication between the clinic team and hospital personnel. To address this, SMSB staff developed a perioperative protocol to be completed for each child prior to surgery. This information is now being sent to the hospital staff one week prior to the scheduled surgery. This procedure allows for planning (e.g., for post-operative nutritional concerns) and exchange of necessary information. (See attachment for Perioperative Protocol form).(IB)

Clinic and hospital staff have held joint meetings to discuss child and family needs and to determine necessary approaches and procedures. New Hampshire Family Voices staff have been included in this process. Subsequent to this endeavor, nursing staff from the Concord Hospital submitted a description of this collaborative effort to the National Society of Pediatric Nurses and received an award for quality care (see NPM 5). (IB)

Parent satisfaction surveys for clinical programs administered by SMSB reflect a high degree of satisfaction with services received. The response rate for the survey was 56% (N=195). Overall satisfaction based on 17 quality indicators was 95% (Very satisfied, 79%; Satisfied, 15%). The highest score was for "Treated with courtesy/compassion" (98%) and the lowest score was for "Told about parent groups" (55

### c. Plan for the Coming Year

In addition to continuing support for NH Family Voices, SMSB will contract with the Upper Valley Support Group (Lebanon, NH) to provide family support services. This agency, through its Parent to Parent of New Hampshire network, provides one-on-one peer matches, emotional support (a listening ear), information and referral, and distributes written materials to families who have children with special health care needs. They provide consultation and technical assistance to coordinators who have been hired by other systems for parent matching and to representatives of other states who are using Parent to Parent of New Hampshire as a model for creating their statewide parent-to-parent networks. The Parent to Parent website is available for requesting matches, communicating with others via a message board and using a Just 4 Kids site. (IB)(ES)

All SMSB supported clinical programs will be required to submit annual reports that include information on parent satisfaction with services and programs. They will receive assistance from SMSB in developing appropriate methodologies to collect this information. Data will be used to plan program improvements. (IB)

Special Medical Services Bureau will continue to support the work of the SMSB/NH Family Voices joint advisory groups working on cost-of-care/insurance and transition issues. (See NPM 4 and NPM 6). These endeavors which rely on professional-parent collaboration, are a major strategy intended to increase satisfaction with services. (IB)

*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)*

### a. Last Year's Accomplishments

The New Hampshire Special Medical Services Bureau continued grant support (\$20,000) to the Center for Medical Home Improvement (CMHI) for support of care coordination in four (4) medical home sites (i.e., Exeter, Plymouth, Monadnock, and Dartmouth-Hitchcock-Concord). On March 28, 2003, staff (Bumbalo) and parent consultants (Madison, Ohlson-Martin) attended the CMHI spring retreat in Fairlee, Vermont. The Bureau Chief participated in a panel presentation on building partnerships with the state Title V programs for CSHCN. (IB)

Upon award of the MCHB funded Partners in Chronic Care grant to Dr. Ardis Olsen (Hood Center), staff (McCann) participated in the orientation session for eight (8) practice sites. Throughout the year staff provided ongoing consultation/technical assistance to individual practices and care coordinators regarding CSHCN who are Medicaid recipients. A SMSB parent partner (Pellitier) provided ongoing consultation to the program to support a focus on family-centered care. (IB)

To enhance collaboration and increase professional capacity, SMSB developed and presented a half-day seminar on strategies for dealing with child abuse and neglect for coordinators from medical home sites and other community partners. (IB)

#### b. Current Activities

SMSB continues to collaborate with the federally funded MCHB projects in our region to determine the skills and competencies necessary to provide community-based care coordination. The State Title V CSHCN program continues to share information on models to determine the level and complexity of care coordination which are being tested by State--based coordinators. SMSB continues to explore the potential for Medicaid support for care coordination in medical home sites, although this is difficult in the current financial climate. SMSB is again requesting technical assistance for strategic planning regarding the issue of adequate insurance/cost reimbursement for care coordination services. (IB)

SMSB staff continue to offer systematic ongoing consultation regarding individual children and families to medical home sites. In collaboration with CMHI and the Vermont Title V program, we provided financial support (\$1000.00) for a bi-state conference, which celebrated the accomplishments of eight sites in achieving "medical homeness" and improving services offered to CSHCN. This two-day conference was held in Lebanon on February 12-13, 2004. Major presentations were related to transition points and future sustainability of the medical home network. The Bureau Chief and two staff members were in attendance to continue networking and plan for future collaboration with medical home sites. (IB)

On April 30, 2004 SMSB staff collaborated with the New Hampshire Leadership Education in Neurodevelopmental Disabilities Program (LEND) to offer a half-day seminar to medical home and other community coordinators on the topic "Differential Diagnosis and Mental/Behavioral Health Issues in Children". The workshop presentations focused on mental and behavioral health issues from different perspectives, including insights from practitioners and families. This collaboration between state Title V programs is supportive of the MCHB mission to develop infrastructure and the capacity of medical home sites to provide quality care. (IB)

#### c. Plan for the Coming Year

SMSB will continue collaborative efforts with the Center for Medical Home Improvement which is now located at Crotched Mountain in Greenfield, N.H.. The CMHI has recently been awarded funding from MCHB for a four year project entitled "Beyond the Medical Home." The focus of this initiative is on integrating medical home sites with other community supports for CSHCN. SMSB will recruit for a state-based public health nurse coordinator position to support the activities associated with CMHI projects. The goal is to maintain the network of current medical home sites and to continue the focus on community-based systems of care. (IB)

Personnel from medical home sites (especially care coordinators and parent-partners) will be invited to attend the statewide conference on health care financing which is scheduled for Fall 04 (refer to NPM #4). It is expected that this program will assist medical home sites to increase their expertise in making requests to insurance companies to cover the cost of care and durable medical goods for CSHCN. (IB)

Pending adequate staff support, SMSB will develop an RFP for the next grant cycle (January '05) to support and convene a statewide Leadership Council on Medical Homes. The intent would be for this group of experts in the field (professionals and parents) to meet on a quarterly basis to develop and implement a strategic plan to sustain the medical home movement in New Hampshire. Such a structure will have the potential to address issues of sustainability and ongoing development. (IB)

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)*

#### a. Last Year's Accomplishments

The Title V CSHCN Health Care Financing Specialist/SSI Liaison (Ustinich) completed orientation to the state infrastructure for services to CSHCN. The work plan was revised in accord with the new National Performance Measures for CSHCN. The SSI Liaison continued to oversee the handling of SSI referral transmittals. Of 553 transmittals in FY '03, 6% (N=35) were for children who were not known to the Bureau, nor receiving Medicaid. These were forwarded to a Care Coordinator (Kaiser) for follow-up. Information regarding public insurance, through the NH Healthy Kids program, and the SSI process was provided to these families, along with assessment of need, appropriate referrals and assistance with the SMSB application. Applications were sent to 15 families (43%). Of these, 53% (N=8) returned the application and 100% (N=8) were enrolled in services. This activity is ongoing. (ES)(IB)

Contact with experts and colleagues at federal and state levels continued. Ms. Ustinich participated in the Maternal and Child Health Leadership Skills Training Institute on "Systems" (St. Louis). Technical assistance in data analysis was received from the NH Office of Health Statistics and Data Management (HSDM). HSDM provided the initial SAS extraction of the National Survey of CSHCN 2001 files of New Hampshire's variables. Training in Access and Excel software programs was obtained. Previously, much of the unit-level data entry was done on Word tables, using a calculator. The introduction of the spreadsheet and database mechanisms resulted in an improvement to operations and enhanced data capacity-building in several areas. (IB)

The Health Care Financing Specialist worked with another program specialist (Cahill) to develop a new State Performance Measure related to transition (SPM #13). Resource files were expanded. An Issue Brief on Insurance Coverage and CSHCN was developed and approved for production and dissemination. The Issue Brief reports on the results of the National Survey for New Hampshire, related to health care financing and impact on families. (IB)

The 'problem case' project collected 'real life' scenarios from parents of CSHCN. Community-based care coordinators and advocacy groups for CSHCN were contacted to help with the project. After six months, the data portion of the project was suspended due to lack of response and insufficient data. A joint SMSB/NH Family Voices Health Care Financing Advisory Group was formed in Jan. '03. The Title V CSHCN program specialist is a consultant to the group, which includes parents of CSHCN, health care professionals and advocates. The group met to prioritize needs and develop strategies regarding the cost of health care for CSHCN. A work product (a toolkit) was identified and a detailed work plan was developed. (IB)

Concept and design of an instrument titled "New Hampshire Insurance/Cost-of Care Survey for Children with Special Health Care Needs" was begun. Selected subpopulations of NH CSHCN will be surveyed. (IB)

#### b. Current Activities

SMSB staff (Ustinich) continue participation in state and regional policy discussions regarding CSHCN and the adequacy of their insurance. A care coordinator (Kaiser) continues to follow-up child SSI referrals. The Bureau is completing the NH Insurance/Cost-of-Care survey instrument and will survey 1200 families of children receiving SSI for their own disability, for needs

assessment and policy discussion purposes. Assessment of emergent trends, problem solving and recommendations continues. The staff is evaluating internal reporting mechanisms and preparing to update report formats, as well as policy and procedure materials. The process is designed to correlate with all the National Performance Measures for CSHCN, as possible. (IB)

SMSB staff (Bumbalo, Ustinich), in collaboration with NH Family Voices, are implementing the work plan of the SMSB/NH Family Voices Health Care Financing Group, to address two-selected priorities. One is the increasing difficulty in obtaining adequate insurance for CSHCN and the other is the increasing demand for insurance coverage for durable medical equipment/non-pharmaceutical products. The group is preparing for a statewide conference on health care financing issues. The event was scheduled for the spring of 04, however state budget cuts resulted in deferment until fall of 04. (ES) (IB)

SMSB disseminated the Issue Brief on Insurance Coverage and CSHCN to identified stakeholders and the public (see attachment). An update, due to emergent data problems, is pending. SMSB has deferred development of the Bureau's web page on the DHHS site, due to the current state reorganization. The Bureau participated in Cover the Uninsured Week, by distributing informational cards (in English and Spanish) and stickers to the service regions, via the community-based care coordinators. (IB)

The Title V CSHCN Health Care Financing Specialist is working with the Special Projects program specialist (Cahill) to assess the status of transition resources for youth with special health care needs in New Hampshire, regarding insurance and SSI issues. (IB)

SMSB is preparing an article for consideration for inclusion in a special issue of the Journal of Maternal and Child Health. The focus is on adequacy of insurance for children with special health care needs and the impact of the child's condition on the family's finances, employment, and time. The Data Research Center for CYSHCN reports that: 27% of New Hampshire CYSHCN do not have adequate insurance (Indicator 5); 11% of families pay more than \$1000 a year for child's medical expenses (Indicator 12); 20% have financial problems due to child's health needs (Indicator 13); and, 28% of families cut back or stopped working due to child's health needs (Indicator 15). New Hampshire's state-level data from the National Survey of CSHCN is being analyzed for the article by Renee Schwalberg, MPH, of Health Systems Research, Inc. (IB)

### c. Plan for the Coming Year

The concentration of effort for FY05 will be to evaluate and improve the Bureau's capacity to lead and assist stakeholders, statewide, in maximizing the access to, and addressing the adequacy of, health insurance for children and youth with special health care needs.

This process will involve the dissemination of state-level data from the National Survey of Children with Special Health Care Needs 2001. An Issue Brief on Insurance and Cost of Care for CSHCN, prepared in FY04, was the Bureau's initial work product using the SLAITS data. The process of extracting and reporting on the variables for New Hampshire was technically difficult, and several problems with the data subsequently emerged. This experience illustrated the Bureau's growing need for improved access to data and expert data analysis. Internal consultation from trained staff has been made more available and consultation on a priority basis has increased. With the recent establishment of the Data Research Center on CYSHCN, the Bureau expects to be able to disseminate many useful new materials to stakeholders throughout New Hampshire.

A major activity for FY05 will involve utilizing data from the New Hampshire Insurance/Cost-of-Care Survey for Children with Special Health Care Needs 2004 in the needs assessment and

planning process for future initiatives and policy considerations. (See attachment). It is hoped that a second, similar, survey may be conducted with 1000 families of children receiving HC-CSD (Katie Becket). This group, as well as the SSI group, appeared to be under-represented in the NH sample for the SLAITS National Survey of CSHCN, and the Bureau would like to have a better 'picture' of these particular families.

Several projects involving the revision of internal materials related to policy and procedure and data collection, analysis and reporting have been, or will be undertaken. This activity will, in part, focus on articulating selected performance measures and desired outcomes in Bureau materials and practices, such as manuals, contracts, and data entry protocols. Issues related to the adequacy of insurance for CSHCN are interwoven with some aspects of these projects, and targeted attention will be paid to such issues and aspects as they are identified.

Education, consultation and technical assistance will be offered to care coordinators and community providers, including contractors, regarding quality assurance protocols for annual reports and data collection and reporting. Support will be provided to the Nutrition Network to assist in their efforts to be able to bill insurance for the services. The Bureau will be following, and perhaps appointed to participate in, a new Commission on Insurance for Families of Children with Special Health Care Needs to be formed by the Department of Health and Human Services, reporting to the Governor and legislators. The report of this Commission (10/04) will greatly influence eligibility for the HC-CSD program in NH. (IB)

*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)*

#### a. Last Year's Accomplishments

Three Neuromotor (NM) clinics were contracted to Child Health Services (CHS) at Manchester. State-employed nurses coordinated NM clinics at Concord. Staff developed a perioperative protocol. Psychology services are available at CHS NM clinics. The Sexuality Manual was updated and distributed to community-based care coordinators, parents and professionals. The NM Resource Manual was completed and distributed. Equipment bank protocols were revised and literature-based criteria for pre-authorization of children's durable medical equipment for the NH Medicaid Program was developed by contracted physical therapist. Development of NM Transition questionnaires began. (IB)

The Child Development Program continues as a contracted service staffed by Dartmouth Hitchcock Medical Center (DHMC) and CHS personnel. Amputee clinic with Boston-based physiatrist (Webster) and SMS coordinator (McCann) was held quarterly. (IB)

Nutrition Feeding and Swallowing Program: The Diabetes Nutrition Education project continued at DHMC (Manchester) to identify the need for pediatric nutritionist services in the leading pediatric endocrinology practice. A Diabetes Pump Start Team was initiated. Training of Nutritionists (3) and swallowing specialists (4) continued. Three Nutrition network providers and pediatric medical residents from DHMC, under supervision of SMSB contracted Nutritionist (Campbell) were provided training at the Diabetes Camp. Ten monthly nutrition in-service trainings (with community based coordinators and SMS Coordinators) were held.

Comprehensive nutrition consultation to Cystic Fibrosis (CF) clients via home visits continued (instead of offering the services at clinic visits). The Autism Task Force report was finalized and submitted. Infant Mental health teams were trained in the AIM system of assessment. Spina Bifida coordination was provided at monthly clinic attendance by SMSB RN (Cahill), who also coordinated financial assistance for CF clinic clients. (IB) (EB) (DHCS)

Contracted community-based care coordinators covered Rockingham, Strafford, Merrimack and Hillsboro counties. State employees managed the remaining six counties. Coordinators utilized the Idaho Coordination Complexity Tier Level Tool. Most families were considered to require moderate services (Level II). Statewide trainings were offered or supported by SMSB: "Genetic Aspects of NM Disorders", "Building Strategies for Professional Success "(Interim conference) and "A Guide to NH Child Protective System". The Service Coordination Task Force submitted its report, with no further action. Two care coordinators resigned (Hoebinger and Butler) Recruitment was delayed due to freeze on state position and inability to recruit qualified contractor. The SMSB Program Manager (McCann) and other state coordinators provided coverage. Cleft lip and palate newborns were offered nutrition assessment and care coordination services. (IB) (EB) (DHCS)

## b. Current Activities

The Nutrition Feeding and Swallowing Program (NFSP) is developing a plan for cost-sharing and SMSB staff will prepare an RFP for administration and billing of Nutrition Services. This approach will allow for additional community-based services. Office-based training of nutritionists in diabetes management is ongoing; the goal is to offer such nutrition services statewide. The Diabetes Pump Start program is deferred due to the lack of staff at the Hitchcock Clinic. The NFSP staff offered regional workshops for families of children with autism. NFSP contractors presented "Gastro-intestinal Concerns and Diabetes" to the Visiting Nurses Associations. (EB)(PB)(IB)

Data collection process and capacity regarding care coordination services and activities is in need of evaluation and upgrading. Community-based coordinators piloted the Transition Questionnaire. A community-based coordinator (Kinsey) for Rockingham and Strafford counties was hired in January 04. The dental health consultant held a forum with SMSB care coordinators and NH Family Voices, and a protocol sheet for obtaining dental services was developed. Continuing education sponsorship included: a LEND /SMSB Conference on Differential Diagnosis: Mental/ Behavioral Health, the SMSB/ Interim Home Health Care Conference "Enhancing Clinical Competencies", and the SMSB Neuromotor Program annual meeting "Focus on Spasticity Management". (EB)(IB)

Monthly continuing education meetings were offered to community-based coordinators. Neuromotor coordinator (Clark) at Child Health Services resigned; a new coordinator (Burgess) was hired. The Neuromotor state-based position (Concord) was unfrozen and a new coordinator was hired (Collins). Equipment bank protocol development is considering a rental option for Medicaid reimbursement. The Neuromotor Clinic is utilizing the Transition Questionnaire and using transition-tracking sheets with the families. The DHMC NM clinic offers Botox injections and oral medication treatment for spasticity management. (EB)(IB)

One contracted nutritionist (Scott) is offering home visits statewide to families of newborn infants with cleft lip and palate. The private multidisciplinary team in the Manchester clinic discontinued services and clients were referred to the DHMC cranial facial program. SMSB staff (Cahill) attended Spina Bifida clinic monthly and provided coordination services. SMSB offers financial assistance to cystic fibrosis clients, and transition services. The NM Perioperative Protocol received an Excellence in Clinical Scholarship Award from the National Society of Pediatric Nurses. The NH Autism Task force issued its report with assessment and intervention recommendations. One nurse coordinator (Landry) completed LEND training. SMSB nursing staff offered home-based assessments and recommendations regarding children's nursing care needs for Medicaid. Two public health nurse coordinator positions remain unfilled. (IB)(DHCS)

## c. Plan for the Coming Year

Trained pediatric nutritionists will offer diabetes education to children who are geographically unable to visit a pediatric endocrinologist and are managed by a pediatrician. A pilot program utilizing a team approach, by including a contracted nutritionist (Campbell) to manage diabetes, will continue for the third year at Hitchcock Clinic in Manchester. Her participation at Diabetes Camp will provide training opportunities for DHMC medical residents in pediatrics and family medicine and UNH Nutrition students. The Diabetic Pump Start program will resume. An RFP for billing of nutrition services will be announced and awarded. Plans are underway for a new contractor to triage applications for the nutrition program and focus on special educational projects. Efforts will be intensified for SMSB contracted nutritionists to collaborate with tertiary nutrition services especially at DHMC metabolic program. (IB)

Training of new coordinators for community based care coordination and Neuromotor program will continue. Another state-based nurse will attend the LEND program. Recruitment for two state-based nursing positions will continue. The newly vacated program manager's position may be frozen or eliminated. There is no anticipated expansion in state funding to support increase of care coordination services. Workload of staff will be evaluated periodically to determine essential services. Community-based care coordinators will meet for continuing education monthly in community settings and include community partners for case reviews. (IB)

Work with the NH LEND program will focus on collaboration and training with emphasis on the National Performance Measures and Medical Home information. Training and support will be offered to Child Health Services to enable billing, with specific training for coding care coordination. Enhanced support of the state's Infant Mental Health teams will be available through braided funding to support a conference with a nationally recognized speaker. Support of Medical Home, by working on increasing revenues through collaboration with private insurance, may expand care coordination services. Family Voices will continue to triage clients in the discontinued Cleft Lip and Palate program to determine needs for care coordination, clinic services and/or financial assistance. The Spanish version of the SMSB program description will be distributed in FY05. Collaboration with the Medicaid program with nursing assessments to support case management will continue. (IB)

*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. Last Year's Accomplishments

Spina Bifida Transition Project activities continued with a focus on in-clinic transition education. A checklist tool was used as a questionnaire for the teens to fill out to report their healthcare knowledge. Clinic staff, primarily the pediatricians and nurse coordinators, was asked to address the issues highlighted. The team began to seek an alternative education approach to the transition luncheons we had been offering because teens were not choosing to attend this event at the end of the clinic day. (IB)

Working in collaboration with the STAR program (Steps Towards Adult Responsibility: A Program for Adolescents with a Chronic Health Condition) at Dartmouth-Hitchcock Medical Center/Lebanon, the Spina Bifida Program clinic coordinator and the SMSB care coordinator (Cahill) planned a telephone survey to parents and teens to determine how they would like to be informed about transition issues. The survey was completed in June-July '03. The STAR Program also provided an intern who helped set up a web site for the Spina Bifida Program. (IB)

The Program for Children with Neuromotor Disabilities, which serves both children and youth, set the goal that all neuromotor clinic teams (both contracted and operated by the central office) will develop a model for planning health care transition to adult services, beginning at 12

years of age. SMSB staff, along with New Hampshire Family Voices and other Neuromotor Program staff, reviewed multiple materials and conducted a pilot project to test various educational approaches and self-assessment instruments for teens and parents. A tool will be finalized in FY'04. (IB)

The first meeting of the New Hampshire SMSB/Family Voices Youth Transition Advisory Group was held in June 2003. (IB)

#### b. Current Activities

SMSB is increasing capacity to provide support and education services about transition to two populations of youth with special health care needs (YSHCN) and their families (i.e., those with spina bifida and those with neuromotor disabilities, such as cerebral palsy). Specific transition education materials are being provided to other program care coordinators to use with their populations of youth.

The goals and objectives of the Neuromotor Transition Project are being met in a variety of ways. A youth questionnaire titled "How Well Do You Manage Your Own Health Care", developed by the project in July 2003, is being used in clinics. A Health Care Transition Checklist, developed in April 2004, is being used in the medical record. Use of these tools is currently being evaluated. (IB) (See attachment).

The Dartmouth-Hitchcock Medical Center Spina Bifida Program is utilizing the assessment materials SMSB developed for the Neuromotor Program. Other transition efforts with this population include conducting a survey, developing a website and individual education at clinic. The telephone survey of 19 families was conducted in June-July 2003 and the results are helping determine how best to reach families and teens to talk about transition issues. (See attachment). Utilizing the Internet received favorable response as a potential educational and support tool since almost all the families have access. Using the Spina Bifida Program website, launched February '04, will begin to meet this interest. This website includes a page about transition and links to on-line transition resources. There is continued interest in discussion/education about transition issues both during clinic and outside of the clinic visit. (IB)

SMSB is addressing the interests of families regarding transition by developing the role and activities of the NH SMSB/Family Voices Youth Transition Advisory Group, comprised of parents, community-based family support professionals and Bureau staff. This group meets quarterly and is assisting the in-house committee by reviewing transition related educational materials and tools. The group plans to produce an SMSB/FV brochure about health care transition for parents by July '04. (IB)

SMSB staff continue to participate in collaborative efforts to improve statewide transition services for YSHCN. SMSB was among four agencies that submitted a proposal to the National Library of Medicine, titled "The Adolescent Chronic Conditions Health Information Project". The submission was not funded, however the principal investigators were invited to re-submit. SMSB participated in the development of the NH Adolescent Health Strategic Plan, which was headed by the New Hampshire Bureau of MCH. SMSB staff are members of a working group on Transition in the New Hampshire Department of Education and bring a perspective on health to this process, by promoting a family-centered, comprehensive and interagency approaches to secondary transition activities. (IB)

#### c. Plan for the Coming Year

The Special Medical Services Bureau plans to submit a proposal for the Champions for Progress Incentive Award offered through the Early Intervention Research Institute at the University of Utah. The primary goal would be to increase our services to office practices to

help them set up transition guidelines/protocols to use with individual youth and their families. (IB)

Care coordinators from SMSB, the Partners in Health family support coordinators, and coordinators in medical practices, such as the Partners for Chronic Care Project and the Medical Homes in NH all need information and resources about how to support health care transition for youth. SMSB intends to disseminate educational and resource materials that have been gathered and reviewed to these individuals. The plan is to develop Transition Manuals (3-ring binders) for internal agency use and to determine whether this is an effective tool for the other agencies. The Bureau will be working on an interagency transition project with Partners in Health to provide regional workshops for families about all aspects of Transition. SMSB will focus on the health care components of these workshops. (IB)

Development of the Youth Transition Advisory Group is ongoing. This group may be expanded to include representatives from other health agencies as well as youth. This year we will ask the group to define whether it would like to expand its' role beyond review and comment to helping set the agenda and recommending activities. (IB)

SMSB is currently the only New Hampshire state agency that is focusing on the health care aspects of transition for Youth with Special Health Care Needs. SMSB plans to develop an Issue Brief on Health Care Transition for dissemination statewide during the upcoming year. (IB)

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

#### a. Last Year's Accomplishments

The Bureau continued to collaborate with NH Immunization Program, using CASA results from Title V funded child health categorical and primary care agencies as a quality assurance component. These contract agencies used their CASA data for this national performance measure which was one of the pediatric clinical performance measures in their FY'03 Title V MCH workplan, a proposal requirement. Goals and activities to improve immunization rates, reduce problem areas such as immunization drop out rates, and utilize feedback from their evaluation plan to accomplish this were included. Bureau site visits assessed immunization tracking and recall policies and procedures to decrease drop out rates and increase follow up of missed immunizations, and to follow up on any recommendations made by the NH Immunization Program on their previous CASA site visit. (IB)

The Bureau required its contract agencies to adhere to the current ACIP/AAP/AAFP "Recommended Childhood Immunization Schedule, United States" and invited the NH Immunization Staff to the Bureau's Fall '02 and Spring '03 meetings organized for representatives of the Title V contract Child Health and Primary Care (and 330-funded) agencies to present information updates. The Immunization Program mailed information on immunization changes to the Title V agencies to keep them updated on changes in the national schedule and in any New Hampshire-specific policies. (IB)

Several Title V funded agencies hosted CDC Immunization Training Teleconferences on behalf of the NH Immunization Program. (PB)

Title V agencies with BMCH Home Visiting grants worked with their families to educate parents on the need for up to date immunizations and to ensure that the immunization status of the enrolled children was current. (D)

#### b. Current Activities

The current collaboration with the NH Immunization Program continues. The Immunization Program communicates any changes in immunization policy or administration either through the BMCH staff or directly to the BMCH Title V contract agencies via meetings and mailings.

(IB)

BMCH contract agencies submitted their completed FY'03 workplans in spring '04 that included successful strategies or obstacles in achieving or not their target for achieving the national performance measure of adequately immunized two year olds and were required to submit their FY'05 workplan by May 21, 2004. The workplan performance measure definitions were revised, reviewed at the Spring '04 MCH Coordinators' Meeting, and a workshop was held in May on how to develop meaningful workplans. For consistency and continuity, agencies will now be requested to use their most recent year's CASA result for the performance measure result. (IB)

BMCH, as part of the larger Office of Community Health, piloted a performance management-based multi-program team site visit to Avis Goodwin Community Health Center, a state and federally funded primary care center. Review included the successful efforts to improve its immunization-related performance measure. (IB)

Two BMCH Title V contract agencies hosted CDC Immunization Training Teleconferences on behalf of the NH Immunization Program. (PB)

The BMCH Home Visiting contract agencies educated families about the importance of getting their children immunized on time and will assist families, as needed, to get to their health care providers. (D)

The BMCH Healthy Child Care New Hampshire Project included in its training to health consultants, the importance of assuring timely age appropriate immunizations in children cared for by child care providers, particularly those children in Title XX funded child care centers. (IP, PB)

The BMCH and the NH Immunization Program reviewed competitive bid applications for a grant to conduct community focus groups in Nashua to better learn about obstacles to obtaining immunizations, especially for racial and ethnic minorities. BMCH will be sharing these focus groups to learn about barriers to obtaining health care for children in its Title V funded child health programs, in general. (PB)

### c. Plan for the Coming Year

BMCH will continue to carry out site visits to direct care agencies to assess tracking and follow up of missed immunizations and process on recommendations from the NH Immunization's CASA site visit and will do another larger, multi-program team performance management based site visit to another primary care center. (IB)

BMCH Title V contract agencies will be encouraged to host CDC Immunization Training Teleconferences on behalf of the NH Immunization Program. (PB)

The BMCH Home Visiting contract agencies will continue to educate families about the importance of getting their children immunized on time and will assist families, as needed, to get to their health care providers. (D)

The BMCH and the NH Immunization Program will assess the results of the community focus groups in Nashua to better learn about obstacles to obtaining immunizations, and health care for children, especially for racial and ethnic minorities. (PB)

The BMCH's Early Childhood Comprehensive Systems grant will include activities which assure timely age appropriate immunizations for all of the state's early childhood population, with particular emphasis on those children in centers receiving consultation from BMCH trained health consultants and especially in Title XX funded child care centers. (IP, PB)

BMCH contract agencies will be submitting their completed FY'04 workplans in Fall '04, which will be evaluated for descriptions of reasons for success in reaching or failure to achieve the desired target, which includes successful immunization of two year olds.

**a. Last Year's Accomplishments**

The BMCH received federal, state and Social Service Block Grant (Title X) funding to assist in its' efforts to provide quality family planning services to populations in need, especially low-income women, the uninsured and teens. Examples of services provided to teen clients include: complete physical examinations; preventive health care (including contraceptive services); testing and treatment for sexually transmitted diseases; immunizations; screening for substance abuse, domestic violence and sexual assault; and health education; Although all Title X funded clinics provide services for teens, specialized family planning teen clinics were provided through 4 agencies at 9 sites. Each teen clinic offered teen-friendly services that were confidential, affordable, available during weekend or evening hours on a walk-in basis, and staffed by both professional staff and teen peer educators. These sites provide extensive pregnancy prevention counseling and education to teen clients. (D,E)

Twelve family planning educators employed by the delegate agencies provided information and training on reproductive health issues to communities throughout the state. Some community education projects included: pregnancy prevention skill building with youth ages 10-19 including negotiation skills, contraception options, adolescent reproductive health services, peer education and abstinence; personal development including mental and emotional health, sexuality development, body image, relationships, substance use, parenting education and communication and listening skills; reproductive health education; professional training services both in-service and community-based; advocacy and community coalitions building; marketing and outreach, and; the use of emergency contraception marketing materials developed by the state. (P)

Collaborations between TANF and BMCH staff resulted in monies being made available for outreach and increased community education activities. Examples included an increase in outreach activities to teen workplaces, marketing campaigns for 'effective contraceptives' were incorporated into teen clinics' plans, and access to emergency contraception was increased. (I, P)

The Adolescent Health Strategic Planning Project project included recommendations and action points to improve adolescent health including strategies to improve reproductive health and reduce teen pregnancies and births. (I)

Activities through the Abstinence Education project included a media campaign consisting of radio PSAs targeted to high-risk communities throughout the state.

The Adolescent Health Program coordinated the State Youth Collaborative, a group consisting of state agency representatives whose programs impact youth, including representation from the family planning program. The group works to coordinate efforts to improve adolescent health.

**b. Current Activities**

Teen clinics continue to offer teen-friendly services that are confidential, affordable, available during weekend or evening hours on a walk-in basis, and staffed by both professional staff and teen peer educators. These sites continue to provide extensive pregnancy prevention counseling and education to teen clients. The Teen Clinic programs have expanded to 5 agencies providing 12 teen clinics. Performance measures include numbers of teens served, the availability of emergency contraception and the effectiveness of community educators in increasing awareness of family planning services. (D,E)

Implementation of the Adolescent Health Strategic Planning Project recommendations have begun this year. Plans to develop regional adolescent health advisory groups, development of a community toolbox resource for local adolescent health planning activities, development of a youth action network and other activities center on advocating for a youth development approach to adolescent health, development of a resource outlining services available to New Hampshire's youth and the contracting for the development of a web-based adolescent health data set that assesses national and state objectives, including the reduction of teen births.

### c. Plan for the Coming Year

Community education activities will continue and will be expanded through further TANF collaboration. Community education activities will impact teen pregnancy through the implementation of evidence-based teen pregnancy prevention curricula in schools and youth serving agencies; through targeted teen pregnancy prevention provided by the community educators using their choice of five activities (parent/child communication, male involvement, contraception presentations, marketing/outreach, and peer education), and; through a comprehensive youth development project in Nashua or Manchester based on the Carerra Model, the only youth development based program proven to reduce teen pregnancy. (D,I,E) The Abstinence Education project will continue with a media campaign targeted to 10-14 year olds as well as providing abstinence-only education through schools and community based agencies choosing to use this model. (P)

The Adolescent Health Program will continue to coordinate the State Youth Collaborative. (I) The Adolescence Resource Center (ARC) is a partner in the Adolescent Health Strategic Planning Project and will work with the Adolescent Health Program to implement recommended strategies of the Adolescent Health Strategic Plan. Results of the needs assessment, recommendations and strategies to improve adolescent health will be disseminated in FY 05. (I,E)

The ARC and the BMCH will work in partnership to establish a statewide Adolescent Health Network to advocate a positive youth development approach to health related programming and to implement the recommendations of the Strategic Plan throughout New Hampshire communities. (I,P)

*Performance Measure 09: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

### a. Last Year's Accomplishments

The Oral Health Program added infrastructure with the state's support for the expansion of an established school-based dental program in our largest city, Manchester. Children and adults received preventive and restorative treatment in 16 state funded community-based dental programs in schools, hospitals, and primary care health centers that provided enabling services to assure patient compliance in keeping appointments and following oral health recommendations. (IB, PBS, ES, DS)

The OHP collaborated with the Office of Health Planning and Medicaid on the improvement of the electronic database used to respond to Medicaid client inquiries for dental treatment placement. (IB, ES, DS)

In cooperation with the CDC chronic disease epidemiologist, OHP collected, analyzed, and added new data from 16 state funded programs to the statewide surveillance system. The OHP manager and the CDC epidemiologist presented the '02 data to hygienists from 15 school-based dental programs. (IB, ES, PBS,)

The OHP supported water fluoridation efforts while opponents pursued their court case challenging the 1999 voting process that fluoridated Manchester's water supply. (IB, PSB)

### b. Current Activities

In cooperation with the CDC chronic disease epidemiologist, OHP collected, analyzed, and added new data from 16 state-funded programs to the statewide surveillance system. The CDC epidemiologist and OHP manager presented the '03 data to hygienists from 16 school-based dental programs. (IB, ES, PBS)

The OHP collaborated with the CDC epidemiologist to publish New Hampshire Oral Health Data, 2003 reporting on all 8 national oral health indicators. (IB, PBS, ES)

The OHP has conducted the second Oral Health Survey of Third Grade Students using the ASTDD model to screen children for the presence of dental sealants. (IB, ES, PBS, DS). The OHP collaborated with the Endowment for Health to release the New Hampshire Oral Health Plan: A Framework for Action. The Implementation Subcommittee meets regularly to prioritize and implement the plan's recommendations to improve the oral health status of NH residents. (IB, PBS, ES)

The OHP has collaborated with the Endowment for Health to fund a year-long planning grant to develop a sustainable statewide sealant project and an applied research grant to analyze three strategies for financing and delivery of Medicaid oral health services. (IB, PBS, ES, DS).

The OHP has collaborated with NH Head Start to convene a statewide Head Start Oral Health Forum. In collaboration with New England dental directors and Region I administrators, the OHP will convene a regional Head Start Oral Health Forum in June '04.

The OHP collaborated with Home Visiting New Hampshire to secure HRSA funds to support oral health activities in 19 HVNH programs. (IB, PBS, ES)

The OHP continues to support municipal water fluoridation in spite of the court's ruling against the regional distribution of fluoridated water without an affirmative vote by each affected community. (IB, PBS)

The Northeast Delta Dental (NEDD) program, a voluntary Medicaid Managed Care program with a prepaid dental benefit, was terminated. To compensate for the loss of the NEDD program, the new Dental Director implemented significant dental reimbursement increases and made personal contacts with established Medicaid providers and potential Medicaid provider enrollees. (IB, ES, PBS, DS)

### c. Plan for the Coming Year

The OHP anticipates that the Endowment for Health (EFH) will fund the implementation of the planned statewide sealant project that will increase the amount of protective sealants on NH's high-risk children. (IB, PBS, ES, DS)

The OHP will collaborate with the CDC epidemiologist to publish the results of the second Oral Health Survey of Third Grade Students. (IB, PBS, ES)

The OHP will collaborate with EFH to implement the "Watch Your Mouth" oral health education and awareness campaign to increase public perception of the importance of good oral health as a component of overall health. (IB, ES, PBS)

The OHP will collaborate with the Area Health Education Centers (AHEC) to provide oral health trainings for prenatal medical providers to educate them about the transmission of oral disease between mothers and infants and the importance of good oral health for their high-risk patients. In collaboration with the Medicaid program and the Endowment for Health, the OHP anticipates the opening of 3 new dental centers in CHC's (Strafford County, Berlin and Littleton), 2 new dental centers clinics in hospitals (Weeks and Alice Peck Day) and the expansion of two urban dental centers in Manchester and Nashua.

*Performance Measure 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

### a. Last Year's Accomplishments

The New Hampshire Child Passenger Safety Program (CPS) is housed at the Injury Prevention Center at Dartmouth.

Certified workforce for child passenger safety: Two updates were held as well as a four-day training. (I)

Inspection stations and Check Up Events: CPS provided technical support as well as resources for these stations. Stations have been responsible for a bulk of the inspections. Twenty-one large check-up events took place, with 565 car seats checked. (P)

Special Needs: The CPS Coordinator went to a special needs/car seat training that included

children who have hip dysplasia and are in a body cast, children who have broken a leg, premature infants, etc. A thousand car seats were distributed to 35 organizations including 78 seats for children with special needs. (P)

Booster Seat Coalition: During this time, a booster seat coalition was formed which introduced developed a policy initiative and introduced legislation to require that children be in approved restraint seats beyond the currently required age of 4 years. The bill was submitted requiring booster seats up to age 8 and/or 80 pounds, which is best practice. (I)

#### b. Current Activities

Certified workforce: A survey of existing technicians and inspection stations determined that the Lakes Region is underserved, lacking in CPS services. Training is currently being planned to take place in that area. Twenty- two technicians completed the course in the southern part of the state. A technician update was held to coincide with the changing of technician certification from AAA to National SAFEKIDS. There are currently 120 certified car seat technicians in the state. (P)

Booster Seat Coalition: A new booster seat law was passed and signed by the governor in September of 2003, which took effect on January 1st of 2004. The law states that children need to be in appropriate child seats up to the age of 6 or 55 inches. To make the public aware, CPS created a flier in the Child Health Month packet and distributed additional yardstick posters, containing a ruler and an explanation of the law. These materials were sent out to many different organizations. Public service announcements are currently being produced.

Inspection stations and Check Up Events: There are currently 18 inspection stations in New Hampshire that continue to do the bulk of car seat inspections. However, 8 large car seat events have taken place so far this year, with 219 seats checked. (P)

#### c. Plan for the Coming Year

Certified workforce: The number of inspections stations will be increased. The technicians at these stations will be paired with a mentor who will be a cps instructor. Work will also take place with partners to ensure an adequate supply of car seats. (P)

Special Needs Training: There will be continuing efforts to educate providers regarding car seats for children with special needs. (I)

Policy: The feasibility of a standard seat belt law/primary seat belt law will continue to be explored. (I)

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

#### a. Last Year's Accomplishments

BMCH staff continued to work with the state WIC Program to support breast feeding education activities, such as serving as consultant to the state Breastfeeding Coalition and disseminating information related to breastfeeding to Title V contract agency staff. (IB)

BMCH staff monitored Title V contract agencies' promotion of breastfeeding by observing for posters and educational material promoting breastfeeding while doing local agency site visits. (PB)

The BMCH staff who coordinates the SIDS Program continued to promote breastfeeding while providing information on a safe sleeping environment including discussion of the bedsharing issue, at all educational offerings on SIDS to Early Childhood Education students, child care providers, and to hospital Perinatal Nurse Managers. (PB)

The project director of the BMCH Home Visiting Program continued to provide training, support, and collaboration with grantees and with other home visiting programs statewide to promote breast feeding activities. (PB)

## b. Current Activities

BMCH staff continues to work with the state WIC Program to support breast feeding education activities including dissemination of breast feeding information to Title V funded Child Health, Primary Care, Prenatal and Home Visiting agencies, and sharing information from medical journals on breastfeeding issues with the WIC Program Breastfeeding Promotion Consultant. (IB)

The BMCH SIDS Program Coordinator continues to promote breastfeeding in public and professional information activities focused on SIDS risk reduction and safe sleep practices including WIC nutritionists (June '04), child care providers (fall '03, spring'04), and early childhood education college students (spring'04). At the June '04 Child Fatality Review Committee Meeting, focusing on the issue of breastfeeding, bedsharing, and accidental asphyxiation deaths, two community breastfeeding advocates have been invited to attend. At the June '04 Perinatal Nurse Manager's meeting, the SIDS Program Coordinator will address the issue of educating and documenting information provided by nursery staff to new mothers about the risks of bedsharing in addition to SIDS risk reduction information. (PB)

BMCH is helping to sponsor the NH Breastfeeding Coalition's annual conference in June featuring Dr. James McKenna. (IB)

## c. Plan for the Coming Year

BMCH staff will continue to work with the state WIC Program to support breast feeding education activities including dissemination of breast feeding information to Title V funded Child Health, Primary Care, Prenatal and Home Visiting agencies, encouraging observation of August as Breast Feeding Promotion Month, and inviting the WIC Program Breastfeeding Promotion Consultant to present mini inservices at the MCH Coordinators' meeting for Title V funded Prenatal and Child Health Program Coordinators, and to Home Visiting Program Coordinators' Meetings and/or training for home visitors. (IB, PB)

The BMCH SIDS Program Coordinator will continue to promote breastfeeding in public and professional information activities focused on SIDS risk reduction and safe sleep practices. A mailing to providers of prenatal and early infant health care and education is planned for fall '04 that will include information on the need to educate parents on the risks of bedsharing. This handout will be developed in collaboration with the state breastfeeding coalition. (PB)

The BMCH Newborn Metabolic Screening Program Coordinator will provide feedback to the state's hospitals with birth facilities on feeding patterns of its infants born the previous year, as indicated on the information section of the newborn metabolic screening program's filter paper. As this is currently the only statewide breastfeeding data available, it is hoped that the feedback will serve as a quality assurance activity as well as providing incentive to each facility to improve their breastfeeding rates. (IB)

*Performance Measure 12: Percentage of newborns who have been screened for hearing before hospital discharge.*

## a. Last Year's Accomplishments

Screening Programs: Four additional hospital screening programs were added between July 2002 and June 2003. This brought the number of hospitals to 20 out of 25 hospitals with birth facilities conducting universal newborn hearing screening. The program staff continue to make visits to hospital newborn hearing screening programs and monitor program activities. (PB)

Advisory Committee: Members of the UNHSP Advisory Committee worked with the program staff to develop a Resource Book for parents of children identified with hearing loss. (IB)

Tracking System: The UNHSP staff worked with Welligent personnel to identify the program needs and customize the Auris system for the New Hampshire program. The training for state program and hospital program staff in preparation for the start of pilot testing of the tracking system occurred on September 3, 2002. However, because administrators of one hospital expressed concerns about transmitting data to the state and compliance with the federal HIPAA legislation, the pilot testing was put on hold. Staff within the NH Department of Health and Human Services developed written assurance of compliance with the HIPAA requirements and the specific exemption of public health activities in February 2003. The guidelines were approved by the NH Hospital Association and sent to hospital administrators. Three hospitals agreed to become pilot sites for the Auris tracking system. Training for the hospital users and UNHSP staff was held in August 2003. (IB)

Pediatric Diagnostic Audiology Centers: Audiologists within three agencies (a hospital, a rehabilitation center and an ENT practice) were selected and received funding for diagnostic ABR equipment. Another audiologist in private practice recently purchased diagnostic equipment. A survey of audiology practices was conducted to determine which have the equipment and expertise needed for diagnostic testing of infants and young children. These additional facilities should significantly decrease the distance families need to travel for pediatric diagnostic audiology services. (E)

## b. Current Activities

The name of the program was changed to Early Hearing Detection and Intervention (EHDI) Program to be consistent with other programs nationally and to more accurately reflect the activities of the program.

Screening Programs: The EHDI Program staff continues to encourage hospitals without newborn hearing screening to develop programs. A telephone survey conducted in December 2003 revealed that one hospital had closed its maternity unit. Dartmouth Hitchcock Medical Center changed from high risk only to universal newborn hearing screening. Two additional hospitals started newborn hearing screening programs. The number of hospitals with newborn hearing screening is now 23 out of 24 hospitals with birth facilities. (PB)

Advisory Committee: Activities of the EHDI Advisory Committee members have included discussion of the development of additional pediatric diagnostic centers, education of physicians about the EHDI process, implementation of the Auris tracking system and use of the data available in the tracking system. (IB)

Tracking System: Hospital users and the EHDI Program staff learned to use the Auris tracking system and collection of data for pilot testing began in September 2003. The data linkages between birth data and the Auris tracking system were established and began testing in November 2003. Staff from the EHDI Program continues to work with programmers from Welligent to refine the data matching process. Primary care physicians were sent a packet which included information about the tracking system, guidelines for screening, diagnosis and identification for hearing loss for infants, and recommendations for appropriate referrals to pediatric diagnostic audiology centers. (IB)

Pediatric Diagnostic Audiology Centers: Audiologists in underserved areas of the state were offered the opportunity to apply for funds for equipment and education for testing of infants and young children.. One private practice was selected for assistance in Fall 2003. Once the contract has been approved, this practice will serve families living in two of the largest cities in NH and decrease the need to travel for services for families in this area. Program staff is conducting site visits to the diagnostic centers. Collection of diagnostic testing data through the Auris tracking system will begin following training for audiologists in March 2004. An updated list of pediatric audiology diagnostic centers will be shared with physicians and hospital screening program staff. (E)

## c. Plan for the Coming Year

Screening Programs: The EHDI Program staff will work to encourage newborn hearing

screening at the remaining hospital without such a program.

Advisory Committee: The Advisory Committee activities will focus on educating parents and providers about the Auris tracking system.

Tracking System: The EHDI Program will establish and maintain use of the tracking system by all hospitals with newborn hearing screening programs and all audiologists testing infants. Program staff will continue to refine the linkages between EHDI and birth data.

Pediatric Diagnostic Audiology Centers: Program staff will support the development of diagnostic centers by providing support to audiologists who test infants and continuing to make site visits.

Resource Book: When the Resource Book for Parents of Children who are Deaf or Hard of Hearing is completed, the materials will be tested with consumers. A distribution plan will be developed to assure that the materials are given to families. (IB)

### Performance Measure 13: *Percent of children without health insurance.*

#### a. Last Year's Accomplishments

The BMCH continued to collaborate with the NH Healthy Kids Program and the NH SCHIP Coordinator to share information, data, updates and policy changes to increase enrollment of uninsured eligible children on Medicaid/Healthy Kids Gold. (IB)

Staff from the NH Healthy Kids Program and the NH SCHIP Coordinator attended an MCH Coordinators' Meeting to get feedback from the Title V local MCH contract agencies on questions, problems, and issues in enrolling children. (IB)

The BMCH Child Health Nurse Consultant participated in the state committee that monitors the workplans of the Robert Wood Johnson-funded "Covering Kids and Families" grant. (IB)

The BMCH continued to require its contract agencies to annually assess and document the financial status of each child upon enrollment and document attempts to enroll the child on Medicaid/Healthy Kids Gold. This documentation is assessed by the MCH Contracts Administrator at agency site visits. (IB)

The BMCH continued to support, with Title V and state funds, 4 community health agencies to provide "Child and Family Health Support services" in lieu of child health direct care services to support efforts made by the local agencies to enroll eligible children in Medicaid/Healthy Kids Gold and Silver. (IB)

As part of their contract requirement, the BMCH contract agencies were required to develop workplan action and evaluation activities pertaining to a performance measure on percent of children without health insurance for their FY'03 workplans

#### b. Current Activities

In addition to the activities outlined above. BMCH reviewed agencies' FY'03 completed workplans, which reported on the success or failure in the agency's ability to reach its target. Written feedback to the agencies was provided. BMCH staff will be reviewing and providing feedback on the recently submitted FY'05 workplans which included the same performance measures.

#### c. Plan for the Coming Year

The BMCH continued to collaborate with the NH Healthy Kids Program and the NH SCHIP Coordinator to share information, data, updates and policy changes to increase enrollment of uninsured eligible children on Medicaid/Healthy Kids Gold. (IB)

Staff from the NH Healthy Kids Program and the NH SCHIP Coordinator attended an MCH Coordinators' Meeting to get feedback from the Title V local MCH contract agencies on questions, problems, and issues in enrolling children. (IB)

The BMCH Child Health Nurse Consultant participated in the state committee that monitors the workplans of the Robert Wood Johnson-funded "Covering Kids and Families" grant. (IB)

The BMCH continued to require its contract agencies to annually assess and document the financial status of each child upon enrollment and document attempts to enroll the child on Medicaid/Healthy Kids Gold. This documentation is assessed by the MCH Contracts Administrator at agency site visits. (IB)

The BMCH continued to support, with Title V and State funds, 4 community health agencies to provide "Child and Family Health Support services" in lieu of child health direct care services to support efforts made by the local agencies to enroll eligible children in Medicaid/Healthy Kids Gold and Silver. (IB)

The BMCH will request that Title V MCH Contract agencies submit their completed FY'04 workplans in fall '04 reporting on the success or failure in the agency's ability to reach its target of percent of children without health insurance. (IB)

The BMCH and the NH Immunization Program will assess the results of the community focus groups in Nashua to better learn about obstacles to obtaining immunizations and health care for children, especially for racial and ethnic minorities. (PB)

*Performance Measure 14: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

#### a. Last Year's Accomplishments

The Bureau continued to collaborate with the NH Healthy Kids Program and the NH SCHIP Coordinator to share information, data, updates, and policy changes to increase enrollment of uninsured eligible children on Medicaid/Healthy Kids Gold. (IB)

Staff from the NH Healthy Kids Program and the NH SCHIP Coordinator attended an MCH Coordinators' Meeting to get feedback from the Title V local MCH contract agencies on issues/concerns identified by local MCH Title V contract agencies to increase enrollment of eligible, uninsured children on Medicaid/Healthy Kids Gold. (IB)

The Bureau continued to require its contract agencies to annually assess and document the financial status of each child upon enrollment and document the attempts to enroll the child on Medicaid/Healthy Kids Gold. This documentation is assessed by the MCH Contract Administrator at agency site visits. (IB)

With State and Title V funds, the Bureau funded 4 community health agencies to provide "Child and Family Health Support Services" in lieu of child health direct care services. This funding supports the efforts made by the local agencies to enroll eligible children in Medicaid/Healthy Kids Gold and Silver (IB).

The Bureau continued to encourage its Title V funded agencies to utilize the newly revised "Prenatal and Child/Family Health Care Support Services" ("Child Health Support") Medicaid code which reimburses Title V funded agencies for education, support, counseling and follow up to children and pregnant women on Medicaid. Revisions included adding services by trained paraprofessionals and expansion of services to pregnant women served by MCH contract agencies. (IB)

#### b. Current Activities

In addition to the activities above, which continued in this fiscal year, BMCH staff worked with staff from the Medicaid financial audit program to review the first audit of a Title V MCH agency's invoices for Medicaid billable services on its MCH clients. Lessons learned from the audit on the need to improve documentation of the Medicaid billable services provided was shared at meetings with the Title V MCH agencies Directors and Program Coordinators. (IB)

The BMCH staff conducted site visits to the 4 Title V funded non-direct care child health agencies to observe use and documentation of the MCH grant during the summer of '04 .

Lessons learned from the visits were shared with the 4 agencies at a February '04 meeting. (IB)

The MCHB funded technical assistance, "CompCare", provided by Health Systems Research, Inc., released its draft report in January '04, which included services needed and used by the Title V eligible MCH population. A preliminary review and discussion of the report findings has been held. (IB)

### c. Plan for the Coming Year

The MCH staff will further discuss how to apply the recommendations of the report by "CompCare", provided by Health Systems Research, Inc., to increase the use of Medicaid eligible children who receive a Medicaid billable service. Included in the discussion will be possible revamping of the current child health direct care scope of services to allow more flexibility in the scope of services to combine usage for both direct care and support services. (IB)

The MCH staff will continue to collaborate with the NH Healthy Kids Program and the NH SCHIP Coordinator to share information, data, updates, and policy changes to increase enrollment of uninsured eligible children on Medicaid/Healthy Kids Gold. With the Commissioner's current "Medicaid Modernization" efforts, it is unclear what, if any, changes may occur that may impact the services provided by the Title V MCH funded agencies. However, if any occur, it will be the role of the MCH staff to work with the agencies in interpreting these changes. (IB)

The MCH staff will continue to monitor its contract agencies' use of Medicaid billable support services and work with agency staff to maximize use in an appropriately documented manner. (IB)

## Performance Measure 15: *The percent of very low birth weight infants among all live births.*

### a. Last Year's Accomplishments

The Bureau of Maternal and Child Health provided partial funding to 12 agencies that offer comprehensive prenatal care services to pregnant and postpartum women with a special emphasis on adolescents and women from low-income families (< 185% of the US Dept. of Health and Human Services Federal Poverty Guidelines). These prenatal agencies provide a variety of enabling services to clients, which may include, but are not limited to: transportation, translation services, outreach, health education, case management services, and pre-certification for Medicaid eligibility. (D)

Bureau staff formed a data team to implement an electronic reporting system for contract providers. The electronic system was piloted with one agency. This will enhance data analysis and will also serve to reduce the overall reporting burden on the prenatal agencies. (I)

Prenatal Program Coordinators' Meetings in FY03 were facilitated biennially. Topics addressed data collection from prenatal programs, tobacco control, and oral health for pregnant women. (I)

Performance Measures were reassessed and the current measures will be kept. Prenatal Clinics are reporting First Trimester Prenatal Care, screening and referral for substance use, tobacco cessation, and MSAFP testing. (D)(I)

The Perinatal Alcohol, Tobacco and Other Drug Use Task Force was dissolved by the State of New Hampshire legislature due to deficit reduction measures within the state budget. The Prenatal Program continues to distribute the FAS brochure to all couples applying for a marriage license in NH. The updated brochure is much more attractive and contains up-to-date information on FAS presented in a non-threatening manner. (P)

The Perinatal Outreach Program at Dartmouth Hitchcock Medical Center provided regular and comprehensive outreach and education to all state hospitals regarding the transfer of high-risk cases to DHMC for delivery. (I, E)

The Prenatal Program utilized needs assessment information to guide strategic planning during FY 03 to further identify program priorities and areas for improvement. Priorities included:

prenatal smoking cessation, first trimester prenatal care entry for the Medicaid and uninsured populations, and improving available data on the state's prenatal population to guide programming. (I)

#### b. Current Activities

The New Hampshire Chapter of the March of Dimes along with the Northern New England Perinatal Quality Improvement Network have cosponsored a Summit on Prematurity. The DHHS provided leadership by presenting the public health perspective and launching a call to action at the Summit closing. (E, I)

BMCH-funded agencies will continue to provide comprehensive prenatal care to low income, uninsured and underinsured women. Performance measures for local prenatal clinics were evaluated using preliminary agency data and revised for the SFY 2004 competitive bidding cycle. In addition, the Prenatal Scope of Services has been revised to reflect the program's focus on prenatal smoking and first trimester care entry. A performance management system for all agencies is in the design phase with implementation expected by the Fall of FY05 (D) The BMCH has led the New Hampshire 2010 MCH Committee during this reporting period. The committee has chosen the reduction of low birth weights as one of the priority objectives under the initiative. Action steps and strategies have been developed. The action steps will be implemented in FY05 and FY06. (E, P)

#### c. Plan for the Coming Year

The Bureau of Maternal and Child Health will continue to foster a collaborative relationship with the Perinatal Program at Dartmouth Hitchcock Medical Center.

BMCH-funded agencies will continue to provide comprehensive prenatal care to low income, uninsured and underinsured women. Performance measures for local prenatal clinics were instituted during the SFY 2002 cycle. During FY 2003, these will be evaluated using preliminary agency data and revised for the SFY 2004 competitive bidding cycle. In addition, the Prenatal Scope of Services will be revised to reflect the program's focus on prenatal smoking and first trimester care entry. (D)

The Prenatal and Adolescent Health Manager will continue to participate on the Folic Acid Task Force, now chaired by DHHS' Bureau of WIC Nutrition Services. The Task Force will continue to work on innovative approaches to getting out the message on preconception folic acid use. (E)(P)

The Prenatal and Adolescent Health Manager will collaborate with the New Hampshire Chapter of the March of Dimes on a state-wide prematurity campaign. This is a national campaign initially launched by MOD in January 2003. The New Hampshire prematurity campaign will increase public awareness on the impact of low birth weight on infant/child health. (E)

The BMCH will release reports on New Hampshire births and disparities in birth outcomes. The prenatal report will present findings on prenatal access to care as well as birth outcomes and the influence of socio-demographic characteristics. A second report will present disparities in birth outcomes within the minority populations of New Hampshire. These reports will be used to inform planning efforts with communities and in particular the prenatal contract agencies of BMCH. (I)(E)

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

#### a. Last Year's Accomplishments

Youth Suicide Prevention Assembly (YSPA): In June of 2003, a meeting was convened to examine the mission and structure of YSPA. The Injury Prevention Center (IPC) remained a co-chair along with a representative from the Division of Behavioral Health and one from The

National Alliance for the Mentally Ill-NH (NAMI-NH). Based on data, YSPA decided to expand its efforts to include youth up to age 24. A group began work on the Suicide Prevention Goals and Objectives for the Injury Prevention Plan. It is expected that these will be the basis for the broader statewide Suicide Prevention Plan. (I)

Policy: House Bill 240 was introduced and passed which established a House Study Committee to examine the issues surrounding youth suicide. (I)

Frameworks Project: NAMI NH took on the leadership of the Frameworks Project. IPC and NAMI NH gave a joint poster presentation on the project at the American Association of Suicidology conference. (P)

Bereavement Packet: Work was completed on a bereavement packet, sent out from the Medical Examiner's Office, to survivors of all youth suicides. It includes printed materials on grief and coping, lists of support groups and community mental health centers and a CD of healing music. (P)

Funding: The IPC applied for funds to develop and implement a workshop on "Counseling on Restricting Access to Lethal Means". (I)

#### b. Current Activities

YSPA: YSPA meets monthly. Meetings are taking place to develop the Suicide Prevention State Plan as well as the state's first Annual Report on Youth Suicide. YSPA is establishing a speakers' bureau. YSPA members helped organize an expanded Survivors Conference in conjunction with the American Foundation for Suicide Prevention teleconference in November. (I & P)

Policy: The House Study Committee made recommendations to recognize YSPA, encourage development of a state plan and increase access to training on suicide prevention for school personnel. YSPA members testified and assisted with the development of recommendations. (I)

Frameworks Project: Work groups are completing the intervention protocols, preparing to begin work on postvention. Pilot site recruitment is underway. (P)

"Counseling on Restricting Access to Lethal Means": While this grant was approved, a special condition prevented the group from accepting the funds. Private funds are being sought to carry out this effort. (I)

Medical Examiner Case Review: The second round of reviews of Medical Examiner records on youth suicides was completed. Analysis is almost complete. (I)

Training: A group participated in Harvard's Injury Prevention Research Center's training. (I)

#### c. Plan for the Coming Year

YSPA: Regular meetings will continue. The Survivors Conference will become an annual event. Efforts will be made to secure funding to allow for ongoing planning and implementation of suicide prevention training and education activities. (I & P)

Frameworks Project: The Frameworks Project will work on its postvention protocols, with implementation at a community pilot site slated for the winter of 2004.(P)

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

#### a. Last Year's Accomplishments

The Bureau of Maternal and Child Health provided partial funding to 12 agencies that offer comprehensive prenatal care services to pregnant and postpartum women with a special emphasis on adolescents and women from low-income families (< 185% of the US Dept. of Health and Human Services Federal Poverty Guidelines).

The Perinatal Outreach Program at Dartmouth Hitchcock Medical Center provided regular and

comprehensive outreach and education to all state hospitals regarding the transfer of high-risk cases to DHMC for delivery. Transfer conferences were held at all provider facilities throughout the state. These conferences delivered provider education on care coordination, prematurity, and care guidelines.

The Prenatal Program utilized needs assessment information to guide strategic planning during FY 03 to further identify program priorities in reducing the need for high-risk transfers. Priorities included: prenatal smoking cessation, first trimester prenatal care entry for the Medicaid and uninsured populations, and improving available data on the state's prenatal population to guide programming. (I)

#### b. Current Activities

The New Hampshire Chapter of the March of Dimes along with the Northern New England Perinatal Quality Improvement Network have cosponsored a Summit on Prematurity. The DHHS provided leadership by presenting the public health perspective and launching a call to action at the Summit closing. (E, I)

BMCH-funded agencies will continue to provide comprehensive prenatal care to low income, uninsured and underinsured women. Performance measures for local prenatal clinics were evaluated using preliminary agency data and revised for the SFY 2004 competitive bidding cycle. In addition, the Prenatal Scope of Services has been revised to reflect the program's focus on prenatal smoking and first trimester care entry. A performance management system for all agencies is in the design phase with implementation expected by the Fall of FY05 (D) The BMCH has led the New Hampshire 2010 MCH Committee during this reporting period. The committee has chosen the reduction of low birth weights as one of the priority objectives under the initiative. Action steps and strategies have been developed. The action steps will be implemented in FY05 and FY06. Education at provider transfer conferences will be used to implement education strategies. (E, P)

#### c. Plan for the Coming Year

The Bureau of Maternal and Child Health will continue to foster a collaborative relationship with the Perinatal Program at Dartmouth Hitchcock Medical Center.

BMCH-funded agencies will continue to provide comprehensive prenatal care to low income, uninsured and underinsured women. Performance measures for local prenatal clinics were instituted during the SFY 2002 cycle. During FY 2003, these will be evaluated using preliminary agency data and revised for the SFY 2004 competitive bidding cycle. In addition, the Prenatal Scope of Services will be revised to reflect the program's focus on prenatal smoking and first trimester care entry. (D)

The Prenatal and Adolescent Health Manager will continue to participate on the Folic Acid Task Force, now chaired by DHHS' Bureau of WIC Nutrition Services. The Task Force will continue to work on innovative approaches to getting out the message on preconception folic acid use. (E)(P)

The Prenatal and Adolescent Health Manager will collaborate with the New Hampshire Chapter of the March of Dimes on a state-wide prematurity campaign. This is a national campaign initially launched by MOD in January 2003. The New Hampshire prematurity campaign will increase public awareness on the impact of low birth weight on infant/child health. (E)

The BMCH will release reports on New Hampshire births and disparities in birth outcomes. The prenatal report will present findings on prenatal access to care as well as birth outcomes and the influence of socio-demographic characteristics. A second report will present disparities in birth outcomes within the minority populations of New Hampshire. These reports will be used to inform planning efforts with communities and in particular the prenatal contract agencies of BMCH. (I)(E)

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

a. Last Year's Accomplishments

The Prenatal Program utilized needs assessment information to guide strategic planning during FY 03 to further identify program priorities and areas for improvement. Priorities included: prenatal smoking cessation, first trimester prenatal care entry for the Medicaid and uninsured populations, and improving available data on the state's prenatal population to guide programming. (D,E)

The BMCH is pilot testing electronic submission of prenatal client data. The BMCH has developed a plan to link this data electronically to the birth certificate data, which will streamline reporting efforts and allow greater population based evaluation of state and community efforts. This is a long term project and a data team from the bureau continues to work on the data plan. (I)

The BMCH funded 13 health agencies to provide comprehensive prenatal care to low income, uninsured and underinsured women. The scope of services specifies standards of medical care, voluntary HIV testing, health education, nutrition services, social services, substance abuse services, smoking cessation counseling, home visiting, staff qualifications, hiring of new personnel and data reporting requirements. These prenatal agencies provide a variety of enabling services to clients, which may include, but are not limited to: transportation, translation services, outreach, health education, case management services, and pre-certification for Medicaid eligibility. (E)

Collaborative efforts with the New Hampshire March of Dimes continued to focus on population based education on the importance of early prenatal care. (P,E)

b. Current Activities

BMCH-funded agencies continued to provide comprehensive prenatal care to low income, uninsured and underinsured women. (D,E)

BMCH-funded Prenatal Program Coordinators' meetings will continue on a biannual basis. These meetings provide a forum for Coordinators to network with their peers and discuss issues pertinent to prenatal care delivery. Topics covered included oral health, medicaid compliance in billing practices for support services, prenatal clinical guidelines development, and the development of performance workplans. (I,E)

Minority focus group information and a birth data report were completed in FY 03. This information was synthesized and a report and presentation developed during FY04. This presentation will be utilized to provide a focal point in gathering community-based resources to initiate improvement measures in the City of Manchester in FY 05 (E,I)

A Performance Management Collaborative has been formed to create a comprehensive system of performance management across state and community systems. The collaborative is made up of MCH staff and provider agency directors. (E,I)

c. Plan for the Coming Year

BMCH-funded agencies will continue to provide comprehensive prenatal care to low income, uninsured and underinsured women. (D,E)

BMCH-funded Prenatal Program Coordinators' meetings will continue on a biannual basis. These meetings provide a forum for Coordinators to network with their peers and discuss issues pertinent to prenatal care delivery. Topics to be covered at the FY 2005 meetings include: The 5A's model of prenatal smoking cessation; prematurity data and best practices; and performance management. (E)

The Prenatal Program will continue to explore options for implementing a PRAMS-like survey. The program's 2001 CDC application for PRAMS was approved but unfunded. The program is considering a one-time PRAMS survey for the City of Manchester in FY 2005. (P,I)

BMCH will collaborate with the NH March of Dimes on a state-wide campaign to increase

awareness of the health impact of preterm births and to promote early prenatal care. (P)  
 The BMCH will implement a system of performance management across all MCH contracted agencies. The BMCH will begin reporting on performance measures - both health status and infrastructure through a report card like format. (I)  
 Due to documented disparities in birth outcomes between the overall population and newly emerging ethnic and linguistic minority communities in the City of Manchester, the Bureau will utilize birth data and minority health reports to create a "Call to Action" among community based partners and healthcare providers. It is anticipated that stakeholders will be brought together to identify strategic action steps that may be taken to address healthcare access and birth outcomes in order to eliminate the existing health disparities. (I)

**FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET**

**General Instructions/Notes:**

List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) 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.				
1. Continue to manage the daily process of reporting out and follow-up.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Continue to direct and support the work of the NH Advisory Committee.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Support the process to implement plans to expand our current panel to 10 conditions as recommended by the Advisory Committee (9-04).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Support of Data Linkage Project.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Development of QA Tool (feedback to birth hospitals on process of newborn screening)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Continue to develop and nurture state and regional partnerships relative to newborn screening.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Development of internal operations manual as recommended by Site Visit Team.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Begin plans to make site visits to all birth hospitals for purpose of education and evaluation of newborn screening process.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Participate in regional activities, representing New Hampshire, Dept of Public Health.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) 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)				

1. Ongoing annual contract (>\$102,000) with New Hampshire Family Voices to support 3 parent consultants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Participation in New England Regional Family Voices Leadership Conference.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Parent satisfaction survey of Neuromotor Clinical Program with an overall satisfaction rate of 95%.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Ongoing development of joint New Hampshire Family Voices and Special Medical Services Bureau activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Use of parent consultant to develop transition component of the Neuromotor Clinical Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Staff participation in the annual New Hampshire Family Support Conference.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Development of materials on insurance issues/alternate funding for use by families.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Survey of families receiving SSI benefits (for child's own disability) to determine issues/needs and satisfaction with care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) 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)				
1. Dedicate .5 FTE position for collaboration with Beyond the Medical Home grant.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Participation in annual retreats for CMHI Medical Home sites.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Consultation regarding structure, process and outcomes of care coordination.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Consultation to medical homes regarding CSHCN who are Medicaid recipients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Presentation on Differential Diagnosis for medical home care coordinators.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Explore potential for Medicaid support for care coordination in medical homes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Develop strategies to support development of network of medical home providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Collaborate with MCHB funded projects regarding the skills and competencies of care coordination.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Develop and present yearly seminars to enhance the professional capacity of medical home personnel.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) 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)				
1. Participation in state, regional and national policy discussions regarding CSHCN, Title V, MCH issues, and the adequacy of insurance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Conducting the New Hampshire Insurance/Cost-of-Care Survey for Children with Special Health Care Needs, 2004, with families of children receiving SSI for their own disability.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Addressing the specified priorities of the SMSB/New Hampshire Family Voices Health Care Financing Advisory Group, through ongoing facilitation to implement the group's work plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continuation of the Special Medical Services Bureau follow-up of child SSI referrals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Dissemination of National Survey of Children with Special Health Care Needs 2001, state-level data for New Hampshire, to identified stakeholders and the public.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Co-sponsor with NH Family Voices a statewide workshop on health care financing resources.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Improving Bureau-level data collection procedures, capacity for analysis, and reporting.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Submit an article on New Hampshire's use of data from the National Survey of CSHCN, for consideration for inclusion in a special issue of the Journal of Maternal and Child Health.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Revising selected Bureau policy and procedure materials and internal reports to better parallel existing and proposed performance measures, including those of the Title V block grant.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) 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)				
1. Increased community-based services and decreased State direct services.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Expansion of community capacity for psychology services and services for children with diabetes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Expansion of program capacity for the Nutrition, Feeding and Swallowing Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continuation of family-centered, community-based care coordination.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Provision of training, technical assistance, and consultation to professionals and consumers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Expanded consultation to Medicaid on policy and procedure areas affecting CSHCN.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Decrease language barrier for non-English speaking Hispanic residents.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Collaborate with the Hood Center's Rural Medical Home and Partners in Chronic Care projects.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Representation on key committees and task forces working to improve systems of care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) 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)				
1. Provide health care transition services to adolescents in the SMSB Neuromotor Program, in the Spina Bifida Program and throughout SMSB? s care coordination services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Collaborate with the two state youth organizations that focus on youth with chronic illness and youth with disabilities to consider how health care transition issues can be integrated into their programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Expand the capacity of the Spina Bifida web site to include family and youth support, as identified in the parent survey, in participation with Dartmouth-Hitchcock Medical Center (Lebanon).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Ongoing assessment activities of the Neuromotor Transition Task Force; evaluate New Hampshire-specific tools.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continued development of the role and activities of the FV/SMSB Youth Advisory Transition Group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Participate in interagency initiatives on transition with the Department of Education and other state agencies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Participate in joint activities with the Adolescent Health Program in the New Hampshire Bureau of Maternal and Child Health as it develops activities related to the Adolescent Health Strategic Plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Analyze the results of the June 04 survey of NH pediatricians serving YSHCN and develop activities based on identified needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Conduct a survey of adult health care providers to determine their capacity to serve YSHCN and their interest in collaborating with pediatricians in their communities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Publish an Issue Brief on Healthcare Transition for YSHCN in New Hampshire.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.				
1. Collaborate with the NH Immunization Program on any state or local activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Communicate immunization policy changes to Title V funded agencies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Use CASA results from Title V funded agencies for quality assurance activities-site visits and performance measures.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Encourage Title V contract agencies to host CDC Immunization Training Teleconferences.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Require the BMCH Home Visiting contract agencies to educate families about immunizations.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. HCCNH to include immunizations in the training and information updates to child care health consultants.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. Contracts providing comprehensive reproductive health services through delegate agencies.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Community education on reproductive issues, including abstinence and contraception.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Statewide abstinence education media project.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Abstinence education community grants.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Development of a data resource linking data sets with relevant adolescent health indicators.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Development of an abstinence-only educators network.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7. Develop Youth Action Networks throughout the State of New Hampshire to implement recommendations of the Strategic Planning Process.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. OHP and Medicaid will continue to collaborate to find treatment for clients.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Collaborating with Medicaid and EFH, the OHP will open new dental centers at 3 community health centers (Rochester, Berlin and Littleton) 2 hospitals (Lebanon, Lancaster) and expand facilities at urban dental centers in Manchester and Nashua.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. The OHP will collaborate with EFH to implement a sustainable statewide sealant program for third grade students.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. In collaboration with EFH, the OHP will implement the ?Watch Your Mouth? oral health awareness/education campaign to increase public perception of the importance of good oral health as a component of overall health.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Collaborating with EFH, the OHP will integrate oral assessment into medical care by educating providers, patients, and parents while initiating the aggressive use of evidence-based preventive interventions.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. In collaboration with EFH, the OHP will evaluate the oral health				

workforce to make recommendations for meeting the evolving needs and demands of the population.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7. The OHP will complete the second Oral Health Survey of Third Grade Students using the ASTDD model to monitor the oral health status of NH children.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
8. The OHP will publish the fourth NH Oral Health Data, 2004 reporting on all 8 national oral health indicators.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. Train and certify child passenger safety technicians and instructors.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue to promote and distribute booster, convertible, and infant seats.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Increase the number of inspection stations.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Pair technicians at inspections stations with mentors who will be CPS instructors.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Educate providers regarding car seats for children with special needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Explore the reasibility of a standard seat belt law/primary seat belt law for the next legislative session.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. Work with the state WIC Program to disseminate breastfeeding information to Title V funded agencies.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Encourage Title V funded MCH contract health and home visiting agencies to promote breastfeeding.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Promote breastfeeding in SIDS and safe sleeping education to public, health professionals, and hospitals.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Collaborate with WIC and state breastfeeding coalition on development of breastfeeding safe sleeping information.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Disseminate breastfeeding and safe sleeping information in mass mailing to prenatal/newborn health care providers and educators.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Utilize data from BMCH Newborn Screening Program to assess breastfeeding rates.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. Increase the number of hospitals in New Hampshire with newborn hearing screening programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Continue the activities of the UNHSP Advisory Committee.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Monitor and analyze all newborn hearing screening data entered by participating birth hospitals into the Auris tracking system funded by the CDC Early Hearing Detection & Intervention Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Promote the development of pediatric audiology diagnostic centers throughout New Hampshire.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
13) Percent of children without health insurance.				
1. Collaborate with the NH Healthy Kids Program and the NH SCHIP Coordinator.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Monitor annual clients financial documentation requirement at site visits.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Fund 4 agencies for "Child and Family Health Care Support" services in lieu of child health direct care.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Monitor performance measure on contract agencies workplans on percent children without health insurance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Carry out feasible recommendations of federal technical assistance project (CompCare).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Participate in workgroup monitoring Robert Wood Johnson "Covering Kids" grant.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Assess results of the Nashua community focus group on access to care for children of racial and ethnic minorities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. Collaborate with the NH Healthy Kids Program and the NH SCHIP Coordinator.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Monitor client's financial documentation requirement at site visits.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Fund 4 agencies for ?Child and Family Health Support Services? in lieu of child health direct care services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Require performance measure on agency workplans re: percent uninsured children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Carry out feasible recommendations of federal technical assistance project.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Work with contract agencies to maximize and appropriately document use of Medicaid reimbursable health care support and care coordination services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Explore revising current child health direct care Exhibit A to allow more flexibility in the scope of services to combine usage for both direct care and support services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live births.				
1. The Folic Acid Task force continues prevention, education and promotion efforts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Dartmouth Medical Center provides professional education on high-risk delivery practices.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Training on the Five A's cessation model continues within public health centers and hospitals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Providing public health leadership role on the March of Dimes, New Hampshire Prematurity Campaign.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Addressing disparities in health care and birth outcomes through data presentations and facilitation of Manchester stakeholders meetings.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. Convene and chair the Youth Suicide Prevention Assembly.				

	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Work on the development of a state suicide plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Implement the state suicide plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue to serve on the Frameworks Steering Committee, Advisory Board, and workgroups.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Secure funding for ongoing planning and implementation of suicide prevention training and education activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Facilitate annual Survivor's conference.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Convene and chair the Firearm Safety Coalition.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
8. Develop Firearm Safety Video/DVD for high school age students.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. The Folic Acid Task force continues prevention, education and promotion efforts.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Dartmouth Medical Center provides professional education on high-risk delivery practices.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Training on the Five A's cessation model continues within public health centers and hospitals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Providing public health leadership role on the March of Dimes, New Hampshire Prematurity Campaign.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Addressing disparities in health care and birth outcomes through data presentations and facilitation of Manchester stakeholder meetings.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				
1. Efforts continue with the NH March of Dimes promoting the importance of early prenatal care.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Refine data collection, analysis, and planning for full linkage into the NH birth files.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue funding agencies to provide prenatal care to low income, uninsured and underinsured women.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**D. STATE PERFORMANCE MEASURES**

**State Performance Measure 1: *The percent of pediatricians who provide transition support to youth with special health care needs (YSHCN) enrolled in their practice. (SPM #13)***

**a. Last Year's Accomplishments**

The SMSB increased efforts to improve communication with families about transition within the Neuromotor Program and the Spina Bifida Program. Strategies included encouraging parents to talk with their child's primary care provider (PCP) about transition, however, no specific transition information was sent to the PCP's about their role in assessing the transition needs of their patients with chronic illness and disability. (ES) (IB)

SMSB staff were not aware of how the health transition process was being handled in the primary care offices, except by occasional anecdotal parent report. It is well known that there are many barriers to successful health care transition to adult services. If pediatric health care professionals have the specific knowledge and skills to assist the youth with SHCN, and their families, to transition, they can help bridge the differences in the two health service delivery systems: pediatric care emphasizing parental control and dependency upon the family, and adult-focused care, which generally requires or presumes a higher degree of self-sufficiency and personal responsibility. (Reference: Geenan, S., Powers, L., Sells.W., "Understanding the Role of Health Care Providers During the Transition of Adolescents With Disabilities and Special Health Care Needs.", *Journal of Adolescent Health* 2003; 32:225-233.) (IB)

The National Survey of Children with Special Health Care Needs 2001 indicates that nationally, only 5.8% of youth age 13-17 are receiving all or most of the services necessary to make transitions to adult life, adult health care, work, and independence (Core Outcome #6). To meet the success threshold for the Core Outcome, the respondents had to answer "always" or "usually" to all five of the questions on transition. The survey results for New Hampshire indicate that only 3.3% of YSHCN are attaining this Core Outcome. However, three of the elements indicated that: (1) 51.7% of doctors had spoken with the family about their child's changing needs as they become adults; (2) 66.5% of the families indicated that their youth did have a plan for addressing changing needs; and, (3) 41.1% reported that doctors had discussed the shift from a pediatric to an adult medical provider. (IB)

**b. Current Activities**

SMSB staff recognizes the need to assess the current status of health care transition activity and capacity for increased activity among pediatric practices in New Hampshire. A survey tool was developed to assess how members of the New Hampshire Pediatric Society were addressing the health care aspects of NPM # 6 (i.e., Youth with special health care needs will receive the services necessary to make transitions to adult life, including adult health care, work, and independence.) The survey, titled "Transitioning Youth With Special Health Care Needs to Adult Providers", was launched on-line through the NHPS to its members in June 2004. (See attachment.)

The Bureau staff are analyzing the collected data about what services pediatric health care practices provide to youth in transition, how they relate to other agencies within their communities, and specifically how they work with adult health care providers. SMSB projects that NH pediatricians will increase the comprehensiveness of their transition services for YSHCN each year in response to increased information and education about health care transition. The ability to provide all six of the recommended services will remain the criteria for success. The six elements are:

1. Provide written information about health transition topics
2. Develop a written health care transition plan with teen and family
3. Educate about managing chronic condition
4. Prepare and maintain a medical summary
5. Talk about how health care needs may change when adult
6. Discuss referral to adult health care providers

Preliminary findings indicate that all six selected transition services are provided to YSHCN at least 60% of the time by only fourteen percent (N=4) of the 27 pediatricians who responded to the online survey. The Bureau plans to survey yearly, using a variety of methods that will include the same variables. SMSB has set the baseline for the objective at 14, and projects that there will be a yearly 5% increase in the number of pediatricians that meet the criteria for this measure. See the attachment for the 04 survey results for the six elements.

The survey also assesses how pediatricians relate to other agencies within their communities, how they work with adult providers and their need for educational and technical assistance. Assistance in developing the instrument was received from the National Center on Healthy and Ready To Work, which provided examples of other surveys. The Center also reviewed the early drafts of the tool. (IB)

### c. Plan for the Coming Year

The plan is to work with New Hampshire pediatric practices to increase their capacity to provide more comprehensive transition education services to YSHCN and their families. SMSB staff will apply for a Champions for Progress Incentive Award from the University of Utah to assist in this endeavor (refer to NPM #6). After analyzing the pediatrician survey SMSB will share the results with the practices and then begin disseminating information. We plan to choose several practices to work with on a case-by-case basis to develop specific teaching modules and protocols to meet individualized needs for transition services. As part of this process, contact will be established with the adult health care system, to identify what their interests and needs are regarding the YSHCN population. One goal for FY05 is enhancement of pediatric-adult healthcare provider relationships in selected New Hampshire communities. These endeavors will be in conjunction with the activities of the Center for Medical Home Improvement and their current MCHB grant project. (IB)

## State Performance Measure 2: *Percent of women statewide who smoked during pregnancy. (SPM #2)*

### a. Last Year's Accomplishments

Prenatal Agencies are required by contract to include assessment and education regarding smoking during pregnancy to each enrollee. Treatment is available on-site or by referral for those who are assessed as ready to quit smoking.

The tobacco intervention performance measure has been refined and agencies have focused efforts on continually assessing and counseling pregnant women at every visit. (D) (I)  
The New Hampshire Tobacco Prevention and Control Program (TPCP) provided statewide train-the-trainer sessions on the full implementation of the Five A's model for smoking intervention. Four Prenatal agencies sent staff to be trained. (E)(D)

#### b. Current Activities

A meeting facilitated by the Bureau staff and attended by all BMCH contracted Prenatal providers focused discussions of best practice in prenatal smoking cessation. The agencies are committed to the implementation of the Five A's program as the standard for cessation intervention with prenatal patients. (E)

The New Hampshire Perinatal 2010 Committee has chosen an objective targeting a reduction of smoking in pregnant women. A minimum of two action steps under this objective will be implemented in the coming year. (P, I)

#### c. Plan for the Coming Year

All MCH contracted providers will use the Five A's model to assist pregnant women to quit smoking. (D)(E)(I)

The BMCH in collaboration with Dartmouth Hitchcock Childrens Program will disseminate the Five A's model to all Hospitals and birthing centers throughout the state. This dissemination and brief training in the model will occur through grand rounds type presentations that are already established (E) (P)

The Prenatal Program will continue to explore options for the funding of a PRAMS-like survey. (P)(I)

*State Performance Measure 3: The rate (per 100,000) of emergency department visits among youths aged 15-19 resulting from being an occupant in a motor vehicle crash. (SPM #14)*

#### a. Last Year's Accomplishments

Policy: The Teen Motor Vehicle Committee wrote an article for Child Health Month explaining the amendment to the state's graduated license law which came into effect on January 1st of 2003. (P & I)

Buckle Up New Hampshire Coalition: The Coalition, with the IPC chairing and the IP Program an active member, held their first annual conference in April of 2003. One component of the conference dealt with teen drivers. Approximately 4500 Buckle Up NH packets were sent out. Five Open Houses were held, getting information on restraint use to over 3,000 people statewide. In addition the statewide Buckle Up New Hampshire Kickoff at the SteepleGate Mall was held. The Coalition sponsored a banner contest on restraint use, with students from Merrimack Valley High School in Penacook winning that age category. Several large banners in each category were printed, displayed and distributed. The Coalition also participated in Race Fever Night in Concord and at the Safety and Health Council Conference.

Intersections Project: The Intersections Project led by an emergency room physician, linked the public health, safety, and first responder community. One of its first efforts was a conference on driving while intoxicated.

#### b. Current Activities

Buckle Up New Hampshire Coalition: The Coalition continues to meet on a monthly basis. For the annual conference in April and during the annual Buckle UP NH week in May, youth programs that educate their peers on proper seat belt use will be highlighted. (P & I)

Injury Prevention Data Report and State Plan: In September of 2003, "NH Injuries, 1999-2001" was released by the Bureau of Health Statistics and Data Management and the IP Program. A sub-committee of the Injury Prevention Program's Advisory Committee met after that to determine model recommendations on reducing death and injury due to motor vehicle crashes for both the IP Program's state plan and for Healthy NH 2010. The IP Program's state plan will be coming out in the spring. (I)

Intersections Project: The Intersections Project has continued to meet looking at ways to link programs addressing related risk factors and driving. (P & I)

### c. Plan for the Coming Year

Policy: The Teen Motor Vehicle Legislation Committee will seek new partners to explore legislative options based on data and best practice programmatic research. This group will also meet to explore the feasibility of introducing legislation with respect to a primary seat belt law. (I)

Buckle Up New Hampshire Coalition: The Coalition will continue to engage teen groups in addressing seat belt use. It will also look into developing a health communications campaign advocating seat belt use along the line of "I always wear a seatbelt, who wouldn't". (P)

Intersections Project: Intersections will continue working with partners regarding impaired driving as it affects teenage drivers and passengers. A conference looking at medical fitness guidelines for driving will take place. (P & I)

## State Performance Measure 4: *Percent of children age two (18-29 months) on Medicaid who have been tested for lead. (SPM #11)*

### a. Last Year's Accomplishments

The NH Childhood Lead Poisoning Prevention Program (CLPPP) staff attended one of two annual MCH Coordinators' Meetings to share with Title V funded Child Health and Primary Care agencies a review/update of lead screening activities, statistics, and new educational material. (IB)

MCH continued to require its contract child health direct care and primary care agencies to screen all enrolled two year olds for lead as part of its contract Exhibit "A" Scope of Services. (IB)

One of the urban MCH contract Child Health agencies, Child Health Services in Manchester, continued to receive targeted funding from CLPPP (From CDC) as part of its MCH contract, to do case management on all of its children identified with an elevated lead level due to the high incidence of lead poisoning among its urban and Medicaid eligible clientele.

MCH staff continued to include lead screening and appropriate clinical follow up as part of its Child Health Title V contract agency and Primary care site visit chart review tool. Policies for scheduling, tracking, and follow up of abnormal lead screening results continued to be part of the agency administrative component for the site visit tool (IB)

MCH continued to require its contract child health direct care and primary care agencies to include a performance measure pertaining to screening two year olds for lead in their annual workplans submitted to MCH both for the upcoming fiscal year, as well as the completed workplan (with descriptions of whether agency targets were met, and why/not) for the previous year.

MCH staff continued to participate in the CLPPP Medical Consultants Group and the CLPPP Advisory Committee.

### b. Current Activities

In addition to the activities described above, which continued in FY'04, the Child Health Nurse Consultant worked with the Program Chief of the CLPPP to develop a policy change and

subsequent memo sent to MCH Title V contract agencies regarding a change in EP's automatically being done on all lead screening samples sent in to the state lab for lead analysis.

### c. Plan for the Coming Year

The CLPPP will be moved into BMCH as a program in upcoming DHHS re-organization changes resulting in even further collaboration between staff.

The (CLPPP) staff will continue to attend one of two annual MCH Coordinators' Meetings to share with Title V funded Child Health and Primary Care information updates. (IB)

MCH will continue to require its contract child health direct care and primary care agencies to screen all enrolled two year olds for lead as part of its contract Exhibit "A" Scope of Services. (IB)

Child Health Services in Manchester, an urban MCH contract Child Health agency, will continue to receive targeted funding from CLPPP (From CDC) as part of its MCH contract, to do lead case management on all of its children identified with an elevated lead level.

MCH staff will continue to include lead screening and appropriate clinical follow up as part of its Child Health Title V contract agency and Primary care site visit chart review tool. Policies for scheduling, tracking, and follow up of abnormal lead screening results will continue to be part of the agency administrative site visit tool (IB)

MCH will continue to require its contract child health direct care and primary care agencies to include a performance measure pertaining to screening two year olds for lead in their annual workplans submitted to MCH both for the upcoming fiscal year, as well as the completed workplan (with descriptions of whether agency targets were met, and why/not) for the previous year.

The MCH Child Health Nurse Consultant will continue to participate in the CLPPP Medical Consultants Group and the CLPPP Advisory Committee.

## State Performance Measure 5: *Percent of adolescents (ages 10-20) eligible for an EPSDT service who received an EPSDT service during the past year. (SPM #15)*

### a. Last Year's Accomplishments

Title V funded Primary Care agencies provided screening and preventive services according to documented state or national guidelines to adolescents in need, including those eligible for Medicaid, at 10 sites statewide. (D)

The Title V funded Teen Clinic in Manchester provides comprehensive screening and assessment services based on nationally recognized guidelines to adolescents in need of services, including those eligible for Medicaid. An adolescent-focused health risk assessment is completed on all clients as soon after entry into care as possible and annually at the health maintenance visit. (D)

In FY03 the Teen Clinic in Manchester reported on 4 measures including the percent of adolescents receiving an annual health maintenance visit. The purpose of this measure is to enhance adolescent health by assuring recommended periodicity of adolescent well care. (IB)

### b. Current Activities

The BMCH continues to monitor the MCH contracted primary care agencies to assure adolescent specific health services are available and appropriate. In FY04 the program has continued to fund the provision of comprehensive teen health services to Manchester youth through the Teen Health Clinic. (D)

The Adolescent Health Strategic Plan was completed and has been sent for publication approval. Contained within the plan are clearly articulated rationale, background information and final recommendations on the need for responsive health care services for youth. The

Plan is scheduled to be disseminated in Summer 2004. (I,E)

### c. Plan for the Coming Year

The Title V funded Teen Clinic in Manchester will provide comprehensive screening and assessment services based on nationally recognized guidelines to adolescents in need of services, including those eligible for Medicaid. An adolescent-focused health risk assessment will be completed on all clients as soon after entry into care as possible and annually at the health maintenance visit. (D)

BMCH and SMSB staff will work together to ensure that all youth, including those with special health care needs receive the recommended periodicity of well care. (IB)

The Adolescent Health Program will develop and fully implement a grass roots Youth Advocacy Network and a web based community tool kit for communities and coalitions interested in creating youth health initiatives. These are the final activities completing the Adolescent Health Strategic Planning activities reported in prior years. (E,PB,IB)

*State Performance Measure 6: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester who had Medicaid as a payment source. (SPM #12)*

### a. Last Year's Accomplishments

The Prenatal Program utilized needs assessment information to guide strategic planning during FY 03 to further identify program priorities and areas for improvement. Priorities included: prenatal smoking cessation, first trimester prenatal care entry for the Medicaid and uninsured populations, and improving available data on the state's prenatal population to guide programming. (D)(E)

The BMCH is pilot testing electronic submission of prenatal client data. The BMCH has developed a plan to link this data electronically to the birth certificate data, which will streamline reporting efforts and allow greater population based evaluation of state and community efforts. This is a long term project and a data team from the bureau continues to work on the data plan. (I)

The BMCH funded 13 health agencies to provide comprehensive prenatal care to low income, uninsured and underinsured women. The scope of services specifies standards of medical care, voluntary HIV testing, health education, nutrition services, social services, substance abuse services, smoking cessation counseling, home visiting, staff qualifications, hiring of new personnel and data reporting requirements. These prenatal agencies provide a variety of enabling services to clients, which may include, but are not limited to: transportation, translation services, outreach, health education, case management services, and pre-certification for Medicaid eligibility. (E)

Collaborative efforts with the New Hampshire March of Dimes continued to focus on population based education on the importance of early prenatal care. (P)(E)

### b. Current Activities

BMCH-funded agencies continued to provide comprehensive prenatal care to low income, uninsured and underinsured women. (D, E)

BMCH-funded Prenatal Program Coordinators' meetings will continue on a biannual basis. These meetings provide a forum for Coordinators to network with their peers and discuss issues pertinent to prenatal care delivery. Topics covered included oral health, medicaid compliance in billing practices for support services, prenatal clinical guidelines development, and the development of performance workplans. (I,E)

Minority focus group information and a birth data report were completed in FY 03. This

information was synthesized and a report and presentation developed during FY04. This presentation will be utilized to provide a focal point in gathering community-based resources to initiate improvement measures in the City of Manchester in FY 05 (E, I)

A Performance Management Collaborative has been formed to create a comprehensive system of performance management across state and community systems. The collaborative is made up of MBCH staff and provider agency directors. (E, I)

### c. Plan for the Coming Year

BMCH-funded agencies will continue to provide comprehensive prenatal care to low income, uninsured and underinsured women. (D, E)

BMCH-funded Prenatal Program Coordinators' meetings will continue on a biannual basis.

These meetings provide a forum for Coordinators to network with their peers and discuss issues pertinent to prenatal care delivery. Topics to be covered at the FY 2005 meetings include: The 5A's model of prenatal smoking cessation; prematurity data and best practices; and performance management. (E)

The Prenatal Program will continue to explore options for implementing a PRAMS-like survey. The program's 2001 CDC application for PRAMS was approved but unfunded. The program is considering a one-time PRAMS survey for the City of Manchester in FY 2005. (P, I)

BMCH will collaborate with the NH March of Dimes on a state-wide campaign to increase awareness of the health impact of preterm births and to promote early prenatal care. ( P)

The BMCH will implement a system of performance management across all MCH contracted agencies. The BMCH will begin reporting on performance measures - both health status and infrastructure through a report card like format. (I)

Due to documented disparities in birth outcomes between the overall population and newly emerging ethnic and linguistic minority communities in the City of Manchester, the Bureau will utilize birth data and minority health reports to create a "Call to Action" among community based partners and healthcare providers. It is anticipated that stakeholders will be brought together to identify strategic action steps that may be taken to address healthcare access and birth outcomes in order to eliminate the existing health disparities. (I)

## State Performance Measure 7: *Percent of children ages 2-5 years enrolled on WIC whose Body Mass Index (BMI) for age is 95th percentile or greater. (SPM #16)*

### a. Last Year's Accomplishments

BMCH requested the 10 state funded primary care and 5 categorical child health direct care agencies to do BMI's on all children receiving preventive health care visits.

### b. Current Activities

The WIC Nutrition Consultant presented on childhood overweight/obesity and use of the BMI at the Fall'03 meeting of the Title V funded agencies' child health coordinators and distributed packets of the Pediatric Weight Management Tool Kit developed by a state committee. BMCH printed a new supply of growth charts for the Title V funded agencies that now includes the BMI chart for the 2-20 population. The Fall '03 packet of the Child Health Month Coalition included a handout on "Sip All Day, Gain Weight, Get Decay".

### c. Plan for the Coming Year

The Child Health Month Coalition is planning to include a handout for its Fall '04 mailing on Healthy lifestyle/exercise/preventing obesity. BMCH will collaborate with the NH DHHS Bureau of Health Promotion in any activities planned, that may include participation by the Title V funded agencies. BMCH will explore the possibility of including a performance measure to the

**State Performance Measure 8: *Percent of state contracted child care programs that receive a minimum of 1 hour per month on-site consultation services from a child care health consultant. (SPM #8)***

**a. Last Year's Accomplishments**

Healthy Child Care New Hampshire (HCCNH), in collaboration with the other New England states (HCCNE), developed a National Training Institute for Child Care Health Consultant (NTI)-based Child Care Health Consultation (CCHC) training curriculum. The project was piloted in February 2003 and consisted of individual state gatherings with interactive telecasts broadcast to the six New England audiences of over 80 CCHC. The four-day, CEU accredited, HCCNE CCHC Training Series was conducted in the summer of 2003. Nine NH professionals completed the training agreeing to provide volunteer child care health consultation and report data to measure outcomes aligned with the goals of Healthy People 2010. State contracted child care facilities have priority for utilizing the CCHC's services. (IB)

HCCNH held a meeting in June 2003 for representatives of NH schools of nursing. The purpose of this meeting was to explore integrating issues of health and safety in child care into nursing curriculum and to stimulate interest in schools of nursing becoming involved as trainers of CCHCs. Two institutions expressed interest. (IB)

HCCNH provided ongoing technical assistance electronically, by phone, on site and through written and audio resources to CCHC, child care providers and other health professionals. (D)  
HCCNH gave presentations to early childhood educators through multiple venues including the Child Development Bureau's Infant Toddler Series and the NH Child Care Resource and Referral Network (NHCCR&R). (D)

The Health and Safety Manual for New Hampshire Child Care Providers was completed by the BMCH and 80 copies were distributed to over 100 child care providers at a celebratory dinner co-sponsored by the NH Child Development Bureau and NH BMCH. (PB)

HCCNH collaborated with the State Fire Marshall to implement Risk Watch? Injury prevention training for child care providers through the NHCCR&R. (IB)

HCCNH project coordinator continues to participate in the state Child Care Advisory Council. The BMCH initiated quarterly meetings with the Chief of the Child Development Bureau. This partnership produced the June 2003 event that launched the Health and Safety Manual for New Hampshire Child Care Providers.

**b. Current Activities**

HCCNH contributed to the development and implementation of the New England Child Care Health Consultant Community of Practice website, <http://hccne.communityzero.com/hccne>. (IB)

Eight CCHC will complete the HCCNE four-day CCHC training series and are contracted to provide 4-6 hours/month consultation to child care providers. The placement process has been streamlined by partnering with the NHCCR&R. (IB)

In December 2003, HCCNH and Healthy Child Care Vermont co-sponsored a CCHC networking meeting and Adult Training Techniques workshop. (IB)

In May 2004, HCCNH co-sponsored a CCHC networking workshop with DHHS Immunization Program, piloting an Immunization training module from the companion trainers guide to the Health and Safety Manual for New Hampshire Child Care Providers. (IB)

HCCNH supplied 50 requests from child care providers for the Health and Safety Manual for New Hampshire Child Care Providers. (PB)

HCCNH continued to give presentations to child care providers and early childhood education students through the Child Development Bureau's Infant Toddler Series, the Child Care Resource and Referral Network, and the New Hampshire Technical Institute.(D)

In August 2003, HCCNH successfully transitioned from a program coordinated outside the state system by a consulting agency into a program embedded within the state Bureau of Maternal and Child Health and the program officially became aligned with other Early Childhood Comprehensive Systems (ECCS) activities and plans. This process formalized the relationship of the program with other child health activities, including ECCS. (IB) Partnership with DHHS immunization program led to an initiative to revise the annual child care immunization survey. (IB)

In June 2004, HCCNH will lead an initial meeting with DHHS departments with initiatives concerning lead, asthma, children with special health care needs, immunization, injury prevention, oral health and obesity to discuss integration and streamlining our efforts related to child care.

Collaboration with the State Fire Marshall's office resulted in implementing an injury prevention curriculum, Risk Watch?, into child care settings through the NHCCRR. (IB)

HCCNH Project Coordinator continues monthly board attendance on Governor's Child Care Advisory Council with a new appointment to Early Learning NH Advisory Board and the Manchester Child Care Advisory Council.

### c. Plan for the Coming Year

Plans for the coming year will reflect three focus areas: lack of availability of high quality child care environments and child care health consultants, lack of data, and lack of awareness. A high priority of HCCNH will be building and sustaining key partnerships in already existing community relationships.

HCCNH will strengthen the CCHC network by providing more technical support to the consultants. (D)

HCCNH will develop a plan to disseminate incentive matching funds to five selected CC providers for the purpose of evolving the role of the CCHC from volunteer to paid consultant. The child care center will agree to match HCCNH incentive funds with their own funds to pay the CCHC for their services. (IB)

Identification and outreach to professionals functioning as CCHC but without formalized training will occur through a survey of CC providers. These professionals will be encouraged to join the HCCNH trainings, workshops, and bi-annual networking meetings. (IB)

Funds from both HCCNH and ECCS have been set aside to support two faculty positions state schools of nursing to attend the National Training Center for Child Care Health Consultation. (IB)

The BMCH will explore how the CCHC role can become a priority activity for BMCH funded agencies in anticipation of new contract cycle beginning 2006. (IB)

HCCNH will provide ongoing professional health and safety trainings and technical assistance to child care providers and child care health consultants through presentations, phone consultation and provision of written and audio resources. Major efforts in this area are the following: support to Family Child Care Association of Early Learning NH concerning issues and events related to health and safety in child care; Coordination with Lakes Region Quality Matters to convene child care providers and CCHC for the purposes of using The Harms, Clifford and Cryer Early Childhood Environmental Rating Scales and Styles Iters and Eccers as a self-assessment tool for self improvement. (D) (IB)

The Health and Safety Manual for New Hampshire Child Care Providers will be made available on DHHS web site and its companion Trainer's Guide will be printed in Summer 2004. (PB)

HCCNH is developing a fact sheet to be included on the NH DHHS, BMCH web page. (PB)

The HCCNH will continue to strengthen existing partnerships with the following:

ECCS Partners: Healthy Child Care New England; Child Development Bureau; Bureau of Child Care Licensing; Bureau of Special Medical Services; Division of Developmental Services, Infant Toddler Program; New Hampshire Resource and Referral Network; Lakes Region Quality Matters; Early Learning New Hampshire; NH Pediatrics Society. (IB)

State Performance Measure 9: *Percent of high school students who smoked cigarettes during the past 30 days. (SPM #9)*

a. Last Year's Accomplishments

The Adolescent Health Program coordinated the State Youth Collaborative, a group consisting of state agencies whose programs impact youth, including representation from the Tobacco Prevention and Control Program. The group works to coordinate efforts to improve adolescent health. (IB)

BMCH-funded Primary Care and Teen clinics assessed smoking status in the adolescent population via comprehensive risk assessment activities and offer counseling and advice to quit as needed. (D,E)

The New Hampshire Tobacco Prevention and Control Program (TPCP) administers State Tobacco Settlement funds and has developed community coalitions addressing the prevention of smoking. All coalitions are required to include activities related to adolescent smoking. (P)(I)

b. Current Activities

Due to the vacancy of the Adolescent Health Coordinator position, core initiatives in progress were maintained but new initiatives were restricted. Thus the priorities under this initiative were the completion of the Adolescent Strategic Planning Project and the dissemination of the plan itself. Collaborations with other programs such as the Tobacco Control Program and the Adolescent Health Resource Center at the University of New Hampshire allowed completion of tobacco control initiatives reported below.

The Adolescent Health Program completed its Strategic Planning process. A written needs assessment for adolescent health including information on adolescent smoking, is a prominent section of the overall plan document. (E)(I)

The final strategic plan will be disseminated among all identified stakeholder groups including health care providers, school health representatives, and community coalitions in order to motivate broad based support for youth prevention efforts such as tobacco control initiatives. (I)

The Annual "Youth Network Opposing Tobacco" Conference was co-sponsored by the NH Tobacco Control Program. This conference brought legislators, youth, public health officials, and community leaders together for a day-long conference. Topics covered in the conference included; media (movies) effects on youth tobacco use, tobacco advertising tactics, women and tobacco use, and empowering youth through engagement in prevention initiatives. (I)(E)

c. Plan for the Coming Year

The Adolescent Health Program will continue to coordinate the State Youth Collaborative, a group consisting of state agencies whose programs impact youth, including representation from the Tobacco Prevention and Control Program. The group works to coordinate efforts to improve adolescent health. (I)

The Adolescent Health Program will be developing a teen advisory group to engage youth in the development of state programs and services. (I)

Adolescent Health Program staff will continue to participate in Youth Network Opposing Tobacco events and consult with the TPCP on youth activities. (D)(P)(I)

State Performance Measure 10: *Percent of third grade students with untreated decay. (SPM #10)*

a. Last Year's Accomplishments

The Oral Health Program added infrastructure with the state's support for the expansion of an

established school-based dental program in our largest city, Manchester. Children and adults received preventive and restorative treatment in 16 state funded community-based dental programs in schools, hospitals, and primary care health centers that provided enabling services to assure patient compliance in keeping appointments and following oral health recommendations. (IB, PBS, ES, DS)

The OHP collaborated with the Office of Health Planning and Medicaid on the improvement of the electronic database used to respond to Medicaid client inquiries for dental treatment placement. (IB, ES, DS)

In cooperation with the CDC chronic disease epidemiologist, OHP collected, analyzed, and added new data from 16 state funded programs to the statewide surveillance system. The OHP manager and the CDC epidemiologist presented the '02 data to hygienists from 15 school-based dental programs. (IB, ES, PBS,)

The OHP supported water fluoridation efforts while opponents pursued their court case challenging the 1999 voting process that fluoridated Manchester's water supply. (IB, PSB)

## b. Current Activities

In cooperation with the CDC chronic disease epidemiologist, OHP collected, analyzed, and added new data from 16 state-funded programs to the statewide surveillance system. The CDC epidemiologist and OHP manager presented the '03 data to hygienists from 16 school-based dental programs. (IB, ES, PBS)

The OHP collaborated with the CDC epidemiologist to publish New Hampshire Oral Health Data, 2003 reporting on all 8 national oral health indicators. (IB, PBS, ES)

The OHP has conducted the second Oral Health Survey of Third Grade Students using the ASTDD model to screen children for the percent of third grade children with untreated decay. (IB, ES, PBS, DS).

The OHP collaborated with the Endowment for Health to release the New Hampshire Oral Health Plan: A Framework for Action. The Implementation Subcommittee meets regularly to prioritize and implement the plan's recommendations to improve the oral health status of NH residents. (IB, PBS, ES)

The OHP has collaborated with the Endowment for Health to fund a year-long planning grant to develop a sustainable statewide sealant project and an applied research grant to analyze three strategies for financing and delivery of Medicaid oral health services. (IB, PBS, ES, DS).

The OHP has collaborated with NH Head Start to convene a statewide Head Start Oral Health Forum. In collaboration with New England dental directors and Region I administrators, the OHP will convene a regional Head Start Oral Health Forum in June '04.

Special Medical Services Bureau staff (McCann) participated in this Forum and the follow-up work group, to provide information about the needs of children with special health care needs, and to provide resources which can be utilized in the provision of training for dentists and hygienists, to provide care to this population. The OHP collaborated with Home Visiting New Hampshire to secure HRSA funds to support oral health activities in 19 HVNH programs. (IB, PBS, ES)

The OHP continues to support municipal water fluoridation in spite of the court's ruling against the regional distribution of fluoridated water without an affirmative vote by each affected community. (IB, PBS)

The Northeast Delta Dental (NEDD) program, a voluntary Medicaid Managed Care program with a prepaid dental benefit, was terminated. To compensate for the loss of the NEDD program, the new Dental Director implemented significant dental reimbursement increases and made personal contacts with established Medicaid providers and potential Medicaid provider enrollees. (IB, ES, PBS, DS)

## c. Plan for the Coming Year

The OHP anticipates that the Endowment for Health (EFH) will fund the implementation of the planned statewide sealant project that will increase the amount of protective sealants on NH's

high-risk children. (IB, PBS, ES, DS)

The OHP will collaborate with the CDC epidemiologist to publish the results of the second Oral Health Survey of Third Grade Students. (IB, PBS, ES)

The OHP will collaborate with EFH to implement the "Watch Your Mouth" oral health education and awareness campaign to increase public perception of the importance of good oral health as a component of overall health. (IB, ES, PBS)

The OHP will collaborate with the Area Health Education Centers (AHEC) to provide oral health trainings for prenatal medical providers to educate them about the transmission of oral disease between mothers and infants and the importance of good oral health for their high-risk patients.

In collaboration with the Medicaid program and the Endowment for Health, the OHP anticipates the opening of 3 new dental centers in CHC's (Strafford County, Berlin and Littleton), 2 new dental centers clinics in hospitals (Weeks and Alice Peck Day) and the expansion of two urban dental centers in Manchester and Nashua.

**FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET**

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of pediatricians who provide transition support to youth with special health care needs (YSHCN) enrolled in their practice. (SPM #13)				
1. Analyze the transition survey of NH pediatricians and develop a work plan to address their educational and technical assistance needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Develop and conduct a survey of NH adult health care providers regarding their current knowledge base and practice experience with YSHCN.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Identify a cohort of adult providers interested in providing care to transitioning YSHCN.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Assess structural and systemic factors that affect the relationship between pediatric practices and adult health care providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Focus on the education of families attending the Neuromotor and Spina Bifida Programs to prepare YSHCN for transition to adult care, utilizing their pediatric providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Apply for a Champions for Progress Incentive Award from the University of Utah to assist in implementing the educational and activities components of the Bureau's survey findings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) Percent of women statewide who smoked during pregnancy. (SPM #2)				
1. Training on the Five A's cessation model continues within public health				

centers and hospitals.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. The New Hampshire Perinatal 2010 Committee has chosen an objective targeting a reduction of smoking in pregnant women.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) The rate (per 100,000) of emergency department visits among youths aged 15-19 resulting from being an occupant in a motor vehicle crash. (SPM #14)				
1. Monitor data trends in adolescent motor vehicle injuries.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue Buckle UP NH teen driver component.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Seek new partners for the Teen Motor Vehicle Legislation Committee to explore legislative options.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue to participate in the Intersections Project which will be hosting a conference looking at medical fitness guidelines for driving.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) Percent of children age two (18-29 months) on Medicaid who have been tested for lead. (SPM #11)				
1. Continue collaboration with NH Childhood Lead Poisoning Prevention Program (CLPPP) on sharing information, policy changes, Q/I results, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue monitoring required performance measure on child health direct and primary care agency workplans.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue CDC-funded lead case management at one high risk MCH contract agency.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Continue lead screening requirement of 1 and 2 yr. Olds in MCH funded child health direct and primary care agencies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue participation in CLPPP Advisory and Medical Consultant groups.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

6. Continue monitoring contract agency lead screening, tracking and follow up of abnormal results at site visits.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Continue training by CLPPP to MCH Home Visiting agencies and HCCNH child health care consultants.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percent of adolescents (ages 10-20) eligible for an EPSDT service who received an EPSDT service during the past year. (SPM #15)				
1. Adolescent lifecycle reviews at primary care centers throughout NH.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Sub-contract adolescent health services to Manchester Teen Clinic.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Continue monitoring performance measures at Teen Clinic.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester who had Medicaid as a payment source. (SPM #12)				
1. Efforts continue with the NH March of Dimes promoting the importance of early prenatal care.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Refine data collection, analysis, and planning for full linkage into the NH birth files.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue funding agencies to provide prenatal care to low income, uninsured and underinsured women.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percent of children ages 2-5 years enrolled on WIC whose Body Mass Index (BMI) for age is 95th percentile or greater. (SPM #16)				
1. Continue collaboration with Bureau of Health Promotion/WIC Program on childhood obesity education activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Monitor Title V child health direct and primary care agencies? use of BMI charts at site visits.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Disseminate fall 2004 Child Health Month handouts related to preventing childhood obesity .	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Explore adding a performance measure to the Title V funded agencies? required workplan on use of the BMI in its pediatric charts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) Percent of state contracted child care programs that receive a minimum of 1 hour per month on-site consultation services from a child care health consultant. (SPM #8)				
1. Provide child care health and safety consultation trainings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Disseminate electronic newsletter to child care health consultants.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Facilitate bi-annual meetings for child care health consultants and Head Start Health Managers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provide materials, telephone and onsite consultation to child care health consultants.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Provide materials, telephone and onsite consultation to child care programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Provide information and support materials to private/public child care agencies and organization.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Work with NH schools of nursing to implement NTI based training on CCHC role into their curricula.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Work with ECCS project.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Continue partnerships with DHHS Public Health Programs that provide resources to child care facilities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of high school students who smoked cigarettes during the past 30 days. (SPM #9)				

1. Continue monitoring and evaluation of clinical assessment and referrals.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Collaboration on local tobacco sales enforcement efforts.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Development of a data system linking data sets with relevant adolescent health indicators.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Pyramid Level of Service</b>			
<b>STATE PERFORMANCE MEASURE</b>	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
10) Percent of third grade students with untreated decay. (SPM #10)				
1. OHP and Medicaid will continue to collaborate to find treatment for clients.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Collaborating with Medicaid and EFH, the OHP will open new dental centers at 3 community health centers (Rochester, Berlin and Littleton) 2 hospitals (Lebanon, Lancaster) and expand facilities at urban dental centers in Manchester and Nashua.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. The OHP will collaborate with EFH to implement a sustainable statewide sealant program for third grade students.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. In collaboration with EFH, the OHP will implement the "Watch Your Mouth" oral health awareness/education campaign to increase public perception of the importance of good oral health as a component of overall health.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Collaborating with FH, the OHP will integrate oral assessment into medical care by educating providers, patients, and parents while initiating the aggressive use of evidence-based preventive interventions.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. In collaboration with EFH, the OHP will evaluate the oral health workforce to make recommendations for meeting the evolving needs and demands of the population.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7. The OHP will complete the second Oral Health Survey of Third Grade Students using the ASTDD model to monitor the oral health status of NH children.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
8. The OHP will publish the fourth NH Oral Health Data, 2004 reporting on all 8 national oral health indicators.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## E. OTHER PROGRAM ACTIVITIES

In addition to previously mentioned activities, the following come under the purview of New Hampshire's Title V program:

Preschool Vision and Hearing Screening: Program staff and trained community volunteers provide services and follow-up for preschool children statewide, targeting low-income families without easy access to affordable health care services. Technical assistance and coordination of services are being provided to primary care centers to reduce duplication of services. /2003/The Preschool Vision and Hearing Program will revise processes to comply with HIPAA requirements during the upcoming year.

/2002/Neural Tube Defect (NTD) Tracking System: Through a CDC cooperative agreement, the BMCH and WIC Nutrition Services are collaborating on the development of a NTD Tracking System. The system presently identifies affected infants through birth certificate data on an ongoing basis, so that mothers of affected infants can then be counseled about folic acid use to prevent further occurrences. Collaboration with the SMSB Spina Bifida Program will assure that affected infants are appropriately linked with supportive services as early as possible.

/2003/New Hampshire Birth Defects Monitoring & Prevention Program: Dartmouth Hitchcock Medical Center was awarded the CDC cooperative agreement, in March 2002, to: establish a high quality, statewide, active, comprehensive birth defect surveillance system; expand NH folic acid education and birth defect prevention activities; and, improve access to health care and early intervention services for infants with birth defects. The MCH and CSHCN program directors will be active members of the project's Advisory Council. The CSHCN program will develop policies and procedures related to access and provide care coordination for all referred infants, in conjunction with the NH Early Supports and Services Program (Part C).

/2004/New Hampshire Birth Defects Monitoring and Prevention Program: the SMSB (Butler) has been working on the third part of the CDC grant, to improve access to health care and early intervention services for infants with birth defects. Written materials are to be designed for NH patients and providers, outlining the Program as well as how the families will be contacted regarding care coordination services provided by SMSB.

Administrative Rules Development: BMCH is revising its Administrative Rules. New Hampshire Administrative Rules describe the responsibilities and required activities for external agencies with regard to State law. BMCH rules will address processes of the SIDS, PSVH, and Newborn Metabolic Screening programs, as well as UNHSP data reporting requirements for hospitals.

Family Resource Connection (FRC): BMCH contributes to braided funding for this information clearinghouse for CSHCN and their families, administered through the New Hampshire State Library. Begun in 1998, use of the FRC has tripled over the past 5 years. In 2002, the program received 3,452 inquiries and 3,398 circulation requests. While 74% of inquiries related to disabilities, other requests included information on parenting, education, child care, health, and social welfare.

"Bringing Children Home" is a grant-funded project of the Visiting Nurse Association Health System of Northern New England, Inc. The goal is to develop a new pediatric care delivery model to bridge the gap between inpatient pediatric care and home. SMSB staff (Landry) sits on the advisory committee, informing the group of services and resources available through SMSB and the State of NH, to help meet the growing demand for pediatric home care services.

SMSB staff (Cahill, McCann) attend Office of Community and Public Health Bioterrorism briefings. Briefings in FY03 included preparedness for mothers and children regarding biological threats, as well as bibliographic resources for preparing for and caring for the needs of CSHCN in such an event.//2004//

***/2005/Safe Sleeping Educational Efforts: The BMCH Child Health Nurse Consultant/SIDS Program Coordinator now includes safe sleeping information in all workshops, meetings, and presentations that previously contained only SIDS risk reduction information as a result of the increasing infant deaths in NH involving bedsharing. A statewide mailing on safe sleeping is planned for Fall 2004 to all health providers of new and expectant parents as an anticipated***

**recommendation from the June Child Fatality Review Committee meeting which will focus on infant bedsharing deaths.**

**SIDS National Data Base: The NH SIDS Program will be participating in the data collection of the national "SIDS in Child Care Setting" study through the Children's National Medical Center in 2004.**

**Healthy NH 2010 MCH Workgroup: BMCH staff is co-chairing a workgroup, with the Director of the NH March of Dimes, to develop and monitor action steps supporting the 5 MCH Performance Measures identified in Healthy People NH 2010.**

**NH Children's Trust Fund (CTF) Performance & Evaluation Committee: The MCH Child Health Nurse Consultant, a board member of the NH CTF, is chairing this committee which includes developing a QI plan, revising the grant proposal application, and related activities.**

**The Injury Prevention Program is the state liaison with the Consumer Product Safety Commission. As such, the program raises awareness of product safety through information and compliance programs throughout the state of New Hampshire.//2005//**

## STATE TOLL-FREE NUMBER

The State maintains a toll-free number for all DHHS services. This computerized, menu-driven system links callers directly with the program area best qualified to respond to their question. Operator backup is included, for those needing operator assistance, and hearing impaired persons can utilize TTY/TDD Relay. Several regionalized information and referral systems supplement the State toll-free number. The CSHCN program maintains its own telephone line for information and referral and supports the toll-free number provided through Family Voices. **/2005/Help lines for CSHCN processed approximately 2200 calls in calendar 03. Inquiries are also responded to through the State's web-based information system for NH DHHS.//2005//**

## F. TECHNICAL ASSISTANCE

/2004/BMCH plans to request the following technical assistance during the coming year:

### I. Funding Allocation & Funding Formula Development

Why assistance is needed: The BMCH allocates funds to programs and community agencies based primarily on historical funding levels. The previous formula for funding allocations was developed prior to 1995 and centered on regional levels of children in poverty and prenatal health data at that time. Subsequently, many changes have occurred in New Hampshire's health care delivery system, such as the development of community health centers in several areas of the state, changes in geographical service areas, and achievement of FQHC status for five agencies. Technical assistance is required to assist with the following activities:

- ? Review current Title V funding allocations as they relate to federal MCHB priorities, specifically direct, enabling, population-based, and infrastructure services provided by the Title V program.
- ? Provide information and instruction on principles of funding formula development in public health programs to BMCH, Family Planning Program and Bureau of Rural Health and Primary Care staff.
- ? Assist the BMCH in identifying factors likely to impact state and community level programs' funding needs, such as regional poverty levels, population density, performance measures and health outcomes.
- ? Assist the BMCH in developing a proposed funding formula for contract agencies that reflects Title V priorities and communities' needs.

Developing a funding allocation strategy and funding formula for BMCH contract agencies providing direct care and enabling services will assist the Bureau to:

1. Plan effectively and economically for population-based and infrastructure services provided by the Title V program
2. Assure an equitable and evidence-based distribution of Title V funds; and
3. Move the BMCH further towards a performance-based contracting system.

## II. Youth Development Integration

Why assistance is needed: The BMCH currently lacks the capacity to adequately measure how well the programs and services we support impact youth development. Further, programs across the NH DHHS lack common language and focus with regard to youth focused programming. Technical assistance is required to assist with the following activities:

- ? Within the BMCH and Bureau of Rural Health and Primary Care, develop youth development language for RFPs and contract Scopes of Services to ensure delegate agencies address these concerns within workplans.
- ? Develop outcome and performance measures reflecting youth development language, including how to assess development in clinical chart reviews.
- ? Assist the BMCH in discussions with the State Youth Collaborative (SYC), an inter-agency working group whose members represent DHHS programs that impact youth, to develop common youth development language for all DHHS contracts.
- ? Assist the BMCH and SYC in developing common outcome and performance measures reflecting youth development language.

Developing common youth development language for BMCH and DHHS contracts will assist the Bureau to:

1. Institute a new adolescent-focused Title V state-negotiated performance measure;
2. Leverage the NH YRBS to include protective as well as risk factor questions;
3. Enable contract agencies to report on new and potentially more useful outcomes; and
4. Move the NH DHHS towards a more coordinated system of adolescent health programming that reflects current best practice knowledge.

Who could help: The National Adolescent Health Information Center; the Konopka Institute for Best Practices in Adolescent Health; the state of Iowa; the state of Alaska; the state of Maine; the Rochester Evaluation of Asset Development for Youth (READY); RMC Research, developers of the Compendium of Assessment and Research Tools for Measuring Education and Youth Development Outcomes (CART).//2004//

## III. Injury Prevention Best Practices

Why assistance is needed: While there are many environmental and regulatory strategies known to be effective in reducing unintentional injuries, such as the use of child passenger safety seats and helmets during a variety of sports, much less is known about how to increase adoption of long-term behavioral changes among those at-risk. The Injury Prevention Program is committed to theory-based educational activities, utilizing theories such as the health belief model, stages of change, and peer diffusion. Technical assistance is requested to assist the Program in identifying educational strategies, programs, curricula, and materials that utilize these theoretical models, and have been proven to be effective, resulting in an increase in consumers' adoption and maintenance of health-protective behaviors.

Technical assistance is requested to conduct a literature review and develop best practices recommendations to:

- ? Increase adoption of long-term behavioral changes among those at-risk for unintentional injury
- ? Utilize theories such as the health belief model, stages of change, and peer diffusion in injury prevention programming
- ? Identify educational strategies, programs, curricula, and materials that utilize these theoretical models, and have been proven to be effective, resulting in an increase in consumers' adoption and

maintenance of health-protective behaviors.

/2004/Who could help: Dr. Carolyn Fowler, Johns Hopkins School of Public Health; University of Alabama School of Public Health

#### IV. Oral Health Educator Role

Why assistance is needed: Dental care in this country is provided by private and safety net systems of care, independent of medical primary care systems. As a result, children who are followed for their primary medical care typically do not have oral health issues addressed by their care provider. One of the greatest challenges in improving oral health is better coordination of medical and dental systems of care. In NH, a pilot project is educating physicians about oral health by training pediatricians and family physicians to screen young children for dental disease and make referrals to local dentists for treatment. However, professional boundaries, time, and attitudes are barriers to accessing dental treatment for young children in need.

A dental hygienist called an Oral Health Educator could facilitate cooperation between the medical and dental professions to improve the oral health of young children. In medical offices, Oral Health Educators can teach physicians about screening young children for dental disease and counsel parents about behaviors that promote dental disease as well as encourage feeding and nutritional practices that can assure a lifetime of oral health. Using established relationships with local dentists, Oral Health Educators can refer families with young children for dental treatment and educate dental professionals in their offices about how to manage young children.

Technical assistance is required to assist with the following activities:

- ? Conduct a literature review for examples of the Oral Health Educator role in other states
- ? Develop a formal job description for the Oral Health Educator
- ? Develop protocols for incorporating the Oral Health Educator role into medical practices
- ? Develop a marketing plan for such a position to improve acceptance by both medical and dental professions

Who could help: Dr. Burton Edelstein, Director of The Children's Dental Health Project in Washington, DC. He has recently released a white paper, "The Interface Between Medicine and Dentistry in Meeting the Oral Health Needs of Young Children"; Early Head Start Programs that have difficulty accessing oral health care for their 0-3 population; Home Visiting programs that incorporate oral health into a curriculum for high-risk pregnant women.

SMSB plans to request the following technical assistance during the coming year:

#### V. Transition for Youth with Special Health Care Needs (YSHCN)

SMSB is requesting technical assistance and consultation from a state comparable to New Hampshire and state/national experts, to develop a statewide strategic plan for enhancing the delivery of transition-related services to New Hampshire YSHCN, including but not limited to:

1. The transition of youth from pediatric health care to adult health care.
2. Healthy and Ready to Work programs/SSI issues.

This request is in accord with National Performance Measures #4 and 6, State Performance Measure #13, State Priority #7, and Health Systems Capacity Indicator #8.

#### VI. Care Coordination & Medical Home Infrastructure

Enhancing the ability to build the statewide infrastructure for care coordination and medical home, including, but not limited to:

1. Applied research regarding process and outcomes, and
2. Data capacity for measures and strategies to support meeting the cost of care coordination,

primarily through developing the adequacy of insurance coverage.

This request is in accord with National Performance Measures #3, #4, and #5.//2004//

***/2005/ Special Medical Services Bureau did not receive the technical assistance requested in V.1.,2. and VI.1.,2. above during FY04, and is re-submitting the request for FY05, with some changes in the suggested providers.//2005//***

## V. BUDGET NARRATIVE

### A. EXPENDITURES

#### SIGNIFICANT EXPENDITURE VARIATIONS APPEARING ON FORMS 3-5

/2004/For the purpose of this application, "significant expenditure variation" is defined as an expended amount in any line item that is greater than 10% above or below the budgeted amount for that year. The following lines on Forms 3-5 adhere to this criterion:

Form 3:

No expended amounts shown for FY 2002 were greater than 10% of the budgeted amounts. However, expended State funds were 4.3%, or \$183,232, greater than budgeted amounts for FY 2002 due in part to relocation of NH Newborn Screening Program costs into the BMCH Appropriation Code in that year.

Form 4:

Lines Ic, Ie, and If: Expended amounts for "Children 1 to 22 years old", "Others", and "Administration" in FY 2002 were greater than budgeted amounts by 20.7%, 12.2%, and 13.9% respectively due to a revised, more accurate method of calculating all expenditures by types of individuals served, used for the first time in this application.

*/2005/*

**Form 5:**

***Expended amounts in Lines I-IV differ more than 10% from budgeted amounts for FY 2002 as a direct result of the implementation of a more accurate methodology for determining these amounts by types of services, used for the first time in this application.***

***A new procedure for determining Title V expenditures is being developed. New Hampshire implemented a Job Code system in 2000. Assignment of job codes permits calculation of expenditures in a more detailed fashion than was previously feasible. For Title V Block Grant reporting, additional job codes are being created that will identify expenditures by the types of services specified on Form 5.***

***All expenditures, including personnel, supplies, equipment, and contractual, will use job codes reflecting classification as direct health care, enabling, population-based or infrastructure building expenses. This will allow for further accuracy in reporting expenditures on Form 5. The new job codes are anticipated to go into effect for FY 2004.***

***Unfortunately, limited job codes are permitted under the NH system, prohibiting the creation of enough codes to also classify expenditures by types of individuals served for Form 4. Those expenditures will continue to be calculated by formula applied to expenditure reports according to line item.//2004//***

### B. BUDGET

#### /2004/HOW FEDERAL SUPPORT COMPLEMENTS THE STATE'S TOTAL EFFORTS

Federal support is essential to the preservation of a comprehensive Title V program in New Hampshire. The Title V Maintenance of Effort and required match help assure a basic funding level for state and local maternal and child health programs. During times of necessary fiscal constraint, difficult decisions must be made about decreasing or eliminating programs and services. In these situations, Title V block grant dollars work to remind all states of the importance of funding MCH activities.

Aside from State funds, other monies are also leveraged by these Federal dollars for MCH services at

both the state and community levels. For example, Title V dollars help fund the New Hampshire Family Resource Connection, a clearinghouse and library service, administered by the State Library on issues related to CSHCN. For this initiative, these \$5,000 BMCH dollars are combined with an additional \$106,000 in Child Care Development Fund, Department of Education, Division of Behavioral Health, Division of Developmental Services, and Division of Children, Youth, and Families dollars to fund the project. Another example of the leveraging power of Title V funds is the strategic planning process for statewide dental sealant services. BMCH funds for this project (\$15,000) are leveraging additional monies from New Hampshire's Endowment for Health, a foundation created by the sale of the non-profit New Hampshire Blue Cross/Blue Shield, and will likely result in additional funding in future years.

At the community level, Title V dollars help fund numerous local agencies and projects that provide a wide variety of services to MCH populations. In these communities, Title V dollars also help leverage funds from municipalities, businesses and private foundations to serve the Title V mission. Often, simply the fact that an agency contracts with BMCH gives them increased credibility with other funders and an increased ability to leverage funds from small, community foundations, the United Way, or fundraising efforts.

#### AMOUNTS UTILIZED IN COMPLIANCE WITH THE 30%-30% REQUIREMENTS

As shown on Form 2, New Hampshire complies with Federal 30%-30% requirements. Services for CSHCN are provided through the SMSB; \$901,676, or 42.42% of New Hampshire's Title V allocation, is appropriated to the SMSB budget for FY 2004. Preventive and primary care services for children are provided through the BMCH; costs include direct care and support services through contracts with community agencies, Preschool Vision and Hearing and Adolescent Health program costs, and infrastructure costs for all BMCH children's services. The total of \$895,559, the amount projected for FY 2004, is 42.13% of the Title V allocation.

#### HOW ADMINISTRATION & MAINTENANCE OF EFFORT ARE MAINTAINED

Administration: This amount is projected using calculations from prior years' cost allocation reports on a specific job code that identifies administrative expenses required to carry out this grant.

Maintenance of Effort: The Title V Block Grant Maintenance of Effort requirement is one factor considered when planning the BMCH and SMSB budgets. The budget development process includes incorporation of the Title V Maintenance of Effort amount in calculating appropriation requests.

#### ACHIEVEMENT OF REQUIRED MATCH

The required State match for Federal Title V dollars is achieved through State appropriations to the BMCH and SMSB budgets. All State funds are appropriations from the New Hampshire General Fund. The State budget is determined by a legislative and gubernatorial process on a biennial basis. The budget development phase involves formulating specific line item requests within BMCH and SMSB appropriation codes. For example, most BMCH personnel costs are a combination of Federal Title V and State General Fund dollars. Similarly, most equipment, supply, travel and contractual line items are shared between Federal and General Fund allocations. Once the Biennium Budget has been approved, the exact Title V match can be determined.

New Hampshire is currently operating under a Continuing Resolution effective for 90 days into SFY 2004. For the purpose of this application, NH House budget figures were used to calculate budget amounts for FY 2004. New Hampshire's projected combined State General Fund appropriation to BMCH and SMSB for FY 2004 of \$5,917,012 is 278% of the FY 2004 Title V allocation of \$2,125,512. //2004//

#### STATE MAINTENANCE OF EFFORT & STATE FUNDS USED

New Hampshire continues to exceed the Maintenance of Effort requirement. The state FY89 Maintenance of Effort {Sec. 505(a)(4)} of \$2,872,257 is compared to the projected FY 2004 Title V budget of \$8,042,524, of which \$5,917,012 is from State General Funds.

#### SOURCES OF OTHER FEDERAL MCH DOLLARS, STATE MATCHING FUNDS & OTHER STATE FUNDS USED TO PROVIDE THE TITLE V PROGRAM

Sources of other Federal dollars, as indicated on Form 2, include grants from the Maternal and Child Health Bureau (MCHB) and other Federal agencies. Only MCHB grants are discussed below:

SSDI Grant: \$100,000

These funds are used for the MCH Data Linkages Project, which is addressing New Hampshire's capacity to improve performance on Health Systems Capacity Indicator #09A.

Abstinence Education Grant: \$96,930

These funds are being used to conduct a targeted media campaign using an abstinence message and community grants to implement abstinence curricula.

Universal Newborn Hearing Screening Grant: \$100,229

These funds are used to establish New Hampshire's universal newborn hearing screening program, including implementation of quality assurance standards and a data-tracking initiative.

/2004/Transitioning Healthy Child Care America 2000 Grant: \$20,833

These funds will be used to bring the Healthy Child Care New Hampshire (HCCNH) program, previously under the rubric of an external agency, within the BMCH in order to integrate HCCNH priorities with those of the Early Childhood Comprehensive Systems initiative.

ECCS Grant, CISS Program: \$100,000

This grant, if awarded, will fund a strategic planning project in the area of early childhood comprehensive systems. Planning will take place over two years within the context of the five focus areas highlighted in the MCHB Strategic Plan for Early Childhood.

All State matching funds, as indicated on Form 2 and explained previously in Achievement of Required Match, are appropriated from the New Hampshire General Fund during the State's biennium budget process.

Due to the configuration of New Hampshire's public health infrastructure and its system of contracting with local agencies to provide MCH services, there are no sources of ?Local MCH? or ? Other State? funds included in the BMCH or SMSB appropriations, as indicated on Form 2./2004//

#### SIGNIFICANT BUDGET VARIATIONS FROM FORMS 3-5

One budget variation on Form 3 requires special mention. The amount of Unobligated Balance estimated in #2 increased from \$52,633 in FY 2002 to \$194,969 for FY 2003. This is partly due to revision of the method of calculating the Unobligated Balance for the FY 2003 budget compared to prior years, and partly due to budgeting Title V carryover funds in Federal budget forms, yet not actually requesting and accepting these carryover funds into the New Hampshire budget in recent years. New Hampshire's Title V program will attempt to correct this over the next year.

/2004/For the purpose of this application, ?significant budget variation? is defined as an increase or decrease in any budgeted line item that is greater than 10% from the budgeted item in the previous year. The following lines on Forms 3- 5 adhere to this criterion:

Form 3:

Line 2: The decrease in ?Unobligated Balance? from \$194,969 in FY 2003 to \$0 for FY 2004

represents an acceptance of Title V funds into the SFY 2003 budget. Although unobligated Title V allotments for a fiscal year remain available for obligation during the next fiscal year from the federal viewpoint, such funds must be accepted into the State budget through a fiscal request approved by New Hampshire's Governor & Executive Council in order to be expended.

Line 3: The increase in "State funds" of 40% is due to the increased allocation of \$1.1 million in State funds to the Community Health Centers and the effect of a reorganization that moved Injury Prevention Program costs back into the BMCH as of SFY 2004.//2004//

Line 8: The increase in "Other Federal Funds" is due to relocation of Injury Prevention Program grants from CDC, which accounts for an additional \$230,457 in Federal funds, the Healthy Child Care grant at \$50,000, and the possible ECCS grant at \$100,000. New Hampshire's previous CISS grant of \$50,000 ended in FY 2003.

Form 4:

Lines Ia-Ic, Ie, and If: Budgeted amounts for "Pregnant Women?", "Infants < 1 year old?", "Children 1 to 22 years old?", "Others?", and "Administration?" in FY2004 were greater than FY2002 budgeted amounts by 19%, 46%, 64%, 61%, and 18.8%, respectively. This is in part due to the increase in State funding for community health centers of \$1.1 million anticipated for SFY04 and in part due to a revised, more accurate method of calculating these amounts by types of individuals served, used for the first time in this application.

Line IIc: The increase in budgeted CISS funds is due to the possible ECCS grant, if awarded.

Line IId: The increase in budgeted Abstinence Education funds is due to the refiguring of the funding allocation for that grant.

Line IIi: The increase in budgeted CDC funds is due to the Rape Prevention Education Grant (\$181,572), and the Violence Against Women grant (\$48,885), which fund Injury Prevention Program activities, and the Early Hearing Detection and Intervention grant (\$148,579), which funds the development of a data tracking system for the Universal Newborn Hearing Screening Program.

Line II.k: The increase in Other Federal funds is due to the Healthy Child Care NH grant.

Form 5:

Budgeted amounts in Lines I-IV for FY 2004 differ more than 10% from budgeted amounts for FY 2002. This is in part due to the increase in State funding for community health centers of \$1.1 million anticipated for SFY04 and is also a direct result of the implementation of a more accurate methodology for determining these amounts by types of services, used for the first time in this application.//2004//

## **VI. REPORTING FORMS-GENERAL INFORMATION**

Please refer to Forms 2-21, completed by the state as part of its online application.

## **VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS**

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## **VIII. GLOSSARY**

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## **IX. TECHNICAL NOTE**

Please refer to Section IX of the Guidance.

## **X. APPENDICES AND STATE SUPPORTING DOCUMENTS**

### **A. NEEDS ASSESSMENT**

Please refer to Section II attachments, if provided.

### **B. ALL REPORTING FORMS**

Please refer to Forms 2-21 completed as part of the online application.

### **C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS**

Please refer to Section III, C "Organizational Structure".

### **D. ANNUAL REPORT DATA**

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.